Boards in Common Meeting in Public Agenda

Date: 8 October 2026
Time: 0930-1230hrs
Venue: **Shropshire Education & Conference Centre (SECC), Royal Shrewsbury Hospital**
Chair: Mr Andrew Morgan, Group Chair

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930 hrs	076/26	Welcome, and apologies	Verbal	-	Group Chair	Noting
	077/26	Staff Story	Enc	**3**	Group CPO	Noting
	078/26	Public Questions	Verbal	-	Group Chair	Noting
	079/26	Noting of Quorum for each Board	Verbal	-	Group Chair	Noting
	080/26	Declarations of conflicts of interest	Verbal	-	Group Chair	Noting
	081/26	Minutes of previous meeting in public 13/8/26	Enc	**6**	Group Chair	Approval
	082/26	Action Log *(No current/outstanding actions)*	Verbal	-	Group Chair	Information
	083/26	Matters arising from previous minutes *(not covered on today's agenda)*	Verbal	-	Group Chair	Discussion
1000 hrs	092/26	**Out of turn item –** SaTH Integrated Maternity & Neonatal Report	Enc	**Page 200 of pack**	Group CNO	Assurance
Reports from the Group Chair and Group Chief Executive						
1015 hrs	084/26	Report from the Group Chair	Verbal	-	Group Chair	Noting
	085/26	Report from the Group Chief Executive	Enc	**25**	Group Chief Executive	Noting
Board Committee Reports						
1030 hrs	086/26	**SCHT:** a. Activity Reports from NEDs b. Resource & Perf Committee Report (Aug 26, inc a verbal report on Sept meeting) c. ***To Note**: The Quality & Safety Committees of SCHT & SaTH have now merged into a new Group 'Quality Committees in Common' – see agenda item 088/26*	Verbal Enc	- **35**	All NEDs NED Chair	Noting
	087/26	**SaTH:** a. Performance Ass Committee Report b. Finance Assurance Committee Report c. Audit & Risk Assurance Committee Report	Encs	**38** **40** **42**	NED Chair NED Chair NED Chair	Noting

	088/26	**Group:** a. Local Care Transformation Assurance Committee Report b. Quality Committee in Common Report	Enc Enc	**45** **47**	NED Chair NED Chair	Noting
		SHORT BREAK				
Strategic, Performance, Financial & Operational Reporting						
1115 hrs	089/26	Integrated Performance Reports **a. SCHT** **b. SaTH**	Encs	**50** **67**	CFO/D.CEO SCHT **(a)** Group Chief Executive **(b)**	Noting
Assurance Framework						
1130 Hrs	090/26	**Group** Winter Plan 2026/27	Enc	**159**	Group COO	Noting
	091/26	**SaTH** Integrated Improvement Plan (SIIP) Monthly Update Report	Enc	**196**	Group Chief Executive	Noting
	092/26	***Item taken earlier in meeting -*** ~~**SaTH** Integrated Maternity & Neonatal Report~~	~~Enc~~	**200**	~~Group CNO~~	~~Assurance~~
	093/26	**SaTH** Board Maternity & Neonatal Safety Champions Reports Aug & Sept 2026	Enc	**213**	Group CMO	Assurance
	094/26	**SaTH** Risk Management Report Q1 2026/27	Enc	**218**	*Group CGO	Noting
	095/26	**SaTH** Board Assurance Framework Q2 26/27	Enc	**227**	*Group CGO	Approval
Regulatory and Statutory Reporting						
1145 hrs	096/26	Group Infection Prevention & Control Report	Enc	**251**	Group CNO	Approval
	097/26	Group Patient Safety Committee Report	Enc	**301**	Group CMO	Assurance
	098/26	Guardian of Safe Working Report	Enc	**308**	Group CMO	Assurance
Board Governance						
1205 hrs	099/26	NED & Board Committee Matters	Verbal	**-**	Group Chair	Noting
	100/26	Quality Committees in Common Terms of Reference	Enc	**311**	*Group CGO	Approval
	101/26	Board Member Conflicts of Interests Report – SaTH & SCHT	Encs	**318**	*Group CGO	Review
Items for Consent – approval recommended by Board Committees						
1215 hrs	102/26	**SaTH** Freedom to Speak Up/Whistleblowing Policy	Enc	**327**	*Group CGO	Approval
Procedural Items						
1220 hrs	103/26	Any other Business – agreed by the Chair	Verbal	-	Group Chair	Discussion
	104/26	Date of next meeting of Boards in Common in public: 10 December 2026 **(at SECC, RSH)**	Verbal	-	Group Chair	Noting
Close of meeting						

**Non-voting*

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Executive Lead**	**Page No**
01 089/26a **SCHT** Int Performance Report Appx 4 Exception Action Plans	Chief Finance Officer	1
02 091/26 **SaTH** IIP Report – Appendices 1-4	Group Chief Executive	51
03 092/26 **SaTH** Int Mat & Neonatal Report – Appendices 1-11	Group Chief Nursing Officer	79
04 SaTH Annual Safeguarding Report 2025/26	Group Chief Nursing Officer	233
05 SaTH Infection Prevention & Control Annual Report 2025/26	Group Chief Nursing Officer	255
06 SaTH Security Annual Report 2025/26	Group Chief Operating Officer	321

Board of Directors' Meeting in Common: 8 October 2026

Agenda item	077/26		
Report Title	Investing in Our Workforce to Improve Outcomes for Young Families – Anne's Story		
Executive Lead	Rhia Boyode, Group Chief People Officer		
Report Author	Sabeena Khanna, Associate Director of Transformation & BP Ruth Smith, Lead for Patient Experience		
Prior Consultation:	**CQC Domain:**		**Link to BAF id(s)**
	Safe		BAF1, BAF2
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	Anne's staff story demonstrates the critical link between workforce wellbeing, professional development and improved outcomes for children, young people and families. Through strong leadership and the effective implementation of the Family Nurse Partnership programme licence, including structured clinical supervision, reflective practice and a culture of continuous learning. Anne has developed a resilient, motivated, and highly skilled Family Nurse Partnership team. By prioritising staff wellbeing and professional growth, she has created an environment where staff feel valued, supported and empowered to deliver high quality, evidence based and trauma informed care. This investment in the workforce enables the team to provide effective support to vulnerable first-time young parents, strengthening family resilience, increasing parental confidence and improving long term outcomes for both parents and their children.		
Recommendations for the Board	The Board is asked to: 1. Note Anne's story as an example of how investment in workforce wellbeing, supervision and professional development supports improved outcomes for service users and communities. 2. Recognise the contribution of specialist services such as the Family Nurse Partnership in delivering preventative, trauma-informed interventions that improve long-term health and wellbeing outcomes for vulnerable families. **3.** Support the continued focus on staff wellbeing, reflective practice and workforce development as key enablers of high-quality, sustainable service delivery across the Group.		
Appendices:	N/A		

1.0 Introduction

1.1 As Team Leader for the Family Nurse Partnership (FNP) service, Anne Griffiths leads a specialist team supporting vulnerable young parents from pregnancy until their child reaches two years of age. Working with first-time parents aged 19 and under, and some vulnerable young adults up to age 25, the service helps families improve health, wellbeing, education and life opportunities through intensive, relationship-based support.

1.2 Anne's story demonstrates the direct connection between workforce wellbeing, professional development and improved outcomes for local communities. By creating a culture where staff feel supported, confident and valued, the Family Nurse Partnership has developed a resilient workforce capable of delivering life-changing support to vulnerable young families.

2.0 Investment in People

2.1 At the heart of Anne's leadership is a commitment to creating an environment where staff can thrive. Recognising the complexity of supporting families facing trauma, adversity and social disadvantage, she has helped embed a comprehensive support framework that prioritises staff wellbeing, professional development and safe practice. Weekly clinical supervision, monthly psychologist-led reflective sessions and safeguarding supervision provide staff with dedicated opportunities to reflect, learn and make informed decisions in challenging situations.

2.2 This investment in people is complemented by a strong culture of continuous learning. Team members participate in regular case reviews, accompanied visits and structured professional development, ensuring practice remains evidence-based, reflective and responsive to the needs of families. Staff receive a minimum of eight hours of training each month, enabling them to continually develop their skills and share best practice.

2.3 The benefits of this approach are evident in both workforce and service outcomes. Despite working with highly vulnerable client groups, the team has maintained strong staff retention and low sickness absence. This stable and experienced workforce enables the service to build trusted relationships with families and deliver consistent, high-quality care.

3.0 Impact on service users

3.1 The impact on service users is significant. Through trauma-informed interventions, practical learning resources and personalised support, the service helps young parents develop confidence, strengthen relationships and improve outcomes for themselves and their children. Continuous quality improvement is embedded within the team's culture, contributing to positive outcomes including increased breastfeeding rates, improved contraception uptake and reductions in repeat pregnancies.

3.2 Anne is particularly proud of the service's commitment to listening to the voices of young people. Annual service reviews have evolved from small meetings involving only a handful of professionals to large collaborative events attended by more than 30 partner organisations and service users. These events provide an opportunity for young parents to share their experiences directly and influence future service development.

3.3 A recent example of the programme's impact came from a former service user who shared her experience via video of how the support she received helped her build a positive future for herself and her child. For Anne, stories like this reinforce the importance of investing in staff, maintaining high-quality supervision and continually improving practice.

4.0 Actions and timescales for completion

4.1 Share Anne's story with the Trust Board to demonstrate the positive impact of investing in staff wellbeing and development not only improves workforce experience and retention but also directly contributes to better outcomes for children, young people and families. It exemplifies the Trust's commitment to compassionate leadership, continuous improvement and delivering high-quality care through a supported and engaged workforce. Timescale: Trust Board meeting 8th October 2026.

Sabeena Khanna, Associate Director of Transformation & Business Partnering
Ruth Smith, Lead for Patient Experience
September 2026

Shropshire Community Health NHS Trust &
The Shrewsbury & Telford Hospital NHS Trust
Meeting of Boards in Common in PUBLIC

Thursday 13 August 2026 @ 0930hrs, held at AFC Telford Utd, Telford

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Group Chair
Ms J Williams	Group Chief Executive
Ms J Barker	Non-Executive Director (SCHT)
Mrs T Boughey	Non-Executive Director (SaTH)
Ms S Dunnett	Non-Executive Director (SaTH)
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)
Prof T Purt	Non-Executive Director/Vice Chair (SaTH) *(virtual attendance)*
Mr A Winstanley	Acting Chief Finance Officer (SaTH)
IN ATTENDANCE	
Mrs R Boyode	Group Chief People Officer
Ms J Fullard-Slawson	Group Chief Communications Officer
Prof H Fuller	Associate Non-Executive Director (SaTH)
Mr N Lee	Group Chief Strategy & Integration Officer
Ms A Milanec	Group Chief Governance Officer
Mr M Neal	Group Chief Estates, Facilities & Capital Officer
Ms B Barnes	Board Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms L Taylor	Deputy Head of Midwifery *(agenda item 069/26)*
Mr D Ballard	FTSU Guardian (SCHT) *(agenda item 073/26)*
APOLOGIES	
Mr S Crowther	Associate Non-Executive Director (SaTH)
Mr R Dhaliwal	Non-Executive Director (SaTH)
Ms R Edwards	Non-Executive Director (SaTH)
Ms M Morris	Group Chief Nursing Officer
Mrs C Purt	Non-Executive Director (SCHT)
Mr J Sargeant	Associate Non-Executive Director (SaTH)

Draft

No	ITEM	ACTION
Procedural Items		
052/26	**Welcome, and Apologies** The Group Chair welcomed all those present, including observing members of the public, to this meeting of the SCHT and SaTH 'Boards in Common', following formation of the agreed alliance between our two organisations as Shropshire, Telford and Wrekin Community and Hospitals NHS Group. Apologies were noted.	
053/26	**Patient Story** Dr Jones was pleased to welcome and introduce Danielle, to speak to the Boards about her patient experience and engagement with Diabetes Services. Danielle highlighted her lived experience of type 1 diabetes, including the challenges she faced during her teenage years in accepting her diagnosis, resulting in lack of engagement with diabetes care and subsequent significant health complications. Following re-engagement with Diabetes Services, Danielle was referred for insulin pump therapy, and she described the pathway as efficient, straightforward and well supported by the clinical team. The resulting effective management of her diabetes has also transformed her life and opportunities. The Boards were pleased to hear that she has recently graduated from university and will now be undertaking a master's degree. Responding to Board questions about what Danielle felt could have been done differently that would have helped her on her patient journey, and her experience of transferring from paediatric to adult care, Danielle felt that being able to receive emotional and psychological support would have helped her considerably. Also, up until the point of her transfer to adult care she had close interaction with the paediatric team but unfortunately, following the move of her care to adult services, she was very much left to her own devices without any structure or guidance, resulting in her feeling anxious and abandoned by the service. She also felt strongly that insulin pumps should be more widely available and not just provided to patients with well-controlled diabetes. The Boards **noted** the importance of timely access to diabetes technology for patients with complex healthcare needs, and acknowledged the value of compassionate, personalised and non-judgmental care in supporting patient confidence, engagement and wider life goals. The Group Chair thanked Danielle for taking the time to attend today's meeting to share her inspiring story, and Board colleagues joined him in congratulating Danielle on her degree, sending best wishes for her Masters.	
054/26	**Public Questions** As no questions from the public had been submitted in advance of	

Draft

	today's meeting, the Group Chair invited any questions from the floor. There were two questions, to which answers were provided as follows: **From David Tooley, Local Democracy Reporter:** ***The Trust advised at the last Board meeting that contract discussions were ongoing between SaTH and Powys Teaching Health Board following proposals by Powys to close inpatient beds in most of the county's community hospitals. Is there any update on those talks?*** *Mr Winstanley advised that discussions are still ongoing regarding the 2026/27 contract, but an agreement is close to being reached.* **From David Sandbach** ***Have the Group objectives to 2030, which are an item on today's agenda, been published yet?*** *Mr Lee clarified that the proposed Group objectives are subject to the final approval of both Boards and the paper was therefore being presented at today's meeting for Board discussion and approval. They will be published on both Trusts' websites once approved.* The Group Chair thanked both observers for their questions.	
055/26	**Noting of Quorum for each Board** Quoracy was declared for both Boards.	
056/26	**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.	
057/26	**Minutes of previous meeting in public session** The minutes of the meeting held on 9 July 2026 were accepted and approved by the Boards as a true and accurate record.	
058/26	**Action Log** The Boards agreed the closure of action log no. 15, noting the comprehensive response which had been provided offline to Ms Nicholson following her questions at the previous meeting on SEND improvements underway as part of local care transformation. There were no further current/outstanding Board actions.	
059/26	**Matters arising from the previous minutes** No additional matters were raised.	
Reports from the Group Chair and Group Chief Executive		
050/26	**Report from the Group Chair** Mr Morgan provided a verbal report which covered the following points: • Group NED appointments: The appointment of Non-Executive Directors across the Group is progressing. As each Trust currently	

Draft

	remains a separate statutory organisation, the Group has also advertised for two Audit Committee Chairs, one for each Board. • Sharing best practice: As referenced at the last meeting, the NHSE Midlands Regional Chair is very keen that the NHS improves in the sharing of best practice. A Midlands Best Practice session has since taken place, led by the Regional Chair, for organisations from across the region to share best practice with other NHS colleagues. The session covered productivity, Patient Initiated Follow Up (PIFU), sickness absence, procurement, patient flow, and ambient voice technology, and attendees felt that the meeting had been positive and informative. • Board Maternity & Neonatal Safety Champion activity: Mr Morgan advised colleagues that he has recently started buddying with Ms Nicholson, Board NED Maternity & Neonatal Safety Champion, on her visits to clinical areas, to help inform his line of sight on Maternity and Neonatal Services. As well as taking away several practical points from his first visit, Mr Morgan's main observation has been what an engaged, enthusiastic and committed team of colleagues we are fortunate to have in our Group. The Boards **noted** the report.	
061/26	**Report from the Group Chief Executive** Before drawing out some of the key points from her written report, Ms Williams was delighted to share that SaTH has been shortlisted for HSJ Trust of the Year 2026, one of the most respected and prestigious awards in the NHS. While the application was submitted by SaTH, this recognition belongs to many more people, reflecting the collective effort, commitment and dedication of individuals and teams who have worked together across our Group, our system partners, and the communities we serve. Their contribution, insight and collaboration have helped shape our progress and strengthened SaTH's ability to deliver on its ambitions. Ms Williams was proud to add that SaTH has also been recognised in two further HSJ national categories. The Trust is shortlisted for Performance Recovery of the Year, recognising our incredible elective improvement work, and Modernising Diagnostics, recognising the revolutionary, innovative TRIOMIC study in collaboration with Origin Sciences and our Colorectal clinical team, delivered at the Community Diagnostics Centre (CDC). To be recognised across three categories is a powerful endorsement of the scale of the improvement delivered by our colleagues. Whilst we are proud of these improvements, all colleagues across the Group understand the work still to do to achieve our ambitions for better care, safer services and a kinder culture for the patients and communities we serve, with progress being accelerated by working as a Group. Taking her report as read, Ms Williams wished to highlight the following key points: • Extreme weather: Whilst July and August are traditionally	

Draft

demanding months for the NHS, due to four heatwaves within as many weeks we have experienced, on a national and local level, greatly increased demand for healthcare services. Nevertheless, colleagues have continued to treat our patients with professionalism, care and compassion, and the Boards are profoundly grateful for their efforts and the difference they make each day.

Ms Long asked whether any work was planned by the Group as a result of any excess deaths due to the heatwaves. Dr Jones, referring to the link between long stays in ED and/or heat, responded that, whilst difficult to quantify, it will be possible to identify trends, which will continue to be reported through the Group Quality & Safety Assurance Committee. Regarding any infrastructure changes to our estate, as many NHS sites nationally have not traditionally been designed to cope effectively with repeated instances of extreme heat, it is assumed that this will be a wider topic of discussion at national level.

- Care Quality Commission (CQC): SaTH has recently been formally notified by the CQC that it has removed the final condition as a service provider from the Trust's registration. This was the last of the original 60 conditions, meaning no conditions now remain on the Trust's registration. This significant achievement reflects the sustained commitment and tremendous efforts of teams across the organisation.

  The CQC reports on their inspections of Urgent and Emergency Care and Medicine at both RSH and PRH, are expected over the coming weeks. It is anticipated that the reports will recognise the progress made across these services, often in challenging circumstances, recognising that there is still more to do to ensure consistently high standards across every service and for every patient. SaTH remains committed to responding openly to feedback, building on the improvements already achieved, and supporting our teams to deliver sustained, high-quality and compassionate care.

- Consultant recruitment: SaTH has had further success in recruiting high-quality consultant colleagues for those areas where we sought to strengthen our teams, and where we continue to do so. The applications being received are of good quality, with applicants showing genuine enthusiasm for joining us in Shropshire, Telford & Wrekin.

  Ms Barker sought assurance on progress with the previously discussed Virtual Ward (VW) consultant appointment, and she also wished to understand why many of the ED appointments detailed in the report are locums. Dr Jones responded that following consideration, he did not feel there was a need to appoint a dedicated VW consultant. This is in line with SaTH's approach to building care into the wider hospital clinician group, and he feels the model the Group is moving to will eventually result in areas of care forming part of defined workloads.

  Regarding locum appointments, with general medicine becoming less common and an alternative preference for specialism, Dr

Jones clarified that the Trust made the important decision to develop our own general medical workforce. In building that workforce we have started with a significant number of people and there are certain regulatory rules we need to abide by. He provided assurance that just because people are locums it does not mean they are not effective in their roles. Ms Williams added that the priority is to build our workforce around our patients' needs.

In response to a query from Ms Nicholson on whether consultants have been able to follow up in practical terms on the expressions of interest they shared at interview, Dr Jones confirmed that he meets with individuals when they have been at the Trust for around six months to discuss their future preferred areas of focus. Ms Williams added that the expressions of interest approach at interviews is being extended to other groups.

Referring to the Group model, Mr Morgan wished to take the opportunity to share with colleagues how much of a strong advocate Dr Jones is for care closer to home when he is out and about in our community settings.

- Engagement Events: 190 senior medical colleagues from across Telford and Shrewsbury attended engagement events in July 2026, providing valuable opportunities to listen to staff experiences and gather insights into opportunities for further improvement. These were positively received and colleagues demonstrated a strong commitment to innovation and exploring how technology can support both clinicians and patients.

  Ms Williams also recently met with 120 SaTH medical secretaries, whose vital contribution supports consultants and patients across hundreds of thousands of interactions. The session provided an important opportunity to listen to their experiences and consider how modern tools could reduce administrative pressures and enable more time to add value for patients.

  A meeting has been arranged for 25 August 2026 between Group executives and local GP/Primary Care Network (PCN) leaders, to begin discussions on strengthening collaboration across primary, community and hospital services in Shropshire, Telford and Wrekin. This will be followed on 15 September by a wider engagement event, bringing together GPs and the Group's senior clinical teams, to strengthen relationships, deepen mutual understanding and identify opportunities for closer collaboration.

- On 29 July 2026, Ms Williams and Mr Morgan attended a scheduled meeting with families involved in the SaTH Ockenden Review, along with members of the Executive team and the Trust's Maternity Communications and Engagement Lead. Ms Williams was grateful to everyone who gave their time to attend and speak so openly about their views and experiences. It is a privilege to meet with families, and these conversations provide an important opportunity to listen, learn and consider how we can continue improving services together.

  The following day, the Learning and Improvement Group brought together families, regional NHS England colleagues, Board

	members and divisional representatives to review progress, share learning, and agree how we will continue working together to deliver meaningful and sustainable improvement. Stacey Thacker, who has recently joined the Trust as Head of Midwifery, was welcomed to the meeting, which gave families an important opportunity to meet Stacey, particularly as several of them had contributed to the recruitment stakeholder panels. The Boards accepted and **noted** the report.	
Board Committee Reports		
062/26	**SCHT Reports:** **a. Non-Executive Director Verbal Activity Reports** Noting that there was nothing to report at this time, Mr Morgan reminded all NEDs that visiting locations across the Group is a valuable and important part of our role, and the more NED colleagues can get out and about within our community settings, the better. **b. Quality & Safety Committee Report** The Boards received the report from the Committee Chair, Ms Barker. Taking the report as read, the following points were highlighted: • C.difficile infections: In response to ongoing concerns on the number of infections both locally and nationally, the Committee requested a system-wide review of the patient pathway through Group Quality & Safety Committee arrangements, to identify opportunities for shared learning, and reduction of infection risk across partner organisations. • Fire safety: The Committee received assurance regarding progress made in implementing actions arising from the Fire Service audit of Ludlow Community Hospital. Whilst welcoming this assurance, the Committee identified the need to strengthen alignment between fire safety reporting and wider estate compliance information discussed through the Resource and Performance Committee. Mr Neal provided assurance on the intention to correlate future organisational fire safety reporting, to provide confirmation of how wider fire safety compliance risks are managed and reported across governance structures. • Deaths in custody: Dr Jones shared with the Boards his very useful recent discussion with the Governor of HMP Stoke Heath, recognising the benefits of the Group and Prison leadership teams working in parallel. With the forthcoming merger of the SCHT and SaTH Quality & Safety Committees under the Group structure, Ms Long wished to put on record her thanks to Ms Barker for her valuable contribution during her tenure as SCHT Q&S Committee Chair. This was echoed by the Group Chair, who added that the Trusts look forward to adopting a joint approach with other Board committees as the Group structure develops.	

Draft

	c. Resource & Performance Committee Report The Boards received the report from the Committee Chair, Ms Long, Taking the report as read, the following points were highlighted: • National Oversight Framework (NOF) amendments: Following publication of the updated NOF in June 2026, the Committee reviewed the proposed metrics for which it takes oversight responsibility. Further work was requested in relation to a small number of KPIs, but the Committee recommended the proposed list to the Boards subject to completion of those reviews. • Efficiency Plan: Whilst SCHT's efficiency plan remained on track at the end of Q1, the capital plan is larger than in previous years and is profiled towards the latter end of the year. There has been no reduction in the value of schemes classed as high risk in terms of delivery, and work is being overseen through the Financial Recovery Group as well as being carefully monitored through the Capital and Estates Group. The Boards accepted and **noted** the above SCHT Committee reports.	
063/26	**SaTH Reports:** **a. Quality & Safety Assurance Committee Report** The Boards received the report from the Committee Chair, Ms Dunnett. Taking the report as read, the following points were highlighted: • Mortuary security: The Committee received an update on progress of work in response to the Fuller Inquiry Report into mortuary security, with 18 of the 20 identified actions completed, and plans in place for the two outstanding actions to be achieved by August 2026. The Committee also heard that work is in progress to strengthen governance in response to the recommendations which relate to mortuary services from the Nottingham Maternity Review and the Amos Review. • Poppy's Promise: The Committee was pleased to hear that very valuable feedback was being provided by service users following the launch of Poppy's Promise in Maternity Services. Ms Williams supported the Committee's view that as the programme is rolled out across the Group, a robust and standardised process will be needed to ensure consistent, timely responses to feedback. **b. Performance Assurance Committee Report** The Boards received the report from the Committee Chair, Ms Edwards. Taking the report as read, the following points were highlighted: • UEC System Integrated Improvement Plan: The Committee heard that the Non-Admitted Working Group is now building in recent feedback from Nexus Consulting (SaTH's delivery partner) on measures that can be taken to reduce the time spent in ED, in particular waits for blood test results and CT scans. • High Intensity Users of Emergency Department (ED): Noting that	

Draft

there had been a 13% growth in this group since November 2025, which accounted for 11% of all ED activity, the Committee heard that a strategic group has been established which meets monthly and has good support from partners across the system. A plan has been developed to reduce the number of visits that fall into this category (ie those with more than five attendances at ED in a 12-month period) by 20% by March 2027.

- Fire safety training: In response to a query from Mrs Boughey on concerns which had been raised by the Committee, it was clarified that their concerns related to ensuring there was always someone appropriately trained on each ward at any one time. Mr Neal provided assurance that a large amount of work is underway in this area and that he has spoken to the Fire Service who are happy with the progress being made.

  Mrs Boyode added that whilst mandatory fire safety training attendance is as high as ever, there is an intention going forward to focus on ensuring this is appropriately applied. Mrs Boughey asked for this to have the oversight of all Board Committees due to its wide relevance across all teams.

  The Boards requested an assurance update on fire safety training, which Mr Neal would provide at October Board, in addition to ongoing Committee reporting.

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:

- Financial performance: Mr Miner highlighted the Committee's growing concern regarding the Trust's 2026/27 financial performance and its current view that SaTH is unlikely to meet its end-of-year forecast without the implementation of significant mitigating actions. In view of the current financial performance and pressures, FAC had agreed that the score for BAF Risk 5 (operating within available resources) should be increased back to 20.

- Draft SaTH Transformation Programme: Mr Miner drew the Boards' attention to a comprehensive report compiled by Tracey Cotterill and her team before she left the organisation. This was acknowledged as an exceptionally good piece of 'front foot' work which has identified multiple opportunities to deliver financial headroom in the medium term, as well as improved patient outcomes. The Committee recommends consideration of this report by the Boards.

d. HTP Assurance Committee Report

The report was received from the Committee Chair, Prof Purt, which was taken as read.

The Committee received assurance that the construction programme is progressing ahead of target and on budget. A growing link to the Local Care Transformation Programme is becoming obvious and is being actively reviewed, with a future joint review planned to avoid

Draft

	duplication and ensure clear oversight. The Boards accepted and **noted** the above SaTH Committee reports, acknowledging the concerns raised by FAC and emphasising the commitment to delivery of our financial plan.	
064/26	**Group Reports:** **a. People Committee Report** The report was received from Mrs Boughey, the Committee Joint Chair. Taking the report as read, the following points were highlighted: • Lord Mann Review: The Committee accepted all of the review recommendations on behalf of the Boards, and received assurance that implementation of the nationally required anti-racism principles will be monitored through existing governance arrangements, including workforce reporting, education compliance, staff survey data, and Freedom to Speak Up reporting, with Group People Committee oversight. • Group Education Strategy: The Committee approved the development of a Group Education Strategy, with continued oversight through the Group People Committee. • Conduct and Behaviours: The Committee noted the large amount of work taking place across the Group focusing on culture, including behaviours and conduct, eg Poppy's Promise. Committee members encouraged a clearer organisational narrative that brings together the multiple people, culture and wellbeing initiatives across the Group. Ms Williams confirmed that explicit guidance was being planned on what is expected of colleagues, to help them navigate all the Group's cultural initiatives and organisational priorities, emphasising that this would not simply be through more written communications. Ms Fullard-Slawson added that work was underway on a communications strategy which will be formed around our Group strategic pledges, to reinforce the key message that quality, finance and workforce are all inter-connected. Whilst moving away generally from the previous approach of separate comms strands, Ms Fullard-Slawson advised that she is working with the Group Chief Nurse on a specific communications campaign focused on Infection Prevention and Control (IPC), linking with our overall Group strategy. • Staff Survey: Ms Long sought assurance on progress with the improvements the Group needs to make following the 2025 staff survey feedback, and Mrs Boyode confirmed that progress is monitored through an update on culture at every People Committee meeting. Ms Williams added that Executive colleagues focus on one of the agreed breakthrough measures at each of their weekly meetings. Mrs Boyode also advised the Boards that the majority of feedback being received from pulse surveys is a reflection of what colleagues are feeling, in the context of a rapidly changing world for the NHS, and uncertainty around the impacts of organisational change resulting from our Group formation. Whilst some colleagues are	

Draft

	very enthusiastic about the future, others are clearly feeling anxious and uncertain of where they will sit within that context. Ms Long expressed her wish to be involved in the development of the Group's cultural improvement work where possible as this was an area she felt passionate about, and Ms Williams confirmed that she was very happy for NEDs to be involved as appropriate. **b. Local Care Transformation Assurance Committee Report** The report was received from Prof Purt, the Committee Chair. Taking the report as read, the following points were highlighted: • Programme composition: The Programme currently comprises 49 projects and requires prioritisation to ensure delivery capacity and resources are focused on initiatives which will provide the greatest benefit and impact on reducing the forecast HTP bed gap. • Process alignment: Work is underway to align processes against the five agreed priority areas and implementation of revised reporting arrangements aligned to those priorities. • Engagement and collaboration: Strong collaborative working was reported between SaTH, SCHT, ICB colleagues and primary care partners in developing programme methodology, prioritisation and impact measures. Mr Hobbs acknowledged the positive engagement taking place across the Group but, as Prof Purt had highlighted, emphasised the importance of very disciplined prioritisation. The Boards accepted and **noted** the above Group Committee reports.	
Strategic, Performance, Financial & Operational Reporting		
065/26	**Integrated Performance Reports:** **a. SCHT** 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: • Report format: Highlighting the change in SCHT reporting format this month, Ms Lloyd confirmed that as our Group continues to mature it is expected that all aspects of performance, including frameworks, measures, monitoring and reporting, will be aligned and presented across the Group as appropriate. • Key Performance Indicator (KPI) changes: There were no changes to KPIs flagged as a concern by the Quality and Safety Committee and People Committee during the month, however the Resource and Performance Committee flagged that the difference between actual and planned 18-week elective performance is now a variation concern. **Operational Summary** • Mr Hobbs was pleased to advise that performance is generally stable. One patient has exceeded the 'Total patients waiting more	

Draft

than 52 weeks to start consultant-led treatment' KPI. The patient has now been seen and is awaiting imminent treatment and a full harm proforma has been completed. There are no resulting significant issues for the patient, but Mr Hobbs wished to raise for transparency.

- Mr Hobbs was also pleased to report to the Boards on the increased level of Group partnership working to support elective community pathways.

Quality and Safety Summary

- There were no medication incidents resulting in moderate harm reported during June 2026, representing the fourth consecutive month of zero moderate harm medication incidents.
- One Category 4 pressure ulcer and one Category 3 pressure ulcer were reported during June 2026. Reviews have identified opportunities for organisational learning, with an After-Action Review and wider thematic review activity underway.
- Inpatient falls remained above SCHT's internal threshold at 5.5 per 1000 occupied bed days, although the number of falls remained stable at 13. A comprehensive falls improvement programme continues across inpatient and community services.
- One unexpected death was reported during June 2026 involving a Virtual Ward patient. A Level 1 Learning from Deaths review form is being completed in line with the Trust's Learning from Deaths Policy.
- C.difficile performance remains above the agreed rolling 12-month threshold, with two cases reported during June 2026. Improvement actions continue through the IPC Improvement Plan.

People Summary

- A number of medical agency/locum workers are in place in UEC and Paediatrics, resulting in total shifts exceeding capped rates.
- The June appraisal compliance rate has slightly increased from 87.19% in May to 87.23%. Work is continuing to ensure hot spot areas are being supported to achieve completion of outstanding appraisals.
- Sickness absence rates increased this month to 5.71%, with the main drivers being stress, anxiety and depression conditions.

The action plans presented in the Board Information Pack describe further detail and the actions being taken to reduce risk and improve performance.

The Boards **considered** SCHT's performance to date and the assurance provided on the actions being taken to improve performance and minimise risks where required.

b. SaTH

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 May/June 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

Dr Jones drew the Boards' attention to the following points:

- Hospital Associated Infection (C.difficile) remains the most significant cross-Trust quality concern, with emphasis on the need for continued improvements in infection prevention, hand hygiene, cleaning standards and antimicrobial stewardship. Ms Morris has requested a new approach to the IPC action plans, and development of an overarching IPC action plan will be undertaken with senior teams and the improvement team.

- Following two Never Events in Ophthalmology over two consecutive months, Dr Jones has initiated an improvement programme, with learning to be taken back through the Quality & Safety Committee.

Operational Summary

Mr Hobbs highlighted the following points:

- Urgent and Emergency Care: Following successive periods of extreme heat, June and July represented the highest number of ED attendances ever on record. Statistically significant improvement has been maintained in July in waits over 12 hours and ambulance handover times, despite the above pressures, however 4-hour waits are still not showing sustained improvement.

  Colleagues noted that the Trust's delivery partner, Nexus, has now concluded the diagnostic phase to support delivery of improvements in ED non-admitted 4 hour performance and Care Transfer Hub management of patients with No Criteria to Reside, and Mr Morgan asked when the Boards can expect to see improvement. Mr Hobbs confirmed that the two most material factors to improvement are within SaTH's gift – the end to end times for blood samples and CT scans, with both processes cutting across ED and diagnostic services. As these are largely process changes, he provided assurance that improvement is expected to be seen over the next few months.

- Planned Care: Performance remains relatively stable but there has been an increase in the Trust's total waiting list over Quarter 1, with mitigating actions in place for Quarter 2.

- Cancer services: Mr Hobbs was pleased to report positive assurance regarding cancer services, with May performance at 82.5% against the 28-day faster diagnosis standard (FDS), making it SaTH's ninth month of delivery of the national 80% standard. 62-day performance was 73.9% against a local target of 70% and 31-day was 99% against a national target of 96%. The Trust's two-year cancer improvement plan for 2026/27 and 2027/28 is in place, aligned to the delivery of the National Cancer Plan, which is designed to move us from recovery to excellence and will be crucial

Draft

	to the delivery of the 2026/27 operational plan commitment. **Workforce Summary** Mrs Boyode advised colleagues that she had nothing additional to report at this time. **Finance Summary** Mr Winstanley covered the following key points:: • SaTH financial position 2026/27: At the end of June 2026 (Month 3) the Trust has delivered a deficit position of £10.94m against a deficit plan of £8.27m pre-deficit support funding, representing an unfavourable variance of £2.67m. This moves to a deficit of £3.31m against a planned deficit of £0.65m post-deficit support. The predominant drivers of the variance are industrial action (£0.75m) and slippage against various efficiency schemes (£1.70m), which have been partly offset with other non-recurrent mitigations. The Boards accepted and **noted** the SaTH Integrated Performance Report.	
066/26	**SCHT 2026/27 National Oversight Framework (NOF) Update** Following publication of the 2026/27 NOF, Ms Lloyd presented proposed amendments to SCHT's Integrated Performance Report KPIs, in line with the Trust's governance arrangements set out within its Performance Framework. Colleagues were referred to the detail within the report on the calculation of each of the measures, which have been reviewed through SCHT's People, Resource & Performance, and Quality & Safety Committees, and each Committee recommends the proposed measures to the Boards for approval. The Boards **reviewed and approved** the proposed list of SCHT Key Performance Indicators.	
067/26	**Group Vision, Pledges and True North Metrics** Mr Lee presented the proposed updated Group strategic vision and pledges, which represent feedback from a number of sources, including Board of Directors' meetings in common, discussions with colleagues, Public Assurance Forum and volunteers. The aim has been to create a vision and a set of pledges that describe the ambition for the Group, which are described under four headings, underpinned by our 2030 objectives and the 'True North' measures of success. The Boards **considered** and **approved** the final version of the Group vision, objectives and True North metrics.	
Assurance Framework		
068/26	**SaTH Integrated Improvement Plan (SIIP) Monthly Update Report** Ms Williams, taking the report as read, confirmed that there were no	

	exceptional items requiring escalation at this time. The Boards: • **Noted** the actions and took assurance from the updates provided, including the evidence of delivery and governance oversight. • **Noted** progress against delivery of the tasks/actions that were due up to and including 31 July 2026, as detailed in Appendices 1-4. • **Noted** progress on the UEC undertakings, which have been incorporated within the 2026/27 UEC SIIP plan, reflecting continued focus on delivery and improvement.	
069/26	**SaTH Integrated Maternity & Neonatal Report** Dr Jones welcomed Ms Lauren Taylor, Deputy Head of Midwifery, to present the report, which detailed 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 Boards were referred to the detail contained within the main report, together with the accompanying appendices in the supplementary information pack which provide further comprehensive information. Colleagues' attention was drawn to the following key points: • SaTH is now fully compliant with all 20 applicable Fuller Review recommendations and has submitted the required Board Assurance Statement to NHS England. • A national scheme has been established to support maternity providers in recruiting newly qualified midwives into additional Band 5 posts. This initiative forms part of the national response to the Ockenden and Kirkup maternity reviews, with the aim of strengthening maternity workforce capacity and improving safety and quality of care. The scheme provides funding of up to £10,000 for each midwifery post recruited. Following discussion with the Finance Team, an expression of interest for 10.7WTE posts has been submitted. • Ms Williams advised, in response to a query from Mr Morgan, that advertising for the Trust's Director of Midwifery post has been withdrawn for now due to a disappointing volume of candidates. This is a critical role for SaTH, and several Ockenden families have expressed their interest in an invitation to participate in the recruitment stakeholder panel. The advert will be issued again in a few months. **The Ockenden Report (Independent Maternity Review) Progress Report:** **Appendix 1** provides the summary Ockenden Report Action Plan at 14 July 2026. 197 out of the total of 210 actions have now been fully completed (evidenced and assured), with four actions currently on track for their expected delivery dates pending evidence that they have	

Draft

been appropriately embedded.

Nine actions remain 'de-scoped' currently, relating to nationally-led external actions (led by NHSE and the CQC), which are not within the direct control of the Trust. As advised in previous reports, the Local Maternity and Neonatal System (LMNS) continues to oversee these actions, which remain under quarterly review and national escalation 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 14 July 2026 is included as **Appendix 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. As the number of eligible cases for review each quarter is quite low, an aggregated review is underway to try and identify overall compliance levels.

Work is ongoing to implement the last four actions currently Not Yet Delivered. These require the recruitment of Neonatal Safeguarding and Family Integrated Care Lead Nurses, which are currently at various stages of the recruitment process.

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.**

A renewed format for the cultural improvement work within the Division is being drafted, which will align with Trust-wide initiatives and priorities, such as embedding Poppy's Promise. The proposed format will be validated through the culture workstream and an update will be included in the next report to Board.

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

Year 8 of the scheme contains six core safety actions, with a focus on outcomes. This approach maintains 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. Details of progress against all safety actions and their sub-items are included in **Appendix 4.**

Of note, a compliance risk has been flagged against the Maternal Care Bundle Element of Safety Action E. Implementation will require system partners such as primary care, the ICB and national digital services to update digital tools for the assessment of Venous Thromboembolism (VTE) as first point of contact during pregnancy, which can occur before the booking assessment within Maternity Services.

Regional Maternity Heatmap: The overall score for SaTH in the

Draft

	Maternity Heatmap for June 2026 was 27, compared with a regional average of 23.2. This indicates that SaTH's score is above the regional average and will continue to be monitored to identify themes, inform workforce and service planning, and support ongoing quality improvement initiatives within Maternity Services. Perinatal Staffing **(Appendix 5)**: CNST Year 8 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 the professional judgement of the Director/Head of Midwifery should be added where appropriate. During June 2026, the service sustained positive acuity levels above 85%, with 89% of shifts reported as Green, 10% as Amber, and 1% as Red. It should be noted, however, that the green acuity rate fell below 90% for the first time this year and will continue to be monitored. Red Flag reporting is now fully aligned with both national and local guidance. A total of 26 Red Flags were reported during June, with 88% relating to delays in undertaking Artificial Rupture of Membranes (ARM). Compliance with one-to-one care in labour and maintenance of the supernumerary coordinator role remained at 100% throughout June, reflecting ongoing risk assessment processes and timely escalation where required to ensure the safety and quality of care. Neonatal Workforce: British Association of Perinatal Medicine (BAPM) compliance remained stable at 95%, and Qualified in Specialty (QIS) compliance remained stable at 59%. A rolling programme of training and development continues to support further improvements in this area. Obstetric Medical Workforce: There has been successful recruitment for the appointment of three Consultant Obstetricians, who will commence in post later in the year. The Boards, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated appendices (Appendices 1-5), accepted and **took assurance** from the report.	
070/26	**SaTH Board Maternity & Neonatal Safety Champions Report** Dr Jones presented the report of the July 2026 meeting. Taking the report as read, he advised the Boards that he and Ms Nicholson continue to focus on the impact of additional elective capacity to support the rising number of caesarean sections. A new Caesarean Report will come to the Maternity & Neonatal Safety Champions meeting from August 2026. Ms Nicholson wished to highlight how responsive the teams have been when concerns have been raised by the Safety Champions during their visits. The Boards accepted and **took assurance** from the report.	

Draft

071/26	**Board Assurance Framework (BAF) Q1 2026/27** Ms Milanec presented the Q1 BAF reports for SCHT and SaTH. Taking the reports as read, the following points were highlighted: **a. SCHT** The Boards' attention was drawn to the BAF Risk Tracker at Appendix A, showing all changes over the period. A new risk, reference 5.3, has been added regarding costs exceeding plan. **b. SaTH** The Boards' attention was drawn to the draft BAF at Appendix 1, in particular to a proposed increase to the total current risk score of BAF Risk 5, from 5x3=15 to 5x4=20, with the likelihood of the risk increasing. The proposed increase is linked to the Trust's current financial position and the risks within the forecast run rate and CIP delivery for 2026/27. The Boards **considered** the information and assurances provided regarding the mitigation of risks to delivery of the strategic objectives of each organisation and **approved** the proposed amendments.	
Regulatory and Statutory Reporting		
072/26	**Guardian of Safe Working Report** As Drs Hollands and Aung were both unable to attend the meeting due to clinical commitments, the report was presented by Dr Jones, the Executive Lead. Taking the report as read, the Boards' attention was drawn to the following key points: • The leave request concerns in the Emergency Department raised at earlier meetings of the Boards have now been addressed, and resident doctors report that the situation has significantly improved. • Some Trust grade and FY2 doctors completing training in August 2026 have expressed anxiety around the timing of their contract extensions. Many of the Trust grade doctors require visas, and this is causing additional stress. Whilst dependent upon the number of training posts available, Dr Jones provided assurance that the Trust is looking at appropriate conversion for those who are keen to stay with the organisation. The Boards accepted and **took assurance** from the report.	
073/26	**SCHT Freedom to Speak Up (FTSU) Q4 / Annual Report 2025-26** Ms Milanec was pleased to welcome and introduce Mr David Ballard, SCHT's FTSU Guardian, to present the report. Taking the report as read, the following key points were highlighted: • Currently, the FTSU portfolio has different Executive Director leadership across each Trust in the Group. Work is being undertaken to standardise the leadership and ensure alignment going forward. Collaboration between the FTSU Guardians of both organisations continues to strengthen, and quarterly Group	

Draft

	Champion meetings are being established, to start in September 2026. • 21 cases were raised in Quarters 3 and 4, of which 10 were associated with bullying/harassment/misconduct. This is not reflected in the Trust's 2025 NHS Staff Survey results, however, with responses all aligned with the benchmark average in those specific categories. • Colleagues who raise concerns are being supported appropriately, through expansion of the Champion network (which now stands at 18 across all SCHT locations), and strengthened partnership working with Professional Nurse Advocates (PNAs) and Occupational Health. • Comments and queries from the Boards are summarised as follows: o Ms Long was encouraged to note that there has been no anonymous reporting during the period, demonstrating that colleagues feel able to speak up. o The Group Chair invited Mr Ballard to identify any assistance that could be provided to FTSU by the Boards. He confirmed that face to face visits to teams across the Trust are proving very helpful, and Mr Morgan was pleased to accept an offer to accompany Mr Ballard on some of these visits in the future. The Boards **noted** the report and **took assurance** from FTSU's continued contribution to supporting colleagues and improving culture across the Group.	
Procedural Items		
074/26	**Any Other Business** • **Colleague farewell** As this was Mrs Teresa Boughey's last Public Board meeting as a Non-Executive Director of SaTH before the end of her 7-year term at the end of August, Mr Morgan expressed his sincere thanks to Teresa for her huge contribution and commitment to the Trust during her term of office, recognising the value that her professional knowledge, skills and experience have brought to the Board. The Boards joined Mr Morgan in wishing Teresa all the very best for the future. There were no further items of business.	
075/26	**Date of Next Meeting** The next meeting of the Boards in Common in Public session is scheduled for Thursday 8 October 2026, at **Shrewsbury Education & Conference Centre (SECC), Royal Shrewsbury Hospital.**	
The meeting was declared closed.		

Draft

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	085/26		
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
	Effective	√	All SATH BAF Risks
	Caring	√	**Risk Register id(s):**
	Responsive	√	-
	Well Led	√	
Executive Summary	With seasonal immunisations now available and the days shortening, winter is definitely approaching. Whilst planning began several weeks ago, September has already brought early pressures for our urgent and emergency care services and community colleagues. In response, we have introduced some new initiatives across the Group to address these growing challenges. Thank you to all our colleagues for the care that they continue to provide, despite the pressures. Financial challenges continue and the Group has had to make some complex decisions to work towards delivery of its £44.3 million efficiency programme. The next six months will be an anxious time for some as we progress further into new ways of working and wider scale transformation. However, the health and welfare of our colleagues will remain upmost in our minds as we endeavour to provide new opportunities within a sustainable healthcare setting.		
Recommendations for the Boards	The Boards are asked to note the contents of this report		
Appendices:	None		

1.0 Introduction/General updates

1.1 This report summarises the Chief Executive's key updates since the public Board meeting held on 13 August 2026.

1.2 The Group continues to face a highly challenging financial environment, driven by growing demand, rising costs and wider NHS pressures. To secure long-term sustainability and protect resources for patient care, we have a comprehensive financial recovery and transformation programme. This includes £20 million in recurring workforce efficiencies within the Group's wider £44.3 million efficiency programme.

Our approach prioritises patient safety, continued investment in key services and delivery of the Group's strategic objectives. Workforce measures include voluntary redundancy, vacancy controls, redeployment and retraining, with compulsory redundancies considered only as a last resort.

Throughout this process, we will engage openly with staff, support affected colleagues and balance financial sustainability with the continued delivery of safe, effective and compassionate care. We recognise that change is difficult, but our focus must remain on delivering greater value for patients. Staff will continue to receive clear information about our position, why action is necessary and how they can contribute. Teams should also have the information, support and autonomy to make improvements locally, where much of the day-to-day difference for patients is made.

These pressures will be familiar. The economic outlook, constrained public finances and difficult choices facing public services, including the NHS, are widely reported. The NHS operates within this wider economic context: funding is constrained, costs are rising and demand for healthcare continues to grow. We must therefore use our resources differently and ensure that every pound delivers the greatest possible benefit for patients and communities.

I would like to thank colleagues for the way they have responded to these challenges. Their professionalism, understanding and constructive engagement, while continuing to provide safe and compassionate care, have been greatly appreciated. I recognise the uncertainty that change can bring and remain grateful for the commitment colleagues continue to show to our patients, one another and the wider Group.

This national context does not make local decisions easier, but it reinforces the importance of financial sustainability in protecting care for our communities now and in the future.

1.3 Since the Board last met in early August, the Care Quality Commission (CQC) published its inspection reports on 21 August 2026. The findings provide encouraging evidence of improvement across the services inspected, with no service now rated Inadequate. While this represents important progress, the Trust recognises that further work is required to address the areas identified and to ensure consistently high-quality care for all patients.



1.4 On 15 September 2026, Lady Justice Thirlwall published the final report of the public inquiry into events at the Countess of Chester Hospital between 2015 and 2018. The report describes profound failures in management, governance and safeguarding, including repeated missed opportunities to act on concerns and protect babies from harm.

Our thoughts remain with the babies and families whose experiences are at the heart of the Inquiry. The findings are a sobering reminder that patient safety must always come first and that concerns raised in good faith must be heard, examined and acted upon without delay.

The report makes 17 recommendations for national bodies and NHS organisations. These include stronger neonatal monitoring and controls over access to insulin; consistent bereavement care; improved safeguarding training and employment requirements; a clear protocol for responding to suspected deliberate harm; stronger use of data and mortality information to identify unusual patterns; greater accountability and regulation of NHS managers; more effective Freedom to Speak Up arrangements; and stronger external scrutiny. NHS England has emphasised that the learning applies to every trust and integrated care board, not only organisations providing neonatal services.

We have reviewed the report and each recommendation in detail with our current baseline assessment. This work also includes Board-level oversight of safeguarding, speaking up, escalation and executive accountability, alongside specific assurance on neonatal safety,

medicines security, mortality review and support for bereaved families. Following our extraordinary Board meeting on Friday 25 September 2026 we have developed our coordinated action plan and submitted it to NHS England (NHSE) as required. Updates, progress and reporting will be through the appropriate quality and governance committees.

1.5 I am deeply concerned by recent reports of NHS staff accessing medical records across the NHS without a legitimate reason. Patients and families rightly expect their information to be treated with respect and kept confidential. Viewing a record out of curiosity, or for any purpose unrelated to care or another authorised role, is unacceptable and undermines public trust in the NHS.

We are clear that colleagues may access a patient or staff record only when they have a legitimate, authorised work-related reason. The ability to access a clinical system does not give permission to view a record. Accessing records out of curiosity or personal interest, including those of colleagues, friends, relatives or oneself are unlawful and a serious breach of confidentiality. Consequences may include suspension of access, disciplinary action up to dismissal, referral to a professional regulator, and criminal investigation or prosecution. Most colleagues manage patient information responsibly and professionally, and we will continue to reinforce these duties and maintain robust controls across the Group.

1.6 September 2026 saw continued high demand for urgent and emergency care services across the Group, with colleagues maintaining their focus on safe and compassionate care in exceptionally challenging circumstances. We have strengthened clinical peer review and introduced weekly reviews of all inpatients who have met the Criteria to Reside for more than 12 days, alongside focused length-of-stay reviews, increased senior clinical leadership across both sites and several initiatives across the Group.

Work is ongoing to improve the 4hour non-admitted pathway which is focused on reducing the time from arrival to clinical assessment, blood-test turnaround times and the interval from CT request to the report. Our winter plan has also been signed off and shared with and tested by the regional NHSE team. I remain incredibly grateful to colleagues for their professionalism, flexibility and resilience, and for the way they continue to support one another and our patients.

We know there is still more to do, but there remains a strong and collective focus at both operational and Board level, and we will keep driving the improvements our patients need. The priority now is to make those improvements sustainable, so that patients feel the difference in the care they receive and we start to see that progress consistently reflected in our headline performance metrics.

1.7 In September 2026, NHSE published on the model hospital dashboard, the National Oversight Framework (NOF) for Quarter 1 2026/2027. The 2026/27 NHS Oversight Framework (NOF) is intentionally evolutionary, retaining the core architecture and oversight approach from the 2025/26 Oversight Framework.

The new framework is once again underpinned by a scoring approach to performance and for certain metrics this score is influenced by benchmarking against other trusts. For those

metrics relevant or included for an organisation, a score will be assigned that will then influence the overall segment an organisation is placed in. Contextual metrics are informative but not comparable or not considered sufficiently mature; they are used to support how NHS England responds to segmentation rather than informing the calculation itself. Each metric has a specific scoring methodology. Examples include scoring based on absolute performance, relative performance to other organisations, a combination of both. · The individual metric scores are then averaged to produce an overall average metric score for each organisation. Average metric scores are then translated into a single overall segment of 1, 2, 3 or 4 using the thresholds below. Financial override means all organisations reporting a deficit or in receipt of deficit support will be limited to a segment no greater than 3.

Segment	1	2	3	4
Average Metric Score	<1.94	1.94 - 2.33	2.34 - 2.77	>2.77

As part of the framework, organisations are given a predefined list of metrics allocated based on organisation type e.g. Acute, Community, ICB. The table below summarises the Group's performance over the past 12 months and highlights the principal points. In some cases, improved performance does not result in a better relative ranking or score because results are benchmarked against other trusts. This is evident in the 62-day referral-to-treatment measure and the proportion of patients admitted, discharged or transferred within four hours, where performance improved between quarterly assessments, but the comparative score did not.

The method for allocating segments has changed significantly. In 2025/26, organisations were ranked by their average metric score and assigned a segment according to their quartile; for example, those in the top 25% were placed in segment 1. In 2026/27, segments are assigned using the predefined thresholds shown above.

Direct year-on-year comparison is therefore not possible because the measures included in the framework have changed: some have been added or revised, while others have been removed. The summary below focuses on measures included in both frameworks, although their scoring methods may also have changed.

SCHT:-
Of the metrics being used to inform 2026/27 segmentation, approx. 40% existed for SCHT in 2025/26 NOF. SCHT have gone from an average metric score of 2.29 (29 out of 61) in Q4 2025/26 to 2.30 (31 out of 58) in Q1 2026/27. Sickness absence rate improved from 6.21% to 5.57%, with a positive impact on the score allocated. A change to the scoring methodology for Relative cost difference (National Cost Collection Index) sees the score go from 1.86 to 1. With a slight improvement to Percentage of cases waiting over 52 weeks for care, also having a positive impact on the score given they have been irradiated.

SaTH: -
Performance under the NHS Oversight Framework has improved significantly over the past year with its league-table position improving from 113th to 74th out of 134 trusts. The latest quarter includes further progress in the proportion of patients spending more than 12 hours in the Emergency Department and improvements in both 62-day referral-to-treatment and four-hour Emergency Department performance. However, the overall score has increased slightly from 2.35 in quarter 4, largely reflecting a deterioration in the combined finance score and a small rise in sickness absence. Changes to the framework and its benchmarking methodology also mean that improved performance does not always result in a better comparative score. SaTH stays in segment 3, and focused action will continue through established reporting routes to strengthen financial delivery, workforce attendance and operational performance.

Trust	Measure	Qtr. 1 25/26	Qtr. 2 25/26	Qtr. 3 25/26	Qtr. 4 25/26	Qtr. 1 26/27
Shrewsbury and Telford Hospitals NHS Trust (SaTH)	Average Metric Score	2.72	2.60	2.47	2.35	2.45
	Segment	5	5	3	3	3
	League table position	113/134	96/134	78/134	72/134	74/134
Shropshire Community Health NHS Trust (SCHT)	Average Metric Score	2.16	2.11	2.05	2.29	2.30
	Segment	2	2	1	2	2
	League table position	17/61	17/61	14/63	29/61	31/58

2.0 Group Update

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

2.2 Last month, an engagement event brought together STW (Shropshire, Telford and Wrekin) GPs and senior medical colleagues from across the Group to share experiences and identify opportunities for improvement through closer working. Priority workstreams will now be agreed, with a further session planned for February 2027. It was encouraging to see so many colleagues attend and to provide a valuable opportunity for networking and building relationships in person.

2.3 At the end of September 2026, we launched the annual NHS Staff Survey across the Group, and I wrote to all colleagues encouraging them to take part. At a time of significant change,

uncertainty and sustained pressure across the NHS, the survey provides an important opportunity to understand colleagues' experiences of working in our organisations.

We want to hear what is working well, what makes colleagues proud, where they feel supported and where we need to improve. Every response contributes to a fuller picture of the experiences of our 10,000 colleagues across hospitals, community services and teams, helping to ensure that decisions are informed by those who deliver care each day. Alongside initiatives such as Poppy's Promise and Our Culture workshops, the survey offers a safe and confidential way for colleagues to share their views. We may not be able to address every issue immediately, but meaningful improvement depends on understanding their experiences. I therefore encourage every colleague to complete the survey when invited. It takes only a few minutes, but each response can make a meaningful difference.

2.4 Our annual staff flu vaccination campaign, *Be Wise, Immunise*, begins on 1 October 2026. I encourage every colleague to take part and have their flu vaccination when offered. By doing so, we can help protect one another, our patients and our families, while reducing the risk of flu spreading across our services during the winter months.

2.5 October marks Black History Month, providing an important opportunity to celebrate the achievements and contributions of Black colleagues and communities, while reflecting on the experiences and inequalities that continue to shape people's lives. Across the Group, we remain committed to listening, learning and creating an inclusive culture in which every colleague feels respected, valued and able to thrive. I encourage colleagues to take part in the activities planned throughout the month and to consider how each of us can help turn awareness into meaningful and lasting change.

2.6 NHS England has announced that Martha's Rule will be extended to all emergency departments, giving patients, families, carers and staff a clear route to request an urgent independent clinical review if they are concerned that a patient's condition is deteriorating and their concerns have not been addressed. In line with the national recommendations, we will build on our existing escalation and governance arrangements and work across adult and paediatric multidisciplinary teams to test a model that reflects both RSH and PRH while maintaining the national core standards. Implementation will need to cover majors, resuscitation, reception and waiting areas, and temporary escalation spaces, with completion expected by the end of March 2028. Progress and assurance will be reported through the appropriate committees through to Board.

2.7 Following July's update, our engagement with families involved in the Ockenden Review has continued. On 16 September 2026, the Chair and I met with families alongside members of the Executive team, the Head of Midwifery and our Maternity Communications and Engagement Lead. The discussion provided further insight into families' experiences and the improvements they expect to see. Their feedback continues to inform our priorities, and we remain committed to ensuring that family voices are central to the design, delivery and oversight of maternity improvement.

The Learning and Improvement Group met the following day, bringing together families, regional NHS England colleagues and Board and Divisional representatives. The Group reviewed progress against agreed actions, identified areas requiring further focus and agreed the next steps needed to translate learning into sustained improvement. Progress will continue to be tracked through the established maternity governance arrangements. We

expect to meet with families again in November 2026, with a smaller stakeholder group meeting in the interim.

2.8 Congratulations to the SCHT Pharmacy team, who won the Care Home category at the PrescQIPP Awards following the success of their pilot. This is a well-deserved achievement for everyone who supported the work. It was a fitting way to mark World Pharmacists Day.

2.9 Congratulations to the orthodontic oral surgery team at SaTH who won a HSJ patient safety award in the advancing patient safety with data and analytics category.

2.10 Congratulations to all the finalists in our inaugural annual Group Staff Awards. We will welcome 300 colleagues to celebrate their achievements over the past year. The response has been outstanding, with more than 500 nominations received. I would also like to thank our sponsors for their generous support of the event.

2.11 In September, we marked Diversity and Inclusion Week by celebrating the breadth of cultures, backgrounds, experiences and perspectives across our Group, and recognising those who help colleagues feel valued, respected and included. Cultural Diversity Day brought this commitment to life through inspiring speakers, thoughtful discussion, cultural performances, wellbeing activities and food. Diversity and inclusion extend beyond a single event or week; they are central to our ambition to build the safest and kindest Group, where everyone feels they belong, can be themselves and can thrive at work.

2.12 Congratulations to the SaTH Estates team who have been shortlisted in the Healthcare Estates Awards. The Team has been nominated for the Net Zero Innovation Award. Shona Baugh, Sustainability Lead, has also been shortlisted for the Champion of Champions Award category. The winners will be announced on 13 October.

2.13 Throughout October, we are supporting Breast Cancer Awareness Month and helping to raise awareness of the importance of breast awareness, early diagnosis and attending screening when invited. We also recognise colleagues across the Group who support patients and families through diagnosis, treatment and ongoing care, and encourage everyone to seek advice promptly if they notice a change that is unusual for them.

2.14 The Neonatal Unit has achieved the UNICEF Baby Friendly Initiative Stage Three accreditation. The UNICEF UK Baby Friendly Initiative (BFI) is a global programme that enables health professionals to better support families with feeding and developing and loving relationships so that all babies get the best possible start in life.

2.15 Thank you to everyone who attended the Group Annual General Meeting at Telford Football Ground. It was great to visit the stalls and hear colleagues from across the Group describe their pride, progress made to date and their ambitions for the next 12 months.

2.16 On Saturday 3 October we are hosting a Maternity and Neonatal Open day. Following successfully securing HHSE graduate funding to support additional newly qualified midwives we have received 81 applications for band 5 midwifery roles. The team are currently finalising the details for Baby Loss Awareness Week 09-15 October 2026 which has been co-produced with families.

2.17 In early October, we will welcome the BBC's journalist, Michael Buchanan to speak with a maternity services midwife who has completed the mandatory Poppy's Promise training. The

BBC will also film Katie Russell to learn more about Poppy's Promise, which was co-produced and launched across the Group.

2.18 October also marks Stoptober, the national campaign encouraging people who smoke to make a 28-day quit attempt. Stopping smoking is one of the most important steps anyone can take to improve their health, with benefits beginning soon after quitting and extending to family and friends through reduced exposure to second-hand smoke.

I encourage colleagues, patients and people across our communities who smoke to take part and make use of the free NHS advice, practical tools and specialist support available. Every quit attempt is a positive step towards becoming smoke-free.

2.19 October is also Freedom to Speak Up Month, an important opportunity to reinforce that every colleague should feel safe and supported to raise concerns, share ideas and challenge where something does not feel right. Speaking up helps us learn, improve and protect patients and colleagues, and no one should experience disadvantage for raising a genuine concern. Colleagues can choose the route that feels most appropriate, whether through their line manager, senior leaders, the Freedom to Speak Up champions. We remain committed to listening, responding openly and taking appropriate action.

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

3.1 The next Board meeting is 26 November 2026, 1.30pm, the venue is still to be confirmed.

4.0 NHSE

4.1 Provider and ICB chief executives and chairs from across the Midlands will attend a regional roadshow on Tuesday 20 October 2026, alongside national directors and members of NHS England's regional and national executive team.

4.2 Following its introduction last year as updated in August 2026, NHS England has launched the 2026 provider capability assessment. NHS trusts are required to assess themselves against capability statements based on The insightful provider board. This year's statements have been updated to include greater board-level focus on cybersecurity, digital maturity and staff wellbeing. As last year, the assessment is intended to strengthen board assurance, focus attention on key governance priorities and support an open, 'no surprises' relationship between providers and regional oversight teams. The findings will also inform the level of oversight applied to each organisation during the year. Submissions are due by Friday 2 October, with capability scores expected in December 2026. At the time of writing this report we are on track to meet this deadline.

4.3 I attended on 29 September with a number of our Executives a national engagement session with NHS England on eliminating corridor care. Corridor care affects everyone: it can compromise patients' privacy, dignity, safety and experience, while placing additional pressure on staff and making it harder for them to deliver the standard of care they want to provide. The Trust has already taken steps to close and remove corridor-care areas across both acute hospital sites. A small number of spaces remain, and we are committed to working with our clinical teams to eliminate them safely and in a planned way.

4.4 *Building a Better Future for Maternity and Neonatal Care* opened on 21 September, and I would encourage all colleagues working across maternity and neonatal services to take part. This national online conversation, led by NHS England, aims to be the largest discussion ever held about an NHS service, giving staff the opportunity to share their experiences and ideas to help shape the future of care for women, babies and families. The conversation is open, anonymous and designed to inform national action plans and local improvements. As an organisation, we know the difference that listening to women, families and one another can make, and our experiences over recent years give us valuable insight to contribute to this important work. Thank you for your continued commitment to delivering safe, equitable and compassionate care, and I encourage you to register and have your say through the Your Voice platform.

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

1 October 2026

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26 August 2026

0. Reference Information

Author:	Stacey Worthington Executive Assistant	**Paper date:**	8 October 2026
Executive Sponsor:	Jill Barker, Chair	**Paper written on:**	27 August 2026
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	Trust Boards in Common meeting	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 26 August 2026 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
  - Finance & Capital Report Month 4
  - Integrated Performance Report
  - Estates and Environment Update
  - Annual Committee 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 26 August 2026. The meeting was quorate with a Non-Executive Director and six Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Jill Barker	Non-Executive Director (Chair of Meeting)
Sarah Lloyd	Chief Finance Officer
Claire Horsfield	Director of Operations (Community) and Chief AHP
Jonathan Gould	Deputy Chief Finance Officer
Sara Ellis-Anderson	Interim Director of Nursing (Community)
Shelley Ramtuhul	Director of Governance

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26 August 2026

Steve Price	Head of Information and Performance Assurance
Ned Hobbs	Group Chief Operating Officer
Martina Morris	Group Chief Nursing Officer
Richard Best	Associate Director of Estates (part-meeting)
Lee Wyatt	Deputy Chief Estates Officer (part-meeting)
Helen Ainsbury	Group Chief Digital Information Officer

Apologies:	
Tina Long	Non-Executive Director and RPC Chair
Richard Milner	Non-Executive Director (SaTH)
Jon Davis	Associate Director of Digital Services and Performance

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
7. Finance and Capital Report		
The Trust continues to deliver its financial plan, noting substantive staffing levels have not yet reached planned levels. Where appropriate, these vacancies have been covered with bank or agency staffing. The Trust's efficiency plan remained on track, however, the value of schemes classed as high risk in terms of delivery has not materially reduced and this work is being overseen through the Financial Recovery Group (FRG). It was noted that the planned reduction in agency spend from month 4 was not delivered and this remains a risk in relation to delivery of the financial plan, also overseen by the FRG. It was noted that the risk associated with delivery of the financial plan remains high, and the mitigating actions were considered.	Full	
8. Integrated Performance Report		
It was noted that the report had been updated to reflect national changes in the Oversight Framework, as approved through the Boards.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26 August 2026

No KPIs overseen by this Committee were reported as both an assurance concern and a special cause variation concern this month. Access to services and waiting times remain the key areas of focus for performance improvement. There had been slight improvements shown across some services, with a small deterioration in RTT 30+ for adult services and Local 40+ for children's services. It was noted that both of these were ambitious, local targets and there were action plans in place to improve the performance. The financial KPIs which are flagged as a concern are due to a change in the revenue plan and the finance report covers all aspects of financial performance in detail.		
9. Estates and Environment Quarterly Update		
Overall compliance across the Trust's estate identified a number of areas requiring attention, although it was noted that none of the non-compliant areas currently identified as a high risk. An independent review is continuing across the estate to identify any planned future work requirements. It was noted that Fire Safety accountability and reporting have changed positively following the development of the Group model. Work to clarify the governance arrangements was agreed, ensuring continued clarity in this important area. There were no high-risk compliance issues to be escalated.	Partial	Review of governance arrangements in relation to Fire Safety following the introduction of Group roles.

3.4 Approvals

None.

3.5 Risks to be Escalated

No new risks were identified within the course of the meeting; although it was noted that the level of financial risk remains stable, rather than declining.

4. Conclusion

The Boards of Directors are asked to note the meeting that took place and the assurances obtained.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Performance Assurance Committee, Key Issues Report		
Report Date: 22 September 2026		**Report of:** Performance Assurance Committee
Date of meeting: 22 September 2026		R Edwards (Chair), R Dhaliwal, N Hobbs, N Lee(part), S Balderstone(part), H Ainsbury, L Mitchell
1	**Agenda**	The Committee considered the following: • Performance Highlights & includes:- • Performance & Financial matters metrics within UEC/ED pathways • Progress Report from Non-Admitted Working Group • UEC SIIP • IPR • Winter Plan 26-17 • Workforce Plan & Performance Impact & includes:- • Update on Workforce Reduction Implementation Associated with Digital Transformation and Efficiency Programmes • Workforce Establishment Update: Vacancy Controls, Recruitment and Workforce Reductions • Health & Inequalities • Climate Change 4A Report • Digital Transformation Assurance Committee 4A Report • Data Quality Update • PAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency Care: 4-hour performance and 12-hour performance decreased in August and long waits over 24 hours and over 48 hours increased. July had seen record numbers of attendances and high non-elective admissions and this affected August's 12-hour performance and ambulance hand-over times. PAC were conscious of the impact this will have on achieving SaTH's Winter Plan. • UEC System Integrated Improvement Plan: PAC heard that average ambulance handover time in August increased following a period of reduced flow through ED. Average ambulance handover time in August 2026 was 68.6 minutes against an operational target of 55 minutes. ED attendances reduced in August compared to the previous 3 months. However, complex LOS in the hospital increased, causing restricted ED flow. As a result, this action (SaTH 3.3.3) is now assessed as "At Risk".
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cancer Care: PAC heard that while July's performance was strong, August's was likely to be even stronger, with SaTH's best 28-day performance. SPC charts show sustained statistically significant improvement. July performance was 86.6% against a plan of 80%, with SaTH maintaining a level of 80% or above since September 2025.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• Winter Plan 2026-2027: PAC endorsed the Winter Plan and the Board Assurance Statement, considering that it gave a fair and balanced account of the measures being taken and the challenges SaTH faced, particularly in the light of the very difficult July and August position. PAC also took note of the additional measures being taken, including the proposed model of Discharge to Assess for patients with complex discharge needs. • Discharge to Assess: PAC received a detailed report on this and noted the potential benefits - people being assessed earlier and in their own homes - and financial risks - if there were to be delays in LA Care taking over from this bridging care. PAC were informed that ShropCom already had

		experience of running such a scheme on a smaller scale, that it would be closely monitored and would initially be a 9-month pilot. • PAC received a report from the Non-admitted Working Group outlining the findings of Nexus Consultancy, and which identified ways to change processes so that blood sample results and CT scan results are obtained much more quickly, allowing patients to start treatment earlier and/or be able to leave ED sooner, giving a better patient experience and reducing overcrowding. These process changes would also benefit patients due to be admitted. Trials of the new processes had already started. • UEC Performance and financial metrics: PAC received SPC charts showing ED Cost per attendance, attendance per WTE, NCTR average patients per day and NCTR average number of patients total cost. This will be included in the Performance Highlights report on a quarterly basis. This first two showed costs going down, the latter two were both increasing. • Prevention and Health Equalities Update: PAC received a report showing significant work in progress in SATH and ShropCom to develop a group prevention and health inequalities programme of work which extends across the Integrated Care System. • Digital Transformation: PAC heard that there have been successful go-lives since the last update including ICE Order Communications for radiology, Digital Pre-Op and digital nursing documentation and doctors 'handover and replacement of the Trust Bleep System, and that RPA (Robotic Process Automation) has gone live for e-referrals in the Patient Access Centre. Five different specialties will going digital and tasks will be removed in bulk. PAC heard that engagement events had been well run and that the transformation process will be closely monitored to ensure that tasks that are essential and needed continue to be performed effectively. • Data Quality Update: PAC heard that the National Cost Collection was completed in July and was fed via the Federated Data Platform (FDP). Following the FDP programme the Trust has formally transitioned from project delivery into a stabilisation and optimisation phase, with previous implementation phases now closed. The focus is now on ensuring that core data flows operate reliably, governance arrangements are embedded within business-as-usual (BAU) processes, and a sustainable operating model is established with progress monitored against delivery of stabilisation and Target Operating Model (TOM) milestones rather than historic Phase 2 objectives. The month 13 submission involved tens of thousands of manual amendments, whereas now there is visibility of data making checking easier and reducing the need for manual adjustments.		
2d	**Actions** ***Significant*** *follow up actions*	• Response times and compliance with service-level standards for Cardiology and Respiratory referrals: PAC will receive future reports on possible ways of systematically tracking referrals; regarding SaTH's progress on 7 day working, this would be within QSAC and PAC's remit. PAC to raise with QSAC. • Discharge to Assess/Domiciliary Care: potential impact on ED flow to be modelled.		
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: 01.09.2026		**Report of:** Finance Assurance Committee
Date of meeting: 01.09.2026		**Attendees:** R Miner (Chair), A Winstanley, S Crowther, J Sargeant, R Muskett, S Balderstone, C McInnes, L Mitchell (Minutes),M Morris, N Hobbs(part), M Neal(part)
1	**Agenda**	The Committee considered the following: • Financial Report M4 including Data Quality/SLAM update, Workforce plan and financial impact & Forecast update • Finance System Integrated Improvement Plan (SIIP) 4A Report • Efficiency & Financial Recovery Report • Contract approvals • Interpretation Services • Quarterly Contract Award update • Procurement Contract Update • Capital Planning Group ("CPG") 4A Report • Financial Recovery Group ("FRG") 4A Report • Operational Performance and Oversight Group ("OPOG") 4A Report • Review FAC Cycle of Reporting • Oncology & Haematology ward fit business case
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• M4 showed a deficit to date of £13.54m against a plan of £10.91m after deficit support and through certain technical adjustments. Although on the surface this didn't show a deterioration from M3, the underlying performance is somewhat worse and if performance does not improve for the remainder of the year, the deficit could reach £40m and will have serious implications for cash flow requiring revenue support. • Workforce and efficiency schemes will require further work as part of a demonstrable, credible (single) plan with achievable actions that can show the greatest impact between now and the end of the year and to close the "gap" to plan.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Cash balances at the end of M4 were £48.38m. • Efficiency savings of M4 were £12.04m against a plan for the year of £40m. To date, this is only £0.3m below plan. • Capital expenditure remains on track at £38.73m. • FAC noted the 4A reports and reporting consistency for CPG, OPOG and FRG. • The cycle of reporting continues to highlight the activities and structure of FAC's work
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The System Integrated Improvement Plan (SIIP) although mainly "green" rated will require review in the light of the current deficit position. • The quarterly contract award update and procurement contract approach will continue to be noted for ongoing improvements.

2d	**Actions** ***Significant*** *follow up actions*	• FAC approved the Haematology and Oncology Business Case to come to Board for further approval subject to further work. • FAC approved the proposed contract for Interpretation and Translation Managed Services to come to Board • As part of the reporting to FAC, we will change around the agenda to give clearer focus to the impact of efficiency and workforce on financial performance.		
3	**Report compiled by**	*Richard Miner, Non-Executive Director, Chair*	**Minutes available from**	*Lisa Mitchell, Senior Governance Support Officer*

Audit and Risk Assurance Committee, Key Issues Report		
Report Date: 2026.10.01		**Report on:** Audit and Risk Assurance Committee
Date of meeting: 2026.09.07		All NED and Associate NED members were present. Also present but not part of the quorum: SaTH Group Chief Governance Officer, SaTH Acting Chief Finance Officer, together with representatives from the Trust's Internal Auditors and Anti-Fraud Specialist, MIAA (the Trust's External Auditors KPMG were not present), and Trust Officers from the Governance and Risk Teams, together with the Operational Lead Executive (for Security Annual Report).
1	**Agendas**	The Committee considered the following specific items: • Internal Audit – Progress Report • Internal Audit Report – Procurement • Internal Audit Report – Cyber Assessment Framework (CAF) / Data Security and Protection Toolkit (DSPT) • Internal Audit Follow Up Report • Anti-Fraud – Progress Report • Losses and Special Payments Report (quarterly) • Procurement Waivers Report (quarterly) • Non-Pay Controls Report (quarterly) • Contract Award Report (quarterly) • Risk Management Report (quarterly) • Security Annual Report 2025/26 • Freedom to Speak Up Report (quarterly) incorporating FTSU Priorities & Improvement Plan 2026/28 • FTSU/Whistleblowing Policy • Report of Register of Interests, Gifts, Hospitality & Sponsorship (bi-annual) • Digital Services Cyber Assessment Report
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• The Committee expressed concern on the continual extension of deadlines on five of the high-risk internal audit actions, noting that the progress made in closing high-risk recommendations over the last three years appears to be stalling. It was agreed that the Group CGO would raise with her executive colleagues the urgent need for evidence to be provided to allow these actions to be closed. • The Committee had requested a report to this meeting on Trust-wide data quality, however as the Chief Executive and Deputy Chief Executive were in the process of finalising permanent executive leadership for data quality, a deferment had been requested to the next meeting on 23 November 2026.This therefore remains an open action on the Committee action log.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• A substantial assurance opinion was provided by the internal auditors for the Procurement audit findings *(however see comment in Section 2c*)*. • The internal auditors provided an overall assurance rating of 'Moderate Risk' following their assessment of compliance with the 12 outcomes of the CAF/DSPT, whilst the confidence level of the Independent Assessor in the veracity of the self-assessment was rated as 'High Confidence'. The

		Committee recognised that the current moderate risk rating aligns with the Trust's developing digital maturity. • The Committee noted the positive assurance provided in relation to High Severity Cyber Alert management and patching compliance, and received assurance that remediation plans, mitigations and NHSE oversight arrangements are in place for residual risks associated with unsupported server operating systems and data-centre network segmentation.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• *Whilst acknowledging the positive Procurement audit opinion, the Committee expressed ongoing concern around the lack of alignment with process controls, as indicated by the continued number of financial waivers. The Executive recognised that a more defined focus at procurement stage, and the provision of more flexible budget holder training, were key to resolving the ongoing waiver issues and proposed the potential inclusion in the 2027/28 internal audit plan of a dedicated audit on waivers. • Two components of the Counter Fraud Standard were noted as amber (access to and completion of training, and fraud, bribery and corruption risk assessment completion). The Committee was advised that the MIAA Anti-Fraud Specialist is working with the Trust on the availability of a fraud e-Learning package for staff with a view to it forming part of mandatory training requirements; and the risk assessment completion is progressing. The introduction / completion of both components will facilitate a green rating. • The MIAA Anti-Fraud Specialist highlighted that imposter fraud is becoming more prevalent nationally, following the rapid development of AI. This led to Committee discussion on the Trust's interview processes, and a recommendation for the Group People Committee to review the use of Teams/non face to face interviews. • The Committee was pleased to note that Pharmacy stock write-offs continue to remain under the 0.5% agreed threshold for the seventh consecutive month. • The Committee noted that 'No PO, No Pay' compliance was below the 95% target previously approved by the Committee in Corporate (86%) and Women & Children's (89%) Divisions, and received assurance that arrangements are being made for dedicated training for those demonstrating recurrent non-compliance. • The 2025/26 Security Annual Report was received by the Committee, noting progress in several key developments to strengthen the Trust's security infrastructure. The Committee recognised that it will be necessary for the Trust to define post-HTP security arrangements during the current financial year, to ensure the correct balance of support between RSH and PRH and in consideration of the large volume of additional space which will be created. • The Committee heard that the FTSU Priorities and Improvement Plan has been refreshed to provide a single framework for delivering and monitoring the Trust's priorities against the FTSU self-reflection principles, providing a clear mechanism for Board oversight and continued improvement in speaking up culture. The Committee also discussed the appropriate governance path for SaTH FTSU reporting going forward, noting that the SCHT FTSU Guardian reports are received by the Group People Committee. It was agreed that it would be logical for both reports to be taken to the People Committee, and the Group CGO would take forward facilitating discussions and actions. • The Committee was pleased to note that compliance against the 80% Counter Fraud Authority standard for declarations of interests remains above the standard, at 86.7% at 1 September 2026. The Committee queried the level of confidence that all consultants' declarations of interests were being

		picked up, citing in particular those also working in private practice. To address this, it was proposed that consultants could sign to confirm completion of their declarations of interest at the same time as the Trust's Job Planning Policy.		
2d	**Actions** *Significant follow-up actions*	No *significant* actions at this time.		
	Report compiled by:	Beverley Barnes, Board Coordinator/ ARAC Secretary, Approved by Prof Trevor Purt, ARAC Chair	**Minutes available from:**	Mrs Beverley Barnes, Board Coordinator

Local Care Transformation Assurance Committee, Key Issues Report		
Report Date 25 September 2026		**Report of:** Local Care Transformation Assurance Committee
Date of Meeting 25 September 2026		**Attendees:** Prof T Purt (Chair), N Hobbs, N Lee, M Neal, S Biffen, S Dunnett, T Long, L Kennedy, S Lloyd, J Fullard-Slawson, G McIver, C McInnes & L Mitchell **Apologies:** J Barker, R Boyode, Dr J Jones, C Horsfield
1	**Agenda**	The Committee considered the following:- • Ops Group 4 A Report • Executive Summary and Programme update (highlight report) • Data Analysis • Integration of pathways • MIU Update • Communications and Engagement • Workforce Update • HTP Update • Domiciliary Care to discharge assess proposal • Board Assurance Framework Risk
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The Committee noted that, whilst good progress had been made in strengthening programme governance and delivery arrangements, further work was required before assurance could be provided that the Local Care Transformation Programme would deliver the full level of change required to support the future ambitions of the Hospitals Transformation Programme. • Members highlighted workforce planning and programme benefit realisation as key areas requiring ongoing focus, together with the need to maintain alignment between Local Care Transformation and HTP delivery plans. • The Committee also identified the need to refresh the current Board Assurance Framework risk (BAF 12) to reflect the programme's revised governance arrangements and responsibilities
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Committee received assurance that significant progress had been made in strengthening programme governance, project oversight, defining key milestone and reporting arrangements. Programme structure had been simplified from 49 projects to 27, allowing greater clarity around delivery priorities and accountability. • Members welcomed progress in pathway redesign, neighbourhood working, multidisciplinary team development and the increasing use of data to support service improvement and care closer to home. • The Committee also recognised the positive development of the proposed Discharge to Assess Bridging Service, which has the potential to improve patient experience, support timely discharge from hospital and enhance system flow.

		• Progress in developing a coordinated communications and engagement approach across partner organisations was also welcomed.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The Committee requested continued reporting on programme outcomes and benefits, with future reports providing clearer evidence of how projects contribute to the programme's strategic priorities and wider transformation objectives. • Further assurance was sought regarding workforce implications, delivery of integrated pathways, progress on neighbourhood models of care and the alignment of Local Care Transformation activity with HTP plans. • Members also requested further updates regarding the development of a revised Minor Injury Unit model and continued oversight of communications and engagement activity as the programme progresses.		
2d	**Actions** ***Significant*** *follow up actions*	• Develop a clearer, outcome-focused reporting framework that transparently aligns with the 5 Board-endorsed priority areas, for future Committee and Board reporting. • Continue joint working between Local Care Transformation and HTP teams to align pathway redesign, workforce planning and programme risks. • Present a revised Minor Injury Unit proposal following completion of further modelling and analysis. • Ensure future pathway development includes appropriate stakeholder, patient and partner engagement. • Progress the development of the Discharge to Assess Bridging Service through the agreed governance process. • Review and update the Board Assurance Framework risk to reflect current programme arrangements and assurance requirements.		
3	**Report compiled by**	Trevor Purt. Non-Executive Director (Chair)	**Minutes available from**	Lisa Mitchell Senior Governance Support Officer

Quality Committees in Common, Key Issues Report		
Report Date: 2026.10.01		**Report on:** Quality Committees in Common
Date of meetings: 1 October 2026		Apologies were received from Jill Barker, NED member. All other members were present together with a number of attendees from both Group organisations.
1	**Agendas**	The Committee considered the following specific items: • SATH: Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • Patient Stories for Quality Committees proposal • SATH: Quality and Safety Assurance Group Key Issues Report • SCHT: Quality and Safety Assurance Group Key Issues Report • SATH: Quality Indicators Integrated Performance (IPR) • SCHT: Report and Exception Report • SCHT / SATH: Patient and Carer Experience Report (Including Complaints, PALS & PaCE Quarterly Report) • SCHT / SATH: Patient Safety Report Learning from Deaths Report& Medical Examiner / Bereavement Service Report (Q1) • Medication Safety Q4 and Annual Report • SCHT / SATH: Medical Regulatory Group Report (Q1) • Maternity and Neonatal Transformation Assurance Committee Key Issues Report • Maternity Dashboard and Key Issues Report • Maternity and Neonatal Safety Champions Report • SCHT / SATH: Joint IPC Report and Improvement Plan, and IPC BAF for both Trusts (SE) • UEC SaTH Integrated Improvement Plan (SIIP) Key Issues Summary Report • Terms of Reference for new Quality Committees in Common • SaTH BAF risk register (covering quality risks) • *Thirwell Report to come to next meeting*.
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• A detailed discussion on Infection Prevention and Control (IPC) took place, and the comprehensive group improvement plan was welcomed. Committee members suggested that repeated IPC failures were becoming normalised, with recurring issues including hand hygiene, adherence to staff uniform policy, and the wearing of prohibited jewellery, with this leading to lack of accountability. However, the Group Chief Nursing Officer /Director of Infection Prevention and Control committed to the implementation of a

		stronger culture programme, increased executive visibility, including 'back to the floor leadership visits, and the need for greater accountability where improvement not achieved.
	Assurance *Positive assurances and highlights of note for the Board*	• The Committees heard that Martha's Rule implementation is progressing across adult and paediatric serviced with telephone escalation arrangements in place and that further work was underway in maternity and emergency care. • The new baby tagging system was reported as being ready to go live with individual staff logins, training, weekly checks and governance reporting. The committee heard that SATH had implemented a formal referral process to the Mental Health Liaison Team (MHLT) at Midlands Partnership University Foundation Trust (MPFT) is to be implemented in response to the regulation 28 report from HM Coroner in May 26. The Committees requested that the referral process at Shrop Comm should be reviewed to provide assurance that it was effective. • Greater confidence in mortality data, established prospective analysis of emergency department deaths, and recurring themes around admissions, readmissions, advance care planning, communication, discharge and patient experience that will inform future work, was reported as part of the Learning from Deaths presentation. It was also noted that the performance team had confirmed that the data submitted to NHS England as part of its regular submissions, was again sufficiently reliable. • Structured judgement reviews are automatically requested for deaths involving patients with learning disability, autism, or serious mental illness. Six reviews were requested for deaths for people with a learning disability or autism and five for serious mental illness; one serious mental illness case was escalated into a patient safety process. • A positive discussion took place re the new Learning from Deaths thematic reporting methodology. For the next meeting the Committees asked that they see: • continued development of ED mortality analysis • stronger focus on admissions, readmissions and advance care planning
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been*	• The Committees agreed that patient stories from across the Group will appear on each agenda going forwards -focusing on quality, safety and outcomes. Stories should find where action is required or showing learnings / improvement. • The number of patient complaints received by the Trusts remains challenging, but work is ongoing to make improvements. A Patient Experience Assessment Framework for both providers will be

	noted / further assurance sought.	provided to the Boards at the December meeting. • The Committees were advised that following attendance at an NHSE meeting in London last week by CEO, Group Chief Nursing Officer, Group Medical Officer, and Group Chief Operating Officer regarding the eradication of corridor care, plans are being put in place to support a reduction in the number of patients being cared for in corridors, with the ultimate desired outcome being the complete eradication of the use of corridors for this purpose. A target timeframe of January 2027 was proposed. • SATH BAF was presented with a proposal that the BAF1 score be reduced. However, members of the Committees highlighted continuing risks from delayed discharge and patient harm, mortality risks, diabetic foot outcomes, ongoing Urgent and Emergency Care (UEC) pressures, resulting in no decrease in the BAF 1 score. The Committees acknowledged the progress since the risk was first identified and asked that the wording in the risk should be updated to reflect the current context. However, BAF risk 9 was reduced following sustained elective care improvement. The other risks (2,8,10 and 12) remain unchanged. • The Committees in Common ToR were reviewed and recommended for approval to the Board. • The overall implementation for this quarter for Saving Babies Lives v3 has decreased from the last quarter from 99%→96%. While women already on hybrid closed loop systems are being switched to pregnancy-specific hybrid closed loop systems, onboarding new patients is stalled due to staffing shortages. The Committees asked for a paper on diabetic care provision across the group to include this unmet need.		
2d	**Actions** *Significant follow-up actions*	• Paper on diabetic care provision across the group, including maternity care, requested. • Work to continue to align papers to maximise impact of Group arrangements. • One page description of underpinning governance structure for quality and safety to be shared with members of the committees. • Confirmation that both Trusts have current published Patient Safety Incident Response Plans. • A Patient Experience assessment framework for both providers will be provided to the Board at its December meeting.		
	Report compiled by:	Sarah Dunnett, Committees in Common Chair	**Minutes available from:**	Michael Price Executive Support Officer

Next Committee meeting will take place on Tuesday 27th October 2026

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	089/26a		
Report Title	SCHT - Integrated Performance Report		
Executive Leads	Sarah Lloyd, SCHT CFO; Martina Morris, Group CNO Ned Hobbs, Group COO; Rhia Boyode, Group CPO		
Report Author	Steve Price, Head of Information and Performance Assurance Operational Leads Sara Ellis-Anderson, Interim Director of Nursing - Community Gina Billington, Head of Resourcing		
Prior Consultation:	**CQC Domain:**		**Link to SCHT BAF id(s)**
Resource and Performance Committee (SCHT), 23rd September 2026 Quality Committee in Common 1st October 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 relevant aspects of this report at its September meeting. Performance information was submitted to Quality Committee in Common and People Committee in Common although both took place after this paper was written. Assurance is provided to each committee on the actions being taken to improve performance and minimise risk through the action plans; these are included within the Board Information Pack.		
Recommendations for the Boards	The Boards are asked to: • **Consider** SCHT's performance to date and the assurance provided in relation to the actions being taken to improve performance and minimise risks where required. • **Approve** the 'True North' metric definitions • **Approve** the KPI changes detailed in the report • **Note** the information presented in relation to the National Oversight Framework		
Appendices:	**Appendix 1:** Board Performance Dashboard Aug-2026 **Appendix 2:** Board SCHT Performance Icons **Appendix 3:** Group True North KPI Definitions **Appendix 4:** Assurance Action Plans – Information Pack Aug 2026		

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 continues to mature, 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. 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.

Each Assurance Committee is responsible for reviewing the relevant performance information and seeking assurance in relation to the actions to reduce risk and improve performance, where required.

2.2 Current Position

The key points for the Boards to consider are:

- There are 67 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. 25 indicators are highlighted as a concern (37.3%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
Resource & Performance	2	14	0	**32**	**16 (50%)**
Quality & Safety	1	1	1	**20**	**3 (15%)**
People	1	2	3	**15**	**6 (40%)**

Table 1: SCHT KPI Summary August 2026

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

As this is the first month of reporting to the Boards following the NHS Oversight Framework 2026 review, the month-on-month changes will be reintroduced in the next reporting cycle.

Action Plans to improve performance and minimise risks are developed in a multi-disciplinary team workshop including Operational Leads and Support Services.

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.

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

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.**

3.2 Summary of key points – Resource & Performance Committee

Of the 32 indicators which are reviewed by SCHT's Resource and Performance Committee (RPC), 16 require focused attention. It is of note that 14 of the 16 indicators requiring attention relate to access to services and waiting times.

Action Plans have been developed for all KPIs which require attention, with exceptions reported to the RPC.

The Resource & Performance Committee reviewed the presented action plans, and confirmed partial assurance was provided in relation to the actions being taken given recent performance of waiting times.

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

Of the KPIs that the Resource and Performance Committee is responsible for, 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. Planned surplus/deficit
2. Percentage of cases waiting up to 18 weeks for care (RTT) versus target

Fourteen KPIs are an assurance concern only - the process is not capable and will fail the target without process redesign.

1. Percentage of patients waiting up to 18 weeks - RTT
2. Percentage of patients waiting over 52-weeks RTT
3. Proportion of patients within 18 weeks
4. Proportion of patients within 18 weeks - Children's Services
5. Percentage of cases waiting less than 18 weeks for community care
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
14. Occupied bed days per 100,000 head of population

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

As this is the first month of reporting to the Boards following the NHS Oversight Framework 2026 review, the month-on-month changes will be reintroduced in the next reporting cycle.

August 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	42 (+3)	390 (+12)	77 (+21)	103 (-13)	119 (+24)	493 (-1)
40+ weeks	2 (-1)	77 (+25)	3 (-3)	10 (-2)	5 (-4)	87 (+23)
52+ weeks	0 (0)	0 (0)	1 (+1)	1 (0)	1 (+1)	1 (0)

Table 2 is categorised based on services within organisational structure and not age of patient.

Table 2 above has been updated to show changes in absolute numbers compared to the previous month. There are areas of improvement and deterioration, in the high waits noted. The action plans contain the detail/trends as well as the actions required for improvement. It is of note that the RTT 30+/40+ KPIs are ambitious, local targets (i.e. not nationally mandated or monitored) to guide the reduction in high waits and return to the standard of 92% within 18 weeks.

The 'Percentage of patients waiting up to 18 weeks – RTT' has shown recent levelling with performance of 80.76% in August compared with 81.5% in July. The August 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 national target for 'Total patients waiting more than 52 Weeks to start consultant-led treatment' KPI was exceeded with one patient waiting in excess of this limit in August; the patient has been dated for their treatment before the end of September. A full harm proforma and incident process is taking place to identify any learning.

The indicator for 'Proportion of patients within 18 weeks' has also levelled recently, with 81.97% in August compared with 82.73% in July. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature.

The indicator for 'Proportion of patients within 18 weeks – Children's Services' has been on a deteriorating trend over the last 6 months with 71.82% in August compared with 72.82% in July.

The appended plans describe the actions being taken to improve performance together with the trajectories for improvement.

There is an ongoing data issue in relation to activity relating to Continence products, impacting the August 2026 position and the indicator 'total activity undertaken against current year plan' will be refreshed once resolved.

Percentage of patients readmitted within 30 days of discharge has been reviewed and it is now an NHS Oversight Framework KPI relevant to SCHT. The Information Team has therefore added this to the dashboards. There is not a nationally set target for this KPI and, once this is assessed locally, a request for approval will be brought through the usual governance process.

In line with SCHT governance processes, The Resource & Performance Committee reviewed the below and supported the recommendation for the Trust Boards to **approve** the proposals:-

- Occupied bed days per 100,000 head of population has been recalculated to accurately reflect the per 100,000 calculation. The target has also been adjusted to take into account the per 100,000 of the population.

- Work has been conducted 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 SPC. The detail of the KPI and definitions can be found in Appendix 3.

3.3 Summary of key points – Quality & Safety Committee

Of the 20 indicators which were previously reviewed by SCHT's Quality & Safety Committee (Q&S) and will now be reviewed by Quality Committee in common, 3 require focused attention. 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:

One KPI is reported this month as a variation concern only – special cause variation of a concerning nature.

1. Safer Staffing - Average Fill Rate Non-Registered Nurses – Night

The dashboard indicates 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 above the target of 95%; this position provides assurance that safe staffing levels are being maintained.

One KPI is an assurance concern only - the process is not capable and will fail the target without process redesign.

1. Rates of Healthcare Associated Infection (C-Difficile) – The action plan for 'Count of c-difficile' covers this KPI.

One KPI is reported this month as both an assurance concern *and* special cause variation concern.

1. NHS Staff Survey – raising concerns sub-score.

Key areas for Quality and Safety Committee are as follows:

No medication incidents resulting in moderate harm were reported in August 2026, marking the sixth consecutive month with no moderate-harm medication incidents. Medication incidents causing low or moderate harm are now reported as rates per 1,000 community contacts and per 1,000 occupied bed days, supporting proportionate comparison and ongoing trend monitoring. In August, the rates were 0.10 per 1,000 community contacts and 0.79 per 1,000 occupied bed days. This provides assurance that medication-related harm remains low across both community and inpatient services, with no evidence of an increase in moderate harm.

Complaints performance remains positive, with complaints continuing to be managed within agreed response timescales and improvement work ongoing through investigation training and compliance with PHSO standards.

Staffing establishments remain safe across inpatient services. Registered and non-registered staffing fill rates continue to exceed the 95% target, with reported variation reflecting historical over-fill rather than staffing shortfalls or patient safety concerns.

No Category 3 pressure ulcers and one Category 4 acquired pressure ulcer were reported in August 2026. The community rate was 0.02%, which is considered low given the volume of community nursing contacts, while the inpatient rate was 0%. The new national KPIs provide clearer oversight across both care settings.

8 inpatient falls were reported in August 2026, this is a reduction of 7 falls from our last monthly report (July 2026 = 15 reported falls). This equates to a Trust rate of 3.1 falls per 1000 Occupied Bed Days (OBDs) (target is 4.0 falls/1000 OBDs) reduced from 5.85 last month.

There was 1 unexpected death recorded in August. This concerned a patient found at their home in respiratory distress by the Therapy Team during a routine home visit. Appropriate care and treatment had been provided.

No Patient Safety Incident Investigations (PSIIs) were commissioned during August 2026. The Governance team continue to review and support in those investigations commissioned over previous months to seek to ensure 6-month timeframe for completion. An extra-ordinary meeting is to be overseen by the Director of Nursing for Community to support progression of actions and learning from previous learning responses.

No new cases of C. difficile were reported in August 2026. However, the Trust remains at the year-to-date threshold. A Group-wide IPC improvement plan is being developed with SaTH. A thematic review of all CDI cases across acute and community services will also be commissioned to identify emerging themes and priority areas for improvement.

The NHS Staff Survey "Raising Concerns" sub-score remains below the national benchmark. SCHT scored 6.48 compared with a Community Trust average of 7.01. A strengthened improvement plan has been developed focusing on speaking up culture, Freedom to Speak Up (FTSU) intelligence, staff feedback, Professional Nurse Advocate support and targeted engagement with low-scoring teams.

3.4 Summary of key points – People Committee

Of the 15 indicators which are overseen by the People Committee, 6 require focused attention. 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:

One KPI is reported this month as a variation concern only – special cause variation of a concerning nature.

1. NHS staff survey engagement theme score

Two KPIs are reported as an assurance concern only - the process is not capable and will fail the target without process redesign.

1. Total shifts exceeding NHSI capped rate
2. Appraisal Rates

Three KPIs are reported this month as both an assurance concern *and* special cause variation concern.

1. Sickness Absence Rate - 12 month rolling
2. National education and training survey satisfaction rate
3. NHS staff survey advocacy rate

At month 5 the total workforce was under plan by 48.8 WTE. Temporary staffing usage in Month 5 is a mixed picture: Bank use has increased slightly on month 4 and Agency use has decreased. Bank usage is showing a positive variance of 2.0 WTE and Agency usage showing a negative increase in variance of 3.4 WTE, against a month 4 variance of (1.3 WTE). Overall workforce variance against plan has decreased from 52.9 WTE to 48.8 WTE.

Month 5 agency use is 19.89 WTE with an expenditure of £195K against a plan of 23.3 WTE and £180K, a variance of (3.41) WTE and £15k 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.

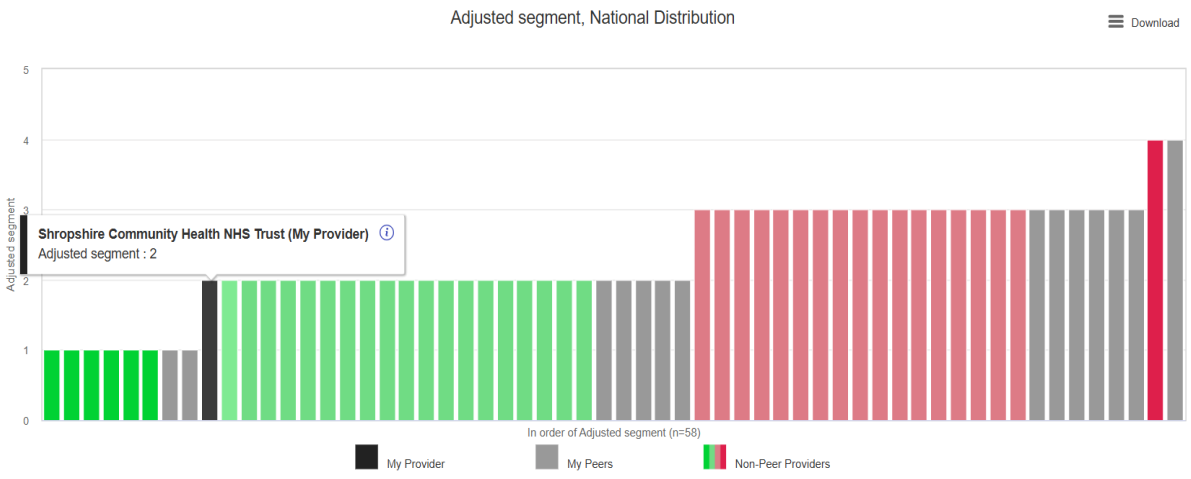
Sickness absence has remained above target since April 2025. Following modest month-on-month increases, the rate reduced to 5.69% in April and 5.68% in May, before increasing to 5.71% in June, 5.77% in July and 5.78% in August. The latest position therefore represents a marginal increase of 0.01 percentage points from July and remains 1.03 percentage points above the 4.75% target. The variance continues to require focused management action. Stress, anxiety and depression remain the principal drivers of sickness absence. These trends continue to shape the Trust's targeted wellbeing and absence-management interventions. Long-term absence continues to account for the largest proportion of overall absence; however, the current trend shows an increase in short-term absence alongside a reduction in long-term absence.

Short-term absence continues to increase and remains the key area of concern. Reports identifying individuals who have reached short-term absence triggers continue to be issued to line managers to support timely intervention in accordance with Trust policy. The People Team provides oversight of this process, monitors management response and escalates areas where action is not progressing as expected. This provides a clear line of assurance that trigger breaches are visible and subject to follow-up.

Appraisal compliance improved slightly to 87.65% in August, compared with 87.52% in July. Although performance remains below target, the position is improving. Targeted oversight and support remain in place for hotspot areas to secure completion of outstanding appraisals.

3.5 NHS Oversight Framework

The Quarter 1 position has been published, reflecting the scores for organisations based on the new metrics and in line with the NHS Oversight Framework (NOF) 2026 guidance. SCHT has been allocated an overall National Oversight Framework segment of 2 which is consistent with the latest position from 2025/26. Organisations rated as 1 are reported as the best performing and organisations rated as 4 requiring the most support.



The Resource and Performance Committee considered the detailed information which supports this score at its meeting in September. Most NOF KPIs relevant to SCHT are included within the Integrated Performance Reports; these are presented to assurance committees for consideration.

It is recognised that there are opportunities for improvement highlighted through the NOF. Details in relation to the actions being taken to improve the performance are shown within the relevant action plans, and assurance is gained through the relevant committees.

3.6 Key Issues & Recommendations

The Boards are asked to note that the work across our Group to reflect 'True North' KPIs within performance dashboards is now being concluded. This will ensure a standardised approach to performance reporting in line with NHSE Making Data Count.

3.7 Conclusion

The Boards are asked to:

- **Consider** SCHT's performance to date and the assurance provided in relation to the actions being taken to improve performance and minimise risks where required.
- **Approve** the 'True North' metric definitions
- **Approve** the KPI changes detailed in the report
- **Note** the information presented in relation to the National Oversight Framework

Resource and Performance Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Experience of care	Average number of days between discharge ready date and actual discharg...	2026-08-31		3.88	3.24	0.64	3.88	3.24	0.64	
Finance, productivity and innovation	Data Quality Maturity Index	2026-05-31		97.0%	95.0%	2.0%	97.0%	95.0%	2.0%	
Finance, productivity and innovation	Financial efficiency - variance from efficiency plan	2026-08-31		1.35%	0.00%	1.35%	1.35%	0.00%	1.35%	
Finance, productivity and innovation	Implied productivity growth	2026-03-31		4.90%	2.00%	2.90%	4.90%	2.00%	2.90%	
Allocating resources	Level of growth in community care contacts	2026-08-31		1.25%	0.00%	1.25%	1.25%	0.00%	1.25%	
Access to services	New Birth Visits % within 14 days - Dudley	2026-07-31		96.01%	90.00%	6.01%	91.83%	90.00%	1.83%	
Access to services	New Birth Visits % within 14 days - Shropshire	2026-07-31		91.33%	90.00%	1.33%	89.30%	90.00%	-0.70%	
Access to services	New Birth Visits % within 14 days - Telford	2026-07-31		90.96%	90.00%	0.96%	91.06%	90.00%	1.06%	
Access to services	Number of patients not treated within 28 days of last minute cancellation	2026-08-31		0	0	0	0	0	0	
Allocating resources	Occupied bed days per 100,000 head of population	2026-08-31		481.26	473.00	8.26	481.26	473.00	8.26	
Access to services	Percentage of cases waiting less than 18 weeks for community care	2026-08-31		83.93%	92.00%	-8.07%	83.93%	92.00%	-8.07%	
Access to services	Percentage of cases waiting up to 18 weeks for care (RTT) versus target	2026-08-31		-13.09	0.00	-13.09	-13.09	0.00	-13.09	
Access to services	Percentage of diagnostic referrals waiting less than 6 weeks	2026-07-31		93.00%	99.00%	-6.00%	93.00%	99.00%	-6.00%	
Experience of care	Percentage of intermediate care beds occupied by patients without criteria t...	2026-08-31		26.71%	20.00%	6.71%	26.71%	20.00%	6.71%	
Access to services	Percentage of patients admitted, discharged or transferred within 4 hours	2026-08-31		99.24%	82.00%	17.24%	99.24%	82.00%	17.24%	
Effectiveness and experience of care	Percentage of patients readmitted within 30 days of discharge	2026-08-31		7.71%		7.71%	7.13%		7.13%	
Access to services	Percentage of patients waiting over 52-weeks for community services	2026-08-31		0.01%	0.00%	0.01%	0.01%	0.00%	0.01%	
Access to services	Percentage of patients waiting over 52-weeks RTT	2026-08-31		0.01%	0.00%	0.01%	0.01%	0.00%	0.01%	
Access to services	Percentage of patients waiting up to 18 weeks - RTT	2026-08-31		80.76%	92.00%	-11.24%	80.76%	92.00%	-11.24%	
Finance, productivity and innovation	Planned surplus/deficit	2026-08-31		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	

Resource and Performance Committee - SPC Summary (continued)

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Access to services	Proportion of patients within 18 weeks	2026-08-31		81.97%	92.00%	-10.03%	81.97%	92.00%	-10.03%	
Access to services	Proportion of patients within 18 weeks - Childrens Services	2026-08-31		71.82%	92.00%	-20.18%	71.82%	92.00%	-20.18%	
Access to services	Total patients waiting more than 30 weeks - all services	2026-08-31		493	0	493	493	0	493	
Access to services	Total patients waiting more than 30 weeks to start consultant-led treatment	2026-08-31		119	0	119	119	0	119	
Access to services	Total patients waiting more than 40 weeks - all services	2026-08-31		87	0	87	87	0	87	
Access to services	Total patients waiting more than 40 weeks to start consultant-led treatment	2026-08-31		5	0	5	5	0	5	
Access to services	Total patients waiting more than 52 weeks - all services	2026-08-31		1	0	1	1	0	1	
Access to services	Total patients waiting more than 52 weeks to start consultant-led treatment	2026-08-31		1	0	1	1	0	1	
Effectiveness and experience of care	Urgent Community Response 2-hour performance	2026-05-31		89.01%	70.00%	19.01%	89.01%	70.00%	19.01%	
Finance, productivity and innovation	Total activity undertaken against current year plan	2026-08-31		92.60%	100.00%	-7.40%	102.35%	100.00%	2.35%	
Finance, productivity and innovation	Variance to plan year-to-date	2026-08-31		0.50%	0.00%	0.50%	0.50%	0.00%	0.50%	
Finance, productivity and innovation	Virtual ward bed occupancy	2026-08-31		84.32%	80.24%	4.08%	84.32%	80.24%	4.08%	

Quality and Safety Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Experience of care	Complaints - (Open) % within response timescales	2026-08-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Experience of care	CQC Conditions or Warning Notices	2026-08-31		0	0	0	0	0	0	
Patient Safety	Compliance with Duty of Candour	2026-08-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Patient Safety	Count of c-difficile	2026-08-31		4	4	0	10	4	6	
Patient Safety	Deaths - unexpected	2026-08-31		1	0	1	1	0	1	
Patient Safety	Deaths in Custody per 1000 prisoners	2026-08-31		0.00	0.00	0.00	0.00	0.00	0.00	
Patient Safety	Falls per 1000 Occupied Bed Days	2026-08-31		3.15	4.00	-0.85	3.15	4.00	-0.85	
Patient Safety	Medication Incidents - Community	2026-08-31		0.10	0.00	0.10	0.12	0.00	0.12	
Patient Safety	Medication Incidents - Inpatients	2026-08-31		0.79	0.00	0.79	0.48	0.00	0.48	
Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-08-31		6.48	7.01	-0.53	6.48	7.01	-0.53	
Patient Safety	Number of cases of MRSA in the last 12 months	2026-08-31		0	0	0	0	0	0	
Patient Safety	Patient Safety Incident Investigations	2026-08-31		0	0	0	3	0	3	
Patient Safety	Percentage of patients to acquire a new category 3 or 4 pressure ulcer - Community	2026-08-31		0.02%	0.00%	0.02%	0.02%	0.00%	0.02%	
Patient Safety	Percentage of patients to acquire a new category 3 or 4 pressure ulcer - Inpatients	2026-08-31		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-08-31		225.00%	100.00%	125.00%	225.00%	100.00%	125.00%	
Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-08-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-07-31		101%	95%	6%	101%	95%	6%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-07-31		118%	95%	23%	118%	95%	23%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-07-31		95%	95%	0%	95%	95%	0%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-07-31		96%	95%	1%	96%	95%	1%	

People Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People	Appraisal Rates	2026-08-31	H	87.65%	90.00%	-2.35%	87.12%	90.00%	-2.88%	F
People	Bank Usage - Variance from plan (WTE)	2026-08-31	L	-1.98	0.00	-1.98	-6.32	0.00	-6.32	?
People	Mandatory Training Compliance	2026-08-31	H	96.14%	95.00%	1.14%	96.14%	95.00%	1.14%	?
People	National education and training survey satisfaction rate	2025-12-31	L	74.08%	90.00%	-15.92%	74.08%	90.00%	-15.92%	F
People	Net Staff in Post Change	2026-08-31		2.25	0.00	2.25	5.48	0.00	5.48	
People	NHS staff standards score	2026-08-31		7.90	7.83	0.07	7.90	7.83	0.07	
People	NHS staff survey advocacy rate	2026-08-31	L	6.81%	7.26%	-0.45%	6.81%	7.26%	-0.45%	F
People	NHS staff survey engagement theme score	2026-08-31	L	6.91	7.09	-0.18	6.91	7.09	-0.18	?
People	Proportion of temporary staff	2026-08-31	L	2.4%	3.4%	-1.0%	2.7%	3.4%	-0.7%	?
People	Sickness Absence Rate - 12 month rolling	2026-08-31	H	5.78%	4.75%	1.03%	5.78%	4.75%	1.03%	F
People	Sickness Absence Rate - In month	2026-08-31		5.50%	4.75%	0.75%	5.50%	4.75%	0.75%	?
People	Temporary staffing cost relative band	2026-06-30		4	1	3	4	1	3	
People	Total shifts exceeding NHSI capped rate	2026-08-31	L	138	0	138	133	0	133	F
People	Total shifts on a non-framework agreement	2026-08-31	L	0	0	0	0	0	0	?
People	Vacancies - all	2026-08-31		8.28%	8.00%	0.28%	8.88%	8.00%	0.88%	?

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.

Indicator	Domain	SaTH/SCHT/ Group	YTD (Avg / Max / Latest)	Target 26/27	Bigger or smaller	NHS OF KPI?	Definition
% of cancer patients receiving treatment <62 days	Access	SaTH	Latest	75%	Bigger is better	Y	Numerator: Cancer patients receiving treatment <62 days Denominator: Total cancer patients receiving treatment
% of cancer patients receiving treatment <62 days	Access	Group	Latest	75%	Bigger is better	Y	Numerator: Cancer patients receiving treatment <62 days Denominator: Total cancer patients receiving treatment
% of colleagues advocating for the standard of care provided by our organisations - Group	People and Workforce	Group	Latest	62.84 (national average)	Bigger is better	N	Staff Survey - Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation - Group
% of colleagues advocating for the standard of care provided by our organisations - SaTH	People and Workforce	SaTH	Latest	61.55% (peer average)	Bigger is better	N	Staff Survey - Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation - SaTH
% of colleagues advocating for the standard of care provided by our organisations - SCHT	People and Workforce	SCHT	Latest	77.57% (peer average)	Bigger is better	N	Staff Survey - Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation - SCHT
% of colleagues recommending our organisations as a place to work - Group	People and Workforce	Group	Latest	58.05 (national average)	Bigger is better	N	Staff Survey - Q25c I would recommend my organisation as a place to work - Group
% of colleagues recommending our organisations as a place to work - SaTH	People and Workforce	SaTH	Latest	60.89% (peer average)	Bigger is better	N	Staff Survey - Q25c I would recommend my organisation as a place to work - SaTH
% of colleagues recommending our organisations as a place to work - SCHT	People and Workforce	SCHT	Latest	68.98% (peer average)	Bigger is better	N	Staff Survey - Q25c I would recommend my organisation as a place to work - SCHT
% of our CYP who are Healthy, Well and ready to learn 2.5 year ASQ - Group	Access	Group	Latest	60%	Bigger is better	N	Proposed definition - 60% at or above expected levels in five areas of development utilising the ASQ (ages and stages) questionnaire at 2.5 year review. Numerator: Number of children achieving who received a 2.5 year review using ASQ, whose scored above the relevant threshold across all five domains of the ASQ. Denominator: Number of children who received a 2.5 year review for which the ASQ was completed as part of their 2.5 year review.
% of our CYP who are Healthy, Well and ready to learn 2.5 year ASQ - SCHT	Access	SCHT	Avg	60%	Bigger is better	N	Proposed definition - 60% at or above expected levels in five areas of development utilising the ASQ (ages and stages) questionnaire at 2.5 year review. Numerator: Number of children achieving who received a 2.5 year review using ASQ, whose scored above the relevant threshold across all five domains of the ASQ. Denominator: Number of children who received a 2.5 year review for which the ASQ was completed as part of their 2.5 year review.
% of our CYP who are Healthy, Well and ready to learn New Birth Visits - Group	Access	Group	Latest	90%	Bigger is better	N	Proposed definition - New birth visits (NBV): Number of babies born within month who have been seen by a Health Visitor within 14 days of birth Numerator: Of the NBV that have taken place, the number that were within 14 days Denominator: Number of NBV
% of our CYP who are Healthy, Well and ready to learn New Birth Visits - SCHT	Access	SCHT	Avg	90%	Bigger is better	N	Proposed definition - New birth visits (NBV): Number of babies born within month who have been seen by a Health Visitor within 14 days of birth Numerator: Of the NBV that have taken place, the number that were within 14 days Denominator: Number of NBV
% of patients waiting <18 weeks RTT (acute & community) - Group	Access	Group	Latest	92%	Bigger is better	Y	Proportion of incomplete Referral to Treatment (RTT) pathways within 18 weeks at the end of the reporting period - Group Numerator: Number of Open Clock Pathways <18 weeks - Group Denominator: Number of Open Clock Pathways - Group

% of patients waiting <18 weeks RTT (acute & community) - SaTH	Access	SCHT	Latest	92%	Bigger is better	Y	Proportion of incomplete Referral to Treatment (RTT) pathways within 18 weeks at the end of the reporting period - SCHT Numerator: Number of Open Clock Pathways <18 weeks - SCHT Denominator: Number of Open Clock Pathways - SCHT
% of patients waiting <18 weeks RTT (acute & community) - SaTH	Access	SaTH	Latest	92%	Bigger is better	Y	Proportion of incomplete Referral to Treatment (RTT) pathways within 18 weeks at the end of the reporting period - SaTH Numerator: Number of Open Clock Pathways <18 weeks - SaTH Denominator: Number of Open Clock Pathways - SaTH
% of Type 1 ED attendances spending <12hrs in ED	Access	SaTH	Latest	98%	Bigger is better	Y	Numerator: Type 1 ED attendances spending <12hrs in ED Denominator: Total Type 1 ED attendances
% of Type 1 ED attendances spending <12hrs in ED	Access	Group	Latest	98%	Bigger is better	Y	Numerator: Type 1 ED attendances spending <12hrs in ED Denominator: Total Type 1 ED attendances
% of WTE worked by substantive Group employees - Group	People and Workforce	Group	Average	92.95%	Bigger is better	N	% of WTE worked by substantive Group employees - Group Numerator: WTE worked substantive employees - Group Denominator: WTE worked - Group
% of WTE worked by substantive Group employees - SaTH	People and Workforce	SaTH	Average	92.50%	Bigger is better	N	% of WTE worked by substantive Group employees - SaTH Numerator: WTE worked substantive employees - SaTH Denominator: WTE worked - SaTH
% of WTE worked by substantive Group employees - SCHT	People and Workforce	SCHT	Average	95%	Bigger is better	N	% of WTE worked by substantive Group employees - SCHT Numerator: WTE worked substantive employees - SCHT Denominator: WTE worked - SCHT
Achievement of financial balance - Group	Finance and Productivity	Group	Latest	100	Bigger is better	N	Numerator: Actual recurrent surplus/deficit (excludes DSF) - Group Denominator: Planned recurrent surplus/deficit (excludes DSF - Group
Achievement of financial balance - SaTH	Finance and Productivity	SaTH	Latest	100	Bigger is better	N	Numerator: Actual recurrent surplus/deficit (excludes DSF) - SaTH Denominator: Planned recurrent surplus/deficit (excludes DSF) - SaTH
Achievement of financial balance - SCHT	Finance and Productivity	SCHT	Latest	100	Bigger is better	N	Numerator: Actual recurrent surplus/deficit (excludes DSF) - SCHT Denominator: Planned recurrent surplus/deficit (excludes DSF) - SCHT
Increase % of patients receiving care taking place in a community location - Group	Access	Group	Latest	71%	Bigger is better	N	Proportion of activity delivered in a setting outside of RSH or PRH as location codes - Group Numerator: Actual Activity Delivered in setting outside of RSH/PRH - Group Denominator: Actual Activity Delivered - Group
Increase % of patients receiving care taking place in a community location - SaTH	Access	SaTH	Latest	20%	Bigger is better	N	Proportion of activity delivered in a setting outside of RSH or PRH as location codes - SaTH Numerator: Actual Activity Delivered in setting outside of RSH/PRH - SaTH Denominator: Actual Activity Delivered - SaTH
Increase % of patients receiving care taking place in a community location - SCHT	Access	SCHT	Latest	98%	Bigger is better	N	Proportion of activity delivered in a setting outside of RSH or PRH as location codes -SCHT Numerator: Actual Activity Delivered in setting outside of RSH/PRH - SCHT Denominator: Actual Activity Delivered - SCHT
Number of moderate, severe and fatal harm events - Group	Patient Safety	Group	Sum	No Target	Smaller is Better	N	Number of moderate, severe and fatal harm events - Group

Number of moderate, severe and fatal harm events - SaTH	Patient Safety	SaTH	Sum	No Target	Smaller is Better	N	Number of moderate, severe and fatal harm events - SaTH
Number of moderate, severe and fatal harm events - SCHT	Patient Safety	SCHT	Sum	No Target	Smaller is Better	N	Number of moderate, severe and fatal harm events - SCHT
Poppy's Promise (Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding) - Group	Effectiveness and experience of care	Group	Latest	9	Bigger is better	N	Best Start in Life (Poppy's Promise*) will be a measure of service user feedback once the Poppy's Promise App/feedback tool is launched. Until then National CQC Maternity Survey Questions C21 and D5 should be used, with a target of 9.0. D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
Poppy's Promise (Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding) - SaTH	Effectiveness and experience of care	SaTH	Latest	9	Bigger is better	N	Best Start in Life (Poppy's Promise*) will be a measure of service user feedback once the Poppy's Promise App/feedback tool is launched. Until then National CQC Maternity Survey Questions C21 and D5 should be used, with a target of 9.0. D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
Poppy's Promise (Thinking about your care during labour and birth, were you treated with kindness and compassion) - Group	Effectiveness and experience of care	Group	Latest	9	Bigger is better	N	Best Start in Life (Poppy's Promise*) will be a measure of service user feedback once the Poppy's Promise App/feedback tool is launched. Until then National CQC Maternity Survey Questions C21 and D5 should be used, with a target of 9.0. C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?
Poppy's Promise (Thinking about your care during labour and birth, were you treated with kindness and compassion) - SaTH	Effectiveness and experience of care	SaTH	Latest	9	Bigger is better	N	Best Start in Life (Poppy's Promise*) will be a measure of service user feedback once the Poppy's Promise App/feedback tool is launched. Until then National CQC Maternity Survey Questions C21 and D5 should be used, with a target of 9.0. C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?
Positive variance for financial performance against plan (income vs expenditure) - Group	Finance and Productivity	Group	Latest	100	Bigger is better	Y	Positive variance for financial performance against plan (income vs expenditure) – Group Numerator: Actual surplus/deficit – Group Denominator: Planned surplus/deficit – Group
Positive variance for financial performance against plan (income vs expenditure) - SaTH	Finance and Productivity	SaTH	Latest	100	Bigger is better	Y	Positive variance for financial performance against plan (income vs expenditure) - SaTH Numerator: Actual surplus/deficit - SaTH Denominator: Planned surplus/deficit - SaTH
Positive variance for Group financial performance against plan (income vs expenditure) - SCHT	Finance and Productivity	SCHT	Latest	100	Bigger is better	Y	Positive variance for Group financial performance against plan (income vs expenditure) - SCHT Numerator: Actual surplus/deficit - SCHT Denominator: Planned surplus/deficit - SCHT
Proportion of patients within 18 weeks (local waits) - Group	Access	Group	Latest	92%	Bigger is better	N	Proportion of patients still on a new waiting list, waiting less than 18 weeks - all services as of end of month - Group
Proportion of patients within 18 weeks (local waits) - SaTH	Access	SaTH	Latest	92%	Bigger is better	N	Proportion of patients still on a new waiting list, waiting less than 18 weeks - all services as of end of month - SaTH
Proportion of patients within 18 weeks (local waits) - SCHT	Access	SCHT	Latest	92%	Bigger is better	N	Proportion of patients still on a new waiting list, waiting less than 18 weeks - all services as of end of month - SCHT
Reduction in acute and community bed days per 100k of the population - Group	Effectiveness and experience of care	Group	Latest	1987.1	Smaller is Better	Y	Reduction in acute and community bed days per 100k of the population - Group (excluding 0 LOS admissions) Numerator - OBD's in Month - Group Denominator - Total Population - Group Calc - Numerator/Denominator *100,000

Reduction in acute and community bed days per 100k of the population - SaTH	Effectiveness and experience of care	SaTH	Latest	1513.98	Smaller is Better	Y	Reduction in acute and community bed days per 100k of the population - SaTH (excluding 0 LOS admissions) Numerator - OBD's in Month - SaTH Denominator - Total Population - SaTH Calc - Numerator/Denominator *100,000
Reduction in acute and community bed days per 100k of the population - SCHT	Effectiveness and experience of care	SCHT	Latest	473.12	Smaller is Better	Y	Reduction in acute and community bed days per 100k of the population - SCHT (excluding 0 LOS admissions) Numerator - OBD's in Month - SCHT Denominator - Total Population - SCHT Calc - Numerator/Denominator *100,000

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	089/26b		
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 - 2026.09.15 PAC - 2026.09.22 FAC - 2026.09.29	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 upadate on progress against the Trust's Operating plan and associated objectives and enablers. The Boards' 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 July 2026/August 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 8th October 2026

Presenting Month 5 performance data

Contents

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain/Report Section	Executive Lead	Slide number
Executive Summary	Chief Executive	3
Quality Patient Safety and Clinical Effectiveness	Group Chief Nursing Officer Medical Director	4
Responsiveness	Chief Operating Officer	44
Well-led (Workforce)	Chief People Officer	67
Well-led (Finance)	Director of Finance	77
Appendix		85

Moving to EXCELLENCE

Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Urgent and Emergency Care (UEC) 4-hour performance for Type 1 and Type 3 attendances remained within expected levels of common cause variation during August 2026. Type 1 performance decreased to 43.3%, while Type 3 performance improved to 89.0%. Average ambulance handover times increased significantly during the month, although performance remains within common cause variation. This deterioration was primarily driven by a marked reduction in the proportion of ambulance handovers completed within 45 minutes. The number of Type 1 patients spending more than 12 hours in the Emergency Department continued to demonstrate common cause 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 August (month five), the Trust has delivered a deficit position of £19.57m against a deficit plan of £13.50m pre deficit support funding, an unfavourable variance of £6.07m. This moves to a deficit of £6.86m against a planned deficit of £0.80m post deficit support.

The Trust's FY26/27 capital programme totals £162.72m, comprising £24.38m operational capital allocation (including IFRS16 expenditure) and £138.34m externally funded schemes. Capital expenditure to the end of Month 5 was £50.83m.

The Trust held a cash balance at end of August 2026 of £46.00m above plan due to the timing of capital; under the most likely revenue cash scenario the Trust will require revenue support in Q4 FY26/27.

The submitted Trust Position for August 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 validated Trust Position for Welsh is 0 x 104 weeks, 8 x 78 weeks, 40 x 65 weeks and 135 x 52 weeks.
The Trust is currently operating below the agreed RTT trajectory. However, a programme of focused improvement work is underway to strengthen productivity across multiple services areas, supported by targeted ERF investment to increase outpatient capacity and delivery.

Confirmed July cancer performance is 86.6% (28-day FDS) vs the local plan of 80%. 62-day performance was 75.1% against a local target of 74.9% and 31 day was 98.1% against a local target of 96%. The 62-day backlog is 147 patients over 62 days of which 36 are over 104 days (as at 22/09/2026).

The submitted DM01 position for August was 73.37%, with notable improvement in performance within Neurophysiology. Non-Obstetric Ultrasound (NOUS) performance deteriorated by 5.5%; however, a recovery plan has been in place since mid-June. Radiology reporting turnaround times for CT examinations have been maintained, with urgent suspected cancer (USC) referral-to-report turnaround times currently at approximately 2 weeks for CT, 2 weeks for MRI, and 1 to 2 weeks for NOUS. Radiologist workforce constraints continue to limit reporting capacity and reduce service resilience during periods of sickness and annual leave. To mitigate this risk and provide greater flexibility in reporting capacity, an additional outsourcing provider has recently been secured.

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	National Standard 26/27	Current Month Trajectory (RAG)	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2	20% < 2025-26	21	26	21	27	35	24	21	35	26	19	22	22	28	28	
	Pressure Ulcers - Category 2 per 1000 Bed Days	20% < 2025-26	0.81	1.01	0.81	1.03	1.30	0.95	0.80	1.22	1.03	0.67	0.86	0.80	1.10	1.07	
	Pressure Ulcers - Category 3	10% < 2025-26	4	4	9	6	2	9	3	9	6	4	6	8	4	17	
	Pressure Ulcers - Category 3 per 1000 Bed Days	10% < 2025-26	0.16	0.16	0.35	0.23	0.07	0.36	0.11	0.31	0.24	0.14	0.24	0.29	0.16	0.65	
	Pressure Ulcers - Category 4	0	0	0	0	0	0	0	0	1	1	1	0	1	0	0	
	Falls - per 1000 Bed Days	5% < 2025-26	4.35	4.58	4.08	4.19	4.09	3.93	4.41	4.61	4.81	4.20	5.25	4.23	4.97	4.76	
	Falls - total	-	112	118	106	110	110	99	116	132	122	119	134	116	127	125	
	Falls - with Harm per 1000 Bed Days	5% < 2025-26	0.22	0.23	0.12	0.23	0.07	0.08	0.15	0.10	0.04	0.25	0.16	0.15	0.16	0.15	
	Falls - Resulting in Harm Moderate or Severe	0	0	6	3	6	2	2	4	3	1	7	4	4	4	4	
Patient Experience	Complaints	-	-	127	106	114	116	105	102	122	118	133	120	133	136	134	
	Complaints - responded within agreed timeframe - based on month response due	85%	85%	49.0%	49.0%	43.0%	50.0%	50.0%	51.0%	60.0%	56.0%	54.0%	52.0%	59.0%	58.0%	56.0%	
	Complaints per 1000 attendances (ED, IP, OP)			1.38	1.24	1.25	1.25	1.22	1.21	1.37	1.39	1.40	1.39	1.58	1.48	1.46	
	Complaints by Theme - Access to Treatment or Drugs			5	6	4	4	8	13	11	7	10	3	7	9	9	
	Complaints by Theme - Admission / Discharge			25	27	16	19	23	24	34	27	26	25	26	33	33	
	Complaints by Theme - Appointment			19	21	19	17	16	27	24	27	23	21	20	21	21	
	Complaints by Theme - Clinical treatment			71	63	59	55	53	63	71	71	78	71	80	83	83	
	Complaints by Theme - Commissioning Decisions			0	0	1	0	1	0	0	0	1	0	0	0	0	
	Complaints by Theme - Communication			60	60	49	46	57	64	70	60	75	85	79	87	87	
	Complaints by Theme - Consent to treatment			2	1	2	2	3	7	4	3	3	5	7	2	2	
	Complaints by Theme - Dementia Care			0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - End of life care			0	6	2	2	5	1	6	2	4	5	2	4	4	
	Complaints by Theme - Facilities			7	13	2	2	2	5	12	5	14	9	7	14	14	
	Complaints by Theme - Mortuary			0	0	0	0	0	0	0	0	0	1	0	0	0	
	Complaints by Theme - Other			2	1	0	1	0	2	3	3	3	1	2	3	3	
	Complaints by Theme - Patient care			18	29	22	23	24	28	36	35	56	51	37	31	31	
	Complaints by Theme - Prescribing			9	6	3	5	5	7	5	4	6	5	4	6	6	
	Complaints by Theme - Privacy & Dignity			7	15	8	8	10	17	17	14	17	10	9	13	13	
	Complaints by Theme - Restraint			1	0	0	0	0	1	0	1	0	0	0	1	1	
	Complaints by Theme - Staff numbers			2	0	2	3	3	2	5	2	4	1	3	4	4	
	Complaints by Theme - Trust admin / procedure / records			11	15	12	7	2	9	21	26	20	22	44	18	18	
	Complaints by Theme - Values & Behaviours (staff)			41	31	34	35	46	40	37	40	41	42	44	39	39	
	Complaints by Theme - Waiting time			19	16	12	13	12	11	15	14	13	11	15	10	10	
	PALS - Count of concerns	-	-	375	318	397	407	321	278	448	408	396	417	422	445	469	
	Compliments	-	-	81	109	145	132	95	145	89	91	84	89	107	107	98	
	Friends and Family Test -SaTH	95%	95%	88.3%	92.4%	79.8%	73.7%	77.1%	76.1%	76.0%	75.0%	75.4%	80.3%	78.7%	76.6%	77.5%	
	Friends and Family Test - Inpatient	95%	95%	96.9%	96.4%	92.0%	93.6%	95.1%	94.0%	92.7%	92.8%	94.3%	92.7%	92.9%	99.3%	94.4%	
	Friends and Family Test - A&E	85%	85%	63.0%	33.3%	62.1%	67.6%	70.5%	71.1%	72.2%	70.9%	71.5%	77.3%	74.7%	70.5%	71.7%	
	Friends and Family Test - Maternity	95%	95%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	85.7%	87.5%	55.6%	100.0%	60.0%	100.0%	90.0%	
	Friends and Family Test - Outpatients	95%	95%	94.0%	92.9%	93.7%	92.2%	95.3%	92.8%	87.1%	91.5%	85.7%	88.0%	94.8%	94.4%	92.1%	
	Friends and Family Test - SaTH Response rate %	-	-	1.3%	1.2%	1.6%	3.6%	4.7%	4.5%	5.2%	4.9%	4.7%	5.5%	5.6%	4.4%	3.9%	
	Friends and Family Test - Inpatient Response rate %	-	-	2.2%	2.9%	2.0%	1.5%	2.6%	1.8%	1.9%	1.8%	1.9%	2.2%	2.5%	1.6%	2.0%	
	Friends and Family Test - A&E Response rate %	-	-	0.7%	0.1%	1.4%	5.0%	6.2%	6.2%	7.4%	7.1%	6.6%	7.7%	7.7%	6.4%	5.2%	
	Friends and Family Test - Maternity (Birth) Response rate %	-	-	0.7%	0.2%	0.4%	0.8%	0.7%	0.0%	0.3%	0.0%	0.0%	0.6%	0.3%	0.3%	0.3%	

Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	National Standard 26/27	Current Month Trajectory (RAG)	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)	100	100	98	93	98	91	97	99	93	89	-	-	-	-	-	
	Trust SHMI - Expected Deaths	-	-	237	224	226	247	236	282	294	249	-	-	-	-	-	
	Trust SHMI - Observed Deaths	-	-	233	208	222	225	229	278	275	222	-	-	-	-	-	
	SJRs Completed by Month			17	12	17	18	14	11	16	10	17	10	20	13	-	
	MRSA - HOHA			0	0	0	0	1	0	2	1	0	0	0	0	0	
	MRSA - COHA			0	0	0	0	0	0	0	1	0	0	0	0	0	
	MRSA - Total	0	0	0	0	0	0	1	0	2	2	0	0	0	0	0	
	MSSA - HOHA	-	-	2	2	1	0	2	3	1	1	4	3	2	3	4	
	C. difficile - HOHA			5	10	8	6	2	7	6	3	9	6	10	9	10	
	C. difficile - COHA			5	3	4	3	3	7	5	6	9	4	3	10	8	
	C. difficile - Total	98	8	10	13	12	9	5	14	11	9	18	10	13	19	18	
	E. coli - HOHA			2	8	6	5	5	5	4	5	7	8	3	4	7	
	E. coli - COHA			10	10	15	11	10	7	9	6	6	7	9	9	12	
	E. coli - Total	146	12	12	18	21	16	15	12	13	11	13	15	12	13	19	
	Klebsiella - HOHA			2	1	4	2	1	2	2	1	0	0	1	3	2	
	Klebsiella - COHA			1	5	4	3	3	2	3	2	3	0	4	1	5	
	Klebsiella - Total	36	3	3	6	8	5	4	4	5	3	3	0	5	4	7	
	Pseudomonas Aeruginosa - HOHA			0	0	0	1	0	0	0	1	1	1	1	1	1	
	Pseudomonas Aeruginosa - COHA			3	1	1	2	1	0	2	2	0	0	1	2	1	
	Pseudomonas Aeruginosa - Total	16	1	3	1	1	3	1	0	2	3	1	1	2	3	2	
	VTE Risk Assessment completion - SATH	95%	95%	77.4%	77.2%	79.2%	79.6%	80.7%	78.3%	77.7%	82.6%	84.7%	85.1%	84.5%	85.2%	-	
	Never Events	0	0	1	0	1	1	0	0	0	0	1	1	1	0	0	
	Psii	-	-	1	0	3	2	3	0	1	0	1	0	2	0	1	
	Mixed Sex Accommodation - breaches	10% < 2025-26	47	52	38	46	63	56	46	66	40	59	38	42	55	84	
	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%	99%	95%	97%	98%	95%	92%	95%	95%	97%	95%	94%	89%	89%	
	Smoking Rate at Delivery	6%	6%	5.0%	4.4%	5.9%	4.2%	4.3%	4.9%	6.6%	3.3%	4.0%	5.7%	5.9%	4.2%	5.5%	

Moving to EXCELLENCE

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Healthcare Associated Infections (HCAIs) remain a significant challenge, particularly Clostridioides difficile infections (CDI), with the Trust likely to breach its target soon. A new Group IPC improvement plan has been developed jointly with SaTH, SCHT, supported by the Deputy Director of IPC NHS England West Midlands and will progress through our governance processes.

Pressure ulcers, particularly Category 3 ulcers, continue to be an area of concern due to sustained high numbers.

Observations on time for our deteriorating patients remain an ongoing area of focus.

Complaints activity remains high across the Trust. While divisions have reduced the length of time complaints remain open through improved response processes, the overall volume of complaints remains high.

There was discussion regarding a potential link between increasing complaint volumes and litigation activity. Acting Head of Legal confirmed there has been a slight increase in claims, including more individuals pursuing claims without legal representation.

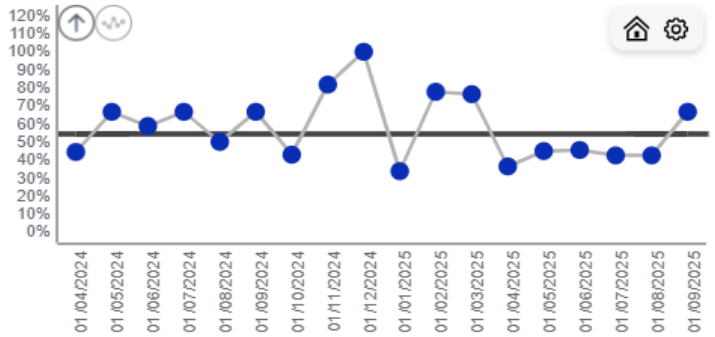
Quality - Safe - Deteriorating Patients - Fragility

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

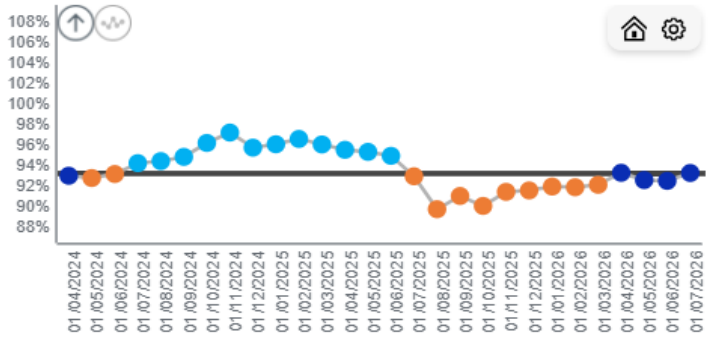
Falls | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025
Improve Dementia screening rates - Patient had an AMT - ED	44.4	66.7	58.8	66.7	50.0	66.7	42.9	81.8	100.0	33.8	77.8	76.5	36.4	44.9	45.5	42.5
Improve Dementia screening rates - Patient had an AMT - Adult IP	59.0	60.0	49.1	54.5	70.4	37.3	73.0	67.0	55.7	58.2	44.6	53.7	47.1	44.7	43.2	48.1
Dementia Awareness Tier 1 3 Yearly	93.01	92.79	93.18	94.24	94.44	94.85	96.21	97.22	95.75	96.08	96.60	96.06	95.54	95.34	94.95	92.96
Dementia Awareness Tier 2 3 Yearly	86.02	90.03	91.95	92.37	91.26	91.35	91.95	92.59	93.25	93.51	93.02	92.99	93.53	93.19	91.93	92.86
Dementia Screening % Score	77	77	70	73	83	59	67	73	67	83	86	87	84	86	92	95
Dementia Screening Audited	251	249	255	264	262	273	251	246	189	207	202	200	245	248	234	250

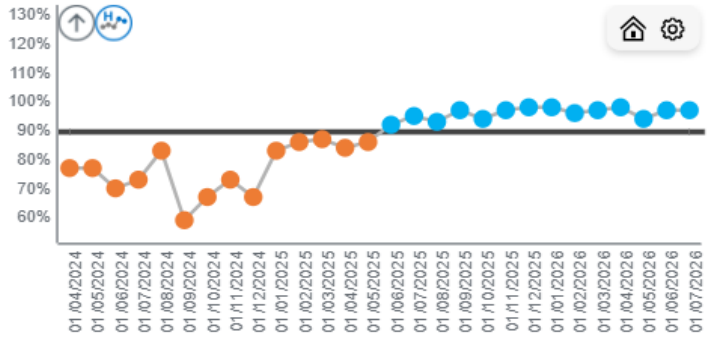
Improve Dementia screening rates - ED



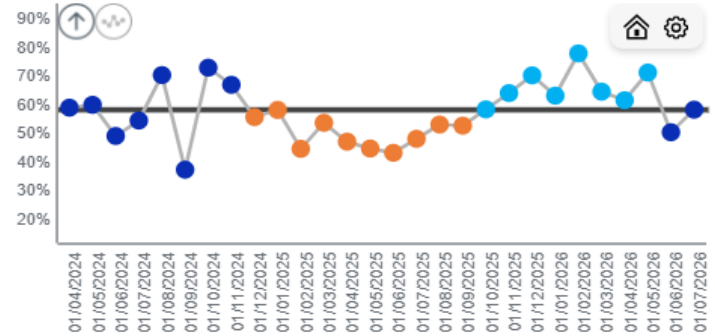
Dementia Awareness Tier 1 - 3 Yearly



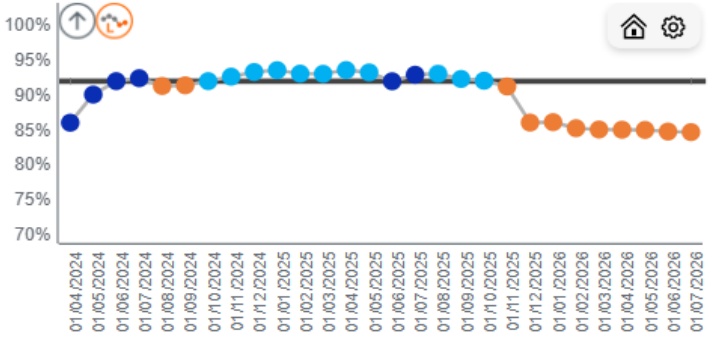
Dementia screening score %



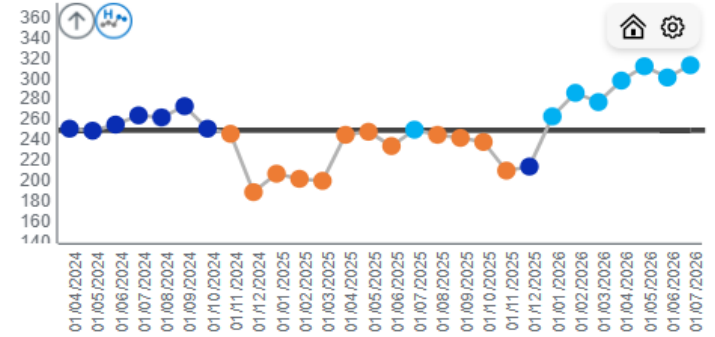
Improve Dementia screening rates - Adult IP



Dementia Awareness Tier 2 - 3 Yearly



Dementia screening audited



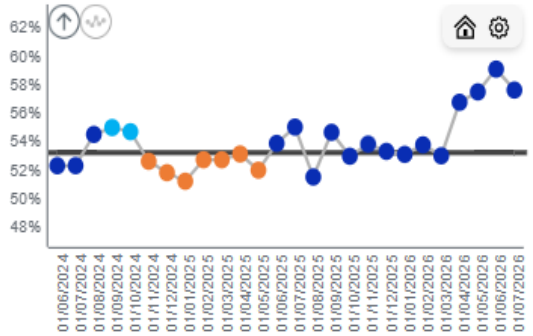
Quality - Safe - Deteriorating Patients - NEWS2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

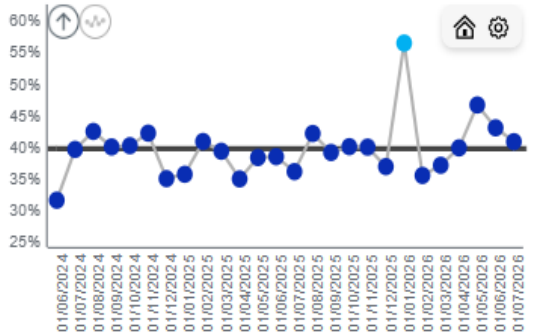
Falls | Deteriorating Patients - Fragility | Deteriorating Patients - PEWS | Medication - Omitted Doses

	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	May-2026	Jun-2026	Jul-2026
% Observation compliance for patients at risk of deterioration	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49	54.63	52.95	53.80	53.29	53.08	53.75	52.98	56.74	57.47	59.07	57.60
% Observation compliance for patients at risk of deterioration - ED	35.74	40.92	39.38	35.01	38.38	38.52	36.16	42.18	39.18	40.10	40.03	36.95	56.47	35.55	37.16	39.91	46.69	43.08	40.89
% Compliance evidence that deterioration risk (NEWS2) escalated	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	85.50	90.30	91.60
% Compliance evidence that deterioration risk (NEWS2) reviewed	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	87.20	84.50	79.70
% Compliance of review within recommended timeframe	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	91.70	94.20	94.30
% Compliance reviewed by recommended seniority	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	85.00	90.80	89.90
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	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	90.00	97.10	85.20

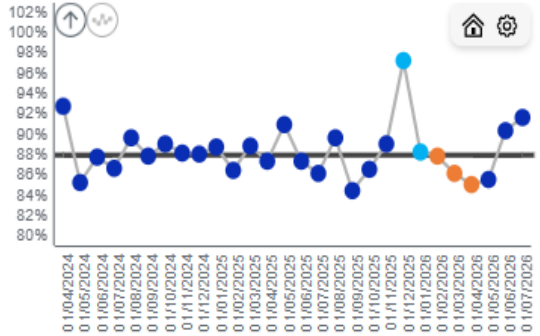
% Observation compliance for patients at risk of deterioration



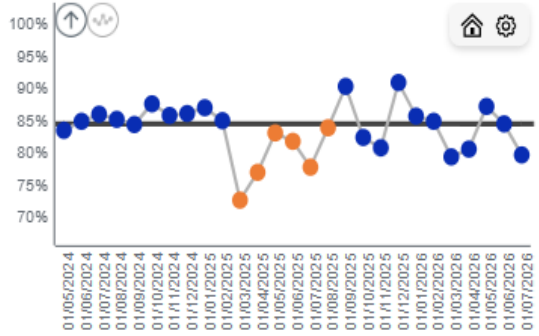
% Observation compliance for patients at risk of deterioration- ED



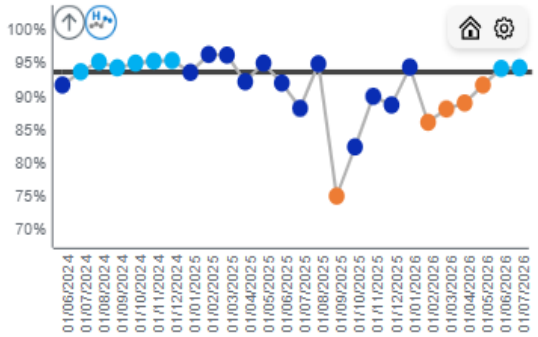
% Compliance evidence that deterioration risk escalated



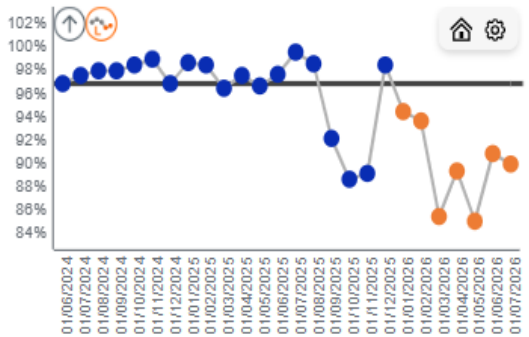
% Compliance evidence that deterioration risk reviewed



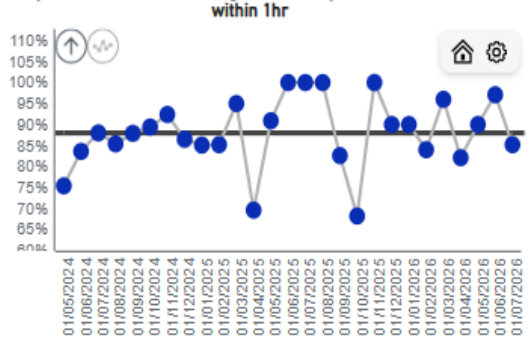
% Compliance of review within recommended timeframe



% Compliance reviewed by recommended seniority



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



Deteriorating patients – NEWS2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
Deteriorating patient observation compliance remains below the ≥90% target. Inpatient performance showed a marginal reduction in July to 57.60% (from 59.07% in June). Emergency Department compliance decreased to 40.89% (from 43.08%); however, performance remains above levels seen earlier in the year, and targeted improvement work is ongoing at a departmental level.
Escalation compliance improved in July, rising from 90.30% in June to 91.60%, thereby maintaining the target threshold. Although overall review compliance decreased to 79.70% (from 84.50% in June), compliance with reviews completed within the recommended timeframe remained consistently high at 94.30% (from 94.20%). Compliance with review by the recommended seniority showed a marginal reduction to 89.90% (from 90.80%).
Compliance with antibiotic administration within one hour for patients stratified as high risk for sepsis decreased to 85.2% in July, compared with 97.1% in June, with two of the 16 patients with high-risk indicators did not receive antibiotics within one hour, and no documented rationale for the delay was recorded.

Recovery Actions:	**Anticipated impact and timescales.**
1.Improve compliance with observation frequency for patients at risk of deterioration • Continue targeted improvement work to increase observation compliance for those at risk of deterioration in inpatient and ED areas • Use digital dashboards and local oversight processes to identify and address missed observation in real time and share learning **2.Strengthen deterioration response reliability** • Sustain improved escalation compliance (91.3%) through focused work with clinical teams & targeted feedback • Improve overall review compliance (79.7%) by reinforcing NEWS2-triggered review requirements for clinical teams (posters) & existing training **3. Improve timeliness and consistency of clinical review** • Maintain gains in timely review (94.3%) and recommended seniority (89.9%) through senior clinical oversight of performance against target. • Monitor variation in review practice and support teams to embed compliant review processes working with clinical teams in clinical areas. • Progress Response sticker trial in acute & respiratory wards to standardise process and documentation for review **4. Sepsis recognition and treatment reliability** • Improve compliance with antibiotic administration within 1 hour for high-risk sepsis (85.2%) through face-to-face discussion-based training in departments • Share learning from delayed cases and reinforce documentation of exemptions and individualised care plans	1. 3 months 2. 12 months 3. 3 months 4. 6 months

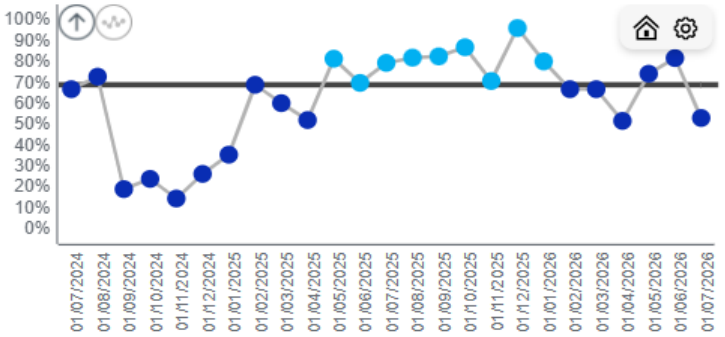
Recovery dependencies:	• Deteriorating patient team to support understanding of systems data to drive improvements • Continued governance and clinical engagement in deteriorating patient workstreams

Quality - Safe - Deteriorating Patients - PEWS

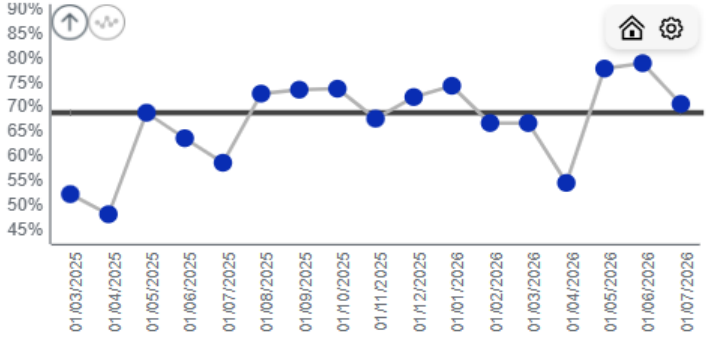
NHS
Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026	Jun-2026	Jul-2026
% Compliance evidence that deterioration risk (PEWS) escalated	69.70	79.30	81.80	82.40	86.80	70.60	96.00	80.00	66.70	66.70	51.50	74.10	81.60	52.90
% Compliance evidence that deterioration risk (PEWS) reviewed	63.60	58.60	72.70	73.50	73.70	67.60	72.00	74.30	66.70	66.70	54.50	77.80	78.90	70.60
% Compliance of review within recommended timeframe - PEWS	85.70	82.40	81.30	88.00	89.30	82.60	94.40	88.50	72.70	87.50	88.90	81.00	76.70	83.30
% Compliance reviewed by recommended seniority - PEWS	57.10	52.90	86.70	66.70	67.90	73.90	58.80	73.10	52.20	62.50	64.70	57.10	86.20	75.00
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr - PEWS	0.00	0.00	0.00	0.00	16.70	0.00	6.30	12.50	0.00	0.00	0.00	0.00	4.50	0.00

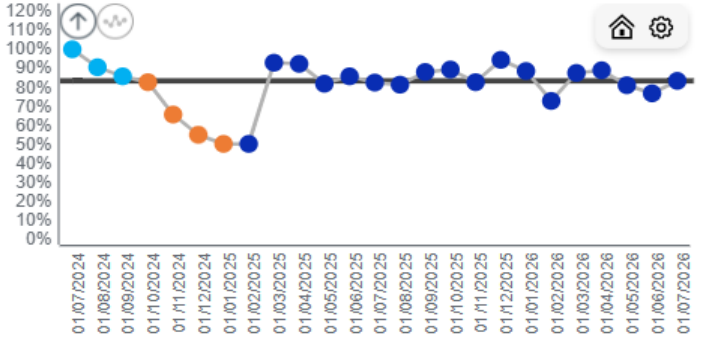
% Compliance evidence that deterioration risk (PEWS) escalated



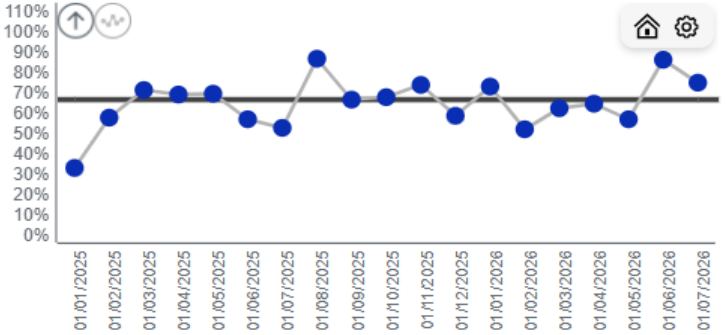
% Compliance evidence that deterioration risk (PEWS) reviewed



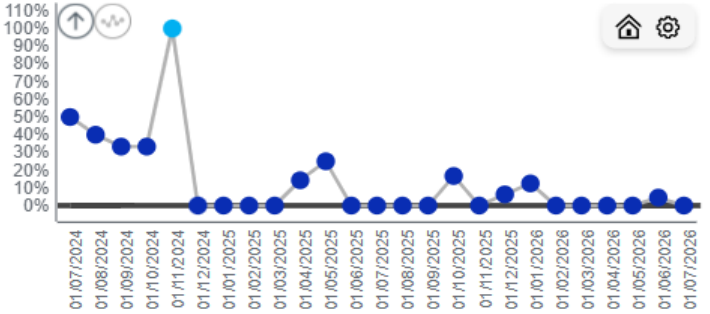
% Compliance of review within recommended timeframe - PEWS



% Compliance reviewed by recommended seniority - PEWS



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



Deteriorating patients – PEWS & NEWTT2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
In July 2026, 20 patients were audited. Of those requiring escalation, 45% (9CYP) had documented evidence of escalation which is a decrease from the previous month. Of the 55% (11 CYP) who did not have documented evidence of escalation, 1 CYP was following a verbal advise, 1 CYP went straight to surgery, 9 CYP had no documented evidence of escalation but came to no harm.

The CYP review, compliance has decreased to 50% (10 CYP). The 50.% (10 CYP) who were not reviewed came to no harm.

With regards to sepsis, 95% (19 CYP) were screened for sepsis at their initial assessment which is an increase compliance from June. 19 CYP screened positively but on clinical assessment only 1 CYP required IV antibiotics who was already receiving these. All other CYP were treated appropriately.

Recovery actions:
On reviewing the audits have improved but further improvement is required in relation to documenting a time 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 1 CYP requiring IV antibiotics within the audit who was already receiving these, alternative diagnosis treated for the other CYP.
- 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
- Consultant Connect launched in July 2026 which also highlight deteriorating CYP by displaying PEWs scores and sepsis screening information

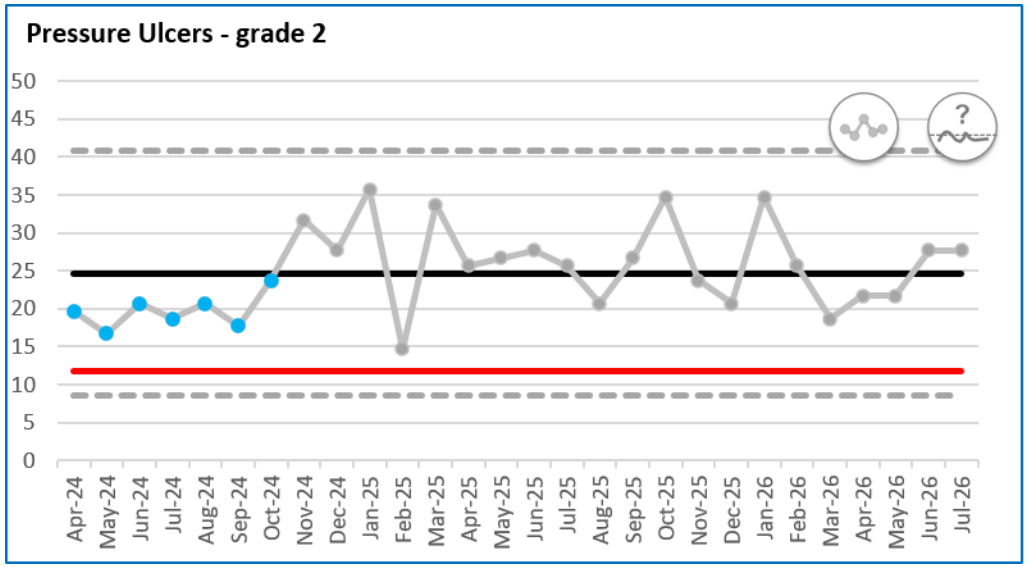
Anticipated impact and timescales for improvement:
6-12 months

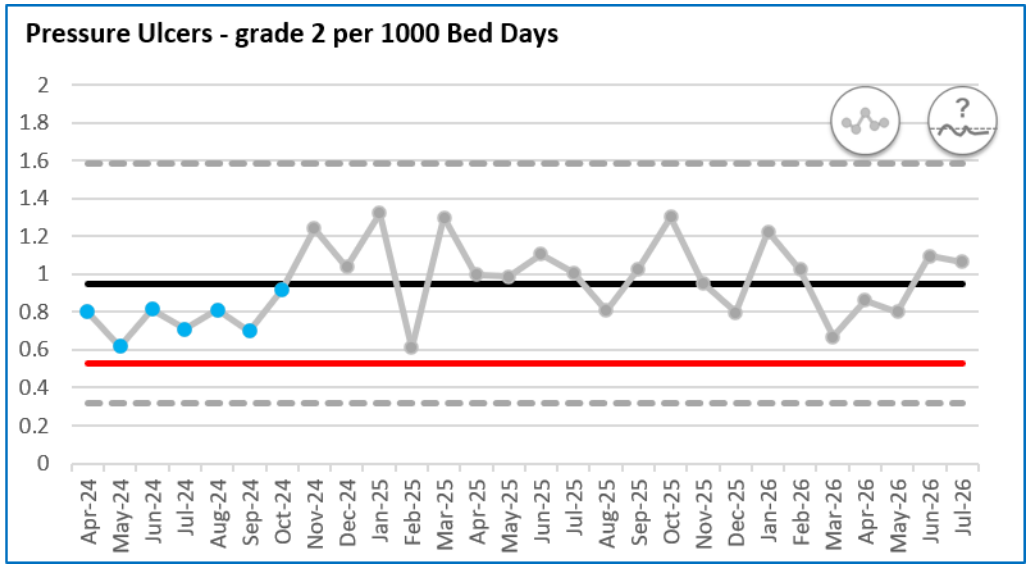
Recovery dependencies:	Support via Performance & Business Intelligence (P&BI) team, transformation project teams and engagement throughout the trust. Support via governance & clinical and operational teams to prioritise deteriorating patient with timely decisions made by DPG

Moving to EXCELLENCE

Patient harm – pressure ulcers – Category 2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



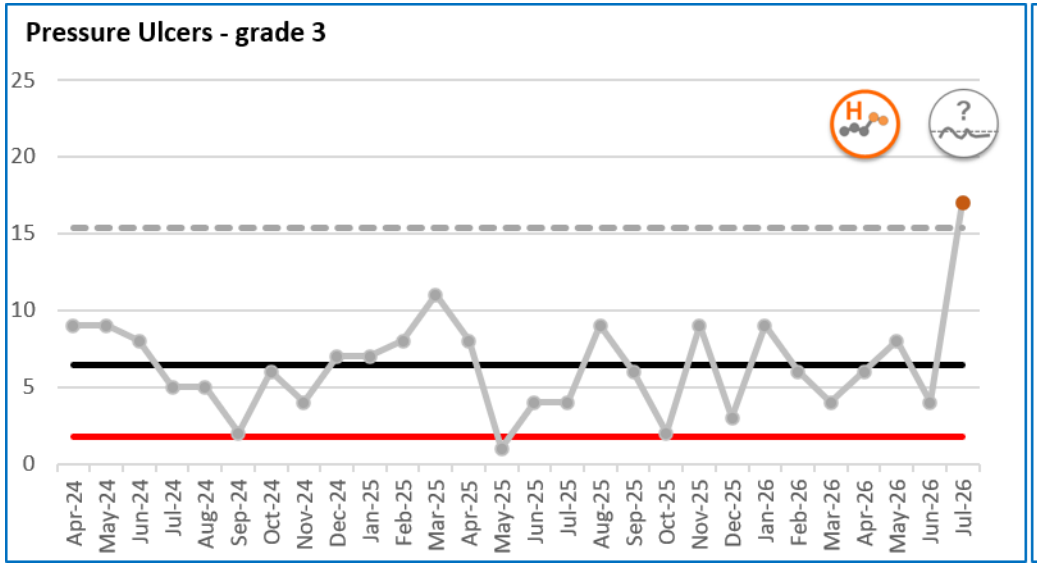


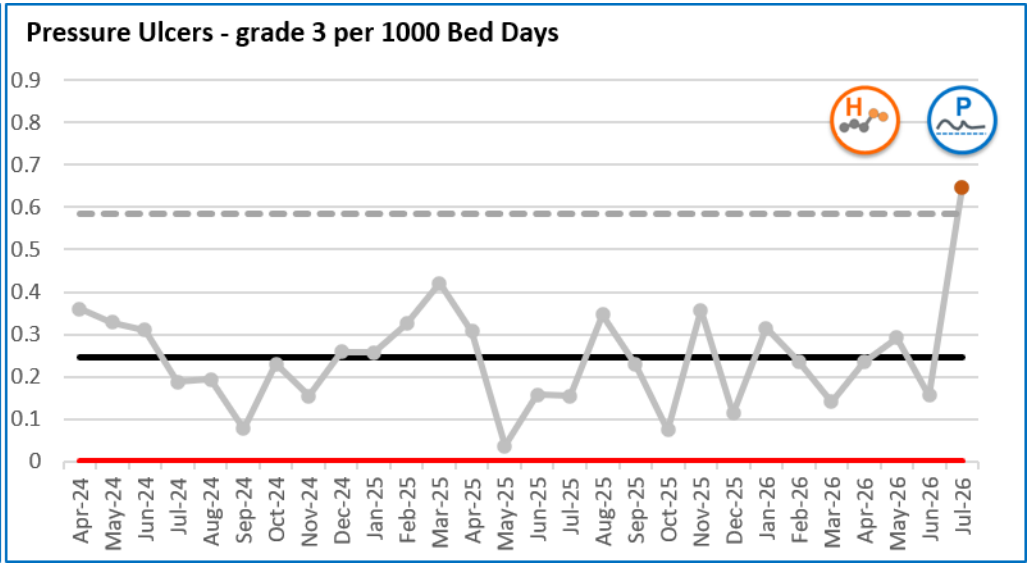
Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	19
Surgery, Anaesthetics and Cancer	9
Women's & Children's	0
Clinical Support Services	0

Moving to EXCELLENCE

Patient harm – pressure ulcers – Category 3

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



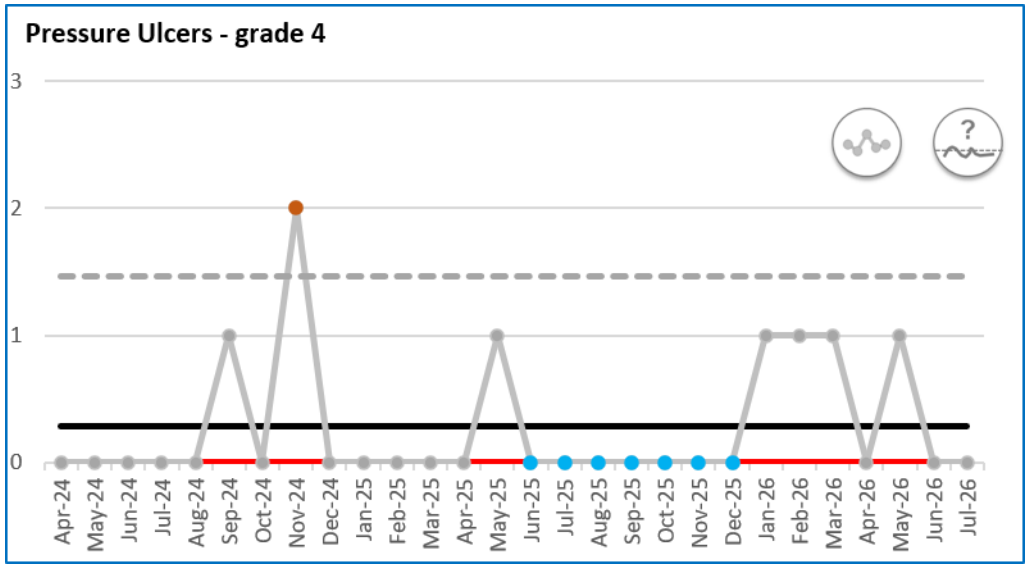


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	12
Surgery, Anaesthetics and Cancer	5
Women's & Children's	0
Clinical Support Services	0

Moving to EXCELLENCE

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

Moving to EXCELLENCE

Patient Harm – pressure ulcers

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary: The number of Category 2 injuries has increased to 28 from May (22). The number of category 3 pressure ulcers has decreased from 8 to 4 in June. There are no reported category 4 pressure ulcers for June. The category 3 pressure ulcers occurred in wards 23 (x2), 24 and 4. The locations were sacrum x 2, right elbow and right hip. Key themes and trends from the investigations then form actions and the Tissue Viability Service provide weekly in-reach support to ensure areas are embedding their actions. There were 25 reported Deep Tissue Injuries this month compared to 37 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 weeks. 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 category 2 and above 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 Director of Nursing (Acute) or their deputy, 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
- Hybrid pressure relieving mattresses have now been introduced in the Trust and a training video is available on LMS

Current actions in place/ongoing are:

- 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
- Weekly in-reach support visits by the TVS to higher incidence areas
- Link worker training days scheduled in October 2026.

Anticipated impact and timescales for improvement

1 WTE joining the TVS week commencing 16th August. Will provide 4 days with TV and 1 day with Quality Team looking at harms/falls. Plan to introduce bedside TV teaching.
Reintroduction of TV Champion link worker training from October
Planned initiatives for medical device related pressure ulcers and deep tissue injuries
Digitalisation of PURPOSE T risk assessment in October 2026.

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

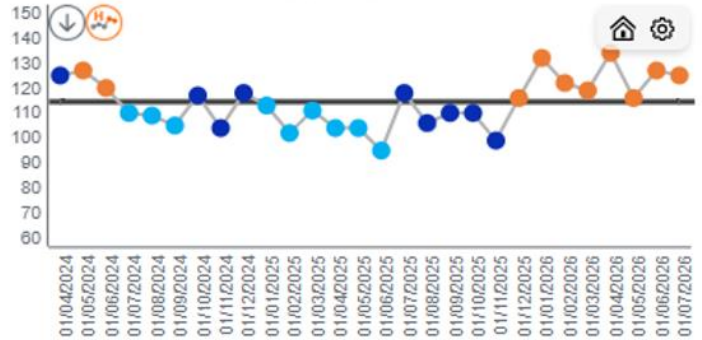
Moving to EXCELLENCE

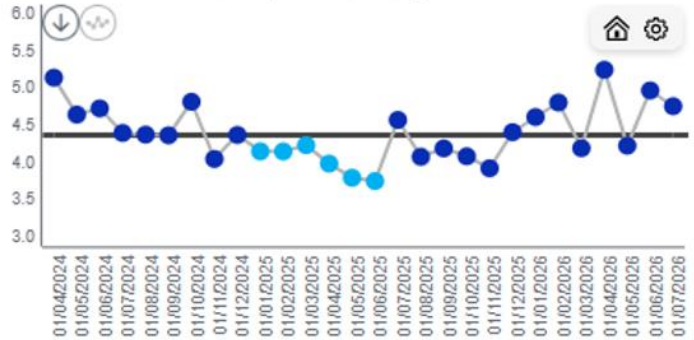
Quality - Safe - Falls

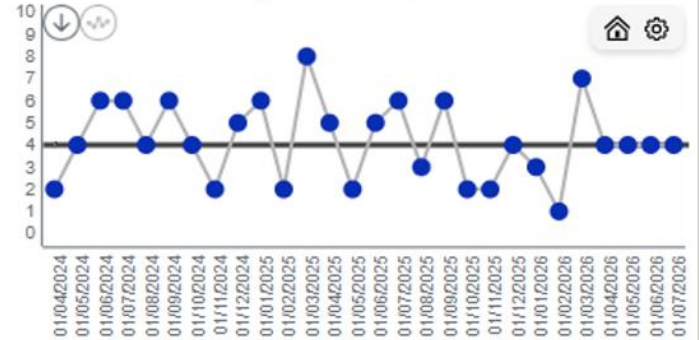
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

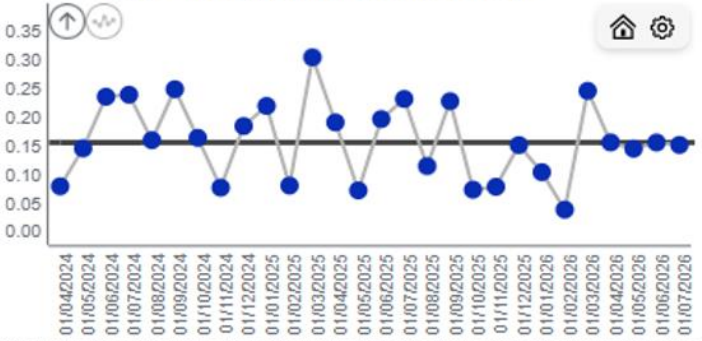
Deteriorating Patient - Fragility | Deteriorating Patients - NEWS | Deteriorating Patients - PEWS | Medication - Omitted Doses

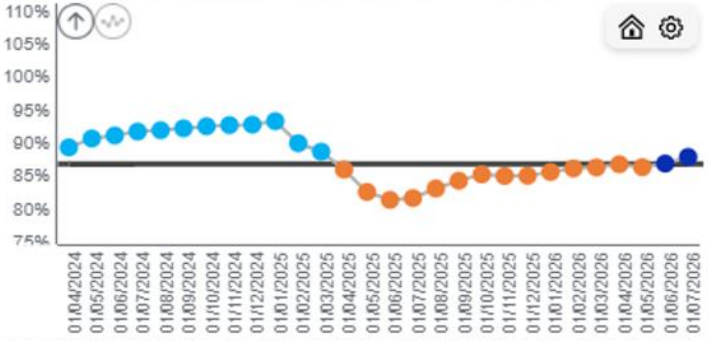
	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026	Jun-2026	Jul-2026
Falls - Total	111	104	104	95	118	106	110	110	99	116	132	122	119	134	116	127	125
Falls - per 1000 Bed Days	4.24	3.99	3.80	3.75	4.58	4.08	4.19	4.09	3.93	4.41	4.61	4.81	4.20	5.25	4.23	4.97	4.76
Falls - Resulting in Harm Moderate or Severe	8	5	2	5	6	3	6	2	2	4	3	1	7	4	4	4	4
Falls - Resulting in Harm - per 1000 Bed Days	0.31	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.15	0.10	0.04	0.25	0.16	0.15	0.16	0.15
Falls Prevention Training Compliance % - 2 Yearly	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	86.40	86.95	87.95
% Completion of Falls Risk Assessments	93	92	92	91	90	92	90	92	93	91	91	91	91	92	91	93	93

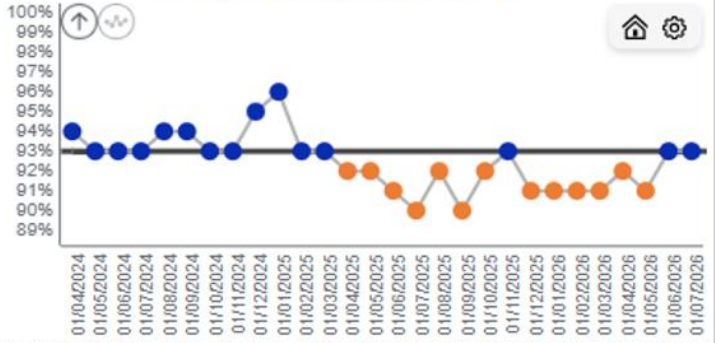












Patient harm - falls

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
There were 125 falls in July which is 2 less falls on the previous month.
There were 4 falls resulting in moderate harm or above.
On review of these 4 falls, all documentation and risk assessments and lying and standing blood pressure had been completed. Post fall 2 patients had not had their post fall check list completed, all risk assessments had been completed and 1 patients management plan had not been updated following the fall. Lying and standing blood pressure for all but 1 patient had been completed or a valid reason for not completing. Training compliance was 87.95% in July which is just below the target of 90% but a slight increase on the previous month.

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 the first quarter 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 rollout commenced in June and will also include the digital risk assessment for BMAT. Digital roll out continues with completion during October for the first stage.
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.
Lying and standing blood pressure completion continues to be a focus with one-to-one teaching taking place across the trust. New lying and standing blood pressure dashboard launched in June which captures where there is a postural drop and compliance figures.
Falls training and completion of risks assessments is discussed in monthly Metrics meetings.

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

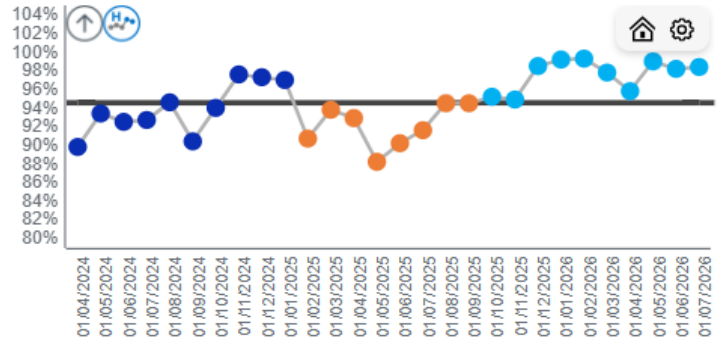
Quality - Safe - Medication - Omitted Doses

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

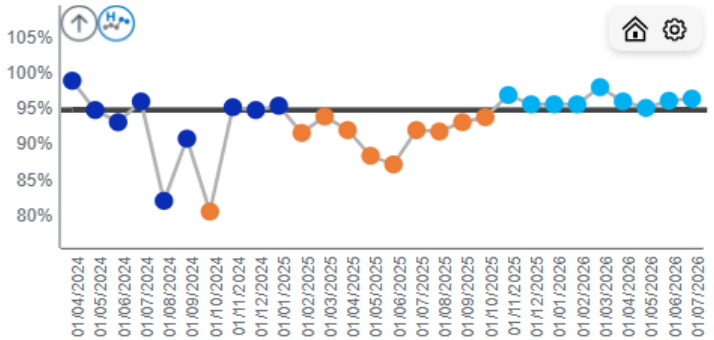
Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	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	May-2026	Jun-2026	Jul-2026
Has all prescribed medication been administered?	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	99.0	98.2	98.4
Was the reason for the omission documented?	92.0	88.4	87.2	92.0	91.8	93.1	93.8	96.9	95.6	95.6	95.6	98.0	96.0	95.1	96.1	96.4
Was appropriate action such as ordering medication, documented?	91.8	92.5	93.8													

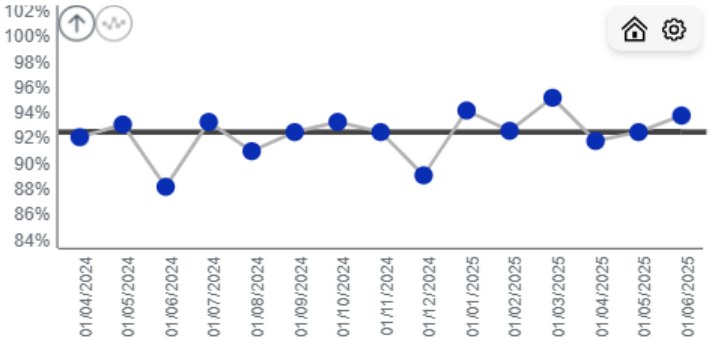
Has all prescribed medication been administered



Was the reason for the omission documented



Was appropriate action such as ordering medication, documented



Medication – omitted doses

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.

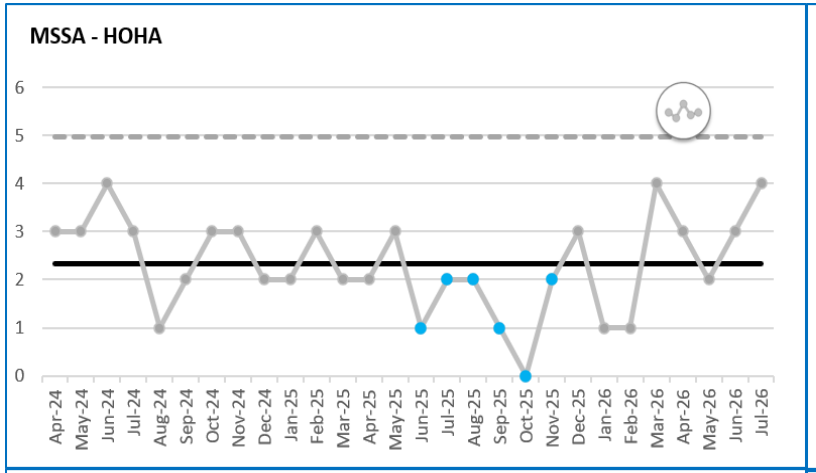
In line with full implementation of EPMA within the Trust.

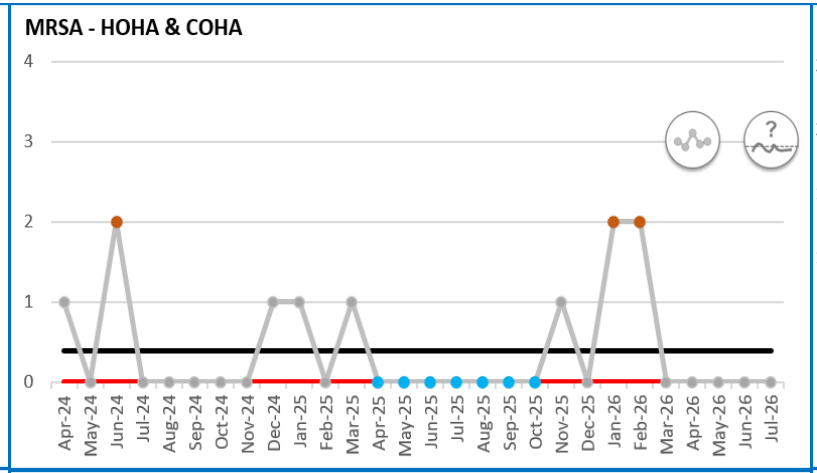
Recovery dependencies:

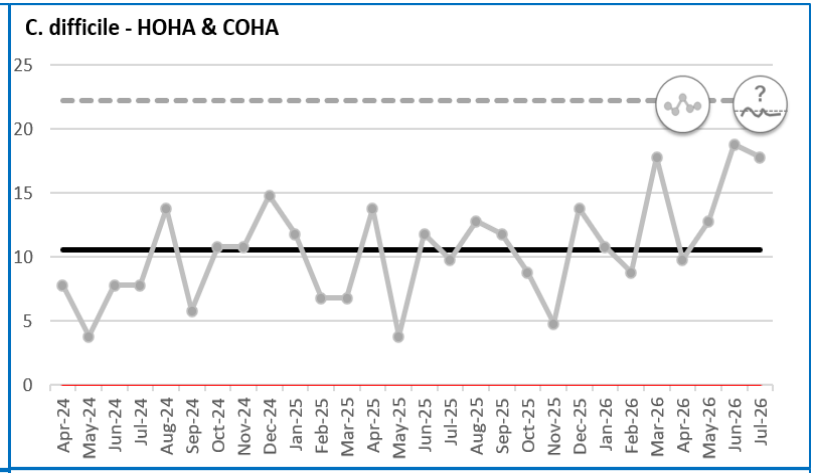
Moving to EXCELLENCE

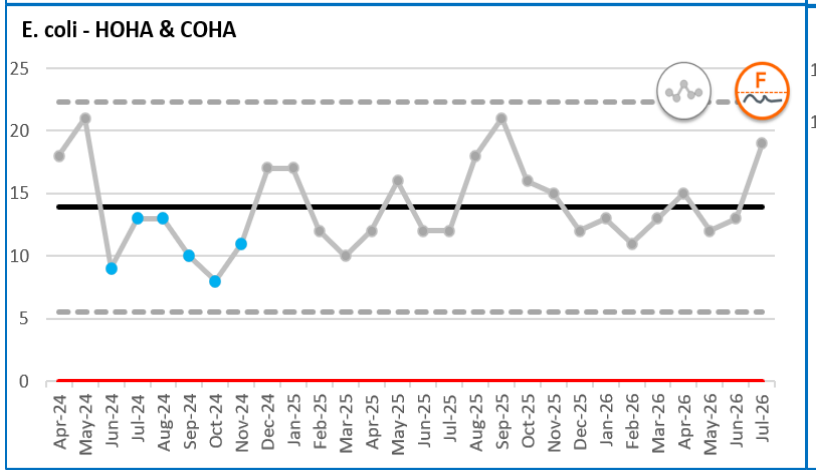
Infection prevention and control

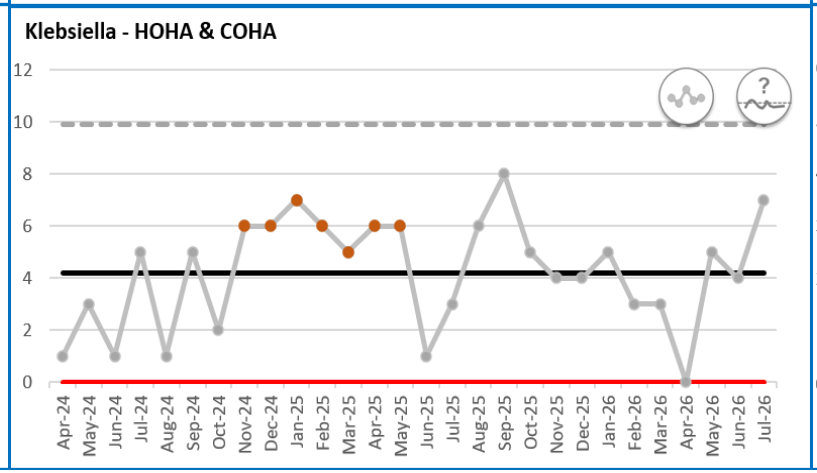
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

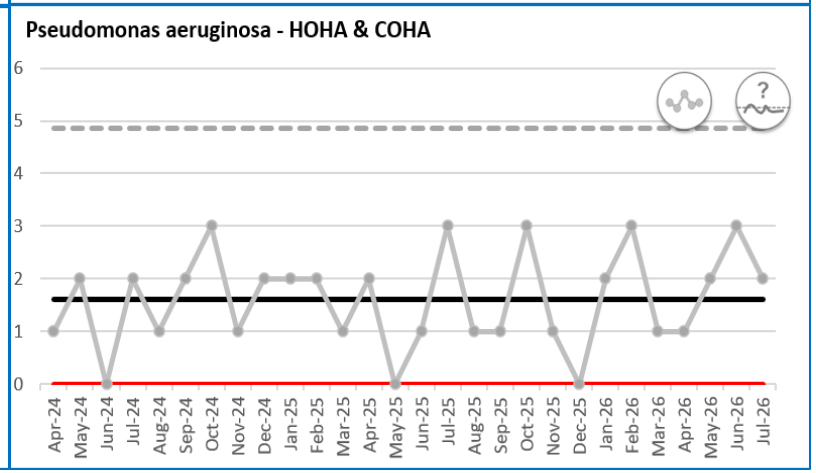








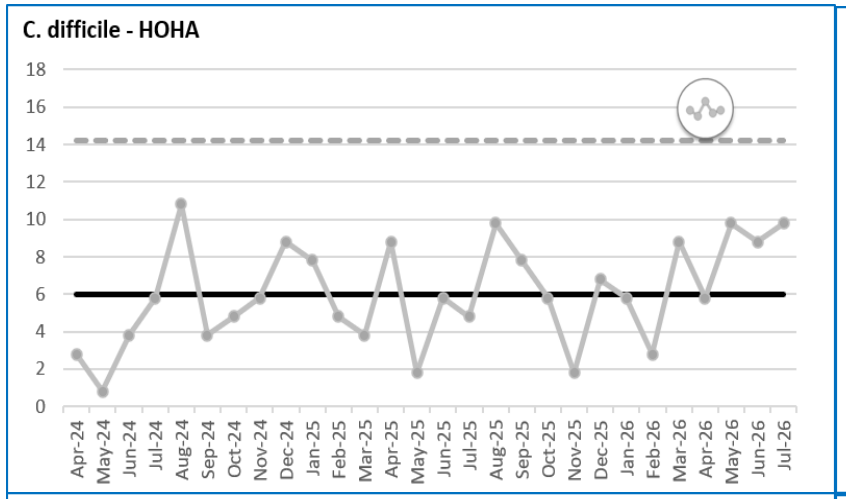


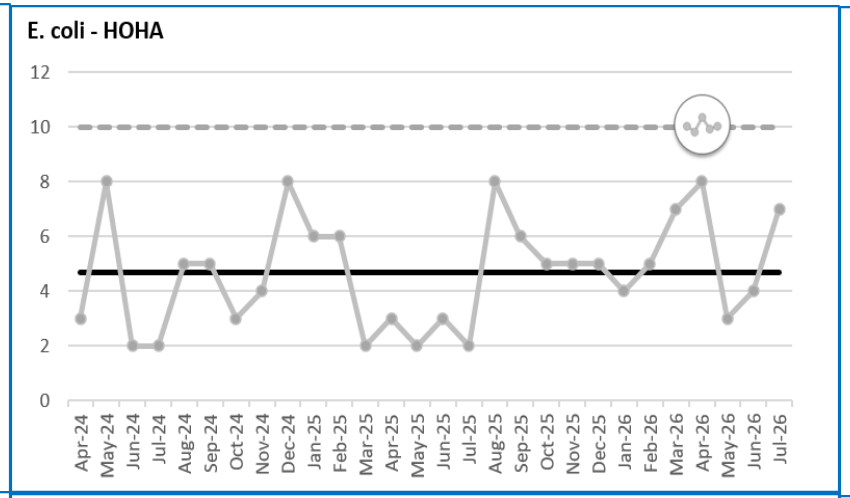


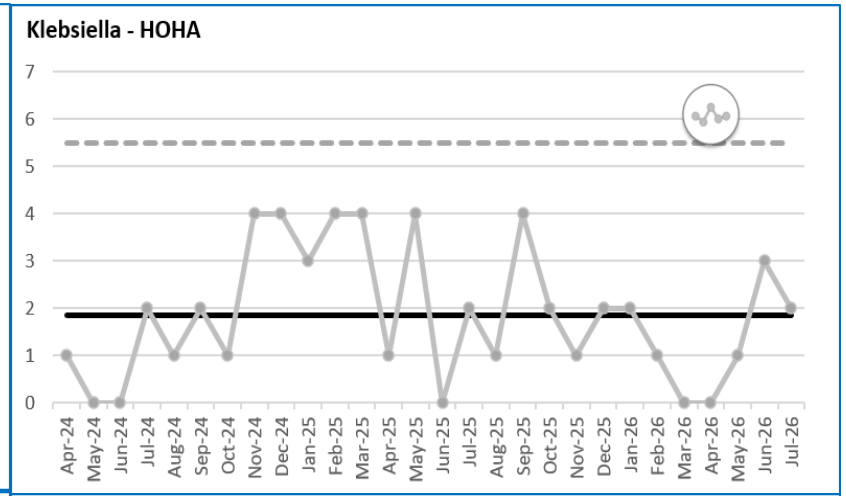
Moving to EXCELLENCE

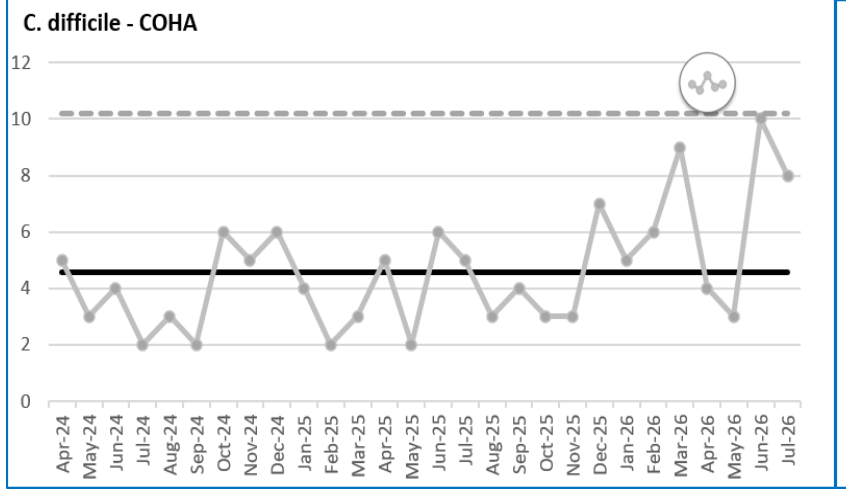
Infection prevention and control

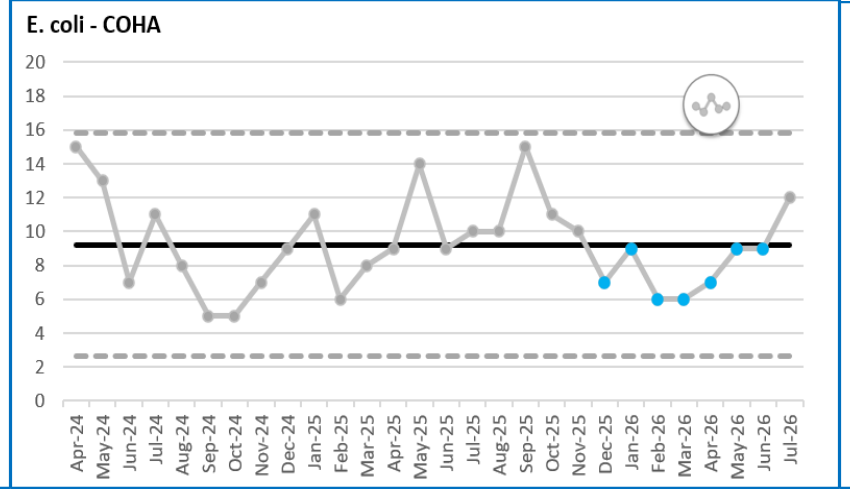
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

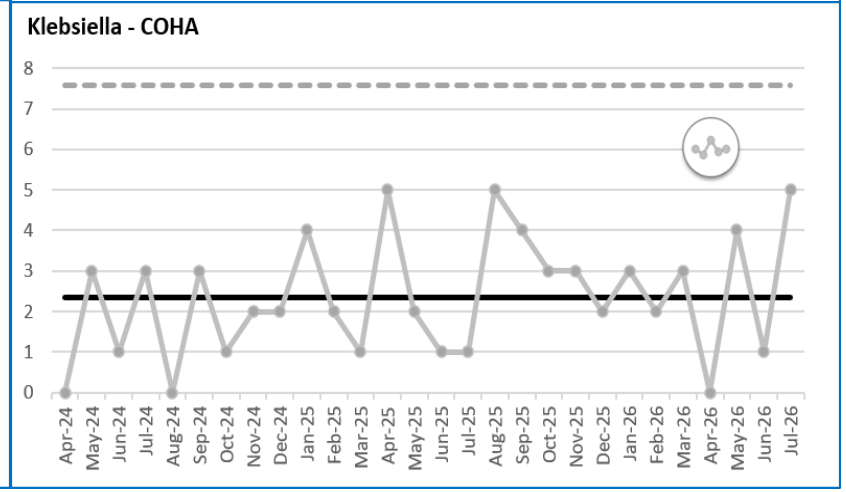












Moving to EXCELLENCE

Infection prevention and control

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
In July 2026 there were the following infections:

- 18 C. diff cases (10 HOHA, 18 COHA)
- 0 MRSA Bacteraemia
- 4 MSSA Bacteraemia (4 HOHA)
- 19 E. coli Bacteraemia (7 HOHA, 12 COHA)
- 7 Klebsiella Bacteraemia (2 HOHA, 5 COHA)
- 2 Pseudomonas Bacteraemia (1 HOHA, 1 COHA)

Recovery actions:

- Group wide overarching improvement plan in progress with engagement from NHSE, DIPC and Deputy, to be presented at IPCOG on 08/09/26
- Deep clean programme remains part of the improvement plan.
- Scoping of external expert in cleaning to provide advice on cleaning/disinfection products and how best to manage deep cleaning programme in the absence of decant space.

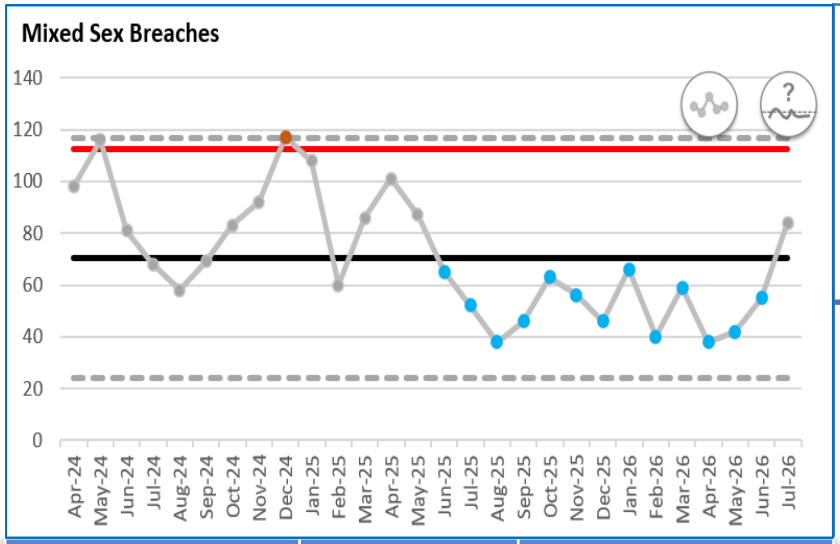
Anticipated impact and timescales for improvement:
Deep clean programme stalled due to capacity.

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

Mixed sex accommodation breaches

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Location	Number of breaches	Additional Information
ITU / HDU (PRH)	4 primary	2 Medical, 1 ENT, 1 Gynaecology
AAU (RSH)	42	over 10 occasions
SDEC (RSH)	6	over 2 occasions
ITU / HDU (RSH)	32 primary	6 Medical, 26 Surgical

Summary:
Mixed sex breaches increased in July 2026 reflecting a common cause variation. Whilst breaches at PRH remained low, the number of breaches at RSH increased significantly across the Acute Floor (48), and Critical Care (32). A contributing factor was the activity in Urgent and Emergency Care which was 9% higher than over Winter 2025/2026. However, the percentage of patients attending ED that converted into admissions remained consistent.

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.

Moving to EXCELLENCE

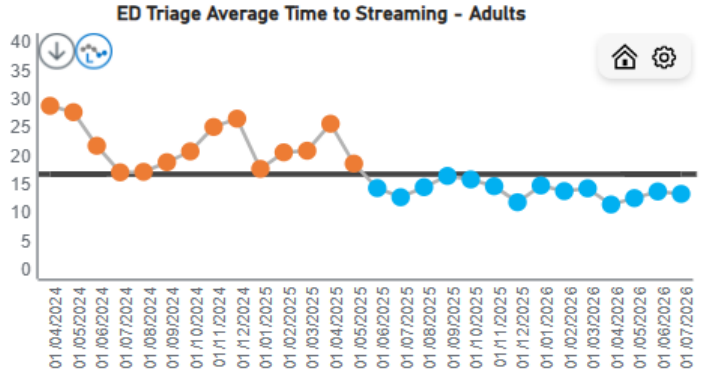
Quality - Effective - Right Care, Right Place, Right Time

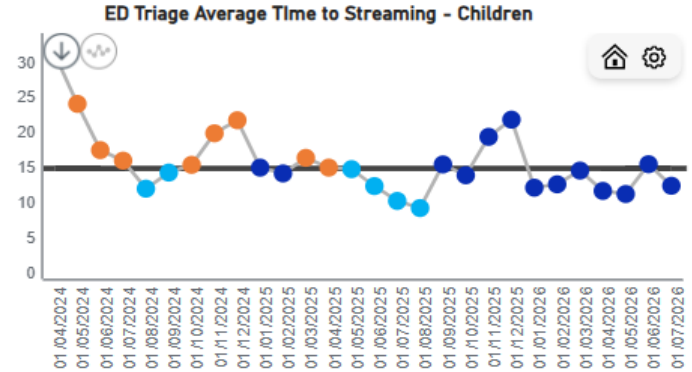
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

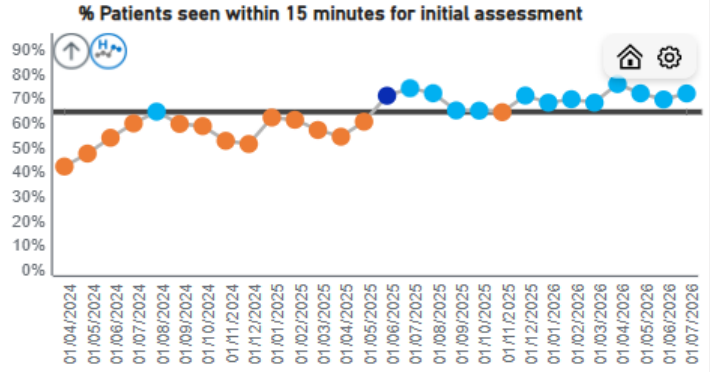
Page 2

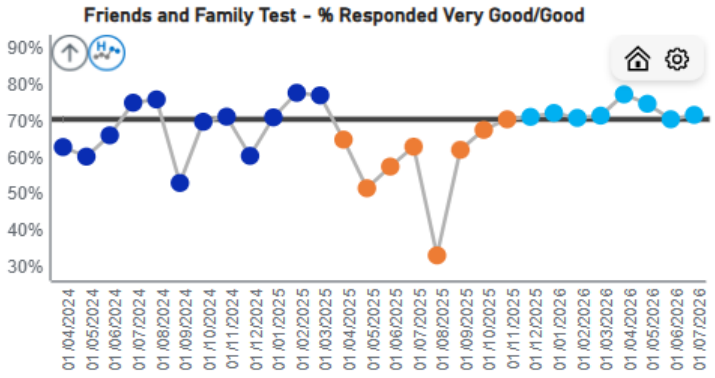
Best Clinical Outcomes

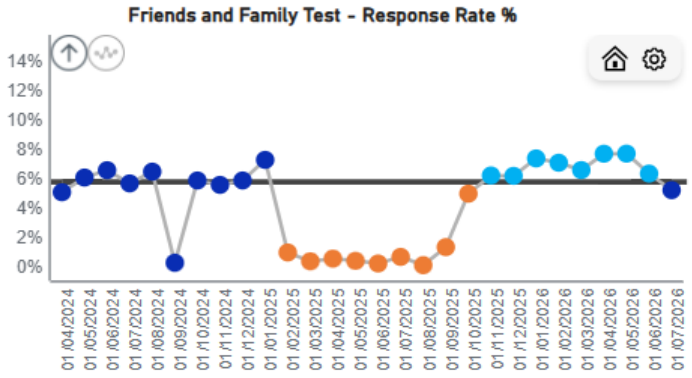
	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026	Jun-2026	Jul-2026
ED Triage Average Time To Streaming - Adults	25.67	18.65	14.33	12.73	14.51	16.48	15.86	14.67	11.85	14.79	13.81	14.29	11.45	12.57	13.74	13.32
ED Triage Average Time To Streaming - Children	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	11.24	15.49	12.42
% Patients seen within 15 minutes for initial assessment	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	72.26	69.77	72.23
Friends and Family Test - A&E - % responded Very Good/Good	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	74.72	70.49	71.67
Friends and Family Test - A&E - Response Rate %	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	7.73	6.37	5.24
Complaints by Theme - Admission / Discharge	25	16	18	25	27	16	19	23	24	34	27	26	25	26	33	33

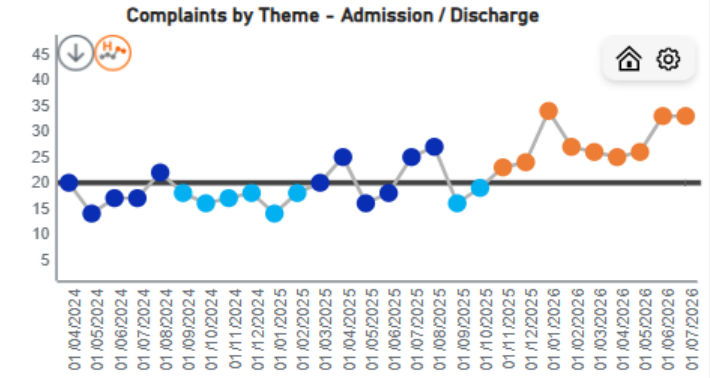












Moving to EXCELLENCE

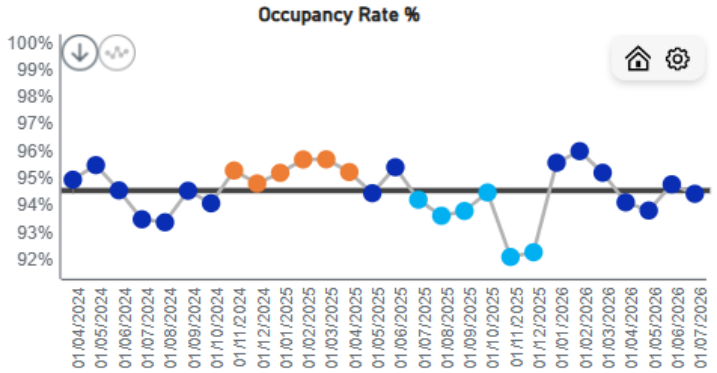
Quality - Effective - Right Care, Right Place, Right Time

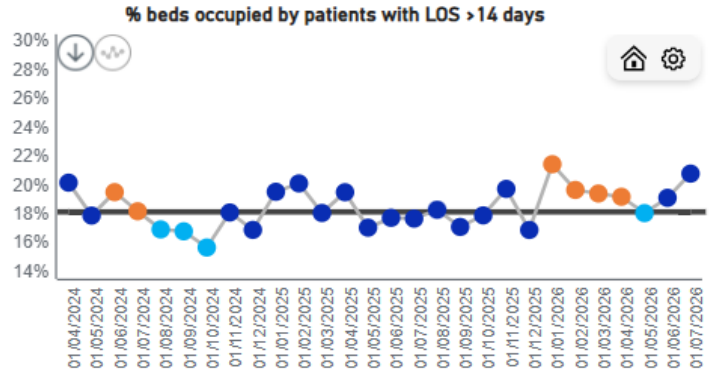
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

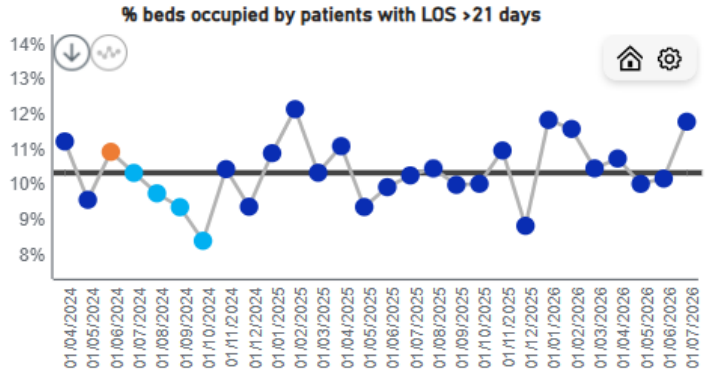
Page 1

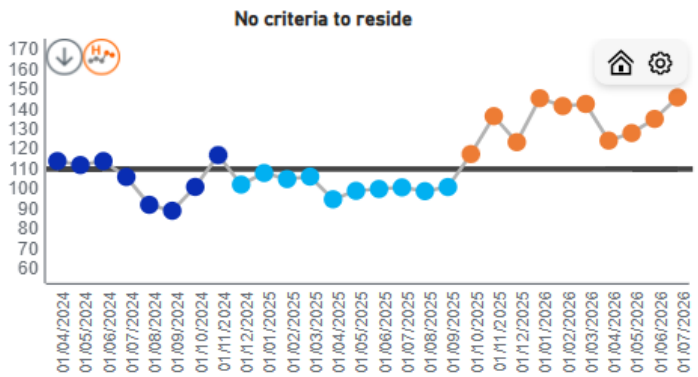
Best Clinical Outcomes

	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	May-2026	Jun-2026	Jul-2026
Occupancy Rate %	95.70	95.23	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	94.78	94.43
% beds occupied by patients with LOS >14 days	18.06	19.50	17.04	17.72	17.67	18.28	17.09	17.89	19.73	16.88	21.44	19.66	19.41	19.18	18.05	19.11	20.79
% beds occupied by patients with LOS >21 days	10.34	11.10	9.36	9.93	10.26	10.47	10.00	10.03	10.98	8.82	11.85	11.59	10.47	10.75	10.02	10.17	11.80
No criteria to reside	106	95	99	100	101	99	101	118	137	124	146	142	143	124	128	135	146





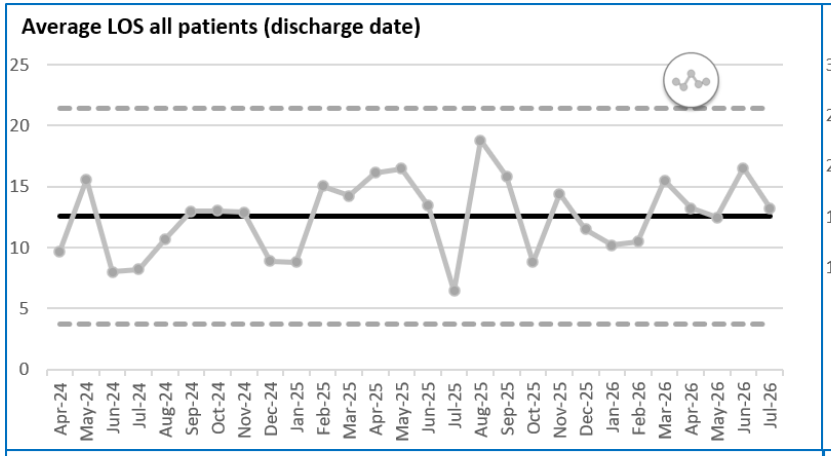


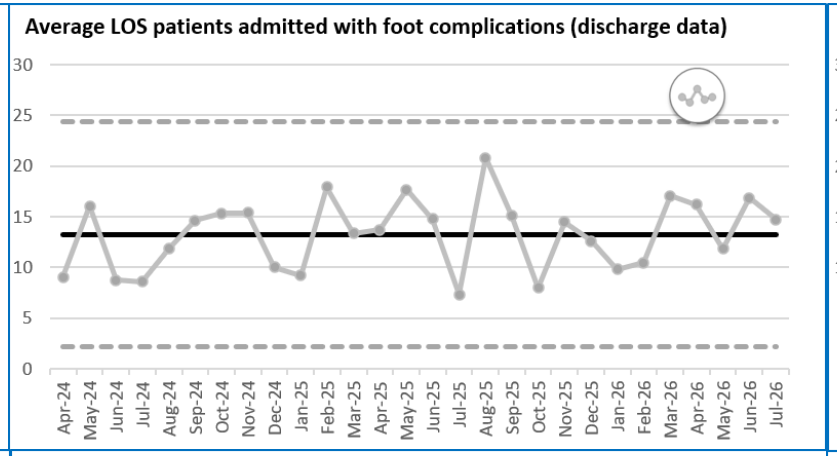


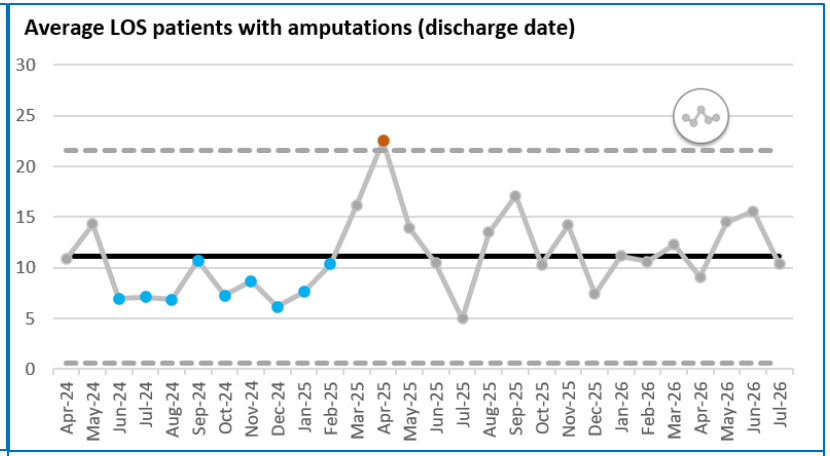
Moving to EXCELLENCE

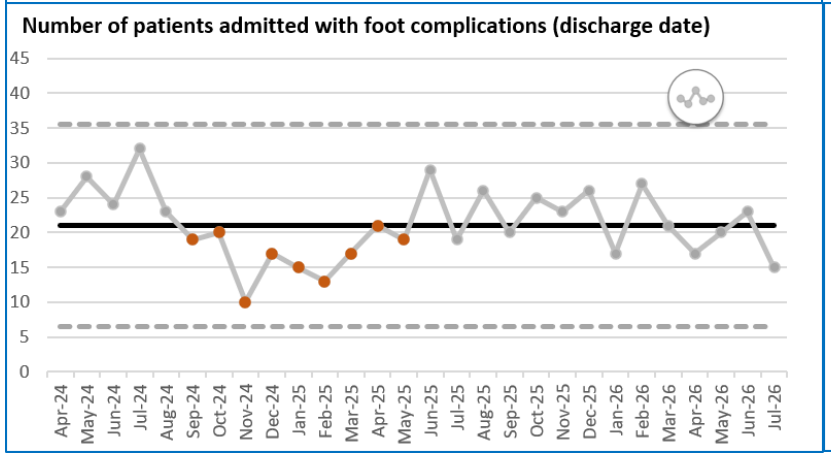
Diabetic foot

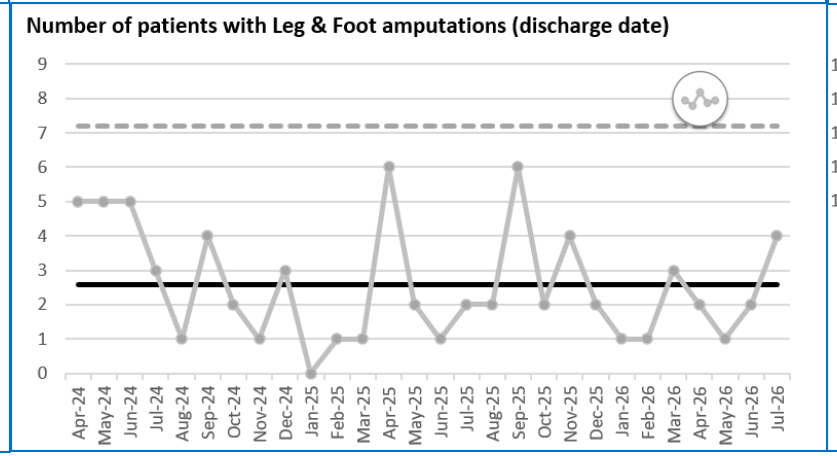
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

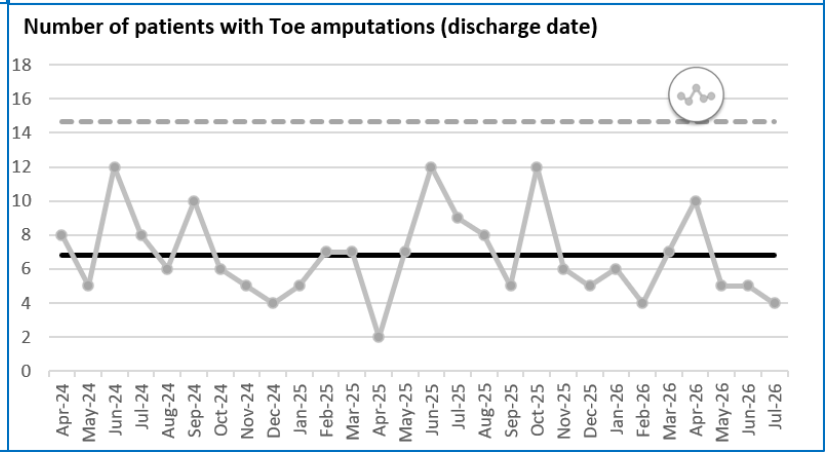












Moving to EXCELLENCE

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 2026 has just been completed – awaiting results.
Current wait time from referral to appointment has increased in the foot clinic due to staffing issues. This is an increased duration (57% within 13 day) More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026 – we have not achieved this, this month).
Increased patient numbers and staffing issues have meant reduction of Podiatry ward visits and inability to see urgent referrals.

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
- 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)

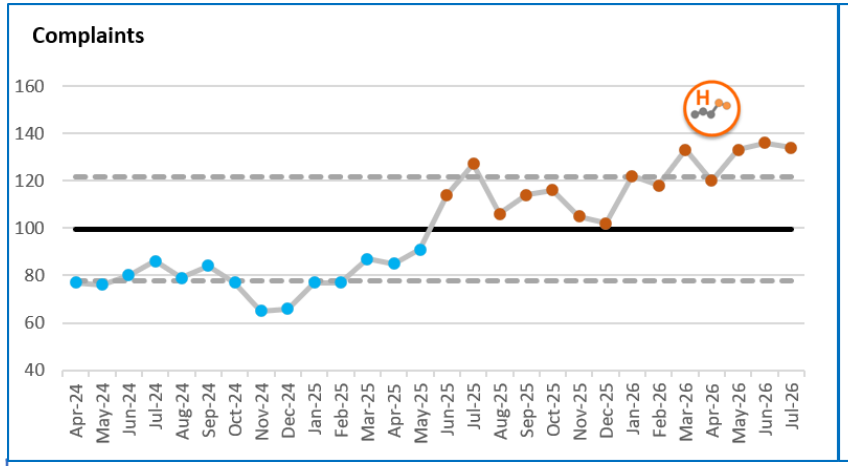
Anticipated impact and timescales for improvement:
Business Case agreed. Staff in post (Nov 2025) since then there has been increased demand that is now not being met. Requires further business case.
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards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

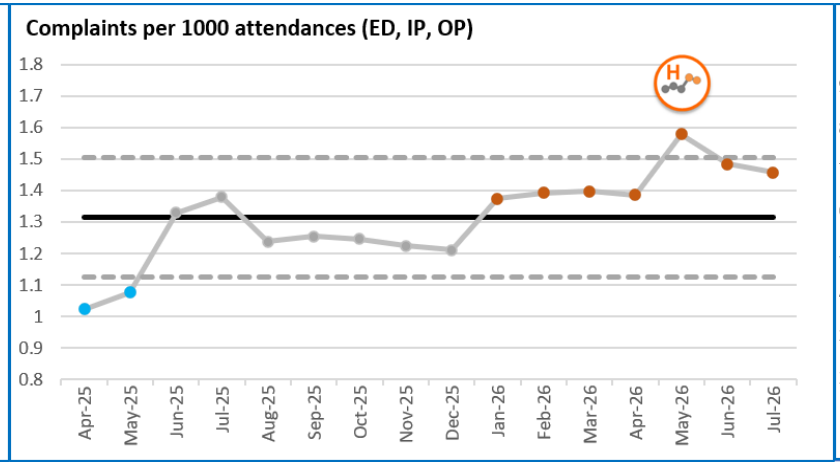
Recovery dependencies:	Ownership of new documentation and education for diabetes foot at ward and matron level Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

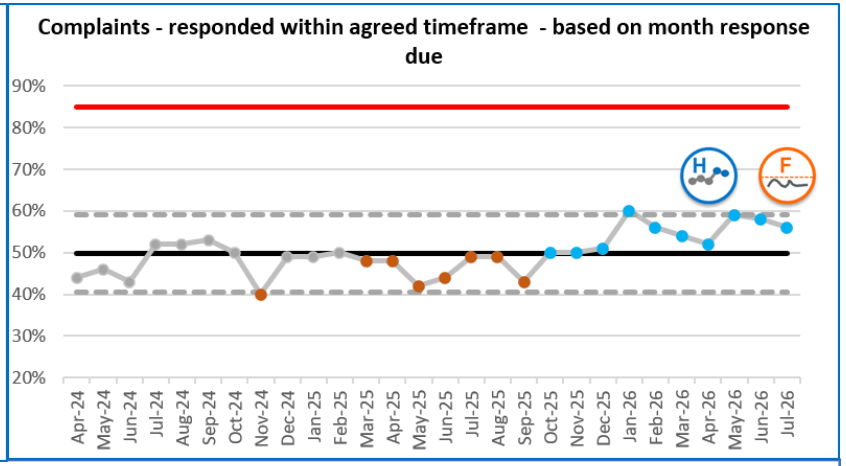
Moving to EXCELLENCE

Complaints

Shropshire, Telford and Wrekin Community and Hospitals NHS Group







Summary:
The Trust continues to receive higher numbers of new complaints. All complaints are logged and acknowledged within three working days and sooner where possible. The Complaints Team continue to work closely with the Divisions to manage this increase and to ensure responses are sent in as timely a way as possible, however there has been a slight decrease in response rates due to the continued high workload. The fast-track complaints process is now being rolled out in the Medicine & Emergency Division.

Recovery actions:
Dashboards on Datix give greater visibility of open cases for specialties.
Weekly complaints review meetings with Divisional and Specialty Teams.
Fast-track process to be rolled out further.
Recruitment to vacancies in PALS team

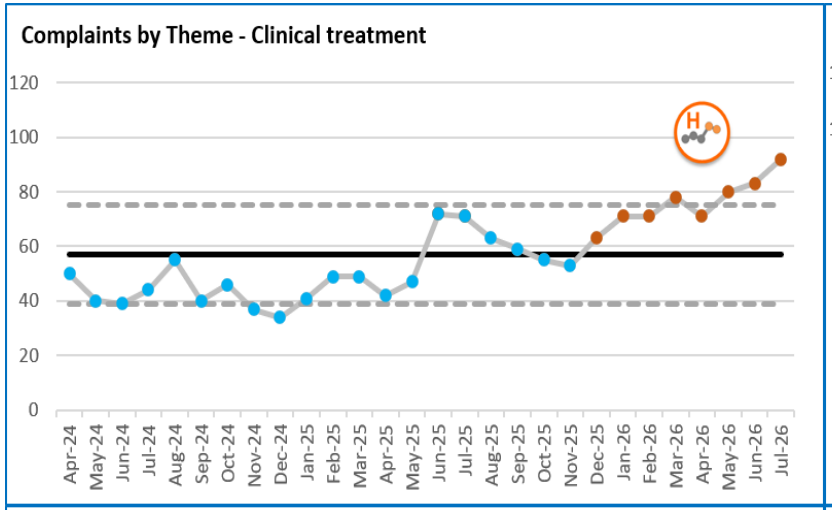
Anticipated impact and timescales for improvement:
Further improvement in timeliness of responses.
Evidence of early involvement and support from divisions/ specialities with complainants.

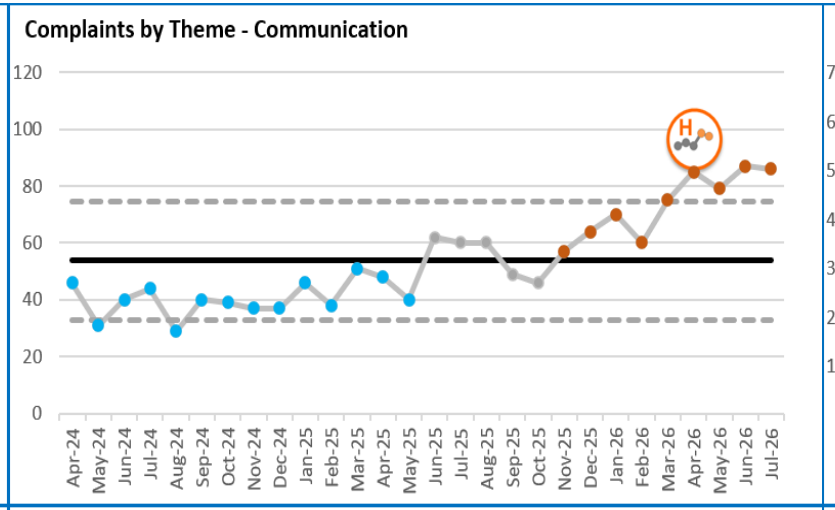
Recovery dependencies:	Continued high levels of numbers are leading to delays in responses from specialties as they manage this increase. The PALS team continue to have significant staffing challenges which will impact on the ability to deal with issues before they become a formal complaint.

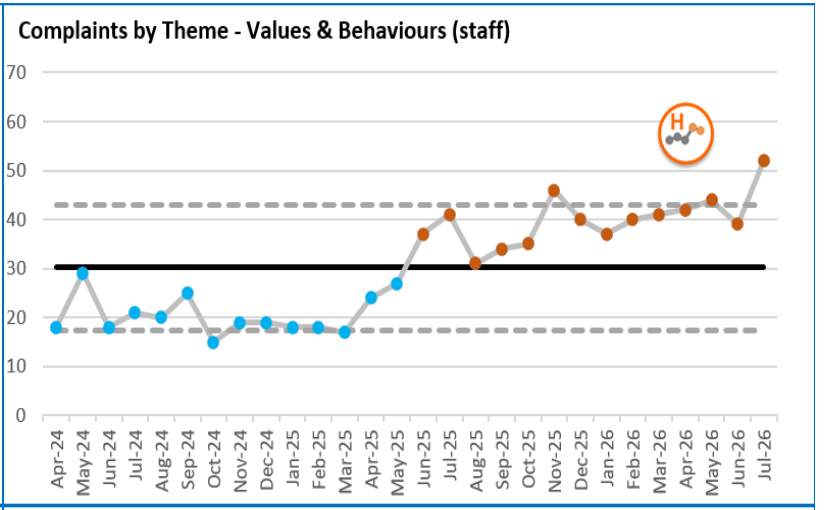
Moving to EXCELLENCE

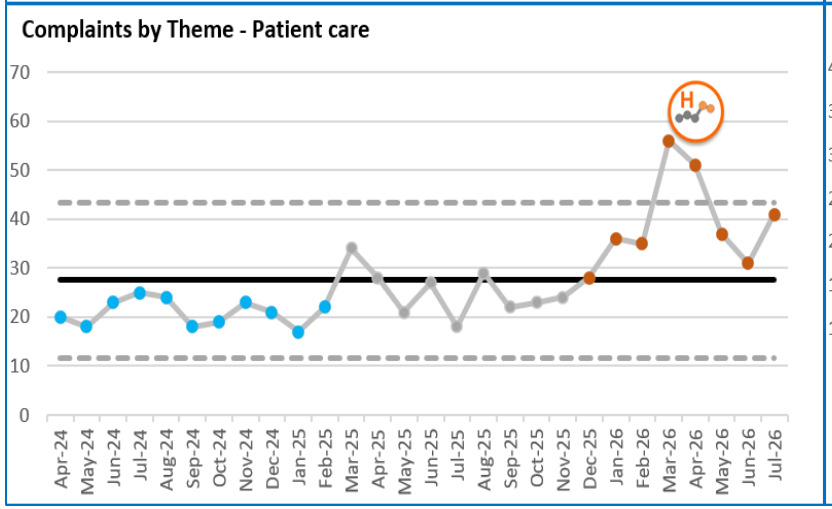
Complaints by theme – Top 6

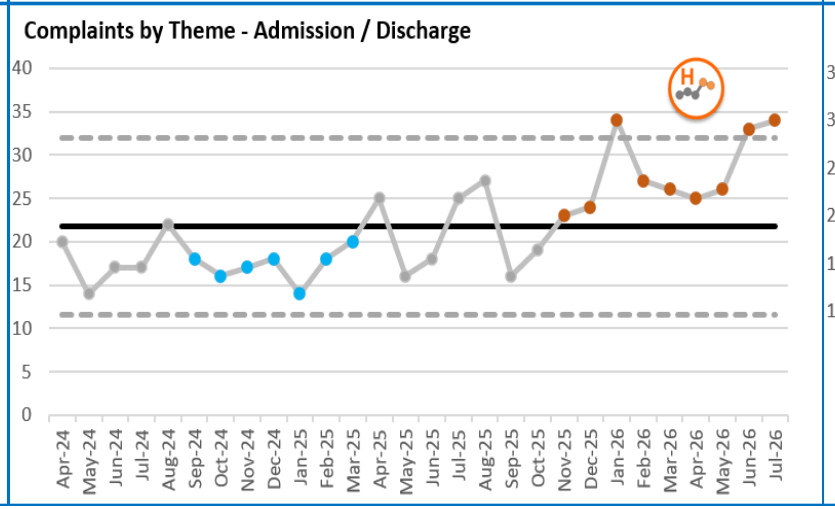
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

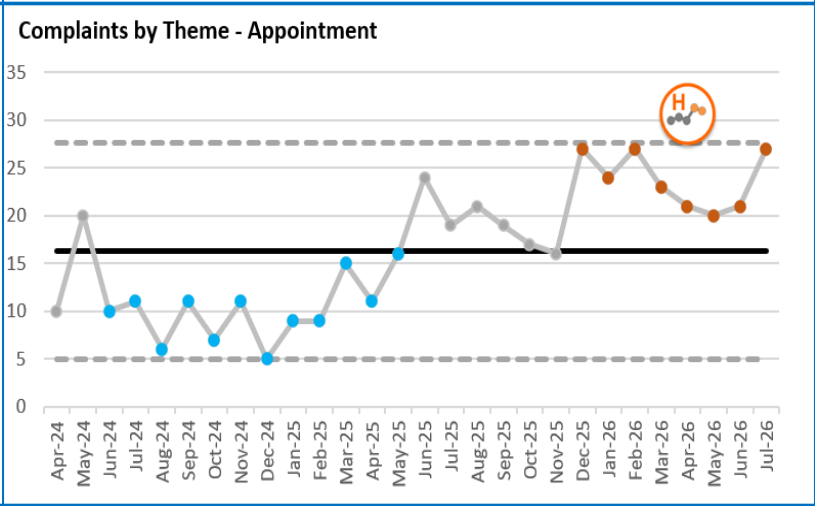












Moving to EXCELLENCE

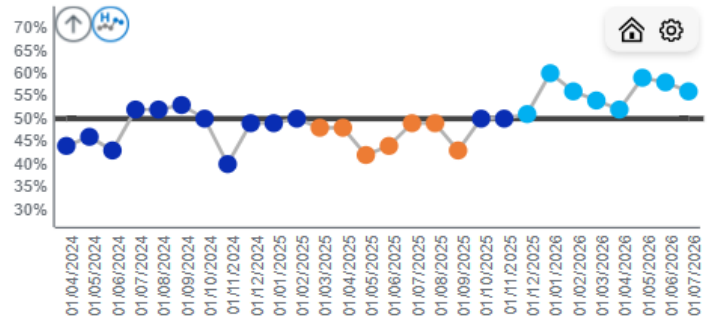
Quality - Patient Experience - Learning from Experience

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

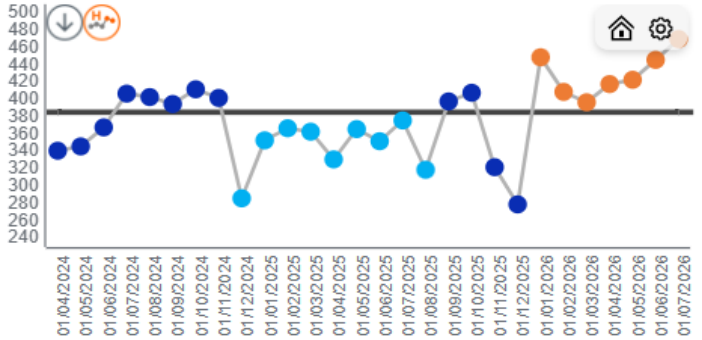
End of Life Care

	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026	Jun-2026	Jul-2026
Complaints - % Responded to within agreed timeframe based on month response due	44	49	49	43	50	50	51	60	56	54	52	59	58	56
PALS contacts	351	375	318	397	407	321	278	448	408	396	417	422	445	469
Complaints by Theme - Staff	115	108	106	91	89	113	121	124	114	133	137	132	139	139
Re-opened complaints upheld	0	1	0	1	0	0	0	0	0	0	0	0	1	1
Compliments Received	110	81	109	145	132	95	145	89	91	84	89	107	107	98
Friends and Family Test % recommenders	96.8	88.3	92.4	79.8	73.7	77.1	76.1	76.0	75.0	75.4	80.3	78.7	76.6	77.5

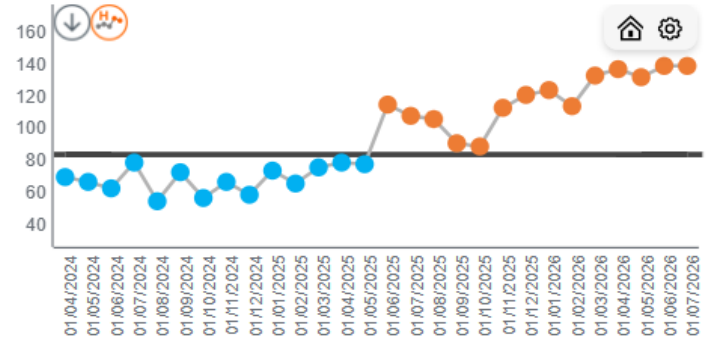
Complaints - % Responded to within agreed timeframe based on month response due



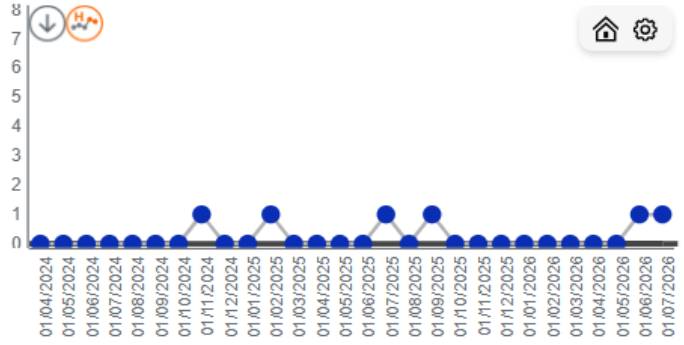
PALS contacts



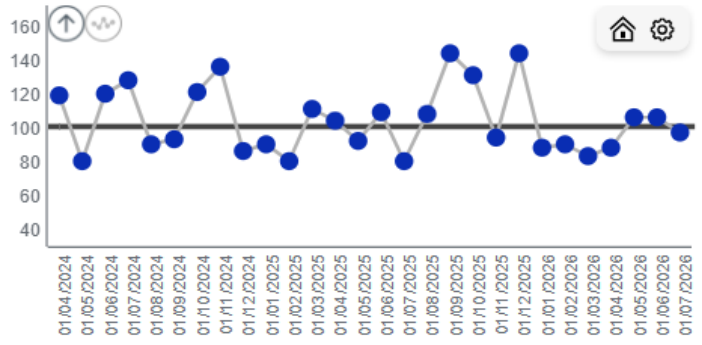
Complaints by Theme - Staff



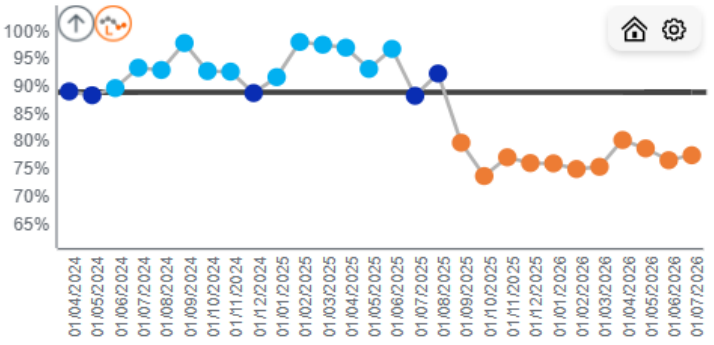
Re-opened complaints upheld



Compliments Received



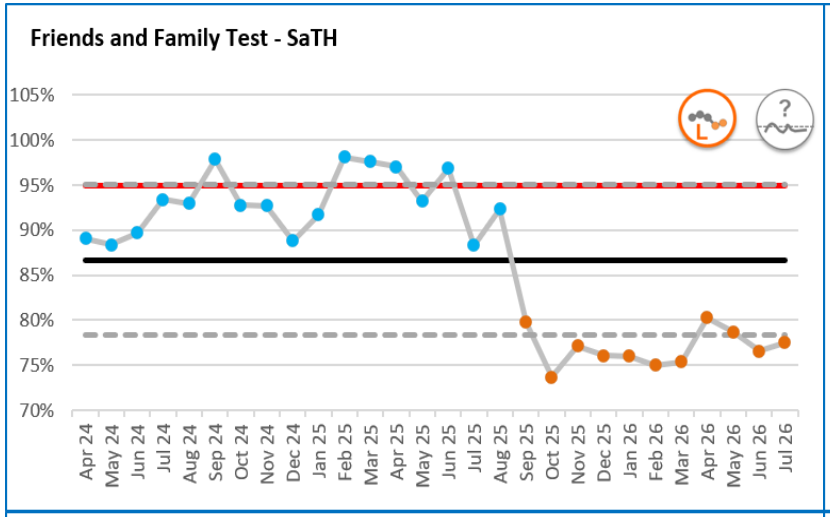
Freinds & Family Test % recommenders

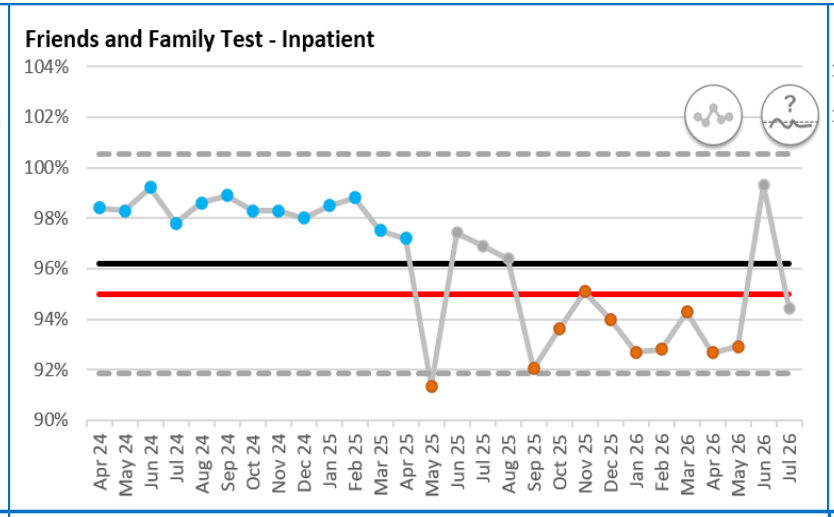


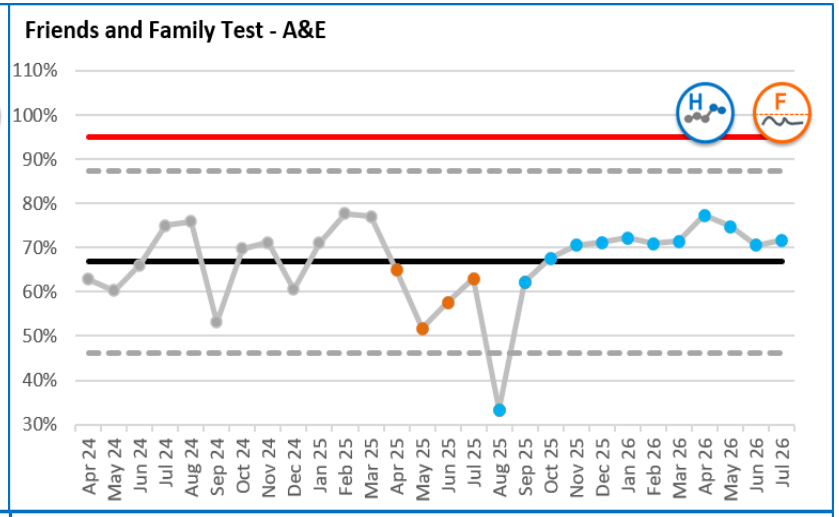
Moving to EXCELLENCE

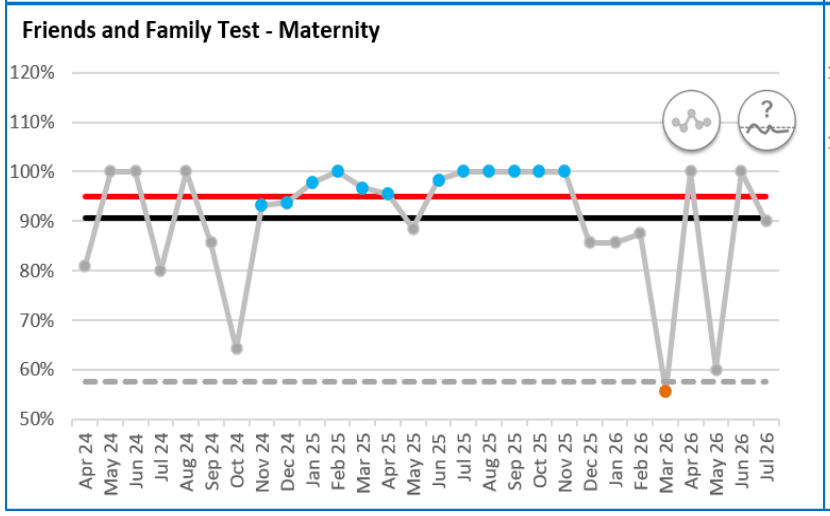
Friends and family test

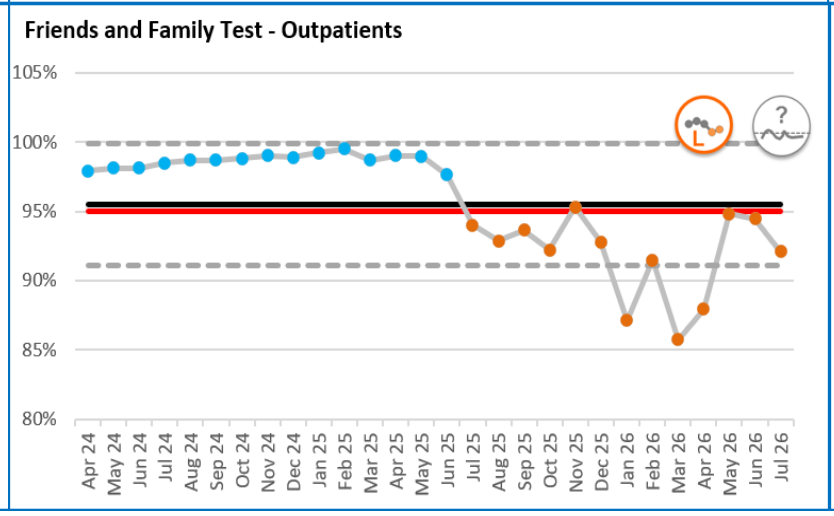
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

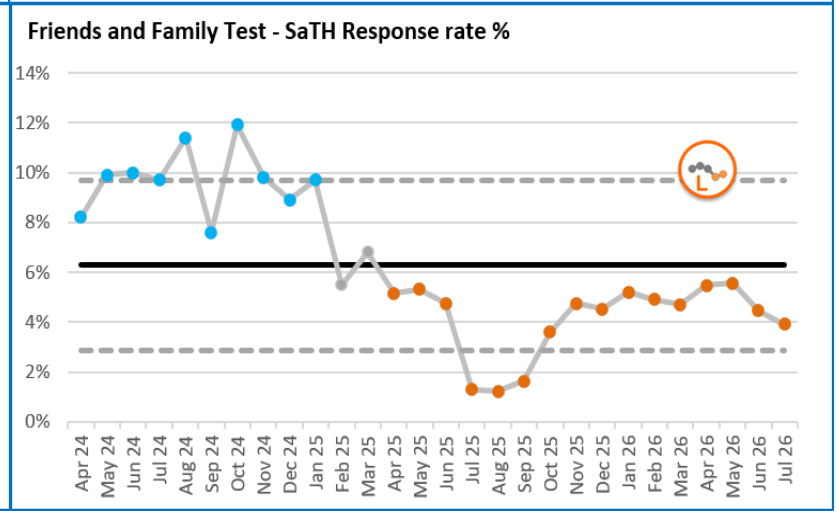








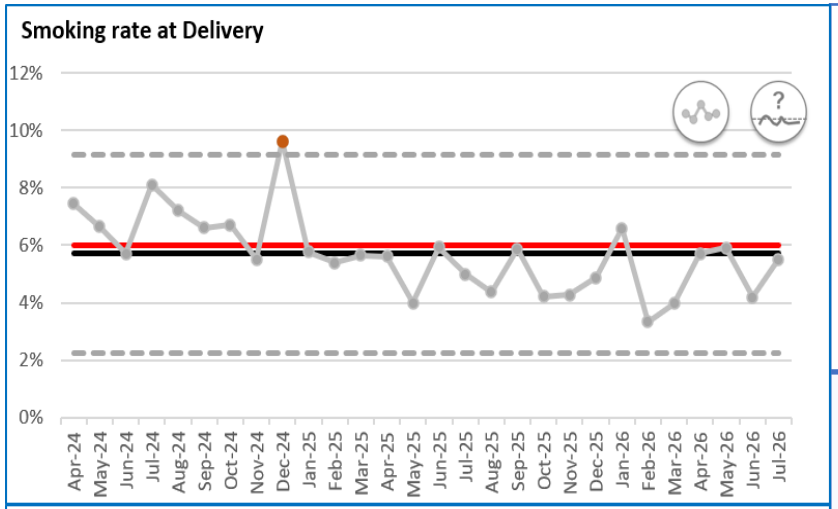


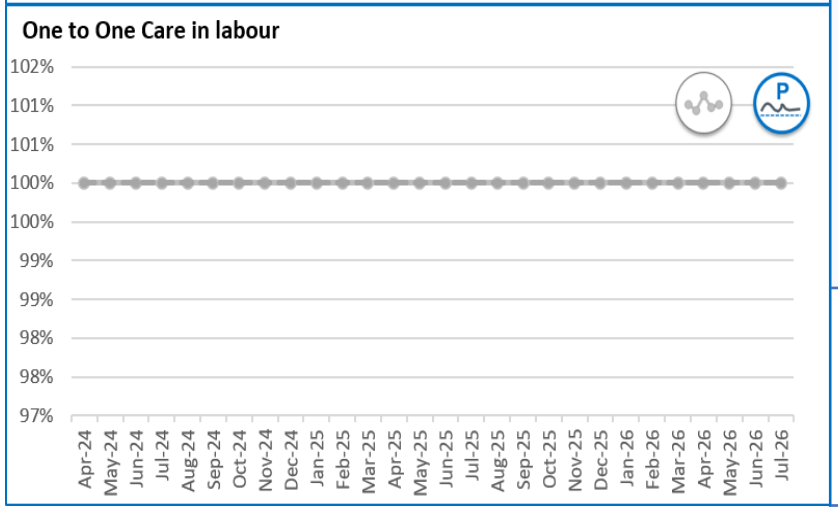


Moving to EXCELLENCE

Maternity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:
July SATOD has slightly increased from 4.2% in June, to 5.5%. The financial year so far sees an overall SATOD rate of 5%, which remains below Government target of 6%

SATOD rates will continue to be closely monitored.

Accurate recording of SATOD status is being 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.

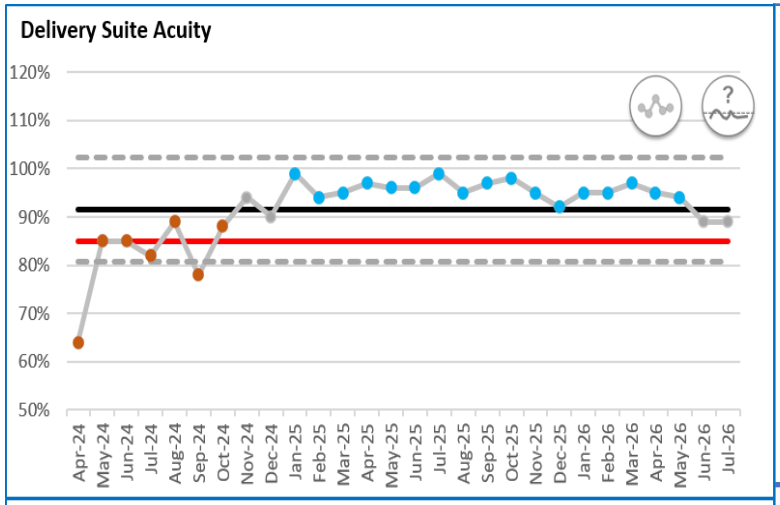
Anticipated impact and timescales for improvement:
Continue to target areas of deprivation and refer family members to local smoking cessation services. The biggest barrier to pregnant women quitting smoking is having a partner who smokes.
As per Saving Babies Lives, all Maternity staff are trained to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

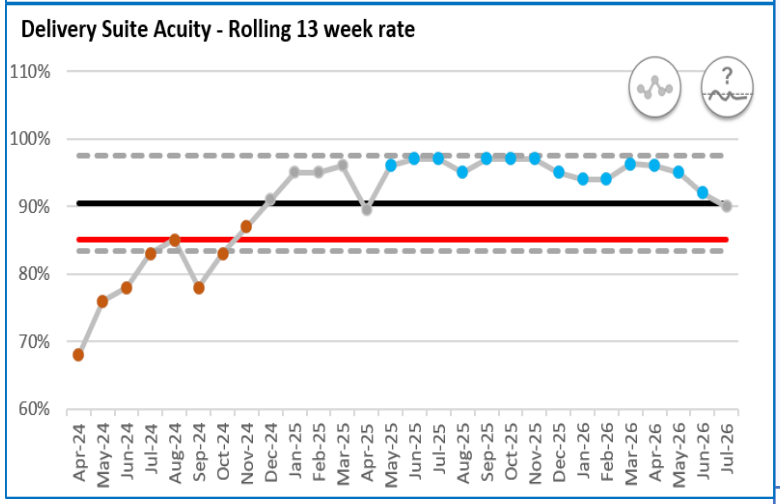
Recovery dependencies:
The local demographic has a higher-than-average deprivation index with increased unemployment and complex social needs, which is linked to higher rates of tobacco dependence. However, SaTH figures are now exceeding Government targets, which demonstrates the value of the HPSS model, 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 has remained above the national target of 85% since January 2025. In June, positive acuity reduced to below 90%, which was anticipated due to increased staff unavailability, primarily as a result of pregnancy-related sickness absence within the maternity workforce.

- To address workforce unavailability, Managers and Matrons meet monthly with HR to review sickness, attendance, and workforce planning. In addition, the Deputy Head of Midwifery holds a monthly oversight meeting to review all informal and formal workforce management processes
- Recruitment and retention remain a key focus. The service continues to recruit to maternity leave vacancies, with interviews scheduled at the end of August for 13.7 WTE preceptorship midwives and additional Maternity Care Assistants
- To further support safe staffing levels, Specialist Midwives are providing a minimum of one clinical shift per week on an interim basis, helping to maintain clinical capacity and service resilience

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

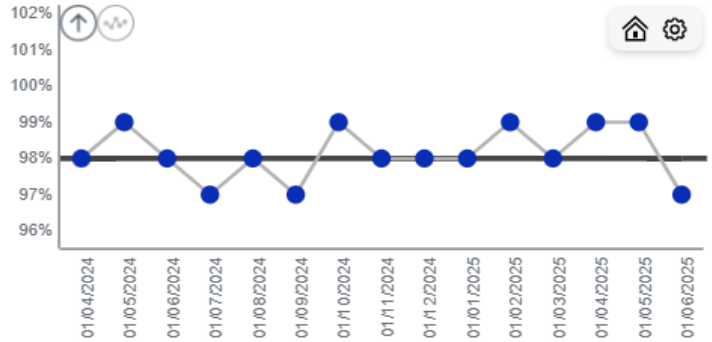
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Page 2

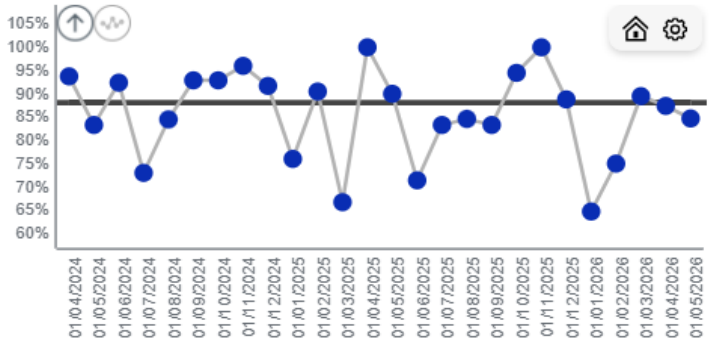
Learning from Experience

	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	May-2026	Jun-2026
Palliative and End of Life Care - Audit Score % Score	99	98	99	99	97												
% Overall rating of the PEoLC - Outstanding	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	89.5	87.4	84.7	
PPOC Discussion - total number	79	98	102	98	88	124	88	88	97	95	95	95	122	104	107	117	94
PPOC Achieved - total number	75	95	94	86	80	119	79	83	89	84	89	95	108	96	103	115	93
% Felt their loved one was comfortable in last days	95.2	60.0	100.0	90.5	61.5	86.7	85.7	58.8	0.0		80.0	70.6	72.0	83.3	91.3	69.2	
Palliative/End of Life Care - Nursing QA Audit	207	207	253	262	244												

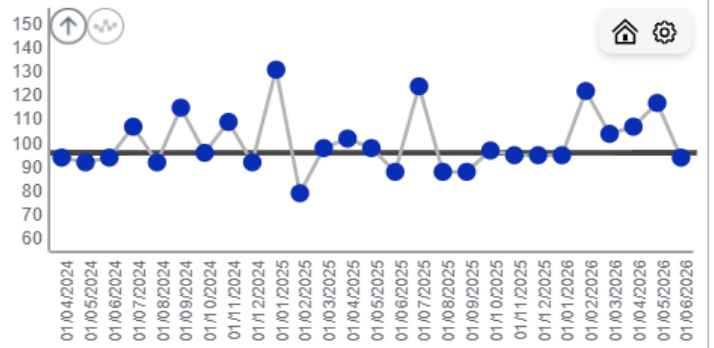
Palliative and End of Life Care - Audit Score % Score



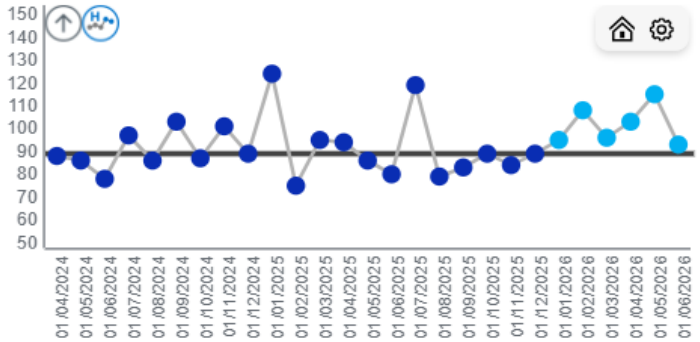
% Overall rating of the PEoLC - Outstanding



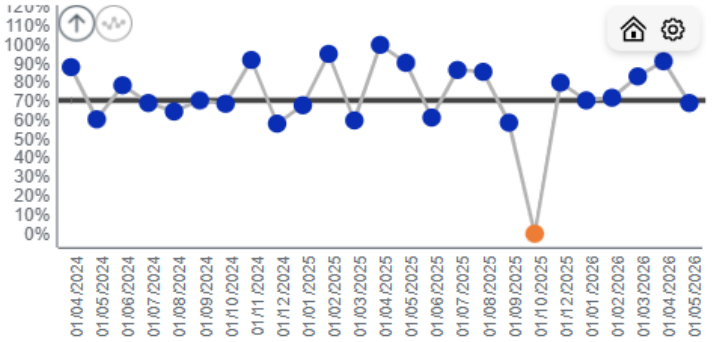
PPOC Discussion - total number



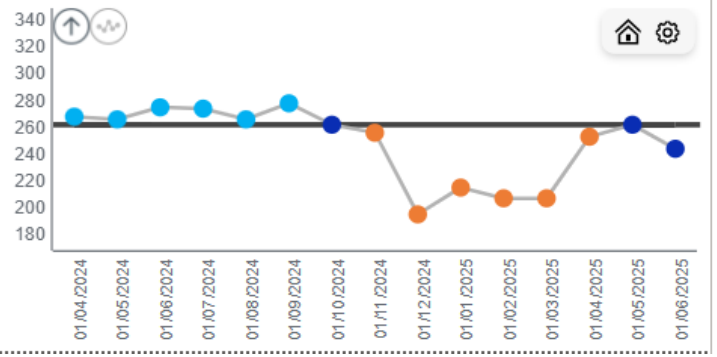
PPOC Achieved - total number



% Felt their loved one was comfortable in last days



Palliative/End of Life Care - Nursing Quality Assurance Audit



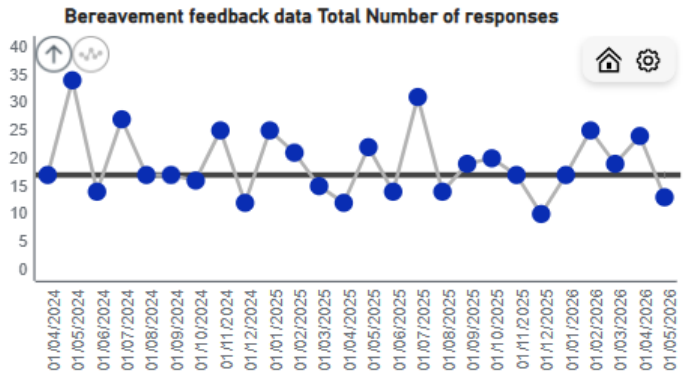
Quality - Patient Experience - End of Life Care

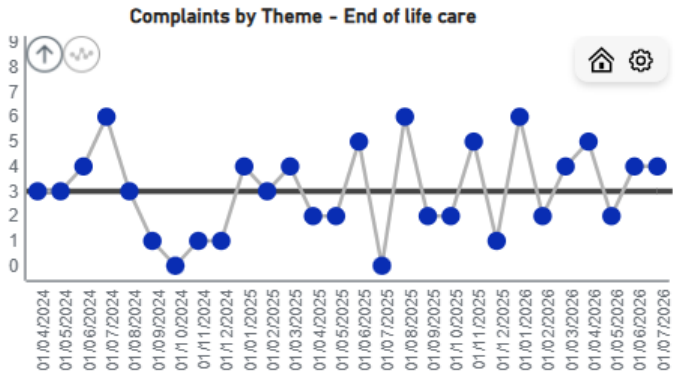
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

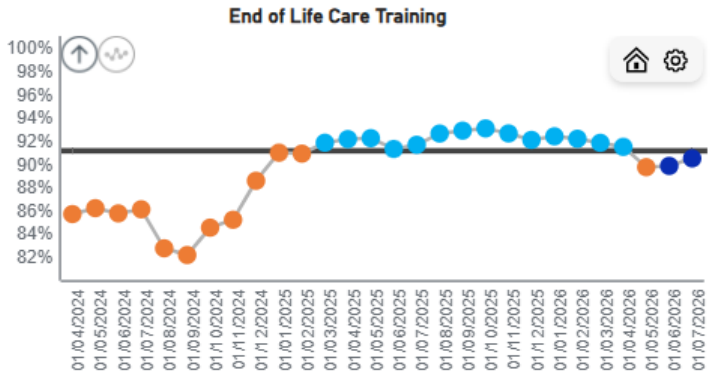
Page 1

Learning from Experience

	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	May-2026	Jun-2026	Jul-2026
Bereavement feedback data - Total Number of responses	15	12	22	14	31	14	19	20	17	10	17	25	19	24	13		
Complaints by Theme - End of life care	4	2	2	5	0	6	2	2	5	1	6	2	4	5	2	4	4
End of Life Care Training	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	89.78	89.89	90.54







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

Mental health demand – July 2026

Board-level overview of ED attendance, MHLT activity and Mental Health Act use

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

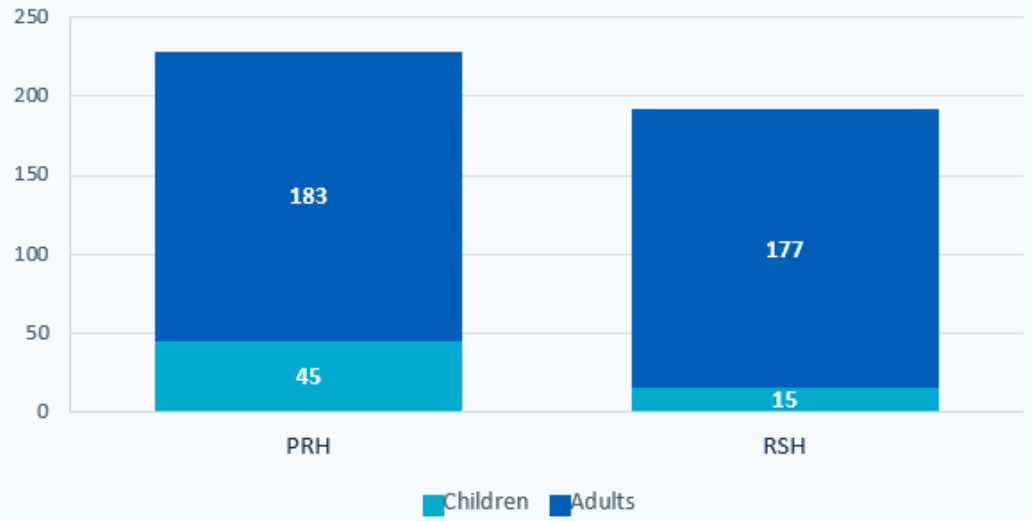
420
MH-related ED attendances
Attendances, not unique people

364
MHLT referrals reported
270 one-hour, 94 24-hour

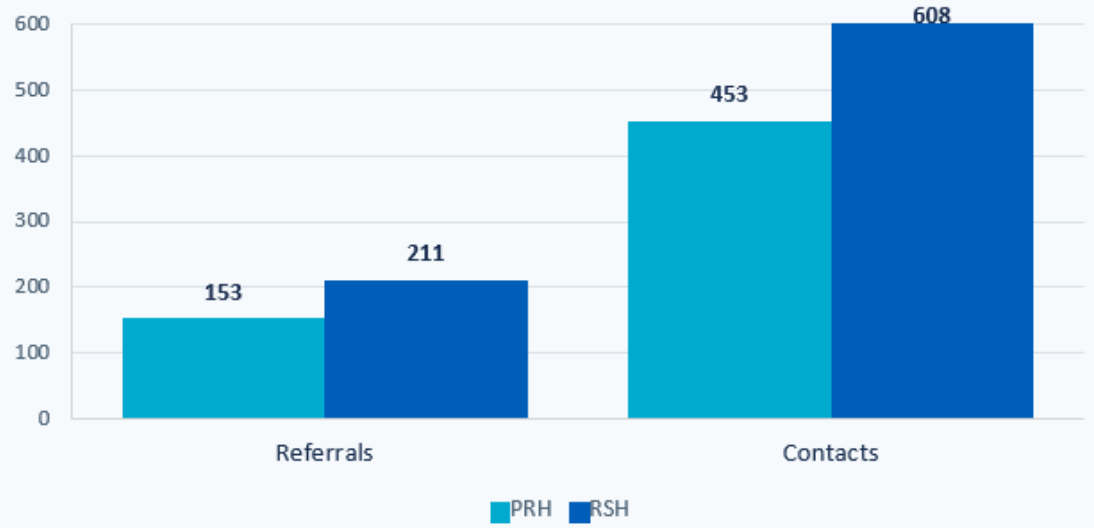
1,061
MHLT contacts
RSH 608, PRH 453

5
people subject to MHA use
6 recorded MHA entries

ED attendances by site and age



MHLT activity by site



What the data shows

PRH recorded more MH-related ED attendances. RSH recorded more MHLT referrals and contacts.
Compared with June, July saw a 3% increase in ED attendances, 10% increase in MHLT referrals and an 8% increase in contacts.

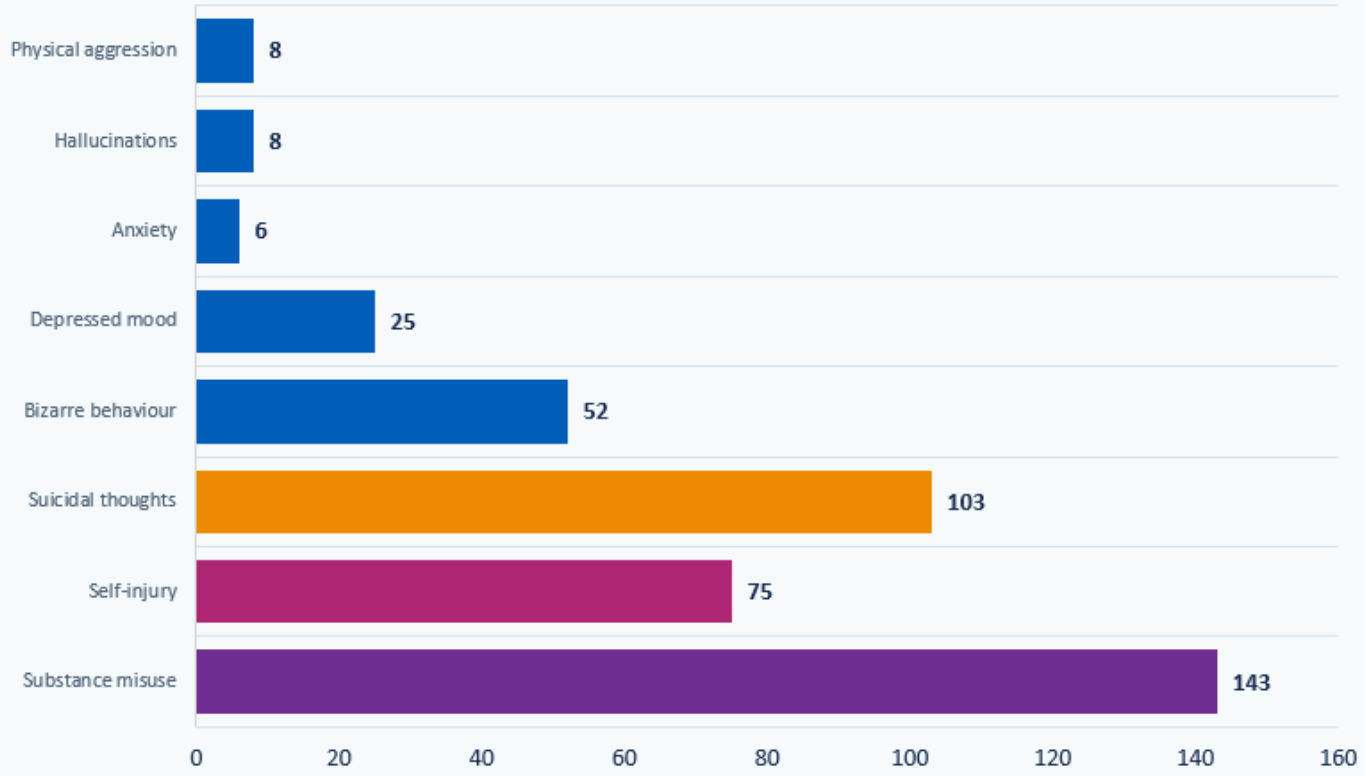
Moving to EXCELLENCE

Mental health - MHLT response time – June 2026

ED presentation profile and the one-hour MHLT response standard

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

ED attendances by recorded complaint



321 attendances - 76% were in the three leading complaint groups

One-hour ED referral standard

100.0%

RSH one-hour

No breaches reported

96.6%

PRH one-hour

4 breaches reported

MHLT Clock

Start: ED referral received by MHLT
Standard: response within one hour

July: Four PRH breaches reported.

- One followed four A&E referrals being received within 2 hours and 47 minutes
- Two involved complex. High-risk presentations requiring 2 nurses to undertake assessments
- One occurred due to sickness absence

Moving to EXCELLENCE

Mental health – CYP - July 2026

CYP presentation profile and site variation

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

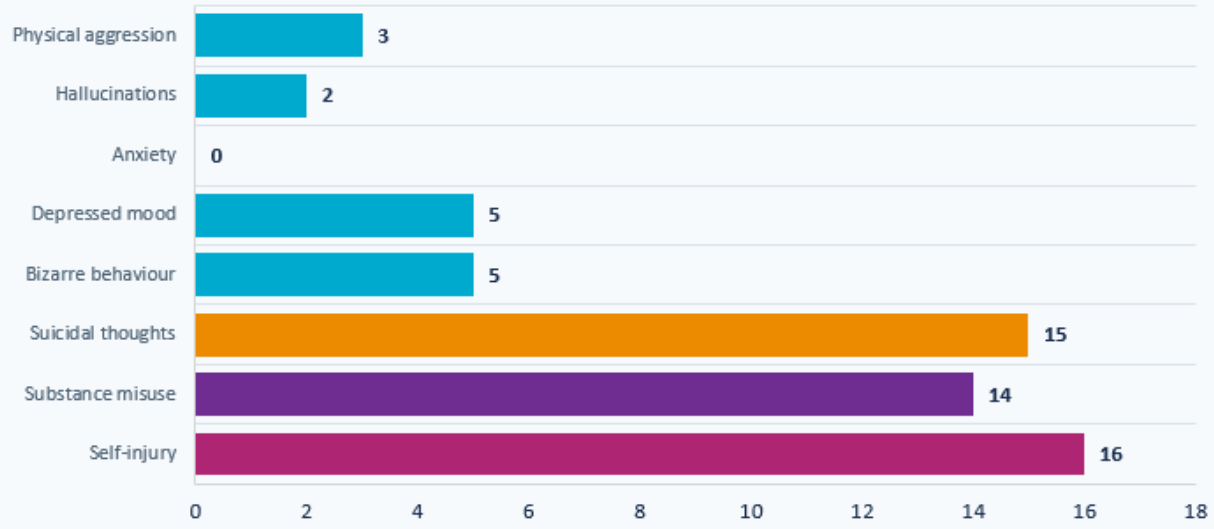
60
CYP attendances
14.3% of all MH attendances

45
PRH CYP attendances
75% of CYP total

15
RSH CYP attendances
25% of CYP total

16
Self-injurious behaviour
Largest CYP complaint group

CYP complaints



Month on month comparison

- CYP attendances decreased from 104 in June to 60 in July a reduction of 42%
- PRH continued to record the majority CYP attendances, accounting for 45 of 60 attendances in July
- Self-injury remained the largest recorded complaint group

Definition CYP: under 18

Moving to EXCELLENCE

Mental Health Act reporting - July 2026

Anonymised activity and future reporting requirements

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

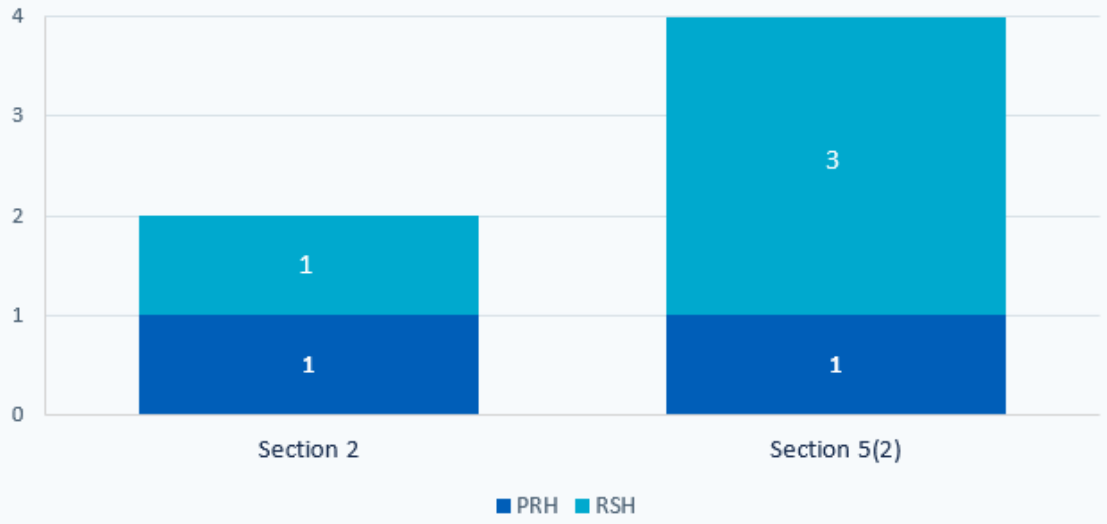
5
Unique patients
Based on supplied monthly register

6
Recorded MHA entries
Based on supplied monthly register

4
Section 5(2) uses
Holding-power events

2 PRH / 4 RSH
Events by site
Events, not unique patients

Recorded MHA entries by section and site



Anonymised outcomes

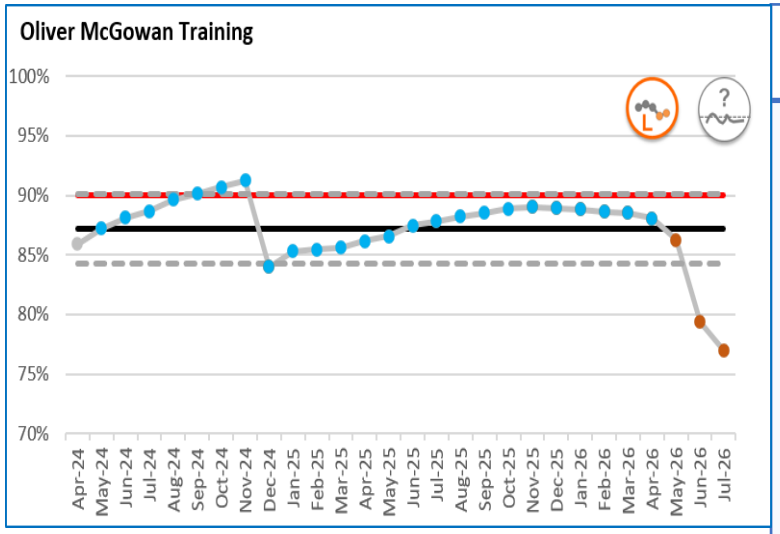
- Two section 5(2) holding powers progressed to section 2
- One of these patients transferred to a mental health hospital
- Two section 5(2) holding powers ended following section 23 discharge
- One section 2 patient transferred to a mental health hospital
- One section 2 ended following section 23 discharge on 4 August

Month on month context Total activity remained unchanged from June.

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 77%
- 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

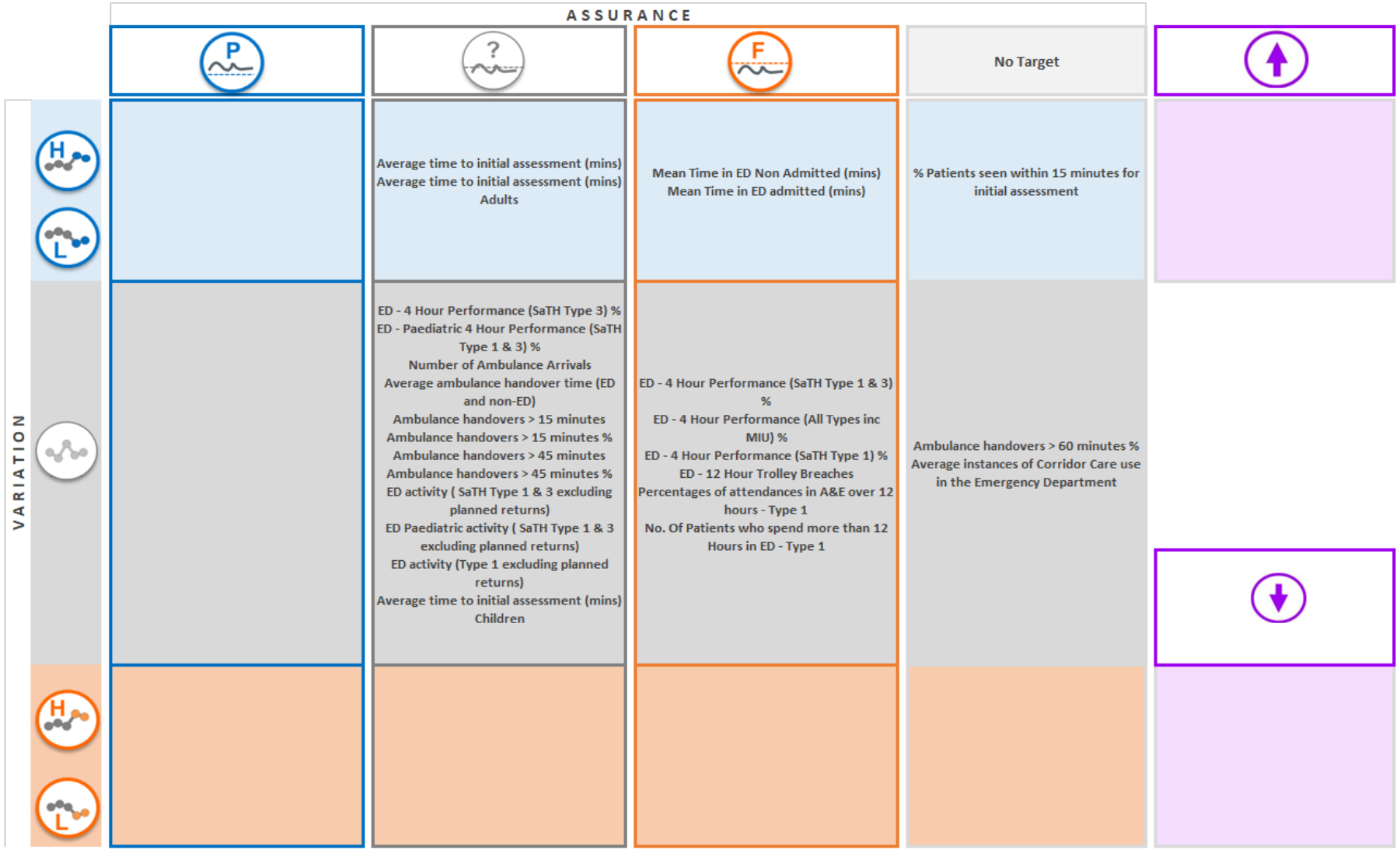
Executive Lead:

Chief Operating Officer
Ned Hobbs

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

UEC watch metrics



Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

UEC watch metrics

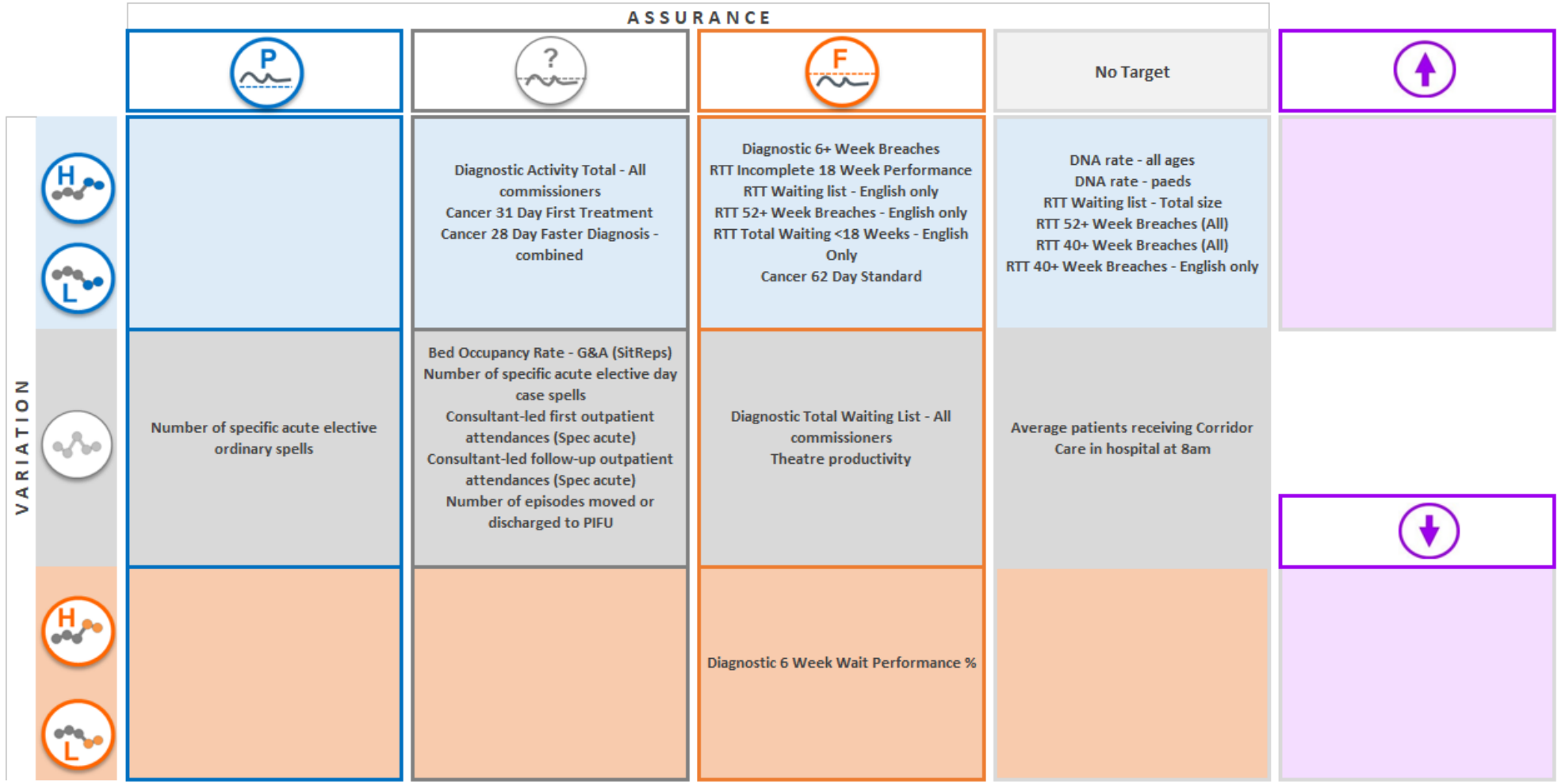
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Trend
ED - 4 Hour Performance (SaTH Type 1 & 3) %	Aug 26	51.7%	62.5%		F	52.2%	47.7%	56.6%	52.1%	53.8%	54.2%	53.6%	52.0%	51.3%	51.9%	52.8%	56.6%	52.9%	51.6%	52.2%	51.7%	
ED - 4 Hour Performance (All Types inc MIU) %	Aug 26	61.2%	68.9%		F	61.4%	57.1%	65.8%	61.1%	63.4%	62.7%	61.7%	60.1%	60.1%	60.8%	61.5%	65.0%	62.4%	61.5%	62.4%	61.2%	
ED - 4 Hour Performance (SaTH Type 1) %	Aug 26	43.3%	56.0%		F	43.9%	39.3%	48.4%	45.6%	45.6%	46.3%	45.5%	43.8%	43.2%	43.9%	45.1%	49.1%	44.8%	43.8%	44.6%	43.3%	
ED - 4 Hour Performance (SaTH Type 3) %	Aug 26	89.0%	90.0%		?	87.4%	80.2%	94.6%	80.9%	87.6%	87.1%	85.9%	83.7%	85.9%	85.4%	86.0%	91.7%	90.6%	87.7%	88.8%	89.0%	
ED - Paediatric 4 Hour Performance (SaTH Type 1 & 3) %	Aug 26	85.4%	85.1%		?	81.3%	72.6%	89.9%	83.5%	86.6%	84.6%	78.9%	75.2%	82.2%	81.7%	81.0%	84.6%	80.6%	79.4%	82.6%	85.4%	
ED - 12 Hour Trolley Breaches	Aug 26	1399	0		F	1188	781	1596	1300	1492	1618	1453	1429	1601	1366	1173	1026	949	1171	1300	1399	
Number of Ambulance Arrivals	Aug 26	3300	3254		?	3229	2781	3677	3392	3041	3210	3221	3373	3294	3103	3412	3371	3473	3223	3379	3300	
Average ambulance handover time (ED and non-ED)	Aug 26	01:09:40	00:30:00		?	01:08:01	00:28:05	01:47:58	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	00:28:50	00:38:32	01:09:40	
Ambulance handovers > 15 minutes	Aug 26	2609	2213		?	2509	2119	2899	2557	2488	2647	2577	2691	2767	2549	2614	2103	1984	1683	2155	2609	
Ambulance handovers > 15 minutes %	Aug 26	79.1%	68.0%		?	77.5%	66.8%	88.2%	75.4%	81.8%	82.5%	80.0%	79.8%	84.0%	82.1%	76.6%	62.4%	57.1%	52.2%	63.8%	79.1%	
Ambulance handovers > 45 minutes	Aug 26	1331	683		?	1073	433	1713	932	1335	1433	1332	1451	1585	1252	875	389	451	451	694	1331	
Ambulance handovers > 45 minutes %	Aug 26	40.3%	21.0%		?	32.5%	12.0%	53.1%	26.7%	43.9%	44.6%	41.4%	43.0%	48.1%	40.3%	25.6%	11.5%	13.0%	14.0%	20.5%	40.3%	
Ambulance handovers > 60 minutes %	Aug 26	33.9%	-			29.5%	12.4%	46.6%	20.7%	37.9%	37.5%	35.3%	37.1%	40.3%	33.5%	19.7%	7.1%	8.8%	9.8%	15.8%	33.9%	
ED activity (SaTH Type 1 & 3 excluding planned returns)	Aug 26	13730	12991		?	13269	11726	14812	13230	12951	13619	13361	13569	13020	12275	14083	13806	14077	14387	14495	13730	
ED Paediatric activity (SaTH Type 1 & 3 excluding planned returns)	Aug 26	1946	1942		?	2512	1763	3261	1940	2332	2415	2731	2856	2326	2370	2870	2693	2759	2800	2558	1946	
ED activity (Type 1 excluding planned returns)	Aug 26	11181	10497		?	10749	9603	11895	10802	10445	10982	10683	10764	10549	9920	11446	11355	11573	11834	12003	11181	
% Patients seen within 15 minutes for initial assessment	Aug 26	67.0%	-	H		63.4%	52.2%	74.5%	72.3%	65.3%	65.2%	64.6%	71.4%	68.5%	69.9%	68.5%	76.1%	72.3%	69.8%	72.2%	67.0%	
Average time to initial assessment (mins)	Aug 26	15.0	15.0	L	?	17.4	11.3	23.4	13.6	16.3	15.5	15.8	14.2	14.2	13.5	14.4	11.5	12.3	14.1	13.2	15.0	
Average time to initial assessment (mins) Adults	Aug 26	16.0	15.0	L	?	17.9	11.1	24.7	14.5	16.5	15.9	14.7	11.8	14.8	13.8	14.3	11.4	12.6	13.7	13.3	16.0	
Average time to initial assessment (mins) Children	Aug 26	9.1	15.0		?	15.5	7.2	23.8	9.2	15.5	13.9	19.4	21.9	12.1	12.6	14.6	11.7	11.2	15.5	12.4	9.1	
Mean Time in ED Non Admitted (mins)	Aug 26	296.4	215.0	L	F	296.8	260.1	333.6	291.5	292.9	291.7	294.2	297.9	303.5	281.4	269.1	244.4	256.8	275.2	285.3	296.4	
Mean Time in ED admitted (mins)	Aug 26	1084.9	500.0	L	F	1111.6	851.3	1371.8	1084.1	1227.1	1144.9	1121.0	1123.8	1212.9	1090.8	917.2	759.1	809.9	877.1	982.2	1084.9	
Percentages of attendances in A&E over 12 hours - Type 1	Aug 26	22.1%	14.4%		F	22.1%	18.9%	25.4%	21.9%	23.4%	23.3%	22.4%	22.0%	24.7%	22.3%	19.0%	16.8%	16.4%	19.2%	20.8%	22.1%	
No. Of Patients who spend more than 12 Hours in ED - Type 1	Aug 26	2466	1516		F	2374	1924	2825	2370	2443	2555	2389	2369	2610	2217	2178	1904	1901	2269	2499	2466	
Average instances of Corridor Care use in the Emergency Departmen	Aug 26	19.6	-			18.6	10.5	26.8	13.5	15.9	17.7	16.8	16.5	18.5	16.5	17.7	15.5	23.8	29.4	32.5	19.6	

Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Activity watch metrics



Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Activity watch metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Trend
Average patients receiving Corridor Care in hospital at 8am	Aug 26	20	-			19	11	27	13	16	18	17	17	18	17	18	16	24	29	33	20	
Bed Occupancy Rate - G&A (SitReps)	Aug 26	94.30%	94.96%			94.51%	92.46%	96.57%	93.6%	93.8%	94.5%	92.1%	92.3%	95.6%	96.0%	95.2%	94.1%	93.8%	94.8%	94.4%	94.3%	
Diagnostic Activity Total - All commissioners	Aug 26	23795	24393			23786	20716	26857	24973	24860	24881	22628	24080	24199	24198	26130	24016	24612	25711	27167	23795	
Diagnostic Total Waiting List - All commissioners	Aug 26	14973	10586			14887	12858	16916	11471	11634	12437	12437	12256	13037	14656	16010	15471	15188	15787	16067	14973	
Diagnostic 6 Week Wait Performance %	Aug 26	73.4%	85.9%			74.3%	66.5%	82.1%	81.8%	85.5%	86.9%	86.4%	81.7%	80.5%	86.5%	86.4%	82.6%	82.3%	79.9%	79.7%	73.4%	
Diagnostic 6+ Week Breaches	Aug 26	3987	1492			3998	2518	5478	2086	1692	1632	1707	2249	2690	1978	2184	2685	2688	3169	3267	3987	
Number of specific acute elective ordinary spells	Aug 26	528	341			495	400	590	518	455	467	451	417	469	491	578	496	512	591	530	528	
Number of specific acute elective day case spells	Aug 26	5261	6179			5721	4909	6533	5564	5975	6367	6050	5555	5848	5472	5671	5360	5560	5725	5959	5261	
Consultant-led first outpatient attendances (Spec acute)	Aug 26	13883	13651			15852	12241	19463	17303	17742	16626	14908	13902	16846	16622	18937	15350	15551	16715	16220	13883	
Consultant-led follow-up outpatient attendances (Spec acute)	Aug 26	20399	21462			22903	17908	27898	21313	24581	24665	22714	22107	23011	21833	24679	22619	20776	24760	24295	20399	
DNA rate - all ages	Aug 26	5.2%	-			5.8%	4.9%	6.8%	7.2%	5.7%	5.4%	5.6%	5.8%	5.7%	5.0%	5.2%	5.1%	4.8%	5.2%	5.3%	5.2%	
DNA rate - paeds	Aug 26	8.9%	-			9.6%	7.8%	11.5%	13.0%	9.1%	8.6%	8.7%	8.3%	8.7%	8.5%	7.9%	8.9%	8.3%	8.6%	9.4%	8.9%	
Number of episodes moved or discharged to PIFU	Aug 26	2319	2508			2300	1742	2857	2288	2523	2488	2472	2283	2325	2335	2575	2475	2199	2529	2592	2319	
RTT Incomplete 18 Week Performance	Aug 26	68.2%	70.5%			56.7%	51.7%	61.7%	58.8%	62.3%	64.0%	65.5%	64.1%	62.9%	63.1%	68.9%	69.1%	69.9%	69.7%	68.0%	68.2%	
RTT Waiting list - Total size	Aug 26	42336	-			44514	40688	48340	37132	36022	36674	37997	36982	37910	37266	38063	38884	40292	41043	41201	42336	
RTT Waiting list - English only	Aug 26	38312	35744			39761	36202	43321	32670	31652	32263	33621	32790	33637	33359	34275	35084	36456	37236	37291	38312	
RTT 52+ Week Breaches (All)	Aug 26	135	-			1792	1225	2359	600	369	313	284	226	235	241	196	168	159	116	131	135	
RTT 52+ Week Breaches - English only	Aug 26	0	0			1440	928	1953	305	125	84	68	20	31	47	0	0	0	0	0	0	
RTT 40+ Week Breaches (All)	Aug 26	1838	-			5345	3939	6751	3001	2154	1741	1731	1830	1833	1769	1569	1683	1702	1677	1749	1838	
RTT 40+ Week Breaches - English only	Aug 26	1485	-			4542	3235	5849	2318	1590	1223	1232	1330	1301	1288	1127	1208	1286	1330	1397	1485	
RTT Total Waiting <18 Weeks - English Only	Aug 26	26122	25187			22134	19698	24569	19210	19717	20651.5	22018.4	21026	21147.6	21059.5	23615.5	24232.5	25466	25944	26058	26122	
Cancer 62 Day Standard	Jul 26	75.1%	74.9%			64.3%	54.2%	74.4%	68.8%	65.2%	71.4%	70.2%	70.1%	68.3%	75.0%	74.5%	71.2%	73.9%	74.5%	75.1%		
Cancer 31 Day First Treatment	Jul 26	98.1%	94.0%			92.1%	84.3%	99.9%	91.6%	94.2%	96.2%	95.5%	98.0%	96.2%	99.2%	97.6%	96.4%	98.6%	98.0%	98.1%		
Cancer 28 Day Faster Diagnosis - combined	Jul 26	86.6%	80.0%			74.5%	66.3%	82.8%	75.9%	80.1%	80.3%	85.7%	83.0%	80.2%	85.5%	86.0%	80.9%	82.5%	85.8%	86.6%		
Theatre productivity	Aug 26	79.4%	85.0%			79.5%	77.5%	81.5%	80.8%	81.1%	79.9%	80.8%	81.0%	80.2%	81.4%	80.5%	80.3%	80.2%	79.2%	78.7%	79.4%	

Moving to EXCELLENCE

Operational Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

SaTH ED - 4-hour performance for Type 1 and Type 3 attendances remained within expected levels of common cause variation during August 2026. Type 1 performance decreased to 43.3%, while Type 3 performance improved to 89.0%. Average ambulance handover times increased significantly during the month, although performance remains within common cause variation. This deterioration was primarily driven by a marked reduction in the proportion of ambulance handovers completed within 45 minutes. The number of Type 1 patients spending more than 12 hours in the Emergency Department continued to demonstrate common cause variation

RTT - The submitted Trust Position for August 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 validated Trust Position for Welsh is 0 x 104 weeks, 8 x 78 weeks, 40 x 65 weeks and 135 x 52 weeks.
The Trust is currently operating below the agreed RTT trajectory. However, a programme of focused improvement work is underway to strengthen productivity across multiple services areas, supported by targeted ERF investment to increase outpatient capacity and delivery.

Cancer - Confirmed July cancer performance is 86.6% (28-day FDS) vs the local plan of 80%. 62-day performance was 75.1% against a local target of 74.9% and 31 day was 98.1% against a local target of 96%. The 62-day backlog is 147 patients over 62 days of which 36 are over 104 days (as at 22/09/2026).

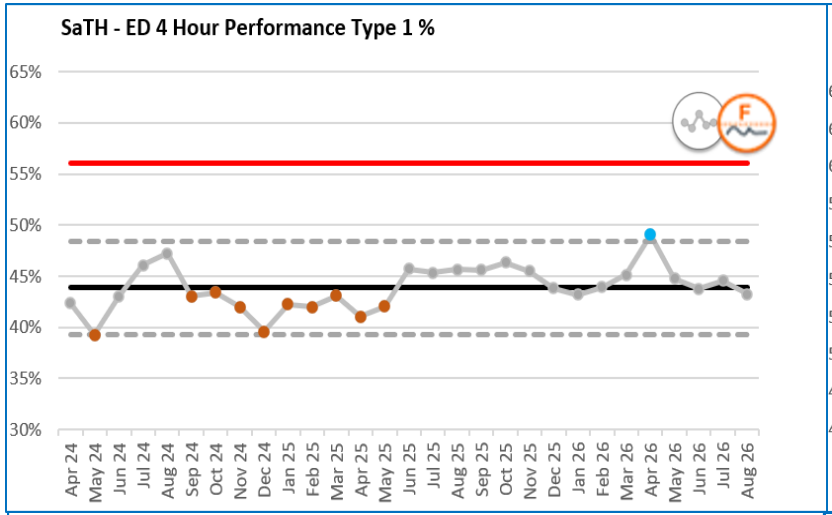
DM01 - The submitted DM01 position for August was 73.37%, with notable improvement in performance within Neurophysiology. Non-Obstetric Ultrasound (NOUS) performance deteriorated by 5.5%; however, a recovery plan has been in place since mid-June and continues to be implemented. Radiology reporting turnaround times for CT examinations have been maintained, with urgent suspected cancer (USC) referral-to-report turnaround times currently at approximately 2 weeks for CT, 2 weeks for MRI, and 1 to 2 weeks for NOUS. Radiologist workforce constraints continue to limit reporting capacity and reduce service resilience during periods of sickness and annual leave. To mitigate this risk and provide greater flexibility in reporting capacity, an additional outsourcing provider has recently been secured.

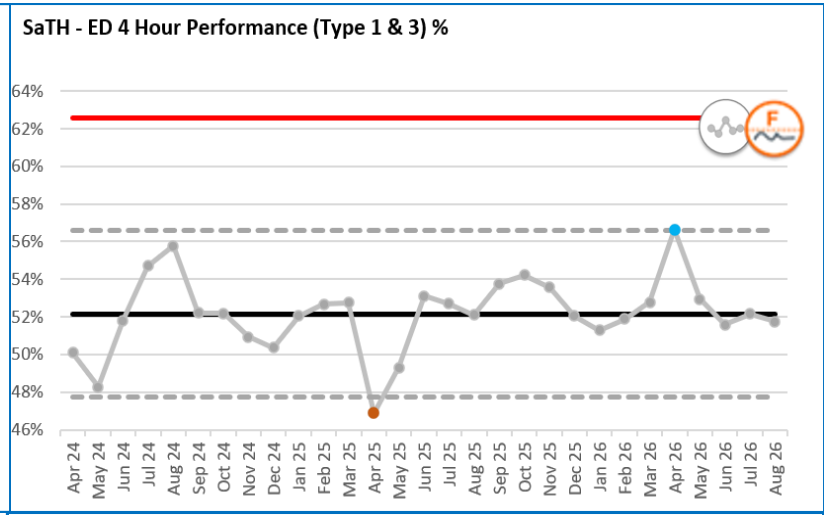
Key actions

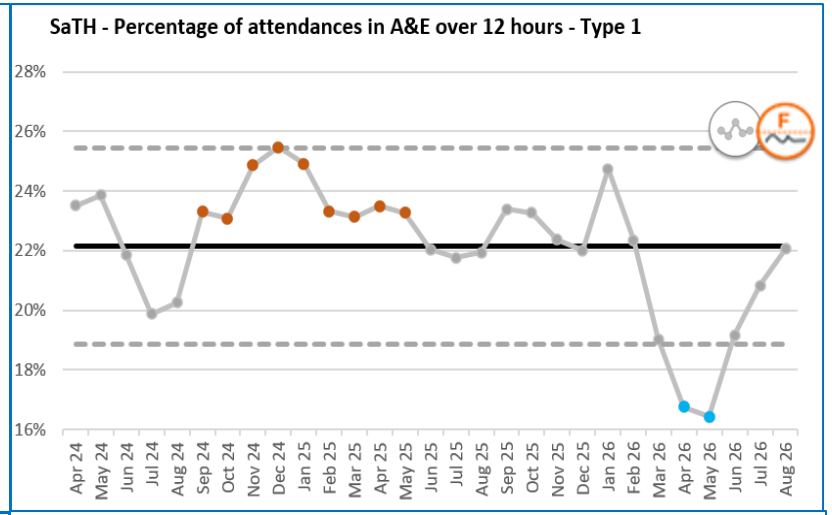
- Delivery partner Test of Change format has commenced on both sites with a focus on earlier blood results, faster decision maker review and earlier CT request and result
- UEC Phase II funding confirmed to support continuation of a selection of schemes tested as part of March 26 Urgent and Timely UEC Campaign
- Outpatient productivity now focussed Single Point of Access rollout along with ICB & Primary Care Colleagues
- Q3 planned care additional activity plan downgraded to support trust financial position, reduction in Inpatient work at the weekend
- New clinic templates in OMFS being implemented on 1st September delivering circa 200 additional slots per month
- Booking & Scheduling and pre-operative assessment work introducing My PreOp+
- 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

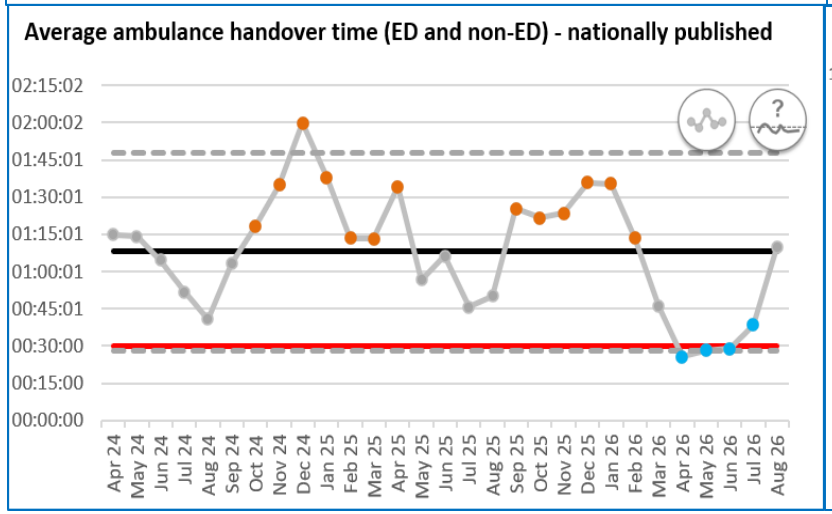
Operational – Emergency Care

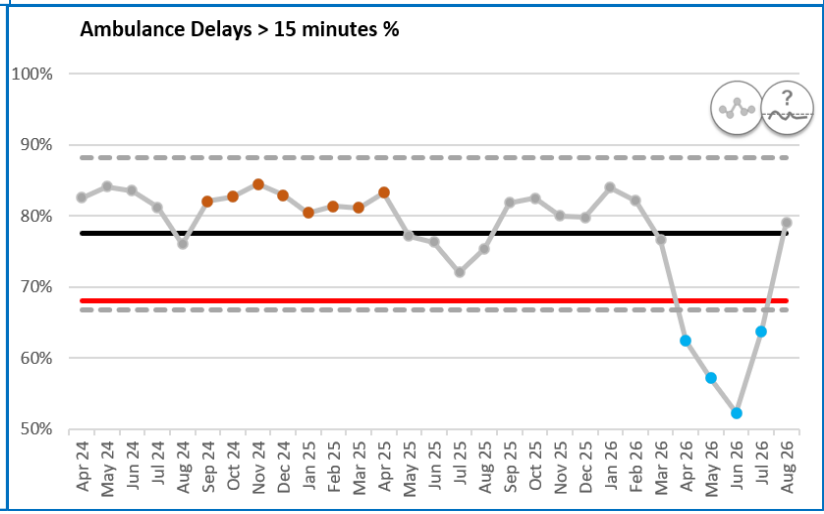
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

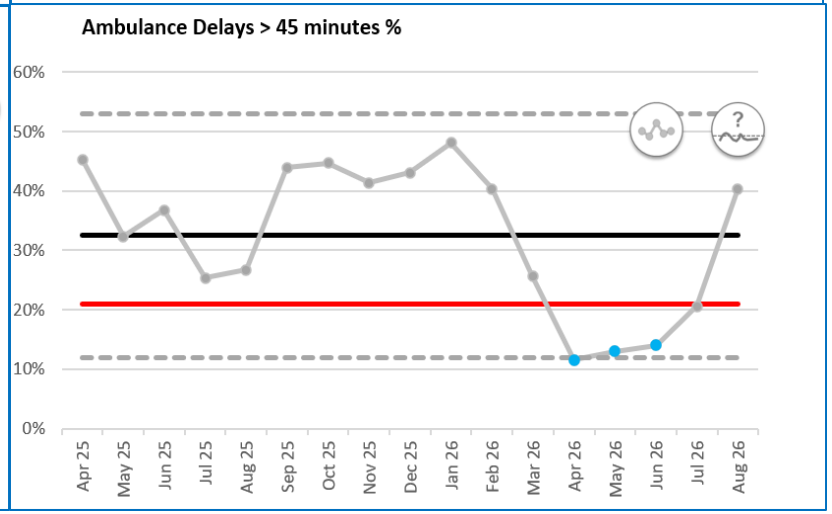












Moving to EXCELLENCE

Operational – Emergency Care

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:

- SaTH ED 4-hour performance was 52% (type 1 & type 3) and remains in common cause natural variation in August 2026
- SaTH number of patients who spend more than 12 hours in ED stays in special cause improving variation with 78% of patients admitted and discharged within 12 hours during August 2026
- Average ambulance handover time shows common cause natural variation in August with 57.7% of ambulance handovers within 45 mins

Recovery actions:

- Delivery partner Test of Change format has commenced on both sites with a focus on earlier blood results, faster decision maker review and earlier CT request and result
- RSH Ambulance Recovery SOP
- Task & Finish Group in place reviewing ED Medical Workforce opportunities
- Focused review of >14 day LoS across all Medical Wards
- Focused HIU programme of work
- Following the launch of Ambulance Threshold 45 release to respond in June 2026 focused support with senior oversight to maintain progress
- Continue to work with WMAS/WAS on 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
- UEC Phase II funding confirmed to support continuation of a selection of schemes tested as part of March 26 Urgent and Timely UEC Campaign
- 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.

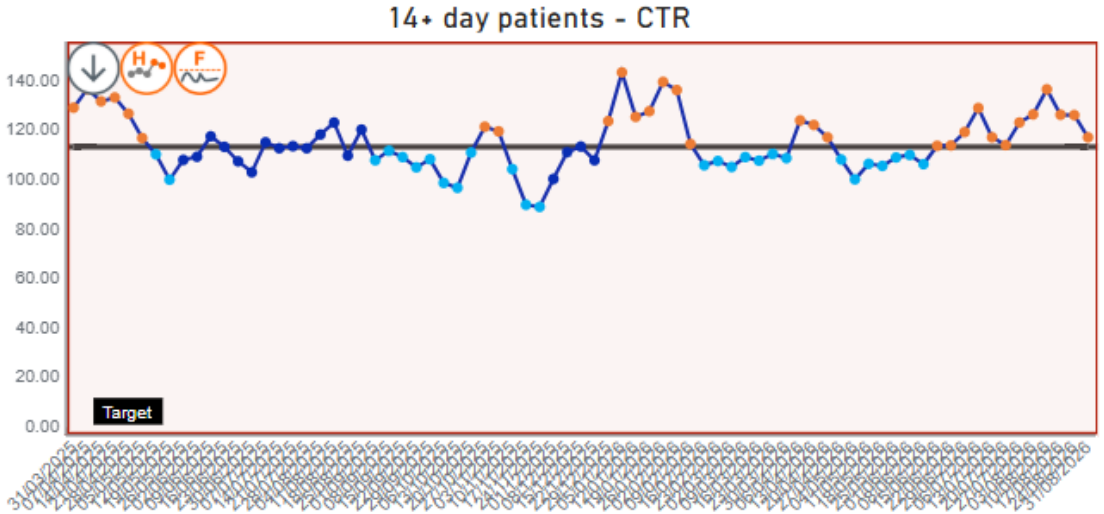
Progress reported monthly through Urgent and Emergency Care Transformation Committee (UECTAC) and weekly cross Divisional metrics meeting.

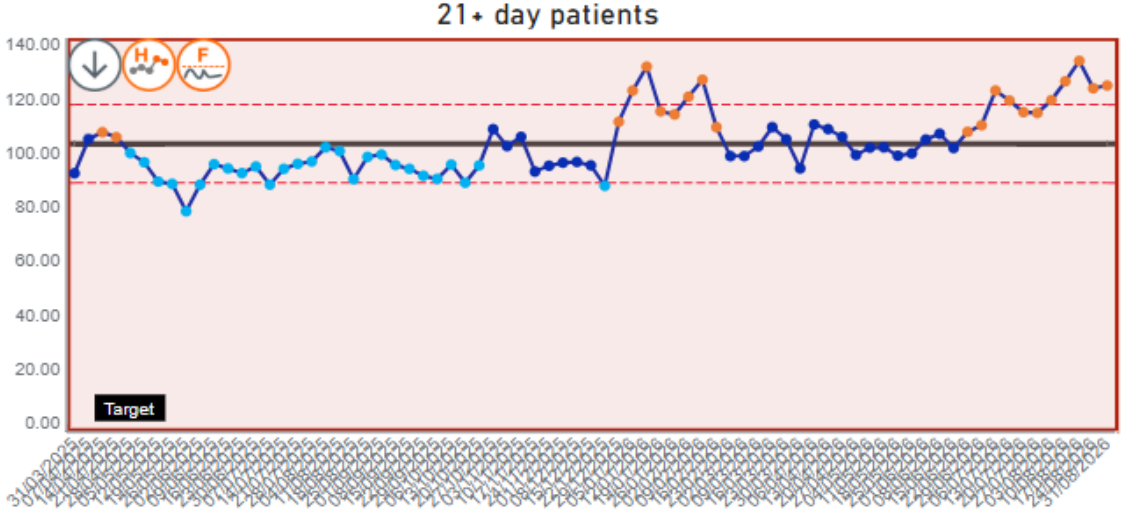
Recovery dependencies:	System tier 1 workstreams – to reduce demand on A&E and reduce exit block

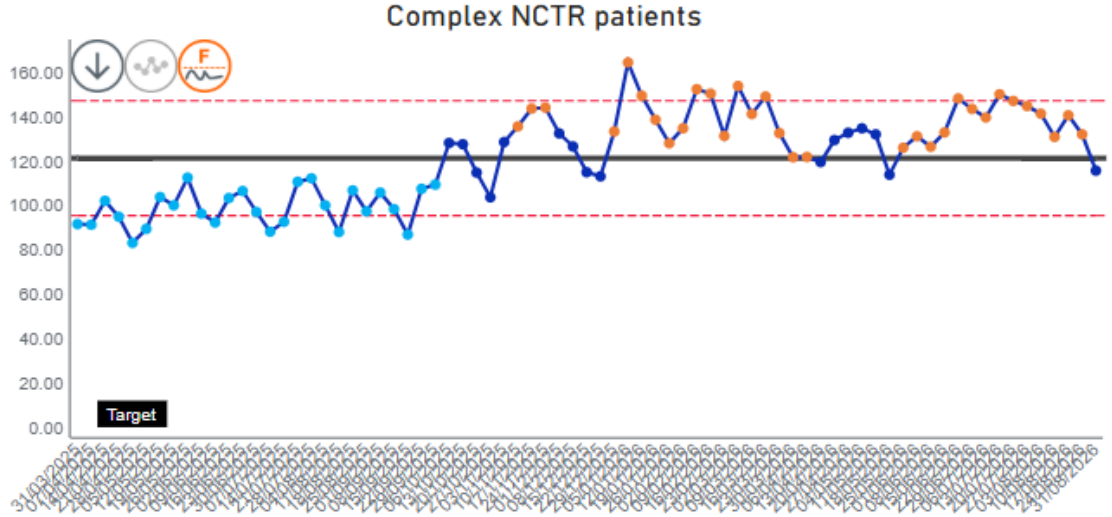
Moving to EXCELLENCE

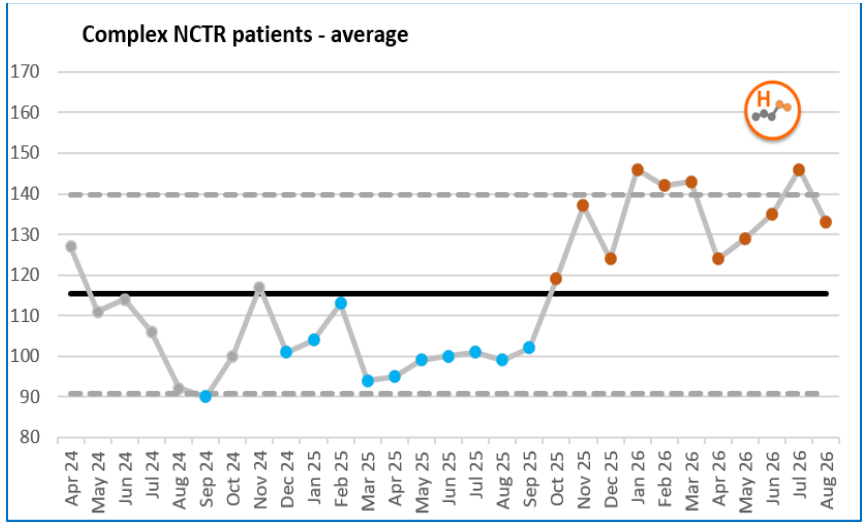
Operational – Patient Flow

Shropshire, Telford and Wrekin Community and Hospitals NHS Group









Operational – Patient Flow

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
- The average number of complex no criteria to reside (NCTR) patients continues to be above the mean, 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 special cause variation

Recovery actions:
- Revised LOS monitoring process - focus on patients over 12 days with CTR reviewed face to face by multi-disciplinary team. Supported by action-focused tracker to improve oversight and reduce delays in patient journeys and discharge
- Reset short-stay criteria on Wards 25 and 36 to support timely patient flow, reduce length of stay, and improve the discharge profile
- Proactive management of community bed capacity, complex discharges, and patient transport arrangements to minimise incomplete (failed) discharges
- Continued focus on the care to home (CTH) and therapy processes to reduce the length of time between NCTR and discharge
- The SaTH Admission Service will move from its current location with Health Heroes to Halesfield, where it will be co-located with ShropCom colleagues to enhance referral signposting and partnership working
- Daily CTH meetings, reviewing patients with NCTR. CTH extended hours 08.00 - 20.00
- Reset the working relationship with the EMED transport provider through a review of contractual arrangements and service expectations
- 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
- RSH Discharge Lounge has now relocated back to Ward 18, which has increased the capacity of patients that can be accommodated
- A dedicated phlebotomy bleep has been introduced to support discharge blood requests across both sites

Anticipated impact and timescales for improvement:

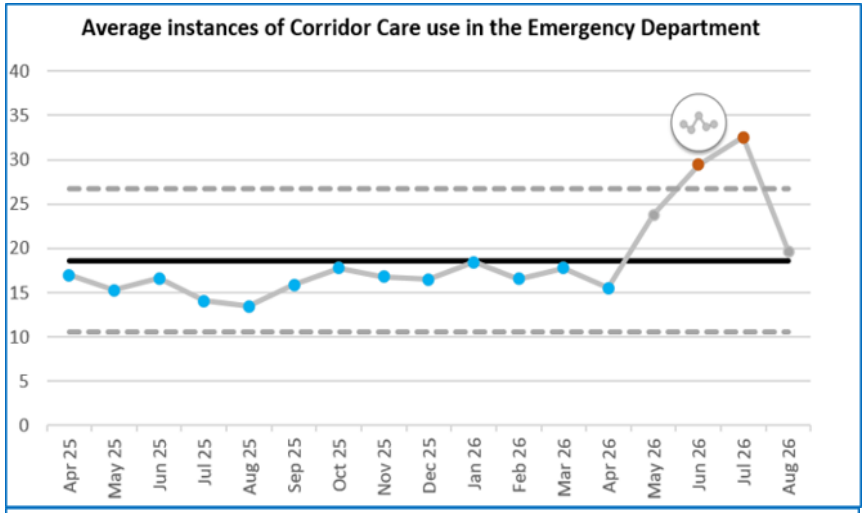
Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting.

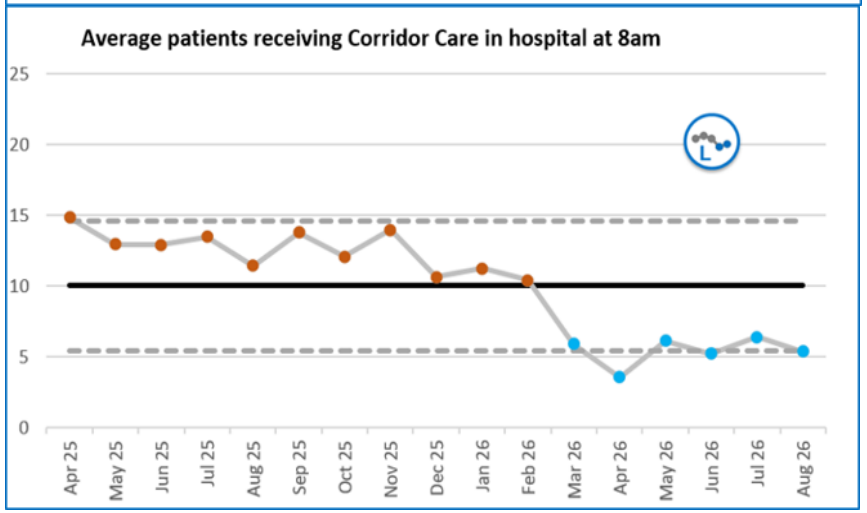
Recovery dependencies:	PW1, 2 and 3 capacity to support complex discharge pathways. Medical decision makers to support discharge decisions available on all wards throughout the day.

Moving to EXCELLENCE

Operational – Corridor Care

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Definition

Corridor care definition

Corridor care is a significant patient safety and experience issue; the NHS is committed to reducing this activity in hospitals across England in both emergency departments and inpatient wards.
To ensure consistency in reporting of activity in relation to corridor care, a definition has been developed to allow acute hospitals to accurately record and count corridor care.

Corridor care definition for the Emergency Department (ED)

A count of the number of patients who received corridor care for more than 45 minutes within the previous 24-hour reporting period, from midnight to midnight, in the same way that attendances are reported.
This includes patients receiving treatment, waiting for assessment, admission or transfer. This is limited to ED. Key criteria to consider are in table A. If the answer is no to any of the criteria, then this is corridor care in ED.
It's important to note that ambulance handover delays should not be included in the count of the number of patients who received corridor care and should continue to be reported separately.

Corridor care definition for general and acute beds

A count of the number of patients who are receiving care for more than 45 minutes on a ward outside of a bed space. This is limited to general and acute beds and excludes ED.
Key criteria to consider are in table A. If the answer is no to any of the criteria, then this is a corridor care bed.

Table A: Corridor care key criteria

Corridor care		
Is the patient in a clinically appropriate and safe setting including bed head services, for example, oxygen, call bells?	Yes	No
Can privacy be maintained?	Yes	No
Can dignity be maintained including access to food, water, toilets?	Yes	No
Can lights be turned off and noise levels minimised to facilitate a sleep?	Yes	No
Has the trust's Infection Prevention and Control team confirmed appropriateness of the space being occupied?	Yes	

Note: SPC's populated using published data for May 26 - August 26 (August unvalidated), April 25 - April 26 has been sourced by retrospectively applying the logic described in the definitions above

Moving to EXCELLENCE

Operational – Corridor Care

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary: Corridor care remains a consequence of sustained urgent and emergency care pressures and reduced patient flow through the hospital. Whilst safety mitigations are in place, focus remains on reducing the requirement for corridor care through improvements in discharge performance, management of long stay patient and optimisation of diagnostic turnaround times.

Recovery actions:

- Working with Nexus to support delivery of the Phase 2 Urgent and Emergency Care Improvement programme and accelerate the pace of operational improvement
- Implementing a refined approach to the management of long stay patients, supported by strengthened Criteria to Reside review
- Restoring Simple Discharge performance on wards where achievement has declined
- Working with pathology and radiology services to improve turnaround times for blood results and CT reports, supporting timely clinical decision-making and patient flow
- Review of the ED escalation and flow processes

Anticipated impact and timescales for improvement:

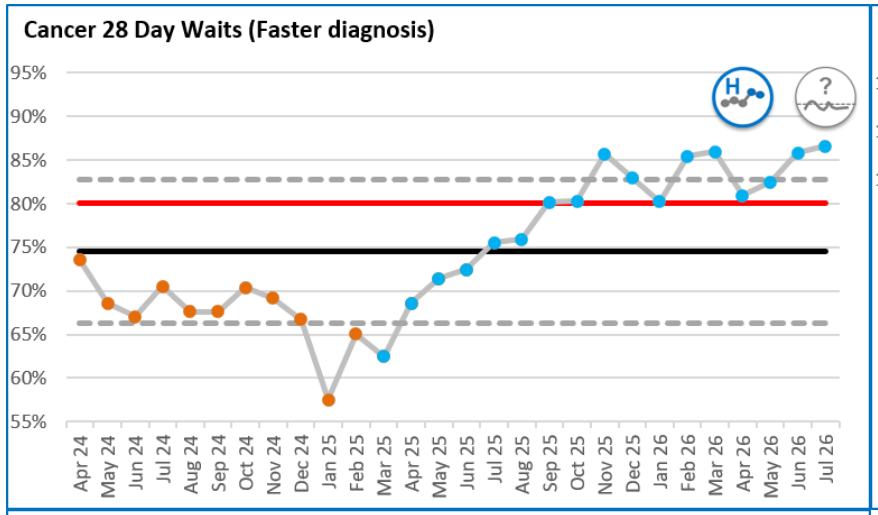
- Improved patient flow through the emergency pathway and reduction in hospital length of stay
- Increased numbers of patients discharged earlier in the day through recovery of Simple Discharge processes
- Reduction in delays associated with diagnostic reporting and clinical decision-making
- Progressive reduction in corridor care utilisation in ED as improvements are embedded across the UEC programme over the next 6 months
- Benefits expected to be realised incrementally

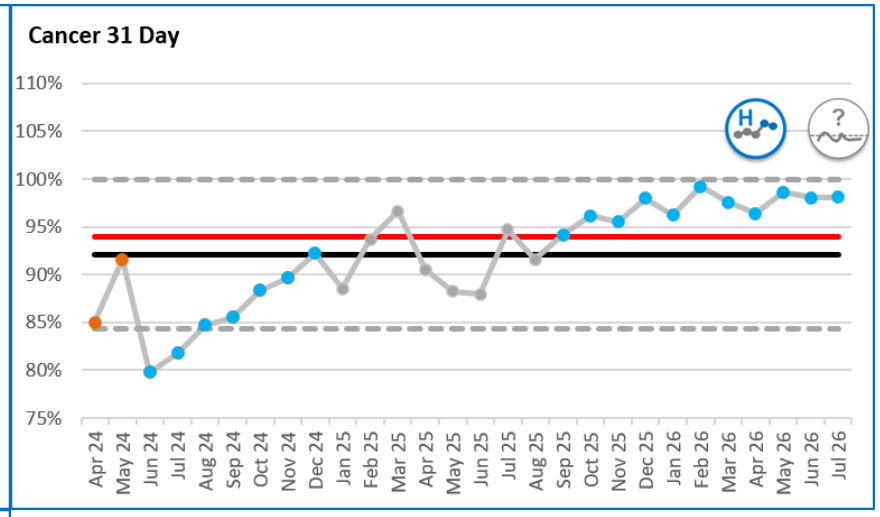
Recovery dependencies:	Recovery is dependent upon continued support from Nexus to deliver operational improvements, sustained engagement of clinical and operational teams to strengthen Criteria to Reside and discharge processes, ongoing improvements in pathology and radiology turnaround times, and access to domiciliary care alongside the development of discharge-to-assess opportunities.

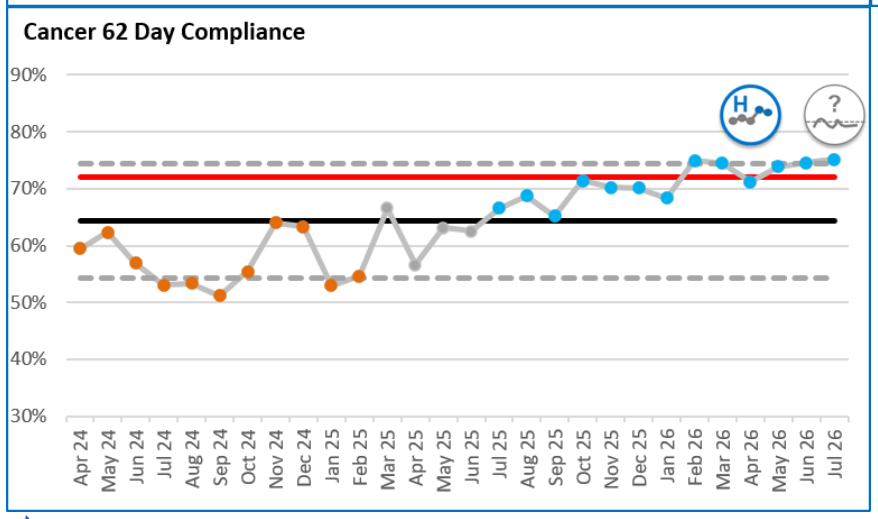
Moving to EXCELLENCE

Operational – Cancer performance

Shropshire, Telford and Wrekin Community and Hospitals NHS Group







Moving to EXCELLENCE

Operational – Cancer performance

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:

Cancer - Confirmed July cancer performance is 86.6% (28-day FDS) vs the local plan of 80%. 62-day performance was 75.1% against a local target of 74.9% and 31 day was 98.1% against a local target of 96%. The 62-day backlog is 147 patients over 62 days of which 36 are over 104 days (as at 22/09/2026).

Key actions:

The Trust is now in Tier 3 of NHSE monitoring for cancer due to improved performance. July performance against the faster diagnosis standard (FDS) was 86.6%, making it our eleventh consecutive month of delivery of the national 80% standard. Performance against the 62-day standard in July was 75.1%. Significant focus is on how we optimise our pathways through 26/27 to achieve 80% 62-day performance by March 27.

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:

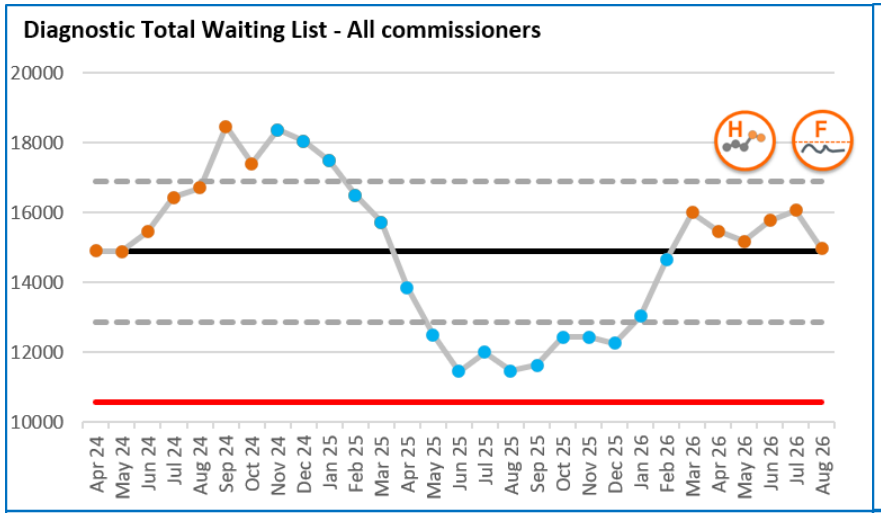
- Pathway optimisation
- Oncology improvement
- MDT optimisation
- Clinical outcomes
- Living with and beyond cancer

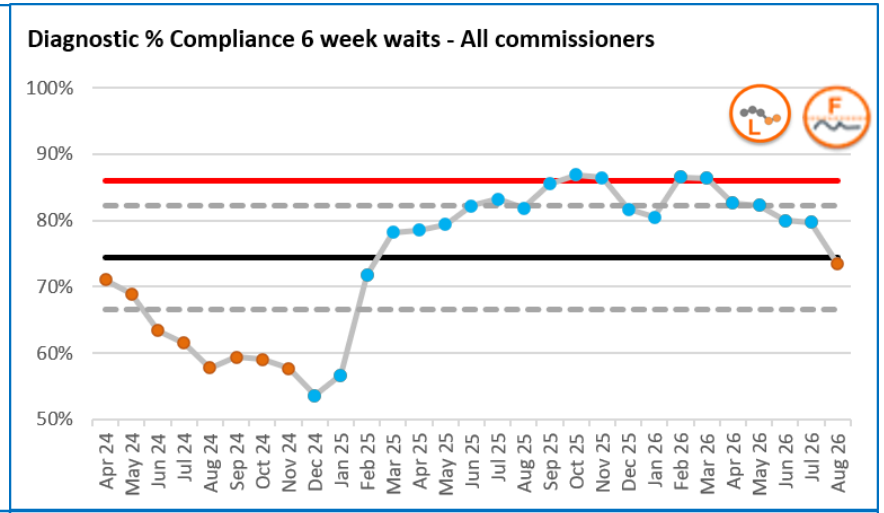
Recovery dependencies:	Workforce constraints

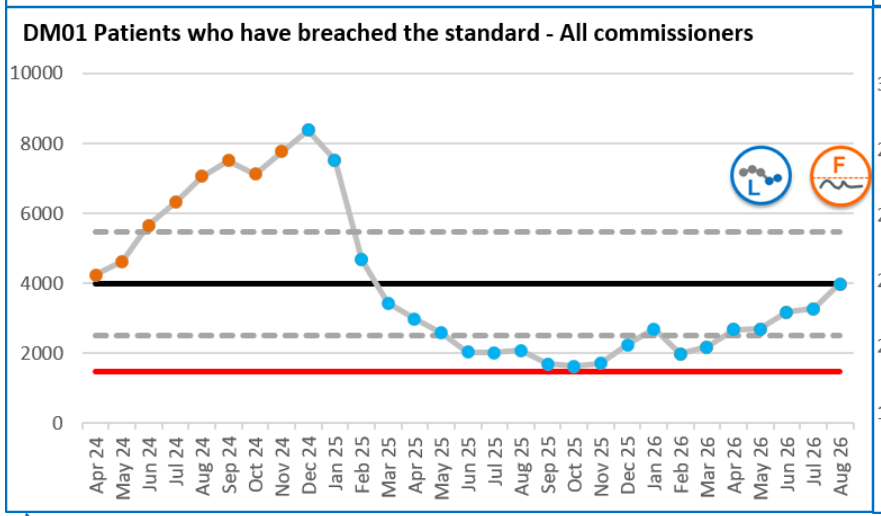
Moving to EXCELLENCE

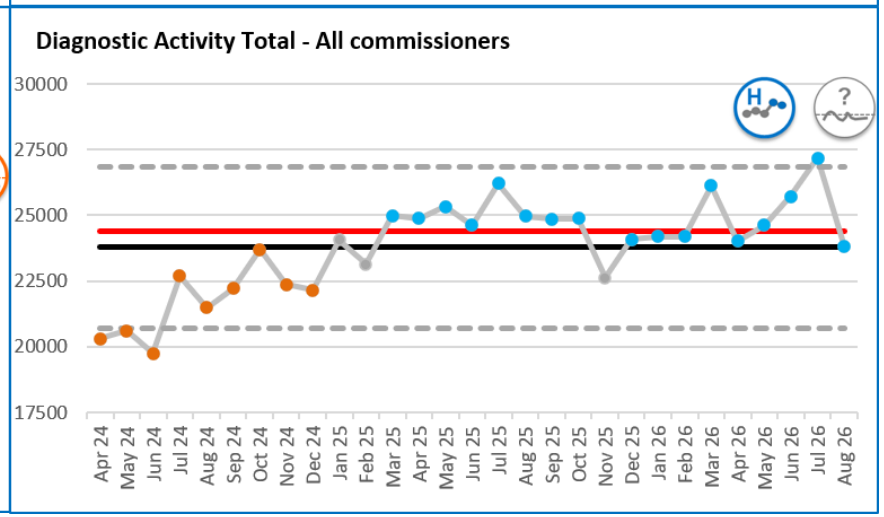
Operational – Diagnostics waiting times

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 August was 73.37%, with particular improved performance seen in Neurophysiology. NOUS has seen the largest drop in one month, a recovery plan has been implemented from mid-June. Radiology reporting turnaround times are being maintained in CT. 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
- 1 mobile MRI unit is on site and continue to deliver activity to support Cancer performance
- Additional WLI and insourcing support continue to support reduction of 13+ww for NOUS and continued improvement of DM01 performance and Cancer TAT
- DM01 performance for CT continues to meet national target of 99%

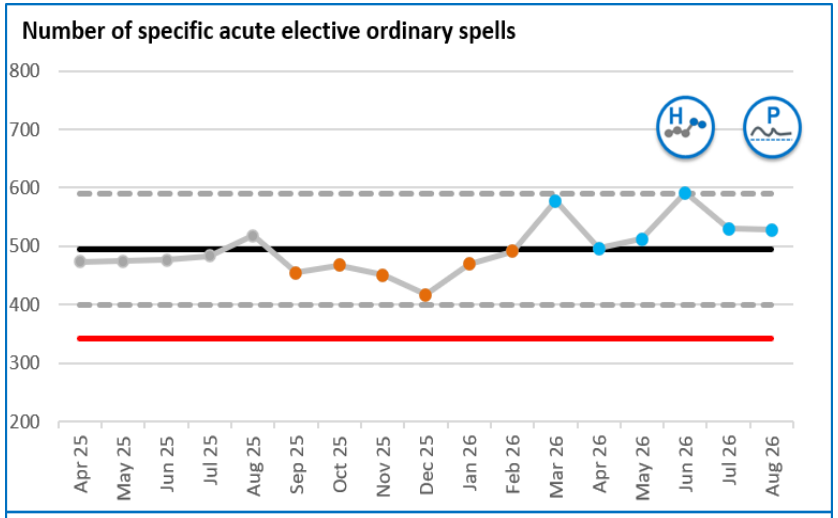
Recovery actions:	**Anticipated impact and timescales for improvement:**
Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times. MRI performance continues to fluctuate with a rise in the number of Cardiac scans remaining outstanding over 6 weeks, a recovery plan is in action to reduce the waiting times. A mobile van is operational to increase scanning capacity and support with cancer performance, which continues to perform within target. 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.	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. Significant focus and targeted capacity it being generated to manage the US performance.

Recovery dependencies:	

Moving to EXCELLENCE

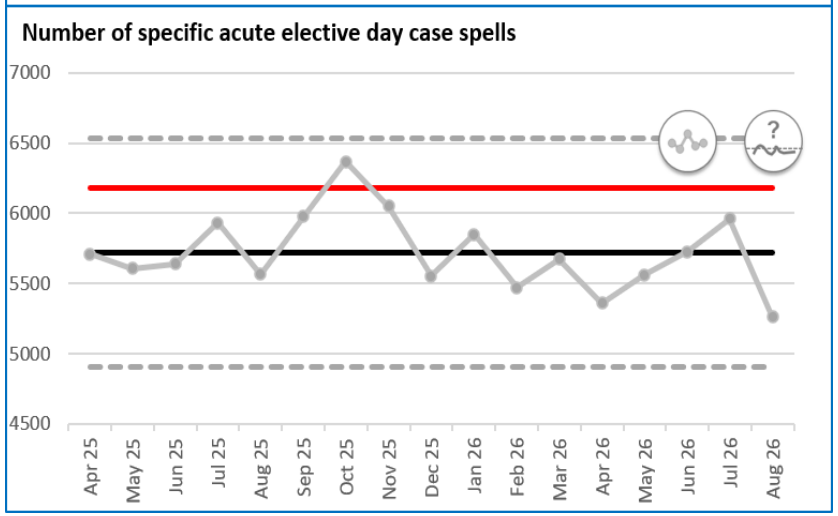
Operational – Elective Activity – IP/DC

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



2026/27

	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
Plan	321	373	386	366	341	327	381	424	401	338	432	473	**4,563**
Actual	496	512	591	530	528								**2,657**
Variance	155.8%	137.6%	154.8%	145.7%	157.5%								**150.0%**



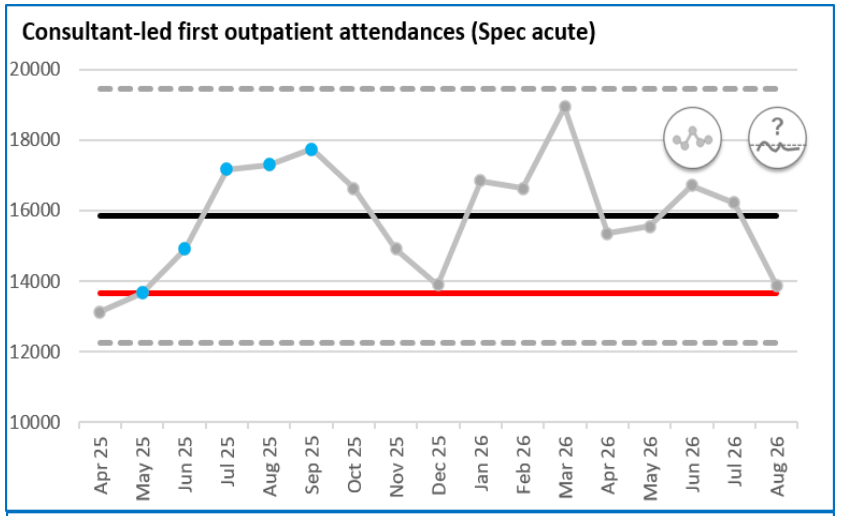
2026/27

	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
Plan	4,612	5,590	5,295	5,713	6,179	5,807	6,371	6,362	6,084	6,438	6,026	6,815	**71,292**
Actual	5,360	5,560	5,725	5,959	5,261								**27,865**
Variance	116.2%	99.5%	108.1%	104.3%	85.2%								**101.8%**

Moving to EXCELLENCE

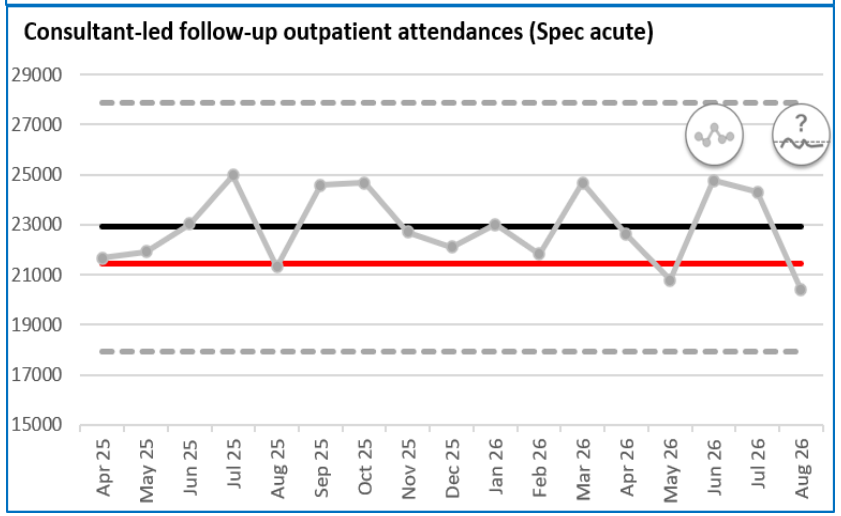
Operational – Outpatient Activity – Consultant Led

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



2026/27

	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
Plan	12,503	14,337	14,078	13,677	13,651	13,778	13,943	15,424	13,742	15,344	14,803	15,350	**170,630**
Actual	15,350	15,551	16,715	16,220	13,883								**77,719**
Variance	122.8%	108.8%	119.1%	118.9%	102.0%								**114.1%**

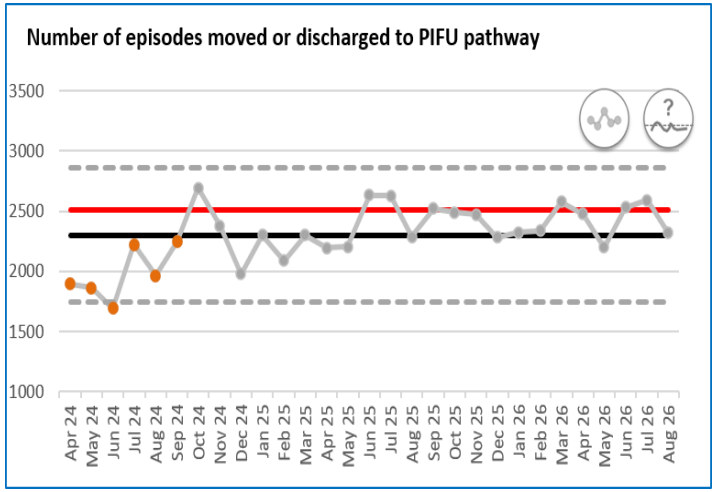


2026/27

	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
Plan	20,546	22,317	21,387	20,590	21,462	20,371	21,266	21,665	19,430	21,954	21,048	22,236	**254,271**
Actual	22,619	20,776	24,760	24,295	20,399								**112,849**
Variance	110.1%	93.1%	115.8%	118.0%	95.1%								**106.2%**

Moving to EXCELLENCE

Operational – PIFU



Summary:
The unvalidated Patient Initiated Follow-Up (PIFU) performance in August 2026 increased to 6.1% which is slightly above target.

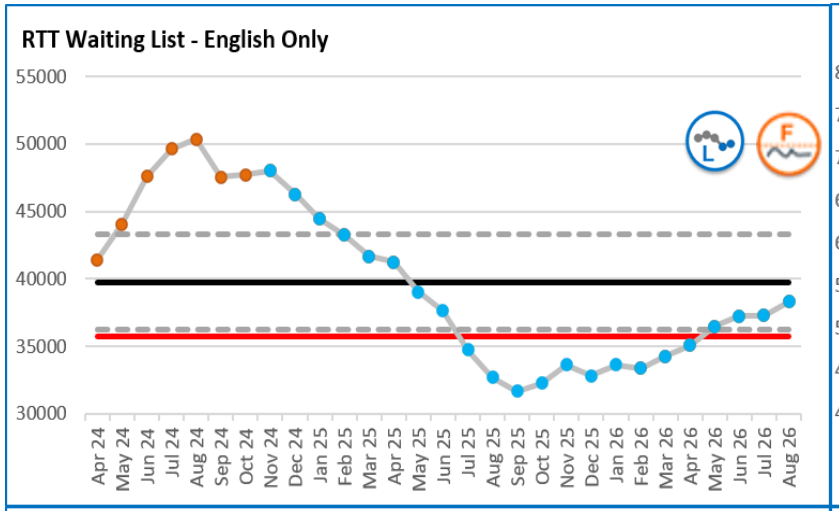
- The Patient Engagement Portal, designed to support PIFU, is remains in its pilot phase with some ENT pathways
- A regular data quality workgroup has been established, involving key stakeholders from the trust, this will address issues and enhance data quality for monitoring
- Clinician attendance at 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

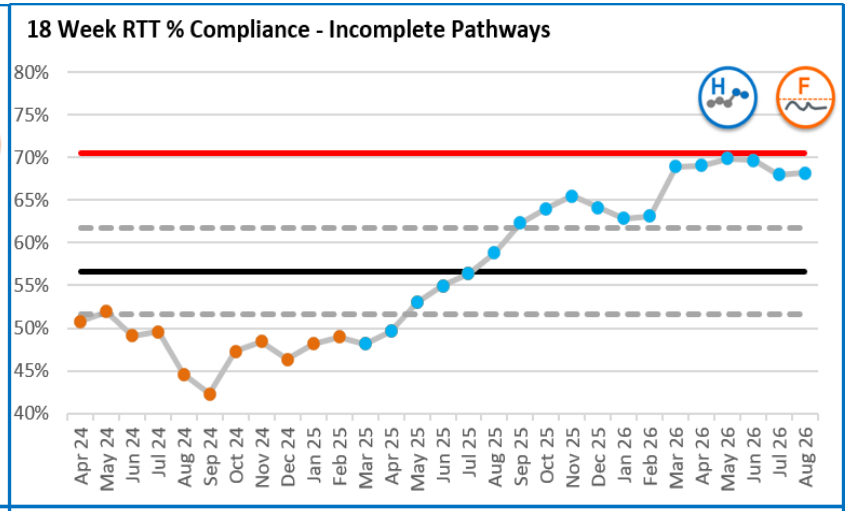
SaTH acknowledges the potential to enhance outpatient service productivity. The identified improvement opportunities include reducing waiting times for planned care by optimising processes and resource allocation through digital tools, improving the quality of planned care via evidence-based practices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

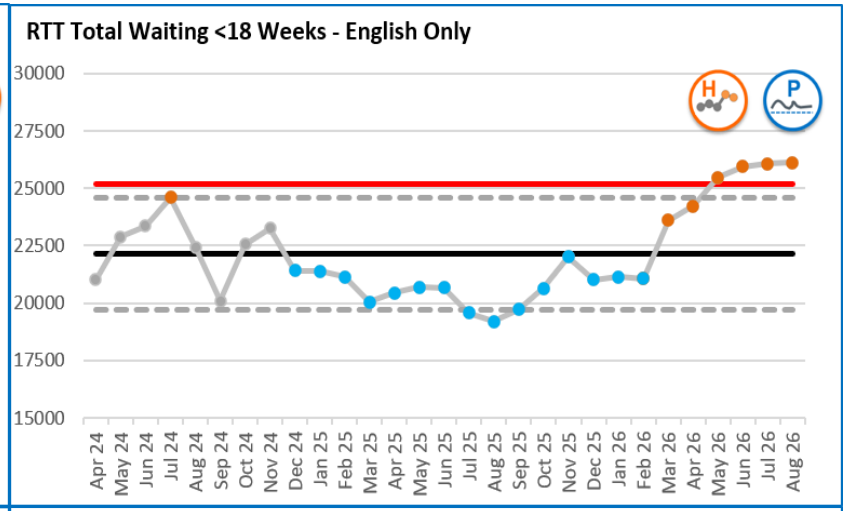
Recovery actions:	**Anticipated timescales for improvement:**
Conversations with respiratory, cardiology and gynaecology and clinical operational leads have taken place, their performance report has been completed with plans to utilise the PIFU pathway. Further conversations required with cardiology 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:	

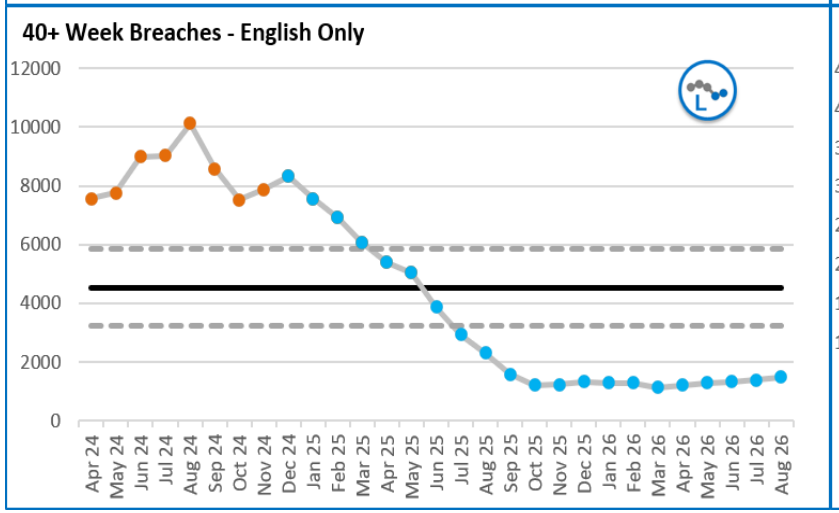
Operational – Referral to Treatment (RTT)

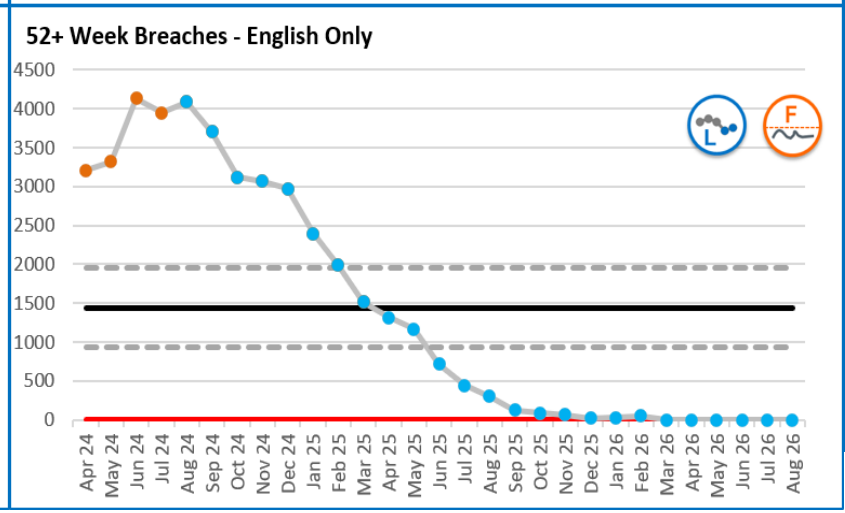
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

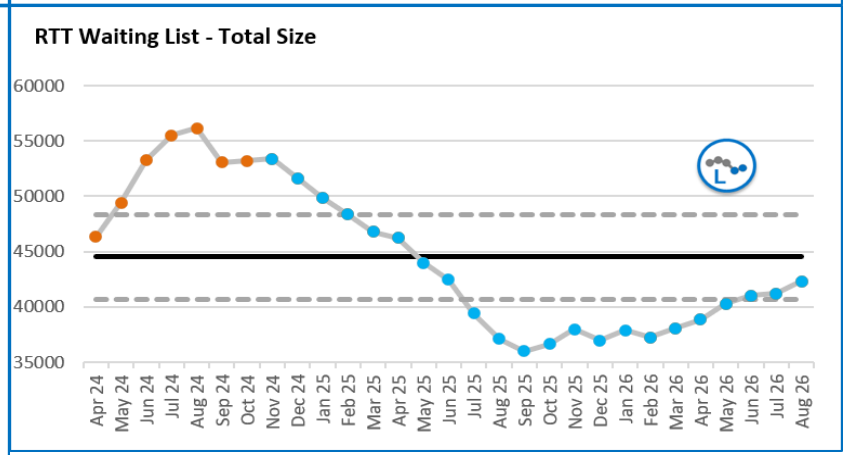












Note: includes Welsh unvalidated August position

Moving to EXCELLENCE

Operational – Referral to Treatment (RTT)

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
The submitted Trust Position for August 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week and 0 x 40 weeks CYP.
The validated Trust Position for Welsh is 0 x 104 weeks, 8 x 78 weeks, 40 x 65 weeks and 135 x 52 weeks.
The Trust is currently operating below the agreed RTT trajectory. However, a programme of focused improvement work is underway to strengthen productivity across multiple services areas, supported by targeted ERF investment to increase outpatient capacity and delivery.

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

Milestone 2 is currently a key area of focus, with approximately 13,000 patients awaiting action to progress to the next stage of their pathway. MBI has been asked to support this as a priority, and a robust process has now been implemented, with operational teams across the Centre's actively involved.

The Trust is currently operating below the agreed RTT trajectory. However, a programme of focused improvement work is underway to strengthen productivity across multiple services areas, supported by targeted ERF investment to increase outpatient capacity and delivery. 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 the 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**: Targeted ERF funding agreed in some specialties with a focus on outpatient delivery. **Productivity**: The planned care improvement programme (PCIP) continues for both outpatients and Inpatients. Work is ongoing within the Trust to build upon the work Foureyes completed with clinic optimisation still a focus and the implementation of centralising bookings.	The methodology to maintain zero 52 weeks and to further improve CYP waiting times is in place. New clinic templates in OMFS being implemented on 1st September delivering circa 200 additional slots

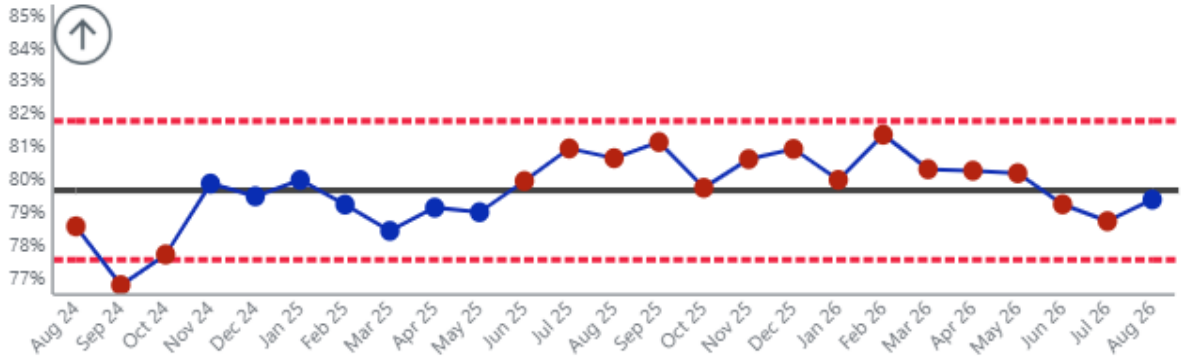
Recovery dependencies:	Continued capacity to validate the PTL, administrative staffing capacity, workforce and theatre staffing.

Moving to EXCELLENCE

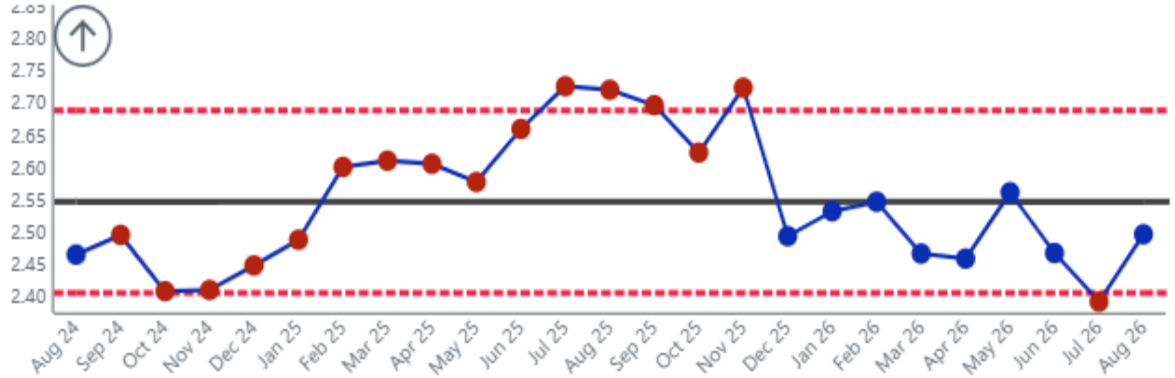
Operational – Theatre Productivity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

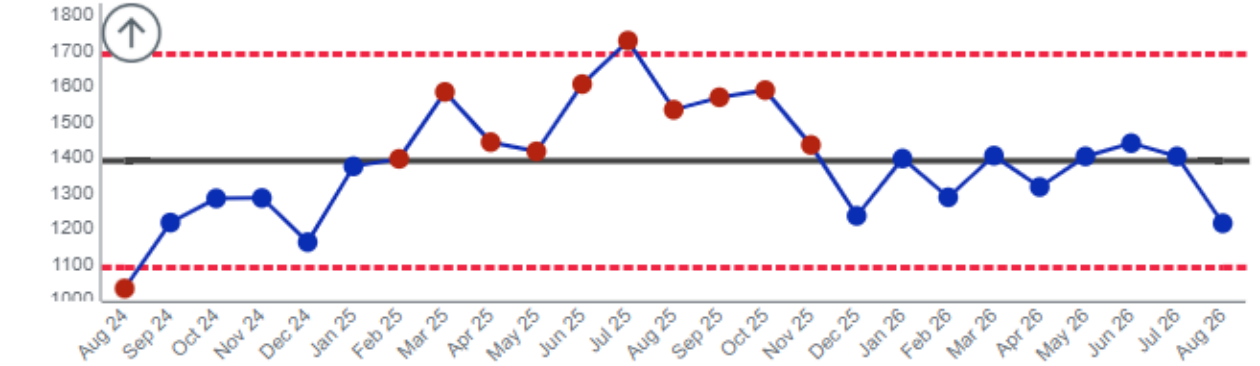
Theatre Capped Utilisation %



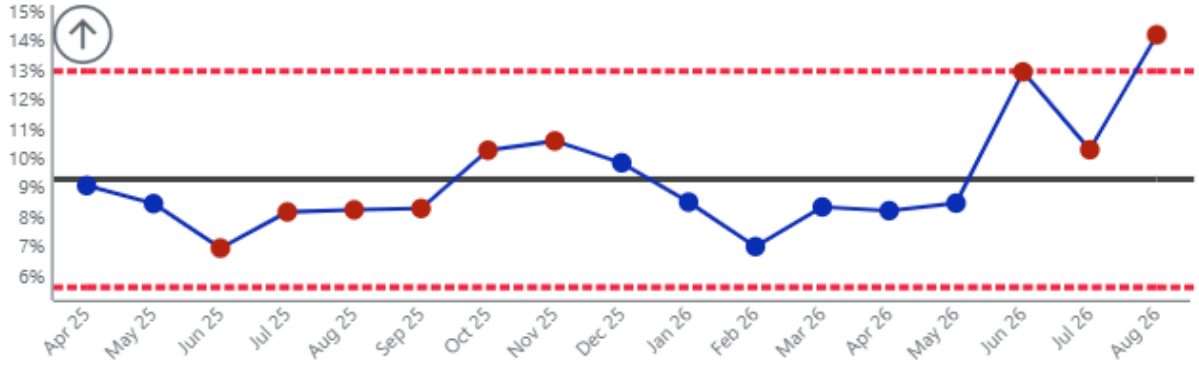
Average Cases Per List Rate



Total Number of Cases



Cancelled Operation %



Moving to EXCELLENCE

Operational – Theatre Productivity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

August 2026 Summary:

Elective Theatre Utilisation

- Overall utilisation has plateaued at 79% remaining below 80% for the third consecutive month
- Focus on Ophthalmology main theatre lists with support from the Improvement Team

Cancellations

- Cancellations increased to 14%, driven mainly by staffing availability, estates issues and overrunning complex cases. The result has been multiple complete sessions being cancelled with these three main causes accounting for nearly 50% of the cancellations

1. Staff unavailability- anaesthetists (18), surgeon (16), theatre staff (11)
2. Equipment / estates failure or unavailability- heat / humidity levels (22), PRH theatres airflow (8)
3. List overrun due to complexity of previous cases

Elective Activity

- The total number of sessions reduced by 100 largely as a result of the causes above
- Elective cases reduced from 1401 to 1213 in line with the drop in sessions
- Productivity improved to 2.5 cases per list, supported by increased activity through the Elective Hub and Cataract Suite

Theatre Task & Finish Group Priorities:

1. Identifying opportunities to shift suitable procedures out of theatre using GIRFT RPRP principles
2. Introduce four joint arthroplasty lists to PRH with a September start date for first list

Continue exploring new data opportunities 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 • Booking & Scheduling and pre-operative assessment work introducing My PreOp+ should start to support earlier planning and optimisation of patients through theatres alongside a reduction in cancellations caused by patient readiness issues	Actions being put in place to support staffing problems to support activity levels cross-site

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

Well Led

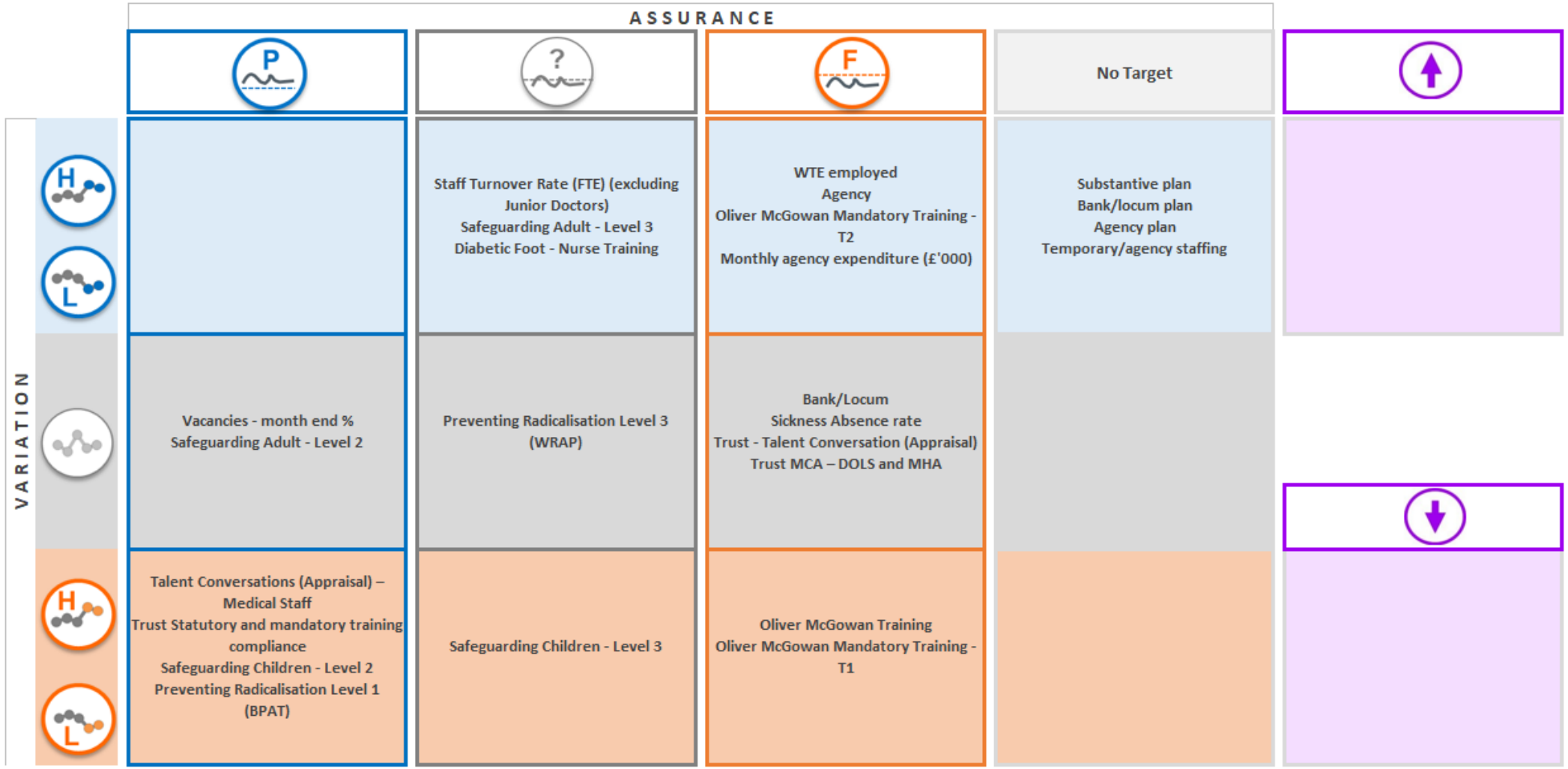
Executive Lead:

Chief People Officer
Rhia Boyode

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Workforce watch metrics



Moving to EXCELLENCE

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Workforce watch metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Trend
WTE employed	Aug 26	7582	7480			7298	7222	7374	7222	7380	7403	7429	7422	7438	7430	7428	7476	7484	7534	7551	7582	
Substantive plan	Aug 26	7480	-			7377	7279	7475	7422	7447	7422	7393	7374	7356	7323	7275	7452	7452	7452	7443	7480	
Bank/Locum	Aug 26	589	535			616	543	689	659	600	625	602	568	575	595	639	577	569	554	577	589	
Bank/locum plan	Aug 26	535	-			560	531	589	588	533	529	557	553	549	545	542	542	542	542	528	535	
Agency	Aug 26	49	51			93	68	118	91	79	58	50	50	38	37	50	43	41	46	46	49	
Agency plan	Aug 26	51	-			72	61	83	78	73	69	69	66	62	59	55	55	55	55	53	51	
Temporary/agency staffing	Aug 26	638	-			726	648	804	749	679	683	652	617	612	632	689	621	610	600	621	638	
Staff Turnover Rate (FTE) (excluding Junior Doctors)	Aug 26	0.8%	0.8%			0.8%	0.3%	1.3%	0.9%	0.7%	0.8%	0.9%	1.0%	0.9%	0.7%	0.8%	0.7%	0.7%	0.5%	0.7%	0.8%	
Vacancies - month end %	Aug 26	6.0%	10.0%			5.3%	3.5%	7.2%	6.0%	3.9%	4.2%	4.1%	4.7%	6.5%	6.0%	5.8%	5.3%	4.7%	5.9%	6.5%	6.0%	
Sickness Absence rate	Aug 26	5.4%	4.5%			5.2%	4.6%	5.9%	4.7%	4.9%	5.2%	5.2%	5.7%	5.8%	5.5%	5.0%	5.1%	4.9%	5.4%	5.4%	5.4%	
Trust - Talent Conversation (Appraisal)	Aug 26	83.8%	90.0%			83.6%	81.2%	86.1%	86.1%	86.4%	86.9%	86.8%	86.1%	85.0%	84.6%	84.7%	84.1%	82.7%	83.9%	84.2%	83.8%	
Talent Conversations (Appraisal) – Medical Staff	Aug 26	90.6%	90.0%			92.9%	90.3%	95.6%	94.4%	95.3%	94.9%	93.5%	92.7%	92.9%	93.6%	94.2%	93.3%	91.4%	90.8%	90.0%	90.6%	
Trust Statutory and mandatory training compliance	Aug 26	90.1%	90.0%			92.0%	90.6%	93.3%	93.2%	93.1%	93.3%	92.9%	92.3%	92.5%	91.9%	91.4%	91.5%	90.0%	90.2%	90.2%	90.1%	
Trust MCA – DOLS and MHA	Aug 26	82.9%	90.0%			83.6%	81.8%	85.5%	85.8%	85.3%	85.2%	85.8%	84.7%	84.8%	84.3%	84.2%	83.1%	82.0%	83.0%	82.9%	82.9%	
Safeguarding Children - Level 2	Aug 26	92.3%	90.0%			94.4%	92.1%	96.7%	96.2%	95.8%	95.8%	95.4%	95.1%	95.2%	94.8%	94.1%	94.1%	93.1%	92.9%	92.4%	92.3%	
Safeguarding Adult - Level 2	Aug 26	94.0%	90.0%			94.5%	92.2%	96.8%	95.7%	95.5%	95.6%	95.5%	94.7%	95.0%	94.6%	94.5%	94.5%	93.9%	94.3%	94.2%	94.0%	
Safeguarding Children - Level 3	Aug 26	77.2%	90.0%			86.6%	82.9%	90.4%	90.3%	88.2%	88.6%	87.1%	86.0%	85.0%	84.0%	81.3%	79.6%	81.1%	79.6%	78.1%	77.2%	
Safeguarding Adult - Level 3	Aug 26	91.3%	90.0%			90.1%	87.2%	93.1%	91.5%	90.5%	90.9%	91.4%	90.3%	90.7%	90.4%	90.7%	90.7%	90.6%	91.0%	91.3%	91.3%	
Diabetic Foot - Nurse Training	Aug 26	94.2%	90.0%			86.5%	80.7%	92.3%	91.3%	90.7%	91.3%	92.2%	92.4%	92.3%	92.1%	91.8%	92.5%	92.4%	93.5%	93.7%	94.2%	
Oliver McGowan Training	Aug 26	75.8%	90.0%			86.8%	83.8%	89.7%	88.2%	88.5%	88.9%	89.0%	88.9%	88.8%	88.6%	88.5%	88.1%	86.2%	79.4%	77.0%	75.8%	
Oliver McGowan Mandatory Training - T1	Aug 26	12.2%	90.0%			14.9%	3.9%	25.8%	25.4%	25.3%	0.0%	5.6%	6.7%	10.0%	12.4%	13.0%	13.1%	14.5%	12.8%	13.1%	12.2%	
Oliver McGowan Mandatory Training - T2	Aug 26	21.8%	90.0%			16.2%	9.7%	22.8%	24.2%	23.9%	11.3%	11.3%	11.1%	12.0%	13.3%	15.2%	16.0%	18.1%	18.6%	19.2%	21.8%	
Preventing Radicalisation Level 1 (BPAT)	Aug 26	91.7%	90.0%			94.2%	92.6%	95.8%	95.13%	94.81%	94.75%	94.75%	94.40%	94.85%	94.17%	93.13%	93.39%	91.93%	92.04%	92.11%	91.71%	
Preventing Radicalisation Level 3 (WRAP)	Aug 26	91.8%	90.0%			92.6%	89.9%	95.3%	94.07%	94.05%	93.98%	93.96%	93.52%	93.92%	93.92%	93.21%	93.06%	91.79%	91.86%	92.14%	91.82%	
Monthly agency expenditure (£'000)	Aug 26	603	476			1032	651	1413	921	820	504	500	525	306	369	520	418	523	591	514	603	

Moving to EXCELLENCE

Workforce Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

2026/27 Workforce Plan – The total workforce is running above plan by 154 WTE at M5. Overall workforce growth has accelerated during the first five months, with total contracted WTE increasing from 8,096 WTE in M1 to 8,220 WTE in M5, compared with a planned increase from 8,048 WTE to 8,066 WTE. The gap to plan has widened steadily through the year, increasing from +47 WTE in M1 to +154 WTE in M5. Growth is being driven primarily by higher substantive recruitment, supplemented by higher-than-planned bank utilisation. Substantive workforce is the main driver of the overspend, exceeding plan in all months and rising from +23 WTE in M1 to +102 WTE in M5. Actual substantive staffing increased from 7,475 WTE to 7,582 WTE over the period. The current workforce profile remains predominantly supported by a substantive workforce, with nursing continuing to represent the largest staff group at 2,182 WTE in August 2026, broadly stable throughout the period. Support to Clinical Staff is the second largest clinical workforce group, although numbers have reduced slightly from 1,429 WTE in April to 1,414 WTE in August.

Turnover - The rolling 12-month turnover rate for August is 9.3% equating to 647 WTE leavers. An in-month turnover rate of 0.8% equates to 56 WTE leavers in August. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.9% equating to 480 WTE NHS leavers.

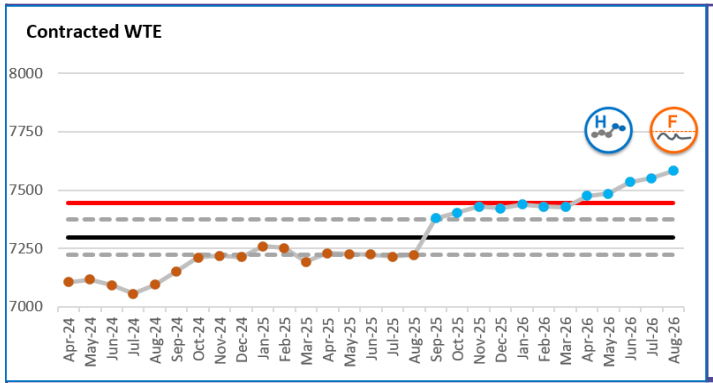
Wellbeing of our staff - August sickness rate of 5.43% (414 WTE) remaining above target by 0.9% (71 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 29% of calendar days lost in August equating to 121 WTE. 11% (46 WTE) of sickness was attributed to other known causes; other musculoskeletal was at 10% (44 WTE). Short-term sickness continues to be a driver for higher sickness rates in M5 compared to M1 and M2.

Talent Conversations and Training - Talent conversation completion rates increased this month by 1.3% but remains below our target of 90%. Training compliance overall is meeting our target of 90%; there are however actions to support improvements in Mental Capacity training and Oliver McGowan as they are the two training modules currently behind our completion targets.

Agency and temporary staffing - Agency usage remains well controlled and below target, partially offsetting the increased substantive and bank workforce. Medical Bank usage has also increased from its May low, with Consultant Bank increasing from 40 WTE to 42 WTE and Medical Career Staff from 43 WTE to 54 WTE by August. While bank staffing continues to provide important flexibility to maintain safe staffing, there remains an opportunity to further reduce reliance through improved workforce planning, substantive recruitment, roster optimisation and effective management of vacancies and availability

Workforce – Contracted WTE

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Substantive figure of 7,582 WTE in August, which is an increase of 30 WTE in month.
Total workforce utilisation in August increased by 47 WTE to 8220 WTE attributable to an increase in substantive of 30 WTE; increase in bank of 12 WTE and an increase in agency of 5 WTE.

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.

- Medical staffing templates and workforce planning tools continue to support establishment reviews, skill mix assessments and identification of staffing gaps
- Focus remains on improving rostering, strengthening establishment controls and increasing substantive staffing
- Workforce planning activity continues, with a focus on efficiency, savings opportunities and alignment to service demand
- Vacancy, sickness absence and employee relations reviews continue across SCHT and SaTH to support redeployment and workforce availability
- Trac Group Employer functionality is being assessed to support collaboration and shared recruitment opportunities with SCHT
- Non-medical HTP workforce plans are completed. Medical HTP workforce plan reviews are underway, with completion scheduled for September
- Demand and Capacity reviews continue to inform workforce planning and workforce model development across divisions. Manager Self Service continues to be embedded as a key digital enabler of the Future Workforce Solution

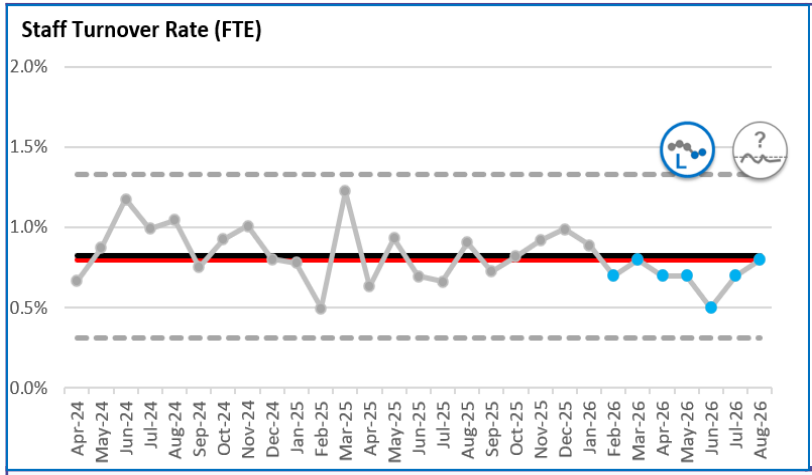
Anticipated impact and timescales for improvement:
We expect to deliver the cost improvement schemes outlined and will be taking mitigating actions to support delivery back to planned levels by M12, this will include digital transformation

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 August is 9.3% equating to 647 WTE leavers. An in-month turnover rate of 0.8% equates to 56 WTE leavers in August. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.9% equating to 480 WTE NHS leavers.
Staff groups with highest turnover rates are: Additional Clinical Services (12.5%); Admin and Clerical (11.8%); Estates and Ancillary (10.4%).
Nursing and Midwifery has a turnover rate of 6.5%.
Relocation is currently the highest reason for leaving with 115 WTE leavers with work life balance as the second highest reason with 95 WTE leavers over the last 12 months.

Recovery actions to achieve our target:

- 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

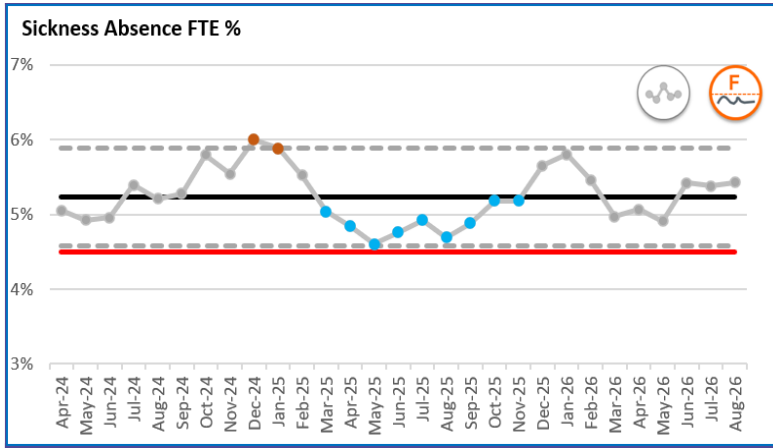
Anticipated impact and timescales for improvement:
Turnover is expected to increase towards end of this year in line with our workforce plans and reductions plans outlined for 26/27.

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%. August sickness rate of 5.43% (414 WTE) remaining above target by 0.9% (71 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 29% of calendar days lost in August equating to 121 WTE. 11% (46 WTE) of sickness was attributed to other known causes; other musculoskeletal was at 10% (44 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 9.0% followed by Additional Clinical Services at 7.1%, Add Prof Scientific and Technical at 6.3% and Nursing and Midwifery at 5.5%.

- Long-term sickness absence cases continue to be reviewed to support timely case resolution and improved workforce availability
- Strengthen sickness absence management through policy changes, return-to-work interviews, sickness trigger management, absence reviews and manager accountability
- Review all Stage 2 sickness cases and conclude cases where appropriate
- Implement digital sickness management system
- Review departments with sickness rates above 7% and implement targeted interventions
- Sickness management approaches for Medical & Dental staff continue to be reviewed and developed
- Staff psychological support and wellbeing initiatives remain in place to support attendance and staff wellbeing
- Focus remains on strengthening sickness prevention, wellbeing interventions and attendance management processes
- Targeted long-term absence management and occupational health support continue, with procurement arrangements progressing

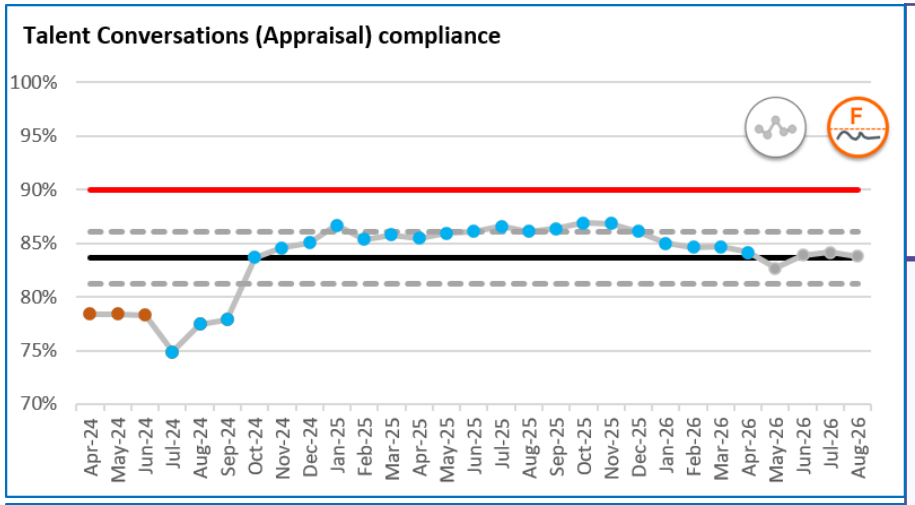
Anticipated impact and timescales for improvement:
Expected reductions in absence levels throughout the year in line with plan with a level of increase over winter months after which we expect a 0.6% reduction.

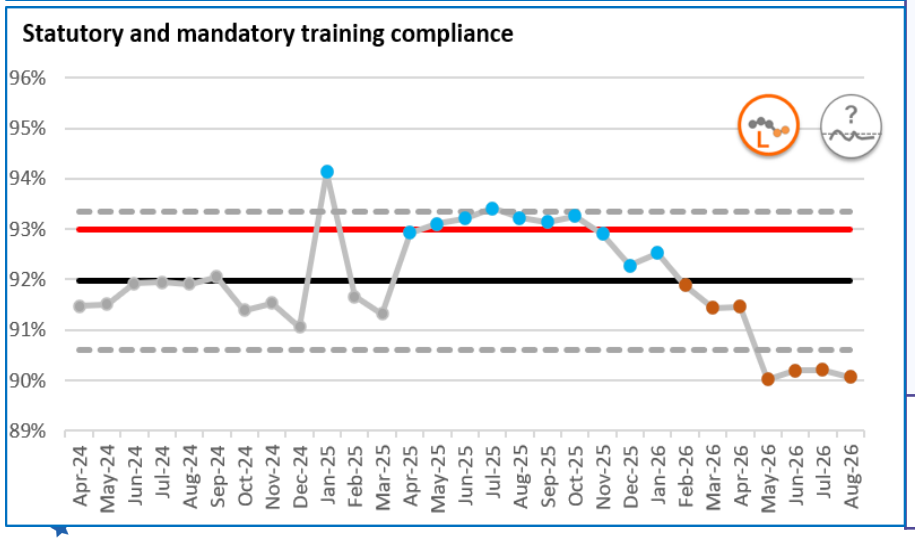
Recovery dependencies:	To ensure strong leadership behaviours, values to support desired culture during challenging times. Support from leaders to ensure proactive management of people and support provided.

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 declined to 83.79% in August.
The compliance rate for Statutory and Mandatory Training in August has declined again to 90.06%.

Recovery actions:

- 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

Workforce capacity challenges within the Education Support Unit have resulted in a backlog of data inputting, creating a risk that the September's compliance will not accurately reflect performance and will result in a decline of training compliance below the national target of 90%. The team is also experiencing an increase in queries from services seeking support and updates. Additional resource is in the process of being implemented to support the data input.

Anticipated impact and timescales for improvement:

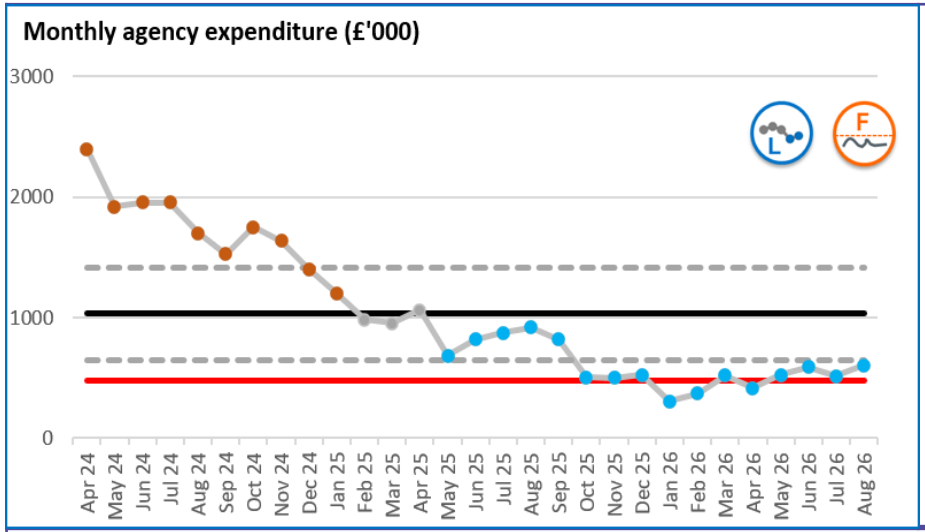
A review of capacity within the Education Support Unit needs to be undertaken urgently. Mitigations have already been put in place.

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 July to August. 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.

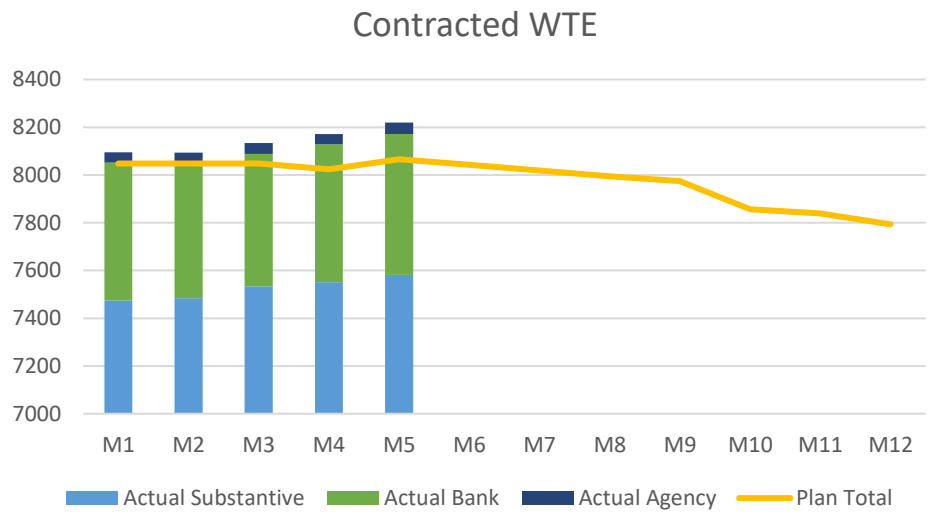
Recovery dependencies:	Escalation plan delivery and workforce unavailability going into winter.

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	7,534	7,551	7,582							
	Bank	577	569	554	577	589							
	Agency	43	41	46	43	49							
	Total	**8,096**	**8,094**	**8,134**	**8,172**	**8,220**							
Variance	Substantive	23	32	82	108	102							
	Bank	36	28	12	49	54							
	Agency	-12	-14	-9	-10	-2							
	Total	**47**	**46**	**86**	**147**	**154**							



Summary:
Total staff usage of 8220 WTE in August which is 154 WTE (Contracted) above plan. Substantive levels have increased by 31 WTE this month as our vacancy level reduced. Bank increased by 12 WTE. Agency usage levels decreased marginally and remain under plan by 2 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

Finance watch metrics



Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Finance watch metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Trend
Balanced £ Position (Cumulative)	Aug 26	-19567	-13499			-10101	-23998	3795	4	-1274	-2290	-3927	-5848	-5604	-4098	4920	-3628	-7368	-10936	-13537	-19567	
Agency Expenditure	Aug 26	603	476			1032	651	1413	921	820	504	500	525	306	369	520	418	523	591	514	603	
Overall Pay Bill	Aug 26	43794	39971			42758	27377	58138	40964	41848	41677	41201	41659	41125	40937	72230	43118	43583	42829	43566	43794	
Overall Pay Bill %	Aug 26	1.38%	6.40%			2.56%	1.42%	3.70%	2.25%	1.96%	1.21%	1.21%	1.26%	0.74%	0.90%	0.72%	0.97%	1.20%	1.38%	1.18%	1.38%	
CIP Delivery	Aug 26	2997	3434			3135	1199	5071	3166	3843	3363	3268	3692	4076	4435	4419	2042	2093	3194	4715	2997	
Cash Position	Aug 26	45996	29444			46549	9657	83440	51400	40294	49296	39293	16298	89066	83003	72968	40867	35115	37628	48379	45996	
Capital - YTD	Aug 26	50976	55115			34698	-11278	80674	32363	41608	53139	61724	76556	87885	102681	149713	0	15295	25487	38727	50976	

Moving to EXCELLENCE

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 August (month five), the Trust has delivered a deficit position of £19.57m against a deficit plan of £13.50m pre deficit support funding, an **unfavourable variance of £6.07m**. This moves to a deficit of £6.86m against a planned deficit of £0.80m post deficit support.

Whilst favourable income has partially mitigated operational cost pressures, the underlying adverse variance is principally driven by workforce unavailability, NCTR, industrial action, additional activity costs and slippage in delivery of efficiency schemes. A number of these pressures have been partially offset through non-recurrent mitigations.

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

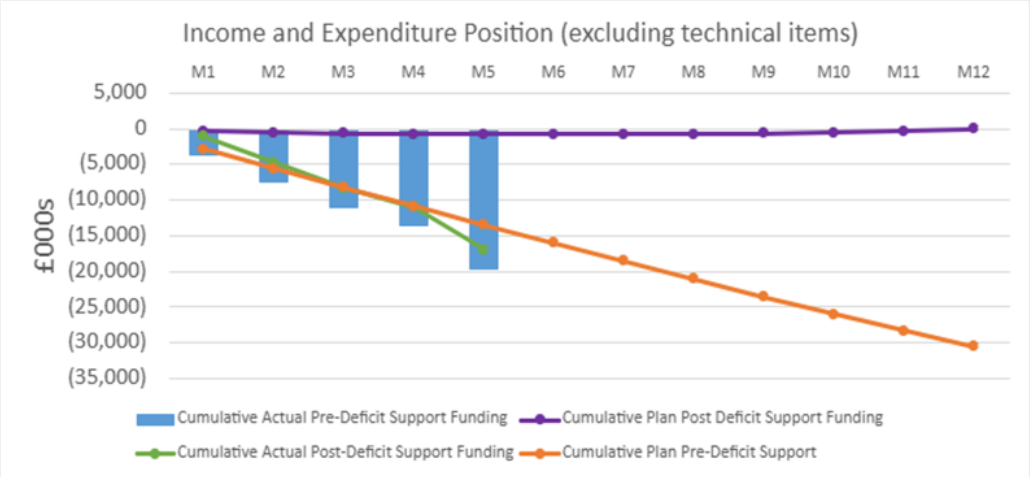
Delivery of the activity plan – There is currently additional income assumed of £6.16m based on an average case mix. Current activity levels exceed those assumed within the operational plan, generating additional income and associated expenditure. Discussions continue with operational colleagues regarding affordability and activity expectations for the remainder of the year.
Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of August, £15.04m has been delivered which is £0.74m less than plan.
Delivery of WTE reduction plan – At the end of August against the numbers planned (actual worked) there has been adverse variance of 133 WTE, reflecting operational demand pressures and workforce unavailability.
Delivery of the agency reduction plan – Agency usage is below the planned levels by 2 WTE, demonstrating continued control of agency deployment. There continues to be a strong focus on medical agency in FY26/27. Whilst WTE have remained consistently below plan this financial year, there is slippage financially of £0.14m YTD due to the workforce mix.

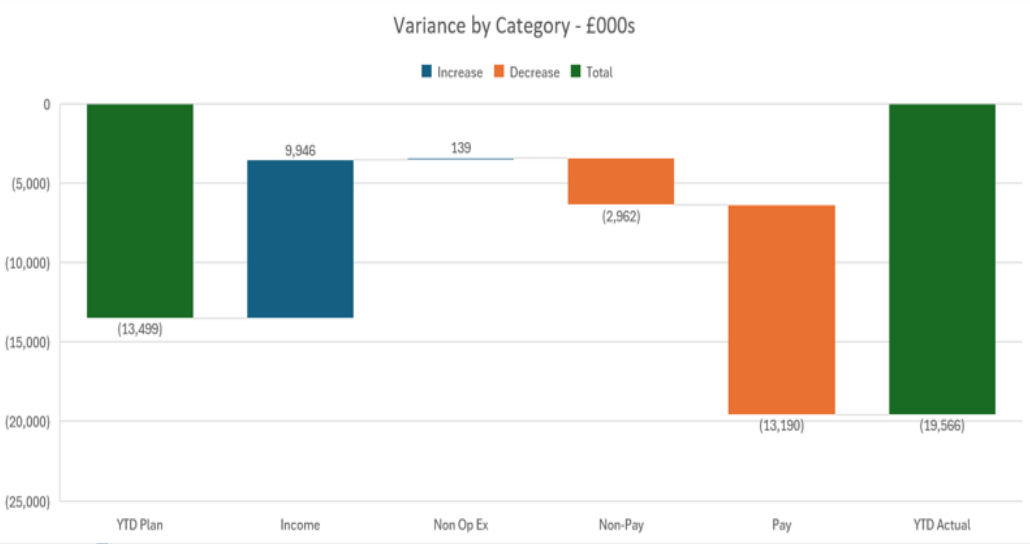
The Trust's FY26/27 capital programme totals £162.72m, comprising £24.38m operational capital allocation (including IFRS16 expenditure) and £138.34m externally funded schemes. Capital expenditure to the end of Month 5 was £50.83m.

The Trust held a cash balance at end of August 2026 of £46.00m above plan due to the timing of capital; under the most likely revenue cash scenario the Trust will require revenue support in Q4 FY26/27.

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 August (month five), the Trust has delivered an adverse variance of £6.07m against a planned deficit of £13.50m.

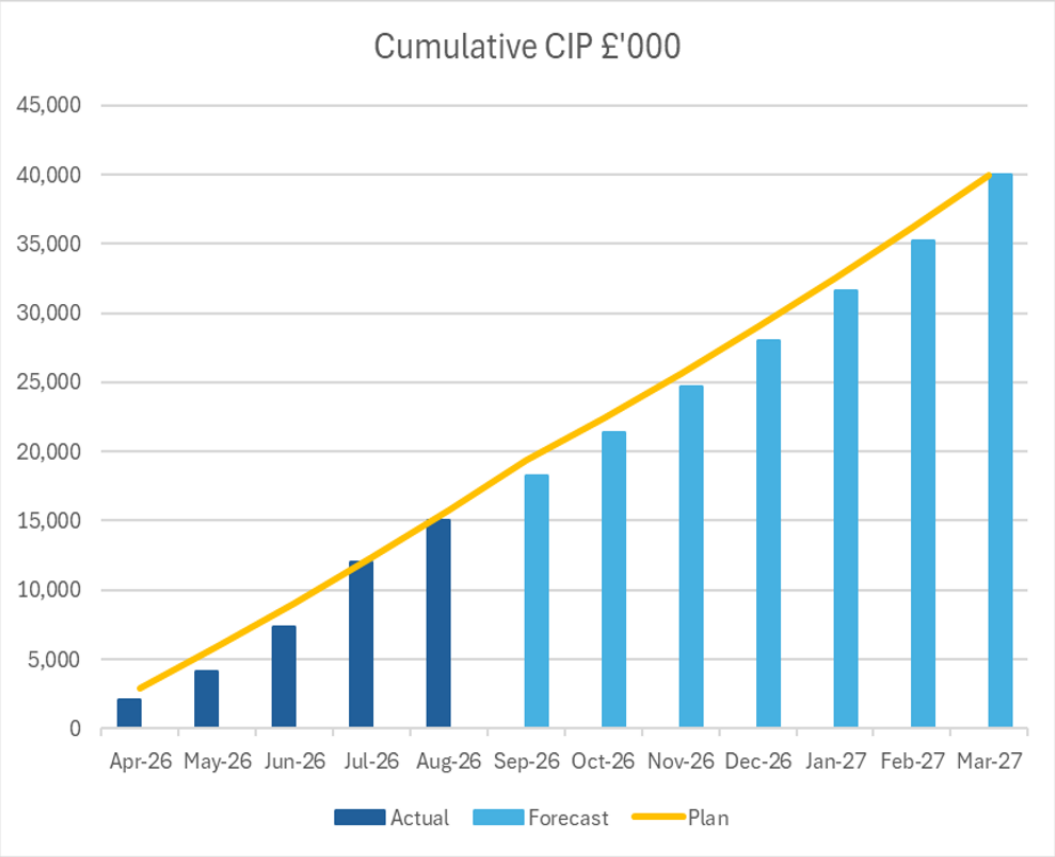
The main drivers of this position are the cost pressure associated with the industrial action (£0.75m) and slippage against efficiency schemes (£2.70m). There is also underlying pressure caused by high levels of unavailability (£2.14m), increased workforce (£0.89m), NCTR (£1.00m) and additional activity, more detail of underlying pressures are highlighted in later slides. 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 additional income assumed of £4.37m based on an average case mix. Current activity levels exceed those assumed within the operational plan, generating additional income and associated expenditure. Discussions continue with operational colleagues regarding affordability and activity expectations for the remainder of the year
- Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of August, £15.04m has been delivered which is £0.74m less than plan
- Delivery of WTE reduction plan – At the end of August against the numbers planned (actual worked) there has been adverse variance of 133 WTE, reflecting operational demand pressures and workforce unavailability
- Delivery of the agency reduction plan – Agency usage is below the planned levels by 2 WTE, demonstrating continued control of agency deployment. There continues to be a strong focus on medical agency in FY26/27. Whilst WTE have remained consistently below plan this financial year, there is slippage financially of £0.14m YTD due to the workforce mix.

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 August (M05), the Trust has delivered £15.04m of efficiency savings for FY26/27 which is £0.74m below the planned delivery.

At M05 the Trust is forecasting to meet its target CIP by the end of the year. £21.00m of this is recurrent and £18.98m is non-recurrent, with a FYE of £35.36m aligned to underlying planned delivery.

When applying plan risk alongside delivery risk the risk adjusted value of identified schemes stands at £31.50m, with worse case scenario being £26.30m

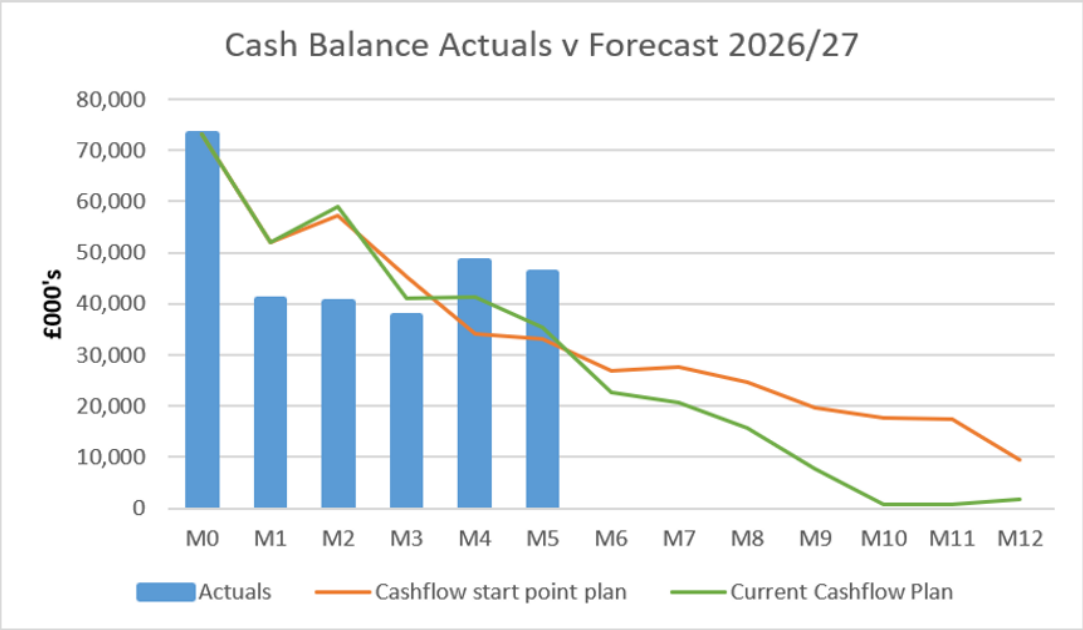
Recovery actions:
- Identification of divisional CIP at pace
- Identification of mitigations for high risk and undelivered CIP across the year

Anticipated impact and timescales for improvement:
Mitigation plan in place and delivering by the end of Q2

Dependencies:	Delivery of actions against PIDs across 26/27

Moving to EXCELLENCE

Cash and Cash Equivalents



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

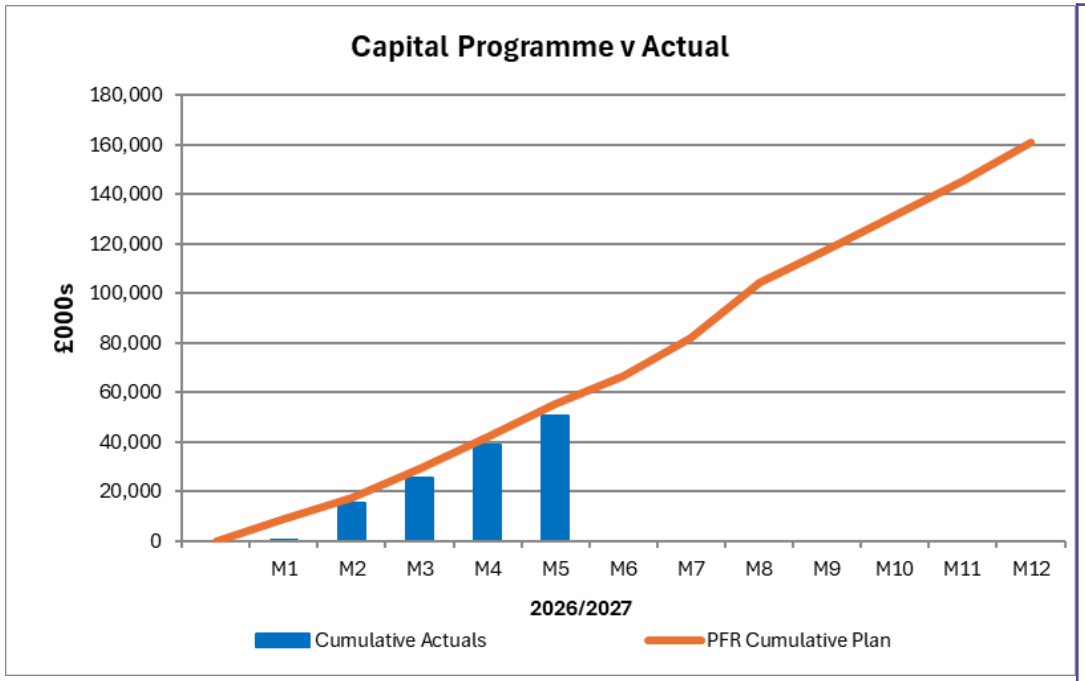
The cash balance brought forward into FY26/27 was £73.21m with a cash and ledger balance of £46.00m held at end of month five (August).

The graph illustrates overall actual cash held against the plan and shows the most likely cash scenario. At month five, actual cash balances were more than forecast, due to the timing of in year capital spend.

The most likely cashflow forecast for FY26/27 is predicated on receiving DSF through Q1 and 2 and assumes 45% cash releasing delivery of the efficiency programme. Based on this it is estimated that Revenue Support will be required at a value of £11.63m during Q4 FY26/27.

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

Capital



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 £138.34m; giving an overall capital programme for FY26/27 of £162.72m.

At month five FY26/27, £3.68m of expenditure (including IFRS 16) relating to the operational capital allocation has been expended and £47.14m of external expenditure incurred, giving total expenditure of £50.85m. This represents 31% of the overall spend required across FY26/27 against an expected 42% 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

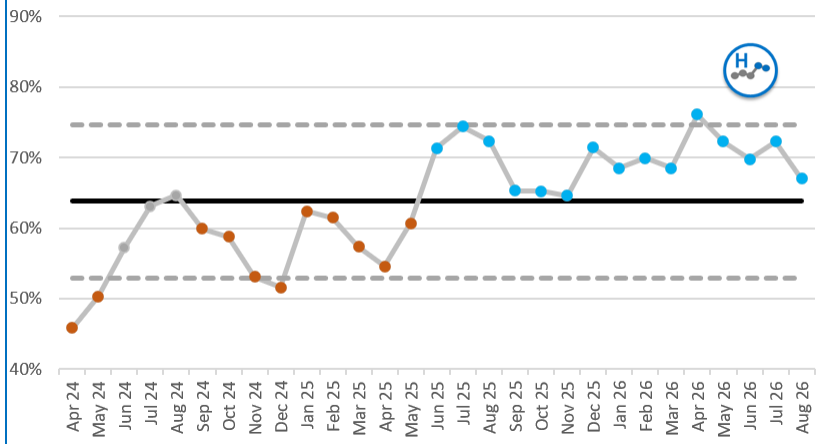
Recovery dependencies:	N/A

Appendices – Responsiveness And Well Led

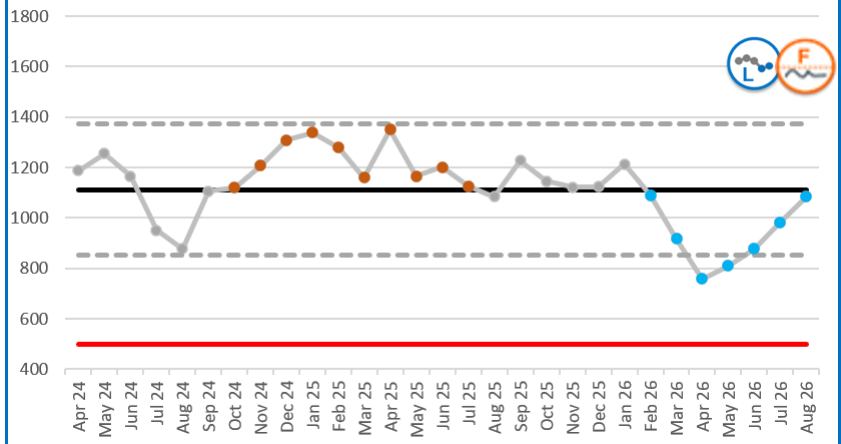
Appendix 1 – supporting detail on Responsiveness

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

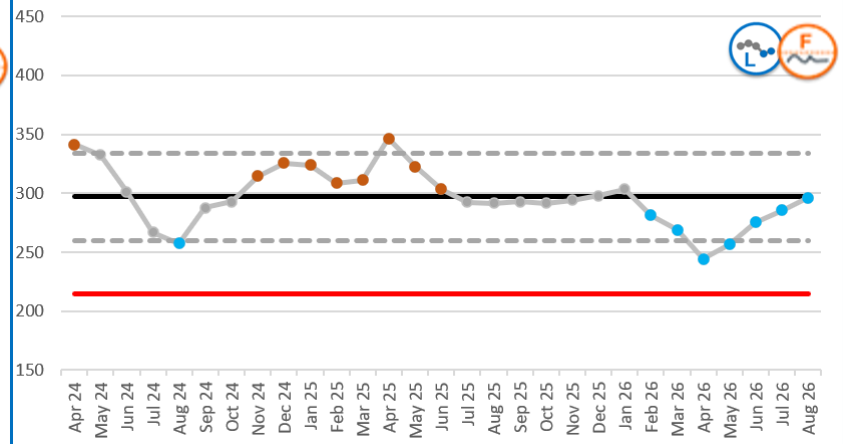
SaTH - % Patients seen within 15 minutes for initial assessment



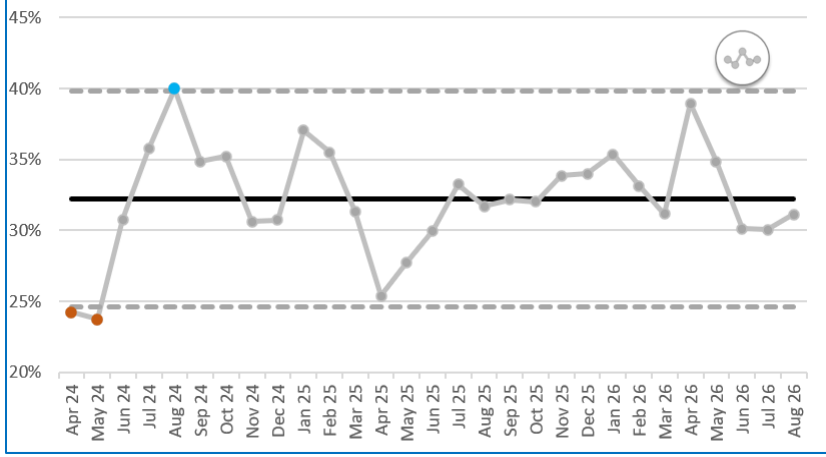
SaTH - Mean Time in ED admitted (mins)



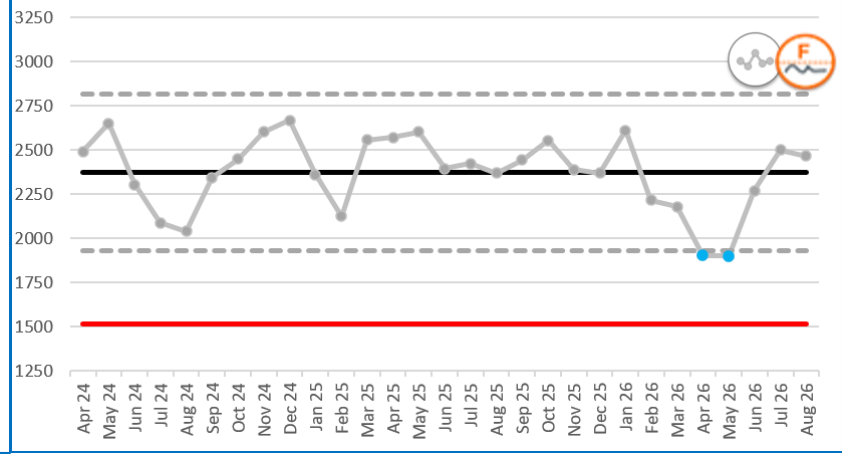
SaTH - Mean Time in ED Non Admitted (mins)



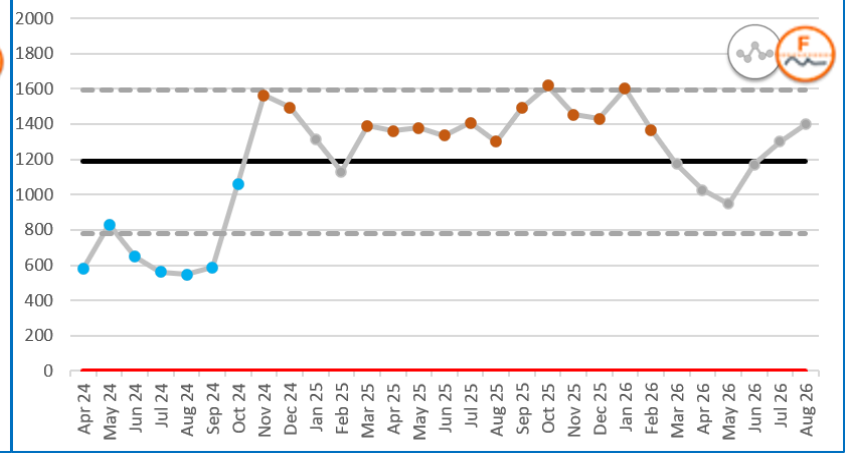
Patients seen within 60 minutes to first clinician %



SaTH - No. Of Patients who spend more than 12 Hours in ED - Type 1



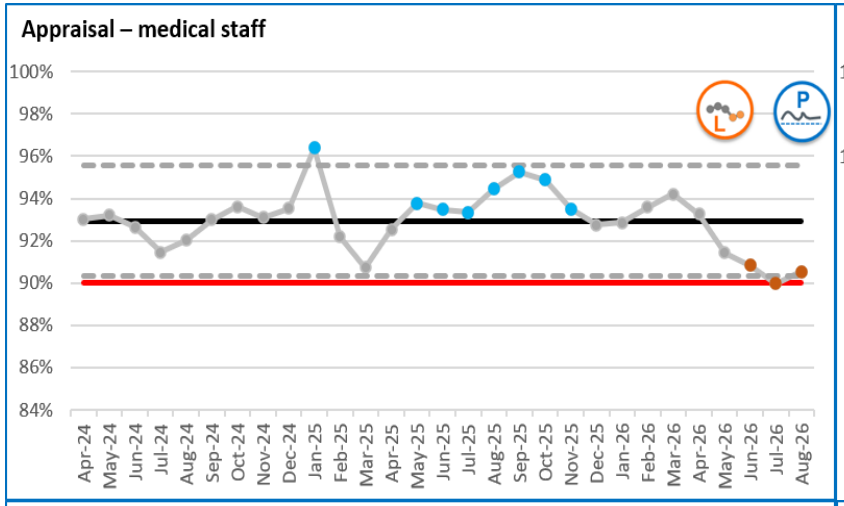
SaTH - >12 Hour DTA

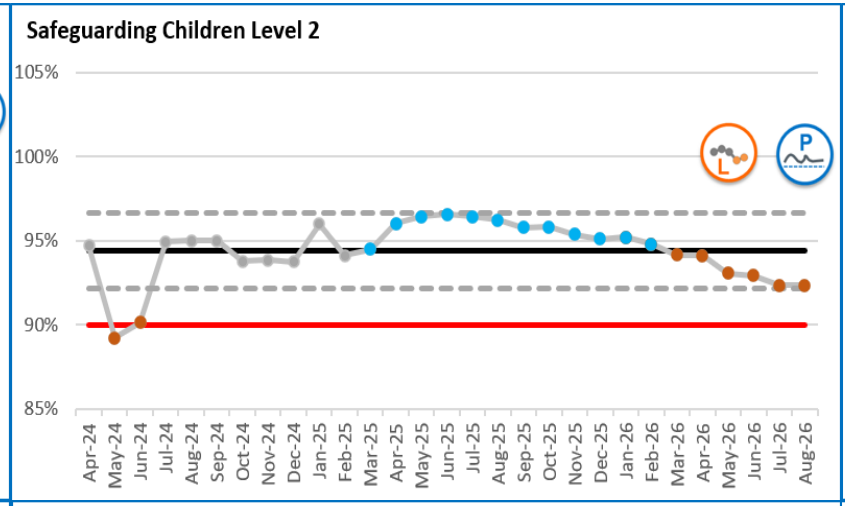


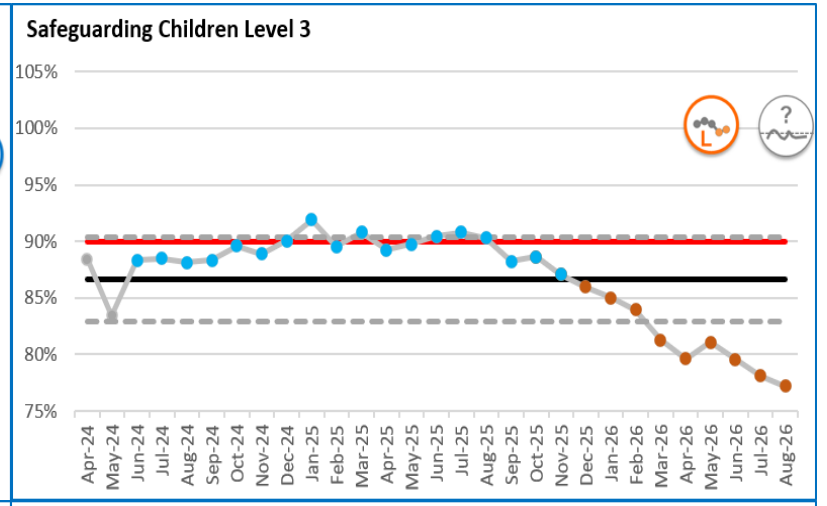
Moving to EXCELLENCE

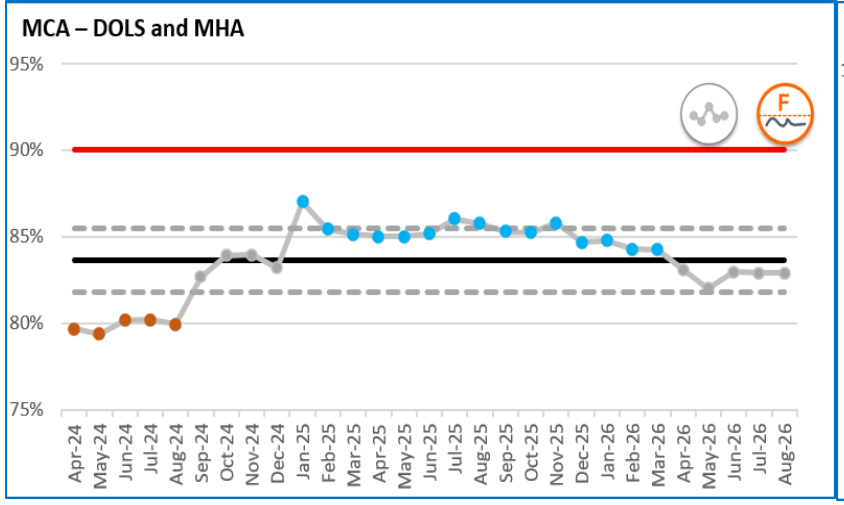
Appendix 2 – supporting Well Led

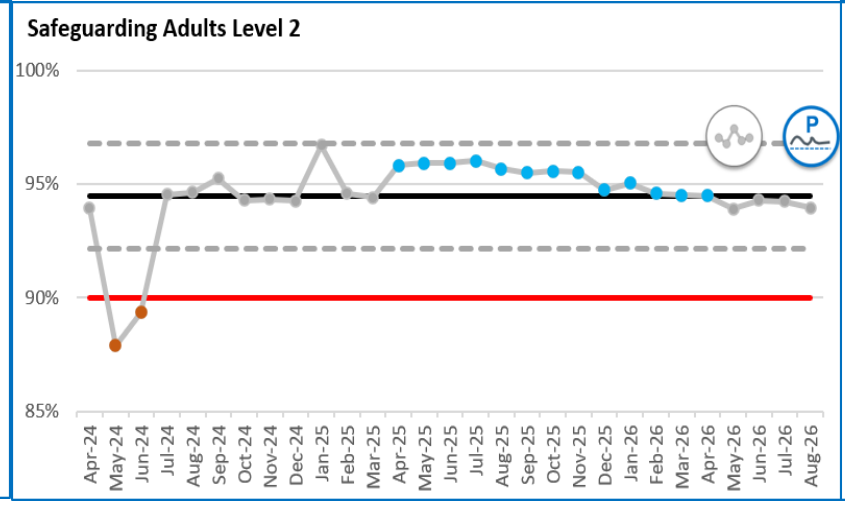
Shropshire, Telford and Wrekin Community and Hospitals NHS Group

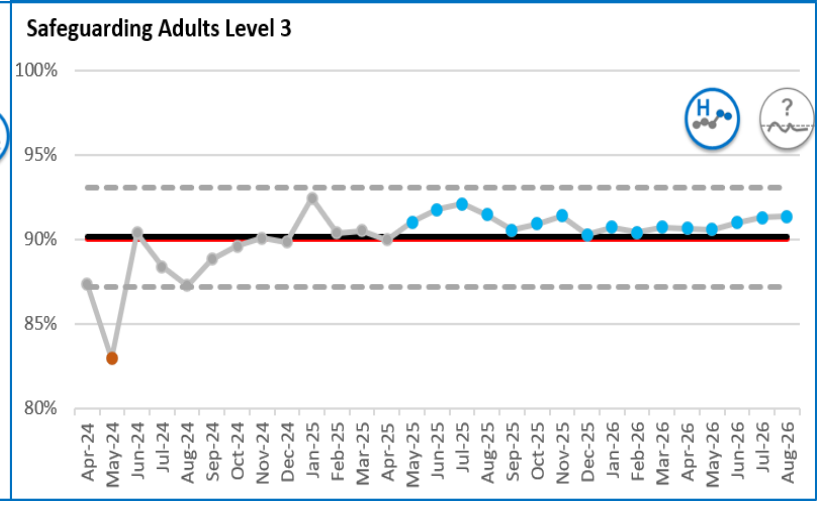












Moving to EXCELLENCE

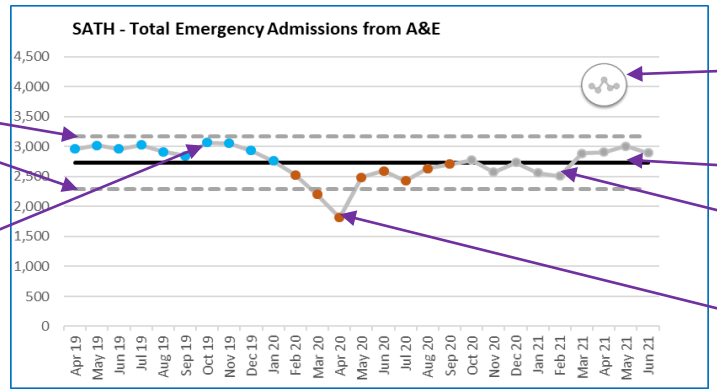
Appendix 3 – Understanding statistical control process charts in this report

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



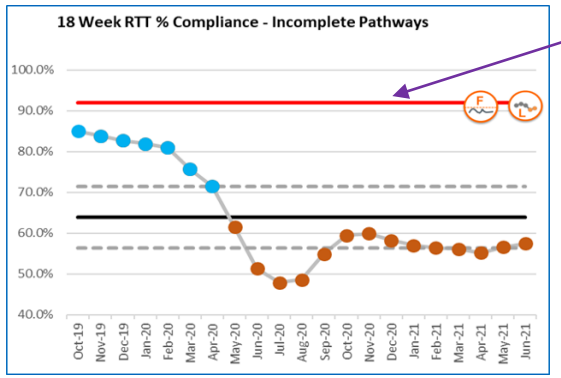
Icon showing most recent point type of variation

Mean or median line

Common cause variation

Special cause variation – data point outside of the process limit

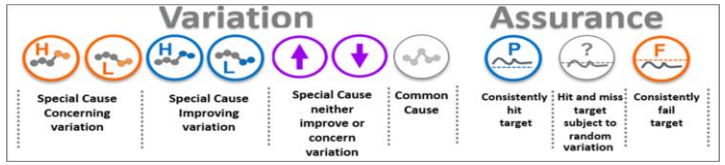
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.

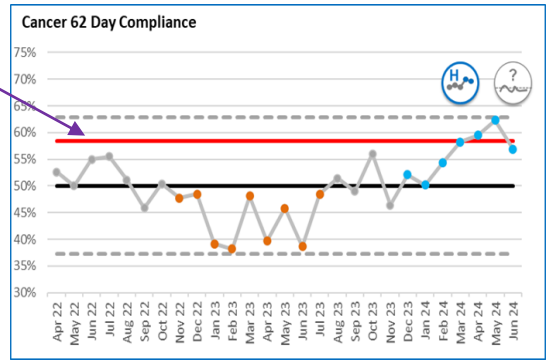


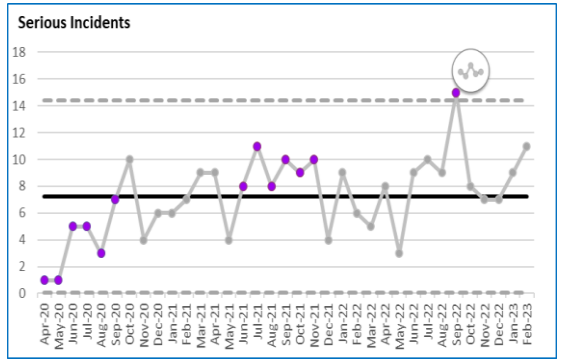
Target line – outside the process limits.

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







Moving to EXCELLENCE

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 – 8 October 2026

Agenda item	090/26		
Report Title	Combined SaTH/SCHT Winter Plan 2026/27		
Executive Lead	Ned Hobbs, Group Chief Operating Officer and Deputy Chief Executive (SaTH) Group Executive Winter Lead		
Report Author	Susanne Crossley, Deputy Chief Operating Officer (SaTH)		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Performance Assurance Committee	Safe	√	BAF9, BAF10, BAF12
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	N/A
	Well Led	√	
Executive Summary	The Board's attention is drawn to:- • **Combined Winter Plan:** The combined SaTH/SCHT Winter Plan 2026/27 sets out a single Group approach to demand, capacity, workforce and discharge for the coming winter, building on lessons from 2025/26. • **Partial assurance on specific Board Assurance Statement checklist items:** The Board is asked to note that full assurance cannot be given against every NHSE checklist item. Areas of partial assurance include discharge pathway delivery, workforce resilience, 4-hour/12-hour trajectories, ED crowding/corridor care, and ambulance handover performance – all of which remain sensitive to the level of winter demand. • **The Group's Discharge to Assess proposal is a material inter-dependency of this plan:** The bed modelling underpinning the Winter plan shows that a discharge to assess model for complex discharge patients is the single largest contributor to the additional bed(-equivalent) capacity created for winter, and that bed occupancy is still likely to exceed 100% in the realistic scenario at times, even with all planned interventions in place. Should the Board not subsequently endorse the Discharge to Assess proposal, the Trust and system will enter winter with a materially greater level of UEC risk than this plan assumes.		
Recommendations for the Boards	The Boards are asked to: **Approve** the Combined SaTH/SCHT Winter Plan 2026/27, noting the areas of partial assurance **Note** the Discharge to Assess proposal is proceeding through committee governance, as a material dependency of the plan		
Appendices:	Appendix 1: Combined Winter Plan 2026/27 (SaTH/SCHT) – full presentation		

Moving to EXCELLENCE

NHS
Shropshire, Telford and Wrekin Community and Hospitals
NHS Group





Winter Plan 2026/27

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

Contents

- National Requirements – Context
- Operational Winter Plan on a Page
- Alignment to the Group Strategic Framework
- Winter 25/26 review
- Operational Priorities
- STW System Transformation
- Local Care (Community) Transformation Programme
- No Criteria to Reside – January
- Governance, OPEL & Escalation
- Managing surge as a Group
- Prevention, Vaccination & Workforce Resilience
- Demand, Capacity & Winter Schemes
- Performance Targets & Next Steps
- Regional Assurance, Board Sign-off & System Change Risk
- Adverse Weather
- Flu Campaign 2026 – Plan
- IPC Principles
- Bed Modelling
- Appendix A, B, C & D (Mental Health, MPFT)



The agreed alliance between Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust

National Requirements – Context

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

The Combined SaTH/SCHT Winter Plan 2026/27 has been developed directly in response to the national expectations set out in the NHS England Winter planning 2026/27.

The Group plan adopts a whole-system, clinically led approach, jointly developed across acute, community and system partners, and is aligned to the national requirements to implement (ahead of winter):

1. The Model Emergency Department,
2. Model Acute Pathway (First 72 Hours of Hospital Care)
3. Model Discharge Pathway



The core aim and intention of the Winter plan for 26/27 is to align all intentions and actions to the elimination of corridor care as a patient safety priority. It reflects the NHS England expectation for integrated demand and capacity planning, strengthened urgent and emergency care pathways, expanded alternatives to hospital admission, and improved discharge and flow arrangements, supported by robust escalation and OPEL processes.

Appendix A, B and C cross reference the entire plan with the requirements outlined within the above documents for assurance that all requirements have been cross referenced and included.

The plan has identified Ned Hobbs, Group Chief Operating Officer, as the single accountable Executive Winter Director for the NHSE return, with Claire Horsfield, Director of Operations SCHT identified as SCHT Winter Director and Susanne Crossley, Deputy COO SaTH, as SaTH Winter Director.

STW ICB's Executive Winter Director for system-wide coordination is Phil Smith

Operational Winter Plan on a Page

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Winter 2025/26 showed how system pressures across Shropshire are interconnected. Although NCTR demand rose significantly (+28.8%), performance also depended on patient flow, discharge, community response, workforce resilience and social care capacity. Improvements by March showed the impact of coordinated acute and community action. This plan aims to embed those lessons ahead of winter through earlier mitigations, strengthened capacity and a unified Group approach to sustainable performance and better patient outcomes.

New for 26/27

- Single combined SaTH/SCHT plan with unified OPEL monitoring
- In-house SaTH Admissions Service (live July 2026);Care Coordination
- Expanded Integrated Front Door
- Integrated Therapy Service across the Group
- Virtual Ward and OPAT expansion of pathways
- HIU workstream,
- Discharge to Assess Service proposal
- Reconfiguration Trauma Floor
- Community winter clinics
- Enhanced bank holiday discharge model (≥20/day)
- Flu vaccination for long-stay inpatients (New for SaTH)
- Whole system approach to flow from acute through Pathway 1 and Community Hospitals
- Standardised ward-based discharge processes and consistent Expected Date of Discharge (EDD) management across SaTH and SCHT, supported through the Nexus improvement programme
- Embedded Neighbourhood MDT's with system partners

Five operational priorities

1. Tackle NCTR before winter starts

Enter winter below 20,000 vs 24,449 in 25/26; Discharge to Assess & integration of therapies, improved ward process. Neighbourhood MDTs in partnership across system to support those most at risk of admission and requiring complex discharge to remain at home wherever is safe to do so.

2. Make January the point of main effort

Pre-deployed capacity; ≥20 complex discharges/day over bank holidays; ring-fenced IFD, collocate with Health Hero, enhanced bank holiday discharge rounds and increased senior oversight to maintain discharge flow during peak periods

3. Sustain performance through winter

Achieve early and sustained improvement in handovers and 12-hr breaches, rather than only recovering performance late in winter as in 25/26 in line with Operational Plan.

4. Operate as one Group

Single plan, aligned escalation, workforce deployed across organisational boundaries. Standardised discharge processes, assessment tools and criteria across SaTH and SCHT to improve consistency and flow following Nexus recommendations.

5. Integrate therapies

D2A therapy service across SaTH and SCHT; therapists into ED;

Headline targets — 25/26 to 26/27

A&E 4-hour performance
52.9% → >60% winter average

12-hour breach rate
18.3% → <17.5%

Ambulance handovers >4hr
8.5% → <5%; <3% by January

NCTR Bed Days (winter total)
24,449 → <20,000

UCR 2-hour response
88.7% (Mar) → ≥85% all winter

Complex discharges (bank holidays)
10/day → ≥20/day

EXCELLENCE

Alignment to the Group Strategic Framework

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

2030 Vision: Better Together — Delivering excellent care and a safer, kinder and more personal experience for everyone

Be among the best trusts to work and employer of choice by 2030

- % work/shifts/WTE done by substantive employees
- 21c: Would recommend as a place to work

Winter Plan link:

Workforce resilience programme; sickness absence target <4.75%; flu vaccination >60%; H&WB plans

Radically shift care into the community — home-first, two thriving acute hospitals by 2027–28

- Increase % care episodes in community location
- % patients waiting <18 weeks RTT/non-RTT

Winter Plan link:

IFD, UCR to midnight, Virtual Ward, Winter clinics, Integrated Therapy, Bed Bureau, Long Covid self-referral — all live pre-winter

Among the safest trusts — highest quality care, people's first choice by 2030

- 21d: Friend/relative happy with care standard
- Reduction in moderate and severe harm events

Winter Plan link:

IPC programme; OPEL governance; EPRR testing; safe staffing oversight; IPC campaign

Listen, learn and deliver the kindest care in the NHS by 2029

- Achieve Children & Young People access standards
- Best Start in Life (Poppy's Promise)

Winter Plan link:

Paediatric UCR and Virtual Ward pilot new for 26/27; children's asthma pathway

Among the best trusts for access — waiting times better than national standards by 2029

- % Type 1 ED attendances <12hrs
- % cancer patients receiving treatment <62 days

Winter Plan link:

12-hr breach target <16%; 1-2-3 pull protocol; SDEC extended hours; elective programme maintainedEnhanced bank holiday discharge rounds

Add value — investing in innovative care and living within our means each year

- Positive variance: income vs expenditure
- Reduction in acute & community bed days

Winter Plan link:

NCTR target; community bed days shifted home-first: Discharge to Assess; SaTH Admissions Service; schemes within budget, Integrated Therapies, D2A

Moving to EXCELLENCE

The "Big Three" (12–18 month focus): Avg ED time to admission | Care episodes in community | % colleagues recommending the Group as employer — all directly tracked through this Winter Plan

Winter 25/26

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Headline metrics — October 2025 to March 2026 vs 24/25

80,012

A&E Attendances
+4.5% vs 24/25

52.9%

4-hr Performance
+0.8pp — marginal gain

18.3%

12-hr Breach Rate
−1.3pp improvement

8.5%

Ambulance >4hr
+2.1pp — worsened

24,449

NCTR Bed Days
+28.8%

+4.76d

NCTR-to-discharge delay
Grew 25.8% vs 24/25

88.7%

UCR 2-hr response (Mar)
vs 80% target

2.3%

Ambulance >4hr (Mar 26)
Best month of winter

86%

VW OCCUPANCY +15% vs 24/25

The NCTR surge (+28.8%) was a dominant constraint. January was the hardest month on every metric — the largest demand spike (+10%), worst ambulance handovers (93.1 min avg), peak NCTR (+41%). March demonstrated what's achievable when conditions are right. The challenge for 26/27 is reaching March standards by November.

Moving to EXCELLENCE

Five Operational Priorities for Winter 2026/27

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

1. Tackle NCTR Before Winter Starts

NCTR is the system's single biggest constraint. Entering winter with a lower NCTR baseline is the highest-leverage action available. Target: <20,000 total vs 24,449 in 25/26. Actions include establishing Discharge to Assess, Integrating Therapy services across the group and improved ward process to prevent deconditioning and support meaningful EDD's Neighbourhood MDTs in partnership across system to support those most at risk of admission and requiring complex discharge to remain safe and well at home where ever is safe to do so.

2. Make January the Point of Main Effort

January was the hardest month on every metric. Maximum capacity and discharge resource should be pre-deployed — protect complex discharge capacity across public holidays (target ≥20/day). Establish ring fenced capacity for Integrated Front Door (IFD) incl Therapy

3. Sustain Performance Throughout Winter

March 26 showed what the system can achieve (2.3% handovers>4hrs, 15.9% 12-hr breach). This performance has been embedded within the demand and capacity model, with planning assumptions aligned to anticipated winter demand. The modelling has enabled the Group to pre-position capacity, strengthen discharge flow, expand community alternatives and establish clear occupancy and escalation triggers that will be in place from November.

4. Operating as one Group

The Group is committed to making the 2026/27 winter planning cycle the strongest to date through the development of a single, joined up acute and community plan. This will provide greater strength and resilience through further aligned demand management and escalation processes, more effective utilisation and deployment of the workforce across organisational boundaries, and a clear set of shared goals, vision and purpose.

5. Integration of Therapies

A single integrated therapy service operating across SaTH and SCHT: targeting therapists into ED for early assessment, faster D2A and rehabilitation planning, and pre-mobilisation rehab to prevent deconditioning and functional decline. Standardised assessment tools and discharge criteria across the Group.

Moving to EXCELLENCE

STW System Transformation Program 2026/2027 and 2027/2028

Pillar 1: **Community Urgent Care**

SRO: Claire Horsfield
Delivery Lead: Gemma McIver

To reduce avoidable acute demand by delivering urgent care and alternatives to admission through neighbourhood-led services

Key objectives

- Transition all MIUs to a **standardised UTC model**,
- Ensure UTCs are fully aligned with **neighbourhood teams and community pathways**.
- Align urgent and intermediate care under INT / neighbourhood leadership (Home First).
- Expand and standardise **community frailty pathways**.
- Strengthen secondary care contribution to neighbourhood frailty and care transfer hubs.
- Improve access to **community diagnostics, wound care and delirium support**.
- Deliver children's **OPAT and Virtual Ward** pathways.
- Ensure appropriate **medical input into neighbourhood urgent care pathways**.
- Improve access to **domiciliary care** to prevent admission and support discharge.
- **Standardised therapy** model across Acute & Community to support early mobilisation.
- Deliver **district nursing and reablement**

Primary outcomes

- Reduced avoidable ED attendances
- Reduced ambulance conveyance
- Increased community-based alternatives to admission
- Increased patients supported at home at 30 days.

Pillar 2: **Acute Flow, Streaming and Care Coordination**

SRO: Ned Hobbs
Delivery Lead: Susanne Crossley

To improve system flow and ambulance performance by strengthening coordination, streaming and same-day clinical decision-making.

Key objectives

- Improve **ambulance streaming and alternative dispositions** to SDEC and community pathways.
- Strengthen **NHS 111 streaming** and system alignment.
- Expand **same-day clinical decision-making** through SDEC models.
- Extend SDEC operating hours
- Improve coordination for **High intensity Users**
- Strengthening of senior decision-making at **weekends**
- Early identification of patients at risk of prolonged stay.

Primary outcomes

- Improved ambulance handover performance
- Reduced ED conveyance
- Reduced 4 and 12-hour breaches
- Improved same-day discharge rates
- Increased weekend simple discharges

Pillar 3: **Discharge Transformation & Capacity Release**

SRO: Claire Horsfield
Delivery Lead: Sarah Robinson

To reduce NCTR, readmissions and length of stay through a genuinely 7-day discharge and intermediate care system.

Key objectives

- Reduce **NCTR**, with explicit stabilisation and transformation thresholds.
- Reduce long length of stay, focusing on **LOS >7, >14 and >21 days**.
- Prevent hospital-associated **deconditioning** through early mobilisation and therapy response standards.
- Restore **Pathway 0 discipline**, with clear ownership and trajectory management.
- Strengthening access to complex discharge services at **weekends**
- Deliver system-wide **7-day discharge model** (Therapy, Pharmacy, Transport, Flow & CTH aligned).
- Close the **weekday/weekend discharge gap** through senior decision-making.
- Expand home-based intermediate care under INT leadership (Home First).

Primary outcomes

- Reduced NCTR
- Reduced long-stay bed occupancy
- Increased weekend discharges
- Reduced functional decline at discharge
- Reduced readmissions linked to deconditioning
- Improved bed availability and resilience
- Increased weekend complex discharges

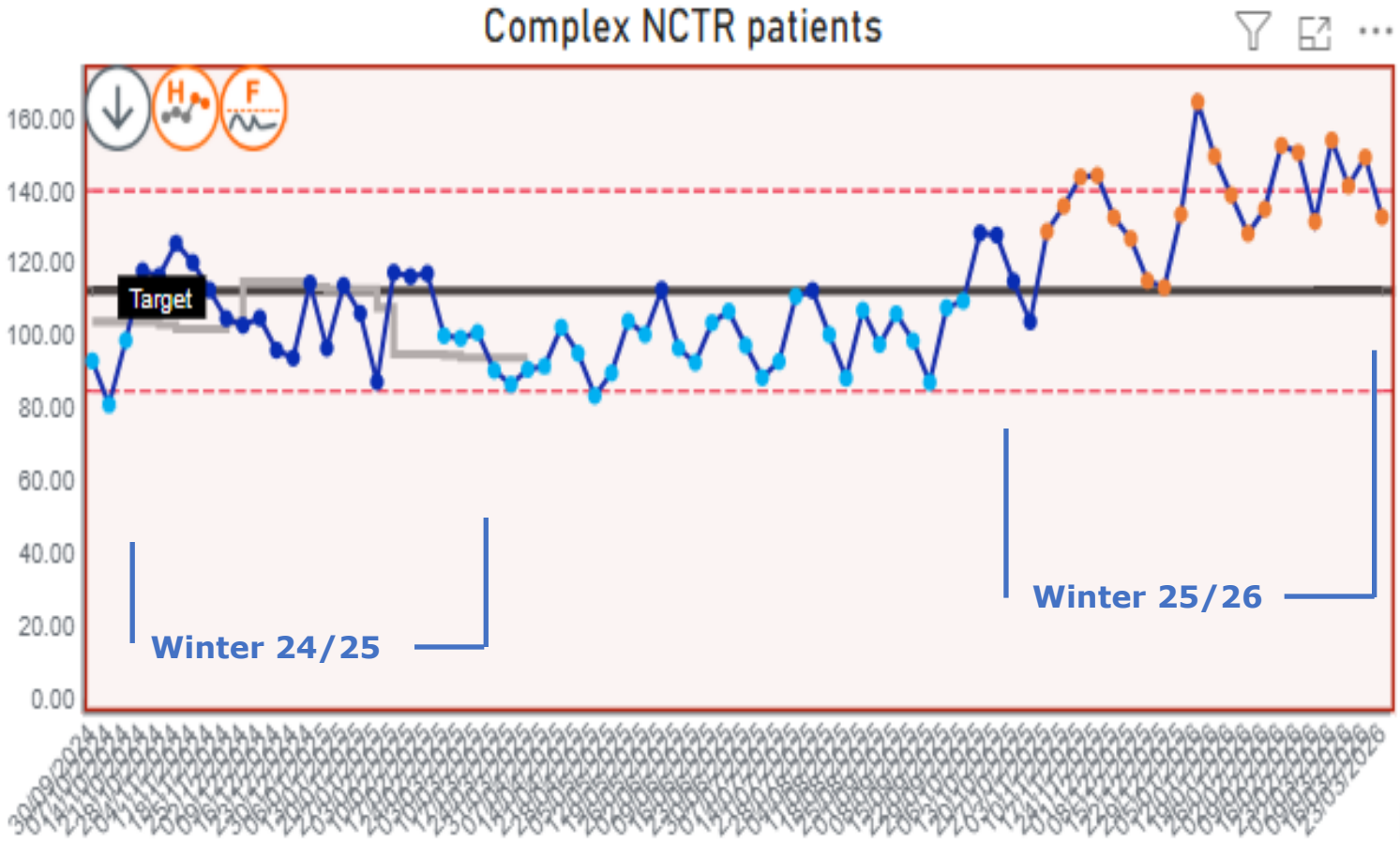
Cross-Cutting: Surge

Stress-tests all pillars, Defines minimum safe operating levels, Avoids reliance on winter-only mitigations

Cross-Cutting: Flow Centre

System-wide visibility, prioritisation and escalation, Supports all three pillars, Enables safe sequencing and winter readiness, Oversight of discharge trajectory and long-stay cohorts.

January & NCTR



January: every metric at peak

+10% A&E, +41% NCTR, 93.1 min avg handover, 4-hr at 51.6%. Festive fortnight creates a discharge backlog that collides with post-festive demand surge.

Festive fortnight impact

Complex discharges fell to 10/day over bank holiday weekends vs 28/day weekdays. Pre-bank holiday days (24th Dec: 56; 31st Dec: 40) couldn't compensate.

What we'll do differently

Complex discharge: ≥20/day target on bank holiday weekends. Pre-clearance push in w/c 8 Dec and 5 Jan. Enhanced CTH bank holiday staffing. SCC tactical oversight from 22 December..

Demand and capacity modelling and targets set for PW1,2 &3 across system partners and expand PW1 Dom care STW pathway splits is Pathway 1- 66% Pathway 2 - 22% Pathway 3- 12% LOS Pathway 1 - 2 days Pathway 2- 3 days Pathway 3 - 5 days , no agreed metric reached in partnership with Powys for Powys

Governance, OPEL & Escalation

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Occupancy risk will be reviewed through shared demand and capacity oversight, joint SaTH/SCHT site calls and real-time OPEL monitoring to support timely operational decisions.

OPEL Level	SCHT Triggers	SaTH Triggers	Response
OPEL 1 Baseline	Bed occ >85–92% NCTR 5–15% UCR >70–80%	4-hr >78–95% Handover <30min NCTR <15%	BAU: CTH calls, NCTR senior review, proactive discharge
OPEL 2–3 Moderate	Bed occ >92–98% NCTR 15–25% UCR >60–70%	4-hr >60–78% Handover 30–60min NCTR 15–20%	Senior reviews; expedite discharges; flex CTH capacity; escalate to Winter Director
OPEL 4 Extreme	Bed occ >98% NCTR >25% UCR <60%	4-hr <60% Handover >60min NCTR >20%	Activate BCP; stand down non-essential; redeploy; 1-2-3 at full intensity; Winter Director commanding

On Call

Schedules for experienced Managers on Call and Directors will be carefully reviewed and optimised for both organisations to ensure maximum operational and clinical decision-making capacity is available during periods of predicted high demand, including weekends and bank holidays. Access to senior clinical decision makers will be maintained throughout these periods to support timely assessment, escalation and discharge decision-making. The Trust level on-call arrangements across SCHT and SaTH will strengthen system-wide coordination during periods of surge, enabling rapid decisions to release, flex and prioritise community capacity.

Winter Directors

Group Executive Winter Lead: Ned Hobbs, COO — devolved authority as below

SaTH Winter Director

Susanne Crossley – Deputy Chief Operating Officer, SaTH

SCHT Winter Director

Claire Horsfield - Director of Operations SCHT & Group Chief AHP

Oversight Forums

- UEC Delivery Group
- System Control Centre
- Care Transfer Hub
- Q&S Committees

Moving to EXCELLENCE

Managing surge as a Group

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

How SaTH and SCHT operate as a single system when demand exceeds individual organisational capacity

Flow & Capacity — Acute to Community

- **Daily long-stay and NCTR reviews, combined with standardised ward-based discharge processes and consistent EDD management** across SaTH and SCHT, will strengthen discharge planning, reduce avoidable delays and improve flow across the system.
- **Seamless transition to community hospitals** — agreed pathways and safe flexing of criteria,
- **Integrated Front Door expanded to HealthHero** — joint clinical coordination centre; IFD as first response to surge, redirecting before acute admission
- **TES beds in Community Hospitals activated** — pre-agreed OPEL 3/4 trigger for community escalation capacity
- **Therapy into ED and outreach into community** — integrated therapy team crossing the acute-community boundary; earlier discharge planning and functional assessment, roll out of discharge to assess
- **Shared demand and capacity visibility** — single group dashboard; joint SaTH/SCHT site calls; real-time OPEL monitoring across both organisations

Clinical & Workforce Response

- **Specialty in-reach to community** — respiratory and diabetes specialist support and Virtual Ward during high-acuity surges
- **Flexible group-wide staff deployment** — pre-agreed redeployment protocols; staff moved to highest-risk areas across both organisations at OPEL 3/4
- **Senior decision-making over bank holidays** — on-call Director cover at Trust level; SCC daily calls from 22 December; Winter Director command at OPEL 4
- **Remote monitoring for high-acuity patients** — Luscii remote monitoring extended; respiratory Virtual Ward patients tracked in real time; reduce acute re-attendance
- **Pre-med and functional rehab in community** — prevent deconditioning and functional decline; 7-day therapy cover across the Group live discharge to assess pathways
- **Acute–Mental Health interface** — SaTH ED flow connects with MPFT's Liaison Psychiatry (0–1hr response) and CRHT; patients in non-MH beds awaiting admission receive daily Liaison review and CRHT reassessment, kept visible within the same flow oversight as physical health NCTR

Group surge response activates at OPEL 3 | Full command at OPEL 4 | Trigger: Winter Director + SCC daily call + joint site meeting within 2 hours

Prevention, Vaccination & Workforce Resilience

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Flu & COVID Vaccination

- Staff flu: target 60-65% (achieved 25/26 — raise for 26/27)
- COVID autumn/winter programme: ≥8,500 people in STW
- Peer vaccinators all areas; increased drop-in clinics
- 'Know Your Numbers' events as incentive
- Weekly uptake tracking; monthly IPCOG reporting
- Flu vaccination offered to long-stay inpatients — new for SaTH 26/27
- SAIS Flu campaign

Infection Prevention (IPC)

- IPEAT winter campaign from October 2026
- POC testing: both EDs, UCR and Virtual Ward teams
- FFP3/PPE readiness: Dental, MIUs, UCR, Virtual Ward
- Enhanced norovirus protocol (touchpoint cleaning)
- RediRoom review; fogging capacity pre-confirmed
- Supply chain resilience is further supported through business continuity plans, mutual aid arrangements and resource pooling to minimise the risk of disruption to PPE availability during periods of increased winter demand.
- IPC team joins 08:45 safety huddles and provides daily sitrep; IP lead nurse part of on-call manager WhatsApp group for advice and guidance
- Infection Prevention and Control (IPC) arrangements are supported through established policies and procedures operating across both organisations, with winter outbreak and patient cohorting arrangements tested through planning and escalation processes in and out of hours

Workforce Resilience

- Dynamic rostering via e-roster (both Trusts)
- Vacancy hotspot analysis monthly; summer recruitment
- SCHT short-term sickness: target back to <4.75%
- H&WB programme: MSK, psychological support, flexible working
- Bank, agency and overtime cover: agreed process in place for rapid decision-making to flex staffing during surge and cover sickness-related gaps, deployed via vacancy hotspot analysis and BCP escalation.
- BCP tested to 30% staffing planning assumption
- Prioritising staff wellbeing by ensuring rest periods, support mechanisms, and safe working environments has helped to maintain operational effectiveness during extended periods of strain.
- Increased PNA support across both Trusts

Moving to EXCELLENCE

Demand, Capacity & Winter Schemes

Reviews across each pathway for PW1, 2 and 3 have taken place through the system improvement programme with each local authority signing up and supporting a daily target which will be overseen via the System Operational daily call and UEC Delivery Group.

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

SaTH Acute Capacity

- HIU workstream: operational pre-winter
- Combined Group Therapy response
- Gynae assessment to 2200 (PRH) (ICB Winter Scheme request)
- Enhanced Bank Holiday Discharge Round (ICB Winter Scheme request)
- Additional Matrons (capacity and flow)
- Nexus internal ward processes – External Consultancy
- Trauma Floor reconfiguration
- Oncology Assessment area
- Transfer Team Test of Change HCA / Mode (ICB Winter Scheme request)
- Sath Admissions Service (SAS) - Enhanced (ICB Winter Scheme request)

SCHT Community Capacity

- Expansion of Virtual Ward and OPAT pathways
- Community winter clinics
- Neighbourhood MDT's for high risk stratified patients
- Improve access to community diagnostics,
- Remote monitoring expanded for Respiratory patients
- CTH 7 days a week with daily escalation call in place across whole system and an embedded home first approach underpinned by Discharge to assess pathways
- Improve access to domiciliary care to support Discharge to Assess (D2A) following PW1 demand and capacity modelling
- Expand home-based intermediate care through a discharge to assess model of care (Home First)
- Pathway 2 and community bed utilisation will be supported through community hospitals, TES escalation beds, integrated therapy services and improved acute-to-community transfer processes

Care Coordination (Live July 26) & Out of Hour Service (HealthHero)



Moving to EXCELLENCE

Performance Targets & Next Steps

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Metric	25/26 Baseline	26/27 Target
A&E 4-hr performance	52.9%	**>60% avg winter**
12-hr breach rate	18.3%	**<17.5%**
Ambulance >4hr (avg)	8.5%	**<5%; <3% by Jan**
NCTR bed days (winter total)	24,449	**<20,000**
NCTR-to-discharge delay	23.18 days	**<18 days**
Complex discharges (bank holidays)	10/day	**≥20/day**
UCR 2-hr response (sustained)	88.7% (Mar 26)	**≥85% all winter**
Staff flu vaccination	≥50% (25/26)	**>60-65%**
Virtual Ward Occupancy	86%	**>86%**

Next Steps

Now–Jul	SaTH Admissions Service go-live; NCTR programme launch
Aug–Sep	Winter Director confirmed; August regional winter exercise; Group EPRR exercise; Board sign-off ahead of 21st August NHSE submission
Sep	Demand trajectories submitted to NHSE (3 scenarios); NHSE regional winter event
Oct 1	All schemes live; CTH bank holiday staffing confirmed; OPEL unified monitoring active
22 Dec	SCC daily calls begin; enhanced discharge activated
Jan 26/27	Pre-deployed resource at full readiness — no reactive response
Mar 27	Winter review commenced; combined plan for 27/28 scoped

Moving to EXCELLENCE

Regional Assurance, Board Sign-off & System Change Risk

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

NHSE Midlands winter letter (16th July 2026) expectations for regional assurance, executive accountability and system-change risk mitigation

Regional Bed Modelling & Board

- **Regional bed model validation** — submitted via separate NHSE spreadsheet return; assumptions on admissions, discharges and capacity validated against local operational intelligence, with local variances flagged to NHSE Midlands
- **Scenario testing — baseline, surge and super-surge** — Group OPEL framework (slide 10) mapped to national baseline/surge/super-surge definitions; mitigations tested against each scenario
- **Named Executive Winter Director for NHSE return** — Ned Hobbs, Group Chief Operating Officer, identified as the single accountable Executive Winter Director within the winter planning submission
- **Board Assurance Statement** — Combined SaTH/SCHT Winter Plan to be presented for Board approval ahead of the 21st August 2026 NHSE submission deadline

Mitigating Risk During System Change

- **SaTH Admissions Service (in-house, live July 2026)** — transition risk to UEC flow mitigated through parallel-run and phased handover from the existing provider co-located with HealthHero
- **Nexus external consultancy (UEC diagnostic)** — findings tracked through working groups to ensure recommendations are integrated without destabilising existing winter schemes
- **Mutual aid arrangements** — Group-wide staff deployment (slide 11) supplemented by mutual aid agreements with wider STW system partners activated at OPEL 3 / 4
- **Elective recovery** — planned care, including Cancer and RTT recovery protected through ring-fenced elective capacity and clear de-escalation thresholds; elective activity stood down only at OPEL 4 under agreed criteria, with a recovery trajectory built into the 26/27 plan.
- **Industrial Action Risk -** Scenario planning, real-time surveillance and hotspot mapping will be used to identify areas of greatest risk and support prioritisation of critical services. Business continuity plans, mutual aid arrangements and workforce redeployment protocols, which have been extensively tested through winter pressures and system escalations during 25/26, provide resilience should workforce disruption occur**.**
- **Mental health services** — 0–1 hour Mental Health Liaison response to ED maintained through winter via MPFT's Crisis and Home Treatment Teams; pre-approved bank/agency/overtime flexes CRHT capacity during surge, protecting 0–4 hour referral response. Weekly bed-flow (CRFD) reporting escalated jointly to ICB and local authorities.

Moving to EXCELLENCE

Regional exercise participation: August 2026 regional winter exercise and September 2026 NHSE winter event

Adverse Weather

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

STW rural geography creates specific access vulnerability — proactive planning protects patients and staff across all sites

Access, Estates & Snow Response

- **Gritting — main sites and priority routes** — RSH and PRH car parks on Estates priority gritting schedule. Satellite and community site car parks are NOT on the priority route — action required pre-winter to agree local arrangements
- **Snow plough provision — local farmers MOU** — CVEC/CVS local farmer network for snow clearance at RSH and PRH to be formally agreed pre-winter (MOU required by October 2026)
- **Centralised 4x4 fleet — formalised MOU** — single group-wide 4x4 support desk; prioritised deployment to UCR, district nursing and community hospital staff; MOU with partner agencies in place by September 2026
- **Met Office Hazard Manager — active monitoring** — 72-hour advance warning triggers pre-positioning of 4x4 vehicles and community team briefings

Patient Safety & Vulnerable People

- **RiO clinical prioritisation flags** — all community nursing caseloads flagged by adverse weather vulnerability; enables rapid prioritisation of visits when access is restricted
- **Fire Service partnership — vulnerable patient welfare** — Shropshire Fire and Rescue Service welfare checks on high-risk housebound patients when clinical teams cannot access
- **Adverse weather hotspot mapping** — geographic analysis of highest-risk rural areas by postcode; used to pre-plan community team deployment and identify patients requiring early contact
- **Adverse weather stress test — August/September 2026** — tabletop exercise testing 4x4 activation, community nursing prioritisation, Fire Service comms, and satellite site gritting protocols before winter

Actions required pre-winter: satellite site gritting MOU | CVEC/CVS farmer MOU (Oct 26) | 4x4 MOU (Sep 26) | Stress test exercise (Aug/Sep 26)

Flu Campaign 2026 - Plan

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

1. Campaign Objectives

- Increase flu vaccination uptake across staff
- Ensure peer vaccinators are nominated & trained for all areas.
- Promote early awareness across all departments
- Walk in and bookable appointment plan established .
- Offer flu vaccination to all long-stay inpatients during admission.

2. Key Milestones and Timescales

Activity	Timeline
Planning & Engagement	July/August 2026
Online learning	August 2026
Pregnant staff Flu vaccinations begin	September 2026
Main staff vaccinations begin	October 2026
Inpatient Flu vaccinations begin	October 2026

3. Training & Resources

- Platform: Review if online training will be available.
- Content: Includes infection control updates, eligibility criteria, FAQs, and consent guidance
- Confirmation that vaccine order has been placed
- Fridge storage organised

Moving to EXCELLENCE

Flu Campaign 2026 – Plan continued...

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

4. Communications & Awareness

- Posters, email bulletins, intranet updates, and team briefings starting early September.
- Staff champions and clinical leads to champion the campaign locally (each division to nominate champions).
- Monthly awareness slot on the Nursing, Midwifery and AHP meeting chaired by site DoNs and GCNO Senior Leaders Group chaired by GCNO

5. Reporting & Oversight

- Uptake data monitored weekly by Flu working group, using RAVS data caption
- FHCW flag to be applied to ESR records
- Monthly updates provided to IPCOG and relevant committees (Provided by workforce)
- Lessons learned to inform Winter Preparedness planning.

Moving to EXCELLENCE

IPC Principles

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

The Group recognises the ongoing IPC challenges and, in preparation for the winter period, has identified a number of actions to maximise infection prevention and control precautions. These actions will form part of a Group-wide IPC Improvement Plan and awareness campaign aimed at driving improvement, strengthening compliance with IPC standards and reinforcing individual accountability for infection preventions and control across both organisations.

- SCHT has prioritised FFP3 fit testing for higher-risk services, including UCR, Virtual Ward and MIU teams, with records held centrally and transition to ESR underway in line with NHSE expectations, oversight of compliance is monitored through the SCHT IPC Committee. Within SaTH, FFP3 compliance is led by the Health & Safety Team and monitored through the IPC Assurance Committee to ensure ongoing oversight and assurance.

- The Group will continue to promote respiratory infection prevention through staff awareness campaigns, flu vaccination programmes and the IPC campaign. SCHT public-facing communications include recorded telephone messages across all four Community Hospital sites advising visitors not to attend when unwell and both organisations reinforce key infection prevention messages through posters displayed at ward and department entrances.

- Point of Care Testing for Respiratory Viruses to be made available to both Emergency Departments

- Deep cleans of high risk areas to reduce the risk of infection using a combination of:

    - The RSH Modulars
    - The additional PRH Beds
    - Implementation of the "menu" choices by Shropshire Community Trust

- Review of "RediRoom" availability to address peak demand for side room capacity

- Review of "fogging" deep clean functions to ensure that patient spaces can be turned around safely and efficiently.

- Established policies and procedures for cohorting with Managers on Call have clear access to out-of-hours escalation arrangements, including specialist IPC advice and support where required during evenings, weekends and bank holiday periods. This is supported by the IPEAT service, outbreak management processes, respiratory testing protocols, PPE readiness arrangements and real-time escalation mechanisms to ensure timely infection prevention decision-making during periods of increased prevalence of respiratory illness.

Bed Modelling

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

- The model starts winter with a bed occupancy of 93% (5,164 occupied beds against 5,533 available bed days per week) in the "œntral" or realistic case.
- Planned interventions include:
    - 6 ambulatory trauma spaces
    - 4 additional ward 32 beds
    - 4 spaces within the Oncology Assessment Area of ward 23
    - Discharge to Assess capacity
    - Enhanced bank holiday discharge arrangements
- Collectively, the schemes deliver around 10% additional capacity with the largest benefit arising from the improved discharge flow through the Discharge to Assess proposal.
- The model assumes an effective 6.3% reduction in available beds due to IPC/bed closures.
- The modelling indicates that, even with the planned interventions in place, bed occupancy in the realistic scenario is likely to exceed 100%, presenting an ongoing operational challenge during the winter period.

Appendix A

Model Emergency Department requirements

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Whole-system responsibility for ED flow	ED flow must be owned by the whole urgent and emergency care system, not ED alone.	The winter plan is a single combined SaTH/SCHT plan with unified OPEL monitoring, shared escalation, and a stated commitment to operate as one Group across acute and community services. Feeds into ICB daily system SOG calls with full system representation Winter Director oversight across all partners to ensure rapid operational response when flow deteriorates. Neighbourhood MDTs in partnership across system to support those most at risk of admission and requiring complex discharge to remain safe and well at home where ever is safe to do so.
Improve 4-hour performance	System partners should support improvement towards the constitutional standard that 95% of patients attending A&E are admitted, transferred or discharged within 4 hours.	The plan sets a 26/27 target to improve A&E 4-hour performance from a 52.9% baseline to greater than 55% winter average, supported by integrated flow, discharge and community schemes.
Reduce overcrowding and corridor care risk	Patient flow must improve to reduce overcrowding, ambulance delays, corridor care and delay-related harm.	The plan identifies NCTR as last years winter constraint and sets a target to reduce winter NCTR from 24,449 to under 20,000, supported by Discharge to Assess, integrated therapies and improved ward processes. Enhanced bank holiday discharge rounds and increased senior oversight to maintain discharge flow during peak periods Standardised discharge processes, assessment tools and criteria across SaTH and SCHT to improve consistency and flow following Nexus recommendations.
Protect ED for patients needing emergency medicine	ED should be prioritised for patients requiring emergency medical care, with alternatives available for those who can be managed elsewhere.	Expanded Integrated Front Door, Care Coordination, HealthHero, community winter clinics, Virtual Ward and OPAT expansion, and strengthened community capacity to redirect and support patients outside acute admission where appropriate. Direct specialty pathways for appropriate patients, reducing unnecessary time spent in ED. Reconfigure Trauma Floor and specialty assessment services providing additional capacity and reducing pressure on core ED areas. Expand SDEC opening hours
Early assessment and front-door streaming	Patients should receive rapid initial assessment and be streamed to the right urgent, emergency or community pathway.	The plan includes an expanded Integrated Front Door, ring-fenced IFD capacity for January, and IFD as the first response to surge, redirecting patients before acute admission where appropriate. Senior clinical decision makers at the front door

Model Emergency Department requirements

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Connectivity between ED, SPoA, 999 and 111	ED front door should connect with community access routes, 999, 111 and SPoA to support admission avoidance and redirection.	Care Coordination live from July 2026, with HealthHero, joint clinical coordination model through expanded Integrated Front Door arrangements Expanded IFD team in SaTH front doors In reach of speciality teams (respiratory in times of surge)
Alternatives to admission	Systems should maximise community services, Hospital at Home, Virtual Ward and other alternatives to unnecessary admission.	Virtual Ward and OPAT pathway expansion, remote monitoring for respiratory patients, community winter clinics, neighbourhood MDTs for high-risk stratified patients and expansion of home-based intermediate care under INT leadership.
Same Day Emergency Care and ambulatory pathways	Maximise SDEC, ambulatory and short-stay pathways to avoid unnecessary admission and long waits in ED.	Extended SDEC hours as part of the access and flow response, alongside OPAT expansion, Virtual Ward expansion and community alternatives.
Frailty pathways	Frail patients should have timely specialist assessment and access to alternatives to admission.	Expanded and standardised community frailty pathways through Virtual ward neighbourhood MDTs for high-risk patients Improved access to domiciliary care to support Discharge to Assess. Integration of therapies to support discharge to assess pathways for frail patients to return home
Children and young people	ED and urgent care pathways must consider children and young people equitably.	The plan includes a pilot for paediatric UCR and Virtual Ward pilot fand a children's asthma pathway as part of its strategic framework alignment.
Integrated therapy model	Therapy input should support early assessment, functional planning, discharge and prevention of deconditioning.	The plan establishes an integrated therapy service across SaTH/SCHT, with therapists targeted into ED for early assessment, faster D2A and rehabilitation planning, pre-mobilisation rehabilitation, and standardised assessment tools and discharge criteria.
Discharge to Assess and Home First	Systems should support timely discharge, admission avoidance and recovery in the most appropriate setting.	The plan includes D2A therapy service across SaTH/SCHT, improved access to domiciliary care to support D2A, expansion of home-based intermediate care under INT leadership, and the Discharge to Assess Service.
NCTR reduction and discharge flow	Flow improvement should reduce patients with no criteria to reside and shorten discharge delays.	The plan sets a target to reduce winter NCTR from 24,449 to under 20,000 and reduce NCTR-to-discharge delay from 23.18 days to under 18 days.

Model Emergency Department requirements

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
January surge preparation	Systems should plan proactively for peak demand periods rather than respond reactively.	The plan identifies January as the hardest month in winter 25/26 and sets January as the point of main effort for 26/27, with pre-deployed capacity, protected complex discharge capacity, ring-fenced IFD and enhanced discharge arrangements from 22 December.
Bank holiday discharge resilience	Systems should protect discharge capacity during public holidays and weekends.	The plan sets a target of at least 20 complex discharges per day over bank holidays, compared with a baseline of 10 per day, with pre-clearance activity and enhanced CTH bank holiday staffing.
Ambulance handover improvement	Improved flow should reduce prolonged ambulance handovers.	The plan sets a target to reduce ambulance handovers over 4 hours from 8.5% to under 5%, and under 3% by January.
12-hour breach reduction	Patients should not experience excessive waits for admission, treatment or onward care.	The plan sets a target to reduce the 12-hour breach rate from 18.3% to below 16%, with the aim of reaching March 2026 standards by November rather than March.
Community urgent response	Community urgent response should support admission avoidance and timely care closer to home.	The plan sets a target to sustain UCR 2-hour response at 85% or above all winter, with UCR operating alongside Virtual Ward, community winter clinics and remote monitoring.
Shared demand and capacity visibility	Organisations should have real-time visibility of pressure, capacity and escalation status.	The plan includes a single group dashboard, joint SaTH/SCHT site calls and real-time OPEL monitoring across both organisations.
OPEL and escalation	Systems should have agreed escalation processes and clear triggers for action.	The plan includes unified OPEL triggers for both SCHT and SaTH, with responses ranging from BAU CTH calls and senior review through to BCP activation, redeployment, 1-2-3 at full intensity and Winter Director command at OPEL 4.
Named executive accountability	Winter delivery should have clear executive ownership and governance.	The plan names Ned Hobbs, Group Chief Operating Officer, as the single accountable Executive Winter Director for the NHSE return, with Claire Horsfield identified as SCHT Winter Director and Susanne Crossley as SaTH Winter Director.
Governance and assurance routes	Winter delivery should be overseen through appropriate operational and quality governance forums.	The plan identifies oversight through UEC Delivery Group, System Control Centre, Care Transfer Hub and Q&S Committees.
Workforce resilience	Workforce planning should ensure safe staffing, deployment flexibility and resilience during surge.	The plan includes dynamic rostering via e-roster, monthly vacancy hotspot analysis, summer recruitment, sickness target recovery, health and wellbeing plans, and flexible group-wide staff deployment protocols at OPEL 3/4.

Model Emergency Department requirements

NHS
Shropshire, Telford and Wrekin
Community and Hospitals

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Mutual aid and cross-boundary deployment	Staff and resources should be deployable to highest-risk areas during escalation.	The plan includes pre-agreed redeployment protocols, group-wide staff deployment at OPEL 3/4 and mutual aid arrangements with wider STW system partners.
Infection prevention and control	Winter plans should include IPC resilience for respiratory viruses and outbreak management.	The plan includes IPEAT winter campaign from October 2026, point of care testing across both EDs, UCR and Virtual Ward teams, FIT/PPE readiness, enhanced norovirus protocol, RediRoom review and fogging capacity confirmation.
Point of care testing	Diagnostics and testing should support timely clinical decision-making.	The plan includes point of care testing for respiratory viruses in both Emergency Departments, UCR and Virtual Ward teams.
Vaccination and prevention	Winter planning should include vaccination, prevention and protection of patients and staff.	The plan sets a staff flu target of over 70%, includes COVID autumn/winter vaccination for at least 8,500 people in STW, peer vaccinators, drop-in clinics, weekly uptake tracking and flu vaccination for long-stay inpatients.
Flu campaign implementation	Flu plans should include clear objectives, training, timescales and oversight.	The plan includes campaign objectives to increase staff uptake, train peer vaccinators, promote early engagement and offer vaccination to long-stay inpatients, with planning from July/August 2026, staff vaccinations from October 2026 and weekly/monthly reporting routes.
Resilience for adverse weather	Winter plans should protect access to services and patient safety during severe weather.	The plan includes gritting arrangements, snow plough provision through local farmer MOU, a centralised 4x4 fleet, Met Office Hazard Manager monitoring, RiO prioritisation flags, Fire Service welfare checks, hotspot mapping and an adverse weather stress test.
Regional assurance and scenario testing	Plans should be tested through regional assurance, bed modelling and surge scenarios.	The plan includes regional bed model validation, baseline/surge/super-surge scenario testing, participation in the August 2026 regional winter exercise and September 2026 NHSE winter event.
Board sign-off	Winter plans should receive formal Board assurance ahead of national submission.	The plan states that the combined SaTH/SCHT Winter Plan will be presented for Board approval ahead of the 21 August 2026 NHSE submission deadline.
Managing risk during system change	System changes must not destabilise UEC flow during winter.	The plan identifies risks around the SaTH Admissions Service transition, with mitigation through parallel run and phased handover, and Nexus UEC diagnostic findings tracked through working groups.
Continuous improvement and winter review	Plans should include learning, review and future planning.	The plan includes winter review commencing in March 2027 and scoping of the combined 2027/28 plan. Senior representation will also be at the regional stress testing event for the plan early September.

Appendix B

The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital

NHS
Shropshire, Telford and Wrekin
Community and Hospitals

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Early senior clinical decision-making	Prompt assessment by competent and consultant-level decision makers; reduce delays and improve discharge planning	In-house SaTH Admissions Service live from July 2026, expanded Integrated Front Door, strengthened clinical streaming and senior review processes to support earlier decision making.
Care in the right place first time	Patients should move rapidly from ED into appropriate receiving areas, SDEC, Virtual Ward or specialty pathways	Expanded Integrated Front Door, Virtual Ward growth, OPAT expansion, Trauma Floor pathways, Frailty pathways and community alternatives to admission.
Reduce ED crowding and 12-hour waits	Reduce prolonged waits, improve flow and eliminate corridor care	Whole-system winter operating model focused on NCTR reduction, discharge resilience, strengthened community capacity and improved flow across acute and community services.
Clinical leadership of patient flow	Clinically led flow with clear ownership and prioritisation of admissions, transfers and discharge	Unified acute-community operating model with oversight through Winter Directors, UEC Delivery Group, Care Transfer Hub and System Control Centre.
Maximise alternatives to admission	Use SDEC, Hospital at Home, UCR and Virtual Wards whenever clinically appropriate	Expansion of Virtual Ward pathways, UCR services, OPAT, Integrated Front Door and community winter clinics to avoid admission where safe. Enhanced SDEC hours/
Continuity of care across first 72 hours	Reduce unnecessary handoffs, improve consultant continuity and coordinated MDT management	Development of integrated therapies across the Group, strengthened care coordination and multidisciplinary discharge planning arrangements.
Daily MDT reviews and discharge focus	Consultant-led reviews, board rounds, discharge planning and action-focused MDTs	Enhanced discharge model, Care Transfer Hub oversight, daily system flow management and integrated therapy support to accelerate discharge. Standardised discharge processes, assessment tools and criteria across SaTH and SCHT to improve consistency and flow following Nexus recommendations.
Specialty support and timely review	Timely specialty input to support diagnosis, treatment and discharge decisions	Expanded specialty pathways through Virtual Ward, OPAT, Frailty and Integrated Front Door models with improved access to specialist advice.
Length of stay reduction	Avoid unnecessary stays and optimise first 72 hours of care	Specific focus on reducing No Criteria To Reside (NCTR), Discharge to Assess, same-day discharge and coordinated discharge planning. Standardised discharge processes, assessment tools and criteria across SaTH and SCHT to improve consistency and flow following Nexus recommendations.

The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital

Shropshire, Telford and Wrekin Community and Hospitals

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Frailty assessment and front-door frailty care	Early identification and comprehensive assessment of older people with frailty	Enhanced Frailty community-based support and alternative admission pathways.
Accurate data capture and operational visibility	Reliable recording of care, activity and flow metrics	Unified OPEL monitoring, shared operational dashboards and measurable targets for NCTR, UCR, discharges and ED performance.
Patient and carer involvement	Clear communication, discharge planning and shared decision-making	Care coordination approach, community support services and improved discharge processes designed around patient flow and home-first principles. Standardised discharge processes, assessment tools and criteria across SaTH and SCHT to improve consistency and flow following Nexus recommendations. Increased use of patient feedback digital tools and volunteers to capture patient feedback.
Governance and board assurance	Board-endorsed action plans, self-assessment and executive oversight	Group Winter Plan signed off through formal governance arrangements with oversight from Winter Directors, UEC Delivery Group, System Control Centre and Board assurance processes.

Moving to EXCELLENCE

Appendix C

Model discharge pathway

NHS
Shropshire, Telford and Wrekin
Community and Hospitals

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
Discharge planning from admission	Discharge begins on admission with clear discharge intent, expected discharge date, early pathway identification and proactive discharge planning.	The plan strengthens front-door decision making through the expanded Integrated Front Door, integrated therapies and plan to align therapy more closely with ED and assessment areas. Discharge planning is embedded through NCTR reduction work, standardised discharge processes and discharge resilience actions across the Group as supported through the Nexus improvement plan.
Home First as the default	Patients should be discharged home wherever possible, supported through D2A, intermediate care, Virtual Ward and community services.	Expansion of Virtual Ward and OPAT pathways, Discharge to Assess to support pathway 1 capacity/ improved access to domiciliary care, neighbourhood MDTs and strengthened community alternatives to admission and discharge all targeted at supporting patients to remain at home or discharge home as soon as they are safe to transfer.
Daily focus on discharge and flow	Daily MDT reviews, active management of discharge barriers and visibility of patients awaiting discharge.	Care Transfer Hub coordination, Winter Director governance, daily flow management, integrated therapy support and enhanced discharge processes to accelerate discharge and reduce NCTR.
No Criteria to Reside (NCTR) reduction	Reduce patients remaining in hospital who no longer require inpatient care.	NCTR identified as the major winter constraint. The plan targets reduction from 24,449 to below 20,000 and reduction in NCTR-to-discharge delay from 23.18 days to under 18 days through Discharge to Assess, integrated therapies and improved ward processes.
Criteria-led discharge	Patients discharged once agreed criteria are met without unnecessary waits for medical review.	Standardised ward-based discharge processes and consistent Expected Date of Discharge (EDD) management across SaTH and SCHT, supported through the Nexus improvement programme, will strengthen multidisciplinary decision-making, improve the accuracy of discharge planning and reduce avoidable delays and drive a criteria led discharge mindset
Seven-day discharge services	Therapy, pharmacy, transport and discharge support should operate across seven days.	Integrated 7-day Therapy Service across the Group, enhanced bank holiday discharge senior decision maker arrangements, increased complex discharge capacity and expanded Care Transfer Hub support during winter periods.
Early-in-day discharge	Discharges should happen as early as possible in the day to maximise bed availability and patient flow.	Enhanced discharge model, protected bank holiday discharge capacity, pre-clearance activity before holiday periods and a target of ≥20 complex discharges per day over bank holidays.
Community in-reach and integrated therapies	Community and therapy teams should support discharge planning while patients remain in hospital.	Creation of a single integrated therapy service across SaTH and SCHT, therapists deployed into ED, D2A therapy teams, pre-mobilisation rehabilitation and integrated discharge planning.

Model discharge pathway

NHS
Shropshire, Telford and Wrekin
Community and Hospitals

Requirement / Expectation	What is expected	What we are doing / assurance evidence from winter plan
System coordination and Care Transfer Hub arrangements	Real-time management of capacity and complex discharges through coordinated multi-agency working.	Care Transfer Hub, System Control Centre, Winter Directors and single group dashboard provide whole-system oversight. Real-time OPEL monitoring and shared demand and capacity visibility support coordinated action.
Pathway 1 capacity (Home with Support)	Systems should maximise discharge home with short-term support and reduce reliance on bed-based care.	Discharge to Assess, improved domiciliary care access, D2A expansion, neighbourhood MDTs, Integrated Front Door and expansion of home-based intermediate care services strengthen Pathway 1 capacity.
Community bed utilisation (Pathway 2)	Community beds should support recovery, rehabilitation and timely discharge from acute care.	Community hospitals, TES escalation beds, integrated therapy services and improved acute-to-community transfers support flow into community capacity when clinically required.
Winter discharge resilience	Surge plans should protect discharge performance during periods of high demand.	January is designated as the point of main effort with protected discharge capacity, enhanced Care Transfer Hub staffing, pre-deployed resources, ring-fenced IFD capacity and SCC oversight.
Leadership and accountability	Named executive accountability and operational leadership for discharge performance.	Named Executive Winter Director (Ned Hobbs) supported by Winter Directors (Claire Horsfield and Susanne Crossley), UEC Delivery Group, Care Transfer Hub and Quality & Safety Committees. Dedicated Care Transfer Hub Group Lead – Sarah Robinson
Data, performance and operational visibility	Organisations should monitor discharge, delays and flow using shared operational metrics and dashboards.	Unified OPEL monitoring, single group dashboard, measurable targets for NCTR, discharge delays, UCR, ambulance handovers and ED performance, with board oversight and assurance arrangements.
Frailty and vulnerable cohorts	Systems should provide targeted pathways for frailty, dementia and patients at risk of harm from delayed discharge.	Expanded and standardised frailty pathways, Virtual Ward, neighbourhood MDTs, Integrated Therapies, remote monitoring and home-first pathways designed to reduce deconditioning and avoid unnecessary admission or prolonged stay.

Appendix D

Mental Health – Assurance area 1 (MPFT): urgent MH helplines, crisis & liaison resilience

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Key question and points to consider	Response
What steps will be taken to maintain and improve patient flow through Mental Health inpatient beds?	Daily bed meeting to clinically prioritise patients waiting an inpatient bed. Weekly report of CRFD escalated to both LA's and ICB.
What arrangements do you have in place with social care and housing to support the discharge of patients from Mental Health beds, including arrangements for escalation.	Weekly meeting between LA's and inpatient matrons to discuss discharge issues. Regular MADE events to address blocks/delays. Use of weekly CRFD report escalated to ICB and LAs.
How will the capacity of your crisis teams and crisis management services be maintained through winter? Are there any areas where capacity will be increased?	Review of staffing on a daily basis with CRHT leads and if unable to meet demand than to review across both teams and deploy staff to meet demand. If unable to manage demands priority will be given to all 0-4 hour referrals and patients on the assessment board. No plans to increase workforce capacity arbitrarily however, pre-approval of bank/agency/overtime to cover surges in demand and/or gaps in capacity has been agreed.

Mental Health – Assurance area 1 (MPFT, continued)

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Key question and points to consider	Response
How will the Mental Health services support a reduced attendance of patients with MH needs but no physical health needs at acute emergency departments?	Good working relationships with VCSE partners, continue to support and encourage utilising Sanctuary, Branches and local crisis cafes. There is now a dedicated 'listening service' available in the evening delivered in partnership between MPFT and Telford After Care Team for known service users to help deescalate potential crisis situations. Developing good working relationship with MH Ambulance and CRHT to look for earlier opportunities to intervene without onward transfer to ED.
How will you improve the timely response and movement of Mental Health patients from ED into Mental Health services	Side-by-side working 0-1 hour response from Mental Health Liaison. Good working between Liaison and CRHT to ensure good communication and handover happens at the point of referral. There is now a M-F liaison mental health offer for children/young people presenting at the ED and wraparound support available in the community from a CAMH crisis service.
Briefly describe any arrangements you plan to have in place to respond to increased demand upon calls to your local crisis lines through the 111 Mental Health option.	Access team already established and in place. We have an Access clinician 8pm-8am each day which is a B6 clinician provided by CRHT to manage calls received via NHS 111 that need triaging.
What plans are in place to support and manage patients who are placed in non-Mental Health beds waiting admission?	Daily advice and support from the on-site mental Health Liaison teams. Daily re-assessment from CRHT's to consider home treatment in the community if awaiting informal admission.

Mental Health – Assurance area 2 (MPFT): crisis & relapse plans for high-risk patients

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Key question and points to consider	Response
Can mental health services identify people who have had required urgent care services over Winter previously?	A review has been carried out of known service users who received interventions from a CRHT and/or LMHT service over Winter in recent years. Where those people are still receiving care from MPFT teams, 'overcoming challenging times' plans will be reviewed to ensure they provide adequate alternatives to presenting at Emergency Departments at times of crisis. Where those people are now discharged from MPFT teams re-present over Winter, CRHT and LMH teams will be requested to develop new plans.
How will mental health services ensure all high-risk patients have a tailored crisis and relapse plan ahead of Winter?	Everybody deemed as requiring an Intensive and Assertive Outreach approach (due to complex comorbidities including psychoses, substance misuse, Long Term Conditions) will have their care plans and risk assessments reviewed to ensure their 'overcoming challenging times' plans provide adequate alternatives to presenting at Emergency Departments at times of crisis.

Mental Health – Assurance area 3 (MPFT): liaison psychiatry & Section 135/136 resilience

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Key question and points to consider	Response
How is workforce resilience maintained in the Liaison Mental Health service (PRH/RSH) and the Health Based Place of Safety (Redwoods Centre) through winter?	No issues with workforce numbers or availability are anticipated in either the Liaison Mental Health service at Princess Royal and Royal Shrewsbury Hospitals, or the Trust's Health Based Place of Safety at Redwoods Centre. Referrals to both services do not show significant seasonal variation, so 'spikes' in demand are not anticipated. Should that situation alter, the Trust would ensure temporary staffing solutions were enabled to maintain operational resilience.
How are Section 135/136 pathways monitored and improved?	A multi-agency operational group reviews Section 135/136 activity on a monthly basis alongside reviewing incidents to support learning and improve pathways, ensuring people are signposted to the right service at the right time.

Board of Directors' Meeting in Common – 08 October 2026

Agenda item	091/26		
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)**
• Group People Committees held in Common 28/09/26. • Finance Assurance Committee 29/09/26. • Performance Assurance Committee 22/09/26. • Quality Committees held in Common 01/10/26.	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 September 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 for completion within the reporting period remain on track. • Given the current financial position, a number of actions have moved from Green to Amber in month. One Finance action (1.1.2) was due in September 2026; however delivery has slipped and is now expected for November 2026 in line with the expected planning submission for FY27/28. Updated plan agreed at FAC and Board to ensure compliance for FY27/28. • The Boards' attention is drawn to Section 2, which outlines 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 September 2026, as detailed in Appendices 1–4. • **Note** progress on the UEC undertakings incorporated within the 2026/27 UEC SIIP plan, reflecting continued focus on delivery and improvement.		
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. The Trust has agreed with NHS England to continue SaTH's Integrated Improvement Plan (SIIP) to demonstrate sustained improvement and oversight. The SIIP has been refreshed for FY2026/27. This report summarises progress against actions due for completion up to and including 30 September 2026. It also sets out the supporting evidence and assurance of delivery. The remaining urgent and emergency care (UEC) undertakings are included in the 2026/27 UEC SIIP plan at Appendix 4. The report covers governance, workforce and leadership, finance and UEC. It provides the Board with a clear view of delivery, impact and remaining areas of 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 in Appendices 1–4 summarises progress against the tasks and actions due up to and including 30 September 2026. Appendix 4 also provides an update on the 2026/27 UEC undertakings. The updates have been approved by the relevant Executive Directors and overseen through the appropriate Assurance Committees, providing assurance over delivery and governance.

Governance / Leadership

- **SaTH 4.1.0** – Governance arrangements continue to strengthen through the Local Care Transformation Assurance Committee, established in June 2026 and now meeting monthly. The Hospitals Transformation Programme (HTP) Assurance Committee's Terms of Reference were approved by the Committee at its September 2026 meeting and will now be submitted to the Board for approval. The Quality Committee in Common will meet on 1 October 2026 to consider its Terms of Reference and revised annual cycle of business for approval.
- **SaTH 4.1.15** – The Hospitals Transformation Programme continues to be overseen through the established HTP Assurance Committee arrangements, with updates reported to the public Board in May and August 2026. Programme activity is progressing across workforce, staff engagement and cross-site transport planning, with delivery monitored against agreed milestones.
- **SaTH 4.2.7a / 4.2.9** – The Group Leadership Team has now been appointed, including the Group Chief Nursing Officer. Boards in Common arrangements continue, while engagement with NHS England has progressed regarding recruitment to replace one Non-Executive Director at SaTH and one at SCHT. The Group Transition Committee continues to oversee development of the operating model, aligned governance documents, a Group cycle of business and working towards a shared Board Assurance Framework and risk appetite.
- **SaTH 4.2.8** – The Group People and OD Committee in Common continues to meet every two months. The Committee is developing well and has provided valuable learning to support other committees moving to arrangements in common. Its annual cycle of business continues to be developed following review with the Group Chief People Officer and team in June 2026.
- **SaTH 4.2.13 / 4.2.14 / 4.3.6** – Group governance arrangements continue to progress. Weekly joint Freedom to Speak Up Guardian meetings are in place, Champion networks have been merged and the first Group Champion meeting was held on 24 September 2026. The refreshed FTSU/Whistleblowing Policy was approved at ARAC on 7 September and the Boards in Common on 10 September 2026. The FTSU Improvement Plan now incorporates all 26 NHS England improvement suggestions. The Group strategic pledges, 2030 objectives and True North metrics have also been approved and will inform development of the Group Board Assurance Framework.

Workforce and Leadership Collaborative

- **SaTH 2.1.26 / 2.2.9** – Workforce digital transformation remains on track, with 95% of resident doctors now on e-rostering, project resource in place and implementation of the Activity Manager module progressing through the Medical Workforce Efficiency Programme. Manager Self-Service ESR is fully deployed across the Trust.
- **SaTH 2.1.28 / 2.1.29** – The five-year workforce plan has been completed and is being shared across the Trust. The 2026/27 job planning programme has commenced, supporting continued alignment of workforce demand, supply, productivity and organisational sustainability.
- **SaTH 2.1.30 / 2.1.31** – HTP workforce planning has progressed following revision of the bed model from 747 to 949 beds. Informal staff engagement has commenced across affected areas, supported by a local staff survey and the HTP Toolkit. Workforce templates are being updated to reflect the revised bed model, alongside costing and reconciliation with the operational plan. A business case for a cross-site shuttle-bus is also being progressed, and feedback from staff engagement will inform workforce, recruitment, retraining and redeployment plans.
- **SaTH 2.1.33 / 2.1.34** – Workforce sustainability activity remains on track. The sickness absence programme outline has been drafted, alongside development of a business case for a digital sickness management platform. The Group temporary staffing strategy continues to progress through a cross-Group task and finish group, including consideration of bank rates and workforce flexibility.
- **SaTH 2.2.8 / 5.3.3 / 5.4.2 / 5.4.5** – Cultural and leadership transformation has progressed through the launch of the Poppy's Promise pilot, completion of the Aqua listening exercises and thematic review, continued review of the Leadership Framework, Executive development activity and preparations for the 2026 NHS Staff Survey. The Poppy's Promise mandatory learning module has been developed, tested and made available to SaTH staff. Robust Ward-to-Board oversight of SIIP delivery remains in place through established Board, Committee, PMO and NHS England bi-monthly PRM assurance arrangements.

Finance

- **SaTH 1.2.11/ SaTH 1.2.23/ SaTH 1.2.24/ SaTH 1.5.1** – Given the current financial position, a number of actions have moved from Green to Amber in month. SaTH
- **SaTH 1.1.2** - was due in September 2026, however delivery has slipped and is now expected for November 2026 in line with the expected planning submission for FY27/28. Updated plan agreed at FAC and Board to ensure compliance for FY27/28.

UEC

- **SaTH 3.1.1.7:** Feedback has been received from Nexus Consultancy on 4-hour non-admitted performance and workshops with the wider ED team took place in August 2026. A new process has been designed for walk-in patients; the process aims to reduce wait to be seen times as well as the time taken to request diagnostics. Early testing has demonstrated positive feedback and results
- **SaTH 3.1.2.17:** The number of complex patients with no criteria to reside increased in July 2026. Nexus Consultancy has shared recommendations to help reduce this at a ward level. The ward-level improvement work focuses on standardising discharge processes; ensuring the consistent use and review of expected dates of discharge; identifying and escalating patients with no criteria to reside at an earlier stage; strengthening therapy and multidisciplinary input; and using bridging and community pathways to support discharge. This work is being progressed through the Nexus improvement programme.
- **SaTH 3.3.2:** The Section 31 condition relating to Initial Assessment has now been lifted by the CQC following a sustained period of improvement in performance.

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 September 2026 as detailed in Appendices 1–4.
- **Note** progress on the UEC undertakings incorporated within the 2026/27 UEC SIIP plan, reflecting continued focus on delivery and improvement.

Board of Directors' Meeting in Common: 8 October 2026

Agenda item	092/26 **Item to be taken out of turn at 1000hrs**		
Report Title	SaTH Integrated Maternity & Neonatal Report.		
Executive Lead	Martina Morris, Group Chief Nursing Officer John Jones, Group Chief Medical Officer		
Report Author	Stacey Thacker, Head of Midwifery Lauren Taylor,- Deputy 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** • The Maternity service achieved greater than 90% compliance at the CNST Maternity Incentive Scheme midpoint assessment in July 2026, meeting all requirements under Action B: Education for Safety. Assurance can be provided that all applicable standards were achieved. The requirement to incorporate Impacted Fetal Head (IFH) management into obstetric emergency training has been implemented within the 2026/27 PROMPT programme. In addition, a multidisciplinary in situ perinatal emergency simulation focusing on IFH was successfully completed on 13 July 2026. As part of the CNST requirements, Trusts that have not received a safety signal are required to undertake a Critical Safety Check drill. As SaTH has not received a safety signal, a safety drill was completed and submitted to the national team as evidence of compliance. • Recruitment: Maternity Services has successfully recruited 17 student midwives who will join the service as newly qualified midwives through the preceptorship programme this year. This recruitment has been facilitated through the Midwifery Graduate Scheme, supporting workforce growth, improving staffing resilience, and strengthening the future midwifery workforce within the Trust. • CNST Safety Action: In accordance with CNST requirements, the Trust has completed the required safety drill for situations where no qualifying safety concerns have been received during the		

	reporting period. The drill was reviewed and approved through Maternity Governance in September 2026 and has subsequently been submitted to the national CNST team as evidence of compliance. • Maternity services sustained positive acuity levels throughout August, maintaining staffing adequacy above 85%. Green acuity was achieved for 96% of the month, demonstrating that staffing levels were sufficient to meet patient acuity and service demands on 96% of occasions. Compliance with one-to-one care for women in labour and the supernumerary Labour Coordinator role remained at 100% throughout the reporting period. Within Neonatal Services, compliance with BAPM staffing standards improved from 90% in July to 100% in August, reflecting consistent achievement of recommended workforce levels and supporting the safe delivery of neonatal care. **Advise** • Baby Loss Awareness Week: Baby Loss Awareness Week takes place from 9th to 15th October. Our Bereavement Team has organised a programme of activities and moments of remembrance for families who have experienced pregnancy or baby loss. This includes illuminating the hospital building in pink and blue as a symbol of awareness and remembrance, alongside a quiet, staffed reflection space within the hospital atrium, supported by EPAS, Hope House, HUGS, and the Bereavement Team. • Baby Friendly Initiative (BFI) Accreditation is now incorporated within the regional maternity heatmap, providing enhanced visibility of performance, benchmarking opportunities, and oversight of progress against accreditation standards. This enables ongoing monitoring of infant feeding and parent-infant relationship initiatives at both Trust and regional level, supporting quality improvement and assurance of compliance with national standards. • Maternity and Neonatal Open Day: The second Maternity and Neonatal Open Day is scheduled to take place on 3rd October 2026. The event provides an opportunity for women, families, and the wider community to visit the unit, participate in guided tours, and meet with maternity and neonatal staff to learn more about the services available. Dedicated information stands will be hosted by individual clinical teams, alongside external partners including Family Hubs and Health Visitors, promoting integrated support and providing families with access to a range of information and resources throughout their maternity journey. • In line with CNST Year 8 requirements, the Trust Board maintains oversight of SBLCBv3 implementation and compliance. Overall compliance remains high at 96%, although this has reduced slightly from 99% in the previous quarter. One standard remains partially implemented relating to the offer of pregnancy-specific hybrid closed-loop systems for women with Type 1 diabetes. **Alert** • The Thirlwall Inquiry Report was published on 15 September 2026. Following its release, a national letter was issued outlining a number of immediate actions required of maternity and neonatal services. • This report provides an overview of the immediate actions identified within the national communication, together with an assessment of the Trust's current position and benchmarking against the required standards. It outlines areas of compliance, identifies any gaps, and details the actions being taken to ensure

	the Trust meets the national expectations and recommendations arising from the report.
Recommendations for the Board	The Board of Directors is requested to: • **Receive** this report for information and **assurance.**
Appendices:	Appendix 1: BoD Ockenden Report Appendix 2: BoD Neonatal Mortality Review Appendix 3: MNTP Phase 2 – July 2026 Appendix 4: Year 8 CNST MIS Progress Report – July 2026 Appendix 5: MOSS Critical Safety Check Drill Appendix 6: Safety Action C Appendix 7: Saving Babies Lives Report Q1 Appendix 8: Perinatal Staffing Appendix 9: Education report Appendix 10: Poppy's Promise Feedback Appendix 11: Thirlwall Inquiry Report and recommendations **All Appendices are available in the Board Supplementary Information Pack.**

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 Information on the Maternity Heatmap, providing an overview of the current position.

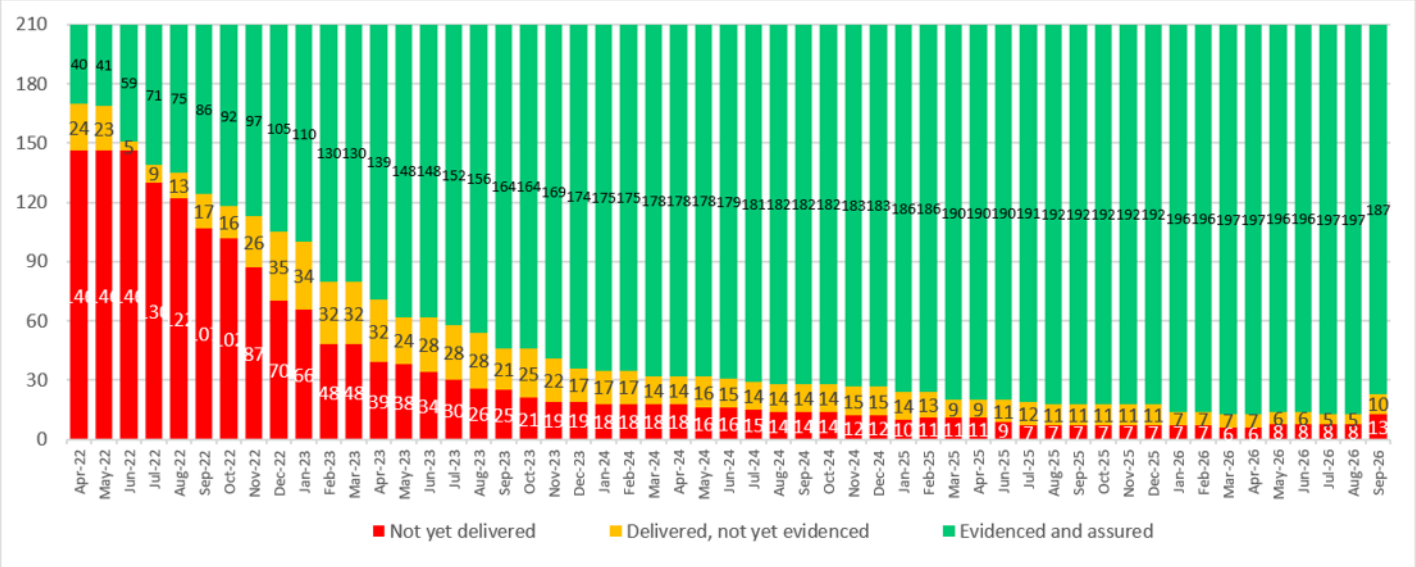
1.6 The Monthly Perinatal Staffing Report providing an overview of workforce capacity, staffing performance, and key workforce indicators across both Maternity and Neonatal Services.

1.7 A summary of the Thirlwall Inquiry Report recommendations, with gap analysis in progress.

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 Committee in Common **Appendix 1** provides the summary of Ockenden Report Action Plan as at 8th September 2026. The overall delivery over time, including current position, is as follows:



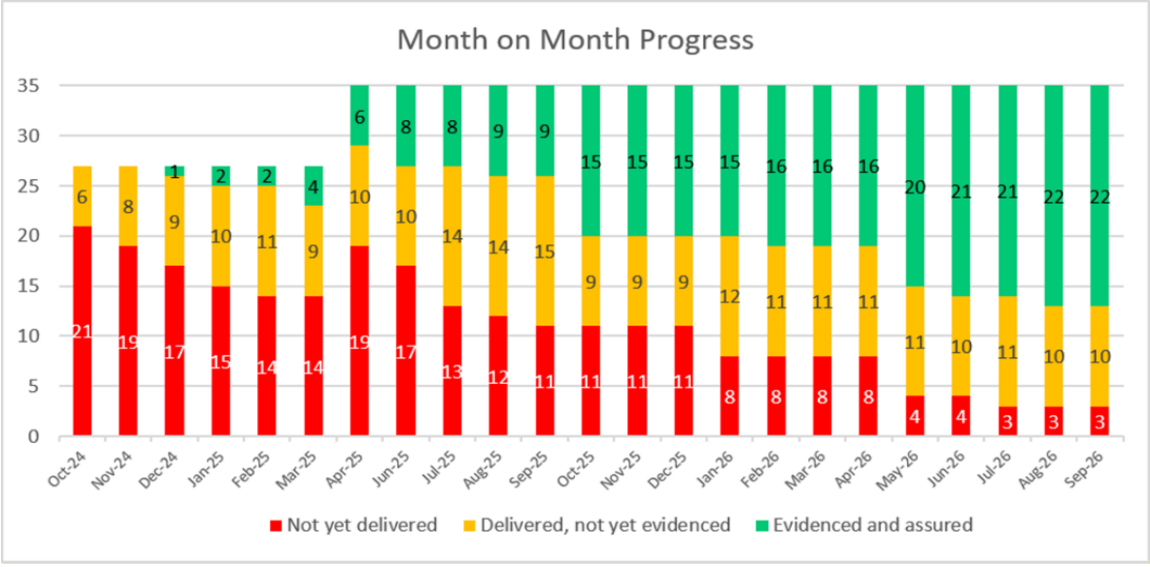
Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	187 (⇩10)	89%
Delivered, Not Yet Evidenced	10 (⇧5)	5%
Not Yet Delivered	13 (⇧5)	6%
TOTAL	210	
Progress Status	**Number (change since last report)**	**Percentage**
Completed fully (Evidenced and Assured)	187 (⇩10)	89%
On track	7 (⇧3)	3%
Off track	0 (⇔)	0%
At Risk	0 (⇔)	0%
Not Started	7 (⇧7)	3%
De-scoped	9 (⇔)	4%
Total	210	100%

2.2 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. They were reviewed in August 2026 and will be revisited in November 2026.

2.3 The 360-assurance led audit has now been completed, and the final report has been received by the Trust. The Women & Children's Division will now review the findings and will initially share the feedback with the families at the L&I meeting in November 2026. The report will then be shared with the Board in December 2026.

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 2** provides the summary Neonatal External Mortality Review (NEMR) Action Plan as of 08 September 2026. The overall trajectory and position are as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	21 (⇔)	60%
Delivered, Not Yet Evidenced	11 (⇔)	31%
Not Yet Delivered	3 (⇔)	9%
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 (⇔)	60%
On track	12 (⇔)	34%
Off track	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. As the number of eligible cases for review each quarter has been too low to provide statistically significant analysis, an aggregated review is underway to try and identify overall compliance levels.

3.3 Progress continues to assure the eleven actions already implemented, while work is ongoing to implement the last four actions currently Not Yet Delivered. They 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 In preparation for the publication of the National Maternity and neonatal plan, expected in December 2026, the team has started a review of all open plans and will be preparing closure reports, where those plans do not align with the 10-Point Plan or are not purely transformational. Those reports will detail the items already in place to meet the required actions and which business as usual governance routes will be utilised to monitor them where necessary. All reports will be brought to the committee for approval and ratification.

4.3 Cultural improvement work across the service and the Division continues to progress. During Q3, the focus will be on enabling leadership and clinical staff to participate in the Perinatal Equity and Anti-Discrimination Programme. The service is also supporting attendance at the Group Culture sessions and will develop a 'Back to Basics' culture plan by December 2026. This will ensure strong cultural foundations are in place to support the successful implementation and sustainability of wider Group Culture initiatives.

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	0	0	7	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	0	0	4	0	0	4
Total	**0**	**1**	**26**	**0**	**0**	

5.3 Details of progress against all Safety Actions and their sub-items are included in **Appendix 4**. 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.

In line with Action B: Education for Safety of the CNST Maternity Incentive Scheme, trusts are required to demonstrate a midpoint compliance rate of greater than 90% across all applicable standards. The midpoint assessment for SaTH was undertaken in July 2026, and I can provide assurance to the Board that compliance was achieved across all required standards.

As part of the scheme requirements, trusts must also ensure that the management of an Impacted Fetal Head (IFH) is incorporated into obstetric emergency training by the end of the reporting period. This requirement has been fully implemented and is included within the PROMPT training programme for 2026/27.

In addition, the Trust has successfully completed one of the required in situ multidisciplinary perinatal emergency simulations. A multidisciplinary Impacted Fetal Head simulation was undertaken on 13 July 2026, involving the relevant maternity and obstetric teams to support preparedness, teamworking, and the safe management of this obstetric emergency.

The service is therefore compliant with the Education for Safety requirements of the CNST Maternity Incentive Scheme and can provide assurance that all associated standards have been met. **(Appendix 9**)

5.4 MOSS Signal (Appendix 5)

As part of the CNST requirements, Trusts that have not received a safety signal are required to undertake a Critical Safety Check drill. As SaTH has not received a safety signal, a safety drill was completed and submitted to the national team as evidence of compliance.

The key area identified for improvement from the exercise was the need to clearly define and specify themes within the review process, ensuring that learning is effectively captured, analysed, and actioned to support ongoing improvements in patient safety and quality of care.

5.5 Safety Action C Assurance (Appendix 6)

The Trust remains on track to achieve compliance with the requirements of CNST Safety Action C. During Quarter 1 2026/27, all eligible incidents were reported via the SPEN portal within the required timescales, with no missed or delayed notifications identified.

During the reporting period, three stillbirths and one neonatal death were reported. All eligible cases have been reviewed, or are scheduled for review, through the appropriate national and local governance processes. Families continue to be actively engaged throughout investigations through the provision of information, opportunities to share their experiences, and follow-up meetings to discuss findings, outcomes, and learning.

The Trust continues to demonstrate strong compliance with external review requirements, with appropriate independent clinical representation included within PMRT reviews, providing assurance regarding the quality and robustness of the review process.

Key themes emerging from incident reviews include documentation, communication, escalation, health inequalities, Duty of Candour, postnatal pain management, and infant feeding support. These themes are being monitored through the governance framework, with actions implemented to support continuous improvement.

Overall, robust systems remain in place to identify, investigate, and learn from adverse events. Ongoing work is focused on embedding learning into clinical practice, strengthening patient safety, and improving outcomes and experiences for women, babies, and their families.

5.6 Saving Babies' Lives Care Bundle Version 3 (Appendix 7)

In accordance with CNST Year 8 requirements, the Trust Board is required to maintain oversight of the implementation and ongoing compliance of the Saving Babies' Lives Care Bundle Version 3 (SBLCBv3). Quarterly reports are therefore presented to provide assurance that standards are embedded and that actions are in place to address any areas requiring improvement.

The August 2026 system review reported an overall implementation score of 96%, a slight reduction from 99% in the previous quarter. One standard remains partially implemented: the offer of a pregnancy-specific hybrid closed-loop system for women with Type 1 diabetes.

Element 1: Smoking Cessation Compliance with carbon monoxide monitoring and Very Brief Advice (VBA) training remains strong for midwives and medical staff. Support staff compliance is currently 87.7%, below the 90% target, and actions are underway to improve compliance through targeted training and communication.

Element 2: Fetal Growth Surveillance Performance remains broadly aligned with national benchmarks. Rates of babies born below the 10th centile are comparable to national averages, whilst rates between the 3rd and 10th centile remain significantly lower than the national average. Detection rates for babies below the 10th centile have fallen below the national benchmark and will continue to be monitored. The Trust continues to perform favourably in relation to false positive rates, reducing unnecessary intervention.

Element 3: Reduced Fetal Movements Audit findings identified opportunities to strengthen documentation of clinical decision-making and increase utilisation of the Reduced Fetal Movements checklist. Patient feedback highlighted positive experiences with Tommy's resources but identified opportunities to improve access to translated information and education regarding anterior placenta and fetal movements. Learning has been shared to support ongoing improvements within maternity triage services.

Element 4: Intrapartum Fetal Monitoring There were no reported cases during Quarter 2 where the method of intrapartum fetal monitoring was incorrectly risk assessed, providing assurance of compliance with SBLCBv3 requirements.

Element 5: Preterm Birth The Quarter 2 preterm birth rate was 7.2%, with an annual rolling average of 6.28%, slightly above the national target of 6%. Performance remains strong in key areas including magnesium sulphate administration and neonatal temperature management, exceeding network and national comparators. Actions are in place to address identified data quality discrepancies and ensure accurate NNAP reporting.

Element 6: Neonatal Care and Infant Feeding Regional SBLCB forums have highlighted innovative approaches adopted by other Trusts, including the use of nursing staff to support women with breast pump education when midwifery staff are unavailable. Opportunities to adopt similar approaches locally are being explored.

Overall, the Trust continues to demonstrate a high level of compliance with SBLCBv3 standards. Targeted actions remain in place to address areas requiring improvement, and Board oversight provides assurance that learning and improvement activities continue to support safer care and improved outcomes for women, babies, and families.

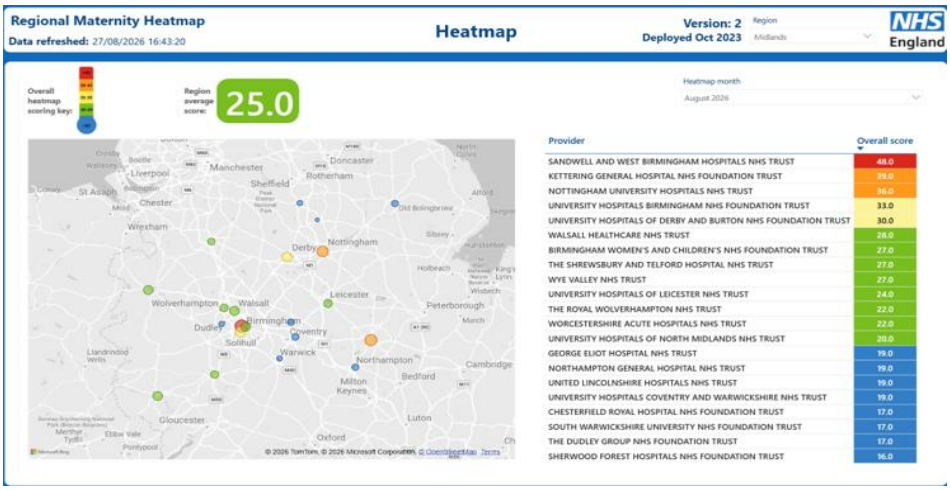
6.0 Maternity Heatmap

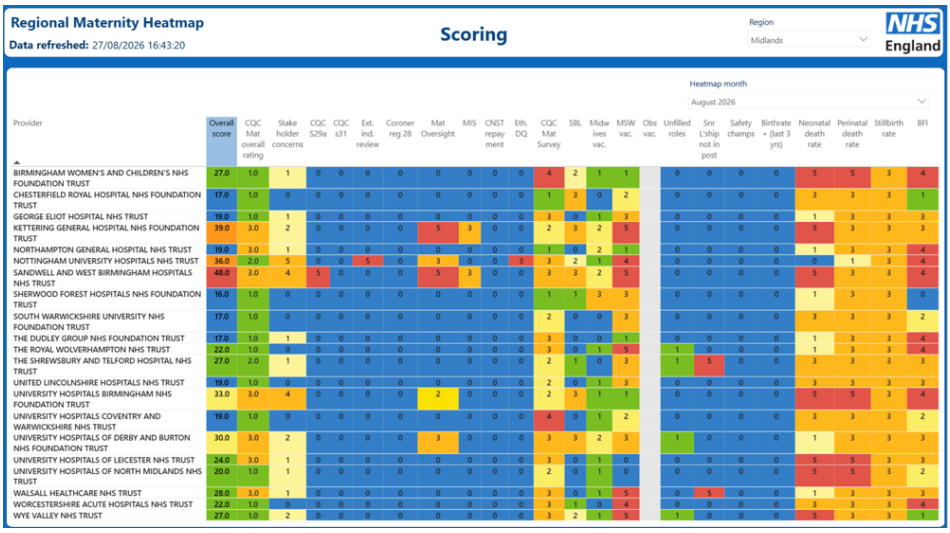
6.1 The Maternity Heatmap for August 2026 has been presented. The overall score for The Shrewsbury and Telford Hospital NHS Trust (SaTH) was 27 (green), compared with a regional average of 25. This indicates that SaTH's score is above the regional average and will continue to be monitored to identify themes, inform workforce and service planning, and support ongoing quality improvement initiatives within maternity services.

6.2 SaTH currently scores highly (5) on the Maternity Heatmap due to a number of senior leadership positions not being held substantively. The vacant Director of Midwifery post continues to contribute to this rating, resulting in a score of 5 within this domain. Ongoing recruitment and leadership arrangements are in place to mitigate associated risks and maintain service oversight

6.3. The Maternity Heatmap also identifies a score of 3 relating to Maternity Support Worker (MSW) vacancies. Recruitment is currently underway to secure substantive appointments to these roles. Recruitment to MSW positions has been challenging, as this remains a relatively new role within the maternity workforce.

6.4 To support recruitment and workforce sustainability, SaTH is currently recruiting to Maternity Care Assistant posts. Once substantive staff are appointed, they will be supported to undertake the required in-house training and development to progress into Maternity Support Worker roles. This approach will strengthen the workforce pipeline, improve vacancy levels, and support the delivery of safe and effective maternity care.





7.0 Perinatal Staffing (Appendix 8)

7.1 NICE published the report Safe Midwifery Staffing for Maternity Settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013). The Maternity Incentive Scheme (MIS) for CNST Year 8 requires. 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. Regional Chief Midwives can support this process if required.

7.2 **Maternity Workforce and Acuity**

During August, maternity services sustained positive acuity levels above the 85% target, reporting 96% Green acuity, 4% Amber acuity, and 0% Red acuity, demonstrating that staffing levels were consistently aligned to patient acuity and service demand.

The confidence factor for data entry was reported at 91%, indicating a high level of accuracy and reliability within the reporting process.

Red flag reporting is now fully aligned with both national and local guidance. A total of 14 red flags were reported during August, with 86% (n=12) relating to delays in Artificial Rupture of Membranes (ARM).

Compliance with one-to-one care in labour and maintenance of the supernumerary Labour Coordinator role remained at 100% throughout August, reflecting ongoing risk assessment, effective escalation processes, and a continued focus on ensuring safety within the service.

August also demonstrated an overall improvement in acuity performance and the quality of red flag reporting, providing increased assurance regarding workforce deployment and the safe delivery of maternity care.

Obstetric Workforce
The obstetric workforce is fully recruited, with some use of NHS locums where substantive consultants are still to join. There was successful recruitment to the Tier 1 rota in August. The consultant-led unit maintains 24hr consultant presence.

7.3 **Neonatal Workforce**
BAPM compliance improved significantly, increasing from 90% to 100%, demonstrating full compliance with recommended neonatal staffing standards during the reporting period.

QIS compliance remains stable at 59%. A rolling programme of training continues to support workforce development, with a further two staff members expected to commence QIS training in November, which will enhance future compliance levels.

The Nurse in Charge (NIC) maintained supernumerary status for 100% of shifts in August, representing an improvement from 93% in July and providing increased leadership and oversight within the clinical environment.

The number of occasions where the unit was required to close to external hospital admissions reduced from seven occasions in July to two in August. One closure was attributable to capacity pressures, with the unit exceeding ITU/HDU capacity, while the second was due to staffing constraints.

Registered staffing fill rates have remained stable. However, unregistered staffing fill rates have reduced slightly, primarily due to annual leave commitments and short-term sickness absence.

Sickness absence decreased from 11.2% to 9.4% during August. The predominant reasons for absence continue to be anxiety/stress-related illness and fractures. There are currently six members of staff on long-term sickness absence. One staff member retired at the end of the month, and a further staff member returned to work on a phased return during August.

Overall, the report demonstrates improvements in compliance, leadership capacity, unit accessibility, and sickness absence rates, providing assurance regarding the continued safe delivery of neonatal services.

The Neonatal medical workforce is fully recruited, with successful recruitment at the Tier 1 and Tier 2 levels in August. There has been successful recruitment to a trainee ANNP post, which commenced training in September.

Anaesthetic & Trained Anaesthetic Assistant Workforce
The Maternity Service has a duty anaesthetist and a trained anaesthetic assistant available 24/7 in line with ACSA standards.

The trust has a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

8.0 Delays in Retinopathy of Prematurity.

8.1 Delays in Retinopathy of Prematurity (ROP) screening have been added to the Trust Risk Register due to the national shortage of paediatric ophthalmologists. This workforce challenge has the potential to impact the timely delivery of screening for eligible neonates.

8.2 To mitigate this risk and maintain compliance with screening requirements, alternative service delivery models are being explored. A pathway is currently being developed to enable the capture of high-quality retinal images to be undertaken by a trained nursing team at SaTH, which can then be reviewed remotely by specialist ophthalmologists. This approach aims to reduce delays, improve access to specialist assessment, and ensure the continued delivery of safe and effective care for neonates requiring ROP screening.

9.0 Thirlwall Inquiry (Appendix 11)

The immediate actions from the Thirlwall Inquiry report are: -

Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.

Sudden and Unexpected Death in Children (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026. It is important to note that SUDIC reporting runs alongside your own internal reporting processes. **This action was completed on Friday 25th September 2026, with Trust wide communication ensured, and will continue to be monitored.**

National Bereavement Care Pathway for stillbirth and neonatal death: ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

Insulin: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

Safeguarding: Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

A gap analysis is currently in progress, and actions are being progressed at pace.

10.0 Poppy's Promise

Poppy's Promise has been successfully piloted within Maternity Services, with a positive level of engagement from women and families. The pilot focused on the booking appointment pathway, with women receiving a follow-up message the day after their booking appointment to gather feedback on their experience. **(Appendix 10)**

The service has received an increasing volume of feedback, the majority of which has been positive. Key areas identified for improvement include the visibility and clarity of notice boards, patient education and information, communication styles, and waiting times.

Maternity Services is currently developing a process to review the feedback on a monthly basis. It is proposed that feedback themes and resulting actions will be shared through a regular 'You Said, We Did' approach, which will be displayed for both patients and staff to demonstrate how feedback is informing service improvements.

11.0 Recommendations

The Board of Directors is requested to:

11.1 Receive this report for information and assurance.

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

Stacey Thacker
Head of Midwifery

Julie Plant
Divisional Director of Nursing

Lauren Taylor
Deputy Head of Midwifery

September 2026

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 6th August 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 06/08/2026		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from 2nd July 2026 • Initial feedback from Oswestry MLU Walkabout 6th August 2026Our Staff Said, We Listened Poster / Safety Champions Poster • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MNTAC update • CNST Update with Appendices • Maternity Services CQIM MSDS Dashboard and AAA • Locally Agreed Safety Intelligence Dashboard (SA9) • Perinatal Staffing Report • Perinatal 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: ○ Terms of reference ○ Information Pack
2a	**Alert**	Staff concerns about reliability and process weaknesses within the baby tagging system were discussed. An update on measures will be in mid-august. Ongoing concern regarding timely retinopathy of prematurity (ROP) screening and business continuity arrangements ahead of the retirement of a key UHNM ophthalmology provider. Further update required from neonatal leads. Delivery suite acuity compliance has reduced from previous performance levels and was below 90%, predominantly due to staff unavailability, but remained above national standard.
2b	**Assurance**	Team are reviewing recommendations of the Amos and Ockenden report to determine content for phase 3 programme and also include the 360 review. Summary report will be presented at Board.

2c	**Advise**	Continue monitoring and addressing delays in Category 2 caesarean sections, with specific focus on documentation accuracy, transfer times, and categorisation of Category 2 versus Category 3 procedures. Engagement with obstetric, anaesthetic and theatre teams is underway. Escalate community maternity estate and infrastructure concerns, particularly unreliable Wi-Fi affecting translation services and excessive heat within community settings, as these have patient safety and staff wellbeing implications. Skin-to-skin contact rates continue to improve and are moving towards the local target of 75%. Positive feedback was received from the Safety Champion walkabout, highlighting strong staff engagement, teamwork, leadership visibility and the contribution of maternity support workers.		
3	**Actions to be considered by the MNTAC / QSAC / Trust Board**			
4	**Report compiled by**	Dr John Jones (group Chief Medical Officer)	**Minutes available from**	Sabrina Kitcher (EA to Group Chief Medical Officer)

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 10.09 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting 03.09.2026		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from 6th August 2026 • Initial feedback from Oswestry MLU Walkabout 6th August 2026. Our Staff Said, We Listened Poster / Safety Champions Poster • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MNTAC update • CNST Update with Appendices • Maternity Services CQIM MSDS Dashboard and AAA • Locally Agreed Safety Intelligence Dashboard (SA9) • Perinatal Staffing Report • Perinatal 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: ○ Terms of reference ○ Information Pack
2a	**Alert**	Category 2 caesarean section delays continue, with performance plateauing. Some of this relates to prioritization for category 3 sections and overnight decision-making and the impact this has on theatre access in the morning. Escalation to relevant divisional medical directors has been agreed. Retinopathy of Prematurity (ROP) screening sustainability remains a risk pending implementation of the local image capture and remote reporting model. CNST Safety Action E (Maternity Care Bundle) remains at risk pending development and Board approval of a system-wide action plan with ICB partners. Recruitment to the Labour Ward Lead Obstetrician post remains unsuccessful, with leadership responsibilities currently maintained through

		interim arrangements. Workforce recruitment challenges continue to present a risk to service sustainability. Ongoing estate and operational risks at the Oswestry MLU, including accommodation uncertainty and IT connectivity issues, pending identification of a suitable long-term location.
2b	**Assurance**	One-to-one care in labour remained at 100%, with maternity acuity above the national threshold and improving in August. Neonatal performance remained positive with term admission rates below target, no neonatal deaths, no cooling cases, and no catheter-related bloodstream infections reported. CNST compliance remains on track overall, with education compliance exceeding required levels and overdue governance actions significantly reduced. Safety Champion walkabout feedback was highly positive, highlighting strong team culture, staff engagement and support for maternity support workers. Enhanced infection prevention measures have been implemented following MRSA cases in maternity theatres, including multidisciplinary review and identification of gaps in overnight housekeeping provision. No further MRSA cases have been reported since these actions were introduced, providing assurance that mitigating controls are in place and being monitored. Positive Safety Champion walkabout findings: The team provided positive feedback regarding team culture, support and engagement during the MLU walkabout.
2c	**Advise**	Maternity and neonatal services continue preparations for BadgerNet/EPR implementation (May 2027) and review of phase 2 Ockenden recommendations. Work is progressing to introduce remote neonatal retinal imaging, including staff training, equipment procurement and commissioning arrangements. Members requested further clarification on the commissioned ophthalmology reporting service, implementation arrangements and start date to ensure sustainability after workforce changes. Review of partner overnight stay arrangements on postnatal wards is underway following patient and family feedback and benchmarking with other trusts.

		Positive patient experience monitoring continues through Poppy's Promise and FFT feedback, with enhanced reporting to be incorporated into future dashboards.		
3	**Actions to be considered by the MNTAC / QSAC / Trust Board**			
4	**Report compiled by**	Dr John Jones (group Chief Medical Officer)	**Minutes available from**	Sabrina Kitcher (EA to Group Chief Medical Officer)

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting in Common: 8 October 2026

Agenda item		094/26			
Report Title		SaTH Risk Management Report Q1 2026/27			
Executive Lead		Anna Milanec, Group Chief Governance Officer			
Report Author		James Webb, Head of Risk Management, SaTH			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients and community		N/A	
Effective		Our people			
Caring		Our service delivery		**Trust Risk Register id:**	
Responsive		Our governance	√	N/A	
Well Led	√	Our partners			
Consultation Communication		Monthly report to Senior Leadership Committee, Operational Monthly report to Executive Team Quarterly report to Audit and Risk Assurance Committee			
Executive summary:		This report presents the quarterly Risk Management Report for Q1 2026/27, highlighting progress in managing risks and enhancing the risk culture at SaTH. The Board's attention is drawn to: • **Effectiveness of Risk Mitigation:** the controls and actions of 13 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout Q1 • **Risk Management Progress:** The report notes a closure of 48 risks in Q1, bringing the number of active risks at the end of June 2026 to 323. • **Training and Culture Improvement:** Staff members are still receiving risk management training, reflecting an ongoing commitment to enhancing the organisation's risk culture.			
Recommendations for the Board:		The Board is asked to: **Note** the current risk position, and the mitigation in place to ensure that Risk Management is practiced across the Trust consistently.			
Appendices:		Appendix 1: Summary of the Corporate Risk Position on 22 July 2026. Appendix 2: Corporate Risk Register on 22 July 2026.			

1.0 Introduction:

The Risk Management Group (the Group) has a reporting line into the Board's Audit and Risk Assurance Committee (ARAC) and provides a quarterly report to the meeting, presented by the Head of Risk Management. An annual risk management report covering 2025/26 was presented at the April 2026 ARAC meeting.

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

Operational matters

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

The table below shows the operational risk position by approval status over April, May and June 2026 (Q1 2026/27).

Trust Wide Risk Position by Approval Status	Apr 2026 Total	May 2026 Total	Jun 2026 Total
1. Total number of **Active Risks** *(Risk has been acknowledged and agreed by the risk owner, the centre / divisional governance meeting / committee / specialist subject group)*	**332**	**321**	**323**
2. Total number of **Newly Identified Risks** *(Default approval status once risk is populated in Datix and has not been reviewed by anyone other than the risk reporting officer)*	**21**	**23**	**31**
3. Total number of **New Risks awaiting Divisional/Directorate review and approval** *(Not currently 'active' - are awaiting authorisation from member of the Leadership's Team, and/or joint team decision made during a speciality/ divisional/ committee/specialist subject group meeting)*	**2**	**2**	**3**
4. Total number of **Overdue Risk Reviews** for **Open risks**	**97**	**120**	**111**
5. Total number of **Overdue Actions Reviews**	**205**	**195**	**189**

See Appendix 1 for Divisional risk profile from April, May and June 2026 (Q1 2026/27) with severity breakdown. N.B. The total numbers in Appendix 1 are points 1, 2 and 3 in the table above added up per month. In addition, the data is live so will change throughout the month.

2.0 Summary of Corporate Risk Position:

The Trust has created a Corporate Risk Register that categorises all high-level risks scoring ≥15 into the five CQC domains, aligns them to the eight categories of risk (corporate goals) and highlights which aspects of the BAF the themes relate to. This is updated every month - see Appendix 2 for a breakdown of the thematic analysis of the risk position. See Appendix 2 for the detail of the Corporate Risk Register on 22 July 2026. N.B. This Corporate Risk Register is a completely separate display of any 'Corporate' risks that come under SaTH's 'Corporate Division' as listed in Datix (not W&C, SACC, CSS or M&E).

3.0 Effectiveness of Risk Mitigation

The table below demonstrates how the controls and actions of 13 extreme risks (scored ≥15) have either resulted in a reduced risk score or overall risk closure throughout April, May and June 2026 (Q1 2026/27).

Month	Risk	Risk Status	Actions Taken to Mitigate / Close Extreme Risk *(at 27/08/2026)*
April 2026	698 'Capacity within Cardiorespiratory'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 9 because support provided by Agile with substantive Cardiologist being recruited and onboarded 09/26. Holter backlog reduced to 7 weeks. Reduced score based on reduced backlog.
	1216 'Cardiac Pacing Services Staffing Risk'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 9 because of recruitment undertaken. Staff not as experienced yet, but service has improved.
Month	**Risk**	**Risk Status**	**Actions Taken to Mitigate / Close Extreme Risk *(at 27/08/2026)***
May 2026	1131 'Mail incorrectly or insufficiently addressed'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 9 due to IG team reintroducing the ability for mailroom staff to open unidentifiable mail for the purpose of rerouting and the dreaded cardboard box removed from PRH mail room. IG guidance has now been delivered face to face to the mailroom staff at PRH and RSH. All mailroom staff have read and understood the guidance, and signatures have been collected.
	1346 'Industrial Action by Resident Doctors (April 2026)'	Closed	Risk closed as strike ended. Debrief Meeting: Resident Doctors Industrial Action 7th-13th April 2026 held on 20/04/2026.
	628 'NUTRITION: Insufficient Specialist nursing team'	Closed	Risk closed as additional team member has been appointed.
Month	**Risk**	**Risk Status**	**Actions Taken to Mitigate / Close Extreme Risk *(at 27/08/2026)***
June 2026	1121 'Lack of admin and clinical capacity to validate patients on non cancer PSA monitoring'	Score reduced but still ≥15 (extreme) and kept on Corporate Risk Register	Score reduced to 16 due to team review of risk.
	861 'Lack of space to deliver all services	Score reduced to ≤15 - risk	Score reduced from 15 to 12 due to team review of risk.

	and therefore expand as demand requires'	removed from Corporate Risk Register	
	1167 'No provisions for cardiac monitoring of patients at RSH site'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 12 because of other options available of HDU and outreach to support with these patients. Mitigations are also present from acute floor.
	1332 'Inflammatory Bowel Disease (IBD) Nursing Workforce Shortfall Causing Critical Backlogs and Patient Safety Risks'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 20 to 12 because new staff have been employed and are currently being trained.
	1002 'Vulnerable Gynae-oncology Clinical Nurse Specialist Service (CNS)'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 10 because a lead is in post.
	848 'All Cardiorespiratory activity is undertaken in CRIS, including booking and scheduling and is not migrated to SEMA'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 15 to 09 due to team review of risk.
	1310 'Minor Ops room Clinic 3, Surgical suite not IPC Compliant'	Score reduced to ≤15 - risk removed from Corporate Risk Register	Score reduced from 16 to 06 because IPC have completed audit of post procedure.
	454 'Patient harm due to significant delays in transferring wardable patients out of ITU to base wards'	Closed	This risk has been refreshed - new risk ID 1367 - 'Significant delays in transferring wardable patients out of ITU to base wards'.

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

- Continue to regularly meet with Trust-wide senior and junior Risk / Governance staff face-to-face to track progress and determine support needed, including discussions on status reports and where risks are escalated to
- Continue to evaluate Corporate division's risks by meeting periodically with a lead for each 'centre' to review their risks, e.g. Estates, the Nursing Directorate and Digital, and the Deputy Chief Operating Officers for operational issues
- Continue to ensure no *proposed* risks are over six months old as per the Risk Management Policy
- Continue to ensure any risk older than three years is accepted (and closed if they have not been reviewed regularly as per RM Policy)
- Complete the Anti-fraud Risk Assessment with the MIAA
- Continue to ensure all Trust-wide senior and junior Risk / Governance staff have received risk management training by 31/12/2026 providing divisions and the Patient Safety Hub with a monthly update
- Deliver 'risk clinics' as part of the National Risk Awareness Day on 07/10/2026 that would support staff to review and have confidence to close risks
- Continue to develop partnership with ShropCom's Risk Management arm
- Discuss with Nigel Lee and Penny Bason how risk management can assist in tackling health inequalities in Shropshire, especially as SaTH works in a group model
- Undertake an anonymised survey focusing on the Risk Management Group process (frequency, length, and time etc.).

Appendices

Appendix 1 – Summary of Corporate Risk Register Position at 22/07/2026

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

Appendix 2 - CORPORATE RISK REGISTER 22 July 2026

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

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

CQC Domain		Title	Owner	Risk Description	Caused by (operational, not strategic, causes)	Resulting in (consequence)	Initial risk score: Likelihood	Initial risk score: consequence	Initial risk score: Score	Controls already in place	Current risk score (with current controls in place): Likelihood	Current risk score (with current controls in place): consequence	Current risk score (with current controls in place): Score	Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe	1	**Risk to the quality of care provided to patients**	**DON /MD**	Quality of care experienced by patients may be below the standard tolerated by the organisation	Increased demand to healthcare services: EDs overcrowded with long waits to be seen, and insufficient flow: Insufficient support from neighbouring authorities / providers re complex care, which affects flow: Challenging substantive workforce numbers: Use of agency: Use of ageing or outdated equipment: Loss of partner services which supported the Trust, e.g. stroke rehabilitation for stroke patients at Bridgnorth: Escalation into poor environments e.g. corridors: Poor medicines management: Delays in transferring wardable patients out of ITU: Variations in the recognition, escalation and management of sepsis risk: Inability to recruit in line with requirement of consultants and speciality level doctors: Potential unavailability of financial resources	Potential for increased safety patient incidents: Poorer experience of patients, their families, and our communities; Patients waiting longer to be seen via referrals: Slow or inaccurate diagnostic test results: Compromised recovery which may result in long term social care placement: Failure to recognise the deteriorating patient in a timely manner: Delayed diagnosis by duplicate electronic records (radiology)	5	4	20	Policies and SOPs in place, including for use of escalation areas; Use of bank staff, agency staff in particular areas; Continued recruitment of specific roles; Introduction of new clinical roles and ways of working being introduced; Visiting third party (royal colleges, etc) peer reviews and reporting; Collaborative working with neighbouring providers where possible; Hospital flow protocols in place; Improved quality governance framework in place Quality Improvement Plan in place, tracked by SOAG / NHSE	4	4	16	Increase collaborative working with partners over services; Further the work relating to HTP to introduce better care models: Continue to introduce new staff grades, and roles: Continue to review, update and implement new policies, and procedures in compliance with regulatory requirements	BAF 1 BAF 2 BAF 8	**CSS:** 535 (15), 1222 (16), 1224 (15) **M&E:** 884 (20), 612 (15), 195 (16), 793 (15), 1174 (16) **SA&C:** 804 (20), 1173 (16), 929 (20), 1030 (20), 1271 (15), 1367 (16) **W&C:** 1092 (15), 1270 (20) **Corp:** 904 (15), 1241 (20)	CSS M&E SA&C W&C Corp
Caring	2	**Poor patient experience**	**DON /MD**	Patients may experience delays in provision of timely care, in a suitable environment	Inability to provide timely and efficient care due to poor flow through the hospitals; Increased waiting times for elective surgery: Escalation into poor environments e.g. corridors.	Delayed clinical diagnosis and outcomes: Insufficient elective theatre capacity: ED's overcrowded with long waits to be seen; Not all escalation areas are suitable for all types of patient care, e.g. same sex.	5	4	20	Hospital flow protocols in place; Use of bank staff, agency staff in particular areas; Leadership/ manager development opportunities available; Ward environment improvement project in place; Quality governance framework in place; Quality Improvement Plan in place, tracked by SOAG / NHSE; collaborative working in place with neighbouring providers where possible	4	4	16	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to work to attract apprentice type roles: Continue to attract skills of recently retired clinical colleagues	BAF 1 BAF 2 BAF 8	**M&E:** 195 (16), 612 (15), 793 (15) **SACC:** 1173 (16), 929 (20), 1030 (20), 1271 (15), 1367 (16) **W&C:** 1092 (15) **Corp:** 904 (15), 1241 (20)	CSS M&E SA&C W&C Corp
Safe / Responsive	3	**Overcrowding in ED**	**COO**	Increased demand on healthcare services, and lack of flow/discharges through 'back door'	Inability to discharge patients (no criteria to reside): Increasing demands upon secondary care, particularly urgent and emergency care: Challenging staffing situation and skill mix: Patients being inappropriately signposted to A&Es rather than to speciality pathways: Bed gap:	Unable to maintain clinical assessment of patients in line with policy: Flow through hospitals affected: Long ambulance waits and offloads - which may lead to offloading critically unwell patients straight into resus and starting high level care in the back of ambulances: Deteriorating patients: Unable to comply with national performance standards, e.g. ambulance offloads: Some level 2 patients admitted to respiratory wards rather than ITU/HDU/RSU	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the area; Business Continuity Plans in place for significantly increased pressures; Regular site safety calls in place 24/7: Scheduled system calls and regular engagement with partners; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Use of bank staff, agency staff in particular areas; Use of daily multi disciplinary meetings	4	4	18	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, e.g. virtual ward, etc.;	BAF 1 BAF 2 BAF 8 BAF 10 BAF 11	**M&E:** 612 (15), 195 (16), 177 (20), 878 (25), 793 (15) **SACC:** 804 (20)	CSS M&E SA&C W&C Corp

main		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe / Responsive	4	**Increased pressure on health services**	**COO**	Increased demand for secondary care, together with poor restoration of services after COVID has affected delivery of inpatient and outpatient care.	Lack of resources in the STW ICS to deliver 7 day services: Delays in provision of tier 4 CAHMS / specialist eating disorder specialist services: Insufficient theatre space for provision of PEGS on both sites: Challenging staffing situation and skill mix:	Lack of radiology for research trials; National shortages of critical medicines: Potential patient harm and poor experience Patients may experience lack of timely intervention in their care: Flow through hospitals affected; Long ambulance waits and offloads; Longer inpatient hospital stays (NCTR)	5	4	20	Incident Command Centre in place, both locally and within the ICS to coordinate support across the patch; Business Continuity Plans in place for significantly increased pressures; Policies and SOPs in place, including for use of escalation areas and hospital flow protocols; Daily nurse staffing review to make best use of available resource:	4	4	16	Continue to work with national policy and seek best practice principles from elsewhere to trial, where resources allow; Increase collaborative working with partners re services, pathways, virtual ward, etc.;	BAF 1 BAF 2 BAF 9 BAF 10 BAF 11 BAF 12	**M&E:** **195 (16), 612 (15)** **SACC:** **804 (20)**	CSS M&E SA&C W&C Corp
Effective / safe	5	**Insufficient staffing capacity / skills**	**DPOD**	National shortage of healthcare staffing and increased vacancies may affect the delivery of services and the standard of patient care provided	Lack of national investment into health care: Ageing workforce: NHS pension rates decreased over last few years - NHS less attractive for long term career; Potential unavailability of financial resources	Increased patient harm: Increase in patient safety incidents: Non compliance with core standards: Inability to complete pre-assessments on some high risk endoscopy patients: Failure to learn from incidents: Decline in staff wellbeing: Increase in patient complaints: Failure to respond to complaint / incident response: Staff wellbeing affected by additional workforce stress: Delays in diagnosis: Gaps in consultant rotas potentially causing delay to consultant statutory training: Unable to meet national clinical standards: Therapy services do not comply with national staffing requirements for paediatric inpatients:	5	4	20	Daily nurse staffing review to make best use of available resource: Patients managed in line with clinical need as par as possible: Increased use of bank staff: Use of agency only in specific areas: Learning and Development offer within the organisation: Choice of leadership skill development in place: Ongoing recruitment campaigns subject to front line requirements Workforce Strategy: Rotas adjusted to cover gaps; Collaborative working with the ICS; Where appropriate, patients given self management advice within the confines of remote care (virtual ward)	4	4	18	Continue to explore new methods of working, including increased use of technology: Continue to introduce new staff grades, and roles: Project re doctor rotas to be completed: Continue to attract apprentice type roles: Continue to attract skills of recently retired colleagues.	BAF 3 BAF 4 BAF 5	**CSS:** **1160 (20), 1151 (16), 953 (20), 1357 (15)** **M&E:** **884 (20), 1017 (15), 1174 (16), 1185 (20), 1238 (16)** **SACC:** **906 (16), 804 (20), 1121 (16), 929 (20), 629 (20), 1269 (16)** **WAC:** **1159 (16), 1195 (20), 1265 (20)** **Corp:** **1206 (15), 1254 (15)**	CSS M&E SA&C W&C Corp
Well Led	6	**Inability to meet regulatory and legislative performance requirements**	**DG**		Increasing demand on healthcare services: Insufficient staffing / leadership capacity: Poor or faulty equipment: Poor governance processes in place, policies out of date Increasing demands from regulators	Increased patient harm: Increased regulatory intervention: Regulatory fines; Legal action taken against the Trust: Financial risk due to potential regulatory fines Failure to learn from incidents	4	4	16	Ward to board governance framework in place: Policies and procedures, reflecting updates national guidance and regulations: Mandated intensive support with NHSE in place through the Recovery Support Programme. Regular communication with CQC	4	4	16	Continue to fully engage with NHSE as part of the Recovery Support Programme; Continue to engage with CQC; Continue to engage with other third party regulators, Royal Colleges, Unions, etc.	BAF 8 BAF 13	**CSS:** **535 (15), 682 (15), 1378 (16)** **M&E:** **1174 (16), 878 (25)** **SACC:** **1173 (16)** **Corp:** **1326 (15), 1359 (15)**	CSS M&E SA&C W&C Corp
Safe / Responsive	7	**Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment**	**FD** (estates) **DS&P** (digital)		Insufficient space (estate) for some services: Escalation areas may not be fully equipped for patient care - may lack usual equipment compliance requirements; Infection control issues in some areas: No electronic system in place which is capable of monitoring whether Radiology Reports have been read or acted on: Write over / duplicate records software can be produced (radiology): Pharmacy Laura software not compatible with widows 7 or above.	Harm to patients / staff: Longer waiting times for patient / poor experience: Diagnosis delays: Poor staff morale: Risk of fire or similar outcome: Non-compliance with healthcare standards: Delays in treatment / referrals: Loss of staff or patient data;	4	5	20	Trust policies and procedures in place regarding use of hazardous equipment; Business continuity plans in place; Training provided for use of specialised equipment; Digital Strategy and work-streams in place for large scale digital upgrading. Increasing numbers of information asset owners (IAOs) being registered to ensure oversight of digital programmes.	4	4	16	Continue to ensure that policies are in place and updated to avoid consequences; Continue to communicate health and safety messages;	BAF 6 BAF 7B	**CSS:** **72 (15), 1222 (16), 1224 (15), 1044 (16)** **SACC:** **1030 (20), 1344 (16)** **W&C:** **700 (16)** **Corp:** **1102 (15), 1267 (15)**	CSS M&E SA&C W&C Corp
Responsive / Well Led	8	**Increasing Cyber Threat**	**DG (SIRO)**	Increasing risk in the potential for a cyber attack, particularly relating to ongoing political unrest	Out of date/ unsupported software and / or systems: Poor maintenance and lack of investment into old systems: Potential non-compliance with Cyber Essentials and Digital CareCert requirements: Lack of technically qualified subject experts:	IT systems lost or compromised: Potential significant data breach: ICO fines or action taken: Reputational damage: Financial loss:	5	5	25	Digital Services have invested in a system to monitor Security Patch compliance, unsupported/out of date software and NHS Digital CareCert compliance in near-real time: NHS Digital High Severity Alerts are acted upon as a priority to minimize exposure: Regular cyber awareness communications are distributed to staff to increase awareness and understanding of cyber related matters; SaTH continues to work toward full compliance with cyber essentials and NHS Digitals Data Security and Protection toolkit, both of which have comprehensive requirements with regards to cyber security Use of other NHS Digital and National Cyber Security Centre Services such as Vulnerability Management, BitSight, WebCheck and Early Warning System to ensure issues are picked up and responded to quickly.	3	5	16	Ongoing work continues. (Specific details have not been included here in order to protect the systems, but details are available on datix.)	BAF 7A	**CSS:** **864 (16)** **Corp:** **499 (15)**	CSS M&E SA&C W&C Corp

main		Title	Owner	Risk Description	Caused by	Resulting in (consequence)	Initial risk score			Controls already in place	Current risk score (with current controls in place)			Controls to be put in place	BAF ID	Operational Risk Register ID	
Safe / Responsive	9	**Poor / ageing estate**	**FD**	Some areas of the organisation's estate require upgrading, attention, or reconfiguring	Current estate means some services are fragmented and located in more than one location: Insufficient space for some services: Potential unavailability of capital resources Use of RAAC in 1980's: Copthorne Lift 54 years old and unreliable: Obsolete nurse call system at PRH ED: Door access control systems are not in use in all clinical areas:	Inability to develop teams and transfer skills: Patients have fragmented pathway: Inefficiencies in flow: Risk of increased lone working: Low staff morale: Potential disruption to service delivery by closure of hazardous areas: Financial risk: Reputational Risk: Harm to patients and staff: IPC issues: Health and Safety issues: Loss of critical services supplies: Unable to acquire regulatory certificates and licences: Reverse Osmosis System at PRH poorly located, and risk of closure of service for 28 days if area flooded, etc. Unauthorised access to clinical areas: Increasing demand for care leads to lack of appropriate office space.	4	5	20	Appointment of Interim Director of Estates: Online reporting system in place for estate concerns and issues to be reported in real time; Business cases in place for various projects / capital spending; Staff receive focussed IPC training in specific areas where this is appropriate, according to the issue; More home working for admin staff where the service allows; Patients transferred to alternative accommodation where appropriate and available; Timely, Trust-wide communications cascade in place for urgent messaging to staff for arising issues, and for communications with the public / patients; Governance processes in place for monitoring ongoing incidents	4	4	16	Continuous oversight of capital plan to endeavour for improvements to be made in a timely manner; Progress HTP, thus enabling relocation of some services to a single site;	BAF 6 BAF 11	**CSS:** **682 (15), 1234 (16), 1281 (15), 1312 (15)** **M&E:** **793 (15), 1231 (15), 1330 (16)** **SACC:** **1232 (15)** **W&C:** **1034 (16)** **Corp:** **1039 (16), 1259 (16), 1276 (16), 1296 (16)**	**CSS** **M&E** **SA&C** **W&C** **Corp**

Board of Directors' Meeting in Common: 8 October 2026

Agenda item	095/26		
Report Title	**SaTH Board Assurance Framework 2026/27- Quarter 2**		
Executive Lead	Anna Milanec, Group Chief Governance Officer		
Report Author	Mary Aubrey, Programme Director		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
People Committee (in common); Perf Ass Committee; Fin Ass Committee; Quality Committee (in common); Local Care Transf Ass Committee; ARAC (via email)	Safe	✓	All BAF risks
	Effective	✓	
	Caring	✓	**(SaTH) Risk Register id(s):**
	Responsive	✓	
	Well Led	✓	
Executive Summary	The Board Assurance Framework (BAF) risks have been reviewed and refreshed by the respective Executive Leads for Quarter 2 of 2026-27. The detailed BAF is provided at Appendix 1. Two significant changes are reported for Quarter 2: • **BAF risk 9:** There is a proposed reduction to the score of BAF risk 9 from 4 x 2 = 8 to 3 x 2 = 6 reflecting sustained improvement in cancer performance including Faster Diagnosis Standard performance of 86.6% in July 2026 and delivery at or above 80% since September 2025, alongside improving 62-day performance and the latest English-patient 52+ week breach position of zero in the latest reported position. • **BAF risk 12:** This risk includes quality and safety implications arising from the potential non-delivery of integrated pathways. The Group Local Care Transformation Assurance Committee has agreed that, now the Committee is established, it will undertake a full review and refresh of BAF risk 12 in line with its Terms of Reference. Pending the outcome of that review, it is proposed that the Group Local Care Transformation Assurance Committee leads the detailed management and monitoring of the risk, with the Quality Committee (held in common) retaining oversight of the quality and safety elements. Following ARAC review, the assurance narrative for the four highest-scoring risks - BAF risks 5, 7a, 7b and 10, each with a total risk score of 20, has been strengthened to include available Quarter 2 outcomes and performance measures.		

Recommendations to the Board	The Board is asked to: a) **Consider** whether the BAF risk(s) content reflects the strategic risks within the organisation and whether the risk scores are appropriate. b) **Consider** whether there is evidence of successful management of the risks; whether actions are being progressed in a timely manner; and whether any further actions/mitigations are required. c) **Approve** the Q2 reduction in the current score for BAF risk 9. d) **Note** that the Group Local Care Transformation Assurance Committee has agreed to undertake a full review and refresh of BAF risk 12, now that the Committee is established. e) **Note** the strengthened assurance provided by the outcome measures and performance metrics for BAF risks 5, 7a, 7b and 10, the four highest-scoring risks, each with a current score of 20. f) **Approve** the Quarter 2 BAF for 2026/27.
Appendices:	Appendix 1: Board Assurance Framework, 2026-27, (draft) Quarter 2.

1.0 Introduction

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

1.2 Work to review and refresh the SaTH BAF content for Quarter 2 was undertaken during September 2026.

2.0 Significant changes to the BAF during Quarter 2 2026/27

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

2.2 There is a proposed **reduction** to the score of BAF risk 9 from 4 x 2 = 8 to 3 x 2 = 6 reflecting sustained improvement in cancer performance including Faster Diagnosis Standard performance of 86.6% in July 2026 and delivery at or above 80% since September 2025, alongside improving 62-day performance and the latest English-patient 52+ week breach position of zero.

2.3 The Group Local Care Transformation Assurance Committee agreed that, now the Committee is established, it will undertake a full review and refresh of BAF risk 12 in the next quarter, in line with its Terms of Reference. The review will include the risk description, controls, assurances, gaps, actions, risk score and appropriate committee oversight arrangements.

3.0 Risks, actions and the organisation's highest scoring top risk(s)

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

3.2 Based on the overall draft current total risk scores for Quarter 2 of 2026/27, there are:

- four risks scored 20: BAF risks 5, 7a, 7b and 10;
- three risks scored 16: BAF risks 2, 6 and 12;
- One risk scored 15 BAF risk 1
- five risks scored 12: BAF risks 3, 4, 8, 11 and 13; and
- one risk scored 6: BAF risk 9.

3.3 In response to feedback received through the committee consultation process, the assurance narrative for the four highest-scoring risks, BAF risks 5, 7a, 7b and 10, each with a current total risk score of 20, has been strengthened to include the available Quarter 2 outcomes, performance measures and evidence of continued investment and improvement activity set out below. The evidence demonstrates active oversight and areas of progress. However, it does not yet show that the principal risk drivers have reduced sufficiently, or that the improvements are sustained, to support a reduction in the current risk scores:

- **BAF risk 5:** The efficiency programme has been identified, MIAA has provided Substantial Assurance over core financial controls and external audit reported no significant value-for-money weaknesses. The Trust continues to progress service transformation and improvement alongside financial and workforce efficiencies. However, delivery of the full financial recovery plan remains in progress; therefore, the score remains 20 against the upper tolerance level of 12.
- **BAF risk 7a:** Monthly regional cyber assurance, twice-yearly ARAC reporting and annual internal audit provide oversight. The Trust continues to prioritise investment in cyber resilience, with national bids submitted for network resilience, network segmentation, backups, vulnerability scanning and security-event logging. These bids remain subject to funding decisions. As some systems and devices continue to require mitigation and further investment, the score remains 20 against the upper tolerance level of 6.
- **BAF risk 7b:** Digital maturity improved from 1.8 to 2.0 and automation of SUS returns through the Federated Data Platform is live. Digital transformation remains an investment priority, with national funding bids submitted for medicines management, electronic prescribing, electronic patient record

optimisation, robotic process automation and artificial intelligence. However, programme and implementation capacity, funding and ageing infrastructure remain material constraints; therefore, the score remains 20 against the upper tolerance level of 12.

- **BAF risk 10:** August 2026 all-type four-hour performance was 51.8% against the 62.5% plan, 22.1% of Type 1 patients waited over 12 hours and the average ambulance handover time was 68.6 minutes. Type 3 performance was 89%, after exceeding 90% in April and May. The Trust and its system partners continue to invest in urgent and emergency care capacity and pathway improvement, including the integrated winter plan, the Integrated Front Door, integrated therapy services, Virtual Ward and OPAT pathway expansion, and standardised discharge processes. Tests of change have also commenced to support earlier blood results, earlier CT requests and faster clinical decision-making. The improvement programme has progressed into delivery; however, performance remains below plan across key standards, and the score remains 20 against the upper tolerance level of 9.

3.4 The four highest top scoring BAF risk(s), each with a current total risk score of 20, are listed in the table below:

The four highest-scoring BAF risks based on the draft current total risk scores for Quarter 2				
Risk No.	**Risk title**	**Overseeing Committee**	**Current proposed risk score at Quarter 2, 2026-27**	**Change in risk score since the previous Quarter**
BAF 5	The Trust does not operate within its available resources, leading to financial instability and regulatory action.	Finance Assurance Committee	5 x 4 = 20	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Audit & Risk Assurance Committee	5 x 4 = 20	↔ No change
BAF 7b	The inability to implement modern digital systems impacts on the delivery of patient care	Performance Assurance Committee	4 x 5 = 20	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Performance Assurance Committee and Quality Committee (held in common)	4 x 5 = 20	↔ No change

Note: In addition to the four highest-scoring risks shown above, the BAF summary page identifies four further extreme risks: BAF risk 1, with a current score of 15, and BAF risks 2, 6 and 12, each with a current score of 16.

3.5 Awareness of the Trust's proposed high scoring top risk(s) should assist the Board in considering:

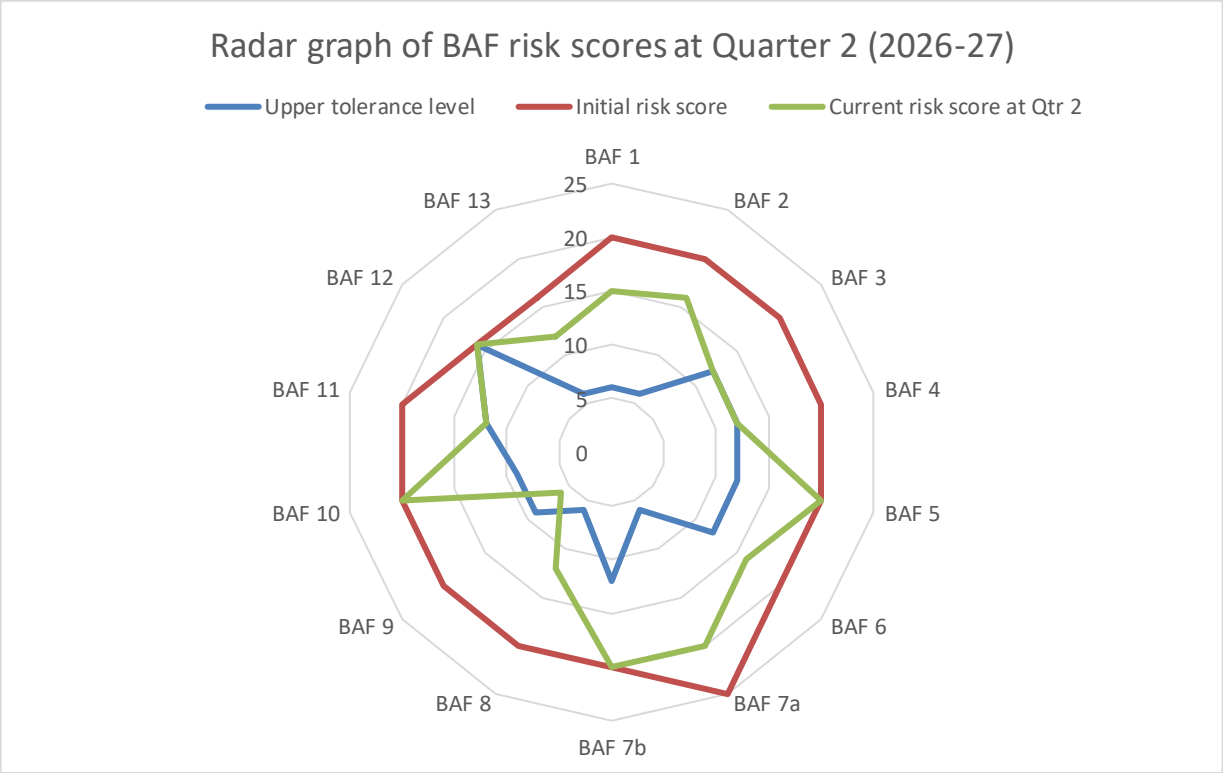
- whether these risks reflect the organisation's current top strategic risks.
- whether sufficient priority and focus is given to the risks and assurances received, and
- whether the comparative scoring of all BAF risks remains appropriate.

4.0 Visual representation of risk scores

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

- identify the gap between each risk's upper tolerance level and current risk score.
- identify where the initial and current risk scores are the same (where the line on the graph overlaps) and consider if the controls are adequate for these risks or if further action and assurance is required.

- assist to reflect upon the upper tolerance levels of BAF risks and whether these remain appropriate and achievable.



4.2 It is acknowledged that BAF risks 3, 4, 11 and 12 are currently at their proposed upper tolerance levels. BAF risk 9 has a current score of 6, which is below its upper tolerance level of 9. All other BAF risks remain above their upper tolerance levels.

5.0 Recommendations

The Board is asked to:

a) Consider whether the BAF risk(s) content reflects the strategic risks within the organisation and whether the risk scores are appropriate.
b) Consider whether there is evidence of successful management of the risks; whether actions are being progressed in a timely manner; and whether any further actions/mitigations are required.
c) Note the Quarter 2 reduction in the current score for BAF risk 9.
d) Note that the Group Local Care Transformation Assurance Committee has agreed to undertake a full review and refresh of BAF risk 12, now that the Committee is established.
e) Note the strengthened assurance provided by the outcome measures and performance metrics for BAF risks 5, 7a, 7b and 10, the four highest-scoring risks, each with a current score of 20.
f) Approve the Quarter 2 BAF for 2026/27.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

SaTH Board Assurance Framework (BAF) 2026/27 - draft quarter 2 (July-Sept 2026)

(Updated September 2026 - Version 1.0)

The Shrewsbury and Telford Hospital NHS Trust

Risk scoring framework

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

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

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

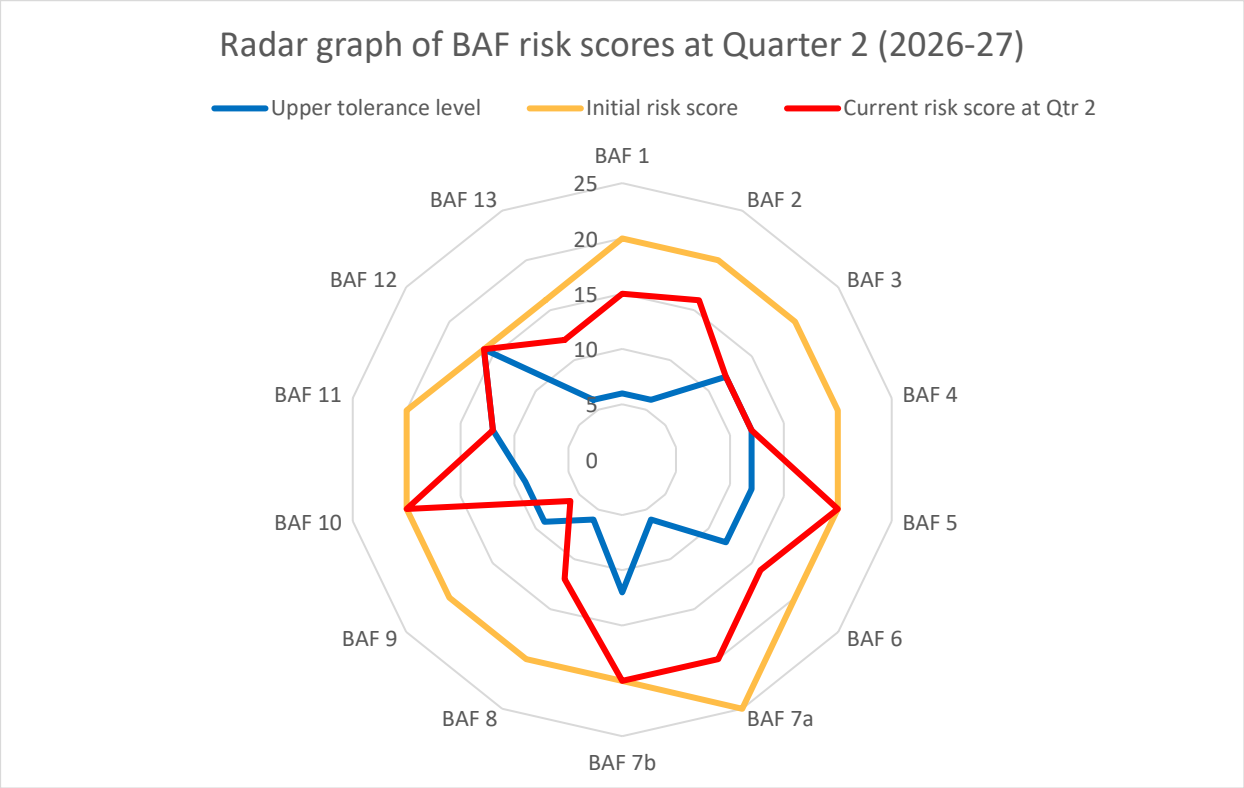
The Shrewsbury and Telford Hospital NHS Trust

							Current total risk score in previous quarters (IxL):				Current total risk score (IxL):	
Board Assurance Framework 2026/27 - Summary at Quarter 2 (July-Sept)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2025-26)**	**Quarter 3 (2025-26)**	**Quarter 4 (2025-26)**	**Quarter 1 (2026-27)**	**Quarter 2 (2026-27)**	**Change in current risk score since previous quarter, plus any further comments**
Ref:	**Risk title:**											
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	**5x4 = 20**	**6 (minimal)**	Group Chief Medical Officer /Group Chief Nursing Officer	Quality Committee (held in common)	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	↔ No change
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	**5x4 = 20**	**6 (minimal)**	Group Chief Nursing Officer/ Group Chief Medical Officer	Quality Committee (held in common)	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**5x4 = 20**	**12 (open)**	Group Chief People Officer	People Committee (held in common)	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	**5x4 = 20**	**12 (open)**	Group Chief People Officer	People Committee (held in common)	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4X3=12**	**4X3=12**	↔ No change
BAF 5	The Trust does not operate within its available resources, leading to financial instability and-regulatory action	Make our organisation more sustainable.	**4x5 = 20**	**12 (open)**	Acting Chief Finance Officer	Finance Assurance Committee	**5x4 = 20**	**5x4 = 20**	**5X3=15**	**5x4 = 20**	**5x4 = 20**	↔ No change
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**4x5 = 20**	**12 (open)**	Group Chief Estates, Facilities and Capital Officer	Performance Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**5x5 = 25**	**6 (minimal)**	Acting Chief Finance Officer	Audit and Risk Assurance Committee	**5x4 = 20**	**5x4 = 20**	**5x4 = 20**	**5x4 = 20**	**5x4 = 20**	↔ No change.
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	**4x5 = 20**	**12 (open)**	Acting Chief Finance Officer	Performance Assurance Committee	**4x5 = 20**	**4x5 = 20**	**5x4 = 20**	**5x4 = 20**	**5x4 = 20**	↔ No change

Board Assurance Framework 2026/27 - Summary

							Current total risk score in previous quarters (IxL):				Current total risk score (IxL):	
Board Assurance Framework 2026/27 - Summary at Quarter 2 (July-Sept)		**Alignment to Trust Strategy - strategic themes/objectives**	**Initial (inherent) risk score**	**Upper tolerance level (and risk appetite)**	**Lead Executive**	**Lead Committee**	**Quarter 2 (2025-26)**	**Quarter 3 (2025-26)**	**Quarter 4 (2025-26)**	**Quarter 1 (2026-27)**	**Quarter 2 (2026-27)**	**Change in current risk score since previous quarter, plus any further comments**
Ref:	**Risk title:**											
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**6 (minimal)**	Group Chief Nursing Officer	Quality Committee (held in common)	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 9	The Trust may be unable to meet the required national elective and cancer care standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Group Chief Operating Officer	Performance Assurance Committee and Quality Committee (held in common)	**4x3 = 12**	**4x3 = 12**	**4X2 = 8**	**4X2 = 8**	**3X2 = 6**	↓ Reduction in total current risk score from 8 to 6 due to sustained improvement in cancer performance, including Faster Diagnosis Standard performance of 86.6% in July 2026 and delivery at or above 80% since September 2025, alongside improving 62-day performance and the English-patient 52+ week breach position at zero. The duration and consistency of these sustained improvements provide assurance that performance is sustainable across foreseeable demand and operational scenarios, supported by ongoing monitoring and established escalation arrangements.
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Group Chief Operating Officer	Performance Assurance Committee and Quality Committee (held in common)	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**5x4 = 20**	**12 (open)**	Group Director of Estates, Facilities, HTP, Capital and MES	Hospitals Transformation Programme Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 12	There is a risk of non-delivery of integrated pathways, led by the ICB and ICS.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x4 = 16**	**16 (eager)**	Group Strategy & Integration Officer and Group Chief Operating Officer	Group Local Care Transformation Assurance Committee / Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 13	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**4x4 = 16**	**6 (minimal)**	Group Chief Governance Officer	Audit and Risk Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change

Visual representation of risk scores



BAF 2

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistencies in care • Inconsistencies and lack of clarity in governance arrangements • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies • Operational pressures • Workforce gaps in specific areas (including vacancies); Inability to recruit and retain the right numbers and skill mix of clinical staff • Clarity of and lack of consistency in the use of policies and procedures • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture **Consequence:** • Increased avoidable harm to patients • Delays in time-critical care • Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • CQC prosecutions and enforcements if standards and frameworks are not in place. • Reputational damage, financial loss and lack of confidence in the organisation	5	4	20	• Moving to Excellence programme. • Targeted transformation programmes • Quality Delivery Plan under development in line with the NHSE Quality Strategy. This is being developed jointly with SCHT; •Quality Priorities for 26/27 in place; •Corporate Strategies • Clinical audit programme • Governance structure in place. •Group Governance structure under development • Safeguarding Policy (including Mental Health and Learning Disabilities), IPC Policy and PSIRF policy in place. • Staff training • Daily incident communications (Datix)and Incident Review Overview Group (IROG) RALIG both in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Hospital Full Policy in place • Contingency arrangements in place with other acute providers around fragile services. • Ward Exemplar Programme	**Reported to Board, committees and elsewhere:** • Quality Committee held in common, reporting to Board (2nd) • Mortality metrics reported to Board and Learning from Deaths Group considered by Board quarterly (2nd) • Quality metrics within Integrated Performance Report to Board (monthly) (2nd) • CQC Report, published August 2026 provides assurance and that improvements are being made across the Trust (3rd). • Quality Account to Quality Committee helf in common/Board 2026 (2nd) • Incidents reports, themes, claims and complaints report to Quality Committee in common and public Board (2nd) • Staff Survey results to Board and quarterly pulse survey results considered at People & OD Committee (2nd) • Executive led Assurance Committees (MTAC, UECTAC) and Trust level operational committees chaired by SaTH DoN and MD which report into QSAC (2nd) • Performance Management Review Meetings (PRM) with Divisions, executive led (2nd) • Externally led quality assurance visits and reports (3rd) • Quarterly FTSU updates to Board (2nd) • External Peer reviews with action plans produced, as required (3rd) • Medical Regulatory Group in place (2nd) • All national patient surveys reported to QSAC with associated action plans (2nd) Evidence of assurance and outcomes are detailed below (Q2 2026/27) (1st, 2nd, 3rd, 4th): • Performance against the Fundamental Standards of Care has seen improvements. Although some standards remain rated amber, they demonstrate a positive trajectory of improvement and continue to be monitored through targeted improvement actions at the Quality and Safety Assurance Group. • Evidence of improvement includes an increase in completed diabetic foot assessments increased from 20% to 60% (2nd). • The 2025 Adult Inpatient Survey recorded an overall inpatient experience score of 8.0/10, rated "About the same" as most other trusts (3rd). • Maternity assurance: 152 of 158 final Ockenden Report actions implemented, including 140 evidenced and assured; remaining actions continue to be monitored (2nd/3rd). • Following CQC inspection in March 2026 within UEC and Medical Care, CQC reported significant improvement in RSH Medicine, now rated Good, and PRH UEC now rated Requires Improvement (from Inadequate) and with three Good rated domains. • Removal of the final Section 31 condition in 2026 (3rd).	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. theatres, endoscopy, doctors within critical care, care of the elderly, emergency medicine. 2. A number of patients with no criteria to reside and lack of alternatives to hospital admission, impacting on patient flow and pressures in the Emergency Department. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Implementation of national Patient Safety Incident Response Framework (PSIRF) and now to work on the outcomes of PSIRF. Development and roll-out of the Group Quality Delivery Plan to underpinned by the NHSE Quality Strategy published in 2026. 5. Notice served on inpatient neurology service by RWT which came to an end on 19 June 2025. 6. Ensuring consistent compliance with Infection Prevention and Control (IPC) standards. 7. Delivering all actions from the Fuller Inquiry report. **Gaps in assurance:** - None	Actions aligned to gaps in control: 1a.Workforce planning - see BAF risk 3 plus Workforce Strategy. 1b. Delivering the trajectories within the Workforce Strategy (timescale: ongoing) . Leads: Kara Blackwell (for nursing, midwifery and AHP) and Simon Balderstone. During 2026/27. 2. *See BAF risk 10.* 3. *See BAF risk 7b.* 4. Development and roll-out of the Group Quality Delivery Plan underpinned by the NHSE Quality Strategy. Executive Lead: Group Chief Nursing Officer. 5. Work with regional and extra-regional partners with support from NHSE and ICB leadership to develop long-term mitigation. Continuing conversations are taking place Executive lead: Group Chief Medical Officer. 6. Develop and implement an overarching IPC improvement plan for the Group during 2026/27. Executive Lead: Group Chief Nursing Officer. 7. Embed the Fuller inquiry report actions during 2026/27 to safeguard the security and dignity of the deceased. Executive Lead: Group Chief Nursing Officer/ Group Chief Medical Officer.	1a. Q2: Oversight and monitoring of Workforce Plan for 2026/27. 1b. Q2: The main remaining challenges in medical recruitment are Cardiology, Max Fax, Neurology, General Anaesthetics, Haematology and Oncology. Q4: We have seen significant reductions in nursing vacancies. Q1 26/27: Unavailability of nursing staff remains a challenge. Medical Workforce Efficiency Programme in place including revised recruitment strategies for medics, plan to utilise external support/headhunting for challenging specialities. 2. Q2: No criteria to reside continues to be above the mean and in special cause concerning variation. Actions in place to support request from NHSE regarding discharge sprint in September 2026. 3. - The roll out of electronic nursing assessments across adult in-patoient wards is in progress. 4. Work in progress to have develop and roll-out of the Group Quality Delivery Plan to underpinned by the NHSE Quality Strategy published in 2026. 5. Q2: Telephone support via a specialist private provider and some short-term interim support from a locum Neurologist remains in place and will continue for the forseeable future. The locum support was extended beyond the end of June 2026 to provide interim resilience. Q2: A joint Consultant Neurologist post with UHB is being progressed for longer-term support. A joint job description has been developed and will be submitted to the Royal College of Physicians for approval, with discussions continuing with UHB regarding the appointment. Q2: Recruitment of an Acute Physician with a specialist interest in Neurology is also being progressed to strengthen local service capacity. 6. Group wide Infection Prevention and Control (IPC) Improvement Plan is being finalised and will be presented to Quality Committee in common and Board in October 2026. 7. Q2: The Fuller report recommendations have been implemented and being embedded. The Board in Common will receive further assurance following further discussion at July and September 2026 Quality Committee in common. The Trust is also in receipt of specific bereavement care actions following the publication of Donna Ockenden's independent review of maternity services at Nottingham University Hospitals report and will undertake an audit of mortuary incident records from 2015-2026, once more specific process details are received via NHSE and HTA.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistent leadership to support a high quality compassionate care environment • Inconsistent embedding of learning when colleagues speak up • Inconsistent approach to ensure acceptable values and behaviours that create psychologically safe team working • Inconsistent organisational support to embed a continuous learning and improvement environment • Leaders inconsistently demonstrating basic good practice in respect of 1 to 1 meetings, health and wellbeing check ins and talent management conversations with colleagues. • Lack of prioritisation of learning and development for colleagues. **Consequence:** • Increased avoidable harm • Poor patient experience • Increased complaints • Reputational damage • Lack of confidence in the organisation • Potential CQC prosecutions and enforcements • Our people are not routinely raising concerns/speaking up on patient safety and anything else that may affect great patient care • Our people do not work as a team and a safety culture is not embedded within the organisation • Poor communication and unable to learn from incidents • Lack of measure of safety culture within the organisation • People normalise poor practice.	5	4	20	• Freedom to Speak Up Guardian and ambassador arrangements • FTSU Vision and Strategy in place, FTSU policy and training in place • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • PSIRF structure and plan/policy in place • Trust Strategy 2022-2027 (includes continuous improvement culture) • Leadership programmes in place, including Galvanise programme for colleagues from ethnic minorities • Staff psychological wellbeing services in place • Staff Survey covers some key safety culture elements (was undertaken Oct to Nov 2025) • Board FTSU self-reflection tool • Professional Nurse Advocacy and professional nurse advocacy roles in place to provide psychological restorative supervision • Regular meetings set up with senior medical leaders and tier two doctors • Incorporation of Ten Point Plan to improve resident doctors working lives during Q3 • SaTH is part of phase 2 of the introduction of Martha's Law • Sexual Safety Charter in place and Sexual Misconduct Policy • As part of the Ten Point Plan for improving Resident Doctors working lives, the Trust has appointed Resident and/or representative for resident doctors and the first report of the Resident Doctor Representative will be included as part of the Guardian of Safe Working Report to Board annually	**Reported to Board and committees:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) • Patient Experience & Complaints Report to QSAC - quarterly (2nd) • ARAC - Audit & Risk Assurance Committee (2nd) - bi-annual FTSU reports • Culture dashboard (annually based on Staff Survey), reported to Strategic People Group (1st) and Group People Committee/PODAC (2nd) • Quarterly FTSU updates to Board (2nd) • Patient Safety Incident Response Framework and policy to Board (2nd) • MIAA internal audit reviews 2024/25 (3rd): • CQC Report published August 2026 (3rd). • Independent Patient Complaints Review Panel (2nd). • Implementing a Kind Life programme to improve the culture across the group (2nd) • National trainee survey (3rd) • National Patient Surveys (3rd) - to QSAC from Oct 2025 • Medical Director and Chief Nurse attending PODAC to provide assurance around meeting standards in care and training of regulated professionals (2nd) • Organ Donation Committee re-established January 2026 (2nd)	4	4	16	**Gaps in control:** 1. Developing a shared purpose, vision and values across the Group Model to support culture. 2. Embedding the new approach to patient safety through the ongoing PSIRF programme of work and the development and delivery of the Quality Improvement Plan in line with NHSE Quality Strategy 2026. 3. Evidence of continuous quality improvement culture. 4. Colleagues having confidence and feeling safe and supported to raise patient safety concerns (FTSU and raising risks and incidents), and that they will be acted upon and learning embedded. 5. Unprecedented continued overcrowding in ED's and its impact on normal culture. **Gaps in assurance:**	Actions aligned to gaps: 1. Report on culture engagement work through Moving To Excellence, PRM's, Strategic People Group and PODAC/Group People Committee. Develop culture and engagement framework to support delivery of the Joint People Strategy - into Q1/Q2 2026/27. Executive Lead: Group Chief People Officer/ Group Chief Nursing Officer 2. Development and roll-out of the Group Quality Delivery Plan underpinned by the NHSE Quality strategy published in 2026. Executive Lead: Group Chief Nursing Officer. 3a. Learning from patient complaints and reduction in common themes - ongoing. Executive Lead: Group Chief Nursing Officer 4a. Continue with implementation of new ambassador network during 2025/26 and into early 2026/27. Executive Lead: Group Chief Director of Governance. 4b. Further develop a FTSU plan by Q3 following the NHSE FTSU review in December 2025 at SaTH, and including changes following new NHSE guidance (NHSE are taking over from the National Guardian's Office). Executive Lead: Director of Governance. 5a. Deliver the actions identified in the culture work stream within UECTAC transformation programme. 5b. UEC Board to deliver agreed milestones. 5c. Review of approach towards cultural change within ED - by Q3 2026. Executive lead: Group Chief Medical Officer/COO/Group Chief Nursing Officer	1. Q1: Board Development session held on 21st May 2026 to finalise Group Culture Programme, under the flagship of Poppy's Promise. This programme will launch in July and is supported by external partners, with oversight via our new Group Culture Accelerator, chaired by the Deputy Group CPO, and reporting into Group People Committee. Part of this work will include developing and embedding new values. The evaluation and success of the programme will be aligned to the QMS approach and the Trust being a 'great place to work' measure, which will be reviewed regularly through a new channel. This will further embed the Culture Dashboard activity. Our progress and plans for the Group Culture Programme were shared with NHSE and ICB colleagues at the Provider Review Meeting on 19th June 2026 and 18 August 2026 for assurance. 2. Work in progress to have develop and roll-out of the Group Quality Delivery Plan underpinned by the NHSE Quality strategy published in 2026. 3a. Q2: Divisions are engaged in responding to complaints. An independent complaints review panel is in place (chaired by a patient representative) and Divisional Directors of Nursing attend to take away the learning and share within Divisions. Q2: This work is now being embedded. 4a. Q4: Work has continued to build and strengthen the Freedom to Speak Up Ambassador Network. Ambassadors have been recruited from both offsite services and hospital sites. We are working to recruit ambassadors in all departments to increase coverage across the organisation. The ambassadors will help raise the profile of FTSU and encourage colleagues to feel confident to speak up. Planning has also started for the 2026/27 programme. This includes beginning joint work with Shropcom to develop and deliver a shared ambassador training programme for both organisations. Q1: This work is now business as usual. **Action closed, Q1 26/27.** 4b. Q1: We are working through the FTSU action plan following the NHSE review in December 2025. Q2 2026/27: The Freedom to Speak Up Improvement Plan 2026–2028 has now been developed and brings together the NHSE review actions, outstanding actions carried forward from 2024/25, MIAA audit findings and local improvement priorities. The plan identifies each action's source, accountable owner, timescale, measurement and BRAG status. Progress is reported quarterly to ARAC and the Trust Board, providing a single route for oversight of actions completed, in progress or requiring further attention. The policy review has also been updated and considered the June 2026 NHSE guidance and is progressing through the established governance route for approval. 5a. Progressing workstream 2 - Staff Culture, Resilience & Wellbeing - this is monitored via the UECTAC using the reverse RAG (red, amber, green) methodology as per MNTAC (Maternity and Neonatal Transformation Assurance Committee). Medicine staff survey results 2024 showed improvement across all People Promise Domains. Progress continues to be monitored through UECTAC. 5b. See BAF risk 10. 5c. Work remains ongoing.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	AK7:L10	Progress notes	I	L	Upper tolerance level
Cause: • Failure to recruit and retain the right number of people at the right level, with the right skill mix. • Staff fatigue burnout. Stress, anxiety, and depression remains a top reason for long term sickness • Lack of certainty around future ways of working and work environments • Shortage of key professionals and occupations in specific roles • Lack of succession planning to mitigate risks when key staff leave and encourage staff retention • Dissatisfaction with pay and reward • Work environment concerns in relation to belonging and staff experience relating to behaviours • Recruitment control processes in place to review current resources and skill mix **Consequence:** • Staff dissatisfaction with the level of engagement, involvements and communication with team leaders and senior leadership leading to low morale • Poor levels of engagement and morale which are correlated with lower patient satisfaction and outcomes • Agency use in medical and dental groups. • High levels of sickness • Poor patient experience, outcomes and quality and safety. • May lead to the financial unsustainability of some services. • Needing to reform our services	5	4	20	• People governance arrangements in place including Strategic People Group (monthly) • Dashboards reporting against People Strategy, action plans and KPI's • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff Survey, pulse survey, improve well and making a difference linked to the culture dashboard. • Extensive Health & Wellbeing (HWB) programme including staff finance, support, physio, clinical psychology and therapy • Group Culture Programme underway • Leadership development framework • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Continued use of new roles such as Nursing Associate Top Up programme allowing development of Nursing Associates to become registered nurses. • Safer Recruitment and Selection workshops have been implemented to support appointing managers during the hiring process. • Developing operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan • Vacancy and spending control panel • Training and delivery model aligned to operational demand and capacity. • Medical workforce efficiency programme in place • Oversight and monitoring of Workforce Plan for 2026/27	**Reported to Board and Committees** • Daily and weekly reports on workforce metrics, temporary staff usage, and agency spend considered (1st). • Executive dashboard on agency expenditure - weekly (1st) • Reports to People & OD Assurance Committee (PODAC)/Group People Committee (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025 (2nd) • Reports to Strategic People Group and Educational Group (SPG) (2nd) • Annual Staff Survey considered by Board along with updates (2nd) • People Strategy approved by Board 2024 (2nd) • Quarterly/monthly People Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at SPG (2nd) • Financial Recovery Group - fortnightly (2nd) • MIAA (internal audit): 2023/24 Staff Wellbeing & Engagement review to ARAC February 2024 - Substantial assurance . • Medical Workforce Efficiency Taskforce Group (2nd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Workforce Digital Group (2nd) • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance • Group Transformation Committee (2nd) • HTP Assurance Committee (2nd) • MIAA (internal audit) 2024/25 Bank and Agency Review Report (3rd) to ARAC November 2024 - Moderate assurance.	4	3	12	**Gaps in control:** 1. Systematic process throughout the Trust to support succession planning. 2. Managing Working Time Directive breaches and management of rosters for medical staff. 3. Ongoing retention initiatives. 4. A plan to support staff to work in new ways, embrace digital in accordance with the NHS People Plan. **Gaps in assurance:** - None	**Actions aligned to gaps:** Executive Lead for actions: Group Chief People Officer. 1. To work with system colleagues to develop a system approach to talent management - during 25/26 and 26/27. 2. Visibility of all rosters and review consultant rosters during 26/27. 3. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 26/27. 4. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans. Workforce plans for HTP and operational planning in place and being monitored during 2026/27.	1. Leadership development and talent management are being delivered jointly across Shrop Com and SaTH. In addition, shared services are also being explored to provide a wider footprint and broader system-wide approach to leadership development and delivery. Q4: Three organisations were appointed to support and review current culture and leadership position, incorporating Poppy's Promise. Q2 2026/27: Task and Finish Groups have been established and are supporting effective joint working between ShropCom and SaTH. People governance arrangements are in place and continue to progress, supporting the development of a shared approach to leadership, talent management and organisational development. 2. Until one roster system is fully implemented, the full benefits of having doctor working hour visibility will not be realised. Q4: Workforce Digital Group established as part of the Medical Workforce Efficiency Programme. An action plan was developed, with delivery throughout 2026/27 against this plan at Q1, Q2, Q3 and Q4. This work will continue during 2026/27 and envisage system switch over within six months (Sept 2026). Q2 2026/27: A revised action plan has been developed and is being implemented. Delivery is overseen through the Workforce Digital Group as part of the Medical Workforce Efficiency Programme. 3. Q4: Training is now available on the LMS and training portal to support managers to have quality conversations. The launch date for the framework is yet to be agreed. Q1: Review of retention interventions as part of the corporate service review for People & OD. Q4: More work to be done and a Wellbeing Strategy required. Q2 2026/27: Workforce wellbeing, retention initiatives and the Quality Conversations Framework are being progressed through the Group Culture Programme. A Group Wellbeing Strategy is also being developed. 4. Q2 2026/27: Divisions continue to implement service reform and organisational change which will be delivered as part of the 2026/27 operational plan.	3	2	12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Engagement in quality improvement initiatives due to competing demands on the team. • Redeployment of staff to support operational activity, reducing the opportunity of staff to be involved in improvement activity or take part in training. • Failure to address inequalities across all protected characteristic groups of staff in terms of promotion, career progression and over representation of staff from minority ethnic groups in formal HR processes. • Leadership styles that do not reflect the Trust values and behaviours framework • Colleagues not accessing appropriate learning and development, including statutory and mandatory training **Consequence:** • The trust's ability to recruit and retain will be impacted on recruitment and retention • Failure to embed and model the values and behaviours of the trust consistently and create confidence in speaking up culture and processes. • Leadership roles not reflecting diverse nature of community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes • Sickness absence will remain above target • Potential incidents if staff are not up to date with mandatory training • Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience, and with attendant risks around staff motivation, morale and productivity. • Increasing agency costs if we are unable to recruit fully • Ability to reform our services	5	4	20	• Educator role for newly qualified nurses (visible role picking up pastoral and education needs) • Equip people to deliver quality improvement locally, to identify and embed organisational learning to provide a positive impact on quality of care • Board and workforce equality committee dashboards reporting against strategy, action plans/KPI's and inclusion plan • Workforce metrics, staff survey, pulse surveys, EDI (equality, diversity and inclusion) groups, staff networks, triangulation of data, coaching methodology, SaTH improvement methodology • Participation in WRES (workforce race equality standard), WDES (workforce disability equality standard), EDS (equality delivery system) frameworks and gender pay gap reporting • Minority ethnic staff leadership programmes • Values based recruitment approach • Agreed targeted recruitment campaigns and retention actions including exit interviews • Learning Made Simple reporting on statutory and mandatory training compliance • Board diagnostic complete and developing external Executive and Board Development Programme • Civility Saves Lives programme roll out • SaTH education offer via education prospectus • SaTH 1 to 4 and STEP Leadership Programmes • Affina team journey interventions • Vacancy and spending control panel • Process to review mandatory training in place via Education Group which meets bi-monthly. • Non-Clinical Bank Review Panel in place since end of August 2025 • Nursing Bank review process in place since November 2025	**Reported to Board and ommittees:** • Education Group - bi-monthly (1st) • System education/training meeting (1st) • Workforce data on leadership profile (1st) • Recruitment dashboard (1st) • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee/Group People Committee - meets bi-monthly (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. • Strategic People Group (SPG), monthly (2nd) • Moving To Excellence progress reviewed/reported monthly (2nd) • Annual Staff Survey considered by Board (2nd) • Group Leadership Forum - operational, monthly (2nd) • People Pulse Surveys reported to OPG quarterly (2nd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Medical workforce efficiency programme reported to FRG, Finance Assurance Committee and Strategic People Group (2nd) • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance (2nd)	4	3	12	**Gaps in control:** 1. Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place 2. New ways of working 3. Embedded EDI champions/networks and local EDI objectives to create a diverse workforce, leadership and inclusive culture 4. High levels of mental health related sickness absence **Gaps in assurance:** - None	**Actions aligned to gaps:** Executive Lead for actions: Group Chief People Officer. 1. Review our retention interventions during 2026/27. 2. Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 2024/25 through to 2030. 3. Develop a refreshed EDI action plan and review against key workforce data with report to Board at least annually. 4. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 2026/27.	1. The development of the Group People Strategy is underway alongside a review of People and OD service structures and priorities. A discussion document on the draft Group People Strategy was presented to PODAC in August 2025. Q2 2026.27: Work has continued to develop the Group People Strategy during the quarter. 2. Q2, 2026/27: External support is in place to scope opportunities for robotic process automation as part of the Digital Transformation Programme. 3. - Q2, 2026/27: EDI will be a key component of the new Group People Strategy and will be informed by relevant workforce data (linked to action 1). 4. Q2 2026/27: The strategic to developing a trauma informed culture continues to be reviewed and aligned with the Group Culture Programme.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level		
Cause: • Overspend against operational budgets driven by operational pressures and inefficient use of resources • Capital constraints • Historic under-investment driving increased capital requirement • A failure to maintain financial sustainability due to non-planned cost pressures • Lack of available appropriate substantive workforce • Continuing to operate in a system with a commissioner with an underlying deficit • Increasing demand placing pressure - inadequate estate available to accommodate need. Inefficient deployment of resources to bridge gap. • Aged infrastructure requiring increased maintenance and potential loss of capacity • Significant CIP plans of 5.3% required to deliver the annual plan • High sickness levels placing additional pressure on service costs • The reliance on insourcing to deliver constitutional standards at premium cost **Consequence:** • Short-term recovery inhibits service quality improvement. • Dwindling cash reserves. • Potential regulatory action taken against the Trust leading to the loss of local control. • Damage to the Trust's reputation and the Trust's continuing ability to function • Inhibits ICS' ability to commission growth in services • Risk of increased cost • Insufficient cash to underpin the capital programme • Reduction in planned investments	4	5	20	• Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system, underpinned by new performance, assurance and accountability framework - Ward to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Chief Executive-led Financial Recovery Group meets fortnightly from December 2025 • Service Review Deep Dives in place to identify opportunity for improving efficiency. • Triangulation of operational, financial and workforce data into a dashboard to provide greater visibility of service performance. • Service Line Reporting to assess service viability and ensure appropriate funding in place. • Annual revenue plan for 2026/27 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing medical doctors rotas to ensure compliance and delivery of planned clinical programmed activities in line with nationally accepted standards • Internal (executive led) vacancy control process. • Strengthening governance via splitting the finance and performance elements within the assurance committees (but recognising the interdependencies between the two). • High levels of authority required to approve discretionary expenditure (non-pay) on Oracle - in practice since January 2025 • Group Chief Nursing Officer and Group Chief Medical Officer approval of bank shifts from December 2025 • Three times a week panel for the approval of non-clinical bank shifts from October 2025	**Reported to Board, committees and elsewhere:** • Monthly Trust-wide finance reports to Board of Directors, Finance Assurance Committee and Financial Recovery Group (2nd) • Sustainability and Efficiency (CIP) report to Innovation & Investment Committee and Senior Leadership Committee-Operational (2nd). • Annual financial plan, planning progress shared with Board for sign off (2nd) • Divisional Performance Review Meetings (PRM), Cascade, Executive messages into the organisation (2nd). •Monthly performance reviews with divisions (1st) • Routine monthly reporting including variance to plan and run rate analysis (1st) • Internal audit reports (MIAA): core financial controls and sustainability and efficiency processes (3rd) - Substantial assurance • Report to region (NHS Midlands) each month and position shared with local Integrated Care Board (2nd). • External audit of annual accounts (3rd) • Workforce plan reported to Strategic People Group and PODAC (2nd) • Weekly Executive Dashboard: beds, nursing WTE and finances - presented fortnightly at FRG (2nd) • Final Budget setting paper for 26/27 approved by FAC and Board (2nd) • Strategic People Group now aligned into Operational Performance Oversight Group to enable better oversight (2nd) • VFM opinion from external audit with no significant weaknesses identified (3rd) • An overarching efficiency and performance recovery programme is in development. This will provide the governance framework for the 11 agreed transformation assurance committees that will drive change over the medium term (2nd). **Evidence of assurance and outcomes for Quarter 2 of 2026/27:** • The full £40 million efficiency programme has been identified, with delivery and de-risking monitored through the Financial Recovery Group and Finance Assurance Committee (2nd). • MIAA has provided Substantial Assurance over core financial controls and sustainability and efficiency processes (3rd). • External audit identified no significant weaknesses in the Trust's value-for-money arrangements (3rd). • The Trust exited the Recovery Support Programme following confirmation from NHS England on 2nd March 2026 (3rd). • Divisional financial escalation arrangements are	5	4	20	**Gaps in control:** 1. Divisions recognise their financial responsibilities and engage well however, financial management, effective sustainability and efficiency planning compete with other high profile priorities across the Trust. 2. Comprehensive identification and delivery of a £40 million cost improvement programme and adherence to cost control policies and processes 3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 4. Risk management process that takes into account quality and safety risk alongside financial risk on a daily basis leading to budget holders prioritising the quality and safety risk and	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 2026/27 via a dedicated multi-disciplinary Financial Recovery Programme Office by December 2025. This is in addition to identifying any mitigations in relation to the 25/26 programme. Executive lead: Chief Finance Officer 1b Development of the financial Recovery Plan for 2026/27 which achieves a break even position b y the end of September 2026. Executive lead: Chief Finance Officer 1c.Workforce reduction aligned to delivery of CIP issued to divisions to achieve agreed exiting whole time plan by March 2027. Executive Leads: Group Chief Operating Officer/Group Chief People Officer/individual executives. 1d. Roll out of performance, assurance and accountability framework (PAFF) with escalation aligned to delivery of key metrics in support of the strategic objectives by end of Q2 26/27. Lead Executive: Group Chief Operating Officer. 1e. Developing an overarching 3-year efficiency and improvement plan that incorporates all transformation (including HTP) across the group and aligns it to the strategic objectives including financial sustainability. Target date - September 2026. Lead Executive: Chief Finance Officer. 2a. £40 million was identified by end May 2026, in line with the NHSE deadline. The priority is to de-risk, identify mitigating alternative schemes and deliver the £40m - timescale end of Q2. Executive lead: Chief Finance Officer. 2b. Identify and recruit resources to support the transformation work required to deliver the CIP. Executive lead: Chief Finance Officer. 2c. Additional controls over bank usage have been tightened and continue to be in place to manage cost pressures. Target date - Ongoing. Lead Executive: Chief Nursing Officer, Group Chief Medical Officer and Chief Finance Officer. 2d. Updated self assessment against the grip and control toolkit has highlighted a number of actions to facilitate improved grip. Target date - Ongoing. Executive Lead - Chief Finance Officer. 2e. Weekly dashboard to Financial Recovery Group (FRG) to be incorporated where possible to a dashboard for Divisions. Target date - ~~March~~ October 2026. Executive Lead- Chief Finance Officer. 3a. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - Q4 2026/27. Executive lead: Chief Finance Officer and Group Chief People Officer. 3b. Finance teams across STW providers collaborating on procurement of a new financial ledger or third party service. 4a. Revised escalation measures, with executive sign off for bank shifts, to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact, Q3 2026/27. Executive lead: Group Chief Medical Officer /Group Chief Nursing Officer 4b. System-wide actions in relation to the UEC pathway, managed by the UEC Transformation Board in order to mitigate the risk of additional	1a. Financial Recovery Taskforce supported by the Financial Recovery Programme Office in place since September 2024. Chief Executive chaired Financial Recovery Group - since August 2024. Fully identified CIP programme for 25/26. Q3/Q4: Plans for 2026/27 in development. 1b Q2 2026/27: Recovber Plan in development and to be presented at the Board on the 25 September 2026. 1c. Whole time reduction monitored on a monthly basis and reported to Finance Recovery Group, Finance Assurance Committee and Group People Committee (in common). 1d. Q1, 26/27: Divisional oversight will be increased as necessary in line with delivery of the measures within the PAAF. Additional support programme in place for divisions who are off-track financially. Q2: Divisional escalation in place up to and including the Finance Assurance Committee where necessary. Action Complete Q2. 1e. Framework designed, meetings planned with SCHT and Improve & Transformation teams in SaTH to establish the key pillars. Q4: Initial meetings held and further work ongoing. Action Complete Q2. 2a. Full efficiency programme identified. De-risking continues to be monitored via Financial Recovery Group and Finance Assurance Committee. ~~Q3: Original action complete~~. Continue to monitor to ensure any further risk is mitigated. 2b. Interviews held Q1 and offers in progress. Q2: Interviews completed and the postholders will commence in post during September and October 2026. 2c. Daily nurse, tri-weekly medical and tri-week ly non-medical panels to review requests in place and executive led. 2d. Self assessment completed and action plans being monitored and managed. Internal audit provides substantial assurance. 2e. Weekly metrics evolving as processes put in place to capture data. Meetings arranged to understand the potential for inclusion in a senior leaders dashboard. Q4: Meetings have taken place to understand potential and the dashboard is being refined (presented fortnightly to FRG). Q2: Dashboard has been developed by the BI team and to be incl;uded in the FRG meeti ngs from October 2026. 3a. Work ongoing during 2025/26. Q3: Discussions have taken place with NHSE as to whether any other trusts have gone through a similar process and could share their learning. Q4: Response received, no new intelligence provided. 2026/27 ~~Q1~~ Q2: Work undertaken to implement post numbers in ESR to improve controls. 3b. Scoping work in hand to develop specification for procurement. 4a. Executive lead bank panels in place for clinical shifts.			12		

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Older buildings built with now outdated regulatory requirements • Restricted physical environment, unable to meet current capacity requirements • Backlog maintenance issues due to limited capital, however Critical Infrastructure Risks (CIR) applications are now welcome by NHSE • Residual gaps in fire safety action plan • The Trust has identified reinforced autoclaved aerated concrete (RAAC) within specific areas within PRH and surveys continue across the Estate. **Consequence:** • Poorer patient outcomes and patient safety issues • Regulatory or legal action possible • Adverse publicity and reputational damage possible • Potential poor working conditions and environment affecting staff health, experience and engagement - increased sickness absence and recruitment.	4	5	20	• Board-approved (limited) Capital Programme including backlog maintenance plan and medical equipment budget in place addressing high risk backlog on a yearly basis, where funding allows. • Capacity & demand led capital programmes, aligned to Hospital Transformation Programme. • Capital Estates Plan 2021-2026 in place - in Capital Planning Group for review (subject to funding each year). • Estates Strategy 2025-2030 • Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure. • Staff survey measures staff levels of engagement and morale (in relation to working environment). • Minor and major works protocols and management plans in place for known risks, e.g. asbestos and RAAC. • RAAC national funding received and removal project in progress. • Fire action plans in place and being monitored. • Annual fire safety audits. • Independent survey of fire doors at PRH - March 2026 • Standardised framework for large capital projects developed and implemented • Critical Infrastructure capital funding applied for in 2026 and granted for backlog works; new applications now open for 2027.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (PAC) (2nd) • Capital plan developed and overseen by Capital Planning Group (CPG), chaired by Director of Finance (2nd) • Annual estates report to Board (2nd) • Annual update backlog six facet survey that informs the capital plan (1st) • Regular updates of fire action plans at Fire Safety Group (1st) • Fire Safety Improvement Action Plan Oversight Group (2nd) • Fire safety updates reported to private Board regularly (2nd) • Operational estates governance and oversight in place including: Decontamination Group (2nd), Medical Gas Committee (2nd), Ventilation Safety Committee (2nd), Water Safety Committee (2nd), Fire Safety Group (2nd), Asbestos Safety Committee (2nd). • Authorising Engineer's Annual Fire Safety Audit 2025 (3rd) - report presented to Assistant Chief Executive and Director of Estates, and February 2026 PAC. • RAAC Project Group in place (monthly) for the duration of the programme (2nd). • Performance Review Meetings (PRM's) bi-monthly (2nd). • Estates Strategy 2025-2030 to Performance Assurance Committee June and July 2025 and to Board September 2025 (2nd) • Fire Enforcement Notice 348 removed July 2025. Plan in place for associated fire stopping works in ward block RSH. • Fire Enforcement Notices 365 and 366 received from Shropshire Fire & Rescue Service for PRH, reported to Performance Assurance Committee February 2026 and added to risk register (negative assurance).	4	4	16	**Gaps in control:** 1. Energy infrastructure at its limit on the site 2. Awaiting confirmation of RAAC funding to enable long-term remedial works 3. Aged nurse call systems require updating. 4. Fire notices continue to be received by the Trust. **Gaps in assurance:** - None	**Actions aligned to gaps:** 1. Utilise Salix funding for replacement infrastructure - supplier identified and project has commenced. Public Dividend Capital (PDC) Fund allocation of approximately £7m (proportion of which relates to energy infrastructure). Continuous exploration for additional external funding opportunities - ongoing. Executive lead: Group Chief Estates, Facilities and Capital Officer. 2. RAAC removal project at PRH has commenced with expected end date of April 2027. Executive lead: Group Chief Estates, Facilities and Capital Officer. 3. Conclude the works for new fixed nurse call systems by end of Q4 26/27 (subject to availability of wards). Executive lead: Group Chief Estates, Facilities and Capital Officer. 4a. Commission Independent survey report of PRH fire doors during March 2026. 4b. Action the recommendations from the independent survey fire report once received - by Q3 26/27 or at a date to be agreed with Shropshire Fire & Rescue Service. Executive lead: Group Chief Estates, Facilities and Capital Officer. 4c. Develop a case to Capital Planning Group to request additional funding, as we only have half the funding currently of the c£500k required for the fire door replacement programme. By Q2. Executive lead: Group Chief Estates, Facilities and Capital Officer.	1. Contractor selected and contract signed. Works commenced March 2025. Two year programme underway. Q1 and Q2: November 2027 is the end date for key power upgrades. 2. NHSE has approved and confirmed funding of £12.2m over two financial years. Contractors selected and approved. Project Group set up and full works have commenced. Q3: Project completion date is now expected as October 2026. Change request form submitted to NHSE, awaiting formal approval for date extension and increased budget of £2.9m. Q1 26/27: Written confirmation of end date now received for funding April 2027. Q2: 2027/28 delays in power contractor works and theatre availability. 3. Q1 and Q2: Working with clinical teams on prioritisation plan for delivery within 26/27. Q2 Delayed in 25/26 due to availability of wards/access. 4a. Q4: Independent Fire Survey completed March 2026. **Action closed Q1 26/27.** 4b. Q1 and Q2: Ongoing with action plan, in liaison with Shropshire Fire & Rescue Service. Prioritising clinical training and fire doors4c. 4c. Q2: Interim Finance Director has agreed this funding from Capitol.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest • Increasing prevalence of threats globally • Funding constraints to invest in digital tools to improve cyber security • Continued national development of cyber strategy, policy and compliance & mitigation framework **Consequence:** • May lead to sub-optimal care, for example could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - e.g. ICO fines • Potential regulatory action - Network & Information System Regulations (note: this area is subject to further expansion) • Reputational damage and negative impact on public confidence • Temporary or permanent loss of data • Reinforces the need for dedicated resource and continued review of the capacity and capability required. • Limited or non-compliance with national framework	5	5	25	• Governance resource in place including Cyber Security Manager, Deputy and SIRO • Trust actively contributing to cyber security management at Integrated Care System (ICS) level • Business continuity plans in place • Cyber security tools in place to support access management, security compliance, single sign-on, password and digital policies, CareCert updates reviewed for high severity alerts, Multi-Factor Authentification compliance for NHS mail, Phishing test cycles. • Security compliance in place to monitor security patch compliance and compliance with Cyber Assurance Framework (CAF) aligned DSPT • Information Governance (IG) strategy, policy and framework • Incident review processes and learning - national and local • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff • Monthly meeting with regional NHSE cyber security lead.	**Reported to Board, committees and elsewhere:** • Information Governance Committee - (2nd) • MIAA internal audit of cyber security - Sept 2025 (3rd) • Annual MIAA internal audit of cyber security, reporting to Audit & Risk Assurance Committee (3rd) • MIAA Technical Review Medical Devices 2024/25 - Moderate Assurance (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Dedicated monthly risk review meeting (1st) • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Bi-annual cyber update reports to Audit & Risk Assurance Committee meeting (2nd) • Monthly meetings held between SaTH Digital Services and NHSE Regional Cyber Security Team since 2024/25 to provide ongoing updates in relation to remediation planning and ongoing risk / impact	5	4	20	**Gaps in control:** 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours 3. Cyber Security strategy to be developed. 4. Funding constraints. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions - ongoing, funding dependent. Executive lead: Executive Lead: Chief Finance Officer 2. Continue our work as a health system partner during 2026/27 as part of the work programme for the ICS Digital Delivery Group. Executive Lead: Chief Finance Officer 3. Develop Trust-level Cyber Security Strategy ~~to~~ support overarching Digital Strategy by Q4 26/27. Executive Lead: Chief Finance Officer 4a. Re-prioritisation of internal digital capital funding during 2026/27. 4b. Continue to explore external funding opportunities during 2026/27. Executive Lead: Chief Finance Officer	1. Q1 26/27: Cyber and Risk update was presented at Audit and Risk Assurance Committee. 2. Q1 26/27: SSOT and STW to confirm terms of reference and governance arrangements. 3. The intention is to ensure that the strategy is aligned with the National Cyber Strategy for Health and Social Care and the NHS England CAF aligned Data Security and Protection Toolkit. Q2: Development of SaTH Cyber Security Strategy has now paused pending delivery of the ICS Cyber Strategy. Q3: 2026/27 work to be undertaken to strategically align with the Group Model. Q4 26/27: The group model digital strategy is to be developed. This will help define a group model cyber strategy during 26/27. 4. Q1 26/27. Several cyber and infrastructure frontline productivity bids including network resiliency, network segmentation, backups, vulnerability management scanning and security event logging, have been submitted nationally. Awaiting national feedback on successful bids and funding. Capital Planning Group are aware of the bids submitted nationally to support Cyber Security Defence via Frontline Productivity funding. Final national approval outstanding. Once the national team have confirmed approval for funding, further update will be presented to Capital Planning group.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of core digital project team resource - appropriate skillsets and experience and national shortage of digital technical personnel • Lack of clinical and operational capacity and capability within Trust • Large scale digital business change programme alongside other competing business change programmes such as financial improvement, UEC and HTP • Network replacement • Prescribing and Medicines Administration (EPMA - electronic prescribing and medicines administration) and Order Communications systems required to improve level of digital maturity. • Order Communication system is past the end of its useful life • Second phase of maternity system required - neonatal system upgrade • Trust's Data Warehouse requires redevelopment and resourcing both in the short and medium term, with alignment to the national federated data platform. • Reduction in digital capital allocation (national, regional and local). **Consequence:** • Could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • Poor data quality • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - misreporting • Coding omissions due to absence/incorrect data, impacting payment (Q4) • Inability to provide national submission reports, which may affect income and activity • Potential regulatory action • Reputational damage and negative impact on public confidence • Potential negative impact on staff morale • Inability to operate in an integrated health and care system, e.g. shared care record (One Health and Care) Inability to adopt modern technologies such as artificial intelligence (AI), robotic process automation (RPA), etc.	4	5	20	• Digital Transformation governance structure in place - EPR Operational Readiness Group established, reporting to the Digital Transformation Assurance Committee and Financial Recovery Group, which in turn reports into Senior Leadership Committee, reporting into Performance Assurance Committee/Trust Board • Business continuity plans in place and to be implemented for new systems • Working closely with procurement to secure recruitment into specialised posts and to continue to recruit substantive vacant posts • Standardised network infrastructure platform • Governance resource in place: Chief Clinical Information Officer and Chief Nursing Information Officer provide Clinical Safety Officer functions. Clinical Safety & Hazard Group in place monthly (safety of software and reducing hazards for patient safety), Chief Information Officer/Director of Digital Transformation in place - at SaTH, Head of Digital Innovation & Transformation in place within the ICB • Digital Design Authority Group and the Clinical Design Authority / Medical Records Committee meet frequently to review the design for systems and sign off to ensure fit for purpose	**Reported to Board, committees and elsewhere:** • Weekly digital senior team meeting and bi-weekly digital design authority meeting for areas of escalation, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Digital Transformation Assurance Committee (2nd) • BI-Weekly Digital Transformation meeting to oversee high priority transformation projects linked to CIP. (2nd) • Bi-monthly update into Senior Leadership Committee (2nd) • Digital updates to Performance Assurance Committee (2nd) • Periodic Digital updates to Trust Board (Board report and/or Board seminar format) (2nd)	4	5	20	**Gaps in control:** 1. Requirement for key roles and increase in substantive capacity in the digital programme. 2. Capacity within wider trust teams for digital system implementations. 3. EPMA and several other digital initiatives do not have a source of full funding in 26/27 and limited national/regional capital funding identified for 26/27. 4. Ageing digital infrastructure and architecture. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Recruit to temporary and substantive posts during 2026/27 to support the digital and patient records transformation programme. Executive Lead: Chief Finance Officer 2a.A review of all digital initiatives has been undertaken and continues to be reviewed during 2026/27, aligned to the prioritisation of the service development capital allocation and recovery programmes. Executive lead: Chief Finance Officer. 2b. The framework for the requirement for SRO, operational lead and clinical lead for each digitally enabled project continues to be described for 2026/27 and work is to be undertaken to review this with corporate leads and Divisions in 2026/27. Executive lead: Chief Finance Officer 3. Ongoing discussions with NHSE National and Regional Digital Team to explore external funding opportunities during 26/27. Executive Lead: Chief Finance Officer 4a. Complete the digital maturity assessment for 26/27and submit to NHSE annually. Executive Lead: Chief Finance Officer. 4b. Develop programme for substantive solution for Data Warehouse supported by national federated data platform (FDP) team by March 2026. Executive Lead: Chief Finance Officer.	1. Q1, 26/27: Paper developed requesting funding for digital resource to support the digital and patient record transformation programme, due to be presented at Capital Programme, June 2026. Capital Planning Group are aware of the bids submitted nationally to support EPR and AI via Frontline Productivity funding. Final national approval outstanding. Once the national team have confirmed approval for funding, further update will be presented to Capital Planning group. 2a.Q1, 26/27: Trust digital programme is discussed in more detail at the monthly executive-led Digital Transformation Assurance Committee which includes representatives from all four clinical divisions and key corporate services. 2b. Q1: In progress. As new projects are requested which meets the digital transformation criteria , they are reviewed for prioritisation by the digital transformation committee. 3. Q1 25/26: Additional external funding has been successfully secured for Laboratory Information Management System (LIMS) and Electronic Order Communications and Results Reporting (OCRR). Q3: Funding beyond 25/26 not yet secured. Submission for external funding through Diagnostics Digital Capabilities being submitted. Women's and Children's Division have finalised funding for Badgernet Neonatal system 2025/26. Divisions have prioritised their capital requests for 25/26; opportunities for use of AI/RPA are being reviewed with controlled proof of concepts within the Trust and will require the development of business cases. Q1 26/27: A number of frontline productivity bids have been submitted nationally including Medicines Management, Electronic Prescribing, EPR Optimisation, Robotic Process Automation and Artificial Intelligence. Awaiting national feedback on successful bids and funding. 4a. Q2: Submission made for 2025/26. Results due to be published Q3 (awaiting). SaTH DMA score 2.0 from previous 1.8. **Action Closed Q1**. 4b. ~~Q1: Successful live automation of the Trust's SUS returns through the Federated Data Platform (FDP). Second phase to transition functionality into the FDP with the national team is underway.~~			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Poor processes, systems and culture • Operational challenges and pressures **Consequence:** • May lead to sub-optimal quality of care • Additional regulatory action. At the end of Q4 2025/26 the Trust had one Section 31 condition in place • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties	4	5	20	• Moving To Excellence Programme • Quality priorities 26/27 • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • CQC inspection report published August 2026 (3rd),	**Reported to Board, committees:** • Reports received monthly at Quality and Safety Assurance Group (2nd) • Quality Committee in common receives quality and safety reports (bi-monthly) and monthly via AAAA report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions - QSAC (2nd) • Quarterly engagement meetings with CQC (3rd) • Moving To Excellence Operational Delivery Group (1st) which feeds into QSAC and Board • UEC Transformation Assurance Committee, reporting to QSAC (2nd) • Provider Review Meeting with NHSE, quarterly (3rd) • Research Committee in place for SaTH and being reviewed as part of the Group Model and reports through to QOC bi-annual.	4	3	12	**Gaps in control:** 1. Delivery the CQC improvement actions from the CQC Inspection report August 2026. 2. Under stage one compliance management for Aseptic and Radiology Services. **Gaps in assurance:** 3. Board reporting on assurance on delivery of research requirements and aspirations	**Actions aligned to gaps:** 1. Deliver new CQC improvement plan currently being developed during 26/27. 2. Deliver improvement plan which relates to training, equipment and work environment during 2026/27: Lead: Chief Pharmacist 3. Develop research assurance reporting by Q2 26/27 . Lead: Group Chief Medical Officer	1. The one remaining section 31 condition relating to assessment of all patients in ED within 15 minutes has been removed following the most recent inspection in Q2. 2. Q2: Work remains ongoing. Updates received at Quality Committee held in common. Q4: A recent re-inspection in UEC and Medical Care has lowered the level of concern from high to moderate reflecting considerable improvements in safety have been achieved. An action plan is being developed for the CQC reports for UEC and Medical Care, due to be submitted to CQC in October. In terms of the interventional radiology inspection report, this is in place and is being delivered. The plan is being monitored by Clinical & Scientific Services Division and an update will be provided quarterly to Quality and Safety Assurance Group via the Divisional report. 3. Q1: There are plans for a presentation to a Board seminar from the Research and Innovation Team in Q1/Q2 2026/27. ~~Q1~~: Q2 26/27: SaTH has worked with Keele University to develop a governance framework for research across both organisations (SaTH and Keele). A meeting has been held and the framework is progressing through development. Q2: Following development and implementation of the Group model, both QSAC and QOC cycle of reporting are being reviewed to include regular assurance reports on research and innovation activity. This strengthens Committee oversight and provides a formal mechanism for monitoring delivery of research priorities, performance and compliance requirements. The next bi-annual Research and Innovation Report is scheduled for presentation at QOC on 20 October 2026.This will also include the Annual Research and Innovation report 2025/26 resented to QOC.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Delayed treatment times and backlog • Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres • Insufficient capacity to meet demand • Insufficient productivity in Planned Care • Ageing population in Shropshire, Telford & Wrekin **Consequence:** • May lead to sub-optimal care • May lead to harm due to the unmet need • Financial activity impact • Regulatory action • Damage to reputation and negative impact on public confidence	4	5	20	Performance controls below (refer to BAF 3 and 4 for workforce controls): • Trust Planned Care Transformation Programme • Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand and performance • Departmental and Divisional monitoring of RTT, imaging and endoscopy • Monthly Performance Review Meetings • Enhanced operational management structure with focus on elective and urgent care • Validation of waiting list to address data quality issues and ensure accuracy of waiting times • Outpatient Transformation Programme • Substantive Head of Cancer commenced March 2026. • Additional elective activity delivered by insourcing providers • Implementation of Quality Management System (QMS) being rolled out during 26/27 • Roll out of new national Electronic Referral System during 26/27	**Reported to Board and committees:** • Performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Weekly Trust Cancer performance meetings (1st) • Weekly Trust RTT performance meetings (1st) • Standing monthly IPR reports to Quality & Safety Assurance Committee and Performance Assurance Committee (PAC) (2nd) • Performance Highlight Report to PAC, including RTT, Cancer, theatre productivity, outpatient transformation and UEC assurance (2nd) • Monthly reporting to Performance Review Meetings (2nd) • Shropshire Telford & Wrekin (STW) Planned Care Delivery Group reporting monthly (3rd) • Midlands Access Board - NHSE (3rd) • Cancer trajectories 26/27 - 62 day backlog, and 28 day faster diagnosis to PAC (2nd) • RTT 25/26 - 40 week recovery trajectory to PAC for adults and children and young people (2nd) • 18 week, 52 week and total waiting list size - all exceeded plan Q4, 26/27. • Planned Care Transformation Assurance Committee - meets monthly - commenced April 2025 (2nd) • MIAA Data Quality review - waiting lists and performance 26/27 - Moderate opinion - (3rd) • Q2 performance outcomes: Faster Diagnosis Standard performance was 86.6% in July 2026 and has remained at or above 80% since September 2025; 62-day performance continues to improve; and the English-patient 52+ week breach position remains at zero (2nd).	3	2	6	**Gaps in control:** 1. Enable elective and cancer treatment to 2028/29 national standards 2. Productivity - opportunity to better optimise core capacity for treating elective and cancer patients 3. Outpatients - opportunity to improve referral and demand management approaches and optimise outpatient capacity 4. Digital - introduce digital enablers to elective care and treatment 5. Risk of insufficient elective income to cover funding of elective activity **Gaps in assurance:**	**Actions aligned to gaps**: (executive lead for actions: Group Chief Operating Officer) 1a. Deliver phase 2 of the cancer transformation plan by March 2027. 1b. Continue recovery trajectory in elective care during 26/27 2a. Implement GIRFT best practice productivity interventions and drive improvement in productivity in theatres and outpatients to 97% session utilisation by March 2027. 3. Implement high impact evidence-based interventions: a) Redesigning referral pathways; b) Transforming outpatients; c) Reducing unwarranted variation - by March 2027. 4. Introduce digital workstream to identify and implement digital tools to enable improved planned care delivery, by March 2027. 5. Dialogue with NHSE and ICB to agree 2026/27 income and performance plan - by December 2026	1a. Q2: Initial focus on treatment part of the cancer pathways, in particular Oncology. Consistent progress in performance has been shown, 1b. Q2: Additional activity (Elective Recovery Fund) agreed for 2026/27. Persistent delivery of zero (NHSE) patients waiting over 52 weeks. Faster Diagnosis Standard performance reached 86.6% in July 2026 and has remained at or above 80% since September 2025, alongside continued improvement in 62-day performance. The duration and consistency of these sustained improvements, supported by ongoing monitoring and established escalation arrangements, provide assurance that progress is sustainable across foreseeable demand and operational scenarios. 2. Theatre productivity improvement workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver theatre utilisation ambitions. Q2: In Q2 of this year, Telford elective surgical hub was accredited by GIRFT. Recovery performance selected in the HSJ Annual Awards 2026. 3. Outpatient transformation workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver outpatient improvement ambitions. Q2: Clinic optimisation project completed with focus on maximising slots within clinics; significant opportunity discovered. New project started on the electronic referral system in early 2026/27. 4. Digital workstream set up to oversee implementation of digital tools and benefits realisation. Initial five key priority systems identified: - Patient Engagement Portal - AI Scribe - Medical Form Digitalisation - Pre-op - SDEC Digital. Q2:The pre-operative assessment new system is now implemented. AI scribe and medical digitalisation are due to be implemented in Q3.			9

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

Risk Description	I	L	Total initial risk score (impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Clinical workforce challenges • Increase in number of patients with no criteria to reside and insufficient community capacity to meet demand for timely discharge • Primary and community health and care capacity not meeting pre-hospital demand • Insufficient effectiveness of SaTH UEC pathways • Increase in high intensity user demand. **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Leads to sub-optimal care and poor patient experience • Regulatory action • Negative impact on reputation and public confidence. • Potential impact on ambulance handover delays and subsequent impact on ambulance availability within the community • Overcrowding and long lengths of stay in Emergency Department, with increased associated risk of harm.	4	5	20	• Revised SaTH 26/27 Urgent & Emergency Care (UEC) improvement programme. • Confirmed System 26/27 Urgent and Emergency Care Improvement Plan • STW UEC Delivery Group • Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care)	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (monthly) (2nd) • Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) • Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) • STW UEC Delivery Group - monthly (2nd) • NHSE Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) • Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd). • Performance Review Meeting (PRM's) (2nd) • NHSE Tier 1 bi-weekly meeting with national director of UEC (2nd) • Mean ambulance handover lifted out of bottom quartile nationally Q1 26/27 - reported to PAC May 2026 • Monthly PAC monitoring of ambulance handovers and patients waiting over 12, 24 and 48 hours, including performance trends, patient impact and recovery actions (2nd). Evidence of assurance and outcomes for Quarter 2 of 2026/27: • In August 2026, all-type four-hour performance was 51.8% against the 62.5% plan (2nd). • In August 2026, 22.1% of Type 1 patients waited more than 12 hours in the Emergency Department and the average ambulance handover time was 68.6 minutes (2nd). • Type 3 four-hour performance was 89% in August 2026, following performance above 90% in April and May 2026 (2nd). • The week commencing 7 September 2026 delivered the best weekly 12-hour and ambulance-handover performance for two months (1st/2nd). • Recovery actions have progressed from the diagnostic phase into delivery, with tests of change focused on earlier blood results, earlier CT requests and faster clinical decision-making for non-admitted major patients (1st/2nd). • The single SaTH and Shropshire Community Health NHS Trust winter plan includes unified escalation monitoring, an expanded Integrated Front Door, integrated therapy services, Virtual Ward and OPAT pathway expansion, and standardised discharge processes (2nd)	4	5	20	**Gaps in control:** 1. Non-delivery of the operational plan for 2026/27 in Q1 relating to 4-hour performance (all types) and four-hour performance (type1). This also includes ambulance handovers and extended ED waits. In August 2026, all-type four-hour performance was 51.8% against the 62.5% plan, 22.1% of Type 1 patients waited more than 12 hours in ED, and the average ambulance handover time was 68.6 minutes. Patients waiting over 24 and 48 hours remain subject to specific monitoring because of the significant impact on patient safety and experience. 2. Proportion of urgent and emergency care patients streamed to the Urgent Treatment Centre (UTC). 3. Proportion of emergency care patients managed through same day emergency care pathways. 4. SaTH interface with system-wide Urgent & Emergency Care (UEC) improvement programme. 5. Increase in patients with no criteria to reside. **Gaps in assurance:** - None	**Actions aligned to gaps in control:** Executive Lead for actions: Group Chief Operating Officer. 1a. The SaTH UEC improvement programme for 26/27 to be agreed at UEC TAC in May 2026. 1b. Secure external delivery support to improve 4-hour performance by Q4 2026/27, 1c. Maintain regular oversight through UECTAC and PAC of patients waiting over 12, 24 and 48 hours, including performance trends, recovery actions and escalation where performance is off trajectory 2. To improve Type 3 performance and the volume of patients streamed to the Urgent Treatment Centre by Q4, 26/27. 3a. Expand Same Day Emergency Care (SDEC) Workstream through the UEC Improvement Programme to other specialities by Q4 26/27. 3b. Review of estate at RSH to provide frailty SDEC space by 31 October 2026 4. To explore opportunities for future collaboration with system partners to improve urgent and emergency care during 26/27. 5a. Working with system partners to identify opportunities to increase capacity to enable discharge of patients. 5b. Secure external delivery support to improve no criteria to reside position by Q4 26/27	1a. Q1: Plan agreed May 2026. Action closed Q1. 1b. Q1: External support secured and 12-week diagnostic phase continues to be underway. Q2: Has progressed from diagnostic phase into delivery. Tests of change commenced in September 2026, focused on earlier blood results, earlier CT requests and faster clinical decision-making for non-admitted major patients. Recovery actions also include revised reviews of long-stay patients, restoring simple discharge levels and updating the RSH ED escalation procedure to support timely ambulance handovers. In August 2026, 22.1% of Type 1 patients waited more than 12 hours and average ambulance handover time was 68.6 minutes. Although performance remains challenged, the week commencing 7 September delivered the best weekly 12-hour and ambulance-handover performance for two months. 1c. Q2: UECTAC and PAC continue to monitor ambulance handovers and patients waiting over 12, 24 and 48 hours including performance trends, recovery actions and escalation where performance is off trajectory. 2. Q1: Further improvement in 4-hour (type 3) performance in April and May 2026 achieving >90%. Q2: The improvement programme is now progressing into the delivery phase. Sustained improvement with performance at 89% in August 2026, following performance above 90% in April and May 2026. Further work is focused on increasing streaming to the Urgent Treatment Centre and maintaining performance through winter. 3a. Q1: The Trauma and Orthopaedic workstream established June 2026. Q2: Continue working on Orthopaedic workstream which is being delivered through the UEC Improvement Programme. Progress and its impact on SDEC activity, avoidable admissions and patient flow will be monitored through the work stream programme. 3b. Q1: Q2: Discussions continue being held for frailty SDEC accommodation at RSH through the monthly Accommodation Control Strategic Group. The action remains in progress against the 31 October 2026 target. 4. Q1: Q2: Opportunities continue being explored through joint working with SCHT and SaTH under the Group Model. Joint working has progressed into delivery through a single SaTH/SCHT winter plan, unified escalation monitoring, an expanded Integrated Front Door, integrated therapy services, Virtual Ward and OPAT pathway expansion, and standardised discharge processes. The plan targets a winter four-hour performance average above 60%, a 12-hour breach rate below 17.5% and fewer than 20,000 NCTR bed days. 5a. In May 2026 the average number of patients with no criteria to reside was 136 which is above the average over the last two years of 120. Working with Local Authorities and Care Transfer Hub to identify opportunities for discharge improvements during 2026/27. Q1: Executive to Executive meetings occurring and Pillar 3 within the System UEC Improvement Plan for 26/27 and 27/28 incorporates opportunities for improvement to no criteria to reside. Q2: No criteria to reside continues to be above the mean and in special cause concerning variation. Actions in place to support request from NHSE regarding discharge sprint in September 2026. 5b. Q1: External support secured. 12-week diagnostic phase underway. Q2: Diagnostic workshops completed and the programme is moving into test of change. Initial actions include revised reviews of long-stay patients and restoring simple discharge levels on identified wards. Impact will be monitored through NCTR and discharge performance.			9

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Emergency Department and multiple services (e.g. emergency surgery, critical care, acute medicine) operating at two sites (Princess Royal Hospital and Royal Shrewsbury Hospital) • Continued challenge in achieving particular national access performance standards, i.e. Urgent and Emergency Care • Insufficient shift to local services outside of the acute hospital setting - requirement to offset additional growth, in line with the Neighbourhood Health Programme. **Consequence:** • Unsustainable infrastructure • Unsustainable clinical services • Reduced patient satisfaction • Potential impact on quality and safety of patient care • Impacts financial sustainability and backlog maintenance not reduced • Reduced staff morale • Less efficient estate • Not achieving national access performance standards • Workforce position unsustainable if continue to duplicate services across two sites.	5	4	20	• Hospitals Transformation Programme (HTP) - the Trust received national approval of its full business case for the programme and work commenced 2024 and remains on track for delivery. This capital investment will deliver a new model of health care in the county. • System, Urgent and Emergency Care (UEC) Plan in place for 2026/27 - led by ICS UEC Delivery Group. • Work remains on track to build detailed clinical pathways that support safe transfer and transformation of services from the current operating model to the new model of care. Priority is being afforded to urgent and emergency care pathways and work with ICS/UEC partners has begun. In parallel to the service transformation work being done in preparedness for the completion of the HTP build, clinical teams are reviewing options for accelerating any pathways that can be expedited prior to HTP 'go live'. • Development of the integrated ICS Workforce Plan. • Neighbourhood Implementation Group is now operational to produce clinical pathways in line with the clinical model. • Revised governance structure for the implementation of the clinical programme. • Workforce programme established for 2025-2028. • A dedicated HTP master programme action plan is in place and being reported against.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly - public/private) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (monthly) (2nd) • Local Care Transformation Assurance Committee (2nd) • Local Care Transformation Operational Group - meets monthly (2nd) • Clinical Services Transformation Group (2nd) • HTP Assurance Committee (bi-monthly) (2nd) • HTP Programme Management Committee - SaTH executives (2nd) • HTP Oversight Group (monthly), including system partners and ICS members, chaired by ICS Chief Finance Officer (2nd) • UEC plan to ICS UEC Delivery Group - monthly (2nd) • Independent Reconfiguration Panel produced/published a report that made 13 recommendations in relation to HTP which agreed with the HTP delivery mechanism to deliver outcomes for the population of Shropshire, Telford & Wrekin and mid-Wales - December 2024 (3rd) • Clinical Assurance Group (2nd) • Strategic People Group (2nd), reporting to People & OD Assurance Committee. • STW Neighbourhood Implementation Group (2nd) • Formal HTP Finance Committee (2nd) • NHSE monthly meeting (3rd) • Emergency Treatment and Transfer Group (2nd)	4	3	12	**Gaps in control:** - **Gaps in assurance:** 1. Dependency on system-wide programmes to deliver the clinical model.	**Actions aligned to gaps:** - 1. Continue to hold regular meetings with system partners to determine details of the strategy and the impact on the delivery of the clinical model, to ensure co-production, throughout the HTP Programme via newly established Local Care Transformation Programme Assurance Committee. Executive lead: Group Director of Estates, Facilities, HTP, Capital and MES - by September 2027.	1. Local Care Transformation Assurance Committee was established in June 2026 with its first meeting held on 26 June 2026.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of integrated model of service delivery locally • High non elective admissions • A shift required from acute to community setting for models of care • Challenges in the recruitment of key practitioner roles across health and care to the rapid response service in the Shropshire area • Lack of health prevention and early interventions • Insufficient current workforce capacity in clinical and corporate teams across the system to deliver new ways of working • Availability of systemwide digital specialist resource to implement effective remote monitoring, and enable timely sharing of robust data, and associated impact of achieving agreed trajectories for virtual ward mobilisation • Lack of cohesive approach to long-term condition management, e.g. diabetes • Capacity of ICB to support and lead local Neighbourhood health programme under pressure. STW ICB moving to cluster with SSOT ICB. Single exec team in place with effect from 01 Dec 2025. Voluntary resignation scheme for both ICBs commenced 01 Dec 2025. **Consequence:** • Increased length of acute inpatient stay • Lack of bed capacity in acute setting impacting on patient flow and reduced delivery of elective activity • May reduce quality of patient care including risk due to ambulance handover delays • Increased demand for emergency department services and non-elective admissions to hospital • Lack of innovation and continuous improvement of services • Reduced staff experience and morale • Increased ambulance conveyances from one care setting to another • Increased emergency community nursing referrals	4	4	16	• Shropshire, Telford & Wrekin ICS Neighbourhood Health Implementation Programme in place • Five year programme plan in place - ICS Joint Forward Plan (updated annually). • Programme management in place with fortnightly PMO meetings - PMO resource combined across ICS with new standardised reporting tools. • 'Deep dive' into each workstream on a regular basis • UEC programme for 25/26 with link to neighbourhood health - overseen by STW UEC Board • Planned Care programme for 25/26 linked to primary care referral management • ICB Chief Medical Officer plan for group of speciality/condition based pathway improvements - priorities remain as : Diabetes, CVD and frailty (through Health and Care Models Transformation Group), MSK (through Planned Care Group). System Transformation and Digital Committee mechanism in place and all of the major programme boards report into this - chaired by Chair in Common	**Reported to Board, committees and elsewhere:** • ICB exec-led Cluster Transformation and Digital Group to be established to replace STW System Transformation and Digital Committee (2nd). • Report to place-based partnership Boards Shropshire Integrated Place Partnership Committee (SHIPP) and Telford and Wrekin Integrated Place Partnership Committee (TWIPP) (2nd) • Neighbourhood Health Implementation Programme - bi-monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Group - monthly (2nd) • UEC Group, National NHIP Group report to Cluster Transformation and Digital Group (monthly) (2nd) • SATH/Shropcom Group model established from 1 April 2026. Ongoing development of transition plan, with focus on hospital to community shift. (2nd) • NHSE Midlands Assurance Review – Group Model between Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Healthcare NHS Trust. Report received 27 Nov 2025. Recommendations built into 2026/27 Group Transition Plan. (3rd) • Group Transition Committee in place (2nd) • Group Local Care Transformation Programme established - Operational Group (exec led; commenced end May 2026) and Group Local Care Transformation Assurance Committee (Non-Executive led; commenced end June 2026) (2nd)	4	4	16	**Gaps in control:** 1. Limited detail and limited delivery of the changes in improvement. 2. Reliance on physical acute beds rather than community UEC capacity and delays within urgent and emergency care caused by lack of flow. 3. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. 4. Lack of Group capacity and expertise to accelerate community transformation/ Neighbourhood Health models. **Gaps in assurance:** - None	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Neighbourhood Health Implementation Programme - ongoing. Lead Executive: Group Chief Operating Officer and Group Chief Medical Officer with support of HTP operational lead and clinical lead. 2. See actions within BAF risk 10. 3. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement. 4. Appoint additional capacity to support programme development by 30 April 2026.	1. Q1: In response to national and local requirements for implementation of Neighbourhood Health Models and hospital to community shift, the Group has established the Local Care Transformation Programme with operational and clinical leaders from the two trusts (SaTH and SCHT). Q2: A comprehensive programme plan has been developed including a prioritisation of projects, and a methodology to show impact. Action taken through the Group Local Care Transformation Programme (LCTP) will be reported to the two STW Place Partnership Boards and Cluster ICB Neighbourhood Health Group. 2. Q1: Group LCTP includes clear overlap with ICS UEC 2026/27 Plan (Pillars 1 (pre-hospital) and 3 (post-discharge)). 3. Q1: ICB has described principles and priorities for Neighbourhood health in a paper to the ICB Board (April 2026) and in the five year commissioning plan/commissioning intentions (May 2026). 4. Six-month fixed-term Community Transformation Programme Manager appointed during March 2026. Q1: SCHT are also appointing community transformation roles. **Action closed Q1, 2026-27.**			16

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Potential poor processes and procedures • Improved culture requires further embeding • Governance improvement workload is high - started from a low base with embedded poor practices in some areas • Change in organisational governance arrangements from establishing a new Group Model • Governance capacity to deliver changes **Consequence:** • Potential lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Incidents • Potential for ineffective committees • Potential data breaches • Regulatory sanctions and/or fines • High workload involved to work together and align systems, processes and teams. • There is a potential risk that Group Model development may not proceed at the required pace, which may result in ambiguity in roles and responsibilities, inconsistent decision-making and reduced oversight and assurance • Additional level of risk during the Group Model transition period.	4	4	16	• Moving To Excellence programme • Trust Strategy • Board Assurance Framework (BAF) reviewed quarterly • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and reviewed Autumn 2025 and approved at January 2026 Board • Managing Conflicts of Interest Policy updated during 2023 (due review Sept 2026) • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests published on the Trust's website, bi-annually • Terms of reference refreshed for all assurance committees of the Board during 2025/26 and ongoing during 25/26 • Review of effectiveness of ARAC, FAC, QSAC and PODAC committees February 2025 and PAC November 2025 • Fit & Proper Person Policy updated (Oct 2023) following publication of new national framework • Fit & Proper reporting status established within the Electronic Staff Record (ESR) • A number of NHSE reviews completed in 2025/26 • Financial Recovery Group now meeting fortnightly (Q4) • Shared corporate and clinical arrangements for Group Model under development and will be shared with NHSE to support transparency and enable effective oversight • Group Model Partnership agreement approved Q4	**Reported to Board, committees and elsewhere:** • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit & Risk Assurance Committee during November 2025 and approved at Board January 2026 (2nd) • BAF considered quarterly at Board and its committees (2nd) • Refreshed terms of reference considered at all Board committees during 2024/25 and 2025/26 (2nd) • 2024/25 Annual Report to Board in June 2025 and subsequently published on the Trust's website following submission (2nd) • Auditor's Annual Report 2024/25 (3rd). External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 2024/25 Auditor's Annual Report (3rd). • Annual General Meeting held in public (face to face) - 25 September 2025 • Head of Internal Audit Opinion April 2026 providing Substantial Assurance that there is a good system of internal control (3rd) • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% standard during 2025/26 (2nd) • Register of interests and gifts and hospitality reviewed by Audit & Risk Assurance Committee - November 2025 (2nd) • Policy Approval Group meeting, monthly (established August 2024) (2nd) • Executive led Financial Recovery Group and Task Force in place (2nd) • System Integrated Improvement Plan (SIIP) relating to governance is in place and currently on track - updates received at Board (monthly) (2nd) • MIAA Fit and Proper Persons Report (Substantial Assurance) 2025/26 (3rd) • Group Transition Committee established - terms of reference to September 2025 Board (2nd) • NHS Provider Board Capability Assessment to Board - October 2025 Board (2nd) and onward to NHSE. • Group Model Partnership agreement approved by both Boards - March 2026. • Trust exit from Recovery Support Programme (RSP) - letter from NHSE dated 2 March 2026. Improvement from Segment 5 to Segment 3 within Oversight Framework. (3rd)	4	3	12	**Gaps in control:** 1. Increasing subject access requests (SAR's) received, and subsequent complaints. 2. Further development of the Group Model with Shropshire Community Healthcare NHS Trust 3. Continue to monitor compliance with Data Security and Protection Toolkit requirements and maintain standards through routine governance, assurance, and evidence review. **Gaps in assurance:** - None ~~3. Data Security & Protection Toolkit assurance.~~	**Actions aligned to gaps:** 1a. Further recruit to IG team by Q3, 2026-27. 1b. Procure and purchase SARs software to improve the search for email requests. 2. Review committee structure and further revisions to committee structure across the Group. 3. Work towards DSPT/CAF (Cyber Assessment Framework) standards for 2025/26 and 2026/27-evidence to be submitted by 30 June 2026, 12 August 2026 and 2027. Lead Executive: Group Chief Governance Officer.	1. Q1: Recruitment in progress. Q2: Interviews were held on 24 September 2026 for the Information Governance Support Officer post, with the outcome now being progressed through the recruitment process. 1b. Q1: We are also going through a procurement process for SAR's software. Q2: Purchase requisition has been raisedand approved and implementation of the SARs software is planned for early Q3. 2. Q1: Progress being made with Quality Committee. Q2: Group Quality Committees (held in common) agenda and cycle of reporting have been reviewed and approved, establishing a consistent approach to quality oversight across the Group. The first Group Quality Committees (held in common) will commence on Thursday 1 October 2026. 3. Q1, 26/27: The 30 June 2025/26 submission has been made with associated improvement plan. Q2: The DSPT improvement plan and supporting evidence were submitted on 12 August 2026 to DSPT. Feedback recieived through the DSPT process who confirmed that the Trust is approaching standards now. Ongoing monitoring is in place to ensure sustained assurance. The improvement plan and progress was presented to the Information Governance Committee on 1 September 2026.			6

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	096/26		
Report Title	Group Infection Prevention & Control Report		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Kara Blackwell, Director of Nursing Acute, Deputy Chief Nurse Sara Ellis-Anderson, Director of Nursing Community (Interim)		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Quality Committee, 1 October 2026	Safe	√	
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	**SATH** - 1241, 722, 444, 1326, 923 **SCHT** – 6781, 5559, 3063, 6783
	Well Led	√	
Executive Summary	The report provides an overview regarding Infection Prevention and Control across SaTH and SCHT, including HCAI performance, training and competency, cleanliness, antimicrobial stewardship, key risks and a summary of the respective IPC Board Assurance Frameworks. It also sets out the proposed Group IPC governance arrangements and the joint Group IPC Improvement Plan. **Assure**: Both Trusts have established IPC governance, surveillance, audit and improvement arrangements, with no areas assessed as non-compliant within either IPC Board Assurance Framework. **Advise**: A joint Group IPC Improvement Plan has been developed, supported by proposed Group governance arrangements and a coordinated Group-wide IPC communications campaign. **Alert:** Continued challenges remain in relation to HCAI performance, training compliance, cleanliness and the healthcare environment, requiring sustained oversight and delivery of improvement actions.		
Recommendations for the Boards	The Boards are asked to: **Approve** the SaTH and SCHT IPC Board Assurance Frameworks and SaTH and SCHT IPC Improvement Plan		
Appendices:	Appendix 1: SaTH HCAI by Ward datasets Appendix 2: SCHT HCAI by Community Hospital dataset Appendix 3: SaTH Cleanliness Monitoring Scores Appendix 4: Group IPC Improvement Plan Appendix 5: SaTH IPC Board Assurance Framework Appendix 6: SCHT IPC Board Assurance Framework		

1.0 Introduction

Infection Prevention and Control (IPC) remains a priority area for both organisations. During 2026/27 the Shropshire, Telford & Wrekin Community Hospitals NHS Group has continued to experience challenges associated with Clostridioides difficile infections (CDI) reflecting both local and national pressures. In addition, The Shrewsbury & Telford Hospital NHS Trust (SaTH) has experienced challenges with other infections and inconsistent IPC compliance. As a result, the new Group Chief Nursing Officer has instigated a strengthened approval to addressing ongoing IPC challenges, which has led to the development of a joint Group IPC Improvement Plan.

In August 2026, a focused NHS England IPC review at SaTH identified opportunities to strengthen governance, assurance, surveillance and operational IPC practice. Whilst many areas of good practice were recognised, the review also highlighted the opportunity for a more systematic and coordinated approach across the Group in driving improvements in IPC practices via a single improvement plan.

This report provides an overview of current IPC and Anti-microbial Stewardship (AMS) performance across the Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (SCHT), highlights key risks and presents the joint IPC improvement plan actions being implemented to address identified gaps, reduce healthcare-associated infections and strengthen compliance with national IPC standards.

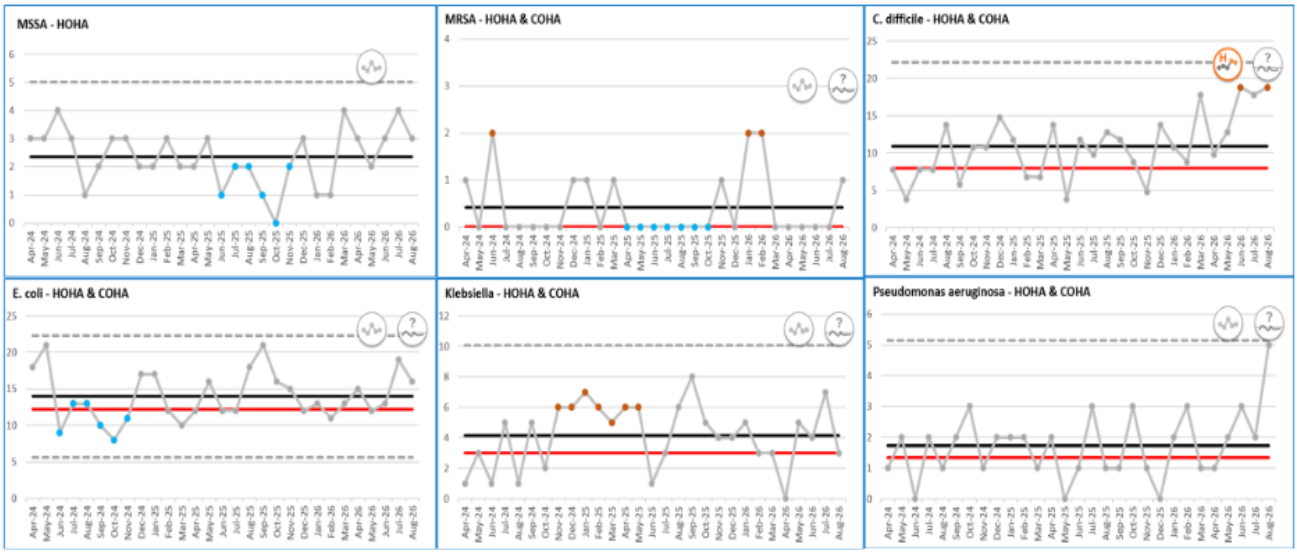
The IPC Board Assurance Frameworks for both Trusts are included as appendices to provide the Quality Committee in common and ultimately the Board in common with the latest position and outline actions in progress to further improve our compliance

2.0 HCAI Performance

2.1 SATH HCAI Performance

SaTH continues to experience challenges in relation to achieving the nationally set targets for Healthcare Associated Infections. In 2025/2026 the Trust breached its targets for C.Diff (132 cases against a target of no more than 98 cases), E.Coli (172 cases against a target of no more than 146 cases), Klebsiella (54 cases against a target of no more than 36), and MRSA (5 against a target of 0 cases).

The number of HCAI cases from April 2024 to YTD 2026/2027 are shown below:



SaTH continues to experience challenges in relation to increases in HCAI cases in 2026/2027, particularly in relation to healthcare-associated *Clostridioides difficile* infection (CDI). Whilst there has been an increasing trend locally and nationally, the Trust has a high number in comparison to other acute Trusts in the West Midlands and has continued to see an increase in cases in 2026/2027 YTD.

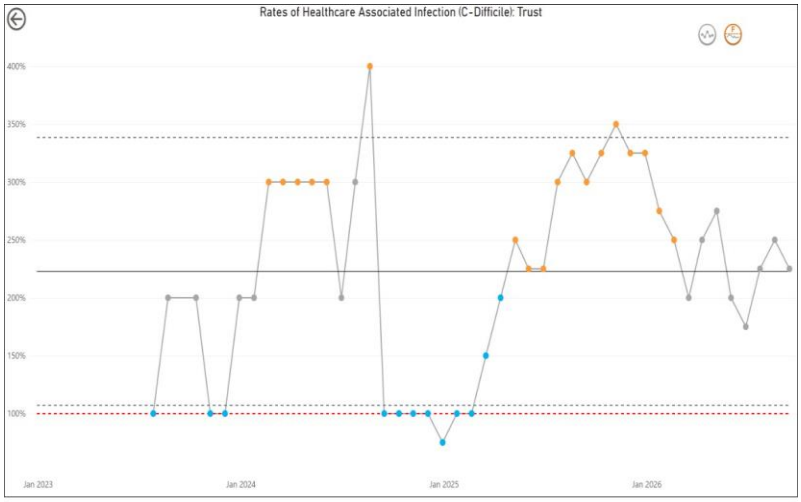
Indicator	Target	Actual (YTD Aug 26)	Trajectory (YTD Aug 26)	Variance	Status
CDI	98	80	40	+40	Significantly above trajectory
E. coli	146	75	60	+15	Above trajectory
Klebsiella	36	19	15	+4	Above trajectory
Pseudomonas	19	13	8	+5	Above trajectory
MRSA Bacteraemia	0	1	0	+1	Above target
MSSA Bacteraemia	0	11	31		No target

The number of cases by Ward/Clinical area are shown in **Appendix 1**. There has been an increase in cases on Ward 23, 17 and RSH AMU in 2026/2027 with the number of cases April to August already exceeding the total number of cases on these wards in 2025/2026. Reduction in the number of cases YTD compared to last year include RSH Emergency Department, Ward 7, Ward 37 and Ward 22SS.

2.2 SCHT HCAI performance

SCHT continues to experience challenges in relation to healthcare-associated *Clostridioides difficile* infection (CDI), reflecting both local and national trends. During 2025/26, SCHT reported 11 healthcare-associated CDI cases against an agreed annual threshold of 4. A thematic review of these cases demonstrated that the majority of cases occurred in patients admitted from an acute hospital and many demonstrating known risk factors including frailty, advanced age, previous antimicrobial exposure, recurrent urinary tract infections, indwelling urinary catheters and previous CDI carriage or infection.

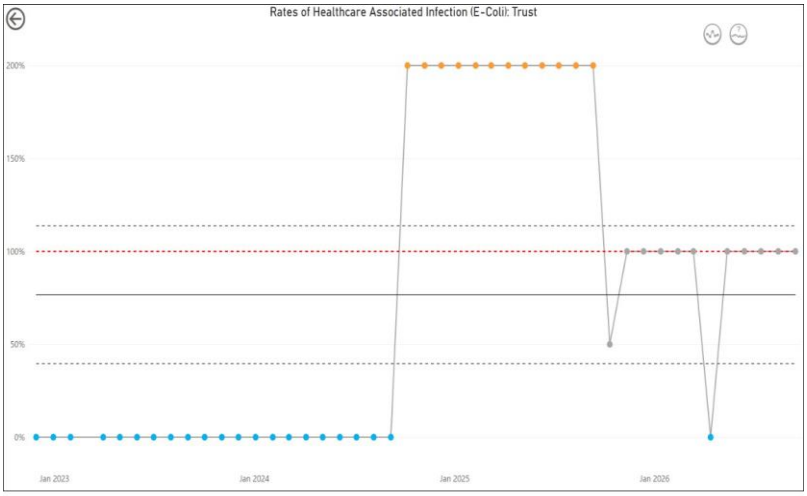
The Trust has reported four healthcare-associated CDI cases year to date in 2026/27 equivalent to the full annual threshold.



The SPC chart demonstrates that whilst the rolling 12-month position remains above the threshold, there has been a reduction in the rate following the peak observed during 2025/26. (Please see **Appendix 2** for CDI cases by SCHT Community Hospitals over the last 12 months).

SCHT has reported one E. coli bacteraemia year to date in 2026/27 against a threshold of zero. The case occurred at Whitchurch Community Hospital. The patient had been

admitted from SATH with a urinary catheter insitu, and both blood and urine cultures were positive for *E.coli*. The review concluded the bacteraemia was most consistent with a catheter-associated urinary tract infection (CAUTI). Learning identified opportunities to strengthen catheter care documentation, recording of indication and review plans to remove catheter at earliest opportunity.



The SPC chart is displayed as a rolling 12-month rate, meaning it reflects cases occurring within the previous 12 months rather than the current month alone. As SCHT's agreed threshold is zero cases, the single bacteraemia results in performance being above threshold for the duration of the rolling 12-month reporting period. No further E. coli bacteraemia cases have been reported to date.

3.0 IPC Training performance

Both SaTH and SCHT have mandatory IPC training in place. This is monitored via IPC Operational Committee monthly at both a Trust and Divisional level. At present the compliance targets for the IPC training g differ with a target of 90% at SaTH and 95% at SCHT, this will be reviewed going forward and aligned so there is an overarch compliance target agreed for both organisations.

3.1 SATH IPC Training

For 2025/2026 the Trust met the IPC level 1 and 2 met standard, however hand hygiene and PPE were below the expected standard of 90%.

Staff Group	Hand Hygiene	Infection Prevention and Control – Level 1	Infection Prevention and Control – Level 2 (Medics)	Infection Prevention and Control – Level 2 (non-medics)	PPE: Donning and Doffing
Add Prof Scientific and Technic	84.05%	96.77%	100%	97.90%	81.82%
Additional Clinical Services	93.69%	95.65%		90.80%	95.14%
Administrative and Clerical	81.82%	94.59%		88.89%	90.91%
Allied Health Professionals	84.82%	95.56%		92.76%	87.06%
Estates and Ancillary	94.92%	95.35%		100%	86.55%
Healthcare Scientists	71.43%	97.94%		94.29%	100%
Medical and Dental	50.78%	84.21%	76.11%		49.13
Nursing and Midwifery Registered	92.29%	100%	94.55%	91.45%	91.58%
Students	100%			100%	100%
Grand Total	**83.76%**	**95%**	**90.22**	**94.5%**	**86.91%**

Compliance for IPC training across the Trust as reported in August 2026 shows that

compliance with hand hygiene and PPE still requires improvement and a decline in medical staff compliance with Level 2 IPC training.

Competency/Training	Month	Compliance (Target 90%)
NHS|CSTF|Infection Prevention and Control Level 1	August 2026	93.75%
NHS|CSTF|Infection Prevention and Control Level 2 Medics	August 2026	90.07%
NHS|CSTF|Infection Prevention and Control Level 2 Medics	August 2026	78.13%
825|LOCAL|Hand Hygiene	August 2026	82.54%
PPE (donning & doffing)	August 2026	85.25%

3.2 SCHT IPC Training

IPC training and competency compliance is monitored at team and divisional level, with oversight provided through the SCHT Infection Prevention and Control Committee. As of August 2026, compliance was above the 95% target for IPC Level 1 at 98.20% and IPC Level 2 at 96.44%. Annual hand hygiene assessment compliance was 94.78%, marginally below target, with local follow-up undertaken for staff whose assessments are due or overdue. Since April 2026, hand hygiene assessments have been recorded on ESR, providing a central record and enabling staff to receive automated reminders when reassessment is due.

Competency/Training	Month	Compliance (Target 95%)
NHS|CSTF|Infection Prevention and Control Level 1	August 2026	98.20%
NHS|CSTF|Infection Prevention and Control Level 2	August 2026	96.44%
825|LOCAL|Hand Hygiene	August 2026	94.78%

4.0 Environment and Cleanliness

Both SaTH and SCHT adhere to the National Standards of Health Cleanliness (2025). Monthly audits are carried out and reported through the two Trust IPC governance structures.

4.1 Environment and Cleanliness at SATH

4.1.1 Cleanliness monitoring

At SaTH monthly cleanliness audits are carried out and reported through to the IPC Operational Group for monitoring and agreement in relation to any remedial actions to address areas of concern and exception reporting is provided at IPC Assurance Committee. Clinical areas are split into two risk categories Functional Risk (FR) 1 - Very high-risk areas such as the Emergency departments & augmented care areas (e.g. Renal, Oncology); these areas are expected to achieve 98% compliance. Functional

Risk (FR) 2 - High risk areas such as general wards are expected to achieve 95% compliance. Compliance in relation to the monthly cleanliness audits is shown in **Appendix 3**.

In 2026/2027, YTD the wards at RSH have seen poorer results in relation to achieving the cleanliness monitoring compliance targets, in particularly the acute floor (AMU, SDEC and Ward 22SS) Ward 25, Ward 27 and Ward 23. Ward 23 oncology and haematology (FR1 area, expected compliance 98%) over the last 12 months (September 2025 to August 2026) has only achieved expected standards 3 times. There is currently a comprehensive support programme in place to address IPC improvements and other quality improvements required on the ward.

The most commonly failed elements in each assessed criteria, Facilities, Nursing and Estates include:

Facilities
- Floor, including skirting
- Low surfaces
- Sinks and taps
- Middle surfaces including windowsills, non-patient furniture, tables,

Estates:
- Flooring
- Low surfaces
- Sinks and Taps
- Middles surfaces

Nursing:
- Medical equipment, e.g drip stands, pumps
- Notes and drug trolleys, patient clipboards
- Patient beds

4.1.2 Deep clean programme

The lack of a deep clean programme has been on the risk register since 2021. A programme of bay-by-bay decants to allow for some deep cleaning and estates remedial works was commenced in May 2026. All areas had a pre-decant estates review with IPC to identify works required. Wards 11,9,7, 27, 23 and 25 were completed in part. Due to the bay-by-bay nature, areas such as the main corridors and ancillary spaces such as the treatment rooms, sluices, kitchens and linen rooms were not consistently completed.

The completion of the patient areas in this way was problematic, often needing to be repeated as works had not been completed to the standard agreed including removal of radiator covers. Not all estates work was completed due to tight timeframes and the stop-start nature of the works due to delays in freeing up bays to enable the works to be undertaken, last minute cancellations in relation to undertaking the work as bays were not vacated and also led to issues in procuring parts/equipment and contractors.

No work on the deep cleaning programme has taken place since August 2026. Long term plans in relation to decant space and a rolling deep clean programme are included in the overarching Group IPC Improvement Plan across both SaTH and SCHT.

4.1.3 Isolation capacity

Lack of appropriate isolation facilities have been on the risk register since 2024. It is scored at 16 (extreme risk). There is no true isolation (per HTM definition) capacity on either acute site, therefore we lack capacity to safely care for a patient with an airborne infection or a high consequence infectious disease.

At SaTH there is minimal single room capacity in inpatient areas, as indicated below:

	RSH	PRH
Inpatients inc. admission wards (exc. EDs)	58	58
Critical care	7	6
Onc/haem	8	3 (paeds)
Maternity/ Gynae	-	34
Paeds/NNU	-	20
Elective ortho	-	2

Often decisions to move patients with alert organisms into an open bay are made on a risk assessed basis, as demand outstrips capacity. The Trust utilises Redirooms as a temporary isolation measure to provide capacity within a bay, there are currently 33 available across both sites.

4.2 Cleanliness Monitoring SCHT

The IPC Committee receives quarterly cleanliness reports. All the inpatient wards are risk assessed as Functional Rating (FR) 2 and performance reports demonstrate compliance >95% overall with the technical audit scores. In 25/26 nursing elements of the cleanliness audits were below standards expected and in response to this the organisation introduced dedicated Housekeeper roles. Early evidence has demonstrated improvement in environmental cleanliness, equipment checks and ward organisation, although further work is underway to ensure standardisation of the role across sites and to review whether current staffing hours are sufficient to meet future demand.

A significant proportion of SCHT's estate is occupied through leased or shared premises and therefore relies on a range of third-party facilities and cleaning providers. This creates additional complexity in assuring cleaning standards, particularly within multi-occupancy sites such as Oswestry Health Centre, where cleanliness concerns have required ongoing contract management and escalation through governance routes. To support this work, facilities leadership arrangements have been strengthened through Group working with the proposal to have a dedicated SCHT operational facilities lead.

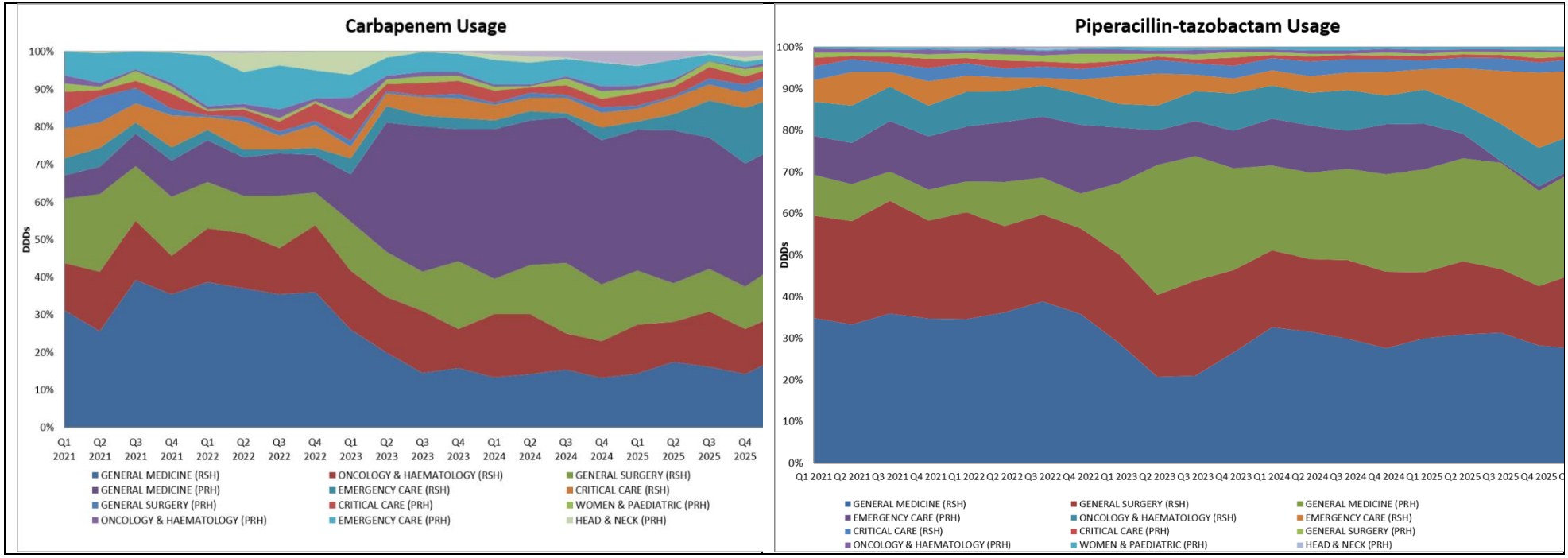
5.0 Antimicrobial Stewardship (AMS)

5.1 Antimicrobial Stewardship at SaTH

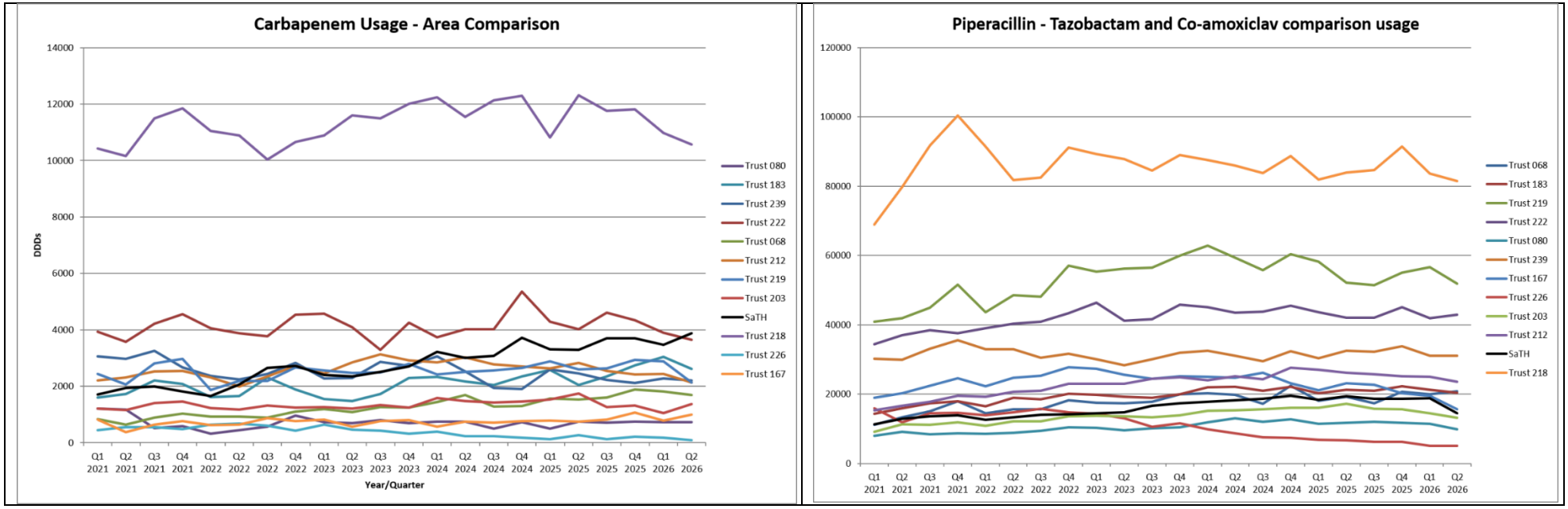
A bimonthly Antimicrobial Stewardship Group (AMG) has been reestablished and has a work plan which will be reported through the IPC governance structure. Membership includes pharmacy, nursing, microbiology and medical staff. The Group provides updates through to the Drugs and Therapeutic Committee and reports into the IPC Operational Group and IPC Assurance Committee.

5.1.1 Tazocin/Carbapenem Usage

SaTH has seen an increase in carbapenem usage, notably in general medicine at PRH. It is difficult to say what the cause of this was but is possibly linked with the opening of an additional medical area at PRH. For Tazocin, we have seen a similar increase in usage in general medicine at PRH as outlined below:



The graphs below produced by the regional team show usage against admissions activity. In comparison to other Trusts in the region we have seen a steady increase in carbapenem usage and are now one of the higher users (to note: Trust 218 is the QE and Trust 222 is Coventry and Warwick, the two trusts with higher usage). Some of this will be impacted by the OPAT service which has a higher usage of carbapenems than we might see in other areas of the hospital.



For SaTH, Tazocin is used where other acute Trusts may use Co-amoxiclav therefore the graph shows both together to provide a better picture. For Tazocin alone SaTH is a higher user however when plotted together with Co-amoxiclav, the Trust is a relatively low users in comparison to other Trusts.

Sath has identified that review of antimicrobials is a problem area leading to extended courses and potential missed opportunities to narrow spectrum or for early switch to oral. We are at a disadvantage due to the lack of electronic prescribing which reduces the ability for us to identify and manage target areas and results in data gaps and delays in identification of issues. However, prescriber education is in process and the pharmacy team are working with our performance team to support increased intervention and improvements in this area which is included in the overarching Group IPC Improvement Plan.

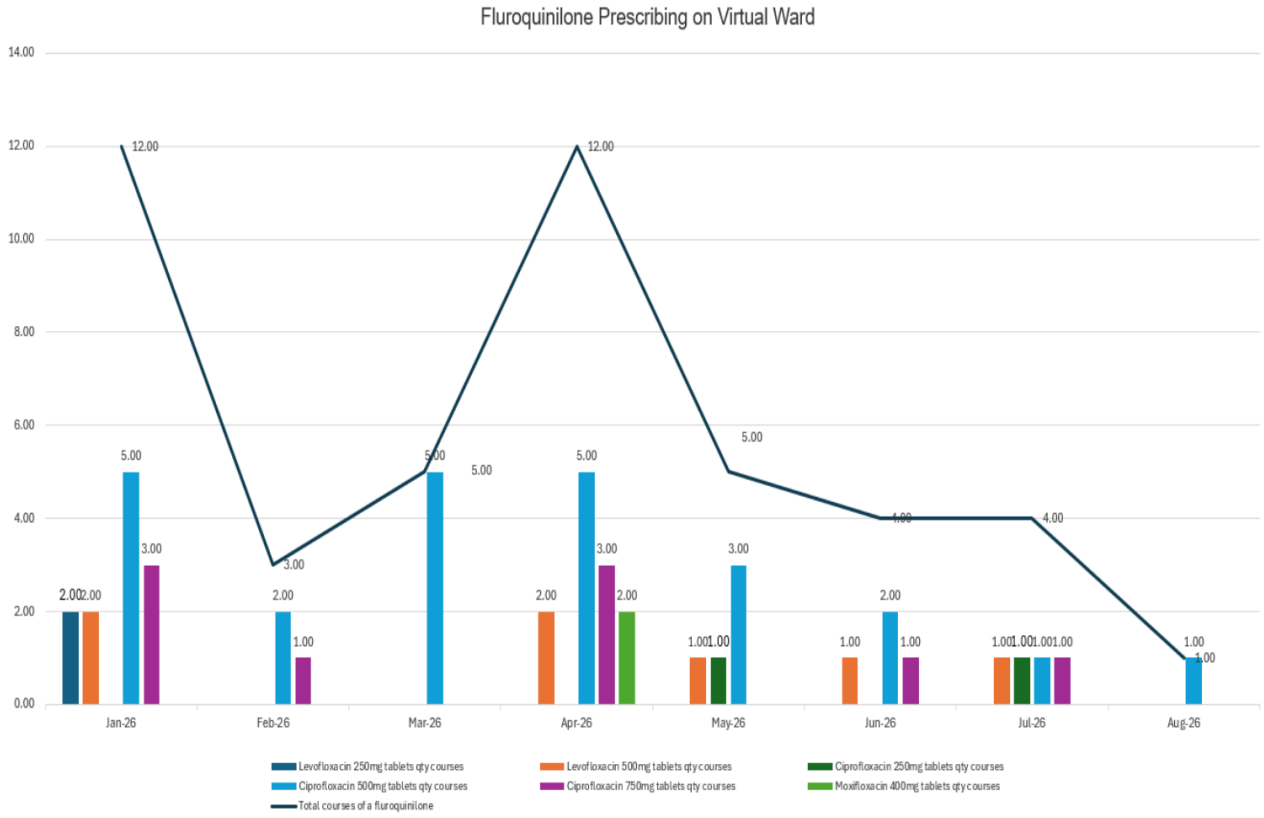
The three priority improvement areas for anti-microbial resistance agreed at Board for 2026/2027 were: 48-72 hour review of antimicrobial prescriptions, intravenous to oral switch, and a reduction in delayed identification of HCAIs

5.2 Antimicrobial Stewardship SCHT

A comprehensive Antimicrobial Stewardship (AMS) report is received by the SCHT Infection Prevention and Control Committee on a six-monthly basis, providing assurance regarding antimicrobial prescribing, stewardship compliance, prescribing trends and associated risks across community hospitals, dental services, virtual wards and non-medical prescribers.

The latest report identified a 34% reduction in antimicrobial prescribing by SCHT non-medical prescribers compared with the previous reporting period (154 prescriptions compared with 234), providing assurance that prescribing remains proportionate and consistent with expected clinical practice. Dental services also demonstrated positive antimicrobial stewardship, with 96.8% of antimicrobial prescriptions issued as five-day courses, supporting the principle of prescribing the shortest effective course of treatment.

The most significant recent area of focus has been the increased use of fluoroquinolone antibiotics within the Virtual Ward service. Following enhanced surveillance and daily review of prescribing, use has reduced from 12 courses per month in April 2026 to 1 in August 2026. Continued monitoring remains in place due to the MHRA safety warning associated with this class of antimicrobial. Please see the prescribing data and charts below.



6.0 Themes arising from Audits, Incidents and Outbreaks

6.1 The Shrewsbury and Telford Hospital NHS Trust

Core Themes	Issues Identified
Care of IV access devices including	• understanding and application of VIP scores • not documenting of IV access devices • Inadequate skin preparation inc. using incorrect products
Care of urinary catheters	• Urinary catheters inserted without clear clinical rationale • Urinary catheters left in place without clear clinical rationale • Urinary catheters used to manage continence • Lack of use of G straps to prevent urethral trauma • HOUDINI and catheter documentation is substandard
Compliance with IPC process and practices	• Inconsistent hand hygiene compliance • Non-compliance with bare below the elbows • Poor PPE use • Cleanliness of shared medical equipment substandard • Cleanliness of bed spaces between patients • Delayed sampling including admission screening for multi drug resistant organisms • Delayed isolation • Poor isolation etiquette
Environment	• Multiple outstanding estates issues due to aging estate • Estate infrastructure not in line with current HBNs and HTMs (ventilation and water) • Overcrowding of patient areas including high risk areas such as EDs • Lack of appropriate amount of toilets and bathrooms • Insufficient isolation capacity

There are a number of actions already in place to address the themes identified through investigations, these include:

- Targeted IPC support, bespoke education and subsequent audit to assess for improvements.
- Local action plans are reviewed through the IPC governance routes and issues addressed with Divisional Directors of Nursing.
- Learning from incidents is shared via IPC governance routes and this is starting to become embedded initially with Emergency and Acute medical doctors.
- CAUTI reduction improvement plan jointly owned by an IPC Specialist Nurse and a Quality Matron.
- Targeted education by practice educators to areas where issues with IV access devices or VIP scoring have been identified.
- Reactive deep cleaning for individual areas noted to have high incidence of infections/alert organisms or on the basis of outbreaks and periods of increased incidence.

These actions are also part of the Group wide IPC Improvement plan.

6.2 Shropshire Community Healthcare Trust

The SCHT Infection Prevention, Education and Advisory Team (IPEAT) delivers a comprehensive annual audit programme covering inpatient, urgent care, community nursing, dental, podiatry, children's services, prison healthcare and other clinical settings.

This includes monthly IPC Quality Assurance Audits across the four community hospitals, alongside scheduled service audits and targeted reviews in response to identified risks. Findings and actions are monitored through the IPC Operational Group and SCHT Infection Prevention and Control Committee.

An analysis of the 25/26 monthly inpatient audits identified strong compliance in areas including alcohol hand-rub availability, stool-chart availability, patient-reported hand hygiene, isolation practice and IPC discussion at daily huddles. Areas requiring sustained improvement included observed hand hygiene practice, stool and catheter documentation, clinical trolley and empty bed-space cleanliness, mattress testing, PPE practice, commode cleanliness and sharps-bin management.

In addition to the routine audit programme, SCHT has undertaken targeted audits of invasive device management in response to recognised risks associated with healthcare-associated infection and the E-Coli bacteraemia case in April 26.

An inpatient catheter audit undertaken across the four community hospitals identified 15 patients with urinary catheters in situ (23% of inpatients reviewed). Compliance with documentation standards remained variable, with the reason for catheterisation recorded in only 64% of applicable cases, highlighting ongoing opportunities to improve documentation, review processes and timely catheter removal.

A separate programme of work focusing on Central Venous Access Devices (CVADs) and PICC lines identified significant opportunities to improve documentation of infection prevention practices. Baseline audit findings demonstrated that only 37% of key IPC practice elements could be evidenced within the patient record, despite higher compliance for documentation of device type (94%) and clinical indication (85%). In response, a quality improvement project introduced a standardised vascular access documentation template within RiO, the electronic patient record and redesigned recording processes across Community Nursing. Re-audit data demonstrated substantial improvement in the ability to evidence IPC-compliant care and line management practices, providing increased assurance regarding hand hygiene, aseptic technique, device surveillance, assessment and ongoing management of vascular access devices. This work has now been adopted more widely and supports the Trust's ongoing focus on reducing device-related infection risk.

All HCAIs, outbreaks and significant IPC incidents are reviewed through SCHT's HCAI and Outbreak Learning Meeting. The forum uses a structured lessons learnt and After-Action Review (AAR) approach to identify contributory factors, share good practice and agree improvement actions. Learning is disseminated through AAR posters and incorporated into the Trust's IPC Improvement Plan to support continuous organisational learning.

6.3 IPC Improvement Plan

6.3.1 A joint Group IPC Improvement Plan has been developed across SaTH and SCHT, bringing together actions arising from the NHS England review, both organisations' IPC Board Assurance Frameworks, risk registers, HCAI case reviews, audits and existing local improvement work **(See Appendix 4)**.

Joint priorities include strengthened reporting, consistent transfer of IPC information, standardised cleaning and housekeeper arrangements, education and competency development, catheter-associated infection prevention and a joint thematic review of CDI cases across acute and community services.

IPC teams and Communications will work together to deliver a coordinated Group-wide IPC campaign. This will promote consistent messages on hand hygiene, PPE, cleanliness, invasive device care and individual responsibility for infection prevention and support the delivery of the IPC Improvement Plan.

7.0 Risks and IPC Board Assurance Framework

7.1 IPC Risk Register

The IPC risk registers at both SaTH and SCHT are reviewed quarterly and monitored through the current IPC governance processes. New governance arrangements are being put in place as part of embedding the new Group model.

7.1.1 IPC Risk Register SaTH

The IPC risk register is reviewed quarterly and monitored through the IPC Operational Group. At the end of July 2026 there were 5 risks on the IPC corporate risk register:

- Four of these are scored as extreme risks and one as a high risk.
- Actions taken in relation to Risk 444 have included the cleaning of some wards using a bay-by bay approach.
- Risk 444,1241, and 722 are linked risks.
- Mitigating actions in relation to risk 923 include the bioquell pods previously installed in ward 24 and Itu and the use of redi-rooms.

Datix Risk ID	Risk Owner	Risk Title	Risk Description	Current Score
444	Group CNO & Group COO	Lack of Deep Clean Programme	As a result of the inability to deliver an annual deep cleaning programme as there is no decant facility there is a risk of infection control issues which might result in patient safety incidents and the risk of increased hospital associated infections	16
923	Group COO & Group CNO	There is a risk of health associated infection due to lack of isolation facilities	As a result of the lack of isolation facilities there is a risk of HCAI due to delays when patients need isolating	16
722	Group CNO	There is a risk that the Trust will exceed its the nationally set targets for HCAIs	As a result of increased incidence of HCAIs the Trust is at risk of breaching the Trust targets for CDiff	12
1241	Group COO	Hospital Overcrowding and associated IPC risk	There is a risk that infections will be spread more easily in these environments due to reduced bed space, toilet/bathroom facilities , and overcrowding in the emergency departments	20
1326	Group People Officer & Group CNO	Risk of lack of identifiable immunity data	There is a risk that staff who do not have immunisation to the disease in question, are not identifiable, meaning there is a delay in any necessary isolation period or public health action,	15

7.1.2 IPC Risk Register SCHT

The IPC risk register is reviewed quarterly through the SCHT Infection Prevention and Control Committee and monitored routinely through IPC Operational Group arrangements. At the June 2026 review, 15 IPC-related risks were identified, comprising 10 moderate and 5 low-rated risks, with no risks currently rated high.

There are 4 risks rated at a current score of 12:

Risks 6781 and 5559 relate to the ability of parts of the SCHT estate to consistently meet IPC standards because of ageing infrastructure and the need for continued capital investment and estate improvements. A related risk concerns compliance with the National Standards of Healthcare Cleanliness at sites where SCHT relies on third-party landlords and cleaning providers. This risk was increased in 2026 following persistent concerns about external cleaning arrangements, particularly at Oswestry Health Centre and HMP Stoke Heath. Risk 3063 reflects the absence of a Facilities Compliance Manager to oversee compliance with national cleanliness standards.

The final risk scored at 12 relates to compliance with FFP3 fit testing requirements to ensure staff caring for patients with airborne infectious diseases have access to appropriately fitted respiratory protective equipment. This risk has been partially mitigated through a risk-stratified approach, with fit testing prioritised for higher-risk clinical services including Urgent Community Response (UCR), Virtual Ward and Minor Injury Unit (MIU) teams. Records are held centrally on a database, with transition to ESR underway in line with NHS England requirements. Further work is planned through planned arrangements for the SATH Health and Safety Team to expand organisational fit-testing capacity across Group and increase the number of staff able to access fit testing in the coming months.

Datix Risk ID	Title	Risk Description	Risk level (current)
6781	Non-compliance with National Cleanliness Standards at SCHT occupied sites	There is a risk of poor standards of cleanliness and non-compliance with National Cleanliness Standards (2025) at SCHT occupied sites where external cleaning agencies are contracted.	Moderate (12)
6783	Non-compliance with FFP3 fit mask testing	There is a risk to staff being asked to care for patients with known/suspected infections transmitted via the airborne route and not having correct level of PPE/RPE as outlined in the NIPCM. Respiratory protective equipment (RPE), i.e., a filtering face piece (FFP) must be considered when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route and when carrying out aerosol generating procedures (AGPs) on patients. RPE also forms part of the requirement for caring for suspected HCID cases.	Moderate (12)
5559	Estate environment and facilities not compliant with Infection Prevention and Control standards	There is a risk that the environment, estate and/or facilities do not meet standards expected for effective infection prevention and control resulting in an increased risk of HAI for patients, visitors and staff in SCHT premises.	Moderate (12)
3063	Lack of Facilities Manager in post to oversee standards of cleanliness	There is a risk of non compliance with Cleanliness Standards 2021 now 2025, and IPC in buildings where external cleaning agencies are contracted. There is no Cleanliness Lead/Facilities Manager to monitor satellite clinics and external services.	Moderate (12)

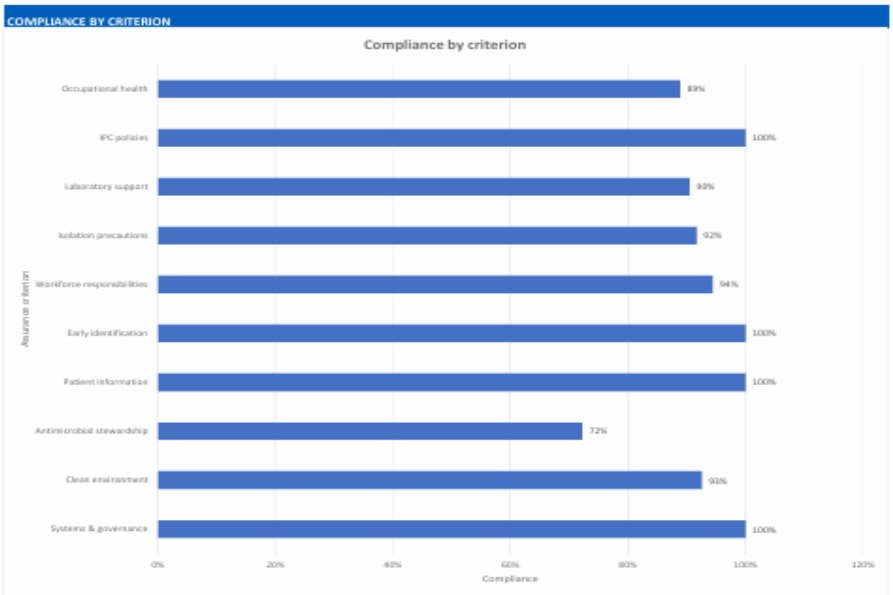
7.2 Board Assurance Framework

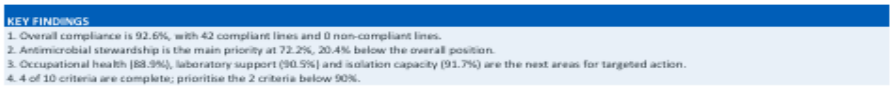
The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) is a self-assessment tool used by healthcare organisations to assure their board of directors that robust systems and practices are in place to manage infection risks and comply with national standards. It provides structured assurance against the ten criteria of the Health and Social Care Act 2008 Code of Practice and the National Infection Prevention and Control Manual and consists of 54 key lines of enquiry.

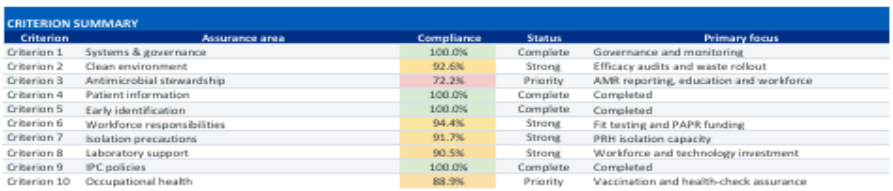
7.2.1 The Shrewsbury and Telford Hospital NHS Trust BAF

At SaTH the IPC Board Assurance Framework is reviewed quarterly, led by the Lead Nurse from IPC with contributions from pharmacy, estates, facilities, nursing. The latest quarterly review of the IPC BAF provides a positive level of assurance, with 92.6% overall compliance and no key lines of enquiry assessed as non-compliant. 42 of the 54 key lines of enquiry are fully compliant and 12 are partially compliant. Improvement activity is focused principally on antimicrobial stewardship, alongside occupational health, laboratory support and isolation capacity, with progress monitored through the IPC Improvement Plan and IPC governance processes.







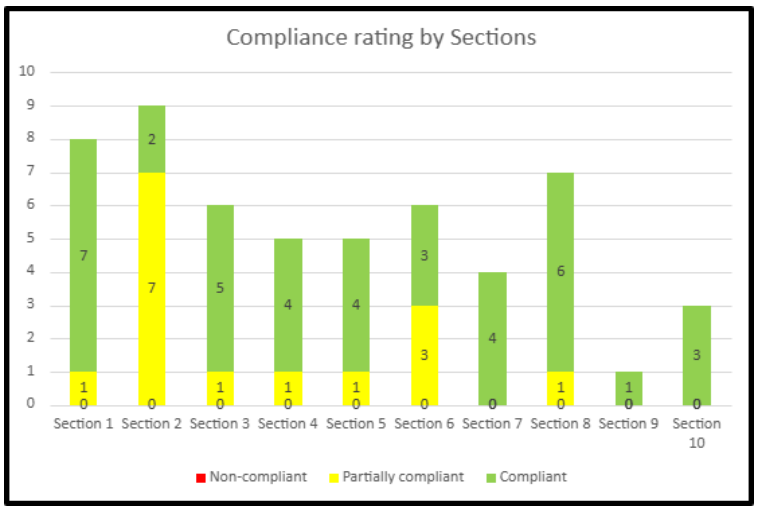


Appendix 5 contains the SaTH IPC Board Assurance Framework (June 2026 review).

7.2.2 SCHT Board Assurance Framework

The SCHT IPC Board Assurance Framework (BAF) provides structured assurance against the ten criteria of the Health and Social Care Act 2008 Code of Practice and the National Infection Prevention and Control Manual. The framework is reviewed on a six-monthly basis through a multidisciplinary tabletop review involving representatives from IPC, nursing, quality and governance, estates and facilities, health and safety, pharmacy and clinical education.

The most recent six-monthly review in March 2026 identified 39 of 54 key lines of enquiry as fully compliant and 15 as partially compliant, with no areas assessed as non-compliant (see chart below).



Areas of partial compliance principally relate to elements of cleanliness assurance, facilities and estate compliance, planned preventative maintenance, FFP3 Fit mask testing, antimicrobial stewardship, and invasive device management.

Improvement actions were monitored through the IPC Committee and associated improvement plan. Any open actions will be transferred on to the newly formed Group IPC Improvement plan going forwards.

Appendix 6 contains the SCHT IPC Board Assurance Framework (March 2026 review).

8.0 Water and Ventilation

8.1 Water and Ventilation at the Shrewsbury and Telford Hospital NHS Trust

There have been a number of building and refurbishment projects undertaken in the last 18 months. There have been challenges identified as water testing, legionella risk assessments and ventilation reviews have not been planned as part of the works, including these at the end of a project has led to delays in occupation and restrictions of use of the rooms. To ensure more robust management of this moving forward the Deputy Chief Operating Officer and Director of Nursing (acute), have worked closely with Estates to ensure all aspects of water safety and ventilation works, timescales and agreed actions and oversight are in place with clear sign off processes.

The general ventilation infrastructure on both sites is not compliant with currents Health Technical Memorandums (HTMs) and Heath Building Notes (HBNs), there is an expectation with the HTMs and HBNs that these are brought up to standard when areas are refurbished.

A whole site review of the Princess Royal Hospital ventilation has been requested by the Director of Nursing (acute) as a pre-emptive measure to ensure that the system is compliant when services and patient cohorts move with HTP.

The Trust has a bimonthly water safety meeting which discusses flushing compliance and any risks associated with the water/wastewater systems; this is reported through to IPCOG.

8.2 Water and Ventilation at the Shropshire Community Health NHS Trust (SCHT)

SCHT has established Water Safety and Ventilation Safety Groups, which meet quarterly and report through the current Trust's IPC governance arrangements. Current technical arrangements are supported through the Estates service-level agreement with Midlands Partnership University NHS Foundation Trust (MPFT). The annual Water Authorising Engineer audit completed in October 2025 received substantial assurance. The outcome of the annual Ventilation Authorising Engineer audit is awaited.

The transition to the Group Estates function requires further work to confirm governance, reporting routes, and the formal appointment and recording of competent, authorised and designated persons for water, ventilation and decontamination from 2026/27.

9.0 Governance

Currently both SaTH and SCHT have in place IPC Operational Groups (IPCOG) which meet monthly and bi-monthly respectively and report through quarterly to IPC Assurance Committee at SaTH, and bi-monthly to IPC Committee at SCHT. At SaTH a Quarterly IPC report is received by the Quality and Safety Assurance Committee with reporting to the Trust Board as part of the QSAC update. SCHT Quality and Safety Committee receive upward chairs reports from IPC Committee and the IPC BAF every 6 months before onward submission to Trust Board. HCAIs at both organisations are reported as part of the monthly Integrated Performance Report to the Trust Board which also receives the IPC Annual Report.

Moving forward a full review of the IPCOG Terms of Reference and Cycle of Reporting will be undertaken to standardise these across the two Trusts. IPCOG meetings will continue to take place monthly chaired by the Director of Nursing for the respective Trust and these will report through to a Group IPC Assurance Committee (IPCAC) which will meet bi-monthly and be chaired by the Group Chief Nurse/Director of Infection Prevention and Control with upward reporting to the Group Quality Committee. New Terms of Reference and Cycle of Reporting will be developed for the Group IPCAC. A quarterly Group IPC report will be presented at Trust Board.

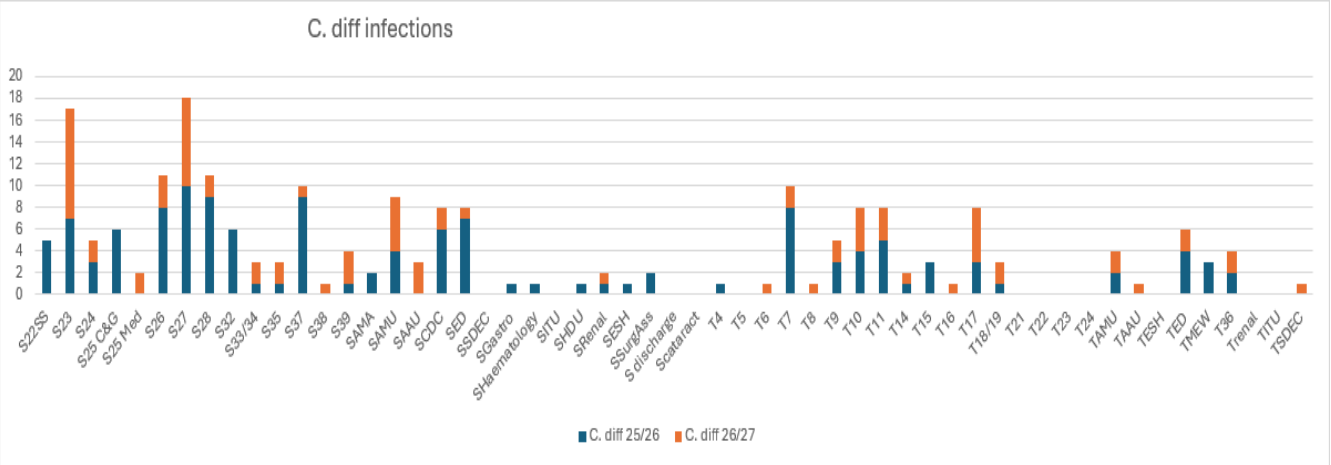
10.0 Conclusion and Recommendations

The report provides an overview of IPC practice across both Trusts, alongside continued challenges relating to HCAI performance, training compliance, cleanliness and the healthcare environment. The joint Group IPC Improvement Plan provides a coordinated approach to addressing these issues, with strengthened governance and outcome monitoring through the proposed Group IPC Assurance Committee.

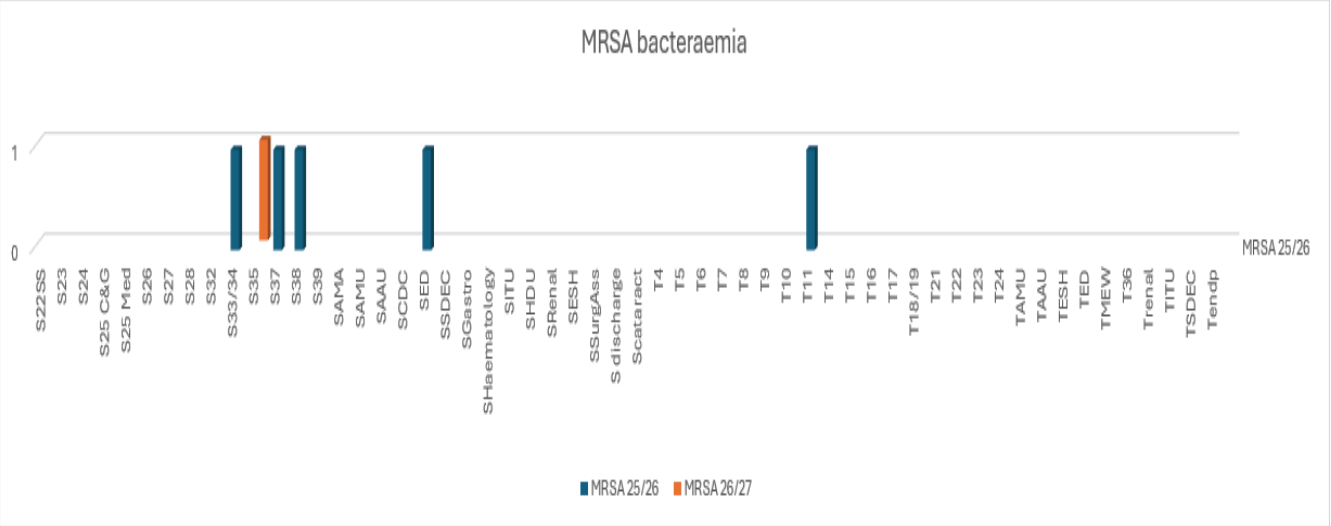
The Board is asked to:
Approve the SaTH and SCHT IPC Board Assurance Frameworks and SaTH and SCHT IPC Improvement Plan

Appendix 1: SaTH HCAI by Ward datasets

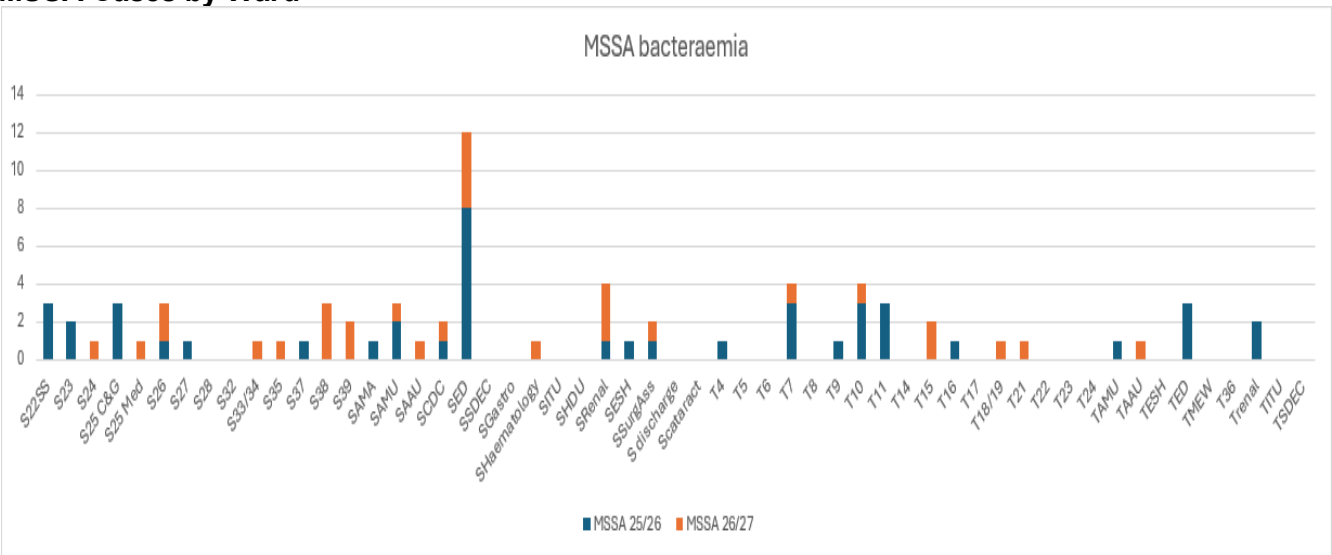
CDiff Cases by Ward



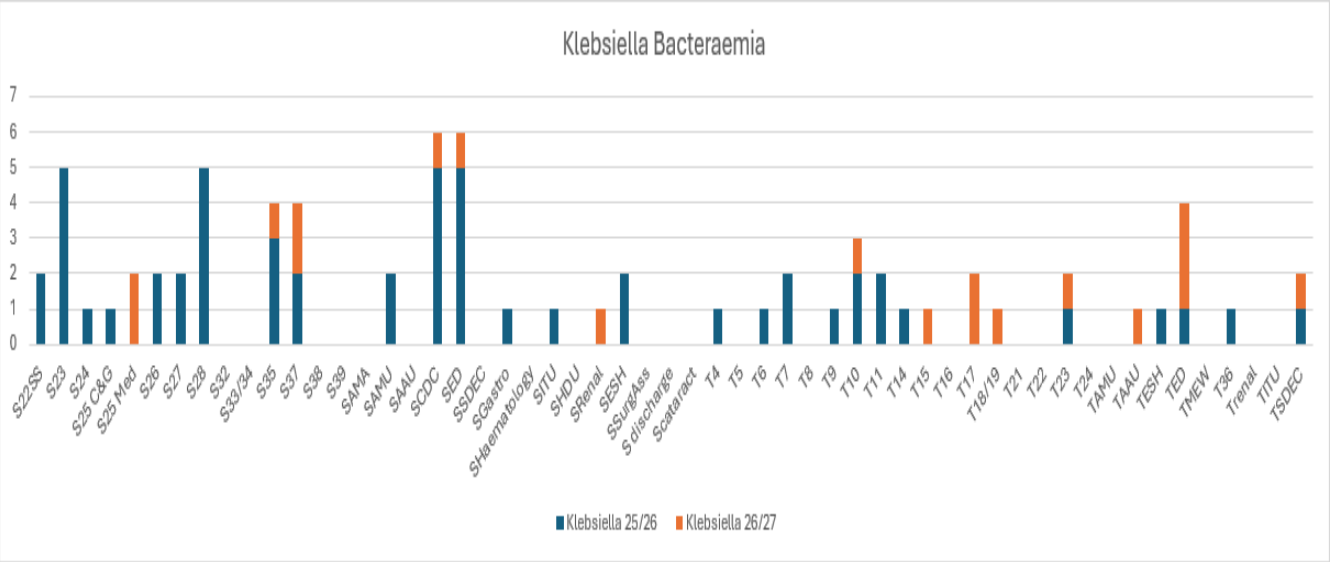
MRSA Cases by Ward



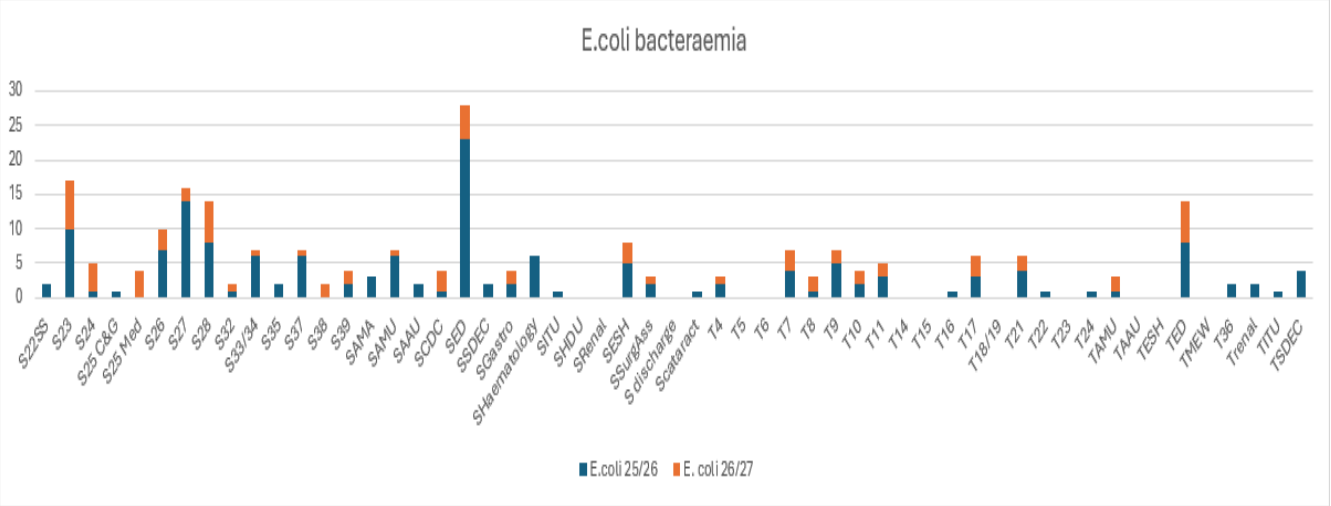
MSSA Cases by Ward



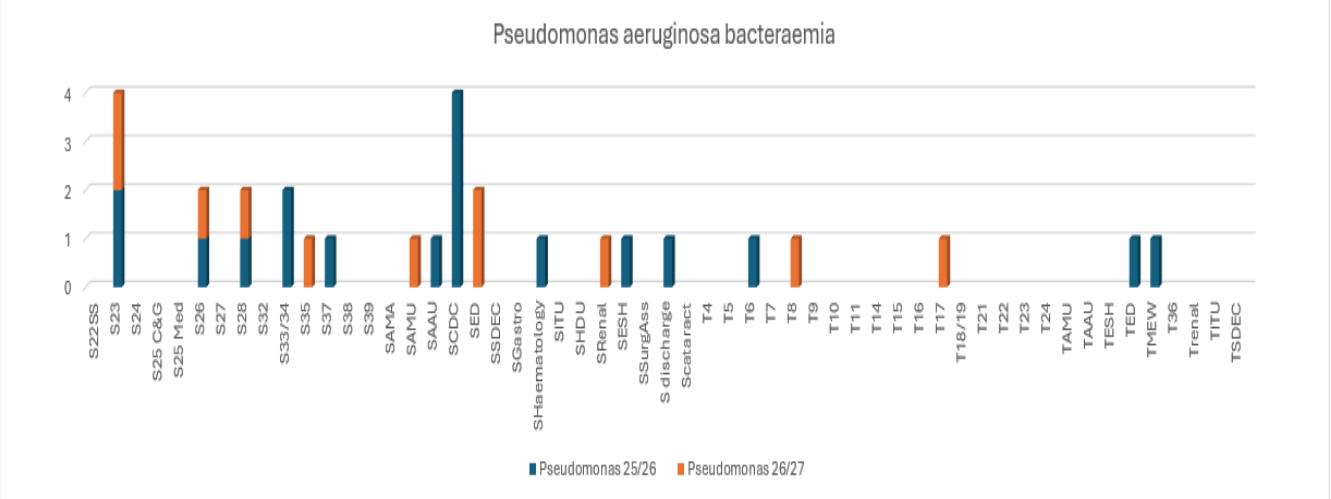
Klebsiella Cass by Ward



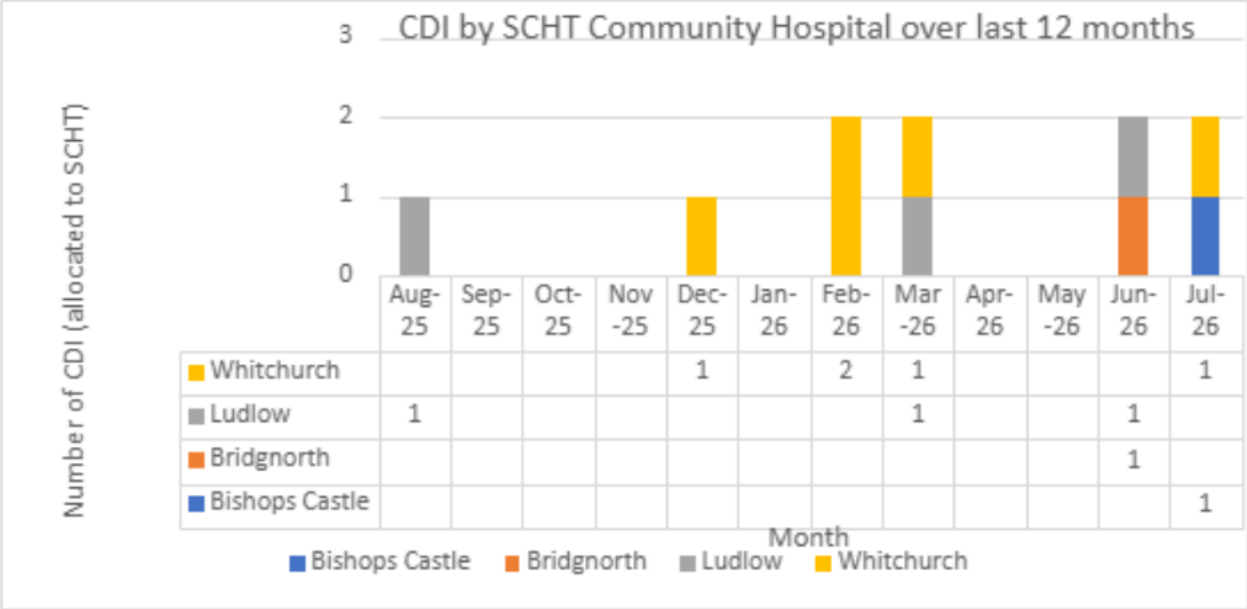
E.Coli Cases by Ward



Pseudomonas Cases by Ward



Appendix 2: SCHT HCAI by Community Hospital dataset



Appendix 3: RSH and PRH Cleanliness Monitoring Scores

Location	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
W&C Paediatric Oncology (NH L1) PRH	98.26%	97.68%	98.87%	99.35%	99.70%	99.66%	99.84%	99.49%	98.75%	99.15%	99.00%	98.22%	97.12%	100.00%
W&C Ward 23 Neonatal Unit (NK L2) PRH	99.36%	99.58%	98.88%	99.70%	99.38%	99.54%	99.73%	99.74%	99.46%	99.23%	98.82%	99.45%	99.57%	99.28%
W&C Ward 24 Delivery Suite (NK L2) PRH	97.84%	98.26%	98.42%	98.92%	99.33%	99.75%	99.42%	98.68%	99.64%	97.90%	99.19%	97.69%	99.19%	98.93%
Medical Escalation (SJ L1) PRH	95.74%	98.19%	98.37%										99.35%	97.11%
W&C Ward 14 Gynae (NG L2) PRH	99.48%	97.81%	98.64%	98.94%	99.48%	99.27%	100.00%	99.35%	98.53%	98.77%	99.29%	99.17%	97.41%	89.77%
W&C Ward 19 Paed In-Patients (NG L1) PRH	96.27%	97.82%	98.66%	96.83%	97.85%	97.39%	98.44%	98.15%	99.14%	97.24%	96.82%	98.29%	97.27%	92.42%
W&C Ward 19 Paediatric Area 2 (NH L1) PRH	96.34%	97.38%	97.13%	95.50%	97.53%	94.03%	96.97%	98.15%	96.55%	94.93%	96.68%	98.56%	98.36%	
W&C Ward 21 Post Natal (NK L1) PRH	96.88%	98.17%	98.91%	98.92%	98.57%	98.22%	98.72%	99.36%	97.91%	98.81%	98.74%	98.67%	94.62%	94.04%
W&C Ward 22 Ante Natal (NK L1) PRH	99.22%	97.93%	99.34%	99.10%	98.36%	98.25%	99.11%	99.62%	97.98%	97.99%	99.26%	96.69%	98.68%	98.71%
W&C Wrekin MLU (NL L1) PRH	98.27%	98.90%	98.71%	99.81%	98.65%	100.00%	98.09%	98.45%	99.16%	98.55%	99.33%	97.40%	98.51%	96.87%
Ward 1 AMU (NF L1) PRH	91.51%	96.31%	95.01%	91.73%	95.70%	95.86%	94.09%	93.68%	96.93%	93.54%	94.62%	94.93%	97.11%	99.10%
Ward 10 (SJ L2) PRH	96.90%	94.54%	93.70%	95.92%	95.82%	96.54%	98.41%	94.86%	94.56%	95.62%	95.91%	95.02%	95.19%	95.83%
Ward 11 (SJ L2) PRH	100.00%	99.32%	99.22%	97.94%	99.61%	98.51%	99.22%	99.65%	99.08%	97.75%	99.24%	100.00%	95.63%	95.75%
Ward 15 (SB L1) PRH	97.78%	96.03%	98.13%	98.85%	98.71%	97.08%	97.88%	98.85%	97.88%	98.86%	96.18%	96.80%	99.58%	99.10%
Ward 16 (SB L1) PRH	97.67%	97.67%	100.00%	98.60%	97.55%	98.67%	99.42%	100.00%	98.78%	99.42%	97.77%	98.21%	95.71%	98.71%
Ward 17 (SD L2) PRH	98.39%	99.08%	97.73%	98.67%	99.27%	98.15%	98.69%	99.23%	97.82%	99.52%	99.12%	96.81%	97.27%	97.78%
Ward 36 (NA L1) PRH	99.36%	99.49%	98.87%	99.35%	98.25%	98.72%	99.09%	96.69%	96.87%	96.19%	95.83%	96.42%	97.36%	98.29%
Ward 4 (SE L2) PRH	94.65%	98.55%	96.30%	99.67%	98.82%	100.00%	98.03%	100.00%	100.00%	100.00%	99.19%	99.64%	96.47%	97.42%
Ward 5 (SE L2) PRH	99.35%	100.00%	100.00%						98.91%	100.00%	99.70%	100.00%	94.12%	95.52%
Ward 6 (SG L2) PRH	96.59%	98.08%	98.71%	98.64%	99.64%	100.00%	100.00%	98.12%	99.58%	99.02%	98.04%	96.60%	100.00%	100.00%
Ward 7 (SG L2) PRH	95.32%	98.83%	98.30%	98.14%	97.25%	98.40%	98.83%	95.45%	97.24%	99.61%	98.05%	96.33%	95.02%	91.02%
Ward 8 (SH L2) PRH	97.26%	97.08%	99.71%	97.49%	98.05%	97.23%	97.14%	97.87%	97.16%	99.67%	97.87%	96.55%	98.60%	98.19%
Ward 9 (SH L2) PRH	95.59%	96.06%	94.90%	96.62%	92.66%	97.68%	97.12%	92.54%	95.43%	95.00%	96.37%	92.92%	98.55%	98.37%

	2025						2026							
Location	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul	Aug
Ward 23 (42 L3) RSH	97.06%	98.31%	97.61%	97.50%	97.95%	96.05%	98.00%	97.14%	98.13%	98.18%	96.50%	97.94%	93.60%	95.78%
Ward 18 (23 L1) RSH	96.58%	98.52%	97.21%	97.54%	98.62%	98.75%	99.33%	98.44%	98.71%	96.24%	98.31%	Not Completed	Not Completed	Not Completed
Ward 20 (23 L1) RSH	98.19%	96.71%	100.00%	100.00%	98.45%	99.08%	97.52%	97.45%	98.71%	99.31%	99.50%	98.96%	99.44%	98.98%
Ward 21 (45 L2) RSH	93.61%	96.96%	95.72%	97.17%	98.81%	95.89%	97.99%	95.87%	97.35%	95.82%	93.88%	93.33%	94.43%	96.62%
Ward 22 AMU (49 L2) RSH	98.77%	96.23%	96.97%	97.78%	99.05%	95.65%	96.31%	96.77%	96.16%	97.34%	97.78%	93.88%	92.09%	96.21%
Ward 22 SDEC & Acute Medicine (42 L2) RSH	92.80%	92.64%	95.17%	95.14%	94.23%	95.66%	94.88%	96.31%	94.28%	95.72%	96.04%	93.55%	94.34%	95.48%
Ward 22 Short Stay (49 L2) RSH	96.51%	93.31%	92.41%	95.38%	96.04%	94.56%	94.70%	95.75%	93.60%	94.20%	95.17%	94.07%	93.01%	92.86%
Ward 24 (42 L3) RSH	99.07%	96.16%	95.98%	98.61%	96.06%	98.15%	97.06%	95.91%	98.49%	97.41%	96.33%	95.93%	94.85%	96.55%
Ward 25 (42 L4) RSH	96.24%	98.88%	95.09%	96.61%	95.20%			94.40%	93.89%	95.04%	92.78%	95.92%	94.93%	94.33%
Ward 26 (42 L4) RSH	95.50%	97.60%	97.65%	96.60%	97.96%	98.73%	98.52%	95.09%	99.53%	95.65%	95.80%	96.39%	96.72%	95.70%
Ward 27 (42 L5) RSH	97.45%	94.10%		96.61%	94.07%	97.04%	96.27%	95.60%	95.44%	96.73%	94.32%	93.81%	96.20%	92.03%
Ward 28 (42 L5) RSH	95.89%	99.10%	99.54%	98.88%	98.78%	99.41%	99.77%	100.00%	98.70%	99.78%	99.05%	97.74%	99.01%	95.51%
Ward 31 (Block 33 L1) RSH	95.24%	98.72%	97.01%	95.52%	98.13%							97.31%	95.65%	94.01%
Ward 32 (Block 33 L1) RSH	97.35%	98.32%	97.30%	97.71%	99.41%	98.93%	98.83%	98.54%	99.33%	98.64%	98.82%	98.77%	96.98%	99.76%
Ward 33 (49 L1) RSH	98.45%	97.93%	97.99%	97.48%	98.91%	98.96%	99.47%	98.74%	96.79%	98.86%	97.95%	98.44%	97.76%	99.24%
Ward 35 (23 L1) RSH	99.69%	100.00%	99.46%	99.53%	100.00%	100.00%	100.00%	100.00%	98.74%	100.00%	100.00%	100.00%	99.07%	100.00%
Ward 37 (59 L1) RSH	98.03%	97.30%	99.00%	99.37%	99.49%	99.19%	98.62%	99.02%	99.20%	99.10%	94.85%	98.34%	99.50%	99.02%
Ward 38 (62 L1) RSH						98.68%	98.37%	98.92%	99.41%	98.80%	99.14%	99.21%	99.30%	99.28%
Ward 39 (62 L2) RSH						99.16%	97.58%	99.18%	99.39%	98.96%	99.39%	96.95%	99.36%	97.01%
X Ray (35 L1) RSH	98.03%	97.34%	98.10%	97.98%	97.01%	96.72%	99.28%	97.19%	97.38%	97.60%	97.13%	96.11%	96.80%	97.35%

KEY: 5 Stars | 4 Stars | 3 Stars | 2 Stars | 1 Star ANC = Audit Not Completed AD = Audt Due

Site	Functional Area	Functional Risk	Target Score	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Bishops Castle	Outpatients & Reception	FR2	95%	96%	97%	97%	96%	90%	97%	98%	96%	98%	97%	96%	97%	95%	95%
Bishops Castle	Ward	FR2	95%	98%	94%	98%	97%	96%	98%	97%	96%	96%	98%	96%	96%	94%	96%
Bishops Castle	Mortuary	FR3	90%	ANC	95%	ANC		90%		100%		100%		90%		90%	
Bishops Castle	Physio Outpatients	FR4	85%	89%			ANC		93%			90%			90%		
Bridgnorth	Theatre	FR1	98%	98% 99% 99% 100%	100% 98% 98% 100% 100%	100% 100% 100%	99% 100% 98% 100%	100% 99% 100% 100%	98% 99% 98%	99% 100% 100%	98% 100% 99%	100% 100% 100%	100% 98% 100%	97% 100% 100% 100%	98% 100% 100%	100% 100% 100% 100%	99% 95% 99%
Bridgnorth	Agnes Campbel Ward	FR2	95%	93%	95%	95%	ANC	96%	97%	96%	93%	97%	99%	99%	97%	ANC	96%
Bridgnorth	Main Kitchen	FR2	95%	95%	97%	97%	100%	ANC	85%	93%	98%	97%	98%	99%	99%	99%	ANC
Bridgnorth	MIU	FR3	90%		ANC		ANC		ANC		ANC		99%		99%		ANC
Bridgnorth	Mortuary	FR3	90%	ANC	100%		100%		89%		ANC		100%		100%		ANC
Bridgnorth	Maternity	FR4	85%			89%			75%		98%	94%	95%	93% 98%	93%		
Bridgnorth	Outpatients	FR4	85%			ANC			94%			ANC	93%		ANC		
Bridgnorth	Physio Outpatients	FR4	85%			92%			95%			99%			97%		
Bridgnorth	X-Ray	FR4	85%			87%			91%			99%			100%		
Ludlow	Dialysis	FR2	95%	98%	98%	93%	97%	97%	98%	97%	97%	98%	99%	98%	98%	98%	94%
Ludlow	Dinham Ward	FR2	95%	94%	95%	92%	98%	96%	97%	96%	95%	97%	92%	96%	97%	90% 91% 97%	96%
Ludlow	MIU Outpatients	FR2	95%	ANC	98%	96%	97%	97%	98%	96%	94%	99%	95%	97%	94%	95%	95%
Ludlow	MIU	FR3	90%		95%		97%		92%		88%		95%		95%		95%
Ludlow	Mortuary	FR3	90%	95%		95%		95%		100%		95%		94%		94%	
Ludlow	Clee	FR4	85%	98%			96%			99%			95%			96%	
Ludlow	Ivy Lodge	FR4	85%			98%			99%			100%			97%		
Ludlow	Links and Reception	FR4	85%	96%			98%			97%			95%			94%	
Ludlow	Maternity	FR4	85%		99%			99%			99%			98%			98%
Ludlow	Physio Outpatients	FR4	85%	94%			98%			92%			97%			89%	
Ludlow	Holly Suite	FR6	75%										95%				
Ludlow	Stretton	FR6	75%		92%												86%
Whitchurch	Outpatients	FR2	95%	100%	93%	ANC	96%	93%	95%	ANC	90%	98%	97%	97%	95%	91%	ANC
Whitchurch	Team 1	FR2	95%	95%	92%	92%	92%	ANC	94%	95%	95%	ANC	94%	94%	94%	96%	97%
Whitchurch	Team 2	FR2	95%	94%	87%	97%	95%	ANC	94%	97%	96%	ANC	96%	94%	99%	95%	96%
Whitchurch	Clinic Rooms (Outpatients)	FR3	90%		94%		94%		100%		ANC		98%		96%		100%
Whitchurch	MIU	FR3	90%		96%		94%	92%			96%	96%			94%	96%	
Whitchurch	Mortuary	FR3	90%		96%		97%		89%		86%		96%				
Whitchurch	X-Ray	FR3	90%		95%		93%		95%		97%		98%		98%		98%
Whitchurch	District Nurses	FR4	85%		93%			AD	94%		87%		94%			AD	90%
Whitchurch	Laundry	FR4	85%	100%			ANC		94%			95%			90%		
Whitchurch	Midwives	FR4	85%		97%			AD	96%		92%	90%			100%		
Whitchurch	Oxygen Store	FR4	85%	ANC			100%			ANC			78%			ANC	
Whitchurch	Phlebotomy	FR4	85%		92%		86%	AD			AD			AD			AD
Whitchurch	Physio Outpatients	FR4	85%	95%			ANC		94%			97%		94%			ANC
Whitchurch	Reception	FR4	85%		98%			92%			95%	95%		ANC		96%	
Whitchurch	Shrop Doc	FR4	85%	100%			95%			AD	90%		94%			ANC	
Whitchurch	Admin Office	FR6	75%	96%											96%		
Whitchurch	Staff Area	FR6	75%				87%										

APPENDIX 4

TRUSTWIDE IPC IMPROVEMENT PLAN

Accountable Executive Officer, Martina Morris, Group Chief Nursing Officer/Director of Infection Prevention Control. Operational Oversight Group: IPC Operational Group at SaTH and SCHT. Assurance oversight via the Group IPC Assurance Committe. Board Assurance and oversight via the Group Quality Committee

SaTH, SCHT, Group	Action ID	Area for Improvement (NHSE)	Individual Action	Organisation	Group Exec sponsor- Group Chief Nurse, Lead Director SCHT and SaTH - Director of Nursing	Operational lead	Target Completion Date	Date Completed	RAG / Status	Progress / Current Position	Supporting Evidence
		1.Governance									
	1.1	Duplication and misalignment of IPCOG and IPCAC agendas, issues for discussion (action plans, learning from incidents etc.) are not discussed in depth. Assurance is often discussed at IPCOG rather than IPCAC.	Review ToR and CoR & agendas for IPCOG, IPCC and IPCAC to ensure adequate time for discussion and cross divisional learning	Group	Kara Blackwell/Sara Ellis Anderson	Kara Blackwell/Sara Ellis Anderson	31-Oct-26		Amber		Updated ToR and CoR approved by Group IPCAC
	1.2.1	Governance reporting to the Board is inconsistent because IPCOG and IPCAC responsibilities and escalation routes are not clearly aligned, creating a risk that significant IPC issues are not reported or acted upon consistently.	Review templates for IPC team report and divisional reports to IPCOG/IPCAC to ensure standard items are discussed and escalated through existing governance processes	Group	Kara Blackwell/Sara Ellis Anderson	Kara Blackwell/Sara Ellis Anderson	31-Oct-26		Amber		Updated template approved by Group chief nurse and PDSA'd in line with reporting cycles
	1.2.2		Develop one overarching Group IPC Board Report	Group	Kara Blackwell/Sara Ellis Anderson	Kara Blackwell	21-Dec-26		Amber	First Group IPC report going to Board in October 2026. Following this final structure for report will be developed	Updated template approved by Group chief nurse and PDSA'd in line with reporting cycles
	1.2.3		Develop a divisional BAF to feed to trust wide BAF. Divisions are responsible for updating.	Group	Kara Blackwell, Sara Ellis Anderson	Janette Pritchard, Sharon Toland	31-Dec-26		NS		Templated for divisional BAF agreed and rolled out reporting into IPCAC Bimonthly
	1.3.1	No single system for reviewing themes and trends from IPC Incidents/outbreaks, bacteraemia cases or C. diff cases	Integrate ICNET with digital systems.	SaTH	Kara Blackwell	Josh Pagden	31-Jan-27		NS		
	1.3.2		Baxter to provide training on fully functional ICNET	SaTH	Kara Blackwell, Sara Ellis Anderson	Kelly Pardy	31-Dec-26		NS		Training provided to IPC team by Baxter
	1.3.3		Investigate use of Datix to report HCAIs and outbreaks, to include forms for wards to add the data to enable reports for oversight	Group	Kara Blackwell/Sara Ellis Anderson	Kelly Pardy/ Kath Preece/ Shelley Ramtuhul	31-Oct-26		Amber	SCHT use Datix to report HCAIs/Outbreaks and Incidents and features in Divisional reports to IPCC	Training provided to IPC team by Datix team. Confirmation that Datix can be used to report as per action. Monthly report to IPCOG
SCHT improvement plan Action 22. IPC BAF 1.2 (v5)	1.4	Alert Organism Surveillance. IT systems do not support flagging patients clinical records with previous alert organisms or newly acquired. This poses a risk that patients may not be effectively managed on admission.	SCHT IPEAT and CSO to explore the potential to acquire additional licences for ICNet for use in the SCHT or consider procurement of ICNet	SCHT	Sara Ellis Anderson	Mark Goodfellow	31.12.26		NS	Linked to SCHT risk ID 5558	
	1.5.1	Recurrent issues identified in subsequent outbreaks, QWWs, case reviews. Action plans in place are often not addressing the cause of a problem and often rely on immediate rectification of a single issue. Actions are not sustained and no evidence provided before closure of an action.	Develop standard quality improvement plan template that incorporates all sources (QWWs, outbreak meetings, Case reviews) for a single area. Once standard template agreed Divisions to bring through IPCOG as part of Divisional update	Group	Kara Blackwell/Sara Ellis Anderson	Janette Pritchard, Kelly Pardy, Sharon Toland	30-Nov-26		NS	Divisional reports in place at SCHT	Developed template approved by group Chief Nurse via IPCAC
	1.4.2		Provide a "What good looks like" poster and who is responsible	Group	Kara Blackwell/ Sara Ellis Anderson	Sue Southworth/ Sharon Toland	31-Oct-26		Amber		Presented to IPCOG and approved for printing. Evidence of roll out
	1.4.4		Implement routine dept. visit with relevant parties (Div DoNs) to review sustainability before actions are closed following HCAI ARR.(Evidence to be provided before closure)	Group	Kara Blackwell/Sara Ellis Anderson	Janette Pritchard/ Emilia Chrusciel/Sharon Toland	31-Jan-27		Amber		Routine visits happening to close off actions, reported with Datix as per 1.3.3 & IPCOG team report
	1.4.5		Closure meeting to be held with Director of Nursing Acute/Lead Nurse IPC/Div DoN/Matron/ward manager / 3 months of compliance before action considered for closure	SaTH	Kara Blackwell/Janette Pritchard	Janette Pritchard	31-Jan-27		Amber		Routine visits happening to close off actions, reported with Datix as per 1.3.3 & IPCOG team report. 3 months compliance data
	1.4.6		Quarterly QWWs should ensure issues identified previously are specifically reviewed and reported via IPC Team Report to IPCOG and via Divisional Reports to IPCOG.	SaTH	Kara Blackwell	Kelly Pardy/Div Dons	31-Jan-27		Amber		Routine visits happening to close off actions, reported with Datix as per 1.3.3 & IPCOG team report. Review of compliance data (3 months)
improvement plan Action 112. IPC BAF 1.4 (v5)	1.4.7		Agree process for closure of actions when AMAT goes live with operational leads	SCHT	Sara Ellis-Anderson	Clare Walsgrove/ Sharon Toland	31-Jan-27		NS	Audit tracking and escalations currently held on IPC operational tracker (Excel) and discussed bi-monthly	
	1.5.1	Increase local accountability in relation to IPC incidents/outbreaks or identified risks	Director of Nursing (acute) and IPC Lead Nurse to set out clear expectations in relation to response, failure to meet expectations to be addressed by Divisional Directors of Nursing and be reported to IPCOG via divisional reports	SaTH	Kara Blackwell	Janette Pritchard	30-Nov-26		NS		
	1.5.2		Develop and initiate standard set of actions to be undertaken if a ward/dept is involved in an outbreak, incident, or is RAG rated red to include responsible person from division to initiate and monitor progress of actions	Group	Kara Blackwell/Sara Ellis Anderson	Janette Pritchard/Kelly Pardy,/Sharon Toland	28-Feb-27		NS	SCHT have Outbreak checklist defining responsibilities and actions	Set actions agreed via IPCOG, added as form in Datix

	1.6.1	The volume and duplication of IPC policies make them difficult for staff to navigate and apply consistently, increasing the risk of conflicting or unclear practice requirements.	Rationalise IPC policies and merge where appropriate	SaTH	Kara Blackwell	Janette Pritchard	31-Jan-27		NS		IPC policy matrix to be developed and approved via IPCAC inc. timelines for completion Completed policies approved via PAG and available on intranet inc. roll out plan for staff
	1.6.2	Some IPC policies are out of date and may not reflect current national guidance or local learning, creating a risk of inconsistent or unsafe practice.	Update policies in line with national guidance and local learning	SaTH	Kara Blackwell	Janette Pritchard	31-Jan-27		NS		All policies updated in line with national guidance, in date and available on intranet
	1.7	Trust IPC intranet page to be rationalised and updated (last updated March 2024)	Update Intranet page and remove out of date documents	SaTH	Kara Blackwell	Zamira Akbarova	30-Nov-26		NS		Intranet page updated and only in date documents.
	1.8.1	Map HCAI against sample positivity for relevant samples and against "accurate" per 100,000 bed day position	Retrospective review since 2024/25	SaTH	Kara Blackwell	Stephen Jones	30-Nov-26		NS		Findings presented to IPCOG
	1.8.2	Scoping exercise, what happened Q2 2024/25	Review IPCC papers and trust board papers to identify trigger Review antimicrobial guidance for hospital	SaTH	Kara Blackwell	Janette Pritchard/Stephen Jones	30-Nov-26		NS		Findings presented to IPCOG
		2. Estates, Facilities & Cleanliness									
	2.1.1	There needs to be a consistent coordinated Trust wide programme of multidisciplinary clinical-area reviews involving IPC, Estates, Facilities and divisional representatives.	Develop and implement a scheduled programme of joint IPC, Estates, Facilities and divisional reviews of clinical areas. Each review will document identified risks, assign a named action owner and target date, and monitor completion through divisional governance and IPCOG.	SaTH	Kara Blackwell	Janette Pritchard/Kelly Pardy	28-Feb-27		Amber		schedule of visits for clinical areas Local improvement plans developed post Visit Reporting through IPCOG
	2.2.1	Clinical areas in poor state of repair, not able to be cleaned effectively. Expectation that departments report defects/issues through MICAD system, relying on clinical staff to know what is/isn't an issue that needs reporting.	Initiate estates audit programme of clinical areas to identify and rectify areas of IPC risk	SaTH	Norman Mitchell	Norman Mitchell, Lee Wyatt	31-Mar-27		NS		To be confirmed by estates
	2.2.2		Develop a RAG rating tool for determining IPC risk	SaTH	Norman MitchellKara Blackwell	Norman Mitchell/Janette Pritchard	31-Mar-27		NS		RAG rating tool
	2.2.3		Completion of jobs to be monitored via estates report to IPCOG	SaTH	Mnorman Mitchell	Norman Mitchell, Lee Wyatt	31-Mar-27		NS		Monthly report in IPCOG
	2.3.1	Generally old estate, not compliant with current HBNs/HTMs inc. hand hygiene facilities, single room/isolation capacity, bed spacing, ventilation	Whole site review of estate infrastructure, to include ventilation, water/wastewater, bed spacing, isolation capacity and hand hygiene facilities Vs current HBNs/HTMs. (Address and rectify where possible, record where not possible to meet and include risk on corporate risk register) Confirmation that minimum acceptable standards audits in line with HTM (section 4 part B 03-01)	SaTH	Norman Mitchell	Lee Wyatt	31-Mar-27		NS		To be confirmed by estates
	2.4.1	There is no consistently functioning Ventilation Safety Group, limiting assurance that ventilation risks are identified, prioritised and managed in accordance with HTM 03-01.	Ventilation safety group meetings to be held monthly and reported through IPC governance inline with HTM 03-01	SaTH	Norman Mitchell	Lee Wyatt	31-Jan-27		NS		Paper to be presented at IPCOG
improvement plan Action 56. SCHT Ventilation Group. BAF 2.4 (v5)	2.4.2		Review process for procurement and use of air-scrubbers across SCHT in high risk areas	SCHT	Lee Wyatt	Ian McCabe/ Rob Lamb	31.10.27		NS		
	2.5.1	Deep clean programme very slow (bay by bay decant) Programme routinely stalling as areas are refilled due to capacity pressures Areas being left not complete when moving onto next area (Side rooms and ancillary areas)	Complete areas that have not yet been completed (wards 27,25,10)	SaTH	Susanne Crossley/Kara Blackwell/ Norman Mitchell	Capacity and Flow Team/ Facilities/ Estates	31-Mar-27		Amber		
	2.5.2		Undertake specialist cleaning review	SaTH	Kara Blackwell/ Louise Kiely	Louise Kiely	31-Jan-27		NS		Paper to be presented at IPCOG
	2.5.3		Adhere to joint sign off of areas before moving on to next area	SaTH	Kara Blackwell/ Matt Neal	Louise Kiely/Div DoNs/Janette Pritchard	30-Nov-26		NS		Sign off template in place
	2.6	No decant space on ongoing plan to enable the Trust to have robust deep clean programme in place now and for future	Develop long term decant deep clean programme in conjunction with Deputy Chief Operating Officer	SaTH	Kara Blackwell/Susanne Crossley, Norman Mitchell	Louise Kiely/Lee Wyatt	31-Dec-26		NS		???
SCHT improvement plan Action 86. C-Diff Thematic Review (Q1 25/26) BAF Criterion 2	2.7.1	Bed spaces not adequately cleaned between patients inc. beds and mattresses	Provide training materials Inc. video on appropriate bed space cleaning inc. bed and mattress (book sim suite)	Group	Kara Blackwell/Sara Ellis Anderson	Sue Southworth/ Sharon Toland	30-Nov-26		NS		Materials produced and available
	2.7.2		Roll out of training to 90% of appropriate staff within 12 months. Divisional trajectory's to be monitored via IPCOG	Group	Kara Blackwell/Sara Ellis Anderson	Sue Southworth/Sharon Toland	30-Nov-27		NS		Included in divisional reports to IPC Governance
	2.7.3		Guidance for Divisions and Operational Teams/site team on appropriate length of time to clean a bed space effectively	SaTH	Kara Blackwell	Sue Southworth	30-Nov-26		Amber		Guidance document

	2.7.4		Ensure that internal professional standards reflect reasonable time to clean before moving patients into empty bed space	SaTH	Kara Blackwell	Sue Southworth	30-Nov-26		NS		Guidance document
	2.7.5		Develop and seek approval via business case for bed cleaning team (LK)	SaTH	Kara Blackwell	Louise Kiely/Janette Pritchard	31-Dec-26		NS		Business reviewed and presented finance committee
	2.7.6		Critical appraisal of models for cleaning including cleaning products	SaTH	Kara Blackwell	Louise Kiely/Janette Pritchard	31-Dec-26		NS		Paper presented to IPCOG and recommendations made in accordance
	2.7.7		Develop mechanism for recording terminal clean of bed space	SaTH	Kara Blackwell	Div DoNs	31-Jan-27		Amber	Current process to be refined and updated	Presented at IPCOG
	2.7.8		Understand what the threshold is for changing level of clean in escalation of extremis.	SaTH	Kara Blackwell/ Susanne Crossley	Louise Kiely/Kelly Pardy/ Sophie Green	30-Nov-26		NS		Develop framework for decision making, include into hospital full policy Presented and approved by group CNO
	2.8.1	Standardised national colour coding for cleaning equipment failing, increased risk of transmission of pathogens between areas. Cleaning trollies not set up in standardised way	Relaunch standardised colour coding	Group	Kara Blackwell/Sara Ellis Anderson	Louise Kielly	31-Oct-26		Amber	SCHT have national colour coding in place	Training compliance presented at IPCOG
	2.8.2		Provide training to domestic teams including escalation routes	Group	Kara Blackwell/Sara Ellis Anderson	Louise Kielly	31-Jan-27		Amber		Training compliance presented at IPCOG
	2.8.3		Provide pictorial guides on standard set up of cleaning trolley	Group	Kara Blackwell/Sara Ellis Anderson	Louise Kielly	30-Nov-26		NS		Presented at IPCOG
	2.8.4		Ensure equipment is available to for repair/replacement	Group	Kara Blackwell/Sara Ellis Anderson	Louise Kielly	30-Nov-26		NS		Confirmation of stock
	2.9.1	Failure to adequately decontaminate shared equipment between uses Inc. beds, mattresses, sanitary equipment, observation machines	Focused education programme on cleaning of shared medical equipment	SaTH	Kara Blackwell	Emilia Chruschiel	30-Aug-27		NS		Include in fundamentals of IPC programme present training compliance by division in divisional reports to IPCOG
	2.9.2		Review what products are being used to clean/disinfect and suitability for continued use.	SaTH	Kara Blackwell	Louise Kiely/Janette Pritchard	30-Nov-26		NS		Paper presented to IPCOG and recommendations made in accordance
	2.9.3		Review of equipment requirements at ward/Department level	SaTH	kara Blackwell	Div Dons	30-Nov-26		NS		Presented by IPCOG Recommendations from IPCOG to relevant committees for funding
SCHT improvement plan Action 94. C-Diff Thematic Review (Q1 25/26) BAF Criterion 2	2.9.4		Review housekeeper role and responsibilities & standardise approach in all clinical areas	Group	Kara Blackwell, Sara Ellis Anderson	Louise Kiely/Kara Blackwell, Sharon Toland	31-Dec-26		NS		???
SCHT improvement plan Action 95. BAF Criterion 2 KLOE 2.1 and 2.3 and 2.9	2.10.	SCHT Facilities Lead required	Shared Services agreement with SATH to be in place to enable SCHT to have dedicated Facilities Lead post	SCHT	Sara Ellis Anderson	Louise Kiely/ Gemma McIver	30.11.26		Amber		
	2.11	SCHT Transition to SATH/Group Estates function	Confirm SCHT water, ventilation and decontamination governance, including committee reporting routes and the formal appointment, competency and recording of authorised and designated persons.	SCHT	Sara Ellis Anderson	Lee Wyatt	30.11.26		NS		
		3. Capacity & Flow									
	3.1.1	Isolation capacity does not meet demand, unable to isolate some patients requiring isolation posing transmission risk	Side room audit utilising Microsoft forms	SaTH	Kara Blackwell	Kelly Pardy	31-Dec-26		Amber		Paper written and presented to IPCOG
	3.1.2		Explore if additional isolation capacity within the existing estate is possible	SaTH	Kara Blackwell/ Norman Mitchell	Norman Mitchell/Kelly Pardy	31-Dec-26		NS		Paper written and recommendations presented to IPCOG
	3.1.3		Record that isolation capacity is a Trust wide risk, escalate to Board and explain the potential consequences before that risk is accepted.	SaTH	Kara Blackwell	Kara Blackwell	01-Oct-26		Green	Already on Risk Register and Reported through to Risk Mananagement Committee	Risk reviewed quarterly and reported to IPCAC
	3.1.4		Understand what capacity looks like post HTP	SaTH	Kara Blackwell/ Sara Biffen	Rachel Webster/Janette Pritchard	30-Nov-26		Amber		Presented capacity post HTP to IPCOG and IPCAC
	3.2.1	Delay in identification of patients who require isolation	Develop a process for use at Divisional level to ensure that microbiology results are checked and acted upon, engage with areas performing well and share learning (T17&S24)	SaTH	Kara Blackwell/Jenni Rowlands	Janette Pritchard, Div Dons	31-Dec-26		NS		
	3.2.2		Discuss with microbiology/Review/Clinical portal about how abnormal micro results are seen on digital systems (can they be red like biochem)	SaTH	Kara Blackwell	Kelly Pardy, Stephen Jones	31-Oct-26		NS		Outcome of discussion
	3.2.3		Develop a process to ensure that patients with existing IPC alerts available on Care flow & clinical portal are checked and acted upon	SaTH	Kara Blackwell	Div Dons	28-Feb-27		NS		Guidance on process to IPCOG
	3.2.4		IPC to escalate again to digital that IPC alerts are not immediately visible on care flow and that it presents a clinical risk	SaTH	Kara Blackwell	Kelly Pardy	31-Dec-26		Amber		Outcome of discussion, entry on risk register if unable to resolve

SCHT improvement plan Action 51. BAF 4.5 (v5)	3.3	IPC risks not adequately communicated at handover, or transfer (internally and externally)	Standardise the transfer policy and ward handover process so that MRSA/MSSA status, likely infection source, invasive devices, isolation requirements and outstanding IPC actions are communicated consistently during internal and external transfers. Implement the revised process and monitor compliance.	Group	Kara Blackwell, Sara Ellis Anderson	Sue Southworth / Lisa Walker / Div Dons Matrons / Ward Managers, SCHT IPEAT and SCHT Clinical and Clare Walsgrove	31-Dec-26		NS		Approved transfer and handover standard; communication and implementation records; handover audit; patient-record review; incident and case-review themes; divisional assurance reports.
	3.4	Significant amounts of patients who are "Medically Optimised for Discharged" remaining in hospital, increasing risk of developing an infection	Review proportion of HCAIs in this cohort	SaTH	Kara Blackwell/ Susanne Crossley	Kelly Pardy/Jane Gough	31-Mar-27		NS		Paper and recommendations take to IPCOG, further discussion with ops and improving discharge profile
	3.5.1	Overcrowding in admission areas, inpatient wards cramped and bed spacing not in accordance with most recent guidance. More recently built ward areas built to new standards, altered to accommodate additional patients Hospital full policy introduces additional patients into an already overcrowded environment.	Review and update the current risk on risk register	SaTH	Kara Blackwell/Suzanne Crossley	Kara Blackwell	01-Oct-26		Green		Risk register reported to IPCOG, IPCAC, QSAC and Trust board via Group IPC report
	3.5.2		Review hospital full policy	SaTH	Kara Blackwell/Susanne Crossley	Kara Blackwell/Suzanne Crossley	30-Nov-26		Amber		Reviewed hospital full policy published and available on the intranet
		4.Clinical Practice/Fundamentals of IPC									
	4.1.1	Compliance with fundamental IPC practices is inconsistent across staff groups, including hand hygiene, PPE, cleanliness and management of patients requiring isolation, increasing the risk of avoidable transmission.	Develop fundamentals of IPC educational programme Face to Face, work with practice educators and corporate education team to ensure adequate implementation programme. Div Dons to be involved. Review SCHT IPC Fundamentals training package.	Group	Sara Ellis Anderson/Kara Blackwell	Rachel Armstrong/Sue Southworth/Sharon Toland	31-Jan-27		NS	SCHT deliver face to face IPC fundamentals training bi-monthly	material developed, approved by group CNO and available
	4.1.2		Ward Managers, Matrons and Divisional Leaders to ensure completion of IPC Fundamentals programme covering hand hygiene, PPE, isolation precautions, clinical handwash basin use, waste segregation, single-use items and shared equipment decontamination. Compliance to be monitored through local governance and mandatory training reports.	Group	Sara Ellis Anderson/Kara Blackwell	Janette Pritchard/Judith Barnes/Div Dons, Sharon Toland	31-Jan-27		Amber	IPC training compliance is already on ward/department dashboards. Update this to reflect the new Fundamentals in IPC education programme	Training vs trajectory included as part of IPCAC report by division. >90% compliance within 12 months
	4.1.3		Review LMS IPC L1&2 programmes as part of 4.1.1 action above	SaTH	Kara Blackwell	Janette Pritchard/Sarah Thomas	30-Nov-26		NS		Reviewed and any recommendations made to IPCOG
SCHT IPEAT and SCHT Clinical and Clare Walsgrove	4.1.4		E-learning module to raise awareness of identification, assessment and treatment of CDI for SCHT inpatient nursing and medical staff	SCHT	Sara Ellis Anderson	Ian McCabe	31.03.27		NS		
SCHT improvement plan Action 59. BAF 6.1 (v5)	4.2	New starters do not receive a consistent local IPC induction, creating a risk that essential expectations and safe practices are not understood from the outset.	Work with relevant teams to include fundamentals of IPC into local induction programmes	Group	Kara Blackwell/Sara Ellis Anderson	Rachel Armstrong/Sarah Thomas/ Fiona McPhearson	31-Jan-27		NS	Local induction checklist and IPC leaflet in place at SCHT	New starters to be >90% compliant with induction reported via divisional report
SCHT improvement plan linked to Action 104 BAF 6.2 and 1.7	4.3	Existing IPC policies and procedures are implemented inconsistently across clinical areas, resulting in variation in practice and reduced assurance of compliance.	Develop a competency framework for sign off of to include MRSA screening, decolonisation, line care, catheter care, blood culture collection, isolation practice and outbreak response (linked to action 4.1.1 above) Scope with ESR to include as a skill	Group	Kara Blackwell/Sara Ellis Anderson	Rachel Armstrong/Sue Southworth/ SCHT clinical education team	31-Jan-27		NS	Linked to CVAD/Line Care audit at SCHT and PSIRF learning responses and improvement actions	Report via ESR per staff group to IPCOG
	4.4.1	Blood-culture contamination exceeds the national benchmark of 3%, indicating inconsistent collection technique and creating a risk of unreliable results, unnecessary treatment and delayed diagnosis.	Staff should be competency assessed and signed off prior to undertaking blood cultures (linked to action 4,1,1 above)	SaTH	Kara Blackwelll/Jenni Rowlands	Deputy MD/Rachel Armstrong	30-Apr-26		NS		Report BC contamination rates per division via divisional IPCOG paper with an action plan
	4.4.2		Explore medical devices that reduce collection contamination for implementation in high incidence areas	SaTH	Kara Blackwell	Kelly Pardy/Gail Martin/IPC Doctor	31-Dec-26		NS		Review findings with medical devices group and make relevant recommendations
	4.4.3		Provide contamination rates at ward/dept level	SaTH	Kara Blackwell	Jessica Riley (Senior specialist biomedical scientist)	30-Oct-26		Amber	In place for admission areas	Report BC contamination rates per division via divisional IPCOG paper with an action plan
	4.5.1	Minimal engagement from IPC link nurses, link nurse programme not having beneficial effect	Relaunch as IPC champions	SaTH	Kara Blackwell	Emilia Chrusciel	31-Dec-26		Amber		Identify minimum of 1 link champion per area with a register
	4.5.2		Implement regional link champion document Inc.	SaTH	Kara Blackwell	Emilia Chrusciel	31-Dec-26		NS		Sign off of competency against register
	4.5.3		Identify link champion roll out programme for education etc.	SaTH	Kara Blackwell	Emilia Chrusciel	31-Dec-26		NS		Rolling programme in place Monitor attendance and report back to divisions via IPCOG
SCHT Improvement plan Action and IPC BAF KLOE 6.5	4.6	All identified staff are fit tested as per HSE requirements and records are maintained	Ensure SCHT staff have access to FFP3 fit mask testing via SaTH H&S team SLA and recording on ESR to maintain central record	SCHT	Sara Ellis-Anderson	Sarah Hoyes/Sharon Toland	31-Dec-26		Amber	Central record held but not on ESR. SLA drafted and funding identified.	ESR record of SCHT FFP3 fit tested staff
		5. IPC Team & Surveillance									

	5.1	Current triangulation of data insufficient to assess respective IPC risk	Implement a monthly ward-level RAG rating process using agreed indicators including HCAI incidence, QWW score, cleaning audit results, commode/mattress audit compliance, estates risks, training compliance and open actions.	SaTH	Kara Blackwell	Janette Pritchard/ Kelly Pardy	31-Dec-26		Amber	already on ward dashboard	dashboard implemented and working
	5.2	Current IPC team establishment insufficient for amount of beds, 2 acute sites, augmented care capacity and current climate of increased HCAIS etc . More recent research suggests establishment of 8 FTE for our bed numbers, bed days, split sites, augmented care capacity and current HCAI rates	Undertake review of Acute and Community IPC team capacity and service delivery model across the Group (SaTH and SCHT)	Group	Sara Ellis Anderson/Kara Blackwell	Sara Ellis Anderson/Kara Blackwell	30-Nov-26		NS		Review completed and outcomes shared with group CNO
		6. HCAI Prevention, Screening, Decolonisation & Device-Related									
	6.1.1	MRSA screening not always completed in line with policy	Relaunch the MRSA screening protocol with an education programme for clinical teams and Ward Managers, reinforcing divisional accountability for completion in line with policy.	SaTH	Kara Blackwell	Kelly Pardy	28-Feb-27		NS	repeated from previous section	Approved screening protocol; education materials and attendance records; communications to divisions; screening-compliance audit. Trajectory to be reported to IPCOG >90% within 12 months
	6.1.2		Develop an accurate MRSA screening compliance report limited to eligible patients admitted overnight, with results available by ward and division for routine monitoring and escalation.	SaTH	Kara Blackwell	Josh Pagden/Kelly Pardy	30-Jun-27		NS		Quarterly point prevalence survey in absence of intelligent report (on this day, was everyone who was supposed to be MRSA screened, screened correctly including all sites) Ward to be reviewed in the presence of MRSA bact. Or outbreak
	6.2.1	Patients with MRSA not decolonised in line with policy, increasing risk of bacteraemia	Set clear expectations with medical teams that MRSA-positive patients receive same-day decolonisation where clinically appropriate, with omissions identified and escalated.	SaTH	Jenni Rowlands	Dr Steven Jones	30-Nov-26		NS		Medical communication; prescription audit; case review of delayed or omitted decolonisation; divisional feedback.
	6.2.2		Review access to decolonisation out of hours	SaTH	Imran Hanif	Rebecca Hawkins	30-Nov-26		NS		Present outcomes to IPCOG with recommendations
	6.2.3		Develop PGD for decolonisation	SaTH	Imran Hanif	Rebecca Hawkins	30-Mar-27		NS		Approved PGD and updated MRSA policy
	6.2.4		Develop Patient education/information for decolonisation (KM task and finish group)	SaTH	Kara Blackwell	Emilia Chruschiel	31-Dec-26		NS		Leaflet approved by IPCOG and in use, documented in pt notes that they have received
	6.3	Patients with MRSA who are discharged are not always decolonised post discharge	Retrospective review over last 12 months, to inform further actions and escalations to ICB	SaTH	Jenni Rowlands	Steve Jones	31-Dec-26		NS		Data presented to ICB for action
	6.4	Reduce the number of IV access device related blood stream infections	Implement competency assessment for vascular-access care covering insertion documentation, VIP scoring, maintenance, daily necessity review and timely removal of unnecessary lines.	SaTH	Kara Blackwell	Rachel Armstrong	31-Aug-27		NS		See 4.5.1
SCHT improvement plan linked to Actions 110 and 111 . BAF 4.5	6.5.1	Reduce the number urinary catheter related blood stream infections	Review HOUDINI and ensure compliance with CAUTI-prevention approach that requires documented daily review of catheter need and timely removal when no longer clinically indicated. Continue to promote CARES bundle	Group	Kara Blackwell/Sara Ellis Anderson	Lisa Walker /Sue Southworth/ Sarah Venn/ IPEAT	31-Mar-27		Amber		Follows below action
	6.5.2		Point Prevalence Survey all catheters on given day to confirm HOUDINI and catheter maintenance, recruit audit team inc. med students, PEFS etc	SaTH	Kara Blackwell	IPC team	31-Dec-26		NS		Outcomes to reported via IPCOG and inform further actions
	6.5.3		Include urinary-catheter management and prevention of unnecessary catheter use in the Fundamentals of IPC education programme, with completion and practice monitored.	SaTH	Kara Blackwell	Lisa Walker /Sue Southworth	31-Jan-27		NS		Link with action 4.1.1
	6.6.1	C. difficile cases are increasing across the county and individual acute case reviews have not identified a clear overall cause. A joint acute-and-community thematic review is required to identify common drivers and determine whether further system-wide measures are needed.	Establish a cross-county multidisciplinary group with the community Trust and undertake a joint thematic review of all C. difficile cases year to date. Draw together acute and community case-review findings and analyse potential themes including antimicrobial prescribing, patient vulnerability, transmission, laboratory testing, community factors, patient pathways and wider health-economy issues. Seek external specialist input where this would strengthen the review, agree system-wide actions and report findings through both organisations' IPC governance arrangements.	Group	Kara Blackwell/Sara Ellis Anderson/ John Jones	IPC Doctor – Acute Trust Dr Stephen Jones IPC Doctor – Community Trust Dr Stephanie Damoa Saikwan Sara Ellis/Kara Blackwell Janette Pritchard/Sharon Toland	30-Apr-27		NS	76 cases reported against an annual threshold of 98 at 25-Aug-26; joint cross-county thematic review and external specialist support proposed.	Thematic review complete and findings reported to IPCOG/IPCAC, QSAC and Trust board and recommendation are added to the improvement plan
	6.6.2		Review commode use on wards and reinforce that, where clinically safe, mobile patients should be supported to use the toilet rather than a commode in the bay. (link to BMAT improvement work) Patients who are not mobile should be supported to use the bathroom wherever feasibly possible.	SaTH	Kara Blackwell	Lisa Walker	31-Dec-26		Amber	Carried forward from C. difficile Action Plan action 8.	??? Division to support demonstration of action in evidence

	6.6.3		Embed appropriate commode use through the ward reconditioning programme and Bedside Mobility assessment tool (BMAT) rollout, with Ward Managers and Matrons monitoring compliance and addressing exceptions.	SaTH	Kara Blackwell	Lisa Walker/Divisional Directors of Nursing	31-Mar-27		Amber	Reconditioning work and BMAT rollout are in progress across medicine wards.	Evidence of BMAT tool completing via ward metrics
	6.7	Wounds may not always be assessed, documented and escalated consistently on admission. Delayed tissue-viability or surgical review can prevent timely source control and increase the risk of invasive infection.	Strengthen wound assessment on admission and ensure a clear escalation pathway for infected or necrotic wounds requiring tissue-viability or surgical review.	SaTH	Kara Blackwell	Lisa Walker/Tissue Viability, Div Dons	31-May-27		Amber		Audit of skin integrity and triangulated with MRSA screening results and TV data reported via Metrics
		7. Antimicrobial Stewardship & Meds Optimisation									
	7.1.1	Antimicrobial prescribing requires stronger assurance that treatment is reviewed, refined and aligned with Trust guidance, reducing avoidable broad-spectrum exposure and the risk of antimicrobial resistance and C. difficile infection.	Implement and audit a documented 72-hour antibiotic review after initiation, in line with Start Smart—Then Focus, to confirm indication, microbiology results, route, spectrum and planned duration, and to stop, switch or narrow treatment where appropriate.	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-May-27		NS		Audit data via RH report to IPCOG >90% compliant within 12 months
	7.1.2		Review and improve antimicrobial prescribing for community-acquired pneumonia, hospital-acquired pneumonia and aspiration pneumonia, focusing on compliance with Trust antimicrobial guidance and addressing recurrent reasons for prescribing outside guidance. Including a CURB65 score.	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist / IPC Doctor	31-May-27		NS		Pneumonia prescribing audit; guideline-compliance data; documented reasons for exceptions; education or intervention records; re-audit and AMG/IPCOG report. Audit of patients with pneumonia and completed CURB65 score and correct abx.
	7.1.3		Review and update the Trust approach to the treatment and management of C. difficile infection, considering current ESCMID and IDSA recommendations and ensuring the approved pathway is communicated, implemented and audited.	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / IPC Doctors / Lead Antimicrobial Pharmacist	31-May-27		NS		Approved CDI treatment pathway; governance approval; communications and education; prescribing-compliance audit; case-review findings; AMG and IPC governance reports.
	7.1.4		Undertake targeted audit of broad-spectrum antibiotic use, particularly Tazocin and Meropenem, in priority clinical areas; provide prescriber feedback and implement actions to reduce inappropriate prescribing.	SaTH	Jenni Rowlands	Angus McGregor/Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		Tazocin and Meropenem audit results by clinical area; indication and guideline-compliance analysis; feedback records; agreed actions; re-audit showing prescribing trend; AMG/IPCOG and divisional governance reports.
	7.1.5		All consultants will attend an antimicrobial stewardship session as an action from their appraisal	SaTH	John Jones/ Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		Consultant attendance to be flagged to CMO for monitoring purposes and to ensure
	7.1.6		QI projects for resident doctors re prescribing in acute med and elderly care	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		Findings presented to IPCOG and recommendations made to be included on this improvement plan
	7.2	Patients prescribed PPIs and not reviewed	Every patient will have PPI reviewed on admissio	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		Evidence of audit presented to AMS group
	7.3	Spurious penicillin allergies recorded prompting use of higher risk antibiotics	Deliver programme of delabelling penicillin allerg	SaTH	Jenni Rowlads	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		Progress against programme exported to AMS group
	7.4	Ensure appropriate medical engagement and attendance at AMS group	100% of AMS meeting quorate and attendance is tracked at meeting to identify of poor engagement	SaTH	Jenni Rowlands	Angus McGregor, Antimicrobial Stewardship Group / Lead Antimicrobial Pharmacist	31-Jan-27		NS		100% of AMS groups quorate

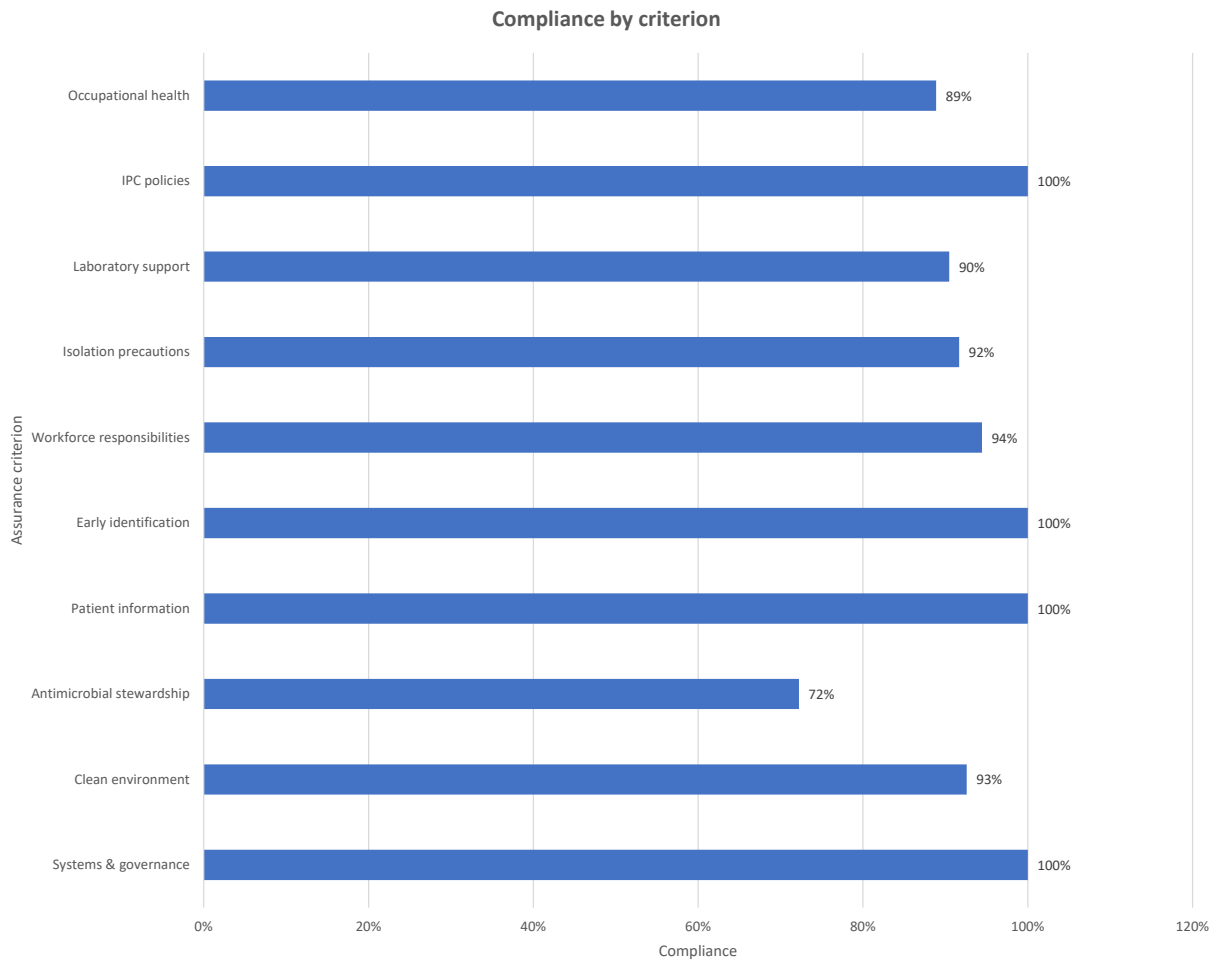
APPENDIX 5

IPC Board Assurance Dashboard

Infection prevention and control assurance position • live summary from the detailed register

OVERALL COMPLIANCE	COMPLIANT LINES	PARTIALLY COMPLIANT	NON-COMPLIANT
92.6%	**42**	**12**	**0**
150 of 162 assurance points	Rating 3	Rating 2 • action required	Rating 1 • urgent action

COMPLIANCE BY CRITERION



KEY FINDINGS

1. Overall compliance is 92.6%, with 42 compliant lines and 0 non-compliant lines.
2. Antimicrobial stewardship is the main priority at 72.2%, 20.4% below the overall position.
3. Occupational health (88.9%), laboratory support (90.5%) and isolation capacity (91.7%) are the next areas for targeted action.
4. 4 of 10 criteria are complete; prioritise the 2 criteria below 90%.

CRITERION SUMMARY

Criterion	Assurance area	Compliance	Status	Primary focus
Criterion 1	Systems & governance	100.0%	Complete	Governance and monitoring
Criterion 2	Clean environment	92.6%	Strong	Efficacy audits and waste rollout
Criterion 3	Antimicrobial stewardship	72.2%	Priority	AMR reporting, education and workforce
Criterion 4	Patient information	100.0%	Complete	Completed
Criterion 5	Early identification	100.0%	Complete	Completed
Criterion 6	Workforce responsibilities	94.4%	Strong	Fit testing and PAPR funding
Criterion 7	Isolation precautions	91.7%	Strong	PRH isolation capacity
Criterion 8	Laboratory support	90.5%	Strong	Workforce and technology investment
Criterion 9	IPC policies	100.0%	Complete	Completed
Criterion 10	Occupational health	88.9%	Priority	Vaccination and health-check assurance

Infection Prevention and Control board assurance framework v0.1							
	Key Lines of Enquiry	Person Responsible	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Organisational or board systems and process should be in place to ensure that:							
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	**IPC Team**	Evidence\2024			There is a governance structure DIPC IPC Lead	**3. Compliant**
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	**IPC Team**	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this. This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports.This also goes to IPCAC 3 monthly				**3. Compliant**
1.3	**That** there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	**Kath Preece**	Implementation of PSIRF across the Trust in December 2023 continues to promote a learning culture with a focus on improving systemic failures. Monthly reporting to QOC and Quarterly to QSAC provides assurance that incidents are managed appropriately. Staff survey and pulse surveys will test assumptions around the reporting culture. Incident numbers/systematic reviews into incidents regardless of level of harm including near miss are monitored and reported to identify themes and trends.				**3. Compliant**
1.4	They implement, monitor, and report adherence to the NIPCM.	**IPC Team**	IPC policies are written in line with the NIPCM, these are ratified and approved through IPCOG and AC by the DiPC.(Reviewed 29.04.26)				**3. Compliant**
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	**IPC Team**	ICNET in place that reports and alerts the team to alert organisms and periods of increased incidence of a particular organism. Action plans are in place for each PII. PIIs are discussed at IPCOG and AC which reports through to board.				**3. Compliant**
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	**IPC Team**	IPC annual programme in line with Health & Social Care act				**3. Compliant**
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	**IPC Team**	IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties. This is either face to face or via E learning	Doctors currently have short face to face training with IPC nurses. More investment required for education on Abx Prescribing	A video will be made if face to face training unavailable	Microbiologists started training 15th October 24	**3. Compliant**

1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	**Kath Titley, H&S Team Manager**	The principles of risk assessment and hierarchies of control are taught on the IOSH Managing Safely course (aimed at line managers) and the STEP course (aimed at new managers). Risk assessments are managed locally. H&S Team advice is available on request. For infectious diseases affecting clinical areas Trust-wide the H&S Team Manager frequently works with the Deputy Lead Nurse for IPC to prepare trust-wide/ generic risk assessments, e.g. for Covid/ flu/ RSV, Mpox, etc. IPC guidance is published within disease-specific policies.				**3. Compliant**
					Score		**24**
					Potential Score		**24**
					Percentage		**100.00%**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
System and process are in place to ensure that:							
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place).	**Sue Hambleton (SH) Facilities Business Manager Shrewsbury and Telford Hospital NHS Trust Email: susan.hambleton@nhs.net Mobile: 07718 575718**	The Trust has implemented the National Standards of Healthcare Cleanliness and cleanliness monitoring is carried out in line with the standards according to the risk rating of the area. Failures and agreed actions are shared with relevant teams at the end of the audit. We have implemented Efficacy Audits for Cleanliness Team cleaning and are working towards the multi-disciplinary approach by trying to incorporate into other on-going audits. Results are reported through to IPCOG each month and assurance given to IPCAC through the exception report. Directors of Nursing also report cleanliness monitoring scores, actions and mitigations for their areas through IPCOG.	We have not fully implemented multi disciplinary Efficacy Audits.	We are doing the efficacy audits for Cleanliness Services which is the group with the most elements under national standards. The Cleanliness Monitoring programme is independent of the cleaning team and the Cleanliness Team are achieving high standards. A SOP has been developed but full efficacy audits have not yet been introduced. The Cleanliness Team do have the most cleaning elements in the national cleanliness standards.	there is no change to date	**2. Partially compliant**
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	**Sue Hambleton (SH) Facilities Business Manager Shrewsbury and Telford Hospital NHS Trust Email: susan.hambleton@nhs.net Mobile: 07718 575718**	Annual PLACE assessments are carried out with the latest being in October/November 2024. Action Plans are compiled. Results and action plans are reported through the PLACE Group, Corporate Specialty Patient Experience Group, PACE Panel and Quality Operational Committee. Action plans discussed at PLACE Group which involves patient representatives and progress is monitored through the other groups				**3. Compliant**
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	**Sue Hambleton (SH) Facilities Business Manager Shrewsbury and Telford Hospital NHS Trust Email: susan.hambleton@nhs.net Mobile: 07718 575718**	The Cleaning schedules identify which staff group is responsible for cleaning which element. These schedules are displayed at ward/department level and are reviewed every 2 years or if anything changes. Schedules are agreed on a multi-disciplinary basis involving Facilities, Estates, IPC and Clinical Teams. They are displayed on every ward/ department. They have just undergone a review and revised schedules are displayed on wards				**3. Compliant**

2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	**Head of Estates**	Monitoring and reporting of water and ventilation processes and issues (inc risk) is via Safety Groups in place and reported thought IPCC. AE(vent) and AE(water) audits (Inc Reports) and safety plans / assessments are in Estates controlled folder: Z:\Estates\Estates Compliance\All Site Compliance Folder Actions formerly recorded and if estates led assigned under our CAFM system for audit.			Minor change from Micad to CAFM as canging our system for estates	**3. Compliant**
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	**Head of Estates**	Planned preventative maintenance program in place for all statutory, mandatory and routine maintenance including any items related to IPC. New build works brought by Project Manager to each specific safety group (vent/water/ elec etc) which IPC attend and schemes signed off by relevant groups. This is to comply with HTM 04-01 for such systems. The details are then inserted into our maintenance software system (CAFM) for ongoing maintenance and its continued compliance to the Standard. We are audited for compliance and also we have regular building surveys againsts defined standards which are reviewed and any funding available then gets prioritised by risk. Any issues arise gets risk assessed and put on coperate Risk Register for mitigation & Action.				**3. Compliant**
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	**Sue Hambleton (SH)** **Facilities Business Manager** **Shrewsbury and Telford Hospital NHS Trust** **Email:** **susan.hambleton@nhs.net** **Mobile: 07718 575718**	The Trust uses an external contractor for the supply of linen which is laundered in line with HTM:01-04. Once in the Trust it is stored for a short time in the linen room which is appropriate before distributing by Cleanliness Technicians to wards/departments. Annual due diligence inspections of premises and processes of contractor carried out involving Senior Cleanliness Manager. Cleanliness Management Team also carry out annual audits of the storage and distribution of linen.				**3. Compliant**

2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	**Mark Leighton (ML)** **Trust Waste Manager** **The Shrewsbury and Telford Hospital NHS Trust** **07355010156 | mark.leighton3@nhs.net**	Offensive waste implemented 90% of all Trust sites in line with HTM 07-01 and the NHS Clinical Waste Strategy. Waste is stored in secure storage areas within locked carts, or in dirty utilities accessible only by staff. Evidenced by legally required annual pre-acceptance audits at each site that produces clinical waste, as well as legally required Dangerous Goods Audits at each site. Z:\Estates\Risk & Environment\Waste\Audits. Transport, treatment and disposal at all Trust sites which produce clinical waste is evidenced by Hazardous Waste Consignment Notes showing every waste collection and treatment route, additionally quarterly returns provided by our contractors (Stericycle and Sharpsmart) showing disposal method Z:\Estates\Risk & Environment\Waste\Clinical Waste\Consignment notes	Overclassification of waste continues to be an issue - packaging and domestic waste is disposed of in clinical waste bags, however this has greatly reduced, and will improve further when recycling is bought into the Trust in line with law changes in 2026. Recycling is slowly being brought into the Trust, with a phased rollout happening across the Trust, focusing firstly on Non Clinical areas. 'Wheelie bin' size bins containing infectious waste are stored on link corridors currently when there is an infectious patient in a ward at PRH due to lack of space in disposal holds.	Quarterly Waste Management Group set up with Senior Stakeholders to ensure compliance and communication as well as effective management of waste - Chaired by Trust Waste Manager. Ward staff must teletrack the Porters to remove waste carts stored on corridors when the infectious patient has been discharged/infection ceased to remove waste. New disposal hold built at PRH outside Ward 8/9, and the disposal hold outside Ward 4 has been extended, with others following suit throughout the FY to assist with storage of waste. Training and awareness carried out by Trust Waste Manager to all departments when required.	Acceptance Audit' carried out by clinical waste contractor which we failed. Main issue was the incorrect disposal of drug infused IV lines and giving sets - these were disposed of into offensive waste bags, which is illegal and a breach of both ours and their waste permits. Due to this, all our waste is now being incinerated - resulting in a significant cost pressure per month. Re-audit being carried out on 10th Sept. Widespread comms messaging, spot checks and engagement to ensure correct practice is being carried out. Effective segregation and awareness has significantly improved as the rollout has continued and staff are engaged with. Compliance with legislation has greatly increased in the last 12 months.	**2. Partially compliant**
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	**Louise Kiely (LK)** **Head of Facilities The Shrewsbury and Telford Hospital NHS Trust** **Extension: 1003** **Direct line: 01743 261003** **Mobile: 07718 575719** **Email: louise.kiely2@nhs.net**	There are no longer any gaps in assurance. There is a Decontamination Lead in place and the Decontamination Committee is fully functioning. The action plan to get to this place is complete and actions have also been taken place to close down the actions on the audit which UHB undertook in 2021. The Decontamination of Medical Devices Policy is also in place and has been fully approved. Independent audits in centralised areas - Endocsopy and SSD - are undertaken in line with HTM frequencies and reported through to Decontamination Committee. Non-centralised areas were also audited by the AE for Decontamination in 2025 and action plans for this audit are being monitored through Decontamination Committee.				**3. Compliant**

2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	**Shelley Simpson (SS) Trust Food Safety Adviser Health and Safety Team [Operational Directorate] Health & Safety Office (Copthorne building) Royal Shrewsbury Hospital Shrewsbury Shropshire SY3 8XQ shelley.simpson1@nhs.net Tel:-01743 261000 ext 3336 Mobile:- 07710019906**	Update 23.7.2025 Food Hygiene training is provided annually for all food handlers starting with Corporate Induction(All food handlers), CIEH Foundation certificate in food safety (Catering staff)and Annual Refresher Food Safety training there after for Catering staff. For Non catering food handlers they have to complete SSU food safety Training modules 1-6. This is commensurate with job Please refer to Trust Food Safety Policy Code of Practice 3 Food Safety for Food Handlers for full details. Link below Update 22.4.26 Training same Patient experience Team are going to be doing a trial with a mocked up visitor board.This will include information on food brought in to enhance methods of communication with patients and visitors to help manage and discourage food being brought in and provide information on what items they can bring in which are lower risk.Food brought in highest reported Food Safety Incident on DATIX.I still believe this to be under reported which is the reason why we are looking at enhance methods of communication				**3. Compliant**
					Score		**25**
					Potential Score		**27**
					Percentage		**92.59%**
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Systems and process are in place to ensure that:							
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated. Has been replaced with : Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**	The pharmacy medicines management team undertakes antimicrobial stewardship in the form of querying prescriptions that are off-guideline with the prescriber, evidenced by interventions within the pharmacy system eScript. Monthly snapshot adits are undertaken by the pharmacy team and reported in to IPCOG and IPCAC	Lack of electronic prescribing and administration records at the trust makes it more difficult to adequately monitor prescribing and provide directed feedback to prescribers/divisions. Depleated pharmacy workforce and other priorities within the trust mean that not all patients are reviewed daily therefore some antimicrobial prescriptions are missed and opportunities to intervene on inappropriate prescribing unavailable. Not had lead for AMS in the trust for several years with lack of assurance that antimicrobial stewardship a priority for Consultant teams.	New AMS committee identified and meeting continue to take place. Working on development of the meeting and establishing clinician engagement. Pharmacy medicines management team continue to intervene on antimicrobial prescribing where they can to reduce inappropriate prescribing, long durations and missed IV to oral switch. Continue to undertake monthly snapshot audits targetting wards considered high risk.		**2. Partially compliant**
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**	Information from Quarterly Antimicrobial Stewardship report to Infection Prevention and Control Operational Group (IPCOG) and Infection, Prevention and Control Assurance Committee (IPCAC) is taken to board by DIPC	No formal report for board relating to progress towards UK AMR National Action Plan Goals	Antimicrobial Stewardship Report adjusted for the IPCOG and IPCAC meetings, more clearly define the activities against the national action plan. In progress as part of Call to Action requirements. Antimicrobial Management Group working on developing report to provide updates on identified focus topics of 72 hour review, IV to oral switch and early identification of infections.		**2. Partially compliant**

3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. The following has been added Rebecca A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early , accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR plan ambitions	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**		No identified executive on the board with responsibility for antimicrobial stewardship.	Dr Angus McGregor - Clinical Support Services Medical Director.		**2. Partially compliant**
3.4	To optimise patient outcomes and minimise inappropriate prescribing: •Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effectiveantimicrobial medicine use' •Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. •Ensure AMS is included in mandatory Training using national materials such as 'start smart,Then focus' and Treat Antibiotics Respobsibly, Guidance, education, Tools (TARGET)	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**	Monthly audits undertaken by the pharmacy medicines management team. Medicines management team monitors antimicrobial prescribing against antimicrobial policy and intervenes on reviewed prescriptions if off-guideline. Yearly education in place for FY1/FY2 doctors and non-medical prescribers.	Formalised education program not in place, lack of Antimicrobial Stewardship Group to support development of education program. Evidence of lack of adequate reviews of antimicrobials in line with start smart then focus likely resulting in longer courses and delayed IV to oral switching. Lack of electronic prescribing and administration record inhibits ability to improve this.	Direct interaction by pharmacy medicines management team regarding antimicrobial prescribing that is off-guidelines. Continue with current education sessions with FY1/FY2 doctors and non-medical prescribers. Education for pharmacy and nursing staff currently on an add-hoc basis. Antimicrobial Management Group developing a workplan which will include review of antimicrobial stewardship education.		**2. Partially compliant**
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •Total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**	Most data already sent nationally from pharmacy systems showing usage. Information from these systems are used to update Antimicrobial Stewardship Report for IPCOG and IPCAC. Audits undertaken for CQUIN requirements and reported at appropriate times.	Lack of electronic prescribing and administration means that usage based only of pharmacy issuing systems, this does not enable further analysis and targetting of areas of higher prescribing.	Trust working towards implementation of electronic prescribing and administration.		**3. Compliant**
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	**Rebecca Hawkins (RH) Antimicrobial Pharmacist**		Depleted pharmacy workforce means pull of antimicrobial pharmacy workforce to cover other areas. Unable to recruit antimicrobial pharmacist on each site. Lack of electronic prescribing and administration system to enable accurate monitoring of prescribing and feedback to individual prescribers.	Development of pharmacy team, includes Pharmacy Team Leader for Antimicrobials, Antimicrobial Pharmacist and Antimicrobial Pharmacy Technician in place to support co-ordination of AMS. AMS part of general medicines management reviews for ward pharmacy team, support from the medicines management team in undertaking monthly snapshot audit.		**2. Partially compliant**
					Score		**13**
					Potential Score		**18**
					Percentage		**72.22%**
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion							
Systems and processes are in place to ensure that:							

4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	**IPC Team**	The IPC Team have developed IPC information leaflets. Information leaflets go through the patient panel to ensure they reflect population demographics, diversity, inclusion, and health and care needs. (Reviewed 04/09/26, no change)				**3. Compliant**
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	**IPC Team**	as above (Reviewed 04/09/26, no change)				**3. Compliant**
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	**IPC Team**	as above (Reviewed 04/09/26)				**3. Compliant**
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	**IPC Team**	Leaflets available on the trust intranet realtaed to specific pathogens, targetted to patients/ relatives and visitors. Regular IPC comms messages trust wide via communications teams- these are both internal targetted at staff, and external targetted at patients/service users/visitors to the trust. Roles and resposnibilities of inividuals/staff groups included in IPC policies.				**3. Compliant**
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	**IPC Team**	All infection status information is included in any transfer information				**3. Compliant**
						Score	**15**
						Potential Score	**15**
						Percentage	**100.00%**
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.							
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:							

5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	**IPC Team/ED**	The Emergency department follow the IPC guidance through the policy in terms of isolation as required. within the ARA/Navigator SOP 43 (for both sites) any isolation requirements cannot be accommodated in ARA due to zero side room provision and must be escalated – see attached latest update ratified at ED CG in April SOP to be added				**3. Compliant**
5.2	Patients' infectious status should be continuously reviewed throughout their stay/period of care. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions	**IPC Team**	All infectious status is reviewed by IPC nurses				**3. Compliant**
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	**IPC Team**	All infection status information is included in any transfer information . Nursing homes are telephoned also by wards				**3. Compliant**
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	**IPC Team**	All wards have appropriate signage				**3. Compliant**
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	**IPC Team**	as per outbreak/PII policy				**3. Compliant**
						Score	**15**
						Potential Score	**15**
						Percentage	**100.00%**
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**						
Systems and processes are in place to ensure:							
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	**IPC Team**	Included in face to face training and e-learning.				**3. Compliant**
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	**IPC Team**	All appropriate staff are included in IPC stat and mandatory training, this is monitored by the division.				**3. Compliant**
6.3	Monitoring compliance and update IPC training programs as required.	**IPC Team**	IPC training is updated periodically and also in response to policy changes.				**3. Compliant**
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	**IPC Team**	All appropriate staff are included in PPE mandatory training, this is monitored by the division.				**3. Compliant**

6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	**Kath Titley**	RPE fit testing takes place at RSH and PRH, on a booked appointment basis. Records of current fit tests are published monthly at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. The report published there is publicised to Ward Managers by the RPE Team monthly. Trends in fit testing figures are reported to the IPCOG quarterly. Buisness case approved to re introduce a stock of hoods/PAPR units and now awaiting identification of funding for purchase.				**2. Partially compliant**
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	**IPC Team**	Record of training is kept within the staff members LMS account which is visible to manangers				**3. Compliant**
					Score		**17**
					Potential Score		**18**
					Percentage		**94.44%**
7. Provide or secure adequate isolation precautions and facilities							
Systems and processes are in place in line with the NIPCM to ensure that:							
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	**IPC Team /ED**	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED. ED have also introduced an ASK 5 audit to ensure that screening questions are asked during the booking in process and details entered to SEMA. The new footprint at RSH also means a higher number of isolation cubicles available within the majors dept.	PRH isolation capacity is 4 potential rooms which leaves capacity low, mitigating actions to be discussed with DivDon. April 25 - a further 8 redirooms have been purchased by the Trust Update Aug 25 EH - Isolation spaces now increased as ARA now have 2 cubicles since relocated in medical escalation area			**2. Partially compliant**
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	**IPC Team**	As per policy				**3. Compliant**
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	**IPC Team**	Contact precations enteric precations protctive isolation signage available/also isolation posters outside each sideroom	need to review that the information is relevant to visitors so they know the etiquette	signage outside all siderooms		**3. Compliant**
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	**IPC Team**	Transfer information . As per policy https://intranet.sath.nhs.uk/document_library/ViewPDFDocument.asp?DocumentID=9337				**3. Compliant**
					Score		**11**

						Potential Score	12
						Percentage	91.67%
8.2 Provide secure and adequate access to laboratory/diagnostic support as appropriate							
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:							
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	**IPC Doctor / Consultant Microbiologist**	Laboratory is UKAS accreditid to ISO 15189 standard and undergoes regular inspection to maitain this accreditation. Laboratory staff are trained to national training standardsa and qualifications.	Continuing to attempt to recruit to vacant posts in what is a very competitive market currently.			**2. Partially compliant**
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	**IPC Doctor / Consultant Microbiologist**	Testing within the Laboratory is largely based on national standards (SIPs) and SOPs and practice complies to all the UK reporting structures and bodies.				**3. Compliant**
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	**IPC Doctor / Consultant Microbiologist**	KPIs are in place for reporting standards including turn-around times. These are reported to relevant users and are discussed within departmental quality meetings.				**3. Compliant**
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	**IPC Doctor / Consultant Microbiologist**	The Trust and the Laboratory comply with all national admission transfer and discharge screening requirements where applicable.				**3. Compliant**
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	**IPC Doctor / Consultant Microbiologist**	Patients undergo diagnostic testing in line with their clinical presentation. The laboratory Microbiologist staff are available to provide advice and guidance on the most appropriate diagnostic testing and management.	Laboratory requires ongoing, and possibly additional, investment to keep-up with the technological demands of a complex and evolving infectious disease environment.	Laboratory management will continually review our technological base and scope out new technologies where there may be advantages to our Trust and patients.	Where applicable business cases will be prepared and submitted via Trust financing structures.	**2. Partially compliant**
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	**IPC Doctor / Consultant Microbiologist**	Protocols and agreements are in place to support all outbreak management. Where this is not possible in-house there are agreements in place for additional support from a network of reference Laboratories (particularly UK-HAS).				**3. Compliant**
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	**IPC Doctor / Consultant Microbiologist**	There are protocols and SOPs in place regarding the transport and packaging of all relevant pathogens and risk category of specimen.				**3. Compliant**
						Score	19
						Potential Score	21
						Percentage	90.48%
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							

9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA and the NIPCM) (UKHSA and NHSE A to Z pathogens list to be added once published). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process	**IPC Team**	The IPC Team monitor daily alerts to ensure staff follow the appropriate policies. The Trust has a policy for the management of outbreaks which includes the documented recording of an outbreak. This is also reported to Trust IPCOG/AC committee via divisional rep[orts & the IPC Team report				**3. Compliant**
						Score	**3**
						Potential Score	**3**
						Percentage	**100.00%**
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:							
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	**Jake Mairs, Deputy Group Chief People Officer**	Risk assessment process in place with support. Documents available on intranet and SaTH app. A range of support activities are also available: • •Staff App –updated with guidance •Optima – Managers Advice Line (Occupational Health) •Employee Assistance Programme- HELP •HR Advice and Support •SaTH Trained Listeners - Hotline Coaching hotline •A free wellbeing support helpline •Peer-to-Peer Listening •Coaching and listening ear support lines available •Redeployment Coaching Support •Wellbeing Hubs •Trust Coaches •Freedom to Speak Up Guardians				**3. Compliant**
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	**Jake Mairs, Deputy Group Chief People Officer**	Exposure process for measles in place. Occupational Health do not provide anti-viral treatment and have no facilities to do so. However do implement vaccination programmes. Staff will be reviewed by OH if they are referred, or contacted by IPCC to become involved in a breach, for example a TB exposure. The Trust has a standard precautions policy for staff to follow. Occupational Health tender process underway for new supplier and will provide an opportunity for greater oversight and awareness.				**3. Compliant**

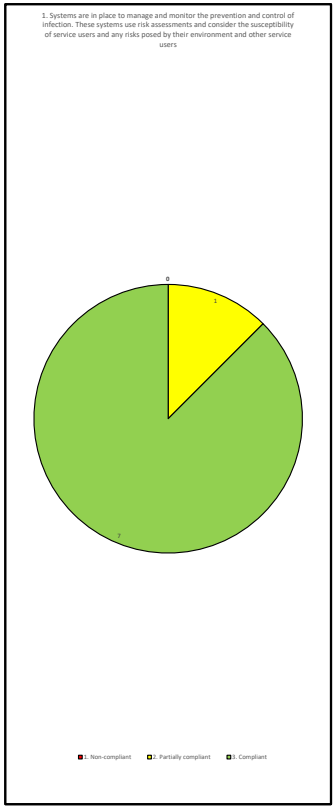
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Jake Mairs, Deputy Group Chief People Officer	For all new started OH clearance needs to be inplace prior to start dates being agreed. Staff Testing Protocols are in place for new starters in the Trust Pre-Placement Questionnaires are completed by every new starter, which highlights any clinical exposure. Guidance detailed below is then used to complete the appropriate screening. During immunisation review employees go through a risk assessment to identify which vaccines or bloods are required as part of their role within the Trust, all of which is in line with UKHSA, DOH, NICE guidelines.	Management information for current staff does not provide adequate assurance that all staff who should have been vaccinated have been. With the recent increase in measles cases. OH cannot provide specific individual information unless contract tracing due to IG. Under GDPR it is not possible to access individual level data to understand which individuals are not vaccinated. This is being reviewed following a data sharing agreement being signed so indidivual level detail should be available soon. Occupational Health tender process underway for new supplier and will provide an opportunity for greater oversight and awareness.	Occupational Health tender process to appoint a new supplier, with greater opportunities for data sharing and insights to support oversight and governance.		**2. Partially compliant**
					Score	**8**	
					Potential Score	**9**	
					Percentage	**88.89%**	

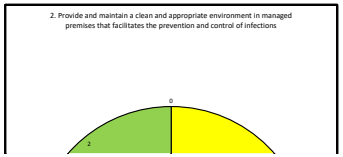
APPENDIX 6

Back to menu

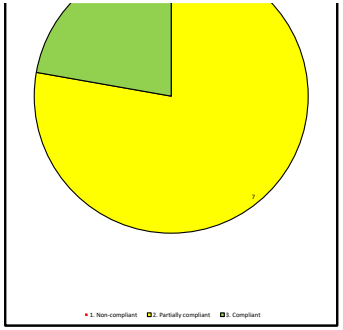
IPC Board Assurance Framework - version 5

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Lead	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Organisational or board systems and process should be in place to ensure that:							
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Formal IPC Governance structure in place (evidence on IPC QMS).					3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks . There is no digital system for surveillance, however, ICNet is awaiting implementation. Budget is not secured for this but Digital Services are aware. This is captured on the IPC Risk Register. Chief Pharmacist is responsible for antimicrobial stewardship reporting through IPC Committee.					3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Consistent high levels of Incident Reporting per month, traning provided on the System to new users, Datix actively used to progress an investigation. LFPSE implentation complete. Workforce and Staff Specific Risks in place across all Risk Registers. IPC Datix dashboard to be available to all IPC Team.					3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC Quality Assurance Audits (QAAs) cover SIPC elements from each section of the NIPCM. SCHT IPC policies are aligned to the NIPCM. In addition, environmental and practice self audits are conducted by operational teams and an annual Sharps Audits by Daniels. Results and actions are monitored at IPCOG and IPCC through unit reports.					3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Targets set locally by ICB. Surveillance data is monitored through IPC report to IPCC. Local antimicrobial resistance patterns are reviewed by Consultant Microbiologist which influences local antimicrobial guidelines. Outbreaks and patient safety incidents are monitored and managed through outbreak meetings, Datix, PIRs. All are contained in the IPC report to IPCC.					3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC Team budget in place. SLA agreement with MPFT for Estates PPM and upgrading. Ops are responsible for cleaning and report compliance against National Cleaning Standards 2021 through IPCC. IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks. There is no digital system for surveillance,		Manual process remains in place until ICNet implemented. This is not a gap in assurance, this is an improvement.	ICNet - This is captured on the IPC Risk Register and on the ICS IPC risk register monitoried by the ICB.		3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff IPC responsibilities are detailed in their job description. IPC training is included in induction. IPC e-learning module through ESR: Annually for clinical, 3 yearly for non clinical. Ad hoc face to face IPC training for wards, IPC training for domestic staff, IPC training for volunteers. Annual Hand Hygiene practical assessment for all patient facing staff. IPC link practitioners for all services who disseminate training provided by IPC team. Education campaigns covering updates and areas identified as requiring additional support.	ANTT is not included in mandatory training or competency checks. No Trustwide compenecy framework in place.	Staff requiring ANTT training have been identified. Training is being rolled out.ESR training group established to review mandaotry training topics	T&F group to be set up with key stakeholders	Associate Director of Workforce, Education and Professional Standards	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Patients are assessed on admission for infection risks and placed appropropriately according to the Isolation Risk Assessment Tool. Individual cases are discussed with IPC or Consultant Microbiologist on call. Heirarchy of Controls is completed for all outbreaks and included as a standing agenda item at Outbreak Meetings. General IPC Risks are logged on Datix with mitgations and monitoring outlined. Systems to monitor alert organisms and Post Infection Review (PIR) system is in place. In the forthcoming year, PIRs will be updated and aligned to PSIRF (Patient Safety Integrated Review Framework).			A digital solution to surveillance would enhance risk assessments (ICNet).		3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
System and process are in place to ensure that:							
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Responsibility for cleanliness and compliance against National Standards of Healthcare Cleanliness (NSHC) ~~2021~~ 2025 is with the Operational Team. DIPC receives cleanliness reports through IPCC and can escalate or challenge operational leads on standards of cleanliness. The Director of Operations has overall Trust responsibility for delivering the National Standards of Healthcare Cleanliness ~~2021~~ 2025	No consistent reports received on compliance with the NSHC 2025~~1~~ audit in line with all elements, e.g Audit cycle is incomplete. No Facilities Lead or Cleaning Lead in community settings. GP practices and social care settings do not follow CS ~~2021~~ 2025. This gap in assurance is due to current legislation.	MyAudit software in process of implementation which will support audit cycle. Facilities Lead has been advertised. Cleaning compliance in buildings where SCHT are tenants are audited by operational leads to highlight and escalate areas of concern in non-Trust owned buildings	Action is included on IPC Improvement Plan. Moving over to new audit system AMAT, under new group arrangements Head of Facilities is Louise Kiely	Claire Horsfield, Director of Operations	2. Partially compliant



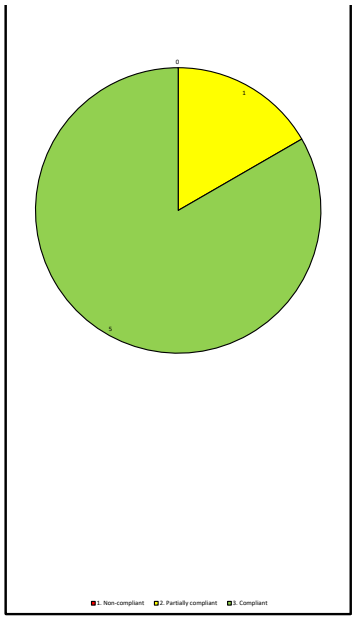


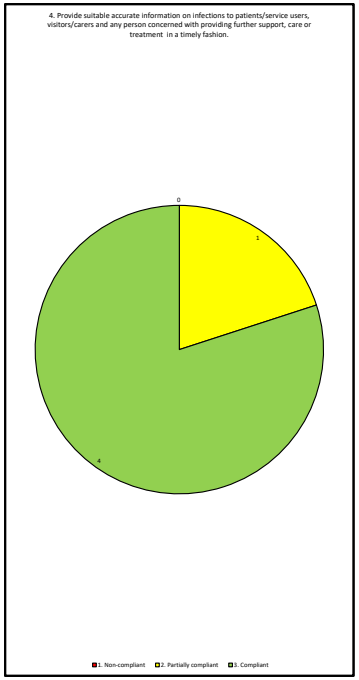
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE audits are conducted by the Patient Experience team and reported through the Patient Experience Committee, Chaired by DDIPC. The IPC team are members of the PLACE audit.	Governance needs strengthening with Annual Report to Board.	Actions monitored through Patient Experience Committee	PLACE audits planned for October 2026 report to be submitted for Nov Patient Exp Com and Board in December	Clair Hobbs, Director of Nursing	2. Partially compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Roles and responsibilities for cleaning in community hospitals is agreed	Cleaning of patient care equipment in satellite clinics and where SCHT are tenants is clearly defined but not the environment.	Serial 2.1		Claire Horsfield, Director of Operations	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Quarterly Water Safety Group attended by Estates, MPFT (SLA in place) Authorised Engineer for water is contracted to conduct annual water safety audit and attends Water Safety Group monitoring compliance with action plan. There is a Ventilation Authorised Engineer under contract and the Associate Director of Estates has full oversight of remedial works to achieve compliance. PAM completed in line with mandatory reporting. Ventilation Safety Group established and reports quarterly to IPCC.					3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09.	SLA agreement with MPFT for Estates PPM and upgrading, MPFT policies for Estates are adopted. Building and Refubishment SOP has been published	MPFT and NHS PS to provide their annual PPM programme	Formal signed Contract in place between partner Standing Operating Procedure for Management of the Trust's Estate linked to the SLA with the maintainer of or non NHS PS esate. Both parties have appointed the same Water AE and have aligned processes and procedures noting the SLA identifes the following of the maintainers processes and policies noting they themselves are an NHS Provider. Monthly updates are provided to IPC with support provided directly by the maintainer into IPC directly. Quarterly meetings are conducted with NHS PS with local "BUG" meetings hosted by NHS PS with site leads. Documenation and evidence is available via the maintenance providers CAFM system MICAD	IPC Team have requested PPM priority list and frequencies to be included.	Richard Best, Associate Director of Estates	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen contract in place and monitored by Operational team to ensure quality of items and adequate supply and provision at ward level. Issues with linen are reported through DATIX.	Linen storage in clinical areas (Whitchurch, Ludlow and Bishop's Castle) are not compliant with HTM 01-04 as linen cupboards have unvarnished wooden slats.	Hotel Services Leads to raise jobs to replace wooden slats. Purchase of mobile linen storage units have been approved by IPC. IPC QAA includes compliance with linen storage	IPC to audit compliance until assurance is achieved. Linen storage is included in the QAA	Locality/Ward Managers Claire Horsfield, Director of Operations	2. Partially compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07-01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste management budget holder is the Associate Director or Estates, with reponsobility delegated to service leads and teams at an operational level. The Premises ssurance Model is used to monitor performance noting the use of datix in the event of individual issues as they arise. Domestic Waste is managed under an SLA with Veolia as procured by the system led by SaTH Clinical Waste is managed via an SLA with a partner NHS Trust and is provided under contract NHS PS provide waste services a spart of their managed estate	Not all areas label their clinical waste bags with the ward/department.	Waste provider is SRCL at Ludlow, and provided via the landlord NHS PS, the bins are removed secured and locked and transported from site to the processing site process observed at site level with photographic evidence. In that process the bins are swapped for clean empty ones therefore avoiding the mixing of waste. At Bridgnorth, the service is provided by Tradebe as a shared contract with another NHS Provider the bins remain in situ and the backs are transported in amongst other waste from other sites.	Review commenced around clinical waste and will be taken forward to provide more robust assurance. Pharmaceutical Waste sits outside of the Estates Lead responsibility and is managed via Pharmacy	Richard Best, Associate Director of Estates	2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Dental instruments are processed in line with guidance and policy Endoscopy equipment is processed in line with guidance and policy and reported through IPCC. The Trust has now formally apointed AE for decontamination and annual audit will take place in APRIL 26.	Annual audit to take place to review level of assurance	Links with Decontamination lead at SATH for advice and guidance	Annual Audit scheduled for APRIL 2026.		2. Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Each Community Hospital has a lead for food hygiene. Food Hygiene policy is in place and being reviewed/updated IPC team review ward kitchens, microwaves, fridges included in the QAA. Community Hospital catering staff have now completed level 2 food safety training refresher. Community Hospital ward staff level 1 food training available. Food Alert appointed as the Trust Food Safety Specilaist Food Safety Group established chaired by DDPIC	Food Safety level 1 training remains below compliance	Progressing discussions with SaTH re shared services agreement. Food Safety Group established. Food Alert appointed as Food Safety Specialist for the organisation	Operational review in progress. Facilities lead will be responsible when appointed. Post has been advertised. Food Safety working group has been established and montiors Level 1&2 Food Safety Training	Claire Horsfield, Director of Operations	2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Systems and process are in place to ensure that:							
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements. Chief Pharmacist has oversight of AMS and produces quarterly reports for IPCC Pharmacist for the Virtual Ward has a background in managing AMS	No lead pharmacist for AMR in post	Pharmacy technician completes AMS audits and reports to IPCC	Meeting arranged within region to develop SCHT staff appropriately and create a network	Susan Watkins, Chief Pharmacist	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Antimicrobial stewardship is formally reported to the IPCC Chair and onwards to the Board via an IPCC Chair's report. Section on AMS contained within IPC Annual report taken to Trust Board and published on Trust website					3. Compliant



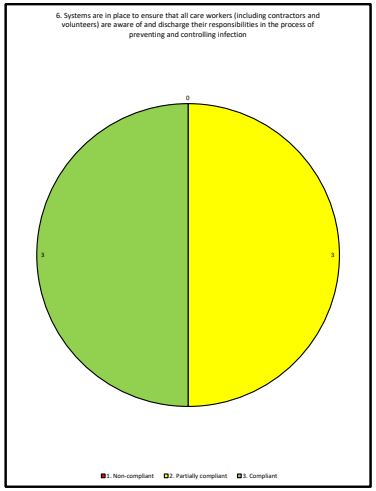
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

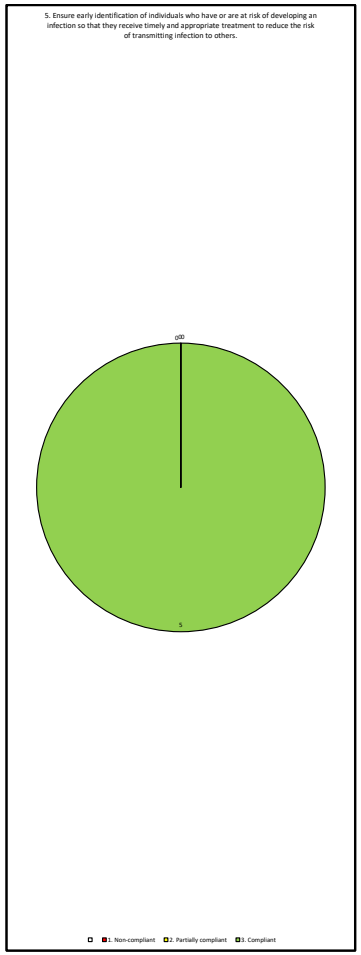
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Antimicrobial stewardship is the responsibility of the DIPC who sits on the Board	Lead Pharmacist in AMS to represent Trust at system wide AMS group.		Check with Chief Pharmacist whether Lead Pharmacist for AMS has dedicated time in job description.		3. Compliant
3.4	To optimise patient outcomes and minimise inappropriate prescribing: •Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' •Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. •Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements. NICE guidance is utilised and shared with clinicians.	Having access to ePMA would further support reviews and enable more efficient review of patient compliance. Now have greater visibility of prescribing data now but do not have assurance for RRUs. Not able to insist SCHT pharmacy provides this. AMS not included in mandatory training.	Pharmacy team on site at the prison and community hospitals a minimum of 5 days per week. PGDs have criteria which provides maximum course lengths and roots for escalation.	Start Smart, Then Focus - to determine whether this is part of the AMS audits. EIFH training has been identifed relating to AMR to be shared during AMR awareness week	Susan Watkins, Chief Pharmacist	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Prescribing and AMS use data is presented to the IPC Committee for ratificaiton which demonstrates any patterns in prescribing behaviour. Information is provided from all services using antibioitics					3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	All prescribers that work within SCHT meet with a member of the pharmacy team and they are supported with safe prescribing and maintainance of AMS. This includes agency staff as well as permanent. PGDs can only be used by staff that have bene signed off as competent, this means there is little use of PGDs by agency which provides the required robustness.					3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion							
Systems and processes are in place to ensure that:							
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPC develop patient and staff information leaflets are reviewed by Patient representatives. For new and emerging health threats, the IPC Team request dissemination of information through communication channels.					3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service	IPC develop patient and staff information leaflets in line with policies.		The IPC Team utilise online accessible information software to assess compliance prior to publishing.		Director of Governance	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	IPC policies are aligned to NIPCM and criterion 9 avaiable on StaffZone intranet. The IPC information and Governance systems support dissemination of IPC information from floor to Board. The IPC Annual Report includes information on IPC, compliance with the H&SCA including AMR. This is published on the SCHT Internet page.					3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	IPC develop and publish patient, contractor and staff information leaflets. These are reviewed and aligned to the NIPCM and NHSE/UKHSA guidance. SOPS on specific actions, e.g. Covid screening, outbreak managent, isolation, are available to staff via the intranet and disseminated through communication channels. OHD and Medicines Managent produce communications around campaigns e.g. antimicrobials, vaccinations, which include desk top banners, newsletters and communication releases.					3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Information on infection status of patients is requested and conferred prior to admission. Patient admission assessment and pre-transfer checklists are completed by capacity hub and ward teams. Admission documentation includes IPC status.	Catheter Passports are not consistently in use across the system. No standardised discharge handover checklist used across organisations.	Current system remains in place until digital surveillance is implemented.	There is no digital system for surveillance although Rio is being used where possible. A full review of invasive devices training and management. Audits planned for Catheter and CVAD care	IPC Team and Continence Service Director of Operations	2. Partially compliant

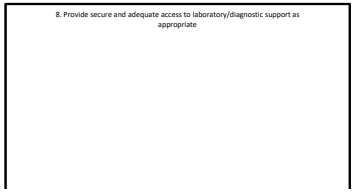


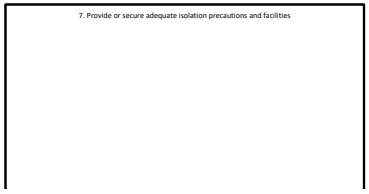


5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.							
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:							
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	All patients are screened for MRSA on admission in line with guidance for Community in-patient areas. Isolation audit and check lists are employed by teams. Identification of signs/symptoms of infection are included in SOPs e.g Respiratory symptoms, diarrhoea and vomiting			Emergence of organisms of significance is monitored by the IPC Team Lead and DDIPC. Potential screening requirements are reviewed.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	Patients are assessed during their stay for signs and symtpoms of infection. SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Non-compliance due to risk assessment is recored on DATIX.	No isolation care plan or daily review mechanism in place.	IPC team to develop document to assess isolaton. Rio team to be notified. Review isolation SOP against national guidance	Isolation care plan tool from NHSE has not been rolled out for wards to use routinely - not used currently. Daily review is undertaken by IPC team	Sara Ellis-Anderson, Deputy Director of Nursing and Deputy DIPC	2. Partially compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Information on infection status of patients is requested and conferred prior to admission in a pre-handover checklist. Admission documentation includes IPC status.			There is no digital system for surveillance, however, ICNet is awaiting implementation - serial 1.6		3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Respiratory Symptoms posters are in place across SCHT premises.					3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak Policy is in place and followed. External stakeholders are invited to outbreak meetings. CQC are informed through submission of a Statuty Notification Regulation 18 (2 (gj) 2009. Outbreak SOPs (respiratoy and diarrhoea & vomiting) are in the on-call folder for IPC guidance in out-of-our period.					3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection							
Systems and processes are in place to ensure:							
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	On-line corporate induction includes required IPC elements. E-learning mandatory IPC training Levels 1 and 2 provided according to role.			Serial 1.7 for ANTT		3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Clearly defined IPC roles and responsibilities are embedded in the JD's of all new and existing roles throughout the Trust. Locality Managers and Site Managers are aware of their resposibility for Estate and IPC. Areas that require improvement are captured on individual IPC Improvement Plans reviewed at IPCOG and during IPC QAA. Training and IPC practice compliance is recored and reported through Unit/SDG reports to IPCC overseen by the DIPC.					3. Compliant
6.3	Monitoring compliance and update IPC training programmes as required.	IPC training compliance is a Trust KPI monitored at Q&SC. A bespoke training package for Healthcare Support Workers for the System has been reviewed and updated					3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	A link to the NIPCM Donning and Doffing is embedded within our Standard Infection Control Precautions policy. IPC Team regularly audit compliance during visits.	All clinical staff are required to be fit-tested to x2 types of FFP3 mask.	Trust has several Fit Mask Testers within the organisation. Reviewing options to link with SATH to expand Trust capability		Deputy Director of Operations	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Records of compliance are now kep on central spreadsheet held by IPCC and reported within Divisional reports to IPCC	Not recorded on ESR - System is reliant on manual updates from team leads			Deputy Director of Operations	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Clinical Skills that involve medical device insertion has a comptency document that the clinician completes in practice following the initial training, for example Venepuncture & cannulation.	Competencies are currently not linked to role. Competency records are not held digitally.	The clinical compentency library is available on Clinical Skills.net Line mangers are responsible to ensure their staff are appropriately trained and individual paper records are held locally.	Role Specific Training and Competencies are to be recorded on ESR. Checklist completed with skills and competencies - starting to align these with different specialities - to consider recording on eroster rather than ESR - T&F group to be set up to help agree recording mechanism	Associate Director of Workforce and Professional Standards	2. Partially compliant
7. Systems and processes are in place in line with the NIPCM to ensure that:							
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Serial 5.1 and 5.2. Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Admissions and transfers that require isolation are allocated and agreed prior, to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required.			Incidents recorded on Datix system if handover information on IPC status differs from clinical presentation		3. Compliant

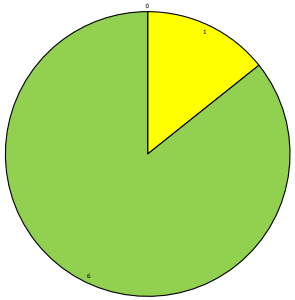


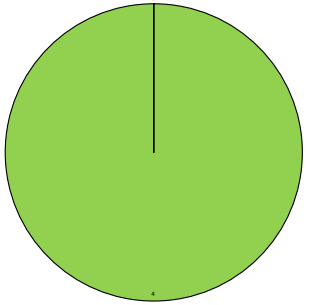




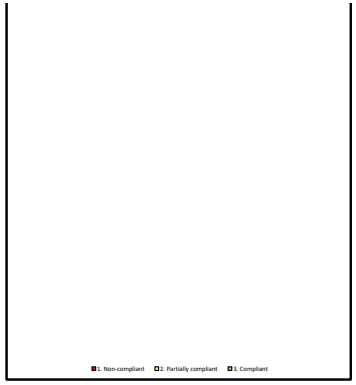


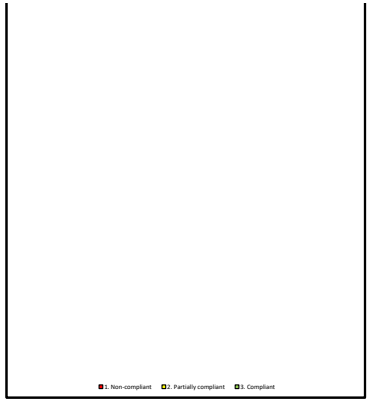
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •If there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Serial 5.2 SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Admissions and transfers that require isolation are allocated and agreed prior to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required. Non-compliance due to risk assessment is recorded on DATIX. Avian flu and zoonotic disease capability is covered by action cards informed by the Incident Management Team having an IPC lead as its subject matter expert. Any other general clinical decisions would fall to the Ops/Clinical teams as part of their business as usual and escalation processes.			New and Emerging Pandemic Plan being written and tested in 2025/26	EPRR Senior Lead	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICPs and TBP Policy is in place aligned to the NIPCM. Signage for precautions are in place and displayed. Compliance is monitored through QAA and spot checks. Results are reported through IPCC and SDG reports.			Redesign of isolation posters are in progress which reflect the NIPCM. This is not a gap in assurance as is an improvement.	IPC Team	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Onward care facilities are advised of patients that require isolation.					3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate							
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:							
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Laboratory specimens are obtained by registered practitioners or HCSW who have had appropriate training and are delegated to complete the task. In the absence of national accrediation training, staff complete the LFD test SOP and competency check.			There is no nationally recognised accrediation system for LFD testing. Staff follow laboratory protocol and SCHT policy when obtaining respiratory Panel PCR, MRSA screen and other specimens.		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	All lab results are reported via SaTH Review system. IPC receive a weekly 'Alert Organism' list from the SaTH labs. SaTH labs will telephone results through - this is evidenced in patient notes.	Results are not manually added to patient record on Rio by ward staff	Manually added to Rio by IPC staff.	Updated alerts currently done by on RIO by IPC team		2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SCHT utilise SaTH laboratories for all microbiology and IPC services. The SLA does not specify turnaround times. SaTH laboratories process SCHT samples in line with their own sampling.	Turnaround times not specified in the SLA.	If samples are to be processed rapidly, individual cases are discussed with the Microbiology team. In the event of late sample results and an issue arising as a result, SCHT will raise a PPF concern and discuss with SaTH laboratory service manager.	SCHT samples are processed in an equitable manner with all samples from the STW system. Including a specified turnaround time within the SLA is not deemed to impact on the current service and therefore not required. This	IPC Team	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	MRSA swabbing on admission as per Trust Policy and compliance is monitored monthly by the IPC Team as an IPC KPI - threshold of 97% YTD.					3. Compliant
8.5	Patients/service users who develop symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Swabbing guidance flowcharts in place in all in-patient areas, as per national swabbing guidance.					3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	The IPC team have access to consultant microbiologist advice 24/7 when needed. Clinical teams also have access to microbiologist advice as required. IPC cover including outbreaks is included in the SLA.					3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	SCHT follow policy: Collection, Packaging, Handling, Storage and Transport of Laboratory Specimens.					3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens, list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	IPC policies are aligned to NIPCM and criterion 9. IPC policy tracker is reviewed at IPC Committee as per the workplan. IPC receive reports from operational teams on IPC Compliance at IPCOG and IPCC. IPC team conduct regular ad hoc and targeted audits to triangulate and verify self-audit findings. Infection Incidents are reported through DATIX. Post Infection Reviews are conducted for all HAI. Outbreaks are managed and reported as criterion 5.5.			All policies refer to NIPCM and list of A-Z pathogens is linked on staffzone		3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:							
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Team Leads and Line amangers carry out this assessment. Referrals are made to OHD.			Any issues that are identified are then notified to Occupational Health and further information and assessment is carried out		3. Compliant





10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	All staff who have an exposure incident are encouraged to contact Occupational Health. They will have an initial assessment by one of the advisors and a plan will be agreed following Trust policy. If the issue happens at the weekend or out of hours the employee can access one of the Sharps Incident Boxes located around the county that contains instructions on what bloods are needed and can access the policy as well as immediate first aid procedures. The incident should also be reported via DATIX.			DATIX summary reports are sent out daily by the Governance Team to senior leads, the DDIPC and DIPC for oversight. Sharps incidents are followed up by H&S Team and are included in the KPI metrics reproted through Q&SC.		3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	All staff who have or may have a patient facing role are seen by Occupational Health before or very soon after commencement in role and a full immunisation check is carried out that includes TB, Hepatitis B, Measles, Rubella and Varicella. Any outstanding vaccines are offered or, in the case of Measles and Rubella blood tests are offered and results followed up	OH are following current requirements but there is potential that guidance will change due to higher prevalence of TB in the UK, to monitor				3. Compliant
		Any person carrying out Exposure Prone Procedures or anyone new to the NHS is asked to undertake a blood test to check for Hep b, Hep C and HIV – this is validated by photographic ID; again any issues are followed up and advise and support offered to the individual and the manager/trust					3. Compliant



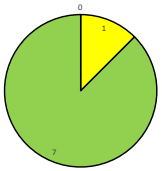




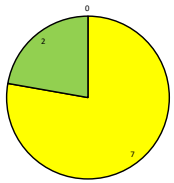


Back to menu

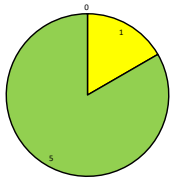
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



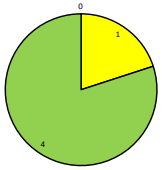
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



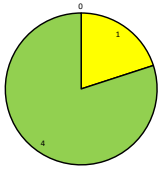
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



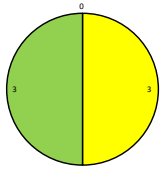
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



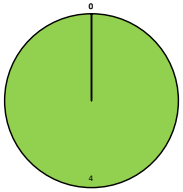
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



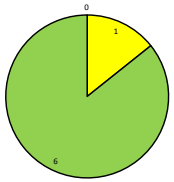
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



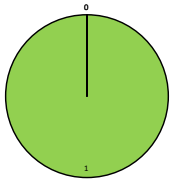
7. Provide or secure adequate isolation precautions and facilities



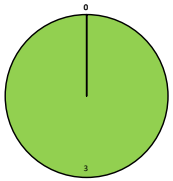
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate



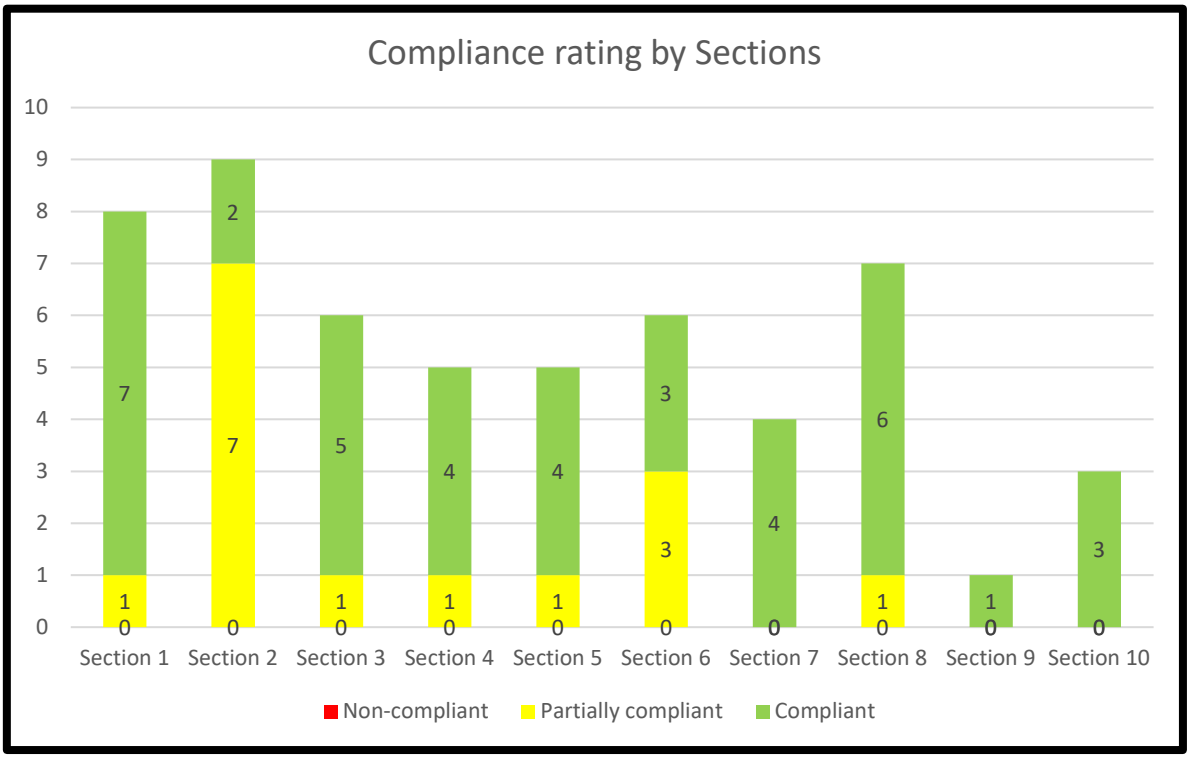
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections



10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection



Back to menu



	Non-compliant	Partially compliant	Compliant
Section 1	0	1	7
Section 2	0	7	2
Section 3	0	1	5
Section 4	0	1	4
Section 5	0	1	4
Section 6	0	3	3
Section 7	0	0	4
Section 8	0	1	6
Section 9	0	0	1
Section 10	0	0	3
		15	39

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	097/26		
Report Title	Group Patient Safety Committee Quarterly Report		
Executive Lead	Dr John Jones, Group Chief Medical Officer		
Report Author	Kath Preece, Deputy Director of Nursing, Clinical Governance (SaTH) Lindsay Barker, Head of Bereavement & Medical Examiner Service (SaTH) Pete Jeffries, Patient Safety Specialist (SaTH) Brenda Maxton, Learning from Deaths Manager (SaTH) Lindsey Regan Senior Governance Manager - Patient Safety and Risk Management (SCHT) Amy Fairweather Patient Safety Officer - Governance Manager for Adults & Community (SCHT)		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Quality Operational Committee (Sath) Quality and Safety Committee – individual reports 30th July 2026	Safe	√	Being updated as per August's Board request
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	The attention of the Boards in Common is drawn to: Section 2.3 – Compliance with death certification (SaTH) Section 2.8 – Service user feedback (SaTH) Section 4.1 – Patienty Safety Investigations (SaTH) Section 5.4 – Thematic review (SCHT) Section 7.2 - Learning from Incidents (SCHT)		
Recommendations for the Boards	The Boards are asked to note and **take assurance** from the report.		
Appendices:	N/A		

1.0 Introduction
The Joint Patient Safety Committee report will be presented to the Board of Directors' in Common meetings quarterly and will include updates from the Medical Examiner Service, Learning from Deaths and Patient Safety for both SaTH and SCHT.

Section One – Shrewsbury and Telford Hospital NHS Trust

2.0 ME & Bereavement Services

2.1. Hospital and Community Deaths

515 hospital deaths were reported in Q1, an increase of 19 compared to Q4 and a consistent picture with the number of deaths that occurred in Q1 of 2025.

725 community referrals were received in Q1, with GP services being the largest source.

The ME service reviewed 1,240 deaths across the Shropshire, Telford, and Wrekin (STW) health system during Q1 of 2026/27.

2.2. Medical Examiner Reviews for SaTH deaths
The ME service undertook scrutiny of 502 of the hospital deaths during this quarter with 13 of the notifications moving into the next reporting quarter.

97% of hospital cases received timely ME support; only 11 cases in Q1 lacked next of kin contact.

The ME service did not detect any significant themes that met the threshold for escalation for any SaTH deaths during this reporting period.

2.3. Medical Certificates of Cause of Death (MCCD)
457 MCCDs were issued for hospital deaths in Q1.

Timeliness of issuing MCCDs within three calendar days has shown stable performance this quarter with 90% of MCCDs issued within 3 calendar days.

Maintaining performance in timely issuing of MCCDs remains a focus of the service, considering the strong performance in this regard by the end of 2025/26. This element of the service relies on positive engagement with medical and surgical teams along with strong operational cohesion between ME & Bereavement services. Quarter one shows that strong emphasis on this performance indicator remains in place.

Assurance has been sought that since the statutory implementation of the Medical Examiner Service; long stay wait times within the mortuary have not been affected and there has been no correlation between the medical examiner processes impacting on mortuary capacity.

Collectively for hospital and community deaths the mean number of calendar days for releasing certificates for registration in Q1 was:

- Date of death (DoD) = 4
- Date of notification to ME = 2 (median was 1 day – which demonstrates the impact of community cases that we receive with extreme delays between DoD and ME notification)

2.4. Structured Judgement Reviews (SJR) and Learning
42 SaTH deaths were recommended for SJR in Q1, an increase from the previous quarter.

38% of SJR recommendations stemmed from concerns raised by bereaved relatives.

89 cases were identified for potential learning Q1. 35 cases in Q1 were signposted to the PALS & Complaints Department, a reduction from the previous quarter.

2.5. Coroner Referrals
81 hospital deaths were referred to the coroner in Q1 (15% of all deaths).
Only 9% of deaths were accepted by the coroner for investigation by progressing to postmortem or inquest.

2.6. Urgent Body Release and Faith Requests
4 urgent body release requests for faith reasons were managed successfully in Q1.

In all cases the Medical Examiner provided timely authorisation for urgent release, respecting the bereaved wishes and traditions of the deceased.

2.7. Hospital-funded Cremations and Genealogy
2 hospital-funded cremations were arranged for patients with no next of kin in Q1, costing £2,875.00

One hospital-funded cremation was avoided during this quarter following genealogical searches which found next of kin.

2.8 Feedback and Complaints
96% of bereavement survey respondents in Q1 found the ME service helpful; 98% felt able to raise concerns.

1 formal complaint involved the ME Service in Q1 which was to seek the services' assistance in clarifying what their recommendation had been when learning had been identified, not a complaint about the service provided by the office or its staff.

2.9. Overall Assurance
In conclusion, the service has continued to deliver a compassionate, responsive, and effective service, providing independent scrutiny of deaths and valuable and timely support to bereaved families across the health and care system. Performance indicators remain strong, with sustained compliance in key certification processes, positive family feedback, and robust engagement with clinical teams to support timely review and certification of deaths. Continued progress and the development of a sustainable model, through the submitted business case will be key to maintaining this trajectory

3.0 <u>Learning from deaths</u>
3.1 Deaths of patient with a confirmed learning disability, Autism or a serious mental illness (SMI)

In Quarter 1, 6 cases were confirmed as meeting the Learning Disability criteria and have been reported to LeDER. One of these cases is subject to a coronial investigation. Two SJRs have been completed.

5 cases were confirmed as meeting the criteria for SMI and 5 SJR completed. One case has been escalated to the patient safety team for further review. The remaining SJRs for those with LD, Autsim & SMI will be included in the Quarter 2 submission.

3.2 Learning to improvement (Adult deaths (Excluding Maternal deaths)
The Learning from Deaths (LFD) team are in the early stages of developing a thematic analysis platform using Sankey charts to assist with the identification of learning through thematic analysis across LFD. The aim is to be able to visualise problems in care and their inter dependencies, and to report on how these affect the patient journey as a series of sequential or coalescing quality outcomes.

3.3 Learning from weekly Mortality Review
247 cases were reviewed. Referrals for Potential Learning and Structured Judgement review, together with learning received from the Community ME Service and the Trust Mortality screening are reviewed and themed. The main themes identified:

- Admission and readmission issues
- Organisational issues
- Communication issues

3.4 Learning identified through Structured Judgement Reviews (SJR)

43 SJRs were completed this quarter, of which 34 identified problems in care, the remaining 9 identified positive learning. The top 5 themes were identified as:

- Admission and readmission issues
- Treatment and management of care

- Medication

4.0 Patient Safety Update Q1

4.1 Patient Safety Incident Investigations (PSII) Q1

In Q1 there were 3 PSII commissioned, which included 2 Never Events. There were 2 investigations closed in the quarter, which included 1 Never Event.

Newly commissioned PSII
Datix 328916 – Never Event Ophthalmology – Wrong patient surgery
Datix 327532 – Failure to follow processes – Emergency Department
Datix 329653 – Never Event Ophthalmology – Wrong site surgery

PSII closed
Datix 307799 – Never Event Maternity – Overdose of insulin
Datix 307777 – Lost to follow up - Cardiology

4.2 Learning from incidents in Q1

Triangulation of learning from incidents has identified the same themes through Q1, as previous quarters with ongoing improvement work underway.

Summarised theme/learning	**Improvement activity**
Use of bleeps	Post the implementation of the new bleep system there have been a number of incidents relating 2222 calls. Initial themes related to new tasks for putting out 2222 calls and clarity relating to members of emergency bleep groups. The task issue is being addressed by further targeted training of switchboard staff. The bleep project group is taking oversight of the issues around clarity of groups and will identify 'owners' for each emergency group who can liaise with switchboard. A further deep dive had identified technical issues in terms of display of bleep numbers in switch which is being addressed with the provider of the bleep system and will be overseen by the bleep project group.
Responding to the deteriorating patient	Response to deteriorating patient remains a consistent theme and in particular the 'response model' in terms of expectations of which clinical staff respond to escalations. This includes clarity on the role of the critical care outreach team and decision making around patients perceived to require ITU admission. An additional related 'sub-theme' has been identified in relation to patients whose care needs may be above those of standard ward care but below thresholds for HDU/ITU. The need to clarify short/medium- and long-term plans around the response model and wider deteriorating patient programme had been raised in Septembers QOC and the acute medical director has requested further discussion.
Discharges	Discharge remains a theme particularly in relation to acute medicine and weekend discharges. The Learning from Deaths team has further identified from SJR's (reinforcing previous themes) key issues around discharge leading to readmission for patients with end of life/palliative pathways further linked to advance care planning and ReSPECT. Themes are being reviewed by the discharge group and Learning from Deaths insights fed to ReSPECT/End of Life Care groups.
Acute medicine follow-up	A theme relating to expectations regarding patients who are able to be discharged but require further follow up post-acute medical care. Initial review of incidents suggests a need for clarity of pathways for return to SDEC/virtual ward and potential mixed perceptions of where responsibilities lie for different conditions across secondary and primary care.
Ophthalmology safety processes	Two PSII's Never Events were raised in Q1, and work is underway in Q2 as a combine investigation to review ophthalmology safety processes. The findings

Summarised theme/learning	Improvement activity
	from this investigation will be rolled into the wider thematic review (and associated actions plans) for ophthalmology which is currently underway
Identification of patients	Learning from an after-action review outlined issues of bed/bay numbers being used to identify patients for treatment where a treatment was delivered to the wrong patient. The AAR outlined this was a wider issue than this single incident. Actions have therefore been identified for reissue of a 'one minute brief' on confirming patient identification, sharing of the learning from this incident at all specialty governance meetings and working with the education team emphasising the importance of three-point identification of patients at induction.

Section Two – Shropshire Community Health NHS Trust

5.0 Medical Examiner (ME) Service Update

5.1 Community Hospitals In-Patient and Community Deaths

7 in-patient deaths occurred in Q1, which is comparable to Q4 2025/26.

5 virtual ward deaths occurred in Q1, which is a decrease from 9 in Q4 2025/2026.

5.2 Medical Examiner Reviews for SCHT deaths.

7 inpatient deaths were reviewed by the ME service in Q1.

5 virtual ward deaths were reviewed by the ME service in Q1.

No significant themes requiring escalation were identified in SCHT deaths.

5.3 Medical Certificates of Cause of Death (MCCD)

7 MCCDs were issued for in-patient deaths in Q1.

2 MCCDs were issued for virtual ward deaths in Q1. To note, due to the model of the virtual ward, there are occasions whereby the patient's GP will complete the MCCD as VW may not be in attendance for the verification of death.

To note, no concerns around timeliness for MCCDs have been raised.

5.4 Structured Judgement Reviews (SJR) and Learning

0 SCHT deaths were recommended for SJR in Q1.

4 cases were identified for potential learning in Q1, which have received a case review and have been presented at the Patient Safety Incident Panel (PSIP) for discussion.

During the quarter, a thematic review was conducted into complaints relating to discharge from community hospital settings, which identified: *Mortality within six weeks of discharge was identified in 3 of the 6 reviewed patients, representing 50.0%. This finding should be interpreted cautiously as a descriptive case-review observation and not as a population mortality rate. Readmission and mortality timeframes should be reviewed alongside discharge risk, frailty severity, deterioration indicators and post-discharge support arrangements.*

0 cases in Q1 were signposted to the PALS & Complaints team.

5.5 Coroner Referrals

There has been 1 prison custody death referred to the coroner in Q1 2026/27, The patient passed way within SaTH and respective case reviews have been submitted to the Prison and Probation Ombudsman ahead of any inquest.

5.6 Urgent Body Release and Faith Requests

0 urgent body release requests for faith reasons in Q1.

5.7 Hospital-funded Cremations and Genealogy

SCHT did not have any hospital funded Cremations in Q1.

5.8 Feedback and Complaints

The SCHT bereavement survey was launched at the beginning of Q4 2025/26, in which time there has been 1 return which provided positive feedback. The survey is included in the bereavement packs provided to the families of the deceased. The Patient Experience team will continue to support the survey process and are open to any improvement suggestions to encourage an increase in response.

1 formal complaint involved the bereavement in Q1, which was a SaTH-led complaint involving virtual ward around poor communication post-death.

6.0 Learning from Deaths Q1

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

There have been 0 deaths identified of patients who died within the Trust during Q1 with a learning disability or autism.

There have been 0 deaths with confirmed SMI in Q1.

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

There have been 0 cases in Q1 identified as potentially death more likely than not as a result in problems in health care.

7.0 Patient Safety Update Q1

7.1 Patient Safety Incident Investigations (PSII) Q1

In Q1 there were 3 PSII's commissioned. There was 0 PSII's closed in the quarter.

Newly commissioned PSII
2026/1534 W82463 - Death in Custody
2026/1535 W82379 - Fractured left neck of femur - Whitchurch Community Hospital
2026/1593 W82543 - Fractured Pelvis - Bishops Castle Hospital

7.2 Learning from incidents in Q1

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
Improvements to Discharge Information given to patients	Discharge Improvement Group are developing a patient owned discharge booklet
Responding to the deteriorating patient	Trust in process of embedding a SPICT (Supportive and Palliative Care Indicators Tool) at point of admission to support identification of deteriorating ill health and to enable staff to have holistic conversations around what is important to the Person/family
	Implementation of Admissions Form Ward Dashboard to enable staff oversight in charting and ensuring timely Patient observations/interventions
Clinical Documentation	Work ongoing with RiO team and clinical documentation group to assess and develop a structured daily documentation form that prompts appropriate entries while preserving individualised narrative documentation
Diabetes Policy update and refinement	Review and update to SCHT's Management of Hypoglycaemia Guidelines to incorporate awareness of/Guidance around Hyperglycaemia
Training and Competency Levels in	Development of a local Nephrostomy competency framework

Summarised theme/learning	Improvement activity
regard Nephrostomy	
Dementia Care	Admiral Nursing to re-join Core Clinical Skills week programme and to support training/awareness around Dementia/unmet needs, clinical assessment across SCHT. Introduction of Dementia Activity Trolley's,
Pressure Ulcer Recognition and Documentation	Introduction of updated Purpose-T care plans [Bishops Castle Community Hospital as a pilot site
More robust Monitoring and Recording of Patient Hydration Needs	Development of a ward hydration SOP. This sets out chart completion, minimum monitoring requirements, escalation triggers, and handover expectations for patients with low intake.
Discharges including fast track	Discharge improvement group in progress with key workstreams including discharge planning/discharge communication and medication

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	098/26		
Report Title	Guardian of Safe Working Hours Quarterly Report Q1 01 April – 30 June 2026		
Executive Lead	Dr John Jones, Group Chief Medical Officer		
Report Author	Dr Robin Hollands, Guardian of Safe Working Hours		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
No committees	Safe	√	BAF 2 and 3
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	Exception report numbers appear steady after the reset which took place at the beginning of February 2026, with reports mainly from most junior doctors and most commonly in medicine and emergency care Delayed response to leave requests has been addressed Exception reporting of excess workload in medical oncology is planned to be addressed by recruitment of additional doctor		
Recommendations for the Boards	The Board are asked to **take assurance** from the report.		
Appendices:	N/A		

1.0 Guardian of Safe Working

Recording and presentation of exception reporting is now being overseen by NHS Data Services using a standardised template. This has only recently come into being, and unsurprisingly there are teething problems in its presentation. I am unhappy with the information in its current format and will feed this back to NHS data services.

Exception report numbers appear steady after the reset which took place at the beginning of February 2026. As in previous quarters, most reports are submitted by the more junior resident doctors and relate to late finishes. General medicine is unsurprisingly the biggest source of reports with an even spread between foundation year and more advanced trainees.

Surgical specialties are infrequent sources of exception reports, this pattern being the normal in all hospitals and having historical reasons reflecting the closer retention of a team structure and the need for access to operating experience.

	FY1/2		CT/ST			
GIM	16		21			
Acute Mec	2		6			
Gen surg	6					
Paeds			14			
ENT	3					
Obs/gyn	6		7			
Oncol			5			
Opth			3			

Key issues from last report:
There were difficulties experienced by resident doctors in obtaining a prompt response to requests for leave. The issue was most notable within the Emergency Department and was the cause of considerable anxiety.

This has been addressed by MPS and clinical leads. There is a new rota/leave co-ordinator in ED. Feedback from the Lead Registrar, resident doctor forums and exception reporting suggests that the situation has significantly improved.

Issues of current concern:
An increase in exception reports from Medical Oncology has been noted in this quarter and going forward. This is a small specialty with the resident doctor rota consisting of a mix of IMT and Trust appointments. The nature of the patient population and clinical management has changed rapidly in recent years. It has been recognised for some time that the workload is increasing steadily and recruiting new doctors to support the rota is difficult. Currently a ward housing 20 patients is managed during the day by two IMT doctors and a Foundation doctor, with consultant support. Detail within exception reports, plus direct conversations with myself suggest that morale is low because of workload and rota gaps due to stress related illness. Discussions with consultant staff suggest that the service is fragile, presenting a safety risk to patients and staff.

The clinical director is in discussion with departmental managers and the DME, with a plan to recruit an additional IMT fellow as soon as possible and a further increase in 2027. Support by the Trust at senior level will be needed.

2. 10 Point Plan Update – By Dr Aung Naig (Lead Resident Doctor)

Due to changeover and unavailability of specialty representative, there were no resident doctors' committee meetings in August and September, but we plan to continue on 5 October.

We welcomed our new resident doctor peer lead as I stepped down from the role and formally handed over to Dr Mohit Inani. To make this transition smooth I will continue to support him alongside.

Below is the summary of our achievements and challenges over last year.

Working environment and wellbeing

- New doctors mess opened at the end of June in PRH.
- Heating issue in RSH mess has been resolved.
- Purple car parking is available outside of park and ride time for On-call doctors.
- Facilities booklet available for resident doctors on the intranet and via QR code in the mess area.
- Resident doctors can complete their portfolios and self-directed learning from appropriate location for them.
- A guidance on self-development time is available. However, it was highlighted that some specialties (e.g. surgical trainees) and locally employed doctors in some specialties (e.g. Junior fellows in Medicine) do not have formal self-development time.
- There has been job security concern among locally employed doctors towards the end of their contracts (August) which were not extended until very close to the end date which created anxiety of finding a new job, relocation, and visa issues.

Work Schedules and Rota Information

- The Trust is compliant with the requirement to provide:
- 8 weeks' notice of work schedules
- 6 weeks' notice of rota information prior to commencement

Annual Leave

- Previously there were some issues raised about timely approval of annual leave in some departments, and they are linked to unavailability of rota co-ordinator. This has now been resolved.
- Updated annual leave policy for resident doctors in place and is available on the intranet.
- SOP for annual leave carry-over between rotation is available on the intranet.
- Quality assurance processes for rota coordinator training are being developed
- Senior Lead and Resident Doctor Peer Lead (RDPL)
- Rosi Edwards is identified as non-executive director for resident doctors
- Dr John Jones is senior lead for resident doctors
- Dr Mohit Inani will be the new RDPL
- RDPL regularly meets senior lead and report to board quarterly.
- RDPL holds monthly resident doctors committee with specialty representatives.
- There is a task and finish group every 2 months which is attended by RDPL.
- RDPL has training and learning opportunities from regular regional and national meetings.

Payroll Errors

- No concerns have been raised regarding payroll errors

Statutory and Mandatory Training

- The Trust is compliant with the Memorandum of Understanding and People Policy Framework
- No concerns have been identified

Exception Reporting

- New exception reporting system is in place which is quicker and easier. It bypasses the clinical or educational supervisor approval. This has been introduced to all resident doctors.

Course-Related Expenses

- Course-related expenses are reimbursed within 6 weeks, provided study leave has been approved.

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	100/26		
Report Title	Terms of Reference for new Quality Committees in Common		
Executive Lead	Anna Milanec Group Chief Governance Officer		
Report Author	As above		
Prior Consultation:	**CQC Domain:**		**Link to BAF risks (strategic)**
Committees Executive Lead, designated Committee Chair, inaugural meeting of the Quality Committees in Common membership.	Safe	√	All SCHT BAF Risks All SATH BAF Risks
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	-
	Well Led	√	
Executive Summary	As the Group's transformation progresses, we have reached the stage where the Quality Committees of both organisations will meet in common. Meeting in common will provide a more efficient and productive way of working across both organisations by bringing Group-wide membership, knowledge and expertise together. Removal of potential organisational siloed working will create greater oversight, consistency in working practices, and will provide broader, more coherent assurance to both organisations. A combined 'In Common' terms of reference has been developed in the Group format originally designed for one of the previous board committees.		
Recommendations for the Boards	The Boards are asked to **approve** the Terms of Reference for the Quality Committees in Common.		
Appendices:	Appendix 1: Quality Committees in Common terms of reference		

Quality Committee(s) (in Common)

(DRAFT) Terms of Reference

DRAFT

1.0 Constitution of Committees

1.1 The Boards of Directors of Shropshire Community Health NHS Trust ("SCHT") and The Shrewsbury and Telford Hospital NHS Trust ("SATH) (together, "the Boards") respectively resolve to establish Committees of the Boards to both be known as the Quality Committee, ("the Committees"), **to meet in Common**.

1.2 The Committees have no executive powers, other than those specifically delegated in these Terms of Reference, or otherwise by the Schemes of Delegation of the respective Boards of Directors (the "Boards"), as they may be applicable.

1.3 The corresponding Standing Orders of SCHT and SATH shall also apply to the conduct of the working of the respective Committees, as they may be applicable.

2.0 Authority

2.1 The **Committees are** authorised by the respective Board**s** to investigate any activity within these terms of reference. The Committee**s** are empowered by the Board**s** to seek external professional advice and to invite external representatives or consultants to the meetings with relevant experience and expertise.

2.4 These Terms of Reference can be amended only with the approval of the respective Boards, **during a formal 'In Common'** board session.

3.0 Purpose

3.1 The Committees' purpose is to ensure that both organisations meet their statutory obligations regarding quality and safety, including oversight, assurance, and evidence of decision-making responsibilities related to patient care and public health, focusing on identifying any adverse quality trends and providing assurance to the Boards that timely interventions are in place where required.

4.0 Membership of the Committees

4.1 The combined voting membership of the Committees shall be appointed collectively by the Boards during a formal In-Common board session, and shall consist of the following:

- Designated NED Committees' Chair (who will chair the Committees)
- Three further NEDs (with at least one NED from each of SATH and SCHT)
- Group Chief Nursing Officer (*Executive Lead for the Committees)*
- Group Chief Medical Officer
- Group Chief Operating Officer

4.2 In the absence of the Designated Committees' Chair, an alternative Non-Executive Director member will chair the Committees' meetings in Common.

5.0 Attendees

5.1 Regular attendees (from both / either organisation) will be:

- SATH Director of Nursing
- SCHT Director of Nursing
- SCHT Medical Director
- SATH Medical Director
- Committees' admin support

5.2 The following Officers may **attend** the meetings of the Committees, at their discretion, but will not be members of either committee:

- The Group Chief Executive Officer
- The Group Chief Governance Officer (or their delegated deputy)

5.3 Other SCHT and / or SATH officers will attend as required by the Committees to provide assurances and explanations when discussing reports or other matters within the area of their responsibility.

5.4 Meetings are not open to members of the public.

5.5 Those in attendance do not count towards the quorums save for where formal acting-up status is specifically in place for **Group Chief Officers**, and / or as per section 6.2 below.)

6.0 Quorums

6.1 A **collective** quorum will be four members of the Committees (in total) which should be made up of two **Designated** Non-Executive Directors (which may include the Chair of the Committees) and two **Group Chief Officers**.

A designated Deputy may act on behalf of a **Group Chief Officer** in their absence, but another Group Chief Officer must also be present. **Deputies should not be asked to act-up on a regular basis, but only by exception.**

6.2 In the absence of a designated Non-Executive Director committee's member, a Non-Executive Director who is not a **Designated** Committee member, may attend the meetings and **will count** towards the **collective** quorum by the agreement of the **Committees in Common** Chair and **Group Trust Chair** in advance.

6.3 No business shall be transacted by the Committees unless a **collective** quorum is present. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committees in Common.

6.4 At the discretion of the **Committees in Common Chair**, business may be transacted through either: a tele/video-conference where an agenda has been issued in advance; or through the signing by at least three of all Committee members of a written resolution (including email) sent in advance to members outside of the meeting and recorded in the minutes of the next formal meeting.

6.5 Committees in Common Members should attend at least 75% of meetings each financial year but should aim to be present for all meetings - attendance logs are maintained.

7.0 Frequency of Meetings

7.1 The **Committees in Common** will usually meet monthly, with at least ten meetings each year.

DRAFT

8.0 Members' roles

8.1 If unable to attend a meeting, Committee members should **email** their apologies to the designated Chair of the Committees in Common, the Group Chief Nursing Officer and copy to the Meetings' Secretary, with adequate notice prior to the meeting.

8.2 If required, Group Chief Officer members should seek the approval of the Chair to send a designated Deputy to attend the Committees in Common on their behalf. The Deputy should be properly briefed and able to contribute to the meetings effectively.

8.3 When matters are discussed confidently at the meetings of the Committees in Common, Members and attendees should maintain such confidence.

8.4 At the start of each Committees in Common meeting, **members should** declare any relevant conflicts of interest/potential conflicts of interest in respect of specific agenda items in order that these can be considered by the Committees' Chair in relation to participation in the agenda item.

9.0 Administration support to the Committees in Common

9.1 The Agendas shall be determined primarily by the agreed annual cycle of business/schedule, together with approval from the Designated Chair of the Committees in Common, and the Executive Lead for the Committees. Agreed agendas will be sent out by the Committees' Secretary to report authors at least 10 working days prior to the date of the Meetings in Common.

9.2 Agenda reports shall be submitted to the Committees' Secretary at least 7 working days prior to the meetings.

9.3. The Committees' Chair reserves the right to remove items from the agreed agenda if reports are not received within 7 working days, or to defer them to a later meeting at their discretion.

9.4 However, the Committees' Chair also reserves the right to include late or additional items to the agreed agendas, at their discretion.

9.5 The agenda and papers will normally be circulated to members at least 5 working days prior to the meetings.

9.6 The Committees' Secretary shall record the minutes of the meetings and provide relevant support for agenda setting, maintaining an annual planner, action logs and meeting invitations.

9.7 The Group Chief Governance Officer is responsible for ensuring appropriate Committees' Secretary support to the Committees.

10.0 Duties of the Committees

The Committees shall provide the Boards with independent, objective and evidence-based assurance that the Boards have effective systems of quality governance, control and improvement, and that **safe**, effective, person-centered and equitable care is delivered consistently.

10.1 **Quality governance and assurance:** oversee the effectiveness of the Trusts' quality governance frameworks, including clear accountability, internal controls, clinical governance, quality impact assessment, escalation arrangements and the reliability of information on quality, risk, performance and outcomes; seek assurance that quality risks are identified, managed and sustainably mitigated, and escalate material gaps or concerns to the Board.

DRAFT

10.2 **Statutory and regulatory compliance:** oversee compliance with applicable legislation, statutory duties, registration requirements, licence conditions, national standards and regulatory guidance, and receive assurance on preparedness for, response to and delivery of actions arising from inspections, assessments, reviews, notices, undertakings or enforcement action.

10.3 **Care Quality Commission:** oversee compliance with the CQC fundamental standards and current assessment framework, including the safe, effective, caring, responsive and well-led dimensions of care; monitor CQC intelligence, ratings, findings and improvement plans, including requirements concerning person-centered care, dignity and respect, consent, safe care and treatment, safeguarding, complaints, good governance, staffing, fit and proper persons and the statutory duty of candour.

10.4 **Patient safety:** obtain assurance that the Trust maintains effective arrangements to prevent avoidable harm, identify and respond to deterioration, manage clinical and non-clinical safety risks, and meet national patient-safety requirements; oversee implementation of the Patient Safety Incident Response Framework, including proportionate learning responses, compassionate engagement with patients, families and staff, delivery and sustainability of safety actions, and compliance with national event-response requirements.

10.5 **Patient experience and involvement:** oversee how the Trust listens and responds to patients, service users, carers, families and communities, using complaints, concerns, compliments, surveys and wider feedback to improve care; seek assurance that people are involved in decisions about their care and in service design, and that communication is accessible, timely and compassionate.

10.6 **Clinical effectiveness and outcomes:** monitor the safety, effectiveness and outcomes of care through agreed indicators, clinical audit, mortality and learning-from-deaths reviews, outcomes data, evidence-based practice and relevant professional standards; require action where unwarranted variation, poor outcomes or deterioration is identified.

10.7 **NHS England oversight and regulation:** oversee the Trust's compliance with the NHS England 2026/27 Oversight Framework, its methodology and technical metric specifications, the NHS Standard Contract, provider licence and other applicable NHS England directions, standards and regulatory requirements; monitor performance across the relevant framework domains, including effectiveness and experience of care and patient safety, alongside access, people and workforce, and finance and productivity where these affect quality.

10.8 **Oversight segmentation, capability and intervention:** review the Trust's position against national priorities, comparative and contextual metrics, organisational capability assessments and published oversight information; obtain assurance on the accuracy of submissions and evidence, require timely recovery and improvement plans for off-track indicators, and oversee delivery of any NHS England support, undertakings, mandated actions or intervention requirements relating to quality.

10.9 **Health inequalities and equity:** seek assurance that the Trust identifies and reduces inequalities in access, experience, safety and outcomes, fulfils applicable equality and human-rights duties, and uses disaggregated data and community insight to address variation and improve equitable care.

10.10 **Safeguarding and vulnerable people:** oversee the effectiveness of arrangements for safeguarding children and adults at risk, mental capacity and consent, restrictive practice and other protections relevant to vulnerable people, ensuring concerns are escalated, investigated and learned from.

10.11 **Workforce and culture for quality:** seek assurance that staffing levels, skill mix, competence, education, professional standards, speaking-up arrangements and organisational culture support safe and high-quality care, and that workforce pressures or changes are assessed for

DRAFT

their impact on quality and outcomes.

10.12 **Medicines, infection and specialist safety:** oversee assurance in relation to medicines safety, infection prevention and control, medical devices, diagnostics and other significant or specialist clinical safety risks relevant to the Trust's services.

10.13 **Quality improvement and learning:** oversee the Trust's systematic approach to continuous quality improvement, ensuring that learning from incidents, deaths, claims, complaints, audits, reviews, staff feedback, research and external reports is translated into measurable, sustained improvement and shared across services and system partners.

10.14 **Service change and transformation:** scrutinise the quality and equality impacts of significant service changes, transformation programmes, digital developments, cost improvement plans and efficiency proposals, ensuring that risks, benefits, mitigations and post-implementation outcomes are appropriately assessed.

10.15 **Integrated and partnership working:** seek assurance on the quality and safety of pathways delivered with commissioners, the integrated care board, other providers and third parties, including safe transitions of care, shared risks, contractual quality requirements and the effectiveness of partnership governance.

10.16 **Policies, plans and reports:** review and, where delegated, approve the principal strategies, statutory reports, policies and plans within the Committee's remit; monitor delivery of the Trust's quality priorities and Quality Account, and recommend matters requiring Boards' approval.

10.17 **Triangulation and assurance:** triangulate quantitative and qualitative intelligence from ward to Board, including patient and staff voice, regulatory intelligence, benchmarking, audits and visits; commission deep dives or independent review where assurance is incomplete, inconsistent or indicates material risk.

10.18 **Reporting to the Boards:** provide timely reports to the Boards after each meeting, identifying assurance received, key risks, areas of limited or no assurance, decisions made and matters requiring escalation; support the Boards in making any required declarations, certifications or public disclosures relating to quality.

11. Reporting

11.1 The Committees are accountable to the Boards, and the Chair of the Committees in Common will report regularly on the Committees' proceedings in discharging their responsibilities and the effectiveness of systems and processes. The Committees' Chair shall bring to the Board's attention, on behalf of the Committees, significant matters that are under consideration and make necessary recommendations on any area within its remit where executive actions or Board decisions may be required.

11.2 The minutes of Committees' meetings shall be formally recorded and made available to the Board of Directors following first draft approval by the Committees' Chair.

12. Monitoring Effectiveness

12.1 An annual review of the Committees' effectiveness will be carried out.

12.2 **The Chair of Committees** will provide an annual report to the Boards the work of the Committees, discharging their duties, delivering their objectives and complying with their terms of reference.

13. Status of these Terms of Reference

DRAFT

13.1 ***Approved by the Boards in Common on 8th October 2026***

DRAFT

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	101/26		
Report Title	Board Member Conflicts of Interest Report (SaTH & SCHT)		
Executive Lead	Anna Milanec, Group Chief Governance Officer		
Report Author	Beverley Barnes, Board Coordinator		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Audit & Risk Assurance Committee, 7/9/26	Safe		BAF13
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		N/A
	Well Led	√	
Executive Summary	The Board members' registers of interests for SaTH (as at 31 July 2026) and SCHT (as at 21 April 2026) are presented for bi-annual review. The registers are published on each respective website alongside the wider registers of interests for each organisation. Board members are asked to review their declarations in the relevant accompanying appendices, to inform early refreshed website publication as necessary.		
Recommendations for the Boards	Board members are asked to **review** their individual declarations of interest for accuracy/completeness, to facilitate the early publication of refreshed registers on each website, as necessary.		
Appendices:	Appendix 1: Board member interests – SaTH Appendix 2: Board member interests - SCHT		

APPENDIX 1

The Shrewsbury and Telford Hospital NHS Trust

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Loyalty interests	WR Partners have been historic clients of my business Jungle HR Ltd	19/03/2025		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	Director - Inclusion 247 Ltd	19/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	Director - Jungle HR Ltd	08/08/2008		
Teresa	Boughey	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	QIAGEN is a client of Jungle HR Ltd	01/01/2017		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Daughter works at Robert Jones & Agnes Hunt Hospital	01/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	My Son is a Volunteer at the Trust (as part of his DofE Gold Programme)	01/11/2023		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Advisory Board Member at Royal Holloway University School of Business and Management	03/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Business Board Member of the All-Party Parliamentary Group for Women and Enterprise, and Chair of the ESG Workstream	01/01/2017		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Trustee of SaTH Charity	01/09/2019		
Teresa	Boughey	Non-Executive Director Trust Board	Non-financial professional interest	Outside employment	NED at Middlemarch Environmental Limited	20/02/2024		

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Rhia	Boyode	Group Chief People Officer	I have no interests to declare			16/01/2024		
Simon	Crowther	Associate Non-Executive Director	I have no interests to declare			28/02/2024		
Simon	Crowther	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests		01/04/2025		Acting as an Agent of the Corporate Trustee to the SaTH Charity
Rajinder	Dhaliwal	Non-Executive Director Trust Board	I have no interests to declare			28/07/2023	04/09/2025	
Sarah	Dunnett	Associate Non-Executive Director	Financial interests	Outside employment	I am employed by Niche Health and Social Care Consulting, an Employee Owned Trust, who supply health and social care investigations, healthcare analytics and assurance projects.	20/02/2024		I work 80% FTE and have declared this employment at SaTH to Niche.
Sarah	Dunnett	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests	Acting as an agent of the Corporate Trustee to the SaTH charity	01/04/2025		
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Branch Secretary of Billesley Branch Labour Party since November 2022. This branch is part of Selly Oak Constituency in Birmingham, with two Labour Councillors. The MP is also Labour. The role is largely administrative and low key. I can see little prospect of a conflict of interest arising with my work at SaTH, given the location of the branch/CLP.	31/05/2023		I continue at Branch Secretary, typically holding joint meetings with a neighbouring branch, Brandwood. The scope for a conflict of interest remains very low.
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial personal interests	Loyalty interests	Daughter Sarah Edwards is now Member of Parliament for Tamworth in Staffordshire. She was re-elected in July 2024 and is now on the Business & Trade Select Committee.	19/10/2023		SaTH has links to University of North Midlands NHS Trust, which provides services to people in Tamworth. It may be that in campaigning my daughter will want to comment on the way services are provided in South East Staffordshire.

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	As a NED I sit on the meeting of the Board acting as Corporate Trustee for the SaTH charity, so it seems I am an agent of the Trustees	01/02/2023		I was appointed as a full NED in February 2023 but did not realise until a board training session on 30 May that this might present a conflict of interest.
Diana (Rosi)	Edwards	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	Honorary President, Birmingham Health, Safety and Environment Association. This is a charity, operating since the 1930s, which aims to improve the management of health and safety at work through companies sharing good practice. I have held this role since November 2016.	31/05/2023		I have continued in this role. I note that SaTH is now a member of BHSEA. The scope for a conflict of interest is very limited.
Heidi	Fuller	Associate Non-Executive Director	Financial interests	Outside employment	I am employed by Keele University with whom SATH have arrangements in place including to host Keele students on clinical placement. My husband is also employed by Keele University.	01/04/2025		
Heidi	Fuller	Associate Non-Executive Director	Non-financial personal interests	Loyalty interests	I am under the care of the Haematology Unit at SATH.	01/04/2025		
Heidi	Fuller	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests	Agent of the Corporate Trustee to the SaTH Charity	01/04/2025		
Heidi	Fuller	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests	Member of the Institute of Orthopaedics Charity research panel	01/08/2023		
Heidi	Fuller	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests	Member of the Muscular Dystrophy UK Medical Research Committee	01/04/2022		
Heidi	Fuller	Associate Non-Executive Director	Non-financial professional interest	Loyalty interests	Member of the Robert Jones and Agnes Hunt Orthopaedic Hospital Research Committee	01/04/2021		

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
John	Jones	Group Chief Medical Officer	Indirect interests	Outside employment	I am a associate providing services to the GMC in their role as the national regulator for medical education, training and professional conduct and capability.	01/04/2013		This involves reading and commenting on matters of relevance to the 's role as well as attendance at virtual meetings and on in person visits to healthcare providers and universities and to premises. It also involves being part of decision-making panels for regulatory work. This work involves occasional overnight stays in hotels, travel and meals which are either payed for directly by the or via invoicing for costs incurred. There are also fees of up to £325/full day.
John	Jones	Group Chief Medical Officer	Indirect interests	Shareholdings and other ownership interests	Director Dr J I W Jones ltd	20/06/2023		
John	Jones	Group Chief Medical Officer	Non-financial professional interest	Loyalty interests		01/04/2025		I am acting as agent of the corporate trustee to the SaTH Charity
Nigel	Lee	Group Chief Strategy and Integration Officer	Non-financial professional interest	Loyalty interests	Agent of SATH Charity	30/05/2024		In addition to trustee role, also Executive Director responsible for Public Participation /Charity directorate Reviewed 10 Dec 25. No change.
Nigel	Lee	Group Chief Strategy and Integration Officer	Non-financial professional interest	Loyalty interests	Trustee - Learning Community Trust, Hadley, Telford. Member of Trust Board and Chair of Audit & Risk Committee.	01/01/2023		Situation category does not fit well. This is a voluntary unpaid role, with no specific allegiance or loyalty involved. Declaration confirmed as part of recruitment to substantive role at SATH. Reviewed 10 Dec 25. Role remains unchanged.
Anna	Milanec	Group Chief Governance Officer	I have no interests to declare			01/04/2023	31/03/2024	
Anna	Milanec	Group Chief Governance Officer	Non-financial professional interest	Loyalty interests	(Non-voting) Member of the Corporate Trustee to SaTH Charity	28/03/2025		

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Richard	Miner	Non-Executive Director Trust Board	Financial interests	Outside employment	I am a shareholder and director in Enterprise FD Limited, a company providing financial consultancy services. Clients include those which may benefit from contracts with sections of the NHS.	01/04/2018		Of those clients, I am a director of OSC Ltd, The UK Education Group Limited and Ensco 1424 Limited, all companies being linked as part of the same group.
Richard	Miner	Non-Executive Director Trust Board	Financial interests	Outside employment	Non-Executive Director of Tictrac Limited, a wholly owned subsidiary of Dialogue Health Technologies Inc of Canada which itself is a wholly owned subsidiary of Canadian listed company, Sun Life Financial Inc.	29/11/2024		Tictrac runs a consumer web portal related to the identification of health risks. The role is a corporate governance one.
Richard	Miner	Non-Executive Director Trust Board	Financial interests	Shareholdings and other ownership interests	I am a director and shareholder and my spouse and son are shareholders in Gadwall Investments Limited, a company which has an interest in some residential properties.	30/05/2017		
Richard	Miner	Non-Executive Director Trust Board	Indirect interests	Loyalty interests	My spouse is a community midwife with another NHS Trust.	01/06/1999		
Richard	Miner	Non-Executive Director Trust Board	Non-financial personal interests	Outside employment	I am the (paid) managing trustee of Dinwoodie Charitable Company, that provides financial support to NHS organisations. I do not benefit financially from these grants but my interactions with senior clinicians and senior health service personnel may enhance my professional standing.	01/04/2022		
Richard	Miner	Non-Executive Director Trust Board	Non-financial personal interests	Shareholdings and other ownership interests	I am an agent of the Corporate Trustee to the Shrewsbury and Telford NHS Charity	01/01/2025		
Andrew	Morgan	Group Chair	Non-financial professional interest	Loyalty interests		01/04/2025		Acting as agent of the Corporate Trustees to the SaTH Charity
Martina	Morris	Group Chief Nurse	Non-financial professional interest	Loyalty interests	Member of the Royal College of Nursing	Late 2000		Professional membership as part of my nursing registration.

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Martina	Morris	Group Chief Nurse	Non-financial professional interest	Loyalty interests	Member of the Chief Nursing Officer for England Strategic Advisory Group	01/07/2025		Advisory role to the CNO for England together with a number of other CNOs across England.
Martina	Morris	Group Chief Nurse	Non-financial professional interest	Loyalty interests	CQC Executive Reviewer – well-led inspection programme for NHS trusts	22/09/2025		I have declared conflict of interest to the CQC for the organisations I have worked in or where my family members are cared for, which includes Shropshire organisations.
Matthew	Neal	Group Director of Estates, Facilities, HTP, Capital and MES	Non-financial personal interests	Loyalty interests	Friend recently employed by Vanguard Healthcare.	18/02/2026		Vanguard is a current supplier of healthcare facilities and equipment to the Trust. I will not liaise with my friend in relation to any business with Vanguard Healthcare.
Wendy	Nicholson	Non-Executive Director Trust Board	Financial interests	Outside employment	I am employed as a NED at UHNM NHS trust	11/01/2026		I would however like to declare the following Chair of Fitness to Practice Panel,
Wendy	Nicholson	Non-Executive Director Trust Board	Non-financial professional interest	Loyalty interests	An Agent of the Corporate Trustee to the SaTH Charity.	23/09/2025		
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Financial interests	Outside employment	Institute of Osteopathy Lay Council Member Chair of ARAC	01/10/2023	30/09/2026	
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Financial interests	Outside employment	West Mercia Police - member of the Joint Audit and Standards Committee (Vice Chair)	01/06/2024	31/05/2026	
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Indirect interests	Outside employment	Wife - NED / SID Shropshire community Trust Wife - Chair of ICB Strategy committee	01/04/2022	31/03/2026	
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Non-financial personal interests	Outside employment	Agent of the Sath Charity - Corporate trustees	01/04/2024	31/03/2026	
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Non-financial personal interests	Outside employment	An agent of the Corporate Trustee to the SaTH Charity	01/10/2019	01/09/2026	

SaTH Board Member Interests (at 31 July 2026)

First Name	Last Name	Position Title	Interest Category	Interest Situation	Interest Description	CoI Date From	CoI Date To	Comments
Trevor	Purt	Non-Executive Director Trust Board (Vice Chair)	Non-financial professional interest	Outside employment	Board member - Rural Health Scientific Advisory Board Lincoln University	01/04/2022	31/03/2026	
Jonathan	Sargeant	Associate Non-Executive Director	I have no interests to declare			01/04/2025		
Joanne	Williams	Group Chief Executive	Non-financial personal interests	Loyalty interests	Trustee - Health innovation West Midlands H/WM Management Board	19/08/2025		
Joanne	Williams	Group Chief Executive	Non-financial personal interests	Loyalty interests	Trustee of 'Versus Arthritis' Charity	01/12/2022		
Joanne	Williams	Group Chief Executive	Non-financial personal interests	Loyalty interests	Agent of the Sath Charity - Corporate trustees	28/07/2025		
Joanne	Williams	Group Chief Executive	Indirect interests	Loyalty interests	Spouse, deputy COO of University Hospital of Birmingham NHS FT	01/01/2017	24/03/2025	
Adam	Winstanley	Acting Chief Finance Officer (SaTH)	Non-financial personal interests	Loyalty interests	Family members work for both SaTH and Shropshire Community Healthcare Trust.	20/01/2025		Family members work for both SaTH and Shropshire Community Healthcare Trust.
Adam	Winstanley	Acting Chief Finance Officer (SaTH)	Non-financial professional interest	Loyalty interests	Agent of the Corporate Trustee to the SaTH Charity.	01/04/2025		Agent of the Corporate Trustee to the SaTH Charity.

APPENDIX 2

Shropshire Community Health NHS Trust

SCHT Board Members Interests as at 21April 2026

Forenames	Surname	Role	Interest Category	Interest Description	Date Registered
Tina	Long	Non-Executive Director	Nothing to Declare		21/04/2026
Gina	Billington	Non-Executive Director	Nothing to Declare		07/04/2026
Claire	Horsfield	Director of Operations & Chief AHP	Decision Making	Husband is Regional Sales Manager at Spaldings Ltd Sister is Finance Director at Business Watch Guarding	26/03/2026
Jill	Barker	Non-Executive Director	Other Interest	Vice Chairman of The Movement Centre-Children's charity No value	12/03/2026
Andrew	Morgan	Group Chair	Decision Making	As well as being the Chair of Shropshire Community Health NHS Trust, I am also the Chair of The Shrewsbury and Telford Hospital NHS Trust. I am also a participant attender at the STW ICB Board meetings. This is a non-voting role. All of the above relates to the full year 2025/26 i.e. 1/4/25-31/3/26	10/03/2026
Clair	Hobbs	Executive Director of Nursing & Clinical Delivery	Nothing to Declare		06/03/2026
Shelley	Ramtuhul	Director of Governance	Outside Employment	Provide training on governance and executive administration via INPD	05/03/2026
Mahadeva	Ganesh	Medical Director	Other Interest	Member of the Learning Community Trust, not employed by the Trust. I have been a member since last 3 years.	05/03/2026
Sarah	Lloyd	Deputy Chief Executive & Director of Finance	Nothing to Declare		31/12/2025
Claire	Horsfield	Director of Operations & Chief AHP	Decision Making	Sister is Finance Director of Business Watch Guarding Ltd	31/12/2025

Board of Directors' Meeting in Common – 8 October 2026

Agenda item	102/26		
Report Title	SaTH Freedom to Speak Up/Whistleblowing Policy		
Executive Lead	Anna Milanec, Group Chief Governance Officer		
Report Author	Chan Kaur, Freedom to Speak Up Guardian		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Staff Side Representatives; Managers attending Workforce Policies & Procedures Group (WPPG); Joint Negotiating & Consultative Committee (JNCC); Policy Assurance Group (PAG); Audit & Risk Assurance Committee (ARAC)	Safe		BAF 1, BAF 2, BAF 3, BAF 4
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		
	Well Led	√	
Executive Summary	A full review has been completed in conjunction with Staff Side colleagues. The revised Freedom to Speak Up/Whistleblowing Policy describes the Trust's approach to raising concerns, whistleblowing and Freedom to Speak Up. It sets out clear, accessible and safe arrangements for employees to speak up, including raising concerns openly, confidentially or anonymously. The policy confirms that all NHS organisations are required to adopt the national Freedom to Speak Up policy as a minimum standard and reinforces the Trust's commitment to ensuring that concerns are listened to, considered appropriately and used to support learning and improvement. The policy also outlines the routes available for raising concerns, the role of the Freedom to Speak Up Guardian, support available to employees, protection from detriment, and the arrangements for oversight, monitoring and reporting through Trust governance processes, including the Audit and Risk Assurance Committee and the Trust Board. The policy was reviewed by the Audit and Risk Assurance Committee on 7 September 2026, who recommend approval to the Board.		
Recommendations	The Board is asked to **approve** the SaTH Freedom to Speak Up/Whistleblowing Policy.		
Appendices:	Appendix 1: Freedom to Speak Up/Whistleblowing Policy		

Partnering Ambitious Caring Trusted

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

The Shrewsbury and Telford Hospital NHS Trust

VETERAN AWARE

Freedom to Speak Up/Whistleblowing Policy

(Also Raising Concerns)

Doc ID: W54

Additionally refer to:

- Bullying and Harassment (W4)
- Disciplinary Policy (W7)
- Equality, Diversity and Inclusion (W30)
- Employee Investigations Policy (W37)
- Grievance Policy (W8)
- Sexual Misconduct Policy (W17)
- Anti-Fraud, Bribery and Corruption (GOV07)
- Incident reporting and investigation (staff, contractors and members of the public) including RIDDOR 2013 (HS02)
- Managing Conflicts of Interest in the NHS (GOV06)
- Prevent Violent Extremism and Radicalisation Policy and Procedure (GOV03)
- Safeguarding Children & Young People Policy (DOC ID 1119)
- Safeguarding of Adults at Risk of Abuse Policy (CG15)
- FREE1 - Anti-Fraud Specialist (AFS) & Freedom to Speak Up Guardian (FTSUG): Liaison & Joint Working Protocol
  Trust values - SaTH Intranet - PACT: Our Values

Version:	V7		
V6 Issued	June 2023		
V7 Approved by	WPPG	JNCC	PAG
V7 Date approved	3.2.26	16.3.26	April 2026
V7 Ratified:	Policy Approval Group (PAG)		
V7 Date Ratified:	April 2026		
Document Lead	FTSU Guardian		
Lead Director	Group Chief Governance Officer		
Date Issued:	March 2026		
Review Date:	March 2029		
Target Audience:	All Employees, Managers		

Version Control Sheet

Document Lead/Contact:	Freedom to Speak Up Guardian
Document ID	W54
Version	V7
Status	Final
Date Equality Impact Assessment completed	Jan 2026
Issue Date	March 2026
Review Date	March 2029 (unless required earlier)
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	Whistleblowing; fraud; prevent strategy; freedom to speak up; FTSU Guardians; FTSU; raising concerns; freedom; speak up; values; W4; governance.
Dissemination	Global Email, Information Bulletin, Managers Resources email list. FTSU Guardians and ambassadors. Document Library on intranet.

Version History

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
V1	Oct 2005		Final	
V2	Jul 2008		Final	
V3	Mar 2011		Final	
V4.0	Jan 2012		Draft	Amendment to sections 8.4, 9.1 and Appendix A
V4.1	Feb 2012		Draft	Amendment to format to comply with NHSLA standards. Contact details updated
V4.2	Mar 2012		Final	Minor amendments. Inclusion of NHS National Prevent Strategy
V5	Jul 2018	Victoria Maher	Final	Amended to reflect National Freedom to Speak Up guidance.
V5.1	Jan 2019	Kate Youlden	Draft	Review at 6 months after implementation. Updates to Web links. Changing Whistleblowing to F2SU
V5.2	Feb 2019	Kate Youlden	Draft	February 2019 Policy Group
V5.3	Feb 2019	Kate Youlden	Draft	Policy numbers removed. Agreed at JNCC. Progress to WFC with recommendation that Trust board approval is not required.
5.4	Mar 2019	Kate Youlden	Final	Update from PAG and Workforce Committee. Ratified at WFC without progress to TB due to minor revisions

5.5	May 2019	Kate Youlden	Final	Change to responsible Executive Director to reflect current arrangements
5.6	Oct 2019	Kate Youlden	Final	Change to responsible Executive Director to reflect current arrangements and additional number for FTSU Guardian
5.7	Jun 2021	Helen Turner	Final	Change to responsible Executive Director to reflect current arrangements and FTSU Guardian. Changes to contacts for fraud team. Changes to NGO contact information
V5.8	Sep 2022	Helen Turner	Final	Reviewed and updated.
V6.0	Jun 2023	Helen Turner	Final	Reviewed and updated.
V6.1	Apr 2024	Helen Turner	Final	Updated contact details.
V7	Feb 2026	Helen Turner/Chan Kaur	Final	Full review undertaken. Updated following JNCC/HR and PAG feedback circulated to PAG members on 22/04/26.

Contents **Page**

1.	Policy on a Page	1
2.	Policy statement – Speak up we will listen	2
3.	Scope	2
4.	Roles and Responsibilities	2
5.	What Can I Speak Up About?	3
6.	We want you to feel safe to speak up	4
7.	Who Can Speak Up	4
7.1	Speaking up Internally	4
7.2	Speaking up Externally	5
8.	How Should I Speak Up?	7
9.	Advice and Support	8
10.	What Will We Do?	7
11.	Protection when speaking up/detriment	8
12.	Protected Disclosure/Whistleblowing	8
13.	Training	10
14.	Review	11
15.	Equality Impact Assessment Statement (EQiA)	11
16.	Process for monitoring compliance of policy	11
17.	References	11
	Appendix A: What will happen when I speak up?	12

1. Policy on a page

This policy describes The Shrewsbury and Telford Hospital NHS Trust's (SaTH) approach to Raising Concerns, Whistleblowing and Freedom to Speak Up.

The aim of the policy is to support managers and employees by setting out clear, accessible and safe arrangements for speaking up, raising concerns or making a protected disclosure.

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt the national Freedom to Speak Up policy as a minimum standard to help normalise speaking up for the benefit of patients and employees. Its aim is to ensure that matters raised are recorded, considered appropriately and used to support learning and improvement.

SaTH actively supports and encourages all employees to raise concerns and will not tolerate anyone being prevented or deterred from speaking up, or being mistreated, harassed or victimised because they have spoken up.

The policy describes the routes available to all employees for raising concerns, including speaking to a line manager, senior manager, Freedom to Speak Up Guardian, relevant specialist team, staff side or trade union representative, or an appropriate external body where this is needed.

Anyone who works, or has worked, for SaTH can speak up. This includes substantive employees, bank and agency workers, temporary employees, volunteers, students, trainees, resident doctors, locums, contractors and staff from other organisations who are working with or visiting SaTH.

Employees can speak up about anything that gets in the way of patient care, affects their working life, or feels wrong. This may include patient safety, quality of care, bullying or harassment, discrimination, fraud, safeguarding, unsafe systems of work, poor behaviours, breaches of policy, or wider concerns about the way services are being run.

Employees can speak up openly, confidentially or anonymously. The Trust will do everything it reasonably can to protect confidentiality where requested, although there may be limited circumstances where information must be shared, for example where there is a legal, safeguarding or patient safety reason to do so.

When someone speaks up, they will be thanked, listened to, supported, and the concern will be considered fairly. Where action is needed, the matter will be directed to the most appropriate route, which may include local resolution, review by a manager or specialist team, referral to an existing policy process, investigation, mediation, or escalation to internal or external bodies.

Feedback will be provided wherever possible, balanced with the need to protect confidentiality and the rights of others. Themes, learning and improvement actions from speaking up will be monitored through the Trust's governance arrangements, including reporting to Trust Board and the Audit and Risk Assurance Committee.

The Trust recognises that speaking up may feel difficult. Employees are encouraged to raise concerns as early as possible and to seek advice or support if they are unsure how to proceed. Support is available from line managers, the Freedom to Speak Up Guardian, People Advisory/HR, staff side or trade union representatives, wellbeing services and other relevant specialist teams.

2. Policy Statement

Speak Up We Will Listen

The Trust welcomes speaking up and will listen. By speaking up at work employees will be playing a vital role in helping improve our services for all patients and the working environment for employees.

This policy is for all employees. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words."

We want to hear about any concerns employees have, whichever part of the organisation they work in. Some groups in our workforce are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that employees with disabilities, or from a minority ethnic background or LGBTQ+ community do not always feel able to speak up.

This policy is for all employees, and we want to hear all our employees' concerns.

At SaTH it is a mandatory requirement that all our employees complete the online training on speaking up. The online module on listening up is mandated specifically for managers to complete and the module on following up is mandated for senior leaders to complete. You can find out more about what Freedom to Speak Up (FTSU) is in these videos.

3. Scope

Anyone who works (or has worked) for SaTH can raise concerns. Concerns may be raised openly, confidentially or anonymously.

This includes bank and agency staff, temporary employees, students, volunteers, trainees, resident doctors, locum, pharmacy, dentistry, optometry, non-clinical employees, receptionists, directors, managers, contractors, staff employed in other organisations who are visiting SaTH to undertake duties. ***All will be referred to as employees in the document from this point on.***

4. Roles and Responsibilities

4.1 Trust Board

- The Trust Board oversees this policy and discharges its responsibility to the Chief Executive and subsequently the Group Chief Governance Officer as the lead director for the development and implementation of this policy. The Trust Board and Audit and Risk Assurance Committee (ARAC) receive quarterly updates from the FTSU Guardians with relevant data.

4.2 Executive Management Team

The Executive Management Team has responsibility to:

- Regularly review data relating to raising concerns/speaking up from the FTSU Guardians and that lessons are learnt and changes in practice are made to culture in the workplace.

- Set the tone for a culture which is psychologically safe and encourages speaking up and raising concerns as normal regular everyday practice.
- Ensure sufficient preventative measures are in place to discourage detriment when employees raise concerns.

4.3 Group Chief Governance Officer has a responsibility to:

- Provide senior support for our speaking up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.

Freedom to Speak Up Guardian will:

- Provide a confidential and safe space for people to discuss their concerns and appropriate route for escalation.
- Actively promote a culture of speaking up/raising concerns and all routes for raising concerns.
- Provide regular reports and data to the Trust Board and ARAC and other groups as appropriate for action/information and triangulation.

Line Managers will:

- Create a culture in their teams where raising concerns and speaking up is welcomed.
- Need to be aware of this policy and their role when employees are raising concerns.
- Promote this policy to all employees they line manage.
- Provide appropriate support and/or signposting for those who raise concerns.
- Routinely respond to those who are raising concerns with feedback and actions taken.
- Ensure confidentiality where appropriate for those raising concerns unless there is a safeguarding concern that needs to be reported.
- For further information on creating a good raising concerns culture employees can refer to the Managers Handbook on the intranet

Employees will:

- Need to be fully aware of this policy and procedure for raising concerns and supporting principles.
- Actively raise concerns if they are worried and support other colleagues to do so
- Promote and actively play a part in a culture that encourages raising concerns and responding to them
- Maintain confidentiality as far as possible unless there is a safeguarding concern that needs to be reported

5. What Can I Speak Up About?

Employees can speak up about anything that gets in the way of patient care or affects their working life. That could be something which doesn't feel right: for example, a way of working or a process that isn't being followed; colleagues being discriminated against; or the behaviours of others is affecting our employee's wellbeing, or that of patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing policies:

- Bullying and Harassment
- Disciplinary Policy
- Equality, Diversity and Inclusion Policy
- Employee Investigations Policy
- Grievance Policy
- Sexual Misconduct Policy
- Fraud, Bribery and Corruption Policy (which includes a new corporate fraud offence of 'failure to prevent fraud'.
- Managing Conflicts of Interest in the NHS
- Safeguarding Children and Young People Guidelines and Procedure
- Managing Allegations against staff who work with Children and Young People
- Safeguarding of Adults at Risk of Abuse Policy
- Managing Allegations against Staff in Positions of Trust Procedure (for those working with Adults with Care and Support Needs)
- NHS Prevent Strategy

We will listen and work with employees to identify the most appropriate way of responding to the issues raised.

6. We Want You to Feel Safe to Speak Up

Employees may be worried about raising a concern and may think it best to not raise it, perhaps feeling it is none of their business or that it's only a suspicion. They may feel that raising the matter would be disloyal to colleagues, managers or to the organisation. They may decide to say something but find they have spoken up to the wrong person or raised the issue in the wrong way and not sure what to do next. At SaTH our leaders are expected to be committed to supporting an open, honest and kind culture for all our workforce. To run the organisation in the best possible way and to do so everyone's help is needed. This policy is to reassure employees that it is safe and acceptable to speak up and enables raising concerns at an early stage and in the right way. Rather than wait for proof, the organisation prefers and supports employees to raise the matter as soon as they have a concern.

Speaking up is a right because it helps identify opportunities for improvement that might not be otherwise known.

SaTH will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

If in doubt – speak up

7. Who Can Speak Up

Anyone who works (or has worked) for SaTH can raise concerns.

SaTH is committed to ensuring that every employee, in every part of our organisation, feels able to speak up.

This includes bank and agency workers, temporary employees, students, volunteers, trainees, resident doctors, locum, pharmacy, dentistry, optometry, non-clinical employees, receptionists, directors, managers, contractors, staff employed in other organisations who are visiting SaTH to undertake duties.

It is also acknowledged that some employees with disabilities or from minority ethnic or LGBTQ+ backgrounds may feel less confident doing so.

This policy supports all employees equally and actively encourages everyone to raise concerns so SaTH can learn and improve.

7.1 Speaking up Internally

Most speaking up happens through conversations with line managers where challenges are raised and resolved quickly. SaTH strives for a culture where that is normal, everyday practice and encourages exploration of this option – it may well be the easiest and simplest way of resolving matters.

However, there are other options in terms of who employees can speak up to depending on what feels most appropriate.

- Senior manager or director with responsibility for the subject matter being spoken up about.
- Freedom to Speak up Guardian – sath.ftsu@nhs.net
- The patient safety team or clinical governance team sath.patientsafety@nhs.net
- Incident reporting or Datix incident report/datix
- Local counter fraud teams (where concerns relate to fraud); Paul.Kay@miaa.nhs.net 07990 082328 or Darrell.Davies@miaa.nhs.uk 07584 774763/0151 285 4500
- People Advisory/HR Team – Advisory Line ext. 2891 sath.hradvice@nhs.net
- Staff Side/Union Representatives - here
- Safeguarding team SaTH Intranet - Safeguarding

7.1.2 Our Freedom to Speak Up Guardian

Who can support employees to speak up if they feel unable to do so by other routes? The FTSU guardian will ensure that employees who speak up are thanked for doing so, that the issues raised are responded to, and that the person speaking up receives feedback on the actions taken.

The role of the FTSU Guardian is to act as an independent and impartial source of advice to employees at any stage of raising a concern. Employees can seek advice or support from the FTSU Guardian at any time.

Chan Kaur, FTSU Guardian 07773 976983; Chan.Kaur@nhs.net

You can find out more about the FTSU guardian role here

7.1.3 Resident Doctors

- The Trust's Guardian of Safe Working – can be contacted via email if you are worried about anything sath.guardianofsafeworking@nhs.net
- Dr Gordon Wood, Director of Medical Education gordon.wood@nhs.net
- Dr Adrian Marsh, Postgraduate Clinical Tutor adrianmarsh@nhs.net
- FY1 Leads Miss Pam Kaur parminder.kaur12@nhs.net and fionajutsum@nhs.net
- FY2 Leads Dr Dodiy Herman dodiy.herman@nhs.net and Miss Rebecca Race rebecca.race@nhs.net
- Junior Clinical Fellow Leads Dr Ahmad Sultan ahmad.sultan@nhs.net and Dr Nayab Shaik nayab.shaik@nhs.net
- Senior Clinical Fellow Lead Dr Dodiy Herman dodiy.herman@nhs.net
- A trainee doctor's Educational Supervisor or Clinical Supervisor
- Any member of the Medical Education Team based with PRH Education Centre or SECC (Shropshire Education and Conference Centre)
- The Educational Lead for the area the trainees are working within.

7.1.4 Student Midwives

The ward manager and each area/ward has an educational link midwife. The clinical placement facilitator – elizabeth.aaron@nhs.net Student midwives also have course leads and their own academic and personal tutor where concerns can be raised to.

7.1.5 Student Nurses

Ward manager, clinical placement facilitators and university personal tutors.

7.1.6 Executive Leads

The senior lead responsible for Freedom to Speak Up – Anna Milanec, Group Chief Governance Officer – Anna.Milanec@nhs.net 07596 318490 – provides senior support for our speaking up guardian and is responsible for reviewing the effectiveness of our FTSU arrangements.

Our non-executive director responsible for Freedom to Speak Up – Teresa Boughey; Teresa.Boughey@nhs.net 07970 778874

7.2 Speaking Up Externally

If employees do not want to speak up to someone within our organisation, they can speak up externally to:

7.2.1 Care Quality Commission (CQC)

For quality and safety concerns about the services it regulates – they can find out more about how the CQC handle concerns here.
Tel: 03000 616161 Email: enquiries@cqc.org.uk

7.2.2 NHS England

For concerns about:

- GP surgeries
- dental practices
- optometrists
- pharmacies
- how NHS Trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
- NHS procurement and patient choice
- the national tariff

NHS England may decide to investigate employees' concerns themselves or ask the employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information provided to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of the concern and how it relates to their various roles.

Link for NHS England

Please note that neither the Care Quality Commission (CQC) nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

7.2.3 Other Sources

- NHS Counter Fraud Agency for concerns about fraud and corruption, using their online reporting form link or calling their freephone line 0800 028 4060.
- If employees would like to speak up about the conduct of a member of staff who is registered with a professional body, you can do this by contacting the relevant professional body directly. This includes the General Medical Council, Nursing and Midwifery Council, Health and Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.
- Healthwatch England – www.healthwatch.co.uk This is an independent statutory body that ensures NHS leaders and other decision makers listen to your feedback and improve standards of care – you can contact them by calling 03000 683 000 Monday to Friday 08:30 – 17:30 or via their website.

8. How Should I Speak Up?

Employees can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

The most important aspect of speaking up is the information provided, not the identity of those raising concerns.

You have a choice about how you speak up:

- **Openly:** employees are happy that the person they are speaking up to knows their identity and that they can share this with anyone else involved with responding.

- **Confidentially:** employees who are happy to reveal their identity to the person they choose to speak up to on the condition that they will not share this without consent. The organisation will do everything it reasonably can to protect the confidentiality of the person speaking up if that is what they would prefer. However, if asked not to disclose the employee's identity, this will not be done so without their consent unless required by law. There may be times when we are unable to resolve a concern without revealing someone's identity, for example where their personal evidence is essential. If this is the case, it will first be discussed with them about how the matter can best be taken forward.
- **Anonymously:** the employee who does not want to reveal their identity to anyone. This can make it difficult for others to ask for further information about the matter and may make it more complicated to act to resolve the issue. It also means that access to any extra support needed may not be available or receive any feedback on the outcome.

In all circumstances, employees must be ready to explain as fully as they can the information and circumstances that prompted them to speak up.

9. Advice and Support

Health and Wellbeing – Local support is available here

Local staff networks are a valuable source of support and to find out more contact the Equality, Diversity and Inclusion Team sath.edi@nhs.net

Chaplaincy – Contact: sath.chaplaincyteam@nhs.net

Unions – at SaTH a number of unions are recognised and their contact details and Trust representatives can be found here

A range of health and wellbeing support can be accessed via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.
- NHS England has a Speak Up Support Scheme

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service (ACAS) gives advice and assistance, including on early conciliation regarding employment disputes.

10. What Will We Do?

The matter being spoken up about may be best considered under a specific existing policy/process; for example, the process for dealing with bullying and harassment. If so, it will be discussed with the employee. If speaking up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix A.

10.1 Resolution and Investigation

SaTH supports managers/supervisors to listen to the issues raised and take action to resolve them wherever possible. In most cases, it is important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

If an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside the organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (the predicted timescales will be shared and regular updates provided), and a report produced that identifies any issues to prevent problems recurring.

Any employment issues that have implication for employee capability or conduct identified during the investigation will be considered separately.

10.2 Communicating with You

Employees will always be treated with respect and thanked for speaking up. The issues will be discussed with those raising the concerns to ensure an understanding of exactly what the employee is worried about. If it is decided to investigate, the predicted timescale of the investigation and progress will be communicated. Wherever possible, the investigation report and findings will be shared. This must be balanced with respecting the confidentiality of others and recognising that some matters may be strictly confidential. There may be circumstances where very limited information can be shared.

10.3 Review

Feedback will be asked from employees about their experience of speaking up and the effectiveness of this policy and our local process will be reviewed annually, with the outcome published and changes made as appropriate.

10.4 Senior Leaders Oversight

The senior leaders will receive a report quarterly providing a thematic overview of speaking up by staff to the FTSU Guardian(s).

11. Protection when speaking up/detriment

SaTH will not tolerate any harassment or victimisation of any person as a result of speaking up and any such occurrence will be handled through our Bullying and Harassment Policy (W4).

However, raising a concern that they know is untrue or malicious will be dealt with through our disciplinary process. If you are raising something that is considered to be in the public interest then legal protection is given if specific conditions are met, and this is called a protected disclosure – see Protected disclosures and whistleblowing section below.

12. Protected disclosures and whistleblowing

Whistleblowing or a protected disclosure describes when an employee raises a genuine concern about serious wrongdoing with someone in authority either internally at SaTH or externally for example with the CQC or NHS England. It can sometimes be difficult to know if speaking up amounts to whistleblowing or a protected disclosure however **this is not something that anyone speaking up should worry about as this can be considered after you have spoken up.** Employees may choose to seek advice before speaking up (see list in section 7.1).

Whistleblowing or a protected disclosure refers to concerns or wrongdoing the disclosure of which is in the public interest. Public interest means that the concern of interest is to the wider public not just to the person who is raising the concern. These are called 'qualifying disclosures. A qualifying disclosure is one made in the public interest by an employee/worker who has a reasonable belief that it is:

The six categories of wrongdoing covered by law are:

1. A criminal offence, for example fraud
2. A miscarriage of justice
3. Someone's health and safety is in danger
4. Risk or actual damage to the environment
5. You believe someone is covering up wrongdoing
6. The organisation is breaking the law, for example it does not have the right insurance

12.1 Making a Protected Disclosure/Whistleblowing

A protected disclosure or whistleblowing is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of employees/worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet this criteria, please seek independent advice from Protect the whistleblowing charity or a legal representative.

To aid understanding further information is contained below:

12.2 What is PIDA?

The Public Interest Disclosure Act 1998, shortened to PIDA, is the law that protects whistleblowers from negative treatment or unfair dismissal. It is part of the Employment Rights Act 1996 (ERA)

PIDA makes it unlawful to subject an employee/worker to negative treatment or to dismiss them because they have raised a whistleblowing concern, raising a whistleblowing concern is also making a 'protected disclosure' in law. Whistleblowing rights under PIDA are day one rights. This means that the employee/worker does not need the same two years' service that is needed for other employment rights.

12.3 Who is protected under PIDA?

Section 43K of the PIDA has a wider definition of worker than other areas of employment law. This means protection is granted to employees as well as certain workers, contractors, trainees and agency staff who make a protected disclosure. However, there are gaps in the law which mean that some employees do not qualify for whistleblower protection e.g. trustees, volunteers, NEDs. This list is not exhaustive.

12.4 What concerns can I raise to be protected?

In order to qualify for protection under PIDA, you must make a 'protected disclosure'. This has three main elements to it:

1. You must provide information of a concern that you "reasonably believe" shows a category of wrongdoing set out in the law.
2. You must reasonably believe that the concern is in the public interest.

3. You must raise your concern in accordance with the law – either internally to your employer or externally to an outside body.

12.5 What is reasonable belief?

It is not necessary for the information disclosed to actually be true. In most cases where a genuine concern has been raised, it is easy for an employee/worker to show reasonable belief. A whistleblower does not need to be right about their concern nor prove it. They simply need to show that they have some reasonable basis or grounding for believing there has been some wrongdoing. That is enough and it will not matter if the whistleblower is later shown to be mistaken.

12.6 What types of concern, can I raise?

A disclosure of "information" can be made verbally or in writing and can include new information or drawing attention to a matter that someone is already aware of. Your disclosure must contain sufficient factual content and be sufficiently specific, as opposed to saying an opinion or making an allegation. You must reasonably believe that the information is likely to illustrate one of the six categories of wrongdoing covered by law.

12.7 What does 'public interest' mean?

Usually where an employee/worker is raising concerns about wrongdoing which affects people other than themselves, it would fall in the public interest. This can be distinguished from cases where the employee/worker is going through a personal issue in the workplace or where their employment rights are affected, making it a grievance matter. However, there may be instances where a concern may also affect the employee/worker raising it, e.g. if there is a culture of bullying or discrimination in the workplace, which would make this a public interest concern.

12.8 If you have made a protected disclosure

If you have made a protected disclosure and you are treated negatively in any way for doing so then this is a breach of your legal rights under PIDA. You may be able to exercise your rights under the legislation to bring a claim for compensation at an Employment Tribunal.

It is understandable that those raising concerns are sometimes worried about possible repercussions. SaTH aims to encourage openness and accountability and will support employees who raise genuine concerns under this policy and who may otherwise be involved when concerns are raised or in any investigation of these concerns. If someone has made untrue allegations maliciously for example in bad faith or with a view to personal gain, this will be dealt with under the disciplinary policy.

Under this policy all concerns whether they would be considered a protected disclosure/whistleblow or not are treated equitably meaning that the same principles apply to protect all employees from detriment.

If at any stage you experience reprisal, harassment or victimisation for raising a genuine concern please contact any of the following people.

- Chan Kaur, FTSU Guardian, 07773 976983; Chan.Kaur@nhs.net
- Our senior lead responsible for Freedom to Speak Up, Anna Milanec, Anna.Milanec@nhs.net; 07596 318490
- Our non-executive director responsible for Freedom to Speak Up – Teresa Boughey; Teresa.Boughey@nhs.net, 07970 778874

13. Training

Training and briefing of this policy and procedure is key to its implementation. FTSU Guardians give regular updates, and the policy will be disseminated through HR admin function, the FTSU ambassadors, staff bulletin and the intranet.
At SaTH it is a mandatory requirement that all our employees complete the online training on speaking up. The online module on listening up is mandated specifically for managers to complete and the module on following up is mandated for senior leaders to complete.

14. Review

The Trust will review this policy when there are changes to relevant legislation, or good practice, or within the normal policy review cycle, i.e. 3 years.

In order that this document remains current, any contact details or any of the appendices to the policy can be amended and approved during the lifetime of the document without the policy having to return to the ratifying committee

15. Equality Impact Assessment Statement (EQiA)

This policy applies to all employees equally and does not discriminate positively or negatively between protected characteristics.

16. Process for monitoring compliance of policy

The level and type of monitoring will be confidential and only data reports showing the numbers of concerns raised with the FTSU Guardian are reported quarterly to Trust Board and Audit and Risk Assurance Committee (ARAC).

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
FTSU arrangements are fit for purpose.	Reports to Trust Board and ARAC	Freedom to Speak Up	Quarterly	Trust Board and ARAC

17. References

NHS England Freedom to Speak Up Policy
ACAS – Whistleblowing at Work
Protect Charity
HCPC Policy
NHS Constitution

Appendix A

What Will Happen When I Speak Up?

We Will

- Thank you for speaking up
- Help you identify the options for resolution
- Have a conversation with you about your health and wellbeing
- Confirm what information you have provided consent to share
- Support you with any further next steps and keep in touch with you

Step Towards Resolution

- Engagement with relevant senior managers (where appropriate)
- Referral to HR process
- Referral to patient safety process
- Other type of appropriate investigation, mediation etc.

Outcomes

- The outcomes will be shared with you wherever possible, along with learning and improvement identified.

Escalation

- If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS Trust). Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body such as the CQC or NHS England. Employees may choose to seek advice before speaking up (see list in section 7.1).