

Boards in Common Meeting in Public Agenda

Date: 13 August 2026

Time: 0930-1230hrs

Venue: AFC Telford Utd, SEAH Stadium, Bucks Way, Wellington, Telford, TF1 2TU (sat nav TF1 2NW)

Chair: Mr Andrew Morgan, Group Chair

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
0930 hrs	052/26	Welcome, and apologies	Verbal	-	Group Chair	Noting
	053/26	Patient Story	Enc	3	Group CNO	Noting
	054/26	Public Questions	Verbal	-	Group Chair	Noting
	055/26	Noting of Quorum for each Board	Verbal	-	Group Chair	Noting
	056/26	Declarations of conflicts of interest	Verbal	-	Group Chair	Noting
	057/26	Minutes of previous meeting in public 9/7/26	Encs	5	Group Chair	Approval
	058/26	Action Log	Enc	29	Group Chair	Approval
	059/26	Matters arising from previous minutes (not covered on today's agenda)	Verbal	-	Group Chair	Discussion
Reports from the Group Chair and Group Chief Executive						
1000 hrs	060/26	Report from the Group Chair	Verbal	-	Group Chair	Noting
	061/26	Report from the Group Chief Executive	Enc	30	Group Chief Executive	Noting
Board Committee Reports						
1015 hrs	062/26	SCHT: a. Activity Reports from NEDs b. Quality & Safety Committee Report c. Resource & Perf Committee Report	Verbal Enc Enc	- 38 51	All NEDs NED Chair NED Chair	Noting
	063/26	SaTH: a. Quality & Safety Ass Committee Report b. Performance Ass Committee Report c. Finance Assurance Committee Report d. HTP Assurance Committee Report	Enc Enc	55 58 61 63	NED Chair NED Chair NED Chair NED Chair	Noting
	064/26	Group: a. People Committee Report b. Local Care Transformation Assurance Committee Report	Encs	67 70	NED Chair NED Chair	Noting

SHORT BREAK						
Strategic, Performance, Financial & Operational Reporting						
1100 hrs	065/26	Integrated Performance Reports a. SCHAT b. SaTH	Encs	73 84	CFO/D.CEO SCHAT (a) Group Chief Executive (b)	Noting
	066/26	SCHAT 2026/27 National Oversight Framework (NOF) Update	Enc	164	CFO/D.CEO SCHAT	Approval
	067/26	Group Vision, Pledges and True North Metrics	Enc	171	*Group CS&IO	Approval
Assurance Framework						
1130 hrs	068/26	SaTH Integrated Improvement Plan (SIIP) Monthly Update Report	Enc	174	Group Chief Executive	Noting
	069/26	SaTH Integrated Maternity & Neonatal Report	Enc	178	Group CNO	Assurance
	070/26	SaTH Board Maternity & Neonatal Safety Champions Report	Enc	188	Group CMO	Assurance
	071/26	Board Assurance Framework Q1 2026/27 a. SCHAT b. SaTH	Encs	190 209	*Group CGO	Approval
Regulatory and Statutory Reporting						
1155 hrs	072/26	Guardian of Safe Working Report	Enc	232	Group CMO	Assurance
	073/26	SCHAT Freedom to Speak Up Report	Enc	238	Group CNO (FTSUG presenting)	Noting
Procedural Items						
1225 hrs	074/26	Any other Business – agreed by the Chair	Verbal	-	Group Chair	Discussion
	075/26	Date of next meeting of Boards in Common in public: 8 October 2026 (SECC, RSH)	Verbal	-	Group Chair	Noting
Close of meeting						

*Non-voting

ITEMS WITHIN THE BOARD INFORMATION PACK		
Reports / Appendices	Executive Lead	Page No
01 065/26a SCHAT Int Performance Report – Exception Action Plans	Chief Finance Officer	1
02 068/26 SaTH IIP Report – Appendices 1-4	Group Chief Executive	51
03 069/26 SaTH Int Maternity & Neonatal Report – Appendices 1-5	Group Chief Nursing Officer	77
04 SaTH HTP SRO Report	Group Chief EF&C Officer	172
05 SCHAT Annual Safeguarding Report 2025/26	Group Chief Nursing Officer	183
06 SaTH PALS, Complaints & Patient Exp Annual Report 2025/26	Group Chief Nursing Officer	204
07 SCHAT PALS, Complaints & Patient Exp Annual Report 2025/26	Group Chief Nursing Officer	283
08 SaTH QSAC Report July 2026 (confirming verbal report at July mtng)	Committee Chair	310

Board of Directors' Meeting in Common: 13 August 2026

Agenda item	053/26		
Report Title	Danielle’s experience: impact of closed loop insulin pump therapy		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Angela Loughlin, Patient Experience Manager Ruth Smith, Lead for Patient Experience		
Prior Consultation:	CQC Domain:		Link to BAF id(s)
	Safe		BAF1, BAF2
	Effective	√	
	Caring	√	Risk Register id(s):
	Responsive	√	
	Well Led	√	
Executive Summary	Danielle’s story highlights the lived experience of type 1 diabetes, including the challenges she faced in accepting her diagnosis and engaging with diabetes care, and the significant health complications that followed. Following re-engagement with diabetes services, she was referred for insulin pump therapy and describes the pathway as efficient, straightforward and well supported by the clinical team.		
Recommendations for the Boards	The Boards are asked to: Note Danielle’s experience and the positive impact of insulin pump therapy, specialist diabetes care and ongoing clinical support. Recognise the importance of timely access to diabetes technology for patients with complex healthcare needs. Acknowledge the value of compassionate, personalised and non-judgemental care in supporting patient confidence, engagement and wider life goals.		
Appendices:	N/A		

1.0 Introduction

- 1.1 Danielle is 30 years old and has lived with type 1 diabetes since childhood. She describes experiencing difficulty accepting her diagnosis during her teenage years and early adulthood, particularly as she wanted to participate in the same activities as her peers. She explains that this resulted in reduced engagement with diabetes care and contributed to significant health complications, including visual impairment, stage 3 kidney disease and gastroparesis.
- 1.2 Following concerns about her vision, Danielle re-engaged with diabetes services and was referred for insulin pump therapy. She describes the referral and initiation process as efficient and straightforward, with the clinical team available to provide support whenever required. Danielle reports that the pump has transformed her life, helped her regain a sense of independence in adulthood, and enabled her to feel a renewed freedom from the daily impact of diabetes.

2.0 Positive facts about the story/impact

- 2.1 Danielle reports that the pump has “completely changed” her life and means she no longer feels her life revolves around diabetes.
- 2.2 She explains that pump therapy reduced the need for multiple daily injections and has been less painful.
- 2.3 She reports a significant improvement in diabetes control, with HbA1c moving from the 80s to the 50s within a couple of months, and later from the 50s to 41 after changing pump type.
- 2.4 Danielle says the team have provided consistent support and guidance, responding to her emails for advice and helping her prepare safely for planning a family.
- 2.5 She describes the care from the Consultant and the nursing team as “impeccable” and says she would recommend the service to others considering pump therapy.

3.0 Identified learning

- 3.1 The story illustrates the importance of timely access to diabetes technology for people with complex healthcare needs, including those who may not have had tightly controlled diabetes before referral.
- 3.2 It highlights how patient confidence and trust in new technology can take time to build, particularly after many years of self-injection.
- 3.3 Danielle’s experience shows the value of responsive, ongoing clinical support alongside the device itself, including advice between appointments and support with wider life goals such as pregnancy planning.
- 3.4 The story reinforces the need for compassionate, non-judgemental care that supports people who have experienced diabetes burnout or struggled to engage with services.

4.0 Actions and timescales for completion

- 4.1 Share Danielle’s story with the Trust Boards in Common to demonstrate the patient impact of diabetes technology, specialist clinical support and personalised care. Timescale: Trust Board meeting 13 August 2026.
- 4.2 Danielle’s patient story was also shared as part of Diabetes Awareness Week, supporting wider public awareness of living with diabetes and the positive impact that timely access to diabetes technology and specialist support can have for patients.

Angela Loughlin, Patient Experience Manager
Ruth Smith, Lead for Patient Experience
August 2026

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

Thursday 9 July 2026 @ 0930hrs, held at AFC Telford Utd, Telford

MINUTES

Name	Title
MEMBERS	
Mr A Morgan	Group Chair
Ms J Williams	Group Chief Executive
Mr R Dhaliwal	Non-Executive Director (SaTH)
Ms S Dunnett	Non-Executive Director (SaTH)
Ms R Edwards	Non-Executive Director (SaTH)
Mr N Hobbs	Group Chief Operating Officer & Deputy Chief Executive (SaTH)
Dr J Jones	Group Chief Medical Officer
Ms S Lloyd	Chief Finance Officer & Deputy Chief Executive (SCHAT)
Ms T Long	Non-Executive Director/Vice Chair (SCHAT)
Mr R Miner	Non-Executive Director (SaTH)
Ms M Morris	Group Chief Nursing Officer
Ms W Nicholson MBE	Non-Executive Director (SaTH)
Mrs C Purt	Non-Executive Director (SCHAT)
Prof T Purt	Non-Executive Director/Vice Chair (SaTH)
Mr A Winstanley	Acting Chief Finance Officer (SaTH)
IN ATTENDANCE	
Mrs R Boyode	Group Chief People Officer
Ms T Cotterill	Group Chief Recovery and Transformation Director (<i>Interim</i>)
Mr S Crowther	Associate Non-Executive Director (SaTH)
Ms J Fullard-Slawson	Group Chief Communications Officer
Mr N Lee	Group Chief Strategy & Integration Officer
Ms A Milanec	Group Chief Governance Officer
Mr M Neal	Group Chief Estates, Facilities & Capital Officer
Mr J Sargeant	Associate Non-Executive Director (SaTH)
Ms B Barnes	Board Coordinator (Minute Taker)
GUEST ATTENDANCE	
Ms L Taylor	Acting Head of Midwifery (<i>agenda item 043/26</i>)
APOLOGIES	
Ms J Barker	Non-Executive Director (SCHAT)
Mrs T Boughey	Non-Executive Director (SaTH)
Prof H Fuller	Associate Non-Executive Director (SaTH)

No	ITEM	ACTION
Procedural Items		
027/26	Welcome, and Apologies The Group Chair welcomed all those present, including observing members of the public, to this second meeting of the SCHAT and SaTH 'Boards in Common' being held in Public. This follows the establishment of the agreed alliance between the two organisations, under the title of Shropshire, Telford and Wrekin Community and Hospitals NHS Group. Mr Morgan extended a warm welcome to Ms Martina Morris, who was attending her first Public Boards in Common meeting as Group Chief Nursing Officer. Apologies were noted.	
028/26	Patient Story Ms Morris was pleased to introduce Cheryl, Admiral Nursing Team Lead, to speak to the Boards about the life-changing impact of Admiral Nurse support. Cheryl shared a video of Jayne, who spoke of how specialist Admiral Nurse support had transformed her experience of caring for a loved one with dementia. Ms Williams invited Cheryl to share with colleagues what she felt would be of most help in enabling them to continue and expand the valuable support they provide. Cheryl advised that this was undoubtedly more team members, which would enable the service to meet the growing and vital need for specialist support to those caring for loved ones with dementia. Acknowledging the importance of this request, Ms Morris proposed engaging with Dementia UK to seek funding assistance. Colleagues would be updated on developments in due course. The Boards were pleased to note the evidence that the case study provided of the positive impact of early intervention, expert clinical advice and ongoing emotional support, in helping families to navigate complex dementia journeys, and the Group Chair commended Cheryl for her clear passion for this valuable service.	
029/26	Public Questions The Group Chair thanked those members of the public who submitted questions in advance of today's meeting. The questions (including two accepted from the floor), and the responses provided at the meeting, are included at the end of these minutes.	
030/26	Noting of Quorum for each Board Quoracy was declared for both Boards.	
031/26	Declarations of conflicts of Interest No conflicts of interest were declared that were not already included on the Registers of Directors' Interests for each organisation.	

	Members of both Boards were reminded of the need to highlight any interests which may arise during the meeting.	
032/26	Minutes of previous meeting in public session The minutes of the meeting held on 14 May 2026 were accepted and approved by the Boards as an accurate record, subject to an amendment requested by Ms Long to the third bullet point of agenda item 011/26b, the SCHAT Quality & Safety Committee Report. She clarified that her reference to medical leadership related to the Virtual Ward not, as stated in the minutes, medical leadership in the community.	
033/26	Action Log There were no current/outstanding Board actions.	
033/26	Matters arising from the previous minutes No additional matters were raised.	
Reports from the Group Chair and Group Chief Executive		
034/26	Report from the Group Chair Mr Morgan provided a verbal report which covered the following points: • NHSE Reference Group: He continues to participate in NHSE's reference group work, focusing on development, terms and conditions, workloads and other elements of Chair and Non-Executive Director roles. Mr Morgan advised colleagues that one of the common issues which had been highlighted by many participants was the volume and length of Board reports. Whilst recognising that this issue is not unique to our Group, he has asked that opportunities are identified to appropriately condense reports, to ensure Board meetings operate as efficiently as possible. • NHSE updates: There are several current and forthcoming NHSE issues and developments upon which Boards will need to assure themselves over the coming months. These include the prevention of unlawful access to patient records, the Baroness Amos report on maternity services, the Nottingham maternity services review, Lord Mann's review on racism in the NHS, new standards for the patient experience in elective care, new NHS staff standards, and a new College of Leadership and Management Framework. Some of these are referred to in Ms Williams' subsequent report, and others will come to Board in due course. • Sharing best practice: Russell Hardy, the NHSE Midlands Regional Chair, is very keen that the NHS improves in the sharing of best practice, and a virtual day will be taking place on 15 July to provide an initial opportunity for selected organisations to share their best practice with fellow NHS colleagues. • Long Service Awards: Mr Morgan was pleased to attend this event the previous day, to celebrate colleagues who had achieved 25, 40 and even, remarkably, 50 years' service. It had been a most enjoyable and inspiring event, and he thanked those responsible for	

	their excellent organisation of the event. The Boards noted the report.	
035/26	Report from the Group Chief Executive Taking her report as read, Ms Williams wished to draw out the following important points: Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, led by Donna Ockenden: Prior to the report publication date of 24 June, Mrs Ockenden kindly agreed to relay an email from Ms Williams to all SaTH's Ockenden Review families, sharing that our thoughts are with all the families at the heart of the review, including those whose experiences were reflected in the SaTH reports four years ago. The Trust recognises, and is truly sorry, that the new publications may bring back painful memories for them. Ms Williams wished to also express her pride in the dedication shown by our maternity services colleagues and the progress that has been made. The themes raised in the reviews – listening, learning, teamwork, safety, and respect – are relevant to every service, every team, and every role across SaTH and SCHAT. Referring to the findings of the Nottingham report on post-death processes, Ms Williams wished to offer assurance to the Boards, and most importantly to families, that SaTH has arrangements in place to provide thoughtful, compassionate and respectful support to families who are bereaved. The Trust has a dedicated bereavement team, with trained staff available on the delivery suite 24 hours a day to provide sensitive care and support. The Maternity Bereavement Room provides families with a private, quiet space where they can spend precious time together and grieve. The Nottingham report requires all Trusts to review and provide assurance against the seven immediate and essential actions set out originally in Mrs Ockenden's SaTH report. These actions are subject to regular audit within SaTH and are embedded within the established audit cycle. The newly appointed Head of Midwifery, who is due to commence in mid-July, will review the approach undertaken to date and assess the progress achieved. In response to a query from Ms Long on whether the Nottingham report included anything that was not within the SaTH actions, Ms Williams confirmed that no additional actions have been identified to date. She added that once a triage has been completed of the findings from the commissioned external audit on the compliance and delivery of SaTH actions, the outcome will be shared with the families, and our Boards. Ms Morris also advised colleagues of NHSE's intention to produce one national maternity improvement plan, with a potential publication date of December 2026. Ms Williams drew the Boards' attention to the additional requirements from the Nottingham review contained in her report, acknowledging that the Nottingham families, those affected by events at SaTH, and many others across the country, have shown remarkable courage in sharing their experiences. She wished to	

assure the public that their loss and resilience remain central to SaTH's learning, and continue to drive its commitment to meaningful, lasting improvement now and in the future.

- Poppy's Promise: This week sees the launch of Poppy's Promise across the organisation. Ms Williams expressed her deep gratitude to Poppy's parents for their unwavering commitment, time, and compassion in working with the Trust to develop this important programme in their daughter's legacy. Poppy's Promise honours Poppy's memory by helping ensure that compassion, listening, and human connection remain central to every interaction and decision we make, and seeks to create lasting positive change.

Mr Morgan also paid tribute to Poppy's parents, acknowledging how remarkable it is that such a dreadful tragedy has led to something so positive. He also paid tribute to Ms Williams for the emotional warmth, compassion and kindness she continues to show every day to those who have suffered such terrible personal loss.

Ms Williams emphasised that it is a huge privilege to be the first Trust in the country to launch Poppy's Promise, and she is confident that our Boards, leaders and colleagues across the Group will take the programme to heart and help to ensure it makes a meaningful difference for our patients and staff.

- Hot weather: Ms Williams expressed her sincere thanks to colleagues across the Group who have continued to provide exceptional care and support to our patients during the recent period of extremely hot weather. She also wished to recognise the incredible contribution of estates colleagues in ensuring patients and staff can remain as comfortable as possible in these difficult circumstances.

Responding to a query from Ms Nicholson on how equipped our Trusts are in being able to respond to adverse weather conditions, Mr Hobbs clarified that whilst there are comprehensive plans in place for both cold and hot weather, much of our infrastructure is unfortunately not suitable for the extreme conditions which are being experienced, and the Group is reviewing how we can build in greater resilience. Ms Williams added that the challenges extreme heat causes for the NHS were acknowledged at the CEO meeting she had attended in London the previous week, whilst also recognising the significant capital investment challenges that the introduction of resilience measures would create.

- Unlawful access to patient records: Ms Williams referred to recent national media reports which have highlighted incidents of staff accessing confidential patient records without a legitimate need, which has reinforced the importance of robust information governance arrangements across the NHS. National guidance and legislation are very clear that access to patient, or staff, information must only occur where there is a lawful and legitimate purpose. She wished to reassure the public that the Group takes this issue very seriously. Any inappropriate access is treated as a serious matter and may result in disciplinary action, including findings of misconduct. These expectations are continually reinforced through mandatory training, staff awareness, and routine audit and

	monitoring of system access. The Boards accepted and noted the report.	
Board Committee Reports		
036/26	SCHT Reports: a. Non-Executive Director Verbal Activity Reports There was nothing to report at this time. b. Quality & Safety Committee Report The Boards received the report from Ms Long in the absence of the Committee Chair, Ms Barker. Taking the report as read, the following points were highlighted: • Virtual Ward: The Committee received assurance regarding the safety and quality of Virtual Ward care delivery, with mitigating actions in place to address medical workforce and clinical leadership challenges, including strengthened oversight and development of a sustainable future medical model. • Friends and Family Test (FFT): The Committee noted ongoing concerns regarding low FFT response rates, which continue to limit the breadth of patient feedback available to inform service improvement. Actions are underway to improve response rates across services and to strengthen the capture of patient feedback. • Infection Prevention & Control: The Committee received substantial assurance overall regarding the effectiveness of IPC governance, training compliance and controls, whilst recognising the need for continued focus on MRSA screening compliance. • Prison Inspection: The Committee received strong assurance from the findings of an unannounced HMIP/CQC inspection, with the inspection finding the healthcare provision of SCHT to be equivalent to community standards. Several examples were also identified of notable practice delivered by SCHT services. c. Resource & Performance Committee Report The Boards received the report from the Committee Chair, Ms Long, which was taken as read. Colleagues' attention was drawn to a presentation received by the Committee on the updated National Oversight Framework (NOF) following its recent publication, noting that the metrics against which community trusts will be monitored will increase to 19. Organisations will no longer be assigned a segment in relation to relative performance against peers nationally but instead will be allocated to specific segments based on the average score across all metrics. The Boards accepted and noted the above SCHT Committee reports.	
037/26	SaTH Reports: a. Quality & Safety Assurance Committee Report	

The Boards received a verbal report from the Committee Chair, Ms Dunnett, due to unforeseen circumstances resulting in a delay to the meeting taking place. Confirming that a formal written report will be included in the Board Information Pack for the next meeting, the following points were highlighted:

- **Annual Medication Safety Report:** The Committee took assurance from the report, which identified a high reporting culture, with the majority of incidents (98%) no/low harm. Colleagues heard that work continues to address omitted doses of medication, with medication unavailability a contributing factor. An improvement plan is being developed, and there is also a workstream to look at how people can be supported to bring their medicines when attending hospital for emergency treatment as there are currently mixed messages across the system.
- **Diabetic Foot Service:** The Committee heard that the service is facing pressure from staff shortages and rising patient numbers, resulting in patients waiting much longer to be seen, and urgent referrals are being signposted to the Emergency Department instead. The Committee has asked for an update on actions being taken to be brought to the next meeting.
- **Quality Indicators:** The Committee discussed the Quality Indicators included in the Integrated Performance Report (IPR) and agreed that there was a need to ensure sufficient mechanisms were in place to identify any hot spots and put in place appropriate support and improvements. It was recognised that this needs to be considered in the development of performance frameworks, and the quality management system, so that all indicators are brought together to provide a comprehensive view of the quality and safety of care.

Ms Williams added, referring to Poppy's Promise, that one of the elements to the programme is a text message to be sent to every mother for instant feedback following visits and appointments, and she highlighted that consideration will be required of how we can monitor and action any improvements which are identified.

b. Performance Assurance Committee Report

The report was received from the Committee Chair, Ms Edwards. Taking the report as read, the following points were highlighted:

- **UEC System Integrated Improvement Plan:** The Committee heard that the Non-Admitted Working Group is now building in recent feedback from Nexus Consulting (SaTH's delivery partner) on measures that can be taken to reduce the time spent in ED, eg in waiting for blood test results and CT scans.
- **Prevention and Health Inequalities:** The Committee received a report outlining the work being undertaken by the Group and system partners to continue this programme of improvement and development. This includes identifying the association between long waits and age in ED and taking actions to reduce long waits, improved data collection in maternity, and significant outreach with

	seldom-heard groups to build trust, better understanding of local needs and identify barriers to early engagement. • Data Quality: The Committee heard that Phase 2 of the Federated Data Platform (FDP) transition has been completed and Phase 3 is underway. Ms Milanec drew colleagues' attention to a recent article in the Health Service Journal (HSJ) on NHSE undertaking a review of both the FDP and Palantir, the platform provider. c. Finance Assurance Committee Report The report was received from the Committee Chair, Mr Miner. Taking the report as read, colleagues' attention was drawn to the following key points: • Financial performance: In view of the financial pressures the Trust is under, and taking account of an update on the current financial recovery actions and expected revenue and cash outlook for the year, the Committee was clear on the need for a series of 'early warnings/triggers' to be in place to drive quick decisions around confirmation of income, deferral of investments, the paring back of activity and the realisation of 'Group' benefits. • Efficiency through Workforce transformation: The Committee received a detailed high level workforce transformation programme update. This will be developed at a more granular level, with targets and dates brought to the next Committee meeting for further consideration. • Committee oversight: Mr Miner confirmed a positive change from previous years, in that the Committee is now very well sighted on the Trust's resulting year-end position if mitigating actions are not taken, and it continues to remain highly focused on delivery of the financial plan. Mr Morgan echoed these comments and reiterated the importance of ensuring SaTH's improved reputation is not compromised by not delivering this year's financial plan. The Boards accepted and noted the above SaTH Committee reports.	
038/26	Group Reports a. People Committee Report The report was received from Mrs Purt, the Committee Joint Chair. Taking the report as read, the following points were highlighted: • DBS checks: The Committee noted an increase in the backlog of DBS checks and sought assurance that staff continue to be subject to the appropriate level of pre-employment checks. Colleagues were assured that additional resource has been deployed, with a risk-based approach to prioritising outstanding cases. • Therapies Services: The Committee was very pleased to note the successful integration of Therapies Services from 1 June 2026, and requested that learning, staff experience and patient outcomes are evaluated and reported back, to inform future service integration across the Group.	

	• Sickness absence: Mr Morgan referred to his earlier report regarding sharing of best practice across the NHS and advised colleagues that sickness will be one of the topics of focus. Prof Purt also reminded colleagues of a planned internal audit review of process around sickness absence as part of the SaTH 2026/27 audit plan. b. Local Care Transformation Assurance Committee Report The report of the inaugural meeting of the Committee was received from Prof Purt, the Committee Chair. Taking the report as read, the following points were highlighted: • Committee focus: The Chair confirmed that the focus of the Committee would remain at a strategic level, with ongoing review of priorities and membership, to ensure the right expertise was engaged as the programme developed. The five areas of initial focus were agreed by the Committee as: ○ Acute bed alternatives as per the recent bed model ○ Support to the UEC pathway and NCR discharge ○ Estate and aligned capital plan to support Local Care, the 10-year plan and HTP ○ Integrated care pathway development to support HTP, and ○ Focus on risk stratification, case management and Primary Care Network (PCB) relationships. It was emphasised that the programme was focused on genuine pathway redesign, and not a 'lift and shift' of services, with priority cohorts identified for transformation. • Reporting and assurance framework: The Committee recognised that a fully developed reporting and assurance framework was not yet in place, limiting the ability to provide robust assurance on programme delivery and impact, and noted that this would be addressed over the next two-three months. A gap also remained to be addressed in confirming outcome metrics, programmes of work and gateway management, including: ○ Demonstrable impact on acute bed capacity and system flow ○ Patient experience and quality outcomes ○ Measurement of inequalities, and ○ Support to the HTP programme • Programme risks: A number of risks were recognised, including the scale and complexity of the programme, with circa 50 projects identified across workstreams, requiring prioritisation. The Boards accepted and noted the above Group Committee reports.	
Strategic, Performance, Financial & Operational Reporting		
039/26	Performance Reports: a. SCHAT Integrated Performance Report Ms Lloyd presented the following information in relation to the key areas of performance relevant to the SCHAT Performance Framework,	

directing colleagues to her report for further supporting information:

- KPIs: This report focuses on the 27 indicators which are reviewed by the Resource and Performance Committee (RPC). Of these, 15 require focused attention, with 12 of the 15 relating to access to services and waiting times. With the exception of the 'average number of days from discharge ready date to actual discharge date', which is now flagged as an assurance concern, 12 are reporting special cause variation of an improving nature.

Of the KPIs for which the RPC is responsible, two are reported as a variation concern only, relating to the financial plan variance year to date, and planned surplus/deficit.

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

- National Oversight Framework (NOF): NHSE published the Quarter 4 NOF segmentations on 11 June 2026 and SCHAT was allocated an overall score of 2, which is a deterioration from the previous rating of 1 but still strong performance. SCHAT performs well across 3 out of 5 domains, scoring above average or higher, and is ranked 29th out of 61 Trusts.
- Operational indicators: Mr Hobbs wished to put on record his thanks to Claire Horsfield of SCHAT and Operations colleagues for the significant progress seen in Elective Waiting Time measures.

The Boards **considered** SCHAT's performance to date and the assurance provided on the actions being taken to improve performance and minimise risks where required, and **noted** the information presented in relation to the National Oversight Framework Quarter 4 segmentation.

b. SCHAT Integrated Quality & Safety Performance Report

Ms Morris presented an overview of the SCHAT Quality and Safety performance indicators to the end of May 2026, directing colleagues to her report and the agreed improvement action plans outlined in appendix 2 within the Board Information Pack, for further supporting information.

Three of the 18 Quality and Safety Dashboard KPIs are showing special cause variation of a concerning nature in Month 2 (May) relating to Category 4 Pressure Ulcers, Safer Staffing and Average fill rate for non-registered nurses (night), and NHS Staff Survey 'Raising Concerns' sub-score:

- Pressure Ulcers: One Category 4 pressure ulcer and three Category 3 pressure ulcers were reported during May. Reviews identified significant patient complexity in the Community and evidence of appropriate escalation and clinical management. Ongoing thematic review work will support organisational learning and further improvement.

- Safer Staffing: Staffing establishments remain safe across inpatient services, with registered and non-registered staffing fill rates consistently achieving or exceeding planned levels. The reported variation in non-registered nurse night staffing reflects a reduction in previous over-fill levels rather than any staffing shortfall and does not indicate a staffing risk.
- NHS Staff Survey 'Raising Concerns' sub-score: The Trust score is below the national benchmark, and an improvement plan is being developed as part of the Trust's annual Quality Priorities, focused on strengthening organisational learning, staff voice and speaking up culture.

The Boards **considered** and **noted** the report, taking assurance that appropriate actions are being taken to address any areas of concern and support continuous improvement.

c. SCHAT Integrated People Performance Report

Mrs Boyode presented a summary of key areas of workforce performance against the Month 2 Workforce Plan position, directing colleagues to her report and the appendices in the Board Information Pack for full supporting information.

There are several KPIs under the delivery of the Workforce Plan that are outside of agreed targets, including sickness/absence management, and agency price cap compliance:

- Sickness/absence management: Sickness absence is a significant driver of temporary workforce usage. Work is underway across the Group to identify interventions that will make tangible improvements to sickness absence rates. This includes preventative measures and improved data analysis, changes to practices and policy, and exploring digital systems. A business case is being prepared in support of implementing a sickness management digital system which has proven successful in other NHS organisations. Early estimates suggest there could be absence reductions of 20% achieved by investing in this approach.

Actions to shape culture will also support sickness absence, with the Group Culture Programme now underway.

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

The Boards **considered** and **noted** SCHAT's performance across relevant workforce indicators to date, and the actions being taken to mitigate any risks relating to either the resources available to the Trust or the Trust's performance.

d. SaTH Integrated Performance Report (IPR)

The Boards received the report from the Group Chief Executive, providing an update on progress against SaTH's Operating Plan and associated objectives and enablers to the end of April/May 2026.

Taking the report as read, Ms Williams invited executive colleagues to provide the headlines from their sections:

Patient Safety, Clinical Effectiveness & Patient Experience Summary

Dr Jones and Ms Morris drew the Boards' attention to the following points:

- **Diabetic Foot Service:** Referring to the pressures on the service covered in the earlier Quality & Safety Assurance Committee Report, Dr Jones highlighted that one of the benefits of our Group model is the integration of services. He assured the Boards that colleagues are committed to completing the work which is required across the Group to improve the service for patients across our communities.
- **Infection Prevention and Control (IPC):** Dr Jones emphasised that infections are the biggest challenge across the Group, and colleagues will be working together on improvements in this respect. Ms Morris added that within the acute Trust we have specific ongoing challenges with C-Difficile infections, and she agreed with Dr Jones that an overarching improvement plan is required.
- **Complaints:** The Trust continues to receive increased numbers of new complaints, which reflects the picture being seen nationally across acute organisations. National meetings are taking place to investigate what is driving the trend and, as an organisation, SaTH is reviewing its processes around complaints. Ms Morris advised colleagues that she also intends to undertake an additional piece of work with teams to focus on patient experience.

Operational Summary

Mr Hobbs summarised the following points:

- **Planned Care:** The Trust remains ahead of plan and demonstrating special cause improvement against all RTT metrics. SaTH is also now in Tier 3 of NHSE monitoring for cancer due to improved performance, with April performance against the Faster Diagnosis Standard (FDS) of 80.9%, making it the Trust's eighth month of delivery of the national 80% standard. In Diagnostics, the submitted DM01 position for May was 80.6%. Whilst there was improved performance in Echocardiology, Non-Obstetric Ultrasound (NOUS) saw a deterioration in performance, and a recovery plan is being implemented. Radiology reporting turnaround times are being maintained.
- **Urgent and Emergency Care:** There have been statistically significant improvements in waits over 12 hours, including further reductions in the number of people experiencing very long waits (over 24 and 48 hours). The improvements seen against the Trust's own performance and peers have taken SaTH out of the bottom decile nationally, although there is still a long way to go. There were also sustained improvements in ambulance handover timeliness in May, with the Trust lifted out of the bottom quartile nationally for a

second consecutive month. However, 4-hour waits were still not showing sustained improvement.

In summary, whilst there is ongoing evidence of improvement, SaTH equally recognises that significant further progress needs to be made to ensure the Trust delivers the levels of service our patients and communities deserve.

Mr Morgan congratulated Mr Hobbs and his teams on the ambulance handover and 12-hour performance improvements. He emphasised, however, the importance of turning around 4-hour performance, as demonstration that the investment made into ED is resulting in improvement for our service users.

Workforce Summary

Mrs Boyode summarised the following points:

- Bank usage: From a cost improvement perspective, one of the main areas of under delivery is the bank reductions, particularly across the Trust's nursing workforce, which have not delivered the projected savings in Month 1 and 2 (£0.22m). One of the main drivers of bank usage has been covering high levels of sickness, and several workshops have been set up to review our sickness reduction action plans and to consider the impact of planned interventions and actions that would further support reductions. There has, however, been a positive reduction in Consultant bank usage seen on a weekly basis since early April 2026.
- Talent Conversations & Training: There is a risk that the Trust will not meet national targets for training and appraisal (Talent Conversations) compliance. Appraisal rates are already below target, and training compliance is continuing to decline, with a potential breach anticipated this month. Due to the ongoing Education management of change and reduced staffing capacity, improvement interventions cannot currently be implemented. There are, however, a number of recovery actions identified for implementation following completion of the management of change process.
- Ms Long raised the difficulties being experienced by colleagues in accessing and undertaking the required Oliver McGowan training. Mrs Boyode confirmed that these were recognised and the Trust continues to raise the issue nationally. As the process is not currently fit for purpose she would investigate if it was possible for the training to be delivered to the Boards in a shared development session.
- Ms Edwards highlighted that she had notified Mrs Boyode by email prior to the meeting of missing data within the table on page 152 of the Board pack, which Mrs Boyode, with apologies, would arrange to be appropriately updated.

Finance Summary

Mr Winstanley provided the following summary relating to Month 2 (May 2026) financial performance, directing colleagues to his report for

	further detailed information: At the end of month 2, the Trust has delivered a deficit position of £7.37m against a deficit plan of £5.61m pre-deficit support funding, representing an unfavourable variance of £1.76m. This moves to a deficit of £2.29m against a planned deficit of £0.53m post-deficit support. The predominant driver of the variance is industrial action (£0.75m) and slippage against various efficiency schemes (£1.76m), which have been partly offset with other non-recurrent mitigations. Colleagues' attention was also drawn to the content of the earlier Finance Assurance Committee report, recognising the importance of 'early warnings/triggers' to drive quick decisions on mitigating actions, to ensure delivery of this year's financial plan. The Boards accepted and noted the SaTH Integrated Performance Report.	
040/26	SaTH Community Engagement Strategy 2026-2030 Mr Lee presented the SaTH Community Engagement Strategy (2026-2030) following extensive community and staff engagement in 2025/26. The Boards were advised that, when approved, the strategy will be available separately and also combined with the other two Public Participation Strategies (Volunteers and Charity) into a single high-level Public Participation Strategy 2026-2030. Progress against the objectives will be monitored through the Trust Public Assurance Forum. In response to a query from the Group Chair, Mr Lee advised of the intention to develop joint community engagement working across SaTH and SCHAT going forward, with a focus on neighbourhood care. Noting the extensive engagement to date, the Boards approved the SaTH Community Engagement Strategy 2026-2030.	
041/26	SaTH Volunteer Strategy 2026-2030 Mr Lee presented the SaTH Volunteer Strategy (2026-2030) following extensive volunteer and staff engagement in 2025/26. As with the strategy above, once approved the Volunteer Strategy will be available separately and also combined with the other two Public Participation Strategies into a single high-level Public Participation Strategy 2026-2030. Progress against the objectives will be monitored through the Group People Committee. The Group Chair noted that the valued contribution of volunteers also lends itself to a Group approach going forward. Noting the extensive engagement to date, the Boards approved the SaTH Volunteer Strategy 2026-2030.	
Assurance Framework		
042/26	SaTH Integrated Improvement Plan (SIIP) Monthly Update Report Ms Williams, taking the report as read, confirmed that there were no	

	exceptional items requiring escalation at this time. The Boards: • Noted the actions and took assurance from the updates provided. • Noted progress against delivery of the tasks/actions that were due up to and including 30 June 2026, as detailed in Appendices 1-4. • Noted progress on the UEC undertakings, which have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4, reflecting continued system focus and delivery trajectory.	
043/26	SaTH Integrated Maternity & Neonatal Report Ms Morris introduced Ms Lauren Taylor, 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 Boards were referred to the detail contained within the main report, together with the accompanying appendices in the supplementary information pack which provide further comprehensive information. Highlights from the report include the following: The Ockenden Report (Independent Maternity Review) Progress Report: Appendix 1 provides the summary Ockenden Report Action Plan at 9 June 2026. 196 out of the total of 210 actions have now been fully completed (evidenced and assured), with five actions currently on track for their expected delivery dates pending evidence that they have been appropriately embedded. Nine actions remain 'de-scoped' currently, relating to nationally-led external actions (led by NHSE and the CQC), which are not within the direct control of the Trust. As advised in previous reports, the Local Maternity and Neonatal System (LMNS) continues to oversee these actions, which remain under quarterly review and national escalation by the Trust. In addition to the Trust's established internal audit process to test how well the actions and recommendations from the Independent Maternity Review have been embedded, an independent external review has been commissioned to validate the Trust's progress and confirm that all recommendations have been fully delivered, as referenced in the earlier Group Chief Executive's report. This has been a substantial undertaking, involving more than 700 individual actions and over 1200 pieces of supporting evidence. The report is due later this Summer and the findings will be shared with the families to ensure they can see the progress made and understand how their voices and experiences have shaped meaningful change. Invited Neonatology Service Review (2023/24): Continued progress is being made to deliver the recommendations from the external invited review of the Trust's neonatal services, led by	

the Royal College of Physicians.

The summary action plan as at 10 February 2026 is included as **Appendix 2**.

One action, linked to the auditing of the Preterm Golden Hour, remains At Risk. Quarterly audits are in place and will be repeated until satisfactory compliance is reached. Progress is monitored and discussed monthly at the Quality and Safety LMNS workstream, allowing for learning from practices within the region. Work is ongoing to implement the last four actions currently Not Yet Delivered. One of these is expected to be presented for a status change in July 2026 and the other three require the recruitment of Neonatal Safeguarding and Family Integrated Care Lead Nurses, which are currently at various stages of the recruitment process.

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

Colleagues were reminded that it was a requirement of the Independent Maternity Review for the Board to receive an update on the MNTP at each of its meetings in public session. The summary MNTP, which is now in its second phase, is included as **Appendix 3**. Progress continues to be made on the cultural improvement programme within the Division and perinatal services.

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

Year 8 of the scheme was launched on 23 April 2026 and contains six core safety actions, with a focus on outcomes. Details of progress against all safety actions and their sub-items are included in **Appendix 4**.

Of note, a compliance risk has been flagged against the Maternal Care Bundle Element of Safety Action E. Implementation will require system partners such as primary care, the ICB and national digital services to update digital tools for the assessment of Venous Thromboembolism (VTE) as first point of contact during pregnancy which can occur before the booking assessment within maternity services. Also, as per CNST Safety Action E, Board oversight is required for a plan to implement the Maternal Care Bundle Gap by March 2027, and a gap analysis has been undertaken to assess the implementation within the Trust. Ms Edwards asked Ms Taylor's level of confidence on system partner engagement with the implementation requirements, and she confirmed that the Trust's joint working with Stoke is extremely positive and the Trust has full support from ICB colleagues.

The Maternity Care Bundle sets out a series of evidence-based interventions designed to improve safety, reduce variation in care, and enhance outcomes for women and babies. Its effective implementation is essential to delivering high-quality, consistent maternity services aligned with national standards, as described in **Appendix 5**.

Birthrate Plus (BR+) is a framework for workforce planning consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings. An independent review of the BR+ methodology published in February 2026 concluded that the tool remains an appropriate and credible foundation for midwifery workforce

	planning. The Year 8 MIS Safety Action A requires that Trusts must have a fully funded midwifery establishment that aligns with a BR+ review completed within the last three years as a minimum baseline. In addition, further adjustment based on professional judgement of the Director / Head of Midwifery should be added where appropriate. As shown in Appendix 6, our budgets and actual wte match the Trust's total clinical establishment as produced from BR+, with the only difference being bank which is being actively managed through CIP schemes. In response to a broad question from Mr Morgan on the level of assurance that we have the right number of staff in the right place, Ms Morris confirmed that in addition to the strategic BR+ and the Trust's annual Safe Staffing Report, daily assurance is provided from within the Division, with any significant staffing issues escalated to herself. Additionally, red flags focus on broader indicators, through reported themes from MTAC and QSAC on a monthly basis. Ms Taylor provided further assurance that she meets with the Division's finance and workforce leads bi-weekly to ensure staffing remains at template, all of which provide confidence that the Trust remains at safe staffing levels. In response to a query from Ms Nicholson on whether there is the same level of scrutiny of medical staffing within maternity services, Dr Jones confirmed a commitment made by the Trust some years ago to ensure that a consultant obstetrician was present on the hospital site 24 hours a day, in addition to permanent 24/7 specialist anaesthetic staff. Both of these commitments provide confidence that there is a constant presence on site of senior medical staff. Ms Taylor provided additional assurance that Multi-Disciplinary Team (MDT) staffing papers will be coming to Board as part of the CNST scheme during the year. Publication of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, and Baroness Amos' Maternity Services Review Report Noting that reference to both of the above had been included within the Group Chief Executive's report earlier in the meeting, this section of the report was taken as read. The Boards, following comprehensive review of the Integrated Maternity & Neonatal Report and all associated appendices (Appendices 1-6), accepted and took assurance from the report.	
044/26	SaTH Board Maternity & Neonatal Safety Champions Reports Dr Jones and Ms Nicholson, as the Trust's Executive and Non-Executive Safety Champions, presented the reports of the May and June meetings respectively. The reports were taken as read, with the following points highlighted: • The Safety Champions heard from midwifery and obstetric colleagues that the number of caesarean sections continues to rise. This is creating additional demand on elective capacity, and additional planned lists have recently been introduced to support capacity. The Safety Champions will receive information on the impact of this new capacity over the coming months. • The postnatal senior leadership team is progressing actions in	

	response to Safety Champions' feedback, including safety risks linked to the tagging system and compliance with prescription charts guidance. There is a national shortage of paediatric ophthalmologists, impacting on the sustainability of ophthalmologist availability for Retinopathy of Prematurity (ROP) screening on the neonatal unit. A business case has been developed to purchase a retinal imaging device and there is ongoing training of neonatal unit staff and ophthalmology to address the gap and ensure timely screening. The Boards accepted and took assurance from the report.	
Regulatory and Statutory Reporting		
045/26	SaTH Patient Safety Committee Q4 / Annual Report 2025-26 The Boards received the report from Dr Jones, incorporating updates from the Medical Examiner Service, Learning from Deaths and Patient Safety. Taking the report as read, Dr Jones confirmed that there was nothing of significance which colleagues should be concerned about at this time, with the report providing assurance that all elements of the above services are running efficiently and effectively overall. The Boards accepted and noted the report.	
046/26	SaTH Freedom to Speak Up (FTSU) Q4 / Annual Report 2025-26 Ms Milanec presented the report on behalf of Ms Chan Kaur, SaTH's Lead FTSU Guardian. The report was taken as read, with the following points highlighted: - Colleagues' attention was drawn to the mandatory FTSU training figures included on page 230 of the Board pack. Ms Milanec highlighted that the third of the three mandatory modules, FTSU Follow Up – Training for Senior Leaders, relates only to Board members, and the compliance figure was not available at the time of the report production. The Group Chair asked that Ms Milanec ensures the figure is published when available. - Responses to queries from Non-Executive Directors are summarised as follows: - Ms Milanec confirmed in response to a query from Ms Edwards that, whilst the report states that detriment guidance is underway as part of the FTSU improvement action plan, the Lead Guardian is not waiting for full guidance completion and already identifies cases where detriment is involved. - Mr Crowther, commenting that it was encouraging to see colleagues continuing to use FTSU, asked how the most relevant individuals were identified to deal with concerns. Ms Milanec confirmed that the Lead Guardian is the initial point of contact for minor/regular concerns. In cases of more serious issues, Ms Milanec, as the SaTH Lead Executive for	

	FTSU, is aware of which executive colleague would be the most appropriate to deal with any particular issue. ○ With the recent closure of the National Guardian's Office (NGO) Ms Nicholson asked what the national FTSU data reporting route would be going forward. Ms Milanec confirmed that the quarterly submission of figures would continue, with responsibilities transitioning to NHSE. ○ Ms Nicholson also queried the FTSU local governance reporting route, noting that she had not seen any reports coming to the People Committee. Ms Milanec clarified that the SaTH FTSU reports are currently taken to the Audit & Risk Assurance Committee, but she does think this needs to be reviewed as the Group develops, particularly as each Trust has a FTSU Lead Guardian and the intention is to develop a joint report going forward. The Boards noted the report and took assurance from FTSU's continued contribution to supporting colleagues and improving our culture.	
Board Governance		
047/26	Annual Review of Compliance with the Fit & Proper Persons Test (FPPT) Framework for Board Members Ms Milanec presented the SaTH and SCHAT reports, which provided confirmation that the required annual checks have been completed on all voting and non-voting executive and non-executive members of each Board. The evidence reviewed confirms that all serving members of the Boards are fit and proper and the Boards noted that the requirements of the annual 2026 FPPT assessment have therefore been fully satisfied.	
Items for consent – approval recommended by Board Committees		
048/26	SaTH Anti-Fraud, Bribery and Corruption Policy renewal Ms Milanec advised colleagues that the above policy has been updated to reflect a new corporate fraud offence of 'failure to prevent fraud', which came into force on 1 September 2025. The updated policy has been reviewed by the SaTH Audit and Risk Assurance Committee, who is recommending approval to the Board, as a reserved policy. In response to a query from Mr Dhaliwal on the reference to 'associated persons' on page 247 of the Board pack, Ms Milanec confirmed that this included third party risk. Mr Winstanley added that whilst this was not necessarily reflected in explicit wording within supplier contracts, the Trust has written to all of its contractors, to make them aware of their obligations under the offence/policy. Colleagues further noted that clarification was included within the policy that reference to 'associated persons' includes contractors, subsidiaries, agents and other service providers or partner organisations.	

	The Board approved the updated SaTH Anti-Fraud, Bribery and Corruption Policy.	
Procedural Items		
049/26	Any Other Business Board colleague farewell As this would be Ms Tracey Cotterill's last Public Board meeting as Interim Group Chief Recovery and Transformation Director before leaving the organisation, Mr Morgan expressed his sincere thanks to Tracey for her huge contribution, particularly the significant role she played in SaTH's exit from special measures. The Boards joined Mr Morgan in wishing Tracey all the very best for the future. There were no further items of business.	
050/26	Date of Next Meeting The next meeting of the Boards in Common in Public session is scheduled for Thursday 13 August 2026, at AFC Telford Utd, SEAH Stadium, Bucks Way, Wellington, Telford, TF1 2TU (sat nav TF1 2NW).	
The meeting was declared closed.		

Public Q&As (agenda item 029/26)

Q1 Submitted by David Sandbach

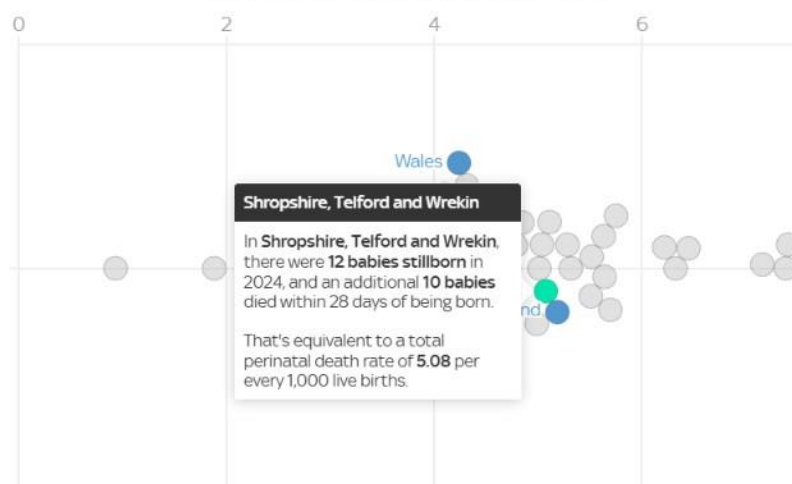
Q I wish to ask if the data below can be explained at the SaTH Board meeting to be held on 9th July 2026 as part of the public question section on the agenda.

Rates of stillbirths and neonatal deaths in your area compared with other UK health boards

Number of babies stillborn, or died within 28 days of birth, per 1,000 live births

● Your area ● National average ● Other

Stillbirths and neonatal deaths per 1,000 births



SOURCE: Sky News analysis of data from English, Scottish, Welsh and Northern Irish health providers

DATAxFORENSICS

Babies born in **Shropshire, Telford and Wrekin** are more likely than the national average to be re-admitted to hospital within 28 days of being born

Percentage of births where baby was re-admitted to hospital within 28 days, in year to March 2026



SOURCE: Sky News analysis of NHS data

DATAFORENSICS

Source: [What is it like to give birth in your area? Use our interactive tool to find out | UK News | Sky News](#)

Can you also provide details about the number of babies returned and where they were returned from by first three letters of their post code.

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

Thank you to Mr Sandbach for his question relating to perinatal mortality and readmissions to hospital. As we have often discussed at Board, a death of any baby is a tragedy with a lifelong impact on families and those close to them. No data on its own should ever give assurance about the quality of care and quality of experience of families being cared for at the beginning of a new life. Every experience of mothers, babies and families matters. This must be held in mind whenever data is analysed or presented.

Perinatal mortality, that is deaths of babies before birth (stillbirths) and deaths of babies within 28 days of birth (neonatal deaths) are included and compared with other similar organisations in local and national reports by “Mothers and Babies Reducing Risk through Audit and Confidential Enquiry” (MBRRACE).

The most recent data published relates to the calendar year 2024 including our own data for babies who were born at SaTH. These reports produce “crude” rates and also “standardised and adjusted” rates which take into account factors that would be expected to affect rates. I am unable to comment on any differences in the data presented in the question compared with the national recognised MBRRACE reports. For example, the perinatal mortality rate and neonatal mortality rates in the question are different from the MBRRACE data.

MBRRACE reports use coloured dots to illustrate relative rates. An orange dot means rates are around average (within 5%). In 2024 our crude perinatal mortality rate was 4.04/1000 births which is within 5% of average (orange dot). Our standardised and adjusted rate was 3.97/1000 births (orange dot).

Our neonatologists have confirmed that our MBRRACE data for 2024 reported 6 neonatal deaths and not the 10 quoted in the question. For stabilised and adjusted rates, perinatal mortality, neonatal mortality and still births were all within 5% of average (orange dots).

Our clinicians explain that readmission to hospital within 28 days tends to be for a variety of reasons including for jaundice and weight loss or readmissions to the children's ward for concerns around infections or breathing problems. We have noted a higher number of readmissions than expected and so we are looking at our neonatal oversight of our postnatal ward to prevent any baby being discharged when they might be at a higher risk of having to be readmitted. Since this is often for treatment of jaundice with phototherapy (light treatment), we are making good progress with our home phototherapy service so babies can remain in the community with their family instead of having to return into hospital for phototherapy for their jaundice. In addition to this we

are using audit in our paediatric services so that we can identify any patterns that might also be suitable for improvements.

With regard to postcode data for “returns”, it would be helpful to have clarity on whether Mr Sandbach is referring to the postcode of family homes whose baby has been readmitted within 28 days. If this is the case, I don’t believe this is data that we routinely collate. I would be happy to explore this but would need to take care to avoid any risk of patient identification.

Q2 Submitted by David Sandbach

Q SaTH press release - [New free app helps people ‘Wait Less’ for urgent care services in Shropshire, Telford and Wrekin – SaTH](#)

Question 2a

Can this tab below on the SaTH web site be replaced with a link to this facility [WaitLess Web](#)

Community Minor Injury Units (MIUs): 60 minutes

URGENT TREATMENT CENTRE / MINOR INJURY UNIT WAITING TIMES

Emergency Department (A&E) Average Wait Times

Princess Royal Hospital
Emergency Department (A&E) - adults
47 minutes

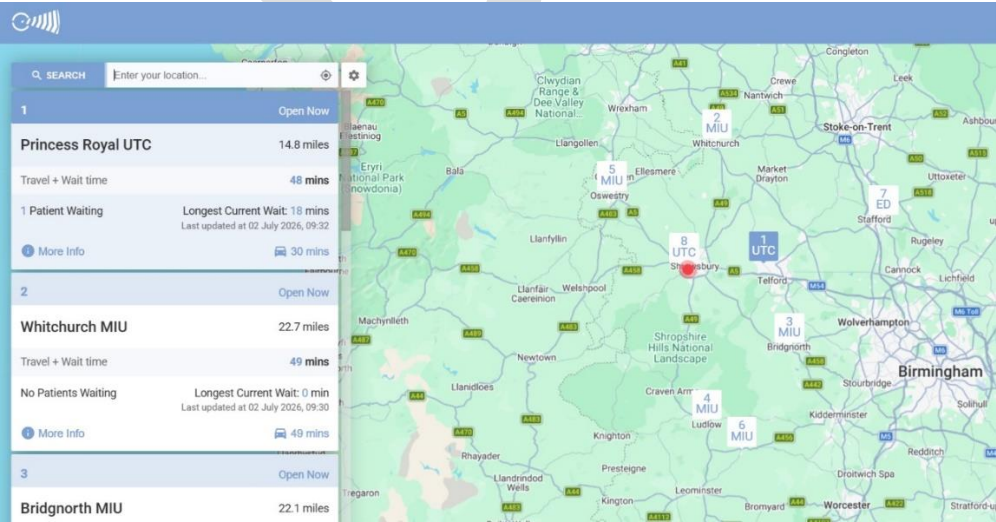
Royal Shrewsbury Hospital
Emergency Department (A&E) - adults
3 hours

Princess Royal Hospital
Emergency Department (A&E) - children
Over 4 hours

Royal Shrewsbury Hospital
Emergency Department (A&E) - children
51 minutes

Community Minor Injury Units (MIUs): 60 minutes

Please be aware that MIUs are not open 24 hours - click [here](#) for opening times.
Learn more about our wait times [here](#).
Last updated on Thursday, 2 July 2026 08:56.



e-waitless.com/

Question 2b

Can the Boards in Common vouch for the veracity of the information provided on the <https://e-waitless.com/> site?

Question 2c

Was the management of the Boards in Common party to agreeing this development and if it was, did anyone think to including this web link on your own web site?

Question 2d

Can the SaTH Board include this web facility [The Shrewsbury and Telford Hospital NHS Trust - My Planned Care NHS](#) as part of the SaTH web site information offering to the public.

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

Question 2a

We welcome feedback on our websites so that we can continually improve the information that we provide to our patients and communities. We can confirm that the websites have been updated to include information on the WaitLess app.

Question 2b

The WaitLess platform has been developed by NHS Shropshire, Telford and Wrekin ICB to support patients in making informed decisions about accessing urgent and emergency care services. The information displayed is drawn from live operational data feeds, including SaTH data sources, and provides waiting times, queue numbers, estimated treatment times, travel information and service details for participating Urgent Treatment Centres and Minor Injury Units. [\[e-waitless.com\]](https://e-waitless.com/).

The Boards in Common can take assurance that the system is used as an operational tool across the local health system and that appropriate governance arrangements are in place for the management of the data it displays. As with any live system, waiting times and service pressures can change rapidly, and the information represents the position at the time it is published. The Board is assured that the information is sourced from operational systems used by participating organisations, including SaTH.

Question 2c

The WaitLess app was developed through a system-wide initiative led by NHS Shropshire, Telford and Wrekin ICB in collaboration with partner organisations, including SaTH, Shropshire Community Health NHS Trust and other providers across the local health and care system. The inclusion of links to external digital tools on individual organisation websites is a matter for each partner organisation – for SaTH, the WaitLess platform link has been added to the Trust's website.

Question 2d

Thank you for your suggestion. We can confirm that the My Planned Care NHS information has been updated on our websites.

Q3 *Submitted by Julia Davies, Chair, LoF Bridgnorth Hospital*

Q We, the League of Friends of Bridgnorth Hospital, have agreed to the purchase of equipment for the MIU. The money has been sent to the ShropCom finance department in early May, but no action seems to have been taken to place the order yet. The line

manager has asked why it has not come yet and I explained we had paid the Trust for it. How do we speed this process up? Also, could finance please send us a proper invoice when we give money for any purchase we make for the Hospital. We are accountable to the people of Bridgnorth who have generously given for it to be spent carefully.

A *Provided by Sarah Lloyd, Chief Finance Officer/Deputy Chief Executive (SCHT)*

The League of Friends of Bridgnorth Hospital kindly agreed to donate funding for the purchase of equipment to use within the Bridgnorth Minor Injuries Unit, which resulted in a generous donation on 5 May 2026.

Unfortunately, due to administrative issues including staff changes and team sickness there was a delay ordering the items. This resulted in new quotes being sought from suppliers to secure the most competitively priced equipment and ensure value for money from the donation.

The equipment order was subsequently placed on 1 July, and delivery of the equipment is anticipated by the end of July.

We wish to apologise to the League of Friends of Bridgnorth Hospital for not providing regular updates throughout this process. As a result, internal processes have been amended to ensure we learn from this.

Shropshire Community Health NHS Trust greatly values the continued support of the League of Friends of Bridgnorth Hospital; their generosity makes a meaningful difference by enabling us to purchase items for the benefit of patients and staff that we may not otherwise be able to provide. We remain very grateful for their ongoing support.

Q3 *From David Tooley, Local Democracy Reporter (taken from the floor)*

Q In light of recent press coverage on proposals by Powys Teaching Health Board to close inpatient beds in most of the county's community hospitals, has SaTH agreed a contract with Powys for 2026/27?

A *Provided by Adam Winstanley, Acting Chief Finance Officer (SaTH)*

A contract has not yet been agreed but discussions are ongoing.

Q4 *From David Sandbach (taken from the floor)*

Q What was the value of the Powys Teaching Health Board contract?

A *Provided by Adam Winstanley, Acting Chief Finance Officer (SaTH)*

The contract value was £35m, with 9% of SaTH's activity relating to Powys.

Log number	Date of meeting	Agenda item	Item	Action	Lead Officer	Deadline	Comment/ Feedback from Lead Officer	Action
2026								
15	09/07/2026	038/26b	Local Care Transformation Assurance Committee Report (integrated care pathway development)	A question on SEND was raised by Ms Nicholson, asking how we ensure our CYP and families see the improvements. A response was provided to Ms Nicholson by email following the meeting from the SCHAT Director of Nursing - Community, as detailed in the Comment/Feedback column.	GCMO	N/A	Improvements are being delivered through a partnership approach involving health, education, local authority and voluntary sector colleagues. The focus is on providing a more joined-up experience for families, improving access to information, strengthening communication, enhancing early identification and support, and developing more integrated pathways across services, including transition arrangements into adulthood. The recently agreed Shropshire SEND Strategy 2024–2029 was developed with input from children, young people, families and professionals. It includes a commitment to measuring outcomes, listening to family feedback and sharing progress transparently with families. There are now a number of mechanisms through which families are kept informed and involved: The Shropshire SEND Local Offer provides a single point of access for information, services, guidance and resources for children and young people aged 0–25 and their families. Regular SEND newsletters are jointly produced by the Local Offer, Shropshire Parent Carer Council (PACC) and NHS Shropshire, Telford and Wrekin, providing updates on service developments, pathway improvements, and sources of support. Families are actively involved through surveys, engagement events and co-production activity. Partners have specifically identified improving communications with parent carers as a priority, particularly to ensure families are aware of support available while awaiting assessment or diagnostic pathways. As an example, SCHAT has introduced a Speech and Language Therapy Advice Line, providing parents, carers and professionals with direct access to advice and support whilst awaiting assessment or intervention, helping families access guidance at an earlier stage. Delivery is overseen through partnership governance arrangements, with progress reported through SEND programme boards. In addition to the wider SEND improvement programme, the Community Transformation Programme has already commenced a number of Children and Young People's pathway developments designed to improve integration across community, primary care and acute services. These include the development of Integrated Neighbourhood Teams for Children and Young People, a new integrated asthma pathway with multidisciplinary support and specialist input, and development of a Paediatric Virtual Ward model to provide care closer to home where appropriate. These developments are intended to create clearer pathways for families, improve coordination between organisations, reduce duplication and strengthen transition arrangements as young people move into adult services.	Response provided - action complete. Recommended to close

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	061/26		
Report Title	Group Chief Executive’s Report		
Executive Lead	Jo Williams, Group Chief Executive		
Report Author	As above		
Prior Consultation:	CQC Domain:		Link to BAF risks (strategic)
None	Safe	√	All SCHT BAF Risks
	Effective	√	All SATH BAF Risks
	Caring	√	Risk Register id(s):
	Responsive	√	-
	Well Led	√	
Executive Summary	Whilst July and August are usually demanding months for the NHS, due to four heatwaves within as many weeks, we have seen, on a national and local level, increased pressure for health care services due to the extreme weather. Nevertheless, our colleagues have continued to treat our patients with care and compassion. These are the colleagues, who sadly, unlike some of our teams, cannot ‘work from home’ in such circumstances. Their determination for this level of care in such conditions is to be applauded, and the Board is profoundly grateful for their efforts and the difference that they make each day. It is difficult to believe that it is only a month since the last board meeting (we usually meet on a bi-monthly basis) and we have managed to achieve so much as we continue with our transformation and improvement programmes. Not only that, but we have established fresh staff engagement opportunities, endorsed new initiatives, carried on listening and learning from others, and we have continued to support others where we could have done more.		
Recommendations for the Boards	The Boards are asked to note the contents of this report.		
Appendices:	None		

1.0 Introduction/General updates

- 1.1 This paper provides the Chief Executive's update on the most significant developments since the public Board meeting on 9 July 2026.

- 1.2 July and August are traditionally demanding months, and the recent period of sustained heat has added further complexity to the pressures already being experienced across our services. Nationally, current levels of demand are being compared with those more usually associated with winter, and I recognise the considerable impact this is having on colleagues working across the Group.

Staff continue to manage elevated levels of activity while maintaining their focus on safe, compassionate care, often in exceptionally challenging circumstances. A range of additional measures is already in place, including strengthened support for discharges through increased consultant presence and greater use of virtual wards and community beds. I am very grateful to colleagues for their professionalism, flexibility, and resilience, and for the way teams continue to support one another and our patients. Their sustained commitment and compassion throughout this prolonged and difficult period are appreciated and should not be underestimated.

- 1.3 On 22 July 2026, the CQC formally notified SaTH, under Section 31 of the Health and Social Care Act 2008, that it had removed the final condition as a service provider from the Trust's registration.

The condition required the Trust to maintain an effective system ensuring that all patients presenting to the Emergency Department were assessed within 15 minutes of arrival, in line with national clinical guidance and taking account of patient acuity and location.

This was the last of the original 60 conditions, meaning no conditions now remain on the Trust's registration. This significant achievement reflects the sustained commitment and tremendous efforts of teams across the organisation.

We expect to receive the CQC reports on the Urgent and Emergency Care and Medicine inspections at both RSH and PRH over the coming weeks. I anticipate that the reports will recognise the progress made across these services, including the commitment of colleagues who continue to provide safe care and treat patients and their families with kindness, dignity, and compassion, often in challenging circumstances. However, we recognise that there is still more to do to ensure consistently high standards across every service and for every patient. We remain committed to responding openly to feedback, building on the improvements already achieved and supporting our teams to deliver sustained, high-quality, and compassionate care.

- 1.4 The organisation has had further success in recruiting high quality consultant colleagues for those areas where we sought to strengthen our teams, and where we continue to do so. We are finding that applications are of good quality and with genuine enthusiasm from individuals to come and join us in Shropshire, Telford & Wrekin.

Details of recent recruitment can be found on the following page.

Division	Post Name	Start Date
Surgery and Anaesthetics	Consultant Anaesthetist	04/08/2026
Surgery and Anaesthetics	Consultant, Oral & Maxillofacial Surgeon	07/09/2026
Surgery and Anaesthetics	Consultant Ophthalmologist	04/01/2027

Division	Post Name	Start Date
Women and Children's	Locum Consultant Obstetrician and Gynaecologist	11/08/2026
Women and Children's	Consultant Neonatologist	01/10/2026
Women and Children's	Consultant Obstetrician & Gynaecologist	26/10/2026
Women and Children's	Locum Consultant Obstetrician & Gynaecologists x3	24/08/2026 07/10/2026 10/01/2027

Division	Post Name	Start Date
Medicine and Emergency Care	Locum Consultant in General Internal Medicine x4	06/07/2026 05/08/2026 x2 01/10/2026
Medicine and Emergency Care	Locum Consultant Acute Physician x3	31/08/2026 01/10/2026 x2

Division	Post Name	Start Date
Clinical & Scientific Services	Consultant Radiologist	TBC
Clinical & Scientific Services	Consultant Oncologist	24/08/2026

2.0 Group Update

- 2.1 The Board papers for this meeting include a comprehensive Integrated Finance and Performance Report, outlining our performance against the plans agreed with NHS England for both SHT and SaTH.
- 2.2 Engagement events held in July 2026 across Telford and Shrewsbury were attended by 190 senior medical colleagues, providing valuable opportunities to listen to staff experiences and gather insights on opportunities for further improvement. Colleagues also shared learning from digital transformation initiatives, including the implementation of Ambient Voice Technology.

Colleagues demonstrated a strong commitment to innovation and exploring how technology can support both clinicians and patients. A key theme was the potential for technology to enhance patient engagement and strengthen human connection by reducing the administrative burden on clinicians, enabling more time to listen to and engage with patients and their families. Important considerations were also raised regarding how we continue to train and support resident doctors as new technologies are adopted across clinical practice.

- 2.3 On 30 July 2026, I met with 120 of our medical secretaries at SaTH, whose vital contribution supports consultants and patients across hundreds of thousands of interactions. They reassure patients awaiting letters or appointments and respond compassionately when concerns arise about a worsening condition. The session provided an important opportunity to listen to their experiences and consider how modern tools could reduce administrative pressures and enable more time to add value for patients. We also heard about practical issues, which we will continue to address together. I remain deeply grateful for the difference our medical secretaries make every day.
- 2.4 On 23 July 2026, Dr Claire Fuller, NHS England's Medical Director for Primary Care and national lead for Neighbourhood Health, visited the Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin systems. The visit reviewed progress, pace and impact, and provided an opportunity to share learning and good practice. Representatives from the ICB, local authorities, NHS trusts, primary care and VCSE (Voluntary, Community and Social) Enterprise) partners took part. Feedback recognised the progress achieved while constructively challenging the systems to accelerate transformation, sharpen their focus on priority populations, strengthen neighbourhood leadership and scale multidisciplinary team models.
- 2.5 Helen Ainsbury has been appointed Interim Group Chief Digital Information Officer until the end of December 2026. Helen has already made a positive impact, bringing valuable experience, energy, and insight to the role. She will provide leadership across the Group's digital portfolio, working with clinical and operational teams to ensure that technology supports safer, more efficient services, and improves the experience of both patients and colleagues.

Helen will also contribute to Board discussions, strengthening oversight and assurance as we continue to develop and deliver our digital priorities. Jonathan Davis from SCHAT will support Helen as Group Deputy, working closely with her, the digital team and wider partners. Together, they will help maintain momentum, strengthen collaboration across the Group and advance a coordinated digital agenda that supports our wider strategic ambitions.

Dr Jenni Rowlands has been appointed Medical Director for SaTH and will support Dr John Jones, Group Chief Medical Officer, in providing senior clinical leadership across the Trust. Working closely with clinical and operational colleagues, she will help strengthen medical leadership, develop the medical workforce and ensure that clinical expertise remains central to decision-making across SaTH and the wider Group. Her appointment will also support continued improvements in quality, safety and patient outcomes. Congratulations to Jenni, Helen and Jonathan on their appointments, and thank you for their ongoing leadership and support.

- 2.6 A meeting has been arranged for 25 August 2026 between Group executives and local GP/Primary Care Network (PCN) leaders to begin discussions on strengthening collaboration across primary, community and hospital services in Shropshire, Telford and Wrekin. The discussion will focus on emerging national policy changes relating to neighbourhood health, integrated neighbourhood teams, commissioning arrangements and opportunities for closer partnership working to improve patient care and outcomes.

On 15 September 2026, we will hold a wider engagement event bringing together GPs and our senior clinical teams to strengthen critical relationships, deepen mutual understanding and identify opportunities for closer collaboration across primary, community and hospital services.

- 2.7 On 29 July 2026, I attended a scheduled meeting with families involved in our Ockenden Review, alongside the Chair, members of the Executive team and our Maternity Communications and Engagement Lead. I am grateful to everyone who gave their time to attend and speak so openly about their views and experiences. It is a privilege to meet with families, and these conversations provide an important opportunity to listen, learn and consider how we can continue improving services together. We remain committed to ensuring that families' voices are heard and remain central to our work.

The following day, the Learning and Improvement Group brought together families, regional NHS England colleagues and Board and Divisional representatives to review progress, share learning and agree how we will continue working together to deliver meaningful and sustainable improvement.

We also welcomed Stacey Thacker, who has joined the Trust as Head of Midwifery. The meeting gave families an important opportunity to meet Stacey, particularly as several had contributed to her recruitment as part of the stakeholder panel. We are delighted to welcome Stacey to the Trust and wish her every success in her new role.

- 2.8 At the Learning and Improvement Group, we were also delighted to welcome Olivia Siegl, a colleague in our Communications Team and founder of "LetterBeams". Drawing on lived experience, this voluntary peer-support initiative provides letters of encouragement and hope to people facing difficult life circumstances. Initially focused on maternal mental health, LetterBeams has expanded to support people affected by bereavement, cancer, dementia, domestic abuse, neonatal care, mental ill health and end-of-life care. Through shared experience and human connection, it has developed a growing national network of volunteers offering compassionate support at some of the most challenging times in people's lives.

We will promote LetterBeams across the Group in the coming weeks, and I am confident that many colleagues will be inspired to support others by becoming volunteer letter writers. This is an exceptional initiative, and Olivia showed great courage in sharing her own experience. I look forward to supporting LetterBeams as it grows across the Group and continues to reach people throughout the country.

- 2.9 Through our 'In Your Shoes' initiative, the Shropshire, Telford and Wrekin Community and Hospitals NHS Group invited patients to share their experiences and help shape the future of care. The sessions, held in July 2026 at the Mercure Hotel in Telford and Shrewsbury

Football Club, each brought together 20–30 people who had used our services within the previous 18 months. I am grateful to everyone who attended and shared their experiences so openly. Further sessions are planned, and feedback and learning will be shared over the coming months.

- 2.10 I would like to thank our colleagues in Bridgnorth for responding quickly to support a local GP practice that was forced to close following significant flooding. Their swift action, kindness and willingness to help, enabled the practice to remain open locally, ensuring that patients continued to receive the care and support they needed. This is an excellent example of partnership working and the strong community spirit across our Group. I am grateful to everyone involved for going above and beyond and demonstrating what can be achieved when we work together to support one another and the communities we serve.
- 2.11 I would like to warmly welcome our new cohort of resident doctors. The first few days and weeks can be both exciting and challenging as you settle in, learn new systems and join new teams. Please remember that you are not alone: a strong support network is available, so I encourage you to ask questions and seek advice whenever needed. You bring fresh energy, new ideas and valuable perspectives, and we look forward to working alongside you, supporting your development and seeing you thrive.
- 2.12 The Trust has been recognised for its contribution to undergraduate medical education following the publication of the 2026 National Student Survey (NSS) results. Keele University has again been ranked within the top five medical schools nationally, reflecting consistently high levels of student satisfaction and the quality of the learning experience provided across teaching placements. Senior colleagues from the University have specifically acknowledged the contribution of placement providers and clinical teams, noting that the results recognise the high-quality educational experience delivered by those involved in supporting medical students. The achievement demonstrates the strength of the longstanding partnership between SATH and Keele University and the commitment of staff to developing the future healthcare workforce.
- 2.13 I was pleased to visit Telford College and meet Lawrence Wood, Principal and Chief Executive; Sarah Davies, Executive Director of Partnerships and Employer Engagement; and colleagues from across the College. The visit demonstrated the strength of our growing partnership and focused on opportunities to collaborate on education and training, apprenticeships, healthcare support worker development and the future skills needed across the local health and care system. I am grateful to college colleagues for their enthusiasm and commitment to helping us build a sustainable local workforce and improve outcomes for the communities we serve.
- 2.14 Poppy's Promise supports both patients and colleagues by promoting compassionate, consistent communication. Effective communication strengthens trust and psychological safety, reduces misunderstanding, and creates a more supportive experience for everyone, recognising the person behind every role and uniform.

The initiative was launched in the Women and Children's Division on 20 July 2026 when founder and Chief Executive, Katie Russell, visited PRH to meet colleagues. Initial elements of the model will include new learning materials, opportunities for reflection, and ways for

patients and colleagues to share feedback. A Trust-wide rollout will follow later in the year, supported by mandatory training for all colleagues to embed compassionate communication and consistent CARE across every service.

- 2.15 Our Culture Programme is progressing, with more than 100 colleagues contributing to 23 listening sessions facilitated by AQUA (Advancing Quality Alliance). An initial report on the findings will be shared later this week. Alongside this work, we have partnered with Tim Keogh's 'A Kind Life' programme, with the ambition of training 10,000 people in compassionate leadership and human connection. We will continue working with AQUA to strengthen leadership across our organisations and foster a culture in which colleagues feel valued, heard, and supported.

Our Group Leadership Conference on 2 October will bring leaders together to reflect on how their behaviours shape compassionate, inclusive, and high-performing teams.

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

- 3.1 The next Board meeting is 24 September 2026, 1.30pm, the venue is still to be confirmed.
- 3.2 On 23 July 2026, Dr Claire Fuller, NHS England's Medical Director for Primary Care and national lead for Neighbourhood Health, visited the Staffordshire and Stoke-on-Trent and Shropshire, Telford, and Wrekin systems. The visit reviewed progress, pace, and impact, and provided an opportunity to share learning and good practice. Representatives from the ICB, local authorities, NHS trusts, primary care, and VCSE partners took part. Feedback recognised the progress achieved while constructively challenging the systems to accelerate transformation, sharpen their focus on priority populations, strengthen neighbourhood leadership and scale multidisciplinary team models.
- 3.3 NHS planning guidance requires systems to improve access and outcomes within a constrained financial envelope, including delivering at least 2% annual productivity growth and shifting care closer to home. This supports the 10-Year Health Plan's ambition to move care from hospitals into communities and from treatment towards prevention. In practice, it means redirecting resources into community and neighbourhood models to enable earlier intervention, reduce avoidable demand and deliver more sustainable, population-based care.

For 2026/27, the framework prioritises frailty and ageing well, cardiovascular risk management, and urgent care and admission avoidance. These priorities reflect population need, current system pressures and wider strategic objectives. The intended outcomes are reduced urgent and emergency care demand, stronger community provision, improved outcomes for people living with frailty and long-term conditions, and narrower health inequalities. This represents a deliberate shift from measuring activity to delivering outcomes, in line with national policy.

SCHT will act as lead provider for Shropshire, Telford, and Wrekin, working closely with the Shropshire and Telford Place Boards. Linking funding directly to outcomes and system impact will support the transfer of resources from acute services into community and

preventative care. This will move the system beyond historic allocation patterns and align investment with measurable improvements in population health and long-term sustainability. The lead provider model will also simplify contractual arrangements and establish clear accountability, while enabling collaborative alliance working with primary care, local authorities, and VCSE partners.

A robust governance framework will operate across system, place, and neighbourhood levels. The Place Boards will oversee local delivery, performance, and coordination, while the ICB will retain overall accountability for outcomes and value for money. This provides local flexibility within a clear system assurance framework.

4.0 NHSE

- 4.1 All provider and ICB chief executives will attend NHS England's national leadership meeting in London on Tuesday 22 September 2026, alongside national directors and the Executive Team.
- 4.2 NHS England has launched the 2026 provider capability assessment, following its introduction last year. NHS trusts are required to self-assess against capability statements based on 'The Insightful Provider Board'. This year's statements include a stronger board-level focus on cybersecurity, digital maturity and staff wellbeing. As previously, the assessment is intended to strengthen board assurance, focus attention on key governance priorities and support an open, 'no surprises' relationship between providers and regional oversight teams. The findings will also inform the level of oversight applied to each organisation during the year. Submissions are due by Friday 2 October, with provider capability scores expected to be published by NHS England in December 2026.

5.0 Recommendations

- 5.1 The Board is asked to discuss the contents of the report, and
- 5.2 Note the contents of the report.

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

5 August 2026

Chair's Assurance Report

Quality and Safety Committee Thursday 30th July 2026

0. Reference Information

Author:	Jessica Donegan, Executive Assistant	Paper date:	13th August 2026
Executive Sponsor:	Jill Barker, Non-Executive Director	Paper written on:	30 th July 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 Thursday 30th July 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 provides scrutiny and challenge regarding all aspects of quality and clinical safety, including strategy, delivery, clinical governance, research, and clinical audit, to obtain assurance and make appropriate reports or recommendations to the Board (Group Board from 1/4/26).

2.2 Summary

Assure

- The Committee received full assurance across the majority of agenda items, including patient safety, safeguarding, mortality reviews, policy governance, risk management, patient experience, paediatric psychology, medical revalidation and committee effectiveness. Robust governance arrangements remain in place with evidence of continued improvement, strong compliance, and effective oversight of quality and safety matters.

Advise

- The Board is advised to note the continued strengthening of quality and safety governance ahead of transition to the Group Quality Committee arrangements and support the Committee's focus on targeted improvement in a small number of areas requiring further assurance.

Alert

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- The Committee noted a small number of areas requiring continued monitoring and scrutiny, including two reported C. difficile cases and ongoing challenges relating to the NHS Staff Survey "raising concerns" score, limited leadership capacity to deliver the Palliative and End of Life Care Strategy, and concerns regarding the effectiveness of mitigations for the diabetic foot screening risk which was acknowledged to be system-wide. Whilst controls are in place, these matters require ongoing oversight to ensure sustained improvement and risk reduction.
- Fire safety update received and progress noted however Committee acknowledged that additional work is required to provide a fully integrated assurance position on fire safety governance, compliance and risk management across the Trust.

2.3. Conclusion

The Boards in Common are asked to **note** the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Shropshire Community Trust Quality and Safety Committee which met on 30th June 2026. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair) Sara Ellis-Anderson, Interim Director of Nursing Community Anna Milanec, Group Director of Governance Claire Horsfield, Director of Operations Community & Group Chief AHP Dr Ganesh, Medical Director Community Sharon Simkin, Quality Lead, ICB Sarah Hoyes, Interim Deputy Director of Nursing, Community (part-attendance) Camilla Johns, Professional Lead and Consultant Clinical Psychologist (part-attendance) Laura Pascoe, Head of Clinical Education UHB (Observing) Jessica Donegan, Executive Assistant
Apologies:
Jo Williams, Group Chief Executive

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Tina Long, Non-Executive Director
Martina Morris, Group Chief Nursing Officer
John Jones, Group Medical Director
Shelley Ramtuhul, Director of Governance Community
Cathy Purt, Non-Executive Director

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Integrated Quality & Safety Performance report		
The Committee reviewed the Integrated Safety and Quality Performance Report, now presented using the Alert, Action and Assurance (AAA) framework to strengthen reporting to the Board. Two indicators remain below target: a Category 4 pressure ulcer and the NHS Staff Survey "raising concerns" sub-score. Investigation of the pressure ulcer identified no failings in SCHAT care; however, concerns regarding adherence to clinical advice within an external care home resulted in a safeguarding referral. The Committee also noted that the Trust has reported two C. Difficile cases in the reporting period of June, against an annual threshold of four, with both cases involving patients transferred from acute hospital settings to Community Hospital beds having received courses of antibiotics and an already extensive hospital stay, increasing individual risk factors. In response to concerns regarding C. difficile, the Committee requested a system-wide review of the patient pathway through Group Quality Committee arrangements to identify opportunities for shared	Full Assurance	

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learning and reduction of infection risk across partner organisations. In relation to the NHS Staff Survey sub score an improvement plan has been implemented to strengthen staff confidence in speaking up, including targeted engagement with teams reporting the lowest survey scores. Improvements to falls reporting will be introduced from 1 August 2026 through enhanced recording of Rambleguard use, while work continues through the Bed Safety Task and Finish Group to address bed rail safety concerns. The Committee welcomed continued strong performance in medication safety, with no medication incidents resulting in moderate harm for the fourth consecutive month.		
2. Performance Framework		
The Committee reviewed proposed amendments to the Trust Performance Framework following publication of the National Oversight Framework. Members were assured that a comprehensive review of indicators had been undertaken by the Performance Team in consultation with relevant Group Executive Directors to ensure alignment with national requirements. The Committee received clarification regarding the replacement of the existing medication safety KPI measuring moderate harm incidents with two new rate-based indicators: medication incidents causing harm per 1,000 occupied bed days and medication incidents causing harm per 1,000 community contacts. Members noted that the revised measures will provide a more meaningful and intelligence-led assessment of medication safety performance across both inpatient and community services, supporting improved trend analysis and oversight.	Full Assurance	The Committee was assured that the proposed changes strengthen the Trust's performance reporting framework and enhance Board visibility of patient safety outcomes.
3. Policy Tracker		
The Quality & Safety Committee received the Policy Tracker report and noted that the overall position regarding overdue policies remains stable, with seven of the ten overdue policies scheduled for ratification within the next two months. The Committee was advised that the Governance Team continues to actively monitor and pursue progress on outstanding policies, while working proactively with policy owners to ensure forthcoming reviews are completed ahead	Full Assurance	

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of expiry dates. Members noted that policy 1876 had been successfully incorporated into policy 1242 (Urinary Catheter Care Policy), which was approved by the Clinical Effectiveness Committee in July, enabling the former policy to be archived. Assurance was also provided that historical versions of policies are retained to support governance requirements and future investigations, and that implementation of the PolicyStat module within Datix will strengthen policy management and document control.. The Committee further welcomed improved communication and reporting arrangements between governance and committee structures, which will support more timely and accurate oversight of policy review and approval processes. The Committee received assurance that effective governance arrangements remain in place to manage the Trust's policy portfolio and maintain compliance with policy review requirements.		
4. Corporate Risk Register		
The Quality & Safety Committee received the Corporate Risk Register report and noted a continued reduction in the number of high-rated risks across the Trust, reflecting progress in risk mitigation and management activity. The Committee welcomed plans to redesign the Corporate Risk Register reporting format to provide a more concise, accessible and assurance-focused view of key risks, themes and trends, supported by enhanced reporting functionality through the Trust's forthcoming risk management system. The Committee discussed the ongoing inclusion of the Ludlow X-ray Department radiographer staffing risk and requested a review of risk ownership following service transfer arrangements to ensure the risk is recorded and managed within the most appropriate register. Detailed discussion focused on Risk 7173 relating to diabetic foot screening. Members expressed concern regarding the effectiveness of current mitigations given persistently poor outcomes across the system, including high rates of diabetes-related lower limb amputation. The Committee recognised that the risk encompasses both Trust-specific operational risks and wider system risks associated with foot screening provision in Primary Care. It was agreed that the	Full Assurance	The Committee was assured that corporate risk oversight remains effective, evidenced by the reduction in high-rated risks. Assurance was also provided that specific concerns relating to the Ludlow radiographer staffing risk and diabetic foot screening risk will be reviewed through established risk management processes, with actions taken to ensure appropriate ownership, clearer risk articulation and strengthened mitigation where required.

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risk should be reviewed to clarify ownership, consider separation of system and organisational elements, and ensure mitigation actions provide stronger assurance of improvement. The Committee also welcomed the opportunity to draw on previous work undertaken by SaTH and system partners to inform future oversight.		
5. PSII report		
Members were advised that 15 overdue PSII actions had been completed since the previous reporting period and welcomed ongoing work to introduce prioritisation and RAG ratings for outstanding actions, enabling greater focus on areas of highest risk and improving oversight through the Patient Safety Committee. The Committee discussed two recent patient safety investigations relating to discharges from Whitchurch Community Hospital and noted emerging themes associated with discharge processes. Assurance was provided that significant improvement work is being overseen through the Discharge Improvement Group, including enhancements to discharge documentation, greater patient involvement in discharge planning and joint working with partner organisations to improve discharge safety and reduce the risk of recurrence. Members reviewed feedback on the implementation of the Patient Safety Incident Response Framework (PSIRF) and noted evidence of increasing staff engagement with incident reporting and organisational learning. The Committee welcomed ongoing patient safety engagement activities and the use of patient stories to demonstrate improvements arising from investigations. Assurance was provided that the Trust continues to demonstrate strong PSIRF compliance and will undertake a formal self-assessment against national standards to support continuous improvement and ongoing assurance. The Committee also considered workforce capacity challenges associated with delivering PSIRF investigations and supported work to establish clearer timescales and escalation processes when investigations are commissioned,	Full Assurance	The Committee was assured that patient safety actions and investigations continue to be actively monitored, that organisational learning is being translated into service improvement, and that arrangements for PSIRF compliance, claims management and incident oversight remain effective. Further assurance was provided that improvement work relating to discharge safety, investigation governance and action management will continue to be monitored through established committee structures.

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helping to balance investigative requirements with operational pressures while ensuring timely organisational learning.		
6. NHS Resolutions Claims report		
In respect of the Claims Report, the Committee received assurance that appropriate oversight of claims and Coroner's Court proceedings remains in place. Members noted that the Trust's five open Coroner's cases relate to deaths in custody within prison healthcare services and do not reflect broader Trust service concerns	Full Assurance	
7. QSC related BAF risks		
The Quality & Safety Committee received an update on the Quality & Safety elements of the Board Assurance Framework (BAF). The Committee approved the closure of BAF Action 4.2 relating to system programmes and oversight, recognising that all relevant programmes are now embedded within Trust governance structures and that the remaining work to align risk management processes across the wider system sits outside the Trust's direct control and is dependent on broader system priorities. The Committee was assured that closure of the action would not diminish existing levels of assurance. The Committee also discussed the operational capacity risk within the BAF, noting concerns that the current narrative and risk score may no longer fully reflect the scale of operational pressures, organisational transformation and Group working arrangements facing the Trust. Members agreed that the risk requires further review to ensure that both the risk description and scoring accurately reflect the current operating environment prior to Board consideration. A review of the risk wording, mitigations and score will be undertaken to strengthen assurance that the BAF continues to present an accurate assessment of the organisation's most significant risks.	Full Assurance	The Committee was assured that Quality & Safety BAF risks continue to be subject to effective oversight through established governance processes and that appropriate governance arrangements are in place for key Trust programmes.
8. Fire Safety Report		

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The Quality & Safety Committee reviewed the Fire Safety Update and received assurance regarding progress made in implementing actions arising from the Fire Service audit of Ludlow Community Hospital. The Committee noted that the audit outcome was rated as <i>broadly compliant</i> and that the recommendations identified are either complete or nearing completion through established improvement plans and oversight arrangements. Positive progress was further reflected in the Fire Service's decision that a planned audit of Bishops Castle Community Hospital was no longer required. Whilst welcoming the assurance provided in relation to the Ludlow audit, the Committee identified the need to strengthen alignment between fire safety reporting and wider estate compliance information discussed through the Resource and Performance Committee. Members highlighted the importance of ensuring that Board reports provide a comprehensive and consistent view of organisational fire safety risks, compliance arrangements and governance oversight. The Committee therefore requested additional clarification regarding how wider fire safety compliance risks are managed and reported across governance structures. The Committee also discussed the need to strengthen future assurance reporting by providing evidence of completion and ongoing maintenance of mandatory fire safety training rather than solely reporting planned training activity. Members agreed that further work is required to reconcile wider fire safety compliance information before the matter is escalated to the Board.	Partial Assurance	The Committee was assured that actions arising from the Ludlow Community Hospital Fire Service audit are progressing appropriately and are subject to ongoing oversight through established governance arrangements. However, the Committee concluded that additional work is required to provide a fully integrated assurance position on fire safety governance, compliance and risk management across the Trust. A further update will be provided following review of the wider fire compliance position and governance arrangements.
9. Palliative End of Life Care Strategy Update		
The Quality & Safety Committee received an update on the Palliative and End of Life Care Strategy and noted positive progress in delivering the Trust's programme in alignment with system priorities. Members welcomed strong partnership working and collaborative development across organisations. The principal risk remains limited dedicated leadership capacity, and work is underway to identify sustainable resource and leadership arrangements to support delivery. The Committee noted that strengthening leadership capacity	Full Assurance	Committee was assured that the Palliative and End of Life Care Strategy remains aligned with system priorities and supported by strong partnership working.

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will be key to progressing priorities including Advance Care Planning and timely completion of ReSPECT documentation, while opportunities to align with Local Care Transformation initiatives and wider system partners continue to be explored.		
10. Quarterly Mortality and Learning from Deaths Report		
The Quality & Safety Committee received the Quarterly Mortality and Learning from Deaths Report and was assured that all deaths were reviewed appropriately, with no concerns regarding care quality identified. Members noted an emerging trend of malignancy-related deaths within community services, which will continue to be monitored. The Committee reviewed two unexpected Virtual Ward deaths, with further learning identified in relation to potential sepsis recognition in one case. Positive findings included effective symptom management and support for patients' preferred place of care and death, while opportunities remain to improve Advance Care Planning, ReSPECT documentation and communication across care pathways. Members welcomed strengthening collaboration with SaTH on Learning from Deaths and requested future reports to provide clearer visibility of actions and improvements arising from mortality reviews.	Full Assurance	The Committee was assured that all deaths were appropriately reviewed, with no care quality concerns identified.
11. Safeguarding Annual Report 2025/26		
The Quality & Safety Committee received the 2025/26 Annual Safeguarding Report and was assured that the Trust continues to meet its statutory safeguarding responsibilities. Members noted high training compliance, effective safeguarding supervision, strong partnership working, and the embedding of learning from safeguarding reviews. Neglect remains the most significant safeguarding theme for both Adults and Childrens Safeguarding referrals and will continue to be a key focus during 2026/27 alongside domestic abuse, implementation of the Family First Partnership Programme, and strengthening multi-agency safeguarding arrangements.	Full Assurance	The Committee received assurance regarding the effectiveness of the Trust's safeguarding arrangements and approved the Annual Safeguarding Report for submission to the Board.

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12. Patient Experience Annual Report 2025/26		
The Quality & Safety Committee received the 2025/26 Patient Experience Annual Report and was assured that patient feedback continues to inform service improvement across the Trust. Friends and Family Test scores remained consistently high, although improving response rates remains a focus. Key themes from patient feedback included communication, access to services, and discharge processes. Complaint levels remained stable, while PALS activity increased, reflecting greater use of the service by patients and carers. The Committee also welcomed the positive impact of patient experience initiatives, including the <i>Leaving Hospital</i> booklet and the Group-wide. It's OK to Ask campaign, which support patient involvement and improved care experiences.	Full Assurance	The Committee received assurance regarding the effectiveness of patient experience arrangements and approved the Annual Patient Experience Report for submission to the Board.
13. Annual Committee Effectiveness		
The Quality & Safety Committee received the Annual Committee Effectiveness Review and was assured that the Committee continues to operate effectively and provide robust oversight of quality and safety matters. The review, which assessed compliance with the Committee's Terms of Reference alongside feedback from Committee members, identified no areas requiring improvement. Members recognised the considerable progress made in recent years to strengthen governance arrangements, including streamlined agendas, improved quality and focus of reports, a well-established sub-committee structure, and enhanced assurance-focused discussion. Feedback from members was overwhelmingly positive, with effective chairing, constructive challenges and meaningful debate highlighted as key strengths supporting the Committee's effectiveness. The Committee received assurance that its governance arrangements remain fit for purpose and continue to support effective scrutiny and assurance to the Board.	Full Assurance	
14. Pediatric Psychology Annual report		

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The Quality & Safety Committee received the Paediatric Psychology Annual Report and was assured that the service has continued to demonstrate strong performance and significant development despite increasing demand and patient complexity. Members noted substantial progress against recommendations from the external peer review, with 13 of 20 actions completed, alongside the successful implementation of a service restructure which has strengthened leadership, supervision, and workforce sustainability. The Committee welcomed approval of a business case to expand psychological support into general paediatrics, addressing historic inequalities in access and supporting future service growth. Assurance was provided that robust governance and clinical practice arrangements remain in place, with planned improvements focused on documentation, outcome measurement, and risk assessment processes. The Committee also noted increasing collaboration with SaTH and the development of a Group-wide psychology network to enhance consistency, shared learning, and service integration. Members commended the service's strong leadership, positive workforce culture, recruitment, and retention performance, and recognised the service as an example of effective co-production, staff wellbeing and continuous improvement.	Full Assurance	
15. Annual Responsible Officer (RO) Report		
The Quality & Safety Committee received the Annual Responsible Officer Report and was assured that robust medical appraisal, revalidation, and professional governance arrangements remain in place across the Trust. During 2025/26, all ten prescribed doctors were appraised within required timescales, no revalidation deferrals were required, and no concerns arose necessitating referral to the General Medical Council (GMC). The Committee noted positive external assurance regarding the Trust's appraisal and revalidation processes and welcomed ongoing work to complete a self-assessment audit. Members also recognised opportunities presented by developing Group arrangements to strengthen medical governance, peer review, and appraisal quality through closer collaboration with SaTH, particularly as clinical services increasingly operate across organisational boundaries. The Committee received	Full Assurance	

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assurance that statutory requirements continue to be met and approved the report for onward submission to the Board and subsequent GMC return.		
16. Chairs Reports		
Clinical Effectiveness The Quality & Safety Committee received the Clinical Effectiveness Committee Chair's Report and was assured that effective oversight of clinical audit, clinical effectiveness and NICE guideline implementation remains in place. Members noted that a small number of clinical audits had been delayed, with mitigating actions in place to support delivery, and welcomed progress with implementation of the AMAT audit management system, which is expected to enhance audit management, reporting and organisational learning. The Committee also received an update on compliance with the newly published NICE Sepsis Guidelines, noting that a baseline assessment demonstrated strong alignment with the guidance and evidence of improved sepsis recognition and management across the organisation. Whilst acknowledging that further training rollout is required across all services to achieve full implementation, the Committee received partial assurance that SCHAT remains compliant with the guidance and noted the continued focus on collaborative sepsis improvement work with system partners involved in patient pathways.	Partial Assurance	Further assurance is required regarding completion of the remaining sepsis training programme, with progress to be monitored through training compliance reporting and evidence of sustained improvement in clinical practice.
Health Inequalities The Quality & Safety Committee received the Health Inequalities Steering Group Chair's Report and was assured that progress is being made to embed health inequalities as a core component of service planning, delivery, and organisational decision-making. Members noted ongoing work to develop a Group-wide approach across SCHAT and SaTH, including plans to establish Health Inequalities Leads within services and a combined Group Steering Group to strengthen oversight and collaboration. The Committee was advised that the current focus is on improving the identification and understanding of health inequalities through	Partial Assurance	Further assurance is required that available population health data and demographic data is being used effectively to drive targeted action and measurable improvement. While the Committee noted that relevant data is available and health inequalities are increasingly being

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enhanced use of population health data, service intelligence, and demographic information, with the next phase aimed at translating this insight into targeted service redesign and improvement activity. Members also noted the forthcoming NHS Provider Board Assurance Provider capability assessment, due for submission in October, which will provide an important opportunity to demonstrate progress and further strengthen organisational assurance, governance, and evidence in this area.		embedded within local care transformation work, further work is needed to translate this insight into service redesign and outcome monitoring.
17. Meeting Evaluation		
The Quality & Safety Committee reflected its final meeting as a standalone SCHAT committee prior to the transition to Group governance arrangements. Members noted the significant progress made in strengthening the Committee's effectiveness, including improved quality of reporting, enhanced assurance processes, robust governance oversight and a culture of openness, transparency and constructive challenge. Particular recognition was given to the inclusive and effective leadership of the Chair, which was acknowledged as a key factor in enabling meaningful scrutiny and engagement across quality and patient safety matters. Members expressed confidence that the Committee is well positioned to transition into the new Group Quality Committee structure, building on a strong foundation of collaborative working, effective governance and a sustained focus on quality, safety, and continuous improvement.	Full	

4. Conclusion

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

Chair's Assurance Report

Resource and Performance Committee Part 1 – 29 July 2026

0. Reference Information

Author:	Stacey Worthington Executive Assistant	Paper date:	13 August 2026
Executive Sponsor:	Tina Long, RPC Chair	Paper written on:	29 July 2026
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	Paper Category:	Governance
Forum submitted to:	Trust Boards in Common meeting	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
 - National Oversight Framework - Amendments to the Integrated Performance Report
 - Service Transformation Update
 - 2025/26 Operational Plan Close
 - Finance & Capital Report Month 3
 - Contract Monitoring Report
 - 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 July 2026. The meeting was quorate with two Non-Executive Director and three Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:

Tina Long	Non-Executive Director (RPC Chair)
Jill Barker	Non-Executive Director
Sarah Lloyd	Chief Finance Officer

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Claire Horsfield	Director of Operations (Community) and Chief AHP
Jonathan Gould	Deputy Chief Finance Officer
Sara Ellis-Anderson	Interim Director of Nursing (Community)
Jon Davis	Associate Director of Digital Services
Mark Mawdsley	Head of Contracting and Costing (part-meeting)
Steve Ellis	Deputy Director of Operational Service Development (part-meeting)

Apologies:	
Richard Milner	Non-Executive Director (SaTH)
Steve Price	Head of Information and Performance Assurance
Shelley Ramtuhul	Director of Governance
Ned Hobbs	Group Chief Operating Officer
Martina Morris	Group Chief Nurse

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
6. National Oversight Framework Amendments		
Following the publication of the updated NOF in June, a review of the metrics for which this Committee takes responsibility for oversight was taken. The Committee reviewed the proposed metrics noting the additions and removals. The Committee requested further work in relation to a small number of KPIs but recommended the proposed list to the Boards subject to completion of these reviews.	N/A	
7. Service Transformation Update		
The Committee received the planned update on relevant aspects of Service Transformation. The Committee was informed that since the last update, several of the programmes had moved to the Local Care Transformation Programme and the reporting will be aligned to the new assurance Committee rather than RPC.	N/A	

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It was noted that discussions continue in relation to joint working across our Group in relation to pharmacy and continued oversight is required.		
9. Finance and Capital Report		
The Committee noted the paper which had an updated format to ensure consistency across the Group. The Trust continues to deliver its financial plan, noting substantive staffing levels have not yet reached planned levels. Where appropriate, these vacancies have been covered with bank or agency staffing. The Trust's efficiency plan remained on track at the end of Quarter 1. However, the value of schemes classed as high risk in terms of delivery has not reduced and this work is being overseen through the Financial Recovery Group. The Trust's capital plan is larger than in previous years and is profiled towards the latter end of the year. The risks associated with delivery of the programme are being carefully monitored through the Capital and Estates Group. The Committee discussed the contents of the report and considered the proposed development of the forward view contained within the reports. It was noted that the risk associated with delivery of the financial plan remains high, and the mitigating actions were considered.	Full	
10. Contract Monitoring Report		
The National Cost Collection submission had been completed and submitted within the required deadline. Inpatient activity coding remained a challenge; however, work is underway across the Group to improve this. Contractual performance and national and local work streams were considered, noting the scale of change for community providers in relation to delivery of the 10 year health plan.	Partial	Full assurance was provided in relation to systems, processes and monitoring however risks in relation to new contracting models for community providers were discussed, resulting in partial assurance.
11. Integrated Performance Report		
There were no KPIs reported as both an assurance concern and a special cause variation concern this month.	Full	

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Access to services and waiting times remain the key areas of focus for performance improvement. There had been slight improvements shown across the 18 week waits metrics across the month. However, one patient had exceeded the 52-weeks RTT target with a harm review undertaken and processes reviewed as a result. The financial KPIs which are flagged as a concern are due to a change in the revenue plan and the finance report covers all aspects of financial performance in detail.		
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3.4 Approvals

None. However, the amendments to the Integrated Performance Report KPIs were recommended to the Boards, subject to a review of a small number of areas.

3.5 Risks to be Escalated

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

4. Conclusion

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

Quality and Safety Assurance Committee, Key Issues Report		
Report Date: 31.07.2026		Report of: Quality & Safety Assurance Committee (QSAC)
Date of meeting: 28.07.2026		All NED and Executive Director members, and regular Trust Officer attendees, were present.
1	Agenda	The Committee considered the following: • Fuller Action Plan • Decontamination Update: Endoscopy • Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Report • Moving 2 Excellence Report • Quality Operational Committee Key Issues Report • Quality Indicators Integrated Performance (IPR) Report and Exception Report • Quarter 1 Board Assurance Framework Update • CQC Update • PALS, Complaints, Patient Experience & PaCE Annual Report • Health, Safety, Security & Fire Annual Report • Maternity and Neonatal Transformation Assurance Committee Key Issues Report • Maternity Dashboard and key issues report • Maternity Neonatal Safety Champions Report • UEC System Integrated Improvement Plan (SIIP) Key Issues Summary Report AAAA
2a	Alert <i>Matters of concerns, gaps in assurance or key risks to escalate to the Board</i>	• The Trust has suspended the decontamination unit in the endoscopy service at the Royal Shrewsbury Hospital due to water quality issues during the decontamination process. There is no evidence of harm to patients. Endoscopic procedures continue at both sites supported by increased activity in the Princess Royal Hospital endoscopy decontamination unit and the use of disposable endoscopes. There are some delays for patients who are part of the surveillance programme. Performance is being closely monitored. Plans have been put in place to resume the service at Royal Shrewsbury Hospital with a rental machine arriving on site on 10 August. The committee will monitor progress and any learning from the incident and response.
2b	Assure <i>Positive assurances and highlights of note for the Board</i>	The committee received an update on progress of work in response to the Fuller Inquiry Report into mortuary security. Currently, the Trust has completed 18 of the 20 identified actions, with plans in place for the two outstanding actions to be achieved by August 2026. Work is in train to strengthen governance in response to the Fuller Report, and the recommendations from the Nottingham Maternity Review and the Amos review which relate to mortuary service. As part of this, the Trust is required to provide a Board Assurance Statement to NHS England by 31st July 2026, which must be Board approved. In addition, an audit of all mortuary related incidents reported from 2015 to date will be completed in line with Human Tissue Authority requirements. Updates on this aspect of bereavement services are being provided via maternity governance reporting

		systems. The PALS, Complaints and Patient Experience Annual Report was presented and provided an overview of the Trust performance. There was positive feedback about staff kindness, compassion and care, further improvement is needed in a number of key areas: communication, involvement in care, accessibility, responsiveness and embedding improvements following feedback and the positive feedback and areas of challenge will be used to make improvements. Transitions in care were highlighted as an area of key focus. The number of complaints has increased. While performance in response to complaints has improved slightly, there is more work to do to improve response times to complaints. The committee was concerned by the reduction in responses following the removal of paper Friends and Family Tests. The committee heard that a text message service for gathering feedback was being rolled out across the Trust in Quarter 2 which should provide richer data. The Health and Safety Management: annual report 2025/26. Training rates have improved. The committee heard of the positive impact of improvements taken in response to incidents such as chemical exposures. There has been an increase in incident reports relating to weather events which requires actions to reduce the impact of climate change in the workplace and how these can be mitigated. The Trust had a higher number of incidents resulting from violence and aggression than HSE sector data, this year. Further work to understand the reasons for this is being undertaken. Maternity/neonatal Maternity acuity rates in delivery remained above target at 89% in June, which remains above the national target of 85% but has dropped below 90% for the first time in many months because of increased sickness. There were no delays in category 1 caesarean sections and 9 delays in category 2 caesarean sections this month, resulting in no harm. The wound infection rate for June was 4.1% with a comprehensive review currently underway and actions already taken to improve IPC practice. The Trust is working to standardise approach to screening for infection and is liaising with other Trusts regionally to identify the best approach. An update will be provided to the committee. The committee was assured by the robust actions taken to strengthen the baby tagging system and will monitor the impact of actions taken. The Trust has launched Poppy's Promise in maternity with very valuable feedback being provided by people using the service. The committee was pleased to hear that the system was accessible for services to receive feedback. As the programme is rolled out across the Trust, the committee identified a need for a standardised approach to ensure consistent, timely responses to feedback.
2c	Advise <i>Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.</i>	The Trust has received the draft CQC inspection report for Urgent and Emergency Care and Medical Care services in the Royal Shrewsbury Hospital and is undergoing factual accuracy checks. This follows the earlier receipt of the PRH report. The CQC have removed the final condition that was in place relating to the timely triage of adults in the Emergency Department in response to the sustained improvement in performance. Work will continue to sustain and further this key performance indicator to ensure that patients are assessed on arrival in the department. 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 discussed the

		proposed reduction of Risk 10 (Urgent and emergency care standards) from 20 to 16. The committee did not agree the reduction and asked for it to return when there was evidence of sustained improvement in response times. Risk 10 therefore remains at 20 and therefore one of the highest risks for the Trust. The committee agreed that the current ratings for the other risks overseen by QSAC were appropriate and no changes to ratings were made. The committee received an update on the pressures that the diabetic foot service is experiencing. The demand for the service exceeds the capacity of the team. Data is not available on the number of patients who are being referred to the Emergency Department. The service has identified actions to support delivery including a locum podiatrist and opportunities to work with Group colleagues. A business case is being drafted to increase the team. The service lead and Group Chief Medical Officer are to meet and bring a further update to the committee. The Trust's challenges with reducing infection rates remain. There is renewed and continued focus on infection prevention and control. NHS England have offered support which has already started. A comprehensive improvement plan is being developed and will be brought to the committee.		
2d	Actions <i>Significant follow up actions</i>	• Reports should be written in an accessible way, with no acronyms and are received in advance of the meeting. • An infection prevention and control improvement plan to be presented at the Quality Safety Assurance Committee. • The Group Chief Medical Officer and diabetic service lead to meet and provide a written update to the committee.		
3	Report compiled by	<i>Ms Sarah Dunnett Chair of Quality and Safety Assurance Committee</i>	Minutes available from	<i>Mike Price Committee Support</i>

Performance Assurance Committee, Key Issues Report		
Report Date: 21 July 2026		Report of: Performance Assurance Committee
Date of meeting: 21 July 2026		R Edwards (Chair), S Dunnett, R Dhaliwal, N Hobbs, N Lee, T Cotterill, M Neal(part), D Bryce(part), S Balderstone, L Mitchell
1	Agenda	The Committee considered the following: • Performance Highlights, incl High Intensity Users • UEC SIIP • Integrated Performance Report • GIRFT & Royal College of Surgeons Accreditation visit report and action plan • Workforce Plan and Performance Impact • Strategy & Integration update – STW Neighborhood health • Fire Safety & Risk Report • Board Assurance Framework • PAC Cycle of Reporting
2a	Alert <i>Matters of concerns, gaps in assurance or key risks to escalate to the Board</i>	• Urgent and Emergency Care: the very hot weather in June resulted in the highest month of average ED attendances per day on record, driven significantly by the record heatwave experienced in late June which placed major pressure on the UEC pathway across the country, and a decline in performance of 4 hour and 12-hour standards, though ambulance handovers remained ahead of plan.
2b	Assurance <i>Positive assurances and highlights of note for the Board</i>	• SaTH Integrated Improvement Plan (SIIP): Urgent and Emergency Care 2026/27 Initial assessment performance continues to remain stable within its improved state. In June 2026, 69.8% of patients were assessed within 15 minutes with an average time of 14 minutes. Both hospital sites remain above the England mean in terms of performance and are also situated within the upper quartile of performance in England. As initial assessment performance has remained in a sustained state of improvement for over 12 months, this action is proposed as “Complete and Evidenced”. PAC noted the very significant and sustained improvement in this performance, and that good performance can result in cost savings through avoiding having to take remedial actions. • The 26/27 Planned Care Transformation plan has been agreed with key focus once again on diagnostics, productivity and outpatients. This supports the delivery of the operational plan and will support the cost improvement plan. Elective care remains on plan, though the waiting list has increased, and in diagnostics a multi-pronged recovery plan is in place to recover performance in non-obstetric ultrasound. • Accreditation of PRH Elective Surgery Hub: PAC heard that following a visit by a team from Getting it Right First Time (GIRFT) and the Royal College of Surgeons in April, the hub had been accredited. The report was very positive particularly regarding staff culture, and its recommendations for further improvement - “optimisation” - are included in a SaTH plan.

2c	Advise <i>Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.</i>	• Urgent and Emergency Care SIIP: PAC noted that from August 2026, increased senior Paediatric cover will be in place to strengthen clinical decision making and that blood sample processes are being redesigned in ED to reduce the amount of time it takes to send samples to pathology services and thereby reduce the duration of the ED episode of care. • Patient Initiated Follow-up: PAC noted the variation in take up of PIFU across specialties and asked if there were specialties who used it particularly well, what was known about the benefits to patients (beyond the convenience of not having to come in for appointments) and beneficial outcomes and whether there could be shared learning. PAC heard there was limited information about benefits and outcomes, and asked if more could be obtained from those specialties whose use of PIFU was best established. • High Intensity Users: PAC received information on progress with the plan to reduce the number of visits by this group (defined as those with more than 5 attendances at ED in a 12-month period) by 20% by March 2027. There had been a 13% growth in this group since November 2025, and they accounted for 11% of all ED activity. A strategic group has been established and meets monthly and there has been good support from partners across the system. Neighbourhood care multi-disciplinary teams will be a key part of providing the right care for this group. • Fire safety: PAC heard that SaTH's Fire Officer would be meeting Shropshire Fire and Rescue Service the following week to discuss progress with the work required by the two enforcement notices (365 and 366). The fire compartmentation survey will be completed by then, and the provision of fire detection is already underway. Ongoing issues are management of oxygen cylinders and prevention of building up of items in hospital street. PAC noted that in both cases cultural change was needed, so that systems are followed and staff are confident that systems will work. PAC also heard that SFRS had been back on impromptu walk-rounds and they and SaTH's Fire Safety team were satisfied that fire doors were not being obstructed. Regarding fire safety training, PAC was concerned whether staff were adequately trained. PAC noted that refresher training intervals had been changed and that staff knew the essentials of fire safety precautions, but that this needed to include complying with systems for keeping oxygen cylinders to a minimum and avoiding building up of equipment and waste. • Neighbourhood care: PAC received a verbal report about national consultation on proposals for neighbourhood care. • Workforce: PAC received a report which included a table on workforce cost improvements and asked if SaTH was on track to make the reductions planned for July onwards. PAC was told that the staff reductions were due to follow on from digital transformation, that the digital transformation was on track and that meetings were being held with staff to explain the benefits of, eg Ambient Voice Technology. While there were vacancies which were being filled, these were typically on short and fixed term contracts. Reductions in staffing would be typically by natural wastage and by redeployment. PAC asked for an additional column to be included in the workforce paper giving vacancies. • Board Assurance Framework: PAC considered a proposal to reduce the score for BAF risk 10, urgent and emergency care, from 20 to 16 in the light of the sustained improvement in ambulance handovers and reductions in over 12 hour waits, but agreed that it would be better to wait until the measures being taken to improve over 12 hour and over 4 hour performance had been able to show long term benefit. QSAC will also receive this proposal.
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2d	Actions Significant follow up actions	- Alcohol Support: a paper to come to PAC in October/November outlining how SaTH and Shropcom work with others including LAs and mental health partners and primary care, and how this ties in with other work on high intensity users. - Report to come to PAC in November/December on the benefits of PIFU in a particular specialty or specialties and how these can be shared. - Update on Fire Safety to come to PAC in October.		
3	Report compiled by	Rosi Edwards, Non-Executive Director (Chair)	Minutes available from	<i>Lisa Mitchell Senior Governance Support Officer</i>

Finance Assurance Committee, Key Issues Report		
Report Date: 28.07.2026		Report of: Finance Assurance Committee
Date of meeting: 28.07.2026		Attendees: R Miner (Chair), A Winstanley, S Crowther, J Sargeant, T Cotterill, R Muskett, S Edmonds, S Balderstone, C McInnes, L Mitchell (Minutes), J Williams, M Morris, W Savage(part), D Bryce(part)
1	Agenda	The Committee considered the following: - Financial Report M3 including financial impact of Workforce Plan and delivery update - Finance System Integrated Improvement Plan (SIIP) 4A Report - Efficiency & Financial Recovery Report - Contract approvals - HTP Professional Advisory Services - Capital Planning Group ("CPG") 4A Report - Financial Recovery Group ("FRG") 4A Report - Board Assurance Framework (BAF) - Review FAC Cycle of Reporting - SaTH Transformation Programme
2a	Alert <i>Matters of concerns, gaps in assurance or key risks to escalate to the Board</i>	- Financial performance to M3 showed a deficit of £10.9m which was adverse to plan by £2.7m. Adverse workforce costs, industrial action and below plan efficiency savings (currently £1.7m) were the main contributors to this. This position is prior to £7.6m of deficit support funding. - Whilst the workforce transformation is underway and is expected to start delivering savings from Q2, doubts remain around whether this work can deliver sufficient momentum in this financial year. - FAC agreed that the score for BAF Risk 5 (operating within available resources) should be increased back to 20 given current financial performance and pressures. The forecast for the year is being regularly updated to provide FAC and Board with the expected year end outturn and to enable actions to be implemented at the earliest point. The Board may be called on to make a decision around the level of investments. - The previously identified "gap" in the 2027/28 plan is expected to be closed by an increase in the efficiency target linked to non-recurrent investment slippage.
2b	Assurance <i>Positive assurances and highlights of note for the Board</i>	- The Trust currently has cash reserves of £37.6m with deficit support agreed for Q2 with a worst-case forecast suggesting support may be required in Q4 if insufficient progress is not made with the control of costs and the achievement of efficiency savings. - Capital expenditure is close to target. - Actions and progress continue against the SIIP. - CPG and FRG 4A reports were noted. - FAC were satisfied that the further due diligence carried out in respect of the Occupational Health Contract now meant it could recommend it to the Board for approval.

		FAC is able to recommend to the Board that it can approve the contract variations in respect of the HTP Professional Advisory Services which fall within the capital plan.		
2c	Advise <i>Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.</i>	- The updated year-end financial outturn including risk adjusted progress with efficiency savings. - The cycle of business remains under review with actions being added as considered necessary.		
2d	Actions Significant <i>follow up actions</i>	The comprehensive (draft) SaTH Transformation Programme drawn up by Tracey Cotterill, Carol McInnes and their team is a comprehensive piece of “front foot” work which has identified multiple opportunities to deliver financial headroom as well as improved patient outcomes. FAC recommends consideration by the whole Board.		
3	Report compiled by	<i>Richard Miner, Non-Executive Director, Chair</i>	Minutes available from	<i>Lisa Mitchell, Senior Governance Support Officer</i>

HTP Assurance Committee, Key Issues Report		
Report Date:		Report of: Hospitals Transformation Programme Assurance Committee (HPAC)
Date of meeting: 28 May 2026		Attended by: Chaired by the HPAC Chair with NED members present. Group Chief Estates, Facilities and Capital Officer, Acting Director of Finance, Deputy Medical Director, Group Chief Operating Officer, 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 • 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 • Workforce and training • Digital programme overview • Communications and engagement • Finance including year to date spending and expenditure. • Programme risks and mitigations. • Urgent Treatment Centre. • Bed modelling update. • Engagement report from public participation team Q4. • Terms of reference updated.
2a	Alert <i>Matters of concern, gaps in assurance or key risks to escalate to the Board</i>	• Medicine and Emergency Care delivery has experienced slippage against some of the key milestones. Recovery remains achievable, with targeted support in place; however, the Chair noted that further assurance will be required at the next meeting to confirm that the position is returning to plan. • The UTC specification and staffing model continue to progress, with the governance route for formal approval being clarified. Further assurance is required to confirm alignment with consultation commitments, ICB/NHSE expectations, workforce planning, public communications and the wider urgent care model; however, this remains recoverable within the current programme approach.

		- Workforce readiness continues to develop and remains linked to the finalisation of clinical pathways, with further assurance to be provided as this work progresses. - Further assurance is being sought on pathway deliverability and the extent to which wider transformation benefits can be realised through the programme approach. - Work is progressing to confirm a single agreed opening date and implementation trajectory, supporting continued Board assurance and maintaining a recoverable position.
2b	Assurance <i>Positive assurances and highlights of note for the Board</i>	The Committee provides the following assurances to the Board of Directors: - The construction programme is progressing to schedule, with assurance received from the Senior Responsible Owner. - Equality and health inequality mitigations are embedded within programme planning, including consideration of rural and deprived communities, transport, communications, out-of-hospital care and patient access. - The overall programme financial envelope remains unchanged, with 2025/26 closing broadly on budget and within tolerance for a programme of this scale. - Digital infrastructure and resilience planning have progressed, including completion of Wi-Fi surveys, remediation of weak coverage areas, improved hub room arrangements and establishment of a dedicated building management system network to mitigate cyber security risk. - Staff engagement continues through site visits and walkarounds, supporting clinical teams to understand progress and prepare for future ways of working. - Governance alignment with the Local Care Transformation Assurance Committee is being actively reviewed, with interim Terms of Reference agreed and a future joint review planned to avoid duplication and ensure clear oversight.
2c	Advise <i>Areas that continue to be reported on, and / or where some assurance has been noted / further assurance sought.</i>	- The overall clinical and operational delivery programme remains rated Amber. Twenty-two approved change requests have been incorporated into the clinical and operational master programme; however, further assurance is required as the programme moves from planning and construction into clinical implementation. - Medicine and Emergency Care remains a focused area of reporting and is currently rated Red, reflecting slippage against a small number of workforce and PRH UTC outputs. Recovery remains achievable, with further assurance to be provided at the next meeting to confirm that delivery is returning to plan. - Workforce planning, training and organisational development remain rated Amber. Further assurance will be provided as workforce plans, medical rota arrangements, staff intentions, training requirements and management of change arrangements continue to be developed. - Clinical pathway development and testing remain important dependencies. Initial pathways and supporting documentation have been submitted, with further development and testing planned to support assurance on deliverability of the clinical model and the intended transformation benefits.

		• Service move planning and opening date alignment continue to progress. Further assurance will be provided once the agreed opening date, service move trajectory and related operational implications have been confirmed. • Specialist relocation support procurement remains under review, with work continuing to secure appropriate support for move planning, move champions and operational readiness. • The Committee will continue to monitor emerging risks as programme complexity increases, ensuring significant matters are identified early and managed through established governance routes. • The Chair requested a review of the Terms of Reference, including confirmation of membership and consideration of alignment with the Local Care Transformation Programme.
2d	Actions	• Non-Executive Director Chair and Deputy Chief Executive / Group Chief Operating Officer to agree the forward agenda for the Local Care Transformation Assurance Committee and alignment with HTP Assurance Committee priorities. • HTP Delivery Director to present commissioning, service models, integrated pathways and workforce planning in a structured format to provide Board-level assurance on progress, dependencies and timelines. • Associate Director of Transformation and Business Partnering / People and OD Lead to schedule workforce as a substantive deep-dive item, covering recruitment, retention, release arrangements, training requirements and management of change. • HTP Delivery Director to provide evidence at the next meeting that the Medicine and Emergency Care Red-rated position has recovered, including completion of workforce templates and the PRH UTC specification. • HTP Delivery Director to provide a fuller update on clinical pathway development and testing, including how pathways support transformation and avoid a “lift and shift” approach. • HTP Delivery Director to meet with the Chair to provide assurance on pathways for Women and Children’s, COPD, coronary heart disease, frailty and cancer. • Deputy Medical Director to convene a dedicated meeting with divisional teams, Clinical Advisory Group representatives and Executive colleagues to agree a single opening date and confirm service move sequencing and implications. • HTP Delivery Director to reissue procurement for specialist relocation support and confirm appointment of a suitable provider to support move planning, move champions and service migration. • HTP Delivery Director to complete the equipment inventory for Building 60 and services outside Building 60 by 17 July, confirm capital scope, identify transferable equipment and clarify residual funding risk. • Associate Director of Transformation to continue local engagement, particularly across Medicine and Emergency Care, to confirm staff intentions, travel and transport issues, training needs, recruitment requirements and management of change implications.

		HTP Programme Manager to circulate the tracked-change version of the updated HTP Assurance Committee Terms of Reference to Committee members.		
3	Report compiled by	<i>Professor Purt Chair of HTP Assurance Committee</i>	Minutes available from	<i>Sharon Stuart</i>

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

Group People Committee, Key Issues Report	
Report Date: 28 th July 2026	Report on: Group People Committee
Date of meeting: 27 th July 2026	Those present: Teresa Boughey Non-Executive Director – meeting Chair (SaTH) Cathy Purt Non-Executive Director (SCHT) Claire Horsfield Director of Operations Community & Group Chief AHP Nigel Lee Group Chief Strategy and Integration Officer Jill Barker Non-Executive Director (SCHT) Jake Mairs Deputy Group Chief People Officer Heidi Fuller Non-Executive Director (SaTH) In Attendance Jo Williams Group Chief Executive Jonathan Gould Deputy Director of Finance (SCHT) – <i>left at 13:50</i> Anthony Simms Associate Director of Finance (SCHT) – <i>joined at 13.50</i> John Jones Group Chief Medical Officer – <i>joined at 14:21</i> Simon Balderstone Director of Workforce & People Services (SaTH) Sabeena Khanna HTP Workforce Transformation Lead (SaTH) Dawn Thompson Associate Director of Culture (SaTH) Martina Morris Group Chief Nursing Office – <i>joined at 14:21</i> Sarah Thomas Acting Head of Education (SaTH) Tracie Black Associate Director of Workforce, Education & Professional Standards (SCHT) Stephanie Young Lead Nurse for Workforce (SaTH) – <i>item 56/26 only</i> Deborah Bryce Head of Corporate Governance & Compliance (SaTH) – <i>Item 66/26 only</i> Julia Clarke Director of Public Participation (SaTH) – <i>item 60/26 only</i> Emma Bayliss Senior Governance Manager for Patient Experience (SCHT) – <i>Item 60/26 only</i> Apologies: Rosi Edwards Non-Executive Director (SaTH), Shelley Ramtuhul Director of Governance (SCHT), Nick Dowd Head of People Advisory & Governance (SaTH), Rhia Boyode Group Chief People Officer, Wendy Nicholson MBE Non-Executive Director (SaTH)

1	Agenda	The Committee considered the following: • <i>Workforce Transformation programme</i> • <i>Local Care Transformation Committee and Hospital Transformation Committee</i> • <i>SaTH Nursing and Midwifery staffing report</i> • <i>Freedom to Speak UP (SCHT)</i> • <i>2025/26 SCHT Operational Plan Outcomes</i> • <i>Education Strategy development</i> • <i>Workforce Support – Volunteers and Charity Q1</i> • <i>Culture and Leadership</i> • <i>Sexual Safety Charter</i> • <i>Lord Mann letter and recommendations</i> • <i>Policy update</i> • <i>Risk report - people risks</i> • <i>SCHT and SaTH Board Assurance Frameworks (BAF)</i>
2a	Alert <i>Matters of concern, gaps in assurance or key risks to escalate to the Board.</i>	• National requirements arising from the Lord Mann Review require implementation by 31st July 2026 including adoption of NHS anti-racism principles. • Committee members highlighted the increasing volume of expectations being placed on staff and managers through initiatives such as anti-racism, sexual safety, and wider cultural programmes. Concerns were raised regarding the need for clear communication of behavioural expectations and organisational standards. • Sickness absence continues to be a significant workforce challenge and contributor to organisational cost and productivity pressures, requiring a coordinated and preventative approach, and taking into account learning from the recent Midlands Exemplar sessions.
2b	Assurance <i>Positive assurances and highlights of note for the Board</i>	• The Committee formally approved adoption of the NHS Race and Health Observatory's seven anti-racism principles. • Assurance was received that the implementation of the Lord Mann recommendations will be monitored through existing governance arrangements, including workforce reporting, education compliance, staff survey data, Freedom to Speak Up reporting, with Group People Committee oversight. • The Committee received assurance regarding workforce risks and Board Assurance Framework (BAF) risks, with no proposed changes to current risk scores and confirmation that key risks remain with agreed tolerance levels. (SaTH) • Confirmation was provided that the Nursing and Midwifery Delivery Plan has not been signed off through staff side arrangements and remains on track against national expectations. • The Committee approved the development of a Group Education Strategy with continued oversight through the Group People Committee
2c	Advise <i>Areas that continue to be reported on, and / or</i>	• Members encouraged a clearer organisational narrative that brings together the multiple people, culture and wellbeing initiatives. • In relation to sickness absence, the Committee supported a holistic approach focused on early intervention, wellbeing conversations, manager capability, workforce adjustments, flexible working and data-led analysis. • The Committee recognised the progress made in developing a more

	<i>where some assurance has been noted / further assurance sought.</i>	integrated Group People Committee and encouraged continued work to strengthen alignment of reporting and demonstrate measurable impact on staff and patient outcomes.		
2d	Actions Significant follow-up actions	• Implement the nationally required anti-racism principles and associated definitions by 31 July 2026 and develop a robust implementation plan for future Committee oversight. • Develop a communications approach to clearly articulate organisational expectations, standards of behaviour and key cultural commitments to all staff. • Return a detailed implementation and progress update on anti-racism work to a future Committee meeting. • Progress the sickness absence improvement programme, including consideration of improved wellbeing conversations, manager support tools and workforce wide engagement. • Continue policy harmonisation and report progress against prioritised policy review through future Committee updates. • Provide a detailed update at the next People Committee meeting on the roadmap for shifting 150 beds of activity, including which services and pathways will be prioritised and required workforce support. The Committee thanked Teresa Boughey for her Co-Chairing and the contributions she made to getting the Group People Committee established with Co-Chair Cathy Purt.		
	Report compiled by:	Diane Davenport (and approved by Teresa Boughey)	Minutes available from:	Diane Davenport, Committee administrator, SCHT

Local Care Transformation Assurance Committee, Key Issues Report

Report Date 22 July 2026		Report of: Local Care Transformation Assurance Committee
Date of Meeting 22 July 2026		Attendees Professor T Purt (Chair), S Dunnett, J Barker, S Biffen, N Hobbs, N Lee, S Lloyd, R Boyode, G Murphy-Walken, P Bason, J Jones, T Long, G Mclver & L Mitchell Apologies C McInnes, C Horsfield, M Neal,
1	Agenda	The Committee considered the following:- • Ops Group 4A Report • Executive Summary and Programme Update • Digital Update • Communication and Engagement • Review of Cycle of Reporting
2a	Alert Matters of concerns, gaps in assurance or key risks to escalate to the Board	• The Programme currently comprised 49 projects and required prioritisation to ensure delivery capacity and resources were focused on initiatives providing the greatest benefit and impact on reducing the forecast HTP bed gap. • The Committee was advised that, although projects had been identified with the potential a gap remained against the overall hospital bed alternatives and full assurance bed reduction requirement and full assurance could not yet be provided. Work is underway with prioritisation and additional options to further identify options. • Delivery of some programme objectives remained dependent on commissioner support, commissioning decisions and wider system partners, creating a risk to timescales and implementation. • Community nursing redesign remained critical to the success of many transformation initiatives and would require continued engagement with commissioners to avoid delays.
2b	Assurance Positive assurances and highlights of note for the Board	• Significant progress had been made in establishing the Local Care Transformation Programme, governance arrangements and reporting structures since inception. • Population health management, Stroke and CVRM engagement activity and business intelligence workstreams previously identified within the action log had been completed and were recommended for closure. • Strong collaborative working was reported between SaTH, Shropshire Community Health NHS Trust, ICB colleagues and primary care partners in developing programme methodology, prioritisation and impact measures. • A programme-wide prioritisation exercise, monitoring framework and impact methodology were being established to provide stronger assurance over mitigated bed days, delivery, outcomes and benefits realisation.

		• Digital developments, including real-time clinical record sharing, patient portal development and enhanced reporting capabilities, were progressing and were recognised as important enablers of community-based care. • Engagement with primary care networks, Healthwatch, local authorities and wider system partners was reported to be positive and strengthening. • The Committee received assurance that staff engagement, service co-design and communications activity were underway to support future transformation.
-2c	Advise Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.	• Work is underway to align progress against the five agreed priority areas and implementation of revised reporting arrangements aligned to those priorities. • Development of the Monitoring and Impact Framework, including quantitative and qualitative measures covering patient, carer and staff experience, is underway together with performance targets. • There has been progress with community nursing redesign and wider commissioning discussions regarding future community service models. • Development of digital solutions, including integrated clinical records, patient portals, remote consultations and telemedicine capability will support delivery. • Ongoing workforce engagement, organisational development, communications and culture change activity are actively supporting transformation. • Regular reporting to and from Place Partnership Boards and wider system partners to maintain visibility of dependencies and collaborative delivery arrangements, is vital. • Financial impact modelling, financial resourcing and investment requirements for several transformation projects remained under development and required further refinement. • Cultural readiness, workforce capacity, staff anxiety relating to transformation and AI, and the need for workforce re-skilling were identified as ongoing risks requiring active management.
2d	Actions Significant follow up actions	• Complete the programme prioritisation exercise and report outcomes through the Operations Group and future Committee meetings. • Continue development of the reporting and assurance framework, including alignment to the five priority areas and enhanced outcome, financial and impact measures. • Develop patient, carer and staff experience measures within the Monitoring and Impact Framework. • Continue engagement with commissioners regarding service redesign, funding requirements and commissioning support for future models of care. • Produce future digital reports in an assurance-focused format and provide updates on implementation of remote consultation and telemedicine solutions. • Develop a communications and engagement timeline, stakeholder mapping and case studies to support workforce and public engagement.

		Revise the Cycle of Reporting to include more frequent reporting, deep dives into priority areas and regular updates from Place Partnership Boards.		
3	Report compiled by	Prof Trevor Purt. Non-Executive Director (Chair)	Minutes available from	Lisa Mitchell Senior Governance Support Officer

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	065/26a		
Report Title	SCHT - Integrated Performance Report		
Executive Lead	Sarah Lloyd, SCHT CFO Martina Morris, Group CNO Ned Hobbs, Group COO Rhia Boyode, Group CPO		
Report Author	Steve Price, Head of Information and Performance Assurance Operational Leads Sara Ellis, Interim Director of Nursing - Community Jake Mairs, Deputy Group Chief People Officer Jon Davis, Associate Director of Digital & Performance		
Prior Consultation:	CQC Domain:		Link to SCHT BAF id(s)
Resource and Performance Committee (SCHT), 29th July 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 and Quality and Safety Committee reviewed the content of relevant aspects of this report at the meetings which took place in July. Performance information was also shared with People Committee members for comment and awareness. Assurance is provided to each committee on the actions being taken to improve performance and minimise risk through the action plans; these are included within the Board Information Pack.		
Recommendations for the Boards	The Boards are asked to: Consider SCHT’s performance to date and the assurance provided in relation to the actions being taken to improve performance and minimise risks where required.		
Appendices:	Appendix 1: Board SCHT Performance KPI June 2026 Appendix 2: Board SCHT Performance Icons Appendix 3: Assurance Action Plans – Information Pack		

1. Introduction

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

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

2. Summary

2.1 Context

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

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

2.2 Current Position

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

- There are 56 performance indicators reported in this period, each assigned to a SCHAT Committee for oversight.
- The table below summarises the number of KPIs highlighted as a concern against each responsible Committee. 25 indicators are highlighted as a concern (44.6%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
Resource & Performance	3	13	0	27	16 (59.3%)
Quality & Safety	2	1	1	18	4 (22.2%)
People	1	2	2	11	5 (45.5%)

Table 1: SCHAT KPI Summary June 2026

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

The below summarises changes to SCHAT's KPIs flagged as a concern during the month:

- **Resource and Performance Committee** - *Difference between actual and planned 18 week elective performance is now flagged as a variation concern*
- **Quality and Safety Committee** – *No change to KPIs flagged as a concern*
- **People Committee** – *No change to KPIs flagged as a concern*

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

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

3. Main Report

3.1 Introduction

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

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

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

3.2 Summary of key points – Resource & Performance Committee

Of the 27 indicators which are reviewed by SCHAT's Resource and Performance Committee (RPC), 16 require focused attention. It is of note that 13 of the 16 indicators requiring attention relate to access to services and waiting times.

The Resource & Performance Committee reviewed the presented action plans, and confirmed full assurance was provided in relation to the actions being taken, the pace of progress and the trajectories for improvement.

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

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

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

- Variance year-to-date to financial plan
- Planned surplus/deficit
- Difference between actual and planned 18 week elective performance

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

- Average number of days from discharge ready date and actual discharge date
- Percentage of patients waiting less than 18 weeks - RTT
- Percentage of patients waiting over 52-weeks RTT
- Proportion of patients within 18 weeks
- Proportion of patients within 18 weeks - Children's Services
- Percentage of patients waiting over 52-weeks for community services
- Data Quality Maturity Index
- Total patients waiting more than 52 Weeks – All services
- Total patients waiting more than 40 Weeks – All services
- Total patients waiting more than 30 Weeks – All services
- Total patients waiting more than 52 Weeks to start consultant-led treatment
- Total patients waiting more than 40 Weeks to start consultant-led treatment
- Total patients waiting more than 30 Weeks to start consultant-led treatment

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

June 2026 position:

	Children's Services incl. Dental		Adult Services		Total	
Patients Waiting	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)
30+ weeks	59	440	51	149	110	589
40+ weeks	4	44	7	20	11	64
52+ weeks	0	0	1	2	1	2

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

Since the last report to Boards in July there has been a deterioration in the RTT applicable high wait KPI. It is of note that the RTT 30+/40+ KPIs are ambitious, local targets (i.e. not nationally mandated or monitored) to guide the reduction in high waits and return to the standard of 92% within 18 weeks.

The local (non-RTT) high waits have improved with the exception of 52+ in adult services, which has remained constant and the 30+ that has deteriorated in Children's services.

One patient has exceeded the 'Total patients waiting more than 52 Weeks to start consultant-led treatment' KPI. The patient has now been seen and is awaiting imminent treatment and a full harm proforma has been completed.

The 'Percentage of patients waiting less than 18 weeks – RTT' has shown a recent levelling although there has been a slight improvement with 82.76% in June compared with 82.16% in May. Whilst the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature. Further detail is captured in the action plans.

The indicator for 'Proportion of patients within 18 weeks' has also levelled recently, although there has been a slight improvement with 83.25% in June compared with 82.88% in May. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature.

3.3 Summary of key points – Quality & Safety Committee

Of the 18 indicators which are reviewed by SCHAT's Quality & Safety Committee (Q&S), 4 require focused attention. The following are currently highlighted as special cause variation of a concerning nature and/or the process is not capable and will fail the target without process redesign:

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

- Category 4 Pressure Ulcers
- Safer Staffing - Average Fill Rate Non-Registered Nurses - Night

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

- Rates of Healthcare Associated Infection (C-Difficile)

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

- NHS Staff Survey – raising concerns sub score

Key areas of discussion noted at the July Quality and Safety Committee are as follows:

No medication incidents resulting in moderate harm were reported during June 2026, representing the fourth consecutive month with zero moderate harm medication incidents.

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

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

Bi-Annual safer staffing report (January data set) for the four inpatient areas deemed no additional change to establishments were required with no staffing-related patient safety incidents and no safer staffing red flag breaches relating to Registered Nurse (RN) availability. The next data set collection is July 2026.

One Category 4 pressure ulcer and one Category 3 pressure ulcer were reported during June 2026. Reviews have identified opportunities for organisational learning, with an After-Action Review and wider thematic review activity underway.

Inpatient falls remained above our internal threshold at 5.5 per 1,000 occupied bed days, although the number of falls remained stable at 13. A comprehensive falls improvement programme continues across inpatient and community services.

One unexpected death was reported during June 2026 involving a Virtual Ward patient. A Level 1 Learning from Deaths review form is being completed in line with the Trust's Learning from Deaths Policy.

No Patient Safety Incident Investigations (PSIIs) were commissioned during June 2026. Work continues to improve timeliness of existing investigations, with revised actions introduced to strengthen oversight and reporting.

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

C. *difficile* performance remains above the agreed rolling 12-month threshold, with two cases reported during June 2026. Improvement actions continue through the IPC Improvement Plan identified through the quarterly thematic reviews focussing on environmental cleanliness and antimicrobial stewardship.

3.4 Summary of key points – People Committee

Of the 11 indicators which are overseen by the People Committee, 5 require focused attention. The following are currently highlighted as special cause variation of a concerning nature and/or the process is not capable and will fail the target without process redesign:

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

- NHS staff survey engagement theme score

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

- Total shifts exceeding NHSI capped rate
- Appraisal Rates

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

- Sickness Absence Rate
- National Education & Training Survey overall satisfaction score

The following was information was provided to the Committee when considering this position.

Total shifts exceeding capped rates - a number of medical agency/locums are in place . These are on the West Midlands agency rate and will continue to be recorded as above price cap. Currently there are medical agency in: UEC (Virtual Ward and Integrated Front door, expansion of services so new medical posts), Paediatrics (long term sickness and wait list).

Appraisal rate - the June compliance rate has slightly increased from 87.19% in May to 87.23%. Work is continuing to ensure hot spot areas are being supported to ensure their outstanding appraisals are completed.

Sickness Absence - Rates increased this month to 5.71%. The main drivers are stress, anxiety and depression conditions.

3.4 Key Issues & Recommendations

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

3.5 Conclusion

The Boards are asked to:

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

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	2026-06-30		6.2	3.5	2.7	6.2	3.5	2.7	
Finance and Productivity	Data Quality Maturity Index	2026-03-31		97.1%	95.0%	2.1%	97.1%	95.0%	2.1%	
Access	Difference between actual and planned 18 week elective performance	2026-06-30		-10.16	0.00	-10.16	-10.16	0.00	-10.16	
Finance and Productivity	Financial efficiency - variance from efficiency plan	2026-06-30		2.90%	0.00%	2.90%	2.90%	0.00%	2.90%	
Finance and Productivity	Implied productivity level	2026-06-30		100.10%	100.00%	0.10%	100.10%	100.00%	0.10%	
Access	New Birth Visits % within 14 days - Dudley	2026-05-31		89.22%	90.00%	-0.78%	90.11%	90.00%	0.11%	
Access	New Birth Visits % within 14 days - Shropshire	2026-05-31		88.41%	90.00%	-1.59%	88.80%	90.00%	-1.20%	
Access	New Birth Visits % within 14 days - Telford	2026-05-31		94.01%	90.00%	4.01%	90.43%	90.00%	0.43%	
Access	Number of patients not treated within 28 days of last minute cancellation	2026-06-30		0	0	0	0	0	0	
Access	Percentage of patients waiting less than 18 weeks - RTT	2026-06-30		82.76%	92.00%	-9.24%	82.76%	92.00%	-9.24%	
Access	Percentage of patients waiting over 52-weeks for community services	2026-06-30		0.01%	0.00%	0.01%	0.01%	0.00%	0.01%	
Access	Percentage of patients waiting over 52-weeks RTT	2026-06-30		0.01%	0.00%	0.01%	0.01%	0.00%	0.01%	
Improving health and reducing inequality	Percentage of people waiting less than 6 weeks for a diagnostic procedure ...	2026-05-31		97.99%	99.00%	-1.01%	97.99%	99.00%	-1.01%	
Finance and Productivity	Planned surplus/deficit	2026-06-30		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Access	Proportion of patients within 18 weeks	2026-06-30		83.25%	92.00%	-8.75%	83.25%	92.00%	-8.75%	
Access	Proportion of patients within 18 weeks - Childrens Services	2026-06-30		73.08%	92.00%	-18.92%	73.08%	92.00%	-18.92%	
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	2026-06-30		105.05%	100.00%	5.05%	99.65%	100.00%	-0.35%	
Access	Total patients waiting more than 30 weeks - all services	2026-06-30		589	0	589	589	0	589	
Access	Total patients waiting more than 30 weeks to start consultant-led treatment	2026-06-30		110	0	110	110	0	110	
Access	Total patients waiting more than 40 weeks - all services	2026-06-30		64	0	64	64	0	64	
Access	Total patients waiting more than 40 weeks to start consultant-led treatment	2026-06-30		11	0	11	11	0	11	
Access	Total patients waiting more than 52 weeks - all services	2026-06-30		2	0	2	2	0	2	
Access	Total patients waiting more than 52 weeks to start consultant-led treatment	2026-06-30		1	0	1	1	0	1	
Effectiveness and experience of care	Urgent Community Response 2-hour performance	2026-04-30		90.00%	70.00%	20.00%	90.00%	70.00%	20.00%	
Finance and Productivity	Variance year-to-date to financial plan	2026-06-30		-354.45%	100.00%	-454.45%	-354.45%	100.00%	-454.4...	
Finance and Productivity	Virtual ward bed occupancy	2026-06-30		81.86%	83.00%	-1.14%	81.86%	83.00%	-1.14%	

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	2026-06-30		1	0	1	1	0	1	
Patient Safety	Category 4 Pressure Ulcers	2026-06-30		1	0	1	1	0	1	
Effectiveness and experience of care	Complaints - (Open) % within response timescales	2026-06-30		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Patient Safety	Compliance with Duty of Candour	2026-06-30		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Effectiveness and experience of care	CQC Conditions or Warning Notices	2026-06-30		0	0	0	0	0	0	
Patient Safety	Deaths - unexpected	2026-06-30		1	0	1	1	0	1	
Patient Safety	Deaths in Custody per 1000 prisoners	2026-06-30		0.00	0.00	0.00	0.00	0.00	0.00	
Patient Safety	Falls per 1000 Occupied Bed Days	2026-06-30		5.51	4.00	1.51	5.51	4.00	1.51	
Patient Safety	Medication Incidents with Moderate Harm	2026-06-30		0	0	0	0	0	0	
Patient Safety	NHS Staff Survey - raising concerns sub-score	2026-06-30		6.48	7.01	-0.53	6.48	7.01	-0.53	
Patient Safety	Patient Safety Incident Investigations	2026-06-30		0	0	0	3	0	3	
Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2026-06-30		225.00%	100.00%	125.00%	225.00%	100.00%	125.00%	
Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2026-06-30		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2026-06-30		0	0	0	0	0	0	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2026-05-31		110%	95%	15%	110%	95%	15%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2026-05-31		107%	95%	12%	107%	95%	12%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2026-05-31		105%	95%	10%	105%	95%	10%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2026-05-31		101%	95%	6%	101%	95%	6%	

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	2026-06-30		87.23%	90.00%	-2.77%	87.15%	90.00%	-2.85%	
People and Workforce	Bank Usage - Variance from plan (WTE)	2026-06-30		-9.70	0.00	-9.70	-9.00	0.00	-9.00	
People and Workforce	Mandatory Training Compliance	2026-06-30		95.93%	95.00%	0.93%	95.93%	95.00%	0.93%	
People and Workforce	National Education and Training Survey overall satisfaction score	2025-12-31		74.08%	90.00%	-15.92%	74.08%	90.00%	-15.92%	
People and Workforce	Net Staff in Post Change	2026-06-30		3.95	0.00	3.95	7.52	0.00	7.52	
People and Workforce	NHS staff survey engagement theme score	2026-06-30		6.91	7.09	-0.18	6.91	7.09	-0.18	
People and Workforce	Proportion of temporary staff	2026-06-30		2.5%	3.4%	-0.9%	2.7%	3.4%	-0.7%	
People and Workforce	Sickness Absence Rate	2026-06-30		5.71%	4.75%	0.96%	5.71%	4.75%	0.96%	
People and Workforce	Total shifts exceeding NHSI capped rate	2026-06-30		116	0	116	130	0	130	
People and Workforce	Total shifts on a non-framework agreement	2026-06-30		0	0	0	0	0	0	
People and Workforce	Vacancies - all	2026-06-30		8.64%	8.00%	0.64%	9.12%	8.00%	1.12%	

Icon Descriptions

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

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	065/26b		
Report Title	SaTH Integrated Performance Report		
Executive Lead	Jo Williams, Group Chief Executive Officer		
Report Author	Ned Hobbs, Deputy Chief Executive Officer		
Prior Consultation:	CQC Domain:		Link to SaTH BAF id(s)
QOC - 2026.07.21 PAC - 2026.07.28 FAC - 2026.07.28	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 Board’s attention is drawn to the sections of Quality, Patient Safety and Clinical Effectiveness, Responsiveness, and Well Led which incorporates both Workforce and Finance. The report provides an overview of the performance indicators to the end of May 2026/June 2026, summarises planned recovery actions, correlated impact, and timescales for improvement.		
Recommendations for the Board:	The Board is asked to: • Note the content of the report.		
Appendices:	Appendix 1: Integrated Performance Report		



Integrated Performance Report

Board of Directors Meeting 13th August 2026

Presenting Month 3 performance data

Contents

Domain/Report Section	Executive Lead	Slide number
Executive Summary	Chief Executive	3
Quality Patient Safety and Clinical Effectiveness	Group Chief Nursing Officer Medical Director	4
Responsiveness	Chief Operating Officer	40
Well-led (Workforce)	Chief People Officer	56
Well-led (Finance)	Director of Finance	65
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Executive Summary

Urgent and Emergency Care (UEC) 4-hour performance (type 1 & type 3) remains in common cause natural variation in June 26. Type 1 performance decreased to 43.9%, and Type 3 performance decreased to 87.9%. Average ambulance handover time shows special cause improving variation in June and was better than plan with 86.4% of ambulance handovers within 45 mins. The number of Type 1 patients who spend more than 12 hours in ED shows special cause improving variation.

The Trust submitted a finance plan to NHSE on 18th March which showed a deficit plan of £30.49m pre deficit support (DSF) which moves to breakeven with deficit support for the year. At the end of June (month three), the Trust has delivered a deficit position of £10.94m against a deficit plan of £8.27m pre deficit support funding, an unfavourable variance of £2.67m. This moves to a deficit of £3.31m against a planned deficit of £0.65m post deficit support.

There have been some variances in the cost categories with income and non-pay favourable to plan and pay adverse to plan. The predominant drivers of the variance are industrial action (£0.75m) and slippage against various efficiency schemes (£1.70m), these have been partly offset with other non-recurrent mitigations.

The Trust has set an operational capital programme of £25.54m (including IFRS 16 expenditure) and externally funded schemes of £138.26m in FY26/27, giving a total capital programme of £163.80m, spend at the end of Q1 totalled £23.56m. The Trust held a cash balance at end of June 2026 of £40.26m.

The submitted Trust Position for June 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.

The unvalidated Trust Position for Welsh is 0 x 104 weeks, 7 x 78 weeks, 34 x 65 weeks 117 x 52 weeks.

The Trust is ahead of plan and demonstrating special cause improvement against all RTT metrics.

Confirmed May cancer performance is 82.5% (28-day FDS) vs the local plan of 80%. 62-day performance was 73.9% against a local target of 70% and 31 day was 99% against national target of 96%. The 62-day backlog is 164 patients over 62 days of which 41 are over 104 days (as at 16/07/2026).

The submitted DM01 position for June was 79.9%, with particular improved performance seen in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan implemented from mid-June. 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.

Quality Patient Safety, Clinical Effectiveness and Patient Experience

Executive Leads :

**Group Chief Nursing Officer
Martina Morris**

**Medical Director
John Jones**

Integrated Performance Report

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Domain	Description	National Standard 26/27	Current Month Trajectory (RAG)	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Trend
Patient Safety & Effectiveness	Pressure Ulcers - Category 2	20% < 2025-26	22	27	28	26	21	27	35	24	21	35	26	19	22	22	
	Pressure Ulcers - Category 2 per 1000 Bed Days	20% < 2025-26	0.79	0.99	1.11	1.01	0.81	1.03	1.30	0.95	0.80	1.25	1.04	0.72	0.86	0.80	
	Pressure Ulcers - Category 3	10% < 2025-26	1	1	4	4	9	6	2	9	3	9	6	4	6	8	
	Pressure Ulcers - Category 3 per 1000 Bed Days	10% < 2025-26	0.04	0.04	0.16	0.16	0.35	0.23	0.07	0.36	0.11	0.32	0.24	0.15	0.24	0.29	
	Pressure Ulcers - Category 4	0	0	1	0	0	0	0	0	0	0	1	1	1	0	1	
	Falls - per 1000 Bed Days	5% < 2025-26	3.61	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.42	4.71	4.87	4.51	5.25	4.23	
	Falls - total	-	99	104	95	118	106	110	110	99	116	132	122	119	134	116	
	Falls - with Harm per 1000 Bed Days	5% < 2025-26	0.07	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.15	0.11	0.04	0.27	0.16	0.15	
	Falls - Resulting in Harm Moderate or Severe	0	0	2	5	6	3	6	2	2	4	3	1	7	4	4	
Patient Experience	Complaints	-	-	91	114	127	106	114	116	105	102	122	118	133	120	133	
	Complaints - responded within agreed timeframe - based on month response due	85%	85%	42.0%	44.0%	49.0%	49.0%	43.0%	50.0%	50.0%	51.0%	60.0%	56.0%	54.0%	52.0%	59.0%	
	Complaints by Theme - Access to Treatment or Drugs	-	-	0	4	5	6	4	4	8	13	11	7	10	3	7	
	Complaints by Theme - Admission / Discharge	-	-	16	18	25	27	16	19	23	24	34	27	26	25	26	
	Complaints by Theme - Appointment	-	-	16	24	19	21	19	17	16	27	24	27	23	21	20	
	Complaints by Theme - Clinical treatment	-	-	47	72	71	63	59	55	53	63	71	71	78	71	80	
	Complaints by Theme - Commissioning Decisions	-	-	0	0	0	0	1	0	1	0	0	0	1	0	0	
	Complaints by Theme - Communication	-	-	40	62	60	60	49	46	57	64	70	60	75	85	79	
	Complaints by Theme - Consent to treatment	-	-	2	2	2	1	2	2	3	7	4	3	3	5	7	
	Complaints by Theme - Dementia Care	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints by Theme - End of life care	-	-	2	5	0	6	2	2	5	1	6	2	4	5	2	
	Complaints by Theme - Facilities	-	-	4	5	7	13	2	2	2	5	12	5	14	9	7	
	Complaints by Theme - Mortuary	-	-	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Complaints by Theme - Other	-	-	0	2	2	1	0	1	0	2	3	3	3	1	2	
	Complaints by Theme - Patient care	-	-	21	27	18	29	22	23	24	28	36	35	56	51	37	
	Complaints by Theme - Prescribing	-	-	6	7	9	6	3	5	5	7	5	4	6	5	4	
	Complaints by Theme - Privacy & Dignity	-	-	11	16	7	15	8	8	10	17	17	14	17	10	9	
	Complaints by Theme - Restraint	-	-	1	0	1	0	0	0	0	1	0	1	0	0	0	
	Complaints by Theme - Staff numbers	-	-	0	0	2	0	2	3	3	2	5	2	4	1	3	
	Complaints by Theme - Trust admin / procedure / records	-	-	7	10	11	15	12	7	2	9	21	26	20	22	44	
	Complaints by Theme - Values & Behaviours (staff)	-	-	27	37	41	31	34	35	46	40	37	40	41	42	44	
	Complaints by Theme - Waiting time	-	-	15	17	19	16	12	13	12	11	15	14	13	11	15	
	PALS - Count of concerns	-	-	365	351	375	318	397	407	321	278	448	408	396	417	422	
	Compliments	-	-	93	110	81	109	145	132	95	145	89	91	84	89	107	
	Friends and Family Test -SaTH	95%	95%	93.2%	96.8%	88.3%	92.4%	79.8%	73.7%	77.1%	76.1%	76.0%	75.0%	75.4%	80.3%	78.7%	
	Friends and Family Test - Inpatient	95%	95%	91.4%	97.4%	96.9%	96.4%	92.0%	93.6%	95.1%	94.0%	92.7%	92.8%	94.3%	92.7%	92.9%	
	Friends and Family Test - A&E	85%	85%	51.7%	57.6%	63.0%	33.3%	62.1%	67.6%	70.5%	71.1%	72.2%	70.9%	71.5%	77.3%	74.7%	
	Friends and Family Test - Maternity	95%	95%	88.6%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	85.7%	87.5%	55.6%	100.0%	60.0%	
	Friends and Family Test - Outpatients	95%	95%	99.0%	97.6%	94.0%	92.9%	93.7%	92.2%	95.3%	92.8%	87.1%	91.5%	85.7%	88.0%	94.8%	
	Friends and Family Test - SaTH Response rate %	-	-	5.3%	4.8%	1.3%	1.2%	1.6%	3.6%	4.7%	4.5%	5.2%	4.9%	4.7%	5.5%	5.6%	
	Friends and Family Test - Inpatient Response rate %	-	-	12.8%	11.5%	2.2%	2.9%	2.0%	1.5%	2.6%	1.8%	1.9%	1.8%	1.9%	2.2%	2.5%	
	Friends and Family Test - A&E Response rate %	-	-	0.4%	0.3%	0.7%	0.1%	1.4%	5.0%	6.2%	6.2%	7.4%	7.1%	6.6%	7.7%	7.7%	
	Friends and Family Test - Maternity (Birth) Response rate %	-	-	6.6%	2.1%	0.7%	0.2%	0.4%	0.8%	0.7%	0.0%	0.3%	0.0%	0.0%	0.6%	0.3%	

Integrated Performance Report

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Domain	Description	National Standard 26/27	Current Month Trajectory (RAG)	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Trend
Patient Safety & Effectiveness	Trust SHMI (HED)	100	100	102	90	98	92	97	90	95	98	-	-	-	-	-	
	Trust SHMI - Expected Deaths	-	-	244	225	238	225	228	249	238	285	-	-	-	-	-	
	Trust SHMI - Observed Deaths	-	-	248	203	233	208	221	224	227	278	-	-	-	-	-	
	SJRs Completed by Month			33	20	17	12	17	18	14	11	16	10	17	0	0	
	MRSA - HOHA			0	0	0	0	0	0	1	0	2	1	0	0	0	
	MRSA - COHA			0	0	0	0	0	0	0	0	0	1	0	0	0	
	MRSA - Total	0	0	0	0	0	0	0	0	1	0	2	2	0	0	0	
	MSSA - HOHA	-	-	3	1	2	2	1	0	2	3	1	1	4	3	2	
	C. difficile - HOHA			2	6	5	10	8	6	2	7	6	3	9	6	10	
	C. difficile - COHA			2	6	5	3	4	3	3	7	5	6	9	4	3	
	C. difficile - Total	98	8	4	12	10	13	12	9	5	14	11	9	18	10	13	
	E. coli - HOHA			2	3	2	8	6	5	5	5	4	5	7	8	3	
	E. coli - COHA			14	9	10	10	15	11	10	7	9	6	6	7	9	
	E. coli - Total	146	12	16	12	12	18	21	16	15	12	13	11	13	15	12	
	Klebsiella - HOHA			4	0	2	1	4	2	1	2	2	1	0	0	1	
	Klebsiella - COHA			2	1	1	5	4	3	3	2	3	2	3	0	4	
	Klebsiella - Total	36	3	6	1	3	6	8	5	4	4	5	3	3	0	5	
	Pseudomonas Aeruginosa - HOHA			0	1	0	0	0	1	0	0	0	1	1	1	1	
	Pseudomonas Aeruginosa - COHA			0	0	3	1	1	2	1	0	2	2	0	0	1	
	Pseudomonas Aeruginosa - Total	16	1	0	1	3	1	1	3	1	0	2	3	1	1	2	
	VTE Risk Assessment completion - SATH	95%	95%	75.0%	75.5%	77.4%	77.2%	79.2%	79.6%	80.7%	78.3%	77.7%	82.6%	84.7%	-	-	
	Never Events	0	0	0	0	1	0	1	1	0	0	0	0	1	1	1	
	Psii	-	-	1	0	1	0	3	2	3	0	1	0	1	0	2	
	Mixed Sex Accommodation - breaches	10% < 2025-26	78	87	65	52	38	46	63	56	46	66	40	59	38	42	
	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%	96%	96%	99%	95%	97%	98%	95%	92%	95%	95%	97%	95%	94%	
	Smoking Rate at Delivery	6%	6%	4.0%	5.9%	5.0%	4.4%	5.9%	4.2%	4.3%	4.9%	6.6%	3.3%	4.0%	5.7%	5.9%	

Patient Safety, Clinical Effectiveness, Patient Experience Executive Summary

- Work is progressing to redesign the Integrated Performance Report (IPR) to align with the Trust's True North priorities and quality management framework, improving readability and focus on key quality metrics.
- Hospital Associated Infection (C. difficile) remains the most significant cross-Trust quality concern, with emphasis on the need for continued improvements in infection prevention, hand hygiene, cleaning standards and antimicrobial stewardship.
- Complaints continue to increase significantly, reflecting both local and national trends. Concerns were raised regarding complaint response timeliness and the importance of early local resolution to prevent escalation



Quality - Safe - Deteriorating Patients - Fragility



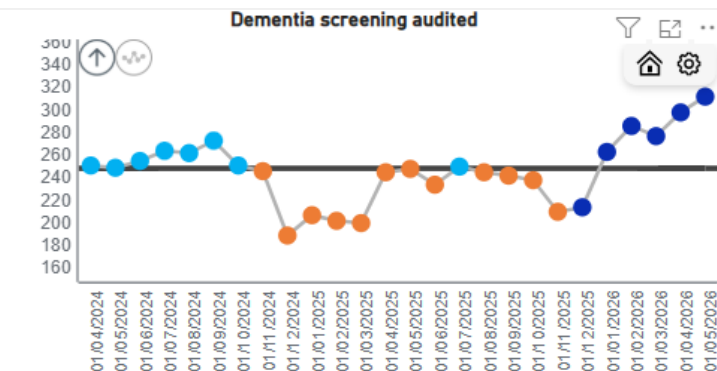
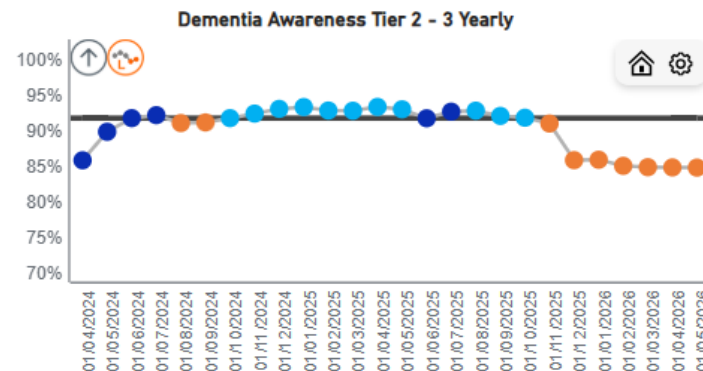
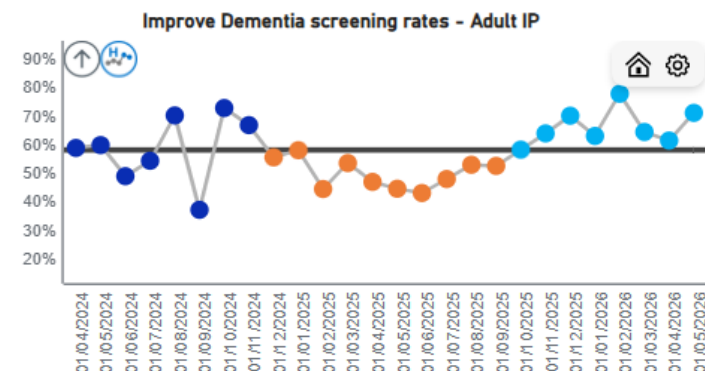
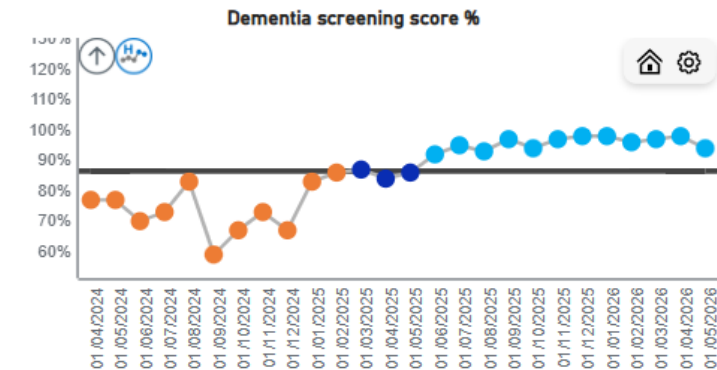
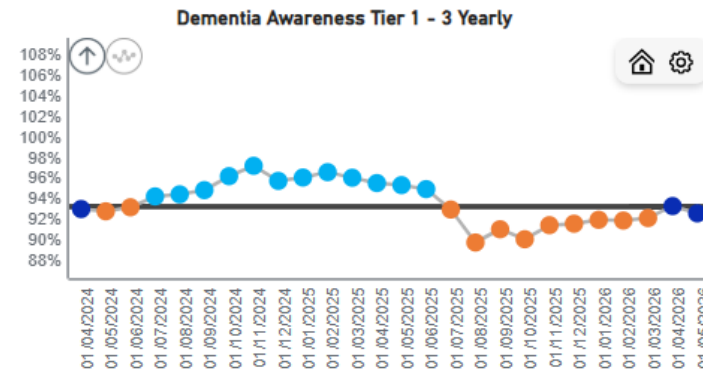
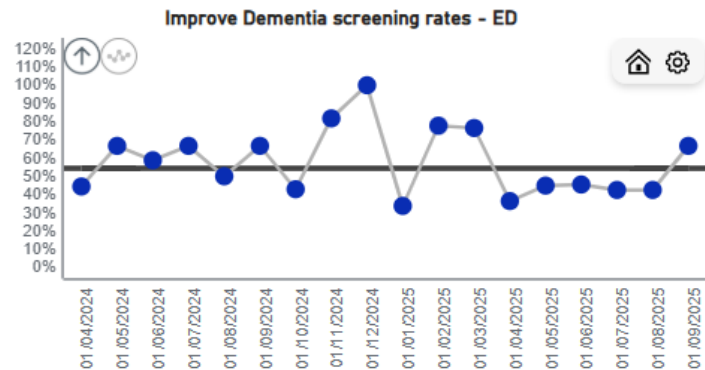
Falls

Deteriorating Patients - NEWS

Deteriorating Patients - PEWS

Medication - Omitted Doses

	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
Improve Dementia screening rates - Patient had an AMT - ED	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	44.6	53.7	47.1	44.7	43.2	48.1	53.1	52.7	58.4	64.1	70.3	63.2	78.0	64.6	61.6	71.3
Dementia Awareness Tier 1 3 Yearly	96.60	96.06	95.54	95.34	94.95	92.96	89.75	91.04	90.07	91.44	91.58	91.96	91.89	92.13	93.30	92.59
Dementia Awareness Tier 2 3 Yearly	93.02	92.99	93.53	93.19	91.93	92.86	93.00	92.26	92.01	91.19	86.04	86.10	85.24	85.05	85.02	84.99
Dementia Screening % Score	86	87	84	86	92	95	93	97	94	97	98	98	96	97	98	94
Dementia Screening Audited	202	200	245	248	234	250	245	242	238	210	214	263	286	277	298	312





Quality - Safe - Deteriorating Patients - NEWS

Falls

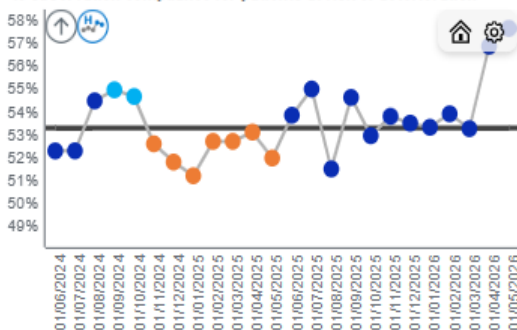
Deteriorating Patients - Fragility

Deteriorating Patients - PEWS

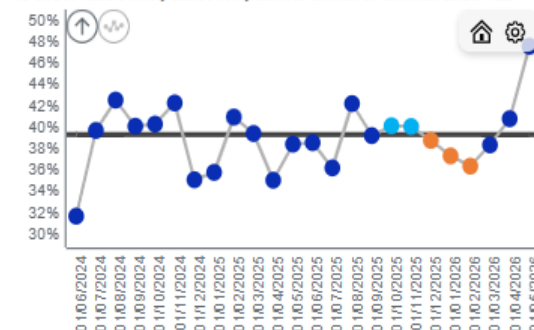
Medication - Omitted Doses

	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	Mar-2026	Apr-2026	May-2026
% Observation compliance for patients at risk of deterioration	52.59	51.79	51.19	52.70	52.70	53.11	51.97	53.85	55.00	51.49	54.63	52.95	53.80	53.50	53.32	53.91	53.26	56.88	57.66
% Observation compliance for patients at risk of deterioration - ED	42.24	35.05	35.74	40.92	39.38	35.01	38.38	38.52	36.16	42.18	39.18	40.10	40.03	38.73	37.28	36.32	38.31	40.76	47.55
% Compliance evidence that deterioration risk (NEWS2) escalated	88.10	88.00	88.70	86.40	88.80	87.30	90.90	87.30	86.10	89.60	84.40	86.50	89.00	97.20	88.20	87.80	86.10	85.00	85.50
% Compliance evidence that deterioration risk (NEWS2) reviewed	85.80	86.10	87.00	85.00	72.70	77.00	83.10	81.80	77.80	83.90	90.30	82.40	80.80	90.90	85.70	84.90	79.40	80.60	87.20
% Compliance of review within recommended timeframe	95.30	95.40	93.60	96.30	96.20	92.20	95.00	92.00	88.20	94.90	75.00	82.40	90.00	88.70	94.40	86.10	88.10	89.00	91.70
% Compliance reviewed by recommended seniority	98.90	96.80	98.60	98.40	96.40	97.50	96.60	97.60	99.50	98.50	92.10	88.60	89.10	98.40	94.40	93.60	85.40	89.30	85.00
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr	92.40	86.50	85.10	85.20	95.00	69.60	90.90	100.00	100.00	100.00	82.60	68.20	100.00	90.00	90.00	84.00	96.00	82.10	90.00

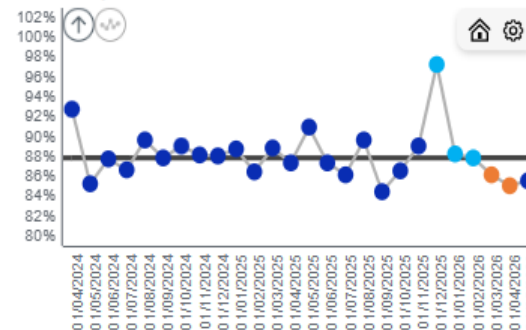
% Observation compliance for patients at risk of deterioration



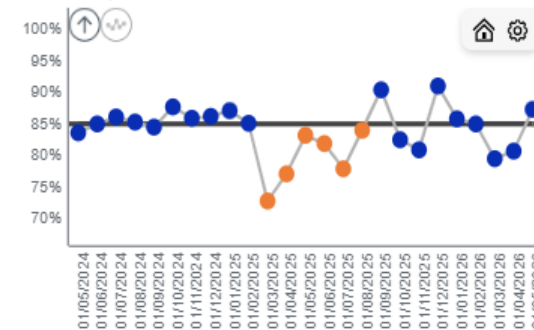
% Observation compliance for patients at risk of deterioration - ED



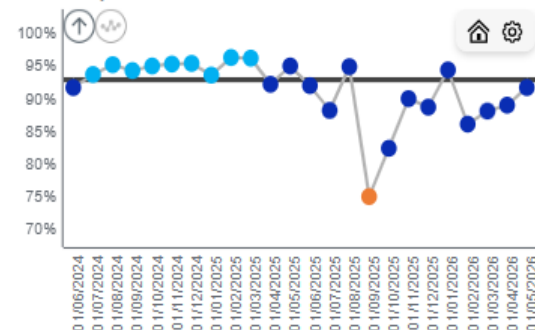
% Compliance evidence that deterioration risk escalated



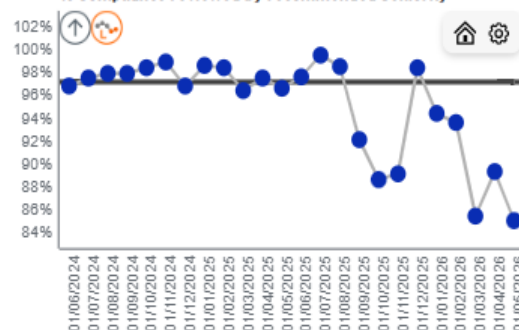
% Compliance evidence that deterioration risk reviewed



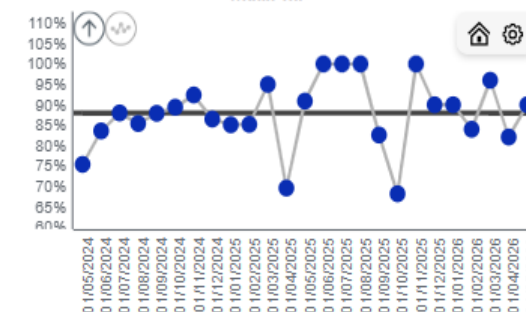
% Compliance of review within recommended timeframe



% Compliance reviewed by recommended seniority



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



Deteriorating patients – NEWS2

Summary:

Deteriorating patient observation compliance remains below the $\geq 90\%$ target, inpatient performance in May demonstrated a slight increase from 56.88% to 57.66%, with ED performance also rising to 47.55% (from 40.76%).

Escalation compliance showed a minor upward shift in May appearing relatively stable at 85.5%.

Review compliance has improved to 87.20% (from 80.60% in the previous month) however the available data continues to demonstrate variability in both the seniority of clinician review and timeliness of response in line with patient acuity (RCP guidance), with current compliance at 85% and 91.70% respectively, reinforcing the need for ongoing oversight and focus.

Antibiotic administration within 1 hour for high-risk sepsis has increased to 90%. This represents 2 out of 21 patients not receiving treatment within 60 minutes; ongoing work to enhance digital visibility of deteriorating patients and associated workflows, alongside initiatives such as e-prescribing, is expected to support greater consistency and improved patient outcomes going forward.

Recovery Actions:

1. Improve compliance with observation frequency for patients at risk of deterioration

- Support teams in use of digital tools to ensure local oversight of most at risk patients
- Reinforce expected standards for Escalation associated with clinical acuity (as per guidance)

2. Strengthen deterioration response reliability

- Embed expected response linking NEWS2 triggers and associated actions with the use of prompts.
- Improve visibility of escalation and review status via digital projects
- Work with clinical teams to address variation identified through local data
- Reinforce senior clinical oversight and decision-making to increase focus on seniority of review, ensuring appropriate clinician involvement at trigger points
- Promote clear documentation of reviewer seniority through prompts, projects such as response sticker trial (MECTP) and audit feedback.
- Support clinical teams through targeted messaging and inclusion in induction programmes
- Reinforce consistent escalation and review practice through focused safety huddles and case reviews

3. Improve timeliness and consistency of clinical review

- Continue monitoring response times against acuity standards, highlighting areas of delay
- Align ward processes to ensure timely review is embedded within routine practice

4. Sepsis recognition and treatment reliability

- Reinforce delivery of antibiotics within 60 minutes, with clear identification of exemptions
- Share learning from delayed cases, including documentation of individualised care plans

Anticipated impact and timescales.

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

Recovery dependencies:

- Deteriorating patient team to support understanding of systems data to drive improvements
- Continued governance and clinical engagement in deteriorating patient workstreams



Quality - Safe - Deteriorating Patients - PEWS



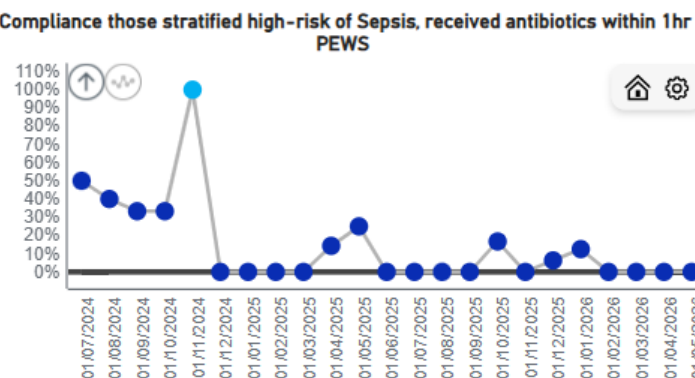
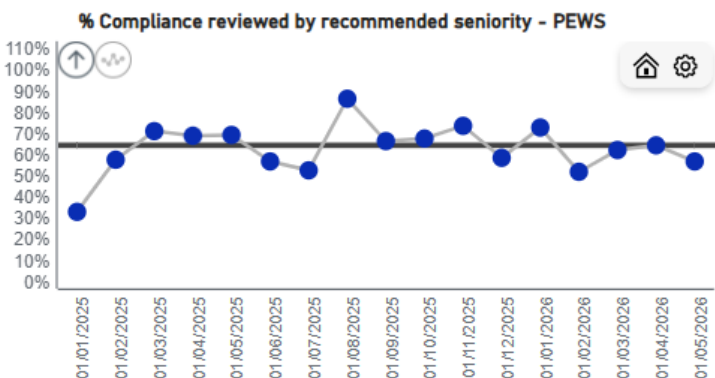
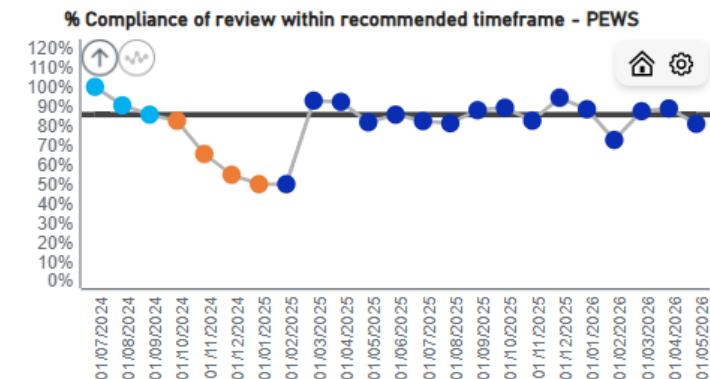
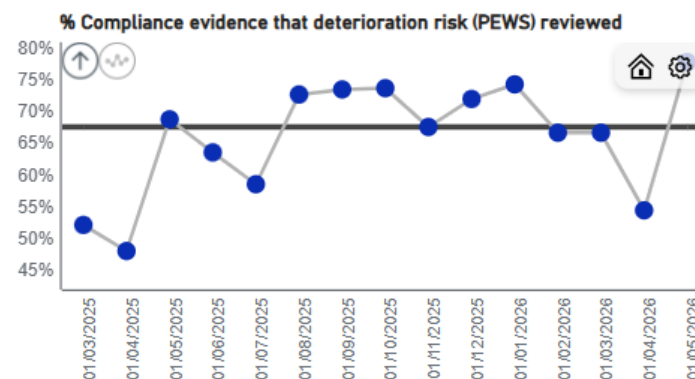
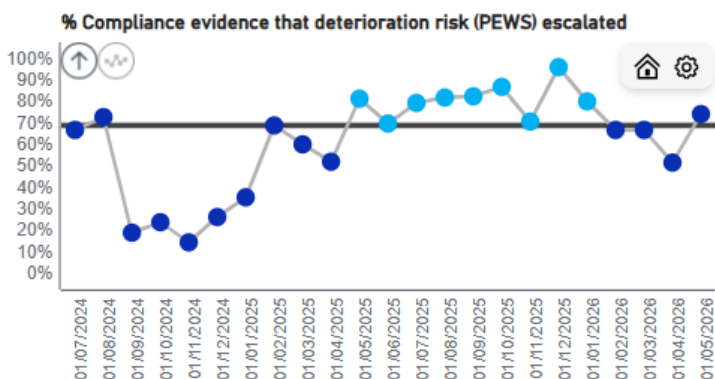
Falls

Deteriorating Patients - Fragility

Deteriorating Patients - NEWS

Medication - Omitted Doses

	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
% Compliance evidence that deterioration risk (PEWS) escalated	51.90	81.30	69.70	79.30	81.80	82.40	86.80	70.60	96.00	80.00	66.70	66.70	51.50	74.10
% Compliance evidence that deterioration risk (PEWS) reviewed	48.10	68.80	63.60	58.60	72.70	73.50	73.70	67.60	72.00	74.30	66.70	66.70	54.50	77.80
% Compliance of review within recommended timeframe - PEWS	92.30	81.80	85.70	82.40	81.30	88.00	89.30	82.60	94.40	88.50	72.70	87.50	88.90	81.00
% Compliance reviewed by recommended seniority - PEWS	69.20	69.60	57.10	52.90	86.70	66.70	67.90	73.90	58.80	73.10	52.20	62.50	64.70	57.10
% Compliance those stratified high-risk of Sepsis, received antibiotics within 1hr - PEWS	14.30	25.00	0.00	0.00	0.00	0.00	16.70	0.00	6.30	12.50	0.00	0.00	0.00	0.00

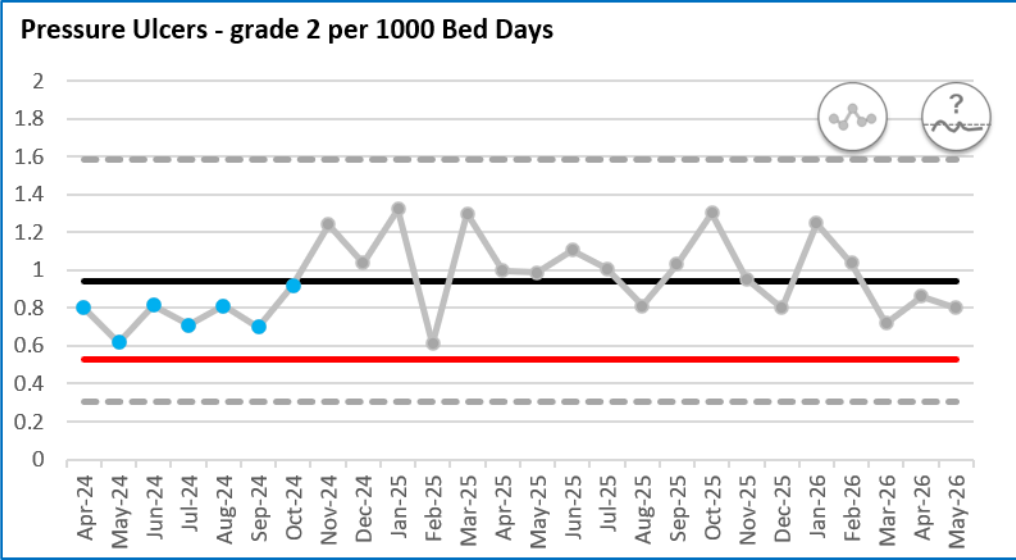
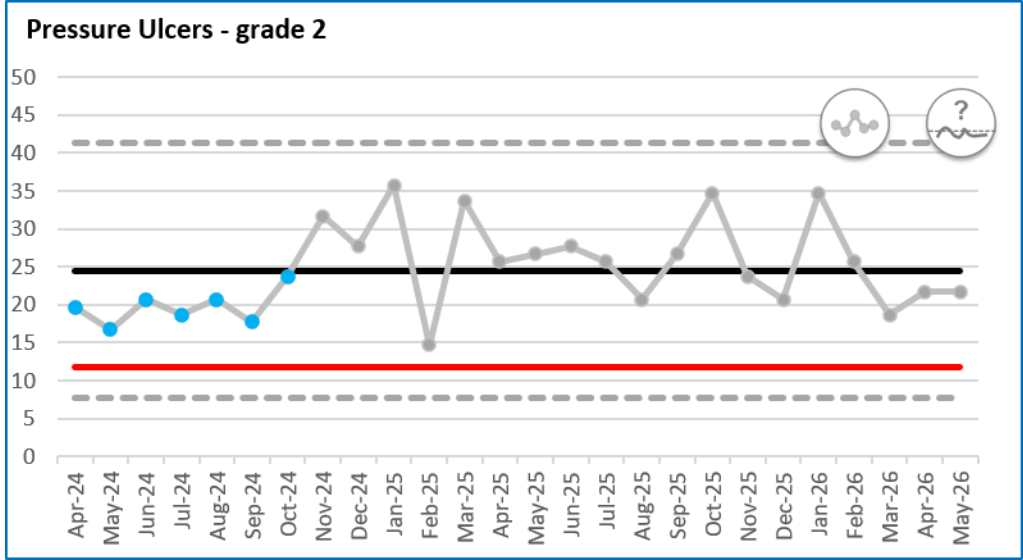


Deteriorating patients – PEWS & NEWTT2

Summary: In May 2026, 28 patients were audited. Of those requiring escalation, 74.1% (21CYP) had documented evidence of escalation which is an increase from the previous month. Of the 25.9% (7 CYP) who did not have documented evidence of escalation, 1 CYP was escalated and seen during the ward round which is documented by the consultant, 6 CYP had no documented evidence of escalation but came to no harm. The CYP review, compliance has increased to 77.8% (22 CYP). The 22.2 % (6 CYP) who were not reviewed came to no harm. With regards to sepsis, 78.6% (22 CYP) were screened for sepsis at their initial assessment which is a slight decrease in compliance from April. 14 CYP screened positively but on clinical assessment did not require IV antibiotics. All patients were treated appropriately.		
Recovery actions: On reviewing the audits further improvement is required in relation to documentation following reviews, De-escalating sepsis when indicated and escalation of PEWS which remains a key message within Paediatrics. • Escalation Compliance: Work to improve documentation of escalation is being supported by the paediatric PEF team, simulation training, and audit feedback via newsletters and huddles • Data is discussed at Governance meetings and sent to the Tier 2 medics/ ACP • IV Antibiotic Compliance: 0% due to no CYP requiring IV antibiotics within the audit, alternative diagnosis treated • Documentation: De-escalation of sepsis triggers via vitals and documenting reviews one of the key challenge within Paediatrics as the majority of children presenting to the department triggering sepsis is due to children's physiology and response to illness. Ongoing education continues for both medical staff and new nurses • New board huddle introduced with Consultants, Ward Managers, Matrons to highlight the children triggering for sepsis who have not been de-escalated		Anticipated impact and timescales for improvement: 6-12 months
Recovery dependencies:	Support via Performance & Business Intelligence (P&BI) team, transformation project teams and engagement throughout the trust. Support via governance & clinical and operational teams to prioritise deteriorating patient with timely decisions made by DPG	

Patient harm – pressure ulcers – Category 2

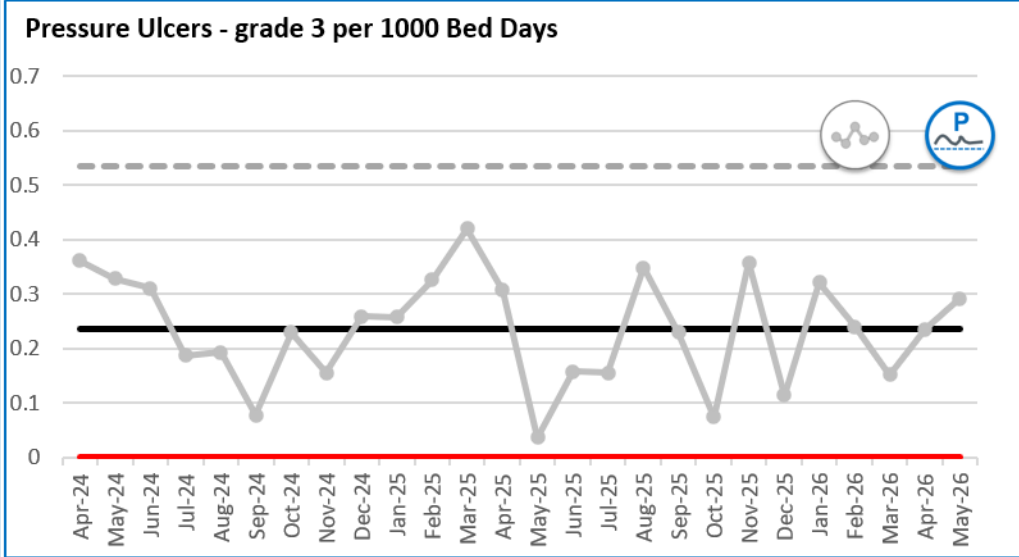
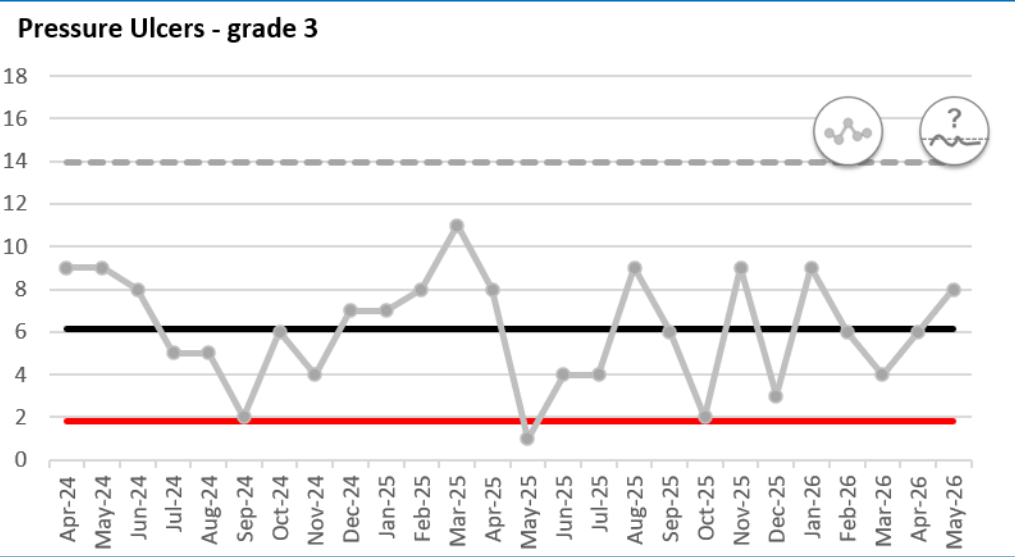
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	18
Surgery, Anaesthetics and Cancer	2
Women's & Children's	1
Clinical Support Services	1

Patient harm – pressure ulcers – Category 3

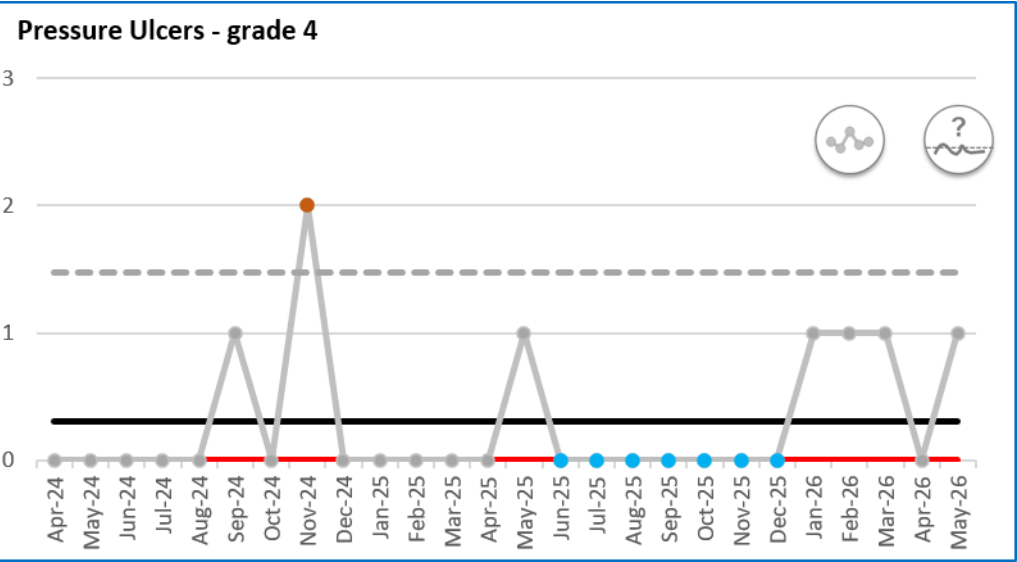
Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	4
Surgery, Anaesthetics and Cancer	2
Women's & Children's	0
Clinical Support Services	2

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	1
Surgery, Anaesthetics and Cancer	0
Women's & Children's	0
Clinical Support Services	0

Patient Harm – pressure ulcers

Summary: The number of Category 2 injuries is the same as previous month (22). The number of category 3 pressure ulcers has increased from 6 to 8 and there has been one reported category 4 pressure ulcer caused by a medical device on ward 26M. Learning and actions have been identified and the TVS is providing in-reach support to the area to ensure they are implemented and sustained. The identified category 3 pressure ulcers occurred on ward 4, 9, 24, 37 with two on wards 23 and 27. 4 were located on the sacrum/buttocks, one to the heel and 3 were caused by medical devices (ear, bridge of nose and right thigh). There were 37 reported Deep Tissue Injuries this month compared to 22 last month. These figures are correct at the time of validation by the Tissue Viability Service.

Recovery actions:

- Hospital acquired pressure ulcer injuries are reviewed by the ward manager/matron within 2 weeks. All injuries are reviewed in line with the aSSKING care bundle to identify areas of learning and to ensure no requirement for after action review
- All injuries category 2 and above sustained in trust are checked against the decision support tool for safeguarding concerns and are escalated if required with the local authority in conjunction with the Trust safeguarding team
- All category 2 injuries sustained in Trust are presented at the monthly Pressure Ulcer Review Meeting where areas for learning and actions taken to embed are discussed. Category 3 and 4 pressure ulcer are discussed at a face-to-face meeting with the chief/deputy chief Nurse, ward manager, Matron and tissue viability. The tissue viability team will assist the ward team with any learning discussed at the initial meeting and a follow up meeting 6 weeks later will take place
- Hybrid pressure relieving mattresses have now been introduced in the Trust and a training programme has been taken place. The current contract with Arjo will cease end of July

Current actions in place/ongoing are:

- Utilisation of ward education Facilitators and the Quality facilitators in education regarding pressure ulcer documentation and associated nursing actions more 1:1 face to face sessions on ward
- Ward manager focus on Tissue Viability Documentation completion, discussed in safety huddle and spot checks carried out and discussed at monthly Nursing Quality metrics
- Weekly in-reach support visits by the TVS to higher incidence areas

Anticipated impact and timescales for improvement

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

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



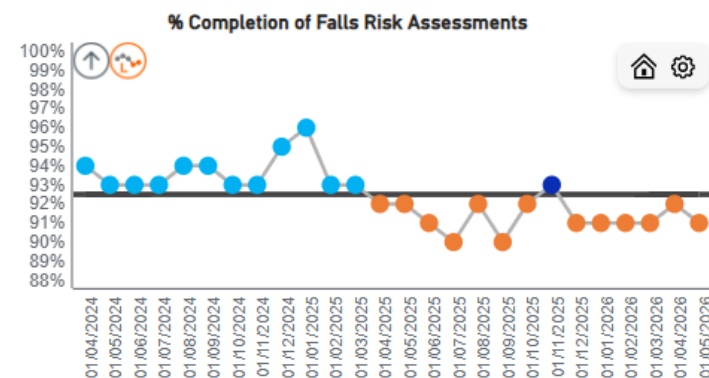
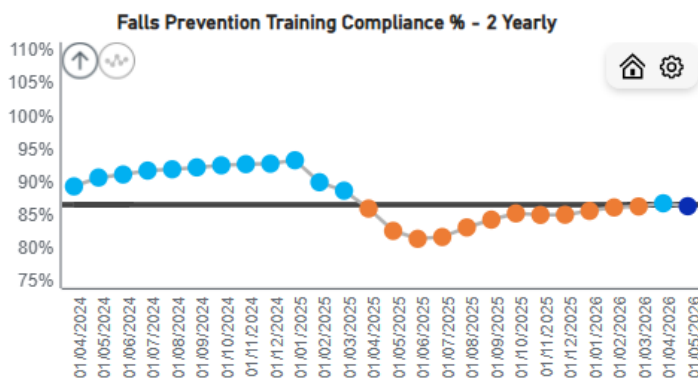
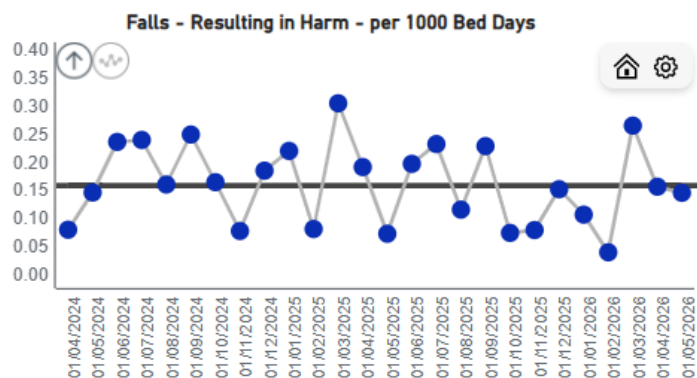
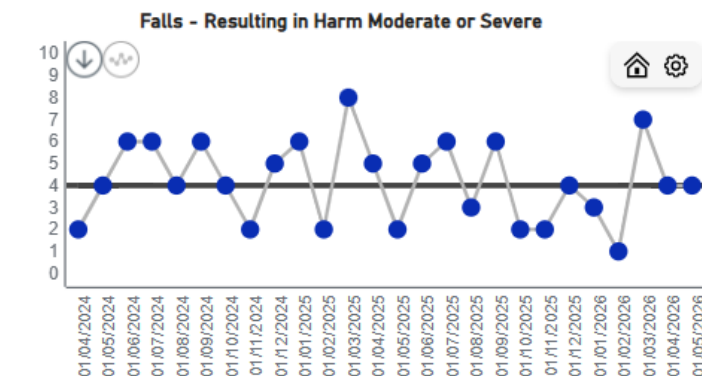
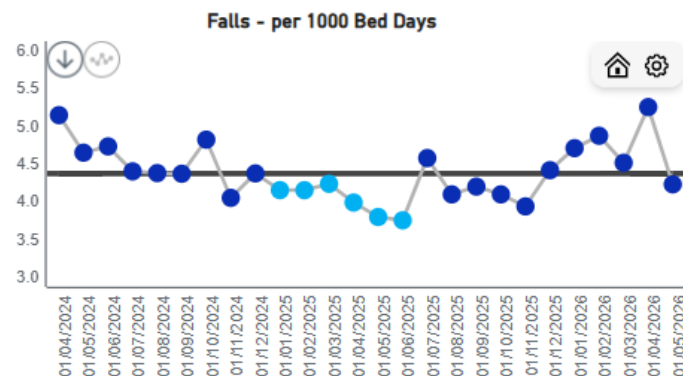
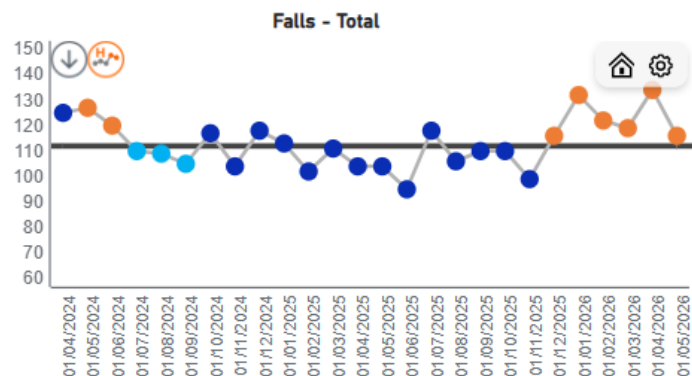
Deteriorating Patient - Fragility

Deteriorating Patients - NEWS

Deteriorating Patients - PEWS

Medication - Omitted Doses

	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
Falls - Total	113	102	111	104	104	95	118	106	110	110	99	116	132	122	119	134	116
Falls - per 1000 Bed Days	4.15	4.15	4.24	3.99	3.80	3.75	4.58	4.10	4.20	4.10	3.94	4.42	4.71	4.87	4.51	5.25	4.23
Falls - Resulting in Harm Moderate or Severe	6	2	8	5	2	5	6	3	6	2	2	4	3	1	7	4	4
Falls - Resulting in Harm - per 1000 Bed Days	0.22	0.08	0.31	0.19	0.07	0.20	0.23	0.12	0.23	0.07	0.08	0.15	0.11	0.04	0.27	0.16	0.15
Falls Prevention Training Compliance % - 2 Yearly	93.36	90.03	88.75	86.04	82.66	81.46	81.73	83.18	84.36	85.31	85.08	85.11	85.68	86.21	86.36	86.84	86.40
% Completion of Falls Risk Assessments	96	93	93	92	92	91	90	92	90	92	93	91	91	91	91	92	91



Patient harm - falls

Summary:

There were 116 falls in May which is 18 fewer falls than the previous month.
There were 4 falls resulting in moderate harm, however, there were no falls involving severe harm in May which is an improvement on last month.
On review of these 4 falls, 3 had all documentation and risk assessments completed. The remaining fall had post fall documentation missing, there was no lying and common cause variation continues to be seen on the falls with harm and falls with harm per 1000 bed days charts.
Training compliance was 86.4% in May which is just below the target of 90%.

Recovery actions:

A pilot of BMAT (Bedside Mobility Assessment Tool), a patient early mobilisation tool which will also help with hospital associated deconditioning took place in March on Ward 26 and ward 11. The project showed more patients were sitting out of bed and therefore less likely to fall due to deconditioning. BMAT will be implemented throughout the trust commencing in June and will also include the digital risk assessment for BMAT. This will commence on ward 35, ward 23 and SeSH.
The Quality team review each patient fall to check process pre and post fall. Ward Managers and Matrons review each fall on their wards with support from the Quality team. Education takes place at the time of the falls review addressing any non-compliance.
Completion of lying and standing BP compliance is still low pre fall, the quality team are focusing on raising awareness and improving compliance. This is also discussed in Metrics.
Falls training and completion of risks assessments discussed in monthly Metrics meetings.
Training compliance and trajectories are discussed in Nursing Quality Metrics

Anticipated impact and timescales for improvement:

Beside mobility assessment – BMAT implementation this year.
Review of all falls continues with feedback presented to WM
Lying and standing blood pressure awareness. This is checked monthly through documentation audits by the Quality team and discussed in Nursing Quality assurance meeting

Recovery dependencies:

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



Quality - Safe - Medication - Omitted Doses

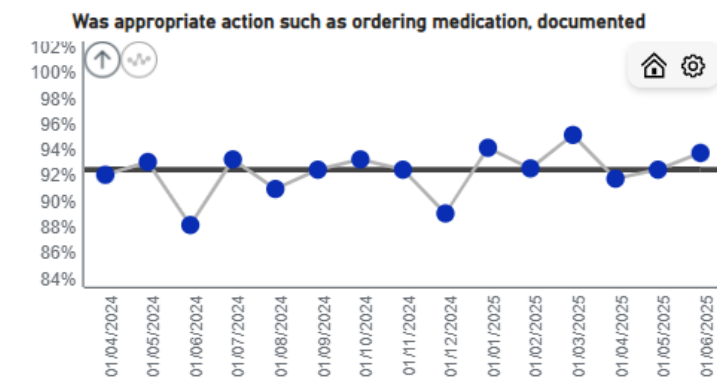
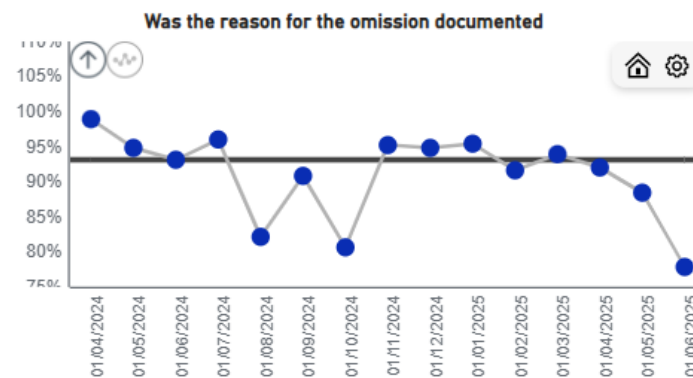
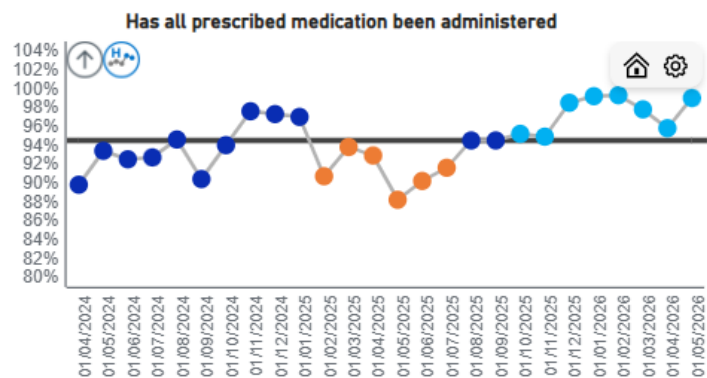


Falls

Deteriorating Patients - Fragility

Deteriorating Patient

	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
Has all prescribed medication been administered?	90.7	93.8	92.9	88.2	90.2	91.6	94.5	94.5	95.2	94.9	98.5	99.2	99.3	97.8	95.8	99.0
Was the reason for the omission documented?	91.6	93.9	92.0	88.4	77.8											
Was appropriate action such as ordering medication, documented?	92.6	95.2	91.8	92.5	93.8											



Medication – omitted doses

Summary:

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

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

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

Recovery actions:

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

Anticipated impact and timescales for improvement:

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

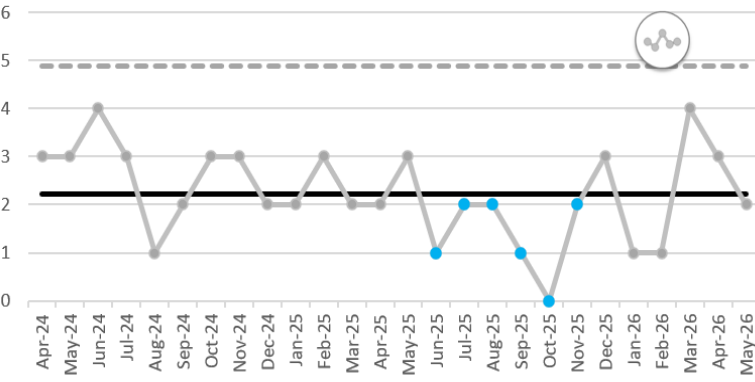
In line with full implementation of EPMA within the Trust.

Recovery dependencies:

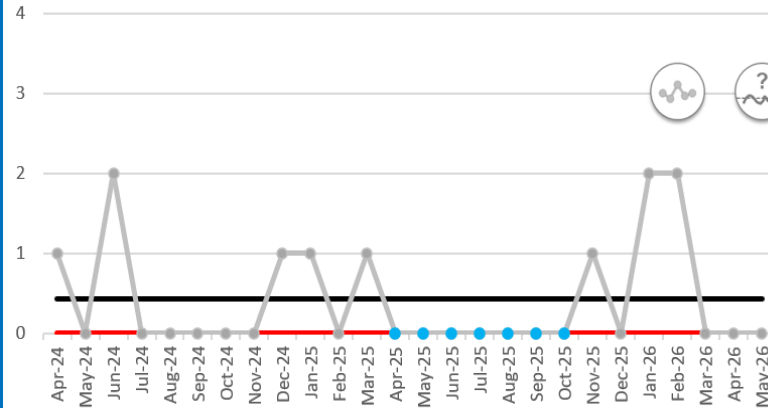
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Infection prevention and control

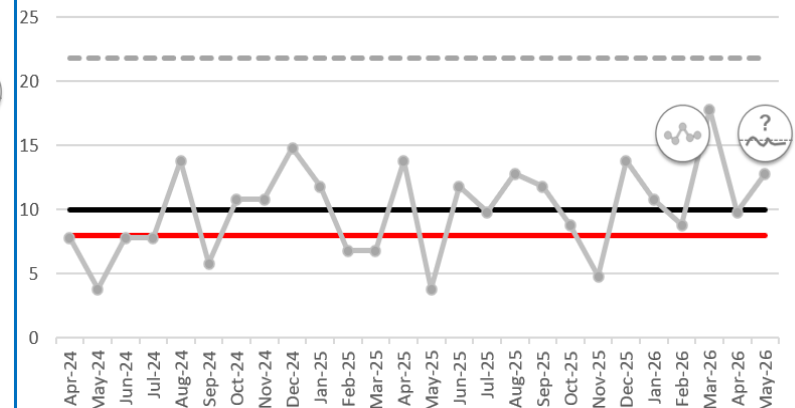
MSSA - HOHA



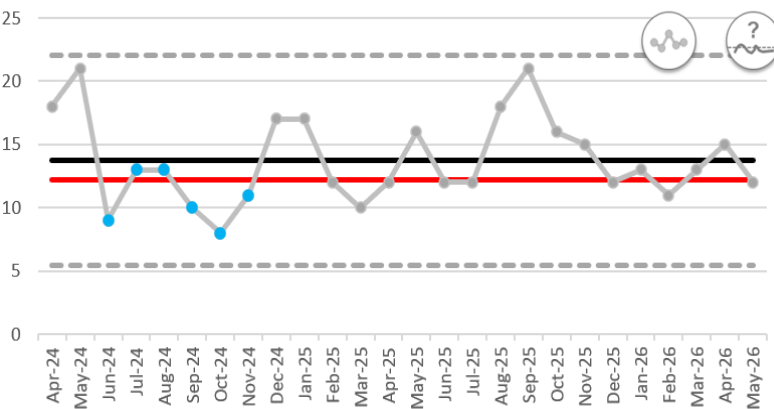
MRSA - HOHA & COHA



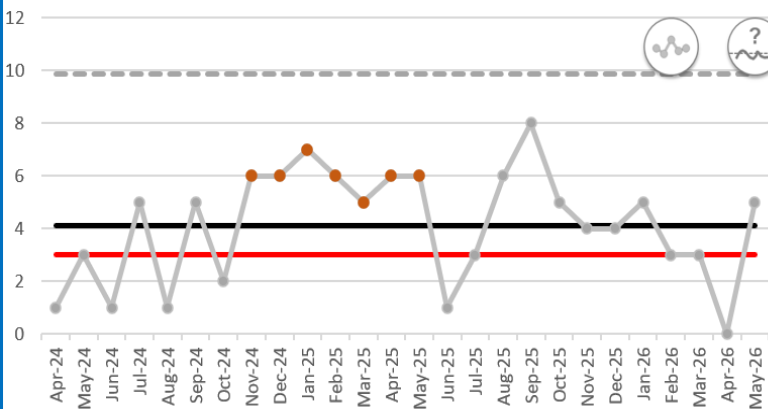
C. difficile - HOHA & COHA



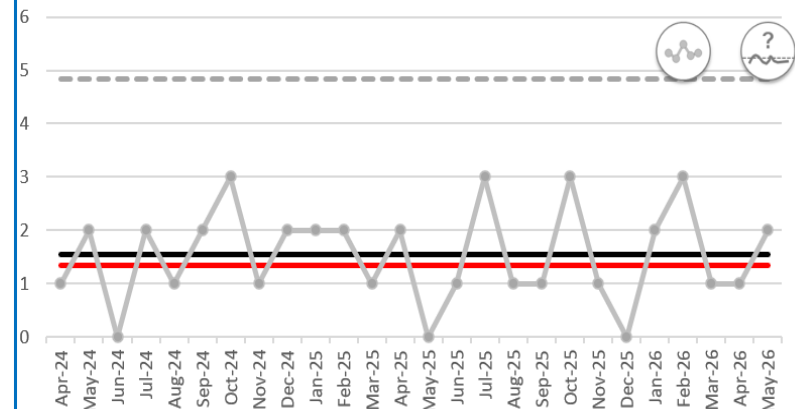
E. coli - HOHA & COHA



Klebsiella - HOHA & COHA

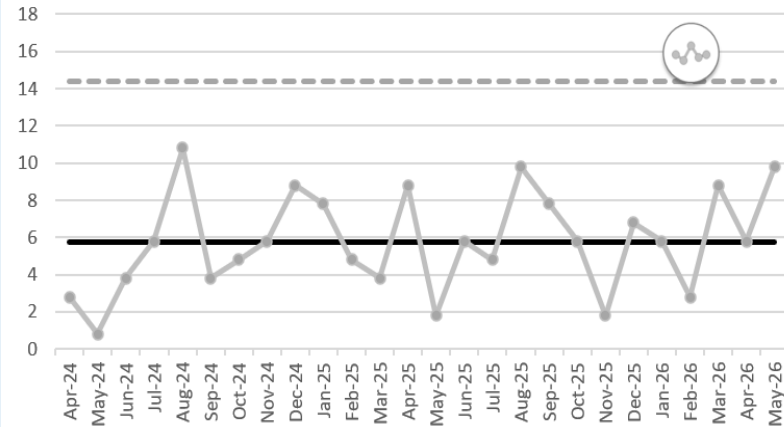


Pseudomonas aeruginosa - HOHA & COHA

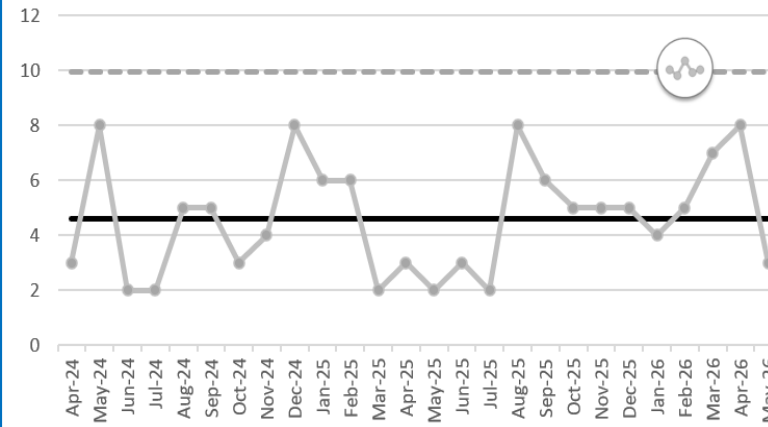


Infection prevention and control

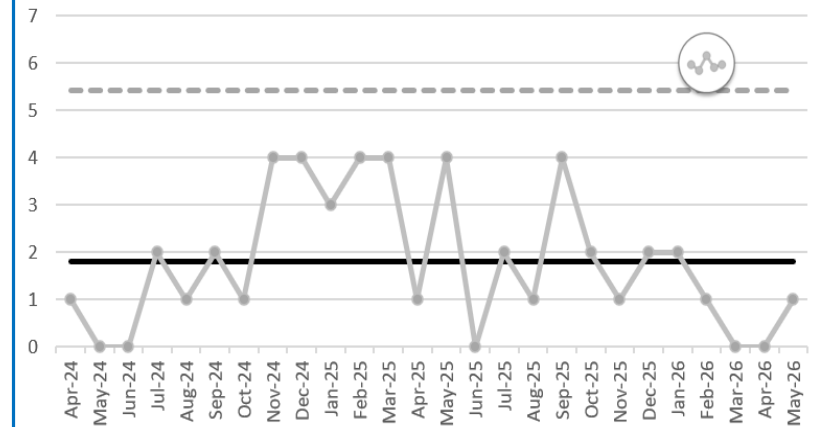
C. difficile - HOHA



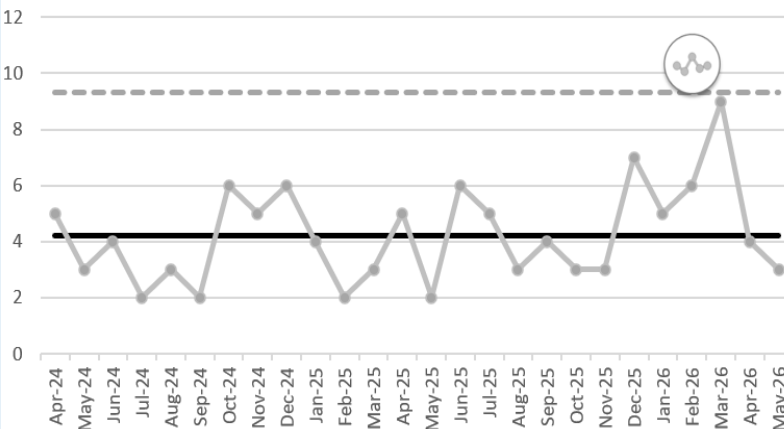
E. coli - HOHA



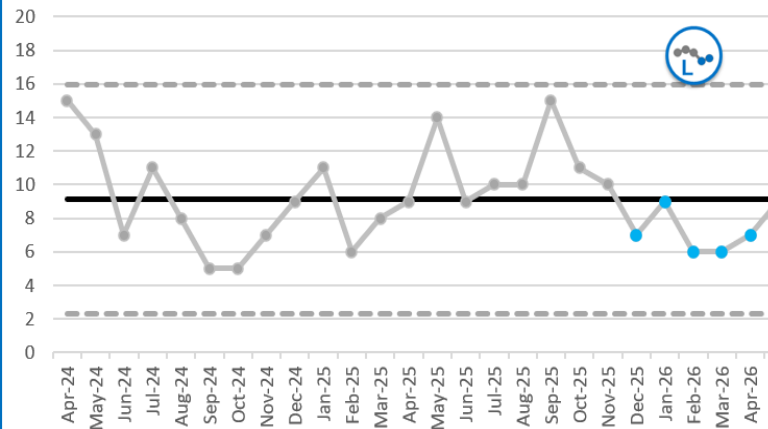
Klebsiella - HOHA



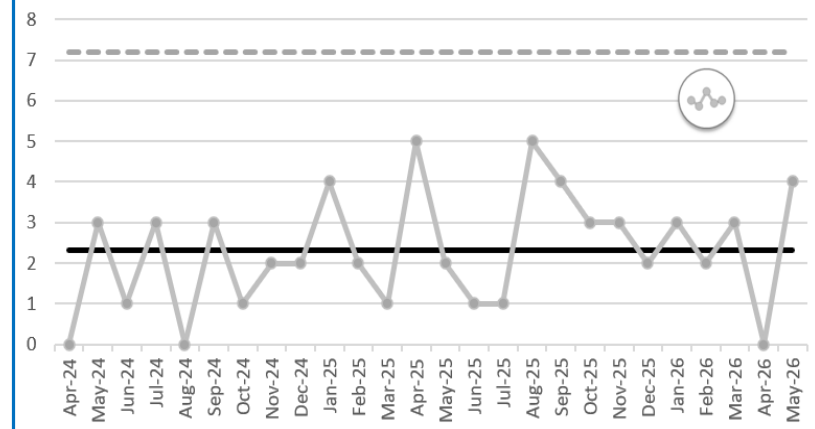
C. difficile - COHA



E. coli - COHA



Klebsiella - COHA



Infection prevention and control

Summary:

In May 2026 there were the following infections:

- 13 C. diff cases (10 HOHA, 3 COHA)
- 0 MRSA Bacteraemia
- 3 MSSA Bacteraemia (2 HOHA, 1 COHA)
- 12 E. coli Bacteraemia (3 HOHA, 9 COHA)
- 5 Klebsiella Bacteraemia (1 HOHA, 4 COHA)
- 2 Pseudomonas Bacteraemia (1 HOHA, 1 COHA)

Recovery actions:

- C.diff action plan ongoing. Deep clean programme commenced, wards S27, T9,T7 and T11 completed, Ward S23 in progress, program has stalled a number of times due to capacity. Decant ward (S18) planned to be available from 20th July to assist with program at RSH
- New Chief Nurse for Group, Martina Morris, has requested a new approach to the IPC action plans, and we will work to develop an overarching IPC action plan with senior teams and the improvement team.

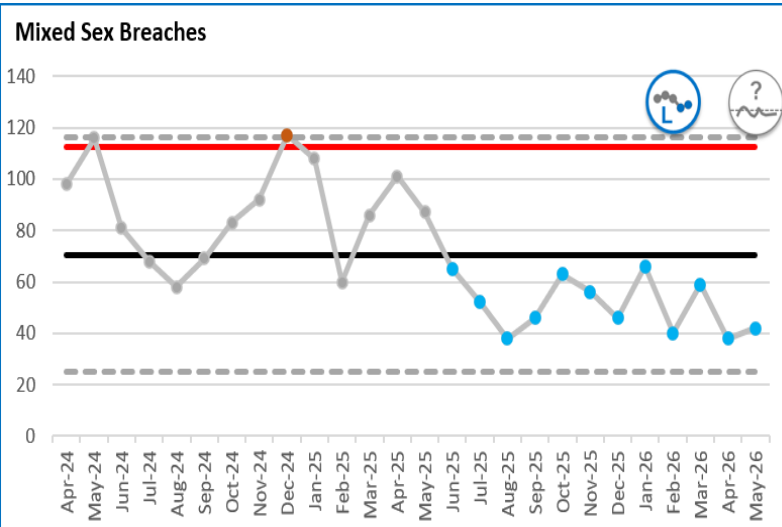
Anticipated impact and timescales for improvement:

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

Recovery dependencies:

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

Mixed sex accommodation breaches



Summary:

Whilst the total breaches across the Trust reflect a low special cause improving variation, May 2026 reflected a small increase in mixed sex breaches compared to the previous month. The increase reflected a rise within AAU (RSH) which had 20 mixed sex breaches, compared to 12 in the preceding month, whilst Critical Care reflect a reduction in May (22) compared to April (26).

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

Recovery actions:

- Ensure Trust's application of the MSA Policy is consistently applied across the Trust
- Improvement work in relation to patient flow, discharges earlier in the day, and a reduction in patients with no criteria to reside continues
- The opening of additional beds at RSH and additional assessment spaces at PRH will help in relation to not bedding in the assessment areas and the timelier step down of ITU patients
- The Clinical Site Team try to prioritise step down patients from ITU when this is possible
- All actions in place to ensure patients comfort and dignity is maintained when AAU is used
- Reconfiguration of Apley beds (PRH) in February 2026
- Extended Discharge Lounge hours (07:00 to 22:00) from January 2026

Anticipated impact and timescales for improvement:

- Beds available earlier in day
- Reduction in no criteria to reside patients in hospital
- Patients cared for in the most appropriate environment to meet their needs
- The March sprint in March 2026 to support ED transfers.
- Clinician at the front door trial (ED, PRH) March to May 2026.

Recovery dependencies:

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

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	3 primary	3 Medical
AAU (RSH)	20	over 5 occasions
ITU / HDU (RSH)	19 primary	3 Medical, 14 Surgical, 2 T&O



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

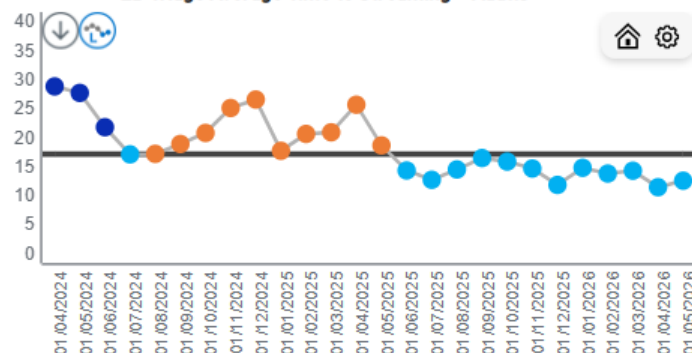


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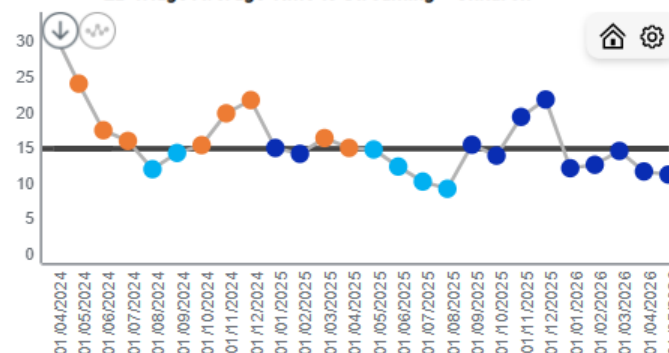
Best Clinical Outcomes

	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
ED Triage Average Time To Streaming - Adults	20.63	20.91	25.67	18.65	14.33	12.73	14.51	16.48	15.86	14.67	11.85	14.79	13.81	14.29	11.45	12.57
ED Triage Average Time To Streaming - Children	14.17	16.40	15.00	14.79	12.37	10.25	9.23	15.46	13.91	19.40	21.85	12.14	12.62	14.58	11.68	11.24
% Patients seen within 15 minutes for initial assessment	61.49	57.31	54.58	60.71	71.30	74.36	72.31	65.30	65.21	64.58	71.37	68.46	69.89	68.48	76.07	72.26
Friends and Family Test - A&E - % responded Very Good/Good	77.70	77.00	64.94	51.67	57.58	63.00	33.33	62.15	67.60	70.47	71.14	72.20	70.86	71.47	77.28	74.72
Friends and Family Test - A&E - Response Rate %	1.00	0.40	0.58	0.43	0.25	0.70	0.14	1.37	5.00	6.24	6.21	7.40	7.11	6.61	7.72	7.73
Complaints by Theme - Admission / Discharge	18	20	25	16	18	25	27	16	19	23	24	34	27	26	25	26

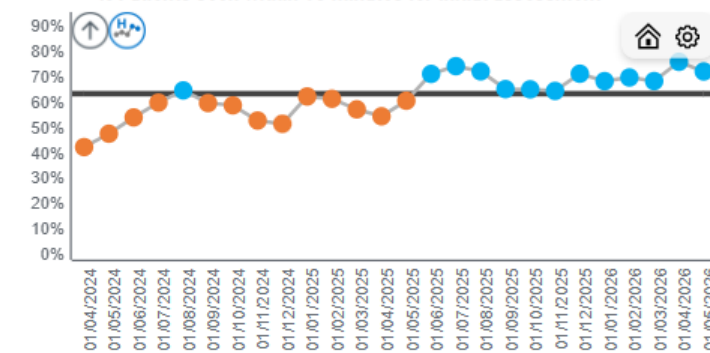
ED Triage Average Time to Streaming - Adults



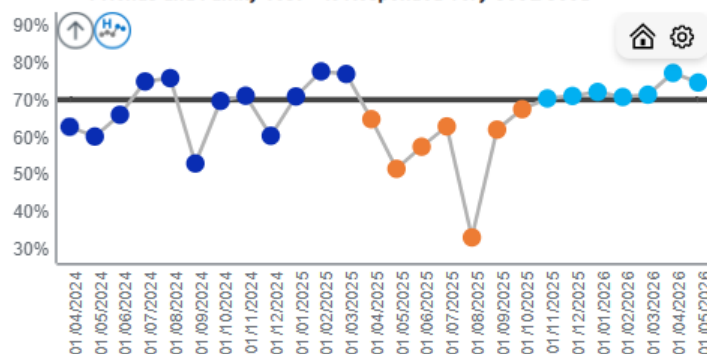
ED Triage Average Time to Streaming - Children



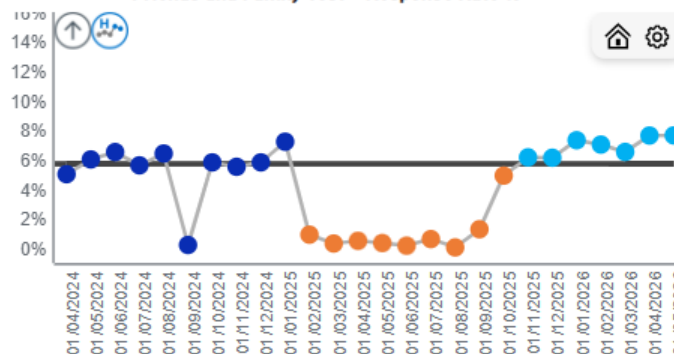
% Patients seen within 15 minutes for initial assessment



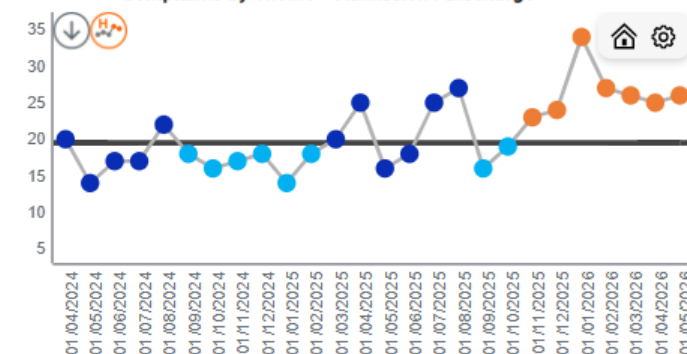
Friends and Family Test - % Responded Very Good/Good



Friends and Family Test - Response Rate %



Complaints by Theme - Admission / Discharge





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



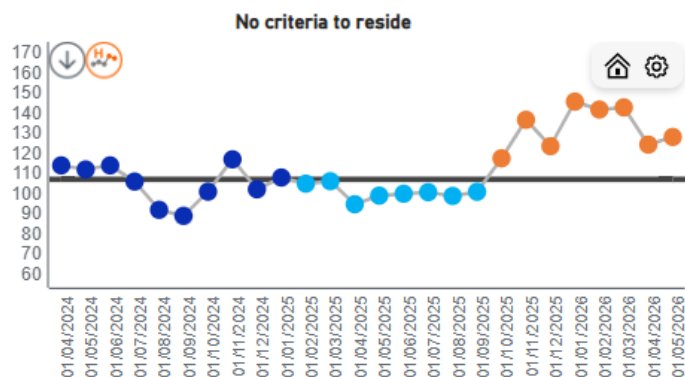
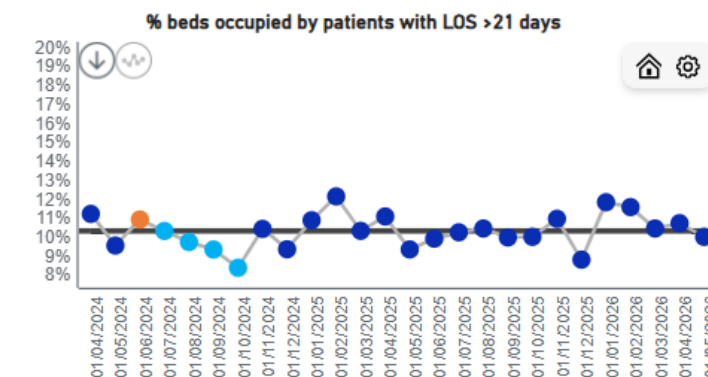
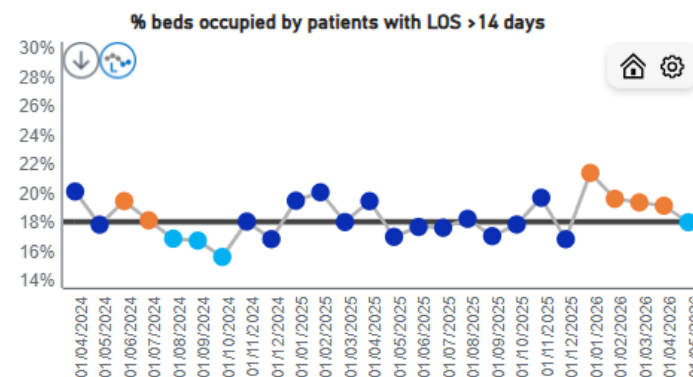
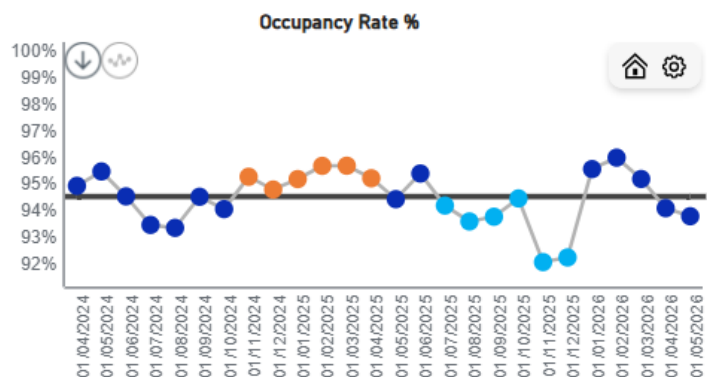
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Best Clinical Outcomes



	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
Occupancy Rate %	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	95.20	94.11	93.81
% beds occupied by patients with LOS > 14 days	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	19.41	19.18	18.05
% beds occupied by patients with LOS > 21 days	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	10.47	10.75	10.02
No criteria to reside	108	105	106	95	99	100	101	99	101	118	137	124	146	142	143	124	128

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Diabetic foot

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 a foot assessment within 6 hours of admission. 60% (improved from 10% 2024) of PWD have a compulsory foot assessment within 24 hrs. People with diabetes foot ulcer should have MDFT referral within 24 hours of finding the wound. 67% (Improvement from 42%) of PWD with wounds were referred to the Multidisciplinary Foot Team (MDFT). People at high risk of developing a hospital acquired foot problem should be issued with heel offloading. Only 53% (improved from 13%) of high risk PWD were issued heel offloading.

Current wait time from referral to appointment has increased in the foot clinic due to staffing issues. This is an increased duration (4.7% within 72 hours and 59.4% within 13 days down from 80.9% last month). More than 70% of new ulcers should receive first expert assessment within 0-13 days by 2026 – we have not achieved this, this month.

Increased patient numbers and staffing issues have meant reduction of Podiatry ward visits and inability to see urgent referrals – who have been signposted to A & E instead.

Recovery actions:

- Heel offloading available on ward – Heel boot available to order on wards – complete
- Hot clinics introduced for A&E and UCC for quick access to multidisciplinary team (MDT) clinic
- New online documentation for admissions - has been taken through the document group, this will lead to easier audit and targeted ward education
- Quick access to outpatients with new diabetes foot complication's introduction of Hot phone complete
- Introduction of integrated orthopaedic prevention clinic for diabetes foot patients – complete
- Lift the sheet check the feet education campaign & annual wound conference introduced – complete
- Inhouse Diabetes Podiatry team (Complete)
- Safety team will compile monthly reports on diabetes foot. This will be cross linked with treatment list. Requested SQL report to be shared
- Introduction of mirrored cards for all necessary staff with Achilles' tool – In process
- New NHS England QOF indicator (DM037) require all GP surgeries to complete all 8 care processes including foot screening. This will be incentive for GPs not currently undertaking this March 26
- Due to increased demand and staffing issues, a business case is needed for a further Podiatrist (In process)

Anticipated impact and timescales for improvement:

Business Case agreed. Staff in post (Nov 2025) since then there has been increased demand that is now not being met. Requires further business case.

Reaudit of inpatient data to show anticipated improvement in statistics nearing NICE guidance standards July 2026.

Root Cause analysis of all diabetes foot amputations highlighting gaps in care and areas of improvement July 2026.

Audit of diabetes foot wound categorisation and reporting – in progress linking with TVNs.

Priority is reducing hospital spells for diabetes foot issued to 15 per 100k population and the relative number of diabetes lower limb amputations by 11 K per 100k population by 2025.

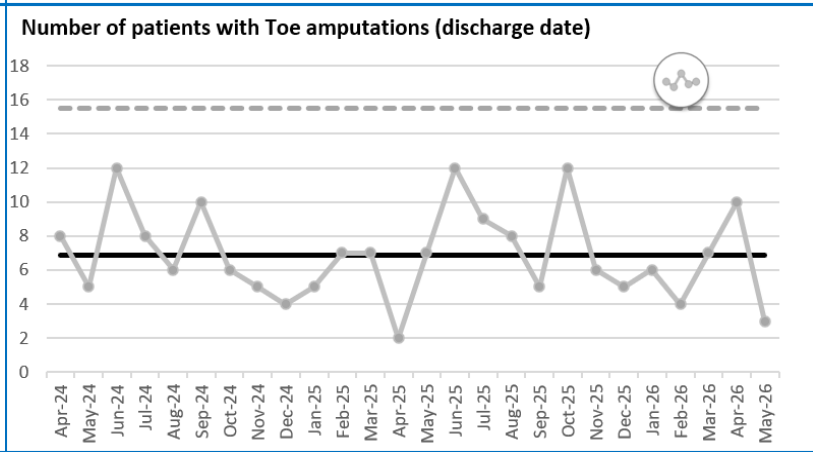
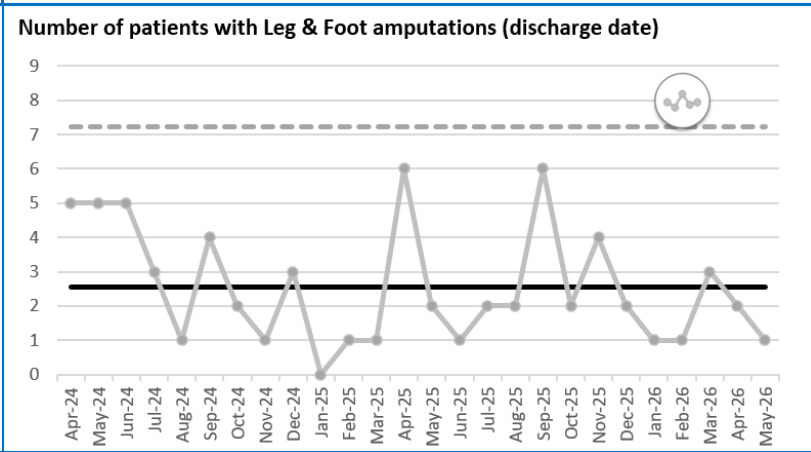
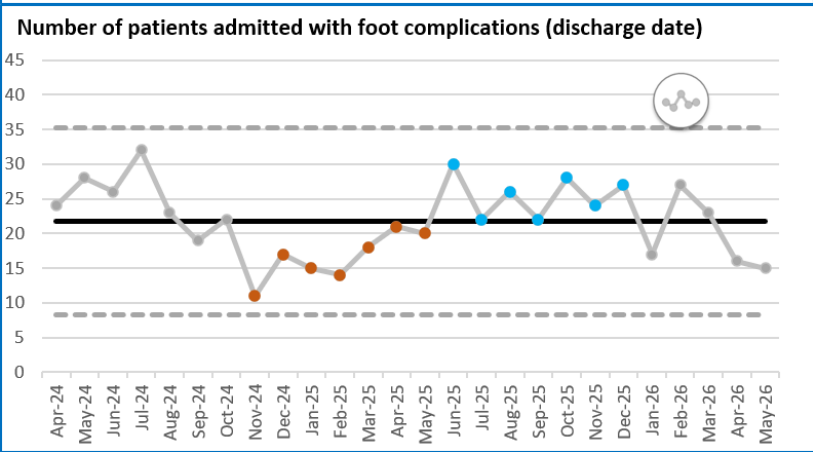
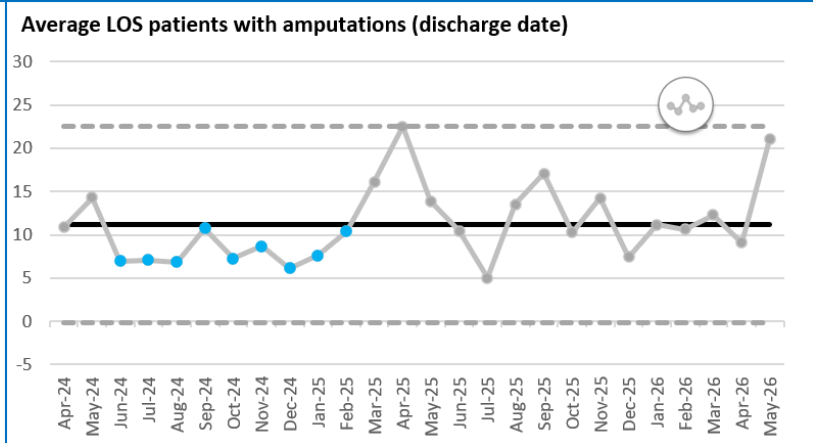
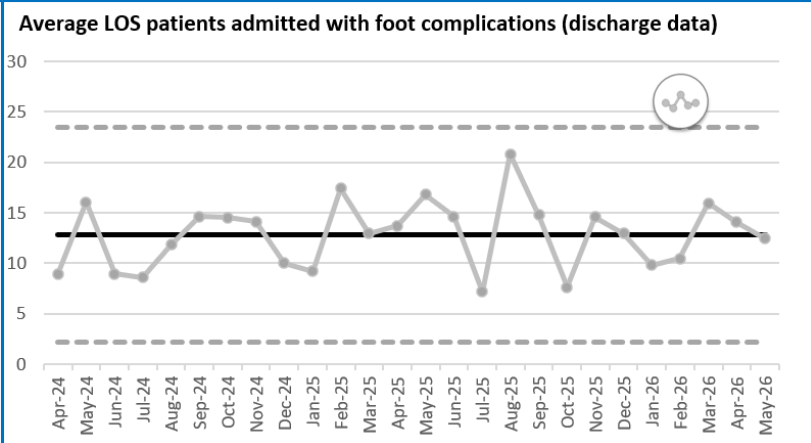
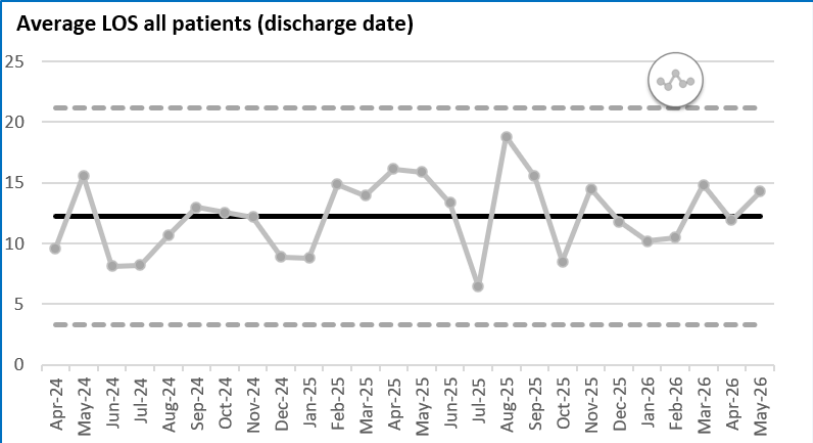
Anticipated impact improvement in Diabetes foot pressure ulcers / hospital acquired diabetes foot ulcers

Recovery dependencies:

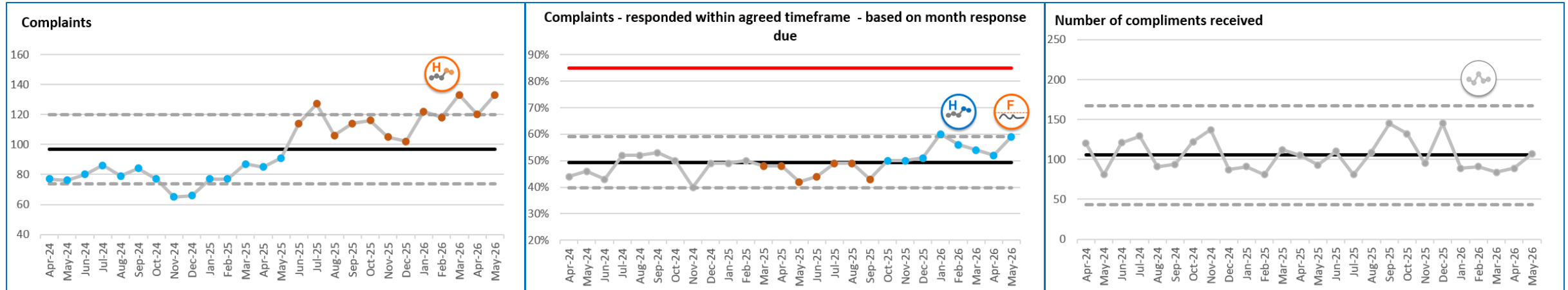
Ownership of new documentation and education for diabetes foot at ward and matron level

Diabetes foot screening must be undertaken in primary care, foot protection in community reducing clinical need in Acute service

Diabetic foot



Complaints and compliments



Summary:

The Trust continues to receive higher numbers of new complaints. The Complaints Team are ensuring that all complaints are managed and acknowledged within three working days and sooner where possible. They continue to work closely with the Divisions to manage this increase and to ensure responses are sent in as timely a way as possible, although this is challenging with the numbers of new cases. Improvements in response rates are being maintained, and the improvement in reducing the amount of time that cases remain open continues.

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.

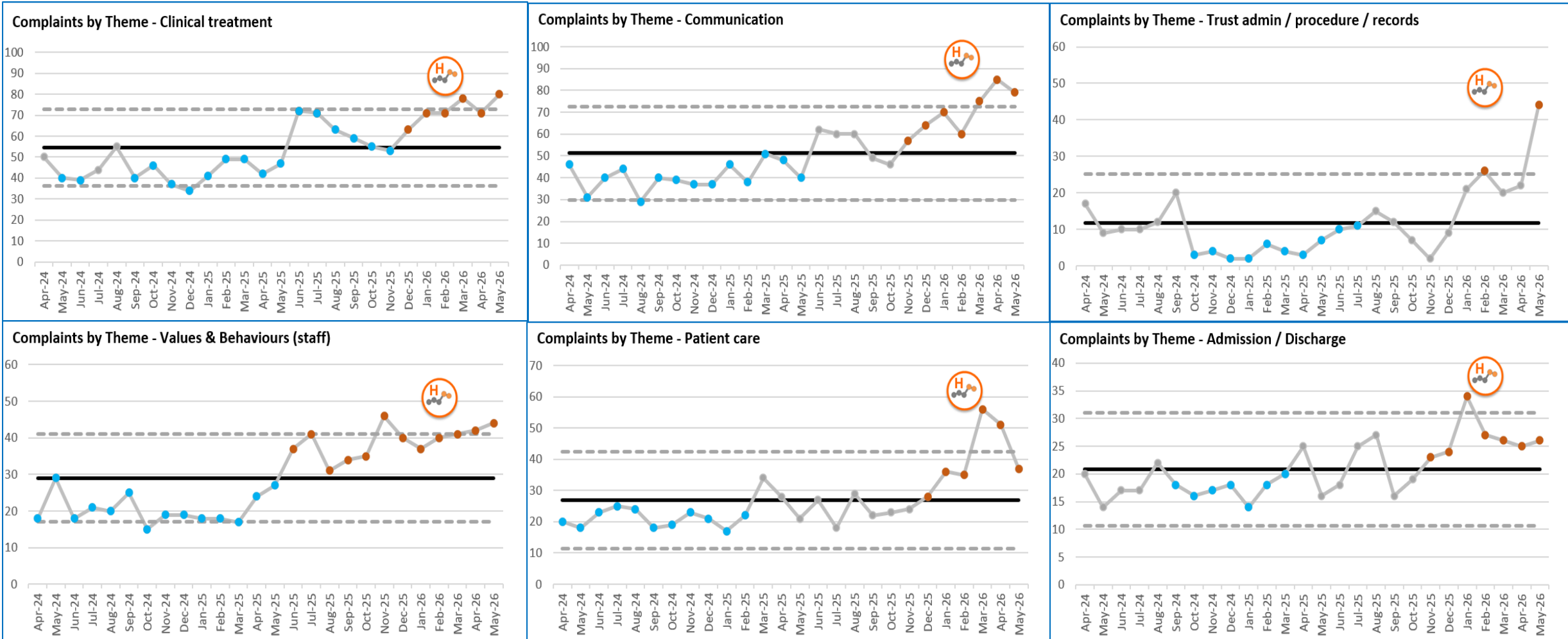
Anticipated impact and timescales for improvement:

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. The PALS team continue to have significant staffing challenges which will impact on the ability to deal with issues before they become a formal complaint.

Complaints by theme – Top 6





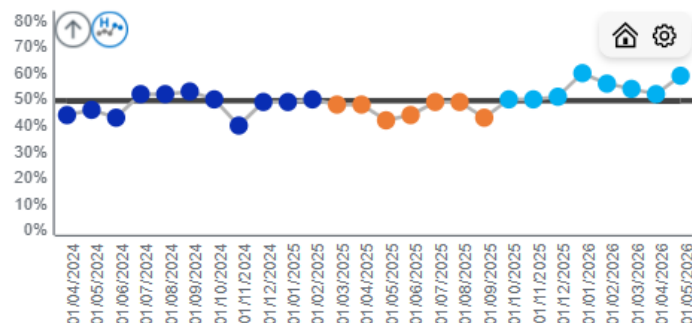
Quality - Patient Experience - Learning from Experience

End of Life Care

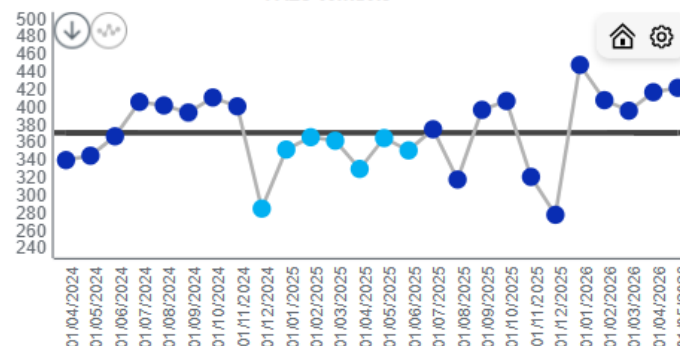
Apr-2025 May-2025 Jun-2025 Jul-2025 Aug-2025 Sep-2025 Oct-2025 Nov-2025 Dec-2025 Jan-2026 Feb-2026 Mar-2026 Apr-2026 May-2026

Complaints - % Responded to within agreed timeframe based on month response due	48	42	44	49	49	43	50	50	51	60	56	54	52	59
PALS contacts	330	365	351	375	318	397	407	321	278	448	408	396	417	422
Complaints by Theme - Staff	79	78	115	108	106	91	89	113	121	124	114	133	137	132
Re-opened complaints upheld	0	0	0	1	0	1	0	0	0	0	0	0	0	0
Compliments Received	105	93	110	81	109	145	132	95	145	89	91	84	89	107
Friends and Family Test % recommenders	97.1	93.2	96.8	88.3	92.4	79.8	73.7	77.1	76.1	76.0	75.0	75.4	80.3	78.7

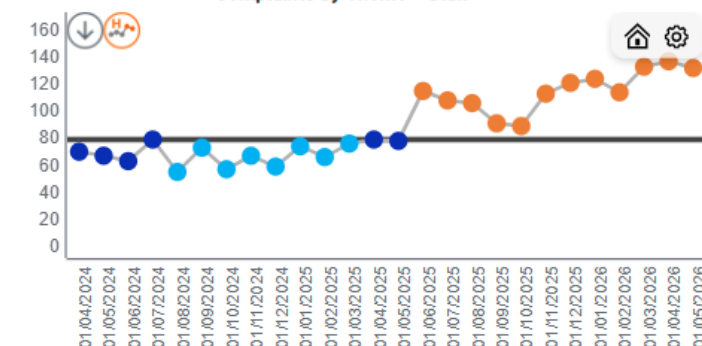
Complaints - % Responded to within agreed timeframe based on month response due



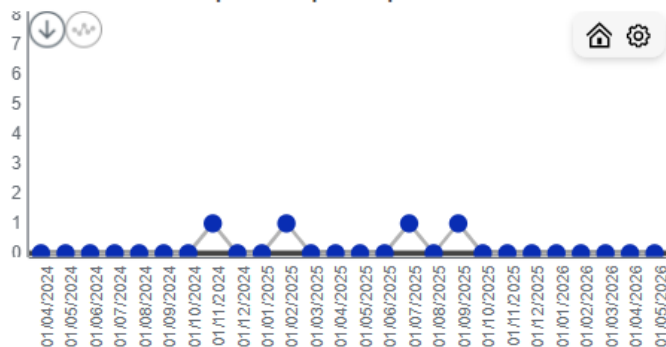
PALS contacts



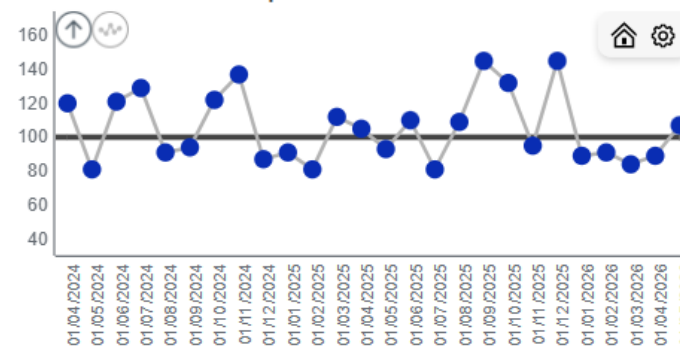
Complaints by Theme - Staff



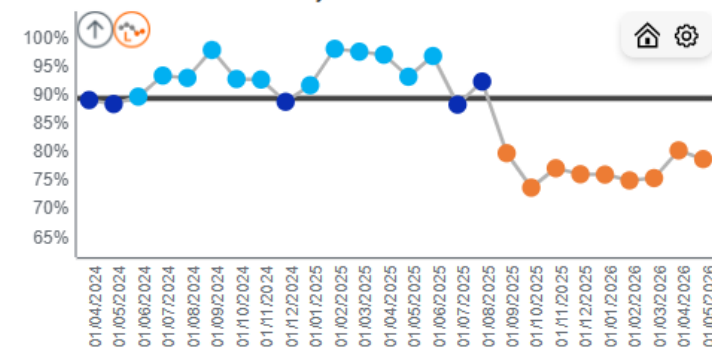
Re-opened complaints upheld



Compliments Received

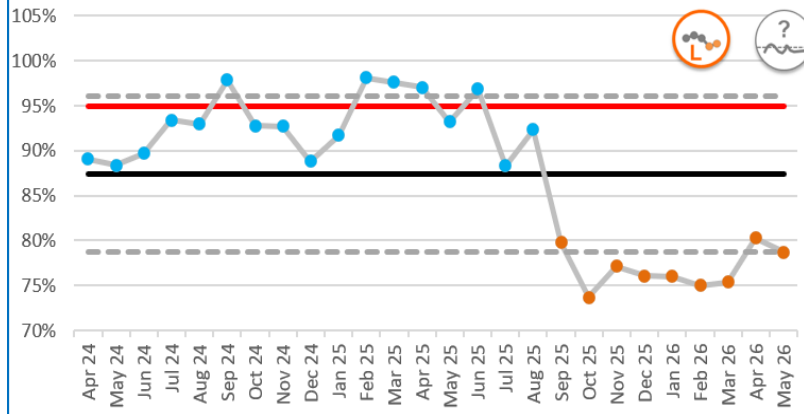


Freinds & Family Test % recommenders

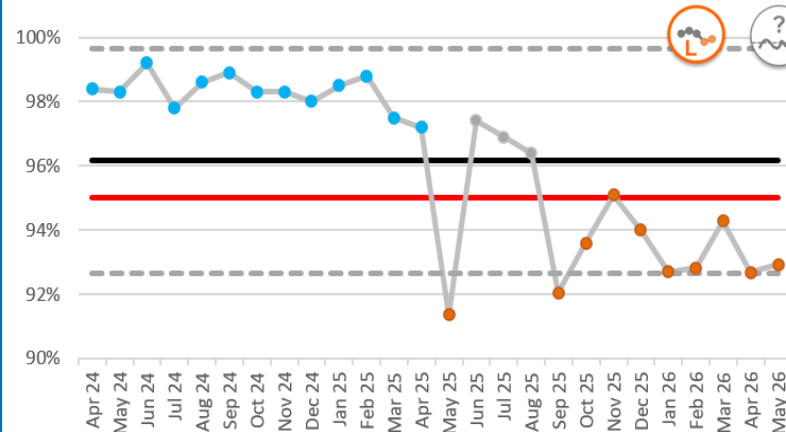


Friends and family test

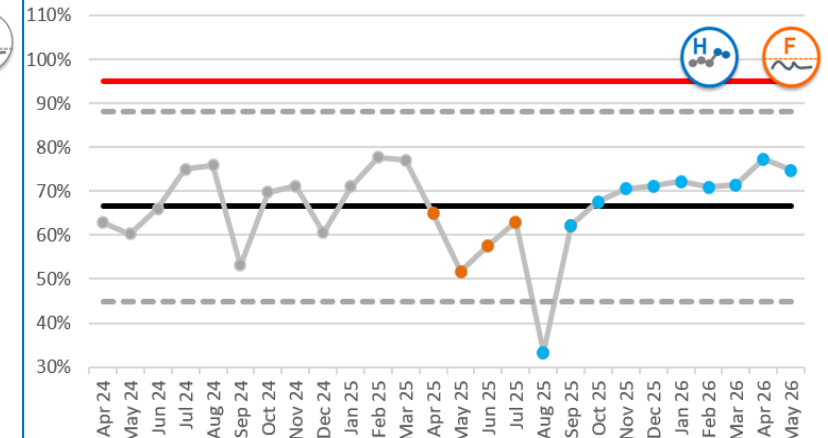
Friends and Family Test - SaTH



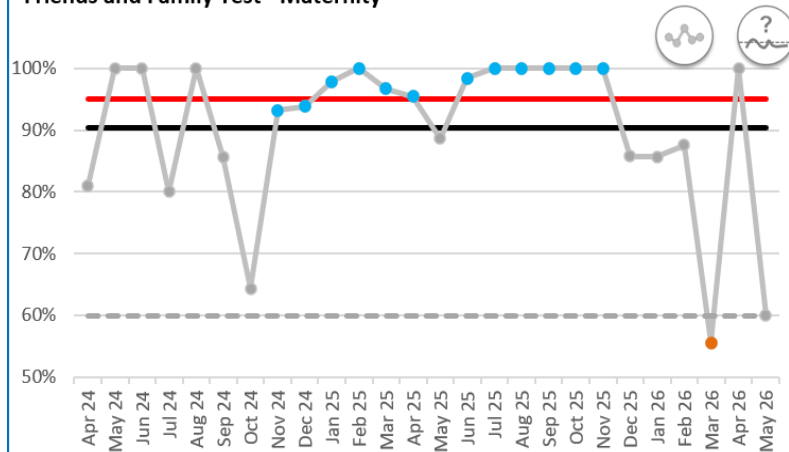
Friends and Family Test - Inpatient



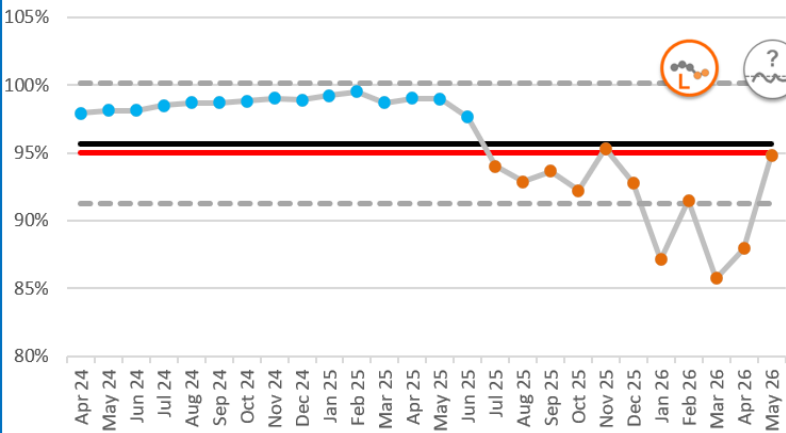
Friends and Family Test - A&E



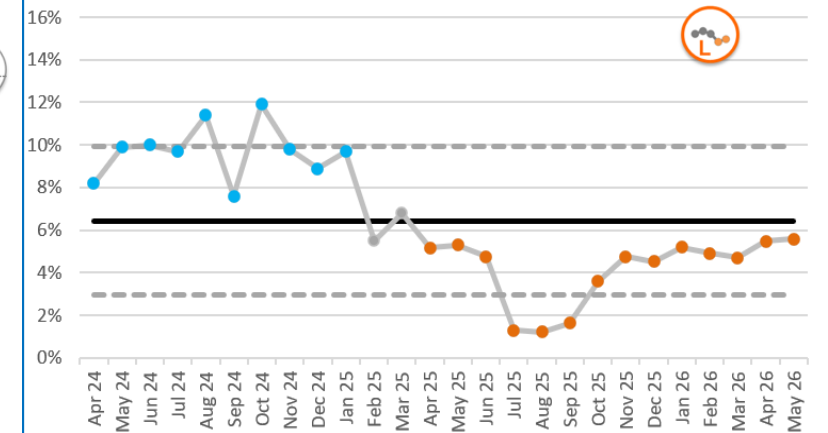
Friends and Family Test - Maternity



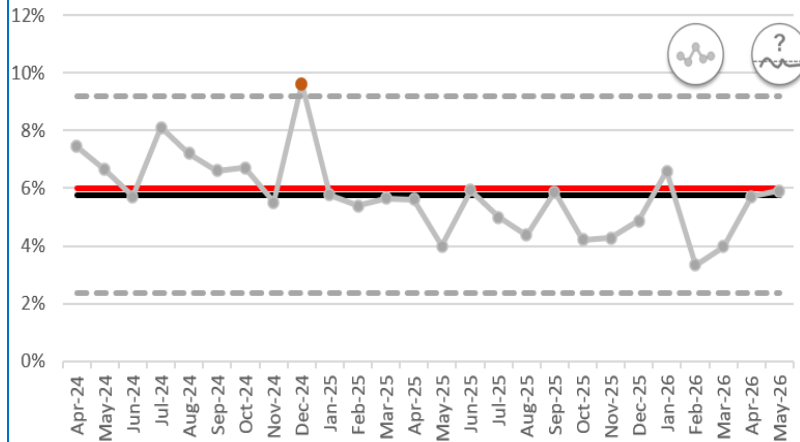
Friends and Family Test - Outpatients



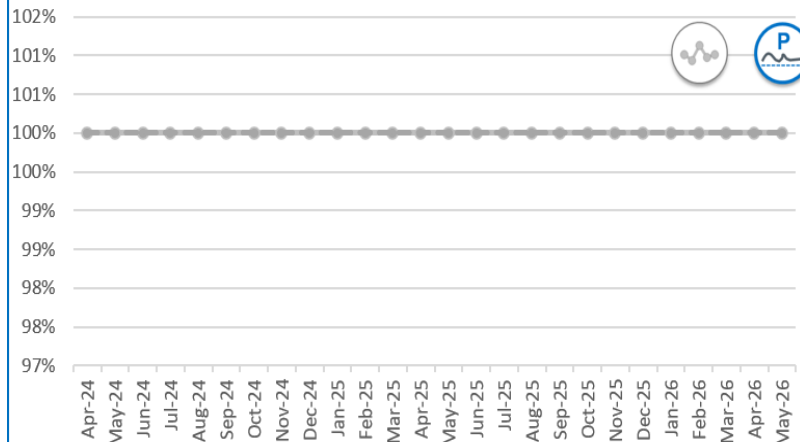
Friends and Family Test - SaTH Response rate %



Smoking rate at Delivery



One to One Care in labour



Summary:

May performance of SATOD has risen slightly to 5.9% from 5.7% in April, however, remains below the Government target of 6%.

Due to the increase in smokers at delivery for April and May, HPSS conducted a deep dive looking at potential barriers to quitting smoking such as social deprivation and mental health concerns.

The report (presented at Maternity Governance) highlighted the highly complex needs of women delivering over this period and their barriers to quitting. SATOD rates will continue to be closely monitored.

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

Recovery actions:

Continue to further decrease SATOD into 2026/27.

Continue to exceed Government target of 6%.

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

Anticipated impact and timescales for improvement:

Continue to target areas of deprivation and refer family members to local smoking cessation services. The biggest barrier to pregnant women quitting smoking is having a partner who smokes.

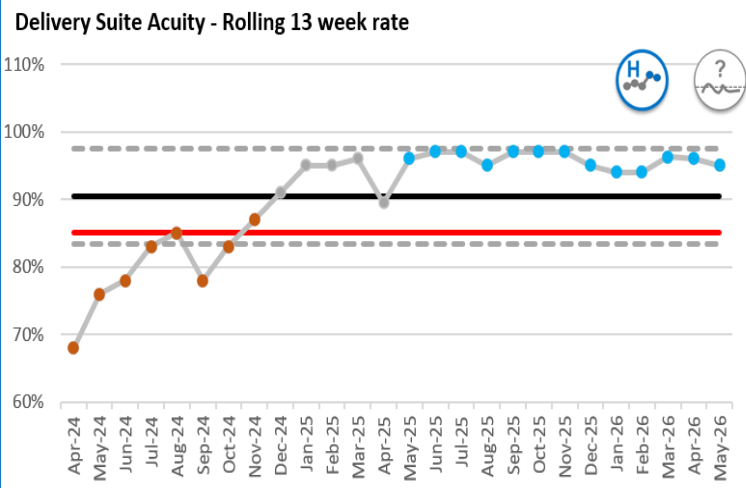
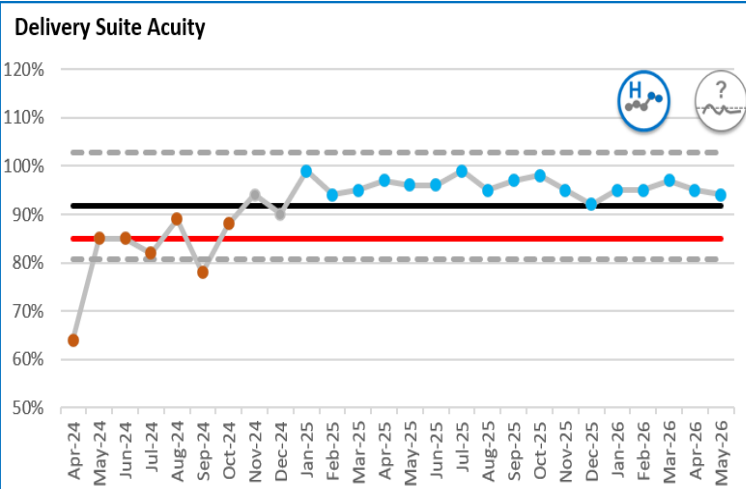
As per Saving Babies Lives, all Maternity staff are trained to offer very brief advice (VBA) and smoking cessation referral at every appointment.

Carbon Monoxide monitoring is completed at every routine antenatal appointment.

Recovery dependencies:

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

Maternity – delivery suite acuity



Summary:

Delivery suite acuity continues to be maintained above the National target above 85% and has been consistently above 90% since January 2025 with March acuity reported at 94%. 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

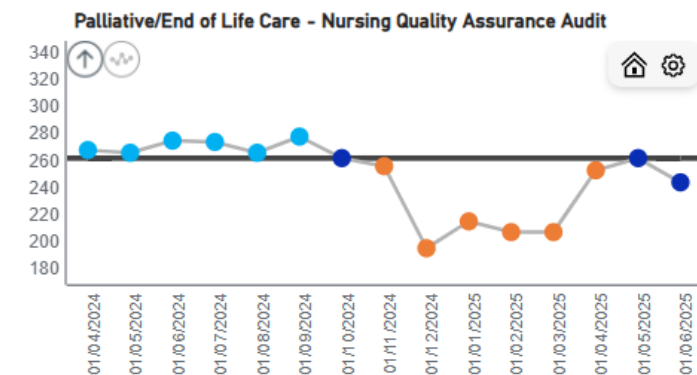
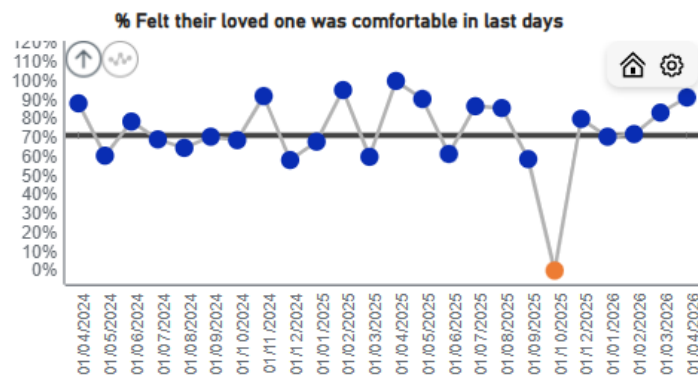
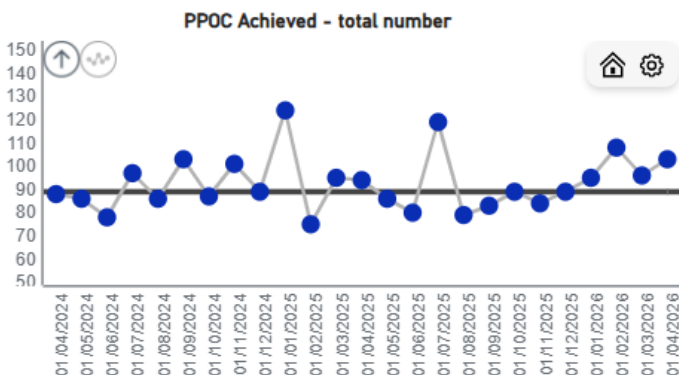
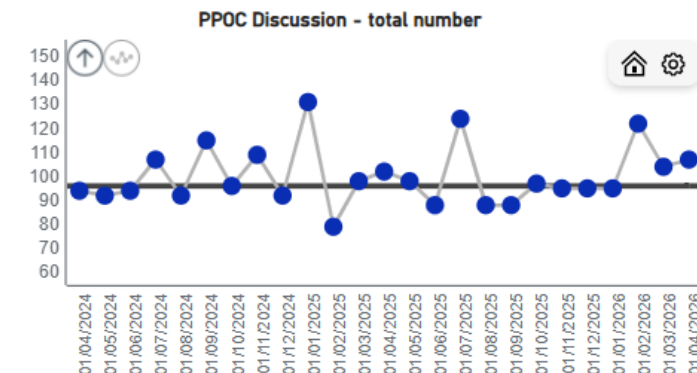
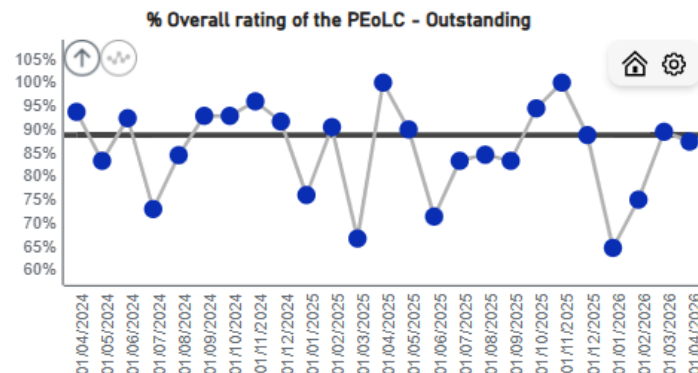
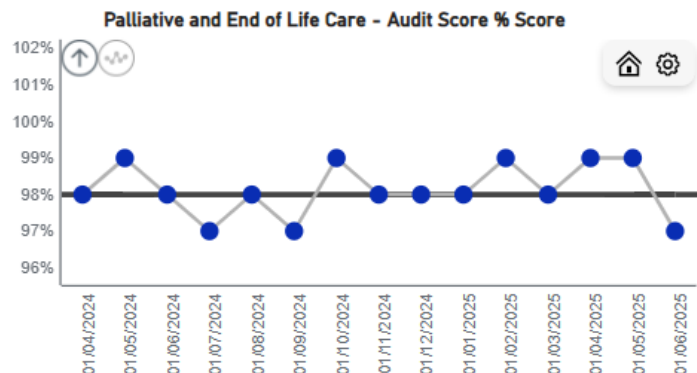


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Learning from Experience



	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
Palliative and End of Life Care - Audit Score % Score	98	98	99	98	99	99	97										
% Overall rating of the PEoLC - Outstanding	91.7	76.0	90.5	66.7	100.0	90.0	71.4	83.3	84.6	83.3	94.5	100.0	88.8	64.7	75.0	89.5	87.4
PPOC Discussion - total number	92	131	79	98	102	98	88	124	88	88	97	95	95	95	122	104	107
PPOC Achieved - total number	89	124	75	95	94	86	80	119	79	83	89	84	89	95	108	96	103
% Felt their loved one was comfortable in last days	58.3	68.0	95.2	60.0	100.0	90.5	61.5	86.7	85.7	58.8	0.0		80.0	70.6	72.0	83.3	91.3
Palliative/End of Life Care - Nursing QA Audit	195	215	207	207	253	262	244										





Quality - Patient Experience - End of Life Care



Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



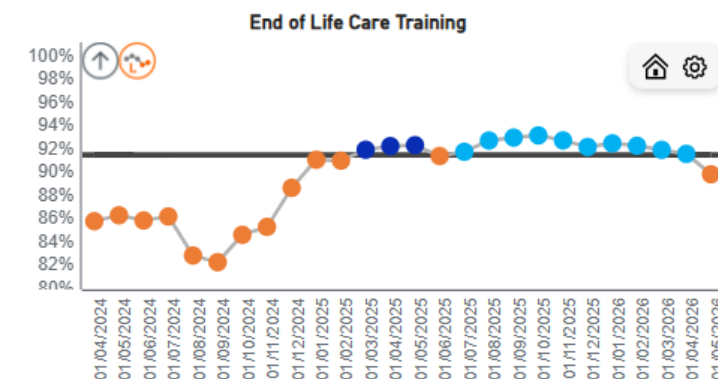
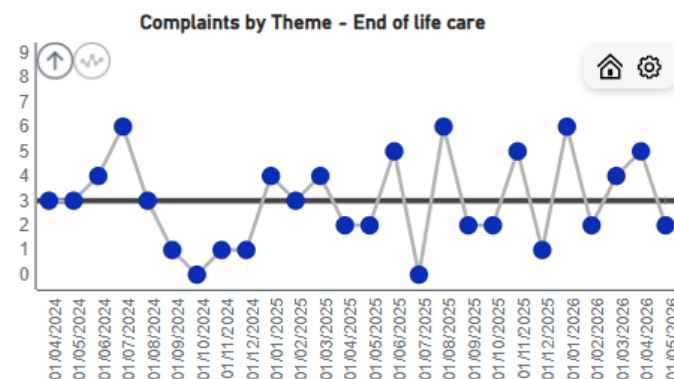
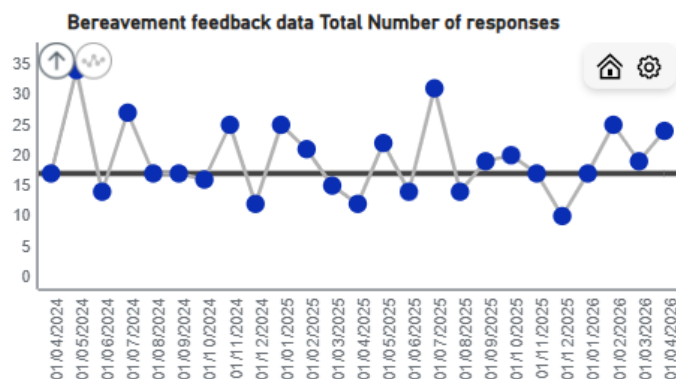
Page 1

Learning from Experience



	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026
Bereavement feedback data - Total Number of responses	25	21	15	12	22	14	31	14	19	20	17	10	17	25	19	24	
Complaints by Theme - End of life care	4	3	4	2	2	5	0	6	2	2	5	1	6	2	4	5	2
End of Life Care Training	91.03	90.95	91.89	92.20	92.28	91.35	91.71	92.68	92.93	93.12	92.69	92.13	92.44	92.23	91.88	91.53	89.78

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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:

There is an overarching PEOLC improvement action plan and a PEOLC dashboard reviewed monthly at the PEOLC Steering Group enabling early identification of actions to maintain or improve compliance.

PEOLC complaints are discussed at the Steering Group, themes relating to communication around end-of-life care continue.

PEOLC ward support programme which supports wards with all aspects of PEOLC.

Small number of patients included in the Nursing Quality Assurance audits can affect the results of these audits. Action to ensure all matrons in ward areas caring for PEOLC patients are completing audits is ongoing.

Anticipated impact and timescales for improvement:

Ongoing monitoring via PEOLC Steering Group to ensure improvements are sustained

Recovery dependencies:

N/A

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:

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

Anticipated impact and timescales for improvement:

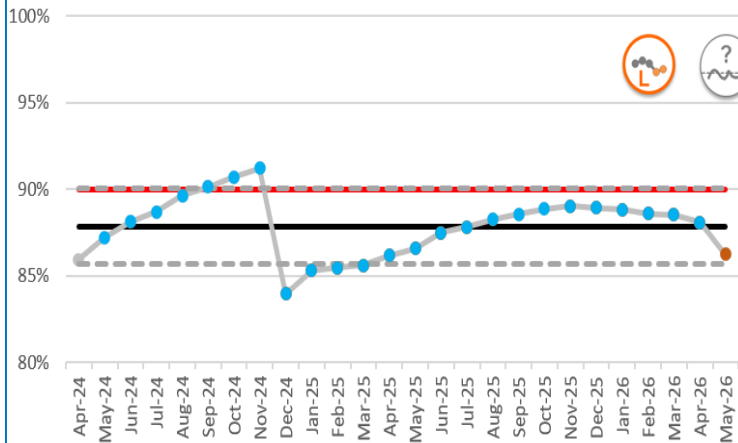
- Improved legal compliance, increased understanding of the Mental Health Act (1983) will reduce the risk of unlawful detention, invalid paperwork and failures in giving patients their rights
- Up to date DMI competencies will lower the risk of harm to patients and staff
- Increased workforce confidence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

Recovery dependencies:

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

Learning disability and/or Autism

Oliver McGowan Training



Summary:

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

Recovery actions:

- Oliver McGowan e-learning training is at 88.6%
- A Trust wide plan for delivery of the T1 and 2 training is now in place with plans to provide training for 3,000 staff in 2026/27
- LD and Autism Patient Experience Group now meeting regularly with good attendance and outputs including launch of patient packs for emergency attenders containing sensory items and easy read information
- Work ongoing to embed the patient passport and raise awareness of reasonable adjustments
- Stronger communication now in place for cases where MCA/BI requires collaborative working
- Oliver McGowan added to the mandatory training requirements for all locum and short-term medical staff
- Reasonable Adjustment Digital Flag implementation plan underway
- Full review and update of the LD policy has been completed
- LD Self Improvement Tool completed and associated improvement plan being actioned
- Targeted improvement work underway within ED
- LD and Autism Improvement Group planned to be joint with SCHT from Q1
- Group pledge poster co-produced at the patient experience group to be displayed in clinical areas

Anticipated impact and timescales for improvement:

These are ongoing actions through 2025/26 and assessment in relation to progress will be made quarterly throughout the year

Recovery dependencies:

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

Responsiveness

Executive Lead:

Chief Operating Officer
Ned Hobbs

Integrated Performance Report

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Domain	Description	National Standard / Plan	Current Month Trajectory (RAG)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Trend
Responsiveness	ED - 4 Hour Performance (SaTH Type 1 & 3) %	65.42% Mar27	60.1%	53.1%	52.7%	52.1%	53.8%	54.2%	53.6%	52.0%	51.3%	51.9%	52.8%	56.6%	52.9%	51.6%	
	ED - 4 Hour Performance (All Types inc MIU) %	70.93% Mar27	67.0%	62.4%	62.8%	61.1%	63.4%	62.7%	61.7%	60.1%	60.1%	60.8%	61.5%	65.0%	62.4%	61.5%	
	ED - 4 Hour Performance (SaTH Type 1) %	59.01% Mar27	53.0%	45.7%	45.4%	45.6%	45.6%	46.3%	45.5%	43.8%	43.2%	43.9%	45.1%	49.1%	44.8%	43.8%	
	ED - 4 Hour Performance (SaTH Type 3) %	90%	90.0%	83.4%	85.5%	80.9%	87.6%	87.1%	85.9%	83.7%	85.9%	85.4%	86.0%	91.7%	90.6%	87.7%	
	ED - Paediatric 4 Hour Performance (SaTH Type 1 & 3) %	87% Mar27	85.1%	81.4%	85.1%	83.5%	86.6%	84.6%	78.9%	75.2%	82.2%	81.7%	81.0%	84.6%	80.6%	79.4%	
	ED - 12 Hour Trolley Breaches	0	0	1334	1407	1300	1492	1618	1453	1429	1601	1366	1173	1026	949	1171	
	Number of Ambulance Arrivals	-	3469	3335	3484	3392	3041	3210	3221	3373	3294	3103	3412	3371	3473	3223	
	Average ambulance handover time (ED and non-ED)	00:45:00	00:50:00	01:06:14	00:45:38	00:50:09	01:25:24	01:21:39	01:23:23	01:35:52	01:35:15	01:13:47	00:46:02	00:25:42	00:28:20	00:28:50	
	Ambulance handovers > 15 minutes	-	2602	2544	2509	2557	2488	2647	2577	2691	2767	2549	2614	2103	1984	1683	
	Ambulance handovers > 15 minutes %	-	75.0%	76.3%	72.0%	75.4%	81.8%	82.5%	80.0%	79.8%	84.0%	82.1%	76.6%	62.4%	57.1%	52.2%	
	Ambulance handovers > 45 minutes	0	1006	1227	884	932	1335	1433	1332	1451	1585	1252	875	389	451	451	
	Ambulance handovers > 45 minutes %	0%	29.0%	36.8%	25.4%	26.7%	43.9%	44.6%	41.4%	43.0%	48.1%	40.3%	25.6%	11.5%	13.0%	14.0%	
	Ambulance handovers > 60 minutes %	0%	-	29.5%	19.9%	20.7%	37.9%	37.5%	35.3%	37.1%	40.3%	33.5%	19.7%	7.1%	8.8%	9.8%	
	ED activity (SaTH Type 1 & 3 excluding planned returns)	-	13848	13528	13638	13230	12951	13619	13361	13569	13020	12275	14083	13806	14077	14387	
	ED Paediatric activity (SaTH Type 1 & 3 excluding planned returns)	-	2604	2492	2329	1940	2332	2415	2731	2856	2326	2370	2870	2693	2759	2800	
	ED activity (Type 1 excluding planned returns)	-	11190	10864	11143	10802	10445	10982	10683	10764	10549	9920	11446	11355	11573	11834	
	Total Emergency Admissions from A&E	-	-	3266	3322	3381	3301	3655	3614	3769	3659	3460	3838	3726	3777	3795	
	% Patients seen within 15 minutes for initial assessment	-	-	71.3%	74.4%	72.3%	65.3%	65.2%	64.6%	71.4%	68.5%	69.9%	68.5%	76.1%	72.3%	69.8%	
	Average time to initial assessment (mins)	15 Mins	15	13.9	12.2	13.6	16.3	15.5	15.8	14.2	14.2	13.5	14.4	11.5	12.3	14.1	
	Average time to initial assessment (mins) Adults	15 Mins	15	14.3	12.7	14.5	16.5	15.9	14.7	11.8	14.8	13.8	14.3	11.4	12.6	13.7	
	Average time to initial assessment (mins) Children	15 Mins	15	12.4	10.2	9.2	15.5	13.9	19.4	21.9	12.1	12.6	14.6	11.7	11.2	15.5	
	Mean Time in ED Non Admitted (mins)	-	215	304	292	291	293	292	294	298	304	281	269	244	257	275	
	Mean Time in ED admitted (mins)	-	500	1202	1127	1084	1227	1145	1121	1124	1213	1091	917	759	810	877	
	Percentages of attendances in A&E over 12 hours - Type 1	-	14.96%	22.04%	21.75%	21.94%	23.39%	23.27%	22.36%	22.01%	24.74%	22.35%	19.03%	16.77%	16.43%	19.17%	
	No. Of Patients who spend more than 12 Hours in ED - Type 1	-	1674	2394	2424	2370	2443	2555	2389	2369	2610	2217	2178	1904	1901	2269	
	Average instances of Corridor Care use in the Emergency Department	0	-	16.6	14.03	13.45	15.87	17.74	16.77	16.52	18.45	16.54	17.74	15.5	23.81	29.43	
	Average patients receiving Corridor Care in hospital at 8am	0	-	12.9	13.46	11.42	13.77	12.06	13.97	10.64	11.25	10.39	5.9	3.57	6.11	5.34	
	Bed Occupancy Rate - G&A (SitReps)	92%	94.96%	95.41%	94.21%	93.61%	93.79%	94.48%	92.09%	92.27%	95.57%	96.00%	95.20%	94.11%	93.81%	94.78%	
	Diagnostic Activity Total - All commissioners	-	24461	24625	26211	24973	24860	24881	22628	24080	24199	24198	26130	24016	24612	25711	
	Diagnostic Activity Total - English only	-	10918	11453	12013	11471	11634	12437	12437	12256	13037	14656	16010	15471	15188	15787	
	RTT Incomplete 18 Week Performance	70% Mar27	64.2%	54.9%	56.4%	58.8%	62.3%	64.0%	65.5%	64.1%	62.9%	63.1%	68.9%	69.1%	69.9%	69.7%	
	RTT Waiting list - Total size	-	-	42449	39438	37132	36022	36674	37997	36982	37910	37266	38063	38884	40292	41035	
	RTT Waiting list - English only	-	32867	37630	34742	32670	31652	32263	33621	32790	33637	33359	34275	35084	36456	37236	
	RTT 52+ Week Breaches (All)	0	-	1103	734	600	369	313	284	226	235	241	196	168	159	117	
	RTT 52+ Week Breaches - English only	-	0	718	444	305	125	84	68	20	31	47	0	0	0	0	
	RTT 40+ Week Breaches (All)	-	-	4757	3661	3001	2154	1741	1731	1830	1833	1769	1569	1683	1702	1677	
	RTT 40+ Week Breaches - English only	0	-	3876	2939	2318	1590	1223	1232	1330	1301	1288	1127	1208	1286	1330	
	RTT Total Waiting <18 Weeks - English Only	0	21109	20670	19581	19210	19717	20652	22018	21026	21148	21060	23615	24233	25466	25944	
	Cancer 62 Day Standard	77% Mar27	70.0%	62.6%	66.6%	68.8%	65.2%	71.4%	70.2%	70.1%	68.3%	75.0%	74.5%	71.2%	73.9%	-	
	Cancer 31 Day First Treatment	96%	94.0%	87.9%	94.7%	91.6%	94.2%	96.2%	95.5%	98.0%	96.2%	99.2%	97.6%	96.4%	98.6%	-	
	Cancer 28 Day Faster Diagnosis - combined	80% Mar27	80.0%	72.5%	75.5%	75.9%	80.1%	80.3%	85.7%	83.0%	80.2%	85.5%	86.0%	80.9%	82.5%	-	
	Theatre productivity	-	85%	80%	81%	81%	81%	80%	81%	81%	80%	81%	81%	80%	81%	80%	

Operational Executive Summary

SaTH ED - 4-hour performance (type 1 & type 3) remains in common cause natural variation in June 26. Type 1 performance decreased to 43.9%, and Type 3 performance decreased to 87.9%. Average ambulance handover time shows special cause improving variation in June and was better than plan with 86.4% of ambulance handovers within 45 mins. The number of Type 1 patients who spend more than 12 hours in ED shows special cause improving variation.

RTT - The submitted Trust Position for June 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP. The unvalidated Trust Position for Welsh is 0 x 104 weeks, 7 x 78 weeks, 34 x 65 weeks 117 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 June 2026 is 80%.

Cancer - Confirmed May cancer performance is 82.5% (28-day FDS) vs the local plan of 80%. 62-day performance was 73.9% against a local target of 70% and 31 day was 99% against national target of 96%. The 62-day backlog is 164 patients over 62 days of which 41 are over 104 days (as at 16/07/2026).

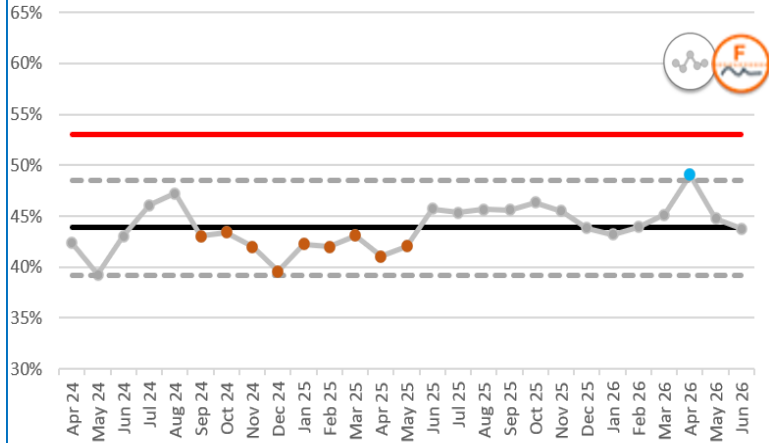
DM01 - The submitted DM01 position for June was 79.9%, with particular improved performance seen in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan implemented from mid-June. Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks.

Key actions

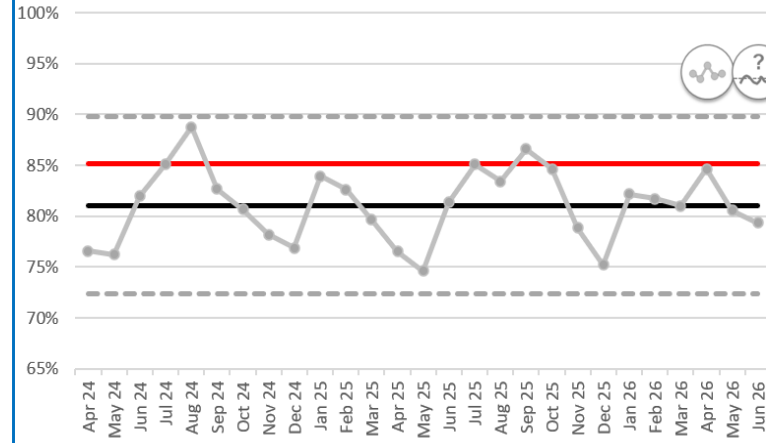
- Delivery partner discovery phase near completion with a focus on 4 hour Non-Admitted ED pathways and No Criteria to Reside processes
- Delivery phase being scoped to support accelerated improvement action
- Endoscopy productivity workstream having material reduction on number of insourced sessions used
- Outpatient productivity now focussed Single Point of Access rollout along with ICB & Primary Care Colleagues
- Diagnostic improvement programme now focussed on NOUS
- Q3 planned care additional activity plan downgraded to support trust financial position, reduction in Inpatient work at the weekend

Operational – Emergency Care

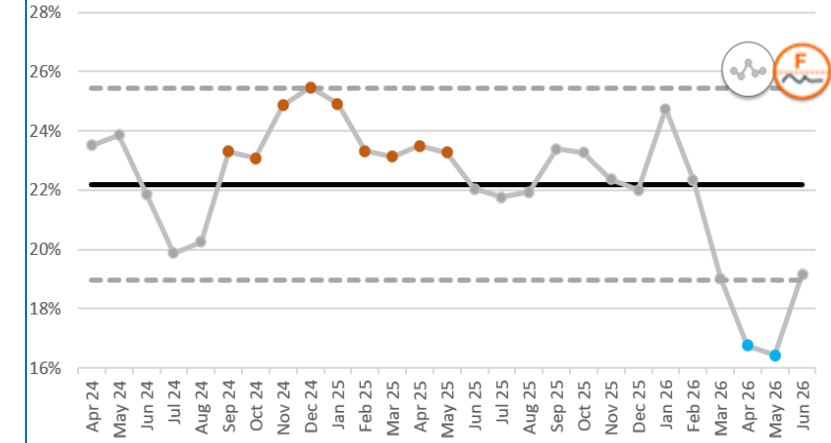
SaTH - ED 4 Hour Performance Type 1 %



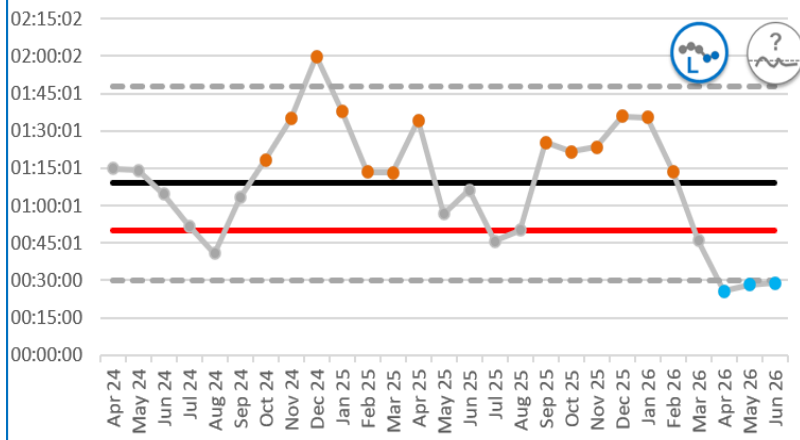
SaTH - ED Paediatric 4 Hour Performance (Type 1 & 3) %



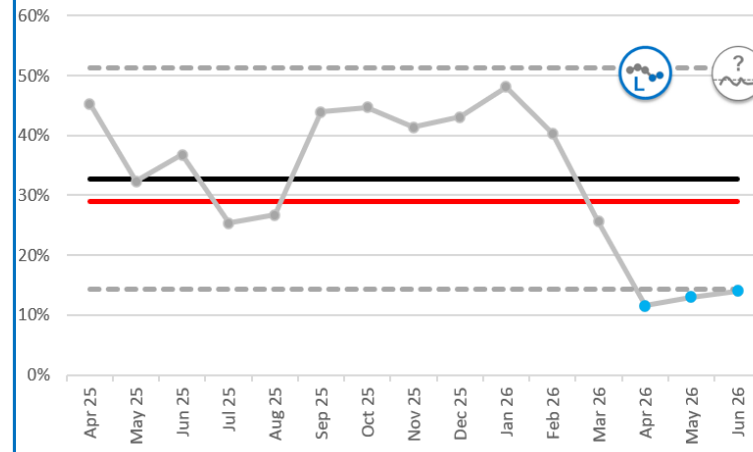
SaTH - Percentage of attendances in A&E over 12 hours - Type 1



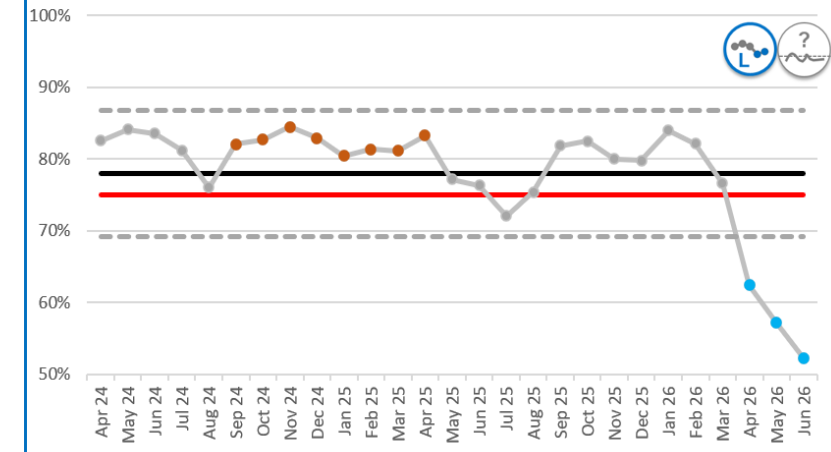
Average ambulance handover time (ED and non-ED) - nationally published



Ambulance Delays > 45 minutes %



Ambulance Delays > 15 minutes %



Operational – Emergency Care

Summary:

- SaTH ED 4-hour performance was 51.7% (type 1 & type 3) and remains in common cause natural variation in June 2026
- SaTH number of patients who spend more than 12 hours in ED stays in special cause improving variation with 80.8% of patients admitted and discharged within 12 hours during June 2026
- Average ambulance handover time shows special cause improving variation in June and was better than plan with 86.4% of ambulance handovers within 45 mins

Recovery actions:

- Delivery partner discovery phase near completion with a focus on 4 hour Non-Admitted ED pathways and No Criteria to Reside processes. Delivery phase being scoped to support accelerated improvement actions
- Ambulance Threshold 45 release to respond launched in June 2026
- Continue to work with WMAS/WAS on maximum handover threshold and immediate handover process
- Continue to work with Health Hero to progress admission avoidance opportunities
- Integrated Community Front Door (IFD) Team in place in both ED Departments
- UEC Phase II funding confirmed to support continuation of a selection of schemes tested as part of March 26 Urgent and Timely UEC Campaign
- 12 hour/4-hour performance: Implementation of additional domiciliary care supporting reduction in length of stay (LoS); 25/26 increase streaming of patients to SDEC increasing 0-day LoS; UTC pathway optimisation; Embed processes in line with UEC recovery plan in line with all additional bed and assessment capacity now opened; system wide 25/26 schemes including; expanded UCR to midnight; additional discharge planning capacity

Anticipated impact and timescales for improvement:

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

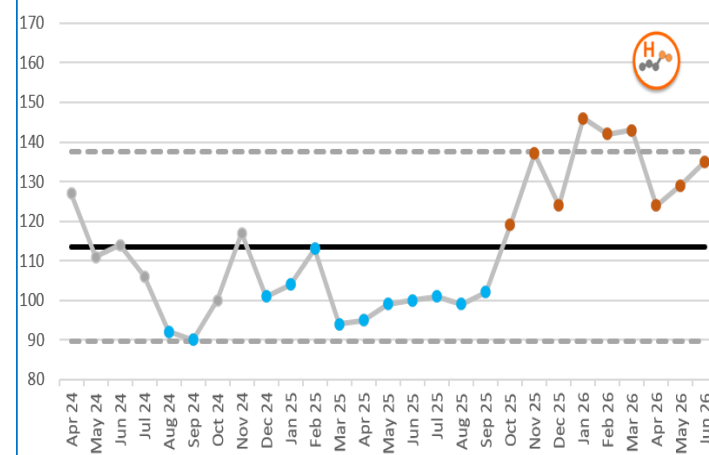
Progress reported monthly through Urgent and Emergency Care Transformation Committee (UECTAC) and weekly cross Divisional metrics meeting.

Recovery dependencies:

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

Operational – Patient Flow

Complex NCTR patients - average



Summary:

- The average number of complex no criteria to reside (NCTR) patients continues to be above the mean, indicating special cause variation
- The average number of days that patients are identified as complex no criteria to reside and awaiting discharge remains above the mean, demonstrating special cause variation

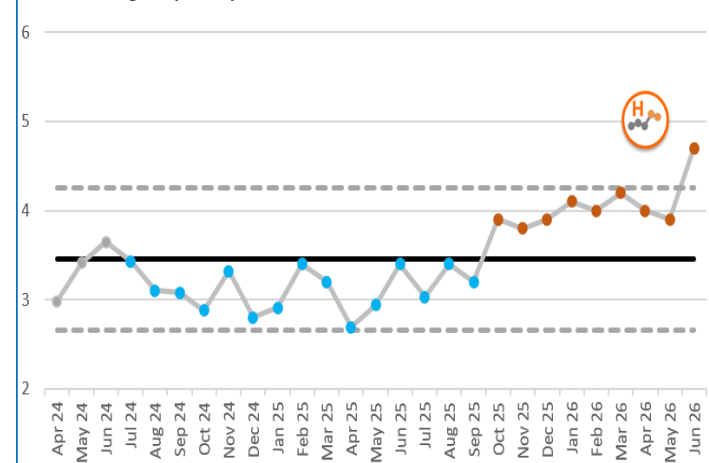
Recovery actions:

- Focus on accurate Estimated Discharge Date (EDD) to refer into Care Transfer Hub (CTH) 5 days prior to EDD to enable CTH to work up patient for discharge on EDD
- Tracking of community beds, complex discharges and transport to reduce incomplete (failed) discharges
- Trust long length of stay review meeting increased to twice weekly with local authorities and Divisional representatives, focusing on patients with CTR
- Continued focus on the CTH and therapy processes to reduce the length of time between NCTR and discharge
- Trial initiated for Transfer team across site for 1 month period to support flow.
- Daily CTH meetings, reviewing patients with NCTR
- CTH extended hours 08.00 - 20.00
- Roll out of the deconditioning change model to all wards continues
- Capacity & Flow Matrons/ Head of patient flow completing daily line by line reviews on Medical wards (M-F)
- Daily monitoring of out of area patients by capacity team- Patient flow managers supporting transfers to local acute trusts
- Increased transfers to the Discharge Lounge by 08.45 - handover the previous night. DL hours extended. Now open 07.00 - 22.00 both sites

Anticipated impact and timescales for improvement:

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

Average days complex NCTR



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 – Corridor Care

Definition

Corridor care definition

Corridor care is a significant patient safety and experience issue; the NHS is committed to reducing this activity in hospitals across England in both emergency departments and inpatient wards.

To ensure consistency in reporting of activity in relation to corridor care, a definition has been developed to allow acute hospitals to accurately record and count corridor care.

Corridor care definition for the Emergency Department (ED)

A count of the number of patients who received corridor care for more than 45 minutes within the previous 24-hour reporting period, from midnight to midnight, in the same way that attendances are reported.

This includes patients receiving treatment, waiting for assessment, admission or transfer. This is limited to ED. Key criteria to consider are in table A. If the answer is no to any of the criteria, then this is corridor care in ED.

It's important to note that ambulance handover delays should not be included in the count of the number of patients who received corridor care and should continue to be reported separately.

Corridor care definition for general and acute beds

A count of the number of patients who are receiving care for more than 45 minutes on a ward outside of a bed space. This is limited to general and acute beds and excludes ED.

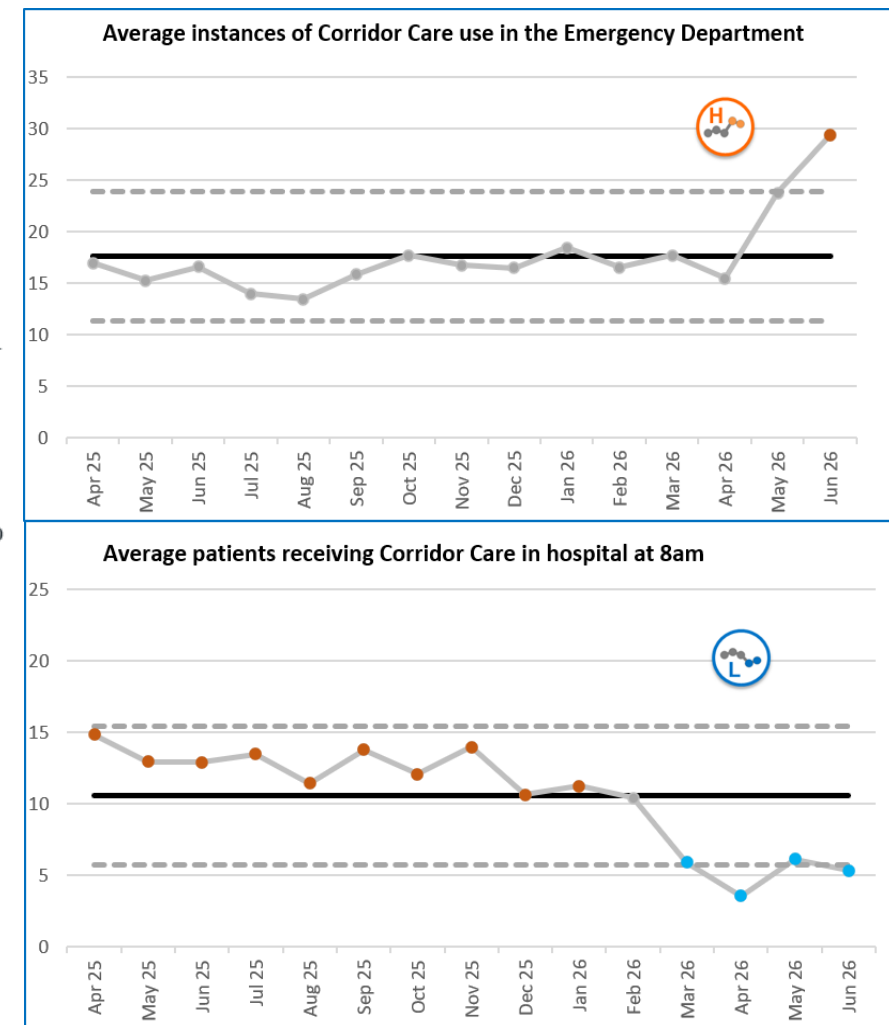
Key criteria to consider are in table A. If the answer is no to any of the criteria, then this is a corridor care bed.

Table A: Corridor care key criteria

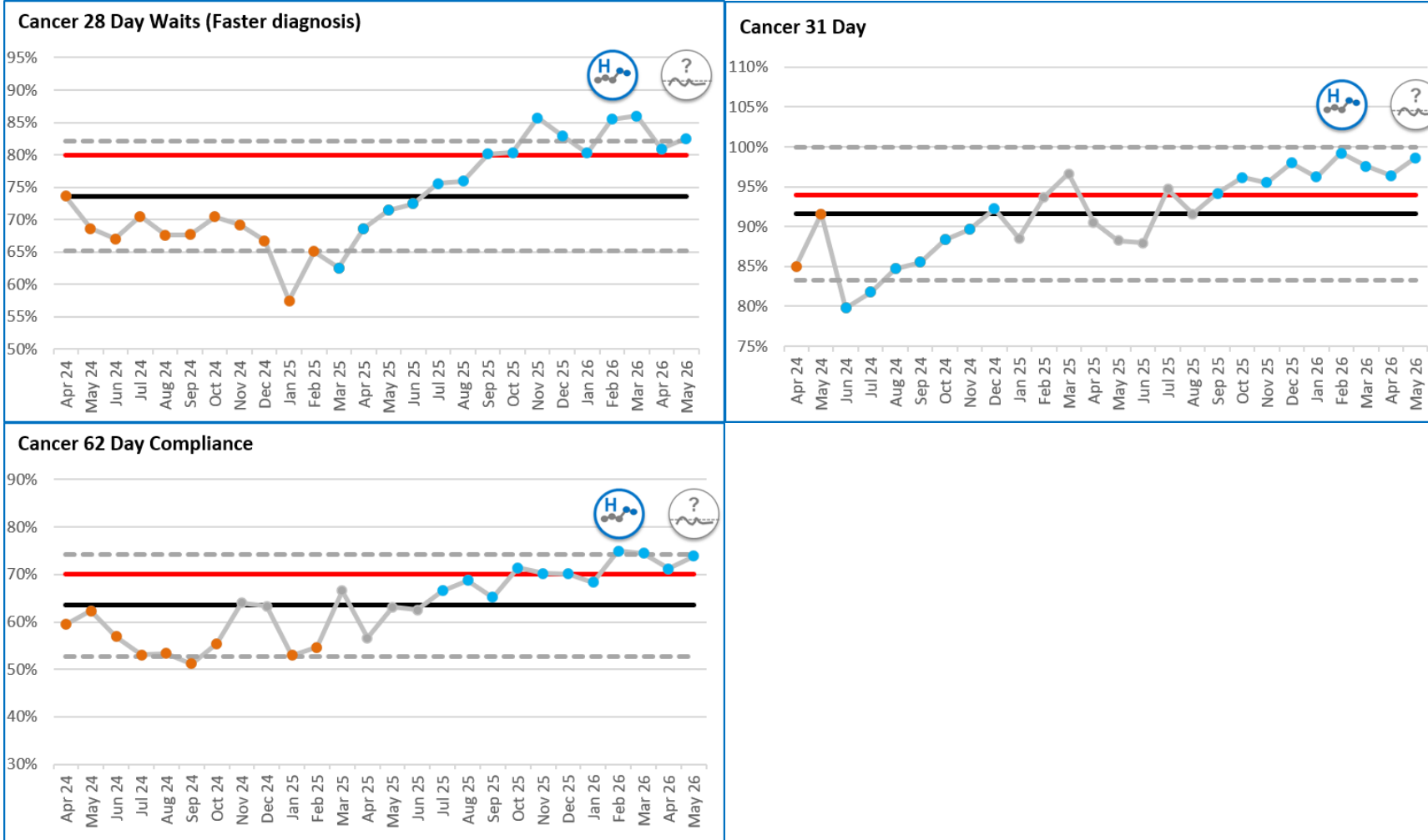
Corridor care

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

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



Operational – Cancer performance



Operational – Cancer performance

Summary:

Confirmed May cancer performance is 82.5% (28-day FDS) vs the local plan of 80%. 62-day performance was 73.9% against a local target of 70% and 31 day was 99% against national target of 96%. The 62-day backlog is 164 patients over 62 days of which 41 are over 104 days (as at 16/07/2026).

Recovery actions:

The Trust is now in Tier 3 of NHSE monitoring for cancer due to improved performance. May performance against the faster diagnosis standard (FDS) was 82.5%, making it our ninth month of delivery of the national 80% standard. Performance against the 62-day standard in May was 73.9%. Significant focus is on how we optimise our pathways through 26/27 to achieve 80% on our 62-day performance.

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

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

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

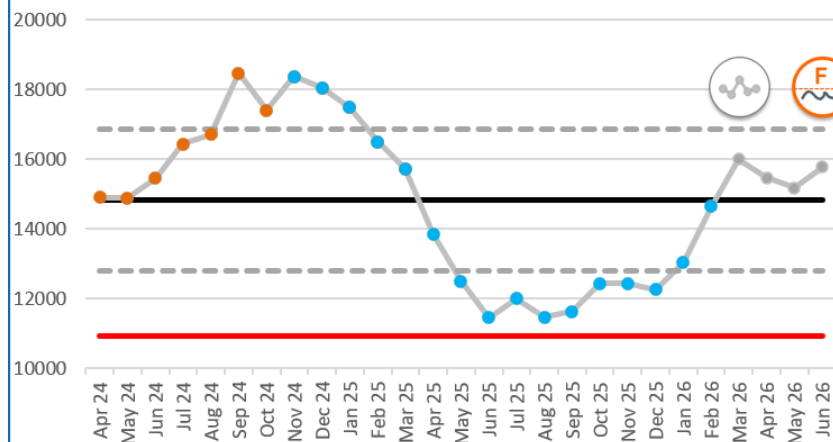
- Pathway optimisation
- Oncology improvement
- MDT optimisation
- Clinical outcomes
- Living with and beyond cancer

Recovery dependencies:

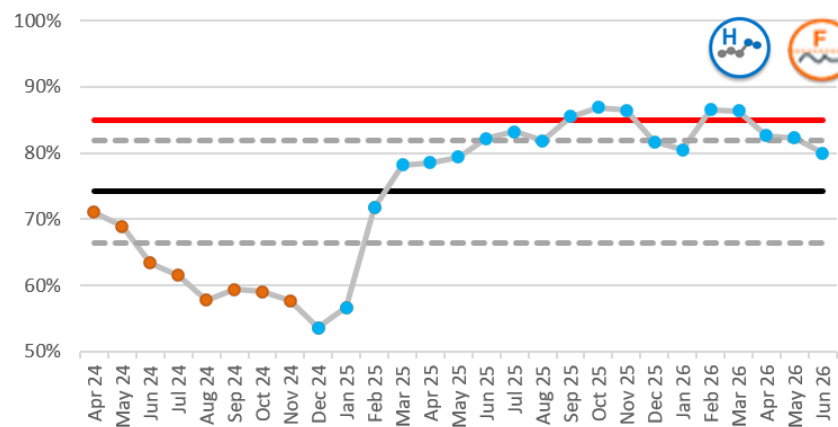
Workforce constraints

Operational – Diagnostics waiting times

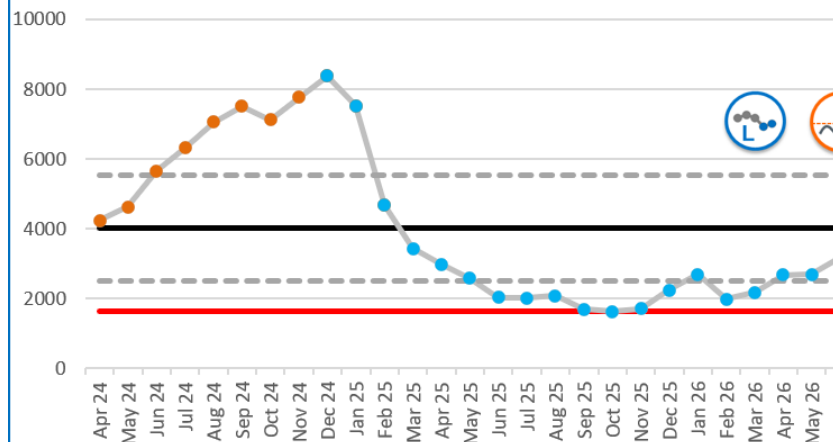
Diagnostic Total Waiting List - All commissioners



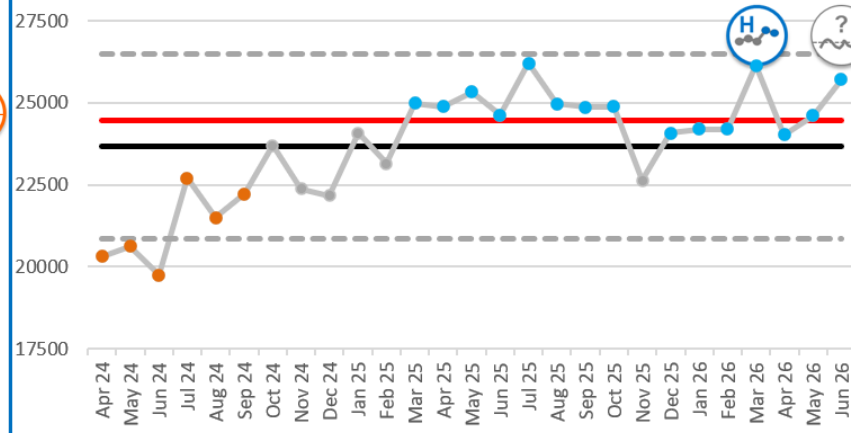
Diagnostic % Compliance 6 week waits - All commissioners



DM01 Patients who have breached the standard - All commissioners



Diagnostic Activity Total - All commissioners



Operational – Diagnostics waiting times

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Summary:

The submitted DM01 position for June was 79.9%, with particular improved performance seen in Echocardiology. NOUS has seen a deterioration in performance with a recovery plan implemented from mid-June. Radiology reporting turnaround times are being maintained. TATs from referral to report for USC are:- CT 2 weeks, MRI 2 weeks and NOUS 1-2 weeks. Radiologist workforce continue to restrict capacity for reporting, with reduced resilience during periods of sickness or annual leave, however we now have another outsourcing provider for reporting to provide more flexibility.

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

Recovery actions:

Outsourced reporting continues to provide additional capacity supporting MRI and CT turnaround times. MRI performance continues to fluctuate with a rise in the number of Cardiac scans remaining outstanding over 6 weeks, a recovery plan is in action to reduce the waiting times. 2 mobile vans are operational to increase scanning capacity and support with cancer performance, which continues to perform within target. Process for avoiding RTT breaches is in place with daily calls attended by the operational teams. Daily calls are also in place between radiology and the gynaecology booking team to ensure all capacity is utilised for PMB USS. A Radiology PTL for Cancer patients has been implemented. Additional U/S slots are being identified to support the urology cancer performance.

The sustainable endoscopy business case has been approved and is a 3-year programme of work requiring support from an IS provider pending recruitment to substantive posts and lead time for training until endoscopy practitioners become independent.

Anticipated impact and timescales for improvement:

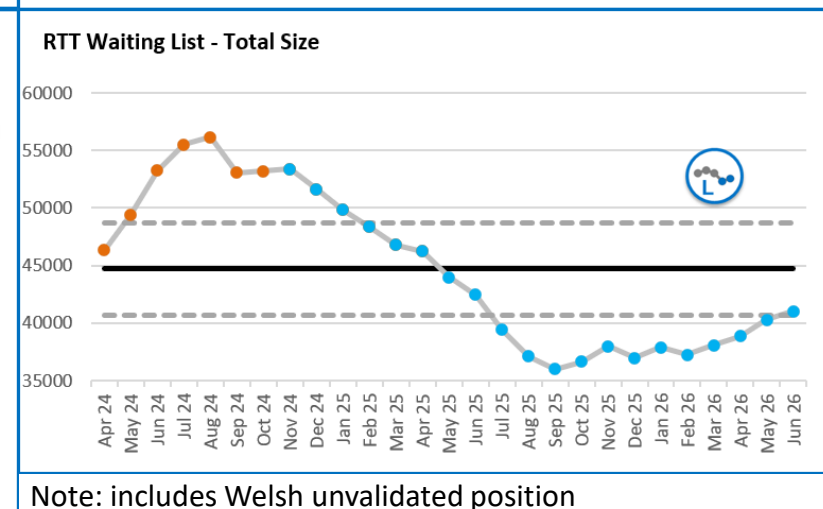
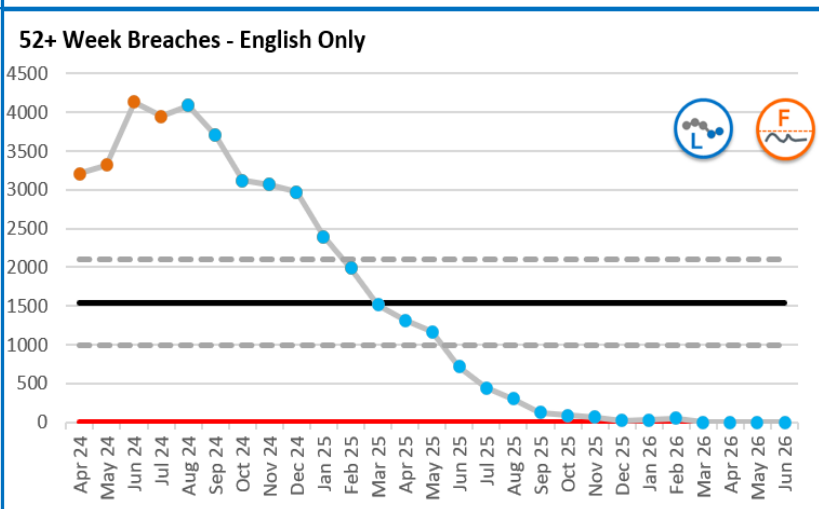
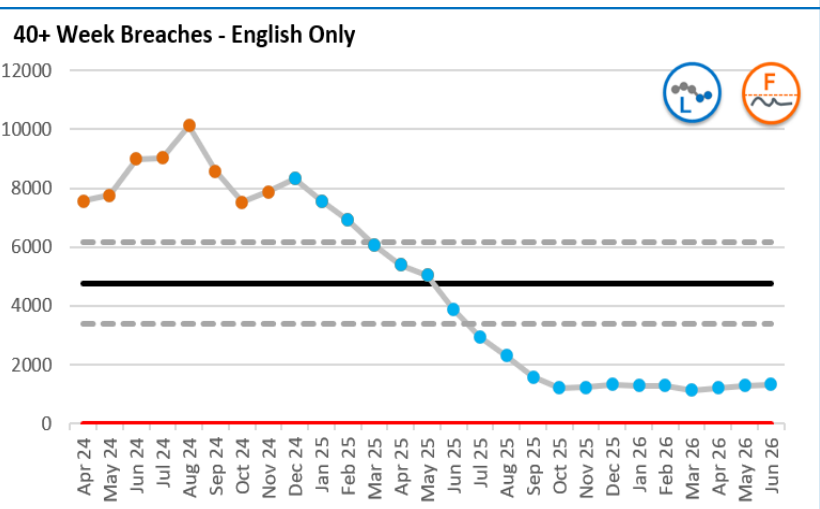
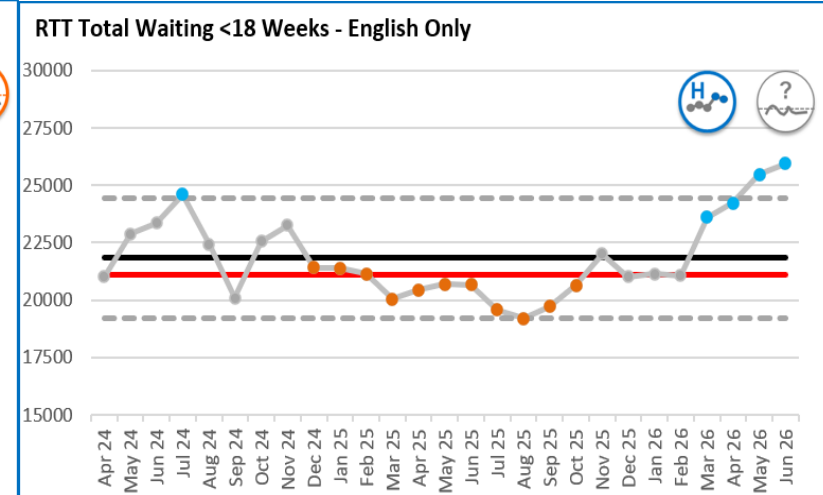
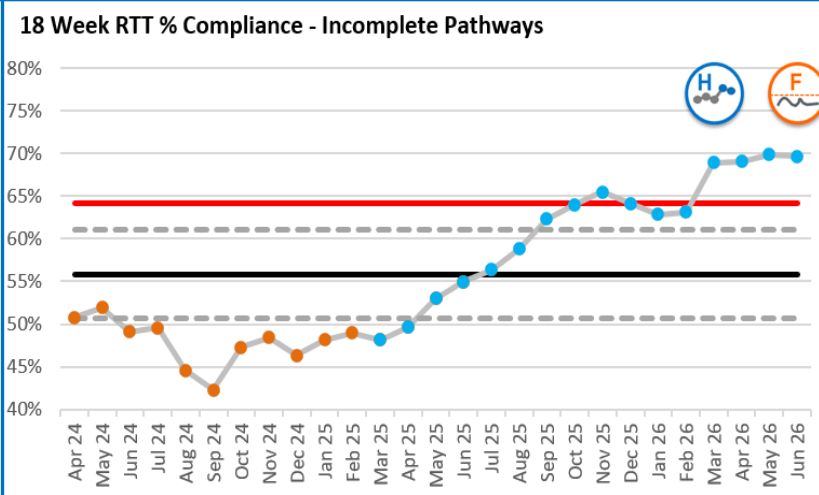
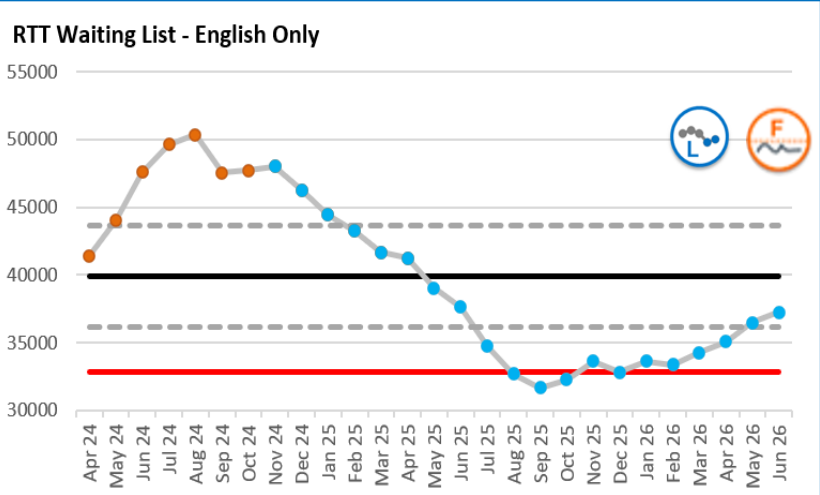
Additional insourcing from '18 Weeks' to support Endoscopy DM01 at weekends has been supported through the ERF. There is ongoing recruitment for radiologists, radiographers and sonographers.

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

Recovery dependencies:

Operational – Referral to Treatment (RTT)

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



Note: includes Welsh unvalidated position

Operational – Referral to Treatment (RTT)

Summary:

The submitted Trust Position for June 2026: English is 0 x 104 weeks, 0 x 78 weeks, 0 x 65 weeks, 0 x 52 week (adult) and 0 x 40 weeks CYP.
The unvalidated Trust Position for Welsh is 0 x 104 weeks, 7 x 78 weeks, 34 x 65 weeks 117 x 52 weeks.

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

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

The Trust remains on plan across all RTT metrics. This progress has been supported significantly by the work delivered through the outpatient transformation programme with Four Eyes Consultancy. The theatre planner is currently being reviewed to ensure that each specialty has the appropriate allocation to meet projected demand for 2026/27. The expectation continues to be that 97% of weekly core lists will run, including the cataract suite.

MBI continues to support the Trust with validation activity. Daily meetings continue to take place with the teams to ensure that there is a focus to ensure our long waits are treated. Each specialty has been given individual targets to achieve and the PTL is now being using to improve 18-week performance and reduce waiting times.

Recovery actions:

Operational governance: The teams are actively using the breach forecasting tool to enable more accurate planning of the capacity needed by specialty to reduce waiting times for patients. Daily and weekly performance monitoring meetings are in place. A methodology to 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 and 2 allocations in place to support delivery.

Productivity: The planned care improvement programme (PCIP) continues for both outpatients and Inpatients. Work is ongoing within the Trust to build upon the work Foureyes completed with clinic optimisation still a focus and the implementation of centralising bookings.

Anticipated impact and timescales for improvement:

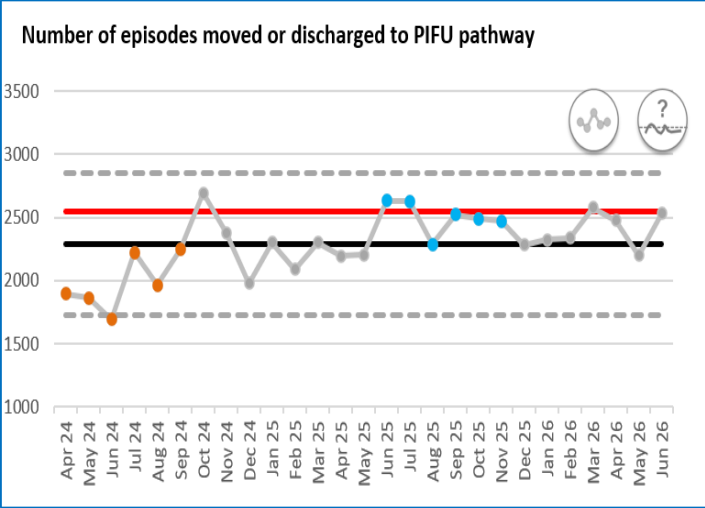
The methodology to maintain zero 52 weeks and to further improve CYP waiting times is in place.

The teams have now submitted plans for ERF funding with quarter 1 and 2 allocations in place to support delivery.

Recovery dependencies:

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

Operational – PIFU



Summary:

The unvalidated Patient Initiated Follow-Up (PIFU) performance in June 2026 decreased from 6.2% to 6% but remains on target.

- The Patient Engagement Portal, designed to support PIFU, is remains in its pilot phase with some ENT pathways
- A regular data quality workgroup has been established, involving key stakeholders from the trust, this will address issues and enhance data quality for monitoring
- Clinician attendance at the GIRFT action plan review meetings is allowing more direct clinical conversation and challenge
- Outpatient productivity continues to be a focus as well as outpatient pathway transformation. Outpatient advice and guidance will be enhanced with the introduction of the SPOA process, due to be implemented by October 2026

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

Recovery actions:

Conversations with respiratory, cardiology and gynaecology and clinical operational leads have taken place, their performance report has been completed with plans to utilise the PIFU pathway. Further conversations required with cardiology clinical director regarding implementation of more PIFU within the department. The implementation of (PEP) Dr Doctor to support the PIFU pathway across all specialties is hoped to encourage engagement.

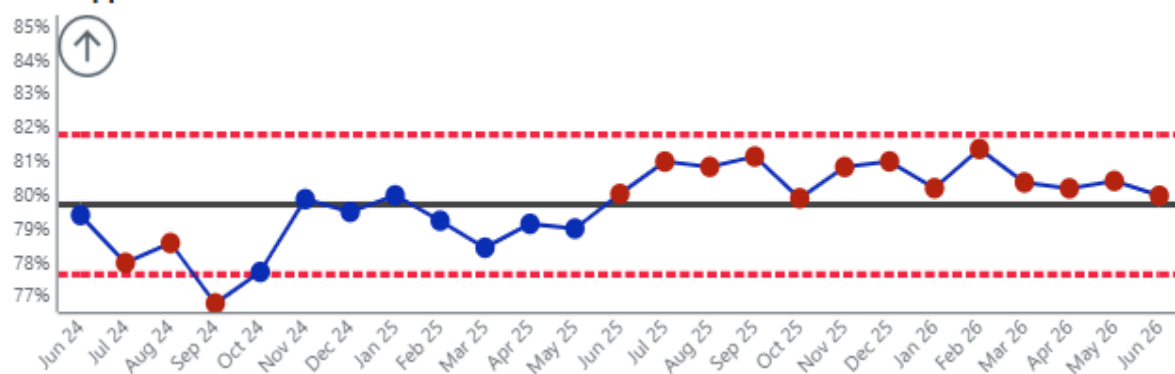
Anticipated timescales for improvement:

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

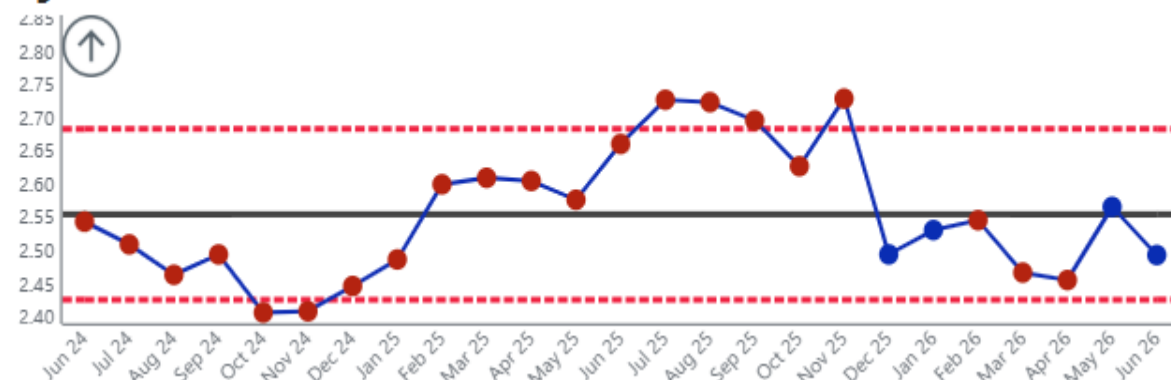
Recovery dependencies:

Operational – Theatre Productivity

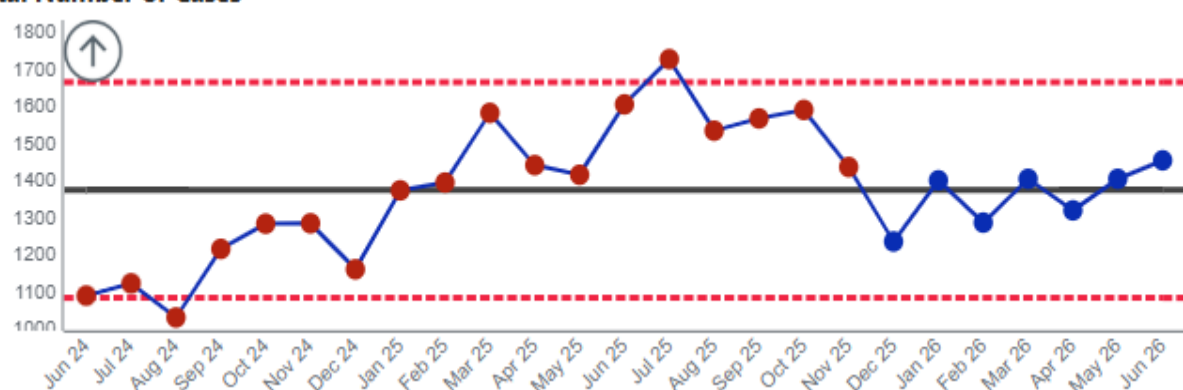
Theatre Capped Utilisation %



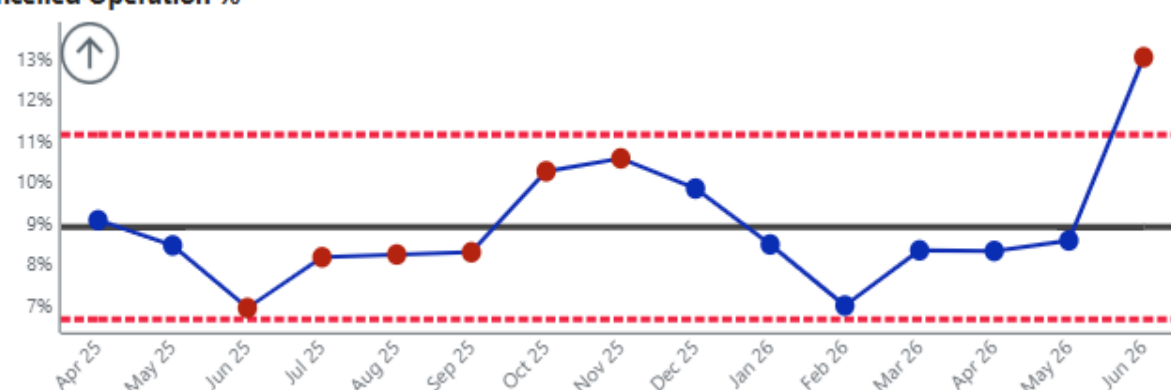
Average Cases Per List Rate



Total Number of Cases



Cancelled Operation %



Operational – Theatre Productivity

June 2026 Summary:

Elective Theatre Utilisation

- Overall utilisation has remained stable at 80%
- Focus on ophthalmology main theatre lists with support from the Improvement Team

Cancellations

- The cancellation rate increased significantly to 13%, primarily due to the cancellation of multiple theatre sessions as a result of excessive humidity and heat levels within theatre environments. Additional contributing factors included:
 1. Clinical staff sickness increase across theatre teams including anaesthetists and surgeons
 2. Treatment deferred to a later date for multiple reasons

Elective Activity

- Despite the number of cancellations, the total number of elective cases increased from 1404 to 1454 which is in line with the increased number of theatre sessions and is the highest since October 2025
- Core cases increased by almost 100
- Cases per list remained stable at 2.5

Theatre Task & Finish Group Priorities:

1. Identifying opportunities to shift suitable procedures out of theatre using GIRFT RPRP principles
2. Embedding learning from high volume theatre lists across multiple specialties to make these lists routine
3. Introduce four joint arthroplasty lists to PRH with an August start date for first list

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
- Booking & Scheduling and pre-operative assessment work to gradually introduce My PreOp+ should start to support earlier planning and optimisation of patients through theatre

Anticipated timescales for improvement:

Planned introduction of ENT activity at RSH in August will also enable the robotic theatre in PRH to reach full session capacity on the four available days.

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)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Trend
Well Led	WTE employed		-	7452	7225	7216	7222	7380	7403	7429	7422	7438	7430	7428	7476	7484	7534	
	Substantive plan				7268	7318	7422	7447	7422	7393	7374	7356	7323	7275	7452	7452	7452	
	Bank/Locum			542	652	692	659	600	625	602	568	575	595	639	577	569	554	
	Bank/locum plan				598	593	588	533	529	557	553	549	545	542	542	542	542	
	Agency			55	86	91	91	79	58	50	50	38	37	50	43	41	46	
	Agency plan				102	95	78	73	69	69	66	62	59	55	55	55	55	
	Temporary/agency staffing		-	-	738	783	749	679	683	652	617	612	632	689	621	610	600	
	Staff Turnover Rate (FTE) (excluding Junior Doctors)		0.8%	0.75%	0.7%	0.7%	0.9%	0.7%	0.8%	0.9%	1.0%	0.9%	0.7%	0.8%	0.7%	0.7%	0.5%	
	Vacancies - month end %		10%	<10%	6.0%	6.2%	6.0%	3.9%	4.2%	4.1%	4.7%	6.5%	6.0%	5.8%	5.3%	4.7%	3.1%	
	Sickness Absence rate		-	4.5%	4.8%	4.9%	4.7%	4.9%	5.2%	5.2%	5.7%	5.8%	5.5%	5.0%	5.1%	4.91%	5.39%	
	Trust - Talent Conversation (Appraisal)		90%	90%	86.1%	86.6%	86.1%	86.4%	86.9%	86.8%	86.1%	85.0%	84.6%	84.7%	84.1%	82.7%	83.9%	
	Talent Conversations (Appraisal) – Medical Staff		90%	90%	93.5%	93.3%	94.4%	95.3%	94.9%	93.5%	92.7%	92.9%	93.6%	94.2%	93.3%	91.4%	90.8%	
	Trust Statutory and mandatory training compliance		90%	90%	93.2%	93.4%	93.2%	93.1%	93.3%	92.9%	92.3%	92.5%	91.9%	91.4%	91.5%	90.0%	90.2%	
	Trust MCA – DOLS and MHA		90%	90%	85.2%	86.0%	85.8%	85.3%	85.2%	85.8%	84.7%	84.8%	84.3%	84.2%	83.1%	82.0%	83.0%	
	Safeguarding Children - Level 2		90%	90%	96.6%	96.4%	96.2%	95.8%	95.8%	95.4%	95.1%	95.2%	94.8%	94.1%	94.1%	93.1%	92.9%	
	Safeguarding Adult - Level 2		90%	90%	95.9%	96.0%	95.7%	95.5%	95.6%	95.5%	94.7%	95.0%	94.6%	94.5%	94.5%	93.9%	94.3%	
	Safeguarding Children - Level 3		90%	90%	90.5%	90.8%	90.3%	88.2%	88.6%	87.1%	86.0%	85.0%	84.0%	81.3%	79.6%	81.1%	79.6%	
	Safeguarding Adult - Level 3		90%	90%	91.7%	92.1%	91.5%	90.5%	90.9%	91.4%	90.3%	90.7%	90.4%	90.7%	90.7%	90.6%	91.0%	
	Diabetic Foot - Nurse Training		90%	90%	88.8%	90.2%	91.3%	90.7%	91.3%	92.2%	92.4%	92.3%	92.1%	91.8%	92.5%	92.4%	93.5%	
	Oliver McGowan Training		90%	90%	87.5%	87.8%	88.2%	88.5%	88.9%	89.0%	88.9%	88.8%	88.6%	88.5%	88.1%	86.2%	79.4%	
	Oliver McGowan Mandatory Training - T1		90%	90%		25.7%	25.4%	25.3%	0.0%	5.6%	6.7%	10.0%	12.4%	13.0%	13.1%	14.5%	12.8%	
	Oliver McGowan Mandatory Training - T2		90%	90%		24.6%	24.2%	23.9%	11.3%	11.3%	11.1%	12.0%	13.3%	15.2%	16.0%	18.1%	18.6%	
	Monthly agency expenditure (£'000)		-	514	817	873	921	820	504	500	525	306	369	520	418	523	591	

Workforce Executive Summary

2026/27 Workforce Plan - The total workforce position ended the first quarter at 86 WTE over planned levels. The substantive workforce has continued to increase each month and is currently 82 WTE over plan. The levels of bank workforce have reduced each month and is marginally over plan by 12 WTE. Agency workforce usage remains under planned levels and has averaged 43 WTE across the first quarter. Since the start of the year all clinical divisions have increased substantive workforce ranging from 0.5% up to 0.7%. Overall vacancies have reduced by 1% since the start of the year, therefore the increase in substantive workforce is in line with the rate at which we have recruited to vacancies.

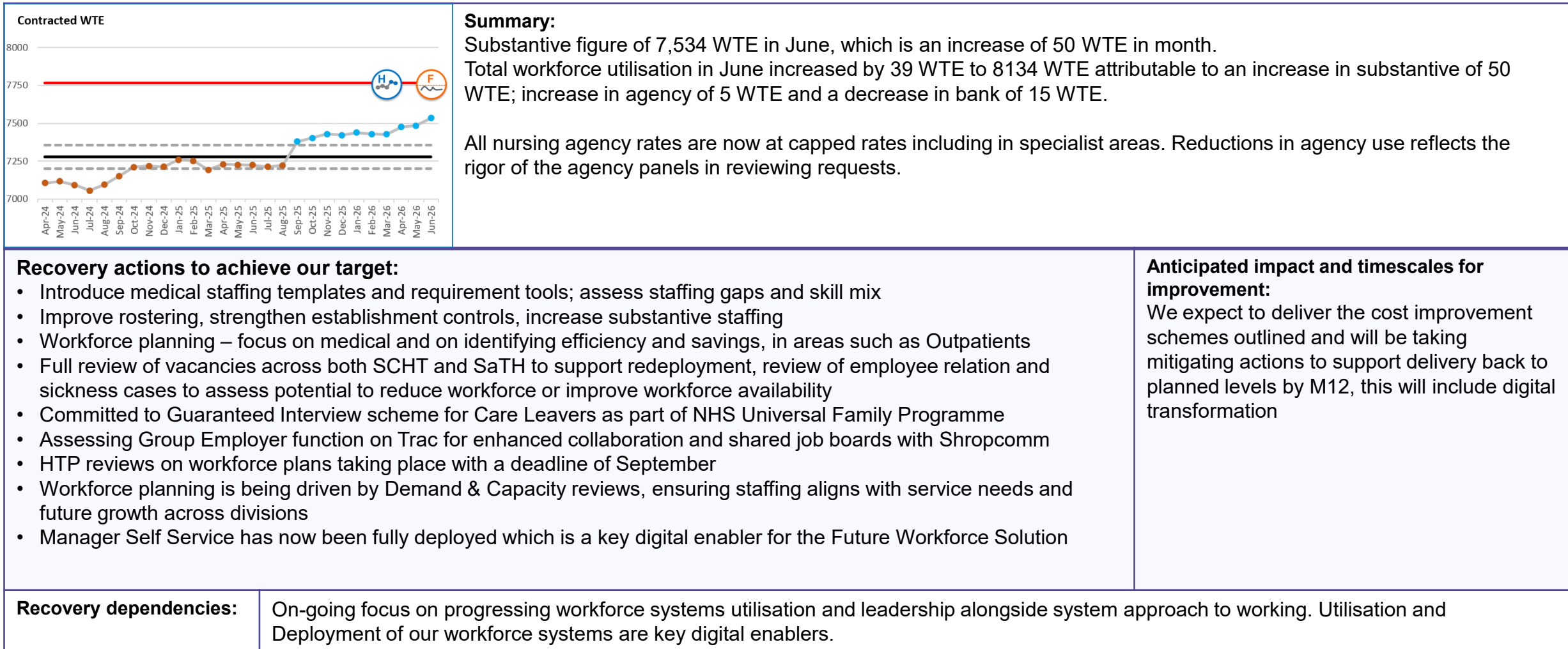
Turnover - The rolling 12-month turnover rate for June is 9.3% equating to 641 WTE leavers. An in-month turnover rate of 0.5% equates to 34 WTE leavers in June. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.9% equating to 474 WTE NHS leavers. Staff groups with highest turnover rates are: Additional Clinical Services (12.2%); Admin and Clerical (11.6%); Estates and Ancillary (9.9%).

Wellbeing of our staff - The June sickness rate of 5.39% (409 WTE) remains above target by 0.9% (67 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 28% of calendar days lost in June equating to 115 WTE. 12% (46 WTE) of sickness was attributed to other known causes; gastrointestinal problems was at 9% (38 WTE). Sickness absence is high in some clinical areas particularly ward based nursing departments, despite this our overall sickness did reduce in M1 and M2. There has been a 0.5% increase in M3 driven by short term absence. Actions to address sickness absence through the development of a holistic approach is now in place.

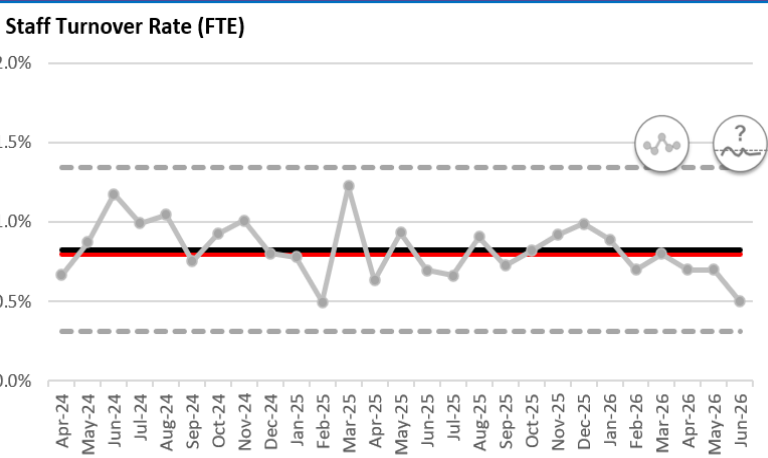
Talent Conversations and Training - Talent conversation completion rates increased this month by 1.2% but remain below our target of 90%. Training compliance overall is meeting our target of 90%; there are however actions to support improvements in Mental Capacity training and Oliver McGowan as they are the two training modules currently behind our completion targets.

Agency and temporary staffing - There has been growth in nursing permanent workforce over quarter one of 22 WTE, the majority within UEC clinical areas, ITU and the Elective hub. Within these areas, there has been a corresponding reduction in bank usage from M1 to M3. Bank reduced by 15 WTE. Agency usage levels increased marginally but remain under plan by 9 WTE this has led to an increase this month in agency expenditure.

Workforce – Contracted WTE



Workforce – Staff turnover rate



Summary:
Our Turnover target for 2026 is 10%. The rolling 12-month turnover rate for June is 9.3% equating to 641 WTE leavers. An in-month turnover rate of 0.5% equates to 34 WTE leavers in June. NHS Leaver turnover rate (those moving outside of the NHS) over the last 12 months is 6.9% equating to 474 WTE NHS leavers. Staff groups with highest turnover rates are: Additional Clinical Services (12.2%); Admin and Clerical (11.6%); Estates and Ancillary (9.9%). Nursing and Midwifery has a turnover rate of 6.6%. Relocation is currently the highest reason for leaving with 106 WTE leavers with work life balance as the second highest reason with 95 WTE leavers over the last 12 months.

Recovery actions to achieve our target:

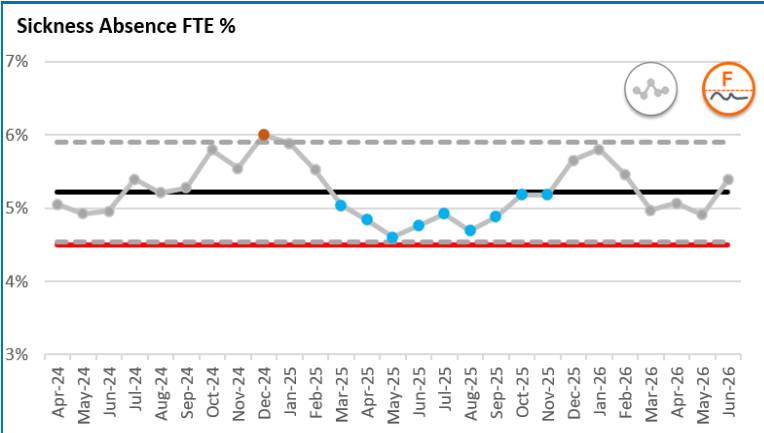
- Redeployment Improvements: The redeployment process is being enhanced in collaboration with the recruitment team to better support staff transitions including movements from other Trusts
- Workforce Realignment and change: The Trust is reshaping its workforce to support service transformation and investment delivery
- Cultural Transformation: Plans to support transition to Group continue to support cultural transformation
- Psychological Support: The Staff Psychology Service is delivering reflective practice, trauma-informed sessions, and mental health support to help reduce stress-related turnover
- 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



Summary:

Our sickness target for 2026 is 4.5%. June sickness rate of 5.39% (409 WTE) remaining above target by 0.9% (67 WTE). Sickness attributed to mental health continues to be the top reason for sickness making up 28% of calendar days lost in June equating to 115 WTE. 12% (46 WTE) of sickness was attributed to other known causes; gastrointestinal problems was at 9% (38 WTE).

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

Estates and Ancillary has the highest sickness rate at 8.3% followed by Additional Clinical Services at 6.7% and Nursing and Midwifery at 6.0%.

Recovery actions to achieve our target:

- Review of all long-term absence (currently 65 WTE) we are now undertaking a full review of long-term sickness cases to identify any cases that can be concluded
- Management of Change Masterclasses: Supporting staff through change to reduce stress-related absence continue
- Sickness Management Trial: Piloting new approaches for Medical & Dental staff
- Staff Psychology Support: Offering mental health and trauma-informed sessions to reduce absence
- Wellbeing Initiatives: Delivering roadshows, wellbeing walks, and targeted support to boost resilience
- Strengthen sickness prevention and wellbeing interventions and policy
- Targeted long-term absence management and occupational health support (Occupational Health procurement process underway)
- Prioritisation of retention and resilience strategies within Bands 5 and 6 and clinical workforce
- Improving workforce planning for winter escalation periods

Anticipated impact and timescales for improvement:

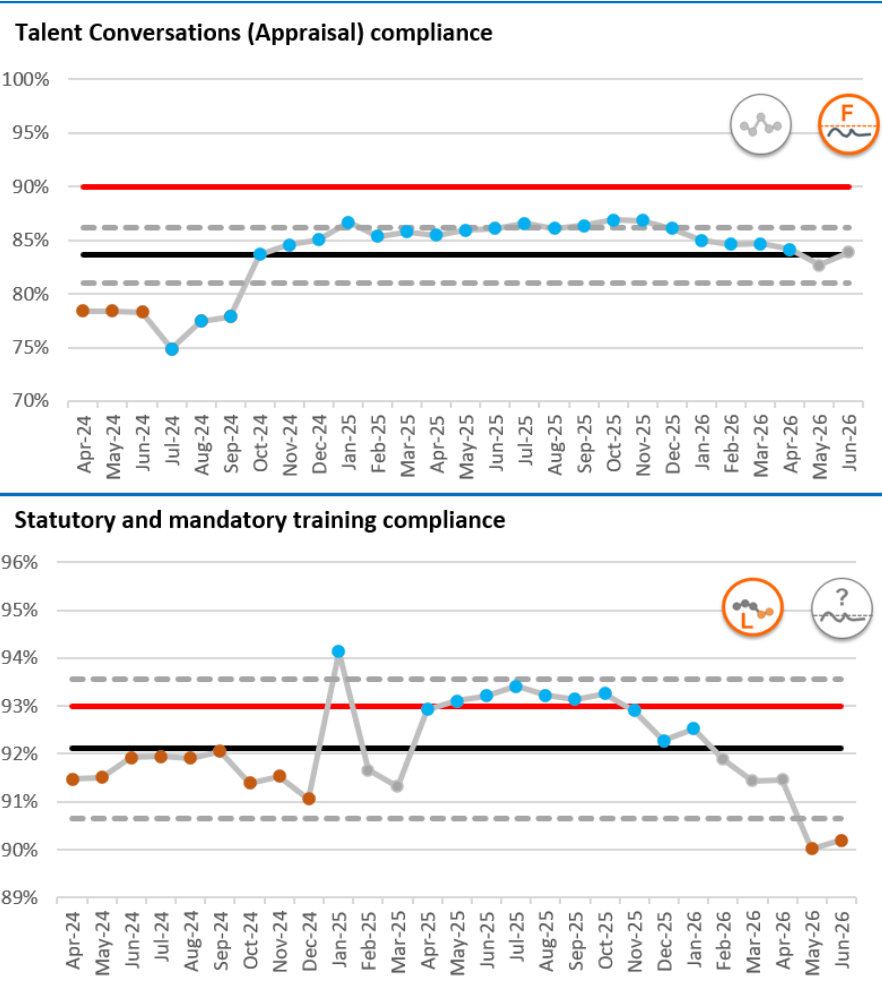
Expected reductions in absence levels throughout the year in line with plan with a level of increase over winter months after which we expect a 0.6% reduction.

Recovery dependencies:

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

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 83.9% in June. The compliance rate for Statutory and Mandatory Training in June has remained at 90.20%. Both training compliance and appraisals have been decreasing month on month

Recovery actions:

- There is a risk that the Trust will not meet national targets for training and appraisal compliance. Appraisal rates are already below target, and training compliance is continuing to decline with a potential breach anticipated this month. Due to the ongoing Education management of change and reduced staffing capacity, improvement interventions cannot currently be implemented
- Review appraisal paperwork
- National mandatory learning policy framework implementation
- Review of NHS Ten-year plan and support development of Joint People Strategy. Investment in clinical educators, expansion in widening participation opportunities, entry routes into the NHS
- Continue to build and work with Keele University, Telford College and Shrewsbury College to develop opportunities to support development of future workforce and workforce skills

Anticipated impact and timescales for improvement:

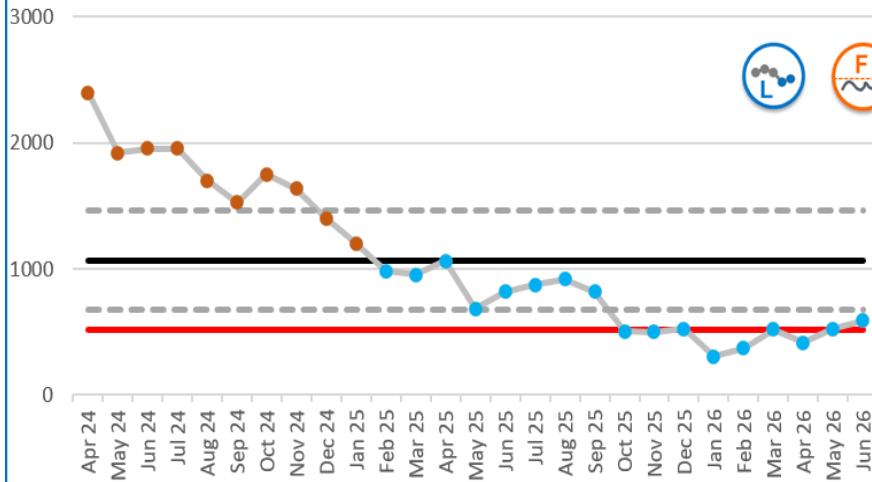
Action plan in place to support compliance over next quarter.

Recovery dependencies:

Completion of the management of change process

Agency Expenditure - Monthly

Monthly agency expenditure (£'000)



Summary:

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

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

Recovery actions to achieve our target:

- Rigor around WTE budgets continues, with vacancy control and reform plans in place to meet 2025/26 requirements. This includes reviewing paused posts and planning for change, with executive-level oversight
- New rates for agency medical now in place
- Regional Price Cap Compliance: The Trust is actively supporting the region to meet PCC targets and is currently reporting zero above-cap agency usage
- Agency Cost Management: Strategic planning continues to reduce premium pay spend and improve workforce efficiency
- Workforce Deployment: Enhanced rostering and unavailability tracking are helping optimise staffing and reduce reliance on agency cover

Anticipated impact and timescales for improvement:

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

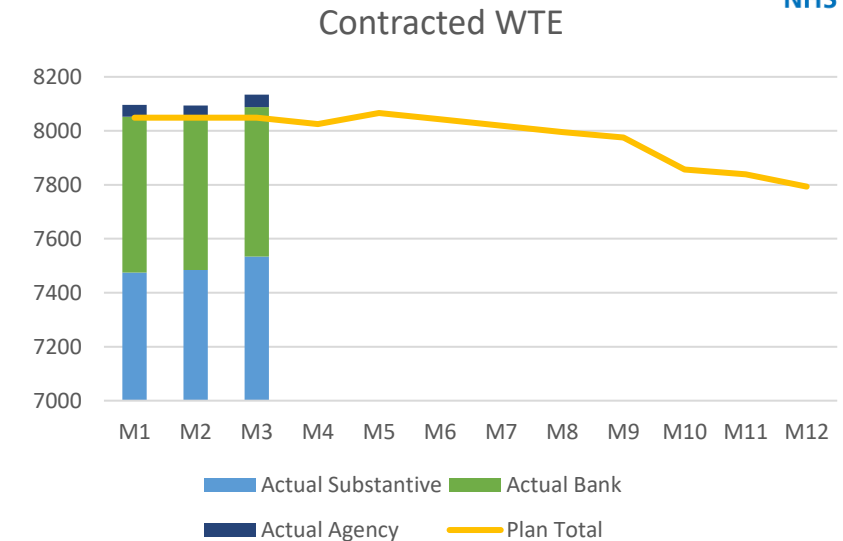
Recovery dependencies:

Escalation plan delivery and workforce unavailability going into winter.

Staffing – contracted actuals vs plan

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Contracted WTE													
Plan / Actual	Staff Group	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	Substantive	7,452	7,452	7,452	7,443	7,480	7,472	7,463	7,455	7,450	7,347	7,345	7,317
	Bank	542	542	542	528	535	522	508	495	482	468	455	442
	Agency	55	55	55	53	51	49	47	45	43	41	39	35
	Total	8,048	8,048	8,048	8,025	8,066	8,042	8,019	7,995	7,975	7,856	7,838	7,793
Actual	Substantive	7475	7,484	7,534									
	Bank	577	569	554									
	Agency	43	41	46									
	Total	8,096	8,094	8,134									
Variance	Substantive	23	32	82									
	Bank	36	28	12									
	Agency	-12	-14	-9									
	Total	47	46	86									



Summary:

Total staff usage of 8134 WTE in June which is 86 WTE (Contracted) above plan. Substantive levels have increased by 50 WTE this month as our vacancy level reduced to 3%. Bank reduced by 15 WTE. Agency usage levels increased marginally but remain under plan by 9 WTE.

Continued actions:

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

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

Anticipated impact and timescales for improvement:

N/A

Recovery dependencies:

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

Finance

Executive Lead:

**Acting Director of Finance
Adam Winstanley**

Integrated Performance Report

Domain	Description	Current Month Trajectory (RAG)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Trend
Finance	End of month cash balance £'000	28,231	41,161	44,343	51,400	40,294	49,296	39,293	16,298	89,066	83,003	72,968	40,867	35,115	37,628	
	CIP Delivery £'000	3,138	2,742	3,579	3,166	3,843	3,363	3,268	3,692	4,076	4,435	4,419	2,042	2,093	3,194	
	Balanced £ Position £'000 (Cumulative)	(8,269)	10	8	4	(1,274)	(2,290)	(3,927)	(5,848)	(5,604)	(4,098)	4,920	(3,628)	(7,368)	(10,936)	
	Year to date capital expenditure £'000	28,987	19,759	24,803	32,363	41,608	53,139	61,724	76,556	87,885	102,681	149,713	0	15,295	25,487	

Financial Executive Summary

The Trust submitted a finance plan to NHSE on 18th March which showed a deficit plan of £30.49m pre deficit support (DSF) which moves to breakeven with deficit support for the year. At the end of June (month three), the Trust has delivered a deficit position of £10.94m against a deficit plan of £8.27m pre deficit support funding, an unfavourable variance of £2.67m. This moves to a deficit of £3.31m against a planned deficit of £0.65m post deficit support.

There have been some variances in the cost categories with income and non-pay favourable to plan and pay adverse to plan. The predominant drivers of the variance are industrial action (£0.75m) and slippage against various efficiency schemes (£1.70m), these have been partly offset with other non-recurrent mitigations.

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

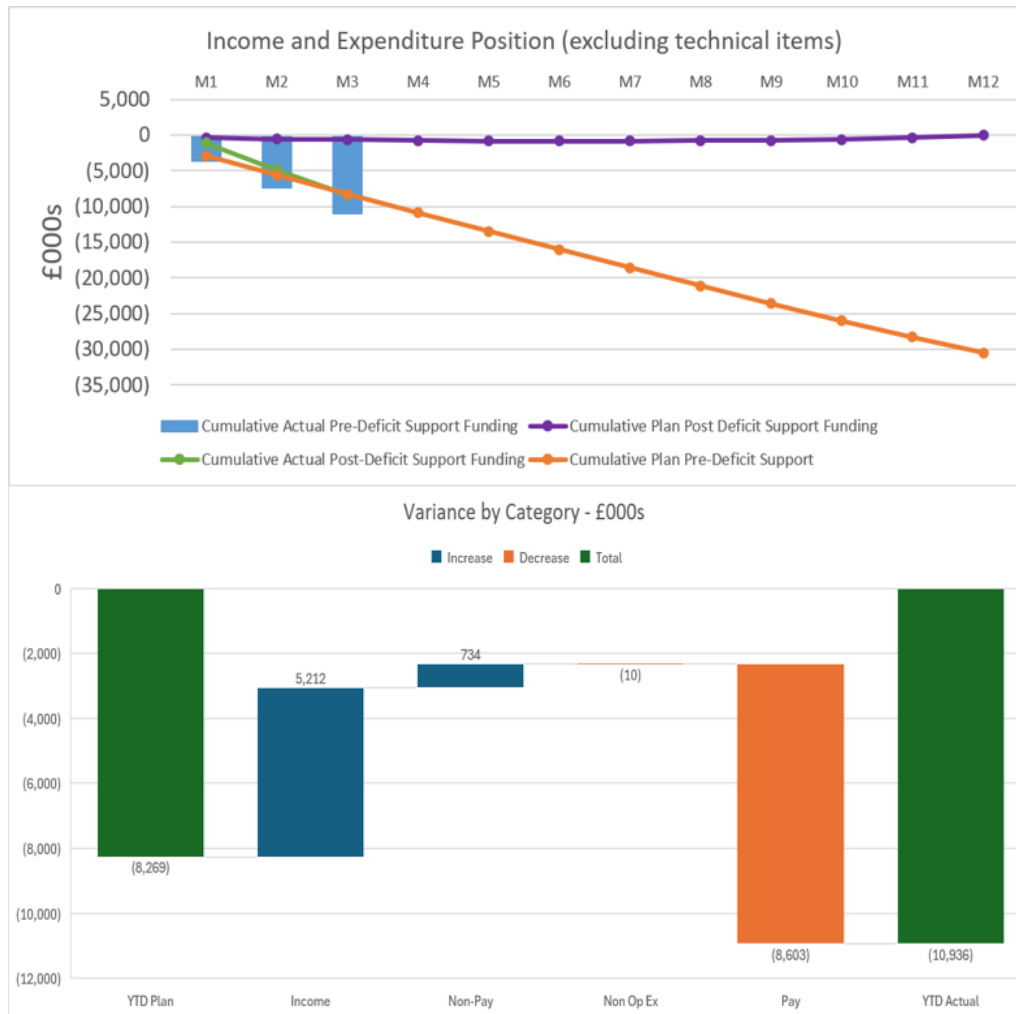
- Delivery of the activity plan – There is currently no change in the reporting of income due to the data warehouse issues at present which will be resolved during the first half of FY26/27. The Trust is actively making Commissioning Data Set (CDS) submissions through to the Secondary Uses Service (SUS) and completing Non-SUS aggregated contract monitoring
- Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of June, £7.33m has been delivered which is £1.70m less than plan
- Delivery of Whole Time Equivalent (WTE) reduction plan – At the end of June against the numbers planned (actual worked) there has been an adverse variance of 56 WTE
- Delivery of the agency reduction plan – Agency usage is below the planned levels by 9 WTE. There will continue to be a strong focus on medical agency in FY26/27

The Trust has set an operational capital programme of £25.54m (including IFRS 16 expenditure) and externally funded schemes of £138.26m in FY26/27, giving a total capital programme of £163.80m, spend at the end of Q1 totalled £23.56m.

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

Income and Expenditure – Year to Date

Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group



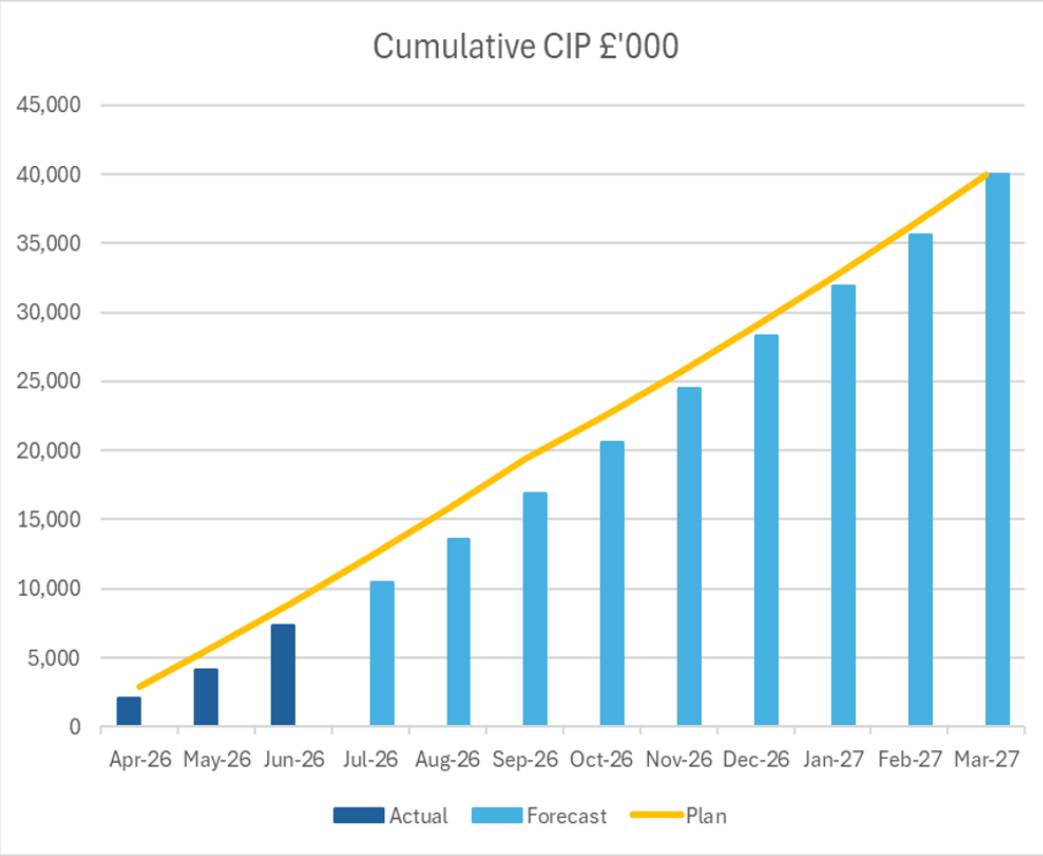
The Trust has a deficit plan of £30.49m pre DSF which moves to breakeven post DSF for FY26/27. At the end of June (month three), the Trust has delivered an adverse variance of £2.67m against a planned deficit of £8.27m.

The main drivers of this position are the cost pressure associated with the industrial action (£0.75m) and slippage against efficiency schemes (£1.70m). These pressures have been partially mitigated by bringing forward delivery of some of the central efficiency schemes associated with technical adjustments.

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

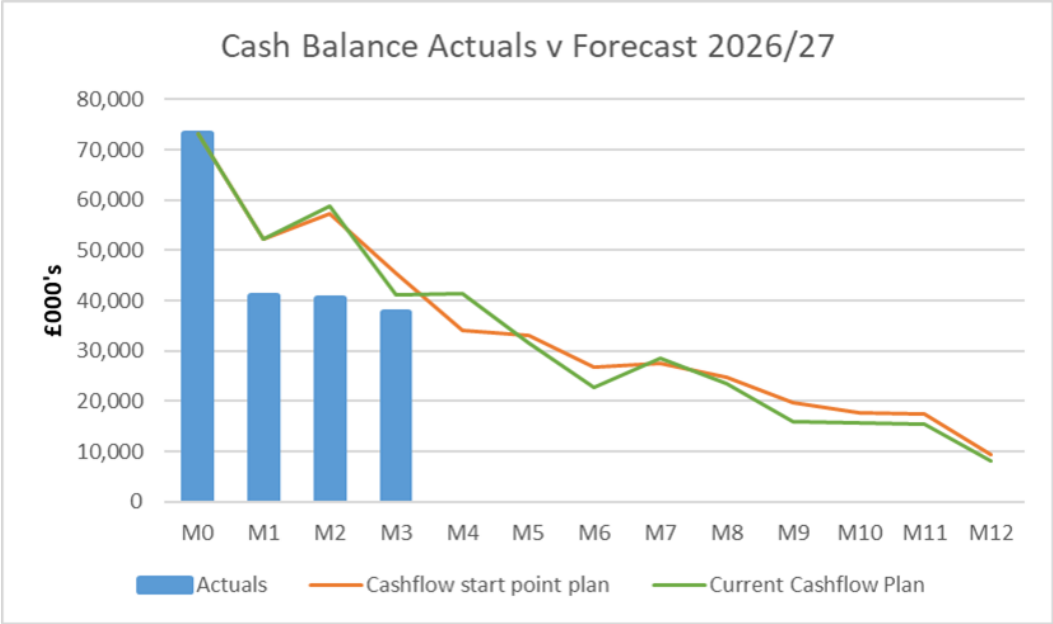
- Delivery of the activity plan – There is currently no change in the reporting of income due to the data warehouse issues at present which will be resolved during the first half of FY26/27. The Trust is actively making Commissioning Data Set (CDS) submissions through to the Secondary Uses Service (SUS) and completing Non-SUS aggregated contract monitoring.
- Delivery of the efficiency plan – The Trust has an efficiency target of £39.98m in FY26/27. At the end of June, £7.33m has been delivered which is £1.70m less than plan.
- Delivery of WTE reduction plan – At the end of June against the numbers planned (actual worked) there has been adverse variance of 56 WTE.
- Delivery of the agency reduction plan – Agency usage is below the planned levels by 9 WTE. There will continue to be a strong focus on medical agency in FY26/27.

Efficiency



Summary: The Trust has a total efficiency target of £39.98m for FY26/27, £35.36m recurrently. As at the end of May (M03), the Trust has delivered £7.33m of efficiency savings for FY26/27 which is £1.70m below the planned delivery. At M03 the Trust is forecasting to meet its target CIP by the end of the year. £21.64m of this is recurrent and £18.34m is non-recurrent, with a FYE of £35.36m aligned to underlying planned delivery. The forecast is risk adjusted, however, there is still risk to this position as highlighted and additional schemes are being added to the programme to mitigate.	
Recovery actions: • Identification of divisional CIP at pace • Identification of mitigations for high risk and undelivered CIP across the year	Anticipated impact and timescales for improvement: Mitigation plan in place and delivering by the end of Q2
Dependencies:	Delivery of actions against PIDs across 26/27

Cash and Cash Equivalents



Summary:

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

The cash balance brought forward into FY26/27 was £73.21m with a cash and ledger balance of £37.63m held at end of month three (June).

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

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

Recovery actions:

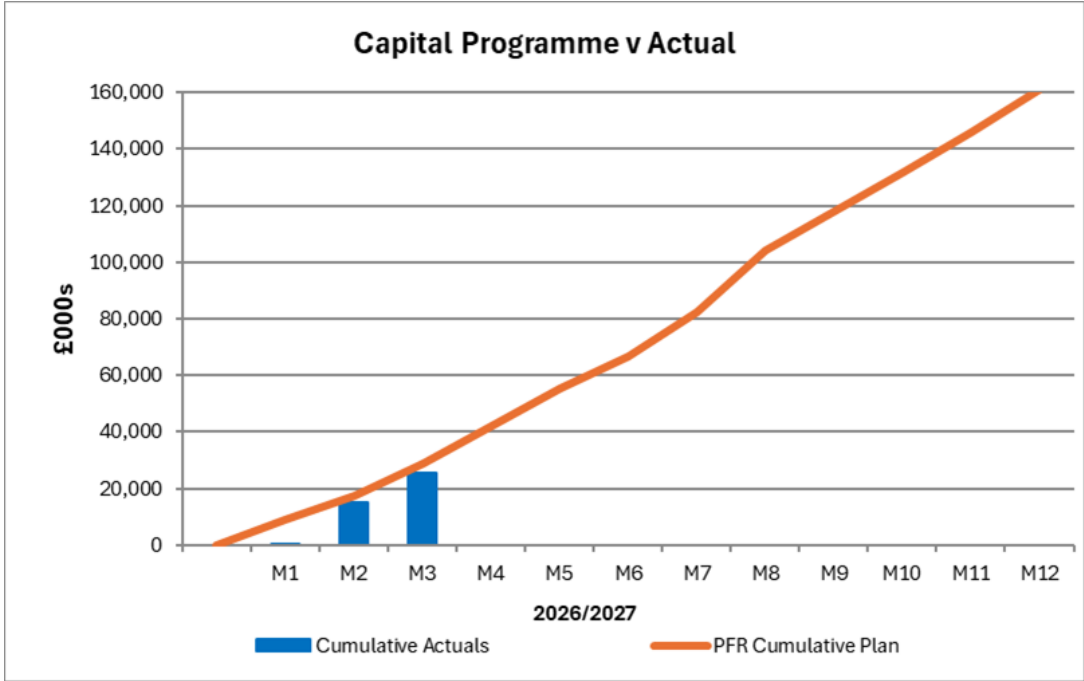
N/A

Anticipated impact and timescales for improvement:

N/A

Recovery dependencies:

N/A



Summary:

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

External allocations have been set at £138.26m; this has increased from month two by £2.90m due to an allocation being received for RAAC, giving an overall capital programme for FY26/27 of £163.80m.

At M3 FY26/27, £2.04m of expenditure (including IFRS 16) relating to the operational capital allocation has been expended and £23.56m of external expenditure incurred, giving total expenditure of £25.60m. This represents 15.7% of the overall spend required across FY26/27 against an expected 25% if the allocation was expended on a straight-line basis over the year.

Recovery actions:

- Work with leads to develop robust spend profiles for agreed programmes

Anticipated impact and timescales for improvement:

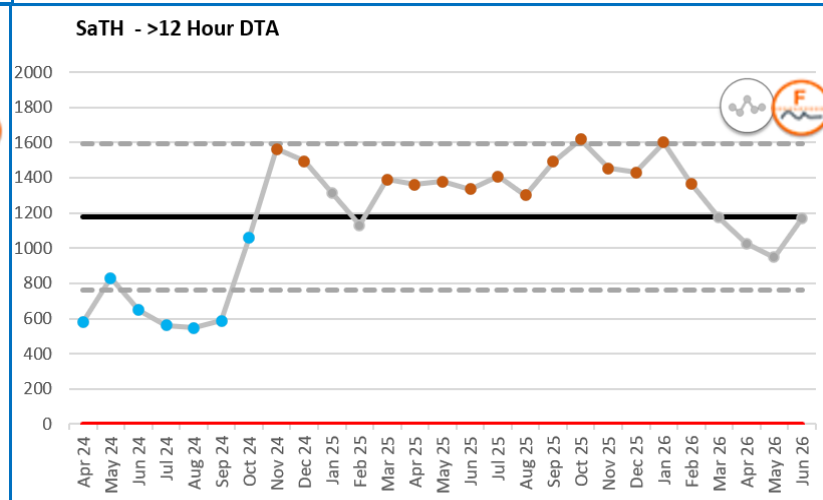
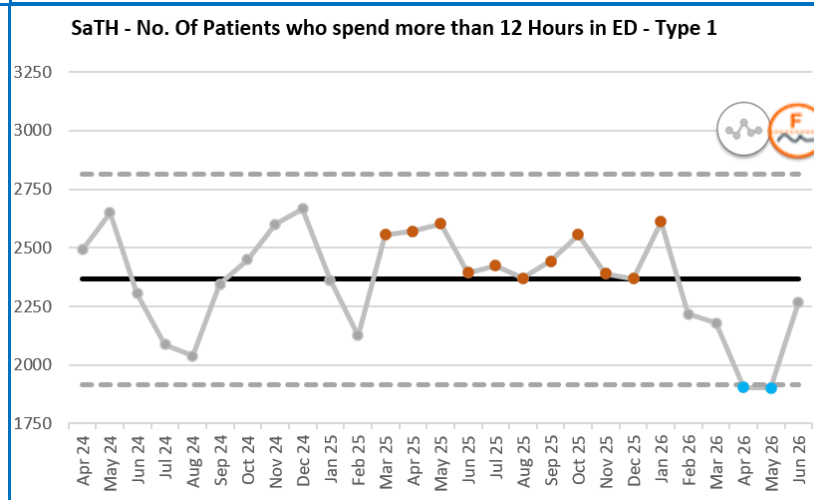
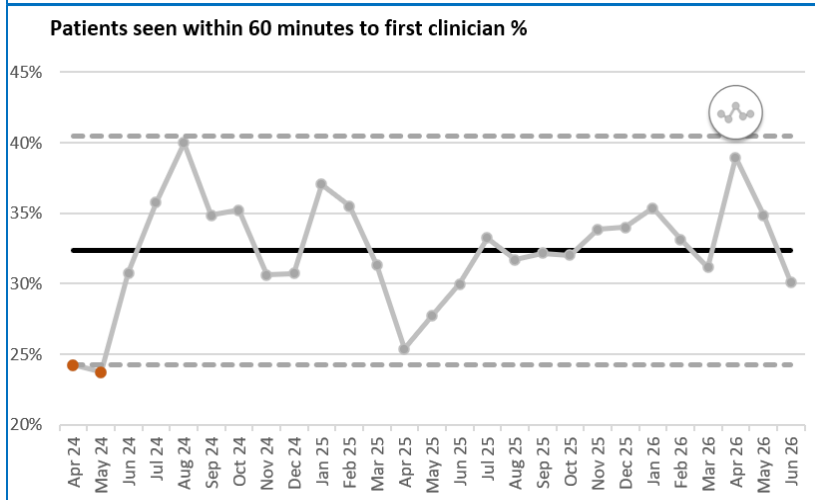
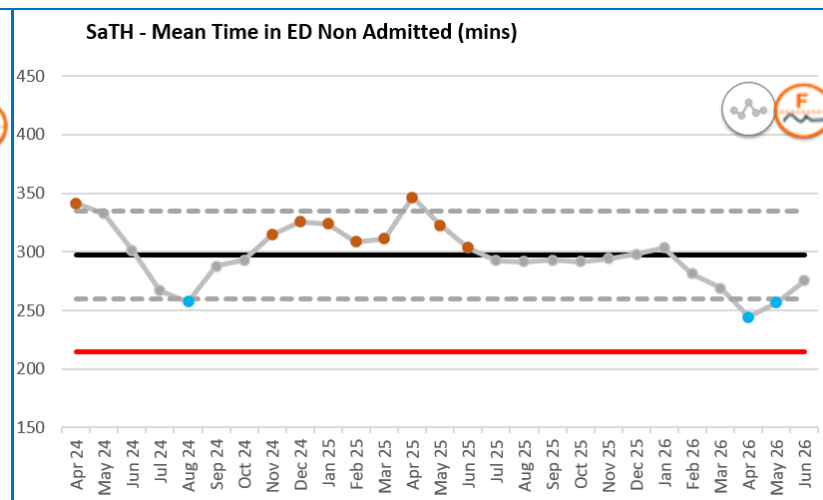
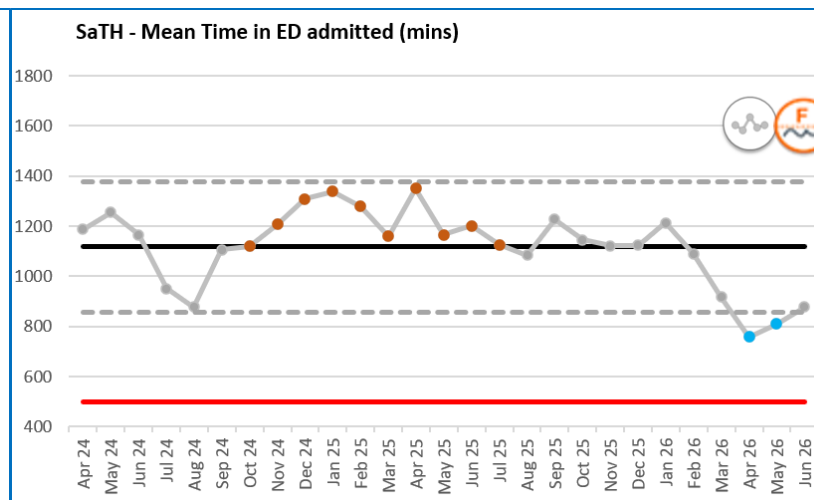
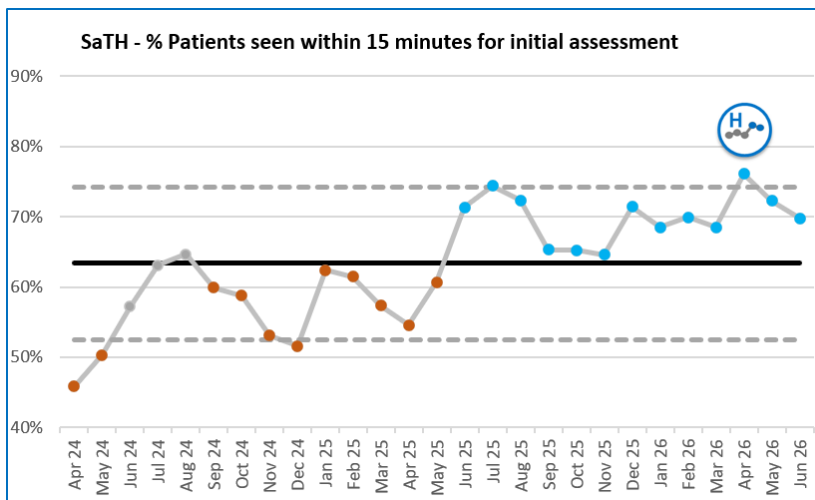
N/A

Recovery dependencies:

N/A

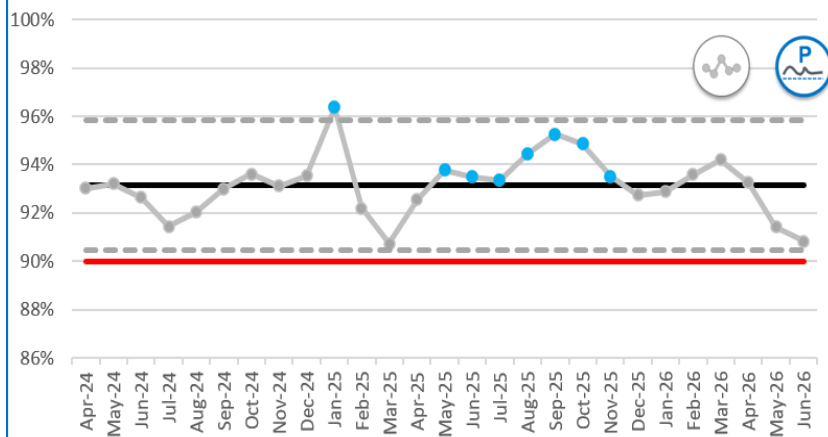
Appendices – Responsiveness And Well Led

Appendix 1 – supporting detail on Responsiveness

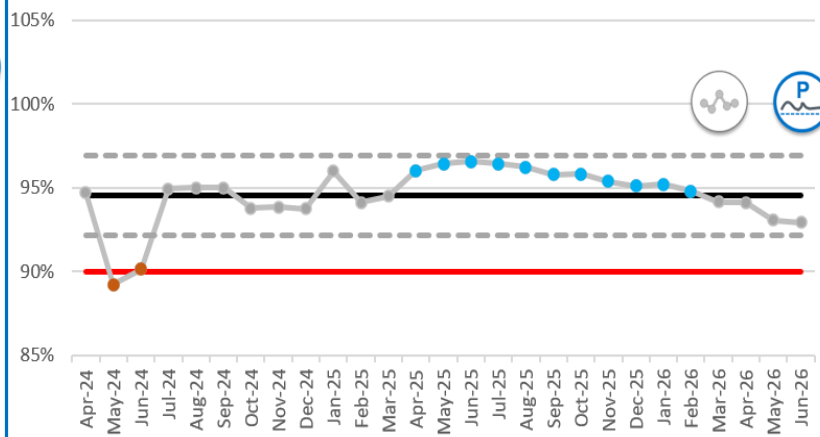


Appendix 2 – supporting Well Led

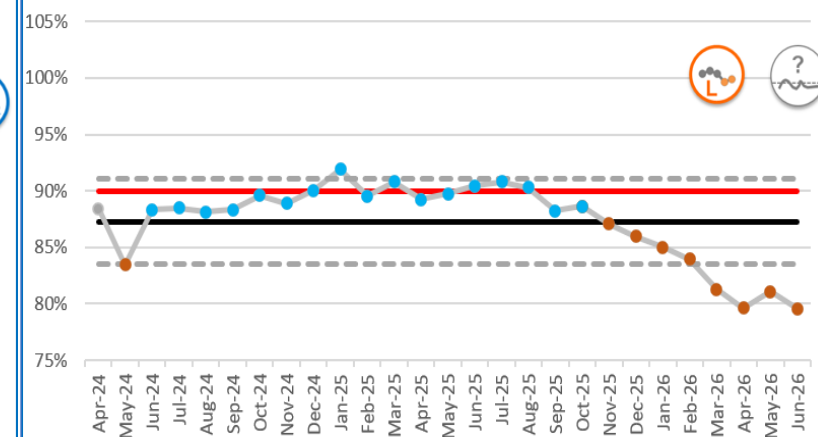
Appraisal – medical staff



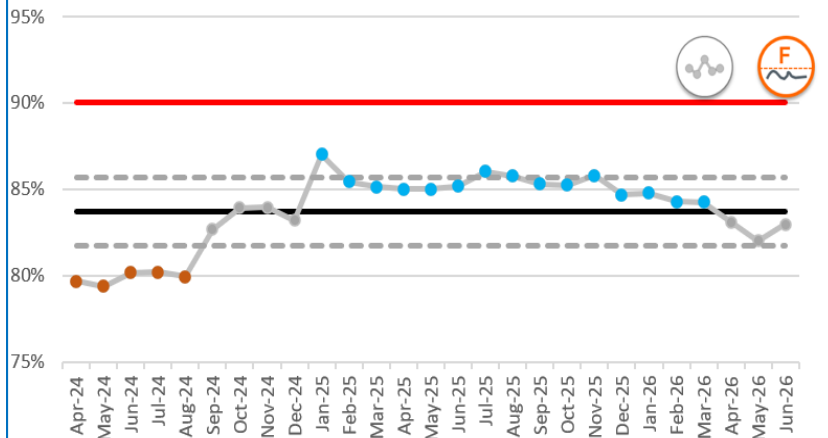
Safeguarding Children Level 2



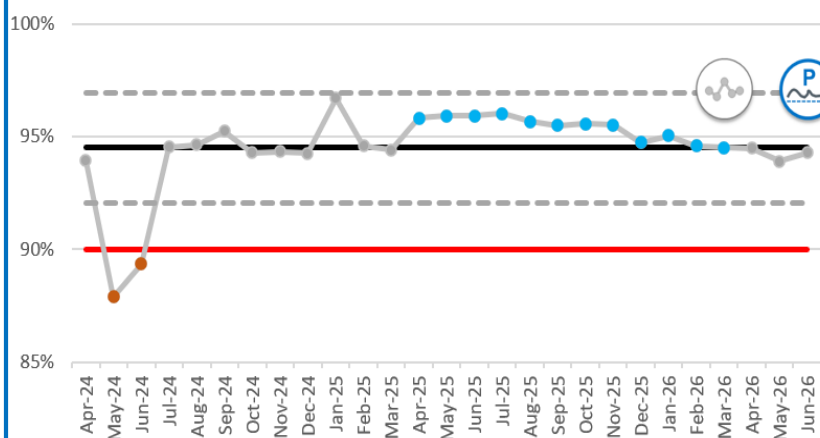
Safeguarding Children Level 3



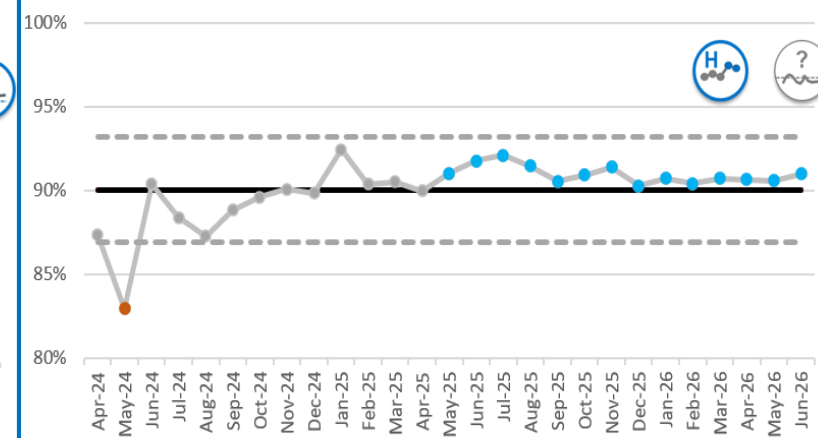
MCA – DOLS and MHA



Safeguarding Adults Level 2

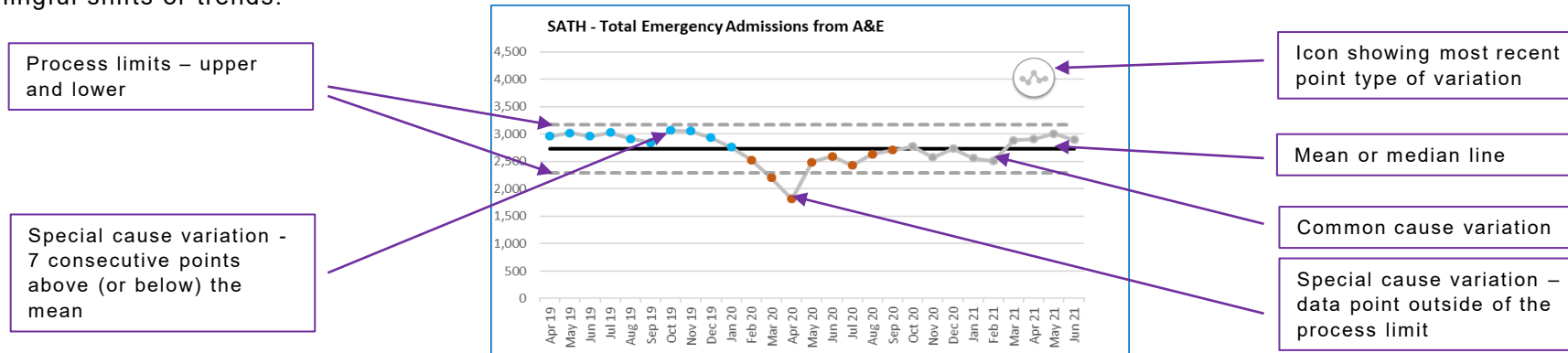


Safeguarding Adults Level 3

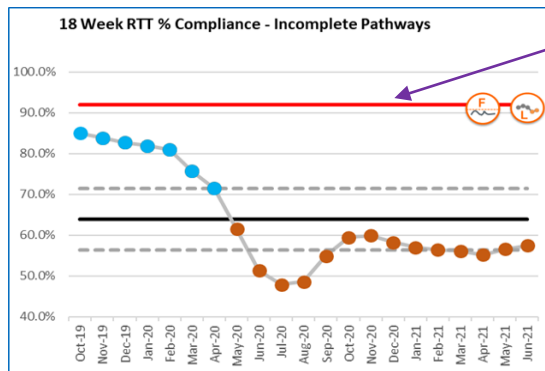


Appendix 3 – Understanding statistical control process charts in this report

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



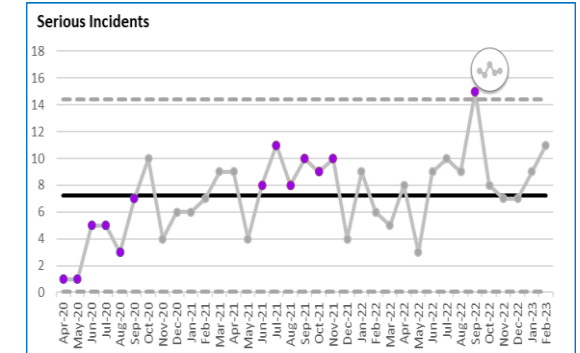
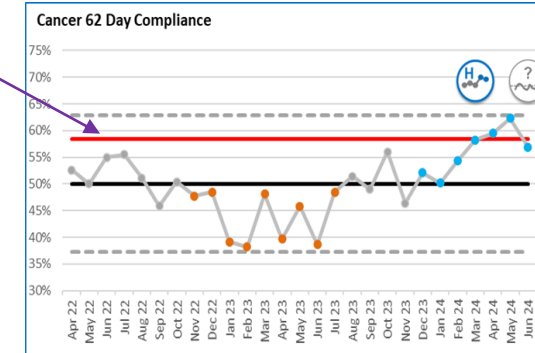
Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.



Target line – outside the process limits.

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

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



Appendix 4 – Abbreviations used in this report

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

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

Appendix 4 – Abbreviations used in this report

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

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

Appendix 4 – Abbreviations used in this report

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

Thank you

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	066/26		
Report Title	SCHAT 2026/27 National Oversight Framework Update		
Executive Lead	Sarah Lloyd, SCHAT CFO		
Report Author	Steve Price, Head of Information and Performance Assurance		
Prior Consultation:	CQC Domain:		Link to SCHAT BAF id(s)
RPC/QSC/People Committee (SCHAT)	Safe	✓	BAF 3.5
	Effective	✓	
	Caring	✓	Risk Register id(s):
	Responsive	✓	
	Well Led	✓	
Executive Summary	This paper is presented to the Boards to review and approve proposed amendments to SCHAT’s Integrated Performance Report KPIs, following publication of the 2026/27 NHS Oversight Framework. This process is in line with SCHAT’s governance arrangements set out within its Performance Framework. This information, together with detail on the calculation of each of the measures, has been reviewed through SCHAT’s People, Resource and Performance and Quality and Safety Committees and each recommends the proposed measures to the Boards in Common meeting for approval.		
Recommendations for the Boards	The Boards are asked to: Review and approve the proposed list of SCHAT Key Performance Indicators devolved to Committees of the Board, in line with current governance arrangements.		
Appendices:	N/A		

1. Introduction

1.1. Why is this paper going the Boards of Directors and what input is required?

A key governance feature of the Trust's approved Performance Management Framework is an annual review of the Trust's performance measures reported within Integrated Performance Reports (IPRs). The initial review was conducted prior to the start of 2026/27 and as was noted at the time, a further review would be conducted in-year should additional guidance be published. The NHS Oversight Framework 2026/27 was published in June 2026, and this has therefore triggered the requirement for an additional review.

This paper is presented to the Boards in Common to review and approve its Key Performance Indicators (KPIs) for the remainder of 2026/27, including any proposed changes.

It is recognised that further changes may be made during 2026/27 and relevant approvals will be sought. Additionally, it is recognised that as our Group develops, we will consider/review the arrangements in relation to performance definitions and reporting; however, prior to completion of this work, it is important that robust arrangements are in place to monitor SCHAT's performance against key metrics.

To ensure robust governance, any further changes; additions, redactions, or amendments to the KPIs within the IPR will be noted and agreed through utilising the IPR front sheet for the relevant Committee and Boards. It is also recognised that once the NOF measures are agreed and reporting is embedded, it would be considered good practice to review the Insightful Provider Board guidance.

2. Summary

2.1. Context

The purpose of this paper is to undertake a review of the IPR following the publication of the 2026/27 NHS Oversight Framework. The paper recommends continuation of many existing measures as well as recommending changes to metrics to allow alignment with internal, local and national priorities.

The KPI review has examined the new 2026/27 NHS Oversight Framework KPIs relevant to this Trust. In addition, consideration has been given to whether the former 2025/26 NHS Oversight Framework measures are relevant to continue as local measures. At this stage the 2026/27 NHS Oversight Framework may be subject to further measure definition changes and clarification, and therefore further updates may be required.

In addition, performance reporting arrangements will be reviewed as our Group develops, which may result in additional changes which will be reported in line with agreed governance arrangements. The paper summarises the suggested amendments and recommends new service measures.

2.2. Proposal

The paper proposes the KPIs that will be included in each Committee's specific IPR. It is of note that some measures are still in development or awaiting a definition and may require further amendment.

This information, together with detail on the calculation of the measures, has been reviewed through SCHAT's People, Resource and Performance and Quality and Safety Committees and each recommends the proposed measures to the Boards in Common for approval.

3. Main Report

In line with the Trust's Performance Management Framework KPIs must be reviewed on an annual basis. This ensures the Board and its committees review and agree objectives and performance measures at least annually. The initial review was conducted ahead of the start of the 2026/27 financial year and as was noted at the time, a further review would be conducted in-year should additional guidance be published. The NHS Oversight Framework 2026/27 was published in June 2026, and this has therefore triggered the requirement for an additional review.

This paper is presented to the Boards to review and approve Key Performance Indicators for the remainder of 2026/27, including any proposed changes.

The proposed measures outlined in this paper are a combination of the 2026/27 NHSE Oversight Framework measures and key local measures. The KPI review has examined the new 2026/27 NHS Oversight Framework KPIs relevant to this Trust. In addition, consideration has been given to whether any of the former 2025/26 NHS Oversight Framework measures are relevant to continue as local measures. Some of the proposed targets are nationally driven while others are based on contract arrangements or local knowledge.

At this stage, the 2026/27 NHS Oversight Framework may be subject to further measure definition changes and clarification, and therefore further updates may be required, and relevant approvals will be sought.

As part of the review, each Accountable Officer (Group Chief Officer) has been given the opportunity to review the proposed list of KPIs and their use in the Performance Framework ahead of the updates being shared with Committees and Board.

The objective of this review is to ensure that key information is available that enables the Board and other key personnel to understand, monitor and assess the Trust's performance against current requirements and expectations.

The IPR will be updated to reflect the KPIs identified in this paper and will be monitored at Board meetings but devolved to each responsible Committee for oversight and to agree any necessary actions.

On release of further guidance or equivalent requirements, or any arrangements linked to our Group, each Committee IPR will be updated to reflect those requirements.

Each Committee reviewed the definitions for each KPI. These are particularly important as there will be measures that are calculated in a very specific manner e.g. 'Percentage of patients waiting over 52-weeks for community services' based on our submission of the Community Health Services SITREP which does not cover all of our services.

A summary of the recommendations provided by each assurance committee are as follows:

4. People Committee

Local KPIs:

- Appraisal Rates
- Bank usage - Variance from plan (WTE)
- Mandatory Training Compliance
- Net Staff in Post Change
- NHS staff survey education and training theme score – to be removed as no longer a NOF and definition was not provided
- Proportion of temporary staff
- Sickness Absence Rate - In month
- Total shifts exceeding NHSI capped rate
- Total shifts on a non-framework agreement
- Vacancies - all

2026/27 NHS Oversight Framework requirements:

- Healthcare worker flu vaccination rate
- National education and training survey satisfaction rate
- NHS staff standards score
- NHS staff survey advocacy rate
- NHS Staff survey engagement theme score
- Sickness Absence Rate - 12 month rolling
- Temporary staffing cost relative band

5. Quality & Safety Committee

Local KPIs:

- Category 3 Pressure Ulcers - to be removed, replaced by new NOF measure
- Category 4 Pressure Ulcers - to be removed, replaced by new NOF measure
- Complaints - (Open) % within response timescales
- Compliance with Duty of Candour
- Count of c-difficile
- CQC Conditions or Warning Notices
- CQC safe inspection score (if awarded within the preceding 2 years) – to be removed
- Deaths - unexpected
- Deaths in custody per 1000 prisoners
- Falls per 1000 Occupied Bed Days
- Medication Incidents - Community
- Medication Incidents - Inpatients
- Medication Incidents with moderate harm – to be removed, 2 new moderate harm rate KPIs added
- Patient Safety Incident Investigations
- Proportion of Harm reviews completed for patients waiting over 52 weeks (local waiting lists)
 - *In review due to high wait KPI changes*
- Proportion of Harm reviews completed for patients waiting over 52 weeks (RTT waiting lists)
 - *In review due to high wait KPI changes*
- Safer Staffing - Average Fill Rate Non-Registered Nurses - Day
- Safer Staffing - Average Fill Rate Non-Registered Nurses - Night
- Safer Staffing - Average Fill Rate Registered Nurses - Day
- Safer Staffing - Average Fill Rate Registered Nurses - Night

2026/27 NHS Oversight Framework requirements:

- NHS Staff Survey - raising concerns sub-score
- Percentage of clinical trials set up within 90 days
 - *Pending as SCHAT isn't currently selected for any clinical trials*
- Percentage of patients to acquire a new grade 3 or 4 pressure ulcer - Community
- Percentage of patients to acquire a new grade 3 or 4 pressure ulcer - Inpatients
- Percentage of safety incidents resulting in harm
- Rate of c-difficile
 - *Awaiting National definition, continuation of 25/26 definition as an interim.*
- Rate of e-coli
 - *Awaiting National definition, continuation of 25/26 definition as an interim.*
- Number of cases of MRSA in the last 12 months

6. Resource & Performance Committee

Local KPIs:

- Average number of days from discharge ready date and actual discharge date – to be removed, replaced by new NOF measure
- Financial efficiency - variance from efficiency plan
- Implied Productivity – Removed as replaced by NOF measure
- New Birth Visits % within 14 days - Dudley
- New Birth Visits % within 14 days - Shropshire
- New Birth Visits % within 14 days - Telford
- Number of patients not treated within 28 days of last minute cancellation
- Proportion of patients within 18 weeks
- Proportion of patients within 18 weeks - Children's Services
- Total activity undertaken against current year plan
- Total patients waiting more than 30 weeks to start consultant-led treatment
- Total patients waiting more than 30 weeks - all services
- Total patients waiting more than 40 weeks to start consultant-led treatment
- Total patients waiting more than 40 weeks - all services
- Total patients waiting more than 52 weeks to start consultant-led treatment
- Total patients waiting more than 52 weeks - all services
- Under 18s elective waiting list growth – to be removed as no longer a NOF and definition was not provided
- Urgent community response 2-hour performance
- Variance year-to-date to financial plan – to be removed, replaced by new NOF measure
- Virtual Ward bed occupancy
- Readmission rate band - National measure not relevant so local measure to be determined.

2026/27 NHS Oversight Framework requirements:

- Average number of days between discharge ready date and actual discharge date
- Combined finance score
 - *Not required as measure uses 2 existing measures to calculate a score*
- Data Quality Maturity Index
- Implied productivity growth
- Level of growth in community care contacts
- Occupied bed days per 100,000 head of population
- Percentage of cases waiting less than 18 weeks for community care
- Percentage of intermediate care beds occupied by patients without criteria to reside
- Percentage of patients admitted, discharged or transferred within 4 hours
- Percentage of cases waiting up to 18 weeks for care (RTT) versus target
- Percentage of patients waiting up to 18 weeks – RTT
- Percentage of patients waiting over 52 weeks for community services
- Percentage of patients waiting over 52 weeks RTT
- Percentage of diagnostic referrals waiting less than 6 weeks
- Planned surplus/deficit
- Relative cost difference (National Cost Collection Index)
- Variance to plan year-to-date

7. Recommendation

The Boards are asked to **review and approve** the proposed list of SCHAT Key Performance Indicators devolved to Committees of the Board, in line with current governance arrangements

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	067/26		
Report Title	Group Vision, Pledges and True North Metrics		
Executive Lead	Nigel Lee, Group Strategy & Integration Officer & Ned Hobbs, Group Chief Operating Officer/Deputy CEO SATH		
Report Author	As Above		
Prior Consultation:	CQC Domain:		Link to BAF id(s)
- Board development session – April 26 - Group Transition Committee – May 26 - Public Assurance Forum – July 26 - Private Boards in Common – June and July 26	Safe	✓	All BAF risks
	Effective	✓	
	Caring	✓	Risk Register id(s):
	Responsive	✓	
	Well Led	✓	
Executive Summary	This paper takes the feedback from a number of sources, including the Board of Directors’ Meetings in Common in June and July 26, as well as discussions with staff, Public Assurance Forum and volunteers, and provides an updated proposal for the Strategic vision and pledges for the Group. The aim has been to create a vision and set of pledges that describe the ambition for the Group. Our pledges are described under 4 headings: - the best place to work - the leaders in modern sustainable healthcare - the safest and kindest care - the best place to receive healthcare These are underpinned by our 2030 objectives, and the ‘True North’ measures of success.		
Recommendations for the Boards	The Boards in Common are asked to: • Approve the final version of the Group vision, objectives and True North metrics.		
Appendices:	Appendix 1: updated pledge ‘poster’		

1.0 Introduction

1.1 This paper takes the feedback from a number of sources, including the Board of Directors' Meetings in Common in June and July 26, as well as discussions with staff, Public Assurance forum and volunteers. From the initial proposals, a number of developments have been incorporated – including a revised vision, change to the high-level 'pledges' (now 4), and revisions to the 2030 objectives and True North metrics.

1.2 Options for the vision were considered and the clearest and most succinct version has been proposed.

Our Vision: *Consistently excellent care – Safer – Kinder – More personal – For everyone.*

1.3 The pledges were developed with a range of input, and reflect the Group's ambition for excellence in all aspects; these are described under four headings:

- the best place to work
- the leaders in modern sustainable healthcare
- the safest and kindest care
- the best place to receive healthcare

These are underpinned by our 2030 objectives, and the 'True North' measures of success. The outputs will be used as context for developing our future Group strategy and clinical strategy, as well as for our Group Board Assurance Framework.

1.4 The work has formed part of a Group-wide focus on embedding a quality management system (QMS) approach, which is an operating framework that aligns organisational strategy with day-to-day frontline care to improve delivery. The summary of 'The Big Three' represents the areas that we believe require the greatest focus this year to help us achieve our Group ambitions.

2.0 Recommendation

2.1 The Boards in Common are asked to:

- **Approve** the revised version of the Group vision, objectives and True North metrics

Group Vision, Pledges and Objectives

Our Vision:

Consistently excellent care

- Safer • Kinder • More personal • For everyone

"The Big Three" our focus for 12-18 months

- Reduce average time admitted patients spend in the Emergency Department, prior to inpatient admission
- Accelerate neighbourhood working – more care delivered in a community location
- Increase the percentage of colleagues that would recommend the Group as a place to work



The best place to work

Everyone has a voice, is valued and is recognised. Everyone is empowered and can thrive. Everyone is supported in the healthiest place to work.

Our 2030 objectives:

- Colleagues recommend us as the best places to work
- We attract the best colleagues, who train, work and stay with us.
- Colleagues are supported with their wellbeing: nutritionally, mentally, physically

Our measures of success:

- Increase % of WTE worked by substantive Group employees reducing the reliance on bank/agency
- Increase % of colleagues recommending our organisations as a place to work (21c)



The leaders in modern, sustainable healthcare

Working in partnership to transform care, embracing innovation, reducing inequalities and meeting the needs of current and future generations.

Our 2030 objectives:

- Adding value for everyone – investing in innovative care and living within our means each year
- A partner of choice - anchored in our communities, modern and interconnected, and continually improving care by 2030

Our measures of success:

- Delivering our financial plan each year – achieving financial balance 2029/30
- Reduction in acute and community bed days per 100k of the population



The safest and kindest care

Leading excellence in safety. Always listening, learning and continuously improving. Everyone receives kindness in every experience.

Our 2030 objectives:

- Be one of the safest trusts in the country and people's first choice for local care by 2030
- 10,000 colleagues trained, supported and empowered to deliver the kindest care. Champions for kindness across the NHS

Our measures of success:

- Increase % of colleagues advocating for the standard of care provided by our organisations (21d)
- A reduction in moderate and severe harm events
- Improve % of our CYP who are healthy, well and ready to learn
- Poppy's Promise - TBC



The best place to receive healthcare

Everyone receives early, responsive care closer to home with fast access to excellent hospital care. People have the best start in life and the best opportunities to lead healthy and independent lives.

Our 2030 objectives:

- Be among the best trusts for access to care in the country - with waiting times that are better than the national NHS standards by 2029
- Shift our approach to person-centred care in the community, home-first, preventative care, supported by two thriving acute hospitals by 2027-2028
- Colleagues have the modern tools they need to deliver excellent care

Our measures of success:

- Increase % of Type 1 ED attendances spending <12hrs in ED
- Increase % of cancer patients receiving treatment <62 days
- Increase % of patients receiving episodes of care taking place in a community location
- Increase % of patients waiting <18 weeks for RTT and non RTT pathways (acute and community)

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	068/26		
Report Title	SaTH’s Integrated Improvement Plan (SIIP)		
Executive Lead	Jo Williams, Group Chief Executive Officer		
Report Author	Mary Aubrey, Programme Director		
Prior Consultation:	CQC Domain:		Link to (SATH) BAF id(s)
Finance Assurance Committee 30/06/26. Perf Ass Committee 30/06/26 Group People Committee 25/05/26. Q&S Assurance Committee 03/07/26	Safe	✓	BAF1, BAF2, BAF4, BAF5, BAF10
	Effective	✓	
	Caring	✓	(SaTH) Risk Register id(s):
	Responsive	✓	CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27
	Well Led	✓	
Executive Summary	- This report provides a summary of progress against the Integrated Improvement Plan (IIP) actions due for completion up to and including 31 July 2026, supported by evidence of delivery and assurance through established governance routes. - The remaining urgent and emergency care (UEC) undertakings have been incorporated into the 2026/27 UEC SIIP plan as Appendix 4 - The majority of actions due within the reporting period remain on track. The principal areas requiring continued oversight relate to UEC Actions SaTH 3.1.1.7, 3.1.1.8 and 3.1.2.1, which remain rated Amber and are being actively managed through established UEC governance arrangements. - The Boards’ attention is drawn to Section 2, which outlines the most significant areas of progress, impact and ongoing focus.		
Recommendations	The Boards are asked to: Note the actions and take assurance from the updates provided, including the evidence of delivery and governance oversight. Note progress against delivery of the tasks/actions that were due up to and including 31 July 2026 as detailed in Appendices 1-4. Note progress on the UEC undertakings incorporated within the 2026/27 UEC SIIP plan, reflecting continued focus on delivery and improvement.		
Appendices (in Board Information Pack)	Appendix 1 - SaTH Governance and Leadership Plan 2026-27 Appendix 2 - SaTH Workforce and Leadership Plan 2026-27 Appendix 3 - SaTH Finance Plan 2026-27 Appendix 4 - SaTH UEC Plan 2026-27 and 2026/27 UEC Undertakings		

1. Introduction

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

This report summarises progress against all Integrated Improvement Plan (IIP) actions scheduled for completion up to and including 31 July 2026 and outlines the associated evidence and assurance demonstrating delivery.

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

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

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

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

The information contained in Appendices 1–4 provides a summary of progress against delivery of the tasks and actions due up to and including 31 July 2026, as defined within SaTH's Integrated Improvement Plan. The UEC plan also includes an update on the UEC 2026/27 Undertakings. These have been approved by the relevant Executive Director and overseen through the appropriate Assurance Committee providing confidence in delivery, oversight and governance assurance.

Governance / Leadership

- **SaTH 4.1.0** – Governance arrangements continue to strengthen with the establishment of the Local Care Transformation Assurance Committee and continued development of Board Assurance structures, providing enhanced oversight of strategic transformation, risk and delivery of the Trust's Moving to Excellence programme
- **SaTH 4.1.15** – The Hospitals Transformation Programme continues to be overseen through established governance arrangements, with ongoing alignment to system transformation priorities and continued development of workforce and programme delivery milestones.
- **SaTH 4.2.7a / 4.2.9** – Progress continues in embedding the emerging Group model, including ongoing Board in Common arrangements and engagement with NHS England regarding future Group Non-Executive Director appointments.
- **SaTH 4.2.8** – The Group People and OD Committee in Common continues to mature, with further development of the forward work programme supporting strengthened Group workforce, culture and people governance.
- **SaTH 4.2.13 / 4.2.14 / 4.2.15 / 4.3.6** – Work continues to progress on the Group governance framework, including Freedom to Speak Up, Group governance documentation, risk management arrangements and alignment of key corporate governance processes across partner organisations.

Workforce and Leadership Collaborative

- **SaTH 2.1.26 / 2.2.9** – Workforce digital transformation continues, with 95% of resident doctors now on e-rostering, preparations underway for consultant rotas through implementation of the Activity Manager module, and Manager Self-Service ESR fully deployed across the Trust. Project resource has now been secured to support delivery of the next phase of the workforce digital programme.

- **SaTH 2.1.28 / 2.1.29** – The five-year workforce plan has been completed and is being socialised across the Trust, supported by launch of the 2026/27 job planning programme. This represents a significant milestone in aligning workforce demand, supply, productivity and organisational sustainability.
- **SaTH 2.1.30 / 2.1.31 / 2.1.32** – Workforce preparation for HTP continues through staff engagement activity, workforce timescale planning with the PMO, and continued alignment of workforce, UEC and transformation activity with STW system priorities. Work is progressing to ensure workforce implications are fully reflected within the HTP Master Programme.
- **SaTH 2.1.33 / 2.1.34** – Workforce sustainability actions continue, including development of the sickness absence improvement programme and Group temporary staffing strategy. A cross-Group task and finish group is supporting development of the future bank workforce strategy, including review of bank staffing rates and workforce flexibility arrangements.
- **SaTH 2.2.8 / 5.3.3 / 5.4.2 / 5.4.5** – Leadership and cultural transformation activity continues through Executive development, Board development, People Pulse and NHS Staff Survey action planning, leadership programmes and Poppy's Promise cultural change work. Governance arrangements remain in place to support delivery of the workforce and leadership agenda through established Board, Committee and SIIP assurance mechanisms.

Finance

- **SaTH 1.1.2 / 1.1.3 / STW 1.1.6 / 1.1.8** – Financial planning remains aligned to organisational, system and NHS England requirements, with continued oversight of the Medium-Term Financial Plan, underlying financial position and longer-term financial sustainability planning. Work continues to ensure alignment between financial, workforce, activity and transformation plans, including future HTP assumptions.
- **SaTH 1.2.1 / 1.2.11 / 1.2.23 / 1.2.24** – Delivery of the 2026/27 financial plan continues through established governance arrangements, with ongoing monitoring of financial performance, activity, demand and capacity through Finance Assurance Committee, Performance Assurance Committee and operational oversight groups. Financial recovery and performance plans continue to be monitored to support delivery of organisational and system objectives.
- **SaTH 1.3.8** – Capital planning remains aligned to system priorities, with ongoing oversight of capital expenditure and investment programmes through established governance processes.
- **SaTH 1.4.6 / 1.4.9 / 1.4.12** – Delivery of internal and external audit recommendations continues to be monitored through established assurance processes. The Trust continues to maintain oversight of audit actions and value-for-money requirements to support effective financial governance and assurance.
- **SaTH 1.5.1** – This action remains rated Amber and has a revised completion date of 31 August 2026 (previously 30 June 2026) due to revised implementation timescales associated with the business-as-usual target operating model. The action remains subject to ongoing monitoring through established governance arrangements.
- **SaTH 1.5.2** – Data quality assurance arrangements continue through established governance processes to support reliable information flows and reporting.

UEC

- **SaTH 3.1.1.3:** It has been agreed that from August 2026, increased senior Paediatric cover will be in place to strengthen clinical decision making
- **SaTH 3.1.1.7:** Blood sample processes are being redesigned in ED to reduce the amount of time it takes to send samples to pathology services and therefore reduce duration of the ED episode of care
- **SaTH 3.1.2.1** – Work continues to improve cardiology and respiratory referral response times through development of response standards and supporting audit arrangements. This action remains rated Amber and is subject to ongoing oversight

- **SaTH 3.3.2:** Due to the sustained improvement in initial assessment performance, this action is now Complete and Evidenced with both hospital sites performing above the England average and within the upper quartile nationally

The Boards are asked to:

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

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	069/26		
Report Title	SaTH Integrated Maternity & Neonatal Report.		
Executive Lead	Martina Morris, Group Chief Nursing Officer John Jones, Group Chief Medical Officer		
Report Author	Stacey Thacker- Head of Midwifery Lauren Taylor - Deputy Head of Midwifery Julie Plant - Divisional Director of Nursing, Women & Children's		
Prior Consultation:	CQC Domain:		Link to (SaTH) BAF id(s)
N/A	Safe	√	BAF1, BAF4, BAF3
	Effective	√	
	Caring	√	(SaTH) Risk Register id(s):
	Responsive	√	CRR, 16, 18, 19, 23, 27, 7,31
	Well Led	√	
Executive Summary	This Integrated Maternity and Neonatal Report includes the latest position in relation to the delivery of actions from the Independent Maternity Review, the Maternity Transformation Programme, NHS Resolution's CNST Maternity Incentive Scheme and the Neonatal Mortality Review action plan. Assure • The Baby Tagging system is currently being installed within the Delivery Suite and Neonatal Unit, with completion anticipated by early August. The Baby Tagging Standard Operating Procedure (SOP) will be updated to reflect the inclusion of these areas, alongside a review of the associated pathway and business continuity arrangements. This will be completed during August. • Birthrate acuity measures the complexity and intensity of maternity care required. Positive acuity indicates that service demand and clinical complexity exceed the available staffing resource, highlighting increased workload pressures and supporting the need for appropriate workforce capacity to maintain safe, high-quality care. One-to-one care in labour and supernumerary status of the coordinator continued to be maintained at 100% in June reflecting the ongoing risk assessment and escalation where necessary to ensure safety in the service. • The Intrapartum acuity tool uses a red, amber, green (RAG) status with a target of 85% to achieve green acuity. This demonstrates an adequate number of midwives available to provide the clinical care required based on acuity of the patients at the time. The Intrapartum area shows that for the periods when a data entry was made the unit was adequately staffed to meet the acuity of the patients 89% of the time in this reporting period. • The Trust is now fully compliant with all applicable Fuller review recommendations (20) and has submitted a Board Assurance Statement to NHS England as per the recent requirement. In addition, a		

	retrospective review of all Human Tissue Authority incidents reported in the last 10 years has commenced.
	Advise • The Newly Qualified Midwife (NQM) Recruitment Support Offer has been established nationally to support maternity providers in recruiting newly qualified midwives into additional Band 5 posts. This initiative forms part of the national response to the Ockenden and Kirkup maternity reviews, with the aim of strengthening maternity workforce capacity and improving the safety and quality of care. The scheme provides funding of up to £10,000 for each additional midwifery post recruited. The Head of Midwifery and Deputy Head of Midwifery have met with the Finance Team to review workforce requirements and funding opportunities and submitted the expression of interest for 10.7WTE posts. • One action within the Neonatal Mortality Review plan, linked to the auditing of the Preterm Golden Hour remains Off Track. Quarterly audits are in place and will be repeated until satisfactory compliance is reached. Progress is monitored and discussed monthly at the Quality and Safety LMNS workstream allowing for learning from practices within the region. Additionally, an action linked to the full adoption of network guidelines on the Neonatal unit has been agreed as Off Track until new timeframes for completing the work can be provided in August. • NHS England has announced a funding opportunity for the Midlands region for the 2026/27 financial year to support Obstetric Sonography Training. At SaTH, all sonographers within the maternity service are midwives by professional background and are part of the maternity workforce. Recruitment to midwife sonographer posts continues to be challenging; therefore, this funding opportunity presents a valuable option to develop and retain our existing workforce through a "grow your own" approach. The Head of Midwifery and Deputy Head of Midwifery are working closely with the Integrated Care Board (ICB) to complete and submit an Expression of Interest by the deadline of 12 August 2026. We are anticipating 1WTE due the cluster model with University Hospitals of North Midlands NHS Trust. • The national Maternity Triage Specification has now been published. A gap analysis will be conducted and create an implementation plan in underway. • The regional maternity Heatmap for June 2026 shows an overall score for The Shrewsbury and Telford Hospital NHS Trust (SaTH) of 27, compared with a regional average of 23.2. This indicates that SaTH's score is above the regional average (a lower score will show improvement). The recent substantive leadership appointments will have a positive impact on the score reducing in its next iteration. Alert • A national shortage of Prostin has been in place since April, with notification received at that time. In response, local clinical guidance was reviewed and updated to reflect the supply constraints and to support the safe management of induction of labour pathways. Ongoing monitoring and contingency planning remain in place to mitigate any risks associated with the national shortage and to ensure the continued provision of safe patient care. • Paediatric ophthalmologists. This workforce challenge has the potential to impact the timely delivery of screening for eligible neonates.

Recommendations for the Board	The Board of Directors is requested to: • Take assurance from this report.
Appendices:	Appendix 1: BoD Ockenden Report Appendix 2: BoD Neonatal Mortality Review Appendix 3: MNTP Phase 2 – July 2026 Appendix 4: Year 8 CNST MIS Progress Report – July 2026 Appendix 5: Perinatal Staffing update All Appendices are available in the Board Supplementary Information Pack.

1.0 Introduction

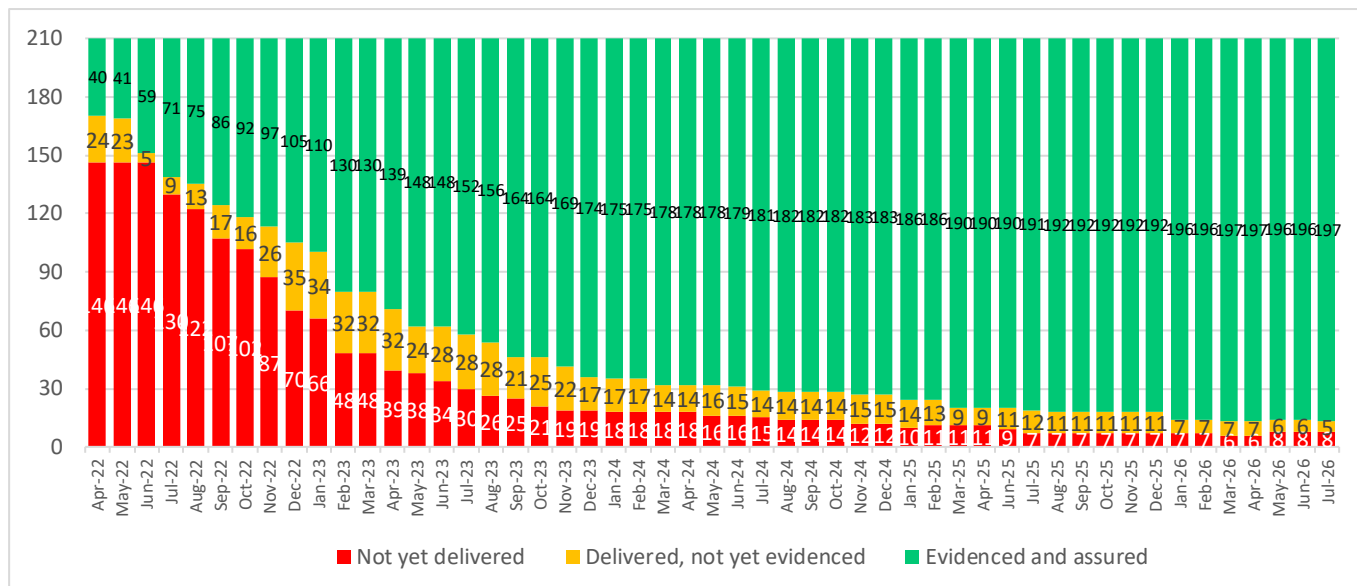
This report provides information and assurance on the following:

- 1.1 The current progress with the delivery of actions arising from the Independent Maternity Review (IMR), chaired by Donna Ockenden.
- 1.2 The position in relation to the progress against the actions arising from the invited review of Neonatal Mortality at the Trust conducted by the Royal College of Physicians.
- 1.3 A summary of progress with the Maternity and Neonatal Transformation Programme (MNTP), which is an IMR action requirement, including an update on the Cultural Improvement Plan.
- 1.4 NHS Resolution's Maternity (and Perinatal) Incentive Scheme (Clinical Negligence Scheme for Trusts - CNST) Year Eight along with suggested wording for recording in the minutes of today's meeting.
- 1.5 Information on the Maternity Heatmap, providing an overview of the current position.
- 1.6 The Monthly Perinatal Staffing Report providing an overview of workforce capacity, staffing performance, and key workforce indicators across both Maternity and Neonatal Services

To support this paper, more detailed information and all appendices are provided in the Board Supplementary Information Pack. Further information on any of the topics is available on request.

2.0 The Ockenden Report Progress Report (Independent Maternity Review - IMR)

- 2.1 Progress against IMR actions are validated at the Maternity and Neonatal Transformation Assurance Committee (MNTAC), and progress is summarised at the Quality Safety and Assurance Committee (QSAC). **Appendix One** provides the summary of Ockenden Report Action Plan as at 14th July 2026. The overall delivery over time, including current position, is as follows:



Delivery Status	Number (change since last report)	Percentage
Evidenced and Assured	197 (↑1)	93%
Delivered, Not Yet Evidenced	5 (↓1)	3%
Not Yet Delivered	8 (↔)	4%
TOTAL	210	

**Rounded percentages

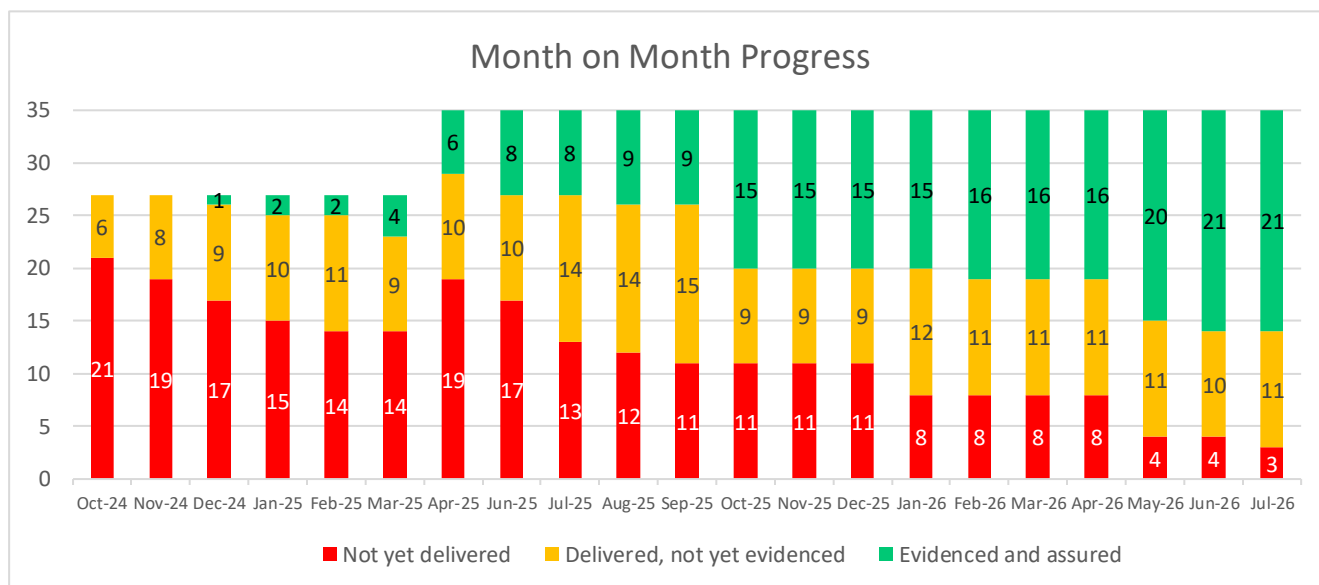
Progress Status	Number (change since last report)	Percentage
Completed fully (Evidenced and Assured)	197 (↑1)	94%
On track	4 (↓1)	2%
Off track	0 (↔)	0%
At Risk	0 (↔)	0%
De-scoped	9 (↔)	4%
Total	210	100%

**Rounded percentages

- 2.2 In total, nine actions remain ‘de-scoped,’ currently. These relate to nationally led external actions (NHS England, CQC) and are not within the direct control of the Trust. Those actions have continued to be reviewed on a quarterly basis and will be escalated again to the national team in Q1. The Local Maternity and Neonatal System continue to oversee these actions. The next quarterly review is now due in August 2026.
- 2.3 Progress against the four actions that remain within the control of the Trust to assure continues with another one expected to be presented for assurance in August.
- 2.5 Following the auditing of our historical completion, 13 actions reviewed by the team were agreed as requiring further assurance. They will be taken to the next assurance committee for a plan to be agreed.

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

3.1 Continued progress is being made to deliver the recommendations from the external invited review of the Trust's neonatal services, which was led by the Royal College of Physicians. **Appendix Two** provides the summary Neonatal External Mortality Review (NEMR) Action Plan as of 14th July 2026. The overall trajectory and position are as follows:



Delivery Status	Number	Percentage
Evidenced and Assured	21 (↑5)	60%
Delivered, Not Yet Evidenced	11 (↑1)	31%
Not Yet Delivered	3 (↓1)	9%
TOTAL (Note: the total number of actions has been revised from 27 in April, as some actions have been broken down into more manageable sub-actions; hence the increase in number)	35	100%

**Rounded percentages

Progress Status	Number	Percentage
Completed fully (Evidenced and Assured)	21 (⇌)	60%
On track	12 (⇌)	34%
Off track	1 (⇌)	3%
At Risk	0 (⇌)	0%
Not Started	0 (⇌)	0%
Descoped	1 (⇌)	3%
Total	35	100%

**Rounded percentages

3.2 One action, linked to the auditing of the Preterm Golden Hour remains At Risk. Quarterly audits are in place and will be repeated until satisfactory compliance is reached. Progress is monitored and discussed monthly at the Quality and Safety LMNS workstream allowing for learning from practices within the region. As the number of eligible cases for review each quarter is quite low, an aggregated review is underway to try and identify overall compliance levels.

3.3 Progress continues to assure the eleven actions already implemented, while work is ongoing to implement the last four actions currently Not Yet Delivered. They require the recruitment of Neonatal Safeguarding and Family Integrated

Care Lead Nurses which are currently at various stages of the recruitment process.

4.0 Maternity and Neonatal Transformation Plan (MNTP) Phase Two – High level progress report

- 4.1 It is a requirement of the Independent Maternity Review, for the Board of Directors to receive an update on the Maternity and Neonatal Transformation Plan at each of its meetings in public. The summary MNTP, which is now in its second phase, is attached as **Appendix Three**.
- 4.2 A review of all descoped actions was completed in July 2026 and presented to the Maternity and Neonatal Transformation Assurance Committee (MNTAC). These actions remain descoped as their completion is dependent on external organisations and agencies. The status of all descoped actions is reviewed quarterly to ensure they remain appropriately categorised and to identify any actions that can be reintroduced into the programme for local delivery and oversight.

A refreshed action plan is currently being developed for the Community Services Transformation Programme to better reflect service developments and changes in population need. The revised plan will ensure alignment with current priorities, operational requirements, and the needs of the local community. A review of the updated action plan is scheduled with the Group Chief Nursing Officer in August.

Following the publication of the recent Nottingham Ockenden (June 2026) and The Baroness Amos (July 2026) reports, a multidisciplinary team (MDT) review meeting has been scheduled for August to consider and challenge the recommendations, assess their applicability to our service, and confirm the required actions. The outcomes of this review, together with recommendations for the Trust, will be presented to the Group Chief Nursing Officer, Group Chief Medical Officer and the Non-Executive Director – maternity and neonatal safety champion by early September to support organisational learning and inform future improvement priorities.

- 4.3 A renewed format for the Cultural Improvement work within the Division is being drafted, which will align with Trust wide initiatives and priorities such as embedding Poppy's Promise and acting on received feedback and implementing the priorities identified through the Perinatal Equity and Antidiscrimination programme. The proposed format will be validated through the Culture workstream, and an update will be brought through the next Board report.

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

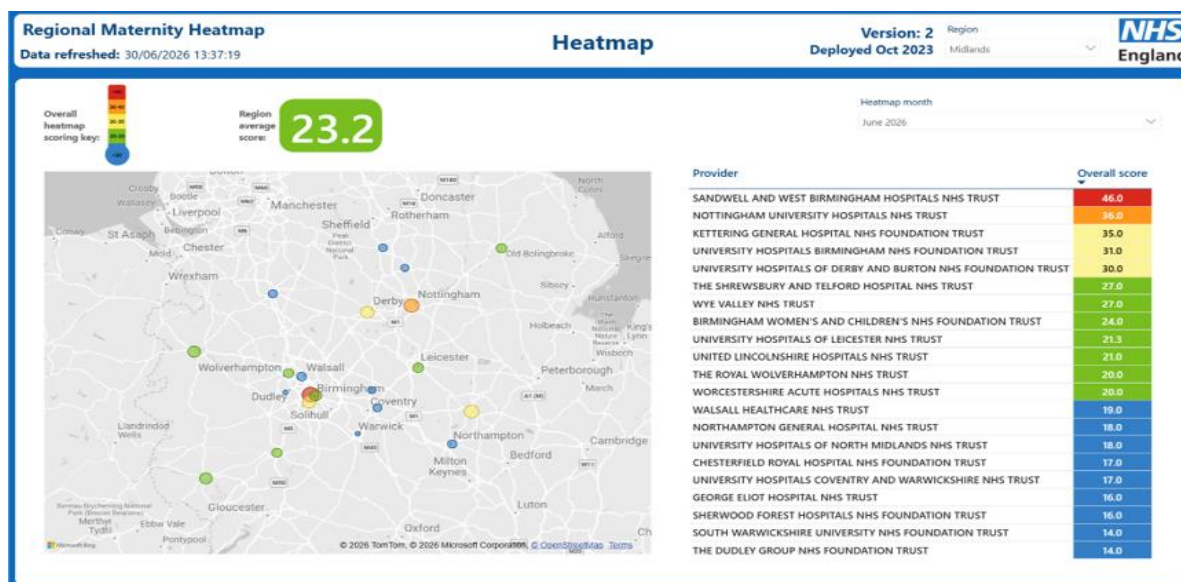
- 5.1 Year 8 was launched on 23rd April 2026 with six core safety actions with the focus being on outcomes, this approach keeps the emphasis on improvements that have a real impact for women, babies and families, recognising the significance of local variation in priorities, pressures and workforce, and the central role of Board accountability.
- 5.2 The below table summarises progress against each Safety Action and their sub-items.

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

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

6.0 Maternity Heatmap

- 6.1 The Maternity Heatmap for June 2026 has been presented. The overall score for The Shrewsbury and Telford Hospital NHS Trust (SaTH) was 27, compared with a regional average of 23.2. This indicates that SaTH's score is above the regional average and will continue to be monitored to identify themes, inform workforce and service planning, and support ongoing quality improvement initiatives within maternity services.
- 6.2 SaTH currently scores high (n=5) within the Maternity Heatmap for senior leadership posts not being in substantive positions. However, this does not yet reflect the recent appointment of the Head of Midwifery and Consultant Midwife, both of whom have now been recruited to substantive posts. It is anticipated that these appointments will be reflected in the next reporting cycle and should result in an improvement in this domain of the Heatmap.
- 6.3 The Maternity Heatmap also identifies a score of 3 relating to Maternity Support Worker (MSW) vacancies. Recruitment is currently underway to secure substantive appointments to these roles. Recruitment to MSW positions has been challenging, as this remains a relatively new role within the maternity workforce.
- 6.4 To support recruitment and workforce sustainability, SaTH is currently recruiting to Maternity Care Assistant posts. Once substantive staff are appointed, they will be supported to undertake the required in-house training and development to progress into Maternity Support Worker roles. This approach will strengthen the workforce pipeline, improve vacancy levels, and support the delivery of safe and effective maternity care.



Regional Maternity Heatmap
Data refreshed: 30/06/2026 13:37:19

Scoring

Region: Midlands
NHS England

Heatmap month: June 2026

Provider	Overall score	CQC Mat overall rating	Stakeholder concerns	CQC S29a	CQC s31	Ext. Ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw. lves vac.	MSW vac.	Obs. vac.	Unfilled roles	Snr L'ship not in post	Safety champions	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate	MOSS
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	4	4	1	0	0	0	0	0	5	5	3	0	0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	17.0	1.0	0	0	0	0	0	0	0	0	0	1	3	0	2	0	0	0	1	3	3	3	0	0
GEORGE ELIOT HOSPITAL NHS TRUST	16.0	1.0	1	0	0	0	0	0	0	0	0	3	0	1	3	0	0	0	1	3	3	3	0	0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	35.0	3.0	2	0	0	0	0	5	3	0	0	2	3	2	3	0	0	0	1	5	3	3	0	0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	18.0	3.0	1	0	0	0	0	0	0	0	0	1	0	3	2	0	0	0	1	1	3	3	0	0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	36.0	3.0	5	0	0	5	0	3	0	0	3	3	2	1	4	0	0	0	0	1	1	3	3	0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	46.0	3.0	4	5	0	0	0	2	3	0	0	3	3	2	5	0	0	0	0	5	3	3	5	0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	16.0	1.0	0	0	0	0	0	0	0	0	0	1	1	4	2	0	0	0	0	1	3	3	0	0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	14.0	1.0	0	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	3	3	3	0	0
THE DUDLEY GROUP NHS FOUNDATION TRUST	14.0	1.0	1	0	0	0	0	0	0	0	0	3	0	0	2	0	0	0	0	1	3	3	0	0
THE ROYAL WOLVERHAMPTON NHS TRUST	20.0	1.0	0	0	0	0	0	0	0	0	3	3	0	1	4	1	0	0	0	1	3	3	0	0
THE SHREWSBURY AND Telford Hospital NHS Trust	27.0	2.0	1	0	0	0	0	3	0	0	0	2	1	0	3	1	5	0	0	0	3	3	0	0
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	17.0	1.0	0	0	0	0	0	0	0	0	0	4	0	1	2	0	0	0	0	3	3	3	0	0
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	30.0	3.0	2	0	0	0	0	3	0	0	0	3	3	1	2	1	5	0	0	1	3	3	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	21.3	2.3	1	0	0	0	0	0	0	0	0	3	0	1	1	0	0	0	0	5	5	3	0	0
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	18.0	1.0	1	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0	5	5	3	0	0
WALSALL HEALTHCARE NHS TRUST	19.0	3.0	1	0	0	0	0	0	0	0	0	3	0	1	4	0	0	0	0	1	3	3	0	0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	20.0	1.0	0	0	0	0	0	0	0	0	0	3	1	0	3	0	0	0	0	3	3	3	3	0
WYE VALLEY NHS TRUST	27.0	1.0	2	0	0	0	0	0	0	0	0	3	2	2	5	1	0	0	0	5	3	3	0	0

7.0 Perinatal Staffing (Appendix 5)

7.1 NICE published the report Safe Midwifery Staffing for Maternity Settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013). The Maternity Incentive Scheme (MIS) for CNST Year 8 requires. Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate. Regional Chief Midwives can support this process if required.

7.2 Maternity Workforce and Acuity

During June 2026, the service sustained positive acuity levels above 85%, with 89% of shifts reported as Green, 10% as Amber, and 1% as Red. However, it

should be noted that the green acuity rate fell below 90% for the first time this year and will continue to be monitored.

The confidence factor for data entry was 91%, demonstrating continued improvement in the quality and reliability of reporting.

Red Flag reporting is now fully aligned with both national and local guidance. A total of 26 Red Flags were reported during June, with 88% (n=23) relating to delays in undertaking Artificial Rupture of Membranes (ARM).

Compliance with one-to-one care in labour and maintenance of the supernumerary coordinator role remained at 100% throughout June, reflecting ongoing risk assessment processes and timely escalation where required to ensure the safety and quality of care.

7.3 Neonatal Workforce

British Association of Perinatal Medicine (BAPM) compliance remained stable at 95%.

Qualified in Specialty (QIS) compliance remained stable at 59%. A rolling programme of training and development continues to support further improvements in this area.

The Nurse in Charge (NIC) role was not fully supernumerary on 19% of shifts, representing an improvement from 28% in the previous month.

The number of occasions the unit was required to close to external hospital admissions increased from 3 to 11 instances. This was primarily attributable to staffing pressures resulting from a significant increase in staff sickness absence. Registered staffing fill rates remained stable during the month. However, there was a slight reduction in unregistered staffing fill rates, partly due to emergency leave and planned annual leave.

Staff sickness absence increased from 6.23% to 8.9%. The most commonly reported reasons for absence were anxiety/stress and fractures. There are currently four members of staff on long-term sickness absence, with one member of staff having returned during the month on a phased return programme.

7.4 Obstetric Medical Workforce

There have been three successful appointments of Consultant Obstetricians (Fetal Medicine, Perinatal Mental Health and Obs and Gynae). These will commence later in the year.

8.0 Delays in Retinopathy of Prematurity.

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

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

9.0 Human Tissue Authority (HTA) Fuller Inquiry Recommendations.

- 9.1 In response to the recommendations arising from the Amos Report, and recognising the wider themes of governance, regulatory compliance, organisational oversight and board assurance highlighted within both the Ockenden Review and the Nottingham Maternity Review, the Trust's Human Tissue Authority (HTA) Committee undertook a comprehensive gap analysis in July 2026.
- 9.2 The Amos Report identified 29 recommendations for the wider NHS, of which 20 are directly applicable to NHS Trusts. The review undertaken by the HTA Committee assessed the Trust's current arrangements against these recommendations and the broader expectations for effective governance, leadership accountability and regulatory oversight set out within national inquiries.
- 9.3 Following a period of compliance related actions, the assessment identified that SaTH is now fully compliant with all recommendations. This demonstrates strong progress in strengthening governance arrangements and provides assurance that the Trust is addressing the key themes of transparency, oversight and regulatory compliance that feature prominently across the Amos, Ockenden and Nottingham reports.
- 9.4 As well as the recommendations for perinatal services, the Trust needs to review the last 10 years retrospective review of all incidents related to the Human Tissue Authority (HTA). This review has now commenced.

10.0 Recommendations

The Board of Directors is requested to:

- 10.1 Receive this report for information and assurance.
- 10.2 Record formally in the minutes of this meeting that the Board has received updates and Appendices listed in the table.

Stacey Thacker
Head of Midwifery

Lauren Taylor
Deputy Head of Midwifery

Julie Plant
Divisional Director of Nursing

August 2026

Maternity & Neonatal Safety Champions - Key Issues Report		
Report Date: 2 nd July 2026		Report of: Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 02/07/2026		Membership Numbers: Quoracy met
1	Agenda	• Chair's welcome and apologies, conflict of interest and minutes reviewed. • Action log and review of AAAA from June 2026 • Safety Champions Update Document from June 2026 • Our Staff Said, We Listened Poster / Safety Champions Poster • Perinatal Quad Meeting Minutes- Bi Monthly • Maternity Quality Dashboard and Oversight Report (AAA) • Neonatal Quality Dashboard and Oversight Report (AAA) • CNST Updates with Appendices • Locally Agreed Safety Intelligence Dashboard (SA9) • Neonatal Staffing & BAPM Report (Safety Action 4) • Maternity Governance Report (including MNSIs and Action Plans) • Maternity & Neonatal Service User Feedback - Themes and Actions • MNVP Neonatal Families/Bereavement/BAME/High Deprivation - Prioritisation Action Plan • Maternity & Neonatal Independent Senior Advocate Feedback - Themes and Actions • Any other business: • Information Pack
2a	Alert	. None
2b	Assurance	New Caesarean report to start coming to MNSC from August 2026. CNST progress remains largely on track, with only a small number of actions requiring focused attention. Neonatal dashboard indicators remained broadly stable, including no babies born outside care pathways and improvements in parental review documentation. Governance processes were reported as timely, with low numbers of overdue incidents and completed PSI investigations progressing appropriately.

2c	Advise	Baby tagging system was discussed. The committee felt further review was required to fully understand system An increase in MRSA-positive wound swabs following caesarean sections was reported. Six cases had been identified over recent months, prompting a deep-dive review and action plan. The group agreed this should be tracked on the dashboard to monitor whether the issue resolves or requires further action National shortage of Paediatric ophthalmologists was discussed again and the sustainability of ophthalmologist availability for Retinopathy of prematurity (ROP) screening on the neonatal unit. A new process for high quality images to be taken by SaTH staff is planned with training planned and capital equipment being requested for funding. This request is currently with League of Friends and but will progress to Capital Funding otherwise		
3	Actions to be considered by the MNTAC / QSAC / Trust Board	J Jones is going to contact Divisional Director of Operations for W&C for further update.		
4	Report compiled by	John Jones (Chair)	Minutes available from	Sabrina Kitcher (EA to Group Chief Medical Officer)

Board of Directors' Meeting in Common: 13 August 2026

Agenda item	071/26a		
Report Title	SCHT Board Assurance Framework		
Executive Lead	Anna Milanec, Group Chief Governance Officer		
Report Author	Shelley Ramtuhul, Director of Governance, SCHT		
Prior Consultation:	CQC Domain:		Link to (SCHT) BAF id(s)
N/A	Safe	✓	All
	Effective	✓	
	Caring	✓	(SCHT) Risk Register id(s):
	Responsive	✓	All
	Well Led	✓	
Executive Summary	The SCHT 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 for 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 the strengthened clinical prioritisation measures in place • New financial risk. Escalation within system oversight framework and increased regulatory scrutiny, inability to invest, loss of opportunity to transform services		
Recommendations for the Board	The Board is asked to: • Consider the assurances provided regarding the mitigation of risks to delivering the strategic objectives • Approve the proposed amendments		
Appendices:	Appendix A: BAF Risk Tracker Appendix B: SCHT Board Assurance Framework		

Appendix A: BAF Risk Tracker

New Ref	Risk Title	Opened	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Movement in Month	Target
1.1	Workforce Team Capacity	Sept 23	16	16	16	16	20	20	20	20	20	12	12	12	12	↓	6
1.2	Recruitment restrictions impact on staff morale and wellbeing	Sept 23	16	16	16	16	16	16	16	16	16	12	12	12	Rec to close	↔	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	Rec to close	↔	6
1.4	Level of transformation impacts on leadership and colleague capacity, wellbeing and morale	July 2026	-	-	-	-	-	-	-	-	-	-	-	-	16	NEW	6
3.3	Completion of actions linked to learning response	May 25	12	12	12	12	12	12	12	12	12	12	12	12	12	↔	4
3.5	Potential for patient harm due to waiting times	Apr 23	16	16	16	16	16	16	16	16	16	9	9	9	9	↓	6
3.6	Recruitment challenges	Apr 22	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	↔	10
4.2	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	9	9	9	9	9	9	9	9	9	9	Rec to close	↔	5
5.1	Cyber attack	Sep 23	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	↔	8
5.3	Costs exceed plan	July 2026													12	↔	6

Risk Increasing		New Risk	
Risk Decreasing		Closed Risk	

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

Key Measures:

Sustained improvement compared to 24/25 across:

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

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- People promise resource available

Lead Director:

Chief People Officer

Objective Details:

Opened: April 2025

Reviewed Date: July 2026

Progress Update:

- Deep dive being carried out into staff sickness with wider triangulation with staff survey to identify and focus on hotspot areas
- Retention remains stable
- Poppy's promise launched and linked to new Group culture programme supported by AQUA and a Kind Life
- NHS staff standards have launched nationally and a gap analysis is being conducted with future reporting via People Committee
- Apprenticeship opportunities continuing

Risks:

- 1.1 Workforce team capacity
- 1.2 Recruitment restrictions impacting on staff morale and wellbeing
Recommended for Closure
- 1.3 National, system and local level changes impacting on staff morale and wellbeing
Recommended for Closure
- 1.4 Level of transformation impacts on leadership and colleague capacity, wellbeing and morale

Lead Committee:

People Committee

Appendix B: Board Assurance Framework 2026

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

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

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~~

Risk Details:

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

Assurance:

Source of Assurance 3

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

Gaps in Assurance:

- A1: Impact on leadership and culture during significant transformation of workforce directorate

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Scoping of collaborative working options	Chief People Officer	~~June 2025~~ Sept 2025 Mar 2026	Working group established and oversight from the Shared Services Programme - completed
C1	Implementation of new workforce structure	Chief People Officer	~~Mar 2026~~ July 2026 Sept 2026	Phase 1 is completed and consultation for Phase 2 has closed and implementation planned for September
A1	Well led and Culture review to be commissioned	Chief Executive	Sept 2026	

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 **RECOMMEND FOR CLOSURE**

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

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

Gaps In Controls:

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

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 to be organised	Chief People Officer	May 2026	Completed – these have taken place with feedback to Exec Team

Risk Details:

Opened: September 2023
 Reviewed Date: [July 2026](#)
 Source of Risk: Internal Risk Assessment
 Corporate Risk Register 5834, 7101

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 Assurance:

- [A2: Board interview feedback to be shared](#)

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 **RECOMMENDED FOR CLOSURE**

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

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

Gaps In Controls:

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

Action Plan to Address Gaps:

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

Risk Details:

Opened: September 2023
 Reviewed Date: [July 2026](#)
 Source of Risk: Internal Risk Assessment
 Corporate Risk Register 5834, 7101

Assurance:

Source of Assurance

2

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ Reduced leaver rate
- ✓ Staff engagement outputs
- ✓ [Transition Committee oversight of integration](#)

Gaps in Assurance:

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

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 1.4

Principal Risk: Level of transformation impacts on leadership and colleague capacity, wellbeing and morale **NEW**

In order to achieve the improvements needed, deliver the efficiency programmes and benefit from group working for both staff and patients there is a significant level of transformation required. There is potential for this to impact on staff sickness, retention and performance.

Risk Rating:

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

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 rolled out
- ✓ Better together bulletin introduced
- ✓ Group Leadership Forum established
- ✓ Staff side engagement
- ✓ Workforce integration framework in place
- ✓ Culture Programme

Gaps In Controls:

- C1: Management of change policy to be aligned across SaTH and SCHAT – absence of any reference to the management of integration (carried forward from risk 1.3)

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 Sept 2026	Joint staff side established and working on joint policy

Risk Details:

Opened: July 2026
 Reviewed Date: July 2026
 Source of Risk: Internal Risk Assessment, Staff Survey
 Corporate Risk Register 5834, 7101

Assurance:

Source of Assurance

2

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ Reduced leaver rate
- ✓ Staff engagement outputs including the QMS for regular monitoring outside of the staff survey
- ✓ Transition Committee oversight of integration

Gaps in Assurance:

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

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

Key Measures:

Sustained improvement compared to 24/25 across:

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

Supporting Programmes of Work:

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

Key Assumptions:

- People Promise Resource

Lead Director:

Chief People Officer

Objective Details:

Opened: April 2025

Reviewed Date: July 2026

Progress Update:

- Plan to reinvigorate the Admin Academy in Q2
- NHS staff standards have launched nationally and a gap analysis is being conducted with future reporting via People Committee
- Automation of recruitment underway
- Exec visits to teams linked to QMS

Risks:

Risks 1.1, 1.2 and 1.3 as above, noting 1.2 and 1.3 are recommended for closure
Risk 1.4 is a new risk that has been added as above

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

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

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Objective Details:

Opened: April 2025
Reviewed Date: July 2026

Progress Update:

- Work on new Datix system is ongoing
- Medication incidents with physical harm have been at 0 for the last 3 months, six monthly thematic reviews continue to be undertaken
- Falls have reduced from 6.48 per occupied bed days in May to 5.5 in June, quarterly thematic reviews continue to be undertaken
- CQUIN Audit for Purpose T results are awaited for Q1
- Thematic review for deaths in custody commissioned and expected in Q2

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 - Community

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

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

Gaps In Controls:

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

Risk Details:

Opened: May 2025
 Reviewed Date: July 2026
 Source of Risk: Internal Audit
 Corporate Risk Register 7101

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 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	Completed – further cohort trained
C4 / C5	To ensure timely completed of PSII's, deadline to be set at time of commissioning	Director of Governance / Director of Nursing	Sept 2026	

Appendix B: Board Assurance Framework 2026

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

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

Gaps In Controls:

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

Risk Details:

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

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 Assurance:

- ~~A1: Lack of formal tracking or reporting of harms process~~
- ~~A2: Policy requires pro forma completion at 52 weeks but no 52 week waiters~~

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. - completed
A1	KPI to be established	Director of Nursing	June 2026	Included in the performance framework but no waiters over 52 weeks - completed
A2	Benchmark proforma completion requirements to aide review of policy for 52 week harms review assessment	Director of Nursing - Community	Oct 2026	

Appendix B: Board Assurance Framework 2026

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

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](#)

Gaps In Controls:

- [C1: Electronic rostering solution to support staffing](#)
- C2: Lack of centralised bank
- C3: Cessation of HCA agency without mitigations

Risk Details:

Opened: April 2022
Reviewed Date: [July 2026](#)
Source of Risk: Internal Risk Assessment / External Guidance and Controls
Corporate Risk Register 3167, 3947, 4595, 4806, 7162

Assurance:

Source of Assurance **3**

- ✓ People Committee oversight
- ✓ Safe Staffing reporting to Board biannually
- ✓ Quality metrics
- ✓ System People Board oversight

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	Chief People Officer	Sept 2025 January 2026	NHSP being used - Completed
C3	Targeted recruitment campaigns for HCAs	Chief People Officer	Dec 2025 Oct 2026	Recruitment drives undertaken but review being undertaken to assess if further recruitment needed
C2	Options appraisal / plan for implementation of centralised bank to be presented to Directors Meeting for onward presentation to the Group Executive Team	Chief People Officer	Oct 2026	

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

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 SCHAT in delivering its Strategy through delivering against critical success factor for these relationships

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

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Objective Details:

Opened: April 2025

Reviewed Date: [July 2026](#)

Progress Update:

- Active partners with ICB in neighbourhood model, leading on the MDT workstream
- Investment in expansion of Community UEC services secured, e.g. RR to midnight, CTH and integrated front door
- Extension of UCR service approved and has been implemented
- [Further options to enhance MIUs being explored](#)
- [Local Care Programme Committee established](#)

Risks:

4.1 Operational Capacity to undertake all programmes of work

4.2 Internal governance and operational oversight arrangements for system programmes

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

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

Gaps In Controls:

- C2: Uncertainty regarding commissioning intentions which have potential to impact on operational capacity
- C3: Capacity to ensure LCTP development & delivery

Risk Details:

Opened: September 2023
 Reviewed Date: July 2026
 Source of Risk: Internal risk assessment
 Corporate Risk Register 3167, 3249, 3947, 4590, 4595, 5834, 6286

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 Assurance:

- -N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Engagement with the commissioners	Director of Ops - Community	June 2026 Sept 2026	Ongoing discussions between senior operational staff and commissioner to understand the implications of the intentions and opportunities for ongoing collaboration. Commissioning Intentions included in LCTP as projects to ensure oversight and capacity
C3	Additional Capacity to LCTP	Director of Ops - Community	September 2026	Programme Directorship Service, Project Management and Operational Leads in process of being recruited to

Appendix B: Board Assurance Framework 2026

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 **RECOMMENDED FOR CLOSURE**

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

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Establishment of system transformation group to improve collaborative working
- ✓ Weekly vacancy panel established at system level

Gaps In Controls:

- C2: Alignment of risk management across the system

Risk Details:

Opened: September 2023
Reviewed Date: July 2026
Source of Risk: Internal Risk Assessment / Integrated System Improvement Plan
Corporate Risk Register N/A

Assurance:

Source of Assurance **3**

- ✓ Quality and Safety Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

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 was prepared and agreed by Governance Leads but has not progressed whilst changes at system level continue. Risk management alignment now being looked at across Group instead – action to be closed

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

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

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Lead Executive

Chief Finance Officer - ShropComm

Objective Details:

Opened: April 2025

Reviewed Date: [July 2026](#)

Progress Update:

- CIP programme exceeding plan at M3 by £74k (£10k recurrent and £64k non recurrent).
- Annual CIP value has been fully identified with work now focussed on de risking the programme
- Additional productivity efficiencies of £2.5m planned for the year
- Digital programmes are progressing with oversight from SCHAT Programme Board and Digital Assurance Group

Risks:

- 5.1 Risk of cyber attack
- 5.2 Digital team capacity
- 5.3 Costs exceed plan

Lead Committee:

Resource and Performance Committee

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

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 with further programme planned

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~~

Risk Details:

Opened: September 2023
 Reviewed Date: [July 2026](#)
 Source of Risk: Internal Risk Assessment
 Corporate Risk Register [N/A](#)

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

- ✓ Audit Committee Oversight
- ✓ Data Security Protection Group
- ✓ DSPT assessment with national oversight
- ✓ Internal audit
- ✓ [Check and challenge sessions on DSPT standards](#)

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	Completed DSPT submission with standards met

Appendix B: Board Assurance Framework 2026

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

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

Gaps In Controls:

- ~~C3: Exploring opportunities to share expertise with system partners~~
- C4: Group collaboration and shared service being explored

Risk Details:

Opened: September 2023
 Reviewed Date: July 2026
 Source of Risk: Internal Risk Assessment / Vacancy Rate
 Corporate Risk Register N/A

Assurance:

Source of Assurance

3

- ✓ Digital Assurance Group

Gaps in Assurance:

- A1: Strengthened Board level to drive digital agenda

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
C4 / A1	Group Chief Digital Officer to be appointed to provide Board level expertise and assurance and deliver efficiencies and productivity across the Group.	Chief Executive	September 2026	Progressing ahead of plan.

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services

BAF 5.3

Principal Risk: Costs exceed plan

Escalation within system oversight framework and increased regulatory scrutiny, inability to invest, loss of opportunity to transform services

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	3	2
Total	20	12	6

Controls:

- ✓ Use of non-recurrent schemes to allow more time to implement recurrent cost saving schemes
- ✓ Medium-term financial planning to assess risks and opportunities
- ✓ Productivity and CIP Groups working on identifying additional CIP schemes, and de-risking existing schemes
- ✓ Robust QEIA process in place
- ✓ Financial Recovery Group in place for operational oversight

Gaps In Controls:

- C1: Risk relating to B5 nursing review – not yet quantified
- C2: Delivery of Local Care Programme and delivery of 10YHP at scale
- C3: 3 year rolling CIP not fully in place

Risk Details:

Opened: July 2026
 Reviewed Date: July 2026
 Source of Risk:
 Corporate Risk Register

Assurance:

Source of Assurance

3

- ✓ Resource and Performance Committee oversight
- ✓ NHSE oversight
- ✓ System Finance Committee oversight
- ✓ KPI Metrics
- ✓ Value for Money audit

Gaps in Assurance:

- A1: Impact of national change in relation to contractual frameworks linked to new models of care e.g. Multi Neighbourhood Provider contracts

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Timeline and scope of review to be outlined to inform risk assessment	Chief People Officer	July 2026	Timeline to be confirmed with NHSE no later than 31 July 2026.
C2	Financial modelling to support Local Care and Community Transformation to be reported through LCTAC for oversight	Chief Finance Officer	Match 2027	Initial update to be provided September 2026
C3	Oversight of 3-year efficiency programme via FRG. Progress update to NHSE on value of efficiencies identified for 2027/28 and beyond.	Chief Finance Officer	Sept 2026	To be presented to RPC and BiC prior to NHSE submission.

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	071/26b		
Report Title	SaTH Board Assurance Framework - Quarter 1, 2026/27		
Executive Lead	Anna Milanec, Director of Governance		
Report Author	Deborah Bryce, Head of Corporate Governance & Compliance		
Prior Consultation:	CQC Domain:		Link to (SATH) BAF id(s)
People & OD Assurance Committee; Performance Assurance Committee; Finance Assurance Committee; Quality and Safety Assurance Committee; ARAC (via email).	Safe	✓	All BAF risks
	Effective	✓	
	Caring	✓	(SaTH) Risk Register id(s):
	Responsive	✓	
	Well Led	✓	
Executive Summary	1. The Board Assurance Framework (BAF) outlines the risks to achievement of the organisation’s strategic objectives. 2. SaTH’s Board Assurance Framework (BAF) risks have been subject to review/refresh for quarter 1, 2026-27 with executive leads. 3. There is a proposed increase to the total current risk score of BAF risk 5 this quarter from 5X3=15 to 5X4=20, with the likelihood of the risk increasing. The proposed increase in score is linked to the current financial position and the risks within the forecast run rate and CIP delivery for 2026/27.		
Recommendations to the Board	The Board is asked to: a) Consider if the BAF risk(s) 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 1 BAF.		
Appendices:	Appendix 1: Board Assurance Framework, Quarter 1 (draft)		

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 SaTH BAF content for quarter 1 was undertaken during June 2026.

2.0 Significant changes to the BAF during quarter 1 2026/27

- 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 As this is the BAF for the new 2026/27 financial year, previously closed actions from last year have been removed and a number of new gaps/actions have been added.
- 2.3 An **increase** to the total current risk score of **BAF risk 5** is proposed this quarter from 5X3=15 to 5X4=20, with the likelihood of the risk increasing. The proposed increase in score is linked to the current financial position and the risks within the forecast run rate and CIP delivery for 2026/27.
- 2.4 A slight change is being proposed to the risk title of BAF risk 5, with the word 'continued' deleted, as follows: 'The Trust does not operate within its available resources, leading to financial instability and ~~continued~~ regulatory action'.
- 2.5 Initially, when the BAF was considered by the committees of the Board during July 2026 there had also been a proposed reduction to the score of BAF risk 10, from 20 to 16 due to consistent improvement in 12-hour Type 1 performance and mean ambulance handover time since March 2026. However, the risk score reduction was not agreed by both Performance Assurance Committee and Quality & Safety Assurance Committee as they wished to be more confident (receiving more assurance) that the measures in place were having a sustained effect before reducing the risk score. Therefore, the score of BAF risk 10 in quarter 1 remains the same as the previous quarter.

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

- 3.1 The BAF risks and proposed actions aligned with gaps in control and assurance can be viewed within the draft BAF (**Appendix 1**).
- 3.2 Based on the overall draft current total risk scores for quarter 1, there are four top risks with a current total risk score of 20; three risks with a score of 16; one with a score of 15, five with a score of 12 and one with a score of 8, as indicated within the BAF summary page.
- 3.3 The four top scoring risks with a current total risk score of 20, are shown below.

The top scoring BAF risk(s) based on draft current total risk scores at quarter 1:

Risk No.	Risk title	Overseeing Committee	Current proposed risk score at quarter 1, 2026-27	Change in risk score since the previous quarter
BAF 5	The Trust does not operate within its available resources, leading to financial instability and regulatory action.	Finance Assurance Committee	5X4 = 20	↑ Increase from 15 to 20
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 Committee and Quality & Safety Assurance Committee	4x5 = 20	↔ No change

Note: The BAF summary page outlines the other extreme risks scored at 15 or 16 above.

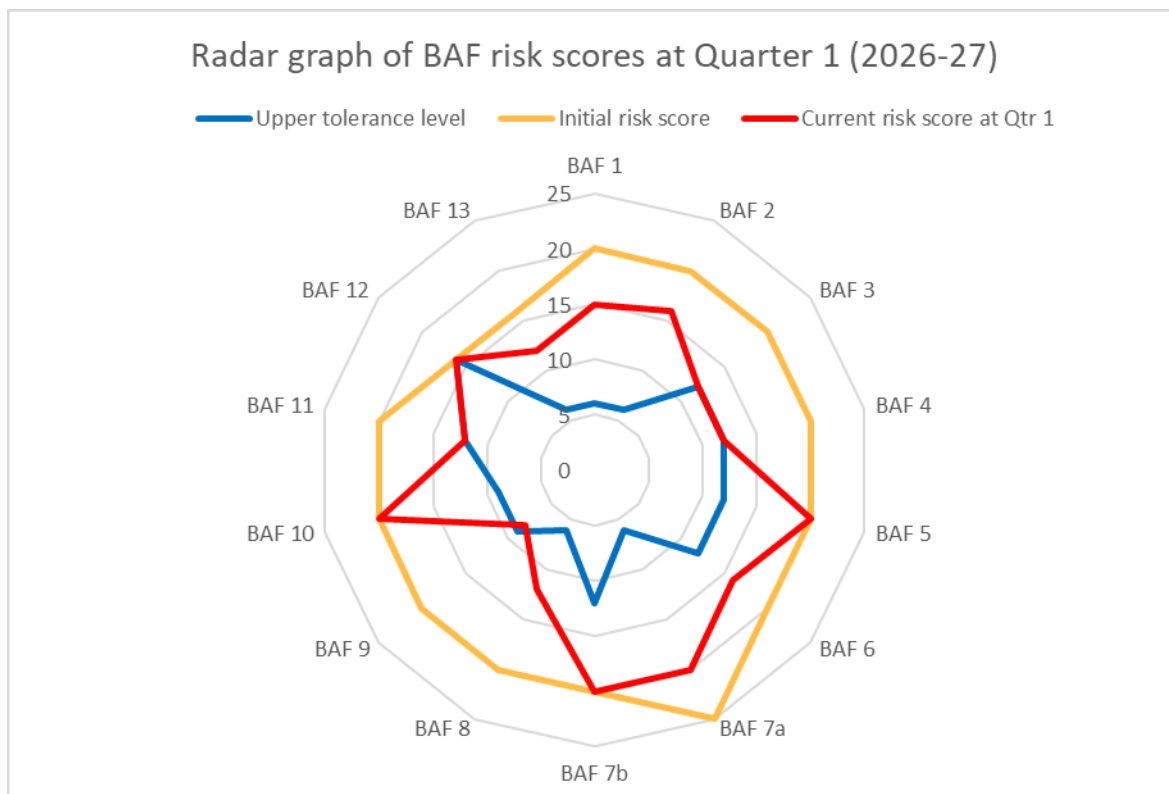
3.4 Being aware of the proposed top scoring risk(s) should assist the Board to consider:

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

- identify the gap between the risk upper tolerance level and current risk score.
- help identify where the initial and current risk scores are the same (where the line on the graph overlaps), 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 is just below its upper tolerance level of 9 as the score is at 8 again this quarter. All other BAF risks are above their upper tolerance levels.

5.0 Recommendations

The Board is asked to:

- Consider if the BAF risk(s) content reflects the strategic risks within the organisation and if the risk scores are appropriate.
- 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.
- Approve** the quarter 1 BAF.

Appendix 1

SaTH Board Assurance Framework (BAF) 2026/27 - draft quarter 1 (Apr-June 2026)

(Updated June/July 2026 - Version 2.0)

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

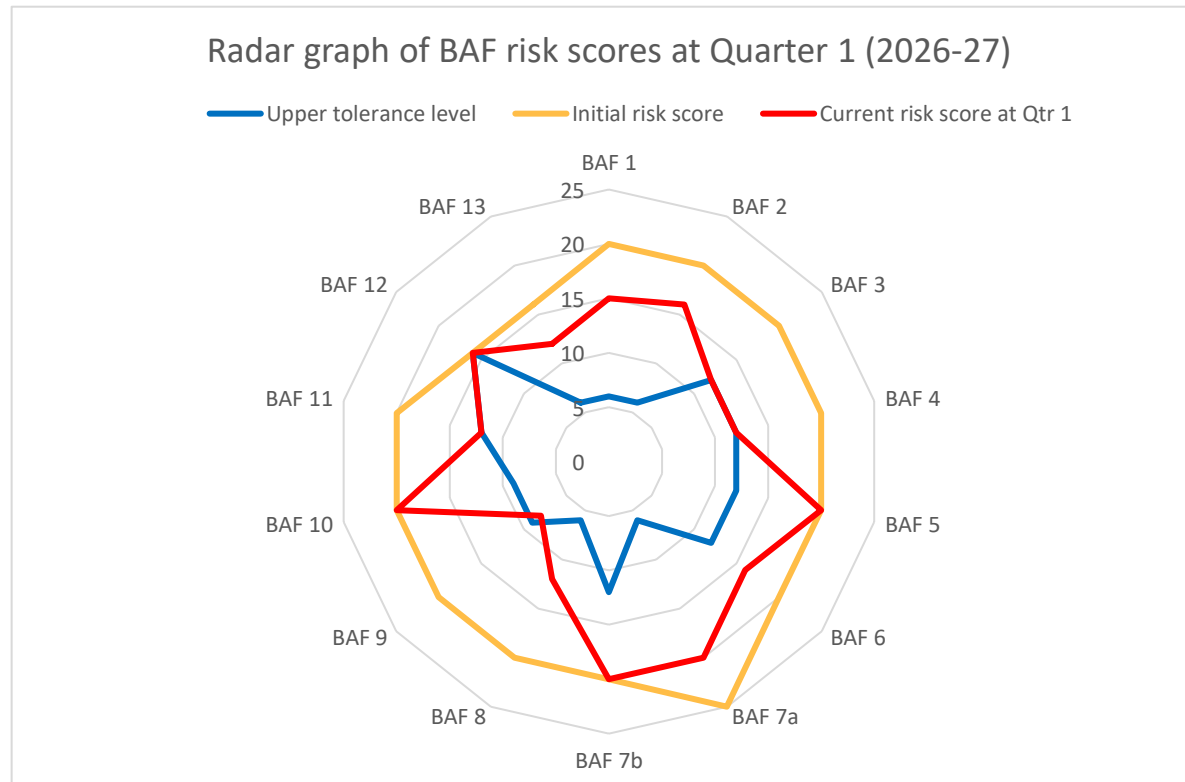
Board Assurance Framework 2026/27 - Summary

						Current total risk score in previous quarters (IxL):					Current total risk score (IxL):	
Board Assurance Framework 2026/27 - Summary at <u>Quarter 1</u> (April - June)		Alignment to Trust Strategy - strategic themes/objectives	Initial (inherent) risk score	Upper tolerance level (and risk appetite)	Lead Executive	Lead Committee	Quarter 1 (2025-26)	Quarter 2 (2025-26)	Quarter 3 (2025-26)	Quarter 4 (2025-26)	Quarter 1 (2026-27)	Change in current risk score since previous quarter, plus any further comments
Ref:	Risk title:											
BAF 1	If the Trust is unable to maintain quality of care standards and clinical safety, outcomes will not be acceptable	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	5x4 = 20	6 (minimal)	Group Chief Medical Officer /Group Chief Nursing Officer	Quality & 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)	Group Chief Nursing Officer/ Group Chief Medical Officer	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)	Group Chief People Officer	People & OD Assurance Committee (in common)	4x4 = 16	4x3 = 12	4x3 = 12	4x3 = 12	4x3 = 12	↔ No change
BAF 4	A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	5x4 = 20	12 (open)	Group Chief People Officer	People & OD Assurance Committee (in common)	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4X3=12	↔ No change
BAF 5	The Trust does not operate within its available resources, leading to financial instability and continued regulatory action	Make our organisation more sustainable.	4x5 = 20	12 (open)	Acting Chief Finance Officer	Finance Assurance Committee	5x4 = 20	5x4 = 20	5x4 = 20	5X3=15	5x4 = 20	↑ Increase in score linked to current financial position and the risks within the forecast run rate and CIP delivery for 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)	Group Chief Estates, Facilities and Capital Officer	Performance Assurance Committee	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16	↔ No change
BAF 7a	Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	5x5 = 25	6 (minimal)	Acting Chief Finance Officer	Audit and Risk Assurance Committee	5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20	↔ No change.
BAF 7b	The inability to implement modern digital systems impacts upon the delivery of patient care	Improve the quality of care that we provide. Ensure seamless patient pathways. Make our organisation more sustainable. Enhance the wider health and wellbeing of communities.	4x5 = 20	12 (open)	Acting Chief Finance Officer	Performance Assurance Committee	4x5 = 20	4x5 = 20	4x5 = 20	5x4 = 20	5x4 = 20	↔ No change

Board Assurance Framework 2026/27 - Summary

						Current total risk score in previous quarters (IxL):					Current total risk score (IxL):	
Board Assurance Framework 2026/27 - Summary at <u>Quarter 1</u> (April - June)		Alignment to Trust Strategy - strategic themes/objectives	Initial (inherent) risk score	Upper tolerance level (and risk appetite)	Lead Executive	Lead Committee	Quarter 1 (2025-26)	Quarter 2 (2025-26)	Quarter 3 (2025-26)	Quarter 4 (2025-26)	Quarter 1 (2026-27)	Change in current risk score since previous quarter, plus any further comments
Ref:	Risk title:											
BAF 8	The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards.	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x5 = 20	6 (minimal)	Group Chief Nursing Officer	Quality & 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)	Group Chief Operating Officer	Performance Assurance Committee and Quality & Safety Assurance Committee	4x4 = 16	4x3 = 12	4x3 = 12	4X2 = 8	4X2 = 8	↔ No change
BAF 10	The Trust is unable to meet the required national urgent and emergency standards.	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	4x5 = 20	9 (cautious)	Group 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)	Group Strategy & Integration Officer and Group 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.		Group Chief Medical Officer/ Group Chief Nursing Officer	Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless patient pathways.	SaTH has a MINIMAL risk appetite for risks that may compromise safety and the achievement of better outcomes and experience for patients. We are willing to consider actions which present a low risk to quality and safety priorities and objectives. We recognise, however, that we may have to tolerate a higher impact within the patient experience domain and greater levels of escalation.		Quality & Safety Assurance Committee				
Risk opened: risk content refreshed 1 April 2023 (previous risk within 2021/22)		John Jones/ Martina Morris								

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (numbered and linked to the actions required)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Inconsistencies in care • Inconsistencies and lack of clarity in governance arrangements • Lack of 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 • Lack of clarity of data and triangulation of data • Lack of capacity to plan service improvement work • Organisational culture Consequence: • Increased avoidable harm to patients • Delays in time-critical care • Inadequate care • Poor patient experience and increased complaints • Increased length of stay • Poor management of deteriorating patients • Reduced staff morale and recruitment and retention • Inconsistencies in governance arrangements • CQC prosecutions and enforcements if standards and frameworks are not in place. • Reputational damage, financial loss and lack of confidence in the organisation	5	4	20	• Moving to Excellence programme. • Targeted transformation programmes • Quality and Safety Strategy under development - <i>this will be done jointly with SCHT</i>; Quality Priorities for 26/27 in place; Corporate Strategy; People Strategy; Digital Strategy; workforce planning; Palliative and End of Life strategy. • Clinical audit programme • Governance structure in place. • Safeguarding Policy (including Mental Health and Learning Disabilities), IPC Policy and PSIRF policy in place. • Staff training • Daily incident communications (Datix)and Incident Review Overview Group (IROG) RALIG both in place • Trust Complaints Process and an independent complaints panel • Freedom to Speak Up Guardian and ambassador arrangements in place • Board Assurance Visits • CQC action plan owned by Divisions • External representation at our quality meetings at QOC, RALIG and Safeguarding • Fortnightly catch ups and quarterly engagement meetings with CQC • MIAA follow-up reports • Hospital Full Policy in place • Contingency arrangements in place with UHNM for emergency Maxillo Facial work. Elective and cancer service contingency arrangements being developed with Royal Wolverhampton. NHSE Specialised Commissioning review of head and neck services across the Midlands started 15 December 2025. • Ward Exemplar Programme	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). <i>March 2026 CQC inspection report is pending.</i> • 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) • Culture dashboard reported to Strategic People Group (1st) and Group People Committee (2nd) • Externally led quality assurance visits and reports (3rd) • Quarterly FTSU updates to Board (2nd) • External Peer reviews with action plans produced, as required (3rd) • Medical Regulatory Group established Q2 24/25 (2nd) • Q1:Pharmacy Aseptic Services - stage one compliance management (enhanced oversight following Environment Agency visit). <i>Re-visit lowered risk from high to moderate</i> (3rd) • Maternity Survey Results (Q3) improvement in all questions and none in the worse than other trusts sections (3rd) . Results due at QSAC. • All national patient surveys reported to QSAC with associated action plans (2nd)	5	3	15	Gaps in control: 1. National shortages in specific workforce, e.g. theatres, endoscopy, doctors within critical care, care of the elderly, emergency medicine. 2. A number of patients with no criteria to reside and lack of alternatives to hospital admission, impacting on patient flow and pressures in the Emergency Department. 3. Prolonged timescale of electronic systems replacing dated and paper based systems. 4. Implementation of national Patient Safety Incident Response Framework (PSIRF) and now to work on the outcomes of PSIRF. Development and roll-out of Patient Safety & Quality Strategy. 5. Notice served on inpatient neurology service by RWT which came to an end on 19 June 2025. 6. Ensuring consistent compliance with Infection Prevention and Control (IPC) standards. 7. Delivering all actions from the Fuller Inquiry report. Gaps in assurance: -	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 2026/27. 2. See BAF risk 10. 3. See BAF risk 7b. 4. Develop a three year Quality & Safety Strategy by Q3 2026/27 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead: Group Chief Nursing Officer. 5. Work with regional and extra-regional partners with support from NHSE and ICB leadership to develop long-term mitigation. By Q4 26/27 (longer-term). Executive lead: Group Chief Medical Officer. 6. Review IPC related actions and improvements with the aim of developing an overarching IPC improvement plan for the Group during 2026/27. Executive Lead: Group Chief Nursing Officer. 7. Complete remaining Fuller inquiry report actions during 2026/27 to safeguard the security and dignity of the deceased. Executive Lead: Group Chief Nursing Officer/ Group Chief Medical Officer.	1b. Q3: The main remaining challenges in medical recruitment are Cardiology, Max Fax, Neurology, General Anaesthetics, Haematology and Oncology. Q4: We have seen significant reductions in nursing vacancies. Q1 26/27: Medical Workforce Efficiency Programme in place including revised recruitment strategies for medics, plan to utilise external support/headhunting for challenging specialities. 2. - 3. - 4. Work in progress to have one overarching Quality and Safety Strategy. Q4: National Quality Strategy still pending, 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. Q1: work has started in Q1 26/27 in relation to how a joint strategy can be developed with SCHT. 5. 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 June 2026. Q4: Also appointing an Acute Physician with an interest in Neurology. Discussions with UHB are ongoing about potential joint appointment. Q1: Current support remains as locum cover plus virtual support from private provider. A joint job description for longer-term support between UHB and SaTH has been developed and will be submitted to the Royal College of Physicians for approval. 6. Q1: Work is underway to review IPC related actions and improvements. 7. Q1: The Fuller report recommendations have been largely implemented, with four governance related actions remaining, which are being progressed. The Board in Common will receive further assurance following further discussion at July 2026 Quality & Safety Assurance Committee. The Trust is also in receipt of specific bereavement care actions following the publication of Donna Ockenden's independent review of maternity services at Nottingham University Hospitals report and will undertake an audit of mortuary incident records from 2015-2026, once more specific process details are received via NHSE and HTA.			6

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' - 1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	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 2025) • 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 • 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) and Group People Committee/PODAC (2nd) • Quarterly FTSU updates to Board (2nd) • Patient Safety Incident Response Framework and policy to Board (2nd) • MIAA internal audit reviews 2024/25: PSIRF (Substantial Assurance) 2024/25 to September 2025 ARAC (3rd). • CQC Report published May 2024 (3rd) and March 2026 inspection report is pending. • 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. 2. Embedding the new approach to patient safety. 3. Evidence of continuous quality improvement culture. 4. Colleagues having confidence and feeling safe and supported to raise patient safety concerns (FTSU and raising risks and incidents), and that they will be acted upon and learning embedded. 5. Unprecedented continued overcrowding in ED's and its impact on normal culture. Gaps in assurance:	Actions aligned to gaps: 1. Report on culture engagement work through Moving To Excellence, PRM's, Strategic People Group and PODAC/Group People Committee. Develop culture and engagement framework to support delivery of the Joint People Strategy - into Q1/Q2 2026/27. Executive Lead: Group Chief People Officer/ Group Chief Nursing Officer 2. Develop a three year Quality and Safety Strategy by Q3 2026/27 which encompasses the key elements of the National Patient Safety Strategy. Executive Lead: Group Chief Nursing Officer. 3a. Learning from patient complaints and reduction in common themes - ongoing. Executive Lead: Group Chief Nursing Officer 4a. Continue with implementation of new ambassador network during 2025/26 and into early 2026/27. Executive Lead: Director of Governance. 4b. Further develop a FTSU plan by Q3 following the NHSE FTSU review in December 2025 at SaTH, and including changes following new NHSE guidance (NHSE are taking over from the National Guardian's Office). Executive Lead: Director of Governance. 5a. Deliver the actions identified in the culture work stream within UECTAC transformation programme. 5b. UEC Board to deliver agreed milestones. 5c. Review of approach towards cultural change within ED - by Q3 2026. Executive lead: Group Chief Medical Officer/COO/Group Chief Nursing Officer	1. Q1: Board Development session held on 21st May 2026 to finalise Group Culture Programme, under the flagship of Poppy's Promise. This programme will launch in July and is supported by external partners, with oversight via our new Group Culture Accelerator, chaired by the Deputy Group CPO, and reporting into Group People Committee. Part of this work will include developing and embedding new values. The evaluation and success of the programme will be aligned to the QMS approach and the Trust being a 'great place to work' measure, which will be reviewed regularly through a new channel. This will further embed the Culture Dashboard activity. Our progress and plans for the Group Culture Programme were shared with NHSE and ICB colleagues at the Provider Review Meeting on 19th June for assurance. 2. Work in progress to have one overarching Quality and Safety Strategy. Q4: National Quality Strategy still pending, 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. Q1: work has started in Q1 26/27 in relation to how a joint strategy can be developed with SCHT. 3a. 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. Q1: This work is now business as usual and continues to be monitored. Action closed Q1, 26/27. 4a. Q4: Work has continued to build and strengthen the Freedom to Speak Up Ambassador Network. Ambassadors have been recruited from both offsite services and hospital sites. We are working to recruit ambassadors in all departments to increase coverage across the organisation. The ambassadors will help raise the profile of FTSU and encourage colleagues to feel confident to speak up. Planning has also started for the 2026/27 programme. This includes beginning joint work with Shropcom to develop and deliver a shared ambassador training programme for both organisations. Q1: This work is now business as usual. Action closed, Q1 26/27. 4b. Q1: We are working through the FTSU action plan following the NHSE review in December 2025. 5a. Progressing workstream 2 - Staff Culture, Resilience & Wellbeing - this is monitored via the UECTAC using the reverse RAG (red, amber, green) methodology as per IMNTAC (Maternity and Neonatal Transformation Assurance Committee). Medicine staff survey results 2024 showed improvement across all People Promise Domains. Progress continues to be monitored through UECTAC. 5b. <i>See BAF risk 10.</i> 5c. Work remains ongoing.			6

Reference and risk title		Lead Executive	Link to strategic themes	Risk appetite		Board Committee				
BAF 3: If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and on the quality of care.		Group Chief People Officer	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.		People & OD Assurance Committee (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: • 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 • Regular meetings between the bank and rostering leads and operational leads to review performance and improvements. • Annual Staff Survey, pulse survey, improve well and making a difference linked to the culture dashboard. • 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 • 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. • Developing operational integrated ICS Workforce Plan • Long-term NHS Workforce Plan • Vacancy and spending control panel • Training and delivery model aligned to operational demand and capacity. • Medical workforce efficiency programme in place • Oversight and monitoring of Workforce Plan for 2026/27 • Launch of the Group Culture Programme with external partners.	• Reports to People & OD Assurance Committee (PODAC)/Group People Committee (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. • Reports to Strategic People Group 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) • 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. Managing Working Time Directive breaches and management of rosters for medical staff. 3. Ongoing retention initiatives. 4. A plan to support staff to work in new ways, post pandemic, in accordance with the NHS People Plan. 5. Measurable objectives on equality, diversity and inclusion for Chair, CEO and Board members. Gaps in assurance: -	Actions aligned to gaps: Executive Lead for actions: Group Chief People Officer. 1. To work with system colleagues to develop a system approach to talent management - during 25/26 and 26/27. 2. Visibility of all rosters and review consultant rosters during 26/27. 3. Ensure that each leader is confident to hold wellbeing and stay conversations to support, engage and retain colleagues during 26/27. 4. To review the NHS People Plan health and wellbeing strategy, to support, review and ensure inclusion within divisional people plans. Workforce plans for HTP and operational planning in place and being monitored during 2026/27. 5. 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.	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. 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). Q1 26/27: A revised action plan has been developed for implementation in 2026/27. 3. 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. Q1: This is now part of the Group Culture Programme for 2026/27. 4. Q1 26/27: Divisions are moving forward with reform and organisational change which will be delivered as part of the 2026/27 plan. 5. 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. Q1: EDI objectives in place. Action closed Q1.	3	2	12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee				
BAF 4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.			Group Chief People Officer	Make SaTH a great place to work. Deliver a better patient journey and experience. Make our organisation more sustainable.	SaTH is OPEN to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice. We are prepared to invest in our people to create an innovative mix of skills. Responsibility for noncritical decisions may be devolved.			People & OD Assurance Committee (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 <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	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 Board diagnostic underway to develop external Executive and Board Development Programme - Civility Saves Lives programme roll out - SaTH education offer via education prospectus - SaTH 1 to 4 and STEP Leadership Programmes - Affina team journey interventions - Vacancy and spending control panel - Process to review mandatory training in place via Education Group which meets bi-monthly. - Non-Clinical Bank Review Panel in place since end of August 2025 - Nursing Bank review process in place since November 2025	<u>Reported to Board, committees and elsewhere:</u> - Workforce metrics within Integrated Performance Report to Board (monthly) (2nd) - People & OD Assurance Committee/Group People Committee - meets bi-monthly (2nd). PODAC meeting in common with Shropshire Community Trust since November 2025. - Strategic People Group (SPG), monthly (2nd) - Education Group - bi-monthly (1st) - System education/training meeting (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) Group Leadership Forum - operational, monthly (2nd) - People Pulse Surveys reported to OPG quarterly (2nd) - People & OD Risk Register reported to PODAC and Strategic People Group (2nd) - Medical workforce efficiency programme reported to FRG, Finance Assurance Committee and Strategic People Group (2nd) - MIAA (internal audit) E-Rostering/Roster Management Report 2025/26 - Moderate assurance	4	3	12	<u>Gaps in control:</u> - Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave is in place - New ways of working Embedded EDI champions/networks and local EDI objectives to create a diverse workforce, leadership and inclusive culture - High levels of mental health related sickness absence <u>Gaps in assurance:</u> -	<u>Actions aligned to gaps:</u> Executive Lead for actions: Group Chief People Officer. - Review our retention interventions during 2026/27. - Utilise technology advances to facilitate system interoperability and advances in robotic process automation from 2024/25 through to 2030. - Deploy Manager Self Service within the Electronic Staff Record by 2025/26. Develop a refreshed EDI action plan and review against key workforce data – by October 2026, with report to Board at least annually. Develop and embed our trauma informed leadership capabilities through our staff psychology offer during 2026/27.	- 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. Q1, 26/27: External support to scope robotic process automation in place as part of the Digital Transformation Programme. - 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. Q1: Fully implemented. Action closed Q1. - Q1: strategic approach for trauma informed culture being reviewed and linked to Group Culture Programme.			12

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (numbered and linked to the actions required)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Overspend against operational budgets driven by operational pressures and inefficient use of resources • Capital constraints • Historic under-investment driving increased capital requirement • A failure to maintain financial sustainability due to non-planned cost pressures • Lack of available appropriate substantive workforce • Continuing to operate in a system with a commissioner with an underlying deficit • Increasing demand placing pressure - inadequate estate available to accommodate need. Inefficient deployment of resources to bridge gap. • Aged infrastructure requiring increased maintenance and potential loss of capacity • Significant CIP plans of 5.3% required to deliver the annual plan • High sickness levels placing additional pressure on service costs • The reliance on insourcing to deliver constitutional standards at premium cost Consequence: • Short-term recovery inhibits service quality improvement. • Dwindling cash reserves. • Potential regulatory action taken against the Trust leading to the loss of local control. • Damage to the Trust’s reputation and the Trust’s continuing ability to function • Inhibits ICS’ ability to commission growth in services • Risk of increased cost • Insufficient cash to underpin the capital programme • Reduction in planned investments	4	5	20	• Annual financial plan - revenue and capital plan. • Planning on a system wide basis with openness and transparency across the system. • Internal performance management system, underpinned by new performance, assurance and accountability framework - Ward to Board. • Monthly financial reporting system - nominal roll, budget statements, divisional committee, Operational Performance Oversight Group (OPOG), Performance Review Meetings (PRM). • Chief Executive-led Financial Recovery Group meets fortnightly from December 2025 • Service Review Deep Dives in place to identify opportunity for improving efficiency. • Triangulation of operational, financial and workforce data into a dashboard to provide greater visibility of service performance. • Service Line Reporting to assess service viability and ensure appropriate funding in place. • Annual revenue plan for 2026/27 that was developed with specialty input and within which activity, workforce and finance triangulate • Reviewing medical doctors rotas to ensure compliance and delivery of planned clinical programmed activities in line with nationally accepted standards • Internal (executive led) vacancy control process. • Strengthening governance via splitting the finance and performance elements within the assurance committees (but recognising the interdependencies between the two). • High levels of authority required to approve discretionary expenditure (non-pay) on Oracle - in practice since January 2025 • Group Chief Nursing Officer and Group Chief Medical Officer approval of bank shifts from December 2025 • Three times a week panel for the approval of non-clinical bank shifts from October 2025	• Monthly Trust-wide finance reports to Board of Directors, Finance Assurance Committee and Financial Recovery Group (2nd) • Sustainability and Efficiency (CIP) report to Innovation & Investment Committee and Senior Leadership Committee-Operational (2nd). • Annual financial plan, planning progress shared with Board for sign off (2nd) • Divisional Performance Review Meetings (PRM), Cascade, Executive messages into the organisation (2nd). • Monthly performance reviews with divisions (1st) • Routine monthly reporting including variance to plan and run rate analysis (1st) • Internal audit reports (MIAA): core financial controls and sustainability and efficiency processes (3rd) - Substantial assurance • Report to region (NHS Midlands) each month and position shared with local Integrated Care Board (2nd). • External audit of annual accounts (3rd) • Workforce plan reported to Strategic People Group and PODAC (2nd) • Weekly Executive Dashboard: beds, nursing WTE and finances - presented fortnightly at FRG (2nd) • Final Budget setting paper for 26/27 approved by FAC and Board (2nd) • Strategic People Group now aligned into Operational Performance Oversight Group to enable better oversight (2nd) • VFM opinion from external audit with no significant weaknesses identified (3rd) • Trust exit from Recovery Support Programme (RSP) - letter from NHSE dated 2 March 2026 (3rd) • An overarching efficiency and performance recovery programme is in development. This will provide the governance framework for the 11 agreed transformation assurance committees that will drive change over the medium term (2nd).	5	4	20	Gaps in control: 1. Divisions recognise their financial responsibilities and engage well however, financial management, effective sustainability and efficiency planning compete with other high profile priorities across the Trust. 2. Comprehensive identification and delivery of a £40 million cost improvement programme and adherence to cost control policies and processes 3. Inefficient reporting routines hampered by an outdated finance system and a misalignment between the finance system and the HR system. 4. Risk management process that takes into account quality and safety risk alongside financial risk on a daily basis leading to budget holders prioritising the quality and safety risk and incurring unbudgeted cost in relation to both medical and nursing staff. 5-Understanding how system partners medium term plans impact SaTH - ensuring that CIPs do not push cost around the system and that interdependencies are clear. 6. Lack of activity data means it is challenging to triangulate spend with changes in activity. Gaps in assurance: 7. Ability to accurately report contract income position.	Actions aligned to gaps: 1a. Continue to engage divisions in a multi-year rolling programme of identifying cost improvements for 2026/27 via a dedicated multi-disciplinary Financial Recovery Programme Office by December 2025. This is in addition to identifying any mitigations in relation to the 25/26 programme. Executive lead: Chief Finance Officer 1b.Workforce reduction aligned to delivery of CIP issued to divisions to achieve agreed exiting whole time plan by March 2027. Executive Leads: Group Chief Operating Officer/Group Chief People Officer/individual executives. 1c. Roll out of performance, assurance and accountability framework (PAFF) with escalation aligned to delivery of key metrics in support of the strategic objectives by end of Q2 26/27. Lead Executive: Group Chief Operating Officer. 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: Chief Finance Officer. 1e. Divisional key variance reports to highlight risks and develop mitigations through the divisional meetings and PRM's to provide greater granularity and visibility of issues. Target date - July 2026. Lead Executive: Chief Finance Officer. 2a. £40 million was identified by end May 2026, in line with the NHSE deadline. The priority is to de-risk, identify mitigating alternative schemes and deliver the £40m - timescale end of Q2. Executive lead: Chief Finance Officer. 2b. Identify and recruit resources to support the transformation work required to deliver the CIP. Executive lead: Chief Finance Officer. 2c. Additional controls over bank usage have been tightened and continue to be in place to manage cost pressures. Target date - Ongoing. Lead Executive: Chief Nursing Officer, Group Chief Medical Officer and Chief Finance Officer. 2d. Updated self assessment against the grip and control toolkit has highlighted a number of actions to facilitate improved grip. Target date - Ongoing. Executive Lead - Chief Finance Officer. 2e. Weekly dashboard to Financial Recovery Group (FRG) to be incorporated where possible to a dashboard for Divisions. Target date - March 2026. Executive Lead- Chief Finance Officer. 3a. Scoping exercise to link Electronic Staff Record (ESR) with finance budgets - Q4 2026/27. Executive lead: Chief Finance Officer and Group Chief People Officer. 3b. Finance teams across STW providers collaborating on procurement of a new financial ledger or third party service. 4a. Revised escalation measures, with executive sign off for bank shifts, to support divisions to ensure timely quality and safety decisions whilst considering budgetary impact, Q3 2026/27. Executive lead: Group Chief Medical Officer /Group Chief Nursing Officer 4b. System-wide actions in relation to the UEC pathway, managed by the UEC Transformation Board in order to mitigate the risk of additional capacity- timescale ongoing. Executive Lead: Group Chief Operating Officer. 5. Discuss proposed CIPs and investments across the Group and system partners to ensure alignment and collaborate to assess inter-organisational impact, adjusting and mitigating plans as necessary. Executive Lead: Chief Finance Officer. 6a. Re-introduce activity data to divisional reporting packs at PRM and OPOG. end of Q2 26/27. Executive lead: Chief Finance Officer. 6b. Devolve Clinical Income to divisions - end of Q2 26/27. Executive lead: Chief Finance Officer. 7. See BAF risk 7b, action 4b regarding Data Warehouse.	1a. Financial Recovery Taskforce supported by the Financial Recovery Programme Office in place since September 2024. Chief Executive chaired Financial Recovery Group - since August 2024. Fully identified CIP programme for 25/26. Q3/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 Committee. 1c. Q1, 26/27: Divisional oversight will be increased as necessary in line with delivery of the measures within the PAAF. Additional support programme in place for divisions who are off-track financially. 1d. Framework designed, meetings planned with SCHAT 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 July 2026. Q4: Draft escalation report format agreed and to be implemented in Q1. 2a. Full efficiency programme identified. De-risking continues to be monitored via Financial Recovery Group and Finance Assurance Committee. ~~Q3: Original action complete.~~ Continue to monitor to ensure any further risk is mitigated. 2b. Interviews held Q1 and offers in progress. 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). 3a. Work ongoing during 2025/26. Q3: Discussions have taken place with NHSE as to whether any other trusts have gone through a similar process and could share their learning. Q4: Response received, no new intelligence provided. 2026/27 Q1: Work undertaken to implement post numbers in ESR to improve controls. 3b. Scoping work in hand to develop specification for procurement. 4a. Executive lead bank panels in place for clinical shifts. 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. Further investment approved in 2026/27 plan to reduce risk and improve performance. 5. System partners meet monthly to discuss delivery against existing efficiency plans and inform partners of any new proposals. Work ongoing. 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. 2026/27 Q1 2025/26 activity data submitted to the ICB. Pilot for FDP BAU link team in place.	12		

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

Risk Description	I	L	Total initial risk score (Impact (I) x Likelihood (L))	Controls (strategic and operational)	Assurance (provides evidence that controls are working) (Including the 'three lines of defence' -1st, 2nd, 3rd lines)	I	L	Total current risk score (Impact (I) x Likelihood (L))	Gap(s) in control and gap(s) in assurance (numbered and linked to the actions required)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: - Older buildings built with now outdated regulatory requirements - Restricted physical environment, unable to meet current capacity requirements - Backlog maintenance issues due to limited capital, however Critical Infrastructure Risks (CIR) applications are now welcome by NHSE - Residual gaps in fire safety action plan - The Trust has identified reinforced autoclaved aerated concrete (RAAC) within specific areas within PRH and surveys continue across the Estate. Consequence: - Poorer patient outcomes and patient safety issues - Regulatory or legal action possible - Adverse publicity and reputational damage possible - Potential poor working conditions and environment affecting staff health, experience and engagement - increased sickness absence and recruitment.	4	5	20	- Board-approved (limited) Capital Programme including backlog maintenance plan and medical equipment budget in place addressing high risk backlog on a yearly basis, where funding allows. - Capacity & demand led capital programmes, aligned to Hospital Transformation Programme. - Capital Estates Plan 2021-2026 in place - in Capital Planning Group for review (subject to funding each year). - Estates Strategy 2025-2030 - Updated Estates risk assessments and planned preventative maintenance of engineering infrastructure. - Staff survey measures staff levels of engagement and morale (in relation to working environment). - Minor and major works protocols and management plans in place for known risks, e.g. asbestos and RAAC. - RAAC national funding received and removal project in progress. - Fire action plans in place and being monitored. - Annual fire safety audits. - Independent survey of fire doors at PRH - March 2026 - Standardised framework for large capital projects developed and implemented - Critical Infrastructure capital funding applied for in 2026 and granted for backlog works; new applications now open for 2027.	Reported to Board, committees and elsewhere: - Performance Assurance Committee (PAC) (2nd) - Capital plan developed and overseen by Capital Planning Group (CPG), chaired by Director of Finance (2nd) - Annual estates report to Board (2nd) - Annual update backlog six facet survey that informs the capital plan (1st) - Regular updates of fire action plans at Fire Safety Group (1st) - Fire Safety Improvement Action Plan Oversight Group (2nd) - Fire safety updates reported to private Board regularly (2nd) - Operational estates governance and oversight in place including: Decontamination Group (2nd), Medical Gas Committee (2nd), Ventilation Safety Committee (2nd), Water Safety Committee (2nd), Fire Safety Group (2nd), Asbestos Safety Committee (2nd). - Authorising Engineer's Annual Fire Safety Audit 2025 (3rd) - report presented to Assistant Chief Executive and Director of Estates, and February 2026 PAC. - RAAC Project Group in place (monthly) for the duration of the programme (2nd). - Performance Review Meetings (PRM's) bi-monthly (2nd). - Estates Strategy 2025-2030 to Performance Assurance Committee June and July 2025 and to Board September 2025 (2nd) - Fire Enforcement Notice 348 removed July 2025. Plan in place for associated fire stopping works in ward block RSH. - Fire Enforcement Notices 365 and 366 received from Shropshire Fire & Rescue Service for PRH, reported to Performance Assurance Committee February 2026 and added to risk register (negative assurance).	4	4	16	Gaps in control: - Energy infrastructure at its limit on the site - Awaiting confirmation of RAAC funding to enable long-term remedial works. - Aged nurse call systems require updating. - Fire notices continue to be received by the Trust. Gaps in assurance: -	Actions aligned to gaps: - Utilise Salix funding for replacement infrastructure - supplier identified and project has commenced. Public Dividend Capital (PDC) Fund allocation of approximately £7m (proportion of which relates to energy infrastructure). Continuous exploration for additional external funding opportunities - ongoing. Executive lead: Group Chief Estates, Facilities and Capital Officer. - RAAC removal project at PRH has commenced with expected end date of ~~October 2026~~ April 2027. Executive lead: Group Chief Estates, Facilities and Capital Officer. Conclude the works for new fixed nurse call systems by end of Q4 26/27 (subject to availability of wards). Executive lead: Group Chief Estates, Facilities and Capital Officer. 4a. Commission Independent survey report of PRH fire doors during March 2026. 4b. Action the recommendations from the independent survey fire report once received - by Q3 26/27 or at a date to be agreed with Shropshire Fire & Rescue Service. Executive lead: Group Chief Estates, Facilities and Capital Officer. 4c. Develop a case to Capital Planning Group to request additional funding, as we only have half the funding currently of the c£500k required for the fire door replacement programme. By Q2. Executive lead: Group Chief Estates, Facilities and Capital Officer.	- Contractor selected and contract signed. Works commenced March 2025. Two year programme underway. Q1: November 2027 is the end date for key power upgrades. - NHSE has approved and confirmed funding of £12.2m over two financial years. Contractors selected and approved. Project Group set up and full works have commenced. Q3: Project completion date is now expected as October 2026. Change request form submitted to NHSE, awaiting formal approval for date extension and increased budget of £2.9m. Q1 26/27: Written confirmation of end date now received for April 2027. Q1: Working with clinical teams on prioritisation plan for delivery within 26/27. Delayed in 25/26 due to availability of wards/access. 4a. Q4: Independent Fire Survey completed March 2026. Action closed Q1 26/27. 4b. Q1: Ongoing with action plan, in liaison with Shropshire Fire & Rescue Service. Prioritising clinical training and fire doors.			12

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee				
BAF 7a: Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.			Acting Chief Finance Officer	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 <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	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 Authentication compliance for NHS mail, Phishing test cycles. • Security compliance in place to monitor security patch compliance and compliance with Cyber Assurance Framework (CAF) aligned DSPT • Information Governance (IG) strategy, policy and framework • Incident review processes and learning - national and local • Utilising NHS Digital provided services, including vulnerability management system, penetration testing, advanced threat protection and Bitsight (cyber security rating service) • Registered with National Cyber Security Centre for alerts and intelligence: Webcheck and Early Warning System • Regular cyber security communications for end users • Cyber element of Information Governance training in place as part of statutory and mandatory training for staff • Monthly meeting with regional NHSE cyber security lead.	Reported to Board, committees and elsewhere: • Information Governance Committee - (2nd) • MIAA internal audit of cyber security - Sept 2025 (3rd) • Annual MIAA internal audit of cyber security, reporting to Audit & Risk Assurance Committee (3rd) • MIAA Technical Review Medical Devices 2024/25 - Moderate Assurance (3rd) • Weekly Digital Services senior leadership team meetings where any issues escalated (1st) • Dedicated monthly risk review meeting (1st) • Active directory review report - NHS Digital/MTI (3rd) - report to Digital Services • Bi-annual cyber update reports to Audit & Risk Assurance Committee meeting (2nd) • Monthly meetings held between SaTH Digital Services and NHSE Regional Cyber Security Team since 2024/25 to provide ongoing updates in relation to remediation planning and ongoing risk / impact	5	4	20	Gaps in control: 1. Some devices and systems will remain non-compliant with risk mitigation plans 2. Skilled resource and availability within ICS outside of core hours 3. Cyber Security strategy to be developed. 4. Funding constraints. Gaps in assurance: -	Actions aligned to gaps: 1. Risk mitigation plans in place - ongoing review. Long-term resolution plans required for non-compliant systems within Divisions - ongoing, funding dependent. Executive lead: Chief Finance Officer 2. Continue our work as a health system partner during 2026/27 as part of the work programme for the ICS Digital Delivery Group. Executive Lead: Chief Finance Officer 3. Develop Trust-level Cyber Security Strategy to support overarching Digital Strategy by Q4 26/27. Executive Lead: Chief Finance Officer 4a. Re-prioritisation of internal digital capital funding during 2026/27. 4b. Continue to explore external funding opportunities during 2026/27. Executive Lead: Chief Finance Officer	1. Q1 26/27: Cyber and Risk update was presented at Audit and Risk Assurance Committee. 2. Q1 26/27: SSOT and STW to confirm terms of reference and governance arrangements. 3. The intention is to ensure that the strategy is aligned with the National Cyber Strategy for Health and Social Care and the NHS England CAF aligned Data Security and Protection Toolkit. Q2: Development of SaTH Cyber Security Strategy has now paused pending delivery of the ICS Cyber Strategy. Q3: 2026/27 work to be undertaken to strategically align with the Group Model. Q4 26/27: The group model digital strategy is to be developed. This will help define a group model cyber strategy during 26/27. 4. Q1 26/27. Several cyber and infrastructure frontline productivity bids including network resiliency, network segmentation, backups, vulnerability management scanning and security event logging, have been submitted nationally. Awaiting national feedback on successful bids and funding.			6

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee					
BAF 7b: The inability to implement modern digital systems impacts upon the delivery of patient care			Acting Chief Finance Officer	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)										

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

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

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 <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
<u>Cause:</u> • Poor processes, systems and culture • Operational challenges and pressures <u>Consequence:</u> • May lead to sub-optimal quality of care • Additional regulatory action. At the end of Q4 2025/26 the Trust had one Section 31 condition in place • Damage to reputation and negative impact on public confidence • May lead to cultural issues, poor morale, and difficulties in recruitment • Financial penalties	4	5	20	• Moving To Excellence Programme • Quality priorities 26/27 • Quality & Safety Assurance Committee and Quality Operational Committee established to monitor position • Quality governance framework • Complaints process • Risk Management Policy and processes • Freedom to Speak Up arrangements • Exemplar programme (ward accreditation) • Monthly quality metrics • CQC action plan owned by Divisions • Speciality Patient Experience Groups and the Patient and Carer Experience Panel. • Board Assurance visits • Core Service CQC Self-Assessments and CQC quarterly engagement events with core services • CQC inspection report published May 2024 (3rd), with March 2026 inspection report awaited.	<u>Reported to Board, committees and elsewhere:</u> • 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) • Quarterly engagement meetings with CQC (3rd) • Moving To Excellence Operational Delivery Group (1st) which feeds into QSAC and Board • UEC Transformation Assurance Committee, reporting to QSAC (2nd) • 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)	4	3	12	<u>Gaps in control:</u> 1. 79 Must and should do actions from CQC Report from May 2024 . 2. Under stage one compliance management for aseptic services. <u>Gaps in assurance:</u> 3. Board reporting on assurance on delivery of research requirements and aspirations	<u>Actions aligned to gaps:</u> 1. Deliver CQC action plan during 26/27. 2. Deliver action plan which relates to training, equipment and work environment during 25/26: Lead: Chief Pharmacist 3. Develop research assurance reporting by Q2 26/27 . Lead: Group Chief Medical Officer	1. 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). 2. 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. 3. 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. Q1 26/27: SaTH associated meetings with Keele University with regard to developing a governance framework for research across the two organisations (SaTH and Keele).			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.			Group Chief Operating Officer	Make SaTH a great place to work. Improve the quality of care that we provide. Deliver a better patient journey and experience. Ensure seamless pathways. Make our organisation more sustainable.	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)				
				Enhance wider health and wellbeing of communities.								
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 (<i>numbered and linked to the actions required</i>)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: - Delayed treatment times and backlog - Workforce gaps - including nursing, medical, Allied Health Professionals, diagnostics and theatres - Insufficient capacity to meet demand - Insufficient productivity in Planned Care - Ageing population in Shropshire, Telford & Wrekin Consequence: - May lead to sub-optimal care - May lead to harm due to the unmet need - Financial activity impact - Regulatory action - Damage to reputation and negative impact on public confidence	4	5	20	Performance controls below (refer to BAF 3 and 4 for workforce controls): - Trust Planned Care Transformation Programme - Specialty level capacity and demand plans - Weekly/monthly monitoring of capacity/demand and performance - Departmental and Divisional monitoring of RTT, imaging and endoscopy - Monthly Performance Review Meetings - Enhanced operational management structure with focus on elective and urgent care - Validation of waiting list to address data quality issues and ensure accuracy of waiting times - Outpatient Transformation Programme - Substantive Head of Cancer commenced March 2026. - Additional elective activity delivered by insourcing providers - Implementation of Quality Management System (QMS) being rolled out during 26/27 - Roll out of new national Electronic Referral System during 26/27	Reported to Board, 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) - Midlands Access Board - NHSE (3rd) - Cancer trajectories 25/26 - 62 day backlog, and 28 day faster diagnosis to PAC (2nd) - RTT 25/26 - 40 week recovery trajectory to PAC for adults and children and young people (2nd) 18 week, 52 week and total waiting list size - all exceeded plan Q4, 25/26 - Planned Care Transformation Assurance Committee - meets monthly - commenced April 2025 (2nd) - MIAA Data Quality review - waiting lists and performance 25/26 - Moderate opinion - (3rd)	4	2	8	Gaps in control: 1. Enable elective and cancer treatment to 2028/29 national standards 2. Productivity - opportunity to better optimise core capacity for treating elective and cancer patients 3. Outpatients - opportunity to improve referral and demand management approaches and optimise outpatient capacity 4. Digital - introduce digital enablers to elective care and treatment 5. Risk of insufficient elective income to cover funding of elective activity Gaps in assurance:	Actions aligned to gaps: (executive lead for actions: Group Chief Operating Officer) 1a. Deliver phase 2 of the cancer transformation plan by March 2027. 1b. Continue recovery trajectory in elective care during 26/27 2a. Implement GIRFT best practice productivity interventions and drive improvement in productivity in theatres and outpatients to 97% session utilisation by March 2026. 3. Implement high impact evidence-based interventions: a) Redesigning referral pathways; b) Transforming outpatients; c) Reducing unwarranted variation - by March 2027. 4. Introduce digital workstream to identify and implement digital tools to enable improved planned care delivery, by March 2027. 5. Dialogue with NHSE and ICB to agree 26/27 income and performance plan - by June/July 2026	1a. Q1: Initial focus on treatment part of the cancer pathways, in particular Oncology 1b. Q1: Additional activity (Elective Recovery Fund) agreed for 2026/27. 2. Theatre productivity improvement workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver theatre utilisation ambitions. Q1: In Q1 of this year, Telford elective surgical hub was accredited by GIRFT. 3. Outpatient transformation workstream in place reporting to Planned Care Transformation Committee with established action plan to deliver outpatient improvement ambitions. Q1: Clinic optimisation project completed with focus on maximising slots within clinics; significant opportunity discovered. New project started on the electronic referral system in early 2026/27. 4. Digital workstream set up to oversee implementation of digital tools and benefits realisation. Initial five key priority systems identified: Patient Engagement Portal AI Scribe Medical Form Digitalisation Pre-op SDEC Digital. Q1: Work remains ongoing, but the pre-operative assessment new system is due to be completed Q2, 26/27.			9

Reference and risk title			Lead Executive	Link to strategic themes	Risk appetite			Board Committee				
BAF 10: The Trust is unable to meet the required national urgent and emergency standards.			Group Chief Operating Officer	Deliver a better patient journey and experience. Make our organisation more sustainable. Enhance wider health and wellbeing of communities.	SaTH is CAUTIOUS and prefers not to take risks to the achievement of internal and external performance standards where there is likely to be adverse consequences.			Performance Assurance Committee (performance impacts) and 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 <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: - Clinical workforce challenges - Increase in number of patients with no criteria to reside and insufficient community capacity to meet demand for timely discharge - Primary and community health and care capacity not meeting pre-hospital demand - Insufficient effectiveness of SaTH UEC pathways - Increase in high intensity user demand. Consequence: - Delays in treatment pathways including increase in acute length of stay - Leads to sub-optimal care and poor patient experience - Regulatory action - Negative impact on reputation and public confidence. - Potential impact on ambulance handover delays and subsequent impact on ambulance availability within the community - Overcrowding and long lengths of stay in Emergency Department, with increased associated risk of harm.	4	5	20	- Revised SaTH 26/27 Urgent & Emergency Care (UEC)improvement programme. - Confirmed System 26/27 Urgent and Emergency Care Improvement Plan - STW UEC Delivery Group - Hospital Transformation Programme - addresses one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows, and consolidating fragmented teams and pathways (including critical care)	Reported to Board, committees and elsewhere: - Performance Assurance Committee (monthly) (2nd) - Urgent and Emergency Care (UEC) metrics within Integrated Performance Report to Board (monthly) (2nd) - Urgent and Emergency Care Transformation Assurance Committee (underpinned by the UEC plan) - monthly (1st) 'Tactical' and 'Strategic' system meetings, as triggered by escalation levels (2nd) - STW UEC Delivery Group - monthly (2nd) - NHSE Delivery meetings - system and regional for CEO's regarding A&E performance, ambulance offloads and CAT 2 response times- fortnightly (2nd) - Monthly CQC update report to Quality Operational Committee and Quality and Safety Assurance Committee (2nd). - Performance Review Meeting (PRM's) (2nd) - NHSE Tier 1 bi-weekly meeting with national director of UEC (2nd) - Mean ambulance handover lifted out of bottom quartile nationally Q1 26/27 - reported to PAC May 2026	4	5	20	Gaps in control: - Non-delivery of the operational plan for 26/27 in Q1 relating to 4-hour performance (all types) and four-hour performance (type1) - Proportion of urgent and emergency care patients streamed to the Urgent Treatment Centre (UTC). - Proportion of emergency care patients managed through same day emergency care pathways. - SaTH interface with system-wide Urgent & Emergency Care (UEC) improvement programme. - Increase in patients with no criteria to reside. Gaps in assurance: -	Actions aligned to gaps: Executive Lead for actions: Group Chief Operating Officer. 1a. The SaTH UEC improvement programme for 26/27 to be agreed at UEC TAC in May 2026. 1b. Secure external delivery support to improve 4-hour performance by Q4 26/27 2. To improve Type 3 performance and the volume of patients streamed to the Urgent Treatment Centre by Q4, 26/27. 3a. Expand Same Day Emergency Care (SDEC) Workstream through the UEC Improvement Programme to other specialities by Q4 26/27. 3b. Review of estate at RSH to provide frailty SDEC space by October 2026 4. To explore opportunities for future collaboration with system partners to improve urgent and emergency care during 26/27. 5a. Working with system partners to identify opportunities to increase capacity to enable discharge of patients. 5b. Secure external delivery support to improve no criteria to reside position by Q4 26/27	1a. Q1: Plan agreed May 2026. Action closed Q1. 1b. Q1: External support secured and 12-week diagnostic phase underway 2. Q1: Further improvement in 4-hour (type 3) performance in April and May 2026 achieving >90%. 3a. Q1: Trauma and Orthopaedic workstream established June 2026. 3b. Q1: Discussions being held through Accommodation Control Strategic Group which meets monthly. 4. Q1: Opportunities being explored through joint working with SCHAT and SaTH under the Group Model. 5a. In May 2026 the average number of patients with no criteria to reside was 136 which is above the average over the last two years of 120. Working with Local Authorities and Care Transfer Hub to identify opportunities for discharge improvements during 2026/27. Q1: Executive to Executive meetings occurring and Pillar 3 within the System UEC Improvement Plan for 26/27 and 27/28 incorporates opportunities for improvement to no criteria to reside. 5b. Q1: External support secured. 12-week diagnostic phase underway.			9

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

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

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

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: • ICB exec-led Cluster Transformation and Digital Group to be established to replace STW System Transformation and Digital Committee (2nd). • Report to place-based partnership Boards Shropshire Integrated Place Partnership Committee (SHIPP) and Telford and Wrekin Integrated Place Partnership Committee (TWIPP) (2nd) • Neighbourhood Health Implementation Programme - bi-monthly highlight reports presented covering actions and milestones (1st) • Relevant projects report to the ICS UEC Group - monthly (2nd) • UEC Group, National NHIP Group report to Cluster Transformation and Digital Group (monthly) (2nd) • SATH/Shropcom Group model established from 1 April 2026. - Ongoing development of transition plan, with focus on hospital to community shift. (2nd) • NHSE Midlands Assurance Review – Group Model between Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Healthcare NHS Trust. Report received 27 Nov 2025. Recommendations built into 2026/27 Group Transition Plan. (3rd) • Group Transition Committee in place (2nd) • Local Care Transformation Programme established - Operational Group (exec led; commenced end May 2026) and Local Care Transformation Assurance Committee (Non-Executive led; commenced end June 2026) (2nd)	4	4	16	Gaps in control: 1. Limited detail and limited delivery of the changes in improvement. 2. Reliance on physical acute beds rather than community UEC capacity and delays within urgent and emergency care caused by lack of flow. 3. Lack of robust involvement and two-way communication with regard to integrated clinical pathways; there remains high health system quality and performance risk areas within: integrated/cohesive diabetes management, Children's and Young People's (CYP) mental health services transformation, safe and effective maternity care, effective acute paediatric pathway, and C'Difficile case numbers. 4. Lack of Group capacity and expertise to accelerate community transformation/Neighbourhood Health models. Gaps in assurance: -	Actions aligned to gaps: 1. Provide operational and clinical support to the Neighbourhood Health Implementation Programme - ongoing. Lead Executive: Group Chief Operating Officer and Group Chief Medical Officer with support of HTP operational lead and clinical lead. 2. See actions within BAF risk 10. 3. Delivery of the ICS Clinical Strategy with six identified priority areas which SaTH takes part and supports. In addition, other streams of work are to be supported by: Paediatric Transformation Programme Assurance Committee (chaired by SaTH Medical Director); continued improvements within maternity via SaTH Maternity Transformation Committee co-ordinated by the Local Maternity & Neonatal System (LMNS), which is chaired by the ICB Medical Director; and development of CYP mental health programme to be led by Midlands Partnership University Foundation Trust reporting into the Provider Collaborative going forwards. Various leads for actions via various partner organisations, including SaTH's involvement. 4. Appoint additional capacity to support programme development by 30 April 2026.	1. Q1: In response to national and local requirements for implementation of Neighbourhood Health Models and hospital to community shift, the Group has established the Local Care Transformation Programme with operational and clinical leaders from the two trusts (SaTH and SCHAT). Action taken through the Group Local Care Transformation Programme (LCTP) will be reported to the two STW Place Partnership Boards and Cluster ICB Neighbourhood Health Group. 2. Q1: Group LCTP includes clear overlap with ICS UEC 2026/27 Plan (Pillars 1 (pre-hospital) and 3 (post-discharge)). 3. Q1: ICB has described principles and priorities for Neighbourhood health in a paper to the ICB Board (April 2026) and in the five year commissioning plan/commissioning intentions (May 2026). 4. Six-month fixed-term Community Transformation Programme Manager appointed during March 2026. Q1: SCHAT are also appointing community transformation roles. Action closed Q1.			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 <u>and</u> gap(s) in assurance (<i>numbered and linked to the actions required</i>)	Actions Required (including target date and lead)	Progress notes	I	L	Upper tolerance level
Cause: • Potential poor processes and procedures • Improved culture requires further embedding • Governance improvement workload is high - started from a low base with embedded poor practices in some areas • Change in organisational governance arrangements from establishing a new Group Model • Governance capacity to deliver changes Consequence: • Potential lack of openness and transparency • CQC 'Requires Improvement' Well Led rating • Incidents • Potential for ineffective committees • Potential data breaches • Regulatory sanctions and/or fines • High workload involved to work together and align systems, processes and teams. • There is a potential risk that Group Model development may not proceed at the required pace, which may result in ambiguity in roles and responsibilities, inconsistent decision-making and reduced oversight and assurance • Additional level of risk during the Group Model transition period.	4	4	16	• Moving To Excellence programme • Trust Strategy • Board Assurance Framework (BAF) reviewed quarterly • Board development programme in place • Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation in place and reviewed Autumn 2025 and approved at January 2026 Board • Managing Conflicts of Interest Policy updated during 2023 (due review Sept 2026) • Declarations of interest made available within Electronic Staff Record from May 2023 • Register of Interests published on the Trust's website, bi-annually • Terms of reference refreshed for all assurance committees of the Board during 2025/26 and ongoing during 25/26 • Review of effectiveness of ARAC, FAC, QSAC and PODAC committees February 2025 and PAC November 2025 • Fit & Proper Person Policy updated (Oct 2023) following publication of new national framework • Fit & Proper reporting status established within the Electronic Staff Record (ESR) • A number of NHSE reviews completed in 2025/26 • Financial Recovery Group now meeting fortnightly (Q4) • Shared corporate and clinical arrangements for Group Model under development and will be shared with NHSE to support transparency and enable effective oversight • Group Model Partnership agreement approved Q4	Reported to Board, committees and elsewhere: • SFI's, Standing Orders and Scheme of Reservation and Delegation to Audit & Risk Assurance Committee during November 2025 and approved at Board January 2026 (2nd) • BAF considered quarterly at Board and its committees (2nd) • Refreshed terms of reference considered at all Board committees during 2024/25 and 2025/26 (2nd) • 2024/25 Annual Report to Board in June 2025 and subsequently published on the Trust's website following submission (2nd) • Auditor's Annual Report 2024/25 (3rd). External audit did not identify any significant weaknesses in the Trust's arrangements in relation to: governance; economy, efficiency and effectiveness; and financial sustainability, in their 2024/25 Auditor's Annual Report (3rd). • Annual General Meeting held in public (face to face) - 25 September 2025 • Head of Internal Audit Opinion April 2026 providing Substantial Assurance that there is a good system of internal control (3rd) • Regular updates to Audit and Risk Assurance Committee on conflicts of interest compliance - achieved 80% standard during 2025/26 (2nd) • Register of interests and gifts and hospitality reviewed by Audit & Risk Assurance Committee - November 2025 (2nd) • Policy Approval Group meeting, monthly (established August 2024) (2nd) • Executive led Financial Recovery Group and Task Force in place (2nd) • System Integrated Improvement Plan (SIIP) relating to governance is in place and currently on track - updates received at Board (monthly) (2nd) • MIAA Fit and Proper Persons Report (Substantial Assurance) 2025/26 (3rd) • Group Transition Committee established - terms of reference to September 2025 Board (2nd) • NHS Provider Board Capability Assessment to Board - October 2025 Board (2nd) and onward to NHSE. • Group Model Partnership agreement approved by both Boards - March 2026. • Trust exit from Recovery Support Programme (RSP) - letter from NHSE dated 2 March 2026. Improvement from Segment 5 to Segment 3 within Oversight Framework. (3rd)	4	3	12	Gaps in control: 1. Increasing subject access requests (SAR's) received, and subsequent complaints. 2. Further development of the Group Model with Shropshire Community Healthcare NHS Trust Gaps in assurance: 3. Data Security & Protection Toolkit assurance.	Actions aligned to gaps: 1. Further recruit to IG team by Q3, 2026-27. 2. Review committee structure and further revisions to committee structure across the Group. 3. Work towards DSPT/CAF (Cyber Assessment Framework) standards for 2025/26 and 2026/27- evidence to be submitted by 30 June 2026 and 2027. Lead Executive: Director of Governance.	1. Q1: Recruitment in progress. We are also going through a procurement process for SAR's software. 2. Q1: Progress being made with Quality Committee. 3. Q1, 26/27: The 30 June 2025/26 submission has been made with associated improvement plan.			6

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	072/26		
Report Title	Guardian of Safe Working Report Q1		
Executive Lead	Dr John Jones, Group Chief Medical Officer		
Report Author	Dr Robin Hollands, Guardian of Safe Working Hours		
Prior Consultation:	CQC Domain:		Link to (SaTH) BAF id(s)
N/A	Safe	√	BAF 2 and 3
	Effective	√	
	Caring	√	(SaTH) Risk Register id(s):
	Responsive	√	
	Well Led	√	
Executive Summary	The number of exception reports has been steady with most reports being from the more junior resident doctors for late finishes Medicine has the highest numbers of reports with infrequent reports from surgical specialties. Detail not included in report to prevent identification The leave request concerns in the emergency department have been addressed by medical people services (MPS) and resident doctors have reported that the situation has significantly improved		
Recommendations for the Boards	The Boards are asked to take assurance from the report.		
Appendices:	Appendix 1: Exception reporting		

General Overview

Recording and presentation of exception reporting is now being overseen by NHS Data Services using a standardised template. This has only recently come into being, and unsurprisingly there are teething problems in its presentation. I am unhappy with the information in its current format and will feed this back to NHS data services.

Exception report numbers appear steady after the reset which took place at the beginning of February 2026. As in previous quarters, most reports are submitted by the more junior resident doctors and relate to late finishes. General medicine is unsurprisingly the biggest source of reports with an even spread between foundation year and more advanced trainees.

Surgical specialties are infrequent sources of exception reports, this pattern being the normal in all hospitals and having historical reasons reflecting the closer retention of a team structure and the need for access to operating experience.

Key issues from last report:

- There were difficulties experienced by resident doctors in obtaining a prompt response to requests for leave. The issue was most notable within the Emergency Department and was the cause of considerable anxiety.

This has been addressed by MPS and clinical leads. There is a new rota/leave co-ordinator in ED. Feedback from the Lead Registrar, resident doctor forums and exception reporting suggests that the situation has significantly improved.

Issues of current concern:

- An increase in exception reports from a speciality has been noted in this quarter and going forward. This is a small specialty with the resident doctor rota consisting of a mix of trainee and Trust appointments. The nature of the patient population and clinical management has changed rapidly in recent years. It has been recognised for some time that the workload is increasing steadily and recruiting new doctors to support the rota is difficult. Currently a ward housing 20 patients is managed during the day by three resident doctors, with consultant support. Detail within exception reports, plus direct conversations with myself, suggest that morale is low because of workload and rota gaps due to stress related illness. Discussions with consultant staff suggest that the service is fragile, presenting a safety risk to patients and staff.

The clinical director is in discussion with departmental managers and the DME, with a plan to recruit an additional fellow as soon as possible and a further increase in 2027. Support by the Trust at senior level will be needed.

Update on 10-Point Plan to Improve Resident Doctors' Working Lives by Dr Aung Naing

1. Working Environment and Wellbeing

Doctors' mess – Resident doctors are grateful for the new PRH doctors' mess which was opened on 20th July.

New doctors are joining the Trust on 5th August. Facilities booklet (access via QR codes) which details catering, parking, accommodation etc will be introduced in the induction.

Job security- Some Trust grade doctors and FY2 doctors completing training in August expressed their anxieties around uncertainty of their contract being extended in time. The main concern is around the timing of the contract extension. Many of the trust grade doctors require visas and this causes additional stress. This is dependent on the number of training posts available as well as another complexity layer of less than full-time number. However, if this can be pushed as early as possible, it would be very helpful in planning such as finding jobs elsewhere or relocation.

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

3. Annual Leave

- No new annual leave issue has been raised.
- Updated annual leave policy for resident doctors in place and is available on the intranet
- SOP for annual leave carry-over between rotation has been developed
- Quality assurance processes for rota coordinator training are being developed

4. Senior Lead and Resident Doctor Peer Lead (RDPL)

- Rosi Edwards is identified as non-executive director for resident doctors
- Dr John Jones is senior lead for resident doctors
 - Dr Aung Phyo Naing will remain as RDPL until the new RDPL is appointed. New job vacancy has been advertised.
- RDPL regularly meets senior lead and reports to board quarterly.
- RDPL holds monthly resident doctors committee with specialty representatives.

5. Payroll Errors

- No concerns have been raised regarding payroll errors

6. Statutory and Mandatory Training

- The Trust is compliant with the Memorandum of Understanding and People Policy Framework
- No concerns have been identified

7. Exception Reporting

- No concerns raised.

8. Course-Related Expenses

- Course-related expenses are reimbursed within 6 weeks, provided study leave has been approved

Appendix 1

Collection name: **Exception Reporting**

For: **THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (RXW)**, Quarter 1 FY2026/27

Submitted: **Fri, Jul 17, 2026, 10:42 AM** by **Kim Best (kim.best5@nhs.net)**

Status: **Draft**

Guidance

Welcome to the Exception Reporting data collection

Thank you for completing this data submission.

Further Information

- Information about this data collection, including Information Governance and Legal Bais can be viewed here: [Exception Reporting data collection - NHS England Digital](#) (Link:)
- Answers to common questions about the Data Collection Framework (DCF) system that is used to collect your data can be found in the [DCF submitting data support guide](#) (Link:)
- For all queries including technical queries, adding or removing users, problems logging in and password resets, please contact us by creating a ticket at the [National Service Desk NHS customer portal](#) (Link:)
- Guidance on the National Service Desk Portal can be found in the [DCF support request guide](#) (Link:)

Submission

1a) Number of exception reports submitted over the last quarter

90

Supporting Information

b) Categories of exception reports submitted

	Outcome				Number of exception reports
	Pay	Time off in lieu		Penalty/Fine	
		Hours	Mins		
Additional hours an unscheduled early start	£ 0	0	0	£ 0	0
Additional hours an unscheduled late finish	£ 2134	2	0	£ 204	74
Breaches of non-resident on-call patterns	£ 0	0	0	£ 0	0
The inability to take contractual breaks				£ 0	0
Inadequacy of clinical support					0

Inadequacy of rostered skills mix		0 *	5 *
Raising concerns of a suspected non-compliant rota pattern		0 *	0 *
Detriment or threat of detriment related to exception reporting		0 *	1 *
Information breach	£ 0 *		0 *
Access and completion resolved in time		0 *	0 *
Access and completion breaches	£ 0 *		0 *
Access and completion test		0 *	0 *
Other	Max 40 characters	£	
Total	£ 2134	2	0
	£ 204	0	90

c) Experiences of actual or threat of detriment

Quarterly survey response rate	0 % *
Doctors experiencing actual detriment as a result of exception reporting	0 % *
Doctors feeling that they are not discouraged from exception reporting	0 % *

d) Withdrawals

0 *
Number of exception reports withdrawn over the last quarter

e) Access to individual doctors' exception reporting data

0 *
Number of exception reports disclosures over the last quarter

f) Work schedule reviews related to exception reporting patterns/instances

2 *
Number of work schedule reviews related to exception reporting pattern/instances

g) Rota gaps on all shifts

79 *
Total number of rota gaps on all shifts over the last quarter

Important Notice: Do Not Submit PID

Please do not submit Personal Identifying Data (PID) like name, national ID, date of birth, or home address. We want to keep your information safe. Please remove these details before submitting your form.

h) Additional information on an ad hoc basis

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The Board is required to raise the system-wide issue with partner organisations (e.g. NHS England) to find a solution.

Annual reporting requirements

2a) Disbursement of fines

Fine	Number of fines applied	Value of fines applied
Additional hours worked breach	2	£ 157
Information breach	0	£ 0
Access and completion breach	0	£ 0
Missed breaks breach	0	£ 0
Total	2	£ 157

Board of Directors' Meeting in Common – 13 August 2026

Agenda item	073/26		
Report Title	Shropshire Community Health NHS Trust (SCHT) Freedom to Speak Up (FTSU) Report Q3 and Q4 2025/26		
Executive Lead	Martina Morris, Group Chief Nursing Officer		
Report Author	Tracie Black Associate Director for Workforce Education and Professional Standards		
Prior Consultation:	CQC Domain:	Link to (SCHT) BAF id(s)	
Group People Committee 27 th July 2026	Safe	√	N/A
	Effective	√	
	Caring	√	(SCHT) Risk Register id(s):
	Responsive	√	N/A
	Well Led	√	
Executive Summary	The report provides an update on the Freedom to Speak Up (FTSU) service at Shropshire Community Health NHS Trust (SCHT). The Trust has committed to enhancing the FTSU service and the work being undertaken is reported on a regular basis to the People Committee and Trust Board. Assure - FTSU Guardian role has increased to a 1.0 WTE position, this change occurred in January 2026. This is to reflect the growing demand for Freedom to Speak Up support. - Peer to peer support infrastructure has strengthened in Quarter 4 with the number of champions rising to 18 members. - FTSU champions have now been recruited to Dudley Health visiting (HV) teams. Advise - Emails remain the primary channel for staff engagement with the FTSU Guardian, offering a confidential route than many staff find most accessible during busy shifts. - FTSU Guardian continues to visit a wide range of locations across the Trust to promote visibility, raise awareness of the Service and encourage staff to speak up with confidence. - FTSU Standard Operating Procedure (SOP) has been updated and approved at People committee in July 2026. - The National Guardians Office (NGO) is s currently the independent, non-statutory body whose purpose is to lead cultural change within the NHS and ensure that ‘speaking up’ becomes business as usual. The NGO’s closure was announced in June 2025 with its oversight responsibilities transferring to NHSE on 1st July 2026. The government and NHSE have confirmed that the provision of a FTSU Guardian remains part of the NHS Standard		

	Contract, with the closure of the NGO marking a shift toward greater local accountability. - Currently the FTSU portfolio has a different Executive Director leadership across both trusts in the Group. Work to standardise the leadership and ensure alignment will be undertaken in the next few months. Alert - Due to the continuing investigation at HMP Stoke Heath, several staff continue to be supported by the FTSU Guardian, the FTSU lead, and other support networks such as Occupational Health. 21 cases were raised in Quarter 3 & 4 of which 10 were associated with bullying/harassment/misconduct. This is not reflected in the Trust's NHS Staff Survey results for 2025, where the associated questions were all aligned to the benchmark average. Staff raising concerns are being supported appropriately, through expansion of the Champion network, and strengthened partnership working with Professional Nurse Advocates (PNAs) and Occupational Health.
Recommendations for the Board	The Board of Directors is requested to note the report.
Appendices:	Appendix 1: Shropshire Community Health NHS Trust FTSU report Quarters 3 & 4

0. Reference Information

Author:	David Ballard, Freedom to Speak Up Guardian	Paper Date:	27 th July 2026
Executive Sponsor:	Tracie Black, Associate Director for Workforce, Education & Professional Standards	Paper written on:	1 st May 2026
Paper Reviewed by:	Tracie Black, Associate Director for Workforce, Education & Professional Standards	Paper category:	Governance
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

1.1 Why is the paper going to People Committee and what input is required?

This paper presents an outline of the ongoing work of the Freedom to Speak Up (FTSU) service and provides a review of the FTSU activity for Quarters 3 and 4 of 2025 – 26.

2. Executive Summary

2.1 Context

The Trust has committed to enhancing the FTSU service and the work being undertaken is reported on a regular basis to the People Committee and Trust Board. The data is collated in relation to the FTSU activity on a daily basis and from the Group monthly meeting held between the Guardian and Champions. This is then collated and included in the quarterly reports to the Committee.

2.2 Summary

The FTSU service has responded to 11 new cases in Q3 and 10 new cases in Q4 of 25 – 26, 9 of which remain open and are receiving ongoing support.

2.3 Conclusion

The Committee is asked to **note** the ongoing activity of the FTSU Service.

3.0 FTSU ACTIVITY

FTSU Reports

There were 11 new cases raised during Quarter 3 of 25 / 26, 6 of which remain open.

Case #	Staff Group	Date / Issued Raised	Category	Action Taken	Case status
43	Admin and clerical	9 Oct 25 Manager behaviours	Bullying and Harassment	Support given. Service restructured	open
44	Nursing and midwifery	9 Oct 25 Staff training	Patient Safety	Investigated. Discussion with Commissioners	closed
45	Nursing and midwifery	13 Oct 25 Manager behaviours	Bullying / Harassment	Support given	closed
46	Nursing and midwifery	22 Oct 25 Manager behaviours	Bullying / Harassment	Support given. Service restructured	open
47	Nursing and midwifery	22 Oct 25 External relations	General	Support given	open
48	HCA / HCSW	31 Oct 25 Manager behaviours	Bullying / harassment	Support given, case escalated	open
49	Admin and clerical	25 Nov 25 Manager behaviours	Ideas, improvements	Support given	closed
50	Admin and clerical	18 Dec 25 Allegations of fraud	Bullying and Harassment	Support given	closed
51	AHP	22 Dec 25 Concerns regarding misconduct	Misconduct	Support given	closed
52	AHP	22 Dec 25 Incorrect recording of drug entries	Patient Safety	Case escalated	open
53	Paramedic	22 Dec 25 Incorrect patient recording	Patient Safety	Case escalated	open

There were 10 new cases raised during Quarter 4 of 25 / 26, 3 of which remain open.

Case #	Staff Group	Date / Issued Raised	Category	Action Taken	Case status
55	Nursing and midwifery	14 Jan 26 Unsafe practice	Patient Safety	Support given. Investigated by CSM	closed
56	Nursing and midwifery	22 Jan 26 Discrimination in the community	Bullying / Harassment	Referred to HR	open
57	Admin and Clerical	22 Jan 26 Banding query	Employment Terms	Support / guidance given	closed
58	Nursing and midwifery	23 Jan 26 Manager behaviours	Leadership / Line Manager	Support given.	closed
59	Nursing and midwifery	26 Jan 26 Manager behaviours	Bullying / Harassment	Support given and investigated	closed
60	Nursing and midwifery	10 Feb 26 Team relationships	Bullying / harassment	Support given, case escalated	closed
61	Nursing and midwifery	19 Feb 26 Manager behaviours	Bullying / harassment	Support given. Ongoing investigation	open
62	Admin and clerical	20 Feb 26 Manager behaviours	Bullying and Harassment	Support and guidance given	closed
63	Unknown	9 Mar 26 Concerns regarding RiO	Ideas, improvement and suggestions	Referred	closed
64	Medical and Dental	9 Mar 26 Lack of support	Leadership / Line Manager	Support given. Referred to OH	open

Headlines, Network Meetings and actions

The decision was made at the end of Q3 to increase the FTSU Guardian role to a full-time, 1.0 WTE position from 1 January 2026. This decision reflected the growing demand for Freedom to Speak Up support across the organisation and the recognition that a dedicated, full-time resource is essential to maintain a responsive, visible, and proactive service. As planned, the change to the 1.0 WTE model was effective from the 1 Jan 26, enabling a greater capacity for case handling, staff engagement, training delivery, and wider cultural development work. It has also positioned the service to meet the expectations set out in national guidance and to better support both Trusts as the Group model continues to mature.

Due to the continuing investigation at HMP Stoke Heath, several staff are showing signs of considerable duress and are being supported by the FTSUG, the FTSU Lead, and other support networks such as Occupational Health.

Of the 21 cases that were raised during Quarters 3 and 4, almost half (10/21) were associated with bullying / harassment / misconduct. This comparatively high level is *not* reflected in the Trust's NHS Staff Survey results for 2025, where the associated questions were all very much aligned to the benchmark average:

Comparator Information		Picker Average 2025	Organisation 2025
Q	Description	n = 17002	n = 995
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	81.2%	82.3%
q14b	Not experienced harassment, bullying or abuse from managers	92.9%	92.3%
q14c	Not experienced harassment, bullying or abuse from other colleagues	88.1%	88.2%

This discrepancy suggests that, whilst our overall organisational culture appears healthy at a surface level (represented by our NHS Staff Survey scores compared to the benchmark average), there are likely to be localised pockets of poor culture, or a specific trust in the FTSU route over traditional reporting lines. To this end, it should be noted that, of the 21 cases raised during Quarters 3 and 4, 7 were raised by staff at HMP Stoke Heath, and of these 7, 4 were associated with bullying / harassment / misconduct.

Email remains the primary channel for staff engagement with the FTSU Guardian (Appendix 1), offering a confidential route that many staff find most accessible during busy shifts. In line with national trends, the Nursing and Midwifery staff group represents the highest volume of concerns (Appendix 2). This high engagement level may be viewed positively as an indicator of psychological safety within these professions, though it also reflects the unique pressures—such as staffing levels and patient acuity—faced by frontline teams. The Board can take assurance that these concerns are being managed in collaboration with other support networks such as Human Resources and Occupational Health.

Our peer-to-peer support infrastructure was significantly strengthened in Quarter 4, with the FTSU Champion network growing to 18 members (Appendix 3). Crucially, this expansion has focused on geographical and service-level reach, with new representation successfully recruited within the Dudley Health Visiting (HV) Teams. This ensures that the FTSU agenda is visible beyond hospital sites and reaches staff working in community settings. These Champions serve as vital 'signposters,' helping to normalise the conversation around speaking up at a local level while maintaining the necessary distinction between informal support and the formal case-handling role of the FTSU Guardian.

Visits

The FTSU Guardian continues to visit a wide range of locations across the Trust to promote visibility, raise awareness of the Service, and encourage staff to speak up with confidence. These onsite engagements remain a key part of strengthening the speaking-up culture, offering staff the opportunity to have informal conversations, ask questions, and build trust in the process. With the Guardian role increasing to a 1.0 WTE position during Quarter 4 2025–26, the capacity for outreach has continued to expand, enabling more frequent visits, broader coverage of services, and a more consistent presence across both Trusts. The tables below outline the visits completed during Quarter 3 and Quarter 4.

Completed FTSUG visits Q3 25 - 26	
Date	Location / Service
4 Nov 25	Ludlow CH
11 Dec 25	Ludlow CH
18 Dec 25	HMP SH

Completed FTSUG visits Q4 25 - 26	
Date	Location / Service
20-Jan-26	SPOR
17-Feb-26	Children's Care Team

09-Feb-26	WCCH
10-Feb-26	HMP SH
12-Feb-26	Special Schools & Respite Team - ONLINE
17-Feb-26	Donnington Medical Practice - ONLINE
23-Feb-26	Community Outpatient Team, BNCH
26-Feb-26	Respiratory Team
02-Mar-26	WCCH
03-Mar-26	Long Covid Team - ONLINE
03-Mar-26	Galvanise Programme - SaTH
05-Mar-26	Respiratory Team
12-Mar-26	Dudley 0 - 19s
24-Mar-26	Family Nurse Partnership
25-Mar-26	Dudley 0 - 19s
25-Mar-26	Shrewsbury North and South Community Nurses
26-Mar-26	Adult Diabetes Team, Madeley Health Centre
31-Mar-26	PPS Team, Monkmoor

FTSU across the Group

Collaboration will be strengthened throughout this Financial Year to ensure a robust and cohesive FTSU service for both Trusts. Weekly meetings between the Trusts' FTSUGs were implemented during Quarter 3, creating a regular forum for support, shared learning, and the exchange of best practice. As the Group approach has become finalised, quarterly updates will transition to a joint reporting format, reflecting the increasingly integrated way of working.

Closure of the National Guardian's Office

Established in 2016, the National Guardian's Office (NGO) is currently the independent, non-statutory body whose purpose is to lead cultural change within the NHS and ensure that 'speaking up' becomes business as usual. Amongst its key roles, it provides training and guidance to a network of over 1,400 Guardians across NHS Trusts, defines the national FTSU policy, and collects and publishes data.

The NGO's closure was announced in June 2025 with its oversight responsibilities transferring to NHSE on 1st July 2026.

The government and NHSE have confirmed that the provision of a FTSU Guardian remains part of the NHS Standard Contract, with the closure of the NGO marking a shift toward greater local accountability.

This will affect the Trust in the following ways:

Transparency & Accessibility: The Trust will have sole responsibility for making Guardian contact details publicly available and easily accessible on our website. (Currently in place).

Training Compliance: The Board must ensure that any appointed Guardian completes mandatory foundation training (to be hosted on the e-Learning for Health platform) before starting their role. (Already completed).

Data Reporting: From April 2026, the Trust—rather than the Guardian—will be formally accountable for submitting quarterly FTSU data via NHSE's national data collection process. (In progress).

Psychological Support: Since the nationally sourced Employee Assistance Programme (EAP) for Guardians will end on 31 December 2026, the Trust must ensure appropriate, independent psychological support is available locally for the Guardian.

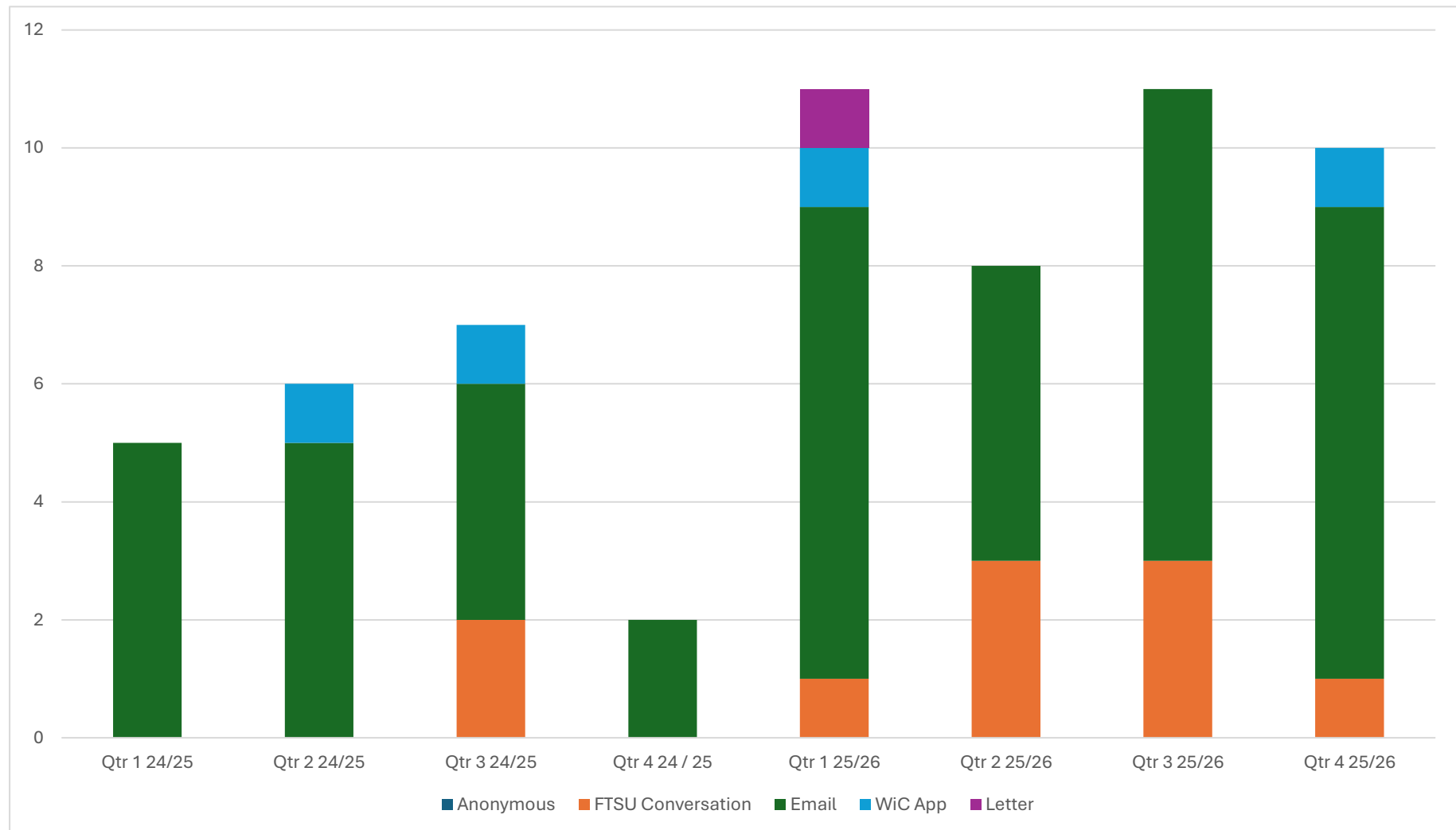
Regulatory Oversight: The Care Quality Commission will continue to assess the effectiveness of our FTSU arrangements through Well-Led inspections.

Communications and Engagement Plan

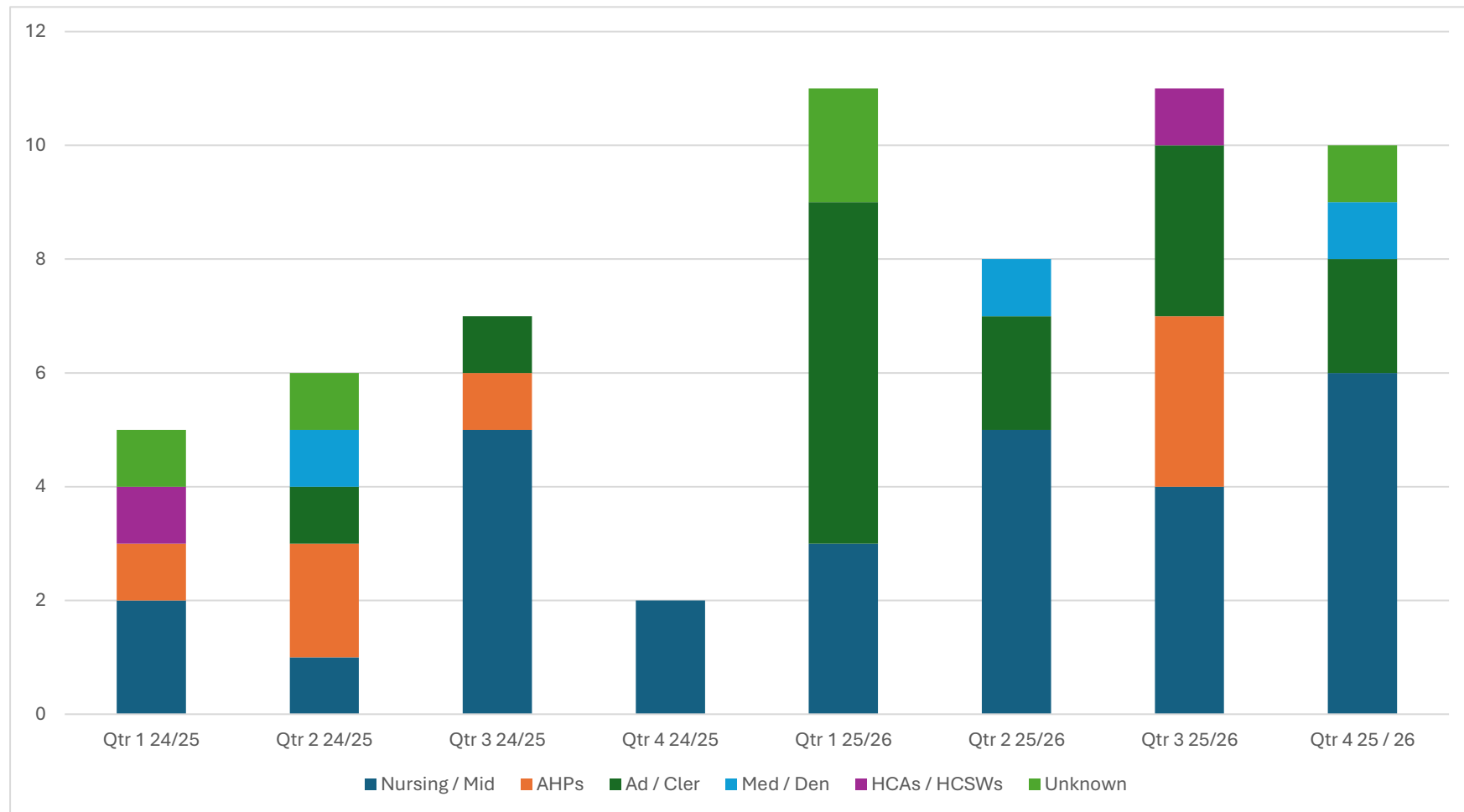
A Communications and Engagement Plan has been developed during Quarter 3 by the Communications team to strengthen awareness, visibility, and understanding of FTSU offer across the organisation. The plan at Appendix 4 outlines a coordinated approach to promoting key messages, increasing staff engagement, and supporting a culture where speaking up is encouraged and valued. It includes targeted communication activities, regular updates, and opportunities for staff to share feedback, ensuring that FTSU remains a prominent and accessible part of everyday practice.

To further lower barriers to speaking up, an update to the Staff Zone landing page was implemented during Quarter 4. By increasing the prominence of FTSU links on the landing page, we have streamlined the route for staff to access support and policy guidance. This digital 'front door' approach aligns with National Guardian Office (NGO) best practice by ensuring that the means to raise concerns is integrated into daily workflows. Early monitoring suggests this has improved signposting for staff working remotely or in non-clinical settings, reinforcing the Trust's commitment to a 'Speak Up, Listen Up, Follow Up' culture.

APPENDIX 1: CONCERNS RAISED BY CHANNEL



APPENDIX 2: CONCERNS RAISED BY STAFF GROUP



APPENDIX 3: FTSU CHAMPIONS



Tracie Black
Associate Director for
Workforce, Education &
Professional Standards
tracie.black@nhs.net

David Ballard
Freedom to Speak Up Guardian
david.ballard@nhs.net



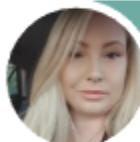
Harmesh Darbhanga
Non-Executive Director
h.darbhangha@nhs.net

Shelley Ramtuhul
Director of Governance
shelley.ramtuhul@nhs.net



Julie Mills
Hotel Services Manager/ Hotel
Services Professional Lead
julie.mills16@nhs.net

Debbie Saklatvala
Health Promotion Lead
HMP & YOI Stoke Heath
debbie.saklatvala@nhs.net



Sophie Messenger
Communications Officer
sophie.messenger@nhs.net

Hope Anyigbo
Deputy Ward Manager
hope.anyigbo@nhs.net



Mike Smith
Clinical Practice Teacher
mike.smith24@nhs.net

Sheranne Cole
Senior Practice Education
Facilitator
sheranne.cole@nhs.net



Sally Stubbs
Locality Clinical Manager -
Central

Sarah Higgins
Senior Practice Education
Facilitator for AHPs
sarah.higgins19@nhs.net



Tracey Fisher
Clinical Practice Teacher
tracey.fisher@nhs.net

Cheryl Scarrott
Admiral Nurse Team Lead
cherylscarrott@nhs.net



Nicola Dixon
Business Support & Quality
Improvement Manager
nicola.dixon6@nhs.net

Chuchu Benny
Deputy Ward Manager
Ludlow CH
chuchu.benny@nhs.net



Rachel Hammond
Lead Radiographer
rachelhammond16@nhs.net

Olivia Siegl
Head of Communications
olivia.siegl@nhs.net



Carolyn Hawkins
HV Team Lead, Dudley
carolyn.hawkins2@nhs.net

APPENDIX 4: COMMS AND ENGAGEMENT PLAN

**Shropshire
Community
Health NHS
Trust**

"Providing the **Right**
care, in the **Right** place,
at the **Right** time by the
Right people."

Freedom to Speak Up Comms & Egt Plan 2025



Agile



Cohesive



Empowering

Communications & Engagement Strategy

To help raise awareness of the FTSU offer and to empower staff to use the service as needed. Clear communications will outline how the FTSU service works, how staff can access the service and will reassure staff that they can raise concerns without fear of reprisal.

Objectives

- Raise awareness of the FTSU service, what it can be used for and how staff can access it.
- Increase awareness of the FTSU policy and procedures.
- Promote a positive speaking up culture where staff feel comfortable raising concerns.
- Educate staff on how to raise concerns through the appropriate channels.
- Demonstrate that concerns are taken seriously and acted upon.
- Reach the hard-to-reach staff groups to ensure as many staff are aware of the service as possible.



Key messages

- Speaking up is encouraged and valued.
- There are clear processes for raising concerns.
- Confidentiality will be maintained.
- Concerns will be investigated thoroughly and appropriate action taken.
- No one will be penalised for raising a genuine concern.

Challenges

- Staff concerned their concerns won't be addressed.
- Staff worried they will be penalised for raising a concern.
- Staff feeling that raising a concern won't result in changes being made.

Audience

- All staff members at all levels inc Board.
- Team leaders and managers.
- Freedom to Speak Up Champions & Guardians.



Internal Communications

A series of well thought out communications across the Trusts internal communications channels will take place.

Internal Communications Channels

- **FTSU Month Bulletin:** Bulletin highlighting the FTSU offer along with the national key theme for FTSU month (October).
- **Staff Noticeboard:** Permanent section in the weekly staff noticeboard along with important updates.
- **StaffZone:** Dedicated FTSU section on StaffZone with regular updates, information about the policy, how to speak up, contact details for champions/guardians, and updates on actions taken.
- **Team Cascades:** Discussions led by managers to reinforce the FTSU culture and address any questions.
- **Desktop banner:** Adhoc throughout the year and during FTSU month.
- **Staff Facebook:** Key updates and information on the offer to be shared in the group.
- **Posters & marketing materials:** Visual reminders placed around the workplace.
- **Induction Training:** New employees should be introduced to the FTSU policy during onboarding.
- **Dedicated Email Address & Web-based platform:** A confidential channel for staff to raise concerns directly.

Communications Assets

The delivery of our Comms and Egt plan will utilise a number of graphic assets designed in line with the national comms toolkit.



Staff Engagement Plan

Health & Wellbeing Days

Attendance at HWB Days through out the Trust to support greater understanding of the FTSU offer.

FTSU Survey

Feedback survey for those who have raised a concern.

People Promise

Activities linked to the People Promise theme 'We each have a voice that counts'

Case Studies

Share positive examples of how speaking up has led to positive outcomes.

Confidential Focus Groups

Gather feedback from staff on their experiences with the FTSU process.

Training Sessions

Provide regular training for all staff on the FTSU policy and procedures



Timings/plan

- Bulletin issued on internal comms channels (email bulletin, StaffZone, Staff Facebook) - Spring time & October
- HWB Days - TBC
- Desktop Banners - TBC
- All other additional activity to be discussed with FTSU Guardian to determine dates for 2025.

Evaluation

All comms activity will undergo evaluation so we can define activities most successful and effective The success of our communications and engagement activities will be monitored and measured in the following ways:

- Social media monitoring including engagement and reach figures
- Analysis of staff engagement
- Feedback from staff & FTSU Team

