Boards in Common Meeting in Public Agenda

Date: 14 May 2026
Time: 0930-1230hrs
Venue: Shropshire Education & Conference Centre
Chair: Mr Andrew Morgan, Group Chair

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930 hrs	001/26	Welcome, and apologies	Verbal	-	Group Chair	Noting
	002/26	Joint Patient/Staff Story	Enc	**4**	Group CNO	Noting
	003/26	Public Questions **a. SCHT** **b. SaTH**	Verbal	-	Group Chair	Noting
	004/26	Noting of Quorum for each Board	Verbal	-	Group Chair	Noting
	005/26	Declarations of conflicts of interest	Verbal	-	Group Chair	Noting
	006/26	Minutes of previous meetings in public session a. **SCHT:** 5 February 2026 b. **SaTH:** 12 March 2026	Encs	**5** **11**	Group Chair	Approval
	007/26	Action Logs – no actions outstanding for either SCHT or SaTH	Verbal	-	Group Chair	Noting
	008/26	Matters arising from previous minutes (not covered on action log or agenda): **a. SCHT** **b. SaTH**	Verbal	-	Group Chair	Discussion
Reports from the Group Chair and Group Chief Executive						
0955 hrs	009/26	Report from the Group Chair	Verbal	-	Group Chair	Noting
	010/26	Report from the Group Chief Executive	Enc	**32**	Group Chief Executive	Noting
SHORT BREAK						
Board Committee Reports						
1015 hrs	011/26	**SCHT:** a. Activity Reports from NEDs b. Quality & Safety Committee Report	Verbal	- **39**	All NEDs NED Chair	Noting

		c. Resource & Performance Committee Report d. Audit Committee Report	Encs	**44** **47**	NED Chair NED Chair	
	012/26	**SaTH:** a. Quality & Safety Assurance Committee Report b. Performance Assurance Committee Report c. Finance Assurance Committee Report d. Audit & Risk Assurance Committee Report e. HTP Assurance Committee Report	Encs	**51** **53** **56** **58** **60**	NED Chair NED Chair NED Chair NED Chair NED Chair	Noting
	013/26	**Group:** a. People Committee Report	Enc	**63**	*Group CPO	Noting
Strategic, Performance, Financial & Operational Reporting						
1045 hrs	014/26	**Performance Reports** **SCHT:** a. Integrated Performance Report b. Integrated Quality & Safety Performance Report c. Integrated People Performance Report **SaTH:** d. Integrated Performance Report	Encs	**66** **77** **79** **85**	CFO/D.CEO SCHT Group CNO *Group CPO Group Chief Executive	Noting
	015/26	**Financial Performance Reports** **SCHT:** a. Financial Performance Report M12/Year End 2025/26 b. 2026/27 Opening Budget **SaTH:** c. Financial Performance Report M12/Year End 2025/26	Encs	**164** **170** **174**	CFO/D.CEO SCHT A.CFO SaTH	Noting Approval Noting
	016/26	**SaTH** Bi-annual Public Participation Report *(Full Report in Board Information Pack)*	Enc	**185**	*Group Chief S&I Officer	Noting
Assurance Framework						
1130 hrs	017/26	Board Assurance Framework (BAF) & Risk Management **SCHT:** **a.** BAF Report Q4 2025/26 **SaTH:** **b.** BAF Report Q4 2025/26 **c.** Annual Risk Management Report (inc Q4) 2025/26	Encs	**191** **208** **231**	*Group CGO	Approval Approval Noting
	018/26	**SaTH** Integrated Improvement Plan (SIIP) Monthly Update Report	Enc	**238**	Group Chief Executive	Noting
	019/26	**SaTH** Integrated Maternity & Neonatal Report	Enc	**241**	Group CNO	Assurance
	020/26	**SaTH** Board Maternity & Neonatal Safety Champions Reports	Encs	**246**	Group CMO	Assurance
Regulatory and Statutory Reporting						
1150 hrs	021/26	**SaTH** Safer Staffing Bi-Annual Review	Enc	**250**	Group CNO	Noting

	022/26	**SaTH** Infection Prevention & Control (IPC) Report Q4 2025/26	Enc	**284**	Group CNO	Noting
	023/26	**Group** Annual NHS Staff Survey Results	Enc	**290**	*Group CPO	Noting
	024/26	**SaTH** Guardian of Safe Working (GoSW) Report Q4 2025/26	Enc	**307**	Group CMO	Noting
Procedural Items						
1225 hrs	025/26	Any other Business – agreed by the Chair	Verbal	-	Group Chair	Discussion
	026/26	Date of next meeting of Boards in Common in public: 9 July 2026	Verbal	-	Group Chair	Noting
Close of meeting						

*****Non-voting*

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	**Executive Lead**	**Page No.**
01 014/26a SCHT Performance Action Plans	SCHT Chief Finance Officer	1
02 014/26b Appendices 1&2 SCHT Int Q&S Performance Report	Group Chief Nursing Officer	7
03 014/26c Appendices 1-4 SCHT Int People Performance Report	Group Chief People Officer	44
04 016/26 Appendices 1&2 SaTH Bi-annual Public Part Report	Group Chief S&I Officer	55
05 018/26 Appendices 1-4 SaTH IIP Report	Group Chief Executive	90
06 019/26 Appendices 1-3 SaTH Int Maternity & Neonatal Report	Group Chief Nursing Officer	116
07 022/26 Appendices 2&3 SaTH IPC Report	Group Chief Nursing Officer	193
08 024/26 Appendices 1&2 SaTH GoSW Report	Group Chief Medical Officer	197
09 SaTH HTP SRO Update March 2026	Group Chief EF&C Officer	201

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	002/26		
Report Title	Joint Patient/Staff Story (Acute & Community Services)		
Executive Lead	Paula Gardner, Chief Nursing Officer		
Report Author	Paula Gardner, Chief Nursing Officer		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
NA	Safe	√	
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	The story will be told by Sharon Angelides (Ward Manager on Wards 15 & 16) and Sam Matthews (Clinical lead for the Enhanced Care Team). The patient was cared for on Ward 15 and 16 from a prolonged stay in ITU. This story does date back to 2023, but I wanted to demonstrate the joint working of the then newly formed ECS team now known as Enhanced Therapeutic Observations & Care (ETOC). The care the patient received in SaTH and the intensive support from the ECS Team enabled him to continue his recovery journey, and the focus on his physical and cognitive development enabled him to be discharged home to the community with wrap around community services support. This is just one case that stood out as this was in the initial stages of the implementation of our ECS team and positively impacted upon the patient and staff.		
Recommendations for the Boards	The Boards are asked to: • **Note** the staff/patient story		
Appendices:	None		

Shropshire Community Health
NHS Trust

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THEATRE SEVERN, SHREWSBURY
AT 10.00 AM ON THURSDAY 5 FEBRUARY 2026

PRESENT

Chair and Non-Executive Members (Voting)	
Mr. Andrew Morgan	(Group Chair)
Ms. Jill Barker	(Non-Executive Director)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Cathy Purt	(Non-Executive Director)
Executive Members (Voting)	
Ms. Jo Williams	(Group Chief Executive)
Ms. Sarah Lloyd	(Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Claire Horsfield	(Director of Operations and Chief AHP)
Executive Members (Non-Voting)	
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Ms. Rhia Boyode	(Chief People Officer)
In attendance	
Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)

Welcome

Mr Morgan welcomed all to the meeting.

Apologies and Quorum

Apologies were received from Ms Tina Long, Non-Executive Director and Ms Clair Hobbs, Director of Nursing. The Group Chair declared that the meeting was quorate.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 4 December 2025

The minutes were agreed as an accurate record of the meeting.

Action Log

There were no outstanding actions.

Staff Story

Sally Stubbs attended the meeting and shared her personal journey in the Trust. Ms Stubbs shared that she had joined the Trust as a bank HCA while undertaking her nursing studies. There was a perception that nurses needed to complete two years in the acute sector before moving to the community, however, this was not true. The Trust had supported Ms Stubbs specialist practice degree and she had been made team leader shortly before covid. Since then she had managed every service within the division and had recently been promoted to the adult operational lead role.

The Board thanked Ms Stubbs for sharing her story and noted her huge dedication and commitment. Ms Stubbs said that every challenge is an opportunity and advised that it was ok to say that you didn't know the answer as that was how you learnt and developed.

In response to a question, Ms Stubbs noted that the work undertaken in patients homes often goes unseen, although the number of compliments the team received stood for themselves. With the national move towards neighbourhood working, she hoped that the limelight would be shared.

Public Questions

There were no questions received in advance of the meeting and none were raised from the floor.

Notification of Any Other Items of Business

There was none.

Chair's Communication

The Chair advised that the group was progressing well, with recruitment underway for the joint executive team. From April, the Board would meet in Common with SaTH and more of the Committee meetings would be in common moving forward. The cluster arrangements with the ICB were also progressing, with their Board meetings now taking place in common and a formal merger was hoped for by April 2027.

The Chair had visited the First Links group at the Shrewsbury Child Development Centre, and described the breadth of services provided by the Trust. The parents at the session were clear on the difference the services were making to their lives and that of their children.

Non-Executive Director's Communication

Ms Purt advised that she had attended the ICB transition Board last week and raised that we must ensure that we don't lose momentum on prevention and health inequalities across Shropshire, Telford and Wrekin.

In addition, Ms Purt had chaired the second Group People Committee and had attended an event in relation to HTP at Whitchurch library.

Chief Executive's Report

The Chief Executive summarised her report and thanked everyone for their hard work over the winter period. She highlighted the excellent performance in waiting times and the recent interview radio interview by the Trust on Time to Talk day.

QUALITY AND SAFETY

Quality and Safety Committee Chair's Report

Ms Barker advised that there was just one outstanding high risk policy, a significant improvement on the position from previously. The Committee gave partial assurance in relation to the risk register, as the teams needed to own the risk, and in relation to patient safety investigations, as more assurance was needed around the timeliness of completion of the investigations.

The Board noted the meeting that took place and the assurances obtained.

Quality and Safety Report

Dr Ganesh presented the report on behalf of Ms Hobbs, Director of Nursing. There were still challenges in relation to C-Difficile, although the Trust maintained a close oversight on each case. There had been two unexpected deaths in the period, which were being reviewed through the usual process. It was clarified that unexpected did not mean unavoidable or unexplainable.

Mr Darbhanga asked about deaths in custody and Dr Ganesh confirmed that all deaths in custody were referred to the medical examiner so are independently reviewed.

A discussion took place in regards to medication incidents and drug charts. Dr Ganesh confirmed that the issue had been identified, actions had been put in place and the situation managed.

Ms Purt asked for reassurance that if a patient needed a specific type of bed, this would be provided despite the standardisation exercise underway with hospital beds, Ms Horsfield confirmed this was the case, as the needs of each patient would be prioritised. The exercise was around ensuring standardisation of regular equipment, which had various benefits, including IPC compliance.

The Board accepted the assurance provided by the update.

Freedom to Speak Up Report

The Board welcomed Mr David Ballard, Freedom to Speak Up Guardian, to the meeting. He summarised the activity in quarter 2, noting the progress made in this time period. In terms of cases raised, there had been 8 new cases raised in Q2, 5 from nursing, 2 admin and 1 external source; the range of concerns include patient safety, lack of resources and behaviours.

The service had recently been audited and was found to offer substantial assurance.

The Chair asked about closing the loop following closure of a case, Mr Ballard confirmed that, if he was concerned that the person was 'not in a good place' he would keep the case open and would look at why the concern was raised initially.

The Board asked if data was collated in relation to if the complainant had previously spoken to their line manager about their concern. Mr Ballard stated that, now he was full time in the role, he would be able to undertake more analysis on this. Ms Horsfield confirmed that triangulation of data was undertaken regularly, to identify any themes.

The Board noted the updated position and the position regarding the self-assessment.

Health Inequalities Report

Dr Ganesh provided an update to the Board. Senior managers within the Trust would shortly receive a self-assessment, which would be used to identify any gaps. Dr Ganesh confirmed that the Health Inequalities and Prevention Group was managed by Local Authorities and was progressing well, with an established agenda and dedication.

Mr Darbhanga asked about digital exclusion, Dr Ganesh stated this was a separate project led by the ICB, this was progressing well.

Ms Purt discussed how neighbourhood working would benefit health inequalities work, as each area would have different needs, Dr Ganesh agreed and noted that this work would be central to neighbourhoods.

The Board accepted the assurance provided by the update.

PEOPLE

Group People Chair's Report

Ms Purt advised that this had been the second meeting of the Group People Committee. She reported that sickness absence was a growing risk for both organisations. Mandatory training compliance had reached 97%, with some specific areas including high risk fire training and resus needing some additional work.

The Board noted the meeting that took place and the assurances obtained.

Integrated People Performance Report

The report had been discussed in detail by committee. Ms Boyode bought to the Board's attention that the actions being taken in relation to sickness absence were not reducing levels to plan so further work was underway in relation to this, particularly in relation to short term absence and mental health.

Mandatory training compliance had improved and should be recognised and celebrated. Mr Morgan asked if there was any progress on a nationally mandated training procedure, Ms Boyode confirmed that this was still being reviewed nationally.

Ms Lloyd confirmed that the Trust remained close scrutiny of all bank and agency usage. The majority of use of bank and agency staffing related to the establishment of new services while substantive staff were recruited.

The Board considered the performance across relevant indicators to date.

Gender Pay Gap

The report was required to be published on the Trust's website by the end of March. There had been little change from previous years, with a small variance in the mean. The Trust would continue to analyse data from the staff survey of experience of both male and female staff. The Board discussed the affect of flexible working on staff retention and recruitment.

Ms Boyode acknowledged that the report was split into male and female categories, however, the Trust had many staff who identified in other ways.

The Board noted the assurance provided by the report and approved publication of the report on the SCHT website and government online services to ensure compliance with legislative requirements.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Mr Darbhanga, on behalf of Tina Long, summarised the report. The Committee had reviewed the Procurement Strategy, which covered many health services across Shropshire. The Committee had reviewed the Trust's financial performance and cost pressures across the Trust.

Ms Ramtuhul advised that she had met with the fire service the previous week and they had been assured on the action plan in place.

The Board noted the meeting that took place and the assurances obtained.

Performance Report

Of the measures requiring attention managed by the RPC, twelve required additional attention. 10 related to waiting times, and there had been a significant, and sustained improvement in all waiting times across the Trust. The report indicated two longer waits, however, this was a data quality issue and had not occurred.

The Trust had received the National Oversight Framework outcome for quarter 2 and had, again, be placed in Segment 2 which was strong performance. The Trust was showing as below average in two areas; patients waiting over 52 weeks in community services, and it was thought that the improvement work undertaken on this, as described above, would be reflected in the Q3 submission and in relation to sickness absence.

The Board considered the Trust's performance to date and the actions being taken to minimise risks and improve performance where required.

Finance Report

The Trust was delivering a favourable to plan surplus of £300k and had a high degree of confidence of delivering the annual plan in full. Bank and agency usage exceeded planned levels, however, the overall pay budget remained within planned levels. All CIP schemes had been de-risked and on target to deliver n excess of the plan.

Ms Lloyd stated that delivering the plan was a testament to all teams in the Trust and that we would exit the year in a stronger financial position than we entered into it.

The Board
- ***Considered the adjusted financial position at month 9 was a surplus of £1,714k compared to a planned surplus of £1,431k, a favourable variance of £283k.***
- ***Considered the underlying / recurrent position year to date was a surplus of £786k, which was a favourable variance to plan of £138k and that the Trust was on course to deliver £1,100k underlying surplus for the year which was favourable to plan by £168k.***
- ***Acknowledged that our forecast outturn was to deliver our planned surplus of £2m, and that we were looking at opportunities which could allow us to exceed this level of surplus.***

AUDIT

Board Assurance Framework

Ms Ramtuhul stated that the relevant sections of the report had been reviewed by Committee and that one change was proposed in relation to risk scoring; reduction of the risk of not achieving our financial plan due to the confidence and likelihood of us delivering the plan in full.

The Board considered and approved the Board Assurance Framework

ANY OTHER BUSINESS – with prior agreement of the Chair

Any Other Business

There was none.

DATE OF FUTURE MEETING

Date of Future Meeting

To be confirmed.

Agenda Item 006/26b

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

Thursday 12 March 2026
Held in Shrewsbury Education & Conference Centre

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Group Chair
Ms J Williams	Group Chief Executive
Ms S Dunnett	Non-Executive Director
Ms R Edwards	Non-Executive Director
Ms P Gardner	Interim Chief Nursing Officer
Mr N Hobbs	Chief Operating Officer / Deputy CEO (SaTH)
Dr J Jones	Executive Medical Director
Mr R Miner	Non-Executive Director
Ms W Nicholson MBE	Non-Executive Director
Prof T Purt	Non-Executive Director / Vice Chair
Mr A Winstanley	Acting Director of Finance
IN ATTENDANCE	
Mrs R Boyode	Chief People Officer
Ms T Cotterill	Interim Director of Financial Recovery and Transformation
Mr S Crowther	Associate Non-Executive Director
Prof H Fuller	Associate Non-Executive Director
Mr N Lee	Director of Strategy & Partnerships
Ms A Milanec	Director of Governance
Mr M Neal	Group Director of Estates, Facilities and Capital Programme
Mr J Sargeant	Associate Non-Executive Director
Ms B Barnes	Board Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms J Bolton	Acting Head of Midwifery *(agenda item 055/26)*
Dr S Jones & Mr I Hanif	Dr in Microbiology / Chief Pharmacist *(agenda item 062/26)*
APOLOGIES	
Mrs T Boughey	Non-Executive Director
Mr R Dhaliwal	Non-Executive Director
Ms I Robotham	Assistant Chief Executive

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No.	ITEM	ACTION
PROCEDURAL ITEMS		
036/26	**Welcome and Apologies** The Group Chair welcomed all those present, including observing colleagues and members of the public. Mr Morgan extended a warm welcome and congratulations to Mr Matt Neal, who formally joins Board in his expanded role as Group Director of Estates, Facilities and Capital Programmes; and congratulations also to Mr Ned Hobbs, Chief Operating Officer, who has been appointed Deputy CEO (SaTH) in addition to his existing portfolio. Apologies were noted.	
037/26	**EDI Midwife Impact Story (Patient Story)** The Interim Chief Nursing Officer welcomed Sherilyn to the meeting, who has been in post as EDI Midwife for just over one year. During that time Sherilyn's impact on our communities, and individual patients, has been tremendous, and she has become a key and valued member of the team. Sherilyn explained to the Board her role as EDI Midwife, the different groups she has experienced in our communities, and her plans to build on and expand the engagement and support offered to the diverse cross-section of expectant and new mothers under our care. As testament to Sherilyn's success, the Board was pleased to hear that other Trusts are looking to replicate the work being done at SaTH. Mr Lee shared with colleagues that Sherilyn has recently made a video about her role for Telford & Wrekin Integrated Place Board, and he highlighted the importance of talking about how we all come together to support our communities as this is fundamental to the Health Inequalities agenda. Ms Williams, observing that it is easy to see why Sherilyn is 'Midwife of the Year', invited her to engage with the Executive Team or wider Board for any support she would find helpful as she develops her role going forward. The Board of Directors was pleased to **note** this inspiring impact story, and Mr Morgan thanked Sherilyn for joining today's meeting to share with the Board the valuable work she is undertaking.	
038/26	**Public Questions** The Group Chair thanked members of the public who had submitted questions in advance of today's meeting. The questions (including those accepted from the floor on the day), and the responses provided at the meeting, are included at the end of these minutes.	
039/26	**Quorum**	

	The meeting was declared quorate.	
040/26	**Declarations of Conflicts of Interest** No conflicts of interest were declared that were not already included on the Register of Directors' Interests. The Board of Directors was reminded of the need to highlight any further interests which may arise during the meeting.	
041/26	**Minutes of previous meeting** The minutes of the previous meeting held on 15 January 2026 were accepted and approved by the Board of Directors as an accurate record.	
042/26	**Action Log** The action log was reviewed, and the Board agreed that action numbers 11 and 13 were complete and could be closed. Regarding action no. 13, the Chief People Officer advised that the Guardian of Safe Working (GoSW) has accepted an invitation to join the next People Committee meeting. This will provide an opportunity to explore previously discussed operational matters in greater depth, along with the issues with rota management and annual leave approvals within ED which the GoSW had requested Board assistance in resolving. Mrs Boyode confirmed that the aim is to agree actionable steps through the Committee, to offer both the GoSW and the Board the necessary assurance.	
043/26	**Matters arising from the previous minutes** No additional matters were raised.	
REPORTS FROM THE GROUP CHAIR AND GROUP CHIEF EXECUTIVE		
044/26	**Exit from the Recovery Support Programme** The Group Chair and Group Chief Executive were delighted to share the news that NHSE has confirmed SaTH's exit from the RSP (Recovery Support Programme) (previously known as 'Special Measures') after demonstrable and sustainable improvements across a range of areas over the last 18 months. Mr Morgan, recognising that this is clearly a very significant milestone in the history of this organisation and our improvement journey, paid huge tribute to our colleagues for their hard work, dedication, and perserverance over many years, and our partner organisations for their valuable support. He also wished to pay tribute to Ms Williams for her leadership, commitment and compassion, which have played a key part in this important achievement. Ms Williams thanked Mr Morgan for his comments and support, and highlighted that it has taken almost eight years for the Trust to exit 'Special Measures', during which time SaTH has been in receipt of	

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	significant support and intervention. Our exit represents a significant achievement and is testament to the comprehensive transformation efforts undertaken across the organisation. She echoed Mr Morgan's comments in thanking all colleagues for their dedication and hard work in enabling us to reach this juncture, and wished to also thank all our partners for their support and for the messages of congratulations they have sent as SaTH marks this key milestone in our transformation. Most importantly, it brings renewed confidence for our patients and our communities, and demonstrates our commitment to delivering consistent, high-quality care. Mr Morgan and Ms Williams provided their assurance that, although many improvements have been made at SaTH, we are not complacent and recognise that there is still much for us to do on our improvement journey to achieve excellence. The Board of Directors was delighted to accept the report, **noting** the accompanying NHSE letter of exit.	
045/26	**Report from the Group Chair** Mr Morgan confirmed that from April 2026, SaTH will be moving to Board Meetings in Common with our Group partners, SCHT. The first Public Board Meeing in Common will take place on 14 May 2026 at SECC, and future meetings will be held at venues across Shropshire and Telford. As referenced previously, arrangements are underway for the establishment of one Group Executive Team and one set of Group NEDs across both organisations, and further Group appointments will be confirmed shortly. The Board of Directors **noted** the update provided.	
046/26	**Report from the Group Chief Executive** The Board of Directors received the report from Ms Williams, who summarised some of the key points and provided further updates since her report had been produced: • Care Quality Commission (CQC): The CQC carried out an unannounced inspection of UEC and Medical departments at both RSH and PRH sites on 3 and 4 March 2026. The initial feedback provided at the end of their visit was positive, and CQC colleagues who had been part of the original inspection team commented how impressive our staff were in wanting to engage with them on improvements and learning. Ms Williams thanked all SaTH colleagues who had been involved in the inspection for their huge team effort. We now await the official report. • National visit: On 26 February 2026, SaTH welcomed the National Elective Care Programme team, together with representatives from No10 and the Secretary of State Delivery	

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	Unit. Ms Williams thanked James Wright, Deputy COO, and all colleagues from across the Trust who had participated in the visit, for presenting an inspiring and informative overview of our improvement journey. • Perinatal mortality surveillance report: As the 2024 perinatal mortality data set had recently been published by MBRRACE-UK, Ms Williams invited Dr Jones to share his comments with the Board on the data provided. Dr Jones wished to emphasise that whilst the content is data-heavy, he is always mindful that the report is talking about babies who have died. For SaTH, he advised that the data shows rates of perinatal mortality in our Trust were similar to, or lower than, other Trusts, and that mortality rates had stabilised, evidencing a tangible link to the work undertaken by SaTH to minimise perinatal mortality. The Board of Directors accepted and **noted** the report.	
REPORTS FROM ASSURANCE COMMITTEE CHAIRS		
047/26	**Audit & Risk Assurance Committee (ARAC) Report** The Board of Directors received the report from the Committee Chair, Prof Purt, which was taken as read. Colleagues were alerted, with apologies, to the incorrect meeting date showing on the report, which should read 16 February 2026. The Board's attention was drawn to the following points: • Pharmacy wastage: Whilst the Committee was concerned to learn that £25k of medication had been rendered unusable due to a pharmacy fridge door being accidentally left ajar, ARAC was pleased to hear that a business case was in development which, if successful, would increase the capacity for medicines recycling, leading to less wastage. • Internal Audit assurance: The Committee was pleased to note the substantial assurance rating in relation to the internal audit of the self-assessment of compliance with NHSE's Grip and Control checklist and the HMFA's Financial Sustainability Checklist. Substantial assurance was also confirmed for the Key Financial Controls internal audit. Prof Purt highlighted that huge credit is due to the Finance team for their implementation of new ways of working, which have secured these positive assurances. • Draft internal audit plan 2026/27: The Committee noted that several changes had been proposed to the draft internal audit plan by the Executive Team, in particular the removal of Group structure audits, as it had been agreed that 2026/27 would be a transitional year for the Group model and thus too early for auditing. The resulting spare capacity in the plan would be redirected to other appropriate areas, and it had been agreed	

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	that the Group audits would take place during the 2027/28 financial year. The Board of Directors accepted and **took assurance** from the report.	
048/26	**Quality & Safety Assurance Committee (QSAC) Report** The Board of Directors received the report from the Committee Chair, Ms Dunnett. Taking the report as read, colleagues' attention was drawn to the following points: • Paediatric Transformation Programme: The Committee received the annual report and was pleased to note the progress against the action plan, with 91% of actions now completed and evidenced. Colleagues noted the Paediatric Transformation Assurance Committee (PTAC) is to stand down from March 2026, with ongoing oversight of outstanding actions to be via usual governance routes. QSAC recognised the positive impact of the programme as a good example of how the team have come together to improve outcomes for children and young people. • Patient Safety Incident Response Framework (PSIRF) Priorities: The Committee was pleased to hear of the progress being made in cross working and joint ownership of the Trust's safety priorities and plans. It has been identified that for complex programmes, such as adult deterioration, there is a need for structured support to maximise impact and track actions. • No criteria to reside (NCTR): The Committee heard with concern that the number of patients with no criteria to reside remains high, and colleagues were advised that the Discharge Improvement Group has invited a representative from the Care Home Sector to support work to improve timely and appropriate discharge. Referring to NCTR and the resulting impact of long waits and performance in Urgent and Emergency Care, Mr Hobbs advised the Board that this would be covered further in the Integrated Performance Report (agenda item 053/26). The Board of Directors accepted and **took assurance** from the report.	
049/26	**Performance Assurance Committee (PAC) Report** The Board of Directors received the report from the Committee Chair, Ms Edwards. Taking the report as read, colleagues' attention was drawn to the following points: • No Criteria to Reside (NCTR): PAC had also expressed concern over the large number of patients with no criteria to reside during January, which had negated the majority of the benefits the	

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	Trust was hoping to see from the additional 56 beds in modular wards at RSH and the additional beds at PRH, whilst recognising that this was a system-wide issue that only the system as a whole could resolve. PAC agreed to a joint review with QSAC of the impact in terms of harm and health outcomes of the delays in discharging these patients. • Shropshire Fire & Rescue Service (SFRS): Following fire safety audit visits to PRH in November and December 2025, SFRS had issued the Trust with two enforcement notices. In particular SFRS stated that it can no longer support the Hospital Full Protocol *"as a reliable long-term means of escape. SaTH may continue to use the current arrangement only on a strictly temporary basis while an alternative, safe and consistently manageable solution is identified and implemented".* The Committee considered that the high level of NCTR is driving the need to apply the Protocol, and that the consequential risks were something SaTH should explain to Local Authorities, noting that the Trust has been given until 26 April 2026 to produce an alternative Protocol. Ms Gardner advised the Board that fire evacuation tests had been carried out on all wards earlier that week, to provide confidence that ward colleagues know what actions need to be taken in the event of a fire. Ms Williams added that each ward use their professional judgement and knowledge of their patients to assess the most appropriate patients for additional bed locations under the Hospital Full Protocol. She also provided assurance that there is very clear oversight on patient locations in the Trust's daily site safety meetings. • Digital: The Committee received a detailed report on the Digital Programme and noted the extent and importance of this work, and the need for careful prioritisation planning. PAC wished to understand how SaTH compared with other trusts in digital maturity and it was agreed that a paper will be brought to the Committee in April/May 2026. Mr Crowther queried what consideration had been given to how we can leverage the Trust's recently awarded University Status with regard to the digital landscape, and his NED colleague, Prof Fuller, confirmed that this has been considered and the Trust and University will be working together to take this forward. Colleagues also noted future opportunities available through the Group model and our partnership working with other Trusts. • Financial risks and impacts: The Committee heard that the Trust's Financial Recovery Taskforce is developing an overarching efficiency and transformation plan that will align all current transformation, improvement and financial recovery projects under one governance strucure. The plan will align with the Group integration and HTP, and will include UEC and the other programmes of work. Specifically for UEC, metrics	

	covering the overall cost and productivity of the UEC pathway are being developed, as well as sub-metrics of the primary drivers of pathway cost and productivity The Board of Directors accepted and **took assurance** from the report.	
050/26	**Finance Assurance Committee (FAC) Report** The Board of Directors received the report from the Committee Chair, Mr Miner. Taking the report as read, colleagues' attention was drawn to the following points: • 2025/26 Financial Performance: The Committee noted that whilst there is currently £2m of unmitigated risk to the year-end beakeven plan, there is an expectation that with the various ongoing negotiations and continuing governance controls, this can be mitigated. • 2026/27 Operational Plan: The Committee heard that the £8.6m 'gap' in our recent 2026/27 Operational Plan submission is now the subject of NHSE scrutiny, with pressure to close the gap. Colleagues recognised the need to continue applying disciplines into 2026/27, however FAC had been encouraged by our grip and control measures, and the early signs of workforce improvement. • Transformation: Acknowledging that it was not feasible to continue focusing on just taking costs out of the organisation, the Committee recognised the importance of identifying significant transformational actions, and these would be a key focus under the new Group model. Mr Morgan, sharing the Committee's 'cautious optimism', observed that if we achieve our year-end breakeven plan, it will be the first time in over a decade that SaTH has delivered its financial plan. Colleagues, however, recognised the importance of continuing to deliver on our financial commitments, including reducing, and ultimately clearing, our deficit support funding. The Board of Directors accepted and **took assurance** from the report.	
051/26	**Group People Committee (GPC) Report** The Board of Directors received the report from Mrs Boyode in the absence of Mrs Boughey, Joint Chair of the Committee. Taking the report as read, colleagues' attention was drawn to the following points: • Strategic Workforce Plan: The Committee had focused at its latest meeting on the plan deliverables requiring completion by the end of 2025/26, with some work extending into 2026/27.	

	• Sickness absence: Colleagues had discussed the rising trend in sickness absence, which was recognised as a key risk for both SaTH and SCHT. The Committee will be undertaking a deep dive at its next meeting. • Nurse recruitment: The Committee was advised that nursing vacancies at SaTH have reduced significantly with the recruitment of newly qualified nurses. Ms Gardner assured the Board of the support provided through the Trust's preceptorship programme. She has been very clear that this support is essential, noting that there is a direct correlation between onboarding and sickness absence. • Consultant recruitment: Mr Morgan referred to the significant level of consultant recruitment panels which continue to take place, and the subsequent extensive onboarding support provided. Ms Nicholson observed the importance to the organisation's consultant retention of ensuring that the Trust ultimately meets the ambitions which were shared by consultants at interview. • Doctor training numbers: Dr Jones commented that one of the biggest challenges for Resident Doctors is undergoing training whilst carrying out patient care. Whilst there are many factors which impact on how many individuals can be trained at SaTH, we are continuing to train as many Doctors as we can. Mrs Boyode, in response to a query from Mr Morgan on whether she was finding the Joint People Committee meetings with SCHT helpful, was pleased to confirm that this was most definitely the case, recognising that joint working would be a key factor in our improvement journey. She added that staff side/unions are also happy to work alongside each other. The Board of Directors accepted and **took assurance** from the report.	
052/26	**HTP Assurance Committee (HPAC) Chair's Report** The Board of Directors received the report from the Committee Chair, Prof Purt. Taking the report as read, colleagues' attention was drawn to the following points: • Service provision settings: The Committee wished to escalate to the Board the need to be very clear, as part of the HTP, which services should be provided within an acute and community setting. The Committee also sought further assurance around the clinical pathway work and how the community health (neighbourhoods) work aligns with HTP. Dr Jones supported the view that there is a role for medical expertise in the community, and Mr Lee assured the Board that work across the system is something we want to build upon, adding that work on	

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	population health management will allow us to focus on better care in the community. • Clinical and Operational delivery: The Committee expressed some concern that, whilst they had received elements of assurance around clinical and operational delivery, there are some areas that remain off track. Further assurance has been requested on these for the next Committee meeting. The Committee had also noted that, whilst construction is progressing well, the more challenging phase will involve integrating new and existing systems, operationalising the new building, and ensuring workforce readiness. The Committee would continue to regularly monitor the opening date and ensure alignment with operational and financial plans. Ms Williams clarified that a key focus for the Executive Team as we move into 2026/27 will be HTP, the Local Care Programme and setting out where our priorities are. Referring also to the System Transformation Group which would be meeting soon, she and the Group Chair will reflect on how information from this comes through the Board. The Board of Directors accepted and **took assurance** from the report.	
STRATEGIC, QUALITY AND PERFORMANCE MATTERS		
053/26	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Group Chief Executive, providing an update on progress against the Trust's Operating Plan and associated objectives and enablers to the end of December 2025/January 2026. Taking the report as read, Ms Williams invited executive colleagues to provide the headlines from their sections. **Operational Summary** Before drawing the Board's attention to the following points, the Chief Operating Officer wished to alert colleagues, with apologies, to an error on page 110 of the Board Pack. The second line of text refers to the number of patients who spent more than 12 hours in ED in January 2026 as 75.3% whereas this figure should read **24.7%**. • Urgent and Emergency Care: Mr Hobbs echoed comments from the Committee reports earlier in the meeting, and stated that SaTH's UEC performance is frankly not good enough, with 4-hour, 12-hour and ambulance handover standards all continuing to show common cause natural variation in January. • Patient flow: Whilst there have been some early signs of pathway improvement (including special-cause improvements in time to initial assessment, simple length of stay, SDEC	

utilisation, and early Discharge Lounge transfers), winter pressures and surges in long length of stay/NCTR have significantly reduced the immediate impact of our additional bed and assessment capacity. For context, the NCTR position was challenging in December 2025, rose to 192 in early January 2026 and stands at today's date at 150 (in comparison with our previous typical daily NCTR position of 100-110). The recent stabilisation and reduction in numbers has been due to a collective system effort, and Mr Hobbs wished to put on public record his thanks to our colleague partners who have demonstrated their proactivity.

- Mr Morgan asked if Mr Hobbs could manage the Board's expectations on a timeline for UEC performance improvement. Whilst NHSE, both nationally and regionally, have commended our operational improvement actions, there is increasing concern and regulatory challenge that the investment in UEC is not resulting in the expected improvement in performance metrics, which are currently not acceptable.

  Mr Hobbs, sharing colleagues' impatience, confirmed that February had seen an improvement in ambulance handover times, and he was confident, through the use of external delivery partners, of the opportunity to improve 4-hour performance in the next few months, although 12-hour performance was likely to take a little longer.

  Mr Miner, noting that the number of 12-hour trolley breaches had spiked again in January, queried what drives that particular number. Mr Hobbs clarified that in general terms most are waiting for an inpatient bed, which links back to previous discussion on long length of stay and NCTR. He confirmed that as the Trust runs with such high bed occupancy normally, it leaves us with limited available inpatient space.

- Elective activity: The total waiting list size remains above plan. Training continues with all teams to ensure that Referral to Treatment (RTT) clocks are not re-activated inappropriately on Careflow. Daily meetings are in place with all clinical centres to monitor and manage the risk of breaches and support additional mitigations.

- Diagnostic waiting times: The submitted DM01 position for January 2026 was 80.5%, representing a declined performance, and driven by a drop in Non-Obstetric Ultrasound Service (NOUS) and Audiology. The diagnostic improvement programme is now focused on NOUS and Urodynamics. Radiology reporting turnaround times are being maintained.

- Cancer performance: Ms Williams wished to put on record that multiple divisions are contributing to the Trust's ongoing cancer pathway improvements. Cancer Improvement Plan Phase 2 is

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being developed, with a focus on the treatment end of the pathway.

Patient Safety, Clinical Effectiveness & Patient Experience Summary

The Executive Medical Director and Interim Chief Nursing Officer drew the Board's attention to the following points:

- Infection Prevention and Control (IPC): The Trust has breached its C.Difficile target, and the C.Diff action plan is ongoing. A deep clean plan for both RSH and PRH is in development, ready for implementation in the new financial year. A business case to move forward with Fidaxomicin as first line treatment of C.Diff is progressing. This reduces the rate of recurrent C.Diff infections and is associated with reduced environmental contamination which would reduce the risk of onward transmission to others.

- Deteriorating patients: Whilst there is high escalation compliance, there is low timeliness of observatIons, particularly in ED. Issues are linked to digital capture, continuous monitoring, and lack of de-escalation. Actions are underway to improve accuracy and relevance.

- Restrictive interventions: Training updates remain a high corporate risk due to Mental Capacity Act compliance and documentation gaps. Weekly Trust-wide review meetings have been reinstated as a control, with confidence that this will restore compliance.

- Pressure ulcers: Although the number of category 2 pressure ulcers has decreased, a spike is starting to be seen in category 3 injuries. Going forward, ward managers will be referred to Ms Gardner in person if their wards have any new category 3 cases. A tender process is underway for 40 additional hybrid pressure relieving mattresses to meet the shortfall due to increasing requests.

- Complaints: Responding to Mr Crowther, who wished to understand the reasons behind the upward trend in complaints relating to staff Values & Behaviours, Ms Gardner expressed a view that the increased instances of unacceptable behaviour are a reflection of how tired our staff are. Appreciating that this is no excuse, she provided assurance that such instances are addressed at source and the staff member is always expected to apologise to the patient (noting there is a different process for repeat 'offenders').

Workforce Summary

The Chief People Officer advised that she had nothing additional to report .

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	Finance Summary The Acting Director of Finance drew the Board's attention to the following points: • At the end of January (month 10), the Trust has delivered a year to date deficit position of £5.6m against the breakeven plan. As covered in the earlier FAC report, whilst there is currently £2m of unmitigated risk to the year-end beakeven plan, there is cautious optimism that with the various ongoing negotiations and continuing governance controls, this can be mitigated. • At the end of January, £32.70m of the £41.40m efficiency target for 2025/26 has been delivered, which is £0.20m more than plan, and the Trust is on track to achieve our biggest ever cost efficiency programme. The Board of Directors accepted and **noted** the Integrated Performance Report.	
ASSURANCE FRAMEWORK		
054/26	**SaTH Integrated Improvement Plan (SIIP) Report** The Board of Directors received the report from the Group Chief Executive. Taking the report as read, colleagues' attention was drawn to Section 2 which detailed the key highlights. The Board **took assurance** from the information provided, and • **noted** that the Trust remains on track to deliver the majority of 2025/26 IIP actions (appendices 1-4 in the Supplementary Information Pack), providing assurance to NHSE as part of the Trust's RSP exit process in Quarter 4, • **noted** that any 2025/26 actions at risk have been transferred into the 2026/27 plan, and • **reviewed and formally approved** the 2026/27 SaTH Integrated Improvement Plans for Governance, Workforce, Leadership, Finance, and UEC (appendices 5-8 in the Supplementary Information Pack), which have been developed to provide assurance to NHSE as part of the Trust's RSP exit process.	
055/26	**Integrated Maternity & Neonatal Report** Ms Gardner welcomed Ms Jacqui Bolton, Acting Head of Midwifery, to present the report, which detailed the latest position in relation to the delivery of actions from the Independent Maternity Review, the Maternity Transformation Programme, NHS Resolution's CNST Maternity Incentive Scheme, and the invited Neonatal Mortality Review action plan. The Board was referred to the detail contained within the main report, together with the accompanying appendices in the supplementary information pack which provided further	

comprehensive information. Highlights from the report included the following:

The Ockenden Report (Independent Maternity Review) Progress Report:

196 out of the total of 210 actions have now been fully completed (evidenced and assured), with six of the remaining seven currently on track for their expected delivery dates pending evidence that they have been appropriately embedded. One action has been flagged as off track, relating to the requirement for Labour Ward Coordinators to attend a nationally accredited programme. We have asked for clarification from the regional team if their recently issued Labour Ward Co-ordinator Training Directory is a suggestion of courses for each organisation to then agree a specific training package, so that accurate costings can be reviewed.

Seven actions continue to remain 'de-scoped', relating to nationally-led external actions (led by NHSE and the CQC), which are not within the direct control of the Trust to deliver. As advised in previous reports, the Local Maternity and Neonatal System (LMNS) continues to oversee these actions, which remain under quarterly review by the Trust.

The summary action plan, as at 10 February 2026, is included as **Appendix 1** in the Board Supplementary Information Pack.

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.

All actions, with the exception of two, remain on track for their expected delivery dates. As reported previously, one of the off track actions relates to the service's 'golden hour' provision, while the service seeks feedback from network partners. A second action was reported as off track in January 2026, as absence within the clinical leadership team has delayed review work, to provide an opportunity to consider learning for the whole Multidisciplinary Team (MDT). The review is now underway and progress is expected to be presented to MNTAC imminently.

The summary action plan, as at 10 February 2026, is included as **Appendix 2** in the Board Supplementary Information Pack.

Maternity and Neonatal Transformation Plan (MNTP) Phase 2 – high level progress report:

Colleagues were reminded that it was a requirement of the Independent Maternity Review for the Board of Directors to receive an update on the MNTP at each of its meetings in public session. The summary MNTP, which is now in its second phase, is included as **Appendix 3** in the Board Supplementary Information Pack. All actions are progressing well, and progress continues to be made with the cultural improvement review.

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	NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts – CNST): The Trust has now signed off on the delivery of all 10 Safety Actions forming Year 7 of the scheme. The CNST Year 7 completion report is included as **Appendix 4** in the Board Supplementary Information Pack, and official validation is expected before the launch of the Year 8 scheme in April 2026. The Board of Directors, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated appendices within the accompanying Board Supplementary Information Pack (Appendices 1-4), accepted and **took assurance** from the report.	
056/26	**Board Maternity & Neonatal Safety Champions Report** The Board of Directors received the report from the Executive Medical Director, providing assurance on the effectiveness of the Safety Champion roles. Taking the report as read, Dr Jones was pleased to confirm, following on from his last report, that formalised arrangements with University Hospitals of North Midlands NHS Trust (UHNM) to provide support on foetal medicine are working very effectively and have made a significant difference to the service. The Board of Directors **noted** and **took assurance** from the report.	
057/26	**Draft Board Assurance Framework (BAF) Q3 2025/26** The Board of Directors received the report from the Director of Governance. Taking the report as read, Ms Milanec confirmed that there are no proposed changes to the BAF current total risk scores this quarter. Colleagues were advised of work underway to deep cleanse all BAF risks as we move into the Group model, and to consider whether we should move to a joint BAF. The Board of Directors: • considered that the BAF content reflects the strategic risks within the organisation and that the risk scores are appropriate, • considered that there is evidence of successful management of the risks; that actions are being progressed in a timely manner, and that no further actions/mitigations are requred, and • **approved** the Quarter 3 BAF.	
058/26	**Risk Management Report Q3 2025/26** The Board of Directors received the report from the Director of Governance, highlighting progress in managing risks and enhancing the risk culture at SaTH.	

<table>
<tr><td></td><td>Taking the report as read, Ms Milanec drew the Board's attention to key highlights from the sections covering the effectiveness of risk mitigation, risk management progress, and training and culture improvement.

The Board of Directors accepted the report, noted the current risk position, and took assurance from the mitigation in place to ensure that risk management is practiced consistently across the Trust.</td><td></td></tr>
<tr><td colspan="3">REGULATORY AND STATUTORY REPORTING</td></tr>
<tr><td>059/26</td><td>Bi-annual Nurse Staffing Review

The Board of Directors received the report from Ms Gardner, providing a summary of the results and outcomes for nursing across the inpatient and emergency departments for the June-July 2025 establishment review.

Taking the report as read, colleagues' attention was drawn to the following key points:
All areas have planned and actual daytime ratio which are better than the minimum recommended ratio of 1:8 Nurse/Patient.
Care Hours Per Patient Day (CHPPD) are in line with peer median and provider median.
The recommendations in relation to progressing the review of the renal templates and development of the business case based on the outcome of this review.
The review recommendations for SAU and Ward 14.
The Board of Directors accepted and noted the report, endorsing the recommendations from the establishment review and the actions taken at individual ward and service level.</td><td></td></tr>
<tr><td>060/26</td><td>Patient Safety Committee Report Q3 2025/26

The Board of Directors received the report from the Executive Medical Director. Taking the report as read, Dr Jones drew colleagues' particular attention to the sections covering compliance with death certification (2.4), service user feedback (2.5) and patient safety investigations (3.1).

Responding to a query from Mr Miner on why 24 of the 54 deaths which were referred to the coroner during Q3 were not accepted, Dr Jones confirmed that, whilst we are duty bound to take deaths to the coroner even when not a suspicious death, following coroner review those deaths did not meet their 'duty to engage', and they consequently issued a 'CN1A' form to enable the Medical Examiner to authorise those 24 deaths.

The Board of Directors accepted and noted the report.</td><td></td></tr>
<tr><td>061/26</td><td>Infection Prevention & Control Report Q3 2025/26</td><td></td></tr>
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	The Board of Directors received the report from the Interim Chief Nursing Officer. Taking the report as read, Ms Gardner advised that she had nothing further to add to the key points which had already been covered in the IPR earlier in the meeting. The Board accepted and **noted** the report.	
062/26	**Antimicrobial Resistance (AMR) – national call to action** Ms Gardner welcomed Dr Stephen Jones and Mr Imran Hanif to the meeting to present to the Board following receipt of a 'national call to action' letter from NHSE (included at appendix 1). The letter advises that The World Health Organisation has declared antimicrobial resistance (AMR) as a top global health and development threat, and that AMR has been listed on the UK Government's Risk Register. Colleagues were advised that by April 2026, the organisation needs to agree and publish three priority areas for AMR improvement, and for each priority: o Define specific, measurable objectives o Assign executive-level accountability o Establish timelines and reporting mechanisms. The Board of Directors **noted** the presentation content, including**:** • the executive-level accountability of the Chief Nursing Officer / Executive Medical Director, • the actions taken to identify gaps, update risk registers, and undertake strategic planning, • that monitoring would be through quarterly reporting to QSAC, and • **supported** the Trust's following three proposed priority areas for AMR improvement for publication: o 48-72 hour review of antimicrobial prescriptions o Intravenous to oral switch o Reduction in delayed identification of Health Care Acquired Infections (HCAIs). The Group Chair thanked Dr Jones and Mr Hanif for their important and informative presentation.	
063/26	**Gender Pay Gap Report 2025** The Board of Directors received the report from the Chief People Officer for final approval, following discussion and endorsement at the Group People Committee on 26 January 2026. Colleagues noted the requirement for the approved data to be publicised on the SaTH website by 30 March 2026, and on online Government Services, to ensure that the Trust is compliant with its statutory obligations.	

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	The Board of Directors **approved** the Gender Pay Gap Report 2025, and the Group Chair proposed a future Board Seminar session to discuss the areas of pay inequality identified within the report.	
ITEMS FOR CONSENT – approval recommended from Board Committees		
064/26	**Business Continuity Management Policy** The Chief Operating Officer advised that the Trust's Business Continuity Management Policy had been updated, primarily to reflect updated NHSE guidance. The policy had been reviewed by ARAC who were recommending approval to the Board. The Board of Directors **approved** the updated Business Continuity Management Policy.	
PROCEDURAL ITEMS		
065/26	**Any Other Business** There were no further items of business, and the meeting was declared closed.	
066/26	**Date and Time of Next Meeting** The next meeting of the Board of Directors in public was scheduled for Thursday 14 May 2026 from 0930hrs–1230hrs. This would be the first Public Board Meeting in Common of SaTH and SCHT.	

Please see next page for Public Questions.

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Public Questions Received - 12 March 2026 Board meeting

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

Q HSJ recently reported that SaTH had received a payment of £462,000 through the 'validation sprint' exercise that began in April 2025, the second highest such payment in the country. This national exercise made provision for a payment of £33 for each patient removed from elective waiting lists, implying the removal of 14,000 cases from SaTH's elective list through validation. It's a surprisingly large number for a relatively small trust.

Is this figure correct? What proportion of the pre-validation elective list was this? Over the same period, how many cases were removed from the list through treatment? Can you please give some background information about the validation exercise? For example, what were the categories/reasons for removal from the elective list and how many cases were recorded in each category; what support was provided to patients to challenge or correct a wrong removal from the list; and how many cases removed through validation have resulted in a re-referral).

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

Context

- At the start of April 2025, NHS England gave NHS Trusts the opportunity to review and cleanse their English-only waiting lists by identifying patients who no longer required care or removing duplicate entries. The aim was to improve data accuracy and operational efficiency. This was a time-limited exercise, with trusts incentivised through a payment of £33 per validated "clock stop" (removal), helping to reduce backlogs while ensuring waiting lists more accurately reflected true demand.
- As SaTH had recently transitioned our EPR system from Semma to Careflow, we were aware of some legacy data issues that had artificially inflated our waiting list. Given the available incentive, we considered it prudent to engage an external company to support the validation sprint and use this as an opportunity to thoroughly cleanse the waiting list.
- Multiple validation sprints have taken place with the first one in April 2025, a second national sprint from July to September 2025, and most recently from January to March 2026.

Impact

- Our English-only waiting list has reduced from 41,669 in March 2025 to 33,637 as of January 2026, a 19% decrease. The Welsh-only waiting list declined from 5,138 to 4,272 during the same period.
- Since April 2025 to January 2026, we have closed 108,362 'clocks'.
- **Validation delivered by MBI**
    - 14,148 removals from 62,475 pathways validated: **22.7% removal rate**
- What support was provided to patients to challenge or correct a wrong removal from the list?
    - The patient is able to discuss any discharge from a waiting list with their GP, and we would engage with the GP if there was a concern with the treatment decision.
- How many cases removed through validation have resulted in a re-referral?
    - This is a difficult question to answer as often referrals occur with differences in initial symptoms and therefore don't directly match why they were discharged.

Q2 ***Submitted by Diane Peacock***

Q SaTH is the main provider of acute secondary care for around half a million people in Shropshire, Telford & Wrekin and North Powys. Longitudinal analysis of the flow of patient

populations into the current configuration of SaTH's two acute hospitals is a vital element when modelling future demand as the Hospital Transformation Plan progresses. Can the Board please explain why public access to basic information on population service demand relating to 1) Royal Shrewsbury Hospital's emergency department and urgent treatment centre and 2) Princess Royal Hospital Telford's emergency department and urgent treatment centre is not currently available and requires a Freedom of Information request?

A ***Provided by Anna Milanec, Director of Governance***

In 2025, the Trust had over 158,000 attendances across our two A&E's. The Trust submitted the data relating to all these attendances, and additional quantities of data (performance data and otherwise) to NHS England. However, whilst the Trust publishes some basic performance data, it does not publish all combinations of data, including those which are available at source; the information is published on the NHSE website.

I have included below a link to the NHSE statistics calendar which may be useful for you, with the data being published on the dates shown on the calendar.
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2026/03/Proposed-12-month-plan-for-2026-27-for-publication.pdf

More often than not, Freedom of Information requests seek particular / specific combinations of data, which the FOI Officer collates and combines as requested, as it is not available as 'standalone' data.

Q3 ***Also submitted by Diane Peacock***

Q What is the justification for the monthly publication of SaTH's Freedom of Information (FOI) disclosure log since January 2022 remaining empty of links to responses? https://www.sath.nhs.uk/freedom-of-information-disclosure-log/ [accessed 9.3.26 at 9.55] The SaTH FOI 'Responses' link https://www.sath.nhs.uk/about-us/freedom-of-information/responses/ displays very few responses, the latest is dated 2021.

A ***Provided by Anna Milanec, Director of Governance***

There is no real justification for the empty links on the website to FOI responses, save for availability of resources, and a substantial increase in the number of FOI's received during 2020 – 2021 (COVID) and then maternity matters and the Independent Maternity Review by Donna Ockenden in 2022. The number of FOIs received almost doubled (to circa 700) over that time **and has not decreased.** Since Covid, we also receive more requests from journalists, compared with pre-Covid.

FOIs have also become more complex, with more requests per FOI, and for specific data which must be combined before it is sent. Sometimes, the same data, although updated, is also requested by the same individual, after only a few months.

Currently, we have one substantive colleague dealing with all FOI requests, with complex responses being overseen by the Senior Information Risk Owner before they are sent out.

The Trust has also been undergoing a large project for some time to update its website and intranet, the work for which we hope to be completed during the 2026/27 financial year, at which time the FOI data will be more visible and updated through a revised Publication Scheme.

Q4 ***Received from David Tooley (Local Democracy Reporter)***

Q There has been a decision by the Honours Committee *(an independent body within the UK Cabinet Office)* to remove an honour from a previous Trust employee, after whom a Trust building is named. Is SaTH planning to rename the building?

A ***Provided by Jo Williams, Group Chief Executive***

We are proposing to review **all** our buildings that are named after individuals, with the intention of renaming them.

Q5 ***Received from David Sandbach***

Q During discussion at a recent Health & Social Care Committee meeting, there was a lot of concern expressed regarding palliative care *(as highlighted in a 2023 report by the Health Services Safety Investigations Body, HSSIB)*. How many patients are cared for in corridors at both sites, and how many patients are cared for in other temporary environments?

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

The Trust is absolutely committed to getting patients in the right place to meet their needs. In the last few years, we have closed PRH corridor and RSH AMU as temporary care locations. We still have five temporary care spaces in the ED corridor at PRH, and two designated spaces in the Ambulance Receiving Area at RSH, in addition to temporary care locations under our Hospital Full Policy. The number of SaTH patients receiving care in temporary locations at any point in time is typically in the region of 20-25 across both sites. Whilst the figure has reduced, we recognise that we have more work to do to achieve a reduction in temporary care environments.

Board of Directors' Meeting in Common – 14 May 2026

<table>
<tr><td>Agenda item</td><td colspan="3">010/26</td></tr>
<tr><td>Report Title</td><td colspan="3">Group Chief Executive's Report</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Joanne Williams, Group Chief Executive</td></tr>
<tr><td>Report Author</td><td colspan="3">As above</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to BAF risks (strategic)</td></tr>
<tr><td rowspan="5">None</td><td>Safe</td><td>√</td><td rowspan="2">All SCHT BAF Risks
All SATH BAF Risks</td></tr>
<tr><td>Effective</td><td>√</td></tr>
<tr><td>Caring</td><td>√</td><td>Risk Register id(s):</td></tr>
<tr><td>Responsive</td><td>√</td><td rowspan="2">-</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">There have been some changes since the last of our Board meetings held in public, including exiting the former NHS financial year, into 2026/2027 (more about this in this report and throughout the meeting).

Locally, this marks the beginning of our transition year to put in place the required structures, governance and collective ambitions and priorities of our group model arrangement between Shropshire Community Health NHS Trust (SCHT) and Shrewsbury and Telford Hospital NHS Trust (SaTH), known as Shropshire, Telford and Wrekin Community and Hospitals NHS Group. Our Boards believe that this will support improved, more timely care for our communities, and reflects the requirements of national ambitions.

Our two organisations remain as individual statutory organisations, and to accommodate this, our decision-making meetings, including the Boards and Board Committees, will still take place as required, but will now come together, with these May Board meetings being the first.</td></tr>
<tr><td>Recommendations for the Boards</td><td colspan="3">The Boards are asked to consider and note the contents of this report.</td></tr>
<tr><td>Appendices:</td><td colspan="3">None</td></tr>
</table>

1.0 Introduction/General updates

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last public Board on 12 March 2026 from the Chief Executive's position.

1.2 This is the first time reporting from the perspective of two Boards (Shropshire Community Health NHS Trust (SCHT), and Shrewsbury and Telford Hospital NHS Trust (SaTH) meeting in Common.

1.3 I wish to formally recognise inclusion in the *HSJ Top 50 NHS Chief Executives* list (number 10), which reflects the growing national profile of our Group and its reputation for quality, improvement, and innovation.

Whilst this recognition came as a shock, and I am not naturally comfortable with personal acknowledgement; I recognise the importance of accepting it on behalf of colleagues across the Group. I am proud of the work our colleagues do every day for our patients, and of the compassion, professionalism, and dedication they consistently demonstrate in delivering and improving care. I also recognise that I often ask others to work outside of their comfort zones, and I try to hold myself to the same expectation in accepting this recognition.

Sincere thanks are extended to all colleagues across the Group for their continued commitment, professionalism, and contribution to delivering high-quality care and driving sustained improvement. This recognition is a direct reflection of the collective effort and dedication of staff across all services.

1.4 On 1 May 2026, the national threat level was raised from Substantial to Severe, meaning that an attack is assessed as highly likely. While there is no specific threat to our organisation or local area, this change serves as a reminder for all colleagues to remain alert and vigilant in both their professional and personal lives.

At work, staff should continue to follow established safety and security procedures, report any concerns promptly, and remain aware of their surroundings. We also encourage colleagues to take reasonable personal precautions outside of work and to stay informed through official government channels.

The safety and wellbeing of our staff and patients remains our priority, and we will continue to monitor the situation closely and provide updates as required

1.5 Congratulations to Tanya Miles on her appointment as the new Chief Executive of Shropshire Council. Tanya has served as the Council's Interim Chief Executive since September 2025. Prior to this, she held the statutory roles of Director of Adult Social Services and Director of Children's Services and has undertaken a range of senior leadership roles in both adult and children's services since joining the Council in 1999 as a social worker.

Tanya has worked closely with partners to maintain momentum on key priorities and continue improvements in services for residents, communities, and businesses, while supporting the Council's journey towards financial stability. We look forward to working with Tanya and the wider team to continue to improve services for our citizens through strong partnership working

2.0 Group Update

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

2.2 Performance continues to improve across a range of Urgent and Emergency Care (UEC) metrics. Currently, 81% of patients spend less than 12 hours in Emergency Departments (ED), representing the best performance since June 2023. Average ambulance handover time was 45 minutes in March 2026, the strongest performance since July 2025.

Across SCHT, urgent community response within two hours has improved, virtual ward occupancy has increased, and 60% of integrated front door cases are now diverted away from ED, demonstrating the growing impact of system-wide collaboration.

While we remain not complacent and recognise that further improvement is required in four-hour performance, the collective work across the Group is clearly contributing to improved patient flow, reduced pressure on urgent care services, and better outcomes for patients.

2.3 On Tuesday 12 May, International Nurses Day will be celebrated, followed by ODP Day on Thursday 14 May. These occasions provide an opportunity to recognise and celebrate the vital contribution of nurses and operating department practitioners across the Group, and their essential role in delivering safe, high-quality patient care.

As Chief Executive, I would like to extend my sincere thanks to all nurses and ODPs for their professionalism, compassion, and unwavering commitment to our patients and services. Their work makes a profound difference every day across the Group

2.4 Congratulations to all colleagues across SCHT for their contribution to this achievement; reaching Segment 1 in the National Oversight Framework, alongside exceeding the financial plan and delivering efficiencies above target for 2025/2026. This reflects the strong collective commitment, professionalism, and effective financial stewardship demonstrated across the organisation.

2.5 For the first time in 10 years, SaTH has delivered its financial plan. This represents a significant achievement and a clear reflection of the hard work, discipline, and determination of colleagues across the organisation.

As a result, and due to the submission of a credible plan for 2026/27, the Trust also received a £4.9m bonus incentive from national deficit funding at the end of the financial year. This strengthened the cash position and enabled the organisation to conclude the year in surplus.

The organisation delivered £41.5m in Cost Improvement Programme (CIP) efficiencies against a plan of £41.4m, the highest level to date and more than double that achieved in 2023/24.

This is a significant milestone for the organisation, demonstrating both delivery against plan and a clear commitment to financial discipline. It reflects a collective commitment to delivering what was promised, with plans translated into delivery in practice

Both SCHT and SaTH have submitted compliant finance plans to NHSE for 2026/2027.

2.6 SaTH and SCHT currently have zero English patients waiting over 52 weeks, placing the Group amongst the top performers nationally for Referral to Treatment (RTT) waiting times. This represents a major milestone in improving timely access to care and demonstrates sustained system-wide improvement in flow, productivity, and patient experience.

SaTH is currently ahead of both national and local RTT performance targets, with SCHT delivering significant reductions in waiting times for community children's services and non-RTT pathways. This improvement is contributing to better access for patients, reduced harm

from long waits, and increased confidence in the Group's ability to deliver against operational standards.

2.7 On 30 April 2026, the Care Quality Commission (CQC) commenced inspections at RSH, PRH, and Hollinswood House to review Diagnostic Services. The inspection process is ongoing and has included data requests and staff interviews. Initial feedback has been positive, with a full report to follow in due course.

Thanks are extended to all colleagues across these areas who welcomed the inspection team with professionalism, warmth, and compassion, and who spoke with pride about the services they deliver and the improvements being made.

2.8 On Thursday, 7 May 2026, attendance at the Galvanise closing celebration took place alongside colleagues from SaTH, SCHT, and The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH).

Galvanise, established in 2023 by Dr Victoria Walton, a former junior doctor at SaTH, is an ethnic minority leadership programme aimed at supporting career progression, promoting cultural understanding, and providing a structured and supportive environment for colleagues to share challenges and opportunities.

The event provided an opportunity to engage with members of Cohort 4, as well as their mentors and buddies, and to reflect on their experiences and achievements. It also highlighted the importance of ensuring that ethnic minority voices are heard, their contributions are recognised, and their value is fully realised across our organisations.

Several colleagues who had previously attended Board meetings reflected on their experiences, emphasising the importance of a clear line of sight between Board-level decision-making and its impact at ward level. They highlighted the value of feeling connected to this process and understanding how decisions translate into practice across the organisation.

As senior leaders, we remain committed to ensuring our organisation is inclusive for all, and that people feel safe, valued, and respected both as staff and as patients.

2.9 Thank you to colleagues at Keele University, School of Medicine, who conducted a Quality Management visit to SaTH on 19 March 2026. The formal report will be shared over the coming weeks, but the initial feedback complemented *"senior leadership, educators, clinical teams, students and support staff for their time, openness and engagement during our visit. The discussions reflected a strong organisational commitment to education and a genuine desire to improve the learning environment for all medical students. The visiting team was unanimous in its impression that SaTH is a welcoming and learner-centred organisation, committed to supporting students as valued members of the healthcare team".*

2.10 The NIHR Research Delivery Network has provided positive feedback on the delivery of the *PANDA Prevention Trial (CPMS 58186)*, a phase III, multi-centre, randomised placebo-controlled study investigating oral iron supplementation for the prevention of maternal anaemia.

The Chief Investigator has highlighted that the study has now recruited over 3,000 participants overall, including 92 participants at The Princess Royal Hospital, Telford. This represents a strong local contribution and reflects effective study set-up, coordination, and delivery by the clinical research team.

The trial is of significant national and international importance, with the potential to inform future practice in relation to maternal and neonatal outcomes, including preterm birth, fetal growth restriction, and stillbirth. The study has also attracted international collaboration, with additional sites joining, including in Canada. Congratulations to all the team involved and thank you for your commitment in supporting research at SaTH.

2.11 Congratulations are extended to Terry and Babs Seston, who have been invited to attend a Garden Party at Buckingham Palace in recognition of their 15 years of volunteering. Terry, who recently celebrated his 91st birthday, continues to volunteer on the Welcome Desk at SaTH (RSH), providing a valued and much-appreciated service to patients, visitors, and staff. This invitation is a fitting recognition of their long-standing commitment and contribution. Their family has arranged a chauffeur-driven limousine to ensure they are able to enjoy the occasion in style.

2.12 A donation of over £80,000 from the League of Friends of The Shrewsbury and Telford Hospital has been used to purchase specialist urology theatre equipment to support prostate surgery at the Royal Shrewsbury Hospital.

The investment will enable the introduction of holmium laser enucleation of the prostate (HoLEP), a procedure used to treat benign prostatic hyperplasia (enlarged prostate), particularly in more complex cases. This development will allow patients to receive treatment locally, reducing the need for out-of-county referrals and associated delays.

The new service is expected to improve patient experience by enabling care closer to home, with similar recovery times to existing procedures, and most patients discharged within 24 hours. We are incredibly grateful to The Friends for their very generous donation which has enabled us to enhance the treatment we can offer our patients and provide care closer to home.

2.13 Week commencing 11 May 2026, the Group is holding an improvement week. A week dedicated to sharing ideas, learning what works and celebrating continuous improvement in everyday practice. The programme includes Dragons' Den drop-in sessions where staff can pitch and explore improvement ideas, tea trolley visits to wards to spark conversations on the ground, and hands-on training sessions to build practical improvement skills. The week also features our Group Sharing Showcase on Thursday 14 May, bringing teams together to see, hear and learn from improvement work happening across SaTH and SCHT.

2.14 There has been further expansion in the use of robotic assisted surgery (RAS), following the introduction of a new robotic system at the Elective Surgery Hub at PRH. This represents an important milestone in the continued development of surgical services at the site. Surgeons began using the system earlier this month, following increased investment approved by the Board.

SaTH first introduced robotic assisted surgery in 2023 at the Royal Shrewsbury Hospital (RSH). Since then, the programme has continued to expand, with almost 1,000 patients treated using this technology to date. Robotic assisted surgery is a form of minimally invasive (keyhole) surgery that enables greater precision and control compared with conventional techniques, reducing the overall impact of surgery on patients and supporting improved clinical outcomes. The benefits for patients are well established and include quicker recovery times, fewer complications, and reduced length of stay, with some patients able to return home on the same day following major procedures. For many, this results in a significantly improved recovery experience and reduced disruption to daily life.

The new robotic system at PRH is designed to support a high volume of routine, low-complexity procedures, improving efficiency and capacity within the Elective Surgery Hub. It

also supports more complex surgical cases, where reduced tissue trauma associated with robotic techniques can enable patients to return to normal activities more quickly.

This development represents a further strengthening of services at PRH and a clear commitment to the site, supporting the ambition to deliver modern, high-quality surgical care closer to home. The system primarily supports women's health procedures and routine abdominal surgery, including hernia and gallbladder operations, and complements existing surgical services across the Group.

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

3.1 This marked the second meeting of the combined ICS as they transition toward becoming a formal cluster, held on 30 April. The session began with Leanne Walker sharing her patient story, highlighting the value of lived experience. She spoke with remarkable courage and passion, offering a powerful reminder that individuals are at the heart of every decision, policy, and action we undertake.

The next Board meeting is 25 June 2026, 1.30pm, Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, Telford, TF1 1LX

3.2 On Friday, 1 May, all STW CEOs participated in the quarterly meeting with STW MPs, providing an effective forum to share updates and address any concerns.

4.0 NHSE

4.1 On 21 April 2026, the Chair and I attended a Midlands NHS England Leadership Meeting in Birmingham, bringing together all Regional ICB and Provider Chief Executives and Chairs. The session was also attended by Sir Jim Mackey, NHS England Chief Executive, and National Directors.

The meeting provided an important opportunity to reflect on progress over the past year, while discussing the clear ambition set for the next 12 months. I was delighted to be asked to present to colleagues on the progress made at SaTH, as well as the opportunities for the Group following the establishment of the new Group model on 1 April 2026 as part of the *Case for Change – Better Together*.

4.2 On Thursday 28 April 2026, all Chief Executives attended the National NHS England Leadership Meeting in London, alongside National Directors and the Executive Team. As part of the session, six exemplar sites were invited to showcase their improvement over the past 12 months, and we were asked to represent the Midlands region.

4.3 Finally, the NHSE CEO has asked every system to maximise the opportunities set out in the recent medium-term plans and to develop a strategic commissioning narrative. This narrative should describe how commissioners and providers will work together to achieve this, with particular emphasis on the four key areas outlined in Appendix 1 of the letter dated 1 April 2026.

Each ICB is required to submit a single document summarising this narrative by Friday 15 May. Provider CEO's have been asked to support the submission with the expectation that all local partners will collaborate closely to ensure strong alignment, clearly identify gaps and barriers, and set out how these will be addressed collectively.

Critical to the implementation will be the voice of patients, carers, communities and frontline staff and we will work to ensure that lived experience informs service design and delivery.

5.0 Recommendations

5.1 The Boards are asked to consider and note the contents of this report.

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

Agenda Item 011/26b

Chair's Assurance Report

Quality and Safety Committee Wednesday 22nd April 2026

0. Reference Information

Author:	Jessica Donegan, Executive Assistant	**Paper date:**	7th May 2026
Executive Sponsor:	Jill Barker, Non-Executive Director	**Paper written on:**	23rd April 2026
Paper Reviewed by:	Sara Ellis-Anderson, Interim Director of Nursing Community	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality & Safety Committee at Shropshire Community Trust meeting held on Wednesday 22nd April 2026 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- The Committee scrutinised quality and safety performance, noting areas of improvement alongside ongoing risks, and agreed that assurance should be strengthened through clearer narrative where targets remain zero-tolerance but trajectories reflect system complexity.
- The Committee received assurance on progress against the Prison Improvement Plan and Fire Safety actions, acknowledging positive external feedback while agreeing further review and follow-up actions to address residual risks and capacity pressures.
- Members reviewed the Board Assurance Framework and Corporate Risk Register, agreeing actions to clarify risk wording, strengthen learning from incidents, and provide balanced Board assurance on key risks, including the Virtual Ward and workforce-related issues.

2.3. Conclusion

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

Chair's Assurance Report

Quality and Safety Committee Wednesday 22nd April 2026

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Shropshire Community Trust Quality and Safety Committee which met on 22nd April 2026. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair) Tina Long, Non-Executive Director Cathy Purt, Non-Executive Director Sara Ellis-Anderson, Interim Director of Nursing Community Paula Gardener, Interim Group CNO Claire Horsfield, Director of Operations – Community & Group Chief AHP Dr Ganesh, Medical Director Community John Jones, Group Medical Director Shelley Ramtuhul, Director of Governance Anna Milanec, Group Chief Governance Officer Sharon Simkin, Quality Lead, ICB Alastair Campbell, Operational Lead Planned Care Jessica Donegan, Executive Assistant
Apologies:
Jo Williams, Group Chief Executive Ned Hobbs, Group Group Chief Operations Officer & Deputy CEO – SaTH Helen Cooper, Divisional Clinical Manager, CYP & Planned Care

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Chair's Assurance Report

Quality and Safety Committee Wednesday 22nd April 2026

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Integrated Quality & Safety Performance report		
The Committee was assured that key quality and safety risks were being actively managed through robust oversight, thematic reviews and learning. An increase in *Clostridioides difficile* cases was noted, with no evidence of linked transmission and clear actions in place in relation to infection control, prescribing practices and environmental standards. The rise in Category 4 pressure ulcers was discussed and linked to increased patient complexity and end-of-life care. Recent cases have highlighted delays in obtaining specialist equipment, so teams are collaborating with partners at Medequip to increase stock levels across the county. The Committee discussed the recent death in custody noting a full PSII had been commissioned as well as a thematic review. Updates were given about immediate actions taken and it was recognised this case would be subject to external PPO review and Coroner investigation. Improvement in falls performance was welcomed, supported by effective digital prevention measures.	Partial	The Committee agreed that assurance would be strengthened by clearer narrative within the report to explain how zero-tolerance targets should be interpreted where trajectories remain off target despite appropriate mitigating actions. Additional narrative to be added to the report to demonstrate the immediate actions taken.
Policy Tracker		
The tracker demonstrated sustained improvement, with a marked reduction in overdue policies and clear visibility of progress for the small number remaining, including status within the approval pathway and anticipated timescales. The forward look provided additional assurance that upcoming policy reviews were being proactively managed, supporting improved oversight, compliance, and forward planning.	Full	
QSC related BAF risks		
The Committee reviewed Quality and Safety related risks within the Board Assurance Framework and was assured that these risks continue to be actively monitored and managed, with clear actions addressing control and assurance gaps. The Committee endorsed a proposed reduction to the risk score relating to patient harm from waiting times, based on effective clinical prioritisation, improving performance	Full	The Board Assurance Framework was approved.

trajectories and mitigations now embedded. The Committee also noted progress in strengthening learning from patient safety incidents, with improved governance oversight, increased investigation capacity and clearer monitoring of actions, and confirmed that assurance is grounded in evidence of learning, action and impact rather than benchmarking alone.		
Corporate Risk Register		
The Committee received the Corporate Risk Register update and was assured that risks continue to be actively and effectively managed, with improved quality, clarity and overall reduction in risk volume demonstrating increasing organisational risk maturity. One workforce related high risk was noted as having reduced following a recent review, with no new risks added or closed during the period. The Committee discussed medical workforce risks relating to the Virtual Ward and agreed that, while the service is delivering safe, effective care with positive outcomes for patients, there are recognised gaps against the NHSE Virtual Ward core components, particularly regarding leadership and out-of-hours provision. The Committee understood these gaps were being mitigated but to support transparent Board assurance, a structured gap analysis and strengthened Board reporting were agreed to present both identified risks and mitigations alongside evidence of service quality and performance.	Partial	The Committee agreed that Board assurance would be strengthened through a clear gap analysis against the NHSE standards and presented alongside evidence of service quality and outcomes to support informed Board and Group level consideration of next steps.
Fire Safety Update		
The Committee received a fire safety update and was assured that the Trust is in a positive and improving position, supported by external feedback from the Fire Service following recent engagement and audit at Ludlow. All previously agreed actions have been completed and closed, with further audits planned. High-risk fire training compliance has improved to just below target with clear actions in place to reach target. Progress was noted in strengthening fire safety governance through the establishment of Buildings	Partial	The Committee also agreed further review of fire evacuation arrangements at Ludlow to explore safe mitigation options relating to safe bed numbers ahead of winter pressures.

Manager roles, with finalisation and targeted training imminent.		
To Note		
Prison Improvement Plan The Committee noted the Prison Improvement Plan and took assurance from significant progress delivered to date, with the majority of actions completed and the service now operating from a more stable footing. Remaining priorities include further integration of the mental health model and development of an in-house pharmacy service. The Committee also noted the recent joint HMIP/CQC/Ofsted inspection, which rated healthcare provision as "reasonably good", with most concerns relating to non-healthcare domains such as estates and education. The Trust is awaiting a copy of the final report relating to the inspection findings which is anticipated in June 2026.	Full	

4. Conclusion

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

Agenda Item 011/26c

Chair's Assurance Report

Resource and Performance Committee Part 1 – 29th April 2026

0. Reference Information

Author:	Stacey Worthington Executive Assistant	**Paper date:**	14 May 2026
Executive Sponsor:	Harmesh Darbhanga, RPC Chair	**Paper written on:**	29 April 2026
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 29 April 2026 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Month 12 Financial Performance
    - Integrated Performance Report

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Resource and Performance Committee which met on 29 April 2026. The meeting was quorate with a Non-Executive Director and four Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Harmesh Darbhanga	Non-Executive Director (RPC Chair)
Sarah Lloyd	Chief Finance Officer
Ned Hobbs	Group Chief Operating Officer
Claire Horsfield	Director of Operations for Community and Chief AHP
Jonathan Gould	Deputy Chief Finance Officer
Shelley Ramtuhul	Director of Governance
Steve Price	Head of Information & Performance Assurance
Richard Miner	Non-Executive Director, SaTH (Observing).

Chair's Assurance Report

Resource and Performance Committee Part 1 – 29th April 2026

Apologies:	
Tina Long	Non-Executive Director
Cathy Purt	Non-Executive Director
Jill Barker	Non-Executive Director
Sara Ellis-Anderson	Interim Director of Nursing (Community)
Gemma McIver	Deputy Director of Operations
Jon Davis	Associate Director of Digital Services and Performance

3.2 Actions from the Previous Meeting

The action log was reviewed, and all open actions were completed and closed.

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. Month 12 2025/26 Financial Performance		
The Committee received the Trust's end of year financial performance report for 2025/26. The Trust delivered a revenue surplus of £3.9m, subject to audit, which exceeded the planned target surplus of £2m; this was largely due to receipt of £1.6m additional national funding during March. The Annual Accounts were submitted ahead of the national deadline, and external auditors are now completing their review. Bank and agency usage exceed planned levels, however overall pay costs remained below planned levels and the Committee noted the opportunities offered by our Group model to support key areas of temporary staffing usage. The 2025/26 CIP target was exceeded both in-year and on a recurrent basis. In addition, plans are fully identified for 2026/27, all of which are assessed as deliverable, and focus is on reducing the delivery risk in relation to these schemes. The Trust's capital funding was fully utilised with £4,958k spent during the year. **The Committee agreed full assurance in relation to this update.**	Full	

Chair’s Assurance Report

Resource and Performance Committee Part 1 – 29th April 2026

8. Integrated Performance Report		
The Committee considered the latest performance information, which was presented in line with the Performance Framework. No KPIs within this Committee’s remit were reported as both an assurance concern and special cause variation concern for this month. It was noted that the KPI for ‘variance year to date in financial plan’ was no longer flagged as having a variation concern. The were zero 52 + week waits for RTT services, however, there had been a slight deterioration in local 52+ week waits across both children’s and adult services, with 7 waits exceeding 52 weeks recorded in March. The Committee discussed the refreshed implied productivity indicator which will be monitored going forward. It was noted that the Trust’s implied productivity stands at 5.4% per the Model Health data. **The Committee agreed full assurance was provided in relation this report.**	Full	
Meeting Evaluation		
The meeting was confirmed as efficient and effective, with good debate and good quality papers.		

3.4 Approvals

None.

3.5 Risks to be Escalated

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

4. Conclusion

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

Chair's Assurance Report

Audit Committee – 22nd April 2026

0. Reference Information

Author:	Poppy Owens	Paper date:	22nd April 2026
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	Paper written on:	28th April 2026
Paper Reviewed by:	N/A	Paper Category:	Governance
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit Committee meeting held on 22 April 2026 for assurance purposes. The Audit Committee is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Committee provides an overarching governance role with a specific focus on integrated governance, risk management and internal control. It also reviews the work of other governance committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. It also receives input from the Trust's internal and external auditors.

2.2 Summary

The Committee met on 22nd April 2026 and was quorate with 3 Non-Executive Directors and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen within the main report.

2.3. Conclusion

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

Chair's Assurance Report

Audit Committee – 22nd April 2026

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Audit Committee which met on 22 April 2026. The meeting was quorate with 3 non-Executive and 2 Executive/Director members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Harmesh Darbhanga	Chair – Non-Executive Director
Tina Long	Non-Executive Director
Cathy Purt	Non-Executive Director
Sarah Lloyd	Director of Finance
Shelley Ramtuhul	Director of Governance
Jonathan Gould	Deputy Director of Finance
David Court	Head of Financial Accounting
Linda Elliott	Internal Auditors – MIAA
Sara Ellis-Anderson	Interim Director of Nursing
Anne-Marie Harrop	Regional Assurance Director - MIAA
Megan Hancox	External Auditors – KMPG
Apologies:	
Jo Williams, Richard Anderson and Jill Barker	

3.2 Actions from the Previous Meeting

The Committee received all items on the work plan with a summary of each provided below:

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
3.	**Declarations of Interest** None declared.	N/A	
4.	**Review of the action log** The Committee reviewed the action log and noted the actions that could be removed.	FULL	
6.	**BAF Assurance** The Audit Committee considered and approved the Board Assurance Framework. The Committee discussed the Groups approach to the 2026-27 Board Assurance Framework and noted that there was work being undertaken on shared objectives which would then inform the risk	Full	

	assessment and assurance in relation to objective delivery.		
7.	**Risk Management Report** The Committee noted the performance information relating to the Trust's risk management processes and system and the current level of assurance. It was accepted that there was full assurance regarding the Trust's risk management systems and processes but recognised that there were still some areas of further work required and therefore partial assurance regarding the implementation of the systems and processes.	PARTIAL	Continued work to improve the Risk Management KPISs
8.	**Annual Losses and Compensations Report** The Committee noted there had been low value losses in relation to stock and the actions being taken to reduce the risk of this happening again and agreed to not have a full report on low value losses, and to have an annual report going forward.	FULL	
9.	**Accounting Estimates Report** The Audit Committee reviewed and evaluated the information on the models and monitoring activities undertaken by Management in respect to material accounting estimates and for entries that require significant judgement. The Audit Committee agree with the models and monitoring activities undertaken by Management in respect to material accounting estimates and for entries that require significant judgement.	FULL	
10.	**Progress Reports** The Committee discussed the completion of the annual audit plan that has been reported. This period of reporting included audits of risk management, assurance framework opinion and the staff wellbeing review. It was noted that there was substantial assurance across all three audits. The data quality review will be brought to the next meeting. HD highlighted some of the results of the Staff Health and Wellbeing Survey and felt these needed further exploration. It was agreed that these would be	FULL	Further assurance sought regarding the staff wellbeing survey results and referred to the People Committee for oversight

	picked up by the People Committee and highlighted to the Board for consideration.		
11.	**FOLLOW UP SUMMARY** The closure of all the previous Internal Auditor's recommendations was shared with Audit Committee. There will be a further report in May.	FULL	
12.	**HEAD OF INTERNAL AUDIT OPINION** The Committee discussed the annual (25-26) report that reflects the internal audit reviews for which the Trust has been provided with an overall substantial assurance.	FULL	
13.	**REFRESHED INTERNAL AUDIT PLAN (FOR APPROVAL)** The Committee approved the refreshed Internal Audit plan for 2026/27, acknowledging if changes need to be made this can be done moving forward.		
14.	**SUPPLEMENTARY BENCHMARKING / INSIGHTS (FOR NOTING)** The paper was noted for information.		
15.	**SECTOR UPDATE** The Committee received updates against the financial statement audit and value for money audit. The field work will be commencing on 27th April and everything is on track to complete mid-June.		

Policies Approved

The Committee was not presented with any policies requiring approval.

4. Risks to Escalate

There were no risks to escalate.

5. Conclusion

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

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 01.05.2026		**Report of:** Quality & Safety Assurance Committee (QSAC)
Date of meeting: 28.04.2026		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	**Agenda**	The Committee considered the following: • Tuberculosis Call to Action Letter • Moving to Excellence (M2E) PMO Transformation Report • Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • Quality Operational Committee Key Issues Report • Quality Indicators Integrated Performance (IPR) Report and Exception Report • Safeguarding Quarterly Report • Clinical Claims and Litigation update • H&S End of Year Progress Report • Quarter 4 Board Assurance Framework (BAF) • Bi-Annual Staffing Paper • IPC Quarter 4 Report • Maternity and Neonatal Transformation Assurance Committee Key Issues Report • Maternity Dashboard and Key Issues Report to papers • Maternity Neonatal Safety Champions Report • Levelling Up Report
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	The Sentinel Stroke National Audit Programme (SSNAP) overall score for the Trust was E (lowest) for this quarter. The Committee has requested a deep dive into stroke care to return to set out actions being taken. The external service which provides the orthopaedic cellular pathology service delivered has temporarily had their UKAS accreditation suspended with a review visit planned in August. SaTH recently took over the cell path service at RJAH, and it is this service at the RJAH site whose accreditation has recently been suspended. The Committee heard that this will not impact on the quality of the reports, the situation is being closely monitored and risk escalated.
2b	**Assure** *Positive assurances and highlights of note for the Board*	QSAC received an update on Delivering a Comprehensive TB Service. The newly expanded service has completed a gap analysis against GIRFT, and work is ongoing to establish the service model, including patient facing work, education, and outreach work. Performance outcome measures will be included in the Integrated Performance Report. There is an opportunity to collaborate with the university for research. QSAC received the Safeguarding Quarterly Report which provided assurance that the Trust was identifying and reporting. There was positive assurance that the Ask 5 audit showed the positive impact on training. It also showed some deterioration in training compliance in some areas/staff groups with focused training sessions in areas where compliance is below target. The MCA and DoLS training level is now rag rated red and there was a discussion on whether this was impacting the poor compliance with Respect forms which was escalated by

		QOC. Actions are in train to help improve the completion of Respect forms. Moving to Excellence quarterly update The only programme currently at risk is UEC improvement. The action plan for 26/27 is being finalised and will be monitored via the SIIP, with external scrutiny from invited NHSE representation, which will report monthly to QSAC. The Committee received the Report of the Health, Safety, Security and Fire Committee November – March which provided assurance on food safety with environmental health inspections of two areas (Hollinswood Renal and RSH main kitchens) resulting in the retention of their rating of 5. Environmental Health had also completed number of advisory visits with no specific actions. Actions had been taken in response to the two fire enforcement notices received at RSH. In response the practice of placing additional beds in wards at PRH has now stopped, and a new hospital full protocol is being developed. The Committee reviewed the Bi-Annual Staffing Paper and noted continued compliance with national standards. The committee noted the key risks identified in the paper: sustained high patient dependency, ongoing bed expansions and ward reconfigurations, environmental layout risks and unavailability which the committee will monitor. The Committee supported the identified actions to mitigate the identified risks. Maternity: Maternity acuity rates in delivery remained above target at 97% in March. There were no delays in category 1 caesarean sections and 10 delays in category 2 caesarean sections this month. Work is ongoing with theatre and obstetric teams to address this, and an update will be provided next month.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	UEC: While there have been improvements in performance for 12-hour waits, patients being transferred to the discharge lounge and patients being assessed within 15 minutes, performance remains challenged in four hour waits and patients with no criteria to reside. The Committee discussed the Clinical Claims and Litigation Update. The Trust received a Regulation 28 report in January with a response sent to the coroner on the 12 March 2026. The Committee will monitor the progress of actions in response to the concerns. The Committee noted the updates to the Board Assurance Framework for the risks overseen by QSAC (1,2,8,9,10 and 12). The Committee agreed the reduction of the risk rating for Risk 9 from 12 to 8 which places it within the risk tolerance. The reduction was in response to 0 52 week waits and the 18-week performance now being in the upper quartile nationally. The Committee agreed that the current ratings for the other risks overseen by QSAC were appropriate and no changes to ratings were made. Risk 10 (Urgent and emergency care standards) remains at 20 and therefore one of the highest risks for the Trust. The Committee reviewed the IPC Quarter 4 Report and noted that the Trust had breached all set targets for reportable HCAIs for 2025/2026. There are actions in place but also continued infrastructure and resourcing constraints. Deep cleaning will commence in May (depending on bed occupancy).
2d	**Actions** ***Significant** follow up actions*	A deep dive on stroke care, including actions to address continued low scores from SSNAP audit is to come to QSAC in July.

3	**Report compiled by**	*Ms Sarah Dunnett Chair of Quality and Safety Assurance Committee*	**Minutes available from**	*Mike Wright Committee Support*

Performance Assurance Committee, Key Issues Report		
Report Date: 21 April 2026		**Report of:** Performance Assurance Committee
Date of meeting: 21 April 2026		**Attendees**: R Edwards (Chair) R Dhaliwal, S Dunnett, N Hobbs, T Cotterill, S Balderstone, N Lee, L Mitchell, D Bryce A Winstanley, S Buckland, M Neal, H Ainsbury
1	**Agenda**	The Committee considered the following: • Performance Highlights includes UTC Performance review update • UEC SIIP • Integrated Performance Report • Action 54; No Criteria to Reside Patients (NCRP); Outcomes review and Quality Safety Assurance implications • Workforce Plan and Performance Impact • Strategy & Partnerships update • Fire Notices SaTH response/update • Digital Transformation Steering Group 4A Report • Data Quality Update • Board Assurance Framework • PAC Chair's Annual Report 2025-2026 • PAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Urgent and Emergency Care: PAC heard that although SaTH is behind its plan regarding its commitments for improvement, the weekly data sets are showing statistically significant improvements in the 12-hour, 4 hour and ambulance handover standards. Regarding the 12-hour standard in March, 81% of patients were admitted or discharged within this time, rather than the planned 83% - this represented the Trust's best performance since June 2023. PAC noted that the number and proportion of very long waits had been steadily decreasing and wished to see this data more vividly expressed in the report (from 1451 over 24 hour waits at 13.3% in October 2025 to 1166 at 11.75% in March). Ambulance handover time in March was averaging 45 minutes, and so far in April 30 minutes. • PAC heard that as overcrowding in ED is reduced process challenges for non-admitted pathways in ED become more visible. SaTH is commissioning external delivery support via a multidisciplinary team to assist in transforming the non-admitted pathways and also on reducing the number of no criteria to reside cases. • Urgent Treatment Centre performance review: PAC heard that while the performance of the service stabilised during 2025-2026, it has not yet recovered to the pre-April 2025 level; the intention in 2026-2027 is for it to improve to the expected levels of performance of 95%. The report covered the reasons for the low levels of performance up to now and the reasons for expecting improvements, including successful filling of vacancies.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Elective Care: looking back over 2025-2026, PAC heard that for the 18 week and 52 week standards SaTH was the most improved trust nationally, exceeding its commitments for the year; for cancer care it was the most improved trust for the 28 day standard and second most improved for the 62 day standard, exceeding its plan for both; and in diagnostics it was the 6th most improved, though not quite achieving planned levels. PAC noted the huge amount of work by the teams involved to achieve these results. • Elective Sprint: the impact of this will be fully validated by 28 April, but indications so far are that it contributed to a 20-percentage point increase in outpatient appointments over the financial year, with over 12000 additional outpatient appointments in Q4.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• No Criteria to Reside (NCTR): PAC received a report on this, which showed a statistically significant increase in numbers since Autumn 2025, which peaked at the start of the calendar year and remained at over 140 patients until the end of March. The majority of the increase has pertained to Shropshire residents with some increase from Powys too. There have been positive meetings with and commitments to work together from both partner authorities. The aim is to get NCTR patients to 110 or less - though it was agreed that this is still a high number with consequent impacts on patient health and UEC performance. • Fire Safety: PAC received a report on the progress being made with regards to Enforcement Notice 365 (hospital streets and common areas) and Enforcement Notice 366 (primarily the wards) and the action plan for remediation to ensure compliance. PAC heard that Shropshire Fire & Rescue Service (SFRS) met with the Trust's Fire Safety Manager on the 8 April and have acknowledged the progress being made. A report on the condition of fire doors has been completed and 6 sets of corridor fire doors have been ordered. A survey of all 400 fire doors will require a plan of restoration over the next couple of years. Regarding corridor storage, this will require investment to create suitable safe storage areas. Fire safety protocols are being redrafted in conjunction with ShropCom's. Hospital full protocol: PAC heard that space has been removed and reduced and escalation spaces have been less needed. Training: releasing staff to attend training courses remains difficult - courses have been run without the fully agreed complement. • Neighbourhood Health: PAC received a report on the group approach to this and noted the important role SaTH and Shropcom, working together, could play in ensuring the 3 shifts and the way the two major transformation programmes - Neighbourhood Health Implementation Programme and Hospitals Transformation Programme - would work together to improve health and reduce inequalities in care. • Data Quality Update: PAC heard that the May submission of SLAM (Service Level Agreement Monitoring) data will go ahead and that while there are still some issues to resolve there is nothing major. The move to business as usual on the Federated Data Platform continues, but without some of the key external staff SaTH has been working with for some time.

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- Digital Update: PAC heard that progress with digital transformation continues, that workshops have been held with senior management in divisions and that individual divisional workshops will be held to talk about the ways forward. Apart from process automation and EPMA, which in itself is a big project, SaTH is also planning transformational work using AI, such as Ambient Voice Technology in clinical areas. These have significant implications for cultural change as well as information governance.
- Board Assurance Framework: PAC agreed that the updated BAF report should go to Audit and Risk Assurance Committee with the score for BAF risk 9 (Elective Care) reduced from 12 to 8, so that it is now within the upper tolerance limit for this risk.
- PAC agreed the Chair's Annual Report for the Board and noted the range and depth of the papers that had been presented to PAC, the follow-up papers to these and the actions that had resulted. PAC also noted the likelihood that it would combine with the Finance Assurance Committee as part of the creation of a group committee structure.

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<tr><td>2d</td><td>Actions
Significant
follow up actions</td><td colspan="3">

- Comparative data month by month on long ED waits to be made clearer in the Performance Highlights report to PAC.
- Fire Action plan to be provided with dates when action has been taken/compliance achieved.

</td></tr>
<tr><td>3</td><td>Report compiled by</td><td>Rosi Edwards (Chair)
Non-Executive Director</td><td>Minutes available from</td><td>Lisa Mitchell
Senior Governance Support Officer</td></tr>
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Finance Assurance Committee, Key Issues Report		
Report Date: 28.04.2026		**Report of:** Finance Assurance Committee
Date of meeting: 28.04.2026		**Members:** R Miner (Chair), A Winstanley, P Gardner, S Crowther, J Sargeant **Attendees** C McInnes, R Muskett, S Edmonds, L Mitchell **Attendees (part)** S Balderstone, H Walpole, S Jones-Perrot, G Parks, D Evers, E Slevin, D Bryce
1	**Agenda**	The Committee considered the following: • Financial Report M12, incl lesson learnt, data quality update • Finance System Integrated Improvement Plan (“SIIP”), 4A Report • Efficiency & Recovery Report • Contract Approval – Alcon Eye Care • Workforce Plan and Financial Impact Progress • MEC Divisional in-year position and financial recovery plan update • Operational Performance Oversight Group (“OPOG”) 4A Report • Financial Recovery Group (“FRG”) 4A Report • Board Assurance Framework • Review FAC Cycle of Reporting
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Notwithstanding the overall surplus to plan, MEC reported a divisional deficit of some £8.22m. MEC provided an update and “lessons learned” to FAC at the meeting and 2026/27 presents challenges but these are understood. • Whilst the service level (SLAM) data work shows signs of promise for completion by the end of April, at the date of reporting to FAC, this was not without its risks including support available. • Delivery of the 2026/27 workforce plan, which itself is predicated on substantial digital transformation, is critical to achievement of the financial plan
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Trust achieved a £4.9m surplus against plan due to performance bonus deficit support funding from NHSE. The Trust reported a break-even position prior to bonus funding. • The efficiency plan delivered a saving of £41.54m (including recurrent savings of £24.437m) against a plan of £41.4m. • The Trust had a cash balance of £73.21m at the end of March partly due to the timing of its capital spend. Subject to achieving performance in 2026/27, there may no longer be a need for cash support. • The Trust delivered its capital programme of £149.7m in line with plan. • Overall, the above demonstrates an outstanding financial and operational achievement for the Trust in 2025/26 but 2026/27 represents an even greater challenge. • FAC received 4A Reports from OPOG and FRG.

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- FAC reviewed and recommended for approval to the Board, the contract with Alcon Eye Care.
- The Cycle of Reporting was reviewed noting particularly some post project appraisals that are to be scheduled.
- The SIIP 4A report was noted in respect of 2026/27.
- FAC considered the Board Assurance Framework in respect of BAF Risk 5 (operating in available resources) and are of the view that while the impact of not doing this remains severe, the likelihood, due to impact of measures and performance in 2025/26 could be reduced to 3, giving an overall score of 15. That said, FAC will be keeping the risks under constant review.

</td></tr>
<tr><td>2c</td><td>Advise
Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.</td><td colspan="3">

- £5.4m (14%) of the 2026/27 efficiency plan of £39.98m is still to be developed and NHSE is requiring a firm commitment to close this gap as well as to identify the next 2 years' CIP.

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<tr><td>2d</td><td>Actions
Significant
follow up actions</td><td colspan="3">

- Run rates particularly in certain critical areas like workforce, and specifically MEC, will be considered at a separate meeting of FAC on 12 May.

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<tr><td>3</td><td>Report compiled by</td><td>Richard Miner, Non-Executive Director, Chair</td><td>Minutes available from</td><td>Lisa Mitchell, Senior Governance Support Officer</td></tr>
</table>

<table>
<tr><td colspan="3">Audit and Risk Assurance Committee, Key Issues Report</td></tr>
<tr><td colspan="2">Report Date:
2026.04.24</td><td>Report on: Audit and Risk Assurance Committee</td></tr>
<tr><td colspan="2">Date of meeting:
2026.04.13</td><td>All NED and Associate NED members were present.

Also present but not part of the quorum: SaTH Group Chief Governance Officer, Acting Director of Finance, SATH Group Chief Financial Recovery and Transformation Director, together with representatives from the Trust's Internal Auditors MIAA, the Trust's external auditors KMPG, with several Trust officers from the Governance and Risk Teams, and Operational Teams</td></tr>
<tr><td>1</td><td>Agendas</td><td>The Committee considered the following specific items:
Internal Audit – Progress Report
Internal Audit Report – Waiting Lists & Performance (moderate assurance)
Internal Audit Report – Risk Management Core Controls (high assurance)
Internal Audit Report – Assurance Framework
Internal Audit Follow Up Report
Internal Audit – Annual Report & Head of Internal Audit Opinion 2025/26
Internal Audit – Draft revised Internal Audit Plan 2026/27
Anti-Fraud – Annual Report 2025/26
Anti-Fraud – Annual Work Plan 2026/27
Losses and Special Payments Report (quarterly)
Procurement Waivers Report (quarterly)
Contract Award Report (quarterly)
Annual Risk Management Report 2025/26
External Audit Plan & Strategy 2025/26 including value for money risk assessment.</td></tr>
<tr><td>2a</td><td>Alert
Matters of concern, gaps in assurance or key risks to escalate to the Board.</td><td>None</td></tr>
<tr><td>2b</td><td>Assurance
Positive assurances and highlights of note for the Board</td><td>A high assurance opinion was provided by the internal auditors for the Risk Management Core Controls audit findings. This outcome had been supported by an up-to-date Risk Management Strategy and Policy being in place with an approved Risk Appetite statement to the latter.
The internal auditors provided positive findings on the Assurance Framework (AF) structure, processes, objectives, risk appetite, engagement, quality and alignment. The Committee noted that all findings represented a positive reflection of the effectiveness of AF processes.</td></tr>
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		• Head of Internal Audit Opinion - for the period 1 April 2025 to 31 March 2026 provides Substantial Assurance that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally applied consistently. This is the fourth year that the organisation has received a HoIA Opinion of Substantial Assurance. * • The draft External Auditors' VFM (Value for Money) Risk Assessment 2025/26 identified no significant risks relating to either of the three standard indicators of 'financial sustainability', 'governance' or 'improving economy, efficiency and effectiveness'. This is an improved position from previous years which had highlighted 'financial stability' as an amber risk.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• Following review by the Executive Team, several remaining changes to the draft internal audit plan were highlighted. It had been proposed that an audit be carried out regarding the medical temporary staffing process. In addition, it was proposed that a trust-wide review of data quality also be undertaken if there was availability in the plan. • The overall losses and special payments for the period 1 January to 28 February 2026 represented a decrease of £32k compared to the same period in 2025. • Pharmacy wastage had also reduced, and the Acting Director of Finance had agreed to investigate when the business case for a Pharmacy Stock Control robot is to be presented for approval. • Seven Competition Waivers and five Breach Waivers had been logged by Procurement in the period February – March 2026, which represented a reduction of x5 from the previous period. One of the Breach Waivers was for the extension of waiting list validation contract following the implementation of the new Careflow system, which was due to a cessation in the service that had been previously supplied via STW ICB. • The 2026/27 Anti -Fraud Annual Work Plan was approved by the Committee.
2d	**Actions** *Significant follow-up actions*	No *significant* actions at this time.

	Report compiled by:	Anna Milanec, Group Chief Governance Officer, Approved by Prof Trevor Purt, ARAC Chair	**Minutes available from:**	Mrs Beverley Barnes, Board Coordinator

*2020/21:	Limited Assurance
2021/22:	Limited Assurance
2022/23:	Substantial Assurance
2023/24:	Substantial Assurance
2024/25:	Substantial Assurance
2025/26:	Substantial Assurance

HTP Assurance Committee, Key Issues Report		
Report Date:		**Report of:** Hospitals Transformation Programme Assurance Committee (HPAC)
Date of meeting: 26 March 2026		**Attended by**: Chaired by the HPAC Chair with NED members present. Acting Director of Finance, Group Chief Medical Director Director of HTP, HTP Clinical Lead and additional colleagues in attendance.
1	**Agenda**	The HPAC considered the following: • Programme updates including the Emergency Department (ED) Phase 2 and New Building Critical Path Overviews • Latest construction update on the new build • Readiness Assessment Checklist for ED2 Section 4 • The remaining phases of refurbishment for ED • The new build phases • Clinical and operational matters in respect of the new HTP model for Medicine and Emergency Care (MEC) • High Level clinical and operational timelines for MEC • Clinical and operational matters in respect of the new HTP model for surgery, anaesthetics, and critical care (SACC) • High Level clinical and operational timelines for SACC • Clinical and operational matters in respect of the new HTP model for Women and Children (W&C) • High Level clinical and operational timelines for W&C • Clinical and operational matters in respect of the new HTP model for Clinical Scientific Services (CSS) • High Level clinical and operational timelines for CSS • Site health and safety update • Workforce and training • Communications and engagement • Finance including year to date spending and expenditure. • Programme risks and mitigations.
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board*	• The Committee requested further assurance on the publication and approval process for the Urgent Treatment Centre (UTC) model. It was requested that a detailed paper be provided that sets out the governance, approvals, and operational processes for the "Go Live" of the Urgent Treatment Centre in line with the agreed consultation process. • The Committee discussed the cash flow for the HTP. Work is continuing to ensure this remains in line with Trust and NHSE agreements. The Committee reiterated the need to keep this under review and for regular updates to be provided going forward.

2b	**Assurance** *Positive assurances and highlights of note for the Board*	**The HTP Assurance Committee wish to assure members of SaTH Board of Directors that:** • The Committee received assurance from the Senior Responsible Owner (SRO) around the construction build programme. The Committee is assured this is progressing to schedule. • Committee members were assured that the readiness assessment checklists were signed off as each area became ready to be handed over. Following this hot and cold debriefs had been undertaken to capture lessons learned. It was recognised that, going forward, fewer departments should be moved on the same day, with moves phased over several days. • Assurance was given around the health and safety aspects of the new build construction site on the operation of the existing hospital. No reportable incidents have occurred, and the Committee was assured that weekly site health and safety walks take place between the Trust health and safety team plus a representative from the Contractor (IHP) to check patient and staff areas. • Assurance was received that the HTP communications and engagement work continues to reach out and engage with local neighbourhoods with efforts to reach diverse communities. The Committee emphasised the need to include everyone's perspectives and to make sure all opinions are considered. • Assurance was received that the overall delivery of the clinical and operational programme was on track, and there could be no further changes to delivery dates.
2c	**Advise** *Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.*	• The Committee noted that work is progressing in accordance with the Building Naming Policy. It was noted that the proposed approach will align with Estates and the overarching strategy for naming across all sites. Public engagement has commenced. • Although construction is advancing successfully, due to the dispersion of clinical areas throughout the Emergency Department it is important to ensure that relevant access and egress to the department remains controlled. Regular assessments of the area will be conducted to ensure this remains in place. • The Committee shall continue to monitor emerging risks as the programme increases in complexity, thereby ensuring that all significant issues are promptly identified and effectively managed in accordance with established governance procedures. • As part of the UTC model, ongoing engagement will be maintained, including stakeholder mapping, which will be a key element of the communications campaign. Testing of the new pathways will be expanded to involve patients, enabling them to influence any changes before finalisation. This will remain a substantive agenda item for the committee to review and to ensure alignment with consultation agreements. • The Chair requested that the Terms of Reference be reviewed, and that the membership be confirmed and presented to the next committee for further consideration. This review will take account of the wider committee structure in relation to Out of Hospital Care (Local Care Transformation Programme).

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<tr><td>2d</td><td>Actions</td><td colspan="3">Director of HTP to distribute the Terms of Reference for the newly formed System Transformation Group to members of this committee.
The HTP Delivery Director to develop a comprehensive plan outlining the schedule for service migration and the associated resource requirements.
Acting Director of Finance agreed to provide confirmation of the failover arrangements for technology assets in the new building, and assurance that a robust and fully tested failover solution is in place.
The HTP Delivery Director has been tasked with preparing a document detailing the next steps for the UTC.
Acting Director of Finance was requested to model the bed modelling impact on the operational plan and on funding allocations, including the effect on contractual financial flows.
Inventory and Equipment – The HTP Delivery Director has been asked to clearly define the position, indicating which items will be newly procured and which will be transferred.</td></tr>
<tr><td>3</td><td>Report compiled by</td><td>Professor Purt
Chair of HTP Assurance Committee</td><td>Minutes available from</td><td>Sharon Stuart</td></tr>
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<table>
<tr><td colspan="2">Group People Committee, Key Issues Report</td></tr>
<tr><td>Report Date:
24 March 2026</td><td>Report on: Group People Committee</td></tr>
<tr><td>Date of meeting:
23 March 2026</td><td>Those present:
Teresa Boughey — Non-Executive Director – meeting Chair (SaTH)
Cathy Purt — Non-Executive Director (Shropcom)
Rosi Edwards — Non-Executive Director (SaTH)
Claire Horsfield — Director of Operations & Chief AHP (Shropcom)
Rhia Boyode — Chief People Officer (SaTH and Shropcom)
Nigel Lee — Director of Strategy and Partnerships, SaTH
Shelley Ramtuhul — Director of Governance (Shropcom)
Jill Barker — Non-Executive Director (SCHT)
Wendy Nicholson MBE — Non-Executive Director (SaTH)
In Attendance
Jo Williams — Group Chief Executive
Jonathan Gould — Deputy Director of Finance (Shropcom)
John Jones — Medical Director (SaTH)
Simon Balderstone — Director of Workforce & People Services (SaTH)
Heidi Fuller — Non-Executive Director (SaTH)
Sabenna Khanna — HTP Workforce Transformation Lead (SaTH)
Kara Blackwell — Deputy to Chief Nursing Officer (SaTH)
Dawn Thompson — Associate Director of Culture (SaTH)
Deborah Bryce — Head of Corporate Governance & Compliance (SaTH)
Clair Ellahee — Professional Nurse Advocate (SaTH) – Item 07
Robin Hollands — Guardian of Safe Working Hours (SaTH) – Item 13
Karen Sargent — Professional Nurse Advocate Lead (SaTH)– Item 07
Jake Mairs — Observing
Sabina Jones
Louise Dodd — Clinical Psychologist – Item 19
Fiona McPherson — HR Manager (Shropcom) Item 16 & 17

Apologies: Tracie Black Associate Director for Workforce, Education & professional Standards (Shropcom), Clair Hobbs Director of Nursing & Clinical Delivery, Paula Gardner Interim Chief Nurse (SaTH)</td></tr>
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1	**Agendas**	The Committee considered the following: • *Staff Story – Professional Nurse Advocate* • *Workforce Performance Report* • *Culture and Leadership Update* • *HTP and Neighbourhood Project update* • *Update on Staff Survey results* • *SaTH – Guardian of Safe Working Quarterly report* • *SaTH – Nursing & Midwifery Staffing report* • *HR Policies/Policy tracker* • *Employee relations update* • *Armed Forces update* • *Stress related sickness deep dive report* • *BAF Report and Risk update* • *Review of Committee planner*
2a	**Alert** *Matters of concern, gaps in assurance or key risks to escalate to the Board.*	• Still working through the medical workforce plans in the UTC pathway. • Guardian of Safe working raised concerns about Resident Doctors booking annual leave and not receiving a response or being allowed to take annual leave. • The Committee noted a rising backlog of DBS checks and requested a further update at the May Group People Committee.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• The Committee was assured around the workforce submission for 2026/27, noting that NHSE observations of the development of acute and community integration. More work to do in ensuring HTP and Neighbourhood integration. • The Committee is supportive of the direction of travel with our partners for the Culture and Leadership work, whilst acknowledging there is several stakeholders to get involved. Board members attending Away day in May to get more detail. • The Committee received assurance that Plans are in place for developing the workforce plans linked with the HTP and Neighbourhood work. • Nursing & Midwifery fill rates remain at 90% and carers per patient we are in quartile 2 but remain in line with our peers. • Employee relations update seeks to give assurance quarterly around our employer report cases for Shropcom and SaTH, providing key data around our cases. • The Committee received a deep dive on stress-related sickness absence and health and wellbeing from the Clinical Psychologist. The Committee noted the increasing proportion of absence attributed to mental health, the importance of supporting managers to effectively support staff, and the Trust's intention to move towards a trauma-informed approach. The Committee noted the relevance of this work in the context of the Occupational Health contract currently out to tender and agreed this area should remain within the Committee's cycle of business, with further updates to follow. • The Committee received a request to reduce the current total risk score of SaTH BAF Risk 4 this quarter from 16 to 12. This brings it into line with its agreed upper tolerance risk level of 12.
2c	**Advise**	• The Committee received the Workforce KPI report and noted that work is ongoing to strengthen and integrate Workforce KPI metrics to support collective oversight as the Group model develops. The Committee

	Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.	received an overview of the Staff Survey results and noted overall progress since 2021, with some decline in the most recent results. The Committee recommended triangulation with the Culture and Leadership work and the HTP transformation programme and will monitor the delivery of action plans. The Committee also supported a review of survey provision across the Group to support more coherent analysis. The Committee noted the progress in terms of policy tracker and Committee have approved and further work through the transformation committee on the policies going forward. • The Committee received a presentation from the Lead Professional Nurse Advocate. The Committee discussed signposting for new and noted the need to review PNA capacity and protected time to undertake the role. The Committee also noted the development of the county-wide network and requested further information on the impact and outcomes of the role to be brought back to the Committee		
2d	**Actions** *Significant follow-up actions*	•		
	Report compiled by:	Diane Davenport (committee administrator) and Teresa Boughey (meeting chair)	**Minutes available from:**	Diane Davenport, committee administrator, ShropCom.

Board of Directors’ Meeting in Common – 14 May 2026

Agenda item	014/26a
Report Title	SCHT - Integrated Performance Report
Executive Lead	Sarah Lloyd, SCHT CFO
Report Author	Steve Price, Head of Information and Performance Assurance Operational Leads

Prior Consultation:	**CQC Domain:**		**Link to SCHT BAF id(s)**
Resource and Performance Committee (SCHT), 29 April 2026	Safe	√	BAF 3.5
	Effective	√	
	Caring	√	**Risk Register id(s):**
	Responsive	√	
	Well Led	√	

Executive Summary	This report provides oversight and assessment of the key areas of performance relevant to the SCHT’s Performance Framework. The Resource and Performance Committee reviewed the content of this report and full assurance was provided in relation to the actions being taken to improve performance and minimise risk. Access and waiting times for services remain the key areas of focus. There has been an improvement in the RTT 52+ week waits, during the month which were zero in March.
Recommendations for the Board	The Boards in Common are asked to: • **Consider** SCHT’s performance to date and the assurance provided to the Resource and Performance Committee in relation to the actions being taken to improve performance and minimise risks where required. • **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus. • **Approve** the changes to the KPI definitions documented within the report.
Appendices:	**Appendix 1:** Board SCHT Performance KPI March 2026 **Appendix 2:** Board SCHT Performance Icons

1. Introduction

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

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

2. Executive Summary

2.1 Context

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

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

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

2.2 Summary

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

- There are 53 performance indicators reported in this period across SCHT committees.
- The table below summarises the number of KPIs highlighted as a concern against each responsible Committee. 21 indicators are highlighted as a concern (39.6%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	0	4	2	**10**	**6 (60%)**
Quality & Safety	2	2	0	**16**	**4 (25%)**
Resource & Performance	0	11	0	**27**	**11 (41%)**

Table 1: SCHT KPI Summary March 2026

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

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

- **People Committee –** no change

- **Quality and Safety Committee**
  The following KPIs are no longer flagged as having a variation concern:-

  - Deaths – unexpected
  - Medication Incidents with Moderate Harm
  - Rates of Healthcare Associated Infection (E-Coli)

- **Resource and Performance Committee**
  -Variance year-to-date to financial plan is no longer flagged as having a variation concern

Action Plans to improve performance and minimise risks are developed in a multi-disciplinary team workshop including Operational Leads and Support Services. The action plans were reviewed at the Resource and Performance Committee for all measures flagged as a concern within this report, with the exception of local waits KPI for 65+ and 78+ weeks as these both remain at 0.

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

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

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

3. Main Report

3.1 Introduction

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

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

3.2 Summary of key points in report

This report focuses on the 27 indicators which are reviewed by SCHT's Resource and Performance Committee (RPC). Of these, 11 require focused attention with 10 of the 11 relating to access to services and waiting times.

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

Of the KPIs 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:

There are no KPIs reported this month as a variation concern only – special cause variation of a concerning nature.

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

1. Percentage of patients waiting less than 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 patients waiting over 52-weeks for community services
6. Data Quality Maturity Index
7. Total patients waiting more than 52 Weeks – All services
8. Total patients waiting more than 65 Weeks – All services
9. Total patients waiting more than 78 Weeks – All services
10. Total patients waiting more than 52 Weeks to start consultant-led treatment
11. Average number of days from discharge ready date and actual discharge date

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

There has been one change to note since the last report to Board:-

1. Variance year-to-date to financial plan is no longer flagged as having a variation concern

March 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)
52+ weeks	0	2	0	5	0	7
65+ weeks	0	0	0	0	0	0
78+ weeks	0	0	0	0	0	0
104+ weeks	0	0	0	0	0	0

Table 2: March 2026 waits is categorised based on services within organisational structure and not age of patient.

Since the last report to Boards in April there has been an improvement in the RTT 52+ week waits, and SCHT is reporting zero. However, the local 52+ week waits have deteriorated slightly across both Adult and Children services with 7 reported in March.

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

The 'Percentage of patients waiting less than 18 weeks – RTT' has shown a recent levelling with 82.92% in February and 81.11% in March, although the March 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 was included in the action plans submitted to Resource and Performance Committee.

The indicator for 'Proportion of patients within 18 weeks' has also levelled, with performance of 83.98% in February compared with 82.33% in March. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature.

The data issue previously reported in relation to Continence products has now been resolved and the indicator 'total activity undertaken against current year plan' has been refreshed, this has made no change to the variation/assurance icons.

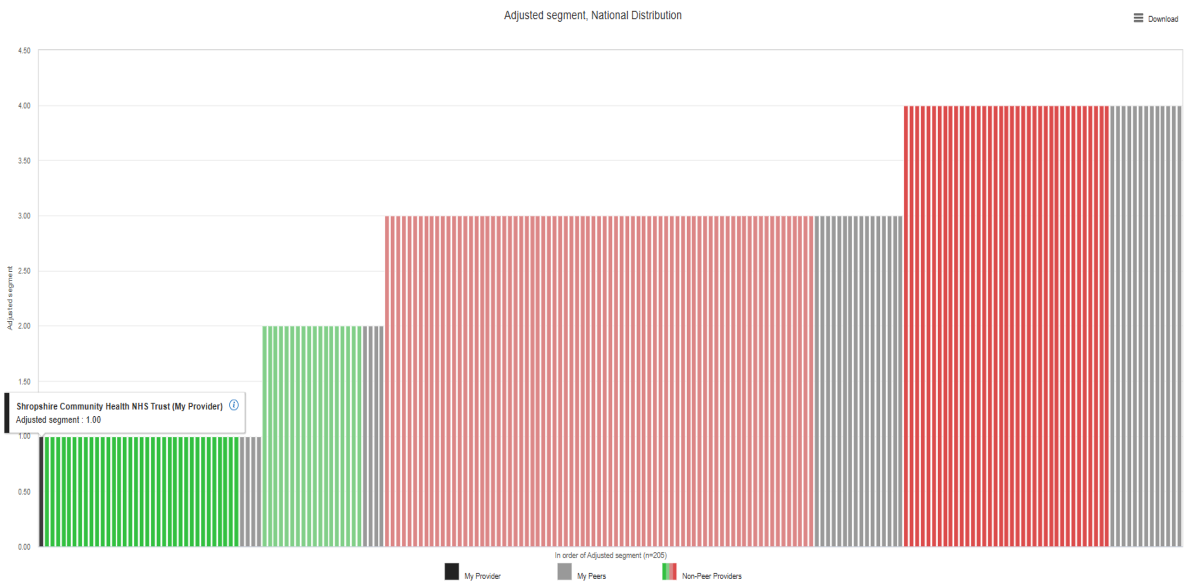
Implied productivity level and Virtual ward bed occupancy measures have also been refreshed, and this has made no change to the variation/assurance icons although Implied productivity level now has a variation icon of an improving nature due to the March year on year performance.

Following further development of the KPIs associated with the Performance Framework, two changes are proposed. The proposed changes are listed below and require **approval** from the Board in line with existing SCHT governance arrangements:-

- Deaths in custody per 1,000 prisoners – definition adjusted to use prison population as at the end of month being reported instead of the average
- Bank Usage (WTE) – change in name to 'Bank Usage - Variance from plan (WTE)'

3.3 National Oversight Framework

In the Quarter 3 position published 18th March 2026, SCHT has shown improvement and has been allocated an overall National Oversight Framework score of 1. Organisations rated as 1 are reported as the best performing and organisations rated as 4 requiring the most support. SCHT performs well across all 5 domains scoring above average or higher within the Oversight Framework and is ranked 14th out of 61 Trusts.



There are individual KPI within the NOF where SCHT is shown as below average in the recent position:

- Sickness absence rate (People Committee remit). It is of note that this position has deteriorated since the date range used in the published scoring (up to September 2025).

Whilst the segment allocation of 1 is positive news for the Trust, it is recognised that there are areas which still require improvement. Details of the actions being taken to improve the performance are shown within action plans presented to the relevant Committees; each Committee is responsible for overseeing performance and ensuring assurance is provided.

3.4 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.5 Conclusion

The Boards in Common are asked to:

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

- **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus.

- **Approve** the changes to the KPI definitions documented within the report.

Performance Update - Appendix 1

Resource and Performance Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Effectiveness and experience of care	Average number of days from discharge ready date and actual discharge date	2026-03-31		6.9	3.0	3.9	6.9	3.0	3.9	
Finance and Productivity	Data Quality Maturity Index	2025-12-31		95.6%	95.0%	0.6%	95.6%	95.0%	0.6%	
Access	Difference between actual and planned 18 week elective performance	2026-03-31		16.11	0.00	16.11	16.11	0.00	16.11	
Finance and Productivity	Financial efficiency - variance from efficiency plan	2026-03-31		1.51%	0.00%	1.51%	1.51%	0.00%	1.51%	
Finance and Productivity	Implied productivity level	2026-03-31		181.42%	100.00%	81.42%	181.42%	100.00%	81.42%	
Access	New Birth Visits % within 14 days - Dudley	2026-02-28		90.74%	90.00%	0.74%	90.63%	90.00%	0.63%	
Access	New Birth Visits % within 14 days - Shropshire	2026-02-28		90.63%	90.00%	0.62%	87.08%	90.00%	-2.92%	
Access	New Birth Visits % within 14 days - Telford	2026-02-28		92.13%	90.00%	2.13%	90.35%	90.00%	0.35%	
Access	Number of patients not treated within 28 days of last minute cancellation	2026-03-31		0	0	0	0	0	0	
Access	Percentage of patients waiting less than 18 weeks - RTT	2026-03-31		81.11%	92.00%	-10.89%	81.10%	92.00%	-10.90%	
Access	Percentage of patients waiting over 52-weeks for community services	2026-03-31		0.05%	0.00%	0.05%	0.05%	0.00%	0.05%	
Access	Percentage of patients waiting over 52-weeks RTT	2026-03-31		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Improving health and reducing inequality	Percentage of people waiting less than 6 weeks for a diagnostic procedure ...	2026-02-28		99.69%	99.00%	0.69%	99.69%	99.00%	0.69%	
Finance and Productivity	Planned surplus/deficit	2026-03-31		1.57%	0.00%	1.57%	1.57%	0.00%	1.57%	
Access	Proportion of patients within 18 weeks	2026-03-31		82.33%	92.00%	-9.67%	82.33%	92.00%	-9.67%	
Access	Proportion of patients within 18 weeks - Childrens Services	2026-03-31		77.23%	92.00%	-14.77%	77.23%	92.00%	-14.77%	
Finance and Productivity	Relative difference in costs	2024-03-31		102.52%	100.00%	2.52%	102.52%	100.00%	2.52%	

Resource and Performance Committee - SPC Summary (continued)

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Finance and Productivity	Total activity undertaken against current year plan	2026-03-31		102.51%	100.00%	2.51%	100.11%	100.00%	0.11%	
Access	Total patients waiting more than 104 weeks - all services	2026-03-31		0	0	0	0	0	0	
Access	Total patients waiting more than 52 weeks - all services	2026-03-31		7	0	7	7	0	7	
Access	Total patients waiting more than 52 weeks to start consultant-led treatment	2026-03-31		0	0	0	0	0	0	
Access	Total patients waiting more than 65 weeks - all services	2026-03-31		0	0	0	0	0	0	
Access	Total patients waiting more than 65 weeks to start consultant-led treatment	2026-03-31		0	0	0	0	0	0	
Access	Total patients waiting more than 78 weeks - all services	2026-03-31		0	0	0	0	0	0	
Effectiveness and experience of care	Urgent Community Response 2-hour performance	2026-01-31		86.57%	70.00%	16.57%	86.57%	70.00%	16.57%	
Finance and Productivity	Variance year-to-date to financial plan	2026-03-31		195.50%	100.00%	95.50%	195.50%	100.00%	95.50%	
Finance and Productivity	Virtual ward bed occupancy	2026-03-31		84.86%	80.24%	4.62%	84.86%	80.24%	4.62%	

Quality and Safety Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Patient Safety	Category 3 Pressure Ulcers	2026-03-31		2	0	2	2	0	2	
Patient Safety	Category 4 Pressure Ulcers	2026-03-31		4	0	4	4	0	4	
Effectiveness and experience of care	Complaints - (Open) % within response timescales	2026-03-31		100.00%	95.00%	5.00%	92.03%	95.00%	-2.97%	
Effectiveness and experience of care	CQC Conditions or Warning Notices	2026-03-31		0	0	0	0	0	0	
Patient Safety	Deaths - unexpected	2026-03-31		1	0	1	1	0	1	
Patient Safety	Falls per 1000 Occupied Bed Days	2026-03-31		5.73	4.00	1.73	5.73	4.00	1.73	
Patient Safety	Medication Incidents with Moderate Harm	2026-03-31		0	0	0	17	0	17	
Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-03-31		6.83	7.08	-0.25	6.83	7.08	-0.25	
Patient Safety	Patient Safety Incident Investigations	2026-03-31		1	0	1	11	0	11	
Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-03-31		275.00%	100.00%	175.00%	275.00%	100.00%	175.00%	
Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-03-31		0.00%	100.00%	-100.00%	0.00%	100.00%	-100.00%	
Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2026-03-31		0	0	0	0	0	0	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-02-28		104%	95%	9%	104%	95%	9%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-02-28		103%	95%	8%	103%	95%	8%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-02-28		104%	95%	9%	104%	95%	9%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-02-28		105%	95%	10%	105%	95%	10%	

People Committee - SPC Summary

Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People and Workforce	Appraisal Rates	2026-03-31		87.37%	90.00%	-2.63%	88.40%	90.00%	-1.60%	
People and Workforce	Mandatory Training Compliance	2026-03-31		96.62%	95.00%	1.62%	96.62%	95.00%	1.62%	
People and Workforce	National Education and Training Survey overall satisfaction score	2024-12-31		88.06%	90.00%	-1.94%	88.06%	90.00%	-1.94%	
People and Workforce	Net Staff in Post Change	2026-03-31		0.14	0.00	0.14	1.40	0.00	1.40	
People and Workforce	NHS staff survey engagement theme score	2026-03-31		7.2	7.2	0.0	7.2	7.2	0.0	
People and Workforce	Proportion of temporary staff	2026-03-31		3.6%	3.4%	0.2%	3.3%	3.4%	-0.1%	
People and Workforce	Sickness Absence Rate	2026-03-31		5.73%	4.75%	0.98%	5.73%	4.75%	0.98%	
People and Workforce	Total shifts exceeding NHSI capped rate	2026-03-31		86	0	86	135	0	135	
People and Workforce	Total shifts on a non-framework agreement	2026-03-31		0	0	0	1	0	1	
People and Workforce	Vacancies - all	2026-03-31		7.86%	8.00%	-0.14%	8.43%	8.00%	0.43%	

Icon Descriptions

Variation \ Assurance	P (Pass)	? (Hit or Miss)	F (Fail)	(No target)
H (Improving, higher)	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 (Improving, lower)	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. Assurance cannot be given as there is no target.
Common cause	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 (Concerning, higher)	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 (Concerning, lower)	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.
Up arrow				Special cause variation of an increasing nature where UP is not necessarily improving or concerning. Assurance cannot be given as there is no target.
Down arrow				Special cause variation of an increasing nature where DOWN is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(Insufficient data)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	014/26b		
Report Title	SCHT Integrated Quality & Safety Performance Report		
Executive Lead	Paula Gardner, Group Chief Nursing Officer		
Report Author	Sara Ellis-Anderson, Interim Director of Nursing, Community Tracie Black, Associate Director for Workforce, Education & Professional Standards		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
SCHT Quality & Safety Committee, April 2026	Safe	√	-
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	-
	Well Led	√	
Executive Summary	This paper aims to provide assurance to the Quality and Safety Committee to support the organisation in the provision of evidence against key lines of enquiry and to contribute to the Trust strategic goals and priorities. The report aims to: • Provide the Board with an executive summary focusing on areas for and areas of improvement. • Provide access to the suite of detailed quantifiable information from the Trust's single data performance repository for reliability and accuracy. • Track progress of actions being taken to improve areas identified as requiring improvement		
Recommendations for the Boards	The Boards are asked to: **Note** and take assurance from the report that appropriate actions are being taken to address any areas of concern		
Appendices: In Board information Pack	Appendix 1: SPC Summary Appendix 2: QSC Action Plan – March 2026		

1.0 Summary

1.1 Clostridium Difficile – There has been two cases of C-Difficile reported in March, one at Whitchurch Community Hospital and one at Ludlow Community Hospital. The organisation has had 11 Hospital-onset healthcare associated (HOHA) C-difficile cases YTD against a threshold of 4. The rolling 12 months now stands at 11. Thematic reviews continue quarterly. Actions for improvement are ongoing with a specific focus on cleanliness, decontamination of equipment and recruitment to Housekeeper roles.

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

1.3 There was 1 unexpected death in March. This death related to a self-inflicted death of a Patient in Custody at HMP Stoke Health. This has been presented at Patient Safey Incident Panel, and a full patient safety incident investigation has been commissioned by way of a learning response, immediate actions taken are to ensure follow up of DNAs of primary mental health appointments. A thematic review has also been commissioned to review the three deaths in custody over the last 12 months.

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

- In March 2026 there were 13 inpatient falls reported within our care (a decrease from 20 in February). The falls per 1000 occupied bed days has subsequently decrease to 5.3 above but remains above the 4.0 target. There was 1 serious harm, a fall at WCH ward that is reportable to National Audit of Inpatient Falls (NAIF). It has been identified for a full Patient Safety Incident investigation (PSII) Falls thematic reviews are presented quarterly to Patient Safety Committee with ongoing improvement work focussing on digital technology with Rambleguard being rolled out in February 2026 and the pilot of a post fall therapy checklist aiming to improve MDT communication and reduce the risk of patient's falling more than once.
- There were two Category 3 pressure ulcers reported in-service in March 2026, issues around complexity of patients and concordance which resulted in wound deterioration.
- There were 0 medication incidents resulting in moderate harm
- There was 1 PSIIs declared in March. The complaint was at Whitchurch and related to a patients discharge. The investigation will review the care and treatment during their inpatient stay and the process and arrangement followed on their discharge.

2.0 Safer staffing data

- Data reporting period covers February 2026
- Average fill rates for RNs were at 104% for day and 105% for night shift.
- Average fill rates for non-registered workers were at 104% for day and 103% for night shift

Harm review data is proposed as a new KPI with a draft definition in place to add to the performance framework that will require Trust Board approval for 26/27. Moderate harm incidents are reviewed as part of the Trust's weekly Patient Safety Incident Panel. Harms review policy has been updated and due for approval at Patient Safety Committee and harms proforma is now on RiO with mandated fields for all services to use.

It is proposed that a new Deaths in Custody metric is added for 26/27 where number of Deaths in Custody per 1000 is added to enable benchmarking. Medicines safety KPIs will also be reviewed for 26/27.

3.0 Conclusion

The Boards are asked to:

- **Note** the information in the report.
- Take assurance from the report that appropriate actions are being taken to address any areas of concern.
- Request any future information that will increase assurance.

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	014/26c	
Report Title	SCHT Integrated People Performance Report	
Executive Lead	Rhia Boyode, Group Chief People Officer	
Report Author	Gina Billington, Head of Resourcing Fiona MacPherson, Head of People Services Sarah Allan, Deputy Workforce Operations Director (Interim)	

Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
	Safe	√	N/A
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	N/A
	Well Led	√	

Executive Summary	The purpose of this report is to provide an oversight of the key areas of workforce performance which are most relevant based on the Trust's Performance Framework. This report focuses on the key areas of performance relevant to People Committee and Trust Board, including a review of performance against the month 12 workforce plan position. The KPI's throughout the report are key drivers of performance, which underpin the delivery of the 2025/26 workforce plan.
Recommendations for the Boards	The Boards are asked to: • **Note** and take assurance from the key actions supporting performance improvements.
Appendices (in Board Information Pack):	Appendix 1: Month 12 (March) 2025/2026 Performance Summary Appendix 2: SPC Summary Information Appendix 3: SPC - Charts Appendix 4: Workforce Action Plans

1. Main Report

1.0 Introduction

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

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

2.0 Summary of key points in report

2.1 The workforce plan for 2025/26 set a 41.72 WTE increase from the start of the year, which incorporated a 34.74 WTE increase in substantive workforce.

2.2 The target set to reduce agency usage was a 42% reduction, to be off set with increases in substantive workforce. At month 12 the total workforce was under plan by 34.4 WTE.

2.3 Temporary staffing usage remained static in Month 12 compared to Month 11, (table below) with Bank usage decreasing by 0.7 WTE and Agency usage showing a slight increase of 0.8 WTE.

	Month 12			Month 11		
WTE	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Substantive	1,656.6	1,604.5	(52.2)	1,644.7	1,604.8	(39.9)
Bank	55.7	77.3	21.6	62.4	78.0	15.6
Agency	27.3	23.4	(3.8)	27.3	22.6	(4.7)
Totals	**1,739.6**	**1,705.2**	**(34.4)**	**1,734.4**	**1,705.4**	**(29.0)**

2.4 Admissions avoidance were again the highest users of agency in Month 12: 7.28 WTE which is above plan (5.60 WTE) a variance of 1.68 WTE. Vacancy levels have decreased and we continue to remain under target (7.86% vs 8.0%) this is a continuing trend since December 2025, following a slight rise in November (8.19%).

3.0 Year to date workforce plan position

Plan	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Substantive	1689.8	1694.7	1702.2	1700.7	1671.1	1670.8	1634.4	1646.3	1,644.7	1,656.6
Bank	62.9	61.4	59.6	57.8	55.7	55.7	62.4	62.4	62.4	55.7
Agency	36.2	31.7	28.7	28.7	27.3	27.3	27.3	27.3	27.3	27.3
Total	1788.9	1787.7	1790.5	1787.2	1754.1	1753.8	1724.1	1736.2	1,734.4	1,739.6
Actual (WTE)	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Substantive	1626.7	1631.4	1631.6	1635.1	1624.8	1621.8	1599.7	1602.9	1,604.8	1,604.5
Bank	81.6	73.4	78.6	76.8	81.5	86.4	77.8	68.4	78.0	77.3
Agency	33.7	30.2	37.4	37.8	34.3	30.3	28.1	29.7	22.6	23.4
Total	1742.1	1735	1747.6	1749.7	1740.7	1729.4	1705.6	1701.1	1,705.4	1,705.2
Variance (WTE)	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Substantive	-63.1	-63.3	-70.6	-65.6	-46.3	-49	-34.7	-43.4	(39.9)	(52.2)
Bank	18.8	12	19	19	25.8	30.7	15.4	6	15.6	21.6

Agency	-2.5	-1.5	8.7	9.1	7	3	0.8	2.4	(4.7)	(3.8)
Total	-46.8	-52.7	-42.9	-37.5	-13.5	-24.4	-18.5	-35.2	(29.0)	(34.4)

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

- Appraisals
- Temporary staffing
- Absence management
- Price cap compliance

Metric	Target	June-25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Appraisal	**90%**	88.89%	91.32%	91.05%	87.81%	87.28%	86.61%	88.56%	87.89%	87.66%	87.37%
Temporary Staff	**3.4%**	2.7%	2.4%	3%	3.9%	3.9%	3.5%	3.7%	3.6%	2.9%	3.6%
Sickness	**4.75%**	5.32%	5.35%	5.41%	5.48%	5.52%	5.60%	5.68%	5.65%	5.68%	5.73%
Total Shifts exceeding NHSI capped rate	**No Target**	56	47	64	64	108	279	303	256	261	114

3.2 SPC charts are included in the Action Plans (Appendix 4) and Appendix 3 for further consideration from a people perspective.

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

3.4 Of the KPIs that the People Committee is responsible for, seven KPIs are a special cause variation of an improving nature and will pass or continue to pass the target if nothing changes, 2 are a special cause variation of a concerning nature where the process is not capable and will fail without process redesign and 1 is a common cause variation with no significant change.

Committee	Variation concern	Variation concern of an improving nature	Both Variation and Assurance	Common Cause Variation – no significant concern	Total KPIs reviewed	Total Requiring Attention
People	2	7	0	1	**10**	**6 (60%)**

1. Appraisal Rates – remains below target but a variation of improving nature
2. Mandatory Training Compliance – a variation of improving nature, remains above target
3. National Education and Training Survey overall satisfaction score - below target, concerning. Results for 2025 have not yet been published
4. Net Staff in Post Change – no significant change
5. Proportion of temporary staff – slightly above target but a variation of improving nature
6. Sickness Rate – below target, concerning (short term sickness increasing trend, long-term decreasing trend)
7. Staff survey engagement theme score - 2025 results, 2026 results not yet published
8. Total shifts exceeding NHSI capped rate – above target due to medical staffing requirements
9. Total shifts on a non-framework agreement – no significant concern. No shifts were booked off framework in Month 12.
10. Vacancy rate – improving position, remains below target

4.0 Appraisal Rates

4.1 The March compliance rate has slightly decreased from 87.66% in February to 87.37%. Due to the reporting parameters changing in 2025 work continues to ensure that all appraisals are recorded correctly.

Work is continuing to **ensure** hot spot areas are being supported to ensure their outstanding appraisals are completed.

4.2 Top 2 Hotspots
Medical division – 75/% this reflects 1 outstanding appraisal which has reduced from 3 outstanding in January
Governance division – 75% this reflects 5 outstanding appraisals
Urgent care division – 78.85% this reflects 44 outstanding appraisals

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

4.3 **Actions to Deliver Improvements - Current Focus**

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

5.0 Mandatory Training

5.1 In March, compliance rates increased by 0.22%, reaching 96.62%, which is a welcomed change after 2 months of decreases. Over the course of the month, compliance decreased across 9 topics, with reductions ranging from 0.05% (Conflict Resolution) to -14.29% for Safeguarding Children - Level 4, however the unusually large drop is due to 1 person being non-compliant but because there is such a small group 1 person has bigger than usual impact.

5.2 Conversely, compliance improved in 18 topics, a significate improvement compared with the previous month. Increases range from 0.05% (Fire Safety eLearning) up to 6.03% (Resuscitation - Level 3 - Paediatric Immediate Life Support).

5.3 Resus Level 2 has seen another increase of just under 0.5% in compliance but it is still below the target of 95%. There are dates in various locations in April, compliance will be continued to be monitored. Since the topic has been targeted, we have seen monthly increases in compliance, so action is being taken. More work needs to be done with regards to the 3-month notification of expiry.

5.4 Resus Level 3 as predicted also did not reach the 95% target. However, there was significant improvement in compliance where it increased by over 5%. Managers have been emailed where staff are non-compliant or due to expire prior to the end of May to try and reach this target in the coming months.

6.0 Sickness rate

6.1 Since March 2025 the rate continues to remain above target with marginal increases each Month until a slight decrease in January 2026, however, we have seen small increases in February and March. The rolling absence for month 12 is 5.73% whereas the in-month absence for January was 5.47%. The main drivers are stress, anxiety and depression conditions. The Managing Attendance Policy is in place and has been reviewed to ensure is fit for purpose. From the absence trigger reports we continue to see lower numbers than we have previously in terms of number of long-term cases (49 in February, 44 in January compared to 68 in December).

6.2 **Review of Short-Term sickness absence**

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

6.3 **Opportunities for Improvement in terms of long-term absence management**
Work is continuing on the following to improve management of long-term absence:

- Timely referral to Occupational Health by line managers.
- Prompt and accurate recording of absences.
- Improved communication between line managers and the People Team.
- Ensuring correct categorisation of absence reasons.

6.4 **Actions to Deliver Improvements - Current Focus**

- Support around health and wellbeing, resilience and flexibility to support reduction in absence levels are being implemented by the People Team.
- Implement the Health & Wellbeing Action Plan which also focusses on prevention
- Sending short term absence trigger reports to Line Managers with People Team oversight
- Conduct a health and wellbeing survey to gain a clear understanding of employees' perspectives on health and wellbeing (HWB) initiatives. This survey aims to identify the types of HWB initiatives employees would like to see introduced, assess employees' awareness of the HWB initiatives that are currently available within the Trust, and gather information on which initiatives employees have accessed to date. The findings will help evaluate engagement and utilisation of existing HWB resources and support the development of the 2026-27 HWB action plan
- Launch Myrecovery app which focuses on MSK issues and will be available to all staff

7.0 Staff survey update

7.1 The Trust has received the results of this year's NHS Staff Survey. We will be reviewing the We are Safe and Healthy elements to inform the HWB action plan for 2026-27.

8.0 Vacancies

8.1 Vacancy levels continue on a positive downward trend and at Month 12 we remain under target (7.86% vs 8.0%).

8.2 Month 12 vacancy position is 7.86% (137.14 WTE) a slight increase on month 11 position (7.68%), Month 12 top hotspots are: Ludlow CH, MSK therapies, LCH 9.1%, UEC, Dudley 0-19 (on hold due to MOC). The recruitment team are focusing on these areas and prioritising recruitment activity accordingly.

8.3 **Actions to Deliver Improvements - Current Focus**

Focussing recruitment efforts by prioritising recruitment hotspot areas. The recruitment team are liaising with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.

- Development of a trust recruitment video which is in the final stages of completion
- The recruitment team have held 5 targeted recruitment events, to recruit bank HCA to limit the need for agency with a total of 77 offers being made on the dates of the recruitment events with a total of 64 progressing through to appointment.
- Rolling bank recruitment events are being scoped with ops and the recruitment team on different options available on venues and format of the event.

9.0 Agency Spend

9.1 Month 12 agency use is 23.4 WTE with an expenditure of £245K against a plan of 27.3 WTE and £228k, a variance of (3.8) WTE and (£100k) respectively.

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

- Long Covid (service dependent on funding),
- UEC (Virtual Ward and Integrated Frontdoor, expansion of services so new medical posts),
- Paediatrics (LTS and wait list)
- Stoke Heath. Stoke Heath have recruited with a start date of 1 May 2026.

9.3 **Actions to Deliver Improvements - Current Focus:**

- New medical posts in UEC – working with Ops managers on job descriptions and Royal College approval. Ops undertaking an Options Appraisal to re-assess the medical workforce required.
- Use of NHSP National Bank.
- Fast tracking any HCA's going through recruitment for bank and permanent roles
- Centralised Bank - a high-level implementation plan is in progress. Additional staffing resources will be considered as part of the People team structure review (phase 2), in the interim, work is being undertaken to scope possible solutions for the provision of a limited centralised bank.
- Introduction of Stream – Initiative designed to support staff with access to accrued salary or bank pay at short notice – planned launch date of 1 May 2026.
- Price Cap Compliance - Medical and Dental staff groups are following the West Midlands Regional Rate card until NHSE advise of the new Price Cap.
- Actions to support reducing vacancies which includes a monthly focus on targeted hotspots and recruitment events.
- Maximise the availability of our workforce through monitoring and improving roster practices.

10.0 Total shifts exceeding capped rate

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

11.0 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

12.0 Conclusion

The Boards are asked to **note**:

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

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	014/26d		
Report Title	SaTH Integrated Performance Report		
Executive Lead	Jo Williams, Group Chief Executive Officer		
Report Author	Ned Hobbs, Deputy Chief Executive Officer		
Prior Consultation:	**CQC Domain:**		**Link to SaTH BAF id(s)**
QOC - 2026.04.21 PAC - 2026.04.21 FAC - 2026.04.28	Safe	√	BAF 1, 2, 3, 4, 5, 8, 9, 10, 11, 12
	Effective	√	
	Caring	√	**SaTH Risk Register id(s):**
	Responsive	√	**All risks**
	Well Led	√	
Executive Summary:	The report provides an update on progress against the Trust's Operating plan and associated objectives and enablers. The 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 February 2026/March 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		

NHS

Shropshire, Telford and Wrekin Community and Hospitals

NHS Group

Integrated Performance Report

Board of Directors Meeting 14th May 2026

Presenting Month 12 performance data

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

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Quality Patient Safety and Clinical Effectiveness	Chief Nursing Officer Medical Director	4
Responsiveness	Chief Operating Officer	40
Well-led (Workforce)	Chief People Officer	55
Well-led (Finance)	Director of Finance	64
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Executive Summary

Urgent and Emergency Care (UEC) 4-hour performance (type 1 & type 3) remains in common cause variation in March 2026. Type 1 performance increased to 45.3% and Type 3 performance increased to 86.1%. Average ambulance handover time shows common cause variation in March and was better than plan with 79.4% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows common cause natural variation and was the best since June 2023.

The Trust has a break-even plan for 2025/26 (this includes deficit support of £45.1m). At the end of March (month twelve), the Trust has delivered a surplus position of £4.92m against the breakeven plan. The trust has an efficiency target of £41.4m in 2025/26. At the end of March, £41.54m has been delivered which is £0.14m more than plan. At the end of March against the numbers reported in February (actual worked) there has been increase of 57 WTE overall, there has been an increase in worked agency of 13 WTE and an increase in worked bank of 44 WTE however substantive remained constant. The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £127.17m in FY25/26, giving a total capital programme of £149.70m. The Trust held a cash balance at the end of March 2026 of £73.21m.

For Electives, the Trust Position for March 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 1 x 104 weeks, 14 x 78 weeks, 79 x 65 weeks 174 x 52 weeks
The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics. Daily meetings are in place with all clinical centres to monitor and manage the risk of breaches and support additional mitigations. Additional capacity was provided during March as part of the Q4 Elective sprint. Theatre utilisation in March 2026 is 81%.

The Trust is delivering above plan for all cancer metrics. Confirmed February cancer performance is 85.5% (28-day FDS) vs the local plan of 77.2%. 62-day performance was 75% against a local target of 68.7% and 31 day was 99.2% against a local target of 95.9%. The 62-day backlog is 163 patients over 62 days of which 33 are over 104 days (as at 7.4.26). The 62 day backlog is 169 as of 20/04/2026 which 33 are over 104 days.

The submitted DM01 position for March 2026 was 84.5%, improved performance in echocardiography and NOUS, but still demonstrating special cause improvement. The number of 6-week breaches increased to 2184.

Quality Patient Safety, Clinical Effectiveness and Patient Experience

Executive Leads :

Interim Chief Nursing Officer
Paula Gardner

Medical Director
John Jones

Integrated Performance Report

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2		20% < 2024-25	29	15	34	26	27	28	26	21	27	35	24	21	35	26	
	Pressure Ulcers - Category 2 per 1000 Bed Days		20% < 2024-25	1.06	0.61	1.30	1.00	0.99	1.11	1.01	0.81	1.03	1.30	0.95	0.81	1.30	1.04	
	Pressure Ulcers - Category 3		10% < 2024-25	6	8	11	8	1	4	4	9	6	2	9	3	9	6	
	Pressure Ulcers - Category 3 per 1000 Bed Days		10% < 2024-25	0.16	0.33	0.42	0.31	0.04	0.16	0.16	0.35	0.23	0.07	0.36	0.12	0.33	0.24	
	Pressure Ulcers - Category 4		0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	
	Falls - per 1000 Bed Days		5% < 2024-25	3.94	4.15	4.24	3.99	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.50	4.90	4.87	
	Falls - total		-	107	102	111	104	104	95	118	106	110	110	99	116	132	122	
	Falls - with Harm per 1000 Bed Days		5% < 2024-25	0.21	0.08	0.31	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.16	0.11	0.04	
	Falls - Resulting in Harm Moderate or Severe		0	0	2	8	5	2	5	6	3	6	2	2	4	3	1	
Patient Experience	Complaints		-	-	77	87	85	91	114	127	106	114	116	105	102	122	118	
	Complaints - responded within agreed timeframe - based on month response du		85%	85%	50.0%	48.0%	48.0%	42.0%	44.0%	49.0%	49.0%	43.0%	50.0%	50.0%	51.0%	60.0%	56.0%	
	Complaints by Theme - Access to Treatment or Drugs				1	7	2	0	4	5	6	4	4	8	13	11	7	
	Complaints by Theme - Admission / Discharge				18	20	25	16	18	25	27	16	19	23	24	34	27	
	Complaints by Theme - Appointment				9	15	11	16	24	19	21	19	17	16	27	24	27	
	Complaints by Theme - Clinical treatment				49	49	42	47	72	71	63	59	55	53	63	71	71	
	Complaints by Theme - Commissioning Decisions				0	0	0	0	0	0	0	1	0	1	0	0	0	
	Complaints by Theme - Communication				38	51	48	40	62	60	60	49	46	57	64	70	60	
	Complaints by Theme - Consent to treatment				1	2	2	2	2	2	1	2	2	3	7	4	3	
	Complaints by Theme - Dementia Care				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - End of life care				3	4	2	2	5	0	6	2	2	5	1	6	2	
	Complaints by Theme - Facilities				3	9	7	4	5	7	13	2	2	2	5	12	5	
	Complaints by Theme - Mortuary				0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - Other				4	2	2	0	2	2	1	0	1	0	2	3	3	
	Complaints by Theme - Patient care				22	34	28	21	27	18	29	22	23	24	28	36	35	
	Complaints by Theme - Prescribing				1	2	4	6	7	9	6	3	5	5	7	5	4	
	Complaints by Theme - Privacy & Dignity				10	8	7	11	16	7	15	8	8	10	17	17	14	
	Complaints by Theme - Restraint				0	0	1	1	0	1	0	0	0	0	1	0	1	
	Complaints by Theme - Staff numbers				2	3	3	0	0	2	0	2	3	3	2	5	2	
	Complaints by Theme - Trust admin / procedure / records				6	4	3	7	10	11	15	12	7	2	9	21	26	
	Complaints by Theme - Values & Behaviours (staff)				18	17	24	27	37	41	31	34	35	46	40	37	40	
	Complaints by Theme - Waiting time				11	18	16	15	17	19	16	12	13	12	11	15	14	
	PALS - Count of concerns		-	-	366	362	330	365	351	375	318	397	407	321	278	448	408	
	Compliments		-	-	81	112	105	93	110	81	109	145	132	95	145	89	91	
	Friends and Family Test -SaTH		95%	95%	98.1%	97.6%	97.1%	93.2%	96.8%	88.3%	92.4%	79.8%	73.7%	77.1%	76.1%	76.0%	75.0%	
	Friends and Family Test - Inpatient		95%	95%	98.8%	97.5%	97.2%	91.4%	97.4%	96.9%	96.4%	92.0%	93.6%	95.1%	94.0%	92.7%	92.8%	
	Friends and Family Test - A&E		85%	85%	77.7%	77.0%	64.9%	51.7%	57.6%	63.0%	33.3%	62.1%	67.6%	70.5%	71.1%	72.2%	70.9%	
	Friends and Family Test - Maternity		95%	95%	100.0%	96.7%	95.5%	88.6%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	85.7%	87.5%	
	Friends and Family Test - Outpatients		95%	95%	99.5%	98.7%	99.0%	99.0%	97.6%	94.0%	92.9%	93.7%	92.2%	95.3%	92.8%	87.1%	91.5%	
	Friends and Family Test - SaTH Response rate %		-	-	5.5%	6.8%	5.2%	5.3%	4.8%	1.3%	1.2%	1.6%	3.6%	4.7%	4.5%	5.2%	4.9%	
	Friends and Family Test - Inpatient Response rate %		-	-	11.6%	16.8%	11.9%	12.8%	11.5%	2.2%	2.9%	2.0%	1.5%	2.6%	1.8%	1.9%	1.8%	
	Friends and Family Test - A&E Response rate %		-	-	1.0%	0.4%	0.6%	0.4%	0.3%	0.7%	0.1%	1.4%	5.0%	6.2%	6.2%	7.4%	7.1%	
	Friends and Family Test - Maternity (Birth) Response rate %		-	-	5.7%	6.9%	0.5%	6.6%	2.1%	0.7%	0.2%	0.4%	0.8%	0.7%	0.0%	0.3%	0.0%	

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

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Integrated Performance Report

Domain	Description	Regulatory	National Standard 25/26	Current Month Trajectory (RAG)	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)		100	100	95	103	93	102	90	98	93	106	-	-	-	-	-	
	Trust SHMI - Expected Deaths		-	-	246	255	240	243	224	238	225	208	-	-	-	-	-	
	Trust SHMI - Observed Deaths		-	-	234	262	224	248	201	232	208	220	-	-	-	-	-	
	SJRs Completed by Month				25	31	20	33	20	17	12	17	18	14	11	16	10	
	MRSA - HOHA				0	1	0	0	0	0	0	0	0	1	0	2	1	
	MRSA - COHA				0	0	0	0	0	0	0	0	0	0	0	0	1	
	MRSA - Total	R	0	0	0	1	0	0	0	0	0	0	0	1	0	2	2	
	MSSA - HOHA		-	-	3	2	2	3	1	2	2	1	0	2	3	1	1	
	C. difficile - HOHA				5	4	9	2	6	5	10	8	6	2	7	6	3	
	C. difficile - COHA				2	3	5	2	6	5	3	4	3	3	7	5	6	
	C. difficile - Total	R	98	8	7	7	14	4	12	10	13	12	9	5	14	11	9	
	E. coli - HOHA				6	2	3	2	3	2	8	6	5	5	5	4	5	
	E. coli - COHA				6	8	9	14	9	10	10	15	11	10	7	9	6	
	E. coli - Total	R	146	12	12	10	12	16	12	12	18	21	16	15	12	13	11	
	Klebsiella - HOHA				4	4	1	4	0	2	1	4	2	1	2	2	1	
	Klebsiella - COHA				2	1	5	2	1	1	5	4	3	3	2	3	2	
	Klebsiella - Total	R	36	3	6	5	6	6	1	3	6	8	5	4	4	5	3	
	Pseudomonas Aeruginosa - HOHA				0	1	0	0	1	0	0	0	1	0	0	0	1	
	Pseudomonas Aeruginosa - COHA				2	0	2	0	0	3	1	1	2	1	0	2	2	
	Pseudomonas Aeruginosa - Total	R	16	1	2	1	2	0	1	3	1	1	3	1	0	2	3	
	VTE Risk Assessment completion - SATH		95%	95%	75.6%	74.3%	75.6%	75.0%	75.5%	77.4%	77.2%	79.2%	79.6%	80.7%	78.3%	-	-	
	Never Events		0	0	0	0	1	0	0	1	0	1	1	0	0	0	0	
	Psii		-	-	2	2	4	1	0	1	0	3	2	3	0	1	0	
	Mixed Sex Accommodation - breaches		10% < 2024-25	97	60	86	101	87	65	52	38	46	63	56	46	66	40	
	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%	94%	95%	97%	96%	96%	99%	95%	97%	98%	95%	92%	95%	95%	
	Smoking Rate at Delivery		6%	6%	5.4%	5.6%	5.6%	4.0%	5.9%	5.0%	4.4%	5.9%	4.2%	4.3%	4.9%	6.6%	3.3%	

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

Pressure Ulcers
A reduction in Category 3 pressure ulcers compared to the previous year, alongside a recent increase in Category 2 and Category 4 pressure ulcers. Enhanced review and assurance processes have been implemented, including senior-led reviews of higher-category ulcers with mandatory six-week follow-up. Progress was noted on the procurement of new pressure-relieving mattresses, with Trust-wide implementation planned for July, supported by staff training. QOC supported extension of the new processes across Shropcom services to ensure consistency.

Falls
It was noted an increase in falls and falls with harm during Quarter 4; however, a year-on-year reduction in overall falls and falls with harm was acknowledged. A six-week pilot of the Bedside Mobility Assessment Tool on two wards demonstrated improved patient mobilisation and a reduction in falls, with no falls with harm recorded during the pilot period. The QOC supported a phased Trust-wide rollout of BMAT, subject to a formal implementation plan and divisional engagement, recognising capacity constraints within the Quality Team.

Norovirus
Operational challenges were noted within frailty SDEC, with disruption attributed in part to a norovirus outbreak affecting service flow.

PEWS
Verbal update on the PEWS figures to be given at the QSAC meeting.

Quality - Safe - Deteriorating Patients - Fragility

Partnering · Ambitious · Caring · Trusted

NHS The Shrewsbury and Telford Hospital NHS Trust

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

	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
Improve Dementia screening rates - Patient had an AMT - ED	81.8	100.0	33.8	77.8	76.5	36.4	44.9	45.5	42.5	42.5	66.7					
Improve Dementia screening rates - Patient had an AMT - Adult IP	67.0	55.7	58.2	44.6	53.7	47.1	44.7	43.2	48.1	53.1	52.7	58.4	64.1	70.3	63.2	78.0
Dementia Awareness Tier 1 3 Yearly	97.22	95.75	96.08	96.60	96.06	95.54	95.34	94.95	92.96	89.75	91.04	90.07	91.44	92.44	92.73	92.98
Dementia Awareness Tier 2 3 Yearly	92.59	93.25	93.51	93.02	92.99	93.53	93.19	91.93	92.86	93.00	92.26	92.01	91.19	86.13	86.31	85.46
Dementia Screening % Score	73	67	83	86	87	84	86	92	95	93	97	94	97	98	98	96
Dementia Screening Audited	246	189	207	202	200	245	248	234	250	245	242	238	210	214	263	286

Improve Dementia screening rates - ED

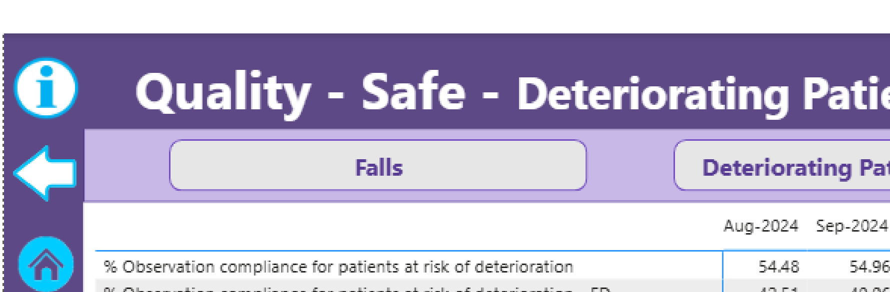
Dementia Awareness Tier 1 - 3 Yearly

Dementia screening score %

Improve Dementia screening rates - Adult IP

Dementia Awareness Tier 2 - 3 Yearly

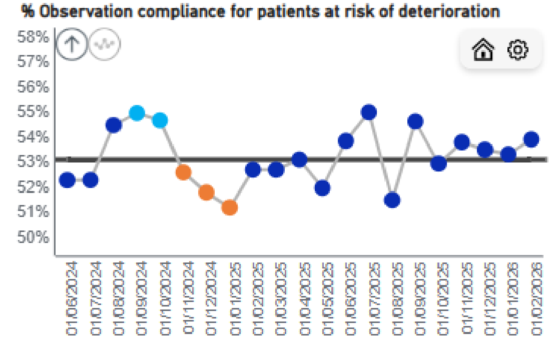
Dementia screening audited

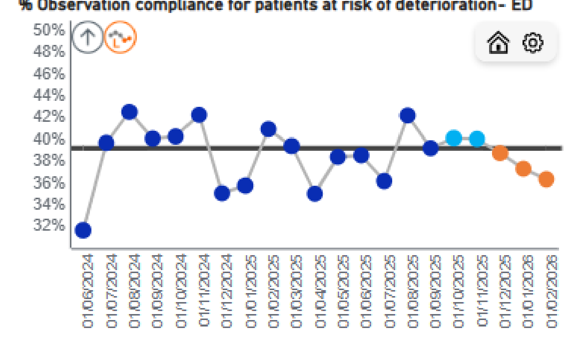


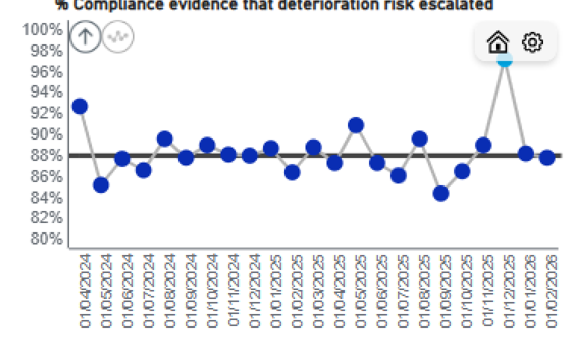
Quality - Safe - Deteriorating Patients - NEWS

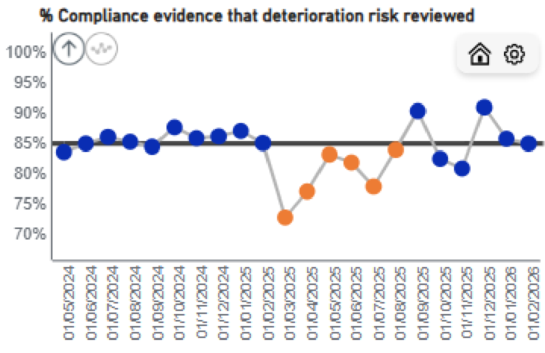
Falls | Deteriorating Patients - Fragility | Deteriorating Patients - PEWS | Medication - Omitted Doses

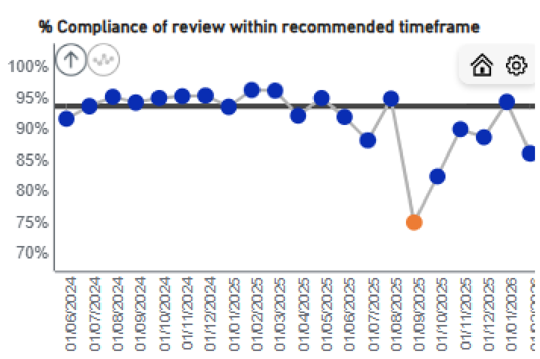
	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
% Observation compliance for patients at risk of deterioration	54.48	54.96	54.67	52.59	51.79	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49	54.63	52.95	53.80	53.50	53.32	53.91
% Observation compliance for patients at risk of deterioration - ED	42.51	40.06	40.26	42.24	35.05	35.74	40.92	39.38	35.01	38.38	38.52	36.16	42.18	39.18	40.10	40.03	38.73	37.28	36.32
% Compliance evidence that deterioration risk (NEWS2) escalated	89.60	87.80	89.00	88.10	88.00	88.70	86.40	88.80	87.30	90.90	87.30	86.10	89.60	84.40	86.50	89.00	97.20	88.20	87.80
% Compliance evidence that deterioration risk (NEWS2) reviewed	85.20	84.40	87.60	85.80	86.10	87.00	85.00	72.70	77.00	83.10	81.80	77.80	83.90	90.30	82.40	80.80	90.90	85.70	84.90
% Compliance of review within recommended timeframe	95.20	94.30	95.00	95.30	95.40	93.60	96.30	96.20	92.20	95.00	92.00	88.20	94.90	75.00	82.40	90.00	88.70	94.40	86.10
% Compliance reviewed by recommended seniority	97.90	97.90	98.40	98.90	96.80	98.60	98.40	96.40	97.50	96.60	97.60	99.50	98.50	92.10	88.60	89.10	98.40	94.40	93.60
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	85.40	87.90	89.40	92.40	86.50	85.10	85.20	95.00	69.60	90.90	100.00	100.00	100.00	82.60	68.20	100.00	90.00	90.00	84.00

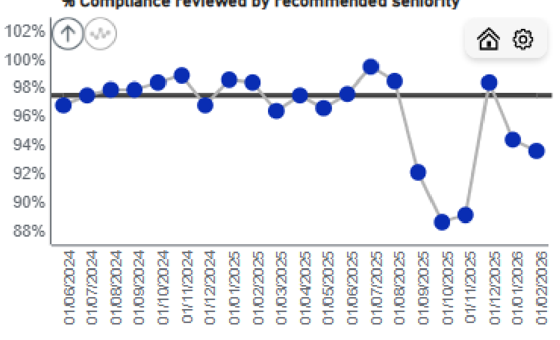

% Observation compliance for patients at risk of deterioration

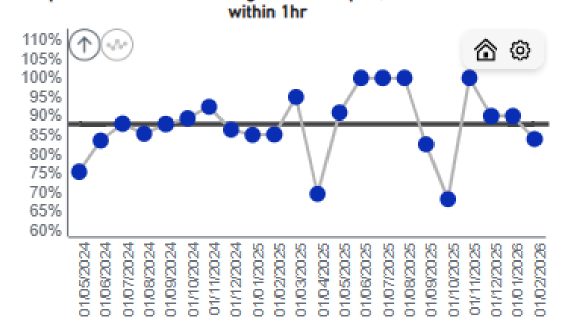

% Observation compliance for patients at risk of deterioration- ED


% Compliance evidence that deterioration risk escalated


% Compliance evidence that deterioration risk reviewed


% Compliance of review within recommended timeframe


% Compliance reviewed by recommended seniority


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

Deteriorating patients – NEWS2

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

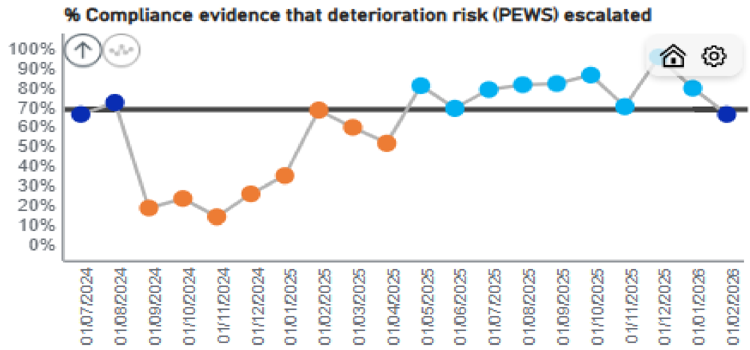
Summary:
Observation compliance remains well below the ≥90% standard, with inpatients at 53.50% and ED at 38.73%, reflecting ongoing challenges in early recognition. Escalation compliance has risen to 97.20%, with review compliance also improved (90.90%) and supported by strong senior oversight (98.40%).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

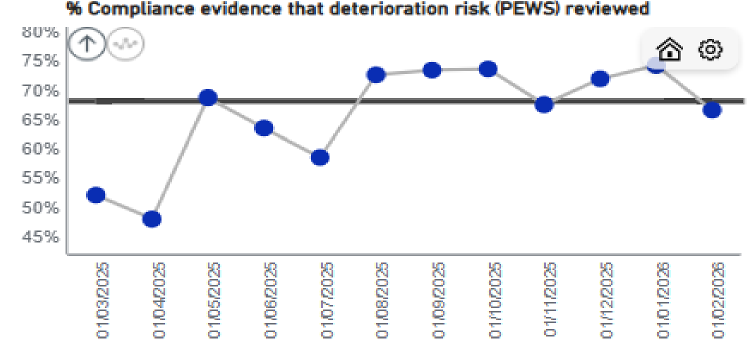
Recovery Actions:	Anticipated impact and timescales.
1.**Driving team-led observation safety** to embed consistent, safe practice • Embed consistent observation safety through team-led practice • Integrate observation reports for system feedback and oversight • Improve visibility via digital tools and dashboards • Work with clinical teams to address issues identified through system feedback • Work with ED teams to support implementation of new observation protocols **2. Enhance personalised care** to ensure the right escalation and response for each patient • Tailored patient response tools (e.g. individualised management plans aligned to enhanced response standards such as the MECTP project) have been designed and are now awaiting medical governance approval to commence trial. **3. Continue monitoring review timeliness** and flagging areas for improvement with clinical teams **4. Sepsis Recognition and Management**: • Maintain sepsis oversight on key metrics, share learning and success stories, ongoing assurance to governance teams	1. 3 months 2. 12 months 3. 1months 4. 6 months

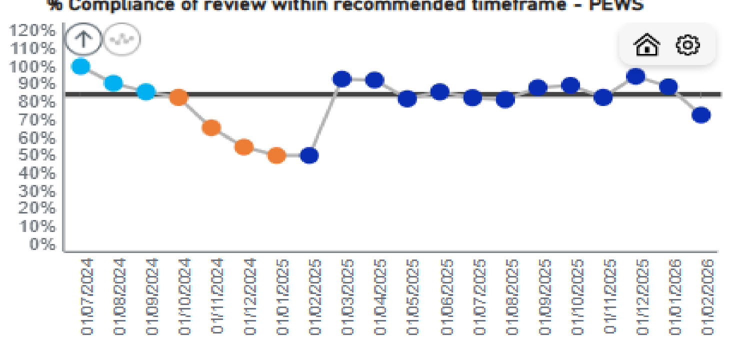
Recovery dependencies:	• Deteriorating patient team to Support understanding of systems data to drive improvement • Continue governance and clinical engagement in deteriorating patient workstreams

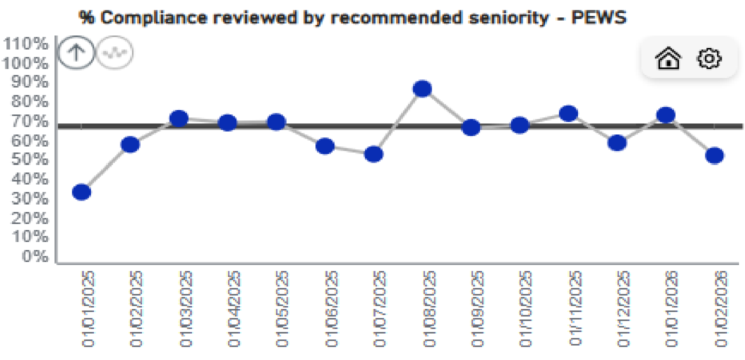
Quality - Safe - Deteriorating Patients - PEWS

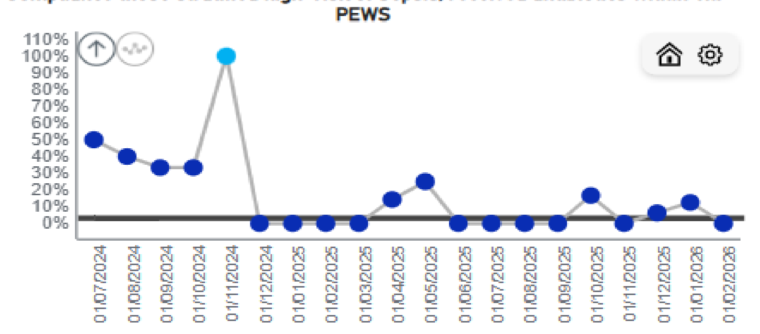
	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
% Compliance evidence that deterioration risk (PEWS) escalated	35.30	68.80	60.00	51.90	81.30	69.70	79.30	81.80	82.40	86.80	70.60	96.00	80.00	66.70
% Compliance evidence that deterioration risk (PEWS) reviewed			52.20	48.10	68.80	63.60	58.60	72.70	73.50	73.70	67.60	72.00	74.30	66.70
% Compliance of review within recommended timeframe - PEWS	50.00	50.00	92.90	92.30	81.80	85.70	82.40	81.30	88.00	89.30	82.60	94.40	88.50	72.70
% Compliance reviewed by recommended seniority - PEWS	33.30	57.90	71.40	69.20	69.60	57.10	52.90	86.70	66.70	67.90	73.90	58.80	73.10	52.20
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr - PEWS	0.00	0.00	0.00	14.30	25.00	0.00	0.00	0.00	0.00	16.70	0.00	6.30	12.50	0.00











Deteriorating patients – PEWS & NEWTT2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

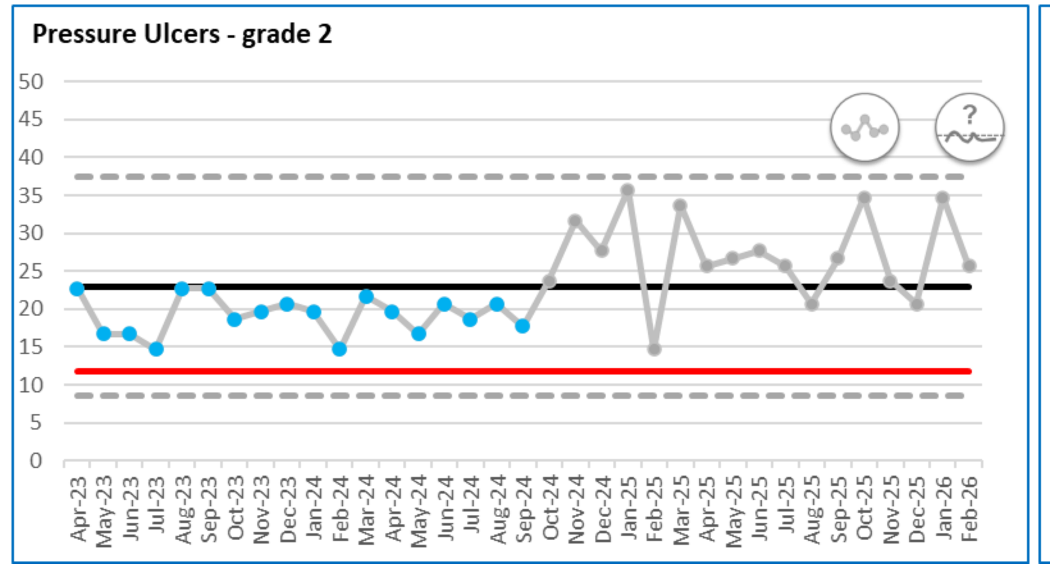
Summary:
In February 2026, 39 patients were audited. Of those requiring escalation, 66.6% (26 CYP) had documented evidence of escalation. Of the 33.3% (13 CYP) who did not have documented evidence of escalation, 6 CYP received verbal advise by the medical staff/ ACP which was documented by the nurse and 7 CYP had no documented evidence of escalation.
Of the CYP requiring review, compliance has decreased to 65 % (13 CYP). The 35 % (7 CYP) who were not reviewed, 2 CYP were following individualised care plan documented by the medical team. The other 5 CYP had no documented evidence of review.
With regards to sepsis, 74.35% (29 CYP) were screened for sepsis at their initial assessment which is a decrease in compliance from 86% in January. 43.58% (17 CYP) showed high-risk indicators. 15% (3 CYP) have been de-escalated, as they were deemed not septic but were being treated for alternative diagnoses.
43.58 % (17 CYP) were eligible for IV antibiotics, 0 % of audited CYP (0 CYP) received IV antibiotics within 60 minutes due to the treatment of alternative diagnosis. The 17 CYP audited showed that 1 CYP was already receiving IV antibiotics, 2 CYP were receiving treatment for Asthma, 3 CYP were on an individualised care plan, 5 CYP were discharged home,1 CYP was treated as RSV, 1 CYP was awaiting a surgical review, 1 CYP was treated for gastroenteritis, 1 CYP was on a palliative care pathway and 2 CYP were receiving oral antibiotics.

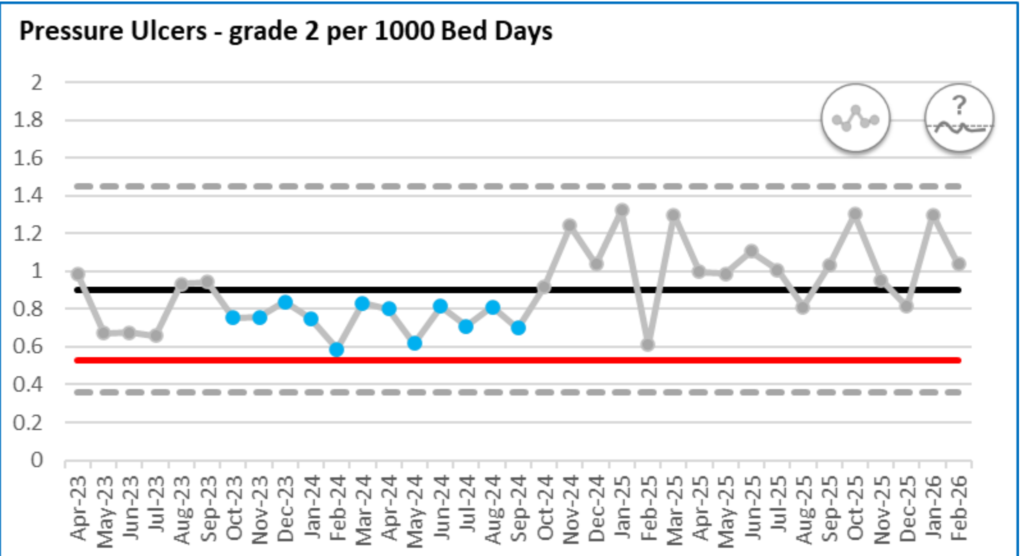
Recovery actions:	Anticipated impact and timescales for improvement:
On reviewing the audits further improvement is required in relation to documentation following reviews, De-escalating sepsis when indicated and escalation of PEWS which remains a key message within Paediatrics. • Escalation Compliance: Work to improve documentation of escalation is being supported by the paediatric PEF team, simulation training, and audit feedback via newsletters and huddles • Data is discussed at Governance meetings and sent to the Tier 2 medics/ ACP • IV Antibiotic Compliance:0% due to no CYP requiring IV antibiotics within the audit, alternative diagnosis treated • Documentation: De-escalation of sepsis triggers via vitals and documenting reviews one of the key challenge within Paediatrics as the majority of children presenting to the department triggering sepsis is due to children's physiology and response to illness. Ongoing education continues for both medical staff and new nurses • New board huddle introduced with Consultants, Ward Managers, Matrons to highlight the children triggering for sepsis who have not been de-escalated. Huddle introduced 10/11/25	6-12 months

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

Patient harm – pressure ulcers – Category 2

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

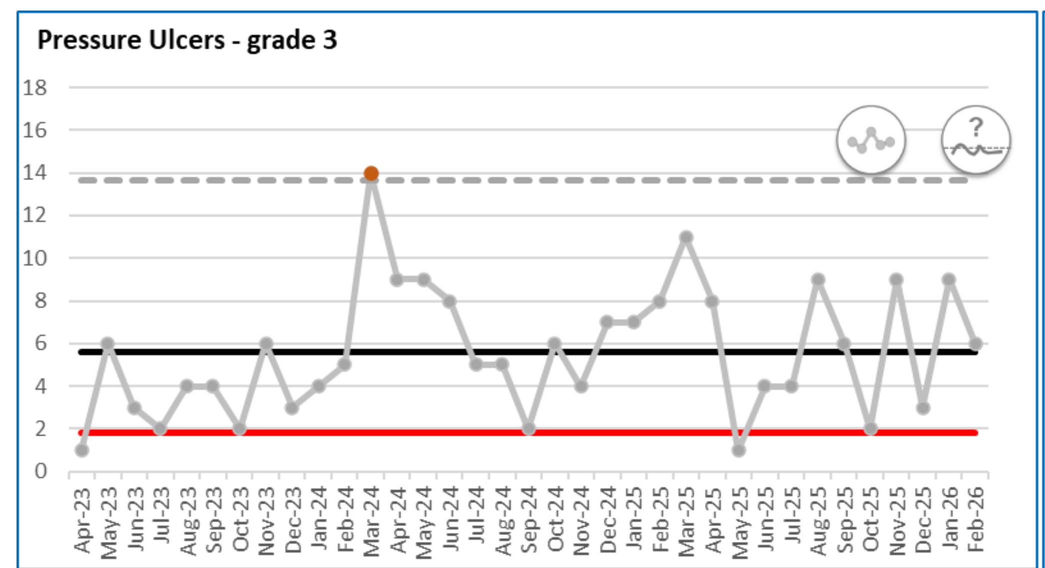


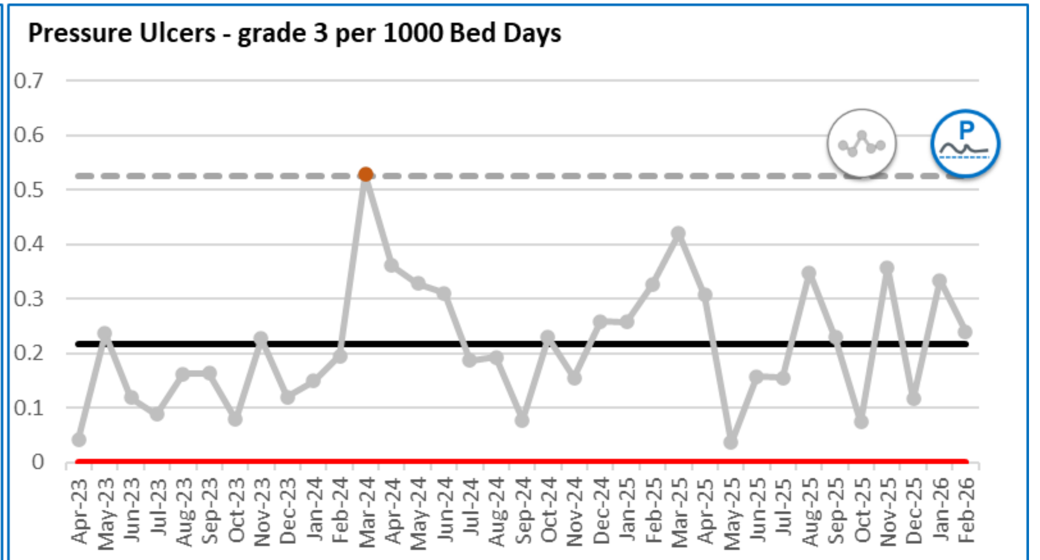


Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	14
Surgery, Anaesthetics and Cancer	11
Women's & Children's	0
Clinical Support Services	1

Patient harm – pressure ulcers – Category 3

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

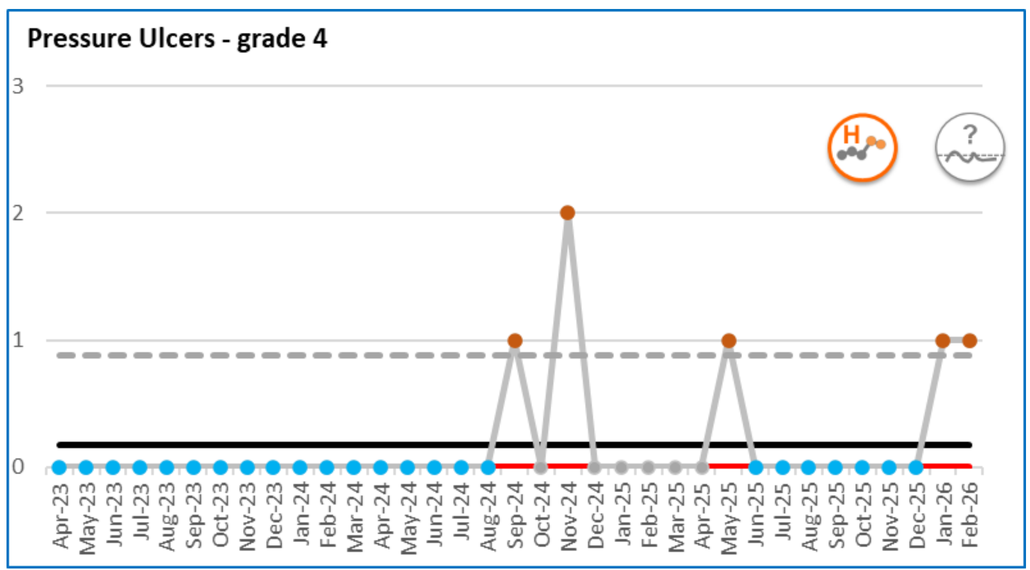




Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	5
Surgery, Anaesthetics and Cancer	1
Women's & Children's	0
Clinical Support Services	0

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	1
Women's & Children's	0
Clinical Support Services	0

Patient Harm – pressure ulcers

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary: The number of Category 2 injuries has decreased this month. The number of category 3 pressure ulcers has also decreased in month. The 6 category 3 pressure ulcers in month were attributed to ward 9,25,26, AMU RSH x2 and ward 37. Of these 6 category 3 pressure ulcers 4 were to buttock/sacrum and 2 were device related. Following the pressure ulcer review meeting the missing elements in documentation were skin assessments, patient repositioning schedule, position change, and core care plan was not completed for 2 patients. There were occasions where pressure relieving equipment was not available, and therefore mitigation would have been more frequent repositioning until equipment became available and a Datix completed. There has been 1 category 4 pressure ulcer this month attributed to ward 4. On review of this there were gaps in repositioning, body maps, patient education, and skin inspection charts. There was also no documentation to say patient was not always compliant. There were 24 reported Deep Tissue Injuries this month which is a decrease of 11 from last month. These figures are correct at the time of validation by the Tissue Viability Service.

Recovery actions:

- Hospital acquired C3 and 4 injuries are reviewed by the Tissue Viability Team and ward manager/matron within 1 week. All category 2 pressure ulcers are reviewed by ward managers. All injuries are reviewed in line with the aSSKINg care bundle to identify areas of learning and to ensure no requirement for after action review
- All injuries sustained in trust are checked against the decision support tool for safeguarding concerns and are escalated if required with the local authority in conjunction with the Trust safeguarding team
- All injuries sustained in Trust are presented at the monthly Pressure Ulcer Review Meeting where areas for learning and actions taken to embed are discussed (new PURM process to commence in March)
- Business case completed for all patients to have a hybrid pressure relieving mattress on admission, this has now been supported and is following the tendering process. An increase of 20%, 40 more pressure relieving mattresses has been agreed to meet the shortfall due to increasing request for mattresses. There are still occasions where the demand for a pressure mattress cannot be met and more frequent repositioning should be considered

Current actions in place/ongoing are:

- Introduction of upgraded alternating air mattress with associated staff education to improve device use and availability
- Increase on the amount of alternating air mattress in the contract in November to meet the demand of patients requiring one (as above)
- Offloading boot availability at ward level to reduce delays in placement
- Utilisation of ward education Facilitators and the Quality facilitators in education regarding pressure ulcer documentation and associated nursing actions more 1:1 face to face sessions on ward
- Ward manager focus on Tissue Viability Documentation completion, discussed in safety huddle and spot checks carried out and discussed at monthly Nursing Quality metrics
- Skin assessment booklet revised and updated

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

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

Quality - Safe - Falls

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

	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
Falls - Total	117	104	118	113	102	111	104	104	95	118	106	110	110	99	116	132	122
Falls - per 1000 Bed Days	4.82	4.05	4.37	4.15	4.15	4.24	3.99	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.50	4.90	4.87
Falls - Resulting in Harm Moderate or Severe	4	2	5	6	2	8	5	2	5	6	3	6	2	2	4	3	1
Falls - Resulting in Harm - per 1000 Bed Days	0.16	0.08	0.19	0.22	0.08	0.31	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.16	0.11	0.04
Falls Prevention Training Compliance % - 2 Yearly	92.59	92.77	92.84	93.36	90.03	88.75	86.04	82.66	81.46	81.73	83.18	84.36	85.31	85.08	85.16	85.61	86.19
% Completion of Falls Risk Assessments	93	93	95	96	93	93	92	92	91	90	92	90	92	93	91	91	91

Falls - Total

Falls - per 1000 Bed Days

Falls - Resulting in Harm Moderate or Severe

Falls - Resulting in Harm - per 1000 Bed Days

Falls Prevention Training Compliance % - 2 Yearly

% Completion of Falls Risk Assessments

Patient harm - falls

Summary:
There were 122 falls in February which is a decrease of 10 from the previous month. From April 2025 until March 2026 there has been a decrease of 33 falls for the same time-period in 2024-25, with a reduction of 8 falls with harm.
There was 1 fall resulting in moderate harm in February which is a decrease from January.
The injuries sustained was a dislocated shoulder on AAU PRH. On review of this fall the risk assessment, management plan, lying and standing blood pressure were all correct and in place pre fall. Post fall the risk assessments and management plan had not been updated. The lying and standing blood pressure could not be completed post fall due to the patient's condition. Common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.

Recovery actions:

Current falls projects being progressed is a pilot of BMAT (Bedside Mobility Assessment Tool), a patient early mobilisation tool which will also help with hospital associated deconditioning. Ward 26 and ward 11 started the trial on 16th February 2026.
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. Letters are sent to the individual nurse who completed the post fall documentation where elements pre/post fall may have been missed. Education takes place at the time of the falls review addressing any non-compliance
Completion of lying and standing BP compliance is still low pre fall, the quality team are focusing on raising awareness and improving compliance. This is also discussed in Metrics.
Falls training and completion of risks assessments discussed in monthly Metrics meetings.

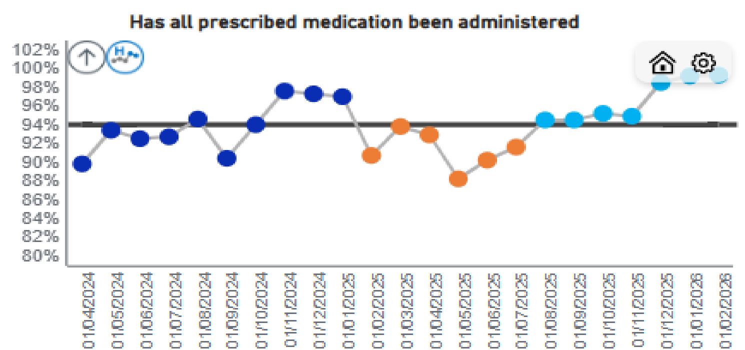
Anticipated impact and timescales for improvement:
Beside mobility assessment – BMAT commenced with a pilot on ward 11 and ward 26 in February 2026.
Review of all falls continues with feedback presented to WM and a letter sent to nurse caring for the patient at the time of fall.
Lying and standing blood pressure awareness. This is checked monthly through documentation audits by the Quality team and discussed in Nursing Quality assurance meeting

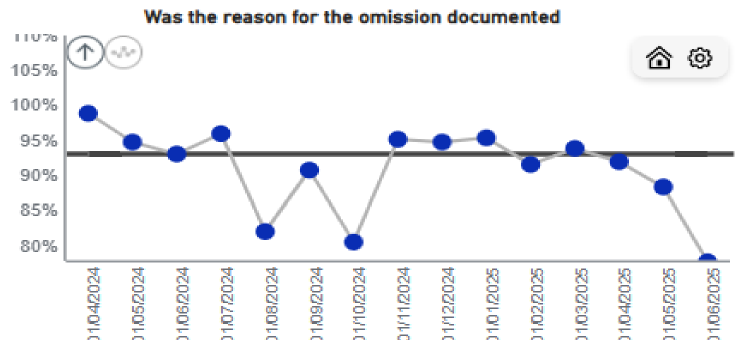
Recovery dependencies:	Support to further embed reconditioning into everyday practices from ward teams by embedding mobilisation dependant on risk assessment

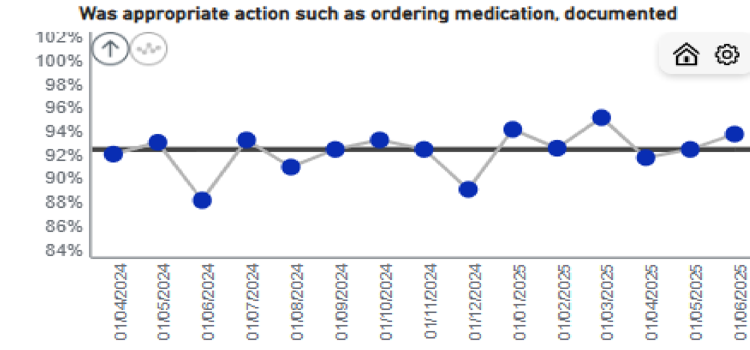
Quality - Safe - Medication - Omitted Doses

Falls | Deteriorating Patients - Fragility | Deteriorating Patient

	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
Has all prescribed medication been administered?	97.6	97.3	97.0	90.7	93.8	92.9	88.2	90.2	91.6	94.5	94.5	95.2	94.9	98.5	99.2	99.3
Was the reason for the omission documented?	95.2	94.8	95.4	91.6	93.9	92.0	88.4	77.8								
Was appropriate action such as ordering medication, documented?	92.5	89.1	94.2	92.6	95.2	91.8	92.5	93.8								







Medication – omitted doses

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

Summary:

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

Performance indicators currently used to identify incidents of omitted doses include:

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

Recovery actions:

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

Anticipated impact and timescales for improvement:

In-line and aligned to the PSIRF Trust Priority – Omitted doses of time critical medication.

In line with full implementation of EPMA within the Trust.

Recovery dependencies:

Infection prevention and control

Shropshire, Telford and Wrekin Community and Hospitals

MSSA - HOHA

MRSA - HOHA & COHA

C. difficile - HOHA & COHA

E. coli - HOHA & COHA

Klebsiella - HOHA & COHA

Pseudomonas aeruginosa - HOHA & COHA

Moving to EXCELLENCE

Shropshire, Telford and Wrekin Community and Hospitals

Infection prevention and control

C. difficile - HOHA

E. coli - HOHA

Klebsiella - HOHA

C. difficile - COHA

E. coli - COHA

Klebsiella - COHA

Moving to EXCELLENCE

Infection prevention and control

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Summary:
In February 2026 there were the following bacteraer

- 9 C. diff cases (3 HOHA, 6 COHA)
- 2 MRSA Bacteraemia (1 HOHA, 1 COHA)
- 3 MSSA Bacteraemia (1 HOHA, 2 COHA)
- 11 E. coli Bacteraemia (5 HOHA, 6 COHA)
- 3 Klebsiella Bacteraemia (1 HOHA, 2 COHA)
- 3 Pseudomonas Bacteraemia (1 HOHA, 2 COHA

Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD 25/26	Annual Target 25/26
C diff Infections	14	4	12	10	13	12	9	5	15	11	9	114	98
MRSA Bacteraemia	0	0	0	0	0	0	0	1	0	2	2	5	0
MSSA Bacteraemia	5	5	3	5	7	2	3	3	6	4	3	46	NA
E. Coli Bacteraemia	12	16	12	12	18	21	16	15	12	14	11	159	146
Klebsiella Bacteraemia	6	6	1	3	6	8	5	4	4	5	3	51	36
Pseudomonas aeruginosa Bacteraemia	2	0	1	3	1	1	3	1	0	2	3	17	16

Recovery actions:
- C. diff action plan ongoing. Plan for deep clean still outstanding, owned by Deputy COO
- All targets for HCAIs 2025/26 breached
- Business case to move forward with Fidaxomicin as first line treatment of C. diff is progressing. Fidaxomicin reduces the rate of recurrent C. diff infections and is associated with reduced environmental contamination with C. diff which would reduce the risk of onward transmission to others
- Reportable bacteraemia reduction action lan to be written by IPC lead nurse which will cover actions intending to reduce MRSA, MSSA, E.coli, Pseudomonas and Klebsiella bacteraemia's, this will include work on management of IV access devices and Urinary catheters

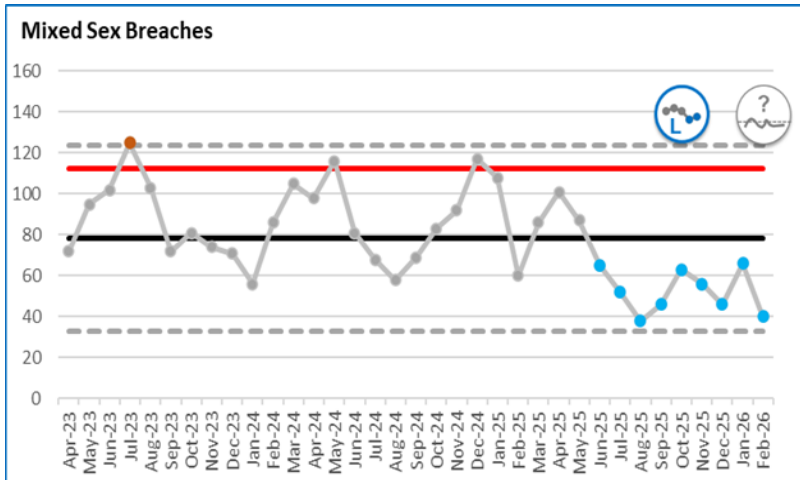
Anticipated impact and timescales for improvement:

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

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

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Mixed sex accommodation breaches



Location	Number of breaches	Additional Information
ITU / HDU (PRH)	2 primary	2 medical
SDEC (PRH)	12	over 3 occasions
Ward 16	6	over 3 occasions
ITU / HDU (RSH)	36 primary	11 medical, 23 surgical, 1 T&O, 1 nephrology
AAU (RSH)	4	1 occasion
SDEC (RSH)	**6**	1 occasion

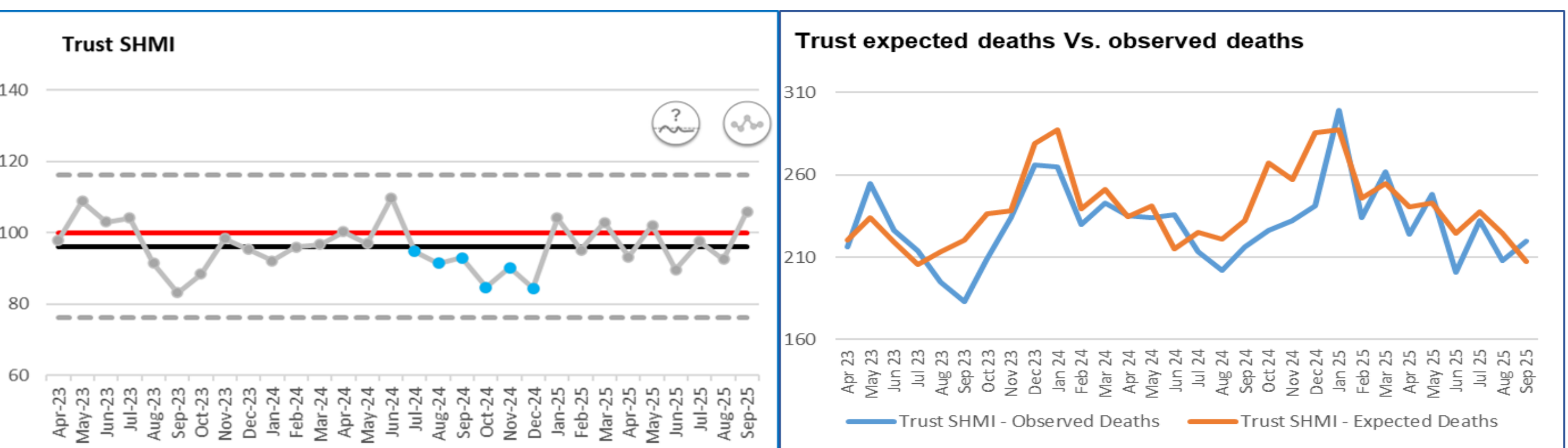
Summary:
February 2026 reflected a slight decrease in Mixed Sex breaches across the Trust, demonstrating a low special cause improving variation. This has been sustained through the high-capacity pressures through the Winter months. Mixed sex breaches in Critical Care are due to bed availability across the Trust and the delay in step down of patients from HDU/ITU particularly at RSH . There have been a number of Mixed sex beaches across the acute floor at both PRH and RSH, with five occasions affecting 22 patients due to capacity pressures. There have similarly been 6 breaches over three occasions in the Stroke Unit due to beds being used by mixed sex patients due to capacity pressures.

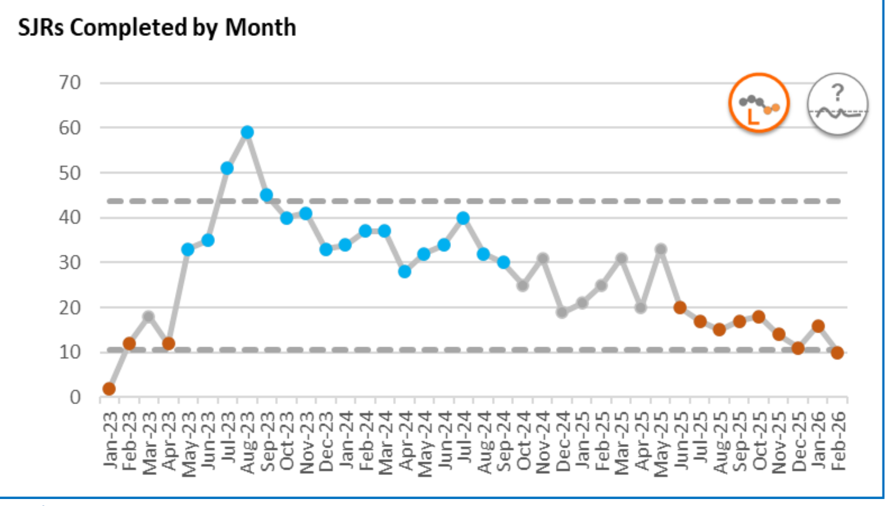
Recovery actions:
- Ensure Trust's application of the MSA Policy is consistently applied across the Trust
- Improvement work in relation to patient flow, discharges earlier in the day, and a reduction in patients with no criteria to reside continues
- The opening of additional beds at RSH and additional 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)
- 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
- Reconfiguration of Apley beds (PRH) in February 2026
- The March sprint in March 2026 to support ED transfers.
- Clinician at the front door trial (ED, PRH) March 2026.

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

Mortality outcome data





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

Mortality outcome data

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:

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

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

Recovery actions:

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

Anticipated impact and timescales for improvement:

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

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

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

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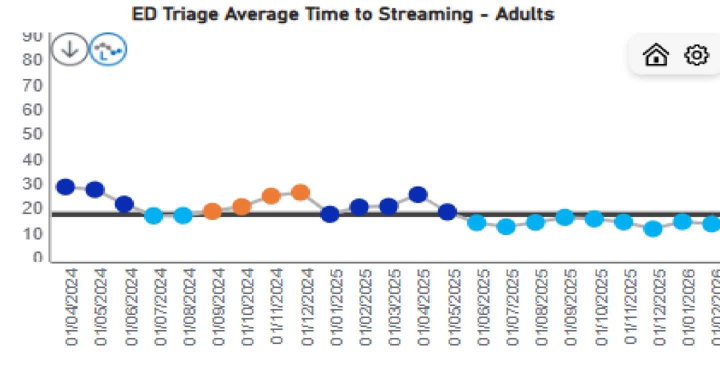
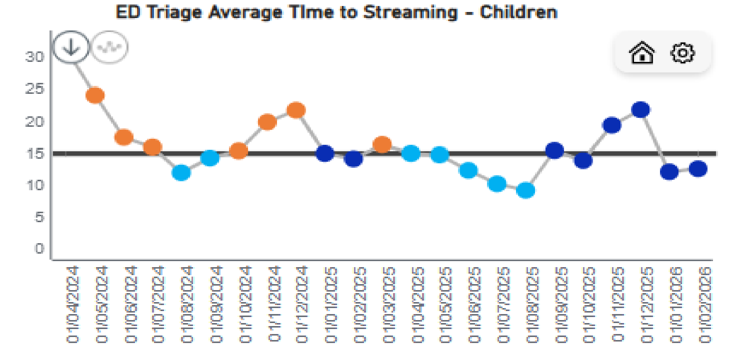
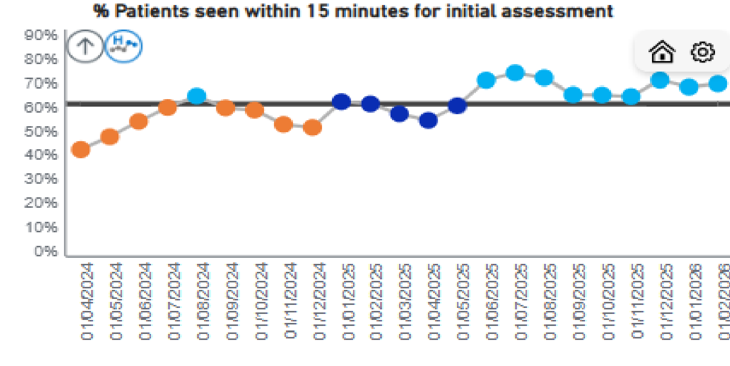
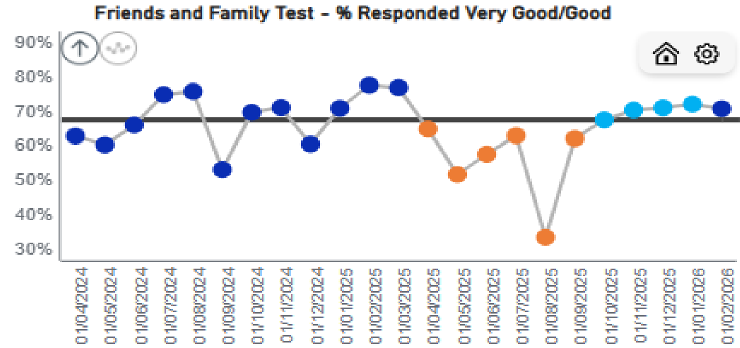
Best Clinical Outcomes

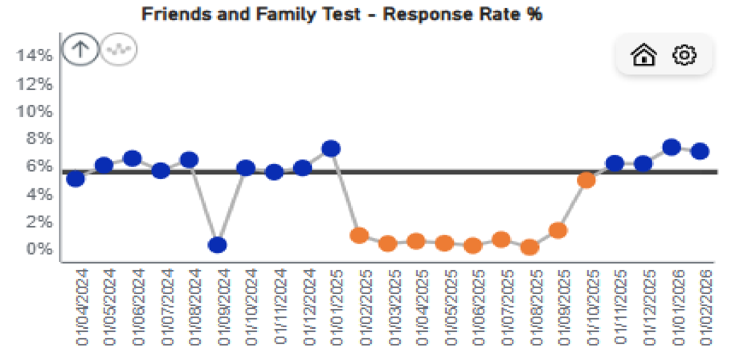
	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
ED Triage Average Time To Streaming - Adults	25.10	26.56	17.72	20.63	20.91	25.67	18.65	14.33	12.73	14.51	16.48	15.86	14.67	11.85	14.79	13.81
ED Triage Average Time To Streaming - Children	19.90	21.77	15.00	14.17	16.40	15.00	14.79	12.37	10.25	9.23	15.46	13.91	19.40	21.85	12.14	12.62
% Patients seen within 15 minutes for initial assessment	52.90	51.61	62.40	61.49	57.31	54.58	60.71	71.30	74.36	72.31	65.30	65.21	64.58	71.37	68.46	69.89
Friends and Family Test - A&E - % responded Very Good/Good	71.20	60.50	71.00	77.70	77.00	64.94	51.67	57.58	63.00	33.33	62.15	67.60	70.47	71.14	72.20	70.86
Friends and Family Test - A&E - Response Rate %	5.60	5.90	7.30	1.00	0.40	0.58	0.43	0.25	0.70	0.14	1.37	5.00	6.24	6.21	7.40	7.11
Complaints by Theme - Admission / Discharge	17	18	14	18	20	25	16	18	25	27	16	19	23	24	34	27

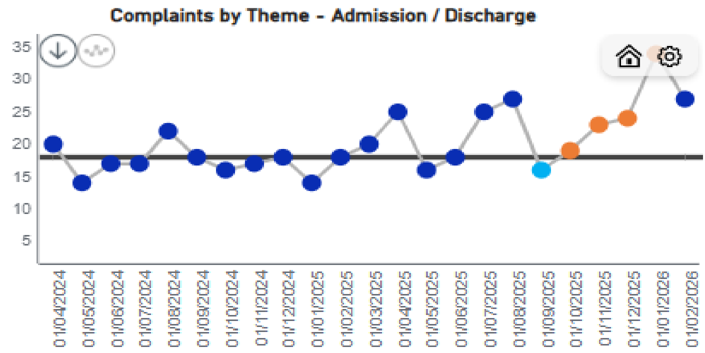










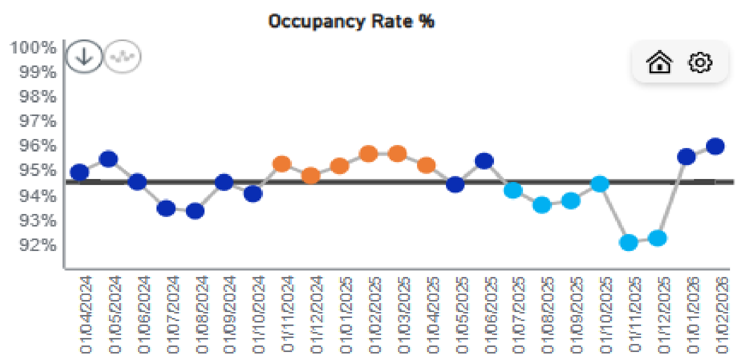


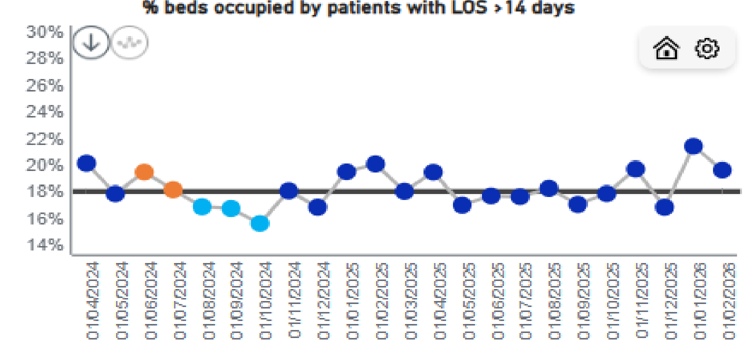
Quality - Effective - Right Care, Right Place, Right Time

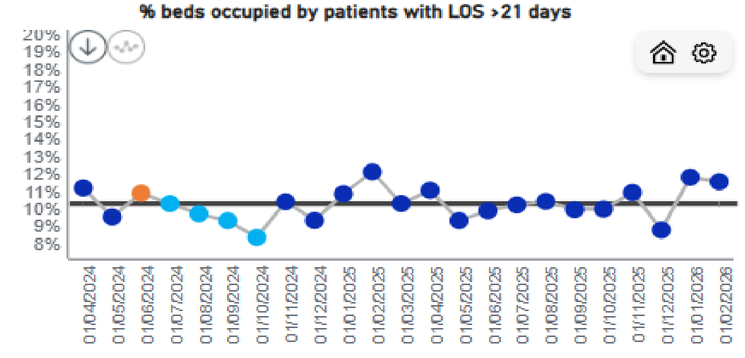
Page 1

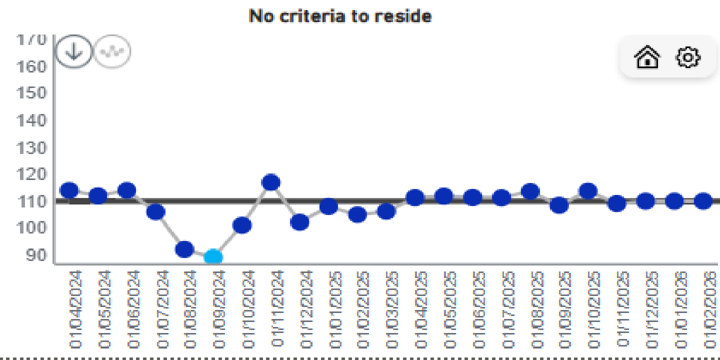
Best Clinical Outcomes

	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
Occupancy Rate %	94.08	95.29	94.81	95.20	95.69	95.70	95.23	94.45	95.41	94.21	93.61	93.79	94.48	92.09	92.27	95.57	96.00
% beds occupied by patients with LOS >14 days	15.66	18.09	16.88	19.53	20.11	18.06	19.50	17.04	17.72	17.67	18.28	17.09	17.89	19.73	16.88	21.44	19.66
% beds occupied by patients with LOS >21 days	8.40	10.45	9.37	10.90	12.16	10.34	11.10	9.36	9.93	10.26	10.47	10.00	10.03	10.98	8.82	11.85	11.59
No criteria to reside	101	117	102	108	105	106	111	112	111	111	114	108	114	109	110	110	110









Diabetic foot

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
Shropshire, Telford and Wrekin (STW) ICB are an outlier for minor and major diabetes foot ulcers. We have a higher than national average of hospital spells for foot disease for people with diabetes (PWD).
Audit 2025 revealed People with diabetes should have foot assessment within 6 hours of admission. 60% (improved from 10% 2024) of PWD have a compulsory foot assessment within 24 hrs. People with diabetes foot ulcer should have MDFT referral within 24 hours of finding the wound. 67% (Improvement from 42%) of PWD with wounds were referred to the Multidisciplinary Foot Team (MDFT). People at high risk of developing a hospital acquired foot problem should be issued with heel offloading. Only 53% (improved from 13%) of high risk PWD were issued heel offloading.
Current wait time from referral to appointment is 1.61 weeks. This is an increased duration (10% within 72 hours and 73.7% within 13 days) More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026 – we have excelled that again this month.

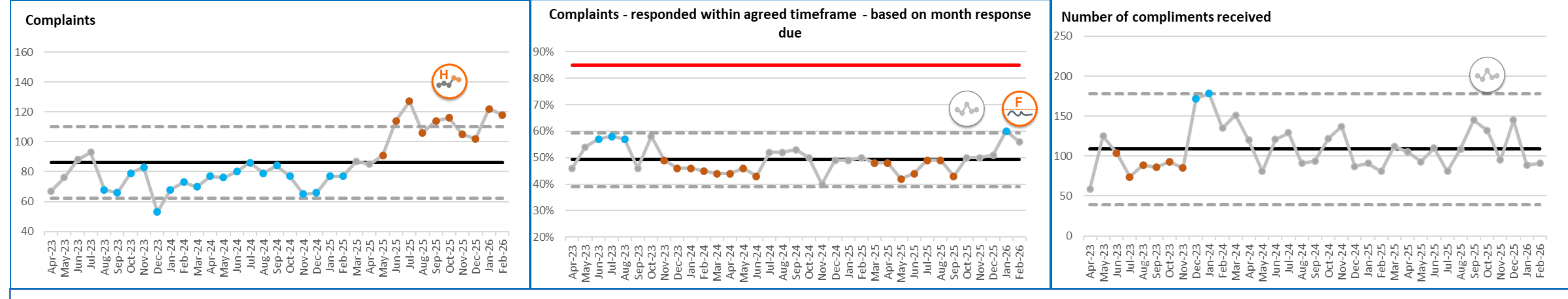
Recovery actions:
- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- New online documentation for admissions - has been taken through the document group, this will lead 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 – delayed
- Monthly minor and major amputation statistics for people with diabetes awaiting data
- 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

Anticipated impact and timescales for improvement:
Business Case agreed. Staff in post (Nov 2025)
Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2025. Complete
Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement May 2026
Audit of diabetes foot wound categorisation and reporting – in progress linking with TVNs (meeting 30.04.26)
Priority is reducing hospital spells for diabetes foot issued to 15 per 100k population and the relative number of diabetes lower limb amputations by 11 K per 100k population by 2025
Anticipated impact improvement in Diabetes foot pressure ulcers / hospital acquired diabetes foot ulcers

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

Complaints and compliments

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary: Numbers of new complaints have continued to remain above expected levels, although there are no specific new themes. Work is ongoing to improve response rates and reduce the amount of time that complaints are open for with the divisions to ensure that these improve further. The fast-track process is working well.	
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.	**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. Industrial action is also likely to impact on timeliness of responses.

Complaints by theme – Top 6

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Complaints by Theme - Clinical treatment

Complaints by Theme - Communication

Complaints by Theme - Values & Behaviours (staff)

Complaints by Theme - Patient care

Complaints by Theme - Admission / Discharge

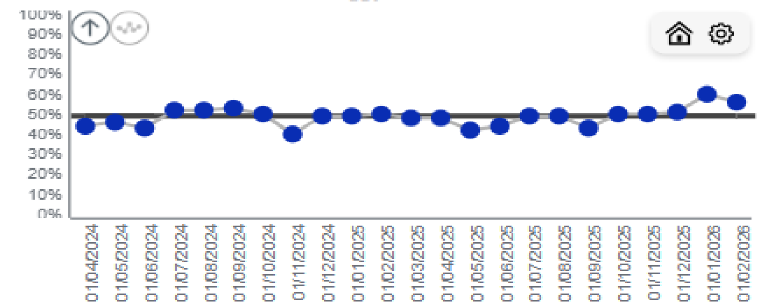
Complaints by Theme - Appointment

Quality - Patient Experience - Learning from Experience

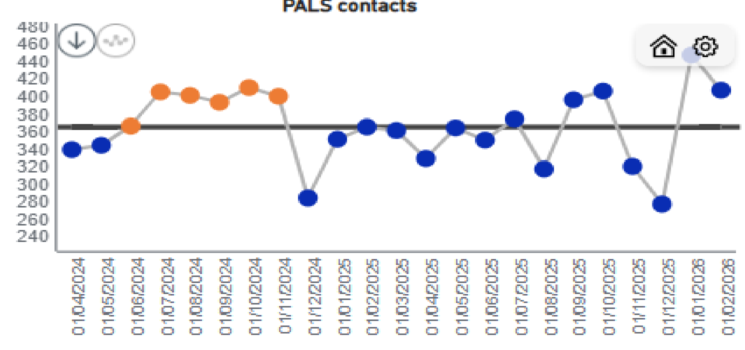
End of Life Care

	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
Complaints - % Responded to within agreed timeframe based on month response due	49	50	48	48	42	44	49	49	43	50	50	51	60	56
PALS contacts	352	366	362	330	365	351	375	318	397	407	321	278	448	408
Complaints by Theme - Staff	74	66	76	79	78	115	108	106	91	89	113	121	124	114
Re-opened complaints upheld	0	1	0	0	0	0	1	0	1	0	0	0	0	0
Compliments Received	91	81	112	105	93	110	81	109	145	132	95	145	89	91
Friends and Family Test % recommenders	91.7	98.1	97.6	97.1	93.2	96.8	88.3	92.4	79.8	73.7	77.1	76.1	76.0	75.0

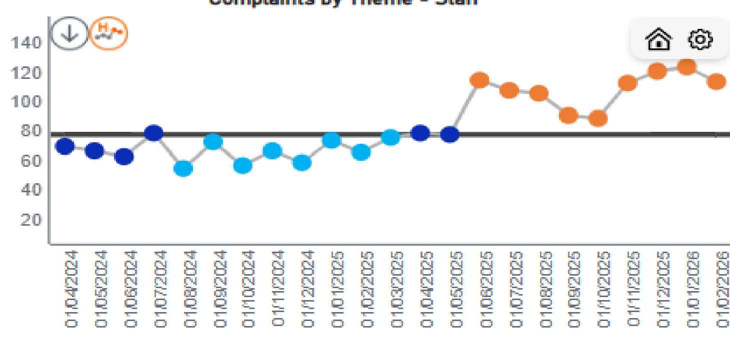
Complaints - % Responded to within agreed timeframe based on month response due



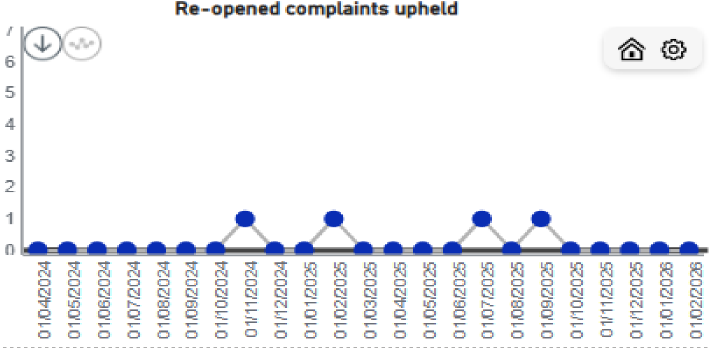
PALS contacts



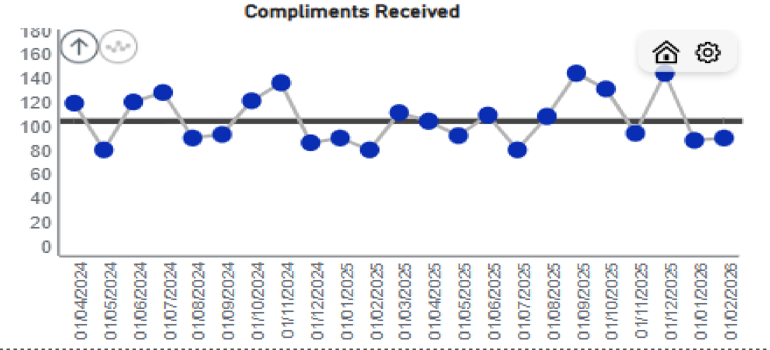
Complaints by Theme - Staff



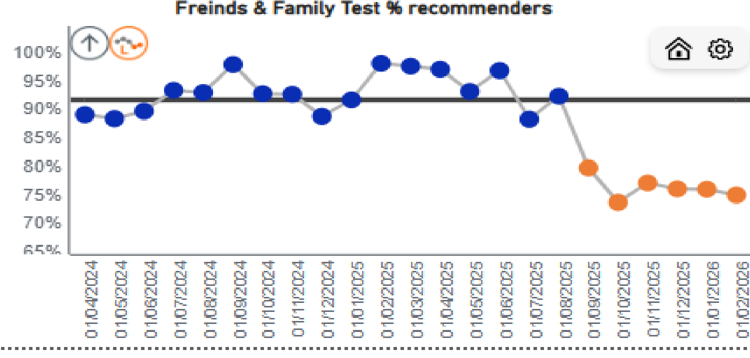
Re-opened complaints upheld



Compliments Received



Freinds & Family Test % recommenders



Friends and family test

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Friends and Family Test - SaTH

105% 100% 95% 90% 85% 80% 75% 70%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Friends and Family Test - Inpatient

100% 98% 96% 94% 92% 90%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Friends and Family Test - A&E

110% 100% 90% 80% 70% 60% 50% 40% 30%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Friends and Family Test - Maternity

105% 100% 95% 90% 85% 80% 75% 70% 65% 60%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Friends and Family Test - Outpatients

105% 100% 95% 90% 85% 80%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

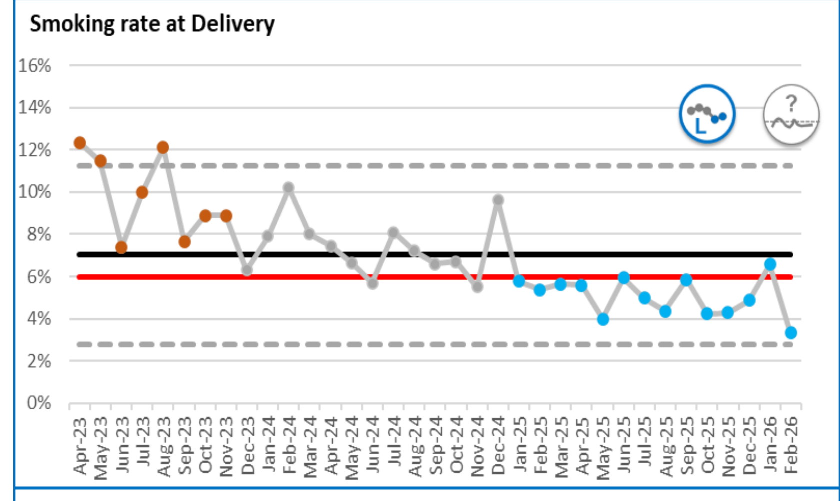
Friends and Family Test - SaTH Response rate %

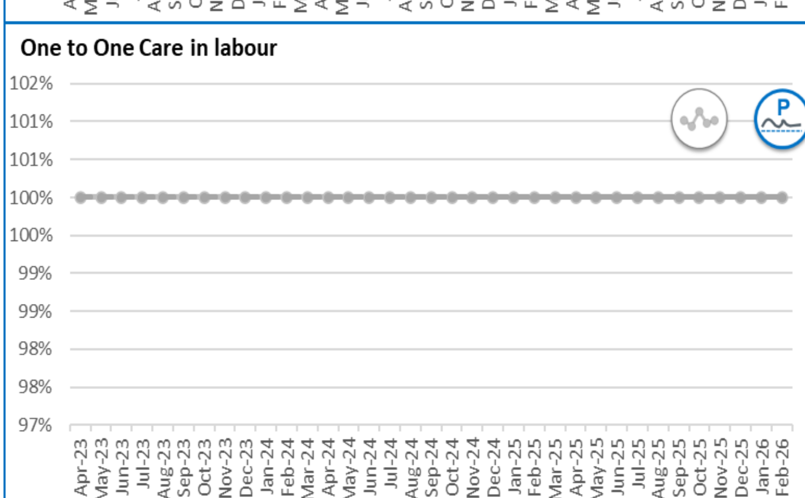
16% 14% 12% 10% 8% 6% 4% 2% 0%

Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Maternity

Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:

February reported as 3.5% data has shown a return to expected rates from the anomalous result in January.
Overall SATOD rates remain stable at 4.9% for the financial year.
This is below Government target of 6% with year-to-date rate of 5.1%

Accurate recording of SATOD status is being closely monitored by the Healthy Pregnancy Support Service (HPSS) team to ensure accurate data is being recorded at time of delivery.

Recovery actions:

Continue to further decrease SATOD throughout 2025/26.

Continue to exceed Government target of 6%.

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

Anticipated impact and timescales for improvement:

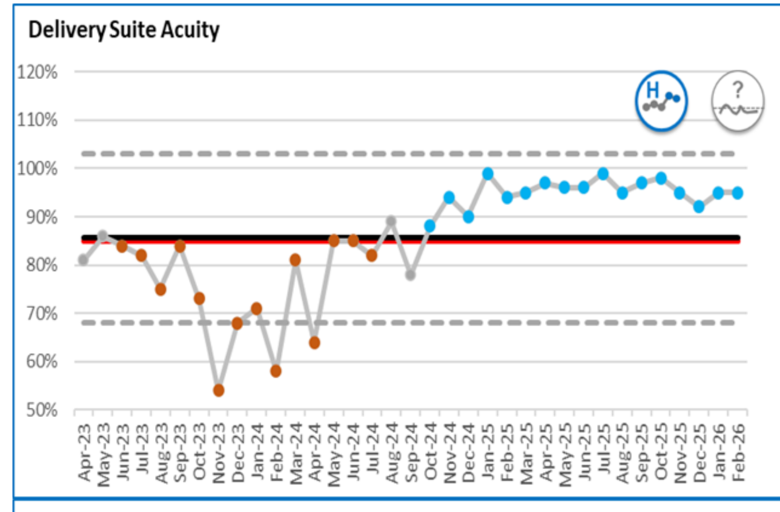
Continue to target areas of deprivation and refer family members to local smoking cessation services. The biggest barrier to pregnant women quitting smoking is having a partner who smokes.
As per Saving Babies Lives, all Maternity staff are trained to offer very brief advice (VBA) and smoking cessation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

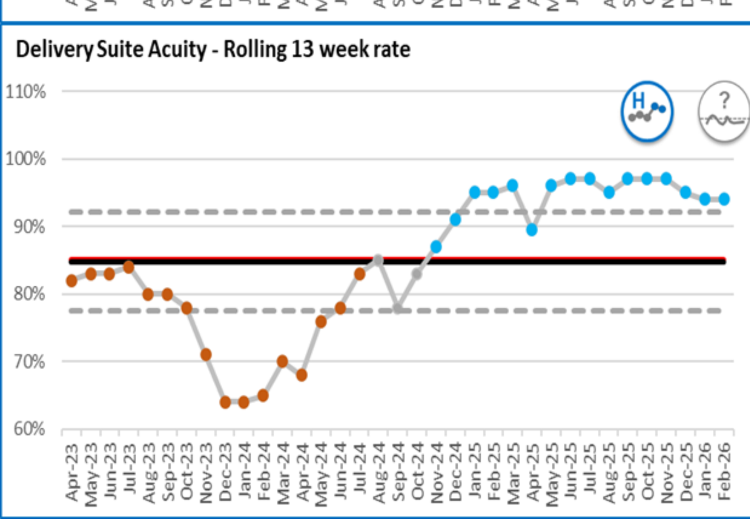
Recovery dependencies:

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

Maternity – delivery suite acuity

NHS
Shropshire, Telford and Wrekin Community and Hospitals NHS Group





Summary:
Delivery suite acuity continues to be maintained above the National target above 85% and has been consistently above 90% for the last eleven months with February acuity reported at 95%. We are seeing improvements in unavailability related to sickness; however, parenting leave remains high (>23 WTE combined sickness and parenting leave against template) . The midwifery workforce lead continues to maintain oversight with proactive monitoring around sickness absence and a robust recruitment and retention process. The unavailability has been mitigated with recruitment over the establishment and when required clinical support from Specialist midwives.

Specialist Midwives maintain a level of clinical contact which is in accordance with their individual roles.

Recovery actions:
We continue to work through a comprehensive workforce plan which focuses on retention of current staff and proactive recruitment in conjunction with active management of attrition rates.

Proactive management of staffing deficits embedded via daily staffing meetings and the escalation policy, ensuring staff compliance with 1:1 care in labour and the coordinator maintains supernumerary status as per Clinical Negligence Scheme for Trusts (CNST).
100% 1:1 care in labour consistently being achieved.

Anticipated impact and timescales for improvement:
Continue to work towards maintaining 85% target for green acuity using proactive management of the clinical midwifery workforce.

Levels of unavailability continue to be anticipated which is mitigated with clinical work for specialist midwives and senior leadership teams.

Specialist roles continue to support the clinical workforce.

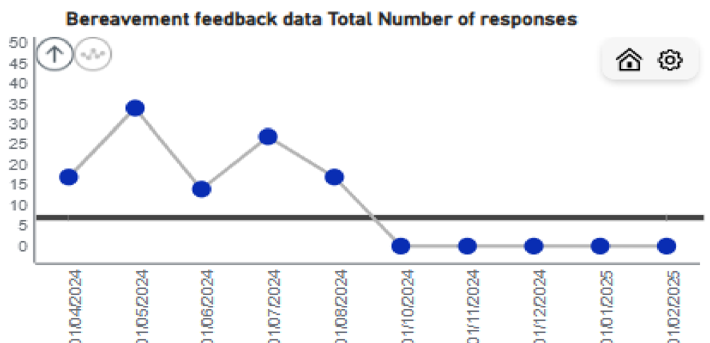
Recovery dependencies:	The introduction of vacancy panels have hindered recruitment, as proactive management of attrition rates has been affected significantly.

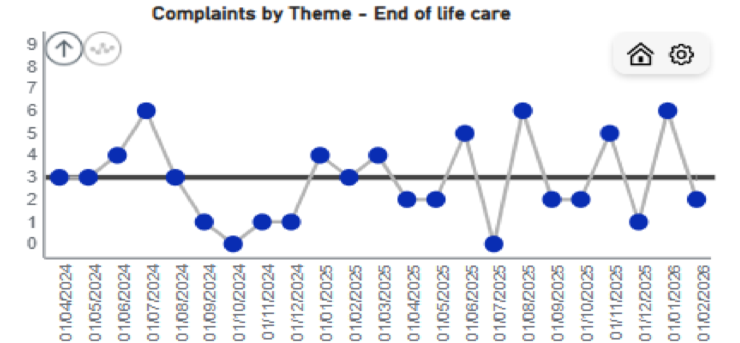
Quality - Patient Experience - End of Life Care

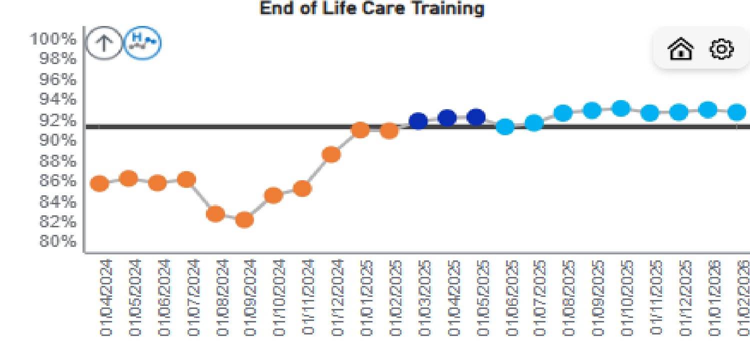
Page 1

Learning from Experience

	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026
Bereavement feedback data - Total Number of responses	0	0	0	0	0												
Complaints by Theme - End of life care	0	1	1	4	3	4	2	2	5	0	6	2	2	5	1	6	2
End of Life Care Training	84.57	85.25	88.61	91.03	90.95	91.89	92.20	92.28	91.35	91.71	92.68	92.93	93.12	92.69	92.76	93.00	92.75







End of life

Summary:
Performance in relation to Palliative and End of Life Care (PEOLC) metrics remain good. Training is above Trust targets and patient feedback remains positive. Ongoing review and monitoring of the metrics takes place monthly via the Palliative and End of Life Care Steering Group and reports quarterly to the Quality Operational Committee.

Recovery actions/Ongoing Process for Monitoring:	**Anticipated impact and timescales for improvement:**
There is an overarching PEOLC improvement action plan and a PEOLC dashboard reviewed monthly at the PEOLC Steering Group enabling early identification of actions to maintain or improve compliance. PEOLC complaints are discussed at the Steering Group, themes relating to communication around end-of-life care continue. PEOLC ward support programme which supports wards with all aspects of PEOLC. Small number of patients included in the Nursing Quality Assurance audits can affect the results of these audits. Action to ensure all matrons in ward areas caring for PEOLC patients are completing audits is ongoing.	Ongoing monitoring via PEOLC Steering Group to ensure improvements are sustained

Recovery dependencies:	N/A

Mental health training

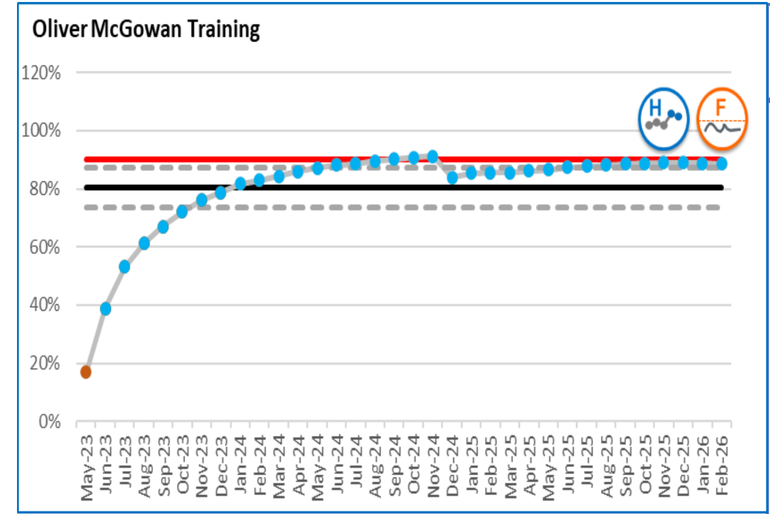
Summary:

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

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

Learning disability and/or Autism



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

Recovery actions:

- Oliver McGowan e-learning training is at 88.6%
- A Trustwide 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.

Responsiveness

Executive Lead:

Chief Operating Officer
Ned Hobbs

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %		78% Mar'26	60.0%	52.8%	46.9%	49.3%	53.1%	52.7%	52.1%	53.8%	54.2%	53.6%	52.0%	51.3%	51.9%	52.8%	
	ED - 4 Hour Performance (All Types inc MIU) %		-	-	61.6%	56.7%	59.0%	62.4%	62.8%	61.1%	63.4%	62.7%	61.7%	60.1%	60.1%	60.8%	61.5%	
	ED - 4 Hour Performance (SaTH Type 1) %		-	49.7%	43.1%	41.0%	42.1%	45.7%	45.4%	45.6%	45.6%	46.3%	45.5%	43.8%	43.2%	43.9%	45.1%	
	ED - 4 Hour Performance (SaTH Type 3) %		-	98.7%	89.9%	74.5%	79.1%	83.4%	85.5%	80.9%	87.6%	87.1%	85.9%	83.7%	85.9%	85.4%	86.0%	
	ED - 12 Hour Trolley Breaches	R	0	0	1390	1362	1379	1334	1407	1300	1492	1618	1453	1429	1601	1366	1173	
	Number of Ambulance Arrivals	R	-	-	3451	3301	3489	3335	3484	3392	3041	3210	3221	3373	3294	3103	3412	
	Average ambulance handover time (ED and non-ED)		-	-	01:13:07	01:34:14	00:56:45	01:06:14	00:45:38	00:50:09	01:25:24	01:21:39	01:23:23	01:35:52	01:35:15	01:13:47	00:46:02	
	Ambulance handovers > 15 minutes	R	-	-	2799	2748	2692	2544	2509	2557	2488	2647	2577	2691	2767	2549	2614	
	Ambulance handovers > 15 minutes %	R	0%		81.1%	83.2%	77.2%	76.3%	72.0%	75.4%	81.8%	82.5%	80.0%	79.8%	84.0%	82.1%	76.6%	
	Ambulance handovers > 45 minutes					New Metric April '25			884	932	1335	1433	1332	1451	1585	1252	875	
	Ambulance handovers > 45 minutes %		0%			New Metric April '25			25.4%	26.7%	43.9%	44.6%	41.4%	43.0%	48.1%	40.3%	25.6%	
	Ambulance handovers > 60 minutes %	R	0%		33.2%	38.5%	25.8%	29.5%	19.9%	20.7%	37.9%	37.5%	35.3%	37.1%	40.3%	33.5%	19.7%	
	ED activity (total excluding planned returns)		-	13350	13917	13267	13908	13528	13638	13230	12951	13619	13361	13569	13020	12275	14083	
	ED activity (type 1 excluding planned returns)		-	10811	11050	10941	11190	10864	11143	10802	10445	10982	10683	10764	10549	9920	11446	
	Total Emergency Admissions from A&E		-	-	3363	3142	3345	3266	3322	3381	3301	3655	3614	3769	3659	3460	3838	
	% Patients seen within 15 minutes for initial assessment		-		57.3%	54.6%	60.7%	71.3%	74.4%	72.3%	65.3%	65.2%	64.6%	71.4%	68.5%	69.9%	68.5%	
	Average time to initial assessment (mins)		15 Mins	15	19.8	23.3	17.8	13.9	12.2	13.6	16.3	15.5	15.8	14.2	14.2	13.5	14.4	
	Average time to initial assessment (mins) Adults		15 Mins	15	20.9	25.7	18.6	14.3	12.7	14.5	16.5	15.9	14.7	11.8	14.8	13.8	14.3	
	Average time to initial assessment (mins) Children		15 Mins	15	16.4	15.0	14.8	12.4	10.2	9.2	15.5	13.9	19.4	21.9	12.1	12.6	14.6	
	Mean Time in ED Non Admitted (mins)		-	215	311	346	323	304	292	291	293	292	294	298	304	281	269	
	Mean Time in ED admitted (mins)		-	500	1159	1350	1165	1202	1127	1084	1227	1145	1121	1124	1213	1091	917	
	Percentages of attendances in A&E over 12 hours - Type 1		-	17.00%	23.45%	23.44%	23.27%	22.04%	21.75%	21.94%	23.39%	23.27%	22.36%	22.01%	24.74%	22.35%	19.03%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1		-	1883	2591	2565	2604	2394	2424	2370	2443	2555	2389	2369	2610	2217	2178	
	Bed Occupancy Rate - G&A (SitReps)		92%	-	95.7%	95.2%	94.4%	95.4%	94.2%	93.6%	93.8%	94.5%	92.1%	92.3%	95.6%	96.0%	95.2%	
	Diagnostic Activity Total - All commissioners			-	24982	24888	25333	24625	26211	24973	24860	24881	22628	24080	24199	24198	26130	
	Diagnostic Total Waiting List - All commissioners			-	15738	13866	12511	11453	12013	11471	11634	12437	12437	12256	13037	14656	16010	
	Diagnostic 6 Week Wait Performance %		99% Mar'26	-	78.2%	78.5%	79.4%	82.2%	83.2%	81.8%	85.5%	86.9%	86.4%	81.7%	80.5%	86.5%	86.4%	
	Diagnostic 6+ Week Breaches		0	-	3437	2982	2577	2039	2016	2086	1692	1632	1707	2249	2690	1978	2184	
	Number of episodes moved or discharged to PIFU		-	3013	2300	2196	2203	2633	2627	2288	2523	2488	2472	2283	2325	2335	2575	
	RTT Incomplete 18 Week Performance		65% Mar'26	60.00%	48.1%	49.6%	53.0%	54.9%	56.4%	58.8%	62.3%	64.0%	65.5%	64.1%	62.9%	63.1%	67.4%	
	RTT Waiting list - Total size	R	-	-	46775	46242	44005	42449	39438	37132	36022	36674	37997	36982	37910	37266	36494	
	RTT Waiting list - English only		-	39663	41669	41238	39042	37630	34742	32670	31652	32263	33621	32790	33637	33359	32706	
	RTT 52+ Week Breaches (All)	R	0	-	1933	1778	1592	1103	734	600	369	313	284	212	235	241	174	
	RTT 52+ Week Breaches - English only		-	376	1512	1312	1170	718	444	305	125	84	68	20	31	47	0	
	RTT 65+ Week Breaches (All)		-	-	115	166	139	114	98	98	87	75	59	37	41	70	79	
	RTT 65+ Week Breaches - English only		0	0	26	18	5	0	3	0	0	0	0	0	0	0	0	
	RTT 78+ Week Breaches (All)	R	0	0	29	34	30	33	27	23	15	14	15	17	12	17	14	
	RTT 78+ Week Breaches - English only		0	0	4	1	0	0	0	0	0	0	0	0	0	0	0	
	RTT 104+ Week Breaches (All)	R	0	0	1	4	3	1	1	1	1	1	1	2	0	0	1	
	RTT 104+ Week Breaches - English only		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Cancer 62 Day Standard	R	75% Mar'26	68.7%	66.6%	56.6%	63.1%	62.6%	66.6%	68.8%	65.2%	71.4%	70.2%	70.1%	68.3%	75.0%	-	
	Cancer 31 Day First Treatment		96%	95.9%	96.6%	90.5%	88.2%	87.9%	94.7%	91.6%	94.2%	96.2%	95.5%	98.0%	96.2%	99.2%	-	
	Cancer 28 Day Faster Diagnosis - combined	R	80% Mar'26	77.2%	62.5%	68.6%	71.4%	72.5%	75.5%	75.9%	80.1%	80.3%	85.7%	83.0%	80.2%	85.5%	-	
	Theatre productivity			85%	78%	79%	79%	80%	81%	81%	81%	80%	81%	81%	80%	81%	81%	

Operational Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

SaTH ED 4-hour performance (type 1 & type 3) remains in common cause variation in March 2026. Type 1 performance increased to 45.3% and Type 3 performance increased to 86.1%. Average ambulance handover time shows common cause variation in March and was better than plan with 79.4% within 60 mins. The number of Type 1 patients who spend more than 12 hours in ED shows common cause natural variation but was the best since June 2023.

RTT for March 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is1 x 104 weeks, 14 x 78 weeks, 79 x 65 weeks 174 x 52 weeks .
The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics. Daily meetings are in place with all clinical centres to monitor and manage the risk of breaches and support additional mitigations. Additional ERF capacity is being provided during April to a range of specialties. Theatre utilisation in March 2026 is 81%.

Cancer - The Trust is delivering above plan for all cancer metrics. Confirmed February cancer performance is 85.5% (28-day FDS) vs the local plan of 77.2%. 62-day performance was 75% against a local target of 68.7% and 31 day was 99.2% against a local target of 95.9%. The 62-day backlog is 163 patients over 62 days of which 33 are over 104 days (as at 7.4.26). The 62-day backlog is 169 as of 20/04/2026 which 33 are over 104 days.

DM01 - The submitted DM01 position for March was 84.0%, improved performance in Echocardiology and NOUS.
Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks.

Key actions

- Ambulance threshold Plan launched 45 minutes on 14th April
- March Safe and timely UEC campaign saw some schemes continue through April
- Endoscopy productivity workstream having material reduction on number of insourced sessions used
- Outpatient productivity now focussed on in session utilisation looking to increase the number of slots delivered per clinic
- Diagnostic improvement programme now focussed on NOUS & Urodynamics
- Cancer Improvement Plan for 26/27 in development
- Q4 Sprint delivery plan delivered with 12,000 additional outpatient attendances undertaken leading to an improved RTT in March

Operational – Emergency Care

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

SaTH Number of A&E Attendances (type 1- type 3)

SaTH - ED 4 Hour Performance Type 1 %

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

Average ambulance handover time (ED and non-ED) - nationally published

Ambulance Delays > 15 minutes %

Ambulance Delays > 60 minutes %

Operational – Emergency Care

Summary:

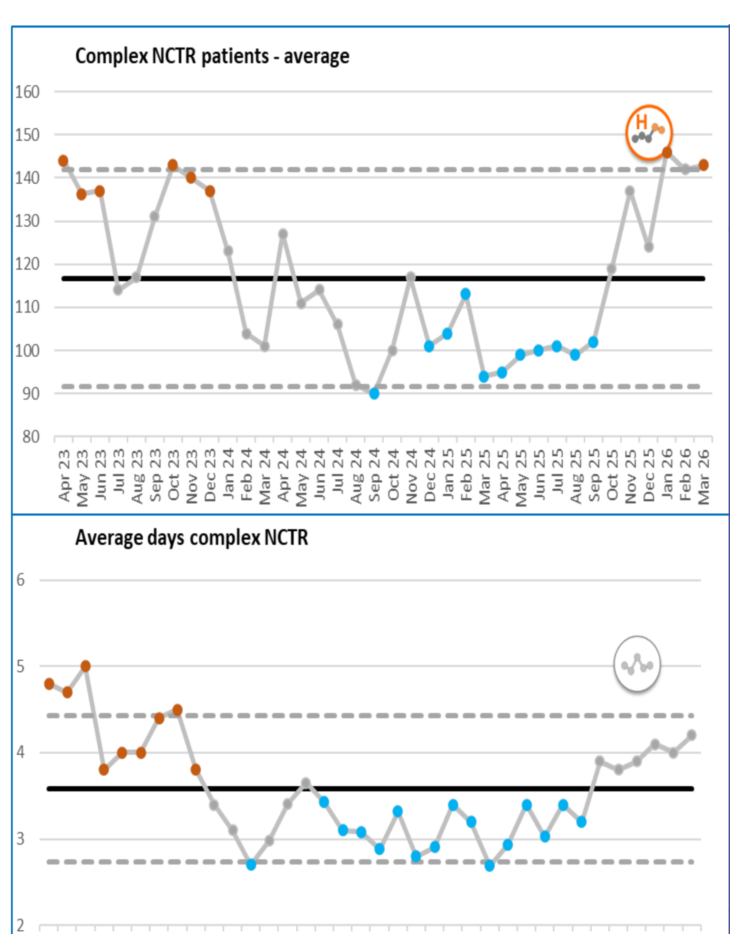
- SaTH ED 4-hour performance was 53% (type 1 & type 3) and remains in common cause variation in March 2026
- SaTH number of patients who spend more than 12 hours in ED has remained in common cause natural variation but was the best since June 2023. 84.2% of patients were admitted and discharged within 12 hours during March 26
- Average Ambulance handover of patients to SaTH premises shows common cause variation in March and was better than plan with 79.4% of handovers within 60 mins

Recovery actions:	Anticipated impact and timescales for improvement:
• Ambulance Threshold 45 launched in April 2026 • Continue to work with WMAS/WAS on maximum handover threshold and immediate handover process • Continue to work with Health Hero to progress admission avoidance opportunities • Integrated Community Front Door (IFD) Team in place in both ED Departments • March Safe and Timely UEC Campaign improvement initiatives including Front Door Clinician, Flow Coordination, enhanced weekend ward rounds continuing into April 2026 • 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	Progress reported monthly through UEC Flow improvement group to Performance Assurance Committee (PAC) and system UEC meeting. Progress reported monthly through Urgent and Emergency Care Transformation Committee (UECTAC) and weekly cross Divisional metrics meeting.

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

Operational – Patient Flow

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:

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

Recovery actions:

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

Anticipated impact and timescales for improvement:

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

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

Operational – Cancer performance

Cancer 62 Day Compliance

90%
80%
70%
60%
50%
40%
30%

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26

Cancer 31 Day

105%
100%
95%
90%
85%
80%
75%

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26

Cancer 28 Day Waits (Faster diagnosis)

95%
90%
85%
80%
75%
70%
65%
60%
55%
50%

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26

Operational – Cancer performance

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Summary:
The Trust is delivering above plan for all cancer metrics. Confirmed February cancer performance is 85.5% (28-day FDS) vs the local plan of 77.2%. 62-day performance was 75% against a local target of 68.7% and 31 day was 99.2% against a local target of 95.9%. The 62-day backlog is 163 patients over 62 days of which 33 are over 104 days (as at 7.4.26). The 62 day backlog is 169 as of 20/04/2026 which 33 are over 104 days.

Recovery actions:

The Trust is now in Tier 3 of NHSE monitoring for cancer due to improved performance. February performance against the faster diagnosis standard (FDS) was 85.5%, making SaTH most improved Trust in the country for FDS (Feb 25 to Feb 26). February performance against the 62 day standard was 75% which was our best performance since combined standard introduced and resulted in SaTH being the second most improved Trust in the country Feb 25 to Feb 26.

The cancer improvement plan for 25/26 has over delivered on the required improvement required to deliver the 25/26 operational plan. Faster diagnosis performance has improved significantly. The Trust has delivered above the 80% national standard since September 2025.

Our two year cancer improvement plan for 26/27 and 27/28 is in development and will continue to focus on improvements to the 62-day pathway target to deliver the 80% commitment by March 28. This will require significant investment and interventions aimed at the treatment end of the pathway, in particular oncology services as well as key diagnostic pathway constraints. The improvement framework will align 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.

Anticipated impact and timescales for improvement:

Phase one and two improvement plans have over delivered against operational plan for 25/26.

A two year cancer improvement plan is in development to achieve the 80% 62-day standard by Marh 28.

Recovery dependencies:	Workforce constraints

Operational – Diagnostics waiting times

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Diagnostic Total Waiting List - All commissioners

20000
18000
16000
14000
12000
10000

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26, Mar 26

Diagnostic % Compliance 6 week waits - All commissioners

100%
90%
80%
70%
60%
50%

H
F

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26, Mar 26

DM01 Patients who have breached the standard - All commissioners

10000
8000
6000
4000
2000
0

L

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26, Mar 26

Diagnostic Activity Total - All commissioners

27500
25000
22500
20000
17500

H

Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sep 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26, Mar 26

Operational – Diagnostics waiting times

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Summary:
The submitted DM01 position for March was 84.0%, improved performance in Echocardiology and NOUS.
Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks. Radiologist workforce continue to restrict capacity for reporting, with reduced resilience during periods of sickness or annual leave, however we now have another outsourcing provider for reporting to provide more flexibility.

- Recruitment is ongoing and we are utilising insourcing and outsourcing to support NOUS and MRI
- Clinical prioritisation of radiology referrals is in place and reporting for the most urgent patients is being targeted alongside elective recovery of long waits
- Staff are deployed to prioritise acute and cancer pathways and the longest waiting patients
- A mobile MRI unit is on site and continues to deliver activity to support Cancer performance
- A NOUS - additional WLI and insourcing support continue to support reduction of 13+ww and continued improvement of DM01 performance and Cancer TAT
- DM01 performance for CT continues to meet national target of 99%.

Recovery actions:
Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times.
MRI performance continues to fluctuate with a rise in the number of Cardiac scans remaining outstanding over 6 weeks. A mobile van is operational to increase scanning capacity and support with cancer performance, which has improved significantly since March 2025 for MRI.
Process for avoiding RTT breaches is in place with daily calls attended by the operational teams. Daily calls are also in place between radiology and the gynaecology booking team to ensure all capacity is utilised for PMB USS. A Radiology PTL for Cancer patients is due to start within the next month. Additional U/S slots are being identified to support the urology cancer performance.
The sustainable endoscopy business case has been approved and is a 3-year programme of work requiring support from an IS provider pending recruitment to substantive posts and lead time for training until endoscopy practitioners become independent.

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

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

Recovery dependencies:

Operational – Referral to Treatment (RTT)

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

RTT Waiting List - English Only

18 Week RTT % Compliance - Incomplete Pathways

52+ Week Breaches - English Only

65+ Week Breaches - English Only

78+ Week Breaches - English Only

RTT Waiting List - Total Size

Note: includes Welsh unvalidated position

Operational – Referral to Treatment (RTT)

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

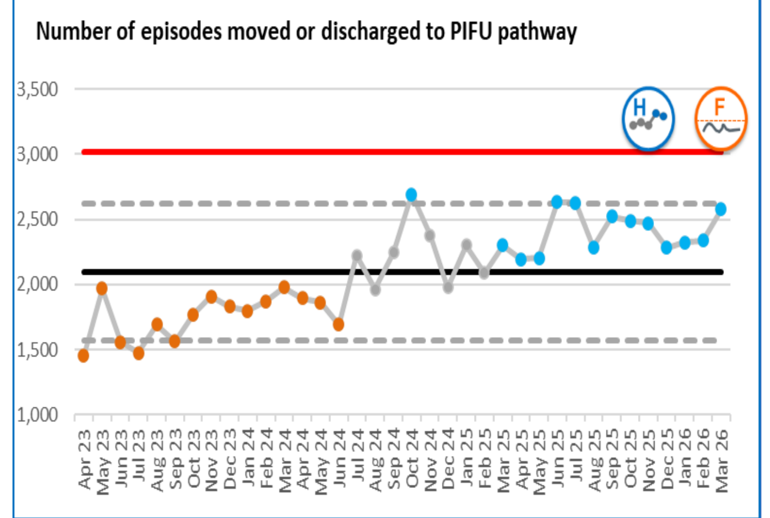
Summary:
The submitted Trust Position for March 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 1 x 104 weeks, 14 x 78 weeks, 79 x 65 weeks 174 x 52 weeks
The Trust remains on plan across all RTT metrics. This progress has been supported significantly by the work delivered through the outpatient transformation programme with Four Eyes Consultancy. As a result, we have achieved a 3–4% improvement in the outpatient booking rate, equating to approximately 300 additional appointments each week.
The theatre planner is currently being reviewed to ensure that each specialty has the appropriate allocation to meet projected demand for 2026/27. The expectation continues to be that 97% of weekly core lists will run, including the cataract suite. This approach has also contributed to a reduction in insourcing activity, with 12 insourcing lists being used in the month March 2026 compared with 96 sessions delivered by insourcing in March 2025.
MBI continues to support the Trust with validation activity.
Daily meetings continue to take place with the teams to ensure that there is a focus to ensure our long waits are treated. Each specialty has been given individual targets to achieve and this PTL is now being using to improve 18-week performance and reduce waiting times.

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

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

Operational - PIFU

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

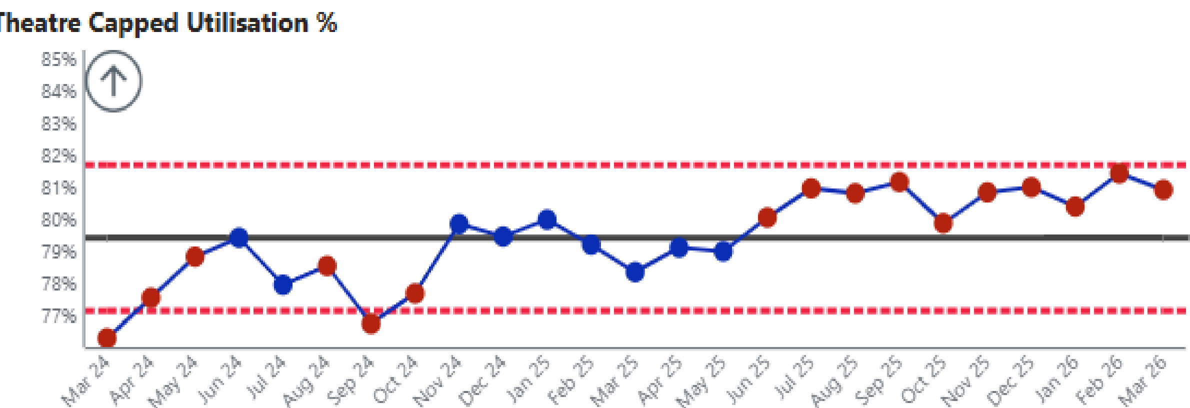


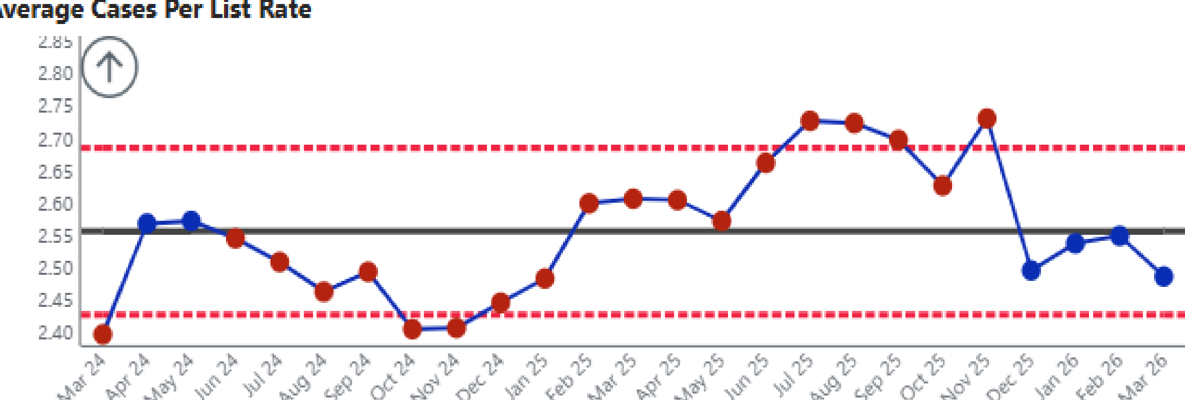
Summary:
The unvalidated Patient Initiated Follow-Up (PIFU) performance in March was maintained at 5.7%, which remains below the 6% target.
•The Patient Engagement Portal, designed to support PIFU, is remains in its pilot phase with some ENT pathways.
•A regular Data Quality Workgroup has been established, involving key stakeholders from the trust, this will address issues and enhance data quality for monitoring.
•Clinician attendance at the GIRFT Action Plan Review meetings is allowing more direct clinical conversation and challenge.
•Outpatient Productivity continues to be a focus as well as Outpatient Pathway Transformation. Outpatient Advice and Guidance will be enhanced with the introduction of the SPOA process, due to be implemented by October 2026.
SaTH acknowledges the potential to enhance outpatient service productivity. The identified improvement opportunities include reducing waiting times for planned care by optimising processes and resource allocation through digital tools, improving the quality of planned care via evidence-based practices and better coordination through digital systems, and enhancing data and digitalisation efforts.
It is anticipated that these initiatives will positively impact PIFU performance.

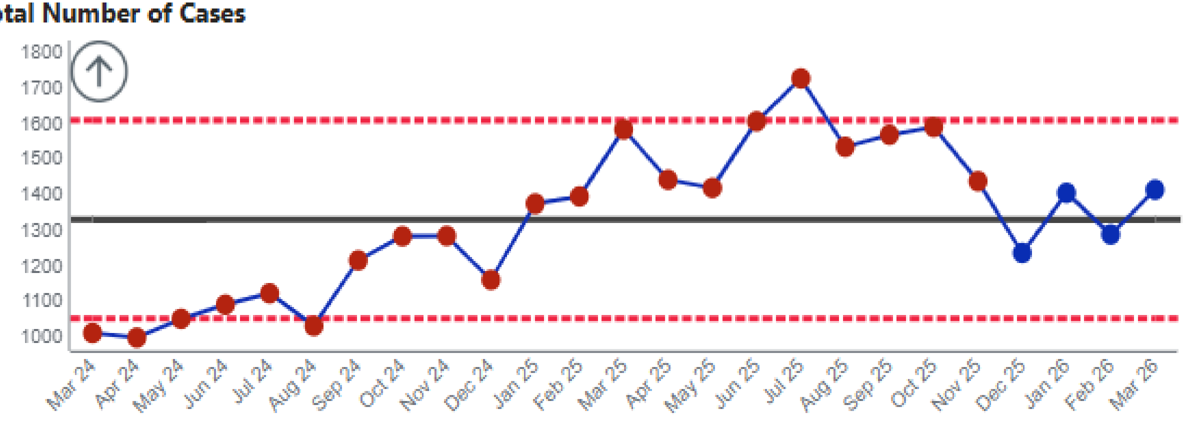
Recovery actions:	**Anticipated impact and timescales for improvement:**
Conversations with Respiratory, Cardiology and Gynaecology clinical and operational leads have taken place, with their performance report has been completed, with plans to utilise the PIFU pathway. Further conversations are required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

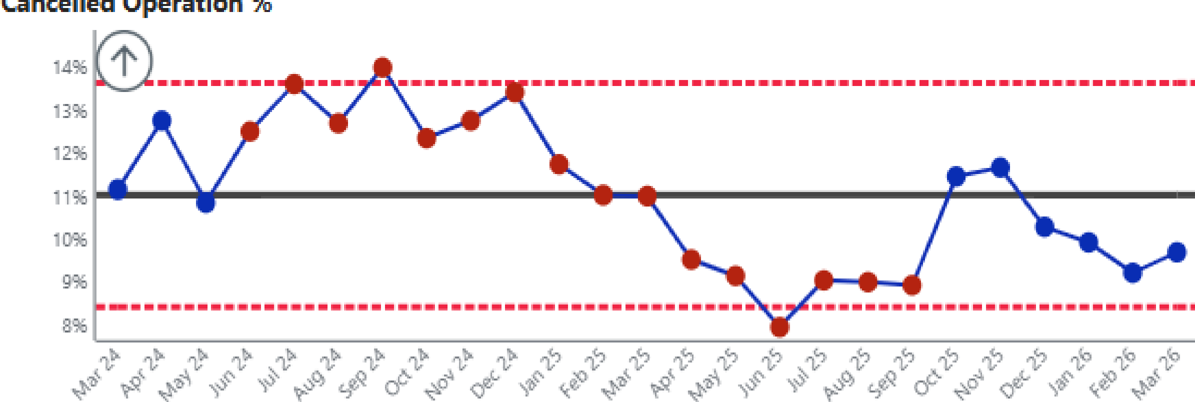
Recovery dependencies:	Availability of the Oliver McGowan Tier 1 and 2 training sessions.

Operational – Theatre Productivity









Operational – Theatre Productivity

March 2026 Summary:

Elective Theatre Utilisation

- Overall utilisation has remained stable at 81%.
- Cataract suite utilisation increased to 86% for sessions that ran, with ongoing work to increase the number of sessions delivered.

Cancellations

- The cancellation rate rose slightly from 9.2% to 9.6%, largely driven by short-notice clinician sickness.

Elective Activity

- 1,411 elective procedures were completed in March — the highest since November — despite a two-week elective hub theatre closure for planned maintenance.
- Cataract suite activity remains reduced, resulting in higher in-session utilisation but lower overall patient numbers. Focus is now shifting to increasing outpatient activity to rebuild the waiting list.
- Insourced sessions increased to 12 in March.

Theatre Task & Finish Group Priorities:

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

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

Performance Recovery and Planning:

- Continued collaboration with the NHSE Regional Theatre Productivity Lead to align with regional priorities and best-practice approach to improving theatre efficiency.
- Ongoing joint work between Theatre Performance, Booking & Scheduling, and clinical specialties continues to refine theatre allocation to meet the theatre session allocation KPI target and ensure lists are assigned to surgeons with suitable waiting list demand to support well-utilised sessions.

Anticipated timescales for improvement:

New theatre plans have been introduced to support the reopening of the arthroplasty service and the introduction of a robotic theatre at PRH. Plans are underway to support training that will enable some ENT sessions to move to RSH, with a view to transitioning these lists and HTP.

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

Well Led

Executive Lead:

Chief People Officer
Rhia Boyode

Integrated Performance Report

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Well Led	WTE employed		-	7848	7192	7229	7227	7225	7213	7222	7380	7403	7429	7423	7439	7430	7428	
	Temporary/agency staffing		-	-	780	705	722	738	783	749	679	683	652	617	612	632	689	
	Staff Turnover Rate (FTE) (excluding Junior Doctors)		0.8%	0.75%	1.2%	0.6%	0.9%	0.7%	0.7%	0.9%	0.7%	0.8%	0.9%	1.0%	0.9%	0.7%	0.8%	
	Vacancies - month end %		10%	<10%	10.0%	4.5%	4.4%	5.7%	5.9%	5.8%	3.8%	4.0%	3.9%	4.5%	6.0%	5.6%	5.4%	
	Sickness Absence rate		-	4.5%	5.0%	4.8%	4.6%	4.8%	4.9%	4.7%	4.9%	5.2%	5.2%	5.7%	5.8%	5.46%	4.97%	
	Trust - Talent Conversation (Appraisal)		90%	90%	85.8%	85.5%	86.0%	86.1%	86.6%	86.1%	86.4%	86.9%	86.8%	86.1%	85.0%	84.6%	84.7%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	90.7%	92.5%	93.8%	93.5%	93.3%	94.4%	95.3%	94.9%	93.5%	92.7%	92.9%	93.6%	94.2%	
	Trust Statutory and mandatory training compliance		90%	90%	91.3%	92.9%	93.1%	93.2%	93.4%	93.2%	93.1%	93.3%	92.9%	92.3%	92.5%	91.9%	91.4%	
	Trust MCA – DOLS and MHA		90%	90%	85.1%	85.0%	85.0%	85.2%	86.0%	85.8%	85.3%	85.2%	85.8%	84.7%	84.8%	84.3%	84.2%	
	Safeguarding Children - Level 2		90%	90%	94.5%	96.0%	96.4%	96.6%	96.4%	96.2%	95.8%	95.8%	95.4%	95.1%	95.2%	94.8%	94.1%	
	Safeguarding Adult - Level 2		90%	90%	94.4%	95.8%	95.9%	95.9%	96.0%	95.7%	95.5%	95.6%	95.5%	94.7%	95.0%	94.6%	94.5%	
	Safeguarding Children - Level 3		90%	90%	90.8%	89.2%	89.8%	90.5%	90.8%	90.3%	88.2%	88.6%	87.1%	86.0%	85.0%	84.0%	81.3%	
	Safeguarding Adult - Level 3		90%	90%	90.5%	90.0%	91.0%	91.7%	92.1%	91.5%	90.5%	90.9%	91.4%	90.3%	90.7%	90.4%	90.7%	
	Diabetic Foot - Nurse Training		90%	90%	85.0%	86.8%	87.5%	88.8%	90.2%	91.3%	90.7%	91.3%	92.2%	92.4%	92.3%	92.1%	91.8%	
	Oliver McGowan Training		90%	90%	85.6%	86.2%	86.6%	87.5%	87.8%	88.2%	88.5%	88.9%	89.0%	88.9%	88.8%	88.6%	88.5%	
	Oliver McGowan Mandatory Training - T1		90%	90%		21.2%	24.3%	28.5%	25.7%	25.4%	25.3%	0.0%	5.6%	6.7%	10.0%	12.4%	13.0%	
	Oliver McGowan Mandatory Training - T2		90%	90%		17.2%	21.1%	23.6%	24.6%	24.2%	23.9%	11.3%	11.3%	11.1%	12.0%	13.3%	15.2%	
	Monthly agency expenditure (£'000)		-	427	955	1063	684	817	873	921	820	504	500	525	306	369	520	
Safe Staffing	Fill Rate % - All Staff - Day/Night			100%	93.3%	93.9%	93.5%	95.0%	95.2%	94.0%	95.4%	93.8%	95.1%	94.3%	93.2%	92.4%	91.5%	
	Fill Rate % - All Staff - Day			100%	92.5%	92.7%	91.8%	93.7%	93.7%	93.0%	94.3%	93.6%	94.4%	93.2%	92.1%	90.1%	89.6%	
	Fill Rate % - All Staff - Night			100%	94.3%	95.3%	95.7%	96.6%	97.0%	95.1%	96.7%	94.1%	95.9%	95.5%	94.5%	94.9%	93.7%	
	Fill Rate % - Registered Nurses/Midwives - Day/Night			100%	101.7%	101.4%	99.3%	101.5%	102.3%	101.1%	100.4%	98.6%	102.0%	102.2%	99.7%	99.4%	97.4%	
	Fill Rate % - Registered Nurses/Midwives - Day			100%	101.6%	100.8%	98.1%	100.0%	101.0%	99.8%	99.1%	99.2%	101.7%	102.7%	99.5%	98.3%	96.6%	
	Fill Rate % - Registered Nurses/Midwives - Night			100%	101.8%	102.1%	100.7%	103.1%	103.7%	102.5%	101.9%	98.0%	102.2%	101.7%	100.0%	100.6%	98.2%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day/Night			100%	97.8%	98.5%	100.2%	99.8%	100.7%	100.4%	103.3%	101.7%	99.2%	96.7%	96.6%	94.1%	95.4%	
	Fill Rate % - Non-Registered Nurses/Midwives - Day			100%	95.8%	96.2%	97.3%	98.8%	98.6%	99.2%	102.2%	100.4%	97.4%	94.1%	94.4%	90.7%	92.0%	
	Fill Rate % - Non-Registered Nurses/Midwives - Night			100%	100.1%	101.1%	103.7%	101.1%	103.3%	101.9%	104.5%	103.3%	101.3%	99.7%	99.0%	98.1%	99.4%	
	Fill Rate % - Registered Nursing Associates - Day/Night			-	18.6%	24.9%	24.5%	27.8%	25.4%	22.4%	25.7%	29.3%	28.6%	30.2%	28.2%	33.4%	30.1%	
	Fill Rate % - Registered Nursing Associates - Day			-	24.7%	30.8%	30.5%	33.4%	30.5%	29.2%	32.3%	33.3%	35.0%	35.0%	33.6%	36.2%	33.6%	
	Fill Rate % - Registered Nursing Associates - Night			-	10.0%	16.6%	15.4%	19.6%	18.4%	13.1%	16.1%	24.0%	20.0%	23.4%	20.3%	29.3%	25.3%	
	CHPPD - Overall - National 11.99			11.99	8.5	8.6	8.7	9.1	8.8	8.8	8.7	8.4	8.5	8.3	8.0	8.0	7.8	
	CHPPD - Registered Nurses/Midwives - National 4.9			4.9	5.1	5.1	5.1	5.4	5.2	5.2	5.0	4.9	5.1	5.0	4.7	4.7	4.6	
	CHPPD - Non-Registered Nurses/Midwives - National 4.9			4.9	3.3	3.3	3.4	3.5	3.4	3.4	3.5	3.3	3.2	3.1	3.1	3.0	3.1	
	CHPPD - Registered Nursing Associates			-	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	

Workforce Executive Summary

2025/26 Workforce Plan – Overall workforce at Month 12 is 245 WTE (contracted) over the planned levels based on our submitted workforce plan. There has been a decrease of 2 WTE in substantive workforce however this is still above planned levels by 153 WTE. Driven by shortfalls of the reduction plan delivery this year and additional workforce required (above original planned levels) for modular wards.

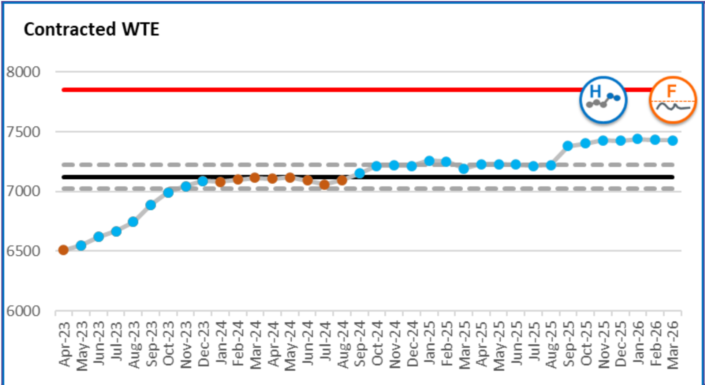
Turnover – the rolling 12-month turnover rate for March is 9.6% equating to 660 WTE leavers. An in-month turnover rate of 0.8% equates to 53 WTE leavers in March. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.8% equating to 470 WTE NHS leavers.

Wellbeing of our staff – March sickness rate of 5.0% (373 WTE) remaining above target by 0.5% (35 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 25% of calendar days lost in March equating to 93 WTE. 12% (43 WTE) of sickness was attributed to other known causes; other musculoskeletal problems was at 11% (42 WTE).

Agency and temporary staffing - Bank usage is over planned levels by 97 WTE. There has been a significant increase in the final month, this has been driven by vacancy gaps across the Surgical division and Women's and Children's and increases in demand for Clinical and Scientific Services and Facilities. We are still reviewing the drivers however sickness absence has been high across nursing teams in the final month increasing demand for temporary workforce. Agency usage levels increased for the first time since July (increase of 13 WTE) and ended the year at 5.4 WTE under planned. There has been a total increase in temporary workforce of 57 WTE, driven by increases in bank workforce across all divisional teams.

Workforce – Contracted WTE

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Substantive figure of 7,430 WTE in March, which is a decrease of 2 WTE in month.
Total workforce utilisation in March increased by 55 WTE to 8117 WTE attributable to an increase in bank of 44 WTE and an increase in agency of 13 WTE and substantive of 11 WTE.

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

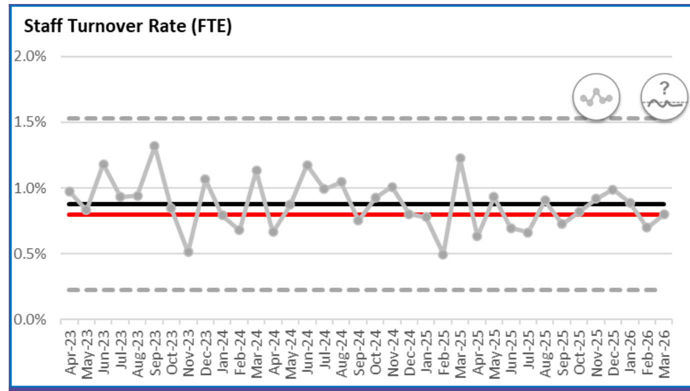
Recovery actions to achieve our target:
- Workforce planning – focus on medical and on identifying efficiency and savings, in areas such as Outpatients
- Full review of vacancies across both SCHT and SaTH to support redeployment, review of employee relation and sickness cases to assess potential to reduce workforce or improve workforce availability
- Exploring Indeed's Talent Scout function for advanced sourcing and screening (launching January 2026)
- Committed to Guaranteed Interview scheme for Care Leavers as part of NHS Universal Family Programme
- Assessing Group Employer function on Trac for enhanced collaboration and shared job boards with Shropcomm
- HTP workshops are underway to complete divisional workforce planning by the end of October
- Workforce planning is being driven by Demand & Capacity reviews, ensuring staffing aligns with service needs and future growth across divisions
- 96% of departments are live or on track for Manager Self Service (MSS); all departments on-track to go-live by May

Anticipated impact and timescales for improvement:
Taking our learning from this year's shortfalls in delivery against the reduction plans we will take the following actions to ensure assurance team will deliver targets.
•Improved action planning, greater accountability and visibility of delivery through monitoring of plans, clear digital strategy to support reductions, utilising national guidance and support in relation to Bank. Improvements expected in 26/27.

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

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 March is 9.6% equating to 660 WTE leavers. An in-month turnover rate of 0.8% equates to 53 WTE leavers in March. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.8% equating to 470 WTE NHS leavers.
Staff groups with highest turnover rates are: Additional Clinical Services (12%); Admin and Clerical (12%); Estates and Ancillary(10%).
Nursing and Midwifery has a turnover rate of 7%.
Relocation is currently the highest reason for leaving with 110 WTE leavers with work life balance as the second highest reason with 105 WTE leavers over the last 12 months.

Recovery actions to achieve our target:

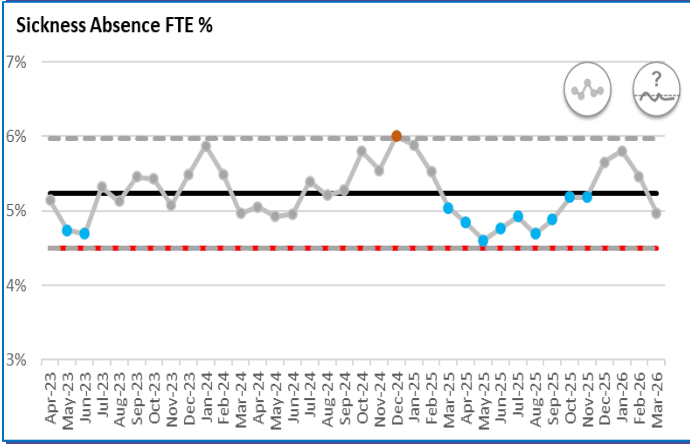
- Staff Engagement: NSS 2025 results due end December/ January. Results will be reviewed and shared under embargo to commence action
- Redeployment Improvements: The redeployment process is being enhanced in collaboration with the recruitment team to better support staff transitions including movements from other Trusts
- Workforce Realignment and change: The Trust is reshaping its workforce to support service transformation and investment delivery
- Cultural Transformation: Plans to support transition to Group continue to support cultural transformation
- Psychological Support: The Staff Psychology Service is delivering reflective practice, trauma-informed sessions, and mental health support to help reduce stress-related turnover
- Leadership Programmes: Continue to deliver and launch of Galvanise cohort 4

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

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

Workforce – Sickness absence

Shropshire, Telford and Wrekin Community and Hospitals NHS Group



Summary:
Our sickness target for 2026 is 4.5%. March sickness rate of 5.0% (373 WTE) remaining above target by 0.5% (35 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 25% of calendar days lost in March equating to 93 WTE. 12% (43 WTE) of sickness was attributed to other known causes; other musculoskeletal problems was at 11% (42 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 and Additional Clinical Services have the highest sickness rates both at 6.8%, with Nursing and Midwifery at 5.6%.

Recovery actions to achieve our target:

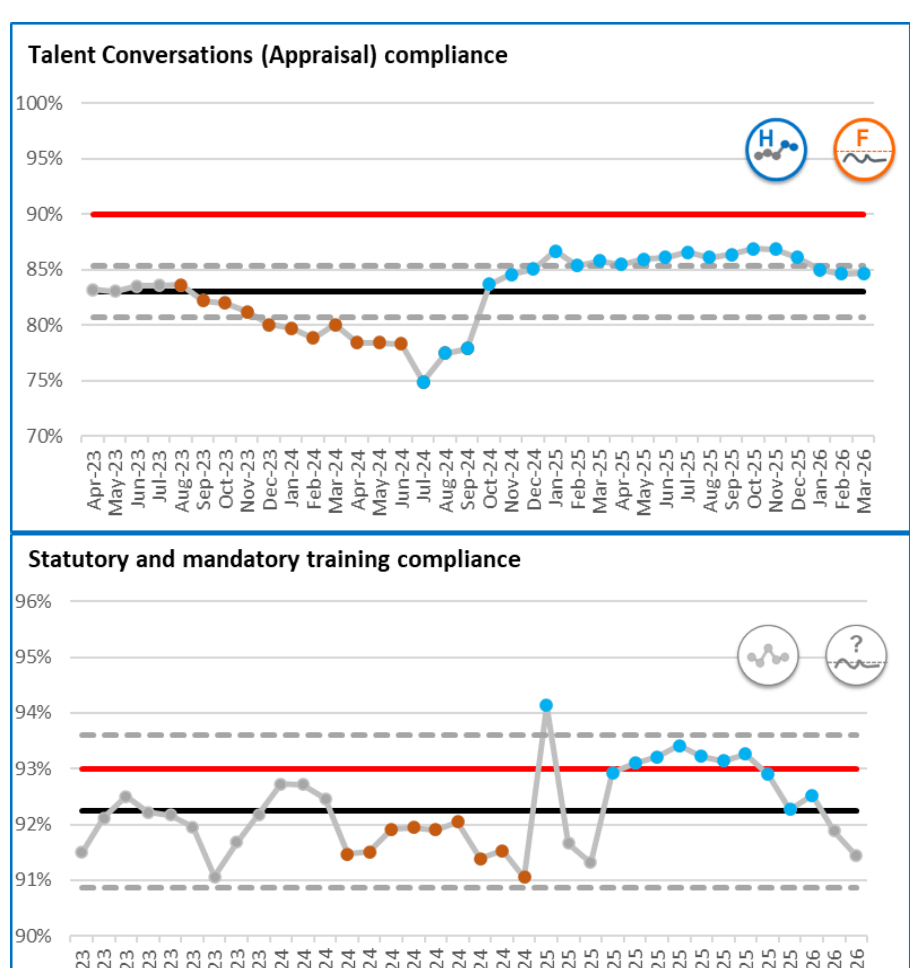
- Review of all long-term absence (currently 75 WTE) we are now undertaking a full review of long-term sickness cases to identify any cases that can be concluded
- Management of Change Masterclasses: Supporting staff through change to reduce stress-related absence continue
- Sickness Management Trial: Piloting new approaches for Medical & Dental staff
- Staff Psychology Support: Offering mental health and trauma-informed sessions to reduce absence
- Wellbeing Initiatives: Delivering roadshows, wellbeing walks, and targeted support to boost resilience
- Cultural Transformation: NSS 2025 results expected
- Divisional Engagement Plans: Helping teams address wellbeing and retention challenges
- Prevention: Review of local needs, Equality Delivery System 22 to ensure clear focus for HWB and prevention
- Review of all long-term sickness to ensure robust support to managers and colleagues

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

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 increased slightly to 84.65% in March.
Our Mandatory and statutory training compliance target by end of March 2027 is 93%, currently our target is 90%. The compliance rate in March has declined to 91.44% but is still above the current target.

Recovery actions:

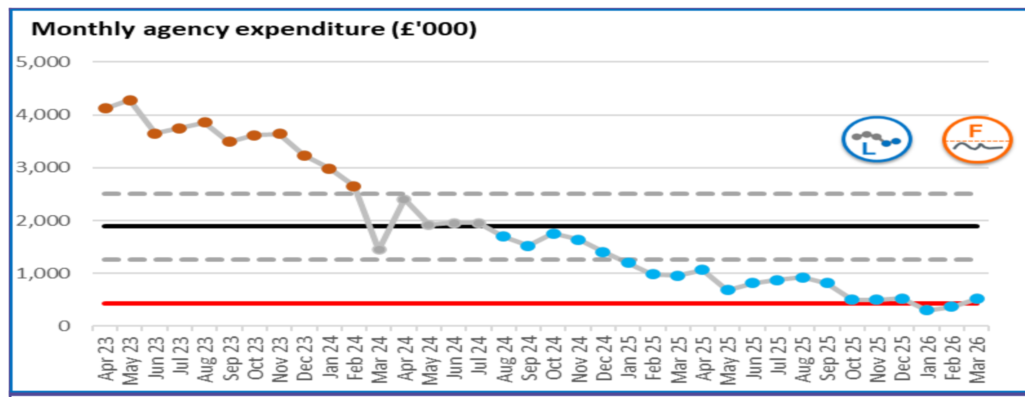
- National mandatory learning policy framework implementation
- Review of NHS Ten-year plan and support development of Joint People Strategy. Investment in clinical educators, expansion in widening participation opportunities, entry routes into the NHS.
- Continue to build and work with Keele University,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

Anticipated impact and timescales for improvement:

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

Recovery dependencies:

Agency Expenditure - Monthly



Summary:
Agency usage levels increased for the first time since July (an increase of 13 WTE) and ended the year at 5.4 WTE under planned. We will now continue to monitor agency levels and keep all governance processes in place throughout 26/27. Key focus will be on medical agency with high-cost specialties / which have hard to fill Consultant vacancies and will be addressed via external recruitment support.

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

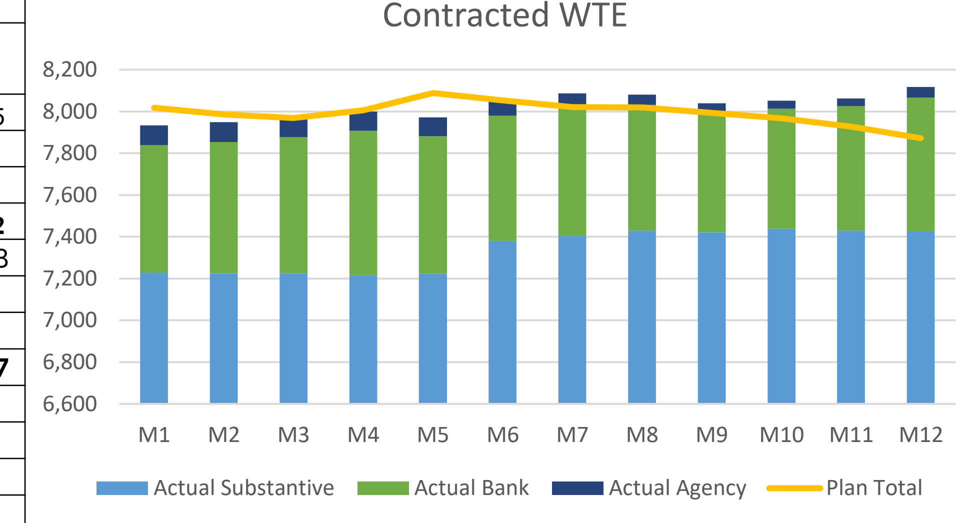
Anticipated impact and timescales for improvement:
Agency expected to reduce in line with plan for 26/27.

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

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	7,259	7,272	7,268	7,318	7,422	7,447	7,422	7,393	7,374	7,356	7,323	7,275
	Bank	641	603	598	593	588	533	529	557	553	549	545	542
	Agency	118	110	102	95	78	73	69	69	66	62	59	55
	Total	**8,018**	**7,985**	**7,968**	**8,006**	**8,088**	**8,053**	**8,020**	**8,019**	**7,993**	**7,967**	**7,927**	**7,872**
Actual	Substantive	7,229	7,226	7,225	7,216	7,222	7,380	7,403	7,429	7,422	7,438	7,430	7,428
	Bank	610	628	652	692	659	600	625	602	568	574.51	595	639
	Agency	95	94	86	91	91	79	58	50	50	37.9	37	50
	Total	**7,934**	**7,948**	**7,963**	**7,999**	**7,971**	**8,059**	**8,086**	**8,081**	**8,039**	**8,051**	**8,062**	**8,117**
Variance	Substantive	-30	-46	-43	-102	-200	-67	-19	36	48	83	107	153
	Bank	-31	25	54	99	71	67	96	45	15	26	50	97
	Agency	-23	-16	-16	-4	13	6	-11	-19	-16	-24	-22	-5
	Total	**-84**	**-37**	**-5**	**-7**	**-117**	**6**	**66**	**62**	**46**	**84**	**135**	**245**



Summary:
Total staff usage of 8017 WTE in March is 245 WTE (Contracted) above plan and an increase from the February position of 55 WTE. Substantive levels have marginally decreased this month. Bank increased by 44 WTE. Agency usage levels have increased, ending the year at 5 WTE under planned levels.

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.

Finance

Executive Lead:

Acting Director of Finance
Adam Winstanley

Integrated Performance Report

Domain	Description	Current Month Trajectory (RAG)	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Finance	End of month cash balance £'000	54,566	61,762	45,006	35,131	41,161	44,343	51,400	40,294	49,296	39,293	16,298	89,066	83,003	72,968	
	CIP Delivery £'000	4,552	5,659	2,392	2,568	2,742	3,579	3,166	3,843	3,363	3,268	3,692	4,076	4,435	4,419	
	Balanced £ Position £'000 (Cumulative)	0	(18,563)	5	1	10	8	4	(1,274)	(2,290)	(3,927)	(5,848)	(5,604)	(4,098)	4,920	
	Year to date capital expenditure £'000	145,915	69,194	2,044	12,632	19,759	24,803	32,363	41,608	53,139	61,724	76,556	87,885	102,681	149,713	

Financial Executive Summary

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

The Trust submitted a finance plan to NHSE on 30th April which showed a breakeven plan with deficit support of £45.15m for the year. At the end of March (month twelve), the Trust has delivered a surplus position of £4.92m against the breakeven plan driven by the Trust receiving bonus deficit support funding. There have been some variances in the cost categories with income favourable to plan and pay and non-pay adverse to plan. The drivers of the variances are; additional costs associated with UEC (£2.57m) and income backed posts (£1.23m) offset by income. There had also been a cost pressure associated with the industrial action (£1.40m) in July, November and December. The costs in July were mitigated by bringing forward an expected CIP scheme in non-pay however, the Trust received £2.5m to support the impact of industrial action. The cost pressure associated with the pay award (£1.70m) had been partially mitigated in earlier months however, this could no longer be mitigated and was a cost pressure along with the premium payments associated with temporary staffing (£19.16m). An increase in pass through devices has also been seen in non-pay increasing expenditure which is offset by an over achievement in income and a benefit in financing costs (£0.60m) resulting from the Trusts' cash position.

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

- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues at present, however the Trust is actively making CDS submissions through to SUS. The Trust have reduced waiting lists significantly in year which has increased costs above funded levels. The Trust received elective sprint funding in Q4, and the Trust was able to re-base the YTD plan to reflect the additional activity undertaken in Q1-3 and as such meant an additional £3m of income to go against costs already incurred
- Delivery of the efficiency plan – The Trust has an efficiency target of £41.40m in FY25/26. At the end of March, £41.54m has been delivered which is £0.14m more than plan
- Delivery of WTE reduction plan – At the end of March against the numbers reported in February (actual worked) there has been increase of 57 WTE overall, there has been an increase in worked agency of 13 WTE and an increase in worked bank of 44 WTE, however, substantive has remained constant
- Delivery of the agency reduction plan – expenditure has increased in month compared to February; however, it remains below the planned levels of expenditure. There will continue to be a strong focus on medical agency in FY26/27
- Delivery of additional capacity (escalation) within a core capacity funding envelope (£14.00m) – at the end of month twelve there has been an overspend of £2.57m against plan

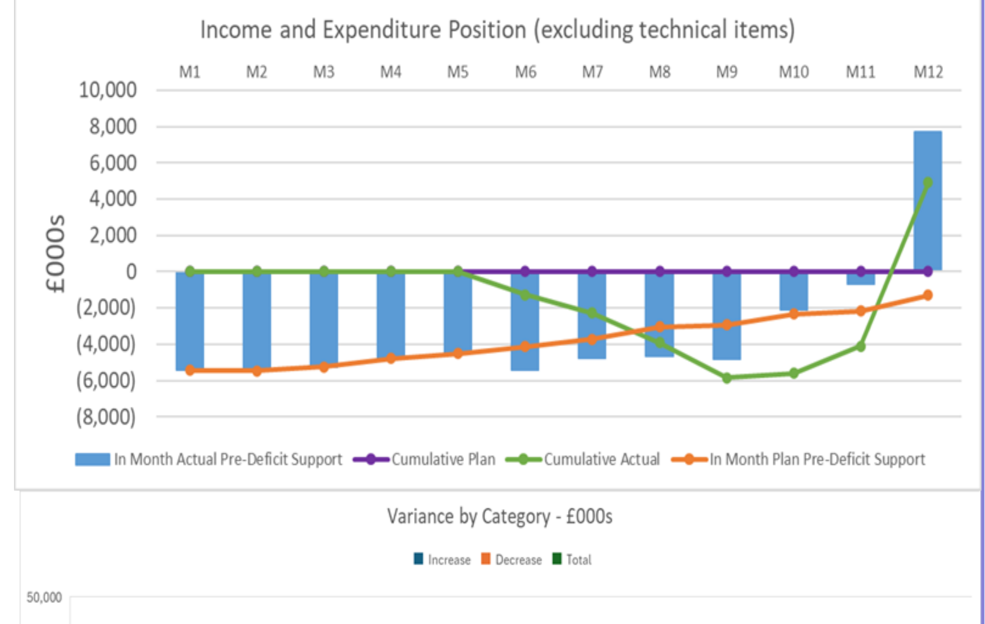
The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £127.17m in FY25/26, giving a total capital programme of £149.70m.

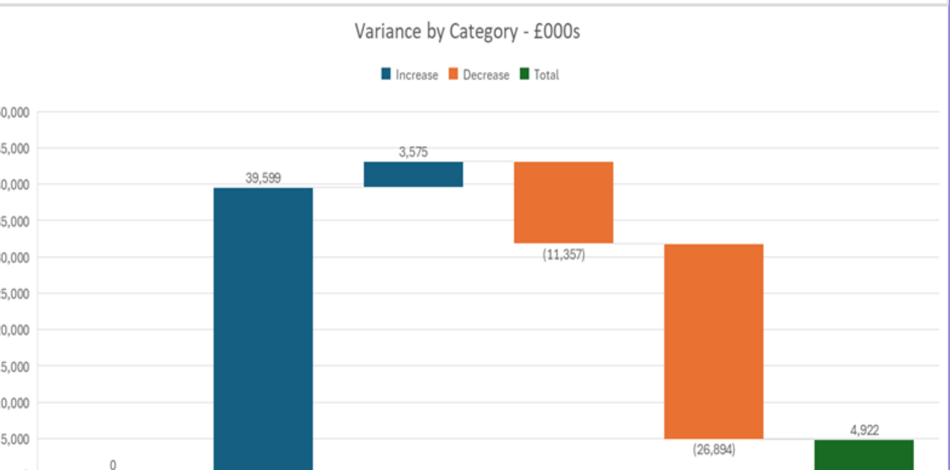
The Trust held a cash balance at end of March 2026 of £73.21m.

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

Income and Expenditure – Year to Date

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group





The Trust has a breakeven plan with deficit support of £45.1m for FY25/26. At the end of March (month twelve), the Trust has delivered a surplus position of £4.9m against the breakeven plan.

The drivers of the variance to plan:

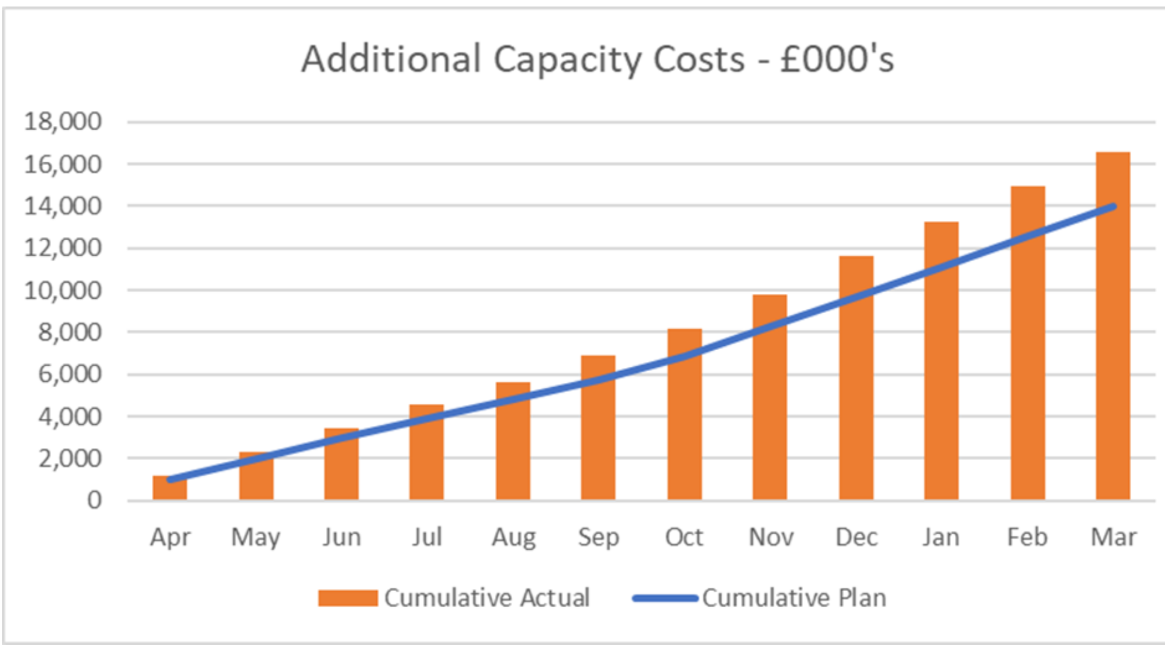
- additional bonus payment of £4.9m received relating to redistributed deficit support funding as a result of delivering plan and submitting a compliant plan for FY26/27
- additional capacity costs for patient safety
- additional cost of accelerated delivery of elective performance improvements
- cost pressure associated with the FY25/26 pay award
- premium staffing costs

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

- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues at present, however the Trust is actively making CDS submissions through to SUS and there are ongoing conversations within the system around redistribution of variable ERF funding. The Trust however have reduced waiting lists significantly in year which has increased costs above funded levels. The Trust received elective sprint funding in Q4 and the Trust was able to re-base the YTD plan to reflect the additional activity undertaken in Q1-3 and as such meant an additional £3m of income to go against costs already incurred
- Delivery of the efficiency plan – The Trust has an efficiency target of £41.4m in FY25/26. At the end of March, £41.5m has been delivered which is £0.1m more than plan
- WTE reduction plan – At the end of March against the numbers reported in February (actual worked) there has been increase of 57 WTE overall, there has been an increase in worked agency of 13 WTE and an increase in worked bank of 44 WTE, however, substantive has remained constant
- Delivery of the agency reduction plan – expenditure has increased in month compared to February, however, it remains below the planned levels of expenditure. There continues to be a strong focus on medical agency in FY25/26
- Delivery of additional capacity (escalation) within a core capacity funding envelope (£14.00m) – at the end of month twelve there has been an overspend of £2.6m against plan.

Additional capacity

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group



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

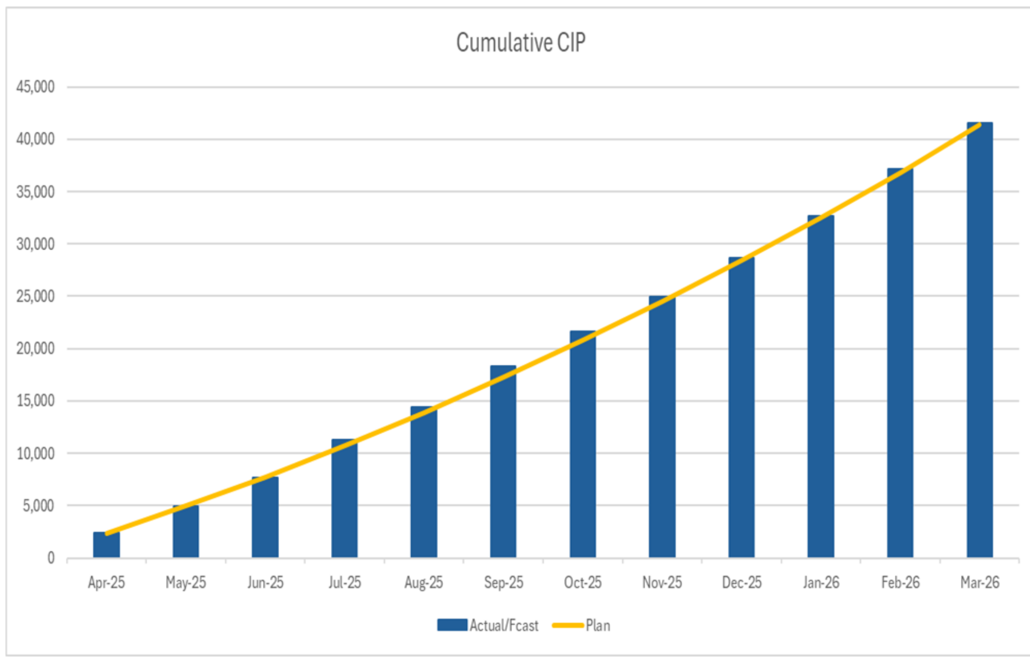
The requirement on a monthly basis is driven by changes in demand, offset by both internal and external interventions such as reduced length of stay and reductions in the number of patients with no criteria to reside, all of which is linked to the delivery of the 4 UEC transformation workstreams.
In March additional capacity costs were consistent with February and remain above the planned levels both in month and year to date with year-to-date costs at £16.56m against a plan of £13.99m, an overspend of £2.57m.

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

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

Efficiency

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



Summary:
The Trust has a total efficiency target for FY25/26 of £41.4m.
As at the end of February (month eleven), the Trust has delivered £41.54m of efficiency savings for FY25/26 which is £0.14m above the planned delivery.

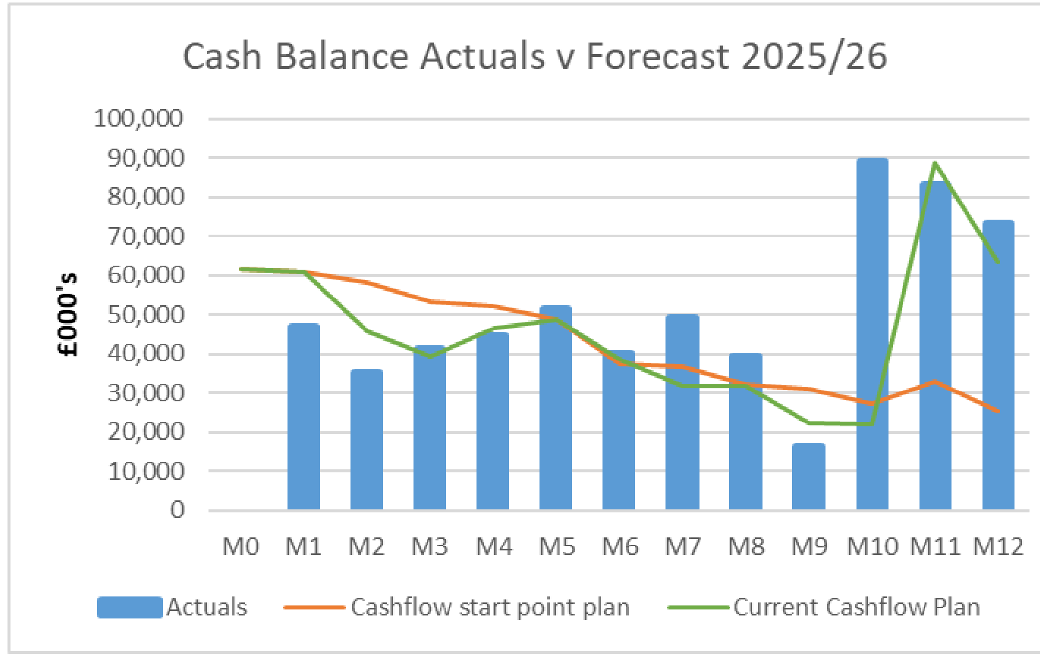
Whilst we under delivered on some of our planned schemes such as headcount, the Trust successfully found mitigations to achieve a slightly over delivery of plan at the end of 25/26.

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

Dependencies:	Delivery of actions against PIDs.

Cash and Cash Equivalents

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group



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

The cash balance brought forward into FY25/26 was £61.76m with a cash and ledger balance of £73.21m held at end of month twelve.

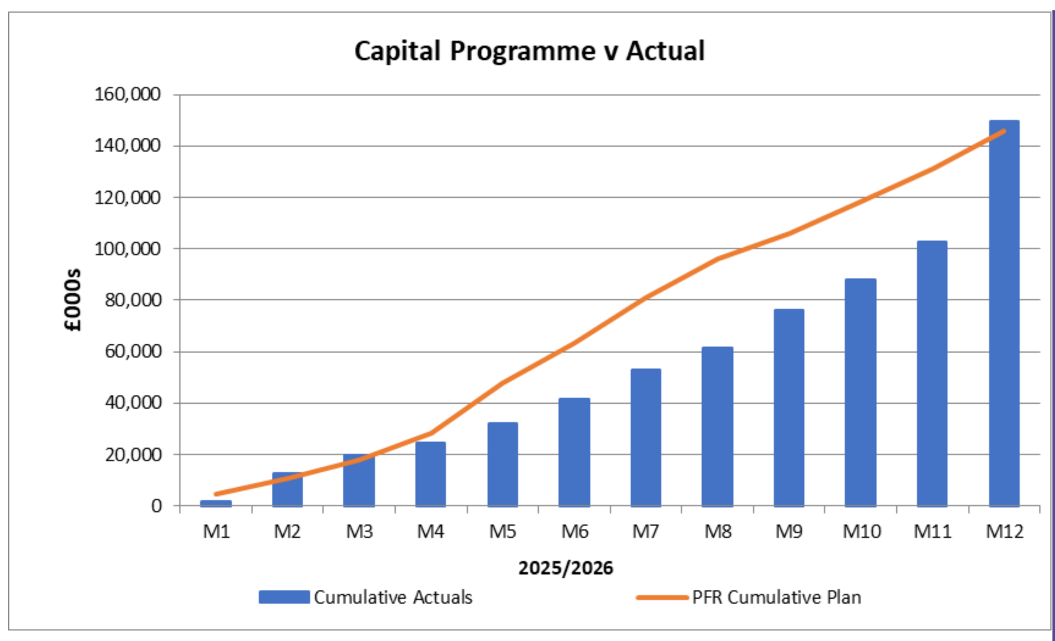
The graph illustrates overall actual cash held against the plan. At month twelve, actual cash balances were greater than forecast, due to the timing of capital spend and receipt of additional cash from STW.

To note the difference in the February and March 2026 cashflow forecast from the start point to the current is primarily driven by emerging pay pressures and the assumptions around cash releasing CIP, offset in part by additional income received and delays in the FY25/26 capital programme resulting in the Trust expecting to hold a capital cash balance of £40.66m.

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

Capital

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group



Summary:

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

External allocations have increased to £127.17m, giving an overall Capital Programme of £149.70m (excluding Salix).

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

At M12 FY25/26, the Trust delivered in line with the Capital Programme.

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

Appendices – Responsiveness And Well Led

Appendix 1 – supporting detail on Responsiveness

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

Appendix 2 – supporting Well Led

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

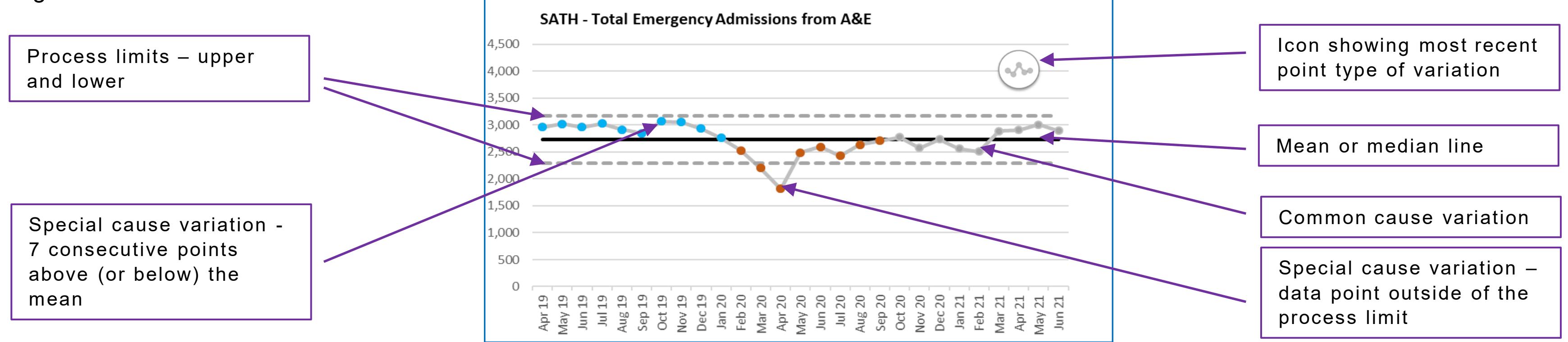
Appendix 3 – Understanding statistical control process charts in this report

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



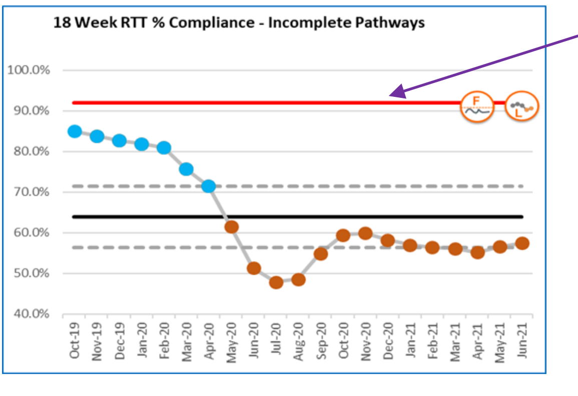
Icon showing most recent point type of variation

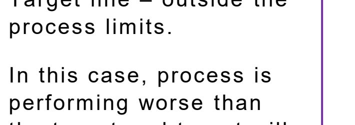
Mean or median line

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.

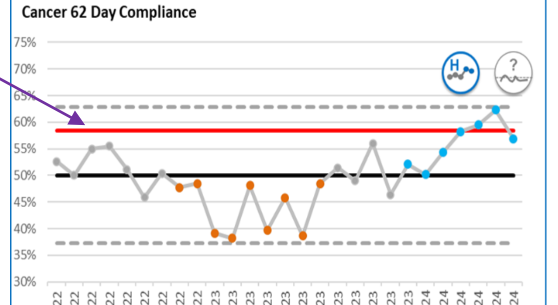


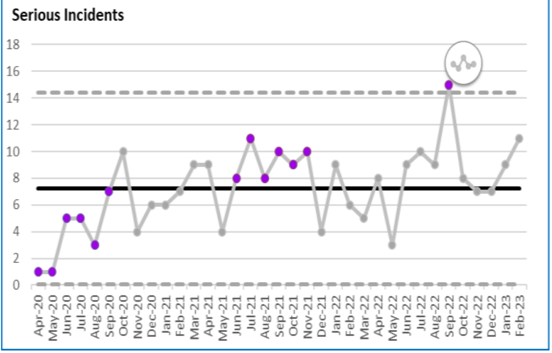


Target line – outside the process limits.

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





Variation				Assurance		
Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation	Consistently fail target

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Appendix 4 – Abbreviations used in this report

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

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

Appendix 4 – Abbreviations used in this report

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

Moving to
EXCELLENCE

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

Moving to
EXCELLENCE

Board of Directors' Meeting in Common – 14 May 2026

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<tr><td>Report Title</td><td colspan="3">SCHT Annual Financial Performance Report Month 12 2025/26</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Sarah Lloyd, Chief Finance Officer, SCHT</td></tr>
<tr><td>Report Author</td><td colspan="3">Jonathan Gould, Deputy Chief Financial Officer</td></tr>
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<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>BAF id(s)</td></tr>
<tr><td rowspan="5"></td><td>Safe</td><td></td><td rowspan="2"></td></tr>
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<tr><td>Caring</td><td></td><td>Risk Register id(s):</td></tr>
<tr><td>Responsive</td><td></td><td rowspan="2"></td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">This paper summarises SCHT's financial performance for the 2025/26 financial year. SCHT has delivered all of its financial obligations, however all reported values remain subject to external audit review.

SCHT delivered a surplus of £3,910k, which is a favourable variance of £1,910k compared to the plan and £1,610k favourable to the agreed forecast outturn of £2,300k.

The driver of the improvement to the agreed forecast outturn was receipt of additional NHSE funding of £1,638k in late March.</td></tr>
<tr><td>Recommendations for the Board</td><td colspan="3">The Board is asked to:
• Consider the adjusted annual financial position of £3,910k surplus
• Acknowledge SCHT's CIP target for 2025/26 of £5,359k was exceeded by £271k, with actual delivery of £5,630k
• Consider that capital expenditure for the year was £4,958k which is in line with plan
• Consider the underlying position was a surplus of £1,137k, which is a favourable variance of £205k compared to the annual plan of £932k surplus
• Acknowledge that the reported position remains subject to audit</td></tr>
<tr><td>Appendices:</td><td colspan="3"></td></tr>
</table>

1. Main Report

1.1. Introduction

SCHT is measured on its financial performance in several ways, but the principal measure is total Income and Expenditure at adjusted financial performance level. This excludes several technical accounting adjustments and is the level at which performance is reported to and managed by NHSE.

1.1.1. Summary of key points in report

The following dashboard summarises key areas of performance in relation to the financial plan.

Annual Financial Performance against Plan (£k)	M12 Plan	M12 Actual	M12 Variance	Annual Plan	Annual Actual	Annual Variance
(Surplus)/ Deficit In Year	(202)	(1,816)	(1,614)	(2,000)	(3,910)	(1,910)
Underlying Position	(107)	(154)	(47)	(932)	(1,137)	(205)
Agency Expenditure	228	246	18	2,939	3,012	73
Bank Expenditure	210	350	140	2,736	4,014	1,278
Cost Improvement Programme	488	534	46	5,359	5,630	271
BAU Capital Expenditure	409	1,023	614	4,975	4,958	(17)

1.2. Adjusted Financial Performance – favourable variance to plan £1,910k

The adjusted financial position is a surplus of £3,910k compared to the planned surplus of £2,000k, which is a favourable variance of £1,910k. Table 1 summarises the Income and Expenditure position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(134,288)	(135,327)	(1,038)
Expenditure excl. adjusting items	132,288	131,417	(872)
Adjusted financial performance total	**(2,000)**	**(3,910)**	**(1,910)**
Adjusting items	140	786	646
Retained (surplus) / deficit	**(1,860)**	**(3,124)**	**(1,264)**

Table 1: Income and Expenditure (surplus) / deficit position as at 31 March 2026

Trust performance is measured against the Adjusted Financial performance total in Table 1. The key adjusting items include asset impairments.

1.2.1. Income – favourable variance to plan £1,038k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System income	(99,035)	(100,018)	(983)
Non-system income	(35,254)	(35,309)	(55)
Total income	**(134,288)**	**(135,327)**	**(1,038)**

Table 2: Income Summary as at 31 March 2026

Income exceeded planned values by £1,038k at year end; this favourable variance largely reflects the national allocation of Deficit Support Funding (DSF) of £1,638k partially offset by a number of smaller adverse variances. National unearned Deficit Support Funding was allocated to organisations which forecast delivery of 2025/26 financial plans and worked within an ICS that forecast delivery of its overall 2025/26 financial plan.

1.2.2. Expenditure – favourable variance to plan £226k

Table 3 shows a summary of expenditure by key categories.

	Annual Plan £k	Annual Actual £k	Annual Variance £k
Substantive	93,201	90,456	(2,745)
Bank	2,736	4,014	1,278
Agency	2,939	3,012	73
Total Pay	**98,876**	**97,481**	**(1,394)**
Supplies & Services Clinical	11,253	11,724	471
Prison Escorts and Bedwatch	262	486	224
Drugs	1,496	1,497	1
Premises	9,093	9,239	145
Travel	1,682	1,493	(189)
Other	9,767	10,283	517
Total Non-Pay	**33,552**	**34,721**	**1,169**
Total Expenditure	**132,428**	**132,203**	**(226)**

Table 3: Expenditure Summary as at 31 March 2026

1.2.3. Pay – favourable variance to plan £1,394k

The overall pay position was a favourable variance of £1,394k. This is due mainly to pay underspends linked to substantive vacancies. The substantive pay underspend is partially offset by the bank staff overspend; bank staff (paid at substantive rates) are utilised to cover vacant clinical shifts, wherever possible, to limit the use of agency staff.

Bank spend for the year was £4,014k; this is £1,278k adverse to plan. This is 4.1% of total pay compared to planned spend of 2.9% and is due to bank staff covering a higher level of vacancies than planned.

Annual agency expenditure was £3,012k – resulting in a small adverse variance to plan of £73k. This reflects ongoing medical vacancies and sickness across a number of services whilst substantive recruitment continues.

The vacancy rate in month 12 was 7.9% (a reduction from 10.9% in March 2025). This equates to 137 WTE vacancies, however it should be noted that 101 WTE temporary staff (77 WTE bank and 24 WTE agency) were used in March with the majority covering clinical vacancies.

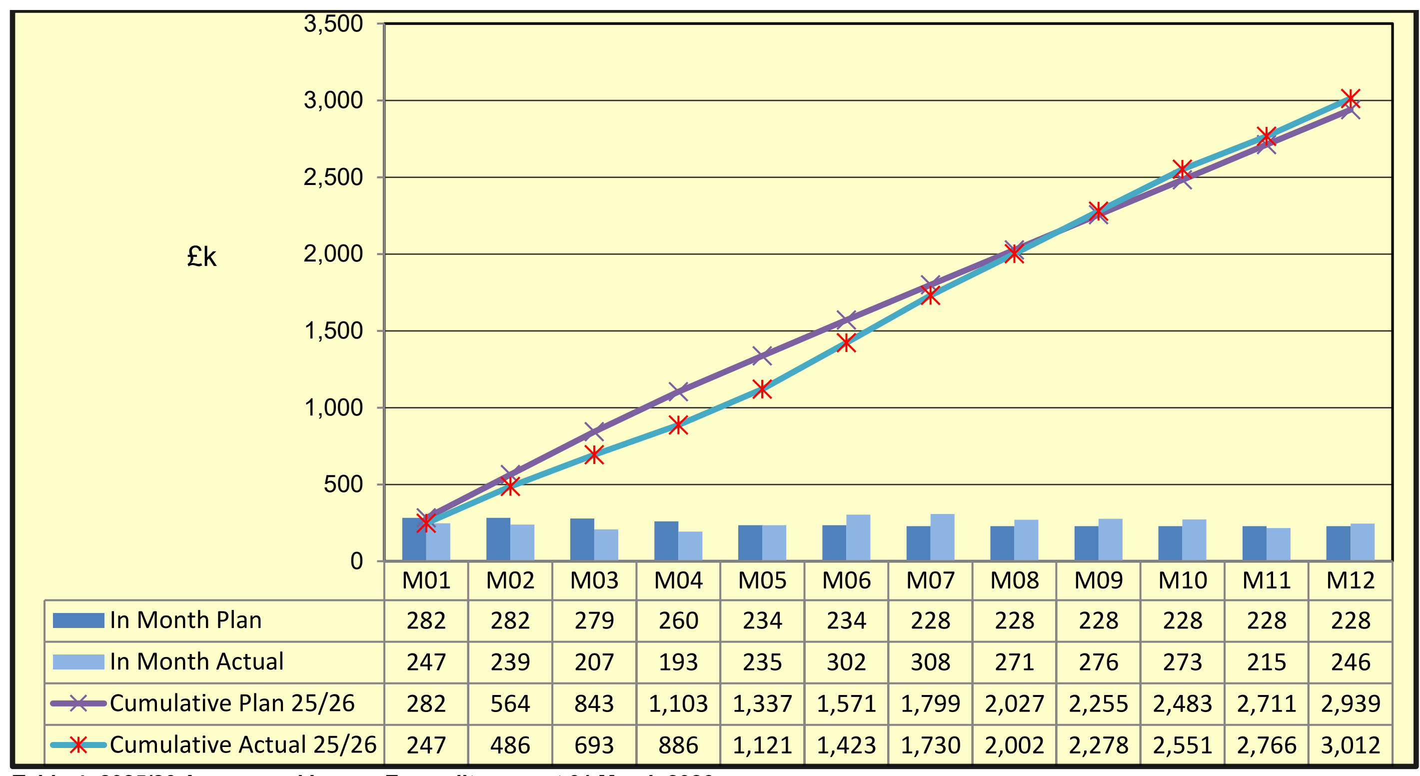
The vacancy position is kept under review through the weekly Vacancy Control Panel and the People Committee. Improved recruitment and retention and managing unavailability remain crucial to reduce the Trust's reliance on temporary staff.

1.2.4. Non-Pay – adverse variance to plan £1,169k

There are continuing cost pressures in the Prison Healthcare service and the Wheelchair service which remain the key reasons for the non-pay overspend. Mitigating actions are in place which have begun to reduce a number of these pressures, and additional measures are being sought to ensure the impact on the Trust's ongoing financial position are minimised. The Trust's Financial Recovery Group maintains oversight of the mitigating actions.

1.2.5. Agency and Locum Expenditure – adverse variance to plan £73k

Table 4 shows agency spend for the year was £3,012k compared to the plan of £2,939k, which is a small adverse variance of £73k. Since September 2025, agency usage has increased due to additional temporary medical staffing requirements and the expansion of the Urgent Community Response service. Total agency spend for the year was 3.1% of total pay compared to the annual plan of 3%.



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
In Month Plan	282	282	279	260	234	234	228	228	228	228	228	228
In Month Actual	247	239	207	193	235	302	308	271	276	273	215	246
Cumulative Plan 25/26	282	564	843	1,103	1,337	1,571	1,799	2,027	2,255	2,483	2,711	2,939
Cumulative Actual 25/26	247	486	693	886	1,121	1,423	1,730	2,002	2,278	2,551	2,766	3,012

Table 4: 2025/26 Agency and Locum Expenditure as at 31 March 2026

1.2.6. Cost Improvement Programme 2025/26 – favourable variance to plan £271k

SCHT's CIP target for 2025/26 was £5,359k comprising £3,574k of recurrent savings and £1,785k of non-recurrent savings. This value is 4.4% against the opening recurrent cost base or 5.3% when the service areas upon which a CIP cannot be applied are taken into account.

Table 5 shows overall CIP delivery of £5,630k for the year-end, which is £271k favourable to plan.

	Annual Plan £k	Annual Actual £k	Annual Variance £k
Recurrent	3,574	3,583	9
Non-recurrent	1,785	2,047	262
TOTAL	**5,359**	**5,630**	**271**

Table 5: 2025/25 CIP delivery as at 31 March 2026

Recurrent delivery was £3,583k which is £9k favourable to plan; the full year effect of the recurrent schemes was £3,930k, totalling £356k favourable to plan.

Non-recurrent CIP delivery was £2,047k; this is £262k favourable to plan.

All relevant CIP schemes are reviewed through Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

1.2.7. Statement of Financial Position

The summarised Statement of Financial Position (SoFP) for period ended 31 March 2026 is shown in Table 6.

	28 February 26 Balance £k	31 March 26 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,520	43,406	886
Inventories	142	139	(3)
Non-current assets for sale	0	0	0
Receivables	2,928	3,846	918
Cash	33,828	29,164	(4,664)
Payables	(16,579)	(12,882)	3,697
Provisions	(3,051)	(2,470)	581
Lease Obligations on Right to Use Assets	(11,807)	(11,081)	726
TOTAL ASSETS EMPLOYED	**47,981**	**50,122**	**2,141**
Retained earnings	38,175	39,674	1,499
Other Reserves	9,806	10,448	642
TOTAL TAXPAYERS' EQUITY	**47,981**	**50,122**	**2,141**

Table 6: Statement of Financial Position as at 31 March 2026

- Property, plant and equipment increased by £886k due to capital expenditure.
- Receivables (amounts we are owed) increased by £918k: this is mainly due to Deficit Support Funding of £1.6m (which will be received in April 2026) partially offset by other receipts.
- Payables (amounts we owe) decreased by £3,697k. Main movements are; settlement of a number of NHS invoices of £1.2m, payment of capital invoices totalling £0.9m and reduction in 0-19 Services deferred income totalling £0.9m.
- Cash decreased by £4,664k, reflecting movements above, primarily payables.

All movements are within the expected monthly range and there are no exceptions to bring to the attention of the Committee.

1.2.8. Capital Expenditure

The 2025/26 plan is £4,975k which comprises operational capital of £2,818k and IFRS 16 lease capital of £2,157k. NHSE guidance now allows flexibility on how the overall capital allocation is spent, and as a result the operational capital spend for the year was £3,613k and for IFRS16 lease capital spend it was £1,345k, which totals £4,958k, an overall underspend of £17k. A summary position is shown in Table 7 below.

Key areas of capital spend in the year include: X-ray replacement Bridgnorth and Oswestry sites, Coral House redevelopment, enhancing clinical space, additional solar panel installation and LED replacement across several site, and digital infrastructure.

Capital Expenditure	Annual Plan £k	Annual Actual £k	Annual Variance £k
Operational Capital	2,818	3,613	795
IFRS 16 Leases	2,157	1,345	(812)
	4,975	**4,958**	**(17)**

Table 7: 2025/26 Capital Expenditure as of 31 March 2026

1.2.9. Underlying financial position

The planned underlying position for 2025/26 was a surplus of £932k with a key enabler being recurrent CIP delivery of £3,574k.

The actual underlying position for the year was a £1,137k surplus, £205k favourable to plan, largely related to income favourable performance.

The underlying position and the key assumptions remain a key area of focus for NHSE, and there is an expectation that this is monitored by Trust Boards and Committees.

1.2.10. NHSE Provider Finance Return and Annual Accounts Submission

The Provider Finance Return (PFR) and the 2025/26 Draft Annual Accounts are consistent with the figures set out in this report and were submitted to NHSE on 27th April 2025, in line with the national timetable.

2. Conclusion

Subject to external audit, SCHT met its financial obligations in 2025/26.

SCHT delivered an adjusted annual financial position of £3,910k surplus compared to the planned £2,000k surplus, resulting in a favourable variance of £1,910k. This position is £1,610k favourable to the agreed forecast position of £2,300k and includes the benefit of £1,638k national funding.

The annual CIP for 2025/26 of £5,359k was exceeded by £271k, with actual delivery of £5,630k and the recurrent plan was exceeded in year and on a full year basis.

Annual capital expenditure for the year was £4,958k, in line with plan.

The underlying position was a surplus of £1,137k, a favourable variance of £205k compared to the annual plan of £932k surplus.

Board of Directors’ Meeting in Common – 14 May 2026

Agenda item	015/26b		
Report Title	SCHT 2026/27 Opening Budget		
Executive Lead	Sarah Lloyd, Chief Finance Officer SCHT		
Report Author	Jonathan Gould, Deputy Chief Financial Officer		
Prior Consultation:	**CQC Domain:**		**BAF id(s)**
	Safe		
	Effective		
	Caring		**Risk Register id(s):**
	Responsive		
	Well Led	√	
Executive Summary	SCHT’s Resource and Performance Committee reviewed the proposed 2026/27 opening budgets at its meeting on 25 March and recommends these to the Boards in Common for approval. The opening budget is consistent with the Trust’s financial plan which was submitted to NHS England in March, and it is compliant with all financial requirements. The opening 2026/27 budget proposes a breakeven revenue plan and planned capital expenditure of £6.38m.		
Recommendations for the Board	The Boards in Common are asked to: • **Consider** the Resource and Performance Committee reviewed SCHT’s opening budgets in detail on 25 March and recommends these to the Trust Boards for approval. • **Approve** the opening 2026/27 annual budgets.		
Appendices:			

1. Main Report

1.1. Introduction

The purpose of this report is to present SCHT's summarised opening budgets for 2026/27. Detailed information was reviewed and discussed at the Resource and Performance Committee on 25 March 2026, and the Committee recommends these budgets to the Boards in Common for approval.

Summary headlines of the 2026/27 opening budgets are presented in Table 1 and are consistent with the plan submitted to NHS England (NHSE) in March:

Detail	Submitted Plan 2026/27	Comments
Adjusted In-Year Financial Performance - Breakeven	£0	Includes recurrent and non-recurrent items and is compliant with NHSE's requirements.
Cost Improvement Target	£4.29m	The CIP target reflects the national efficiency requirement within the tariff plus an additional target to fund likely cost pressures.
Cost Improvement as % of Cost base	3.5% (4.2%)	CIP requirement via the national tariff of 2.0% plus an additional 1.5% to offset pressures.
Productivity as % of cost base	2.0% (2.4%)	**Total efficiency including productivity is 5.5%, this equates to 6.6% when we exclude service areas where we are unable to apply efficiencies** e.g. contracts with which already have built in efficiencies
Net Capital Expenditure Plan	£6.38m	Inclusive of £3.6m Freedom and Flexibilities capital granted to the Trust due NOF rating. The £3.6m matches the Trust's 24/25 surplus.

Table 1: Key Financial Headlines in Plan and Opening Budget 2026/27

2.1 Income

Relevant income from patient care activities has been adjusted to reflect an inflationary uplift in line with NHSE planning guidance, shown in Table 2 below:

Detail	Inflation
Total Uplift	2.03%
Less efficiency target	-2.00%
Net Tariff Uplift	**0.03%**

Table 2: Inflationary uplift rates in 2026/27 Opening Budgets

System income will continue to be paid under the Aligned Payment and Incentive (API) model. This includes a fixed element to fund an agreed level of activity other than for elective activity. Planning guidance proposes that elective activity continues to be paid for using NHSPS unit prices, with the relevant adjustments applied.

Non-system income includes income from all other NHS bodies and non-NHS organisations and is based on 2025/26 forecast outturn uplifted for inflation.

2.2 Expenditure – Pay

Pay budgets for funded establishments are at 2025/26 pay rates for staff in post as at October 2025. Vacancies are funded at mid-point of relevant pay bands and establishments, and related pay budgets are also adjusted for any service changes which have taken place.

Recurrent pay budgets have been uplifted by 2.1%, inclusive of 0.1% incremental pay drift, as per planning guidance; this is set aside in a specific centrally held budget to be allocated when the final pay agreements are confirmed.

Budgets will be adjusted to reflect the impact of national pay awards, once agreed. The expectation is that any potential increase above the planning assumption of 2.1% will be matched by central funding.

2.3 Expenditure – non-pay

Apart from adjustments relating known service changes, non-pay budgets are largely unamended unless specific cost pressures have been identified. In line with planning guidance, non-pay inflation is calculated at 2.2% and 0.58% for drug expenditure. The general non-pay inflation uplift is held in a specific centrally held budget and will be allocated on a case-by-case basis.

2.4 Efficiency Programme

The Cost Improvement Programme (CIP) target of £4.29m (3.5%) is a result of the in-year requirement of 2.0%, based on the national tariff, and an additional 1.5% to offset cost pressures.

£4.29m is equivalent to 3.5% of SCHT's total opening recurrent cost base, however, there are expenditure areas where CIP is not possible, for example contracts where savings are already assumed within the agreed funding envelope. After exclusion of these areas, the remaining services are required to deliver 4.2% efficiency to achieve the CIP.

In addition, SCHT is planning for productivity improvements of 2% (when adjusted as above this becomes 2.4%) which will support unplanned cost pressures and additional activity within services to meet demand.

The total efficiency and productivity plan for the year therefore equates to 6.6% after adjusting for known exceptions.

2.5 Recurrent Budgets

The recurrent financial plan for the year is a surplus of £1.32 million, with a number of non-recurrent adjustments resulting in an in-year breakeven plan.

2.6 Non-Recurrent Budgets

The Covid Vaccination Programme is financed on a non-recurrent basis, and this plan includes non-recurrent income to support the ongoing costs associated with the programme. There remains a risk that the final allocation may not fully cover the cost of delivering the service, however upon confirmation of the final allocation, the delivery model will be reviewed as necessary to ensure a breakeven outcome.

2.7 Profile of 2026/27 Budgets

Table 3 presents SCHT's summary annual budget and quarterly profile.

	2026-27 Plan £'000				
Details	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total**
I&E POSITION					
Income	31,512	31,511	31,511	32,677	127,211
Pay	(23,943)	(24,219)	(24,129)	(25,440)	(97,731)
Non-pay	(7,626)	(7,290)	(7,350)	(7,213)	(29,480)
Adjusted Financial Performance	**(57)**	**2**	**32**	**23**	**0**
CIP					
CIP - Recurrent	622	891	1,087	1,087	3,686
CIP - Non Recurrent	150	150	150	150	600
CIP TOTAL	**772**	**1,041**	**1,237**	**1,237**	**4,286**
VARIABLE PAY					
Agency Spend	771	536	445	445	2,197
Bank Spend	941	941	941	941	3,763
VARIABLE PAY - TOTAL	**1,711**	**1,477**	**1,386**	**1,386**	**5,960**

Table 3: Quarterly Phasing of Opening Budget 2026/27

2.8 Capital

SCHT's 2026/27 annual capital plan totals £6.38m including IFRS16 leases, which includes an additional £3.6m allowance from the Freedom and Flexibilities initiative due to the National Oversight Framework rating. This £3.6m is generated from SCHT's 2024/25 surplus.

The plan includes premises development, backlog requirements, equipment and Digital investments and was developed through multidisciplinary team prioritisation including clinical, operational, estates, digital and finance representatives.

As in previous years, the capital programme will be entirely resourced from internally generated funds and there will be no borrowing requirement.

2.9 Conclusion

The presented 2026/27 opening budgets are in line with the final version of SCHT's plan submitted to NHSE on the 18 March, and full detail was reviewed through the Resource and Performance Committee on 25 March. The Committee recommends this opening budget to the Boards in Common for approval.

Any subsequent changes to the budgets will be approved in line with relevant governance arrangements.

3.0 Recommendation

The Boards in Common are asked to:

- **Consider** the Resource and Performance Committee reviewed SCHT's opening budgets in detail on 25 March and recommends these to the Trust Boards for approval.
- **Approve** the opening 2026/27 annual budgets.

Board of Directors' Meeting in Common – 14 May 2026

<table>
<tr><td>Agenda item</td><td colspan="3">015/26c</td></tr>
<tr><td>Report Title</td><td colspan="3">SaTH monthly financial performance report – March 2026 (month twelve) update</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Adam Winstanley, Acting Chief Finance Officer - SaTH</td></tr>
<tr><td>Report Author</td><td colspan="3">Adam Winstanley, Acting Chief Finance Officer - SaTH</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to (SATH) BAF id(s)</td></tr>
<tr><td rowspan="5">Finance Assurance Committee – 28th April 2026</td><td>Safe</td><td></td><td rowspan="2">BAF 5</td></tr>
<tr><td>Effective</td><td></td></tr>
<tr><td>Caring</td><td></td><td>(SaTH) Risk Register id(s):</td></tr>
<tr><td>Responsive</td><td></td><td rowspan="2">N/A</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">At the end of month twelve (March) the Trust recorded a £4.9m surplus (£4.9m surplus to the break-even plan). The surplus to plan is driven by the receiving of bonus deficit support funding. Whilst there were pressures relating to additional capacity costs, premium rate staffing and unavailability these have been mitigated in year. There are variances across the cost categories with income favourable to plan and pay and non-pay adverse to plan.

This in-year delivery is in line with forecast and prior to bonus funding (£4.9m), is after £45.1m of deficit support funding.

The Board's attention is drawn to sections in relation to the year-end financial, capital and cash sections.</td></tr>
<tr><td>Recommendations for the Board</td><td colspan="3">The Board is asked to:
• Note the financial, capital and cash position at the end of FY25/26.</td></tr>
<tr><td>Appendices:</td><td colspan="3">Appendix 1: Month 12 Finance Report</td></tr>
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Appendix 1

Finance Report at Month 12

Board of Directors

May 2026

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

Executive Summary

The Trust submitted a finance plan to NHSE on 30th April which showed a breakeven plan with deficit support of £45.15m for the year. At the end of March (month twelve), the Trust has delivered a surplus position of £4.92m against the breakeven plan driven by the Trust receiving bonus deficit support funding. There have been some variances in the cost categories with income favourable to plan and pay and non-pay adverse to plan. The drivers of the variances are; additional costs associated with UEC (£2.57m) and income backed posts (£1.23m) offset by income. There had also been a cost pressure associated with the industrial action (£1.40m) in July, November and December. The costs in July were mitigated by bringing forward an expected CIP scheme in non-pay however, the Trust received £2.5m to support the impact of industrial action. The cost pressure associated with the pay award (£1.70m) had been partially mitigated in earlier months however, this could no longer be mitigated and was a cost pressure along with the premium payments associated with temporary staffing (£8.0m). An increase in pass through devices has also been seen in non-pay increasing expenditure which is offset by an over achievement in income and a benefit in financing costs (£0.60m) resulting from the Trusts' cash position.

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

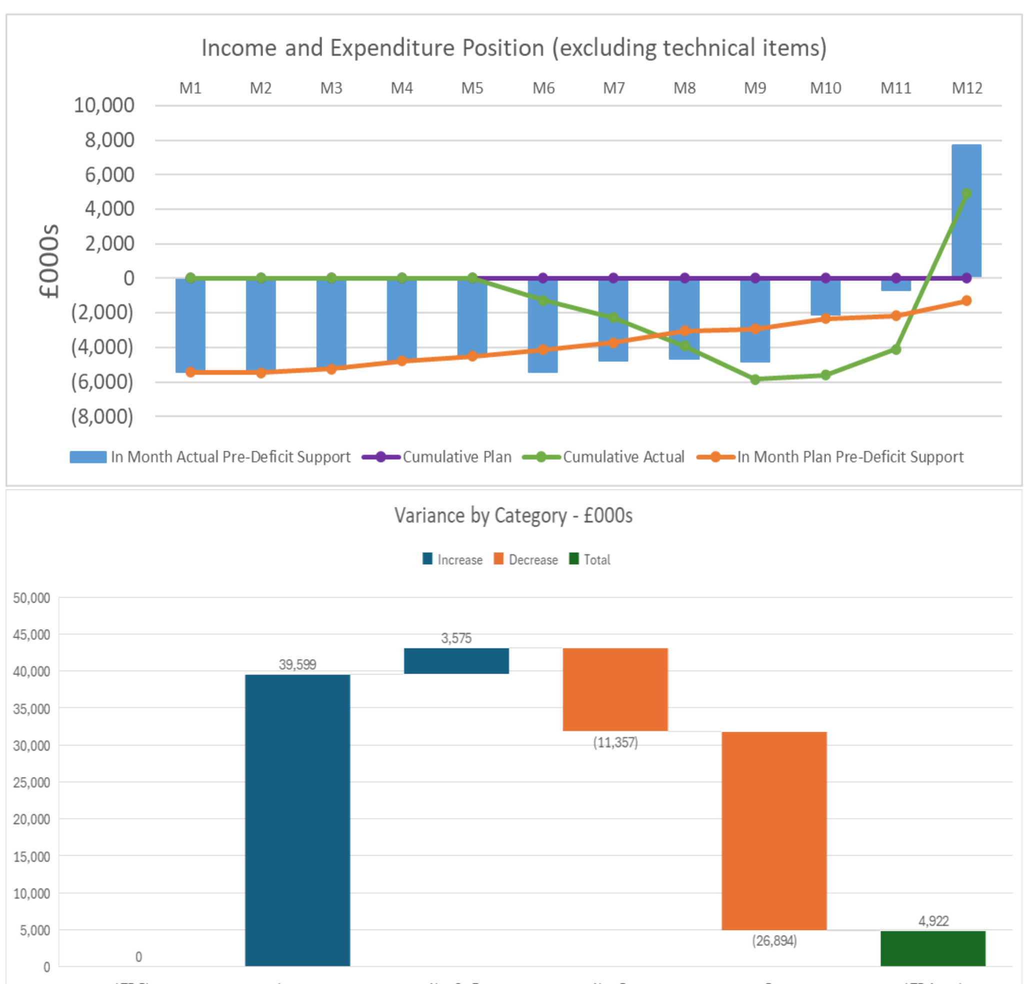
- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues, however the Trust is actively making CDS submissions. The Trust reduced waiting lists significantly in year which has increased costs above funded levels. The Trust received elective sprint funding in Q4.
- Delivery of the efficiency plan – The Trust had an efficiency target of £41.40m in FY25/26. At the end of March, £41.54m has been delivered which is £0.14m more than plan.
- Delivery of WTE reduction plan – At the end of March against the numbers reported in February (actual worked) there has been increase of 57 WTE overall, there has been an increase in worked agency of 13 WTE and an increase in worked bank of 44 WTE, however, substantive has remained constant.
- Delivery of the agency reduction plan – expenditure has increased in month compared to February, however, it remains below the planned levels of expenditure. There will continue to be a strong focus on medical agency in FY26/27.
- Delivery of additional capacity (escalation) within a core capacity funding envelope (£14.00m) – at the end of month twelve there has been an overspend of £2.57m against plan.

The Trust has set an operational capital programme of £22.53m (including IFRS 16 expenditure) and externally funded schemes of £127.17m in FY25/26, giving a total capital programme of £149.70m.

The Trust held a cash balance at end of March 2026 of £73.21m.

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

Income and Expenditure – Year End



The Trust had a breakeven plan with deficit support of £45.1m for FY25/26. At the end of March (month twelve), the Trust has delivered a surplus position of £4.9m against the breakeven plan.

The surplus to plan is driven by additional bonus payment of £4.9m received relating to redistributed deficit support funding as a result of delivering plan and submitting a compliant plan for FY26/27. Whilst there were pressures in the following areas these were mitigated in year:

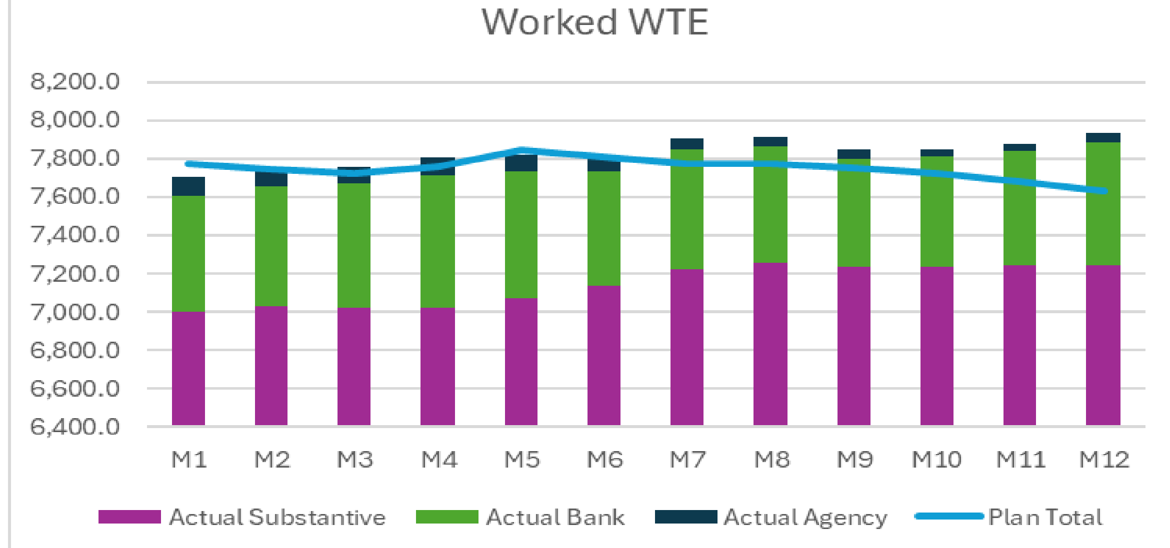
- additional capacity costs for patient safety
- additional cost of accelerated delivery of elective performance improvements
- cost pressure associated with the FY25/26 pay award
- premium staffing costs

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

- Delivery of the activity plan to secure the ERF and potentially additional income – there is no change in the reporting of income due to the data warehouse issues, however the Trust is actively making CDS submissions. The Trust reduced waiting lists significantly in year which has increased costs above funded levels. The Trust received elective sprint funding in Q4.
- Delivery of the efficiency plan – The Trust had an efficiency target of £41.40m in FY25/26. At the end of March, £41.54m has been delivered which is £0.14m more than plan.
- Delivery of WTE reduction plan – At the end of March against the numbers reported in February (actual worked) there has been increase of 57 WTE overall, there has been an increase in worked agency of 13 WTE and an increase in worked bank of 44 WTE, however, substantive has remained constant.
- Delivery of the agency reduction plan – expenditure has increased in month compared to February, however, it remains below the planned levels of expenditure. There will continue to be a strong focus on medical agency in FY26/27.
- Delivery of additional capacity (escalation) within a core capacity funding envelope (£14.00m) – at the end of month twelve there has been an overspend of £2.57m against plan.

Staffing - Worked

Worked WTE													
Plan / Actual	**Staff Group**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**
Plan	Substantive	7,015.0	7,028.0	7,024.0	7,074.0	7,179.0	7,203.0	7,178.0	7,149.0	7,131.0	7,112.0	7,079.0	7,031.0
	Bank	641.0	603.0	598.0	593.0	588.0	533.0	529.0	557.0	553.0	549.0	545.0	542.0
	Agency	118.0	110.0	102.0	95.0	78.0	73.0	69.0	69.0	66.0	62.0	59.0	55.0
	Total	**7,774.0**	**7,741.0**	**7,724.0**	**7,762.0**	**7,845.0**	**7,809.0**	**7,776.0**	**7,775.0**	**7,750.0**	**7,723.0**	**7,683.0**	**7,628.0**
Actual	Substantive	6,998.0	7,027.0	7,018.0	7,022.0	7,072.4	7,133.4	7,220.0	7,256.7	7,232.0	7,237.2	7,243.8	7,244.0
	Bank	610.0	628.0	652.0	692.0	658.8	599.5	624.9	602.1	567.7	574.5	595.4	639.4
	Agency	95.0	94.0	86.0	91.0	90.7	79.4	58.4	50.1	49.6	37.9	37.0	49.6
	Total	**7,703.0**	**7,749.0**	**7,756.0**	**7,805.0**	**7,821.9**	**7,812.4**	**7,903.2**	**7,908.9**	**7,849.3**	**7,849.5**	**7,876.3**	**7,933.0**
Variance	Substantive	(17.0)	(1.0)	(6.0)	(52.0)	(106.6)	(69.6)	42.0	107.7	101.0	125.2	164.8	213.0
	Bank	(31.0)	25.0	54.0	99.0	70.8	66.5	95.9	45.1	14.7	25.5	50.4	97.4
	Agency	(23.0)	(16.0)	(16.0)	(4.0)	12.7	6.4	(10.6)	(18.9)	(16.4)	(24.1)	(22.0)	(5.4)
	Total	**(71.0)**	**8.0**	**32.0**	**43.0**	**(23.1)**	**3.4**	**127.2**	**133.9**	**99.3**	**126.5**	**193.3**	**305.0**



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

Total staff usage of 7,933 WTE in March is higher with the figure reported in February. Agency usage increased by 13 WTE and bank increased by 44 WTE however, substantive remained consistent. Agency remains below the planned levels (by 5 WTE) however, substantive and Bank remain above plan by 213 WTE and 97 WTE respectively.

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

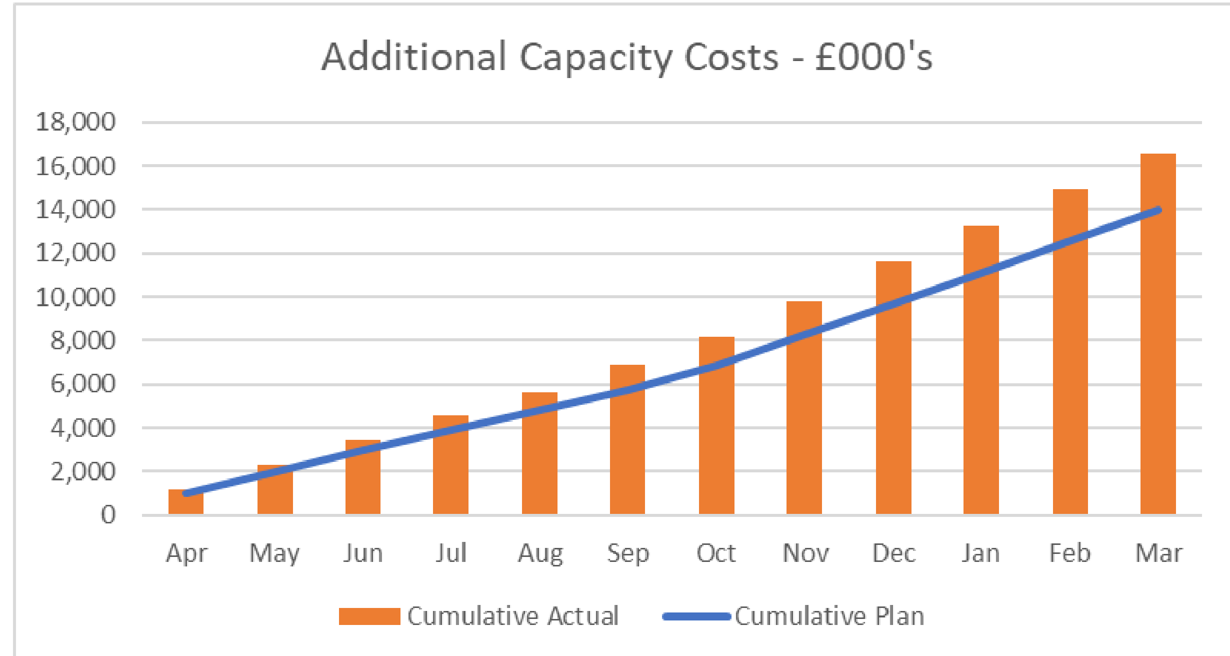
Continued actions:
Continued focus to keep reducing the reliance on agency staffing and increased focus on bank usage as well as rates for locum doctors.

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

Anticipated impact and timescales for improvement:
N/A

Recovery dependencies: On-going focus on progressing workforce systems utilisation, culture and leadership alongside system approach to working.

Additional capacity



Summary:

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

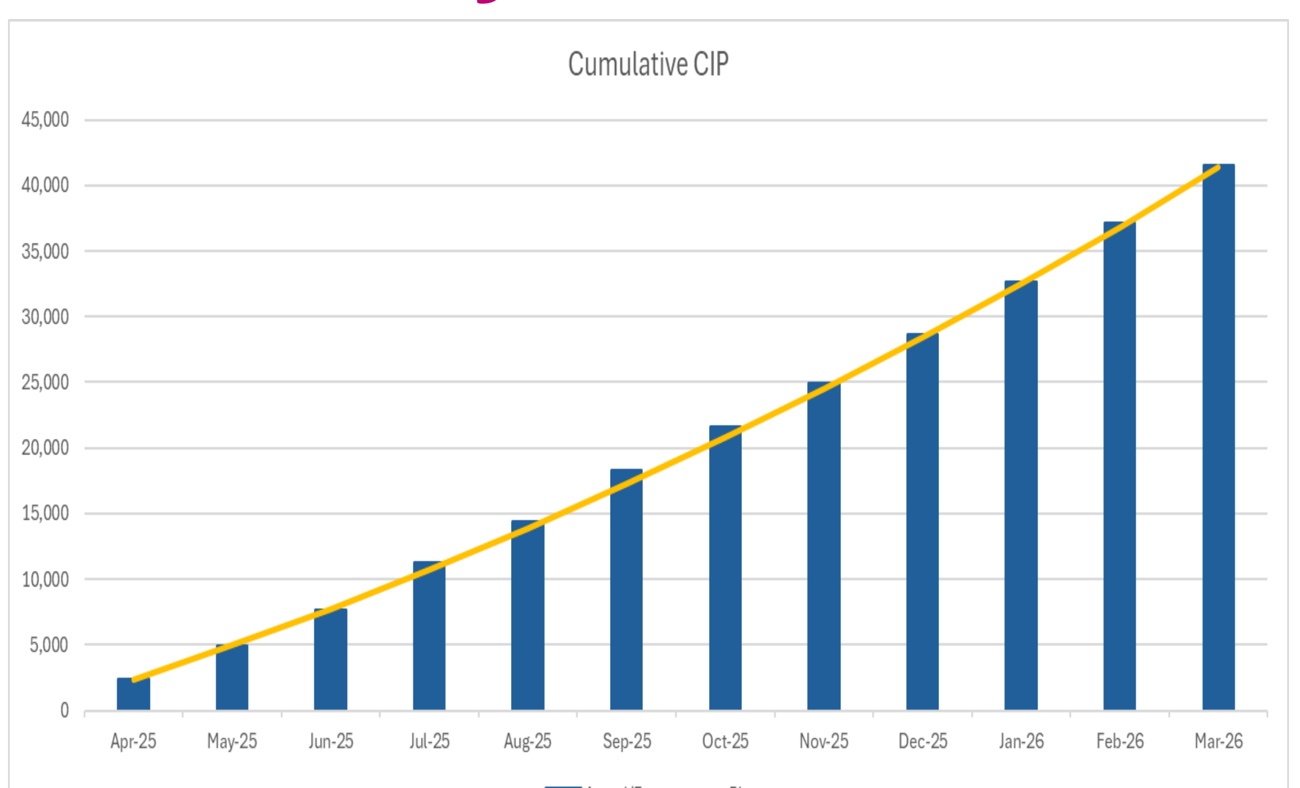
The requirement on a monthly basis is driven by changes in demand, offset by both internal and external interventions such as reduced length of stay and reductions in the number of patients with no criteria to reside, all of which is linked to the delivery of the 4 UEC transformation workstreams.

In March additional capacity costs were consistent with February and remain above the planned levels both in month and year to date with year-to-date costs at £16.56m against a plan of £13.99m, an overspend of £2.57m.

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

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

Efficiency

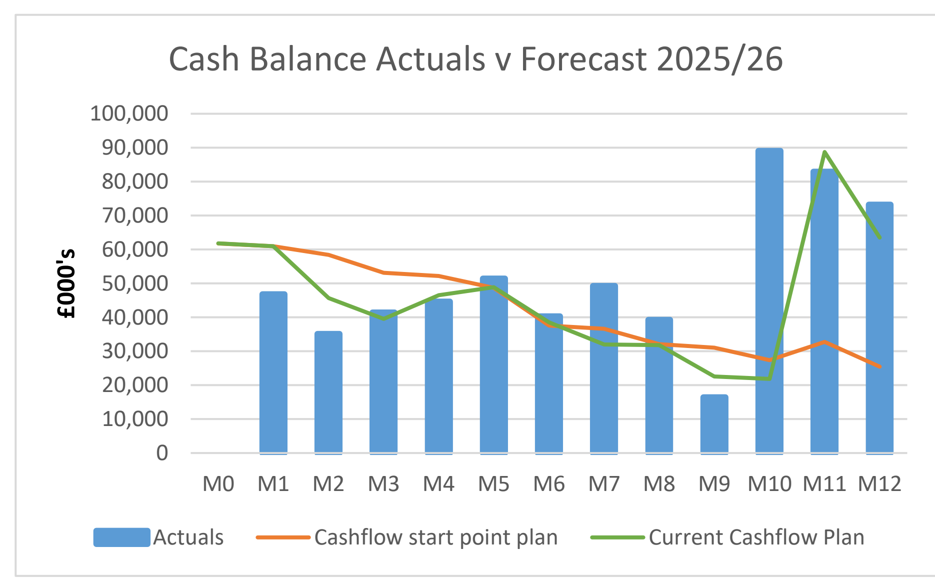


Summary:
The Trust has a total efficiency target for FY25/26 of £41.4m.
As at the end of March (month twelve), the Trust has delivered £41.5m of efficiency savings for FY25/26 which is £0.1m above the planned delivery.

Whilst we under delivered on some of our planned schemes such as headcount, the Trust successfully found mitigations to achieve a slight over delivery of plan at the end of 25/26.

In addition, the Trust has delivered its recurrent target of £29.9m in full on a full year effect basis.

Cash and Cash Equivalents



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

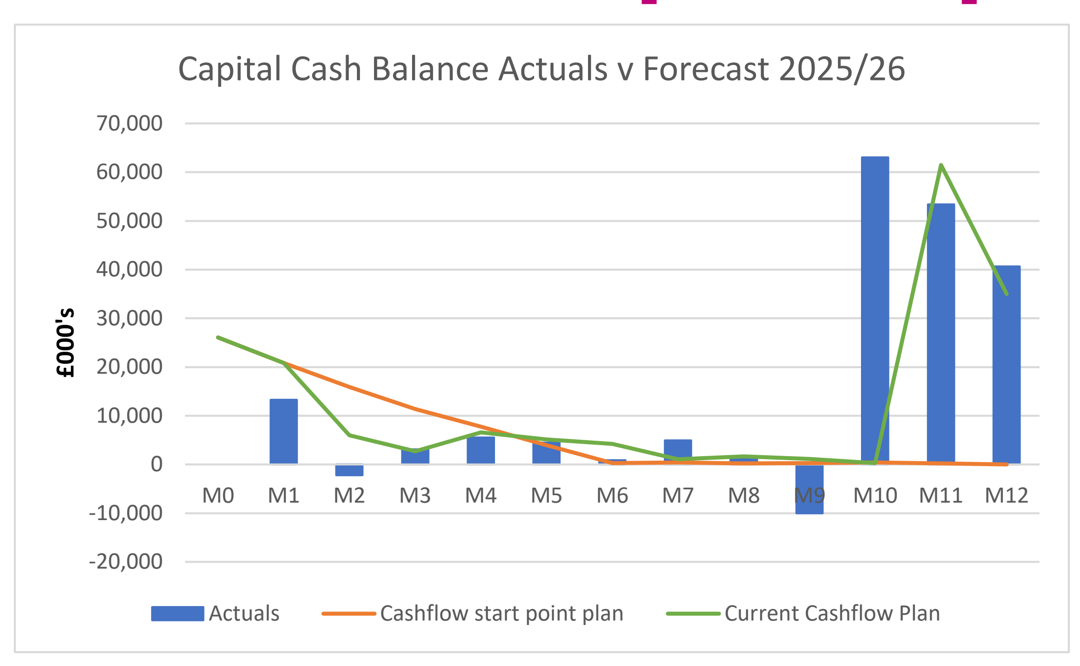
The cash balance brought forward into FY25/26 was £61.76m with a cash and ledger balance of £73.21m held at end of month twelve.

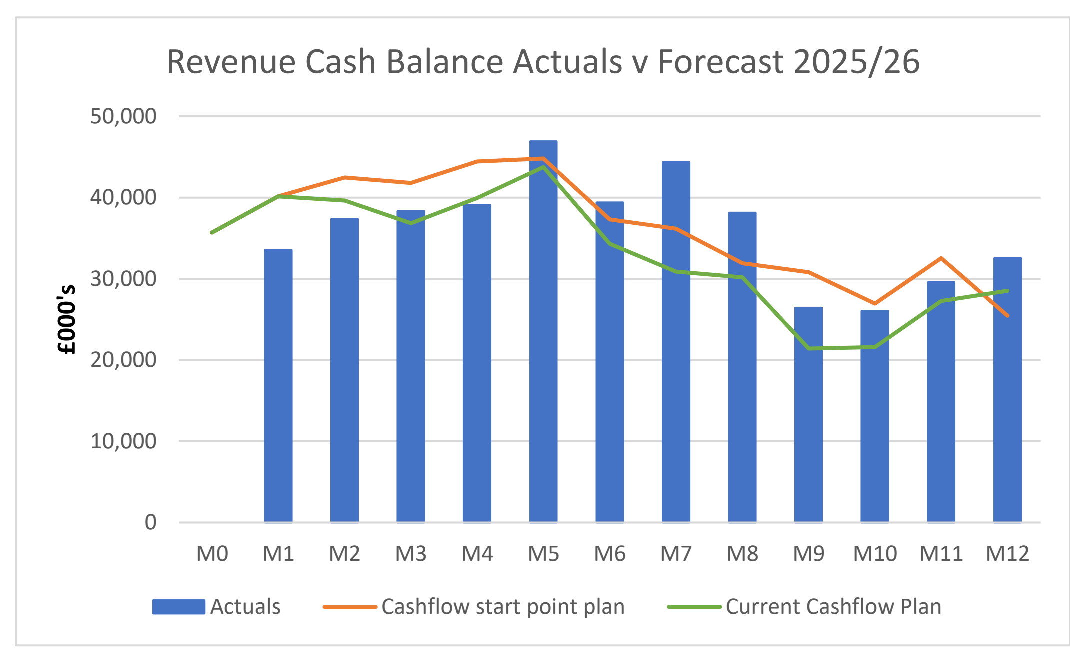
The graph illustrates overall actual cash held against the plan. At month twelve, actual cash balances were greater than forecast, due to the timing of capital spend and receipt of additional cash from STW.

To note the difference in the February and March 2026 cashflow forecast from the start point to the current is primarily driven by emerging pay pressures and the assumptions around cash releasing CIP, offset by additional income received and delays in the FY25/26 capital programme resulting in the Trust holding a capital cash balance of £40.66m.

The current cashflow forecast for FY26/27 is estimating that no Revenue Support as being required due to bonus DSF and additional STW allocations negotiated through the contracting route.

Cash and Cash Equivalents - Revenue & Capital Split



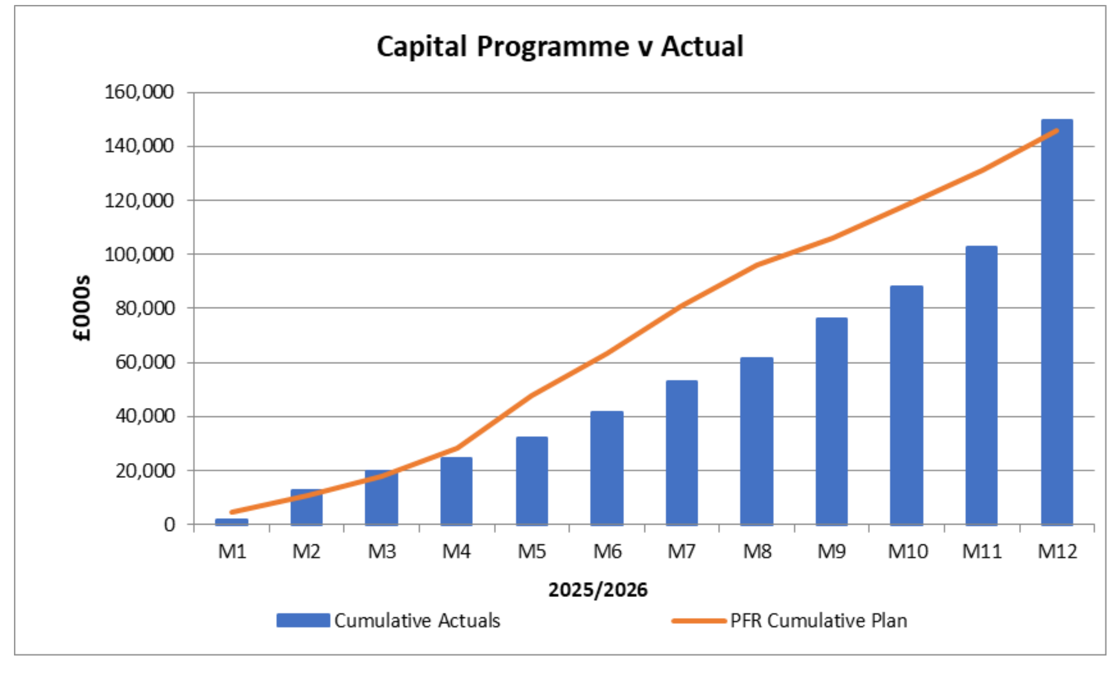


The graphs above show the revenue and capital split of cash.

As can be seen the actual position regarding capital cash is higher than current plan due to the timing of capital expenditure.

Revenue cash is also higher than current plan due to additional income being received in March and less outflow than plan for creditors, mainly around working balances, offset by additional outflow for pay.

Capital



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

External allocations have remained at £127.17m, giving an overall Capital Programme of £149.70m (excluding Salix).

In addition, the second year of the Public Sector Decarbonisation Scheme grant of £8.10m has been received in FY25/26 which was spent on the decarbonisation initiative on the Shrewsbury site.

At M12 FY25/26, the Trust delivered in line with the planned Capital Programme.

Statement of Financial Position

	March 2025 £000s	February 2026 £000s	March 2026 £000s	Variance to February 2026 £000s	Explanation
Property, Plant and Equipment	394,007	481,939	500,384	18,445	Capital Programme additions in month greater than depreciation charge due to externally funded schemes
Intangible Assets	24,658	20,591	23,307	2,717	
Leased Assets	19,472	18,815	18,623	(192)	
NHS Receivables > 1 year	605	605	553	(53)	
Non-NHS Receivables > 1 year	1,223	1,071	1,213	142	
Total Non Current Assets	**439,965**	**523,021**	**544,080**	**21,060**	
Inventories	10,108	10,144	10,450	306	
NHS Receivables < 1 year	3,929	6,974	15,176	8,202	
Non- NHS Receivables < 1 year	2,839	2,570	3,331	762	
Prepayments and Accrued Income	7,474	11,959	9,823	(2,136)	
Provision for Impairment of Receivables	(1,741)	(2,038)	(2,590)	(552)	
VAT	1,286	578	1,375	797	
Cash and Cash Equivalents	61,518	83,003	72,979	(10,024)	
Total Current Assets	**85,413**	**113,189**	**110,544**	**(2,645)**	
NHS Payables	(1,829)	(1,918)	(1,798)	120	
Non -NHS Trade Payables - Invoiced Revenue	(8,757)	(8,678)	(13,154)	(4,476)	
Non -NHS Trade Payables - Other Payables	(5,614)	(9,688)	(6,086)	3,601	
Non -NHS Trade Payables - Capital	(28,070)	(15,728)	(45,033)	(29,305)	Capital invoice accruals
Non-NHS Payables Accruals	(34,093)	(25,387)	(29,522)	(4,135)	
Tax and Social Security Costs	(9,945)	(11,616)	(11,548)	68	
Payments received on Account	(24)	(49)	(56)	(8)	
Leases < 1 year	(3,560)	(3,627)	(3,482)	145	
Deferred Income	(4,141)	(3,482)	(1,264)	2,218	
Provisions < 1 year	(267)	(267)	(293)	(26)	
Total Current Liabilities	**(96,300)**	**(80,439)**	**(112,237)**	**(31,799)**	
Net Current Assets/(Liabilities)	**(10,887)**	**32,750**	**(1,693)**	**(34,444)**	
Leases > 1 year	(15,812)	(15,398)	(15,202)	196	
Provisions > 1 year	(649)	(605)	(552)	53	
Total Assets Employed	**412,617**	**539,768**	**526,633**	**(13,135)**	
Public dividend capital	636,537	761,918	763,709	1,791	DHSC capital programme allocation received
Income and expenditure reserve	(303,857)	(302,087)	(313,347)	(11,260)	In month I&E including donated income/expenditure adjustment
Revaluation reserve	79,937	79,937	76,270	(3,666)	
Total Taxpayers' Equity	**412,617**	**539,768**	**526,633**	**(13,135)**	

Board of Directors' Meeting in Common – 14 May 2026

<table>
<tr><td>Agenda item</td><td colspan="3">016/26</td></tr>
<tr><td>Report Title</td><td colspan="3">Public Participation Report Quarters 3&4 2025/26</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Julia Clarke, Director of Public Participation</td></tr>
<tr><td>Report Author</td><td colspan="3">Julia Clarke, Director of Public Participation</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to SATH BAF Risk:</td></tr>
<tr><td rowspan="5">Public Assurance Forum 28 April 2026</td><td>Safe</td><td></td><td rowspan="2">BAF9</td></tr>
<tr><td>Effective</td><td></td></tr>
<tr><td>Caring</td><td></td><td>SaTH Risk Register ID:</td></tr>
<tr><td>Responsive</td><td></td><td rowspan="2">N/A</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">The Shrewsbury and Telford Hospital NHS Trust is committed to ensuring that the patient-public voice is at the centre of shaping our health services, both now and in the future. At the heart of our organisation and its future success are our patients, carers and local communities.

The Public Participation Department consists of three small teams supporting Volunteering, Shrewsbury and Telford Hospital Charity and Community Engagement which focuses on reaching out to seldom heard communities and leading engagement around the Hospitals Transformation Programme.

We look to engage and involve our local communities with their local hospitals and under the banner of #GetInvolved, https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ we aim to provide a range of opportunities for our communities to be involved with us. We reach out to engage with the public, and the emphasis is on everything we do directly linking to our local communities and that we are responsive to their needs across Shropshire, Telford & Wrekin and Mid-Wales.</td></tr>
<tr><td>Recommendations for the Board</td><td colspan="3">The Board is asked to:
Note the current activity from October 2025–March 2026 across the Public Participation Team and take assurance from this work that our statutory duties are being met as well as CQC Well-Led requirements.</td></tr>
<tr><td>Appendices:
(within Board Information Pack)</td><td colspan="3">Appendix 1: 6-month Public Participation Trust Board Report
Appendix 2: Plans on a Page for Volunteers, SaTH Charity and Community Engagement</td></tr>
</table>

1.0 Public Participation Team

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

- Volunteering
- Shrewsbury and Telford Hospital Charity (this is a separate legal entity to the Hospital Trust)
- Community Engagement including the Hospitals Transformation Programme (HTP)

Under the banner of Get Involved – Make a Difference https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ there are lots of different ways to Get Involved and we've listened to feedback from our communities and made it easier to do. We reach out to engage with the public, and the emphasis is on everything we do directly linking to our local communities. We have also undertaken extensive engagement with staff, public and volunteers to develop our Community Engagement and Volunteer 5-year Strategies to support the Shrewsbury and Telford Hospital Charity 5-year Strategy approved last year. These will all be combined into one overarching Public Participation 5-year Strategy.

The teams are relatively small, currently none are fully staffed but when they are there are 3.8wte in Volunteers, 1.8wte in Charity plus 1 Apprentice and 2.6wte in Community Engagement.

The presentation at Appendix 1 shows some of the highlights over the past six months and Appendix 2 shows performance against the objectives set for each service for 2025/6

2.0 Volunteers

2.1 Current Position - We currently have 214 volunteers, who have given over 12,000 hours of volunteer time over the past 6 months. We have over 30 different role descriptions across all areas on the Trust including non-clinical support roles. There was a pause in volunteer recruitment due to a delay in recruitment, but we have now recommenced recruitment since March 2026 as we have new members of staff in place and on average, we are taking 3.2 weeks to carry out the relevant recruitment checks and training for new volunteers. A meeting is planned in May to discuss opportunities for closer working with colleagues from Shropshire Community Trust.

2.2 Volunteer Welfare - As part of our engagement on the Volunteer Strategy we have introduced a number of welfare steps including wellbeing sessions with the staff psychological service for support and resilience, welcome walks where we visit volunteers new in their role, monthly coffee and chat sessions on each site and a six-monthly cake and update evening session led by Julia Clarke, Director of Public Participation. We have also introduced Wellbeing Calls to volunteers to offer support and check if there are any issues we can help with.

2.3 National Partners - We have become an Approved Activity Provider for volunteering for the Duke of Edinburgh's Award and have been invited to a Garden Party at Buckingham Palace to celebrate the success of the young people completing their Awards. We have several young people who have begun their volunteering with this as part of the scheme.

2.4 We are also supporting young people through our Volunteer to Career Scheme (open to all age groups) and were proud to be showcased by Helpforce, a national Volunteer Partner when they were awarded the "Staffing Solution of the Year" Award by the Health Service Journal in March. Helpforce also invited Julia Clarke and Hannah Morris to the House of Commons to celebrate the launch of their Report "Reimagining Healthcare Volunteering", where our Volunteer Driver scheme was featured as an example of best practice. This scheme has gone from strength to strength and was recently featured across a range of BBC media channels, including BBC Midlands today. 90.5% of patients were collected within 30

minutes of the request being made, the service has been extended to support maternity and renal patients recently, and we are also in discussion with DAART and Ophthalmology. Our data also shows that 44.8% of patients who utilised our transport volunteer service were in the 1st and 2nd quintiles for deprivation.

3.0 Shrewsbury and Telford Hospital Charity

3.1 Current position - The Charity has over 60 Trust Funds which means patients can donate to clinical areas close to their hearts.

Income for the 5 months from October 2025 to February 2026 was £223,801 compared to £210,604 in the same period last year (please note that March 2026 figures are not yet available). Expenditure for the same period was £196,574 compared to £188,854 in 2024/5.

A new expenditure request process was approved by the Charitable Funds Committee which has streamlined the process. All requests over £15,000 are approved by the Charitable Funds Committee and then the clinical area is invited back to update on the benefits for patients and staff. The feedback on the new process has been universally positive.

3.2 For 2025/6 SaTH Charity had 1152 supporters.
Donors (1488) - Provide financial support to the charity – this could be through a one- off donation, or multiple donations. 269 of these donors have donated more than once.
Fundraisers (140) – Organised events, and other initiatives, such as a sponsorship for a marathon, to raise money and donations. 38 of these fundraisers have organised events more than once.

3.3 Supporting our patients – there are some examples in the report of equipment provided by generous donations, including a breast x-ray specimen window in theatre to improve and speed up diagnosis times. Also, the purchase of two pupilometers for both Critical Care Units to obtain more accurate measurement results. Also featured is the much-loved Santa by Christmas Helicopter event organised by RAF Shawbury to bring joy and excitement to children and adults alike!

3.4 Celebrating our Fundraisers – the Charity has done a lot in recent years to raise its visibility both internally and externally and there is certainly much greater awareness, but there is still much to do. There are some examples of the range of support we get in the report – from Integrated Health Partners (our HTP construction partner), to a musical volunteer who organised a marvellous evening with Jackfield Brass Band in November, who both raised funds for the HTP children's garden and sensory room, through to customers of the Red Lion, Caresws who came up with a range of weird and wonderful events to raise funds for the HTP Critical Care and Oncology Garden to young Henrietta who's raised over £2000 for families on the neonatal unit with her squat challenge.

3.5 Supporting our staff - there is only one trust fund that is entirely for staff – the Small Things Big Difference Fund which is funded by our staff lottery. We now have 1350 staff signed up to the Lottery – half the income is given back in prizes each month and half goes into the Small Things Big Difference Fund where any member of staff can apply for items to benefit their department. This is often quite small things that wouldn't be funded from NHS budgets such as microwaves for staff rooms, or benches to sit outside when the weather permits. But the impact on staff morale is truly astonishing and has encouraged such a massive sign-up in the few years that it has been running. We have been approached by several Trusts who have unsuccessfully tried to launch lotteries and have also provided a poster for the NHS Charities Together Conference in May.

3.6 Also supporting our staff was a successful bid for £48,965 to NHS Charities Together for a Staff Menopause Service, led by consultant specialist Dr Jo Ritchie to support our staff experiencing this. The first clinic was held in October and will run for a year, and it is hoped that the evidence from the scheme will secure funding from the NHS to continue it. It has been agreed that from 1 April 2026 the scheme will also be open to women from Shropshire Community Health NHS Trust.

3.7 Working in Partnership – There are several significant local Charities that SaTH Charity works very closely and positively with, these include Friends of SaTH, Lingen Davies Cancer Support and local Rotary Clubs. We are working with Shrewsbury Severn Rotary to design and provide the Critical Care and Oncology garden on the third floor of the new build at RSH. Lingen Davies launched their £5m PRH Cancer Centre appeal last year that we are supporting and they work alongside us in the Transforming PRH Hub. We are also in discussion with the Friends of SaTH around the development of a county-wide Respiratory Centre at PRH.

4.0 Community Engagement including HTP

4.1 Current position - The Care Quality Commission (CQC) now requires providers to demonstrate proactive, continuous engagement that drives improvement, moving beyond reactive feedback. Under their 2023–2026 strategy, this involves gathering, analysing, and acting on feedback from people using services - particularly those with protected characteristics—to shape care, culture, and service improvements. These requirements are embedded into the new regulatory framework's "**Quality Statements**," moving away from the old KLOE system to a more ongoing assessment of how providers listen to and empower their users.

Key Requirements:

- **Proactive & Inclusive Engagement:** Actively involving people who use services, their families, and staff in decision-making and service design, not just asking for feedback after an event.
- **Addressing Inequalities:** Focusing engagement efforts on reaching people experiencing health inequalities and those with protected characteristics to ensure their voices influence care.
- **Culture of Listening:** Gathering and demonstrating how feedback has directly shaped improvements in service quality.
- **Robust Feedback Loops:** Creating safe, accessible, and trusted methods for sharing experiences, which are then used to update care practices.
- **Community Links:** Building strong relationships with local communities and stakeholders beyond mandatory requirements.

NHS Trusts have a legal duty to engage with the public; at SaTH we take these requirements very seriously. In the overview of the SaTH Care Quality Commission Inspection Report published in May 2024, the CQC found "*People who use services, the public and staff were highly engaged and involved to support high-quality sustainable services*"

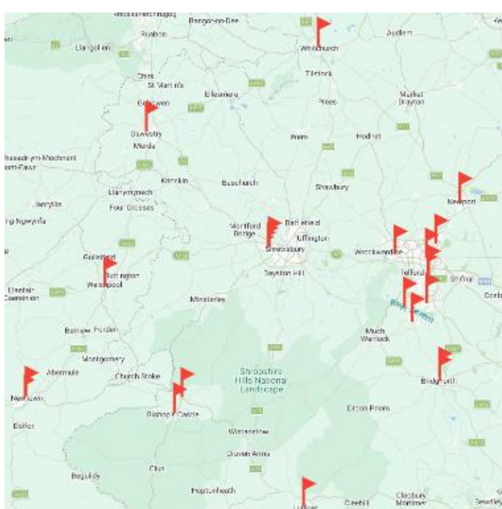
4.2 Community links - Our community members (5359) and organisations (474) continue to increase (Slide 11 details), and they have access to a wide range of ways to find out more about the Trust and to get involved. One of our most popular hospital events is the series of About Health broadcasts. These are one hour long on a specific subject and are delivered by a Trust specialist in that area with an opportunity to ask questions. In the last 6 months there have been 6 events covering a range of areas including Menopause, Diabetes, Living with Cancer, Cardiovascular disease, Patient Portal and HTP. The recordings are all published on our website About Health Recordings – SaTH

4.3 Seldom heard communities and health inequalities (Core 20Plus 5) - Our engagement team has focused their engagement this year on four core areas – Dementia, Diabetes, Respiratory and Cardiovascular, which align well to the national priority cohorts of patients as part of the National Neighbourhood Health programme. They have focused working with other agencies such as Local Authorities to maximise reach and impact and there are plans to discuss closer working with colleagues from Shropshire Community Health NHS Trust, especially around neighbourhood care and local transformation plans.

4.4 Hospital Transformation Programme - The Public Participation Department has been leading the work to engage with our local communities around the Hospitals Transformation Programme (HTP). This has included talking to thousands of hospital visitors to the PRH site in our Transforming PRH hub to provide information on plans for future developments on both sites.

The team has also organised several events including two of our regular quarterly public focus groups as well as focus groups for patients with specific conditions or specific areas. The focus groups have significantly and proactively contributed to the design of the services and ensured feedback has been used in planning and design. In December we held a focus group with staff and patients from critical care and oncology on the design of the garden with Shrewsbury Severn Rotary after a visit to the balcony area in the new build. All focus groups have an extensive Q&A section to gain the views and comments from attendees. All presentations are published on our website along with the Q&As and action logs (after they've been reviewed by the attendees) to ensure full transparency. For more information please see our website: **HTP Focus Groups - SaTH**

4.5 We have also attended 26 events across the county and mid-Wales. The map below shows the spread of the face to face meetings and details of all locations/meetings we attended are in the report.



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

- W&C HTP Play Garden focus group - April 2026
- Critical Care and Oncology Garden focus group - April 2026
- HTP Public Focus group - 2 June 2026
- HTP Furniture focus group – Summer 2026
- Visit to sample rooms – Summer 2026

4.7 Public Assurance Forum (PAF) - Engagement activity and HTP engagement is reported to the quarterly Public Assurance Forum which is co-chaired by a SaTH NED (Professor Trevor Purt) and a public member from Montgomery Health Forum (Cllr Joy Jones). The PAF has a wide range of community, voluntary and statutory sector organisations as members, who have the opportunity to discuss issues directly with our Divisional teams, who also attend. The HTP paper includes a section on fundraising and seldom heard groups. The papers are published on our website for full transparency Public Assurance Forum – SaTH and key items from the meetings in November 2025 and January 2026 are included in the report.

5.0 Looking Forward

- The Public Assurance Forum to meet quarterly and review its constitution when Foundation Trust guidance issued
- Continue to support staff with any future service changes engagement
- Support the HTP Engagement programme, including the quarterly focus group for the public and patients.
- Maximise opportunities for joint engagement working with Shropshire Community Health NHS Trust with focus on neighbourhood care
- Continue to support staff wellbeing through Charity Small Things Big Difference Fund
- Support fundraising for the Hospitals Transformation Programme
- Continue to grow and support our volunteers and the opportunities we provide to them
- Develop Volunteer schemes to address hospital priorities eg Discharge Response Volunteer, Neighbourhood Care (outlined in 10-year NHS Plan) and work closely with Shropshire Community Health NHS Trust to maximise effectiveness

6.0 Recommendations

The Board is asked to **note** the current activity from October 2025-March 2026 across the Public Participation Team and **take assurance** from this work that our statutory duties are being met as well as CQC Well-Led requirements.

Julia Clarke, Director of Public Participation
April 2026

Board of Directors' Meeting in Common – 14 May 2026

<table>
<tr><td>Agenda item</td><td colspan="3">017/26a</td></tr>
<tr><td>Report Title</td><td colspan="3">SCHT Board Assurance Framework</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Anna Milanec, Group Chief Governance Officer</td></tr>
<tr><td>Report Author</td><td colspan="3">Shelley Ramtuhul, Director of Governance</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to (SCHT) BAF id(s)</td></tr>
<tr><td rowspan="5">N/A</td><td>Safe</td><td>√</td><td rowspan="2">All</td></tr>
<tr><td>Effective</td><td>√</td></tr>
<tr><td>Caring</td><td>√</td><td>(SCHT) Risk Register id(s):</td></tr>
<tr><td>Responsive</td><td>√</td><td rowspan="2">All</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">The Board Assurance Framework (BAF) is presented to the Board of Directors for consideration and approval.

The BAF has been reviewed with the relevant Director Leads and Committees with oversight from the Audit Committee.

The Board is asked to note the following changes to the BAF since its last presentation:

• Delivery of the objectives as at Q4
• Updates against the actions being taken to address identified control / assurance gaps
• The reduced risk in the workforce team capacity reflecting the benefits of the strengthened leadership across Group
• The reduced risk for recruitment restrictions re a more streamlined process, reflecting a more streamlined decision-making process
• The reduced risk in relation to patient harm linked to waiting times reflecting the downward trajectory of waiting times from the strengthened clinical prioritisation measures in place.</td></tr>
<tr><td>Recommendations for the Board</td><td colspan="3">The Board is asked to:
• Consider the assurances provided regarding the mitigation of risks to delivering the strategic objectives
• Approve the proposed amendments</td></tr>
<tr><td>Appendices:</td><td colspan="3">Appendix 1: BAF Risk Tracker
Appendix 2: SCHT Board Assurance Framework</td></tr>
</table>

Appendix 1: BAF Risk Tracker

New Ref	Risk Title	Opened	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Movement in Month	Target
1.1	Workforce Team Capacity	Sept 23	16	16	16	16	16	16	16	16	20	20	20	20	20	12	↓	6
1.2	Recruitment restrictions impact on staff morale and wellbeing	Sept 23	16	16	16	16	16	16	16	16	16	16	16	16	16	12	↓	6
1.3	National, system and local changes impact on staff morale and wellbeing	June 2025	-	-	16	16	16	16	16	16	16	16	16	16	16	16	↔	6
3.1	Reliance on volunteer input for key patient experience workstreams such as observe and act	Sept 23	12	12	12	12	-	-	-	-	-	-	-	-	-	-	CLOSED	4
3.2	Quality Team Capacity	Oct 24	12	12	12	12	12	12	4	-	-	-	-	-	-	-	CLOSED	4
3.3	Completion of actions linked to learning response	May 25	-	-	-	12	12	12	12	12	12	12	12	12	12	12	↔	4
3.4	Demand exceeds capacity	Apr 22	15	15	15	15	-	-	-	-	-	-	-	-	-	-	CLOSED	6
3.5	Potential for patient harm due to waiting times	Apr 23	16	16	16	16	16	16	16	16	16	16	16	16	16	9	↓	6
3.6	Recruitment challenges	Apr 22	16	16	16	16	16	16	16	16	16	16	16	16	16	16	↔	6
4.1	Operational capacity to undertake all programmes of work	Sep 23	15	15	15	15	15	15	15	15	15	15	15	15	15	15	↔	10
4.2	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	15	15	15	15	9	9	9	9	9	9	9	9	↔	5
5.1	Cyber attack	Sep 23	12	12	12	12	12	12	12	12	12	12	12	12	12	12	↔	6
5.2	Digital Capacity	Sep 23	12	12	12	12	12	12	12	12	12	12	12	12	12	12	↔	8
5.3	Costs exceed plan	Apr 22	12	12	16	16	16	16	16	12	12	12	12	6	-	-	CLOSED	6
5.4	Insufficient capital funding	Sep 24	9	9	9	9	9	-	-	-	-	-	-	-	-	-	CLOSED	6

Risk Increasing	(red)	New Risk	(blue)
Risk Decreasing	(green)	Closed Risk	(grey)

Board Assurance Framework 2025-26

Looking after our People — OBJ 1

Principle Objectives: We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership

This objective will focus on the Trust's Culture and Leadership Programme (inc EDI and People Promise) and the Health and Wellbeing Programme

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2026

Key Measures:

Sustained improvement compared to 24/25 across:

- ✓ Staff sickness
- ✓ Staff retention
- ✓ Staff survey results
- ✓ Temporary staffing efficiency
- ✓ Apprenticeships completed
- ✓ Clinical utilisation

Progress Update:

- Still improvement needed for staff sickness
- Retention remains stable
- Work commenced on Poppy's Promise which will support the wider culture programme

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- People promise resource available

Risks:

1.1 Workforce team capacity
1.2 Recruitment restrictions impacting on staff morale and wellbeing
1.3 National, system and local level changes impacting on staff morale and wellbeing

Lead Director:

Chief People Officer

Lead Committee:

People Committee

Board Assurance Framework 2025-26

Principle Objective: We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership — **BAF 1.1**

Principal Risk: Workforce Team Capacity

Insufficient capacity results in key programmes of work not being delivered or insufficient traction being made in the areas of staff experience and engagement

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	4	3↓	2
Total	16	12↓	6

Risk Details:

Opened:	September 2023
Reviewed Date:	May 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	2495

Controls:

- ✓ Ongoing monitoring of team capacity and prioritisation
- ✓ Revised workforce team structure
- ✓ Streamlined workforce processes
- ✓ Recruitment of a designated HRD
- ✓ Increased leadership capacity through collaboration with SaTH and the joint appointment of Deputy Chief People Officer

Assurance: **Source of Assurance** **3**

- ✓ People Committee oversight on key programme metrics
- ✓ Pulse checks
- ✓ System People Board
- ✓ Performance Board

Gaps In Controls:

- C1: New workforce structure being developed
- C2: Capacity to progress with centralised bank
- C3: Staffing vacancies in ESR team – being mitigated and will be addressed through new structure

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Scoping of collaborative working options	Director HR and OD	~~June 2025~~ ~~Sept 2025~~ Mar 2026	Working group established and oversight from the Shared Services Programme - completed
C1	Implementation of new workforce structure	Director HR and OD	~~Mar 2026~~ July 2026	Phase 1 is completed with one vacancy remaining for the education role, comms has gone out to the organisation and phase 2 has commenced and is ongoing

Principal Objective: We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership **BAF 1.2**

Principal Risk: Recruitment restrictions impact on staff morale and wellbeing

Additional scrutiny of non-patient facing roles resulting in vacancies not being recruited to / recruitment temporarily paused with an impact on the remaining staff

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	4	3↓	2
Total	16	12↓	6

Risk Details:

Opened:	September 2023
Reviewed Date:	May 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	5834, 7101

Controls:

- ✓ QEIA process to ensure robust consideration of impact
- ✓ Scrutiny of vacancy panel decisions at Finance Recovery Group
- ✓ Case of Need proforma to assess options
- ✓ VRF panel chaired by Director of Ops and DoN
- ✓ VRF panel agreements – agreed and prioritised weekly by executive team
- ✓ System panel for vacancy approvals
- ✓ Collaborative working promoted
- ✓ Civility and Respect training
- ✓ Wellbeing conversations being rolled out

Assurance: **Source of Assurance** **3**

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ System People Board Oversight
- ✓ Staff Survey
- ✓ Incidents
- ✓ Quality & Safety Committee
- ✓ Reduced leaver rate

Gaps In Controls:

- o C3: Age profile of the organisation means high level of retirees
- o C4: Response to latest staff survey

Gaps in Assurance:

- o A2: Board interview feedback to be shared

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Promotion of flexible work and retire and return	Chief People Officer	Ongoing	Comms has been issued about flexible working and retire and return
A2	Board interview feedback to be shared with Exec Team before onward submission to the Board	Chief People Officer	~~June 2025~~ ~~Sept 2025~~ Feb 2026	Cultural programme being informed by the board interview feedback and developed in the context of group - completed
C4	Staff feedback sessions have been organised	Chief People Officer	May 2026	Shropcom specific programme being devised

Principal Objective: We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership **BAF 1.3**

Principal Risk: National, system and local changes impact on staff morale and wellbeing

Required corporate office reductions will impact on staff and security of roles, the integration with SaTH will create significant organisational change, potential to impact on staff turnover, staff morale and performance

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	4	4	2
Total	16	16	6

Risk Details:

Opened:	September 2023
Reviewed Date:	May 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	5834, 7101

Controls:

- ✓ QEIA process to ensure robust consideration of any changes
- ✓ Management of change cases to be developed to inform any organisational change
- ✓ Organisational Change Policy in place
- ✓ Wellbeing conversations being rolled out
- ✓ Staff engagement sessions being held on group model
- ✓ Better together bulletin introduced
- ✓ Group Leadership Forum established

Assurance: **Source of Assurance** **2**

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ Reduced leaver rate
- ✓ Staff engagement outputs
- ✓ Transition Committee oversight of integration

Gaps In Controls:

- C1: Management of change policy to be aligned across SaTH and SCHT – absence of any reference to the management of integration

Gaps in Assurance:

- A1: Staff engagement ongoing so outputs not yet collated / known

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Review of management of change policy	Director of HR	~~July 2025~~ ~~Sept 2025~~ March 2026	Joint staff side established and working on joint policy

Looking after our People — OBJ 2

Principle Objective: We will establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services

This objective will focus on the NHS Long Term Workforce Plan development and benefits realisation from the Admin Academy

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2026

Key Measures:

Sustained improvement compared to 24/25 across:

- ✓ Staff sickness
- ✓ Staff retention
- ✓ Staff survey results
- ✓ Temporary staffing efficiency
- ✓ Apprenticeships completed
- ✓ Clinical utilisation

Progress Update:

- Admin Academy continues to develop and grow
- Hotspot areas identified but attracting, training and retaining staff is positive overall for the Trust

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme
- E-community roll out

Key Assumptions:

- People Promise Resource

Risks:

Risks 1.1, 1.2 and 1.3 as above

Lead Director:

Chief People Officer

Lead Committee:

People Committee

Caring for Our Communities — OBJ 3

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home

This objective can be broken down into the following key components; continuing to deliver on the clinical quality strategy ambitions and achieving the annual quality performance targets linked to the Patient Safety Incident Response Framework priorities

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025
Reviewed Date: April 2026

Key Measures:

- ✓ Delivery of Year 1 of Clinical Quality Strategy
  - Raise staff and stakeholder awareness
  - Approved outline of the delivery plan necessary to achieve the specific Clinical Quality Ambitions
- ✓ Improved Patient Safety
  - Reduction in falls per bed days
  - Reduction in medication incidents resulting in harm
  - Improved patient risk assessments to prevent pressure damage
  - Decreased number of admissions to community hospitals out of hours

Progress Update:

- After Action Review Training has been completed by a further cohort of staff
- Thematic reviews continue to be completed and taken through Q&S Committee
- Observe and act schedule in place
- Work on new Datix system is ongoing
- Medication incidents with physical harm have reduced, six monthly thematic reviews continue to be undertaken
- Falls remain within normal variation limits, quarterly thematic reviews continue to be undertaken
- CQUIN Audit for Purpose T shows improvement
- Admissions out of hours have improved

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF 3.3	Completion of actions linked to learning responses
BAF 3.5	Potential for patient harm due to waiting times
BAF 3.6	Recruitment challenges

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home — **BAF 3.3**

Principal Risk: Completion of actions linked to learning responses

Operational pressures impacting on staff ability to implement learning identified through PSIRF learning responses

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	3	1
Total	16	12	4

Risk Details:

Opened: May 2025

Reviewed Date: April 2026

Source of Risk: Internal Audit

Corporate Risk Register 7101

Controls:

- ✓ All actions recorded on Datix and monitored by the Governance Team
- ✓ Escalation via Divisional Governance Meetings of overdue actions
- ✓ Escalation to Director of Nursing with holding to account meetings held

Assurance: **Source of Assurance** **3**

- ✓ Oversight from Quality and Safety Committee
- ✓ PSIRF Audit
- ✓ Patient Experience Committee oversight of complaints actions
- ✓ Audit programme linked to learning response actions
- ✓ Quarterly board oversight report

Gaps In Controls:

- C3: Capacity of staff training in PSIRF to lead investigations
- C4: Overdue PSII reports
- C5: Operational capacity to complete the actions

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	No of trained staff to be increased	Director of Governance / Director of Nursing	~~Jan 2026~~ April 2026	Additional training has taken place for after action reviews with date scheduled for investigation training and staff booked on
C4	Ownership of the reports to be reinforced	Director of Governance / Director of Nursing	April 2026	Completed and backlog has reduced
C5	Oversight at Divisional Governance Meetings of action plans	Director of Governance / Director of Ops	March 2026	Completed with ongoing reporting

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home **BAF 3.5**

Principal Risk: Potential for patient harm due to waiting times

Increase in demand post-Covid and inability to meet demand, recover waiting times resulting in increased waiting times, poor patient experience and potential for harm. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	3↓	3
Likelihood	4	3↓	2
Total	20	9↓	6

Risk Details:

Opened:	April 2023
Reviewed Date:	April 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	3249, 3620, 3167, 3947, 4590

Controls:

- ✓ Programme of work to eliminate waits of in line with nationally mandated requirements
- ✓ Patient Safety Incident Panel reviewing any harms assessments with moderate harm or above
- ✓ Harms assessment process
- ✓ Harms proforma on Rio with audit capability
- ✓ Patient prioritisation according to clinical need

Assurance: **Source of Assurance** **3**

- ✓ Quality and Safety Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee
- ✓ Patient Safety Committee in place
- ✓ Incident data

Gaps In Controls:

- ~~C1: Harms assessment process has only embedded in some areas~~
- ~~C2: Consistency of application of policy across all areas~~

Gaps in Assurance:

- ~~A1: Lack of formal tracking or reporting of harms process~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Review all services with waiting times	Director of Nursing / Director of Operations	June 2026	All services have been made aware of the policy and harms process in place for every service.
A1	KPI to be established	Director of Nursing	June 2026	Included in the performance framework update to QSC

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home **BAF 3.6**

Principal Risk: Recruitment challenges

Inability to meet safe staffing requirements, reliance on agency staff, impact on service delivery, reduction in standards of care and patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened:	April 2022
Reviewed Date:	April 2026
Source of Risk:	Internal Risk Assessment / External Guidance and Controls
Corporate Risk Register	3167, 3947, 4595, 4806, 7162

Controls:

- ✓ Recruitment programme
- ✓ International recruitment as a system
- ✓ Availability of system mutual aid
- ✓ Planned early start to recruitment with potential 'recruit as risk' for key posts approach to minimise service delays and financial consequences
- ✓ Electronic rostering in place for the teams that utilise temporary staffing

Assurance: **Source of Assurance** **3**

- ✓ People Committee oversight
- ✓ Safe Staffing reporting to Board biannually
- ✓ Quality metrics
- ✓ System People Board oversight

Gaps In Controls:

~~C1: Electronic rostering solution to support staffing~~
C2: Lack of centralised bank
C3: Cessation of HCA agency without mitigations

Gaps in Assurance:

- -N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Explore options of third party NHS bank staff provider	Director of HR	~~Sept 2025~~ January 2026	This is still under exploration
C3	Targeted recruitment campaigns for HCAs	Director of HR	Dec 2025	Ongoing

Caring for Our Communities — OBJ 4

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention

This objective will focus on implementing integrated neighbourhood (INT) schemes – Phase 1 and partnership management prioritisation and approach

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: April 2026

Key Measures:

- ✓ Evidence of left shift of work and care to community services
- ✓ Strengthened relationships with system partners in developing INT model
- ✓ Identify key partners beyond ICS and LA support SCHT in delivering its Strategy through delivering against critical success factor for these relationships

Progress Update:

- Co-location of single point of access and SCHT UCR test of change completed and to continue due to success
- Re-sequencing of Directory of Services enacted to re-direct flow away from EDs
- Active partners with ICB in neighbourhood model, leading on the MDT workstream
- Investment in expansion of Community UEC services secured, eg RR to midnight, CTH and integrated front door
- Extension of UCR service approved and has been implemented

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services
- Development of Integrated Care Coordination in system
- Development of Integrated neighbourhood Teams
- Development of Frailty pathway
- Further embedding of VW & RR pathways

Key Assumptions

- N/A

Risks:

4.1 Operational Capacity to undertake all programmes of work

4.2 Internal governance and operational oversight arrangements for system programmes

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention **BAF 4.1**

Principal Risk: Operational capacity to undertake all programmes of work

Potential for operational pressures to affect prioritisation of system programmes both internally and across the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	2
Total	20	15	10

Risk Details:

Opened:	September 2023
Reviewed Date:	April 2026
Source of Risk:	Internal risk assessment
Corporate Risk Register	3167, 3249, 3947, 4590, 4595, 5834, 6286

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Revised operational structure
- ✓ Transformation Board and Programme Board in place for senior operational oversight
- ✓ Review of OPEL level action cards to ensure capacity is prioritised during periods of high escalation

Assurance: **Source of Assurance** **3**

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance
- ✓ Programme Board Meetings in place for oversight

Gaps In Controls:

- C2: Uncertainty regarding commissioning intentions which have potential to impact on operational capacity

Gaps in Assurance:

- -N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Engagement with the commissioners	Director of Ops	June 2026	Ongoing discussions between senior operational staff and commissioner to understand the implications of the intentions

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention **BAF 4.2**

Principal Risk: Internal governance and operational oversight arrangements for system programmes

System programmes are taken through system governance and don't have links into the Trust's governance and operational oversight arrangements, potential for risks to not be identified and mitigated from a Trust perspective when SROs sit outside of the organisation

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	3	5
Likelihood	4	3	1
Total	20	9	5

Risk Details:

Opened:	September 2023
Reviewed Date:	April 2026
Source of Risk:	Internal Risk Assessment / Integrated System Improvement Plan
Corporate Risk Register	N/A

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Establishment of system transformation group to improve collaborative working
- ✓ Weekly vacancy panel established at system level

Assurance: **Source of Assurance** **3**

- ✓ Quality and Safety Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C2: Alignment of risk management across the system

Gaps in Assurance:

- A2: Alignment of risk management across the system

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2/A2	Amendment to Risk Management Strategy to include the management of system risk	Director of Governance	~~December 2025~~ ~~February 2026~~ May 2026	Draft statement has been reviewed by Governance Leads and feedback provided, awaiting final draft for approval – delayed due to changes in personnel within the ICB

Managing Our Resources — OBJ 5

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services

This objective will focus on delivering an in year CIP and 3 year rolling CIP plan, achieving digital maturity (DCF) and the ten year sustainability plan annual goals

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: April 2026

Key Measures:

- ✓ Delivery of the financial efficiency targets sustained through attainment of both in year and updated rolling CIP schemes
- ✓ Demonstrable productivity improvements through automation
- ✓ Demonstrable improvement in patient access, quality of care and reduced risks
- ✓ Continued improvements in our environmental efficiency and sustainability against clear goals from central government
- ✓ Demonstrating a financial return on investments

Progress Update:

- Exceeded delivery against financial plan, CIP and productivity target
- Sustained improvements in patient access as demonstrated through our improved oversight framework score
- ERIC returns demonstrate improved estate management
- Digital investment supporting improved efficiency and more directly the cost improvement plans

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

5.1 Risk of cyber attack
5.2 Digital team capacity
5.3 Costs exceed plan

Lead Executive

Chief Finance Officer - ShropComm

Lead Committee:

Resource and Performance Committee

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services **BAF 5.1**

Principal Risk: Cyber attack

Loss of data or operationality of systems, reputational damage, impact on service delivery.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	3	2
Total	20	12	6

Risk Details:

Opened:	September 2023
Reviewed Date:	April 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	N/A

Controls:

- ✓ DSPT Toolkit compliance oversight
- ✓ External expertise input into cyber risk management
- ✓ SIRO and Deputy SIRO oversight
- ✓ Cyber security programme
- ✓ Information asset owners and register
- ✓ Business continuity plans in place
- ✓ Board Cyber training completed

Assurance: **Source of Assurance** **3**

- ✓ Audit Committee Oversight
- ✓ Data Security Group
- ✓ DSPT assessment with national oversight
- ✓ Internal audit

Gaps In Controls:

- C3: New standards require assessment and revision to systems and processes to ensure compliance
- C4: Gaps with clinical coding impacting on DSPT compliance

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C3	Full DSPT compliance to be achieved	Director of Governance	June 2026	Compliance met for 2024-25 and on track for 2025-26 with submission due in Q2 with expected output of 'standards met'

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services **BAF 5.2**

Principal Risk: Digital Team capacity

Lack of capacity results in programmes of work being paused or delayed, loss of momentum with digital agenda, staff unsupported with digital service needs. Potential to impact on improvement with RTT

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	4
Likelihood	5	4	2
Total	20	12	8

Risk Details:

Opened:	September 2023
Reviewed Date:	April 2026
Source of Risk:	Internal Risk Assessment / Vacancy Rate
Corporate Risk Register	N/A

Controls:

- ✓ Digital strategy and programme of work in place with clinical prioritisation of projects through the digital assurance group
- ✓ Regular team meetings with oversight from Director of Finance

Assurance: **Source of Assurance** **3**

- ✓ Digital Assurance Group

Gaps In Controls:

- ○ C3: Exploring opportunities to share expertise with system partners

Gaps in Assurance:

- ○ N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Digital workstream for shared services to be progressed	Director of Finance	March 2026	Working group established and working on three prioritised areas to deliver Q4-Q1 and overseen by the Transition Committee. Completed

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	017/26b		
Report Title	**SaTH Board Assurance Framework – Draft Quarter 4, 2025/26**		
Executive Lead	Group Chief Governance Officer – Anna Milanec		
Report Author	SaTH Head of Corporate Governance & Compliance– Deborah Bryce		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Board Committees: GPC/PODAC 23/3/26; PAC 21/4/26; FAC and QSAC 28/4/26; and ARAC via email	Safe	√	All BAF risks
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	The Board Assurance Framework (BAF) content has been reviewed and refreshed for quarter 4 of 2025/26 by the executive risk owners and their relevant senior team members. There is a proposed reduction to the current total risk scores this quarter of BAF risks 4, 5, and 9.		
Recommendations to the Boards:	The Boards are asked to: a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate. b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required. c) **Approve** the Quarter 4 BAF.		
Appendices	Appendix 1: Board Assurance Framework (draft) – Quarter 4		

1.0 Introduction

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

1.2 Work to review and refresh the BAF content for quarter 4 was undertaken during March and early April 2026.

1.3 The Boards oversee all BAF risks.

2.0 Significant changes to the BAF during quarter 4 2025/26

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

2.2 There is a proposed **reduction** to the current total risk score of **BAF risk 4** this quarter from 4X4=16 to 4X3=12 due to consultant vacancies being their lowest in recent times/history, with some difficult to fill roles being recruited to. This risk score reduction was agreed at People Committee/PODAC on 23 March 2026.

2.3 A **reduction** to the total current risk score of **BAF risk 5** is proposed this quarter from 5X4=20 to 5X3=15. The reduction in score is linked to forecast out-turn to deliver the financial plan in 2025-26. However, risk remains in relation to the underlying position going into 2026-27. This risk score reduction was supported at Finance Assurance Committee on 28 April 2026 due to the Trust exiting the Recovery Support Programme (RSP) and having delivered the 25/26 financial plan. The risk score will be kept under review in early 2026/27.

2.4 A **reduction** to the total current risk score of **BAF risk 9** is proposed this quarter from 4X3=12 to 4x2=8. The reduction in score is due to zero patients waiting over 52 weeks (NHSE, March 2026); and 18-week performance now upper quartile nationally. This risk score reduction was agreed at Performance Assurance Committee on 21 April and Quality and Safety Assurance Committee on 28 April 2028, as a jointly owned risk.

2.5 An additional gap in control and associated actions have been added to BAF risk 6 regarding regulatory fire notices continuing to be received by the Trust.

2.6 An additional gap in control and associated action have been added to BAF risk 10 regarding an increase in patients with no criteria to reside.

2.7 An additional gap in control and associated action have been added to BAF risk 12 regarding lack of Group capacity and expertise to accelerate community transformation/Neighbourhood Health models.

2.8 Several actions have been closed throughout the BAF this quarter.

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

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

3.2 Based on the draft current total risk scores for quarter 4, there are three top risks with a current total risk score of 20 (previously four in Q3); three risks with a score of 16 (previously three in Q3); two with a score of 15 (previously one in Q3), five with a score of 12 and one with a score of 8, as indicated within the BAF summary page.

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

The top scoring BAF risk(s) based on draft current total risk scores at quarter 4:

Risk No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 4, 2025-26	Change in risk score since the previous quarter
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Audit & Risk Assurance Committee	5X4 = 20	↔ No change
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Performance Assurance Committee	4x5 = 20	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Performance Assurance & Quality & Safety Assurance Committees	4x5 = 20	↔ No change

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

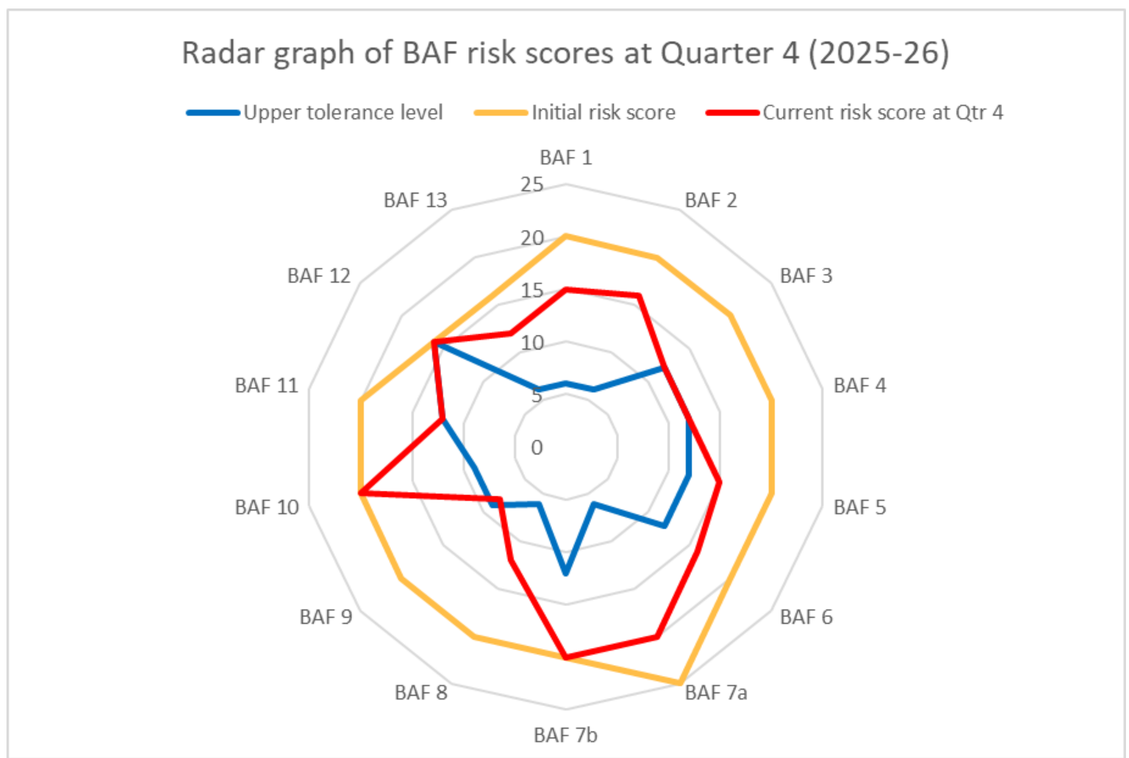
3.4 Being aware of the proposed top scoring risk(s) should assist the Board to consider:

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

4.0 Visual representation of risk scores

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

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



4.2 It is acknowledged that for BAF risks 3, 4, 11 and 12, the current total risk score has achieved (is at) the proposed upper tolerance level. BAF risk 9 has now fallen just below its upper tolerance level of 9 as the score is at 8 this quarter. All other BAF risks are above their upper tolerance levels.

5.0 Recommendations

The Boards are asked to:

a) Consider if the BAF content reflects the strategic risks within the organisation and if the risk scores are appropriate.
b) Consider if there is evidence of successful management of the risks; if actions are being progressed in a timely manner; and if any further actions/mitigations are required.
c) **Approve** the Quarter 4 BAF.

Appendix 1

Board Assurance Framework (BAF) 2025/26 - draft quarter 4 (Jan-Mar 2026)

(Updated April 2026 - Version 1.2)

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

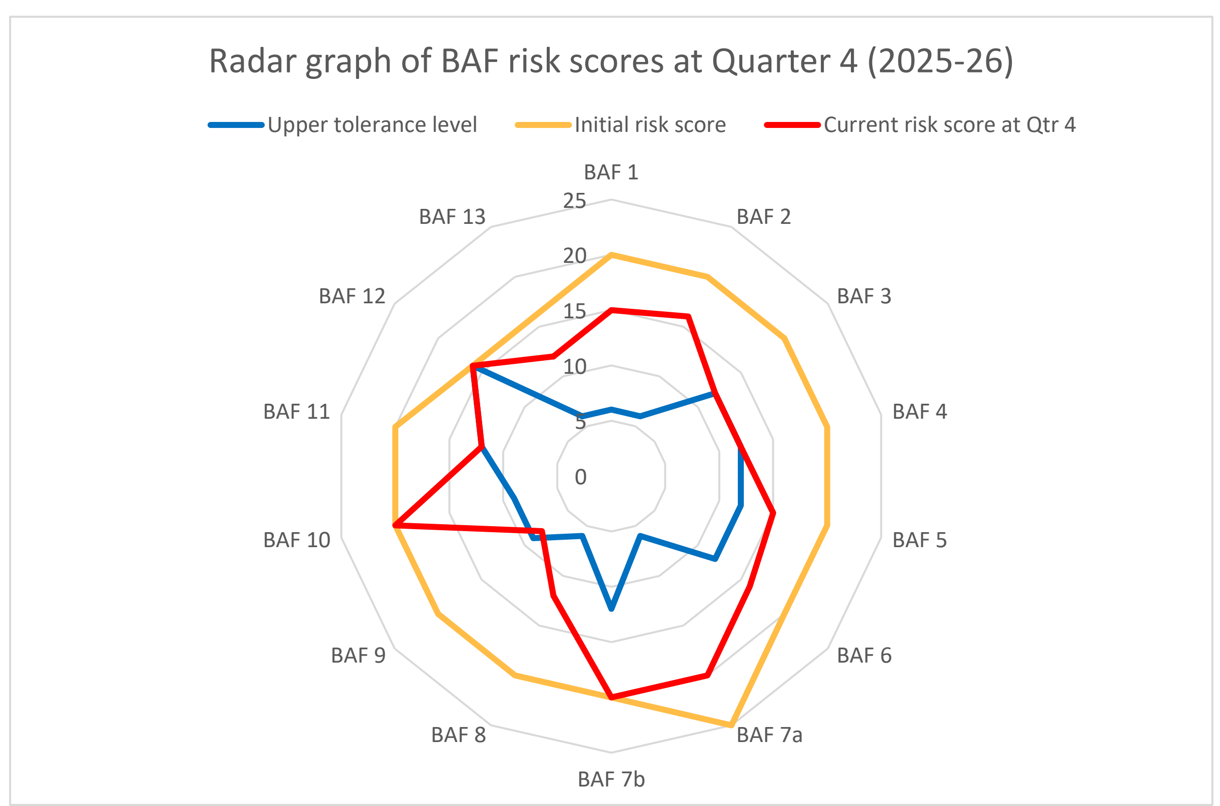
Board Assurance Framework 2025/26 - Summary

Ref:	Risk title:	Alignment to Trust Strategy - strategic themes/objectives	Initial (inherent) risk score	Upper tolerance level (and risk appetite)	Lead Executive	Lead Committee	Current total risk score in previous quarters (IxL): Quarter 4 (2024-25)	Quarter 1 (2025-26)	Quarter 2 (2025-26)	Quarter 3 (2025-26)	Current total risk score (IxL): Quarter 4 (2025-26)	Change in current risk score since previous quarter, plus any further comments
Board Assurance Framework 2025/26 - Summary at Quarter 4 (January-March)												
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	5x4 = 20	6 (minimal)	Medical Director /Chief Nursing Officer	Quality & Safety Assurance Committee	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15	↔ No change
BAF 2	The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways. Make our organisation more sustainable.	5x4 = 20	6 (minimal)	Chief Nursing Officer/ Medical Director	Quality & Safety Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 3	If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Chief People Officer	People & OD Assurance Committee (in common)	4x4 = 16	4x4 = 16	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)	Chief People Officer	People & OD Assurance Committee (in common)	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4X3=12	↓ Reduction in score due to consultant vacancies being their lowest in recent times/history, with some difficult to fill roles being recruited to.
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Make our organisation more sustainable.	4x5 = 20	12 (open)	Acting Director of Finance	Finance Assurance Committee	4x5 = 20	5x4 = 20	5x4 = 20	5x4 = 20	5X3=15	↓ Reduction in score is linked to forecast out-turn to deliver the financial plan in 2025-26. However, risk remains in relation to the underlying position going into 2026-27.
BAF 6	Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	4x5 = 20	12 (open)	~~Assistant CEO~~ Group Director of Estates, Facilities, HTP, Capital and MES	Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	5x5 = 25	6 (minimal)	Acting Director of Finance	Audit and Risk Assurance Committee	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 Director of Finance	Performance Assurance Committee	4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20	↔ No change

Board Assurance Framework 2025/26 - Summary

Board Assurance Framework 2025/26 - Summary at Quarter 4 (January-March)		Alignment to Trust Strategy - strategic themes/objectives	Initial (inherent) risk score	Upper tolerance level (and risk appetite)	Lead Executive	Lead Committee	Current total risk score in previous quarters (IxL): Quarter 4 (2024-25)	Quarter 1 (2025-26)	Quarter 2 (2025-26)	Quarter 3 (2025-26)	Current total risk score (IxL): Quarter 4 (2025-26)	Change in current risk score since previous quarter, plus any further comments
Ref:	**Risk title:**											
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**6 (minimal)**	Chief Nursing Officer	Quality & Safety Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change
BAF 9	The Trust is unable to meet the required national elective and cancer care standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x3 = 12**	**4x3 = 12**	**4X2 = 8**	↓ Reduction in score due to zero patients waiting over 52 weeks (NHSE, March 2026); and 18 week performance now upper quartile nationally.
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**4x5 = 20**	**9 (cautious)**	Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	**4x5 = 20**	↔ No change
BAF 11	The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**5x4 = 20**	**12 (open)**	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)**	Director of Strategy & Partnerships and Chief Operating Officer	Quality & Safety Assurance Committee	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	**4x4 = 16**	↔ No change
BAF 13	The Trust is unable to ensure that robust corporate governance arrangements are in place resulting in poor processes, procedures and assurance	Improve the quality of care that we provide. Deliver a better patient journey and experience. Make our organisation more sustainable.	**4x4 = 16**	**6 (minimal)**	Director of Governance	Audit and Risk Assurance Committee	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	**4x3 = 12**	↔ No change

Visual representation of risk scores



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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistencies in care • Inconsistencies and lack of clarity in governance arrangements • Lack of resources • Lack of clarity of standards and frameworks especially where practice may be different across sites • Incomplete training and competencies • Operational pressures • Workforce gaps in specific areas (including vacancies); Inability to recruit and retain the right numbers and skill mix of clinical staff • Clarity of and lack of consistency in the use of policies and procedures • Unable to off-load ambulances in a timely way because of lack of patient flow through the organisation • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture **Consequence:** • Increased avoidable harm to patients • Delays in time-critical care • Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • CQC prosecutions and enforcements if standards and frameworks are not in place. • Ambulance rapid handover could result in a greater volume of patients in ED than can be received and cared for • Reputational damage, financial loss and lack of confidence in the organisation	5	4	20	• Moving to Excellence programme. • Targeted transformation programmes • Quality and Safety Strategy under development; Quality Priorities for 25/26 in place; Corporate Strategy; People Strategy; Digital Strategy; workforce planning • Clinical audit programme • Governance structure in place. • Safeguarding Policy (including Mental Health and Learning Disabilities), IPC Policy and PSIRF policy in place. • Palliative and End of Life strategy • Staff training • Daily incident communications (Datix)and Incident Review Overview Group (IROG) RALIG both in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • Board Assurance Visits • SaTH Improvement Hub and Clinical Lead for Improvement in place • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Hospital Full Policy in place • Dispatches action plan in place • Contingency arrangements in place with UHNM for emergency Maxillo Facial work. Elective and cancer service contingency arrangements being developed with Royal Wolverhampton. NHSE Specialised Commisssioning review of head and neck services across the Midlands started 15 December 2025. • Footprint for the space available for assessing acutely unwell medical patients is being increased in both hospitals as part of the Winter Plan - during December/Q3.	**Reported to Board, committees and elsewhere:** • Quality & Safety Assurance Committee, reporting to Board (2nd) • Mortality metrics reported to Board and Learning from Deaths Group considered by Board quarterly (2nd) • Quality metrics within Integrated Performance Report to Board (monthly)(2nd) • CQC Report, published May 2024 provides assurance that improvements are being made across the Trust (3rd) • Quality Account to QSAC/Board 2025 (2nd) • Incidents reports, themes, claims and complaints report to QSAC and public Board (2nd) • Staff Survey results to Board and quarterly pulse survey results considered at People & OD Committee (2nd) • Executive chaired assurance committees which report into QSAC (2nd) • Performance Management Review Meetings (PRM) with Divisions, executive led (2nd) • Operational groups in place (2nd) • Culture dashboard reported to Operational People Group (1st) • Externally led quality assurance visits and reports (3rd) • Quarterly FTSU updates to Board (2nd) • External Peer reviews with action plans produced, as required (3rd) • Q4: Reset and Review meeting - national maternity team - awaiting results (3rd) • MIAA internal audit reviews 2024/25 (3rd): PSIRF (Substantial assurance) • Medical Regulatory Group established Q2 24/25 (2nd) • Q3-Q4: Pharmacy Aseptic Services - stage one compliance management (enhanced oversight following Environment Agency visit) (3rd) • Maternity Survey Results (Q3) improvement in all questions and none in the worse than other trusts sections (3rd) . Results due at QSAC. • All national patient surveys reported to QSAC with associated action plans (2nd)	5	3	15	**Gaps in control:** 1. National shortages in specific workforce, e.g. theatres, endoscopy, doctors within critical care, care of the elderly, emergency medicine.	Actions aligned to gaps: 1a.Workforce planning - see BAF risk 3 plus Workforce Strategy. 1b. Delivering the trajectories within the Workforce Strategy (timescale: ongoing) . Leads: Kara Blackwell (for nursing, midwifery and AHP) and Simon Balderstone. During 2023, 2024 and 2025.	1b. Q1: Ongoing recruitment to all nursing and AHP roles, including theatre staff. Continuing with our student nurse associate programme. Regular trust-wide recruitment days in place for the year. Recruitment via fixed-term contracts for maternity leave to help manage unavailability gaps is progressing. Recruitment of further permanent gastroenterologists and further completion of training for clinical nurse practitioners within colonoscopy. Q2: Improved consultant recruitment in critical care, emergency medicine and gastroenterology such that we are almost recruited to template. Q3: Recruitment of Student Nurse Associates remains ongoing - had biggest cohort with 50 appointed to undertake the training in September 2025. Also about to potentially appoint fully to critical care consultants and almost fully recruited to emergency department for consultants. The main remaining challenges in recruitment are Cardiology, Max Fax, Neurology, General Anaesthetics, Haematology and Oncology. Q4: We have seen significant reductions in nursing vacancies.			6
									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.	2. See BAF risk 10.				
									3. Prolonged timescale of electronic systems replacing dated and paper based systems.	3. Electronic Patient Record planned by end of 2025. New patient administration system (PAS) to be in place as per agreed implementation plan (see BAF risk 7b). Executive lead: Director of Strategy & Partnerships.	3. Following the successful implementation of the Careflow PAS and Careflow ED in early 2024, together with other clinical systems and core technologies, the EPR programme continues in 2025/26. Endoscopy Medilogik went live in June 2025, and work is in progress to upgrade Badgernet Neonatal. Order Comms ICE for radiology is in progress (noting that this also covers RJAH and General Practice) albeit with a supplier capacity risk. Funding has now been confirmed for the next phase of Winpath Laboratory Information Management System (LIMS) in collaboration with UHNM. Teams are finalising the business case and plan for EPMA with expectation that this begins in late Q2/early Q3. To note, these systems do require strong clinical and operational leadership alongside technical expertise, with projects needing medium term involvement. Q3: Vitals system upgrade due 19/20 January 2026. The Trust is preparing to roll out CareFlow Connect (CFC) to support digital handover, referrals and task management across inpatient areas, from March 2026.			
									4. Implementation of national Patient Safety Incident Response Framework (PSIRF) and now to work on the outcomes of PSIRF. Development and roll-out of Patient Safety & Quality Strategy.	4. Develop a three year Quality & Safety Strategy by Q3 2025/26 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead: Chief Nursing Officer.	4 In progress. Working to align the Patient Safety Strategy to the Quality Strategy. Plan to ensure consultation with stakeholders on the strategy in Q1 and Q2, with revised draft end of Q3 and then onward to QSAC and Board. Q3: Meeting with stakeholders (Surgery, Medicine and W&C) held in November 2025. Follow up meeting due to finalise priorities and metrics - due by end of January 2026. Completion of draft strategy now expected end of Q4, followed by subsequent approvals. Q4: Quality priorities drafted for 26/27. National Quality Strategy due, so awaiting sight of this in relation to our local strategy. Two engagement sessions held (Q4) in relation to quality and safety strategy and priorities also discussed.			
									5. Standardisation of education for clinical ward leaders to ensure standardised approach across the organisation.	5. Roll out of I Care Braver Leader Programme by Q2. Executive lead: Chief Nursing Officer.	5. Q4: Running the I Care Braver Leader Programme - two cohorts - one in April and one in Sept 2025 with band 7 ward managers. Q1: Scoping the requirements for a Band 6 programme and a Matrons programme to deliver in Q3 and Q4. Q2: Matrons programme being delivered in October 2025; band 6 programme will be during 26/27. Q3: The two cohorts of training for ward managers is complete, with the matron training ongoing. We are looking to review divisional Directors of Nursing development programme in 26/27. Q4: Matrons training completed in March 2026. Divisional Directors of Nursing training programme commences in April 2026. Deputy Divisional Directors of Nursing programme to be arranged for the end of 26/27. Original **action closed Q4**.			
									6. Lack of Policies and Procedures Group to sign-off clinical policies, plus no overarching Documentation Group.	6. Agree refreshed Policy for Policies Q3 25/26. Executive Lead: Director of Governance (as per BAF risk 13).	6. The Trust's Policy for Policies was considered and agreed by the Policy Approval Group on 16 October 2024 and agreed by lead Executive. Policy Approval Group commenced during August 2024, and continues to meet monthly. **Action closed Q3.**			
									7. Notice served on inpatient neurology service by RWT which came to an end on 19 June 2025.	7. Work with regional and extra-regional partners with support from NHSE and ICB leadership to develop short term and longer-term mitigation. By August 2025 (short-term) and April 2026 (longer-term). Executive lead: Executive Medical Director.	7. Telephone support via a specialist private provider and some short-term interim support from a locum Neurologist in place. Q3: Developing a job description for a joint consultant appointment with UHB. The locum support is due to end at the end of ~~January~~ June 2026. Q4: Also appointing an Acute Physician with an interest in Neurology. Discussions with UHB are ongoing about potential joint appointment.			
									Gaps in assurance: 8. Multiple different programmes of work and groups focusing on improving quality with the risk of loss of oversight of the overarching themes.	8. Deputy Chief Nurse and Deputy Medical Director to work together to review the function of each group including Learning from Deaths and Deteriorating Patients Groups to consolidate working arrangements and nature of the reports to Board - by October 2025. Executive lead: Executive Medical Director/Chief Nursing Officer.	8. Single Group being created to consolidate the outputs from learning from deaths, medical examiner and incidents during quarter 3. Q3: The first example of a joint paper between Learning From Deaths, Medical Examiner and Patient Safety is due at Board in January 2026. Q4: A joint paper (Patient Safety Committee Report) went to Board in January and March 2026. **Action closed Q4.**			

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistent leadership to support a high quality compassionate care environment • Inconsistent embedding of learning when colleagues speak up • Inconsistent approach to ensure acceptable values and behaviours that create psychologically safe team working • Inconsistent organisational support to embed a continuous learning and improvement environment • Leaders inconsistently demonstrating basic good practice in respect of 1 to 1 meetings, health and wellbeing check ins and talent management conversations with colleagues. • Lack of prioritisation of learning and development for colleagues. • Discontent from resident doctors around a number of national issues including pay, training opportunities and regulation of Physician and Anaesthetic Associates. **Consequence:** • Increased avoidable harm • Poor patient experience • Increased complaints • Reputational damage • Lack of confidence in the organisation • Potential CQC prosecutions and enforcements • Our people are not routinely raising concerns/speaking up on patient safety and anything else that may affect great patient care • Our people do not work as a team and a safety culture is not embedded within the organisation • Poor communication and unable to learn from incidents • Lack of measure of safety culture within the organisation • Strain placed on relationships between resident doctors and Physician Associates • People normalise poor practice.	5	4	20	• Embedding NHS Impact • Freedom to Speak Up Guardian and ambassador arrangements • FTSU Vision and Strategy in place, FTSU policy and training in place • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance visits • PSIRF structure and plan/policy in place • SaTH Improvement Hub and improvement methodology courses in place • Trust Strategy 2022-2027 (includes continuous improvement culture) • Leadership programmes in place, including Galvanise programme for colleagues from ethnic minorities • Staff psychological wellbeing services in place • Staff Survey covers some key safety culture elements (was undertaken Oct to Nov 2024) • Civility and Respect workshops in place in the Trust that are available for clinical and non-clinical teams. Plus EDI training in place. • Board FTSU self-reflection tool • Professional Nurse Advocacy and professional nurse advocacy roles in place to provide psychological restorative supervision • Regular meetings set up with senior medical leaders and tier two doctors • Incorporation of Ten Point Plan to improve resident doctors working lives during Q3 • SaTH is part of phase 2 of the introduction of Martha's Law • Sexual Safety Charter in place and Sexual Misconduct Policy • Patient Safety Committee • As part of the Ten Point Plan for improving Resident Doctors working lives, the Trust has appointed Resident and/or representative for resident doctors and the first report of the Resident Doctor Representative will be included as part of the Guardian of Safe Working Report to Board in January 2026.	**Reported to Board, committees and elsewhere:** • Reports to Quality & Safety Assurance Committee held monthly, reporting into Board (2nd) • Patient Experience & Complaints Report to QSAC - quarterly (2nd) • ARAC - Audit & Risk Assurance Committee (2nd) - bi-annual FTSU reports • Culture dashboard (annually based on Staff Survey), reported to Strategic People Group (1st) • Quarterly FTSU updates to Board (2nd) • Patient Safety Incident Response Framework and policy to Board (2nd) • MIAA internal audit reviews 2024/25: Freedom to Speak Up (Substantial Assurance) to ARAC August 2024; PSIRF (Substantial Assurance) 2024/25 to September 2025 ARAC (3rd). • CQC Report published May 2024 (3rd) • Independent Patient Complaints Review Panel (2nd). • Culture reviews being reported to PODAC - December 2024 and onwards (2nd) • National trainee survey (3rd) • National Patient Surveys (3rd) - to QSAC from Oct 2025 • Medical Director and Chief Nurse attending PODAC to provide assurance around meeting standards in care and training of regulated professionals (2nd) • Organ Donation Committee re-established January 2026 (2nd) • Paediatric Stakeholder Group re-established Q4 2026 (2nd)	4	4	16	**Gaps in control:** 1. Developing a shared purpose, vision and values across the Group Model to support culture.	**Actions aligned to gaps:** 1. Report on culture engagement work through Moving To Excellence, PRM's, Strategic People Group and PODAC. Develop culture and engagement framework to support delivery of the Joint People Strategy - by Q4, 25-26 and into Q1/Q2 2026/27. Executive Lead: Chief People Officer/ Chief Nursing Officer	1. Draft framework has been developed and socialised. Early engagement has commenced with colleagues across the two Trusts and patients, families and volunteers. Q3: Work ongoing.			6
									2. Embedding the new approach to patient safety.	2. Develop a three year Quality and Safety Strategy by Q4 2025/26. Executive Lead: Chief Nursing Officer	2. In progress. Working to develop an overarching Quality and Patient Safety Strategy. Plan to ensure consultation with stakeholders on the strategy in Q1 and Q2, with revised draft end of Q3 and then onward to QSAC and Board. Q3: Meeting with stakeholders (Surgery, Medicine and W&C) held in November 2025. Completion of draft strategy now expected end of Q4, followed by subsequent approvals. Q4: Quality priorities drafted for 26/27. National Quality Strategy due, so awaiting sight of this in relation to our local strategy. Two engagement sessions held (Q4) in relation to quality and safety strategy and priorities also discussed.			
									3. Evidence of continuous quality improvement culture.	3a. Learning from patient complaints and reduction in common themes - ongoing. Executive Lead: Chief Nursing Officer	3a. Q1: all learning is logged on Datix and shared with the divisions through monthly reporting. Q2: Working With Families work underway led by the Programme Director. Q3: Divisions are engaged in responding to complaints. An independent complaints review panel is in place (chaired by a patient representative) and Divisional Directors of Nursing attend to take away the learning and share within Divisions.			
										3b. Use the intelligence gained through triangulation of learning from incidents/complaints/learning from deaths and legal cases to develop a continuous cycle of themed improvement projects throughout 25/26. Executive lead: Chief Nursing Officer.	3b. The Safety Intelligence Triangulation Group (as part of PSIRF) has a key role to play in identifying themes and trends and was established in September 2024. Q3: A new Patient Safety Committee has been established, chaired by the Deputy Medical Director. It brings together Patient Safety, Learning from Deaths, Medical Examiner Service, and the Deteriorating Patient Group. The aim of the committee is to ensure a shared approach to improvement and learning and to combine specialities to ensure triangulation and focus. Q4: The first Patient Safety Committee report to the Board of Directors was presented in January 2026 and replaces the previous individual reports for Learning from Deaths and Medical Examiner Service. **Q4: Action closed.**			
									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.	4. Continue with implementation of new ambassador network during 2025/26. Executive Lead: Director of Governance.	4. 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.			
									5. Clinical Lead for Improvement gap.	5. Appoint Clinical Lead for Improvement during 25/26. Executive lead: Medical Director/Chief Operating Officer.	5. Q2: Clinical Lead for Improvement started early September 2025. **Action closed Q2.**			
									6. Unprecedented continued overcrowding in ED's and its impact on normal culture.	6a. Deliver the actions identified in the culture work stream within UECTAC transformation programme during 25/26. 6b. UEC Board to deliver agreed 25/26 milestones. 6c. Review of approach towards cultural change within ED - by March 2026. Executive lead: Medical Director/COO/Chief Nursing Officer	6a. Progressing workstream 2 - Staff Culture, Resilience & Wellbeing - this is monitored via the UECTAC using the reverse RAG (red, amber, green) methodology as per MNTAC (Maternity and Neonatal Transformation Assurance Committee). Medicine staff survey results 2024 showed improvement across all People Promise Domains. Progress continues to be monitored through UECTAC. 6b. *See BAF risk 10.* 6c. Work remains ongoing.			
									Gaps in assurance: 7. Board reporting of regulatory training programmes	7. Review of terms of reference and business cycle of People & OD Assurance Committee (PODAC) in relation to receiving regulatory training reports/surveys and meeting standards. By Q1 25/26. Executive Lead: Director of Governance.	7. PODAC business cycle has been updated to include annual regulatory training report. Training already included in PODAC terms of reference. **Action closed Q1.**			

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Failure to recruit and retain the right number of people at the right level, with the right skill mix. • Retirement remains as a leading reason for staff turnover • Staff fatigue burnout. Stress, anxiety, and depression remains a top reason for long term sickness • Lack of certainty around future ways of working and work environments • Shortage of key professionals and occupations in specific roles • Lack of succession planning to mitigate risks when key staff leave and encourage staff retention • Dissatisfaction with pay and reward • Work environment concerns in relation to belonging and staff experience relating to behaviours • Recruitment control processes in place to review current resources and skill mix **Consequence:** • Staff dissatisfaction with the level of engagement, involvements and communication with team leaders and senior leadership leading to low morale • Poor levels of engagement and morale which are correlated with lower patient satisfaction and outcomes • High use of agency staff in medical and dental groups. • High levels of sickness and turnover. • Poor patient experience, outcomes and quality and safety. • Adverse publicity and/or reputational damage. • May lead to the financial unsustainability of some services. • Needing to reform our services	5	4	20	• People governance arrangements in place including Strategic People Group (monthly) • Dashboards reporting against People Strategy, action plans and KPI's • Inclusion Improvement Plan and Recruitment and Retention plan supporting it. • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff Survey, pulse survey, workforce transformation ICB/ICS programmes such as HCSW and Talent programme, improve well and making a difference linked to the culture dashboard. • Enabling programmes in place with escalation/assurance to SPG/SLT/PAC/FAC and QSAC committee through to People board where indicated. • Extensive Health & Wellbeing (HWB) programme including staff finance, support, physio, clinical psychology and therapy • Culture, respect and inclusion programmes • Leadership development framework • Working group in place engaging with workforce to create a plan new way of working alongside estate and digital plans to support. • Regular meetings with Consultant new starters with a member of the executive team, this is with the People and OD Director and for Nursing and Allied Health Professionals is with Chief Nursing Officer • Developed a monthly recruitment dashboard to provide key metrics on both medical and non-medical recruitment activity. • Continued use of new roles such as Nursing Associate Top Up programme allowing development of Nursing Associates to become registered nurses. • Safer Recruitment and Selection workshops have been implemented to support appointing managers during the hiring process. • Developed operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan • Vacancy and spending control panel • Training and delivery model aligned to operational demand and capacity. • Medical workforce efficiency programme in place • Workforce Plan for 2026/27 developed and submitted.	**Reported to Board, committees and elsewhere:** • Reports to People & OD Assurance Committee (PODAC) (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. • Reports to Strategic People and Educational Group (SPG) (2nd) • Daily and weekly reports on workforce metrics, temporary staff usage, and agency spend considered (1st). • Annual Staff Survey considered by Board along with updates (2nd) • People Strategy approved by Board 2024 (2nd) • Equality, Diversity & Inclusion Strategy approved by Board 2020 (2nd) • Quarterly/monthly People Pulse Surveys received (2nd) • Associated risk register entries reviewed and updated regularly at SPG (2nd) • Financial Recovery Group - fortnightly (2nd) • Executive dashboard on agency expenditure - weekly (1st) • MIAA (internal audit): 2023/24 Staff Wellbeing & Engagement review to ARAC February 2024 - Substantial assurance . • Medical Workforce Efficiency Taskforce Group (2nd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Workforce Digital Group (2nd) • MIAA (internal audit) 2024/25 Bank and Agency Review Report (3rd) to ARAC November 2024 - Moderate assurance. • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance • Group Transformation Committee (2nd) • HTP Assurance Committee (2nd)	4	3	12	**Gaps in control:** 1. Systematic process throughout the Trust to support succession planning. 2. Recognition schemes. 3. Managing Working Time Directive breaches and management of rosters for medical staff. 4. Ongoing retention initiatives. 5. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS People Plan. 6. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. To work with system colleagues to develop a system approach to talent management - during 25/26. 2. Developing monthly recognition scheme delivered alongside our annual recognition programme during 24/25. 3. Visibility of all rosters and review consultant rosters during 24/25 and 25/26. 4. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 25/26. 5. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans. Workforce plans for HTP and operational planning required by Q3. 6a. Board and executive team must have EDI objectives that are SMART and be assessed against these as part of the annual appraisal process, by March 2025. 6b. Board members should demonstrate how organisational data and lived experience have been used to improve culture, by March 2026. 6c. The Board must review relevant data to establish EDI areas of concern/celebration and prioritise actions, by March 2026.	1. Leadership development and talent is shared across Shrop Comm and SaTH. In addition, we are exploring shared services which will have a wider footprint across the system for leadership development and delivery. Q2: The Task & Finish Groups are now being established for joint working. Q3: meetings are established and ongoing. Q4: Three organisations appointed to support and review current culture and leadership position, incorporating Poppy's Promise. 2. Proposal to be taken to Executives in Q4 for monthly recognition approach. Slight delay in proposal due to financial position. Plans underway to launch a bi-monthly recognition programme during Q2, 25/26. **Action complete** Q1 25-26. 3. Until one roster system is 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. Action plan developed and continue to deliver against this at Q1, Q2, Q3 and Q4. This work will continue during 2026/27 and envisage system switch over within six months (Sept 2026). 4. Q4: Training is now available on the LMS and training portal to support managers to have quality conversations; date to launch the framework is to be agreed. Q1: Review of retention interventions as part of the corporate service review for People & OD. Q4: More work to be done and a Wellbeing Strategy required. 5. Q1: Divisions actively developing their workforce plans to support delivery of operational plan which is a key part of their local people plans. Q2: Workforce plans have been refreshed in light of exit programmes. Divisions are moving forward with reform and organisational change which will contribute to the planning for 2026/27. 6a Q1: Objectives need to be reviewed and finalised for Board members for current year (25/26) and remain outstanding. Executives and Non-Executives received appraisals during 25/26 which included EDI elements (original action closed). This is going to be reviewed and finalised in light of the new Group Board for 26/27. 6b Q1: Active executive sponsorship for each of the staff networks. Also involved in system-wide development of communications campaign We All Belong. Active engagement with our patients, families and volunteers as part of the Culture and Engagement Framework to support development and improvement of services. Q3: Patient experience story presented to November 2025 Board highlighting the link between culture, staff and patient experience. Q4: Board seminar being held during March 2026 to cover this area. Action closed Q4. 6c. Q1: EDI WRES and WDES data has been submitted to inform future planning. The report was discussed at Strategic People Group in July 2025 and was received by PODAC in August 2025. Q4: Gender Pay Gap Report received at January 2026 Group People Committee. Action closed for 25/26 at Q4	3	2	12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Engagement in quality improvement initiatives due to competing demands on the team. • Redeployment of staff to support operational activity, reducing the opportunity of staff to be involved in improvement activity or take part in training. • Failure to address inequalities across all protected characteristic groups of staff in terms of promotion, career progression and over representation of staff from minority ethnic groups in formal HR processes. • Leadership styles that do not reflect the Trust values and behaviours framework • Colleagues not accessing appropriate learning and development, including statutory and mandatory training • Recruitment control processes in place to review current resources and skill mix **Consequence:** • The trust's reputation will be compromised impacting on recruitment and retention • Failure to embed and model the values and behaviours of the trust consistently and create confidence in speaking up culture and processes. • Leadership roles not reflecting diverse nature of community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes • Turnover and sickness absence will remain above target • Potential incidents if staff are not up to date with mandatory training • Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience, and with attendant risks around staff motivation, morale and productivity. • Increasing agency costs if we are unable to recruit fully • Reforming our services	5	4	20	• Educator role for newly qualified nurses (visible role picking up pastoral and education needs) • Equip people to deliver quality improvement locally, to identify and embed organisational learning to provide a positive impact on quality of care • Board and workforce equality committee dashboards reporting against strategy, action plans/KPI's and inclusion plan • Workforce metrics, staff survey, pulse surveys, EDI (equality, diversity and inclusion) groups, staff networks, triangulation of data, coaching methodology, SaTH improvement methodology • Participation in WRES (workforce race equality standard), WDES (workforce disability equality standard), EDS (equality delivery system) frameworks and gender pay gap reporting • Minority ethnic staff leadership programmes • Values based recruitment approach • Agreed targeted recruitment campaigns and retention actions including exit interviews • Learning Made Simple reporting on statutory and mandatory training compliance • Target interventions on culture dashboard metrics, using Pareto analysis • External Executive Directorship Training • Civility Saves Lives programme roll out • SaTH education offer via education prospectus • SaTH 1 to 4 and STEP Leadership Programmes • Affina team journey interventions • Vacancy and spending control panel • Process to review training in place - SEMTRAG (SaTH Education Mandatory Training Group) established in February 2024 • Non-Clinical Bank Review Panel in place since end of August 2025 • Nursing Bank review process in place since November 2025	**Reported to Board, committees and elsewhere:** • Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) • People & OD Assurance Committee - meets bi-monthly (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. • Strategic People Group (SPG), monthly (2nd) • Education Group (1st) • System education/training meeting (1st) • Culture Group reporting and culture dashboard to Operational People Group (1st) • Moving To Excellence progress reviewed/reported monthly (2nd) • Annual Staff Survey considered by Board (2nd) • Workforce data on leadership profile (1st) • Recruitment dashboard (1st) • Senior Leaders Committee - operational, monthly (2nd) • People Pulse Surveys reported to OPG quarterly (2nd) • EDI reporting into EDI Performance Group, which feeds into OPG (1st) • MIAA (internal audit) 2023/24 Staff Wellbeing & Engagement review to ARAC February 2024 - substantial assurance (3rd) • People & OD Risk Register reported to PODAC and Strategic People Group (2nd) • Medical workforce efficiency programme reported to FRG, Finance Assurance Committee and Strategic People Group (2nd) • MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance	4	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. Developing workforce supply routes 3. New ways of working 4. Systematic process throughout the Trust to support succession planning. 5. EDI champions and local EDI objectives to create a diverse workforce, leadership and inclusive culture 6. High levels of mental health related sickness absence **Gaps in assurance:** -	**Actions aligned to gaps:** Executive Lead for actions: Chief People Officer. 1. Review our retention interventions during 25/26. 2. Continue to embed our widening participation approach during 25/26 3a. Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 24/25 through to 2030. 3b. Deploy Manager Self Service within the Electronic Staff Record by 25/26. 4. To work with system colleagues to develop a system approach to talent management - during 2025/26. 5. Refresh and deliver EDI action plan and review against key workforce data. by March 2026, with report to Board at least annually. 6. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 2025/26.	1. The development of the Joint People Strategy is underway and review of People and OD service structures and priorities. Discussion document on draft Joint People Strategy received by PODAC August 2025. Q4: Work will continue to develop the strategy during Q1/Q2 2026/27. 2. Q1: Graduations of our DFN Project Search interns (a national charity that enables young adults who have a learning disability or autism spectrum condition to secure meaningful permanent employment) across both PRH and RSH sites and plans complete for the next cohort starting in September 2025. Q3: **Action closed**. Cohorts underway. 3a. Implemented ESR Go for medic on duty which provides a mechanism for automating staff contractual changes and taking information processed on ESR and updating Health Roster. ESR Business Intelligence alerting functionality is developed. Currently exploring robotic process automation opportunities and investment levels required. Q1: Submitted an application to NHSE to trial robotic process automation which was not accepted, although the organisation is exploring other opportunities for this. Q4: Working Group on RPA to be convened to consider how to make progress, with some support, based on learnings from UHNM. Working with Digital Team/PMO. 3b. A trial of team based rostering was completed on ward 23 during 24/25 . Roll out programme of Manager Self Serve is in place and is 90% complete at Q4. Working with remaining teams to roll this out by April 2026. 4. Leadership development and talent is shared across Shrop Comm and SaTH. In addition, we are exploring shared services which will have a wider footprint across the system for leadership development and delivery. Q4: The Task & Finish Groups are in place for joint working with a reset exercise currently underway. 5. Q1: EDI WRES and WDES data has been submitted to inform future planning. The report was discussed at Strategic People Group in July 2025 and was received by PODAC in August 2025. Q4: Action closed. 6. Q1: Leadership development programmes have been reviewed to incorporate trauma informed leadership as part of these programmes. Engagement conversations held with patient advocate groups which is supporting the formulation of the joint people strategy and priorities.Q2: Change Agent training being delivered across the organisation and psychology are part of these programmes. Q4: Clinical Psychologist joining Chief People Officer at March 2026 Board development session to cover trauma informed leadership. Action closed for 25/26.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Overspend against operational budgets driven by operational pressures 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 deficit • Increasing demand placing pressure - inadequate estate available to accommodate need. Inefficient deployment of resources to bridge gap. • Aged infrastructure requiring increased maintenance and potential loss of capacity • Significant CIP plans of 6.4% required to deliver the annual plan • High sickness levels placing additional pressure on service costs **Consequence:** • Short-term recovery inhibits service quality improvement. • Dwindling cash reserves. • External action being taken against the Trust • Continue imposition of regulatory controls leading to the loss of local control. • Damage to the Trust's reputation and the Trust's continuing abilities to function • Inhibits ICS' ability to commission growth in services • Risk of increased cost.	4	5	20	• Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system - budget holder to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Chief Executive-led Financial Recovery Group meets 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 2025/26 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing medical doctors rotas to ensure compliance • Internal (executive led) vacancy control process. • Strengthening governance via splitting the finance and performance elements within the assurance committees (but recognising the interdependencies between the two). • High levels of authority required to approve discretionary expenditure (non-pay) on Oracle - in practice since January 2025 • Chief Nursing Officer and Medical Director approval of bank shifts from December 2025 • 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 Operational People Group (1st) • Weekly Executive Dashboard: beds, nursing WTE and finances - presented fortnightly at FRG (2nd) • Interim Budget setting paper for 25/26 to FAC and Board (25th Feb 2025 to FAC and 13th Mar 2025 to Board) (2nd), with final budget approved by Board (on 25th Mar 2025) • Operational People Group now aligned into Operational Performance Oversight Group to enable better oversight • VFM opinion from external audit with no significant weaknesses identified (3rd). • Trust exit from Recovery Support Programme (RSP) - letter from NHSE dated 2 March 2026 (3rd)	5	3	15	**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.	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 2026/27 via a dedicated multi-disciplinary Financial Recovery Programme Office by December 2025. This is in addition to identifying any mitigations in relation to the 25/26 programme. Executive lead: Director of Finance. 1b. Staff reduction targets with a monthly recruitment ceiling issued to divisions to achieve agreed exiting whole time revised plan by March 2026. Executive Leads: Chief Operating Officer/Director of People & OD/individual executives. 1c Monthly Operational Performance Oversight Group to be chaired by Director of Finance with COO as Vice Chair to review financial and workforce performance with a regime of escalation for divisions not delivering to plan - ongoing. Lead Executive: Director of Finance. 1d. Developing an overarching 3-year efficiency and improvement plan that incorporates all transformation (including HTP) across the group and aligns it to the strategic objectives including financial sustainability. Target date - September 2026. Lead Executive: Director of Finance. 1e. Divisional key variance reports t highlight risks and develop mitigations through the divisional meetings and PRM's to provide greater granularity and visibility of issues. Target date - Feb 2026. Lead Executive: Director of Finance.	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. Whole time reduction monitored on a monthly basis and reported to both Finance Assurance Committee and People & OD Assurance Committee. 1c. Operational Performance Oversight Group in place. Divisions will be escalated as necessary. Q3: Additional support programme in place for divisions who are off-track financially. Q4: Draft performance and accountability framework in discussion aligned to a reset of the Performance Review Meetings to take effect in the new financial year. 1d. 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. 1e. Draft in progress and to be finalised during Feb 2026. Q4: Draft escalation report format agreed and to be implemented in Q1.			12
									2. Comprehensive identification and delivery of a £41.4 million cost improvement programme and adherence to cost control policies and processes	2a. £41.4 million was identified by the time of the final operating plan submission on 30 April 2025. The priority is to de-risk, identify mitigating alternative schemes and deliver the £41.4m - timescale end of Q2. Executive lead: Director of Finance. 2b. Identify and recruit a financial improvement director byend of April 2025. Executive lead: CEO 2c. Additional controls over bank usage have been tightened and continue to be in place to manage cost pressures. Target date - Ongoing. Lead Executive: Chief Nursing Office, Medical Director and Director of Finance. 2d. Updated self assessment against the grip and control toolkit has highlighted a number of actions to facilitate improved grip. Target date - Ongoing. Executive Lead - Director of Finance. 2e. Weekly dashboard to Financial Recovery Group (FRG) to be incorporated where possible to a dashboard for Divisions. Target date - March 2026. Executive Lead- Director of Finance.	2a. Full efficiency programme identified. De-risking continues to be monitored via Financial Recovery Group and Finance Assurance Committee. Q3: **Original action complete**. Continue to monitor to ensure any further risk is mitigated. 2b. Action complete Q1. 2c. Daily nurse, tri-weekly medical and tri-weekly non-medical panels to review requests in place and executive led. 2d. Self assessment completed and action plans being monitored and managed. Internal audit provides substantial assurance. 2e. Weekly metrics evolving as processes put in place to capture data. Meetings arranged to understand the potential for inclusion in a senior leaders dashboard. Q4: Meetings have taken place to understand potential and the dashboard is being refined (presented fortnightly to FRG).			
									3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system.	3. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - Q4 2025/26. Executive lead: Director of Finance and Director of People and OD.	3. Work ongoing during 2025/26. Q3: Discussions have taken place with NHSE as to whether any other trusts have gone through a similar process and could share their learning. Q4: Response received, no new intelligence provided.			
									4. Risk management process that takes into account quality and safety risk alongside financial risk on a daily basis leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost in relation to both medical and nursing staff.	4a. Revised escalation measures to be introduced to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact - by end July 2025 . Executive lead: Director of Finance/Chief Operating Officer. 4b. System-wide actions in relation to the UEC pathway, managed by the UEC Transformation Board in order to mitigate the risk of additional capacity- timescale ongoing. Executive Lead: Chief Operating Officer.	4a. Review of monthly meetings taking place and escalation process to be implemented by Q2 2025/26 following divisional forecasting at the end of Q1. Q3: Additional support programme in place for divisions who are off-track financially. **Action closed.** 4b. Previous escalation capacity included as core capacity in the 25/26 operational plan. Further additional capacity implemented as approved within the Winter Plan agreed at Board in September 2025.			
									5.-Understanding how system partners medium term plans impact SaTH - ensuring that CIPs do not push cost around the system and that interdependencies are clear.	5. Sath have completed a medium term financial plan as part of the HTP business case, system-wide medium term financial plan required which is linked to a system-wide demand and capacity model - by-end of Q2 25/26. Executive lead: Director of Finance.	5. Work commissioned to develop a system-wide demand and capacity model has been completed, model continues to be updated by the ICB and has been shared with system partners. System wide medium-term financial plan using high level assumptions shared with respective organisational finance committees during Q1 25/26. As part of the national phase 1 work, underlying positions and medium-term financial plans will be submitted to NHSE during Q2. Q2: Underlying positions submitted on a monthly basis through the Provider Finance Returns. **Q3: Action closed.**			
									6. Lack of activity data means it is challenging to triangulate spend with changes in activity.	6a. Re-introduce activity data to divisional reporting packs at PRM and OPOG. end of Q4 25/26. Executive lead: Director of Finance and Assistant CEO. 6b. Devolve Clinical Income to divisions - end of Q4 25/26. Executive lead: Director of Finance.	6a and 6b. Q1: Investigating the most appropriate approach to devolving income and reporting income and activity at division, specialty and Point Of Delivery level. Q2: interim solution of ICB sharing relevant data agreed pending longer-term solution. Q3: Data is now being shared, however data quality issues remain and are being worked through. Q4: Additional resources with specific technical knowledge have been recruited to the team to expedite the programme.			
									Gaps in assurance: 7. Ability to accurately report contract income position.	*7. See BAF risk 7b, action 4b regarding Data Warehouse.*				

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 Director of Estates, Facilities, HTP, Capital and MES (From March 2026)	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 2025 and granted for backlog works; new applications now open for 2026.	**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. Lack of up-to-date Estates Strategy. 3. Awaiting confirmation of RAAC funding to enable long-term remedial works. 4. Aged nurse call systems require updating. 5. Fire notices continue to be received by the Trust. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Utilise Salix funding for replacement infrastructure - supplier identified and project has commenced. Public Dividend Capital (PDC) Fund allocation of approximately £7m (proportion of which relates to energy infrastructure). Continuous exploration for additional external funding opportunities - ongoing. Executive lead: Director of HTP (SRO). 2. Develop and approve Estates Strategy by end of Q2 2025. Executive lead: Assistant CEO. 3. RAAC removal project at PRH has commenced with expected end date of October 2026. Executive lead: Assistant CEO. 4. Develop plan for new fixed nurse call systems, where appropriate by end of Q1 2025/26 (plan) and conclude the works by end of Q4 25/26. Executive lead: Assistant CEO. 5a. Commission Independent survey report of PRH fire doors during March 2026. 5b. 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.	1. Contractor selected and contract signed. Works commenced March 2025. Two year programme underway. 2. Draft Estates Strategy submitted to Performance Assurance Committee in June 2025 and returned in July 2025. Estates Strategy 2025-2030 approved by Board on 11 September 2025. **Action closed Q2.** 3. NHSE has approved and confirmed funding of £12.2m over two financial years. Contractors selected and approved. Project Group set up and full works have commenced. Q3: Project completion date is now expected as October 2026. Change request form submitted to NHSE, awaiting formal approval for date extension and increased budget of £2.9m. Q4: Still awaiting written confirmation of date extension and additional funding. 4. Q1: Received PDC Estates Safety Programme funding covering high risk nurse call systems. Developing a plan with clinical teams to install in this financial year. Q4: Work underway for most critical systems. Due for completion April 2026. 5a. Q4: Independent Fire Survey underway at PRH March 2026.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of resource • Lack of capacity and capability • Continually changing threat landscape - technology and political unrest • Increasing prevalence of threats globally • Funding constraints to invest in digital tools to improve cyber security • Continued national development of cyber strategy, policy and compliance & mitigation framework **Consequence:** • May lead to sub-optimal care, for example could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - e.g. ICO fines • Potential regulatory action - Network & Information System Regulations (note: this area is subject to further expansion) • Reputational damage and negative impact on public confidence • Temporary or permanent loss of data • Reinforces the need for dedicated resource and continued review of the capacity and capability required. • Limited or non-compliance with national framework	5	5	25	• Governance resource in place including Cyber Security Manager, Deputy and SIRO • Trust actively contributing to cyber security management at Integrated Care System (ICS) level • Business continuity plans in place • Cyber security tools in place to support access management, security compliance, single sign-on, password and digital policies, CareCert updates reviewed for high severity alerts, Multi-Factor Authentification compliance for NHS mail, Phishing test cycles. • Security compliance in place to monitor security patch compliance and compliance with Cyber Assurance Framework (CAF) aligned DSPT • Information Governance (IG) strategy, policy and framework • Incident review processes and learning - national and local • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff • Monthly meeting with regional NHSE cyber security lead.	**Reported to Board, committees and elsewhere:** • Information Governance Committee - (2nd) • MIAA internal audit of cyber security - Sept 2025 (3rd) • Annual MIAA internal audit of cyber security, reporting to Audit & Risk Assurance Committee (3rd) • MIAA Technical Review Medical Devices 2024/25 - Moderate Assurance (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Dedicated monthly risk review meeting (1st) • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Bi-annual cyber update reports to Audit & Risk Assurance Committee meeting (2nd) • Monthly meetings held between SaTH Digital Services and NHSE Regional Cyber Security Team since 2024/25 to provide ongoing updates in relation to remediation planning and ongoing risk / impact ~~• STW Digital Delivery Group (exec lead) - meets monthly (2nd)~~	5	4	20	**Gaps in control:** 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours 3. Cyber Security strategy to be developed. 4. Funding constraints. **Gaps in assurance:** 5. Continued joint working between digital services and MES.	**Actions aligned to gaps:** 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions - ongoing, funding dependent. Executive lead: Executive Lead: Acting Director of Finance 2. Continue our work as a health system partner during 25/26 and 26/27 as part of the work programme for the ICS Digital Delivery Group. 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by Q4 25/26. Executive Lead: Acting Director of Finance 4a. Re-prioritisation of internal digital capital funding during 2025/26. 4b. Continue to explore external funding opportunities during 2025/26. 5. Establish a Medical Devices Security Working Group by Q3. Executive Lead: Acting Director of Finance, supported by Assistant CEO.	1. Risk mitigations plans are in place and compliance continues to evolve and be kept up to date in line with national guidance. Q1: Digital services have reviewed cyber plans for 25/26 as part of the digital delivery programme. Cyber update received at September 2025 Audit and Risk Assurance Committee (ARAC). Q3: Cyber update to be presented at February 2026 ARAC. Q4: ARAC cyber update was not required in February; expect cyber update to be included at the next ARAC meeting. 2. Q4: From December 2024, ICS Cyber Operational Group established, focusing on Cyber and Infrastructure Optimisation. Q2: STW ICS Digital Cyber Strategy has commenced. Q3: ICS Digital Lead no longer in post. Review alternative meeting chair. In addition, Digital Shared Services Task & Finish Group meetings are in place, with Staffordshire & Stoke-On-Trent and Shropshire Telford and Wrekin ICB cluster representatives attending. One of the Task & Finish Groups being Cyber Security and Compliance. Q4: Task & Finish meetings continue. Interest in ICB Cluster wide cyber group is positive and conversations ongoing to create the group. 3. The SaTH Cyber Security Strategy is currently under development, with a view for completion by December 2025 following alignment with new Cyber Assurance Framework aligned DSPT. The intention is to ensure that the strategy is aligned with the National Cyber Strategy for Health and Social Care and the NHS England CAF aligned Data Security and Protection Toolkit. Q2: Development of SaTH Cyber Strategy has now paused pending delivery of the ICS Cyber Strategy. Q3: 2026/27 work to be undertaken to strategically align with the Group Model. Q4: The group model digital strategy is to be developed. This will help define a group model cyber strategy during 26/27. 4. Continue to monitor digital funding and prioritise in accordance with the national policy, recognising the constraints on capital funding. 5. Group in the process of being set up with both digital and medical device colleagues and will be chaired by digital colleagues. First meeting scheduled for October 2025. Q3: Initial medical device working group took place November 2025. **Action Closed.**			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of core digital project team resource - appropriate skillsets and experience and national shortage of digital technical personnel • Lack of clinical and operational capacity and capability within Trust • Large scale digital business change programme alongside other competing business change programmes such as financial improvement, 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 ~~- funding sought for increase in scope~~ • Trust's Data Warehouse requires redevelopment and resourcing both in the short and medium term, with alignment to the national federated data platform. • Reduction in digital capital allocation (national, regional and local). **Consequence:** • Could lead to interruptions to vital IT applications which in turn could result in sub-optimal patient care. • Poor data quality • May lead to inability to provide essential services for patients, work together with partners, and / or cease service provision • Potential financial penalties - misreporting • 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 - Operational Readiness Groups which feeds into appropriate Programme Board. All digital projects report into Digital Oversight Group which reports into Senior Leadership Committee, reporting into Performance Assurance Committee/Trust Board • Business continuity plans in place and to be implemented for new systems • Working closely with procurement to secure recruitment into specialised posts and to continue to recruit substantive vacant posts • Standardised network infrastructure platform • Governance resource in place: Chief Clinical Information Officer and Chief Nursing Information Officer provide Clinical Safety Officer functions. Clinical Safety & Hazard Group in place monthly (safety of software and reducing hazards for patient safety), Chief Information Officer/Director of Digital Transformation in place - at SaTH, Head of Digital Innovation & Transformation in place within the ICB • Digital Design Authority Group and the Clinical Design Authority / Medical Records Committee meet frequently to review the design for systems and sign off to ensure fit for purpose	**Reported to Board, committees and elsewhere:** • Weekly digital senior team meeting and bi-weekly digital design authority meeting for areas of escalation, along with monthly summary (1st) • Monthly programme reports to Programme Board which feed into Digital Oversight Group (2nd) • Bi-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) ~~• Report to STW ICS Digital Delivery Committee with system updates to the ICB Strategy and Prevention Committee (2nd~~)	4	5	20	**Gaps in control:** 1. Requirement for key roles and increase in substantive capacity in the digital programme. 2. Capacity within wider trust teams for digital system implementations. 3. EPMA and several other digital initiatives do not have a source of full funding in 25/26 and 26/27 and limited national/regional capital funding identified for 25/26 and 26/27. 4. Ageing digital infrastructure and architecture. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Continue to recruit into substantive vacant posts that were approved as part of 25/26 operational plan. Executive lead: Acting Director of Finance. 2a.A review of all digital initiatives and projects has been undertaken and continues to be reviewed during 25/26, aligned to the prioritisation of the service development capital allocation and recovery programmes. Executive lead: Acting Director of Finance. 2b. The framework for the requirement for SRO, operational lead and clinical lead for each digitally enabled project has been described for 2025/26 and work is to be undertaken to review this with corporate leads and Divisions in 25/26. Executive lead: Acting Director of Finance. 3. Ongoing discussions with NHSE National and Regional Digital Team to explore external funding opportunities during 25/26 and 26/27. Executive Lead: Acting Director of Finance. 4a. Complete the digital maturity assessment for 25/26 and submit to NHSE annually. Executive Lead: Acting Director of Finance. 4b. Develop programme for substantive solution for Data Warehouse supported by national federated data platform (FDP) team by March 2026. Executive Lead: Acting Director of Finance.	1. Digital positions continue to be appointed to, but it remains challenging to appoint to the specific technical expertise required for key programmes, which reflects the current market position. 2a.Trust digital programme is discussed in more detail at the monthly executive-led Digital Oversight Group which includes representatives from all four clinical divisions and key corporate services. Q1: Regular planning, review and prioritisation sessions with all divisions will continue through 25/26. Q2: Digital update due at October 2025 Board. Q3: Digital update presented at October 2025 Board. **Action closed.** 2b. Q1 and Q2: In progress. Q3: As new projects are submitted, a review of key project stakeholders are identified. **Action closed 31.03.2026** for 25/26. Work has been undertaken to embed this process and will be transitioned into business as usual, with escalation as required. 3. Q1 25/26: Additional external funding has been successfully secured for Laboratory Information Management System (LIMS) and Electronic Order Communications and Results Reporting (OCRR). Q3: Funding beyond 25/26 not yet secured. Submission for external funding through Diagnostics Digital Capabilities being submitted. Women's and Children's Division have finalised-funding for Badgernet Neonatal system 2025/26. Divisions have prioritised their capital requests for 25/26; opportunities for use of AI/RPA are being reviewed with controlled proof of concepts within the Trust and will require the development of business cases. 4a. Q2: Submission made for 2025/26. Results due to be published Q3 (awaited). 4b. Q1: Successful live automation of the Trust's SUS returns through the Federated Data Platform (FDP). Second phase to ~~fully~~ transition functionality into the FDP with the national team ~~has commenced~~ 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. **Risk opened**: risk within 2021/22			**Chief Nursing Officer** Paula Gardner	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 Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Poor processes, systems and culture • Operational challenges and pressures **Consequence:** • May lead to sub-optimal quality of care • Additional regulatory action • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties • At the end of Q2 2025/26 the Trust has two Section 31 conditions in place	4	5	20	• Moving To Excellence Programme • Quality priorities 25/26 • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Palliative and End of Life Steering Group • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Patient Safety Specialist in post • Board Assurance visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • CQC inspection report published May 2024 (3rd)	**Reported to Board, committees and elsewhere:** • Reports received monthly at Quality Operational Committee (QOC) (2nd) • Quality & Safety Assurance Committee (QSAC) reports received (bi-monthly) and monthly via AAAA report to Board (2nd) • Quality, safety and performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Regular reporting to QSAC, Quality Operational Committee and other divisional, specialist groups and committees (1st) • Compliance monitoring with CQC actions - QSAC (2nd) • RALIG meeting (1st) • Incident Review Oversight Group (1st) • Rapid Review process reporting (1st) • Patient & Carer Experience Group (1st) • Mortality Group (1st) • Deteriorating Patient Group (1st) • Infection Prevention and Control (IPC) Assurance Committee (2nd) • Safeguarding Assurance Committee (2nd) • Operational meetings for IPC, safeguarding, workforce and maternity (1st) • Bi-weekly informal meetings with CQC - chaired by Director of Nursing (2nd) • Quarterly engagement meetings with CQC (3rd) • CQC action plan owned by Divisions and confirm and challenge in place (1st) • NHSE IPC inspection for C'Diff undertaken April 2025 - action plan updated and reported via IPCAC and QSAC (3rd) • Moving To Excellence Operational Delivery Group (1st) which feeds into QSAC and Board • External Peer reviews in neonatal, trauma and critical care in Q3 • MIAA internal audit reviews 2024/25 (3rd): Freedom to Speak Up (Substantial Assurance). • UEC Transformation Assurance Committee, reporting to QSAC (2nd) • SaTH Provider Review Meeting with NHSE, and ICB attendance - monthly (3rd) • CQC unannounced visit on 3 and 4 March 2026 covering medical wards and emergency departments at both sites - outcome awaited (3rd) • National Director of Urgent and Emergency Care for NHSE did a site visit of RSH ED and acute floor in Q4 with positive feedback (3rd).	4	3	12	**Gaps in control:** 1. Lack of whole system support for healthcare services (e.g. children and young peoples mental health and Urgent and Emergency Care - UEC). 2. 79 Must and should do actions from CQC Report from May 2024 . *3.* Under stage one compliance management for aseptic services. **Gaps in assurance:** 4. Board reporting on assurance on delivery of research requirements and aspirations	**Actions aligned to gaps:** 1. System leadership required. 2. Deliver CQC action plan during 24/25 and 25/26 3. Deliver action plan which relates to training, equipment and work environment during 25/26: Lead: Chief Pharmacist 4. Develop research assurance reporting by Q3. Lead: Executive Medical Director	1. The Trust is working with the ICS. A Midland Partnership Foundation Trust and SaTH meeting was held in June 2024 for new ways of working for children and young people with mental health. Children and Young People mental health summit occurred in September 2023. Q3: Work remains ongoing on a case by case basis. Q4: improvement seen. Dealing with on a case by case basis, as required, including MDT meetings. Risk being managed. **Action closed Q4.** 2. Agreed governance through transformation programme and our existing governance structures in the trust. Full action plan quarterly to ICB Quality Surveillance Committee and UEC action plan monthly to the contract monitoring meeting. Q2 25/26: we have applied for one Section 31 condition to be removed and are awaiting the outcome from the CQC. Q3: outcome of application of Section 31 removal not yet received. Q4: Section 31 relating to children triaged within 15 minutes within the Emergency Department (ED) removed, with one condition on our licence remaining (relating to time to initial assessment within ED). 3. Q3: Work remains ongoing. Updates received at Quality Operational Committee (QOC). Q4: A recent re-inspection has lowered the level of concern from high to moderate reflecting considerable improvements in safety. A new action plan will be monitored by QOC. 4. Q2 25/26: SaTH has received confirmation that it has been awarded University Hospital Status in recognition of its research and education work. Q4: There are plans for a presentation to a Board seminar from the Research and Innovation Team in Q1/Q2 26/27.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Delayed treatment times and backlog • Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres • Bed capacity and urgent care demand • Insufficient capacity to meet demand • New Electronic Patient Record operational issues Insufficient productivity in Planned Care **Consequence:** • May lead to sub-optimal care • May lead to harm due to the unmet need • Financial activity impact • Regulatory action • Damage to reputation and negative impact on public confidence	4	5	20	Performance controls below (refer to BAF 3 and 4 for workforce controls): • Trust Planned Care Transformation Programme • Specialty level capacity and demand plans • Weekly/monthly monitoring of capacity/demand and performance • Departmental and Divisional monitoring of RTT, imaging and endoscopy • NHSE Diagnostic Task Group • Monthly Performance Review Meetings • Enhanced operational management structure with focus on elective and urgent care • Validation of waiting list to address data quality issues and ensure accuracy of waiting times • Outpatient Transformation Programme • Associate COO for elective recovery commenced December 2024 • Substantive Deputy COO for Planned Care commenced February 2025. • Substantive Head of Cancer commenced March 2026. • Divisional Medical Director for Surgical Division commenced May 2025. • Substantive Director of Operations for W&C commenced April 2025 • Additional elective activity delivered by insourcing providers	**Reported to Board, committees and elsewhere:** • Performance metrics within Integrated Performance Report to Board (monthly) (2nd) • Weekly Trust Cancer performance meetings (1st) • Weekly Trust RTT performance meetings (1st) • Standing monthly IPR reports to Quality & Safety Assurance Committee and Performance Assurance Committee (PAC) (2nd) • Performance Highlight Report to PAC, including RTT, Cancer, theatre productivity, outpatient transformation and UEC assurance (2nd) • Monthly reporting to Performance Review Meetings (2nd) • Shropshire Telford & Wrekin (STW) Planned Care Delivery Group reporting monthly (3rd) • Elective Recovery Board - Midland NHSE (3rd) • Cancer trajectories 25/26 - 62 day backlog, and 28 day faster diagnosis to PAC (2nd) • RTT 25/26 - 52 week recovery trajectory to PAC for adults and children and young people (2nd) • DMO1 (diagnostics)recovery trajectory 25/26 to PAC (2nd) • MIAA (internal audit) DM01 Diagnostics Audit 24/25 (Moderate assurance) (3rd) • 18 week, 52 week and total waiting list size - all exceeded plan Q4, 25/26 • Planned Care Transformation Assurance Committee - meets monthly - commenced April 2025 (2nd) • Improvement in performance reported to Performance Assurance Committee - March 2026 (2nd): Elective care: De-escalated from NHSE Tier 1 (highest level of performance management) to Tier 3; Reduced number of people on waiting list by over 30% in the last year; Eradicated 52 week waits; Biggest improvement. Best 18 week RTT performance in March 2026 for 5.5 years. Cancer: Improved performance in cancer 28 day Faster Diagnostic Standard (FDS), with February 2026 performance well into the top half nationally; Improved performance in cancer 62-day Referral To Treatment with February 2026 performance the best since the combined standards has been reported, and now in line with national average; De-escalated out of NHSE Tier 1 and Tier 2 oversight to Tier 3. Diagnostics - More than 30 percentage points increase in patients waiting less than 6 weeks over the last year; De-escalated out of NHSE Tier 1 and Tier 2 oversight to Tier 3 (Q4). • The Trust has received £2m capital as most improved trust in the country for 18 weeks RTT.	4	2	8	**Gaps in control:** 1. Diagnostics turnaround times to enable elective and cancer treatment 2. Productivity - opportunity to better optimise core capacity for treating elective and cancer patients 3. Outpatients - opportunity to improve referral and demand management approaches and optimise outpatient capacity 4. Digital - introduce digital enablers to elective care and treatment **Gaps in assurance:** 5. Further development of demand and capacity, development of leadership in planned care management, clinical capacity challenges	**Actions aligned to gaps**: (executive lead for actions: Chief Operating Officer) 1a. Develop and monitor diagnostics improvement workstream by March 2026 1b. Design and introduce cancer diagnostics dashboard to allow real time visibility of cancer imaging performance by May 2025. 2a. Implement GIRFT best practice productivity interventions and drive improvement in productivity in theatres and outpatients to 97% session utilisation by March 2026. 3a. Implement high impact evidence-based interventions: a) Redesigning referral pathways; b) Transforming outpatients; c) Reducing unwarranted variation - by March 2026. 3b. Reduce waiting times for planned care by optimising processes and improving outpatient booked utilisation by 4% by September 2025. 4. Introduce digital workstream to identify and implement digital tools to enable improved planned care delivery, by March 2026. 5. Complete demand and capacity modelling as part of planned care right sizing exercise by March 2026, leading to a reduction in clinical capacity issues. Development of leadership capability as part of national programme delivered by NHS Impact.	1a. Diagnostics workstream set up and reporting monthly to Planned Care Transformation Committee. **Action closed Q4.** 1b. Cancer diagnostics dashboard created and implemented, May 2025. **Q3: Action closed.** 2. Theatre productivity improvement workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver theatre utilisation ambitions. Q4: Available session utilisation has increased by more than 100 per month over the last 18 months. 3a. Outpatient transformation workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver outpatient improvement ambitions. Q4: Work remains ongoing. The Trust completed Q4 Outpatient Sprint (national programme). 3b. Four Eyes outpatient utilisation project: Q2: phase one completed to improve booked utilisation identified. Phase two commenced to optimise clinic templates during Q2. **Q3: Action closed.** 4. Digital workstream set up to oversee implementation of digital tools and benefits realisation. Initial five key priority systems identified: Patient Engagement Portal AI Scribe Medical Form Digitalisation Pre-op SDEC Digital. Q4: Work remains ongoing. 5. SaTH was part of Cohort 1 for leadership training delivery with NHS Impact commenced Aug 2025. Demand and Capacity modelling is to be undertaken in conjunction with a proposal from Four Eyes. **Q4: Action closed.**			9

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • ~~lack of acute bed capacity and workforce~~. • Clinical workforce challenges • Increase in complexity of demand and length of stay • 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 **Consequence:** • Delays in treatment pathways including increase in acute length of stay • Urgent work impacting on elective capacity • Leads to sub-optimal care and poor patient experience • Regulatory action • Negative impact on reputation and public confidence. • Impact on ambulance handover delays and subsequent impact on ambulance availability within the community • Overcrowding and long lengths of stay in Emergency Department, with increased associated risk of harm.	4	5	20	• Revised SaTH 25/26 Urgent & Emergency Care (UEC)improvement programme. • Confirmed System 25/26 Urgent and Emergency Care Improvement Plan • STW UEC Delivery Group • Capacity and demand analysis • Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care) • UEC project initiation document in place including implementation plan and Gaant chart • Transformation Lead Nurse for UEC appointed - commenced February 2025 • Deputy COO for UEC appointed - commenced March 2025 • STW UEC Improvement Director commenced April 2025 • Substantive Director of Operations for Medicine & Emergency Care commenced September 2025.	**Reported to Board, committees and elsewhere:** • Performance Assurance Committee (monthly) (2nd) • Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) • Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) • 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) • STW UEC Delivery Group - monthly (2nd) • NHSE Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) • Monthly reporting to the CQC (2nd). • Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd). • Performance Review Meeting (PRM's) (2nd) • Weekly System Key Performance Metrics Meeting (2nd) • NHSE Tier 1 monthly meeting with national director of UEC (2nd) • External GIRFT and ECIST criteria to admit audit - completed Q1 25/26. (3rd) • Trust Board approved UEC Improvement Plan at September 2025 meeting (2nd)	4	5	20	**Gaps in control:**	**Actions aligned to gaps:** Executive Lead for actions: Chief Operating Officer.				9
									1. Inpatient bed capacity.	1. Develop workstream for SaTH bed base which will encompass project milestones detailing PRH acute bed base and RSH capacity increases alongside the exploration of further capacity, if feasible, by December 2025	1. Q2: Workstream commenced in July 2025 as part of the UEC Improvement Programme. 56 additional inpatient beds at RSH through two new modular wards. 40 additional (trolley and bed) assessment spaces at PRH. Both planned December 2025/ January 2026. Q3: New modular wards opened 08 December 2025 at RSH. **Q4: Action complete**			
									2. Proportion of urgent and emergency care patients streamed to the Urgent Treatment Centre (UTC).	2. To improve Type 3 performance and the volume of patients streamed to the Urgent Treatment Centre by Q4, 25/26.	2. Q3: continued recovery of Type 3 four-hour performance. Q4: Recruitment into the service continues. March 2026 Type 3 four-hour performance improved slightly to 86.1% and the action will be carried through to the 2026/27 plan in order to complete the necessary recruitment and support performance.			
									3. Proportion of emergency care patients managed through same day emergency care pathways.	3a. Establish Same Day Emergency Care (SDEC) Workstream through the UEC Improvement Programme.	3a. Q1: To commence July 2025 and to increase the percentage of patients streamed to SDEC areas by 5%, Q4, 25-26. Q4: Evidence submitted and approved by NHSE Evidence Review Panel 14 January 2026. **Action complete Q4.**			
										3b. Review of clinical space to deliver SDEC services, by September 2025.	3b. **Action Complete Q2**. RSH SDEC will move to current Acute Medical Assessment (AMA) location. PRH SDEC will expand into current AMA location.			
									4. SaTH interface with system-wide Urgent & Emergency Care (UEC) improvement programme.	4. To explore opportunities for future collaboration with system partners to improve urgent and emergency care during 25/26.	4. Q1: System approval for funding of interventions for Shropshire Community Trust: extension of urgent community response service; implementation of the integrated front door team; and extension of the service provided by the care transfer hub - implemented Q3. Q2: New GP Out of Hours care co-ordination centre provider (Health Hero) commenced 1 October 2025. Q3: Urgent Community Response service extended until midnight; commenced December 2025. **Q4: Action complete.**			
									5. Increase in patients with no criteria to reside.	5. Working with system partners to identify opportunities to increase capacity to enable discharge of patients.	5. In March 2026 the average number of patients with no criteria to reside was 142 which is significantly 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 Q4 and into 2026/27.			
									Gaps in assurance: -					

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 2025/26 - led by ICS UEC Board. • Work remains on track to build detailed clinical pathways that support safe transfer and transformation of services from the current operating model to the new model of care. Priority is being afforded to urgent and emergency care pathways and work with ICS/UEC partners has begun. In parallel to the service transformation work being done in preparedness for the completion of the HTP build, clinical teams are reviewing options for accelerating any pathways that can be expedited prior to HTP 'go live'. • Development of the integrated ICS Workforce Plan. • 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. • HTP Workforce Lead appointed. • Revised terms of reference for the Strategic People Group. • Workforce programme established for 2025-2028. • A dedicated HTP master programme action plan is in place and being reported against.	**Reported to Board, committees and elsewhere:** • SaTH Board (meets monthly - public/private) (2nd) • Shropshire Telford & Wrekin ICS Strategy Committee (monthly) (2nd) • HTP Assurance Committee (bi-monthly) (2nd) • HTP Programme Management Committee - SaTH executives (2nd) • HTP Oversight Group (monthly), including system partners and ICS members, chaired by ICS Chief Finance Officer (2nd) • UEC plan to ICS UEC Board - monthly (2nd) • Independent Reconfiguration Panel produced/published a report that made 13 recommendations in relation to HTP which agreed with the HTP delivery mechanism to deliver outcomes for the population of Shropshire, Telford & Wrekin and mid-Wales - December 2024 (3rd) • Clinical Assurance Group (2nd) • Strategic People Group (2nd), reporting to People & OD Assurance Committee. • STW Neighbourhood Implementation Group (2nd) • Formal HTP Finance Committee (2nd) • NHSE monthly meeting (3rd) • Emergency Treatment and Transfer Group (2nd)	4	3	12	**Gaps in control:** 1. Insufficient capacity at present for divisions to deliver all of the key milestones within the master programme. **Gaps in assurance:** 2. Dependency on system-wide programmes to deliver the clinical model.	**Actions aligned to gaps:** 1. Meet with Divisions to further align some dedicated resource - by 31 December 2025. Executive Lead: COO 2. HTP Director to hold regular meetings with ICB to determine details of their strategy and the impact on the delivery of the clinical model, to ensure co-production, throughout the HTP Programme. Executive lead: Director of HTP. Ongoing - by 2027.	1. Meeting held on 09 December 2025 and resource identified by Division from 1 April 2026. **Action closed Q4** and to be monitored through assurance committee. 2. HTP Director is a member of the Neighbourhood Health Implementation Group to ensure HTP aligns with local care transformation programmes. Work has been ongoing to create stronger links between the two programmes. HTP are monitoring the ongoing impact of the system-wide initiatives on bed requirements included within the FBC. Q1: system-wide workshop held on 16 May 2025 with all system partners to understand all of the work being undertaken to support the community model. Follow-up meeting planned for 24 June 2025 with senior responsible officers for all of the programmes. Q2: STW Neighbourhood Implementation Group now supersedes Health & Care Transformation Programme, focussing more on neighbourhoods. Q3: Metrics to be identified which demonstrate the move of services/patients into a community care setting. Q4: Employed temporary resource to support the community left shift as part of the HTP full business case and clinical model.			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. Risk opened: 1 April 2022	**Director of Strategy & Partnerships and Chief Operating Officer** Nigel Lee and Ned Hobbs	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	**SaTH is keen/EAGER to form collaborations and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve. Guiding principles or rules will be in place that welcome considered risk taking in organisational actions and the pursuit of, for example, partnership and collaborative working priorities.**	**Quality & Safety Assurance Committee**

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Lack of integrated model of service delivery locally • High non elective admissions • A shift required from acute to community setting for models of care • Challenges in the recruitment of key practitioner roles across health and care to the rapid response service in the Shropshire area • Lack of health prevention and early interventions • Insufficient current workforce capacity in clinical and corporate teams across the system to deliver new ways of working • Availability of systemwide digital specialist resource to implement effective remote monitoring, and enable timely sharing of robust data, and associated impact of achieving agreed trajectories for virtual ward mobilisation • Lack of cohesive approach to long-term condition management, e.g. diabetes • Capacity of ICB to support and lead local Neighbourhood health programme under pressure. STW ICB moving to cluster with SSOT ICB. Single exec team in place with effect from 01 Dec 2025. Voluntary resignation scheme for both ICBs commenced 01 Dec 2025. **Consequence:** • Increased length of acute inpatient stay • Lack of bed capacity in acute setting impacting on patient flow and reduced delivery of elective activity • May reduce quality of patient care including risk due to ambulance handover delays • Increased demand for emergency department services and non-elective admissions to hospital • Lack of innovation and continuous improvement of services • Reduced staff experience and morale • Increased ambulance conveyances from one care setting to another • Increased emergency community nursing referrals • Increased acute diabetes presentations.	4	4	16	• Shropshire, Telford & Wrekin ICS Neighbourhood Health Implementation Programme in place • Five year programme plan in place - ICS Joint Forward Plan (updated annually). • Programme management in place with fortnightly PMO meetings - PMO resource combined across ICS with new standardised reporting tools. • 'Deep dive' into each workstream on a regular basis • UEC programme for 25/26 with link to neighbourhood health - overseen by STW UEC Board • Planned Care programme for 25/26 linked to primary care referral management • ICB Chief Medical Officer plan for group of speciality/condition based pathway improvements - priorities remain as : Diabetes, CVD and frailty (through Health and Care Models Transformation Group), MSK (through Planned Care Group). System Transformation and Digital Committee mechanism in place and all of the major programme boards report into this - chaired by Chair in Common	**Reported to Board, committees and elsewhere:** • Reports to Shropshire Telford & Wrekin ICS Integrated Care Delivery Board and System Transformation and Digital Committee, chaired by SaTH/SCHT Chair in Common (monthly) (2nd) • Report to place-based partnership Boards Shropshire Integrated Place Partnership Committee (SHIPP) and Telford and Wrekin Integrated Place Partnership Committee (TWIPP) (2nd) • Neighbourhood Health Implementation Programme - bi-monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Board - monthly (2nd) • UEC Board, NHIP Group report to System Transformation and Digital Committee (monthly) (2nd) • System Quality Risk Register reported to ICS Quality and Performance Committee (2nd) • Planned Care Assurance Committee at SaTH (monthly), which reports into SaTH Performance Assurance Committee and ICS Planned Care Delivery Group • SATH/Shropcom Group model approved by Trust Boards on 23 Sep 2025. Ongoing development of transition plan, with focus on hospital to community shift. • NHSE Midlands Assurance Review – Group Model between Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Healthcare NHS Trust. Report received 27 Nov 2025 (3rd)	4	4	16	**Gaps in control:** 1. Limited detail and limited delivery of the changes in improvement. 2. System agreement to the services "as is " services in and out of scope of the programme. 3. Reliance on physical acute beds rather than community UEC capacity and delays within urgent and emergency care caused by lack of flow. 4. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. 5. Lack of Group capacity and expertise to accelerate community transformation/Neighbourhood Health models. **Gaps in assurance:** -	**Actions aligned to gaps:** 1. Provide operational and clinical support to the Neighbourhood Health Implementation Programme ongoing. Lead Executive: Chief Operating Officer and Medical Director with support of HTP operational lead and clinical lead. 2. *Not a SaTH action to lead* 3. See actions within BAF risk 10. 4. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement. 5. Appoint additional capacity to support programme development by 30 April 2026.	1. From June 2025 ICB Chief Medical Officer takes chair of Neighbourhood Health Implementation Programme Group. This Group has full representation across ICS partners. Programme aligned to NHSE neighbourhood health guidelines. Q3: STW Frailty strategy and delivery plan year 1 and year 2 approved (Sept 2025). STW Cardio Vascular, Renal and Metabolic/Diabetes strategy drafted. Risk stratification approach endorsed and embedded in General Practice. National Neighbourhood Health Implementation Programme (NNHIP) commenced in Shropshire Place area October 2025 - focus on patients with two or more long term conditions, with aim to reduce UEC demand. SaTH Deputy Medical Director supporting NNHIP. Q4: As part of the preparation for the Group Model, we are reviewing the workstreams (community transformation/Neighbourhood health) to ensure appropriate clinical operational and project resource to support delivery. 2. SaTH taking part in this work with all partners. As part of system wide population health management led prioritisation, initial pathways for development will include Diabetes, Cardiovascular disease (CVD) and all age Mental health. Q3: Three initial priority pathways confirmed - Diabetes, CVD and Frailty (urgent care perspective) and MSK (planned care perspective). Q2: action closed - Population Health Management priorities agreed. 3. UEC Programme for 25/26 will play an important part in development of community UEC pathways (in accordance with NHSE neighbourhood health guidelines). Q2: STW investment in non-bed based community UEC capacity confirmed with implementation plans in Q3 25/26. Q3:2026/27 STW UEC plan under development and expected to include greater inter-relationship between UEC and Neighbourhood Health/Place programmes. Q4: 26/27 STW UEC plan approved at UEC Programme Board and includes relevant projects which provide greater community based treatment and care. 4. Q2: SaTH continues to play a major role in both STW place-based partnerships and the ICS Neighbourhood Health Implementation Programme Group which are the primary mechanisms for system-wide integrated pathway development. SaTH and Shrop Comm Boards have approved plans to form a shared leadership Group Model with a key objective of accelerating transformation of neighbourhood health services, including clinical pathways. Q3: STW Chief Medical Officer & Chief Nursing Officer have updated the ICS clinical strategy, to represent the priority clinical pathways, three shifts and neighbourhood health as part of the medium term planning framework submission. Q4: STW ICS clinical strategy has been further developed and shared with all partners for final comment. 5. Six-month fixed-term Community Transformation Programme Manager appointed during March 2026.			16

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (*numbered and linked to the actions required*)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Trust Policy Framework requires further embedding • Potential poor processes and procedures • Improved culture still not fully embedded • Governance improvement workload is high - started from a low base with embedded poor practices in some areas • Change in organisational governance arrangements from establishing a new Group Model **Consequence:** • Lack of clear guidance for staff to follow and some out of date policies • Potential lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Incidents • Potential ineffective committees, including late circulation of papers and breach of Standing Orders • Potential data breaches • Regulatory sanctions and/or fines • High workload involved to work together and align systems, processes and teams. • There is a potential risk that Group Model development may not proceed at the required pace, which may result in ambiguity in roles and responsibilities, inconsistent decision-making and reduced oversight and assurance • Additional level of risk during the Group Model transition period.	**4**	**4**	**16**	• Moving To Excellence programme • Trust Strategy • Board Assurance Framework (BAF) with ongoing review • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and reviewed Autumn 2025 and 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 E92023) 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 developed 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) • Managing Conflicts of Interest Policy approved at Audit Committee and Board during 2023 (2nd) • Refreshed terms of reference considered at all Board committees during 2024/25 and 2025/26 (2nd) • 2024/25 Annual Report to Board in June 2025 and subsequently published on the Trust's website following submission (2nd) • Auditor's Annual Report 2024/25 (3rd). External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 2024/25 Auditor's Annual Report (3rd). • Annual General Meeting held in public (face to face) - 25 September 2025 • Head of Internal Audit Opinion April 2025 providing Substantial Assurance that there is a good system of internal control (3rd) • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% by March 31st 2024 and in 2025/26 (2nd), with subsequent associated Counter Fraud Authority Standard achievement confirmed by internal audit May 2025 (3rd). • Register of interests and gifts and hospitality reviewed by Audit & Risk Assurance Committee - November 2025 (2nd) • Policy Approval Group meeting, monthly (established August 2024) (2nd) • Executive led Financial Recovery Group and Task Force in place (2nd) • System Integrated Improvement Plan (SIIP) relating to governance is in place and currently on track - updates received at Board (monthly) (2nd) • MIAA Fit and Proper Persons Report (Substantial Assurance) 2025/26 (3rd) • Group Transition Committee established - terms of reference to September 2025 Board (2nd) • NHS Provider Board Capability Assessment to Board - October 2025 Board (2nd) and onward to NHSE. • Group Model Partnership agreement submitted to both Boards for approval 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. Trust Policy Framework (and document access). 2. Outstanding subject access requests (SAR's), and subsequent complaints. 3. Delivery of the Group Model with Shropshire Community Healthcare NHS Trust **Gaps in assurance:** 4. Data Security & Protection Toolkit assurance.	**Actions aligned to gaps:** 1a. Agree refreshed Policy for Policies Q3 25/26. Lead Executive: Director of Governance. 1b. Case to be developed for new document library for easier policy access/search - offer support to Communications Team as part of case for new intranet - by Q1 25/26. Director of Governance. 2a. Senior manager put in place to support training and establishment of new processes within legal department. 2b. Procure a company to scan the medical records (by Q1) for SAR's to assist with backlog. Clear the backlog by Q4. 2c. Data Protection Officer to continue to liaise with the ICO - ongoing. 2d. Develop action plan for outstanding and overdue SAR's and monitor via-Information Governance Committee from April 2025 onwards. 3. Appoint a Project Manager for delivery of the Group Model by Q3. 4. Work towards DSPT/CAF (Cyber Assessment Framework) standards for 25/26 - evidence to be submitted by 30 June 2026. Lead Executive: Director of Governance.	1a. The Trust's Policy for Policies was considered and agreed by the Policy Approval Group on 16 October 2024 and agreed by lead Executive. Policy Approval Group commenced during August 2024, and continues to meet monthly. **Action closed Q3** 1b. Q1: Support offered. Q2: Communications Team have developed a new intranet specification (under consultation in Sept 2025). Q3: More work required following November 2025 intranet working group meeting where it was confirmed that a policy archive will not form part of the new intranet. 2a. Senior manager is in place and more efficient processes have been adopted. Action closed Q2 25-26. 2b. Company procured. Q4: Backlog is substantially reduced. Q2: work is now business as usual. Action closed. 2c. Q2: Action complete in relation to SAR's. Q3: action closed. 2d. Action plan in place and continues to be monitored by management. Q3: Action closed. 3. Project Manager to begin mid-December 2025. Q4: Project Manager in place. **Action closed Q4**. 4. Q4: The Trust's current DSPT standards status at 31 December 2025 is 'approaching standards'. MIAA (digital side) are supporting cyber and IG work to further improve.			**6**

Board of Directors' Meeting in Common – 14 May 2026

<table>
<tr><td>Agenda item</td><td colspan="3">017/26c</td></tr>
<tr><td>Report Title</td><td colspan="3">SaTH Annual Risk Management Report 2025/26 (inc Q4)</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Anna Milanec, Group Chief Governance Officer</td></tr>
<tr><td>Report Author</td><td colspan="3">James Webb, SaTH Head of Risk Management</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to SATH BAF risk:</td></tr>
<tr><td rowspan="5">Monthly report to Senior Leadership Committee
Monthly report to Executive Team
Quarterly report to Audit & Risk Ass Com (ARAC)</td><td>Safe</td><td></td><td rowspan="2">N/A</td></tr>
<tr><td>Effective</td><td></td></tr>
<tr><td>Caring</td><td></td><td>SaTH Risk Register ID:</td></tr>
<tr><td>Responsive</td><td></td><td rowspan="2">N/A</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">1. The Board's attention is drawn to the progress made in managing risks and improving SaTH's risk culture.

2. The number of: overdue risks; overdue actions; risks awaiting activation; and risks with no actions have been drastically reduced, and there were more risks closed than were opened between April 2025 – March 2026.

3. We are currently strengthening Divisional assurance to Risk Management Group through to ARAC and Board.</td></tr>
<tr><td>Recommendations for the Board</td><td colspan="3">The Board is asked to:
Note the current risk position, and the mitigation in place to ensure that risk management is practiced consistently across the Trust.</td></tr>
<tr><td>Appendices:</td><td colspan="3">N/A</td></tr>
</table>

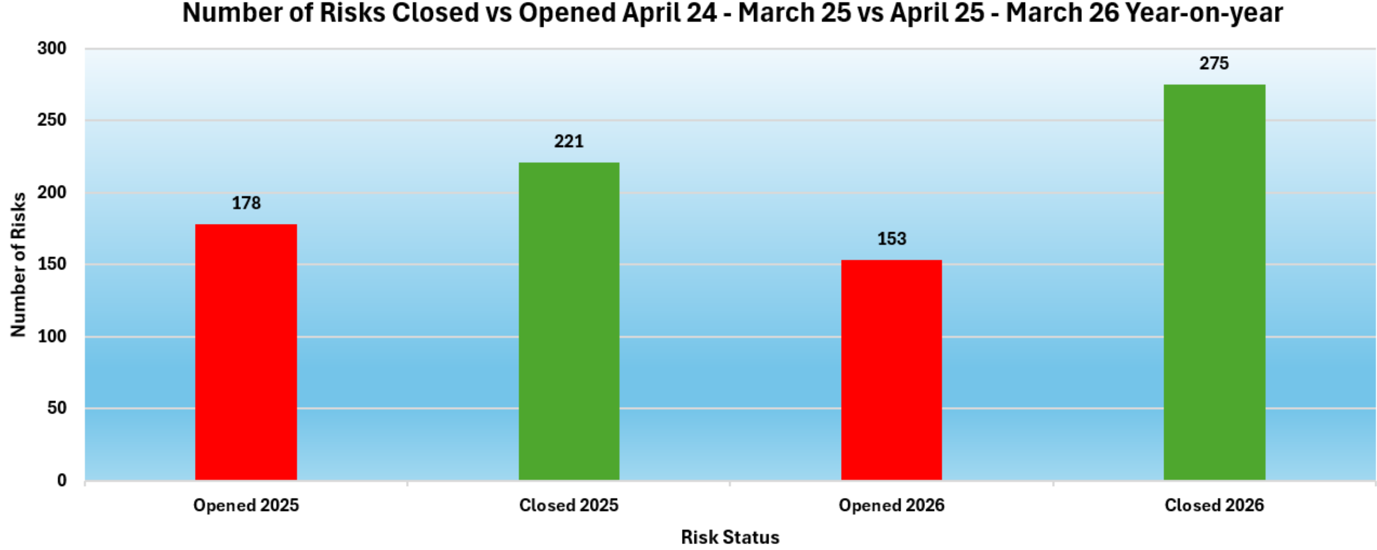
1.0 Introduction

1.1 Divisions review their extreme risks (scored ≥15) monthly, high risks (scored 8-12) every two months, and moderate risks (scored 4-6) and low risks (scored 1-3) every quarter as part of their Divisional Board meetings. New extreme risks are also presented at the Risk Management Group (RMG), where they are made active.

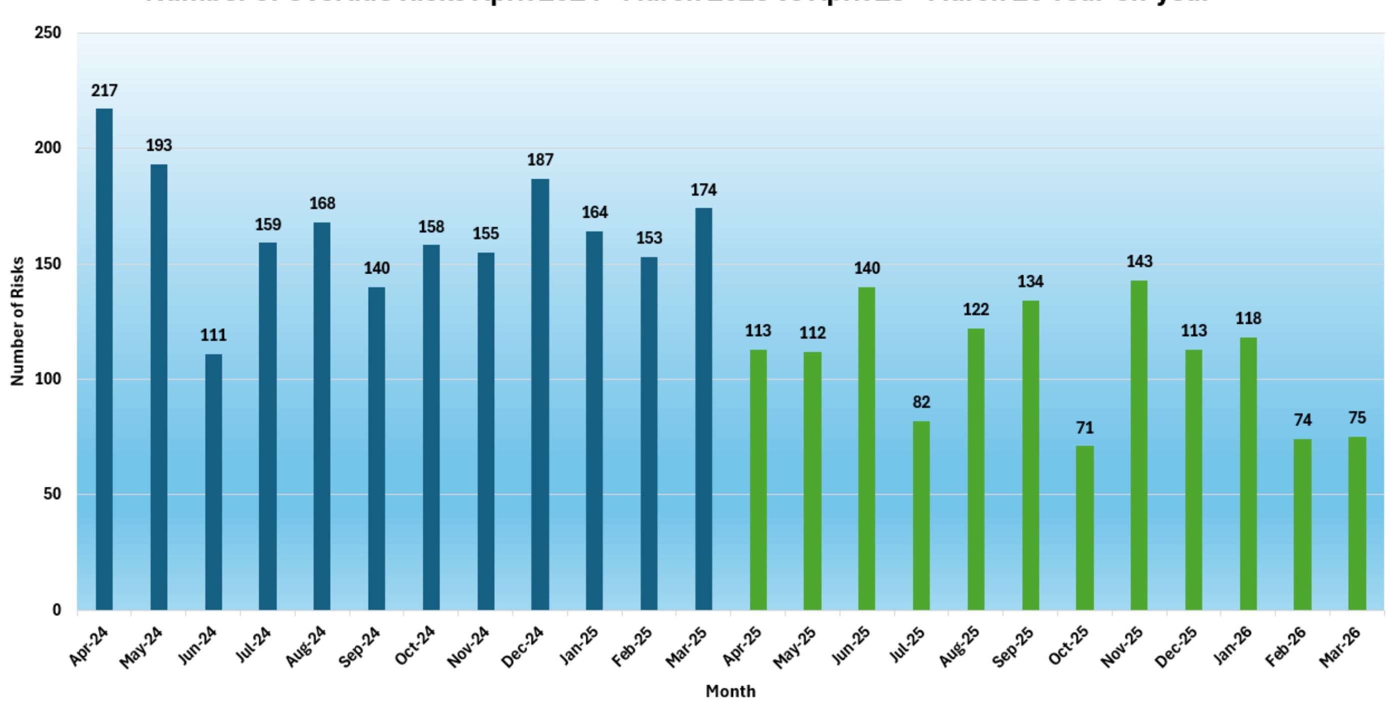
2.0 In-Year Achievements

2.1 From 01 April 2025 – 31 March 2026, the Risk Management Team have achieved the following:

Closed more risks than were opened. Additionally, fewer risks were opened, and more risks were closed year-on-year – see graph below:



Significantly reduced the rate of overdue risks from 113 at the beginning of the year to 75 at end year (difference of 38) – see graph below:

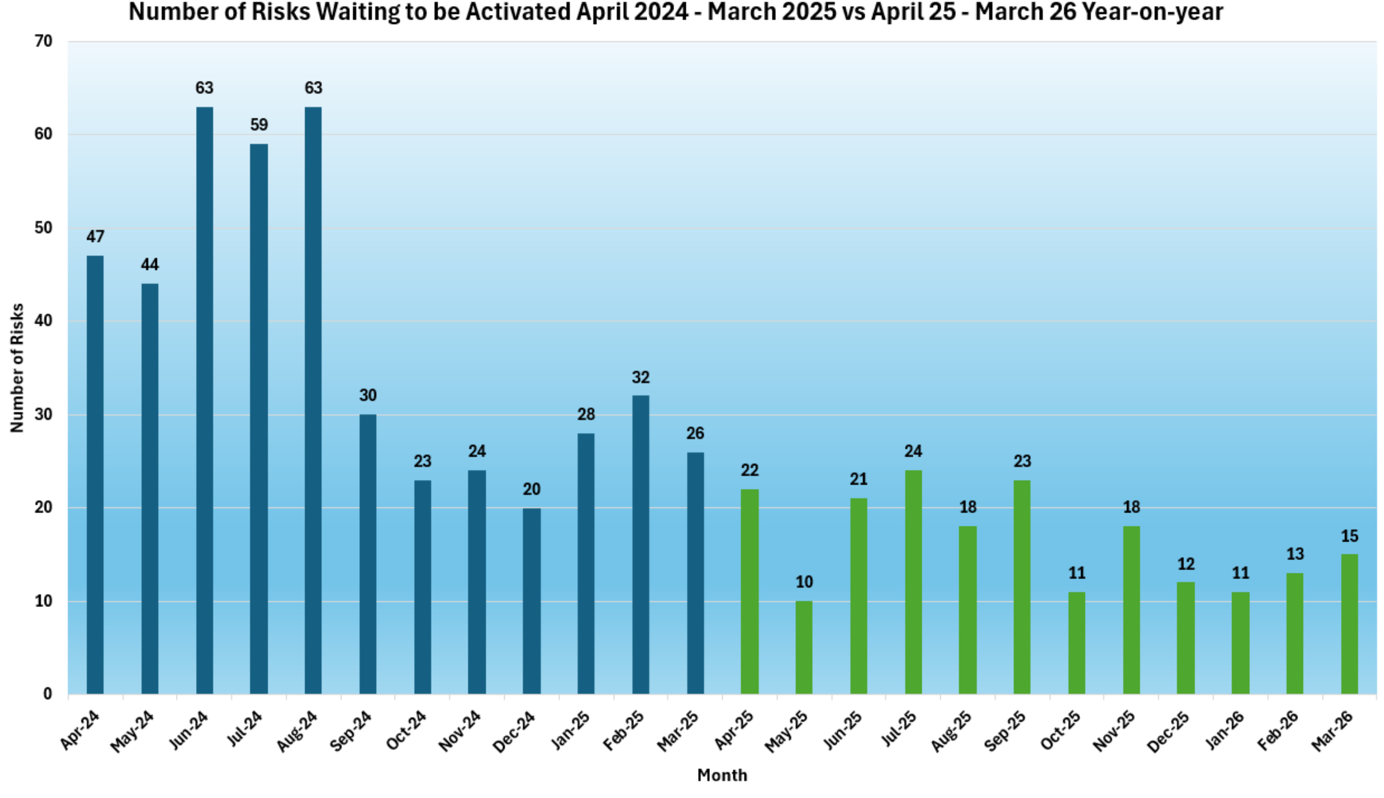


Significantly reduced the rate of overdue actions from 167 at the beginning of the year to 150 at end year (difference of 17) – see graph below:

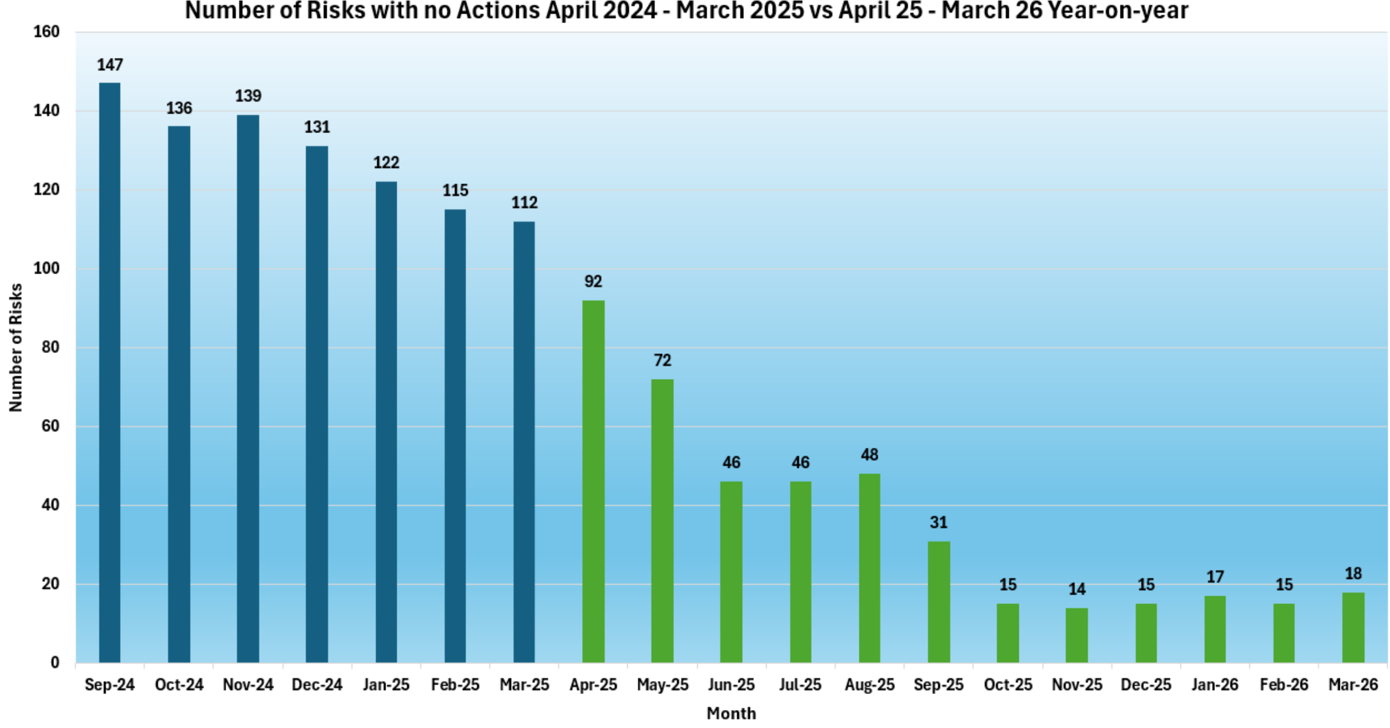
Number of Overdue Actions April 2024 - March 2025 vs April 25 - March 26 Year-on-year

Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of Actions	414	335	296	203	221	238	248	200	202	193	208	135	167	151	171	132	132	161	143	261	198	263	181	150

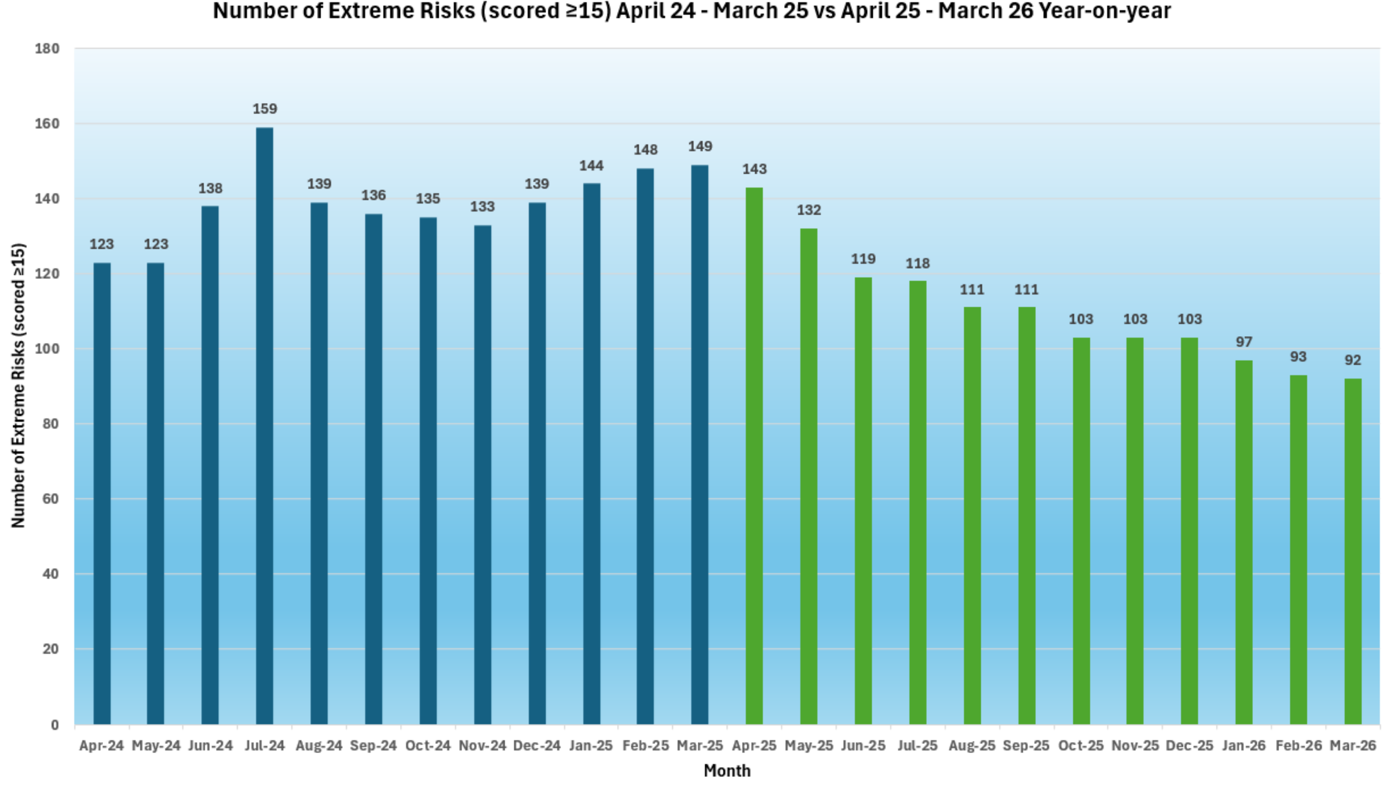
Significantly reduced the rate of risks waiting to be activated from 22 at the beginning of the year to 15 at end year at end year (difference of 7) – see graph below:



Significantly reduced the rate of risks with no actions from 92 at the beginning of the year to 18 at end year at end year (difference of 74) – see graph below:

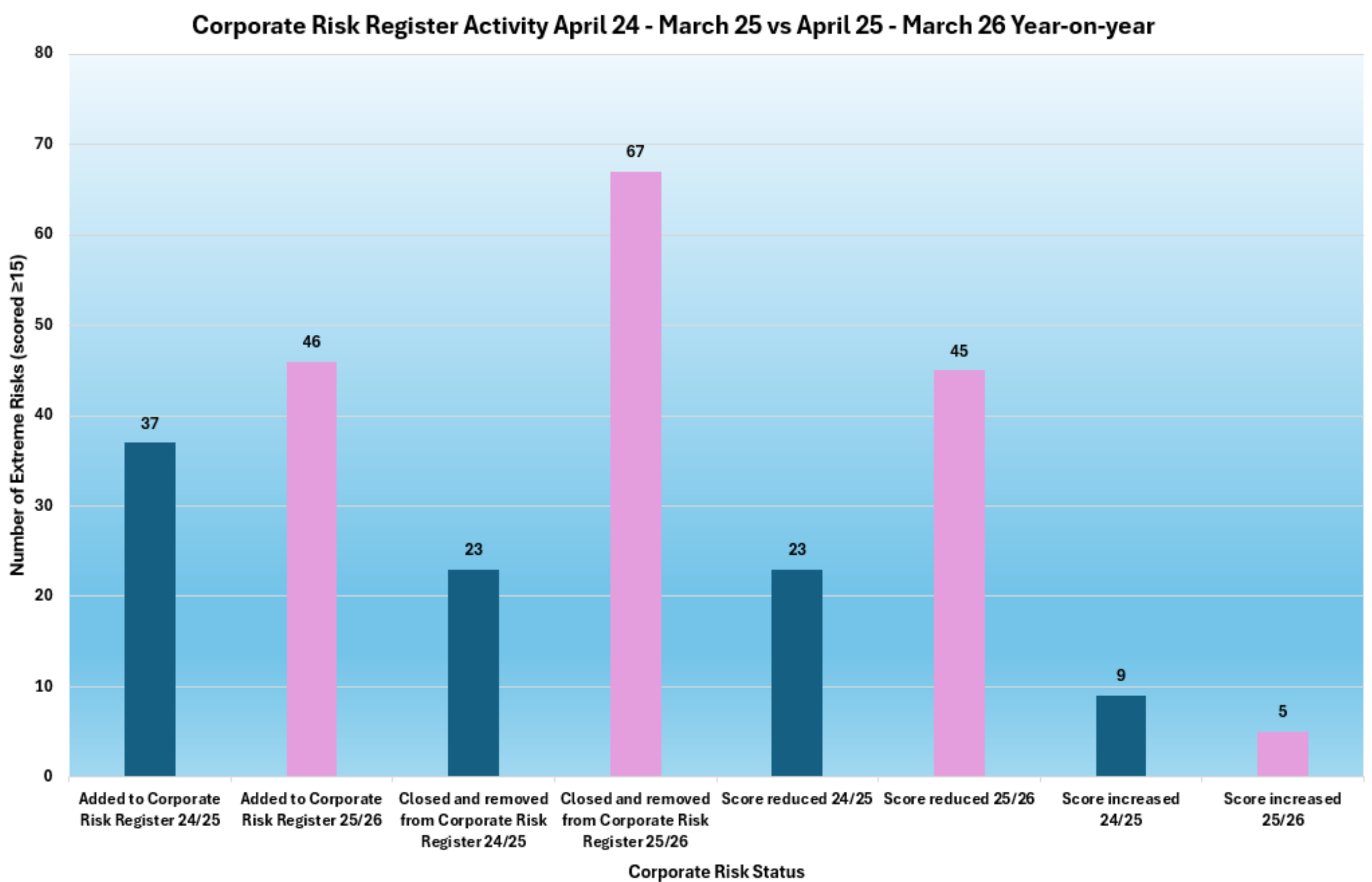


Significantly reduced the number of extreme risks from 143 at the beginning of the year to 92 at end year at end year (difference of 51) – see graph below *(this includes live / active risks as well as newly identified risks)*:



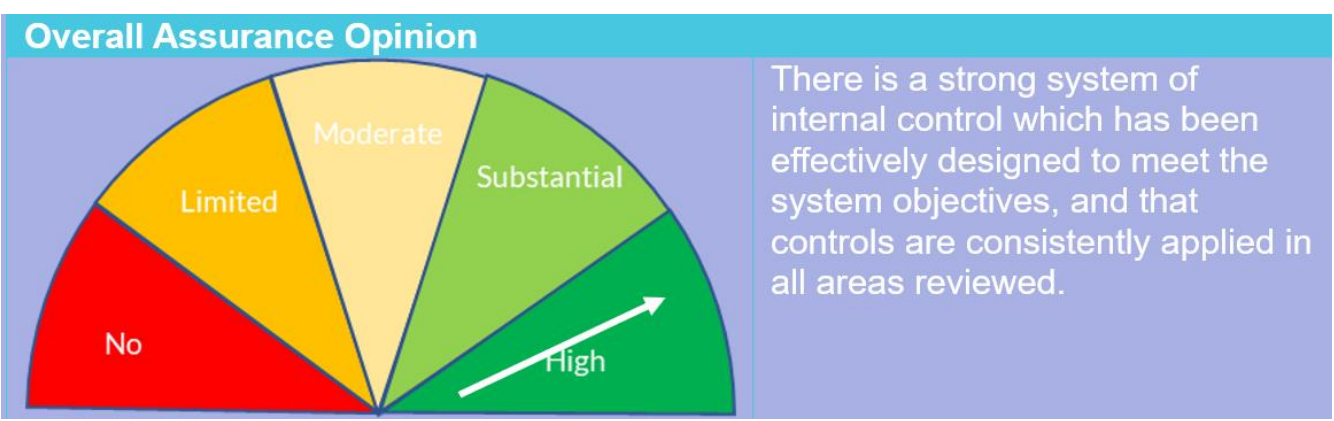
Tracked a Corporate Risk Register that categorises all extreme-level risks scoring ≥15 into the five CQC domains and aligns them to the eight categories of risk (corporate goals). This breakdown has allowed for a monthly thematic analysis of the risk position, where the themes are: 1) Risk to the quality of care provided to patients; 2) Poor patient experience; 3) Overcrowding in ED; 4) Increased pressure on health services; 5) Insufficient staffing capacity / skills; 6) Inability to meet regulatory

and legislative performance requirements; 7) Inappropriate use of expired, outdated or substandard equipment or lack of appropriate equipment; 8) Increasing Cyber Threat; and 9) Poor / ageing estate. The graph below shows the Corporate Risk Register activity (year-on-year), where, in 2025/26, 46 extreme-level risks scoring ≥15 were added, 112 risks were either closed or reduced in score and 5 risks' score increased:



2.2 Achievements throughout 2025/26 to Improve Risk Culture

- The Mersey Internal Audit Agency's (MIAA) audit for findings in the *Risk Management - Core Controls Assignment Report 2025/26* provided the highest 'overall assurance opinion', stating *"There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed."* The previous report's overall assurance opinion was 'moderate'; two levels lower. This 'High' rating was achieved partly through closing the outstanding recommendations listed by MIAA including reviewing the Risk Management Policy and Risk Management Strategy (see image below)



- Continued to provide the Board and key stakeholders assurance that risks are being managed effectively through: '4A' (Alert, Assurance, Advise and Actions) reports; monthly Risk Management reports; monthly Senior Leadership Committee Risk Management reports; weekly Operational Delivery Group Risk Management slides; and presenting at monthly Cascade meetings
- Members of the national NHS Counter Fraud Authority (NHSCFA) team advised SaTH stood out as an exemplar due to the processes and documentation that had been put in place at the organisation for the prevention of fraud, bribery and corruption. NHSCFA have offered to provide more support to the Head of Risk Management to strengthen the link between risk management and fraud
- Over 300 staff members have received risk management training since 01 April 2024. The syllabus has been continuously updated as per feedback and to cater for different needs such as neurodivergent staff
- Delivered risk management training at the Striving Towards Excellence Programme (STEP), Quality Improvement Practitioner Programme, the Surgical Patient Improvement Group (SPIG) Meeting and delivered a 'Leadership Masterclass' in Risk Management
- Met with all Executive Directors to determine whether/how they receive risk assurance from the centres within their portfolio, ultimately linking each extreme corporate risk with each portfolio
- Approached all staff with 'risk', 'governance' and 'quality' in their job title to enrol them on risk management training
- Held 11 monthly Risk Management Group meetings including representation from Executive Directors
- Contribute to the Triangulation Group, supporting the Patient Safety team's current work on triangulating safety intelligence to outline significant themes and trends that can be cross referenced to known existing safety challenges and ongoing improvement work
- Supported the HTP team, Digital Service Risk Group, Clinical Safety Committee, Artificial Intelligence Group and Climate Change Group in risk management
- Worked with NHSE's Director of National Recovery Support Team on Trust-wide risk cleansing exercise, highlighting where risks could be rescoped and determining whether the issue(s) exists
- Merged risks where there were common themes
- Updated and distributed Risk Assessment Tool
- Updated Trust Risk Appetite Statement for 2025–26
- Supported risk owners in ensuring that every Extreme risk has a Business Continuity Plan completed and uploaded to Datix (where applicable)
- Added a cancer field to Datix to support the new Cancer Steering Group
- Refreshed 'How to' videos on the intranet page to aid risk management within Datix
- Approached the heads of all corporate centres and specialties to ensure risks were managed effectively and escalated accordingly
- Collaborated with ShropCom, Robert Jones and the ICB to discuss how SaTH can work in partnership regarding risk management across the ICS.

<u>2.3 Next Steps to support the change of Risk Management Culture</u>

- Ensure all Trust-wide senior and junior Risk / Governance staff have received risk management training by 01/06/2026 providing divisions and the Patient Safety Hub with a monthly update
- Deliver 'risk clinics' that would support staff to review and have confidence to close risks
- 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).

3.0 Conclusion

The Board is asked to **note** the current risk position, and the mitigation in place to ensure that risk management is practiced consistently across the Trust.

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	018/26
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)**
Perf Ass Committee 21/04/26 Group People Committee 23/03/26 Q&S Ass Committee 28/04/26 Finance Ass Committee 28/04/26	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	SaTH exited the Recovery Support Programme (RSP) in FY2025/26. However, to demonstrate sustained improvement and oversight, the Trust has agreed with NHS England to continue with SaTH's Integrated Improvement Plan (SIIP) which has been updated for FY2026/27. • This report provides a summary of progress against the Integrated Improvement Plan (IIP) actions due for completion up to and including 30 April 2026, supported by evidence of delivery, and highlights a number of at-risk actions that have been transferred into the 2026/27 plan. Progress across the governance, workforce and leadership, finance, and urgent and emergency care (UEC) domains is summarised. • All RSP undertakings have now been removed, with the exception of the urgent and emergency care (UEC) undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4 • The Boards' attention is drawn to Section 2, which details key highlights.
Recommendations	The Boards are asked to: • **Note** the actions and take assurance from the updates provided. • **Note** progress against delivery of the tasks/actions that were due up to and including 30 April 2026 as detailed in Appendices 1-4 • **Note** that all RSP undertakings have now been removed, with the exception of the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4 • **Note** that the 2026/27 SaTH Integrated Improvement Plans include any 2025/26 tasks that have not yet been completed alongside actions that are intentionally continuing as part of planned sustained improvement.
Appendices (in Board Information Pack)	Appendix 1 - SaTH Governance and Leadership Plan 2026-27 Appendix 2 - SaTH Workforce and Leadership Plan 2026-27 Appendix 3 - SaTH Finance Plan 2026-27 Appendix 4 - SaTH UEC Plan 2026-27 and 2026/27 UEC Undertakings

1. Introduction

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

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

The RSP undertakings have now been removed, with the exception of the urgent and emergency care (UEC) undertakings, which have been incorporated into the 2026/27 UEC SIIP plan (Appendix 4).to ensure continued oversight and delivery.

The 2026/27 SaTH Integrated Improvement Plans also include:

- Any 2025/26 tasks that have been assessed at risk and not yet completed; and
- Actions that are intentionally continuing as part of planned sustained improvement.

Progress across the governance, workforce and leadership, finance, and urgent and emergency care (UEC) domains is detailed within this report.

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

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

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

Governance / Leadership

- **SaTH 4.1.0 | 5.3.3** – Strong and mature governance arrangements are in place to support delivery of the SIIP, HTP and transition to the Group Model, including refreshed committee structures and clear escalation routes.
- **SaTH 4.1.15** – Delivery of HTP is overseen through a dedicated HTP Assurance Committee. The Terms of Reference have been revised and are going through the formal approval process.
- **SaTH 4.2.7a | 4.2.8 | 4.2.9** – Group governance arrangements continue to be developed including joint committees, aligned leadership forums and development of shared accountability frameworks.
- **SaTH 4.2.13 | 4.2.14** – Freedom to Speak Up is being formally integrated into the Group governance model and overseen through 2026/27.

Workforce and Leadership Collaborative

- **SaTH 2.1.30 | 2.1.31 | 2.1.32** – Delivery of the workforce foundations for HTP and the Group Model is underway, including staff engagement activity, workforce impact planning and system-wide collaboration with STW partners.
- **SaTH 2.1.26 | 2.2.9** – Medical e-rostering and digital workforce enablers continue to progress, strengthening deployment, productivity and managerial oversight across services.
- **SaTH 2.1.28** – A 5-year workforce plan has been commissioned and is nearing completion, providing a clear plan to support sustainable workforce supply.
- **SaTH 2.2.7** – Active work with Higher Education Institutions is progressing to develop future clinical roles, apprenticeships and progressive career pathways aligned to the strategic workforce plan.
- **SaTH 5.4.5 | 2.2.8** – Group-wide leadership, OD and cultural programmes including People Pulse and Staff Survey action planning are in place to support sustained improvement in leadership effectiveness and staff experience.
- A small number of workforce actions representing ongoing transformation (e.g. medical e-rostering, workforce digital enablement, education pathways and cultural programmes) have been transferred

into the 2026/27 Integrated Improvement Plan, reflecting the sustained and iterative nature of workforce and leadership improvement rather than incomplete delivery.

Finance

- **SaTH 1.1.6 | 1.2.1** – A compliant financial plan for FY26/27 was submitted in March 2026, aligned to system and NHSE requirements.
- **SaTH 1.2 (FY25/26)** – SaTH achieved the FY25/26 financial plan, delivering a surplus of **£4.9m**.
- **SaTH 1.3.1** – A Financial Recovery Director has been appointed and a Financial Recovery Group established to support efficiency delivery and financial recovery.
- **SaTH 1.2 | 2.1.34** – Increasing alignment between financial and workforce governance is strengthening grip on cost, workforce deployment and productivity.
- **SaTH 2.1.34** – Reducing reliance on agency staffing is making good progress, with further work underway to achieve equivalent reductions in bank usage.

UEC

- **SaTH 3.1.1.7**: A 3-week pilot of the Front Door Clinician was held at PRH in March 2026. Clinicians saw 275 patients, of which 128 were discharged home.
- **SaTH 3.1.2.16:** Ringfenced slots have been made available for suspected cauda equina cases in ED. An out-of-hour service is planned with a management of change in progress to implement.
- **SaTH 3.3.3:** Average ambulance handover time in March 2026 reduced to 45.2 minutes
- A number of UEC actions scheduled for completion in 2025/26 have not been fully achieved and have been incorporated into the 2026/27 UEC SIIP (Appendix 4) to ensure continued oversight, monitoring and delivery.

3. Governance Arrangements

The delivery of individual elements of SaTH's Integrated Improvement Plan is reported and monitored via the relevant Assurance Committee with overall progress reported to the Board of Directors.

Delivery against the Quality Improvement Plan (QIP) is now monitored as business as usual via the Quality and Safety Assurance Committee with overall progress reported to the Board of Directors.

4. Recommendations

The Boards are asked to:

- **Note** the actions and take assurance from the updates provided.
- **Note** progress against delivery of the tasks/actions that were due up to and including 30 April 2026 as detailed in Appendices 1-4
- **Note** that all RSP undertakings have now been removed, with the exception of the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4
- **Note** that the 2026/27 SaTH Integrated Improvement Plans include any 2025/26 tasks that have not yet been completed alongside actions that are intentionally continuing as part of planned sustained improvement.

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	019/26		
Report Title	SaTH Integrated Maternity & Neonatal Report		
Executive Lead	Paula Gardner, Chief Nursing Officer		
Report Author	Jacqui Bolton, Interim Head of Midwifery Julie Plant, Divisional Director of Nursing, Women & Children's		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
NA	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.		
Recommendations to the Boards	The Boards are requested to: • Note and **take assurance** from this report.		
Appendices:	Appendix 1: BOD Ockenden Report Appendix 2: Neonatal review Board of Directors Appendix 3: Phase 2 slides **All Appendices are available in the Board Supplementary Information Pack**		

1.0 Introduction

1.1 This report provides information on the following:

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

1.3 The position in relation to the progress against the actions arising from the invited review of Neonatal Mortality at the Trust conducted by the Royal College of Physicians.

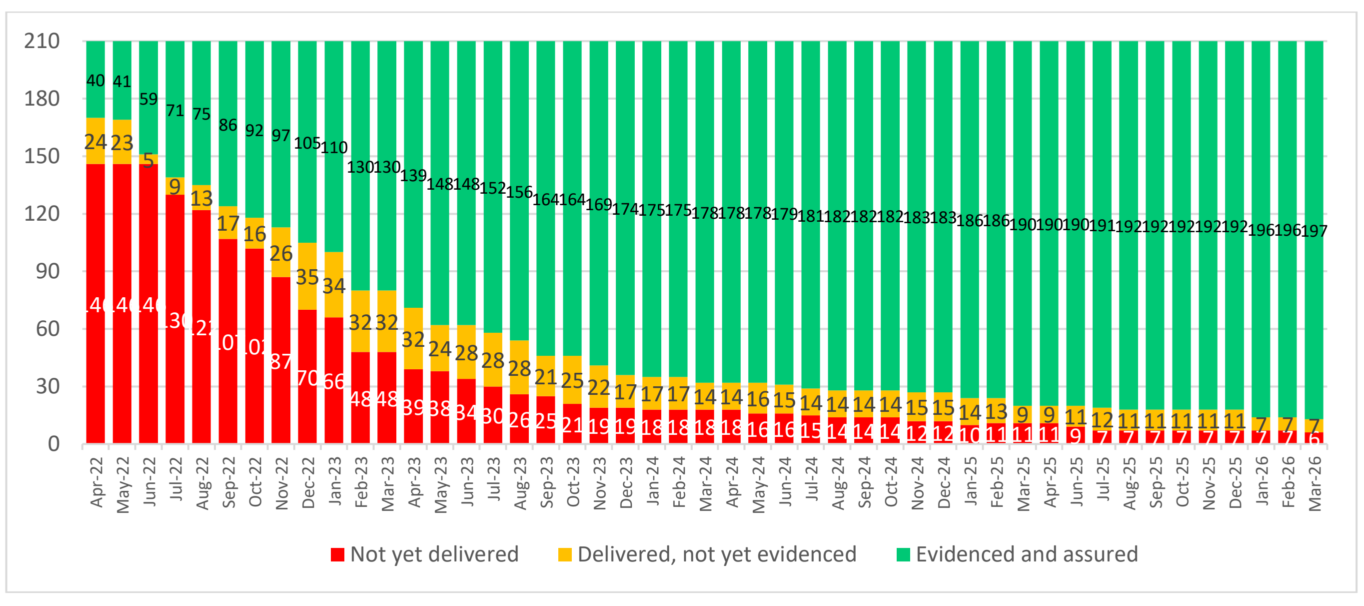
1.4 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.

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

1.6 To support this paper, more detailed information and all appendices are provided in the Board Supplementary Information Pack. Further information on any of the topics covered is available on request.

2.0 The Ockenden Report Progress Report (Independent Maternity Review - IMR)

2.1 Progress against IMR actions are validated at the Maternity and Neonatal Transformation Assurance Committee (MNTAC), and progress is summarised at the Quality Safety and Assurance Committee (QSAC). **Appendix One** provides the summary Ockenden Report Action Plan at 10 March 2026 as the April assurance committee was not quorate and could therefore not agree any status changes. The overall delivery over time, including current position, is as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	197 (⇧1)	94%
Delivered, Not Yet Evidenced	7 (⬄)	3%
Not Yet Delivered	6 (⇩1)	3%
TOTAL	210	

**Rounded percentages

Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	197 (⇧1)	94%
On track	5 (⇩1)	2.5%
Off track	1 (⬄)	0.5%
At Risk	0 (⬄)	0
De-scoped	7 (⬄)	3%
Total	210	100%

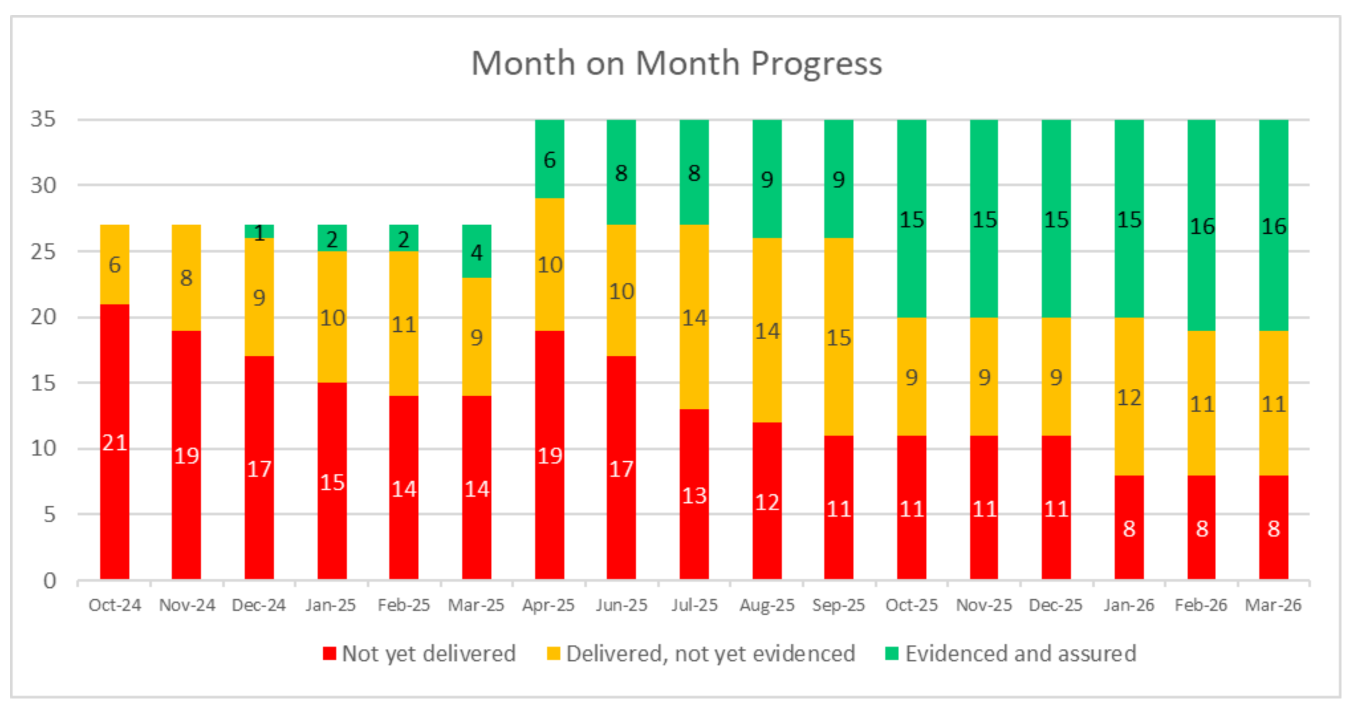
**Rounded percentages

2.2 In total, seven actions remain 'de-scoped,' currently. These relate to nationally led external actions (NHS England, CQC), and are not within the direct control of the Trust. Those actions have continued to be reviewed on a quarterly basis and will be escalated again to the national team in Q1. The Local Maternity and Neonatal System continues to oversee these actions. The next quarterly review is now due in April 2026.

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

3.0 Invited Review: The Shrewsbury and Telford Hospital NHS Trust Neonatology Service Review (2023/4)

3.1 Continued progress is being made to deliver the recommendations from the external invited review of the Trust's neonatal services, which was led by the Royal College of Physicians. **Appendix Two** provides the summary Neonatal External Mortality Review (NEMR) Action Plan as of 10 February 2026. The overall trajectory and position are, as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	16 (⇔)	46%
Delivered, Not Yet Evidenced	11 (⇔)	31%
Not Yet Delivered	8 (⇔)	23%
TOTAL *(Note: the total number of actions has been revised from 27 in April, as some actions have been broken down into more manageable sub-actions; hence the increase in number)*	**35**	**100%**

**Rounded percentages

Progress Status	Number	Percentage
Completed fully (Evidenced and Assured)	16 (⇔)	46%
On track	16 (⇔)	46%
Off track	2 (⇔)	5%
At Risk	0 (⇔)	0%
Not Started	0 (⇔)	0%
Descoped	**1 (⇔)**	**3%**
Total	**35**	**100%**

**Rounded percentages

3.2 Of note, progress against NEMR18, one of the Off-Track actions, was presented at April's Maternity & Neonatal Transformation Assurance Committee (MNTAC); a status change could not be ratified due to committee quoracy issues.

4.0 Maternity and Neonatal Transformation Plan (MNTP) Phase Two – High level progress report

4.1 It is a requirement of the Independent Maternity Review, for the Board of Directors to receive an update on the Maternity and Neonatal Transformation Plan at each of its meetings in public. The summary MNTP, which is now in its second phase, is attached at **Appendix Three**.

4.2 All actions are progressing well. All actions in the 3 Year Delivery Plan are expected to be implemented (Amber or Green) by the end of March 2026, with the exception of the Maternity Services certification for BFI stage 3. Status change proposals were presented at April's MNTAC but could not be ratified due to quoracy issues.

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

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

5.1 The Trust has now received the public official release to confirm achievement of all 10 Safety Actions for Year 7.

5.2 Year 8 was launched on 23 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.

6.0 Summary

6.1 Good progress continues to be made with actions from the Independent Maternity Review, The Maternity and Neonatal Transformation Plan and the Clinical Negligence Scheme for Trusts.

7.0 Recommendations

7.1 The Boards are requested to:

- Note and **take assurance** from this report
- Record formally in the minutes of this meeting that they have received the Appendices listed in the report cover sheet.

Jacqueline Bolton
Interim Head of Midwifery

Julie Plant
Divisional Director of Nursing

May 2026

<table>
<tr><td colspan="3">Maternity & Neonatal Safety Champions - Key Issues Report</td></tr>
<tr><td colspan="2">Report Date:
5th March 2026</td><td>Report of: Maternity and Neonatal Safety Champions Meeting</td></tr>
<tr><td colspan="2">Date of last meeting:
05/03/2026</td><td>Membership Numbers:
Quoracy met</td></tr>
<tr><td>1</td><td>Agenda</td><td>• Chair’s welcome and apologies, conflict of interest and minutes reviewed.
• Action log and review of AAAA from February 2026
• Maternity Quality Dashboard and Oversight Report (AAA)
• Neonatal Quality Dashboard and Oversight Report (AAA)
• MTP/Ockenden Report Action Plan and Assurance Report
• Locally Agreed Safety Intelligence Dashboard (SA9)
• Neonatal Staffing & BAPM Report (Safety Action 4)
• Our Staff Said, We Listened Poster and Safety Champions Poster
• Maternity Governance Report (including MNSIs and Action Plans)
• Maternity & Neonatal Service User Feedback
• Maternity & Neonatal Independent Senior Advocate Feedback - Themes and Actions (Deferred)
• Terms of Reference
• Information Pack</td></tr>
<tr><td>2a</td><td>Alert</td><td>• No alerts</td></tr>
<tr><td>2b</td><td>Assurance</td><td>• Despite sickness, required staffing levels have been maintained
• Data discrepancy relating to skin to skin and breast feeding has been resolved
• Positive acuity, 95% with SATH being above national target (85%)
• The joint working with the MNVP continues to strengthen, with actions plans being developed to address service user feedback
• The neonatal Unit achieved the Bliss Baby Charter Gold and are preparing for BFI stage 3 accreditation in March</td></tr>
<tr><td>2c</td><td>Advise</td><td>• Term admissions to the Neonatal Unit increased, with over half of theses being attributed to respiratory causes. Fluctuations across the year are expected and within the usual trend
• Smoking at delivery rates increased – the Heathy Pregnancy Support team continue to work with families
• The recruitment for a digital lead within maternity and neonates in currently underway, the role will support the roll out of badgernet</td></tr>
</table>

<table>
<tr><td>3</td><td>Actions to be considered by the MTAC / QSAC / Trust Board</td><td colspan="3">The process and ongoing reporting for the Ockenden – most actions are complete and some are outside of SATHs control requiring regional action</td></tr>
<tr><td>4</td><td>Report compiled by</td><td>Wendy Nicholson MBE (Non-Executive Director, Board Level Safety Champion) / Steve McKew (Deputy Medical Director)</td><td>Minutes available from</td><td>Charlotte Allmark (PA to Deputy Medical Directors)</td></tr>
</table>

Maternity & Neonatal Safety Champions - Key Issues Report		
Report Date: 2nd April 2026		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 02/04/2026		**Membership Numbers:** Quoracy met
1	**Agenda**	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from March 2026 • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • MTP/Ockenden Report Action Plan and Assurance Report • CNST Completion Report • Locally Agreed Safety Intelligence Dashboard (SA9) • Neonatal Staffing & BAPM Report (Safety Action 4) • Our Staff Said, We Listened Poster and Safety Champions Poster • Maternity Governance Report (including MNSIs and Action Plans) • Maternity & Neonatal Service User Feedback • Maternity & Neonatal Independent Senior Advocate Feedback - Themes and Actions • Office Space / Lockers • Terms of Reference • Information Pack
2a	**Alert**	• None.
2b	**Assurance**	• The Neonatal team have achieved Stage 3 BFI status, and Gold Bliss Baby Charter accreditation.
2c	**Advise**	• A visit to Ludlow MLU took place in April 2026. Safety Champions heard about increasing prevalence of choice to give birth outside of guidance. • Having previously observed a decrease in delays for category 2 caesarean sections, there has since been a rise to 21.3% in the month of February. Work is underway with Obstetric and Theatre teams to address this, and an update will be provided next month. • There is a gradual increase in the number of caesarean sections which is creating challenges in terms of planning theatre capacity. • The service proposed adoption of the Miscarriage Collection Cradle to support safe, standardised and compassionate management of early miscarriage. The cradle enables consistent collection of pregnancy tissue in hospital or at home, reducing variation in current pathway

		and improving patient experience. This mitigates risks linked to inconsistent tissue handling, delays in histopathology and potential distress for women and families. Charitable and other funding options are being explored to support initial procurement. Implementation is expected to strengthen quality, safety and regulatory compliance across early pregnancy loss pathways. • The Maternity and Neonatal Independent Senior Advocacy pilot has come to an end. New referrals are now closed, and families with existing referrals will continue to receive support over the next 6 months. • The Digital Lead Practitioner and Digital Nurse roles have been successfully appointed. • Interviews for the Consultant Midwife post are scheduled for the 7th of May. • The Safety Champion Poster, produced by Jane Tench, was approved for printing.		
3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• New MNSC poster to be printed and distributed.		
4	**Report compiled by**	Dr John Jones (Executive Medical Director, Board Level Safety Champion)	**Minutes available from**	Charlotte Allmark (PA to Deputy Medical Director & Associate Medical Director)

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	021/26
Report Title	SaTH Bi-Annual Nurse Staffing Review
Executive Lead	Paula Gardner, Chief Nurse
Report Author	Steph Young, Lead Nurse Workforce, Kara Blackwell, Deputy Chief Nurse

Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Nursing, Midwifery, AHP Steering Group, 20 April 2026 Quality and Safety Assurance Committee, 28 April 2026	Safe	√	BAF1, BAF4, BAF8
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	327, 247, 220, 192, 1547, 130, 129, 128, 111, 581, 549
	Well Led	√	

Executive Summary	It is a requirement for all NHS Trusts to undertake a formal nursing and midwifery inpatient establishment review, bi-annually, using evidence-based tools, professional judgement, and clinical outcomes. To be compliant with the 2018 Developing Workforce Safeguards, there is a requirement for the reviews to be undertaken in collaboration with finance and HR workforce representatives and signed off by the Chief Nurse. Compliance with the Developing workforce Safeguards and CNO sign off enables presentation of the nursing staffing position to Trust Board both from an assurance and risk perspective. This paper provides a presentation of the results and outcomes for nursing across the inpatient and emergency departments for the January/February 2026 Safer Nursing Care Tool (SNCT) census and subsequent staffing establishment review.
Recommendations for the Boards	The Boards are asked to **note** the recommendations highlighted in Section 5.0 of the report.
Appendices:	Appendix 1: SNCT Data January/February 2026 Appendix 2: Divisional Ward Summaries

Bi-annual Safer Staffing Report – April 2026

1.0 Introduction

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

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

Establishment reviews meetings completed which were completed in February and March 2026 followed a triangulated approach where quantitative, qualitative and operational contexts were considered. Professional judgement was applied alongside reviewing key metrics and outputs of the Safer Nursing Care Tool (SNCT) census. Census data was collected in January and February 2026 across a period of 30-days in adult inpatients wards, acute assessment units, and paediatric ward, and across a 12-day period in the Emergency Departments as per the SNCT guidance.

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

2.0 RIGHT STAFF

2.1 Nurse to Patient Ratios

National Quality Board (2016) safe staffing principals expects ‘a triangulated approach’ is used to make staffing decisions rather than making judgements on solely on the numbers or ratios of staff to patients.

NICE guidance (2014) does not mandate specific numerical ratios, noting there is no single nurse-to patient ratio that can be applied across all adult acute wards, only that daytime ratios where nurses are caring for eight or more patients is defined as a ‘red flag’ threshold as risk of harm to patients significantly increases whereas lower nurse to patient registered nurses ratios are associated with better patient outcomes and lower mortality.

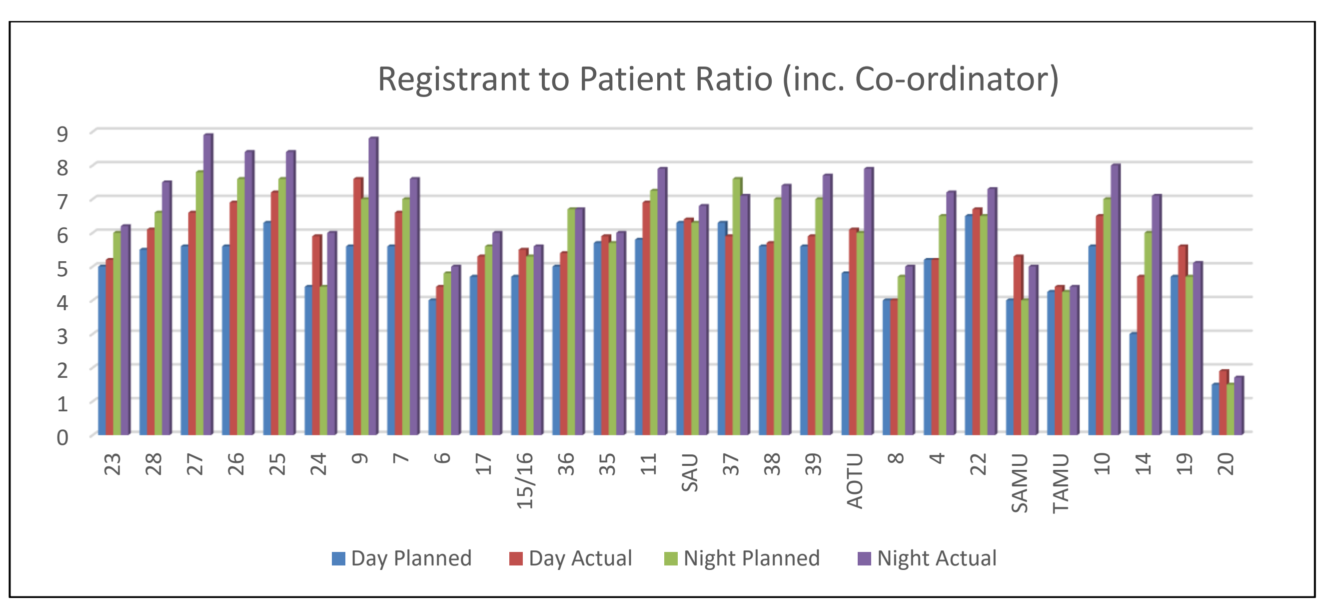


Chart 1. – Patient to registrant ratio planned v actual

Chart 1 presents the average Registered Nurse (RN) to patient ratio at Shrewsbury and Telford Hospital (SaTH) during the 30-day census period between January and February 2026**.** Nurse Associates have been included within these calculations as registered practitioners, reflecting their contribution to direct patient care and the wider clinical skill mix.

Across all inpatient areas, both planned and actual daytime and night-time ratios remained better, i.e. below the 1:8 RN-to-patient threshold, indicating that planned establishments have been set within safe parameters.

However, the ratio of RN to Patient have increased compared to the previous audit, driven predominantly by two factors:

1. Increased bed occupancy and additional patients placed in ward areas, which stretched the available RN establishment.
2. Staffing gaps associated with sickness absence during the audit period, contributing to extended RN/NA:patient ratios.

The average daytime actual ratios did not exceed the 1:8 threshold. There is no national guidance on night duty ratios.

Table 1: Average RN: Patient Ratio

Division	Ward	Beds	Additional Beds	Day Planned	Day Actual	Night Planned	Night Actual
CSS	23	23	0	5	5.2	6	6.2
MEC	28	28	0	5.5	6.1	6.6	7.5
MEC	27	39	0	5.6	6.6	7.8	8.9
MEC	26	38	0	Early 5.6/ Late 6.2	6.9	7.6	8.4
MEC	25	38	0	6.3	7.2	7.6	8.4
MEC	24	30	1	4.4	5.9	4.4	6
MEC	9	28	2	5.6	7.6	7	8.8
MEC	7	28	1.5	5.6	6.6	7	7.6
MEC	6	24	0	4	4.4	4.8	5
MEC	17	27	1	4.7	5.3	5.6	6
MEC	15/16	42	0	4.7	5.5	5.3	5.6
MEC	36	20	0	5	5.4	6.7	6.7

MEC	35	17	0	5.7	5.9	5.7	6
MEC	11	29	2	5.8	6.9	7.25	7.9
SACC	SAU	38	0.57	6.3	6.4	6.3	6.8
SACC	37	32	6	6.3	5.9	7.6	7.1
SACC	38	28	0	5.6	5.7	7	7.4
SACC	39	28	0	5.6	5.9	7	7.7
SACC	AOTU	24	0.4	4.8	6.1	6	7.9
SACC	8	14	0.4	4	4	4.7	5
SACC	4	26	1.3	5.2	5.2	6.5	7.2
UEC	22	26	0	6.5	6.7	6.5	7.3
UEC	SAMU	20	0	4	5.3	4	5
UEC	TAMU	17	0.6	4.25	4.4	4.25	4.4
UEC	10	28	1	5.6	6.5	7	8
W&C	14	12	1.15	3	4.7	6	7.1
W&C	19	33	0	4.7	5.6	4.7	5.11
W&C	20	3	0	1.5	1.5	1.5	1.71

2.2 Setting Evidence Based Establishments

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

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

- Using the Safer Nursing Care Tools (SNCT) to assess acuity and dependency, daily for 30 days across all adult wards, acute assessment units, children and young person's inpatient wards and the emergency departments. The assessment is undertaken by staff trained in the use of the tool.
- The SNCT is repeated twice per year to ensure validity (to note, for this year census was completed twice, across a 30-day period in January/February 2026 and June/July 2025).
- A multi-professional establishment review meeting is convened involving the Ward Manager/Unit Manager, Matron, Divisional Director of Nursing, Corporate Lead Nurse for Workforce, Chief Nurse, Deputy Chief Nurse and colleagues from Finance and Workforce. During this meeting, Safer Nursing Care Tool (SNCT) data is triangulated with nursing quality indicator outcomes, patient outcomes and professional judgement. This collective review ensures a robust assessment of staffing adequacy and enables agreement of establishment levels that ensure the right staff, with the right skills are in the right place at the right time.

2.3 Establishment and Headroom Principals

Staffing establishments at SaTH are developed to ensure that nurses and care staff have sufficient time to undertake continuous professional development, as well as to fulfil essential mentorship, supervision, and leadership responsibilities. A set of core principles underpins how nursing establishments are determined:

Supervisory Ward Manager Role.

- Ward Managers hold a supervisory role, utilising their time to provide front-line clinical leadership, coordinate safe and effective care, support patient flow and discharge, and help mitigate unfilled shifts through active oversight and escalation.

- During the census period, Ward Managers were temporarily required to work 40% clinically to maintain safe staffing levels.
- From April 2026, Ward Managers have reverted to their full supervisory function, in line with establishment review outcomes.

Headroom and Uplift Allowances

- The Carter Report recommends a 25% uplift for headroom to ensure adequate allowance for leave, training, and sickness.
- The Safer Nursing Care Tool (SNCT) sets the minimum headroom at 22.5%, increasing to 27% for Emergency Departments due to the complexity and turnover of care needs.
- At SaTH, the headroom uplift is set at 24%, applied as follows:
  - 16.5% allocated directly within ward/department budgets.
  - 4% allocated to temporary staffing to support sickness cover.
  - 3.5% centrally held to support maternity leave
    (The centrally held maternity leave element sits within the 24% total uplift.)

This approach ensures that teams can release staff safely for training, appraisal, competency development, supervision, and non-clinical professional responsibilities without adversely impacting day-to-day staffing.

Establishment reviews are approved at Board level and feed directly into the annual operational planning cycle and budget setting processes, ensuring alignment with Trust priorities and financial planning.

SNCT Training and Data Validity is undertaken via:

- All nursing staff who contribute to the SNCT census have completed SNCT competency training delivered by the Lead Nurse for Workforce.
- Nursing staff responsible for validation of SNCT data at ward level have also received the appropriate training, ensuring data quality, consistency, and reliability in establishment setting.

2.4 Nursing Establishment Review January/February 2026

2.4.1 Safer Nursing Care Tool Data Results

The Safer Nursing Care Tools (SNCT) calculates clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions.

The tools:

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

The levels of acuity within the tool range from Level 0 to Level 3 (Table 2). Level 3 patient acuity is only delivered within ED and Critical Care for adult patients. Not all current versions of the tools (ED and CYP) include all acuity categories, however NHSE Clinical Workforce lead has advised a new version of the Children and Young persons tool is due for release imminently as current versions of the tool don't reflect currently complexity and intensity of care in this department.

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

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

The review was undertaken across adult inpatient wards, acute assessment areas, Emergency Departments, and Paediatric wards. Data from this census is not considered in isolation; it is triangulated with data from previous census periods and reviewed as part of the establishment review meetings, ensuring trends and changes over time are fully considered.

A number of new wards have opened since the last census:

- Ward 38 – Gastroenterology
- Ward 39 – Colorectal
- Ward 25 – General Medicine
- Ward 36 - Medicine

In addition, the Frailty Assessment Unit on Ward 9 has relocated to a new area thus allowing for expansion of the Ward 9 beds from the current 22 beds to 28.

AMU PRH opened an additional 8 beds on Apley ward. As this area became operational in the final days of the audit period, a full data set is not available. Therefore, the AMU census for PRH was based on 17 beds only.

Medical Escalation at PRH closed in its previous location and has been repurposed as an Acute Assessment Unit.

Ward 5 was closed for essential estates work, so no census was undertaken.

AMU at RSH expanded from a 20-bedded unit to a 39-bed service, delivered across two conjoined locations. The previous AMA unit, collocated with the old AMU has been relocated. At the time of reporting, staffing templates and budgets had not yet been split, therefore a budgetary comparison between the new AMU configuration and SNCT outputs has not yet been completed.

A number of wards are operating above planned capacity, with additional beds in regular use. These beds have been included in the census data collection to ensure the data accurately reflects patient acuity, dependency, and the workload experienced by ward teams, rather than the planned establishments only.

Adult inpatient wards and Paediatric wards census data was collected over a 30-day census period.

Emergency Departments data collection was undertaken over a 12-day period, with patient acuity captured twice daily, providing a representative view of staffing demand across the 24-hour period.

The NQB Professional Judgement Framework is utilised alongside the outputs of the Safer Nursing Care Tool (SNCT) and is reviewed alongside key workforce metrics, and quality data.

Table 3 - Summary of SNCT recommended WTE for Jan/Feb 2026 Census Period

	Recommended WTE inc 1c/1d			Recommended WTE exc 1c/1d			
Ward	Reg	Unreg	Total	Reg	Unreg	Total	1c/1d
TAMU	17.38	13.11	30.5	17.38	13.11	30.5	-
SAMU	47.98	29.4	77.38	47.81	29.3	77.11	0.27
AOTU	24.10	18.94	43.04	23.98	18.84	42.82	0.22
Ward 4 Ortho	26.38	20.73	47.11	26.38	20.73	47.11	-
Ward 5 Elective Ortho	NA – closed for estates work						
Ward 6/CCU	25.76	10.02	35.37	25.44	9.89	35.33	0.04
Ward 7 Med	28.42	23.25	51.67	28.42	23.25	51.67	-
Ward 8 H&N	15.82	7.28	23.1	15.82	7.28	23.1	-
Ward 9 Frailty	28.14	22.11	50.25	28.09	22.07	50.16	0.09
Ward 10SS	23.33	15.56	38.89	23.33	15.56	38.89	-
Ward 11 Med	26.25	20.62	46.87	26.25	20.62	46.87	-
Ward 14 Gynae	8.81	4.34	13.15	8.81	4.34	13.15	-
Ward 15 Stroke/Rehab	25.68	21.01	46.68	25.68	21.01	46.68	-
Ward 16 Acute Stroke	20.61	10.15	30.75	20.61	10.15	30.75	-
Ward 17 R	31.08	17.48	48.77	31.02	17.45	48.56	0.21
Ward 36 M	27.39	19.84	47.26	26.47	19.17	45.63	1.63
Ward 22SS	24.52	14.4	38.93	24.12	14.17	38.29	0.64
Ward 23OH	24.61	13.25	37.86	24.54	13.22	37.76	0.1
Ward 24 R	33.18	18.66	51.85	32.89	18.55	51.83	0.02
Ward 25 Med	23.8	19.48	43.28	23.8	19.48	43.28	-
Ward 26 Med	39.38	29.71	69.09	36.92	27.85	64.77	4.32
Ward 27 Med	33.79	27.65	61.33	33.46	27.38	60.69	0.64
Ward 28 Frailty	31.67	23.89	55.56	28.5	21.5	50.0	5.56
SAU	35.61	26.87	62.48	35.61	26.87	62.48	-
Ward 35 Renal	13.61	13.61	27.32	13.61	16.31	27.32	-
Ward 37 Surgery	42.1	16.37	59.44	41.29	16.06	58.32	1.12
Ward 38	22.77	20.199	42.96	22.57	20.02	42.59	0.37
Ward 39	22.59	20.03	42.63	22.47	19.93	42.40	0.23
Ward 19 Paeds (33 beds)	-	-	-	44.0	22.4	66.3	-
Ward 20 Paeds Onc.				4.2	2.2	6.4	-

SNCT guidance requires review of at least two census periods before making establishment or budget changes, with further census undertaken where results vary significantly. Due to ward moves and changes in function, SNCT has limitations when like-for-like comparison is not possible; therefore, SNCT outputs are always triangulated with quality outcomes and professional judgement to inform safer staffing decisions.

For bi-annual reviews, a 65:35 RN:HCA benchmark has been applied for adult inpatient wards. While the evidence-based gold standard is 70:30, recent censuses show a sustained higher dependency (1b) patient profile, particularly across medicine and surgery. Any proposed establishment changes resulting in an RN:HCA ratio below 65:35**,** or any establishment change, requires completion of a Quality Impact Assessment (QIA) to ensure patient safety and care quality are maintained.

2.4.2 Adult Inpatient Wards SNCT %

The overall average percentage data for all adult wards for the last four SNCT periods is shown below. The main acuity of patients is stable requiring ward care (Level 0) or stable and dependent (Level 1B), with 37.1% and 54.1% respectively in January/February 2026.

Table 4 – average acuity by census (%)

	Empty Beds	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2026	1.2	37.1	5.6	54.1	0.6	0	1.6	0
Jun/Jul 2025	3.44	46.18	5.34	42.37	0.76	0	1.91	0
Jan/Feb 2025	2.74	44.55	5.59	45.45	0.51	0.01	1.14	0
Sept/Oct 2024	2.72	43.6	6.52	45.83	0.87	0.82	1.31	0

2.4.3 Surgery, Anaesthetics and Cancer Wards SNCT Establishment Review Jan/Feb 2026

Recent data collected for surgical areas (see Chart 2) indicates that the highest proportion of patients were recorded in the level '0' patients (normal ward care) and '1b' category (stable – dependent patients). The change in acuity from previous census is likely to reflect the new wards opening and SAU transferring dependent patients out of the acute space to improve flow and lower acuity patients in this area.

Chart 2 -SAC Average acuity (%) by census period.

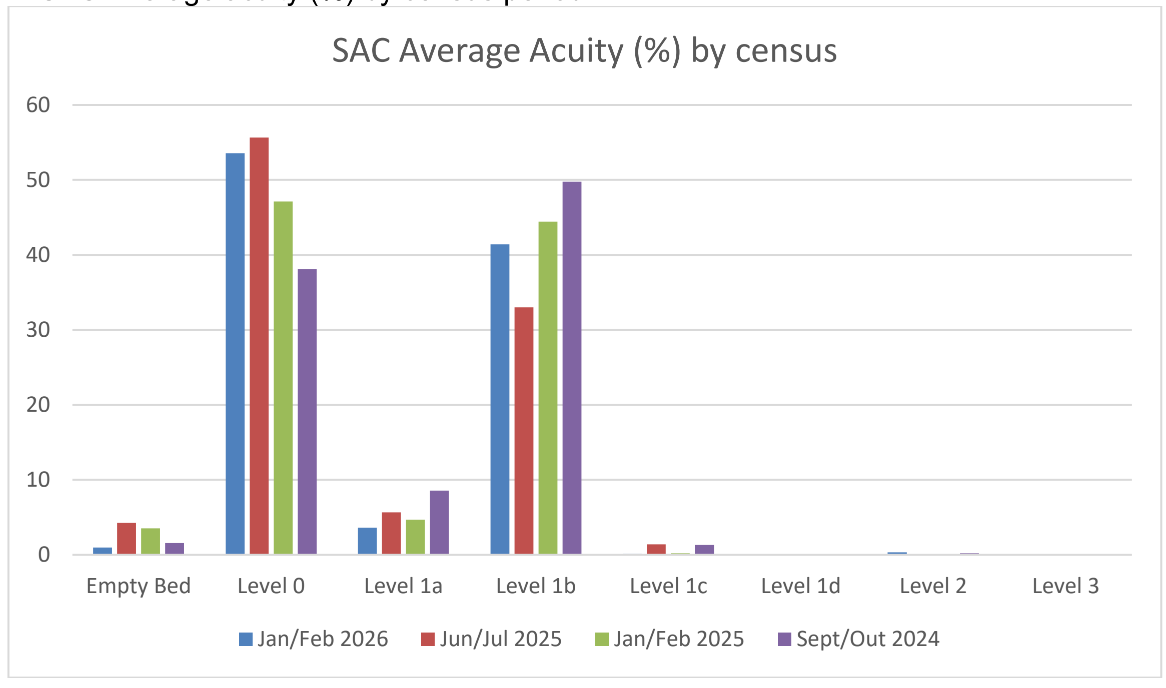


Table 5 - SAC Average acuity (%) by census period.

SAC	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2026	0.98	53.55	3.6	41.4	0.12	0	0.33	0
Jun/Jul 2025	4.25	55.66	5.66	33.02	1.42	0	0	0
Jan/Feb 2025	3.53	47.12	4.69	44.41	0.22	0	0.1	0
Sept/Oct 2024	1.56	38.1	8.55	49.78	1.33	0	0.19	0

Recent SNCT census reviews across trauma, surgical and specialist wards demonstrate a sustained increase in patient dependency and care complexity, driven by an ageing trauma population, increased cognitive impairment and falls risk, higher levels of enhanced observation, and growing ambulatory and assessment activity. These factors place increased demand on nursing staff, much of which is not fully captured within standard SNCT methodology.

Overall, SNCT recommendations remain largely aligned with current funded establishments, providing assurance that baseline inpatient care is appropriately resourced. In several areas, professional judgement has been applied where workload extends beyond SNCT measures, including ambulatory trauma areas, assessment units, ward-attender activity and environmental risks associated with modular ward design and reduced visibility.

Most wards (AOTU, Ward 4, Ward 8, Wards 38/39) do not require changes to their agreed establishments at this time. Current staffing models offer sufficient flexibility to manage acuity, throughput and specialist activity, with some pressures expected to reduce as temporary factors resolve (e.g. reopening of Ward 5, seasonal variation). Continued monitoring through further SNCT audits and operational data is recommended.

Two key areas require attention:

- Ward 37 is operating at 38 beds (above its original 32-bed design). While staffing has been appropriately uplifted, this remains unfunded. A decision is required to either secure recurrent funding for the enhanced staffing model or reduce bed capacity to align with the funded establishment, as current arrangements create ongoing financial and safety risk.
- Surgical Assessment Unit (SAU) has experienced a significant rise in assessment activity (circa 100 additional patients per month year-on-year), with particular risk during evening and night-time periods. A targeted enhancement of one additional Registered Nurse on twilight/night duty in the assessment area is recommended to mitigate patient safety risks, support flow and maintain effective functioning of the unit.

In summary, the review provides strong assurance on overall nursing staffing adequacy, whilst highlighting specific, targeted actions required to address sustained service change, patient safety risk and unfunded workforce pressure.

2.4.4 Medicine and Emergency Care Wards SNCT Establishment Review Jan/Feb 2026

Data collected across the medical ward areas indicates that the majority of patients continue to fall within Level 0 (stable – normal ward care) and Level 1b (stable but dependent patients) categories. This reflects a predominantly stable inpatient population with ongoing dependency needs requiring ward-based nursing support.

It is noted that the proportion of patients requiring Level 2 care has reduced when expressed as a percentage of the overall inpatient population. However, the medical bed base has increased, which has diluted the proportional representation of higher-acuity patients. In absolute terms, the number of Level 2 patients remains broadly consistent with previous census periods. This highlights that while acuity distribution appears to have shifted, the actual workload associated with caring for higher-acuity medical patients has not reduced, and the ongoing requirement for skilled nursing care remains unchanged.

Chart 3 -MEC Average acuity by census period.

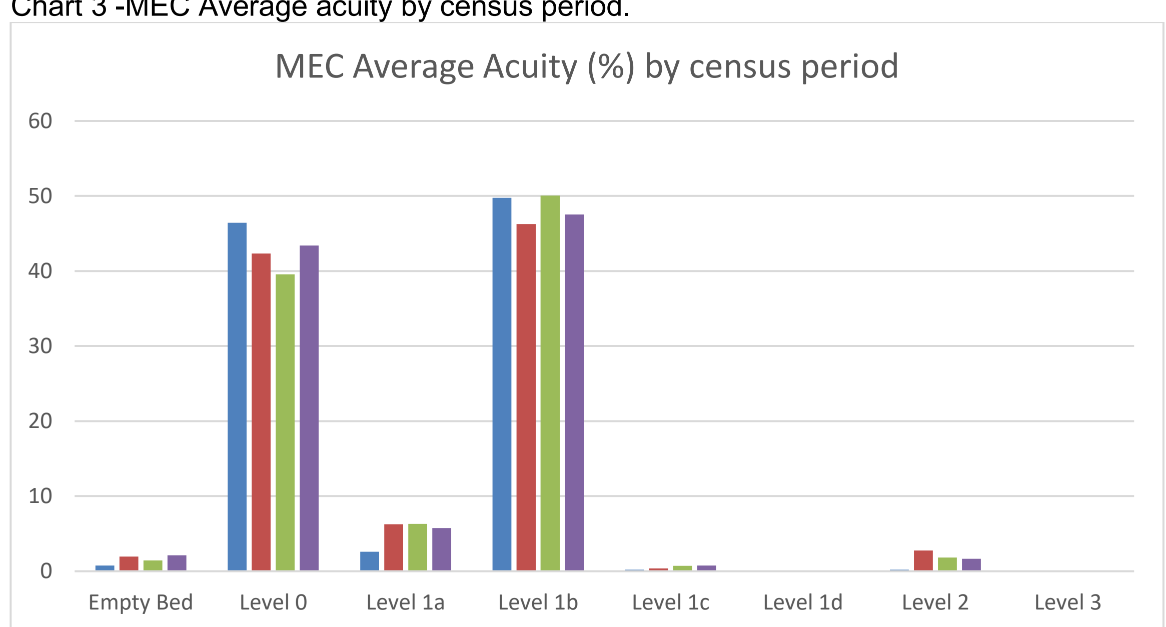


Table 6 – MEC average acuity (%) by census period

MEC 2024	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2026	0.78	46.42	2.6	49.77	0.22	0.02	0.21	0
Jun/Jul 2025	1.96	42.35	6.27	46.27	0.39	0	2.75	0
Jan/Feb 2025	1.46	39.57	6.31	50.04	0.73	0.02	1.85	0
Sept/Oct 2024	2.13	43.41	5.76	47.56	0.76	0.03	1.64	0.01

The latest SNCT review across medical wards confirms a sustained increase in patient acuity, dependency and complexity, driven by hospital-wide capacity pressures, service reconfiguration, expanded bed bases and an increasing prevalence of frailty, cognitive impairment and enhanced observation requirements. Many wards are regularly operating above their core bed capacity in line with the Hospital Full Policy, increasing nursing workload and reducing staffing resilience.
Seasonal variation remains a significant factor, with higher dependency and operational demand typically observed during winter months. This must be considered when interpreting SNCT outputs, particularly as the majority of medical wards are currently showing recommended staffing levels above the funded establishment.

Service reconfiguration at RSH, particularly following the opening of Ward 25, has impacted patient flow and case mix. Ward 25 admits patients with lower dependency, creating a reciprocal increase in acuity on receiving wards, which is likely to have influenced SNCT outputs during this census period.

SNCT outputs do not mandate automatic changes to funded establishments. In line with NHS England guidance, at least two consecutive census periods demonstrating sustained variance are required before permanent establishment or budget changes are considered, except where there is an immediate and significant patient safety risk.

Following establishment review meetings, SNCT outputs were triangulated with workforce and quality metrics and considered alongside professional judgement. It was concluded that no immediate permanent establishment changes are required for most wards at this time. Wards remain safely staffed within current funded establishments, supported by experienced teams,

flexible deployment, daily staffing review, senior nurse oversight and established escalation processes. Ongoing monitoring is required as service models continue to embed and further census data becomes available.

SNCT outputs should be interpreted with caution due to:

- Recent ward function changes or first census datasets (Wards 25 and 36)
- Environmental constraints affecting visibility (side rooms, isolated locations)
- Specialist care requirements and fluctuating demand for Level 2 beds not fully reflected in standard ratios (Wards 6, 17 and 24)

Targeted mitigations are recommended where sustained risk has been identified:

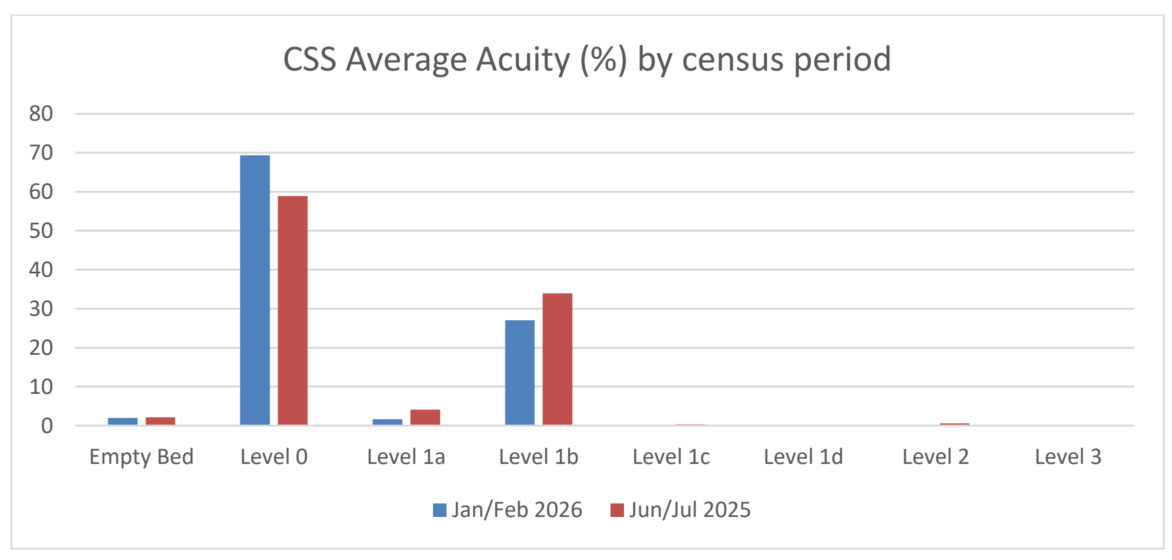
- Ward 7: Introduction of a twilight shift to support increased dependency, escalation beds and outlier activity.
- Ward 26: Extension of an existing additional Registered Nurse to a full long-day shift to address rising dependency and emerging quality indicators, prior to any permanent establishment uplift.

Significant operational reconfiguration on the Acute Floor at RSH, including AMU expansion and redesign of assessment pathways, means SNCT outputs require cautious interpretation until rosters, budgets and a full census cycle align with the new operational model. No immediate staffing changes are recommended; however, continued oversight is required to ensure sustainable alignment and patient safety.

In summary, the review provides overall assurance on nursing safety and staffing adequacy, while identifying specific, proportionate actions and areas requiring continued monitoring as capacity pressures and service changes stabilise.

2.3.5 Clinical Support Services (Ward 23 Oncology/Haematology)

Chart 4 – Ward 23OH average acuity (%) by census period



Ward 23 is a 30-bed specialist Oncology and Haematology ward supported by four weekday assessment spaces delivering haematology reviews and chemotherapy, contributing to national cancer access standards. Although SNCT data shows a higher proportion of Level 0 patients, this does not fully reflect increasing clinical complexity, including immunotherapy use and the need for enhanced nurse–patient ratios for neutropenic or unstable patients. When fully staffed, the current establishment is sufficient to provide safe care, and no changes to the staffing template are recommended at this time, with continued monitoring in place.

Table 7 – Ward 23OH Average acuity (%) by census period

CSS	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2026	2.0	69.33	1.67	27.0	0	0	0	0
Jun/Jul 2025	2.1	58.9	4.1	33.9	0.33	0	0.57	0

2.4.6 Women and Children (Ward 14 Gynae and Ward19 Paediatrics Establishment Review January/February 2026

Ward 14

Chart 5 – Ward 14 Average acuity by census period.

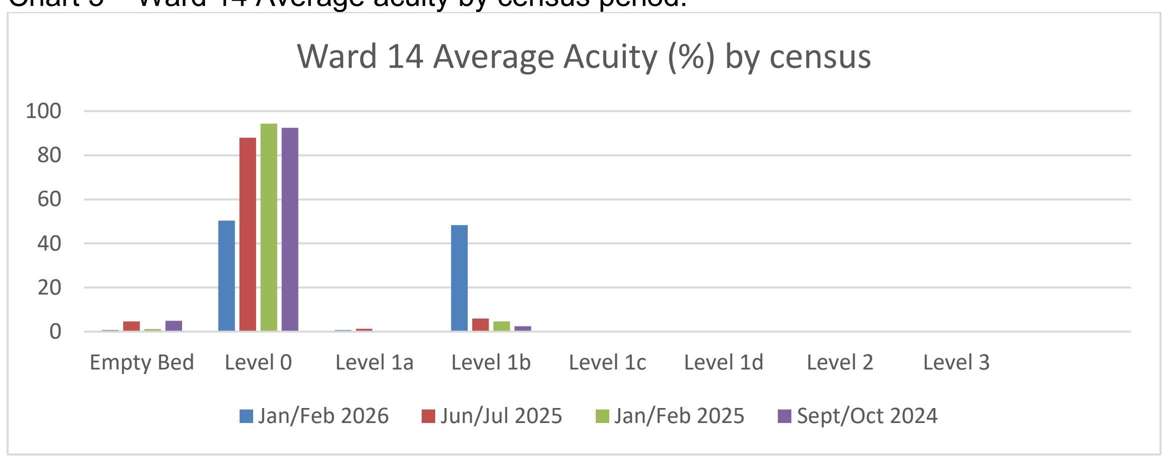


Table 8 – ward 14 acuity by census period

Ward 14	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2026	0.68	50.4	0.68	48.3	0	0	0	0
Jun/Jul 2025	4.6	87.9	1.3	5.9	0.25	0	0	0
Jan/Feb 2025	1.1	94.4	0	4.6	0	0	0	0
Sept/Oct 2024	5	92.5	0	2.5	0	0	0	0

SNCT limitations for smaller wards are recognised, including reduced reliability due to limited data points and constrained staffing flexibility. The requirement to maintain a minimum of two Registered Nurses per shift results in the funded establishment exceeding SNCT recommendations on Ward 14. Ward acuity has remained stable with minimal variation, and the current staffing template is appropriate and supports safe care delivery. It is also noted that the Ward 14 co-ordinator provides operational support to both Ward 14 and GATU, which is not fully reflected within the budget.

Paediatrics

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

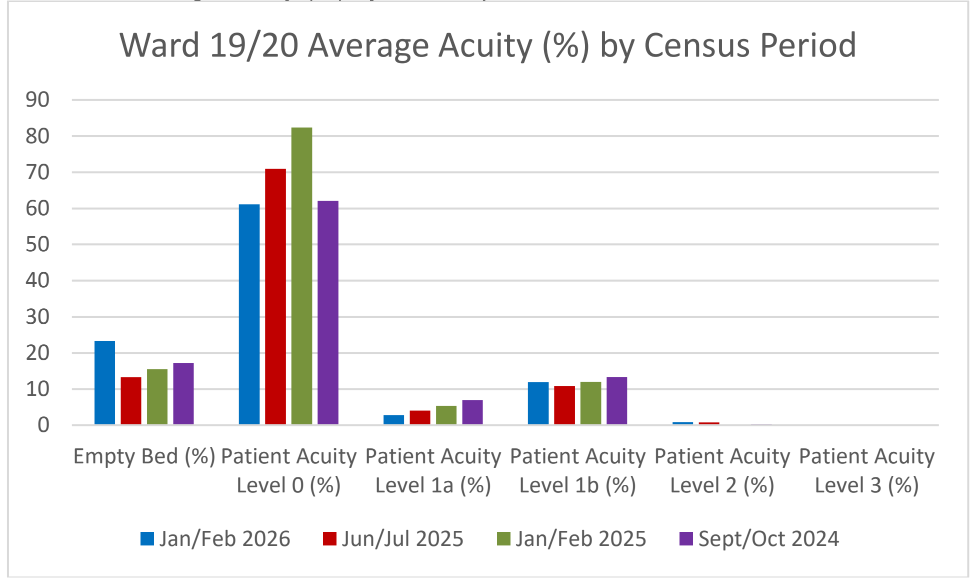


Table 9 – Ward 19/20 average acuity (%) by census period

Ward 19/20	Empty Bed (%)	Patient Acuity Level 0 (%)	Patient Acuity Level 1a (%)	Patient Acuity Level 1b (%)	Patient Acuity Level 2 (%)	Patient Acuity Level 3 (%)
Jan/Feb 2026	23.33	61.11	2.78	11.94	0.83	0
Jun/Jul 2025	13.29	71	4.08	10.88	0.76	0
Jan/Feb 2025	15.5	82.4	5.4	12.0	0.2	0
Sept/Oct 2024	17.27	62.12	6.97	13.33	0.3	0

Revised paediatric summer and winter staffing templates were implemented in 2025 to reflect seasonal variation, with winter staffing based on 33 beds and summer on 28 beds. The latest SNCT census shows recommended staffing marginally above the combined winter budget; however, average occupancy during the census was 26 beds, requiring interpretation alongside acuity. Staffing stability has improved with minimal vacancies. SNCT does not fully capture essential off-ward responsibilities (ED resuscitation support, specialist transfers, MRI sedation escorts), though some buffer capacity exists within the combined establishment. A 24% uplift remains in place, with fixed-term posts used to cover maternity leave. An updated SNCT for Children and Young People is anticipated, expected to better reflect complex care and constant observation requirements.

2.4.7 Emergency Department Establishment Review February 2026

Chart 7 - ED Average acuity by census period.

ED SNCT Average Acuity (%) by census period

80
70
60
50
40
30
20
10
0

Patient Acuity Level 0 | Patient Acuity Level 1a | Patient Acuity Level 1b | Patient Acuity Level 1c | Patient Acuity Level 2 | Patient Acuity Level 3

RSH Oct 2024 | RSH Feb 2025 | RSH Jul 2025 | RSH Feb 2026
PRH Oct 2024 | PRH Feb 2025 | PRH Jul 2025 | PRH Feb 2026

Table 9 – ED acuity by census period

	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 2	Patient Acuity Level 3
RSH Oct 2024	53.9	20.6	20.1	4.6	0.6	0.1
RSH Feb 2025	57.2	12.1	25.2	3.9	0.9	0.9
RSH Jul 2025	62.6	14.1	18.7	3.2	1.3	0.1
RSH Feb 2026	53.1	15.9	27.4	2.8	0.8	0
PRH Oct 2024	59.3	22.9	13.5	3.7	0.7	0
PRH Feb 2025	63.4	15.7	15.1	4.4	1	0.2
PRH Jul 2025	63.4	15.7	15.1	4.7	1	0.2
PRH Feb 2026	70	12.5	13.6	2.3	1.4	0.2

A recent update to the Emergency Department Safe Nursing Care Tool (SNCT) was implemented to better reflect the operational realities of modern emergency care. This update included an adjustment to the calculator to ensure patients remaining in the department for greater than 12 hours were accounted for appropriately.

PRH Emergency Department

Using the revised tool, the PRH ED census identified an increase in recommended staffing when compared with the previous census. This aligns with a recorded daily average of 42.2 patients with ED stays exceeding 12 hours across the census period.

A slight variation in acuity was noted when compared with the previous census, with:

- An increase in Level 0 care and Level 2 care
- A reduction in Level 1a and Level 1c care

Average activity mapped across the 12-day census period demonstrated a reduction in admissions overnight, with increased activity during the day, particularly between 10:00 and 22:00. This pattern is consistent with previous census periods.

RSH Emergency Department

At RSH ED, the census identified:

- An increase in dependent patients (Level 1b) compared with the previous audit.
- A reduction in Level 0 care, which represents walk-in attendees, minor injuries, or patients whose needs can be met through routine interventions.

A daily average of 41.1 patients staying over 12 hours were recorded in the department across the census period. Overall, ED activity demonstrated a reduction overnight; however, several hourly peaks in activity were recorded.

Professional Judgement
Taken in isolation the revised SNCT establishment is lower than the budgets for the Departments. Triangulating this with professional judgement enables consideration of the environmental and operational challenges which should be acknowledged in workforce planning and safe staffing assessments.

As the SNCT captures acuity at two fixed time points daily over a 12-day period, it is essential that the activity recorded accurately reflects normal departmental demand. Where this is not the case, consideration should be given to increasing the number of census periods completed.

On review of the census findings, the senior departmental team expressed concern that the activity captured did not fully reflect the complexity of patients routinely managed within the Emergency Departments. This included:
- Critical care interventions
- Complex safeguarding cases
- Mental health presentations

These factors have implications for interpretation of the data, and further audits are required if subsequent censuses do not adequately represent expected acuity and dependency.

In addition, limitations within the SNCT methodology are noted, including its ability to capture:
- Offload to assess activity.
- Designated paediatric workforce requirements (a regulatory obligation)
- Rapid triage and initial assessment demands, where delays significantly increase clinical risk (e.g. sepsis, stroke, cardiac events)
- Critical care and other time-critical interventions

Paediatric acuity is not currently stratified separately from adult acuity within the tool. The Divisional Director of Nursing has requested that future census activity reflects adult and paediatric patient groups separately, to provide a clearer understanding of paediatric demand and daily admissions. This will be implemented across both Emergency Departments.

Both Emergency Departments have benefitted from estates developments that have improved the patient environment; however, these changes also have staffing implications.

At RSH ED, this has included the development of:

- 20 major cubicles, all single occupancy
- 10 cubicles with IPC isolation capability

PRH has managed to reduce the use of temporary escalation space (corridor care) and improved the patient experience enhancing privacy and dignity with estate changes including ceasing using the portacabin as the ambulance receiving area and decision to admit unit from December 2025 through opening of a new space following closure of Medical Escalation ward at PRH.

Both departments have not delivered the 2025/26 operational plan for either the 4-hour or 12-hour performance standards. Key challenges include:

- Long waits to be seen by the medical team, with waiting times averaging 5–12 hours.
- Ambulance handover performance placing the department in the bottom decile.

Improvement will be reliant on delivery of several key initiatives during 2025/26, including:

- 24/7 nurse-led offload to assess.
- Timely initial assessment and streaming
- Maintained waiting-room nurse oversight.
- Implementation of the fit-to-sit model.
- Effective utilisation of all areas of the Emergency Department

Agreed key quality metrics have demonstrated consistent improvement (Table 10). Quality audit outcomes are triangulated with safety and training data and reviewed through the monthly Nursing Quality Audit Meetings, where actions are agreed and monitored.

Table 10 – Assurance Dashboard for UEC

Metric	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total	Target	Progress
NMQ									
ED - Documentation	94.5 (222)	93.9 (204)	94.8 (164)	94.3 (151)	95 (135)	93 (160)	94.2	80 - 90	
ED - Skin integrity	89.4 (222)	91.5 (204)	91.3 (164)	87.5 (151)	87.7 (135)	92.7 (160)	90.1	80 - 90	
ED - Nutrition	96.7 (222)	96.3 (204)	98.7 (164)	100 (151)	96.7 (135)	97.8 (160)	97.6	80 - 90	
ED - Safety, Privacy & Dignity	96.1 (233)	94.9 (216)	96.3 (173)	94.8 (160)	92.8 (141)	96.5 (166)	95.4	80 - 90	
ED - Patient Experience	94.7 (271)	93.5 (263)	89.1 (206)	91.8 (190)	90 (172)	92.8 (188)	92.2	80 - 90	
ED - Comfort Care Round	96.5 (204)	96.6 (180)	95.2 (152)	91.2 (129)	86.2 (122)	92.9 (146)	93.7	80 - 90	
ED - Fluid Balance	89.9 (222)	93.5 (204)	93.5 (164)	94 (151)	90 (135)	91.5 (160)	92.1	80 - 90	

The daily presence of Matrons undertaking Quality Assurance audits within the departments has been instrumental in providing assurance around safety and quality. This approach has also enabled real-time restorative actions and education to support continuous improvement.

At present, no changes to the staffing templates are recommended, but it is recognised that the department will need to continue adapting its working practices to meet demand safely and effectively. However, the Divisional Director of Nursing recognised at the establishment review meeting there was the potential opportunity to review the nighttime staffing template.

2.3.8 Nurse Sensitive Indicators

Quality data and nurse-sensitive indicators are routinely reviewed at monthly metrics meeting to monitor staffing, red flag reporting and harm to patients. A review of trend over time is considered at establishment review meetings to identify trends and assess any correlation between staffing levels and patient harm, particularly during SNCT census periods.

All patient safety incident investigations included a review of staffing levels to determine whether staffing may have been a contributing factor. No incidents reported during this period identified staffing concerns as a root cause, providing assurance around current staffing model and suggests that the harms are multifactorial. However, it was noted January and February 2026 had higher levels of falls with low of no harm, and an increase in Category 3 and reported Category 4 pressure ulcer, with ward 26 and Ward 25 reporting a Category 3 in

both January and February. Action at this stage support targeted interventions and continued surveillance, especially during periods of reconfiguration with new wards embedded and acuity across a number of areas fluctuating.

Table 11 - Quality Metrics dashboard February 2026

Location	Sickness rate (%) - ESR	Quality Indicators Complaints	Medication Errors	Nursing medication - administration errors	MRSA	MSSA	cDiff	Falls - Total (exc severe)	Falls with Harm	Pressure Ulcer Category 1 - Hospital Acquired	Pressure Ulcer Category 2 - Hospital Acquired and TVN	Pressure Ulcer Category 3 and unstageable - Hospital	Pressure Ulcer Category 4 - Hospital Acquired and TVN	Serious Incidents (SIs) - reported to STEIS	Patient Safety Incident Investigations (PSIIs)	Staffing issues - Datix raised
Accident & Emergency Department (PRH)	4.9	17	7	7	0	0	0	2	0	0	0	0	0	0	0	4
Accident & Emergency Department (RSH)	5.4	15	6	2	0	0	0	13	0	0	0	0	0	0	0	1
Acute Medical Unit (AMU) (PRH)	3.8	3	6	5	0	0	1	3	0	0	0	0	0	0	0	1
Acute Medical Unit (AMU) (RSH)	7.6	6	3	2	0	1	0	4	0	0	0	2	0	0	0	0
Acute Orthopaedic Trauma Unit (AOTU) (RSH)	3.1	0	3	1	0	0	0	1	0	0	0	0	0	0	0	1
ITU/HDU (PRH)	8.2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ITU/HDU (RSH)	6.3	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0
Ward 10 - Short Stay (PRH)	10.8	1	0	0	0	0	0	4	0	0	1	0	0	0	0	1
Ward 11 Nephrology (PRH)	11.5	4	2	1	0	0	0	4	0	0	0	0	0	0	0	1
Ward 14 - Gynaecology	13.8	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0
Ward 15/16 Stroke Unit (PRH) Structure	6.2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 17 - Respiratory (PRH)	17.7	2	0	0	0	0	0	7	0	0	1	0	0	0	0	1
Ward 19	5.3	3	2	1	0	0	1	0	0	0	0	0	0	0	0	0
Ward 21 - Postnatal	-	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 22 - Antenatal	-	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 22 - Short Stay (RSH)	3.5	1	1	1	0	0	0	2	0	0	0	0	0	0	0	2
Ward 23 - Neonatal	7.5	0	3	2	0	0	0	0	0	0	0	0	0	0	0	0
Ward 23 - Oncology & Haematology	8.4	0	2	1	0	0	0	5	0	0	1	0	0	0	0	0
Ward 24 - Delivery Suite (PRH)	5.8	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1
Ward 24 - Respiratory (RSH)	6.3	0	2	2	0	0	0	0	0	2	3	0	0	0	0	2
Ward 25 - Colorectal and Gastroenterology	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 25 - General Medicine (RSH)	2.3	4	3	1	0	0	0	6	0	0	1	1	0	0	0	0
Ward 26 - Endo/Medicine (RSH)	8.5	2	2	1	0	0	0	10	0	1	1	1	0	0	0	3
Ward 27 (RSH)	8.9	2	0	0	0	0	1	5	0	0	3	1	0	0	0	1
Ward 28 Medicine & Frailty (RSH)	7	0	2	1	0	0	0	3	0	0	0	0	0	0	0	2
Ward 34 Surgical Assessment Unit (SAU) & Short S	2.9	2	0	0	1	1	0	2	0	0	0	0	0	0	0	0
Ward 35 Nephrology (RSH)	12.8	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Ward 36 - Medicine (PRH)	6.7	0	0	0	0	0	1	4	0	0	1	0	0	0	0	0
Ward 37 - Surgical (RSH)	7.7	3	1	1	0	0	1	8	0	0	4	1	0	0	0	0
Ward 38 - Gastroenterology (RSH)	5.2	0	2	2	0	0	0	5	0	0	0	0	0	0	0	0
Ward 39 - Colorectal (RSH)	1.6	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Ward 4 - Trauma & Orthopaedics (PRH)	5.8	2	3	2	0	0	0	1	0	0	1	0	0	0	0	1
Ward 5 - Elective Orthopaedic (PRH)	5.9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 6 - Coronary Care Unit (PRH)	3.4	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0
Ward 7 - Endo/Cardio (PRH)	16.2	1	0	0	0	0	0	5	0	0	1	0	0	0	0	0
Ward 8 - Head & Neck (PRH)	16.8	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0
Ward 9 - Frail and Complex (PRH)	16.5	2	3	1	0	0	0	6	0	0	0	1	0	0	0	1
Wrekin Midwife Led Unit	5.3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

In February 2026, staffing-related risks were consistently identified and appropriately escalated across clinical areas, with all 35 Datix incidents resulting in no or low harm; however, recurring shortages in staff numbers and skill mix, short-notice unavailability, and high patient dependency levels meant mitigations were frequently limited due to system-wide pressures. While staff followed Trust processes and prioritised patient safety, the repeated inability to resolve staffing gaps indicates that risk is often being tolerated rather than eliminated. Ongoing workforce gaps due to current sickness levels (Table 10) continue to pose risks to patient safety, staff well-being and service continuity.

Chart 8 - Staffing related Datix by area February 2026

2.3.11 Red Flag Reporting

The use of SafeCare Live was re-launched across the Trust in 2024 as a real-time workforce tool to support staffing decision-making, escalation, and red-flag reporting, enabling safer and more responsive workforce management. The system allows frontline teams to flag indicators that staffing levels may be insufficient to deliver safe care, supporting early identification of risk and timely mitigation.

In February 2026, a total of 121 workforce-related red flags were recorded, with the most common issue being shortfall in Registered Nurse (RN) hours (81 instances). All red flags are actively monitored, and Matrons are required to review and follow up each open flag to assess any potential impact on quality or patient safety. Where actual or potential harm is identified, a Datix incident report is required in line with Trust policy.

During this reporting period, no staffing-related Datix incidents were classified as moderate or severe harm; all were recorded as no-harm or low-harm events, providing assurance that risks were identified early and mitigated effectively. Mitigation actions were consistently documented and included redeployment of staff from other clinical areas and Ward Managers providing clinical cover, ensuring patient safety was maintained.

Table 12 – Red Flag reporting

	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-25
Open	6	0	0	7	9	26	57
Reviewed	40	55	59	50	54	83	59
Resolved	26	19	9	13	14	11	5
Total	72	74	68	70	77	120	121

2.3.12 Ward Manager Clinical Cover

Since May 2025, Ward Managers have been required to record time spent working clinically to mitigate short-notice staffing gaps. While Ward Managers are expected to operate in a supervisory capacity, focusing on patient experience, quality, safety, staff development and service improvement, extended clinical working can compromise their ability to fulfil these core non-clinical responsibilities.

Between January 2026 and the end of March 2026, Ward Managers were asked to plan up to 40% clinical working to support safe staffing levels. During this period, ten managers reported working in excess of 40%, with three managers exceeding 60% clinical time, largely due to short-notice staffing pressures. It is recognised that this level of clinical commitment impacts their ability to deliver strategic oversight, leadership, and improvement activity; therefore, the requirement for Ward Managers to undertake planned clinical shifts will revert to normal supervisory expectations from the start of the new financial year.

2.4 Comparison with Peers

2.4.1 Fill rates

Acute Trusts are required to report monthly staffing fill rates to NHSE, comparing planned (rostered) against actual hours worked for Registered Nurses (RN), Nurse Associates (NA) and Healthcare Support Workers (HCSW). Over the past 12 months, RN fill rates have consistently exceeded the 95% target. When RNs and NAs are combined, registrant fill rates have remained at or above 90%, with the exception of October 2025 night duty (89%). Overall fill rates remain satisfactory, with continued ward-level monitoring to ensure any red-flag occurrences are reviewed alongside quality and safety data.

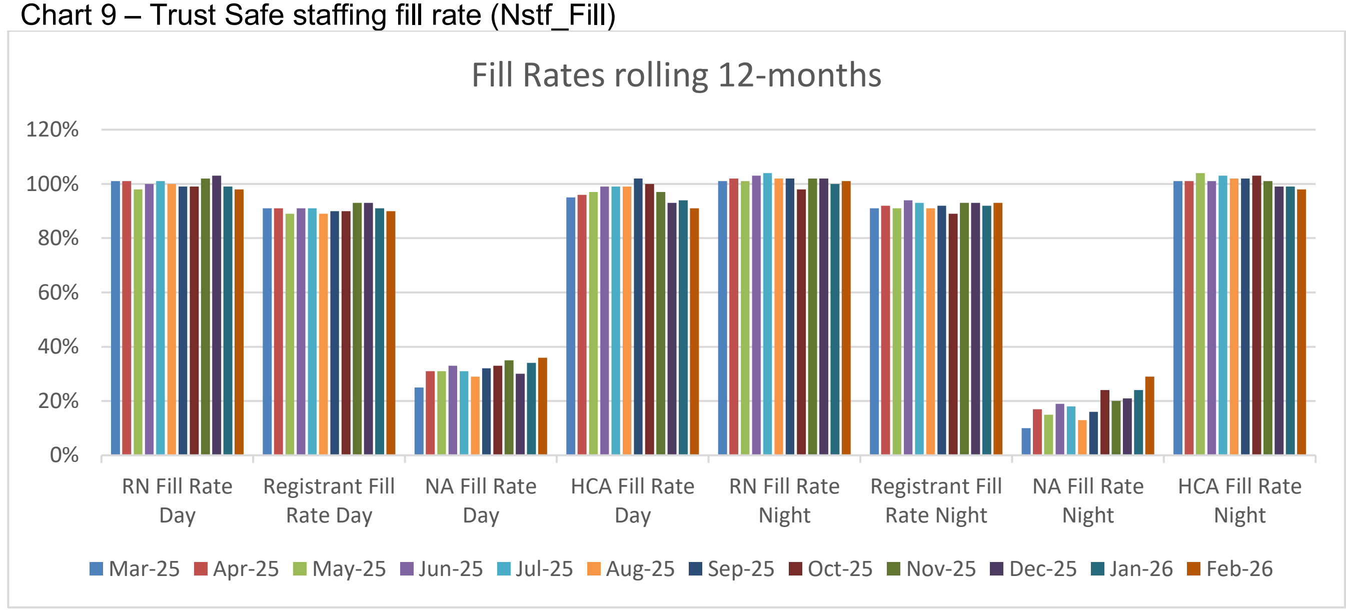
Despite strong overall performance, there have been isolated ward-level pressures, including on-the-day or monthly average fill rates below 80%. In these cases, red flags and Datix reports were raised where appropriate. All staffing-related Datix incidents in the last six months were rated no harm or low harm, providing assurance that mitigation processes are effective.

Fill rates have been sustained through successful recruitment, although temporary staffing remains necessary to cover sickness, maternity and other leave. Agency use is now limited to Theatres and Emergency Departments, with ED agency usage expected to reduce and cease in the coming months. Theatre agency use has reduced, though some skill gaps remain due to a junior workforce requiring ongoing training.

Band 4 Nurse Associate vacancies remain high, and Registered Nurses have been recruited to offset these gaps where appropriate. This planned substitution explains the higher RN fill rates and lower NA fill rates. A trainee NA pipeline is in place, with vacancies projected to reduce to approximately 30 WTE by September 2027, and further cohorts planned to support full establishment by 2028.

HCSW fill rates have fallen below the 95% Trust target in recent months due to sickness, movement into NA training posts, new ward openings, and escalation capacity. While some wards reported fill rates below 80% when Enhanced Care Team hours are excluded, Matrons report no quality or safety concerns, providing assurance that care standards have been maintained.

Chart 9 – Trust Safe staffing fill rate (Nstf_Fill)

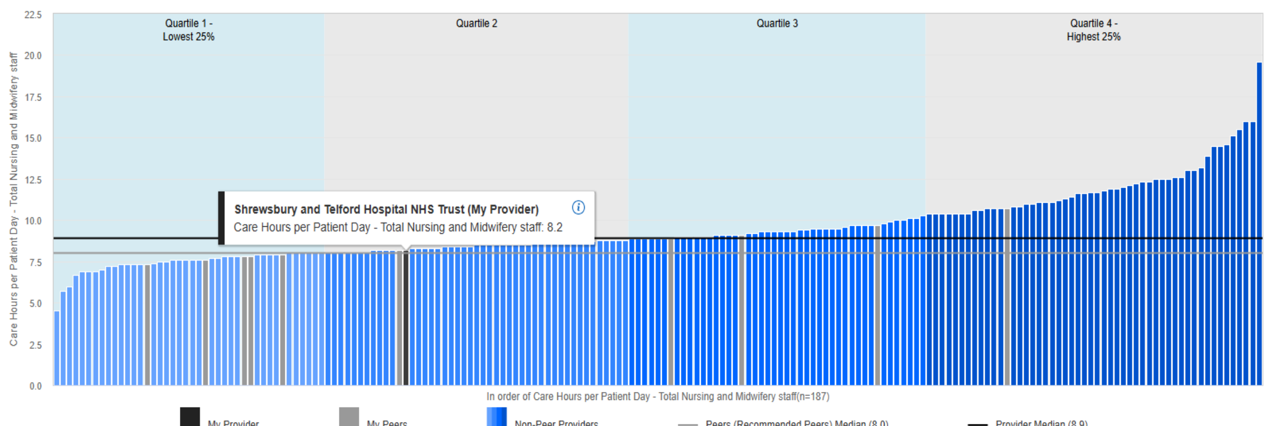


2.4.2 Care Hours per Patient Day (CHPPD) – Model Hospital Comparison

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

Care Hours Per Patient Day for Total Nursing, Midwifery and AHP staff (CHPPD) reported for December 2025 is reported as 8.2 in Quartile 2. When benchmarked against other peer Trusts and nationally, Shrewsbury and Telford Hospital NHS Trust (SaTH) is in line peer median of 8.0 and below provider median of 8.9.

Chart 10 – CHPPD national distribution



[Source Model Hospital CHPPD (Dec 2025 data, accessed 6th April 2026)]

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

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

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

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

CHPPD enables comparisons between wards within the same hospital or across peer organisations via platforms like Model Hospital. Significant variation between similar wards may indicate the need to review staffing deployment, ensuring the right skill mix and numbers are in place. While CHPPD is a valuable indicator of staffing input, it does not directly measure care quality, safety, or responsiveness. Therefore, it is best used in conjunction with quality and safety metrics, such as patient outcomes, red flag incidents, patient experience data and SNCT recommendations.

Results available on Model Hospital have been compared with peer data. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. Generic categories for peer comparison do have some limitations, as the accuracy of benchmarking can be affected especially for specialist or mixed acute wards.

Table 13 – CHPPD by Ward in comparison with National benchmark

RSH	Actual CHPPD Sept-25	Peer CHPPD Sept -25	Peer CHPPD Category	PRH	Actual CHPPD Sept-25	Peer CHPPD Value Sept-25	Peer CHPPD Category
AMU	9.97	7.8	General Medicine	TAMU	9.64	7.8	General Medicine
W22	6.32	7.8	General Medicine	W4	7.51	7.87	Trauma and Orthopaedics
SAU	6.74	6.84	General Surgery	W6	7.09	8.64	Cardiology
W23	6.76	7.86	Clinical Oncology	W7	8.04	7.8	General Medicine
W24	7.85	6.84	Respiratory Medicine	W8	9.62	7.59	ENT
W25	6.7	7.52	General Surgery	W9	No data	7.34	General Medicine
W26	6.24	6.2	General Medicine	W10	No data	7.8	General Medicine
W27	6.84	7.8	General Medicine	W17	6.74	6.84	Respiratory Medicine
W28	8.19	7.8	General Medicine	W11	5.59	7.8	General Medicine
W32	7.90	7.87	Trauma & Orthopaedics	W14	7.67	7.49	Gynaecology
W35	9.1	8.9	Nephrology	W19	8.82	15.41	Paediatrics
W37	7.87	7.2	General Surgery	W15-16	7.82	6.32	Rehabilitation

3.0 RIGHT SKILLS

3.1 Recruitment and Retention

3.1.1 Vacancies

During the January/February 2026 SNCT census period, the Trust's Band 5 Registered Nurse (RN) workforce was in a positive position, with a planned over-recruitment of 79 WTE. This approach was deliberately taken to mitigate workforce risk by:

- Offsetting significant Band 4 Nurse Associate (NA) vacancies (currently 102 WTE), and
- Providing resilience for maternity and parenting leave, particularly within paediatric and nursing teams.

This strategy has supported sustained RN fill rates and contributed to maintaining safe staffing levels, as reflected in the combined registrant fill rate.

At the time of review:

- NA vacancies stand at 102 WTE, reduced from 125 WTE in July 2025.
- The NA role, introduced into staffing templates in 2022, remains under-filled due to limited national supply of qualified NAs.

To address this, the Trust is implementing a medium-term workforce strategy to grow its own NA supply through a Student Nurse Associate programme, supported by the Pre-registration Education Team. Key elements include:

- A five-year training trajectory aligned to forecast demand,
- A preparation programme to support internal applicants,
- Expansion of the programme to external candidates, and

- Recruitment of 47 WTE trainees into the September 2025 cohort, with similar numbers planned for 2026.

In previous years, under-subscription to NA programmes constrained progress against workforce trajectories. Without sustained improvement in NA recruitment, there remains a risk of continued cost pressure from the need to maintain elevated RN recruitment as a compensatory measure.

Notwithstanding these challenges, the Trust has maintained a positive recruitment position, despite the opening of new wards and additional beds in December 2025.

Chart 11 **–** Total Nursing & Midwifery vacancies (including Nurse Associates) for areas SNCT census completed

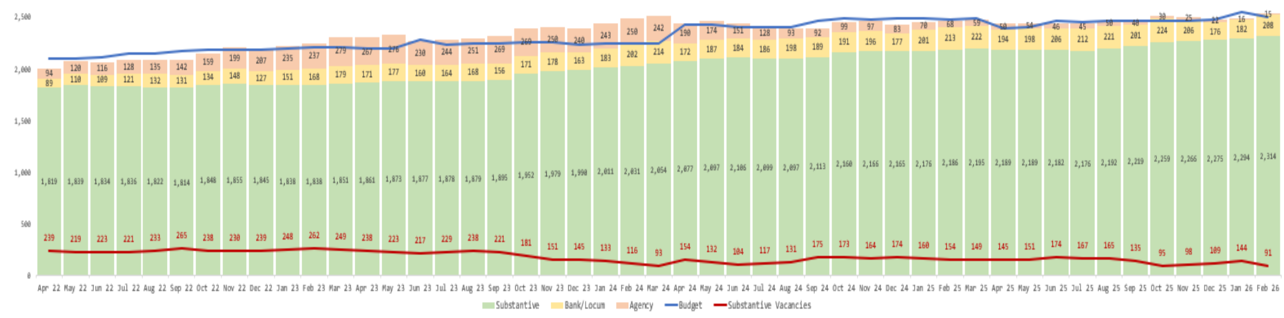
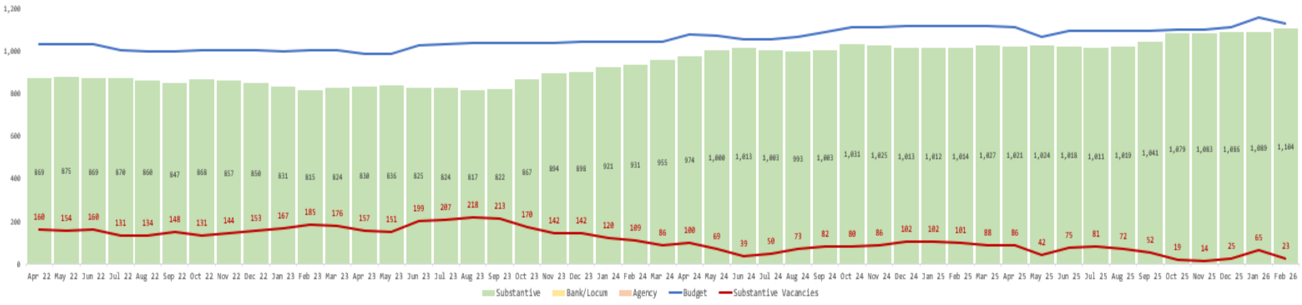


Chart 12 –Combined Band 5 and Band 4 Nurse Associate vacancies for areas SNCT completed.

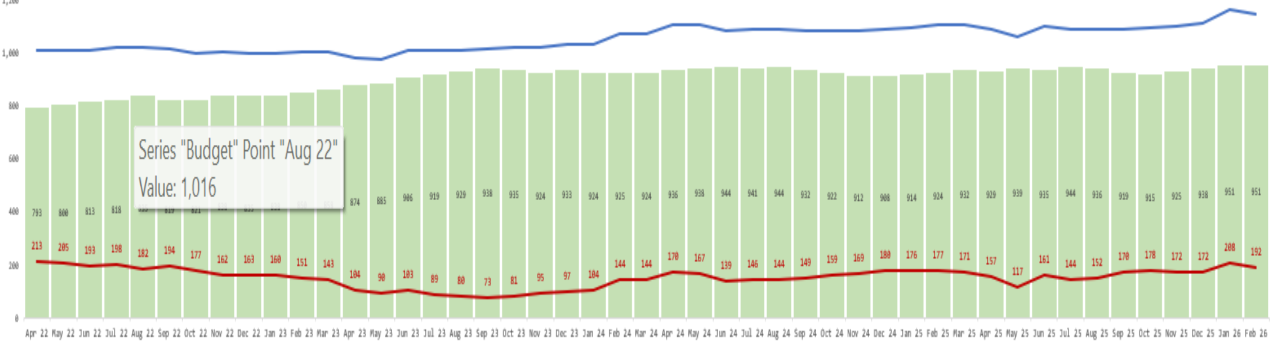


The Healthcare Assistant (HCA) vacancy position has remained stable over the past six months, with a recent increase noted in January linked to budget uplifts associated with the opening of new wards**.** A proportion of these vacancies are being offset by Trainee Nurse Associate (TNA), who work within their base wards during training in a non-registered capacity**.** There are currently 71 WTE trainee Nurse Associates, contributing 60% of their time to ward staffing, with the remaining time spent in supernumerary training activity.

Ongoing recruitment activity continues to improve the HCA position across wards, although recruitment challenges remain within Endoscopy and Theatres. Targeted recruitment initiatives, including dedicated recruitment open days**,** have been arranged in collaboration with the recruitment team to support these areas.

In addition, a workforce development plan is in place to uplift staff in line with Agenda for Change banding and job evaluation outcomes**,** enabling HCAs currently working at Band 2 who meet the criteria to progress to Band 3, supporting retention, career progression, and workforce sustainability.

Chart 13 - Total HCA/ Nursing Support Worker Vacancies



3.1.2 Nursing Turnover

Data taken from Model Hospital shows Nurses leaver rates continues to decrease and is reported at 3.9% which is lower than peer median which is reported at 4.5%.

Chart 12 – SaTH v Peer/Provider comparison NHS leavers

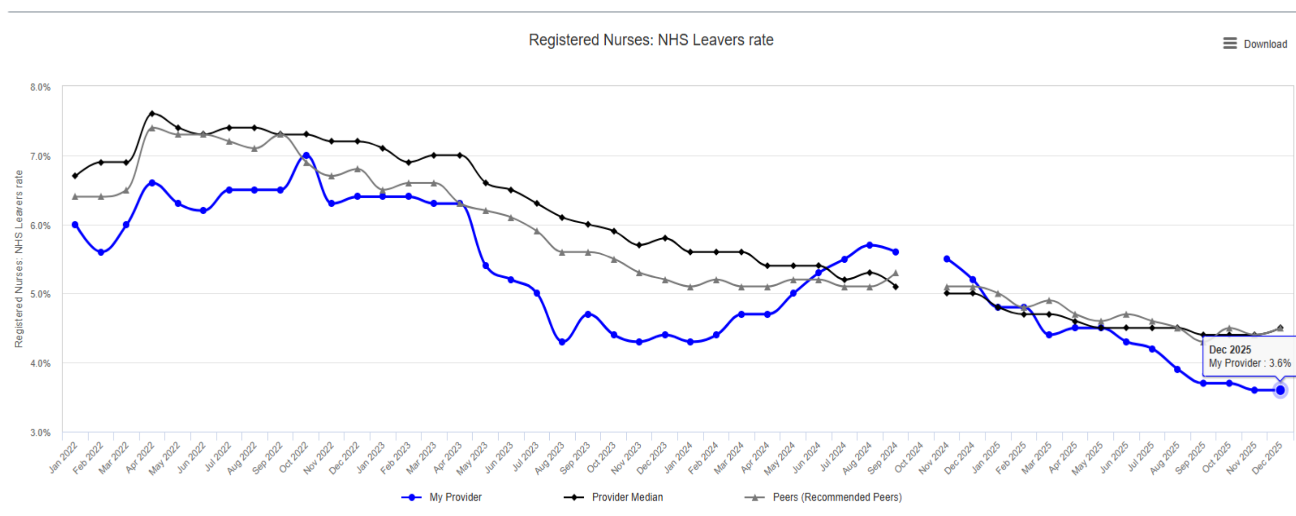
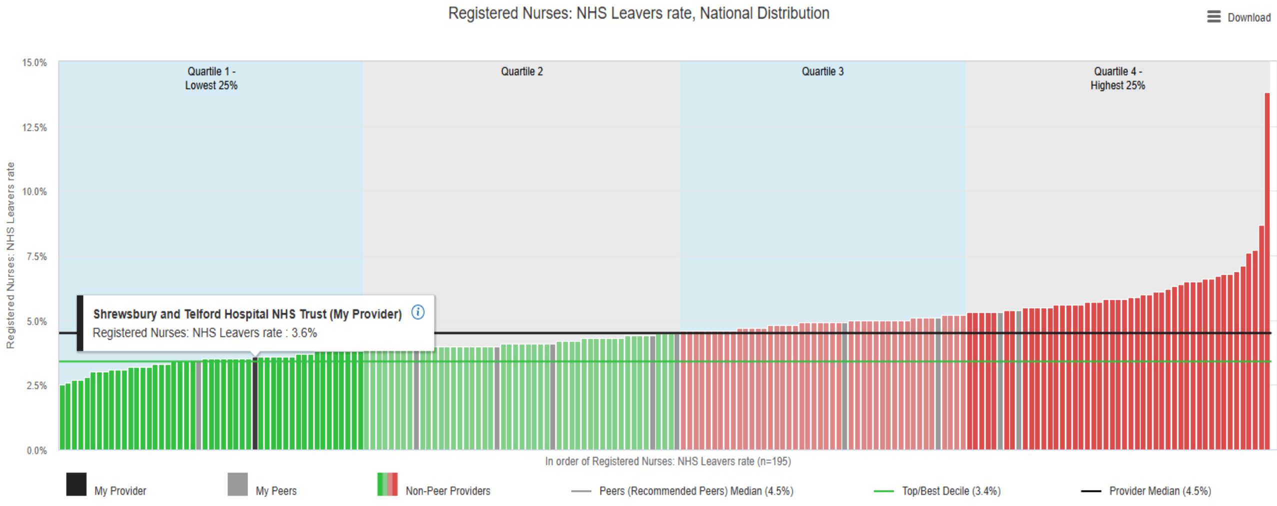


Chart 13 = Registered Nurse Turnover rate - SaTH in comparison to national distribution



3.2 Professional Nurse Advocates

The Professional Nurse Advocate (PNA) role was introduced nationally in March 2021 using the A-EQUIP model to provide restorative supervision, support professional development, improve wellbeing, and strengthen teamworking, with the aim of improving staff retention. PNAs require protected time (minimum 7.5 hours) to undertake this role effectively.

SaTH currently has 24 qualified PNAs, equating to a 1:75 PNA to RN ratio, compared to the national ambition of 1:20 and the local aspiration of a PNA in every department. Achieving this would require approximately 100 PNAs, and due to financial constraints, further expansion will require a business case.

PNA activity is monitored monthly, including restorative supervision sessions, career conversations, and quality improvement support. Over half of PNAs report regular activity, showing a positive and sustained upward trend supported by divisional leadership. Feedback demonstrates clear benefits to wellbeing and retention, with 29 staff members reconsidering leaving their roles within the last six months. Preparatory work is underway to align with emerging national PNA Quality Mark standards.

4.0 RIGHT PLACE AND TIME

4.1 Temporary Staffing

Significant work has been undertaken over recent years to strengthen substantive recruitment and reduce reliance on temporary staffing, particularly agency. This has been supported by strong recruitment delivery and monthly operational recruitment and retention meetings. All agency spend is now at capped rates, with agency usage eliminated across all services except Emergency Departments (ED) and Theatres. ED agency usage is expected to reduce and cease in April, while theatre agency use continues to reduce, with remaining skill gaps linked to a developing junior workforce requiring ongoing training.

Temporary staffing remains essential to maintain patient safety and care quality during short-term staffing gaps. Bank usage has increased, reflecting new ward openings, escalation capacity, and periods of high staff unavailability, including sickness and maternity leave. In March, additional temporary staffing was agreed to support operational priorities around patient flow, experience, and reducing admission waits, particularly within Emergency Departments and SAU, with bank staff utilised in response to the short-term nature of this plan.

Chart 14 – Agency by Tier WTE

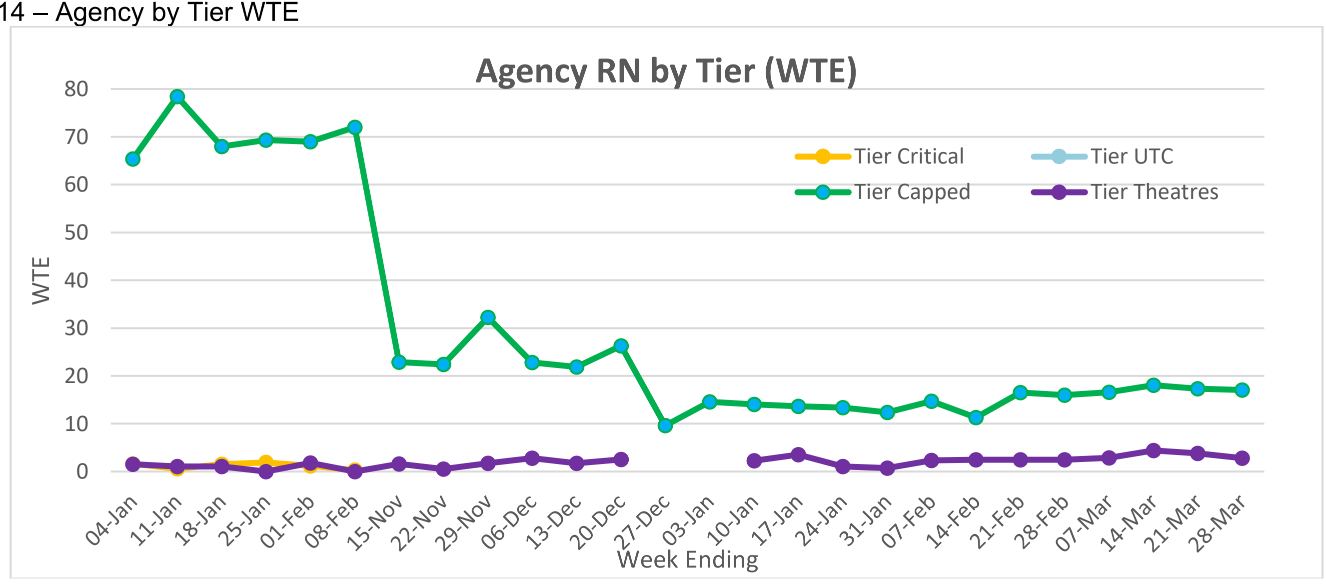
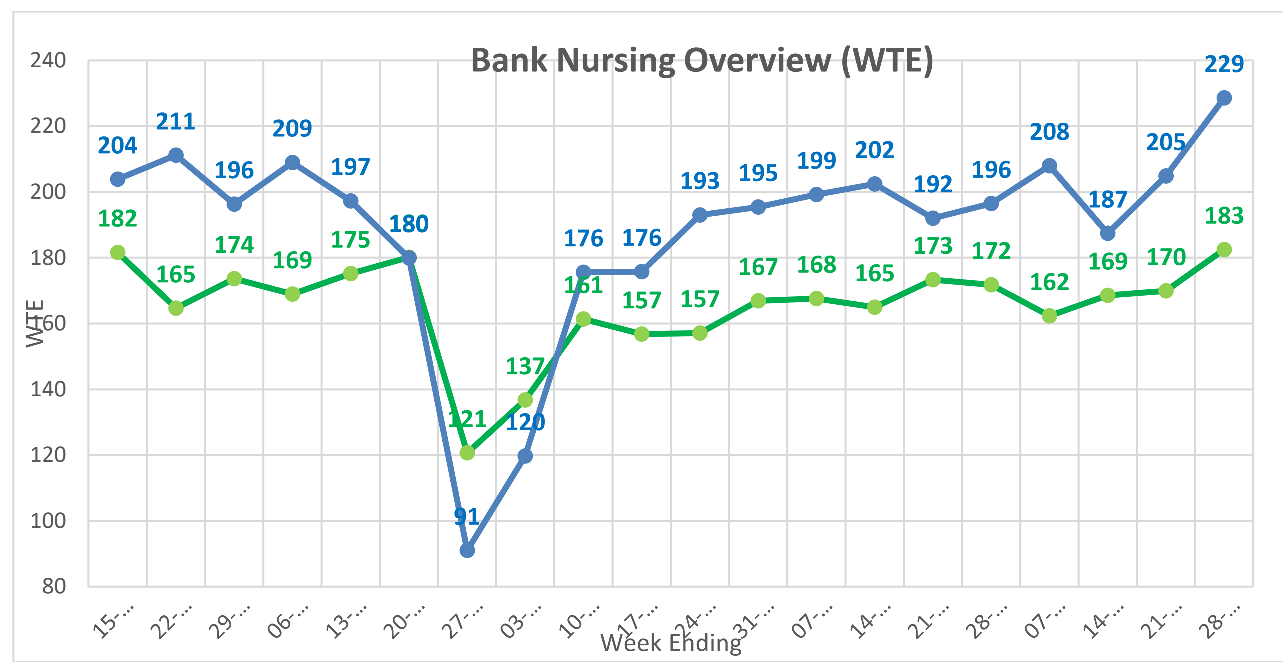


Chart 15 – Internal bank overview



4.2 Substantive Unavailability

Substantive staff unavailability has remained above target across all roster periods over the past six months, averaging 31%. Annual leave is generally satisfactorily managed; however, elevated unavailability is driven by sickness (8%), parenting leave (4%), study leave (2%), other leave (2%), and working day allowance (1%). Training requirements, including Trainee Nurse Associate (TNA), and speciality-specific training, continue to impact available capacity.

Use of additional shifts is tightly controlled through the twice daily bank/agency approval panel, with shifts added to rosters only to support enhanced care and escalation capacity. Roster approval times had fallen below the 8-week standard in Medicine and Women & Children, largely due to Ward Managers undertaking clinical duties; however, a slight improvement has been noted recently as managers have been able to allocate more protected time to roster production.

Roster scrutiny has strengthened since the introduction of enhanced bank approval processes in January 2026. All bank shifts now require second-level approval from the Chief Nurse or Deputy Chief Nurse. Shifts are approved eight weeks in advance, supported by a weekly prospective planning meeting and daily approval meetings to review short-notice requests, improving governance, control, and assurance over temporary staffing use.

Chart 17 – Roster Scorecard stratified to areas under review.

SATH ROSTER SCORECARD

Reset View | *Data Updated: 01/04/26*

Division: All | Unit Type: NON MEDICAL | Unit: Multiple selections | Service: All | Centre: All

15 FEB 26 - 14 MAR 26

	APPROVAL WKS	FILL RATE	FILL % AGENCY	AGENCY WTE	ADD. WTE	NET HRS EXC.	UNAVAILABILITY	CHPPD BELOW
	7.1	86%	1%	16	35	6%	32%	36%
	-0.0	-1%	+0%	+4	+3	-0.4%	+1%	-1%
CSS	9.3	86%				3%	34%	32%
MEC	6.8	85%	2%	16	25	6%	31%	43%
SAC	8.1	90%			10	5%	29%	23%
WAC	6.1	80%				8%	37%	16%

DIVISION	APPR WKS	FILL RATE	FILL% SUBS	FILL% BANK	FILL% AGCY	AGCY WTE	ADD. WTE	NET HRS EXC.	UNAV. TOTAL	UNAV. A/L	UNAV. SICK.	UNAV. STUDY	UNAV. PAREN.	UNAV. WORK.	UNAV. OTHER	CHPPD BELOW	SKILL MIX
⊞ CLINICAL & SCIENTIFIC SERVICES	9.3	86%	86%	14%	0%	0	1	3%	34%	16%	7%	3%	7%	2%	0%	32%	63/37
⊞ SURGERY, ANAESTHETICS AND CANCER	8.1	90%	85%	15%	0%	0	10	5%	29%	14%	6%	2%	4%	0%	2%	23%	54/46
⊞ MEDICINE AND EMERGENCY CARE	6.8	85%	79%	19%	2%	16	25	6%	31%	14%	8%	2%	4%	1%	2%	43%	57/43
⊞ WOMENS AND CHILDRENS	6.1	80%	87%	13%	0%	0	0	8%	37%	17%	9%	3%	5%	2%	1%	16%	72/28
Total	**7.1**	**86%**	**81%**	**18%**	**1%**	**16**	**35**	**6%**	**32%**	**14%**	**8%**	**2%**	**4%**	**1%**	**2%**	**36%**	**58/42**

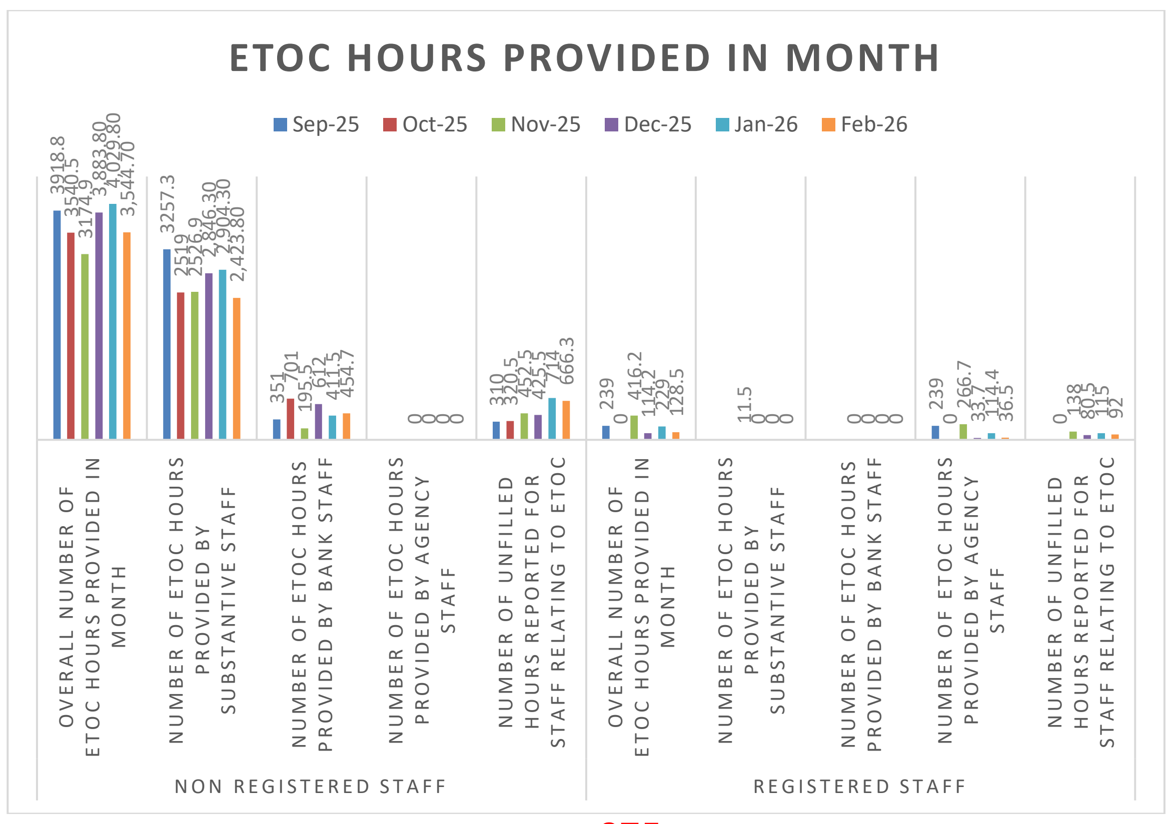
4.3 Enhanced Therapeutic Observation and Care (ETOC)

Following the 2022 nurse template review and the appointment of a Clinical Lead in October 2022, the Trust has established a substantive Enhanced Care Team (ECT) to deliver high-quality 1:1 enhanced care and close observation for patients who require increased supervision. The model is explicitly aligned with the NHS England Enhanced Therapeutic Observation and Care (ETOC) approach, focusing on therapeutic engagement, least-restrictive practice, and the delivery of dignified, person-centred care. The ECT supports patient safety, reduces distress and de-conditioning, and has been recognised nationally, contributing to the emerging ETOC programme and shared learning across the NHS.

Strong governance arrangements are embedded within the model, ensuring that all patients receiving enhanced care are subject to regular multidisciplinary review, with clear accountability and escalation processes to confirm that any enhanced observation or restrictions are proportionate, justified, and applied for the minimum necessary duration. Enhanced Care staff are trained in de-escalation and intervention techniques, supporting safer management of patients with challenging behaviours, improving patient experience, and providing specialist support to ward teams.

In line with national ETOC reporting requirements, monthly returns to NHS England are completed to monitor enhanced care demand and coverage. While the Safer Nursing Care Tool (SNCT) captures 1:1 and 2:1 care requirements, internal analysis demonstrates month-to-month variation and highlights limitations in visibility of cohorting activity. Work is therefore underway with the Business Intelligence team to improve identification, reporting, and triangulation of enhanced care demand, consistent with national ETOC learning that staffing models should not rely on SNCT data in isolation.

Since implementation, ECT usage has reduced, with average activity decreasing from 40 WTE to less than 30 WTE, reflecting greater stability, improved governance, and more appropriate utilisation of enhanced care. As a result, a permanent budget adjustment will be made to align establishment with sustained demand. While some monthly variation remains and occasional gaps are not fully backfilled with temporary staffing, staff capacity has been flexibly redeployed into ward and departmental areas during periods of lower enhanced care demand, reducing reliance on bank staffing and supporting overall efficiency without compromising quality or safety.



4.4 Nurse and Midwifery Job Planning

A structured job planning exercise was undertaken with 2026 for Clinical Nurse Specialists (CNSs), Midwifery Specialists, Advanced Nurse Practitioners, and Nurse Consultants to review role content, deployment, and alignment with service priorities.

This work assessed the balance between direct clinical activity, specialist interventions, and non-patient-facing work (including education, service development, audit, and leadership responsibilities), alongside contribution to inpatient flow and patient outcomes. The exercise provided improved visibility of specialist capacity and variation across services and has informed professional judgement regarding staffing models and skill mix, recognising that specialist activity is not fully captured within SNCT methodology.

The outcomes of this review will feed into wider Trust work with opportunities for more consistent job planning approach, standardisation of clinic templates and role responsibilities, innovative ways of working, and future workforce sustainability to be considered. Governance arrangements will be strengthened through the formalisation of an annual job planning and review cycle, aligned to Trust objectives and overseen through established clinical and workforce governance structures. Outputs from service development and role review will be required to feed directly into operational planning, workforce modelling, and establishment reviews, ensuring alignment between specialist roles, service demand, and strategic priorities. Clear accountability for oversight, review, and approval will be embedded within divisional leadership and professional governance forums, providing assurance that specialist roles continue to deliver value, support patient flow, and remain responsive to evolving service needs.

5.0 Recommendations and Key Actions 2026

The Boards are asked to receive assurance that:

- No moderate or severe staffing-related patient safety incidents were identified during the reporting period; all staffing-related Datix incidents were recorded as no or low harm.
- Nurse-to-patient ratios, registrant fill rates and CHPPD remain within acceptable and peer-comparable ranges.
- Strengthened temporary staffing controls (including second-level approval and forward planning) provide improved governance, cost control and safety assurance.
- The Enhanced Therapeutic Observation and Care (ETOC) model is well embedded, appropriately governed and aligned with national best practice, supporting the management of cognitively impaired and high-risk patients.
- Workforce risks are routinely triangulated with nurse-sensitive indicators, red flag reporting and professional judgement, with appropriate escalation through established governance structures.

The Boards are asked to note and monitor the following key workforce and safety risks:

- Sustained high patient dependency (Level 1b) across medical, surgical, frailty and emergency care wards, increasing nursing workload despite stable overall acuity.
- Ongoing operational bed expansions, ward reconfigurations and new ward openings where staffing templates and budgets are still embedding.
- Environmental and layout risks (e.g. modular builds, reduced visibility, isolated wards) that increase supervision requirements and are not fully reflected in SNCT outputs.
- Continued workforce pressures arising from sickness, training requirements and Nurse Associate vacancies, with reliance on registered nurse substitution as a mitigating strategy.

The Boards are asked to note the Steering Group's supported recommendations arising from the establishment review, where actions are required to mitigate patient safety risk associated with sustained service change:

- **Ward 7:** Introduction of one HCA twilight shift to support increased dependency, escalation beds and transition between day and night staffing.
- **Ward 36:** Alignment of funded establishment to include an additional HCA to reflect sustained bed expansion.
- **Ward 37:** Recurrent funding of the additional Registered Nurse and HCA if the 38-bed configuration remains operational.
- **Surgical Assessment Unit (SAU):** Addition of one Registered Nurse on twilight/night duty within the assessment area to mitigate safety risk associated with increased assessment activity.
- **Ward 26:** Extension of one Registered Nurse Day shift from 7.5 hours to 11.5 hours to strengthen cover during peak activity periods pending further monitoring.

The Boards are asked to note non-financial actions required to strengthen assurance and data quality:

- Stratification and clarification of Acute Floor rosters at RSH to reflect operational reconfiguration.
- Separation of adult and paediatric data collection within Emergency Department SNCT census activity to improve acuity visibility and workforce planning.

6.0 Conclusion

The Boards are asked to note that the Trust has robust and well-embedded governance arrangements in place to assure safe nursing, midwifery and AHP staffing. The bi-annual staffing review has been undertaken in line with national guidance using a triangulated approach incorporating Safer Nursing Care Tool (SNCT) data, professional judgement, workforce intelligence and nursing quality indicators, with clear executive oversight from the Chief Nurse and multidisciplinary partners.

The report identifies known and material workforce risks associated with increasing patient dependency (particularly Level 1b), ongoing service reconfiguration, bed expansion and environmental constraints not fully captured by SNCT. These risks are actively monitored, escalated and controlled through established daily senior nurse review, real-time red-flag reporting, enhanced matron oversight and strengthened temporary staffing governance. Targeted and proportionate actions have been agreed where sustained operational change or patient safety risk warrants adjustment or enhanced monitoring and will continue to be reviewed through established quality, workforce and operational governance routes. Overall, the report provides clear assurance to the Boards that staffing-related patient safety risks are being effectively identified, mitigated and governed, while recognising the need for continued vigilance as services embed and workforce pressures persist. The Group Chief Nurse and Group Chief Medical Officer have confirmed that they are satisfied with the safety, effectiveness and current sustainability of staffing levels at the Shrewsbury and Telford Hospital NHS Trust.

Appendix 1 SNCT data collected Jan/Feb 2026

Specialty/ Ward	Beds as per SNCT audit	SitRep occupancy Rate (July) %	Empty Bed %	Dependency Level Summary / SNCT element 0 %	1a %	1b %	1c %	1d %	2 %	3 %	Proposed SNCT FTE (excluding 1c/1d)	Budget (inc Band 7, RN, NA and HCA)	correct or over/under established based on stratified budgets	Ratio (percentage of RN to non RN day and night) - Budget	Recommendations or comments
Emergency Care															
AMU PRH	17.6	97.15%	0.0%	62.5%	8.5%	29.0%	0.0%	0.0%	0.0%	0.0%	30.5	37.48	5.98	57%	Ward has expanded capacity, SNCT based on 17 beds - no change recommended
AMU RSH	39.0	96.86%	1.3%	23.6%	16.4%	58.5%	0.3%	0.0%	0.0%	0.0%	77.11	42.78	-35.33	62%	Ward has expanded capacity, SNCT based on 39 beds - Revise template to reduce 1B7 WM creating new post.
SAU (W33/W34)	38.6	96.43%	0.0%	78.0%	7.0%	15.0%	0.0%	0.0%	0.0%	0.0%	62.48	56.3	-8.18	57%	No ward change, increase of 1 RN on night duty in assessment area
A&E RSH				53.1%	15.9%	27.4%	2.8%		0.8%	0.0%	108	152.63	43.63	68%	No change recommended
A&E PRH				70.0%	12.5%	13.6%	2.3%		1.4%	0.2%	106.8	138.3	30.50	79%	No change recommended
Medical															
Ward 6 CCU	24.0	98.32%	0.4%	23.2%	49.4%	13.3%	0.0%	0.4%	13.3%	0.0%	35.33	40.14	3.81	73%	No change recommended
Ward 7 - Endo/Gen Med (PRH)	29.5	99.19%	0.0%	19.0%	0.0%	81.0%	0.0%	0.0%	0.0%	0.0%	51.67	42.8	-9.87	56%	Increase unregistered staff 1 TWL
Ward 9 Frail and Complexe	30.8	95.21%	1.9%	30.2%	0.3%	67.5%	0.0%	0.0%	0.0%	0.0%	50.16	42.8	-8.36	56%	No change recommended
Ward 11 Nephrology (PRH)	31.0	98.89%	0.0%	44.4%	0.6%	55.0%	0.0%	0.0%	0.0%	0.0%	46.87	42.8	-5.07	56%	No change recommended
Ward 10 Short Stay	30.0	98.27%	0.3%	68.0%	0.0%	31.7%	0.0%	0.0%	0.0%	0.0%	38.89	40.14	0.25	60%	No change recommended
Ward 15	24.4	95.47%	0.4%	5.6%	0.0%	94.0%	0.0%	0.0%	0.0%	0.0%	46.68	48.44	0.76	50%	No change recommended
Ward 16	17.4		0.6%	17.7%	1.8%	68.3%	0.0%	0.0%	11.6%	0.0%	30.75	32.12	0.37	67%	
Ward 17 Respiratory	27.5	95.51%	0.0%	16.4%	1.8%	68.3%	0.0%	0.0%	11.6%	0.0%	48.56	45.5	-4.06	64%	No change recommended
Ward 36	26.0	98.21%	1.2%	14.7%	1.2%	81.1%	1.9%	0.0%	0.0%	0.0%	45.63	32.16	-14.47	60%	Funding required for nighttime HCA with opening of 6 beds
Ward 22 Short Stay	26.0	98.76%	1.5%	34.6%	18.1%	45.4%	0.4%	0.0%	0.0%	0.0%	38.29	37.48	-1.81	63%	Options for adressing daytime RN to pt. ratio to be considered
Ward 24 Respiratory	30.1	95.21%	0.3%	17.0%	21.7%	47.3%	0.0%	0.0%	13.7%	0.0%	51.38	58.77	6.39	64%	No change recommended
Ward 25 Medicine	38.0	94.74%	9.4%	75.6%	0.5%	14.4%	0.0%	0.0%	0.0%	0.0%	43.28	61.64	17.36	60%	No change recommended
Ward 26 Endo / Medicine	38.0	98.98%	0.0%	20.3%	0.3%	75.8%	3.7%	0.0%	0.0%	0.0%	64.77	55.18	-10.59	57%	Increase 1 RN from 7.5 hr to 11.5 hour duty
Ward 27 Gen Med	39.1	98.84%	1.0%	37.5%	1.8%	59.2%	0.5%	0.0%	0.0%	0.0%	60.69	58.77	-2.92	55%	No change recommended
Ward 28 Medicine & Frailty (RSH)	33.0	95.77%	0.9%	38.5%	0.0%	55.5%	5.2%	0.0%	0.0%	0.0%	50.00	53.44	2.44	57%	No change recommended
Ward 35 Renal	17.1	95.56%	4.7%	27.6%	5.3%	62.4%	0.0%	0.0%	0.0%	0.0%	27.32	32.15	3.83	50%	No change recommended
Surgery															
Ward 37 Surgery	38.0	98.13%	1.4%	42.3%	0.0%	56.1%	0.0%	0.2%	0.0%	0.0%	58.32	56.11	-3.21	53%	Decision required on funding additonal beds
Ward 38 Gastroenterology	28.0	96.20%	0.0%	43.6%	1.4%	54.5%	0.2%	0.0%	20.0%	0.0%	42.59	45.46	1.87	53%	No change recommended
Ward 39 -Colorectal	28.0	98.39%	1.2%	17.2%	0.0%	0.0%	81.6%	0.0%	0.0%	0.0%	42.4	45.46	2.06	53%	No change recommended
Ward 8 H&N	14.4	92.06%	0.0%	22.0%	0.0%	78.0%	0.0%	0.0%	0.0%	0.0%	23.1	23.98	-0.12	69%	No change recommended
Muscoloskeletal															
Ward 4 Trauma and Orthopaedic	27.3	90.09%	0.6%	38.8%	3.0%	56.7%	0.9%	0.0%	0.0%	0.0%	47.11	42.8	-5.31	56%	No change recommended.
Ward 5 Elective Orthopaedic															Ward not operating fully as elective orthopaedics due to IPC works required - no changes recommened.
Ward 32 Acute Orthopaedic Trauma Unit	24.4	95.53%	1.2%	17.2%	0.0%	81.6%	0.0%	0.0%	0.0%	0.0%	42.82	42.8	-1.02	56%	No change recommended
Oncology															
Ward 23OC Oncology & Haematology	30.0	95.81%	2.0%	69.3%	1.7%	27.0%	0.0%	0.0%	0.0%	0.0%	37.76	45.47	6.71	64%	No change recommended
Womens & Childrens															
Ward 14 Gynaecology	12.6	87.84%	0.7%	50.3%	0.7%	48.3%	0.0%	0.0%	0.0%	0.0%	13.15	20.1	5.95	67%	No change recommended
Ward 20 Paediatric Oncology	3.0	no data	33.3%	56.7%	0.0%	6.7%			0.6%	0.0%	6.4	10.65	4.25	100%	No change recommended
Ward 19	33.0	78.98%	22.4%	61.5%	3.0%	12.4%			0.6%	0.0%	66.3	59.17	-9.13	73%	No change recommended (budget is based on winter seasonal template for comparison to SNCT)
Total													16.71		

Appendix 2

SACC	
Acute Orthopaedic Trauma Unit (AOTU)	• AOTU is a 24-bedded ward with consistently high patient dependency across the last three SNCT census periods, reflecting an ageing trauma population with increased supervision, mobility and personal care needs. • Patient safety risks are heightened by cognitive impairment, falls risk and ward layout, requiring continuous observation across all bays; lower acuity patients are outlied elsewhere. • SNCT outputs remain aligned with the funded establishment (including 24% uplift); no staffing changes are recommended at this time.
Ward 4 Orthopaedic	• Ward 4 is a 26-bedded Trauma and Orthopaedic ward that also accommodates medical outliers and has managed sustained additional bed pressure due to the temporary closure of Ward 5. • An Ambulatory Trauma Area (ATA) operates flexibly, at times increasing inpatient capacity and workload; additional senior nurse cover is included on nights within the ward establishment to support this activity. • Despite consistently high dependency and temporary increases in bed numbers, current establishment levels remain appropriate, with no changes recommended pending the reopening of Ward 5 and recognition of ongoing seasonal demand.
Ward 8 H&N	• Ward 8 is a 14-bedded specialist Head and Neck ward delivering complex post-laryngectomy and tracheostomy care, with additional non-admitted activity managed through a treatment room, including ED redirections. • Changes to Oral Maxillofacial Services have resulted in increased Trauma and Orthopaedic outliers, raising patient dependency and nursing workload alongside specialist care. • Although budgeted staffing sits slightly above SNCT recommendations and does not capture ward attender workload, the current establishment provides sufficient flexibility; no changes are recommended at this time.
Ward 37 Surgery	• Ward 37 has expanded from its original 32-bed design to 38 beds in response to sustained demand, supported by an additional RN and HCA on day and night shifts; this enhanced staffing model is currently unfunded. • Workforce stability and skill mix have significantly improved over the last year, resulting in a confident, experienced and cohesive nursing team. • Although budgeted staffing appears above SNCT recommendations, this does not reflect the increased bed base, modular layout, visibility challenges and associated safety risks; recurrent funding for the additional RN and HCA is recommended if the 38-bed configuration is maintained.
Surgical Assessment Unit (SAU)	• SAU comprises a 38-bedded mixed-use unit with both inpatient and assessment functions; SNCT methodology does not adequately capture the workload generated by the assessment area. • Increased surgical flow has improved patient throughput but resulted in rising assessment activity (≈100 additional patients per month), with peak evening demand and significant night-time staffing risks, particularly relating to visibility, patient observation and imaging escorts. • A targeted staffing enhancement is recommended: one additional Registered Nurse on a twilight/night shift within the assessment area to mitigate patient safety risk, support peak demand, and sustain effective SAU function.
Wards 38 (Gastroenterology) and 39 (Colorectal)	• Wards 38 (Gastroenterology) and 39 (Colorectal) opened in December 2025 as two new 28-bedded modular wards, expanding capacity from 38 to 56 beds and requiring additional recruitment. • Ongoing vacancies have led to reliance on temporary staffing, affecting workforce stability and continuity of care during the transition period following relocation. • Modular design presents visibility challenges for a high-risk patient cohort, driving increased demand for enhanced observation and additional care input beyond baseline staffing. • This is the first SNCT census post-move; although recommended staffing is slightly below budget, environmental risks and workforce instability are not fully reflected, and no establishment changes are recommended at this stage.
MEC	
Ward 7 Endocrine and Gen Med	• Ward 7 is a 28-bedded Endocrinology/General Medicine ward that frequently operates at 30 beds due to sustained capacity pressures. • A sustained rise in patient acuity and dependency following the specialty change has resulted in repeated SNCT recommendations above the funded establishment,

	driven by high levels of cognitive impairment, falls risk, and enhanced observation needs. • Additional pressure arises from cardiology outliers requiring telemetry, further increasing skill mix and workload demands. • An uplift to the staffing template is recommended, specifically the introduction of a twilight shift role to support peak activity, improve patient safety, and strengthen transition between day and night staffing.
Ward 17 Respiratory	• Ward 17 is a 28-bedded ward with a defined Respiratory Unit, including four Level 2 beds (1:2 nursing) and eight further monitored beds supporting patients with acute respiratory needs. • The ward provides 24-hour NIV initiation, requiring a minimum of two nurses with specialist respiratory competencies on every shift, adding complexity to roster planning and resilience. • SNCT outputs indicate staffing levels slightly above the funded establishment; however, given the specialist service and dependency profile, no changes are recommended at this time, with continued monitoring advised.
Ward 6/ CCU	• Ward 6 is a 23-bedded cardiology ward with 10 monitored acute cardiac beds, frequently operating at 24 beds due to capacity pressures. • The ward manages a highly acute and unpredictable workload, including frequent internal and external transfers requiring nursing escorts and periods of 1:1 or 2:1 care, significantly increasing staffing demand. • Staffing requires flexibility due to Cath Lab cover, high acuity interventions and skill development of newer staff.
Ward 9 Frail & Complex	• Ward 9 changed function in December 2025 and now operates as a 28-bedded inpatient ward, an increase from the previously audited 22-bed model. • The patient cohort includes high levels of delirium and cognitive impairment, increasing supervision, de-escalation and observation requirements, with particular risk identified overnight. • There is increased reliance on the Enhanced Care Team to manage safety and distressed behaviour. • Only one SNCT data set is available post-change; therefore, no staffing establishment changes are recommended at this time, with further review required once additional data is available.
Ward 11 Nephrology/Medicine	• Ward 11 is a 29-bedded general medical/renal ward that has frequently operated at 31 beds due to escalation pressures; escalation beds were stepped down in early March 2026. • During escalation, the ward manager has regularly worked clinically to maintain safe staffing, reducing leadership capacity and creating an unsustainable model, compounded by frequent staff redeployment. • SNCT outputs show recommended staffing above the funded establishment, reflecting temporary bed increases and high patient dependency; staffing remains sensitive to escalation and staff movement. • The ward has a stable, experienced workforce, but staff morale is being affected by cumulative escalation pressures and redeployment; no immediate establishment changes are recommended at this time.
Wards 15 and 16 Stroke/Rehab	• Wards 15 and 16 operate as a single stroke service with distinct functions: Ward 16 as the Hyper Acute Stroke Unit (HASU) managing acutely unwell patients (including Level 2 care and thrombolysis activity), and Ward 15 providing rehabilitation and recovery care. • The Thrombolysis Room on Ward 16 sits outside the SNCT census but requires continuous staffing to support rapid assessment and treatment; the current staffing model provides sufficient flexibility to manage fluctuating acute demand. • Recent SNCT outputs show stability for Ward 15 and a slight increase for Ward 16, largely due to additional patients accommodated under the hospital full policy; this demand has been managed safely within existing establishments. • No further staffing establishment changes are recommended for either ward at this time.

Ward 36 Medicine	• **Ward 36** is a newly established ward that increased from 20 to 26 beds during the SNCT census period, limiting the reliability of the outputs. An agreed night-shift HCA to support the additional six beds has not yet been reflected in the finance template and should be incorporated into the establishment. • The additional beds are predominantly side rooms with reduced visibility; operational mitigations are in place, but the ward is currently managing a high-dependency cohort. As the ward function is expected to evolve towards a lower-acuity, short-stay model, ongoing monitoring is required, with formal review if higher dependency care continues.
Ward 10 Short Stay	• Ward 10 operates primarily as a short-stay ward with a predominantly low-dependency patient profile (approximately 68% Level 0 / 32% Level 1b). • The most recent SNCT census shows a modest increase in Level 1b dependency and temporary use of two escalation beds, but overall activity remains consistent with short-stay care delivery. • Seasonal increases in acuity are recognised, particularly in winter months, and high sickness levels have required the ward manager to work clinically, reducing managerial oversight. • No changes to the funded staffing budget are recommended at this time, though sickness and leadership capacity require ongoing attention.
Acute Medical Unit (PRH)	• The PRH AMU census remains consistent with previous periods, showing a predominantly lower-acuity patient profile with a slight increase in dependent and acute patients. • During the census, AMU expanded from 17 to 25 beds with the opening of eight side-room beds in the former Apley Ward; these beds are not captured in the current SNCT data set and will require future full-cycle review. • Patient flow has improved following the opening of the AAU, significantly reducing over-capacity care within AMU corridors. • Although SNCT outputs sit below the funded establishment, they do not reflect the operational impact of service expansion or the non-patient-facing Band 6 co-ordinator role central to admissions and flow management. • No immediate staffing establishment changes are recommended; a formal review is required once a full census captures the expanded bed base.
Ward 35 Renal	• Ward 35 is a specialist renal ward located in the Copthorne building which is located away from the majority of wards, with geographical separation and fire safety requirements necessitating higher minimum staffing levels than those generated by SNCT alone. • Staffing demand is increased by transport and escort requirements, ward layout and visibility challenges, cross-site renal nurse support for peritoneal dialysis, and non-inpatient activity including Rituximab infusions and renal biopsy day cases. • Although SNCT outputs recommend staffing below the funded establishment, they do not account for these location-specific, safety-critical and service-related factors; therefore, minimum safe staffing levels must be maintained irrespective of SNCT variance.
Ward 28 Frail & Complex	• Ward 28 cares for a high proportion of cognitively impaired, high falls-risk patients, requiring active cohorting and enhanced observation, which reduces staffing flexibility and increases pressure on available resources. • A review is underway to relocate the Frailty SDEC service in line with GIRFT guidance, which is expected to reduce demand and improve pathway alignment for frail patients. • The Division has identified potential benefit in introducing an additional unregistered twilight shift to strengthen observation, support de-escalation and reduce reliance on enhanced care; however, with potential changes in ward bed base with any relocation of Frailty SDEC no changes are recommended at this time.
Ward 27 General Medicine	• Ward 27 is a 39-bedded general medical ward caring for a complex cohort, with a high proportion of patients with cognitive impairment requiring enhanced observation and support under MCA, DoLS and Best Interest frameworks. • These care needs place additional demands on staffing, supervision and multidisciplinary coordination. • The ward benefits from a stable, experienced workforce with low vacancy and turnover rates, supporting continuity and quality of care. • The latest SNCT census mirrors previous findings, showing sustained high dependency and a slight increase above the funded establishment; however, as this is the first variance since the 2025 template changes, no staffing establishment changes are recommended at this time.

Ward 24 Respiratory	• Ward 24 is a 31-bedded ward incorporating an acute respiratory unit with six Level 2 beds, a dedicated NIV initiation side room, and seven monitored beds for patients with acute respiratory needs. • Patient isolation within PODs reduces staff visibility and flexibility, increasing reliance on workforce resilience and skill mix. • At this time, no changes to the funded staffing establishment are recommended.
Ward 25 Medicine/Escalation	• Ward 25 opened in December 2025 as a new medical short-stay unit, initially operating at 20 beds and escalating to 38 beds to support acute floor flow, with an intended average length of stay of up to 72 hours. • The ward manages a high turnover of lower-acuity medical patients. The original staffing template for 38 beds was amended on a temporary basis to better align with workload intensity, increasing Registered Nurse provision on day shifts and reducing by one RN overnight. • This represents the first SNCT census for Ward 25; therefore, no staffing establishment recommendations are made at this time.
Ward 26 Endocrine/Medicine	• Ward 26 is a 38-bedded General Medical and Endocrinology ward with a demonstrated increase in patient acuity and dependency, reflected by a reduction in Level 0 patients and a rise in Level 1b dependency. • The ward has a regular requirement for enhanced care support and has seen increases in patient safety incidents, including pressure ulcers and falls, indicating growing supervision and care complexity needs. • Current SNCT outputs recommend a more significant staffing uplift than in previous reviews; however, a full permanent establishment change is not recommended at this time as the ward has been impacted by the opening of ward 25 and a period of embedding is required as activity stabilises. • As an interim measure, it is recommended that the additional Registered Nurse currently rostered for part of the day shift is extended to a full long day, strengthening cover during peak activity periods and supporting patient safety while further monitoring takes place.
Acute Medical Unit (RSH)	• The Acute Floor at RSH has undergone major reconfiguration, with AMU expanding from 20 to 39 inpatient beds and redesigned assessment pathways, including relocation of SDEC, closure of AMA, and opening of a new Acute Assessment Unit (AAU). • Although staffing templates have not formally changed, staff have been redistributed to support new ways of working; current budgets, rosters, and SNCT outputs do not yet fully reflect the expanded AMU footprint or assessment activity. • The expanded AMU manages higher acuity patients, including enhanced care and monitored beds, with increased reliance on continuous monitoring and telemetry due to delays in cardiology transfers. • SNCT outputs should be interpreted with caution until activity stabilises, and a full census cycle captures the new operational model. • The Division proposes reconfiguring senior leadership by reducing ward manager posts by one and converting the role to a Band 7 clinical leadership position focused on quality, safety, and coordination across the acute medical take, within existing budget. However, although this narrative was provided by the Divisional Director of Nursing after the establishment review it was not discussed as part of the establishment review meetings and any changes will need to be considered and approved by the Chief Nurse, taking into consideration how this aligns with the existing band 6 coordinators, navigator role and the 2 clinical band 7 flow co-ordinator roles already in place within the acute floor footprint and the future staffing changes already templated as part of HTP workforce reviews undertaken last year • Further work is required to align rosters and budgets, clarify staffing accountability across redefined areas, and continue monitoring acuity, dependency, and enhanced care demand.
Ward 22 Short Stay	• Ward 22 is a 26-bedded short-stay ward with a separately staffed discharge area supporting seven-day patient flow across the acute floor; this activity sits outside inpatient budgets and SNCT benchmarking. • The latest SNCT census shows a slight increase above the funded establishment, the first upward variance for the ward, potentially influenced by system changes following the opening of Ward 25 as an additional short-stay unit. • The ward's operational model requires the Nurse in Charge to function largely supernumerary on day shifts due to high turnover, discharge coordination, and flow management demands, limiting direct patient allocation. • Options considered include removing the discharge area, retaining the current model, or adding an additional day-shift Registered Nurse; the preferred option is an

	additional RN to preserve flow, safety, and the Nurse in Charge role, acknowledging this model differs from other wards.
CSS	
Ward 23 Oncology/Haematology	• Ward 23 is a 30-bedded specialist Oncology and Haematology ward, supported by four weekday assessment spaces for haematology reviews and chemotherapy delivery, contributing to national cancer access standards. • Clinical complexity has increased, particularly due to expanding immunotherapy use; although SNCT data shows a higher proportion of Level 0 patients, this does not reflect the need for enhanced nursing ratios for neutropenic or clinically unstable patients. • When fully staffed, the current establishment is considered sufficient to meet patient needs safely. • No changes to the staffing establishment are recommended at this time.
Women & Children's	
Ward 14 Gynaecology	• Ward 14 is a small ward where SNCT reliability is limited due to low patient numbers and reduced flexibility in adjusting staffing to acuity changes. • Minimum safe staffing requirements, including a baseline of two Registered Nurses per shift, result in funded staffing exceeding SNCT recommendations; however, acuity remains stable with minimal variation. • The current staffing template is therefore justified and necessary to maintain patient safety and care standards. • In addition, the Ward 14 co-ordinator role provides functional support to both Ward 14 and the Acute Gynaecology Treatment Unit (GATU), a responsibility not reflected within SNCT or budgeted establishment figures.
Ward 19 Paediatrics & Ward 20 Oncology/Haematology	• A revised paediatric summer and winter staffing template was implemented in 2025 to reflect seasonal variation, with winter staffing based on 33 beds and summer on 28 beds across five paediatric areas. • The latest SNCT census shows a slight variance above budget for Wards 19 and 20 combined (72.7 WTE vs 69.82 WTE winter budget), with occupancy averaging 26 beds during the census and improved workforce stability with minimal vacancies. • Significant non-ward duties (ED resuscitation support, specialist transfers, and MRI sedation escorts) reduce real-time ward staffing but are not captured within SNCT; some buffer capacity exists within the combined establishment to mitigate this. An uplift of 24% remains in place (aligned with other areas), with fixed-term posts agreed to cover maternity leave. An updated Children and Young People SNCT is expected imminently, which may better reflect complex care and constant observation requirements.

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	022/26		
Report Title	SaTH Infection Prevention and Control Report Q4 2025/26		
Executive Lead	Paula Gardner, Chief Nursing Officer		
Report Author	Kelly Pardy, Deputy Lead Infection Prevention Control Nurse		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
IPC Operational Group, April 2026 Quality & Safety Assurance Committee, April 2026 IPC Assurance Committee, May 2026	Safe	√	
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	The Trust has breached all set targets for reportable HCAIs for 2025/26 • 5 MRSA bacteraemias vs target 0 • 132 C. diff vs Target 98 • 172 E. coli bacteraemias vs target 146 • 54 Klebsiella bacteraemias vs target 36 • 18 Pseudomonas bacteraemias vs target 16 Infrastructure and resourcing constraints persist, notably limited isolation facilities, lack of decant space, and restricted deep-cleaning capacity. These continue to feature on the IPC risk register as extreme risks. Overall compliance with the Health and Social Care Act (2008) remains high at 97%, with a single, red-rated element linked to gaps in occupational health contact tracing.		
Recommendations for the Board	The Board is asked to **note** the report, and in particular**:** • the continued exceedance of HCAI trajectories and actions in place to mitigate. • Support investment in IPC infrastructure and workforce to address systemic constraints. • Endorse strengthened clinical engagement and accountability in RCA and infection prevention processes. • Recognise the outstanding occupational health contact tracing gap as a contractual and governance risk		
Appendices: (Appendices 2&3 in Board Information Pack)	Appendix 1 HCAI targets 2025/26 Appendix 2 HCAI graphs Appendix 3 – Health and Social Care Act 2008 self-assessment tool		

1.0 INTRODUCTION

This paper provides a report for Infection Prevention and Control for Quarter 4 (January – March 2026) against the 2025/26 objectives for Infection Prevention and Control. An update on hospital acquired infections: - Methicillin Resistant *Staphylococcus aureus* (MRSA), Clostridioides Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E. Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for October – December 2025 is provided. An update in relation to Covid-19 is also provided. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

The HCAI targets (See Appendix 1)

2.1 MRSA Bacteraemia
The target for MRSA bacteraemia was at zero cases for 2025/26. The Trust breached this target and ended the financial year on 5 cases.

This is a rate of 1.7 per 100,000 bed days.

In Quarter 4, there were 4 MRSA bacteraemia cases (table 1, appendix 2).
2 of the 4 cases were believed to be contaminants- not true bacteraemias.
1 case believed to have been caused by a catheter change procedure in the community
1 case believed to have been caused wound/broken toe (reason for admission).

The themes identified from investigations include
- Missed sites on admission screen (groin and wounds)
- Inadequate documentation and resultant maintenance of peripheral IV access devices.
- Inadequate documentation of skin assessment and wounds

2.2 Clostridioides Difficile
The Trust trajectory for C diff cases in 2025/26 was no more than 98 cases. The Trust breached this target and ended the financial year on 132 cases.

There was a total of 38 cases of C diff for Quarter 4 2025/26 (table 2 appendix 2). 18 of these cases were HOHA and the remaining 20 cases were COHA.

This is a rate of 47.8 per 100,000 bed days for Q4 2025/26, table 3 appendix 2 (this is based on an estimated bed day figure). This is a reduction on both Q1 and Q2 C. diff rate.

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

So far, of the 90 case C. diff cases reviewed for this financial year 33 cases are likely to have been caused by inappropriately prescribed antibiotics.

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

2.3 E. coli Bacteraemia
The Trust trajectory for E.coli bacteraemia cases in 2025/26 was no more than 146 cases. The Trust breached this target and ended the financial year on 172 cases.

In Quarter 4, there were 38 cases attributed to the Trust (table 4, appendix 2). 17 of these cases were HOHA, and the remaining 21 cases were COHA. 7 of the HOHA cases in Q4 were considered

to be device or intervention related, and the source in all 7 cases was considered to be urinary, with a catheter in place.

2.4 MSSA Bacteraemia
There is no nationally set target for MSSA. The trust reported 51 cases in 2025/26, a decrease from 61 cases last year. In Quarter 4 2025/26, there was a total of 12 cases of MSSA Bacteraemia. 6 of these cases were HOHA and the remaining 6 were COHA (table 5, appendix 2). 1 of the HOHA cases in Q4 was considered to be linked to a device. The source in this case was considered to be urinary, with a catheter in situ.

2.5 Klebsiella Bacteraemia
The Trust trajectory for Klebsiella bacteraemia cases in 2025/26 was no more than 36 cases. The Trust breached this target and ended the financial year on 48 cases.

In Quarter 4 2025/26 there were 11 cases of Klebsiella Bacteraemia attributed to the Trust (table 6, appendix 2). 3 of these cases were HOHA, and the remaining 8 cases were COHA. None of the HOHA cases in Q4 were considered to be device related.

2.6 Pseudomonas Aeruginosa
The Trust trajectory for Pseudomonas bacteraemia cases in 2025/26 was no more than 16 cases. The Trust breached this target and ended the financial year on 18 cases.

In Quarter 4 2025/26 there were 6 cases of Pseudomonas Aeruginosa attributed to the Trust (table 7, appendix 2). 2 of these cases were HOHA, and the remaining 4 cases were COHA. None of the HOHA cases were considered to be device or intervention related.

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

In Quarter 4:
Of the 12 MSSA cases reported, 4 are expected to have RCAs, 2 of which were due to source being IV access device, 2 due to unknown source.
Of the 38 E. coli cases reported, 2 are expected to have RCAs as the source is believed to be a urinary catheter

Learning from completed RCAs include:
- Mismanagement of IV cannula- not recorded on vitals and not dated

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

3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

Month	Ward	Organism	Outcome/ Typing	Comments
January	S27	COVID		6 patients
	S28	C. diff	Not an outbreak- typing different	3 patients
	T 6	Flu		8 patients
	T7	COVID		4 patients
	T7	C. diff	Not an outbreak- typing different	2 patients
	T9	RSV		4 patients
	T9	Flu		2 patients
	T11	Flu		2 patients
	T 11	MRSA	Not an outbreak- Typing different	3 patients
February	S25	C. diff	Typing the same- outbreak	2 patients
	S26	COVID		2 patients
	T 9	Flu		2 patients
March	S 26	Flu		7 patients
	S26	C. diff	Not an outbreak- typing different	2 patients
	S26	ESBL	Unable to type one case	2 patients
	S 27	C. diff	3 of 4 cases different, 1 result pending	4 patients
	S28	D & V	No causative organism identified	8 patients
	S37	C. diff	Not an outbreak- typing different	3 patients

The themes identified during the investigation of these incidents are

- Missed opportunities for hand hygiene for staff and patients (mealtimes)
- IPC care plan, screening tool and daily documentation of poor quality in nursing notes
- Substandard cleanliness of the immediate patient environment and equipment
- Non-compliance with Bare Below the Elbows
- Inappropriate use of gloves
- Broken/ damaged equipment (inc. commodes) unable to be cleaned
- Shared use of single patient use items (wash wipes)

4.0 INCIDENTS RELATED TO INFECTION PREVENTION & CONTROL

1 confirmed case of Measles on Ward 19, PRH in January
32-week-old child, too young to have been vaccinated. No known contact with another case, however had been to a caravan park on holiday out of region earlier in the month.
Contacts managed. No further cases identified.
Issues with obtained immunity data for staff to guide on decisions re. staff exclusions- escalated through workforce, work in progress to allow controlled access of immunity data ongoing.

5.0 IPC INITIATIVES

- Quality ward walks continue monthly by matrons, quarterly by the IPC team and more frequently in response to outbreaks and periods of increased incidence.
- Daily ward visits with IPC advice and education
- Statutory Face to Face training delivered on both sites to all grades of staff.
- Progressing with trial of hypochlorous acid on NNU as an alternative to Tristel Fuse, this may be rolled out more widely across the trust if well received.
- Mealtime visits completed by IPC to ensure compliance with patients' and staff hand hygiene prior meals.
- IPC team providing guidance and sign off for bed base reconfiguration and opening of refurbished areas across the Trust and movement of areas off site.
- IPC deputy lead nurse completed braver leaders programme.
- IPC and workforce working together to get person identifiable immunity data in a controlled way from occupational health provider, to enable swift action when IPC exposure incidents occur.
- IPC working with IT and Baxter to enable pre-purchased modules for ICNET and integrate Care Flow with ICNET, this will assist in the identification and management of outbreaks.

6.0 RISKS AND ACTIONS

There are 5 risks on the IPC risk register, all of which are rated as extreme risks and are reviewed monthly

- Risk 1326 Risk of lack of person identifiable immunity data (jointly owned with workforce)
- Risk 923 Risk of HCAI due to the lack of isolation facilities
- Risk 1241 Hospital overcrowding and associated IPC risk (requested that this is owned by operations)
- Risk 444 Lack of deep clean programme
- Risk 722 Exceeding nationally set targets for reportable HCAIs

7.0 IPC BOARD ASSURANCE FRAMEWORK

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

8.0 HEALTH AND SOCIAL CARE ACT COMPLIANCE UPDATE

The Health and Social Care Act (previously known as Hygiene Code) is reviewed quarterly by the IPC team and presented at the IPC Operational Group. Following the full review, the Trust is currently 97% compliant, being RAG rated 'Green' for 248 elements, 'Amber' for 19 and RAG rated 'Red' for 1. The "red" element is in relation to follow of up of staff by occupational health as contact tracing is not included in the contract with Optima. This has been escalated to workforce as a risk.

The Trust self-assessment compliance against each of the 10 domains and the current gaps are shown the self-assessment Tool (see appendix 3)

9.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 4 of 2025/26.

Appendix 1 HCAI targets 2025/26

	2023/24 Target	2023/24 Actual	2024/25 Target	2024/25 Actual	2025/26 Target	2025/26 Actual
MRSA	0	0	0	6	0	5
C. diff	32	97	98	112	98	132
E. coli	90	147	146	159	146	172
Klebsiella	22	38	36	48	36	54
Pseudomonas	18	21	19	19	16	18

Board of Directors' Meeting in Common – 14 May 2026

Agenda item	023/26	
Report Title	NHS Annual Staff Survey results – Group	
Executive Lead	Rhia Boyode, Group Chief People Officer	
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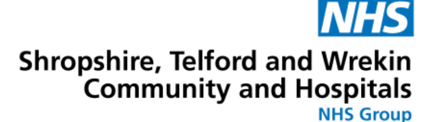
Prior Consultation:	**CQC Domain:**	**Link to (SATH) BAF id(s)**
Group People Committee January 2026	Safe √	BAF3, BAF4
	Effective √	
	Caring √	**(SaTH) Risk Register id(s):**
	Responsive √	N/A
	Well Led √	
Executive Summary	1.The Boards' attention is drawn to Section 2 where the 2025 Staff Survey results show that both Trusts are below the respective sector average in scores for all the People Promises, apart from SaTH's score for 'We work flexibly'. There are common areas for focus across both Trusts, these are Advocacy, Involvement and Health and Wellbeing. Note that the scores for some of the People Promises have altered due to the weightings applied during the benchmarking process. 2.The Boards are asked to acknowledge that several actions can take longer periods of time to embed before they are felt/ experienced by staff. NHSE suggests that the staff survey data provides rich and valuable data to support and inform continuous improvement and cultural change for longer term 3–5-year planning. This means that we may not achieve BAF3 as quickly as we would hope.	
Recommendations for the Boards	The Boards are asked to: • **Note** the contents of this report	
Appendices:	Appendix 1: Annual Staff Survey Results 2025/26	



APPENDX 1

We each have
a voice that counts

Annual Staff Survey Results
2025/26

1.0 Introduction

1.1 The purpose of the paper is to provide an update on the 2025 National NHS Staff Survey results across the Group.

1.2 The paper presents a detailed analysis of our respective performance against national and regional benchmarks, highlighting areas of improvement between 2021 and 2024, as well as those requiring further action.

1.3 Data on the National Staff Survey portal is weighted to ensure equitable comparisons between organisations, and the national dataset has been used for this report.

1.4 Divisional and clinical leads, supported by the Group People Directorate, are accountable for the delivery of local action plans.

2.0 Executive Summary- Group

2.1 The staff survey is aligned to the NHS People Promise and provides the opportunity to listen and respond to our teams to deliver the best possible colleague experience across the Group.

2.3 A longer term analysis demonstrates that both Trusts have improved since 2021, when measuring against the NHS People Promise first began.

2.4 Results across both Trusts show common areas for focus in 2026/27:

- Advocacy – making our Trusts a great place to work and to receive care.
- Involvement – ensuring that colleagues' voices are heard and colleagues are involved in changes and improvements that matter to them.
- Health and Wellbeing – too many of our colleagues are feeling the effects of burnout.

2.5 The next steps will focus on continuing our communication and engagement activity to ensure the results are shared widely and colleagues can clearly see the impact and value of having their voice heard. We will celebrate areas of success, learn from teams who have made improvements, and be open about where further focus is needed to address underperformance.

3. Action Plans

3.1 This year, staff survey data and further supportive information was shared to Senior Leaders in early 2026, pre-embargo being lifted (12th March), to allow them to understand their data earlier and identify key themes and actions. Oversight and ownership of individual action plans will be through the relevant Performance Review Meeting's (SaTH) and Performance Board (SCHT), and

Committees, and delivery of action plans will be monitored through our Group People Committee.

3.2 The Executive Leadership Team has committed to key pledges linked to People Promises and themes where improvements are required which will be underpinned by local action plans. These pledges are;

- We want every colleague to feel proud to work and receive care across our Group ('engagement – advocacy')
- Place compassion and kindness at the heart of our services and our working culture (we are compassionate and inclusive)
- Build strong, supportive teams across the Group and create a working environment where colleagues feel valued, listened to, and able to thrive ('we each have a voice that counts')
- Improving our approach to health and wellbeing, supporting and retaining our colleagues and sustain high-quality patient care ('we are safe and healthy')

3.4 The Group has more work to do to ensure colleagues with a disability or long-term condition are treated equally to other colleagues. The percentage of colleagues reporting experiencing discrimination due to disability has increased and is higher than the sector average. The Group People Directorate is actively working in partnership with appropriate staff networks and staff side to improve this, and a dedicated action plan is in place and will be monitored via our in common Joint Negotiating Consultative Committee (JNCC/JNP).

3.5 Other actions that have already been taken, or are underway, include:

- Launched a global communication campaign to acknowledge and learn from areas requiring improvements, with an ongoing focus in all Trust and Group communications moving forward
- Dissemination and sharing of divisional and local headlines, shared by respective senior leaders.
- Divisional and local action plans in-place and progress reviewed as part of the Performance Review Meetings
- Launch of Poppy's Promise in Maternity and ED, to further embed compassionate into all our interactions and what we do
- Continue to deliver on our Group Culture Programme, in conjunction with our partners, and ensure a focus on psychological safety
- Designed and co-produced the Insight disability development programme for 2026, with a focus on supporting colleagues to role-model compassionate and inclusive leadership
- Continuing with focused work around sexual safety and embedding the NHS Sexual Safety Charter, supported by an ongoing communications campaign and implementation of the national requirements around colleague training
- A health and wellbeing campaign to raise awareness of the offer and support available, in conjunction with the development of a dedicated Belonging and Wellbeing Plan for the Group

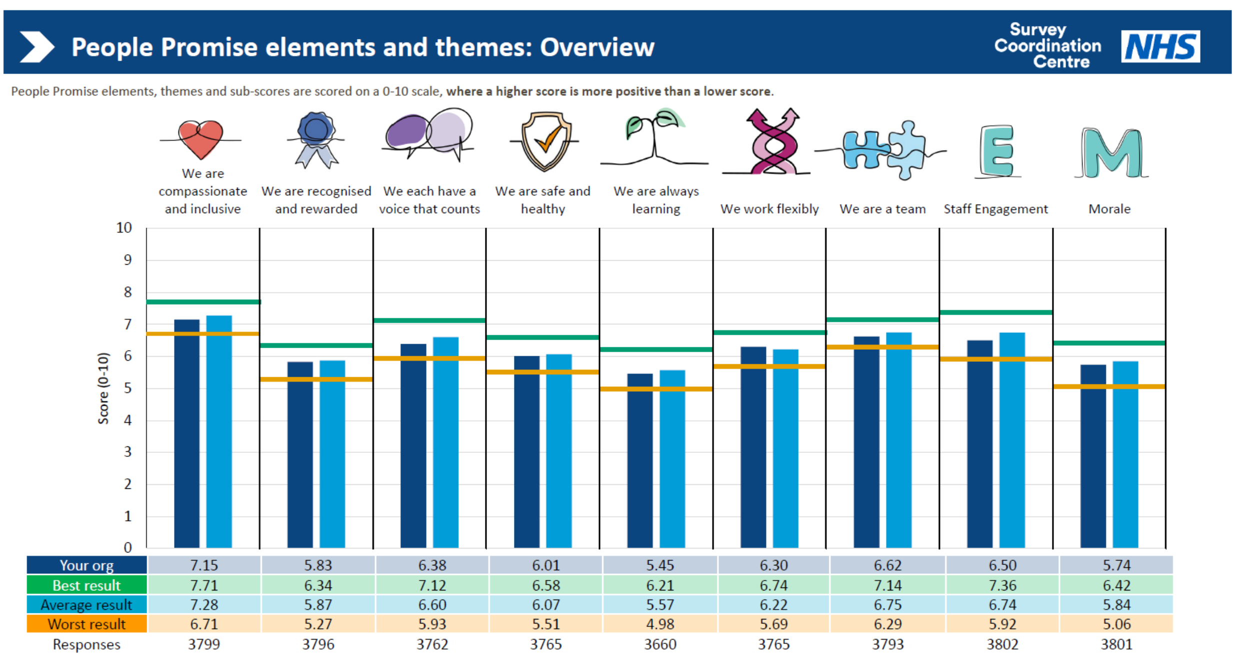
4.0 Key Survey Findings 2025 – SaTH

4.1 SaTH achieved a response rate of 46%, which is a 5% decrease compared to the previous year; it is also below the median for our sector benchmarking group (47%).

4.2 The full report can be found at NHS Staff Survey 2025 Benchmark Reports with the Interactive dashboards Results | Working to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com).

4.3 The table below provides a high-level summary of the overall Trust scores for all seven People Promises and two themes. We are above our sector average for 'We Work Flexibly', and below the sector average for the other Promises and themes.

Table 1 (taken from National Staff Survey Co-ordination Centre Benchmark Report)



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.15	5.83	6.38	6.01	5.45	6.30	6.62	6.50	5.74
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3799	3796	3762	3765	3660	3765	3793	3802	3801

4.4 The Trust has seen improvements from 2024 to 2025 in three of the People Promise areas: *We are recognised and rewarded*, *We work flexibly*, and *We are a team*. Scores have decreased in three areas: *We each have a voice that counts*, *We are safe and healthy*, and *We are always learning*. In addition, both the Staff Engagement and Morale scores have declined compared to last year. The score for *We are compassionate and inclusive* has remained unchanged.

Table 2

4.5 The table below shows our progress since 2021, when the survey first became aligned to the NHS People Promise. 2021 also marks the beginning of our cultural improvement journey.

Table 3

	2021	2022	2023	2024	2025	
We are compassionate and inclusive	6.84	6.93	7.14	7.15	7.15	
We are recognised and rewarded	5.51	5.54	5.86	5.81	5.83	↑ 2025
We each have a voice that counts	6.21	6.24	6.45	6.47	6.38	
We are safe and healthy	5.60	5.70	6.04	6.06	6.01	
We are always learning	4.89	5.09	5.41	5.48	5.45	
We work flexibly	5.57	5.75	6.17	6.26	6.30	↑ 2025
We are a team	6.26	6.39	6.63	6.61	6.62	↑ 2025
Staff Engagement	6.29	6.32	6.59	6.59	6.50	
Morale	5.31	5.42	5.79	5.84	5.74	

4.6 Continuing from last year, we are above the average for our sector in the sub-theme of Diversity and Equality. We are also slightly above the average in the sub-themes of Inclusion and Support for Work-Life Balance, and show above average scores for Negative Experiences, Development, Flexible Working and Motivation.

4.7 Table 4 below shows that results for 'we each have a voice that counts', Staff Engagement and Morale are significantly lower than 2024. The changes for the

remaining People Promise elements are not statistically significant. This means that the range within which scores have changed are so tight that the difference is minimal.

Table 4 (taken from National Staff Survey Co-ordination Centre Benchmark Report)

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.15	4069	7.15	3799	Not significant
We are recognised and rewarded	5.81	4071	5.83	3796	Not significant
We each have a voice that counts	6.47	4021	6.38	3762	Significantly lower
We are safe and healthy	6.06	4030	6.01	3765	Not significant
We are always learning	5.48	3904	5.45	3660	Not significant
We work flexibly	6.26	4042	6.30	3765	Not significant
We are a team	6.61	4059	6.62	3793	Not significant
Themes					
Staff Engagement	6.59	4071	6.50	3802	Significantly lower
Morale	5.84	4071	5.74	3801	Significantly lower

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

4.8 Our Score for ‘We are Compassionate and Inclusive’ has remained the same as last year, however, has increased year-on year since 2021. Our culture improvement programme and the work we have done with Equality, Diversity and Inclusion is beginning to embed across the organisation, although we recognise there is still more we plan to do in this space. It is also worth noting that the average score and ‘best score’ for our sector has seen a decrease from 2024.

4.9 It is encouraging to note we are also higher than our comparators for the sub-theme of Diversity and Equality (8.44 compared to the sector average of 8.37). Our score has increased from 2024, against the trend compared to the average for our sector, which has decreased.

4.10 Our score for the sub-theme of compassionate culture has decreased from 6.55 in 2024, to 6.48. This reflects reductions in all but one of the questions that make up this sub-theme. A slight increase was seen in the question ‘I feel that my role makes a difference to patients/service users, from 87.13% in 2024 to 87.53% in 2025.

The score for compassionate leadership has remained the same as 2024 at 6.86. The percentage of colleagues selecting agree/strongly agree to the question ‘My immediate manager cares about my concerns’ has increased from 67.15% in 2024 to 68.28%.

4.11 Our score for the 'We work flexibly' People Promise has increased year on year since 2021, and we are above the average score for our sector this year at 6.30, compared to 6.22. We have scored above the sector average for all of the questions that make up the 'We work flexibly' People Promise. The percentage of colleagues selecting agree/strongly agree to the question 'My organisation is committed to helping me balance my work and home life' has improved from 48.32% in 2024 to 48.79%. The percentage of colleagues feeling able to approach their immediate manager to talk openly about flexible working has increased from 70.07% in 2024 to 70.41%.

4.12 Our overall score for 'We are always learning' has seen a decrease on last year's score from 5.48 to 5.45, however we have seen a 0.56 increase since 2021 when our Talent programme (Appraisal) began. The sub-theme of Development is higher than the sector average at 6.31 compared to 6.29, although has decreased from 6.43 in 2024.

4.13 The percentage of colleagues having an appraisal or talent conversation has increased from 81.91% last year to 83.55%, and the percentage of colleagues feeling that it helped them improve how to do their job increased from 24.84% in 2024 to 25.50% in 2025, which is slightly above the sector average although we recognise that overall, this score is lower than we would like.

4.14 We have a seen an increase from 2024 for the People Promise 'We are recognised and rewarded' from 5.81 to 5.83.

During 2025 we re-introduced our colleague recognition scheme, Moving to Excellence Awards, and early in 2026 we began a trial of 'Share Gratitude' an online platform that allows patients and staff to recognise colleagues.

4.15 The Culture Dashboard has seen improvement of 1% in the domain of Compassion; the other 5 domains have seen a decrease on 2024.

4.16 Our overall score for Engagement has decreased since 2024 from 6.59 to 6.50, with the score for the sub-theme of Motivation being above the average for our sector (although has declined from 2024). The score for the sub-theme of Involvement has seen a reduction this year from 6.75 in 2024 to 6.62.

4.17 Similarly, Advocacy has decreased from last year from 6.04 to 5.97. It's also important to recognise that our scores for recommending the organisation as a place to work and to receive care are noticeably lower than the sector. These scores are often linked to psychological safety and relationships with line managers, therefore focus in these areas will help to improve these results. Our score for Morale has also decreased from 5.84 in 2024 to 5.74 in 2025 and remains below our sector average.

4.18 We have seen a positive decrease in scores for colleagues experiencing discrimination from their manager or colleagues, from 8.18% in 2024 to 8.13% For ethnic groups this score has reduced year on year since 2021 and has reduced from 17.71% in 2024 to 14.4% and is lower than the average score for ethnic groups. This lower score is a positive trend. These measures are noted

as success metrics within our EDI 6 High Impact Actions Plan, however 8% is still a concern.

4.19 The percentage of colleagues experiencing discrimination on the grounds of Disability is notably higher than the sector average, at 17.94% compared to 10.47%. Year on year trend data is not available for this question due to the change of wording/question options.

4.20 The percentage of colleagues experiencing bullying, harassment or abuse from staff in the last 12 months has seen a further decrease this year, with ethnic groups also showing a further reduction from 24.80% in 2024 to 23.93% and is lower than the sector average. These measures are noted as key success metrics for High Impact 6 in our EDI High Impact Actions Plan.

4.21 Our overall score for 'We are Safe and Healthy' has decreased from 6.06 in 2024 to 6.01. Our scores for all sub-themes (Health and Safety Climate, Burnout and Negative Experiences) have decreased this year. The percentage of colleagues agreeing they have adequate materials, supplies and equipment to do their job has decreased from 56.42% in 2024 to 49.23% and is at it's lowest since 2021. This reflects the impact of the challenging financial position the Trust is facing.

4.22 The overall score for 'We have a Voice that Counts' has decreased significantly from 6.47 in 2024 to 6.38. Both sub-themes of 'Autonomy and Control' and 'Raising Concerns' have seen decreases this year. The percentage of staff feeling safe to speak up about anything that concerns them in the organisation has fallen from 54.09% in 2024 to 52.88% and has fallen year on year since 2023. There has also been a reduction in the percentage of staff feeling able to make suggestions to improve the work of their team/department from 69.60% in 2024 to 66.69%.

5. <u>SaTH – Divisional Breakdown</u>

5.1 The chart below shows the Divisional People Promise scores compared to the Trust. Medicine and Emergency are below the Trust score for all areas apart from 'we are always learning', with Corporate being above for all areas.

Table 5

2025 NHS Staff Survey - Breakdown Organisation vs Division / Department											
People Promise & Theme	**Organisation**	**Division**									
		CSS		Corporate		MEC		SAC		W&C's	
We are compassionate and inclusive	7.15	6.97	⇩	7.29	⇧	6.95	⇩	7.14	⇩	7.29	⇧
We are recognised and rewarded	5.83	5.59	⇩	6.26	⇧	5.61	⇩	5.76	⇩	5.70	⇩
We each have a voice that counts	6.38	6.11	⇩	6.56	⇧	6.23	⇩	6.38	⇔	6.55	⇧
We are safe and healthy	6.01	5.78	⇩	6.62	⇧	5.50	⇩	6.05	⇧	6.01	⇔
We are always learning	5.45	5.16	⇩	5.66	⇧	5.50	⇧	5.42	⇩	5.26	⇩
We work flexibly	6.30	6.08	⇩	6.98	⇧	5.98	⇩	6.18	⇩	5.92	⇩
We are a team	6.62	6.35	⇩	6.92	⇧	6.41	⇩	6.68	⇧	6.40	⇩
Staff Engagement	6.50	6.24	⇩	6.62	⇧	6.41	⇩	6.48	⇩	6.66	⇧
Morale	5.74	5.36	⇩	6.17	⇧	5.48	⇩	5.81	⇧	5.74	⇔

6.0 SaTH - High Level Regional Results

6.1 The table below shows our position when compared to other Acute and Acute & Community Trusts in the Midlands Region. The red highlights indicate those Trusts that scored lower than SaTH for each of the People Promise Elements and Themes.

6.2 'We work flexibly' is one of our areas of strength, ranking us 8th out of 22 in our sector in the region.

6.3 We are one of the weakest for our Engagement score, placing us 16th in the Midlands region, with South Warwickshire University NHS Foundation Trust achieving the best score of 7.26.

6.4 Our worst performing score is for 'we each have a voice that counts' which places us 18th out of 22 Trusts.

Table 6

Trust	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Engagement	Morale
The Shrewsbury and Telford Hospital NHS	**7.15**	**5.83**	**6.38**	**6.01**	**5.45**	**6.30**	**6.62**	**6.50**	**5.74**
Walsall Healthcare NHS Trust	7.08	5.79	6.44	5.88	5.35	6.13	6.67	6.54	5.65
Chesterfield Royal Hospital NHS Foundation	7.50	6.05	6.77	6.16	5.72	6.59	6.94	6.80	5.99
South Warwickshire University NHS Foundati	7.67	6.22	7.04	6.35	5.90	6.74	7.03	7.26	6.29
University Hospitals of North Midlands NHS T	7.12	5.64	6.48	6.04	5.41	6.05	6.46	6.67	5.86
Sherwood Forest Hospitals NHS Foundation	7.36	5.86	6.66	6.04	5.72	6.15	6.83	6.72	5.89
University Hospitals Coventry and Warwicksh	7.21	5.80	6.60	6.10	5.75	6.16	6.75	6.74	5.92
The Royal Wolverhampton NHS Trust	6.97	5.60	6.33	5.89	5.25	6.00	6.39	6.40	5.54
Wye Valley NHS Trust	7.52	6.23	6.93	6.21	5.93	6.58	7.03	7.07	6.13
George Eliot Hospital NHS Trust	7.33	5.91	6.75	6.23	5.97	6.46	6.88	6.95	6.12
The Dudley Group NHS Foundation Trust	7.12	5.63	6.41	5.88	5.40	6.14	6.55	6.46	5.54
Kettering General Hospital NHS Foundation T	6.97	5.58	6.36	5.92	5.48	6.16	6.52	6.44	5.67
Northampton General Hospital NHS Trust	7.04	5.66	6.42	5.97	5.55	6.24	6.59	6.55	5.76
Birmingham Women's and Children's NHS Fo	7.42	5.84	6.70	6.01	5.34	6.35	6.79	6.87	5.73
University Hospitals Birmingham NHS Founda	7.10	5.75	6.48	6.04	5.53	6.22	6.64	6.62	5.84
University Hospitals of Derby and Burton NHS	7.13	5.70	6.44	5.93	5.32	6.11	6.56	6.53	5.70
United Lincolnshire Teaching Hospitals NHS	6.99	5.74	6.31	5.94	5.44	6.08	6.47	6.42	5.67
University Hospitals of Leicester NHS Trust	7.33	5.94	6.74	6.25	5.92	6.42	6.83	6.87	6.05
Worcestershire Acute Hospitals NHS Trust	7.36	6.03	6.73	6.26	5.69	6.64	6.81	6.84	6.13
Nottingham University Hospitals NHS Trust	7.20	5.78	6.52	5.92	5.42	6.20	6.62	6.56	5.70
Sandwell and West Birmingham Hospitals NH	7.09	5.79	6.45	6.04	5.40	6.11	6.67	6.49	5.75

7.0 SaTH - Bank staff Survey Results

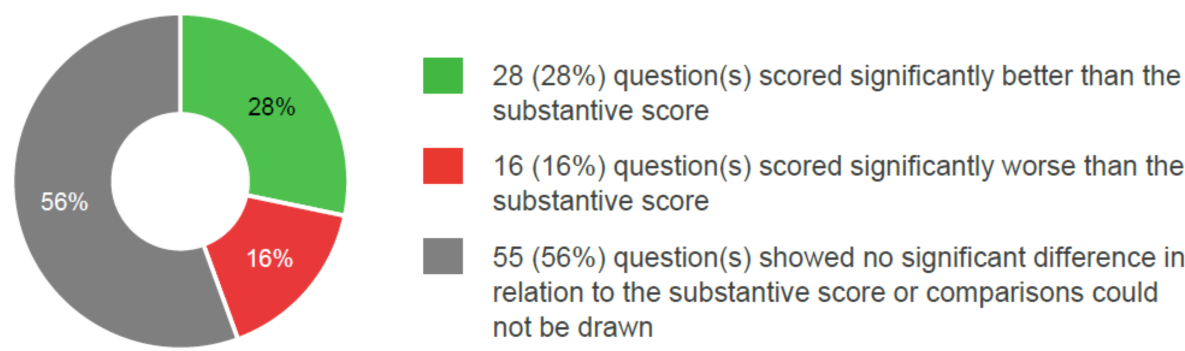
7.1 The response rate for the Bank survey was the same as 2024 at 24%, with 243 responses out of a possible 986 eligible colleagues.

7.2 All of the 7 People Promise elements have increased year-on-year. The theme of Morale has seen a slight decrease of -0.01 from 2024, and Staff Engagement has increased from 6.50 in 2024 to 6.67.

7.3 Of the 28 People Promise measures in the Bank staff survey, 23 measures were higher than 2024.

7.4 The below table 7 shows the comparison in scores compared to substantive staff:

Table 7 (taken from the IQVIA Management Report)



7.5 There are some key differences between the experiences of Bank colleagues compared to substantive colleagues:

- Bank staff score more positively in the 'We are Safe and Healthy', 'We are Always Learning' and 'We work Flexibly' People Promises.
- Bank staff are less positive to questions relating to their immediate manager.
- Bank staff are less likely to feel involved in the workplace, in particular with proposed changes which affect them.
- Bank staff reported less positively when it comes to autonomy and control, they feel less likely to be able to make changes and improvements at work. They also report less positively to development opportunities.

8. <u>Key Survey Findings 2025 - SCHT</u>

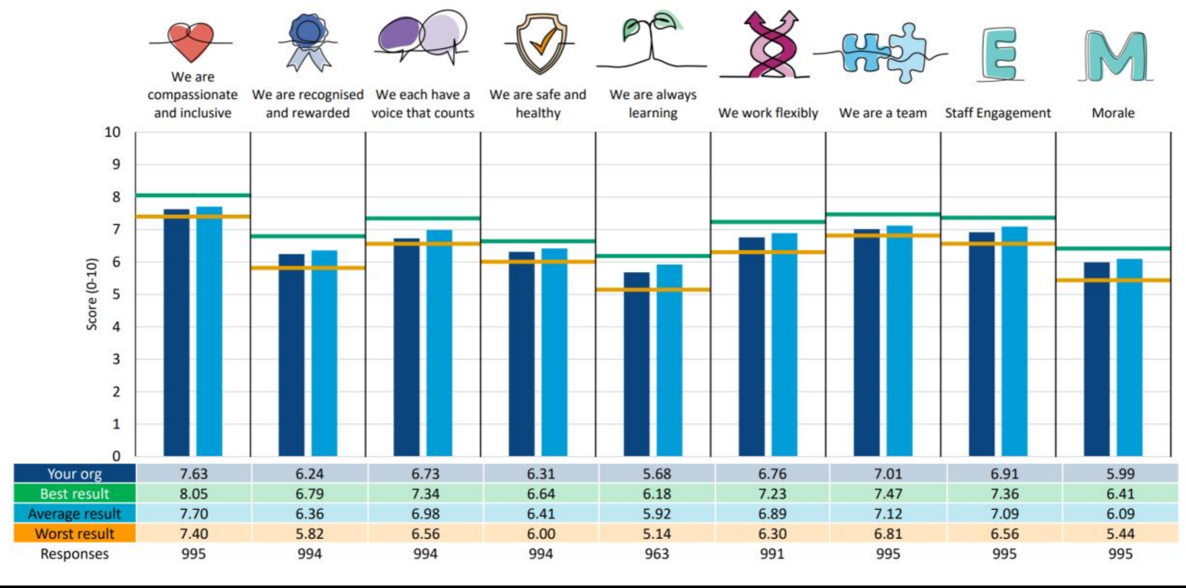
8.1 SCHT achieved a response rate of 50.25%, an 11% decrease since 2024. The average response rate across the Community Trusts, commissioned by Picker was, 60.92%.

In summary, our Advocacy scores are: -

- 59% of our colleagues recommended SCHT as a place to work
- 71% said that if a friend or relative needed treatment they would be happy with standard of care provided
- 74% felt that care of patients and service users is organisations top priority

We are neither the best or worst performing Trust when compared to 13 other NHS Community Trusts. Our results for 2025 fall below average in all areas.

Table 8

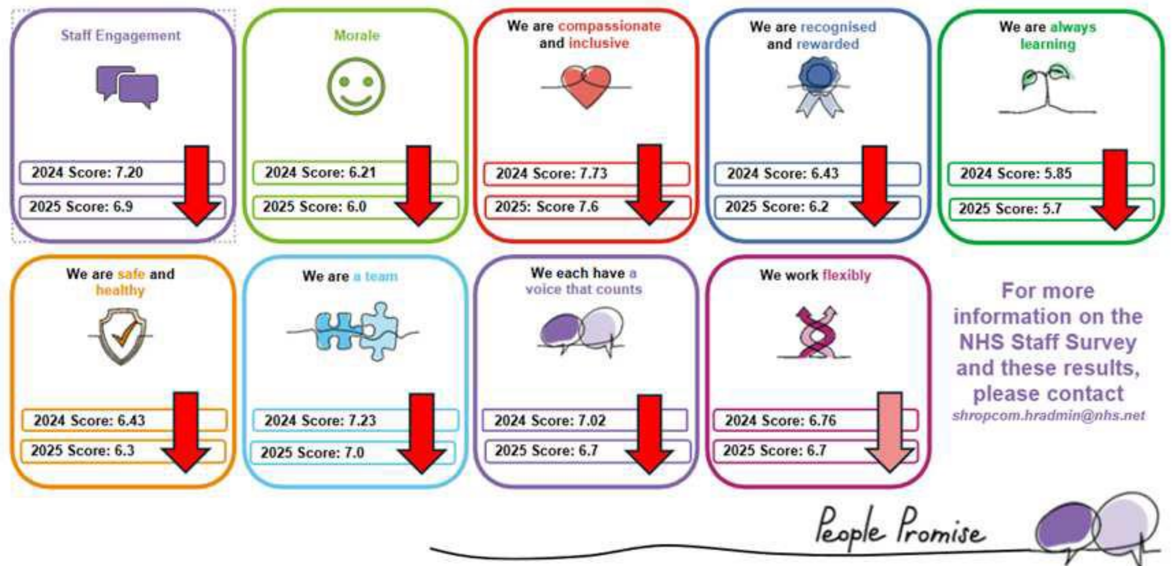


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.63	6.24	6.73	6.31	5.68	6.76	7.01	6.91	5.99
Best result	8.05	6.79	7.34	6.64	6.18	7.23	7.47	7.36	6.41
Average result	7.70	6.36	6.98	6.41	5.92	6.89	7.12	7.09	6.09
Worst result	7.40	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Responses	995	994	994	994	963	991	995	995	995

9. SCHT - Comparison to 2024 Results

9.1 Our results show that all the People Promise Themes, and Engagement and Morale elements have marginally declined since 2024, with We Work Flexibly seeing the smallest reduction and We Each Have a Voice that Counts and Staff Engagement seeing the largest reduction.

Table 9



9.2 The following table shows our top / bottom and most improved / declined questions, in comparison to the Trust average and 2024.

Table 10

Top 5 scores vs Organisation Average	Org	Picker Avg
q7i. Feel a strong personal attachment to my team	72%	68%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	69%	65%
q5c. Relationships at work are unstrained	58%	53%
q5b. Have a choice in deciding how to do my work	64%	61%
q7e. Enjoy working with colleagues in team	88%	85%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q19d. Feedback given on changes made following errors/near misses/incidents	55%	66%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	56%	65%
q24f. Able to access clinical supervision opportunities	62%	71%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	69%	78%
q25b. Organisation acts on concerns raised by patients/service users	69%	76%

Most improved scores	Org 2025	Org 2024
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	78%	73%
q23a. Received appraisal in the past 12 months	94%	90%
q3i. Enough staff at organisation to do my job properly	32%	28%
q4d. Satisfied with opportunities for flexible working patterns	66%	64%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	82%	80%

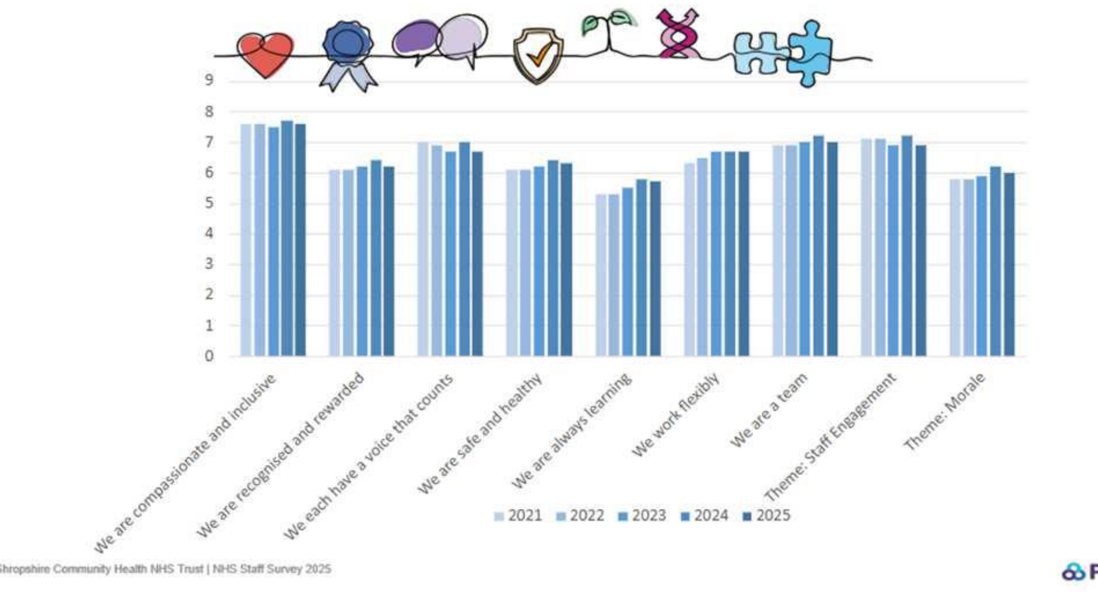
Most declined scores	Org 2025	Org 2024
q25f. Feel organisation would address any concerns I raised	49%	58%
q24b. There are opportunities for me to develop my career in this organisation	41%	48%
q3e. Involved in deciding changes that affect work	50%	57%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	69%	76%
q26b. I am unlikely to look for a job at a new organisation in the next 12 months	52%	59%

10. SCHT - Comparison to results since 2021

10.1 Whilst our 2025 results have declined in comparison to 2024, the following two tables demonstrate overall sustained improvement across most People Promise elements and themes when compared to results between 2021-2024.

Table 11

People Promise Theme	2021	2022	2023	2024	2025
We are compassionate & Inclusive	7.7	7.7	7.6	7.8	7.6
We are recognised & rewarded	6.1	6.1	6.2	6.4	6.2
We are always learning	5.3	5.3	5.5	5.8	5.7
We are safe & healthy	6.1	6.1	6.2	6.4	6.3
We are a team	6.9	7.0	7.0	7.2	7.0
We each have a voice that counts	7	6.9	6.7	7	6.7
We work flexibly	6.3	6.5	6.7	6.7	6.7
Staff Engagement	7.1	7.1	6.9	7.2	6.9
Staff Morale	5.8	5.8	5.9	6.2	6.0



11. SCHT - Organisational Breakdown

11.1 In comparison to the Trust average score, Finance and Digital, and Nursing and Clinical directorates both score significantly higher than the Trust average in all areas. The Operations Directorate scores marginally below the Trust average in all areas, Governance scores are significantly below the Trust average in all areas other than We Work Flexibly, and the People and OD Directorate scores are significantly below the Trust average in all areas.

Table 12

	Org	Finance Digital	Nursing Clinical Delivery	Ops	People & OD	Trust Board Medical	Gov
We are compassionate & Inclusive	7.63	7.9	8.2	7.6	6.8	*	7.3
We are recognised & rewarded	6.21	7.0	7.3	6.1	5.3	*	5.6
We each have a voice that counts	6.73	7.1	7.5	6.7	5.6	*	6.5
We are safe and healthy	6.31	7.1	7.3	6.2	5.6	*	6.0
We are always learning	5.68	6.2	6.9	5.6	4.5	*	5.6
We work flexibly	6.76	8.3	7.9	6.6	6.5	*	7.3
We are a team	7.01	7.5	8.2	6.9	6.3	*	6.5
Staff Engagement	6.91	7.3	7.9	6.9	5.7	*	6.6
Morale	5.99	6.7	7.1	5.9	4.1	*	5.4

12. SCHT – High Level Regional Results

12.1 The table below shows the position when compared to other Community Trusts in the Midlands Region. The red highlights indicate those Trusts that scored lower than SCHT for each of the People Promise Elements and Themes.

12.2 SCHT are the lowest scoring in the region for Community Trusts for 'We are always Learning', and a focused opportunity that Group presents us to improve.

12.3 SCHT rank in 2nd place in the region for Community Trusts for 'We are compassionate and inclusive', 'We are recognised and rewarded', and 'We are a Team', reflective of the culture, leadership and approach.

12.4 The top performing Trust in the region for all People Promises is Derbyshire Community Health Services NHS Foundation Trust.

NHS
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Table 13

Trust	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Engagement	Morale
Shropshire Community Health NHS Trust	**7.63**	**6.24**	**6.73**	**6.31**	**5.68**	**6.76**	**7.01**	**6.91**	**5.99**
Lincolnshire Community Health Services NHS Tr	7.40	6.12	6.69	6.21	5.84	6.62	6.85	6.75	5.81
Derbyshire Community Health Services NHS Fou	7.76	6.36	7.03	6.47	5.86	6.89	7.09	7.09	6.18
Birmingham Community Healthcare NHS Founda	7.47	6.06	6.79	6.20	5.77	6.68	6.99	6.89	5.90

13. Bank Staff Survey Results – SCHT

13.1 The response rate for SCHT's Bank Survey was 13.72%, which represents 9.04% decrease from 2024, and below average (20.93%) for Community Trusts commissioned by Picker to administer the NSS.

SCHT saw decreases in 6 People Promise elements and themes, improvements in 2 (Recognised and Rewarded, and Morale), and remained the same in 'We Work Flexibly'.

14. Group Free Text Comments and Themes

14.1 Initial analysis of the free text comments provides the following insight into the following recurring themes:

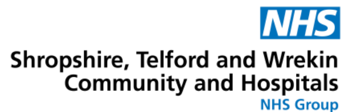
Staffing Pressures, Workload, Burnout
Comments describe increasing workload, vacancies and expectations to 'do more with less', with concerns about sustainability, retention and impact on patient care and colleague health and wellbeing.

Leadership, Culture and Fairness
Colleagues frequently mention lack of visible leadership, inconsistent decision making, perceived unfairness and experiences of bullying, blame and low psychological safety when raising concerns.

Operational Barriers (Parking, Facilities)
Comments describe numerous issues relating to day-to-day barriers that add frustration and stress, including parking, IT systems/processes and facilities.

Pay, banding, recognition, and feeling undervalued
Mostly attributed to Senior management / NHS and organisational policy / some line-manager inconsistency

14.2 Line managers are often described as being supportive, approachable and are 'doing their best,' but are constrained by lack of authority, staffing, or clarity.



15. Overall Conclusion

15.1 Boards are asked to note a marginal decline across the People Promise elements and Themes in 2025 across Group (with the exception of 'We work flexibly for SaTH) and to note improvements made since 2021.

15.2 Results were expected to be varied this year due to the impact of the overall NHS challenges, as well as the number of change programmes and transformation that is taking place across the Group.

15.3 Even though many scores are still below sector average, our focus is on continuing with an upward trend, as evidenced by the improvements seen in both Trusts since 2021.

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Board of Directors' Meeting in Common – 14 May 2026

Agenda item	024/26		
Report Title	Guardian of Safe Working Hours Quarterly Report: 01 January – 31st March 2026		
Executive Lead	Dr John Jones, Group Chief Medical Officer and Responsible Officer		
Report Author	Dr Robin Hollands, Guardian of Safe Working Hours		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
	Safe	√	BAF1, BAF2, BAF3, BAF4, BAF8
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	
Executive Summary	New exception reporting system has been instigated with good initial feedback. Four fines were levied by GOSW in quarter 4 for hours worked in excess of maximum. Health roster implementation is almost complete with 96% of resident doctors rotas now being live. New auto approval for leave booking has been introduced to address previous concerns about failure to approve in a timely way and medical people service is working closely with rota coordination in emergency medicine to ensure rotas are provided in a timely way. Regular meetings taking place between senior Lead and resident Doctor peer lead in line with 10-point plan.		
Recommendations for the Board	The Board is asked to: • **note the report**		
Appendices:	Appendix 1: Exception Reports Q4 Appendix 2: Locum Bookings by Department, Grade and Reason		

1.0 Introduction

1.1 The safeguards around doctors working hours within Schedules 04-06 of the NHS Doctors and Dentists in Training (England) 2016 Contract and the role of the Guardian of Safe Working (GoSW) hours is recognised across the Trust.

1.2 In accordance with Schedule 06 Paragraph 11 of the NHS Doctors and Dentists in Training (England) 2016, this quarterly Board report includes data relevant to the safe working hours for resident doctors and locally employed doctors including, but not limited to, exception reports, vacancies and locum usage. Any issues identified and subsequent actions taken are summarized within the report. Serious escalations related to decisions or actions not addressed at department level are highlighted.

2.0 Resident and Locally Employed Doctor Workforce and Guardian Resourcing Overview

2.1 The table below outlines key metrics relating to the resident doctor and dentist workforce, including contractual arrangements, Guardian of Safe Working Hours resourcing, and educational supervisor job planning.

Number of posts for resident doctors / dentists	410
Number of resident doctors / dentists on 2016 TCS:	318
Number of locally employed doctors:	202
Amount of time available in job plan for Guardian:	2PAs per week
Admin support provided to the Guardian:	0.2WTE
Amount of job-planned time for Educational Supervisors:	0.25PAs per resident

3.0 Exception Reports

3.1 Despite our concerns the new reporting system was introduced on 04 Feb without problems. There have been no reports or breaches relating to detriment or confidentiality and no resident doctors have reported difficulties in accessing the system. MPS are to be congratulated for this achievement. During Q4, exception reports were submitted across specialties, with 65 reports closed and 1 remaining outstanding [see Appendix 1]. There were 6 submissions relating to safety issues. These were due to shifts running beyond statutory hours. Obstetrics and Gynaecology recorded most reports (12), primarily linked to late-running theatre lists, 14 are resolved with 1 outstanding. ED (A/E) received 11 reports relating to late finishes. All are resolved.

4.0 Work Schedule Reviews

There have been no work schedule reviews during this quarter

5.0 Fines

5.1 During Q4, the Guardian of Safe Working Hours levied four fines in response to breaches of maximum permitted working hours, specifically where shift length was exceeded. Two fines were issued within Medicine, one in Ophthalmology and one within Anaesthesia.

5.2 As a result, the Guardian's account reports a cumulative total of £5,977.94 at the end of Q4.

6.0 Locum bookings

6.1 Locum shift data for the quarter indicates a total of 3,560 shifts were filled by bank staff and 330 by agency, with 10 shifts remaining unfilled. Full locum usage data and further comments from Medical Peoples Services are available in Appendix 2.

7.0 Vacancies - data awaited

8.0 Issues Arising & Actions Taken

8.1 Ophthalmology is a smaller specialty staffed by higher surgical trainees. The out-of-hours rota is based upon a non-resident on-call system. Payment for hours spent on-site whilst on call is based upon a prediction applied to this rota. If trainees are regularly exceeding these hours, then a workplace review will be undertaken.

8.2 A follow-up monitoring exercise will be undertaken in 2026 Q1 to assess the effectiveness of this intervention and ensure it addresses the previously reported concerns.

9 Digital Rostering

9.1 The largest source of disputes brought to the attention of the GOSW arises from the booking of annual and study leave.
The management of medical rotas is a challenge in all Trusts. SATH has particular difficulties, with two acute hospitals and the complexities of the ongoing development within the Emergency Department. Communication between resident doctors and rota managers has not been clear with large departments such as medicine and ED finding it difficult to meet the statutory rules for the booking of leave. The lack of a consistent and fair system can lead to a perception of bias when the booking of leave is left to medical staff acting in an unofficial manner.
The BMA in conjunction with the Trust has agreed that resident doctors who do not receive a response to a leave request submitted within the Trust rules, may assume that their leave can be taken.

9.2 Delivery of Healthroster is progressing well. It is now live for 96% of Resident Doctors; Anaesthetics templates are complete and ready to implement, with go-live timing being confirmed. Progress is governed and reported via the Financial Recovery Group (Medical Workforce Efficiency Programme) and Transformation Assurance Committee.

9.3 Healthroster will strengthen reporting and oversight of safe working hours and is already supporting the February Exception Reporting reforms, providing evidenced capture of additional hours and visibility against Working Time Regulations limits and 2016 TCS safe working hours requirements.

10 Exception Reporting Reforms

Following consultation between the BMA and employers, changes to exception reporting were implemented from 4th February of this year. Details regarding planning and implementation have been covered in previous reports to the board but as a reminder the key changes are:

a) Clinical supervisors are no longer included in the exception report process
b) Only the GOSW, DME and key staff in MPS are permitted to see identifiable data in a report.
c) Fines are levied against the Trust for detriment.

Evidence from Trusts which have undertaken early implementation of these changes suggests that a large increase in exception reporting is likely to take place. Our experience over the 2 months since implementation supports this view.

11.0 Fatigue and Facilities Charter

11.1 In 2018 the Trust committed to the BMA Fatigue and Facilities Charter. It remains the responsibility of the GoSW to notify the Board of any conditions within the Charter that are not being met. Currently all conditions have been addressed.

12.0 Summary of 10-Point Plan to Improve Resident Doctors' Working Lives

12.1 Working Environment and Wellbeing

- Car parking – Remains a challenge despite various initiatives by the Trust. Many resident doctors report stress related to finding parking spaces. Purple "on-call" parking is available for eligible resident doctors at RSH and will be operational at PRH by the end of May. A facilities booklet, including parking, catering, and accommodation information, is now available.
- Doctors' mess – The new PRH doctors' mess is due to open in June. Heating issues at the RSH doctors' mess have now been resolved.
- Hot meals – Weekend catering options are currently being explored.
- Rest facilities – A standard operating procedure (SOP) is in place for accommodation or travel arrangements when doctors are too tired to drive home.
- Self-development time (SDT) – An SOP for SDT has been developed. This currently applies only to resident doctors in training. While some departments provide SDT for locally employed doctors, many do not. It is recognised that SDT is essential for all resident doctors' professional development.

12.2 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

12.3 Annual Leave

- Annual leave policy is under review
- SOP for annual leave carry-over has been developed
- Some challenges in the Emergency Department regarding leave approval were linked to a vacant rota coordinator post, which is now under review
- Quality assurance processes for rota coordinator training are being developed

12.4 Senior Lead and Resident Doctor Peer Lead (RDPL)

- RDPL has direct access to the senior lead and Trust Board
- Monthly meetings take place between the senior lead and RDPL
- RDPL participates in regional and national engagement meetings and development training
- RDPL chairs monthly Resident Doctor Committee meetings with representatives from all specialties.

12.5 Payroll Errors

- No concerns have been raised regarding payroll errors.

12.6 Statutory and Mandatory Training

- The Trust is compliant with the Memorandum of Understanding and People Policy Framework
- No concerns have been identified

12.7 Exception Reporting

- A new exception reporting system has been implemented to encourage reporting by resident doctors

12.8 Course-Related Expenses

- Course-related expenses are reimbursed within 6 weeks, provided study leave has been approved

13.0 Summary

13.1 Progress is being made with digital rostering with Emergency and Acute Medicine now fully live rostered and General Medicine templates in development.

13.2 National reforms to exception reporting have been implemented within the Trust. There has been an increase in the number of reports submitted.

13.3 Difficulties remain in the booking of leave. Medical People Services is working with specialty rota managers to improve the booking process and meet the Trusts obligations.

Conclusion: The Board is asked to **NOTE** the contents of this report.