Shropshire Community Health NHS Trust

Trust Board - 6 February 2025

MEETING

6 February 2025 10:00 GMT

PUBLISHED

3 March 2025

Agenda

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Ludlow Mascall Centre	6 Feb 2025	10:00 GMT

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MINUTES OF THE PUBLIC BOARD MEETING

HELD AT SECC, SHREWSBURY
AT 10.00 AM ON THURSDAY 5 DECEMBER 2024

PRESENT

Chair and Non-Executive Members (Voting)

Mr. Andrew Morgan	(Chair in Common)
Ms. Jill Barker	(Non-Executive Director)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Alison Sargent	(Non-Executive Director)
Ms. Cathy Purt	(Non-Executive Director)

Executive Members (Voting)

Ms. Patricia Davies	(Chief Executive)
Ms. Sarah Lloyd	(Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Clair Hobbs	(Director of Nursing)
Ms. Claire Horsfield	(Director of Operations and Chief AHP)

In attendance

Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)

Welcome

Mr Morgan welcomed all to the meeting.

Apologies and Quorum

Apologies were received from Ms Tina Long, Non-Executive Director, and Ms Shelley Ramtuhul, Director of Governance.

The Chair in Common declared the meeting to be quorate.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 3 October 2024

Subject to the amendments of typographical errors, the minutes were agreed as an accurate record of the meeting.

Action Log

It was confirmed that the update on electronic prescribing would be presented at the February Board meeting.

Notification of Any Other Items of Business

There was none.

Chair in Common's Update

Mr Morgan advised he was now in his third month in post and had been meeting colleagues from across the System and wider area. He shared his thanks to everyone who had made him feel welcome and who had been very honest in their views on how to move forward.

Mr Morgan noted the difficult financial circumstances of the whole System and nationally. He noted that there were regular discussions on flow, winter pressures, UEC and waiting times.

Ms Purt asked if Mr Morgan had visited any of the community hospitals, Mr Morgan confirmed he had not visited all the sites but there was a schedule of visits in place.

Non-Executive Directors' Communication

Mr Darbhanga said that he and Ms Lloyd had visited Halesfield for a GEMBA walk, which had been extremely informative. He had also had a discussion with a member of staff about leadership and culture, particularly in relation to how the Trust was embracing diversity in our organisation, particularly within leadership roles.

Ms Barker stated that she had visited Stepping Stones in Telford with Ms Lloyd and had been very impressed with the team. They had raised some interesting points about mandatory training, which they felt was geared towards adults rather than children's services. They also had thoughts about utilisation of clinical space.

Public Questions

None received.

Staff / Patient Story

Due to illness, this item was withdrawn.

Chief Executive's Update

Ms Davies summarised her report and highlighted a number of areas. The Trust had submitted its response to the NHS 10-year plan engagement the previous week, following workshops with senior leaders and trade unions. The national team meeting had been positive, although there was still a long way to go.

Ms Davies also congratulated the winners of the first ACE awards and noted that nominations had been made by the winners' peers.

Mr Morgan discussed the organisation's staff flu vaccine rate and asked about reasons given for not wanting to have the vaccine, Ms Boyode said the main themes were vaccine fatigue, lack of prioritisation and myths around the vaccine. Ms Hobbs noted that this was closely monitored by the IPC Committee.

Ms Sargent asked about national awards and how staff were encouraged to put themselves forward for these. Ms Davies stated that there was a strategy in place, but leaders were encouraged to look at awards they could put their teams forward for.

System Integrated Improvement Plan

Mr Morgan said it was important that the Trust signed up for the plan but noted the Board could not agree the plan until it was in front of them. It was vital that each organisation delivered their part, but also acted to hold each other to account.

Ms Davies noted that all of the Boards agreed to the principle, but it needed to be done in the right way and this was still being worked through. Monitoring was vital and key issues needed to be clear, a single PMO would help this. Mr Morgan agreed that all organisations needed to be able to see how each other were performing. Ms Purt noted that this was monitored through the ICB Strategy committee, at which all partner organisations were represented.

QUALITY, SAFETY AND PEOPLE

Quality & Safety Committee Chair's Report

Ms Barker summarised the report and noted that, due to System pressures, the meeting had been shortened to consider only items that were required for Board.

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

Integrated Quality and Safety Report

Ms Hobbs summarised her report and noted that, of the 16 KPIs monitored by the Quality and Safety Committee, 3 were showing as special case of variation:

- C-Difficile – the annual threshold was 4 cases and we had now reached 2, both of which were at Ludlow. A deep cleaning plan was in place.
- E-Coli – there had been one case, meaning that the threshold had been met. It was noted that this was a complex patient and a review had confirmed that there were no lapses in care that could have prevented the case.
- LFPSE – national data collection had been paused.

Ms Hobbs stated that the number of falls had reduced and there was no change in relation to MRSA. Staffing fill rates remained green and there were areas where additional resource was being added, to ensure safety.

Mr Darbhanga asked about deep cleans and if they happened regularly or after an incident. Ms Hobbs stated that an annual deep clean was gold standard and that a plan was being worked up for regular deep cleans of all the community hospitals.

Mr Darbhanga asked about falls and if this was an area of concern. Ms Hobbs stated that it was not and that these patients were rehabilitation patients and getting them moving did come with a risk. Staffing in these areas had been bolstered to support patients. The demographics of patients in the wards had changed, which was challenging but not concerning.

Ms Davies discussed the strategic commissioning of the models of care and if this needed to be changed due to the changed cohort of patients. Ms Hobbs stated that she needed further data to really understand the model of care needed. It was important the AHPs were included within the model of care, particularly for this cohort, as they would form a key part of the rehabilitation programme. Ms Horfield noted that there was no national safer staffing tool for AHPs, but there was ongoing work in integration of therapies at SaTH and the benefit this would give for all patients.

The Board
- ***Accepted the assurance provided by the update.***
- ***Took assurance from the report that appropriate actions were being taken to address any areas of concern***

Quarterly Guardian for Junior Doctor Safe Working Report

Dr Ganesh stated that this was an exception report and there were no breaches to report for the Trust.

Mr Darbhanga asked about assurance of compliance, Dr Ganesh confirmed that any breaches would be reported but there had not been any.

The Board accepted the report.

Emergency Planning and Business Continuity

Ms Hobbs stated that there were two policies for approval, these had been picked up as part of the Trust's Core Standards as requiring Board approval. They had been presented to Quality and Safety Committee which had been fully assured.

Mr Darbhanga asked if there were any other reports that required Board approval and it was agreed that this would be clarified after the meeting.

The Board
- ***Approved the contents of the report and amended approval routes for both documents.***
- ***Approved both documents for the current annual cycle.***

PEOPLE

People Committee Chair's Report

Ms Purt summarised the report. It was noted that due to System pressures, this meeting had been reduced to consider items for Board approval only.

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

Integrated People Performance Report

Ms Boyode noted that there was a lot of focus on the completion levels of mandatory training and that there was a national directive to look at mandatory training to see if it was relevant and outcome driven. There had been a slight decline in appraisal rates, particularly in those who were close to retirement, work was underway on educating staff on the options available to them.

A discussion took place regarding the mandated committee on training, Ms Boyode confirmed that the directions did not state it was to be time limited, however, she would ask for clarification on this.

Mr Darbhanga asked Ms Boyode for her opinion on the appraisal documentation, she replied that the forms do not necessarily facilitate the capture of important conversations about the support that staff required or their clarity about their role and its purpose.

The Board

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

Bi-Annual Review of Safer Staffing

Ms Hobbs noted that the community nurse staffing tool was paused nationally at the beginning of the year, so there was no clear data, however lots of work had taken place locally around demand and capacity. It was further noted that Bishops Castle Hospital was not included within the data set, as it had not re-opened at the point of data collection.

Ms Hobbs noted that E-Roster and Safecare had been introduced in the last year, which allowed the team to view, shift by shift, the acuity and dependency of patients and understand where the risk were.

The registered nurse to HCA ratios continued to be low and this needed to be increased. There had been 3 incidents in relation to revalidation, however, no shifts had been worked by nurses without a valid PIN.

Mr Morgan asked what the staff's opinion would be on the report, Ms Hobbs said she thought they would say it was fair and that the Band 6 and 7 leads had been trained in the tools and understand the data within.

A discussion took place regarding the lack of a national tool for community nursing and the impact this had on commissioning of resource. Ms Hobbs stated that data was triangulated with quality and safety data but a nationally recognised toolkit would be extremely useful.

Ms Barker asked about the vacancy level on Ward 18, Ms Hobbs confirmed this was a new ward and had now been fully recruited to.

A discussion took place regarding the revalidation of AHPs. It was noted that revalidation dates for AHPs were flagged through the workforce systems, and it was agreed that a regular report would be provided to the Board on their revalidation.

The Board reviewed the information and accepted that there is assurance for safer staffing within the Community Hospitals and RRUs and moderate assurance on Workforce Safeguard compliance.

Safeguarding Annual Report

Ms Hobbs presented the annual summary of the activity of the safeguarding team. There had been good success on adults e-learning and work was underway with the Dudley 0-19 Services to ensure that safeguarding procedures were aligned as they were in Shropshire, Telford and Wrekin.

The Board

- ***Noted the key safeguarding activities across the organisation.***
- ***Accepted the report as assurance that SCHT was meeting its statutory responsibilities regarding safeguarding and promoting the welfare of children, adults and families that encounter our services as set out in the Children's Act 1989 and 2004 and the Care Act 2014.***
- ***Approved the annual report.***

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Ms Lloyd presented the report in the absence of Ms Long, the Committee Chair. Each item received full assurance. There had been a number of Terms of Reference approved by the Committee and lengthy discussions on the digital strategy. The Committee recommended a Board discussion on cyber security to take place.

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

Performance Report

Ms Lloyd summarised that of the KPIs monitored by the RPC, 11 required attention. Ms Lloyd noted that one was in relation to data quality, which was extremely close to target, the other 10 related to waiting times, which were largely unchanged from previously. The Board were advised that each patient who was waiting was closely monitored.

In relation to the 0-19 contract with Dudley, it was noted that the current KPI target was set at 95% of newborn visits to be completed and it had been proposed to move this to 90%. The Board agreed to this amended target but noted that the Trust should continue to strive for 100% compliance, with 95% the stretch target, although noted the reasons that this would not always be possible, including babies in NICU and parental choice.

Ms Purt asked about TeMS and the likelihood of the service transferring by December, Ms Horsfield confirmed that she has the highest confidence she has had that this would transfer. It was noted that conversations regarding this were ongoing regularly.

The Board
- ***Considered the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.***
- ***Considered the current action plan reporting and if any amendments were required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.***
- ***Approved the retrospective update of the target for New Birth Visits % within 14 Days – Dudley.***

Finance Report

Ms Lloyd stated that at the end of October, the Trust was reporting a very positive year to date position, with a surplus of £1.1m. There were no new risks to highlight and that the Trust's CIP was ahead of plan, with 11% of schemes deemed high risk in terms of delivery. Agency use was below plan; however, it was noted that this would be challenging going into winter.

A discussion took place on delivering a surplus and it was important to support the overall System position.

Ms Barker asked about the CIP target and noted that the majority of the target was still to be delivered, Ms Lloyd advised that the plan was always weighted towards the end of the year and the majority of the schemes, over 90%, had been de-risked.

Ms Barker asked about the medical cover for the RRUs, Ms Horsfield confirmed that there were two elements for cover: in and out of hours. A procurement exercise was completed for in hours cover, which was completed and went live earlier this week. Out of hours cover would be considered in due course.

The Board
- ***Considered the adjusted financial position for the year to date is a surplus of £1,112k compared to the planned surplus of £663k which is a favourable variance of £449k***
- ***Recognised that agency and overall pay costs must remain within planned levels to ensure we deliver our financial plan.***
- ***Acknowledged that schemes are now fully identified to deliver the annual CIP target of £3.6m, although £0.4m of identified schemes are rated as high risk in terms of delivery.***

- ***Recognised that we have reprofiled our capital expenditure plans and are working with system partners to assess potential further changes to our capital allocation.***
- ***Considered the forecast outturn is to deliver our planned surplus of £1,768k but there remained a number of risks, mitigations and opportunities which may impact upon delivery.***

Estates Strategy Progress Report

Ms Lloyd stated that the Trust was working closely with many partner organisations, including Local Authorities and other provider, and this was a real area of focus for partners. Ms Davies stated that the majority of sites used by the Trust were leased and not owned.

There was an overarching Infrastructure Strategy developing at the ICB, which the Trust was connected into. There was ongoing, proactive work to support the strategy.

Ms Purt asked about Shirehall, Ms Lloyd noted that the Trust was actively engaged with Shropshire Council. Ms Lloyd noted that some services were already co-located with the Council, such as digital services.

The Board
- ***Acknowledged that our estate is being actively managed to support delivery of our estates strategy.***
- ***Recognised that there are no material risks to bring to the Board's attention in relation to the delivery of this strategy.***

Planning Update

Ms Lloyd said that the Trust's operational plan had 8 key priorities and had been driven by the national and local context. The report provided an update against the current years operational plan, noting that each committee had reviewed its progress and each had reported to be on track.

Work was underway in developing next years operational plan. Work was ongoing ahead of the national planning guidance and engagement with teams had taken place. The same themes were emerging.

Mr Darbhanga welcomed the growth in digital services. Ms Lloyd agreed and noted that the Trust needed to improve how it captured the benefits of digital services. Dr Ganesh agreed that digital services were a good enabler, and that we have just started the journey.

The Board
- ***Acknowledged that the 2024/25 interventions and milestones are currently on track to support delivery of our operational plan.***
- ***Recognised the key milestones and deadlines for developing our 2025/26 operational plan.***
- ***Considered the baseline activity analysis submission to the ICB, in line with the 2025/26 planning timetable.***

PEOPLE

Audit Committee Chair's Report

Mr Darbhanga summarised the meeting which had been chaired by Mr Featherstone.

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

Board Assurance Framework

Ms Lloyd confirmed that the RPC had reviewed their BAF, this had not occurred for People and QSC as the meetings had been reduced. There were two new risks within the plan; the capacity of

the quality improvement team and capital funding. The risk in relation to LFPSE had been closed as we are now compliant.

The Board approved the Board Assurance Framework.

Annual Review of Standing Orders, Standing Financial Instructions, Scheme of Delegations and Scheme of Reservation

Ms Lloyd stated that this was the annual review of the Trust's key governance documents, which had been reviewed by the Audit Committee and recommended for approval. The report was based on the Department of Health and Social Care model and outlined key changes from previous years. The Audit Committee had asked for two new sections within the delegation scheme in relation to where tenders and business cases were approved, it was difficult to benchmark these and would be reviewed.

The Board approved the amendments within these governance documents.

Charitable Funds Account

Ms Lloyd stated that the Board was the Corporate Trustee of the Charitable Funds Account and was required to approve the Accounts. The Accounts had been reviewed by Audit Committee who had recommended approval by the Board.

There had been several very generous donations to the fund this year and the Board expressed their thanks for each one. The money would be spent in the right way on the right things.

As the funds were fairly low, £172k, they did not require a full audit, however, the Trust's external auditors, Grant Thornton, had completed an independent examination and required no changes to be made. Once the Board approved the accounts, the auditors would finalise their report which would then be sent to the Charities Regulator.

The Board formally adopted the 2023/24 Charitable Fund Annual Report and Accounts, as approved by the Charitable Funds Committee on 18 November 2024 and in accordance with its delegated authority.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 6th February 2025

Trust Board

Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
03-Oct-2024	**2024/10/13 - QSC Chair's Report**	Update on the electronic prescribing system to be bought to Board	CHor		*Update to be provided at a future Board Meeting*	ONGOING
05-Dec-2024	**2024/12/16 - EPRR**	Director of Governance to confirm if there are any other policies that are in place which require Board approval	SR			ONGOING
05-Dec-2024	**2024/12/19 - Bi-Annual Safer Staffing**	Regular report on revalidation of AHPs to be presented to the Board	CHor			ONGOING
05-Dec-2024	**24/12/21 - RPC Chair's Report**	Cyber Security Paper to be bought to Board	SL			ONGOING

CHIEF EXECUTIVE'S REPORT – February 2025

Introduction

This report sets out issues of importance to the organisation (for information) not picked up in other Board reports. These are presented under the headings of our three strategic objectives:

- Looking after our People
- Caring for our Communities
- Managing our Resources

In addition, the paper sets out any national and local issues of note. The Board is asked to consider the impact of this report.

National and Local Issues

1. Local issues – Winter

As this is the first public Board meeting in 2025, I would like to take this opportunity to wish our staff, partners and public a very Happy New Year. I would also like to recognise and thank our STW and Dudley SCHT staff who are truly inspirational. Huge gratitude and thanks also to our wider Shropshire, Telford, and Wrekin (STW) health and care partners, SaTH, RJAH, colleagues in primary care and West Midlands Ambulance service and our wonderful council teams across Shropshire Council, Telford and Wrekin Council and Dudley Council for their commitment, compassion, and dedicated focus over the last few weeks of what has been a challenging mid-winter. Whilst there continues to be significant pressure across our communities the relationships and the way in which all system partners have tirelessly worked together, has been nothing short of amazing. **Thank you all!**

The impact of flu, COVID and Norovirus and extreme weather has had a palpable impact on urgent and emergency care services nationally and locally, with infection rates 3.5 times higher than for previous winters, with longer spells and spikes of infection following the holiday period. The system declared one critical incident at the time of writing this report, but through the collective efforts managed to stand down this incident within 48 hours. Long waits remain and this is something we all in the local NHS and care system find unacceptable. We are managing this position collectively in terms of mutual aid, support, use of and deployment of skills and resources to ensure that patient safety across all our services remains at the fore during this challenging winter.

2. National issues

Since my last report there have been a series of national announcements that I would like to share briefly in addition to the National Change Campaign, which I reported on last month.

National Change Campaign. The Campaign has now closed to the public, NHS staff, systems, and organisations in terms of feedback, but regional roadshow and workshops will continue throughout this quarter to support the development of the 10-year plan due in the Spring. As reported in December, we have actively communicated in tandem with our system colleagues to encourage our workforce to contribute to the feedback. Further, SCHT submitted an organisational response to the Change. NHS consultation based on our experience of leading the Local Care Transformation Programme, developing integrated care with our partners and innovations in sub-acute as well as being specialists in rehabilitative care and care at home. SCHT colleagues along with system partners have been involved in local and regional engagement sessions about the plan. We expect the plan to focus on the three big shifts for the NHS: from hospital to community, from analogue to digital and from treatment to prevention and to seek to set out the changes that will be necessary to delivery these successfully.

Operating Plan for 2025/26. Just before Christmas Chairs and Chief Executives joined a session with Amanda Pritchard and the Secretary of State who outlined the principles that will underpin the new operating model for the NHS – one of the recommendations from Lord Darzi's review – yet to be published. These reinforce the responsibility of providers for delivery, quality, safety, and finances as well as working with partners to introduce integrated neighbourhood care. The role of ICBs as the local leaders of the system and strategic commissioners responsible for neighbourhood health is reinforced whilst the performance management and oversight role of both ICBs and providers for NHE England is confirmed.

Governance. NHS England has published "The Insightful Board" which provides guidance for NHS trust boards on how to undertake their functions effectively. It particularly offers advice on how boards should gain assurance and the indicators they should consider in doing so. We will spend more time on what this means for the way we work in SCHT as an Executive and board and through our proposed forthcoming Well Led Review.

Regulation. The government has launched a consultation on potential approaches to professional regulation for NHS managers as well as announcing that there will be a new Very Senior Managers (VSM) framework due in the Spring. Alongside these measures, NHS England has shared more detail on the national support and development framework for NHS leaders.

Taking Care of Our People

3. Staff Recognition

The Trust has launched an award scheme to celebrate the hard work and dedication of our staff and innovation across the Trust. We launched the ACE awards at our AGM in October in line with our ACE cultural characteristics:

Agility	be responsive at pace to the needs our community, continuously learning and improving as we go.
Cohesion	we work together to deliver services for our community, acting with integrity, inclusivity, and transparency.
Empowerment	decisions are made by those with the best information. People have permission to act, safely, quickly, and accurately.

Nominations can come from anyone in or outside the Trust. These are bimonthly awards. Award Nominations for March are now out and I will be announcing the winners of these awards in the April Board.

4. The Staff Survey

We had our highest ever response rate to the survey. Our final response rate was 62% which means 1192 staff out of 1933 WTE responded to the survey, up from 869 last year. I would like to thank staff for responding to this survey which serves as an important barometer in terms of how we are doing as a Trust.

We are still awaiting the detailed comparative data but the early return from Picker is encouraging and suggests that we have seen improvements across the majority of the People Promise themes and elements.

The staff survey is one lens that we are using as a Trust alongside the People Promise programme of work and wider work that we are doing to constantly engage with our staff. For example, we have launched our Culture and Leadership programme, undertaken a flexible working campaign and flexible working survey, undertaken a financial wellbeing survey and much more.

5. Wellbeing offer & Flu vaccination.

In line with the People Promise and engagement work, the Trust has been building on the already established wellbeing offer we have including, access to financial advice and training workshops, wellbeing days, keeping healthy, well woman and man workshops to name but a few. As we are now well into the winter season, our vaccination offers to staff has been a key theme. Our overall uptake as of 20 January 2025 is 51%, the highest uptake for Shropshire and Telford and Wrekin System and upper quartile for Trusts regionally, this includes individuals who have received their vaccination through alternative routes such as their GP and Pharmacist. In terms of internal delivery of the vaccination a total of 754 vaccinations have been administered compared to our final figure of 715 last year. We continue to raise the issue of importance of vaccination to staff through staff briefings and line management support and continue to make the vaccination available and administration as flexible as possible for our teams.

6. Culture and Leadership Programme

During November, the Trust commenced the Discovery phase of the programme with the gathering of our Culture Change Team and Champions. This was well attended with a fantastic number of employees coming together, all from different roles, bandings, backgrounds, and services to share why they wanted to be part of this vital culture change initiative and get started with this important work. The group divided into two and mapped out how the culture change team will undertake **Board Conversations**, and a **Leadership Behaviours Survey**, with a clear path forward.

Caring for Our Communities

7. COVID Autumn Campaign

As system lead for the COVID vaccinations programme, the Trust has again been supporting the coordination and delivery of the COVID vaccine.

Vaccination against COVID continues to help protect against severe illness, hospitalisations and deaths arising from COVID-19. Just to put this into context last year across the UK, between November, December and January over 38,000 people were admitted to hospital with the virus. As such vaccinations remains as a real plank in our armoury for winter. As per previous years, the eligible groups are, with some minor changes:

- adults aged 65 years and over
- residents in a care home for older adults
- individuals aged 6 months to 64 years in a clinical risk group (as defined in tables 3 or 4 in the COVID-19 chapter of the Green Book)
- frontline NHS and social care workers, and those working in care homes for older people.

The eligibility is the same across the 4 nations of the UK (England, Scotland, Wales and Northern Ireland).

Following a change in the reporting system used by NHSE and a data reconciliation exercise, the eligible population for Autumn 2024 vaccination booster has reduced from 212,509 patients to 199,196 patients. Our target level of uptake for this campaign is 60.8%, the same as Autumn 2023, which equates to 121,111 individuals.

As of 13 January 2025, our Vaccination Programme has delivered 97,709 vaccinations which is 49.1% of the total eligible population and 80.7% of our target. At approximately the same point last year the Vaccination Programme delivered 124,810 vaccinations which was 60.7% of the total eligible population (205,748) and 99.8% of our Autumn 2023/24 target.

At 13 January 2025, STW are within the Median range for all cohorts when benchmarked against Midland's region Systems. During the current campaign there has been an increased level of vaccine fatigue and resistance in relation to Covid-19 vaccinations which is a risk to achieving our overall target uptake of 60.8%. We continue to promote the benefits of taking up the offer.

8. Infection Prevention and Control Team

In line with Region, we have seen an increase in healthcare associated infections over recent weeks with most of these being linked to seasonal viruses. This has put additional challenge on our clinical teams and patients to ensure prevention and control has remained at a level we would wish to protect our patients and staff. Whilst we have a small Infection Prevention and Control Team (IPC), there continues to be excellent advice and assurance across our clinical areas. Currently we are seeing increased numbers of Flu, Covid, Norovirus and Clostridium Difficile cases which has been a challenge but very well contained.

We have made difficult decisions in recent weeks regarding opening additional inpatient capacity including temporary escalation spaces which has put even more emphasis on managing and preventing infection whilst balancing the large system risk in Urgent and Emergency Care. The Director of Infection Prevention and Control (Director of Nursing) and the IPC Team continue to have full oversight of all risks and outbreaks to ensure we are doing all we can to prevent healthcare associated infections or transmission in outbreaks.

Managing Our Resources

9. Managing Our Resources

Managing resource effectively is not only vital to ensure financial efficiencies but also to improve our patient pathways and streamline care across all our services at a system level.

Managing our resources appropriately is also vital in times of high surges in demand across key areas and incident management. Through our emergency preparedness, resilience and response (EPRR) work we have robust business continuity plans across operational and corporate teams. These were particularly put to the test during the extreme weather alerts and subsequent snow. Having robust plans in place to cover staff emergencies, unplanned events and system critical incident is vital to maintain patient safety across the communities we serve.

Following Covid the management of our resources to recover elective care has been of a paramount focus and in January Guidance was provided by NHS England that sets out how the NHS will now further reform elective care services. Below is a summary of the proposed commitments with further guidance due in the annual operational planning guidance.

- Meet the 18-week referral to treatment standard (92% incomplete target) by March 2029.
- By March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally.

- Every trust will need to deliver a minimum 5 percentage point improvement by March 2026. We then expect sufficient increases annually (exact figures to be confirmed in the planning guidance) to reach 92% in 2029.

The reforming elective care documentation also makes reference to a number of digital requirements and developments to help in supporting recovery which include the use of Patient Engagement Portals (PEP's) which are accessed through the NHS APP, development of the Electronic Referral Service (e-RS), remote monitoring and the extension of Artificial Intelligence, all of which are either work streams underway across the digital portfolio and operational teams or currently planned through capital investment.

And Finally – Good News Stories

The end of December saw a number of fantastic initiatives from staff across the Trust raising funds and making donations to charities supporting communities and families across STW:

South Telford community nursing team Christmas present collection

South Telford Community Nursing Team collected 27 bags of Christmas presents that were delivered to STAY. This is the second year the team have chosen not to do the usual 'Secret Santa' but instead have been donating and collecting for charity. STAY is a charity that provides housing and support services to homeless and vulnerable people in the Telford areas.

Food bank thanks for Halesfield

Staff from Halesfield have been thanked by Telford Crisis Support for their kind donation to the food bank. The Care Home MDT initiated the collection in lieu of Christmas gifts and staff from all services were able to gift food. The donations were then made into Christmas hampers for families in need throughout Telford and Wrekin.

Dudley Central Health Visiting Team raise funds for charity

Dudley Central Health Visiting Team, who took part in the Christmas jumper day for 'Save the Children', helped to raise almost £100 towards this amazing cause. They also completed a reverse advent calendar throughout December and donated lots of food and toiletries to the Black Country Food Bank

Change NHS

ShropCom is supporting the Change NHS campaign and since it's national launch in October, the national surveys and campaign details have been shared on both internal and external comms. We are encouraging all staff to take part and have their voices heard and we will be supporting our ICB colleagues who are hosting a couple of engagement sessions later this month.

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality and Safety Committee Thursday 20th January 2025

0. Reference Information

Author:	**Jessica Donegan, Executive Assistant**	**Paper date:**	**6th February 2025**
Executive Sponsor:	Jill Barker, Non-Executive Director	**Paper written on:**	30th January 2025
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**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 meeting held on Thursday 30th January 2025 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- Pressure Ulcer thematic review was presented to Committee
- EPMA Business case was highlighted as a key feature in patient safety and was supported
- Bishops Community Hospital (BCCH) comparative report showed improvements and good progress against the latter 2024 report
- RRU Benefits realisation paper showed improvements on the acute setting across several KPIs including a reduction on occupancy and a reduction in patients that have 'no criteria to reside' (NCTR) following the opening of the RRU units

2.3. Conclusion

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

3. Main Report

3.1 Introduction

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality and Safety Committee Thursday 20th January 2025

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 30th January 2025. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair) Clair Hobbs, Director of Nursing, Quality and Clinical Delivery Claire Horsfield, Director of Operations & Chief AHP Dr Ganesh, Medical Director Shelley Ramtuhul, Director of Governance/Company Secretary Patricia Davies, Chief Executive Tina Long, Non-Executive Director Cathy Purt, Non-Executive Director Alison Sargent, Non-Executive Director Sara Ellis-Anderson, Deputy Director of Nursing and Quality Susan Watkins, Chief Pharmacist Jodie Jordan, Tissue Viability Service Lead & Wound Healing Service Manager (part) Tom Seagar, Clinical Director BDS MFDS RCS Edin Dip Cons Sed (part) Jane Sullivan, Senior Quality Lead ICB Jessic Donegan, Executive Assistant/Minute Taker
Apologies:
No apologies to note

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Integrated Quality & Safety Report		
Highlights from the report discussed with Committee include: - **C. diff Cases:** It was highlighted that the threshold for C. diff cases of 4 for the year has been exceeded, with	Y	

Chair's Assurance Report

Quality and Safety Committee Thursday 20th January 2025

6 hospital-acquired cases this financial year and a total of 8 within the rolling 12 months. A thematic review is being conducted, and deep cleans of inpatient areas are ongoing to mitigate the issue. So far there are no gaps or concerns with any of the cases that have been identified as a contributing factor. - **Medication Incidents:** A slight increase in medication incidents in December was reported, with a notable number related to Insulin. Chief Pharmacist added that the majority of incidents were due to communication issues during patient transfers from acute settings to community teams. - **Unexpected Death:** This was a patient that sadly died very soon after transfer to Ludlow from another provider. The case is being reviewed by the Learning from Deaths panel and has been recently discussed at Patient Safety Incident Panel with initial findings indicating issues with agency workers' skills but these are not directly attributed to the patient death. Once the Learning from Deaths panel has been concluded, a Permission to Pause will be produced for wider learning. - **Patient Falls:** there has been an increase in patient falls, particularly at Whitchurch, where additional temporary escalation spaces were opened. The falls were mainly related to patients mobilising without assistance, and efforts are being made to address this issue. - **Staffing Levels:** reported that staffing levels were above 90% and 100% on nights, primarily due to the high levels of enhanced care required in inpatient beds. The dependency of patients once again increased in December, adding pressure on staff, which is being mitigated on a shift-by-shift basis with additional temporary numbers. - There were no PSIIs reported for December 2024. The report provided a comprehensive overview of the current quality and safety metrics, highlighting areas of concern and ongoing efforts to address them		
2. IPC BAF		
Committee received an update on progress on compliance and areas of concern such as FFP3 mask testing and facilities cleanliness. Reporting that 44 out of 55 key lines of inquiry were fully compliant, with 11 partially compliant. Since the previous review 4 areas have moved from partial to full compliance. FFP3 Fit Mask Testing was raised as a concern, highlighting to Committee the need for more staff to be trained, as the majority of those who are trained reside within the UEC Division and it is difficult to release them when needed.	Y	Approved by Committee to go to Board.

Chair's Assurance Report

Quality and Safety Committee Thursday 20th January 2025

External provider is being sourced for training pending staff release. Ongoing risks related to waste and cleaning, there has been a new post recruited to oversee cleanliness. There are mitigations in place alongside the actions for these areas with partial compliance moving forward. The IPC BAF report provided a detailed assessment of compliance, highlighted significant risks, and outlined ongoing actions to address partial compliance areas with mitigation.		
3. Policy Tracker		
The report provided an overview of the policies and documents due for review within the coming 12 months. It will be tracking progress over time and lists the oldest overdue policies with narratives on actions being taken to update them. A list of high-risk policies has been identified and will be tracked to ensure they are rectified as soon as possible. Committee agreed the report has improved and has requested the addition of a forward trajectory with clear completion dates for the policies alongside ensuring executive involvement in the process. It provided a comprehensive overview of the current state of policies aligned to Quality and Safety, sighted Committee on the overdue policies and outlined next steps. It was agreed the process as a whole will be strengthened in regard to Executive policy owners having oversight of progression and escalation as necessary.	Partial	
4. QSC related BAF risks		
The BAF has been updated with no material changes to the scores, but actions to address identified gaps in controls or assurances have been addressed. Objective 4, relating to quality improvement and patient experience, has seen significant work and a new Patient Experience Lead will present to the Board which should help reduce this risk. Specific risks, such as patient harm and governance arrangements, are being addressed through ongoing processes and system collaboration. Committee agreed the need for a stop and check to be implemented at the end of the current financial year to ensure effective risk management.	Y	

Chair's Assurance Report

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5. DRAFT PSIRF Plan		
The plan includes the addition of the Patient Safety Incident Panel (PSIP) which is now fully implemented. Local priorities from the previous year have been carried forward, with the addition of deteriorating patients as a new priority due to observed incidents. Minor changes were suggested to the plan prior to being submitted to Board for approval, aligning terminology and a change to a panel title.	Y	Approved to go to Board
6. Violence Prevention and Reduction Update		
Committee discussed the new standards for Violence Prevention and Reduction, emphasising the importance of staff education and support. The new standards were introduced in December 2024 and ongoing assessment will be completed by the Trust to ensure compliance with the new standards and identify any significant gaps. Emphasis was placed on the importance of staff education and support in managing challenging situations, particularly in community teams and MIU's. The Trust will also be reviewing staff feedback from surveys and the importance of listening to clinical staff who have experienced violence and aggression in the workplace. Regular updates are provided to Health and Safety Committee, and it was agreed that a thematic review be planned for the end of Q1 to gather more detailed information on staff experiences and the effectiveness of the current implemented measures.	Partial	
7. RRU Benefits realisation		
The report highlights improvements in performance metrics such as occupancy within the acute sector, reduction in patients with no criteria to reside and fewer 12-hour breaches in emergency departments. Indicators show that the RRUs have comparable quality and safety metrics to other inpatient areas and there is a focus on staff satisfaction and the improved Nurse to HCA ratios within the RRU, which are better than in other community inpatient areas. The report also indicated positive staff satisfaction within the RRUs, likely due to the robust MDT working environment and the seven-day therapy workforce. The units are fully recruited to and the additional Registered Nurse on early shifts for Ward 18 has helped reduce agency spending and supported staff to maintain patient safety.	Y	

Chair's Assurance Report

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The Director of Nursing stated that, the main concern to address currently links with deteriorating patients and the pathway for movement back to acute care. Committee did emphasise the importance of patient feedback as a quality indicator and suggested incorporating this into further reports, the Deputy Director of Nursing will look to complete a thematic review of deteriorating patients in the RRUs to better understand.		
8. EPRR Update		
Highlights of the report presented to Committee: The Trust scored 91% on the final submission of the annual assurance return, an improvement from last years 77%. This score indicates substantial compliance and places the Trust in a favourable position. There were no non-compliant standards and the partial compliance areas mainly involved testing of communications and supply chain resilience which is a system wide issue. The deep dive on cyber and communication and information did not affect the overall score, and work continues in this area. The focus for 2025 will be on pandemic preparedness, following recommendations from Baroness Hallett's COVID-19 inquiry. The partial compliance areas will be addressed as part of the 2025 workstream and business continuity plans continue to be worked through.	Y	
9. BCCH Comparative report		
The report provided Committee with an update on the progress of the improvement actions that were identified for BCCH. A total of 82 improvement actions were identified, with 14 actions delivered, 58 delivered with ongoing monitoring and 10 remaining open. The remaining actions however do not significantly impact quality and safety. The ward is back open to 16 beds with restricted criteria for patient admissions continuing. Leadership is still a challenge within the ward; however mitigations are in place and a new Matron will be starting in post shortly. The Team at BCCH are also still receiving corporate support from Clinical Education, Infection Prevention and Control and the Safeguarding Team.	Y	

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Continued monitoring and support for the remaining open actions alongside coordination of Non-Executive Director visits to BCCH to observe progress and gather feedback are being implemented.		
10. Chairs reports		
Patient Safety Committee Highlights from the report: - NEWS2 Audit and Action Plan: Improvements have been seen but further work is still needed, and committee have requested regular updates - Discharge letter compliance: concerns were raised, particularly with Whitchurch and there are ongoing escalations and discussions in place **QEIA** Highlights from the report: - Reduction of beds at Whitchurch: the discussion within Committee focused on the reduction of beds to 25, supported by quality and safety improvements. Due to current pressures, escalation beds have since been added and a new QEIA is expected to return in February to describe the impact **Health & Safety Committee** Highlights from the report: - Violence Prevention and Reduction Standards (as discussed) - Fit Mask Testing - Dog Bites: there has been an increase in dog bites being reported with work being completed to address the issue - Bed Rails continue to be updated to Committee The DIPC requested that information regarding the Dog bites be passed to IPC Team and IPCC via Occupational Health standard report.	Y Y Y	
11. EPMA		
The report highlighted the need for implementing EPMA within the Trust, highlighting its benefits for patient safety and efficiency. Key points to note: - EPMA is mandated by NHSE for NHS Trusts - The Trust is digitally immature compared to others within the system, with RJAH looking to go live as early as April 2025 - A business case was previously submitted in 2019, and funding was awarded but the project did not proceed due to revenue cost concerns - EPMA is expected to improve patient safety, reduce drug errors and increase efficiency by saving staff time and improving patient flow		

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Quality and Safety Committee Thursday 20th January 2025

- The five-year cost of the business case is approximately £1.97million, including capital, revenue and depreciation costs. Committee emphasised the importance of pushing the business case through internal processes and collaborating with system partners and agreed that the next steps should pursue internal processes such as Nemiwashi to explore funding options		
12. Thematic Review		
Pressure Ulcer Thematic Review The Thematic review covers in service pressure ulcers reported from January 2024- July 2024. - 416 in service pressure ulcers were reported - 16 cases reported in the community hospitals and 6 cases reported in the RRUs - IDT team (NE) reported the most cases, 75, and (SE) reported the fewest cases, 22. - 17 cases were reviewed at the patient safety panel and were category 3 or 4 - One case required an AAR The review highlighted that Heels and buttocks were the most common locations being reported. Themes and contributing factors the report highlighted: - Missed wound care visits, due to capacity issues and patient acuity - Frailty and EOL status - Non-compliance of patients Going forward there is a collaboration with the Podiatry team to provide training on diabetes and pressure relief to focus on heel care Skill mix and support in specific teams will be looked at, especially where there has been a loss of experienced staff and ongoing quality improvement work to improve quality and safety in pressure ulcer management. Committee praised the report and the work of the team and looked forward to the upcoming report to see the comparative narrative. **Deaths In Custody Thematic Review** The review covered two historical cases of deaths in custody from 2021-2022. Both cases went through coroners' investigations with no findings against the Trust. Many actions had been implemented before the thematic review was conducted and the prison healthcare team was involved in the review process, ensuring that actions were taken, and improvements were made.	Y Y	A follow up thematic review covering the latter part of the year will be conducted and will incorporate progress against the current recommendations.

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New cases now go through the Patient Safety Incident Response Framework (PSIRF) for a more structured review process. DoN requested that a death in custody thematic review should be regular reporting, bi-annually, to ensure continuous monitoring and learning, emphasizing the importance of fully understanding the issues related to drugs and ligatures. Committee requested that they need to see that the recommendations from the two deaths in custody have been closed.		

3.4 Approvals

Approval Sought	Outcome
Radiation Policy	Approved
Temporary Escalation SOP	Approved
Medicines Management Strategy	Approved
Learning from Deaths Policy	Approved

4. Conclusion

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

0. Quality and Safety Report – January 2025

Author:	Chris Panayi – Governance Data Manager Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	6th of February 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	22nd January 2025
Paper Reviewed by:	Sara Ellis-Anderson – Deputy Director of Nursing and Quality	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.

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

2. Executive Summary

2.1 Context

The report aims to:

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

2.2 Summary

6 of the 16 Quality and Safety dashboard KPIs are showing **special cause variation** in Month 9:

- *Clostridium Difficile* – 2 cases reported in December in Bishops Castle and Whitchurch Community Hospitals bringing the 12-month rolling count to 8. IPC thresholds have been published for 2024/25 and the organisation has had 6 Hospital acquired *C-difficile* cases against a threshold of 4.
- E-Coli bacteraemia remains at 1 for the rolling 12 months with a case being reported in September. No lapses in care were identified.
- Medication incidents with harm have increased to 10 in December. PSIRF thematic reviews are being completed quarterly with improvement actions identified.
- There was one unexpected death in December.
- Consistency of reporting patient safety incidents - Rolling data updated monthly, to show the number of patient safety incidents reported to the National Reporting and Learning System (NRLS) in the last 12 months. **NHSE have currently paused the publishing of this data while we consider future publications in line with the introduction of LFPSE. The data was last published June 2023**.
- The Information department have changed how they are reporting the 'National Patient Safety Alerts not completed by deadline' KPI, so this will show as 1, from March 24 to date. An initial breach of deadline was reported 1st March 2024.

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

- In December 2024 there were 22 inpatient falls reported within our care at the Community Hospitals and Rehabilitation and Recovery Wards. This equates to a rate of 5.02 falls per 1000 Occupied Bed Days (OBDs), which represents a lower incidence rate in comparison to Month 8.
- There were 3 reported cases for category 3 pressure ulcers developed in service in December. The first thematic review on pressure ulcers has been completed.
- There was 0 Patient Safety Incident Investigations (PSII) reported in December.

Safer staffing data and harm review data remains in the report in previous format and awaiting addition to the Quality and Safety Dashboard. The Quality and Safety Committee and Trust Board have **approved** the Safer Staffing KPI definition, and this will be included in the Quality and Safety Dashboard from February 2025.

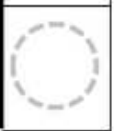
2.3. Conclusion

The Trust Board is asked to:

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

Quality and Safety – SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff ...	2024-12-31		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-12-31		3	0	3	3	0	3	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-12-31		8.00	0.00	8.00	8.00	0.00	8.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-12-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-12-31		97.84%	95.00%	2.84%	98.42%	95.00%	3.42%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2024-12-31		33.33%	100.00%	-66.67%	33.33%	100.00%	-66.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-12-31		1.00	0.00	1.00	1.00	0.00	1.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-12-31		5.02	4.00	1.02	5.02	4.00	1.02	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-12-31		10	0	10	51	0	51	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia...	2024-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Never Events	2024-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-12-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-12-31		0	0	0	3	0	3	

Variation	Assurance			
				
	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.

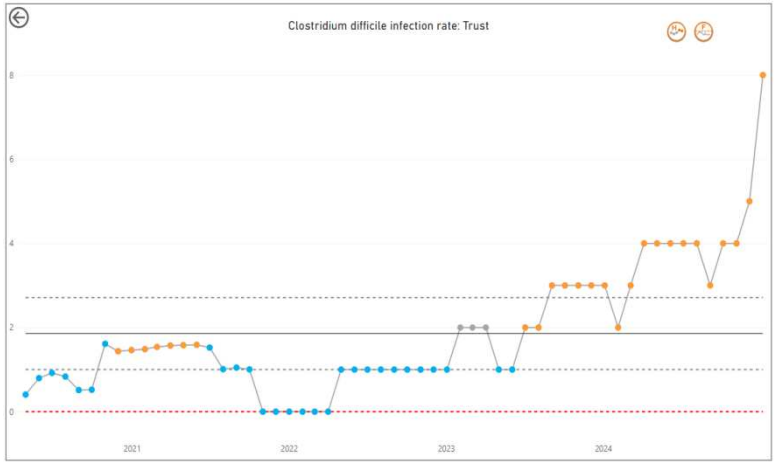
Exception Report - Action Plan

Clostidium difficile infection rate

12-month rolling counts of Clostridioides difficile (C. difficile) infections by NHS organisation and prior trust exposure (from April 2019) in patients aged 2 years and over.

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Clostidium difficile infection rate	Number	4	3	4	4	6	8	2
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	0	0	1	1	0	0	0



Narrative/Description:	Rolling 12 months total now stands at 8 for December following a further two cases in December. A Post Infection Review is completed for each case with many patients having been on multiple courses of anti-biotics for other infections. The QI and IPC Teams are currently carrying out a thematic review of all cases to identify any areas for improvement. SCHT IPC team are also part of a STW task and finish group for C-Diff. The 6 C diff cases year to date are: 4 in Ludlow - (June, September, 2 x November) 1 in Bishops Castle – (December) 1 in Whitchurch – (December)				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Thematic review of all C-Diff cases	Dec-24	Feb-25	In progress	
	Rolling annual deep clean programee for Community Hospitals and RRUs to be developed	Jan-25	Apr-25	In progress	
Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	21/01/2025		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/01/2025		

Exception Report - Action Plan

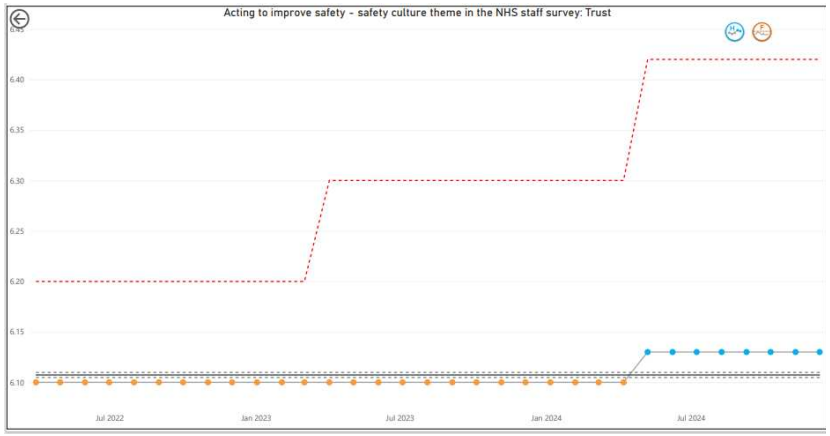
Acting to improve safety - safety culture theme in the NHS staff survey

Output from NHS Staff Survey - safe and healthy theme sub score

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Acting to improve safety	Number	6.13	6.13	6.13	6.13	6.13	6.13	6.13
	Target	6.4	6.4	6.4	6.4	6.4	6.4	6.4

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	6.40	6.40	6.40	6.40	6.40	6.40	6.40

TO BE UPDATED ONCE PER YEAR IN APRIL



Narrative/Description:	There is a documented process for handling patient safey incidents in accordance with the Patient Safety Incident Response Framework (PSIRF) and the governance team work closely with staff involved in investigations. The Learning Needs Analysis is set out in the Trust's Patient Safety Incident Response Policy. The governance team will develop jdocumented systems and processes to ensure compliance and work closely with divisional teams, quality and others. The Trust has a system development programme in place for Datix that will provide improved automation and reporting. The governance team will develop a framework that will set out the reporting mechanism and support functions that feed into the governance and the Board committee framework.						
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**		
	This data is held by the Information department. The figure will remain the same for each month due to the staff survey being completed once per year in April. These results will be updated every April.			static			
	A Trust wide awareness compaign will continue to roll throughout Jan to Dec 2025. The Learning Needs Analysist is currenlty under review for 202502026 and will be approved at Patient Safety Committee in Feb/March. .	Sep-24	Mar-25	In progress			
	Links to the Quality Team to be strengthened. The Governance team to develop systems and processes that will build on collaboration. Governance to develop a SOP that demonstrates the link with others, such as complaints, patient experience, operational and corporate teams.	Jan-25	Mar-25	In progress			
	To develop a framework for attendnace at the the national and local Patient Safety national groups and forums has been sporadic due to capacity issues for the Patient Safety Specialist.	Jan-25	Mar-25	Ongoing			
Author	Gill Richards - Associate Director of Governance/Patient Safety Specialist	**Date**	13/01/2025				
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**					

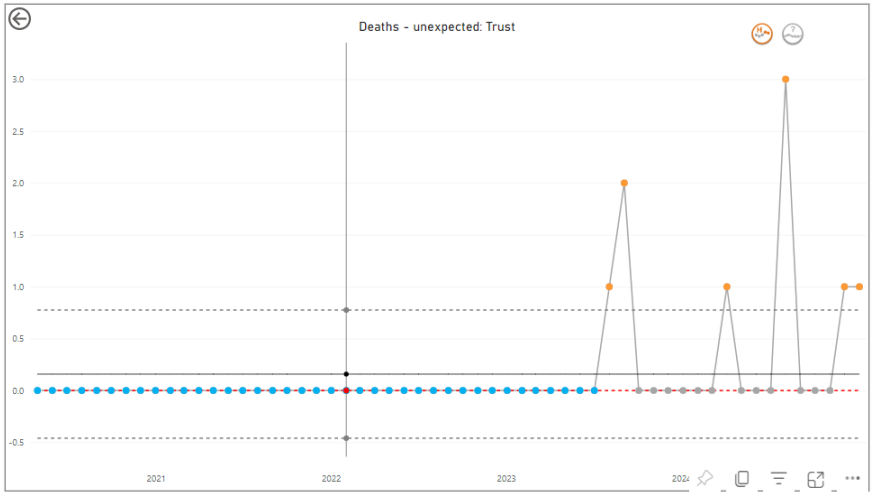
Exception Report - Action Plan

Deaths - Unexpected

Deaths - Unexpected

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Deaths - unexpected	Number	3	0	0	0	1	1	4
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	0	0	0	1	0	0	0



Narrative/Description:	In accordance with the Trust's Learning from Deaths Policy, all deaths that are unexpected are required to be added to the Trust's Incident Reporting System and a Learning from Death Review Completed. There was 1 unexpected death recorded in December. The death occurred at Ludlow Community Hospital and this case will be reviewed through our learning from deaths group.				
Action Plan	October		**Start Date**	**End Date**	**Status**	**Outcome**
	The Trust's Learning from Death Policy is in the process of review and to ensure it is aligned to the Trust's Patient Safety Incident Resposne Framework. The draft is on the Agenda for approval for Patient Safety Committee on the 17.01.25		Oct-23	Jan-25	In progress	
Author	Amy Fairweather - Patient Safety Officer	**Date**	09/01/2025			
Accountable Officer Approval	Dr Mahadeva Ganesh	**Date**				

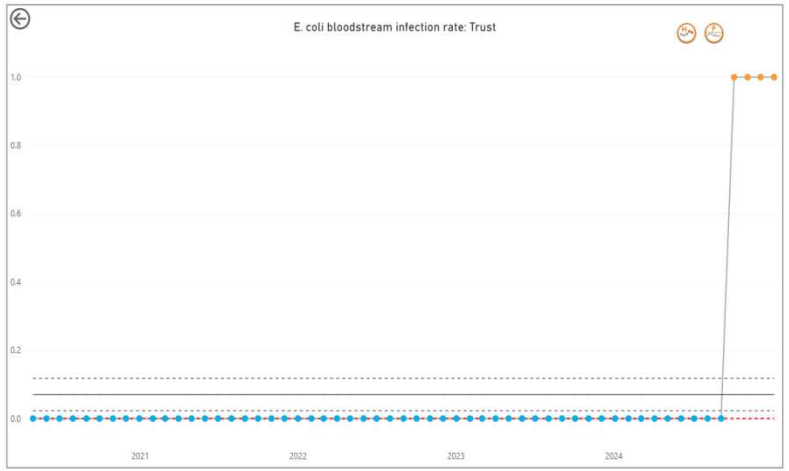
Exception Report - Action Plan

E.coli bloodstream infection rate

12-month rolling counts of E.coli bloodstream infection rate reported by the trust

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
E.coli bloodstream infection rate	Number	0	0	1	1	1	1	1
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	0	0	0	0	0	0	0



Narrative/Description:	There was 1 reported incident of E.coli in September. Investigation from IPCN established that the patient was admitted onto Ward 18 with a history of bowel cancer. The patient had no invasive devices and no breaks in skin identified. He was reported unwell on the 25 September 2024 and a fever was noted. Reviewed by the medical team, blood cultures were taken and Tazocin prescribed, and an IV device inserted. The patient also had a history of gram-negative bacteraemia. There have been no further cases in October so the Trust remains at 1 for the rolling 12 month count year to date.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Ensure Trust has SOP for taking blood cultures on RRUs and Community Hospitals	Oct-24	Jan-25	In progress	
	Ensure Trust training needs analysis incorporates taking Blood Cultures	Oct-24	Dec-24	Complete	

Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	21/01/2025	
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/01/2025	

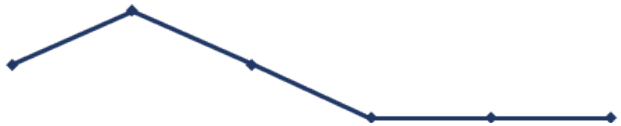
Exception Report - Action Plan

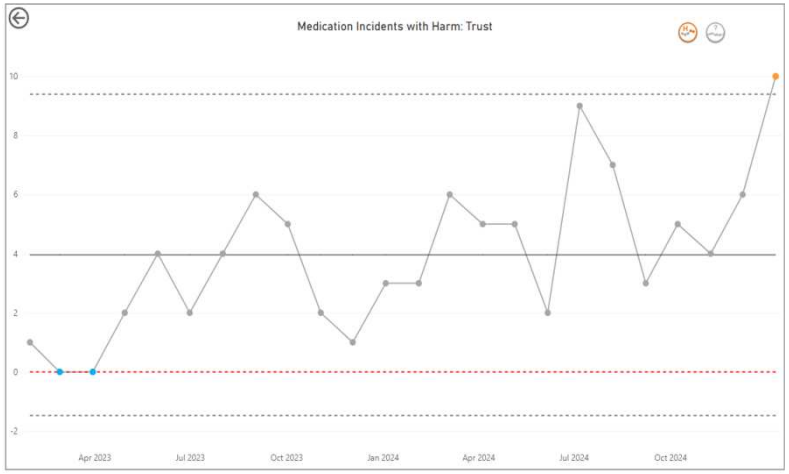
Medication Incidents with Harm

Number of medication incidents per month resulting in harm

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Medication Incidents with Harm	Number	7	3	5	3	6	10	51
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	5	6	5	4	4	4	4





Narrative/Description:	All of these incidents are included in the Patient Safety Incident Response Framework (PSIRF) quarterly thematic review. **Low** **3 x External –** 1.Patient's daughter administered wrong insulin 2.Patient missed dose of regular insulin due to not being referred 3.Unable to commence EOL medication for patient due to not being ordered at point of referral **7 x Internal -** 1.Patient prescribed Furosemide and Bumetanide at the same time 2.Patient received overdose of Medopar 100/25 3.Patient administered wrong insulin 4.2 x Patient given underdose of insulin 5.Patient administered overdose of insulin 6.Patient administered Furosemide instead of Famotidine as prescribed (sent with patient from acute trust)				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Escalated at PSIP the number of medication incidents due to patients not being referred for continuation of insulin / other regular medicines by acute trust.	Nov-24	Jan-25	In Progress	Escalated to ICB Quality team
	Amendments being made to RiO RR/ VW Medication module to reduce number of RR/VW related medication incidents	Nov-24	Jan-25	In Progress	Awaiting implementation from RiO team
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Jan-25	In Progress	
Author	Lucy Manning - Medicines Safety Officer and Non-Medical Prescribing Lead	**Date**	15/01/2025		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/01/2025		

Category 3 and 4 Pressure Ulcers

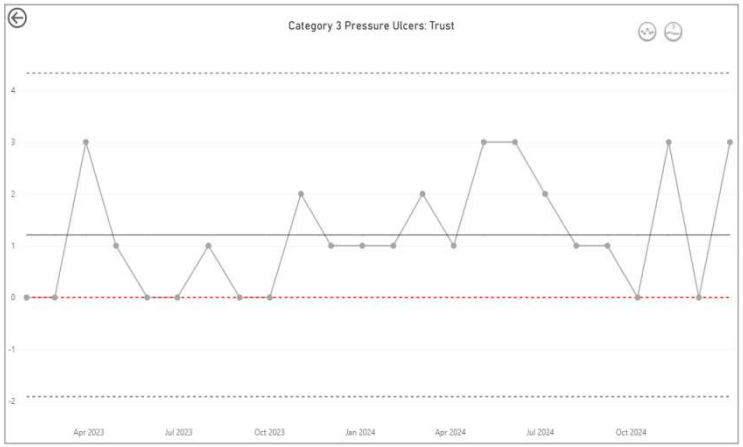
Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Category 3 Pressure Ulcers	Number	1	1	0	3	0	3	0
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	1	1	1	1	1	1	1



Narrative/Description:	There have been three category 3 and zero category 4 pressure ulcers in December. - The Tissue Viability Team are supporting the South East IDT by attending safety huddles daily to discuss new or deteriorating pressure ulcers to the caseload. Also supporting newly qualified nurses within the team with tissue viability skills and shadowing opportunities at specialist TV clinics				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Roll-out PURPOSE T implementation to community hospitals and RRU - this continues due to clinical capacity within wards and also Tissue Viability	Dec-24	Jan-25	In progress	
	Recorded training videos for Pressure Ulcer Prevention (How to complete PURPOSE T assessment, how to measure a wound etc)	Jan-25	Mar-25	In progress	
	Support at Safety Huddles for teams with high numbers of pressure ulcer	Jan-25	Mar-25	In progress	
	Revising pressure ulcer competencies in line with NWCS core corriculum	Feb-25	Mar-25	In progress	
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	16/01/2025		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/01/2025		

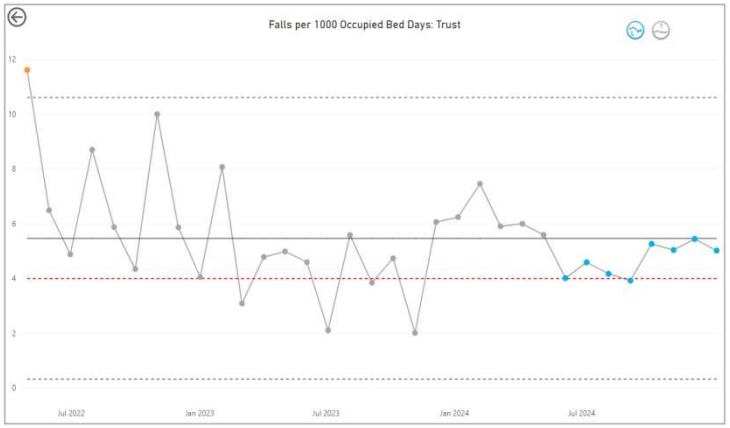
Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Falls per 1000 OBDs	Number	4.19	3.92	5.26	5.04	5.44	5.02	5.02
	Target	4	4	5	5	5	5	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	4.50	3.00	4.00	4.00	4.00	4.50	4.50



Narrative/Description:	In December 2024 there were 22 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Wards. This equates to a rate of 5.02 falls per 1000 Occupied Bed Days (OBDs), which represents a lower incidence rate in comparison to M8. (The number of falls and OBD reflects the removal of duplicated falls recorded in Datix). The number of falls per individual Community Hospital site is as follows: Increase in falls rate at Whitchurch Community Hospital (10), Bridgnorth (5), PRH RRU (5), reduction in falls at RSH RRU Ward 18 (2) , Ludlow (3) Bishops Castle (5). The indicated level of harm recorded is (11) falls recorded as no harm/injury and, (9) falls recorded as low harm resulting in minor bruising/marking to the skin, (2) Falls recorded moderate harm, with head injury/lacerations and bruising. (7) patients were transferred to ED following a fall, (5) of those patients were on anticoagulant therapy and reviewed in ED as per policy. The identified themes this month align to, (12) falls happened in the day between the hours of 8am and 8pm, (10) falls occurred at night between the hours 8pm - 8am. The rate of unwitnessed falls identified was (18) which remains high, however due to high level system escalation and winter pressures throughout December, the number of beds was also increased with a number of beds in Temporary Escalation Spaces and less visible escalation bed spaces. The second theme this month was the (8) of falls related to patients mobilising to get to the toilet, patients had not used the call bell on all of these falls. Ward managers are reviewing the safer care recordings to identify any trends and further opportunities for a continuous bay tag nursing/baywatch and			
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	SWITCH to Decaff approved at QEIA - Following staff Education delivery the pilot with go live in Bridgnorth Community Hospital.	Sep-24	Jan-25	In Progress	QI project is now live . Falls have reduced to (3) falls in December in comparison (5) in November .Which is meeting the target of falls reduction with SWITCH to Decaff this month .
	Falls prevention assessment and management plan updated - Trailed on Ward 36	Sep-24	Dec-24	Complete	Waiting meeting with RIO config Team to upload new falls assessment with EPR . Revised assessment form approved at Patient Safety Committee December 2024.
	Improving Hydration, reducing UTIs project piloting at Whitchurch. QI project paroseal is being considered for patients with cognitive impairment , and digital solutions to monitor patients at high falls risk during mobilisation .	Sep-24	Dec-24	In Progress	Trial fluid intake form updated to reflect the jug lid colours and ensure accurate recording of fluid balance. Discussions with the RIO configuration team regarding building the form in RIO have been held and a plan is in place subject to document approval and sign off.
	End PJ Paralysis week 6th January 2025	Jan-25	Jan-25	Complete	End PJ Paralysis Information / education videos have been shared with staff and Patients at Bishops castle. Report of the findings has been completed with follow up actions and recommendations . Plan moving forward to revisit BC and complete a further End PJ Paralysis week in April 2025
	Falls Prevention Policy reviewed, updated and ratified by Patient Safety Committee	Jan-25	Mar-25	In Progress	Falls policy reviewed and updated , currently out for consultation and will be discussed on the patient safety committee on 17th January. Falls clinical working group under development - focus to review current fall pathways and align to integrated system pathway
	NEW (Action Plan Meeting) Enhanced supervision policy is in place whereby risk assessments are completed and any requests for additional staff to mitigate the risk of falls can be requested for approval	Dec-25	Feb-25	Complete	Daily calls to dynamically risk assess which wards can take each patient and what staff they require. Capacity Hub Manager, Ward Manager and Assoc Director of Workforce facilitate this.

Author	Sarah Venn - Clinical Lead for Quality	**Date**	13/01/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	21/01/2025

Exception Report - Action Plan

Patient Safety Incident Investigations (PSII)

The number of Patient Safety Incident Investigations reported each month

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Patient Safety Incident Investigations	Number	0	0	2	0	1	0	3
	Target	0	0	0	0	0	0	0

Trajectory	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number	0	0	0	0	0	0	0

Narrative/Description:	There was 0 Patient Safety Incident Investigations (PSII.) declared for December.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	The governance team has a process in place to triage incidents on a regular basis. This includes representatives from governance and clinical experts e.g. TV and medications. The process is more streamlined with the implementation of LFPSE. The governance team review incidents in accordance with the PSIRF national guidance and identify incidents that meet the criteria for presenting to the Patient Safety Incident Response Panel who will then decide what the learning response is and identify Investigating Officers when needed.	Sep-24	Mar-25	In Progress	
	The governance team is reviewing all processes and policies to ensure that they are PSIRF compliant, this includes the development and upgrade of the incident reporting system Datix which will continue to automate and digitise the processes. The system development will significantly change the way we process, monitor and manage incidents and risks and will ensure that there is a robust governance framework in place. The governance experts are working together to ensure that the areas of patient safety, patient experience, complaints, PALS, compliments and clinical effectiveness are alligned.	Sept	Mar-25	In Progress	

Author	Amy Fairweather - Patient Safety Officer	**Date**	13/01/2025	
Accountable Officer Approval	Shelley Ramtuhul, Director of Governance	**Date**	13/01/2025	

Safer Staffing

The National Quality Board (NQB, 2016) recommend a 'triangulated' approach to staffing decisions. The Trust has a validated tool for acuity and dependency for both the Community CNSST (Community Nursing Safer Staffing Tool) and Inpatient Wards SNCT (Safer Nursing Care Tool) this will enable a robust triangulated approach. Data collection is collected twice a year and this data forms part of planned biannual staffing reviews to allow SCHT to comply with National safer staffing guidelines. The National Team has paused with the CNSST tool however the relaunch is planned for 25.01.2025. We continue to utilise Fill Rates. A description of both is below. Fill Rate is calculated by comparing planned hours to that of actual hours worked. A figure over 100% indicates more hours worked than planned.

Community Hospital Inpatient ward fill rates

December 2024

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bishops Castle	103.1%	96.3%	102.1%	120.1%
Bridgnorth	100.6%	114.2%	103.2%	123.1%
Ludlow	101.3%	193.1%	103.4%	191.1%
Whitchurch	98.5%	148.1%	102.7%	190.4%
Ward 18 RSH	98.8%	152.7%	100.3%	159.5%
Ward 36 PRH	119.3%	170.8%	135.3%	157.9%

November 2024

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bishops Castle	102.2%	99.2%	100.5%	107.2%
Bridgnorth	109.9%	100%	100%	100.9%
Ludlow	92.1%	158.6%	103.5%	177.3%
Whitchurch	97.7%	114.4%	114.6%	172.5%
Ward 18 RSH	99.1%	114.4%	100%	108.2%
Ward 36 PRH	99.3%	149.4%	100%	150%

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day and night shifts during December 2024 for all six of the open inpatient wards. The overall trend shows staffing levels on day and night shifts for both RN and HCAs were above 90% for all areas day and night. The HCA cover on night duty is over 100% on all of the wards, for Whitchurch and Ward 36 escalation beds and temporary escalation spaces have been opened to a total of 13 beds. As well as escalation beds the increase is staffing can be attributed to the high demand for enhanced care in all inpatient beds for both days and nights.

BCCH occupancy remains lower, beds were reopened to 16 beds in December and so should see an increase in January data.

Bed Occupancy Rate

Hospital Site	Bed Occupancy Rate for December 2024
Bishops Castle	**89.9%**
Bridgnorth	**94.8%**
Ludlow	**91.5%**
Whitchurch	**96.4%**
Ward 18 RSH	**97.3%**
Ward 36 PRH	**96.3%**
Overall Target 91%	**94.7% ↑ by 0.4 % on previous month**

Registered Nurse shifts covered in Community Wards- November and December 2024

	November 2024	**December 2024**
Total number of RN shifts covered	1314	1415
Substantive staff	**1014**	**1111**
Percentage	77.17%	78.5%
Percentage change from previous month	**1.4% ↑**	**1.3% ↑**
Bank	149	155
Percentage	11.34%	11%
Percentage change from previous month	**3.1%**	**↓ 0.3%**
Agency	**151**	**178**
Percentage	11.49%	12.6%

Percentage change from previous month		**1.1% ↑**

There was a total of 8-night shifts that were 100% RN agency for the month of December 2024 with 3 shifts at night in Bishops Castle due to sickness and 5 nights shifts in Ludlow Community Hospital due to vacancies and sickness.

18 Week Referral to Treatment (RTT) Pathways – Harm Proformas

Harm Proformas have been completed for all new patients seen over 52 weeks as an essential, but also for follow up patients if the clinician deems necessary. 844 harm proformas have been completed to date; with 81.27% indicating no harm and 16.94% indicating low harm and can be treated and resolved.

There have been 15 cases (1.80%) of moderate harm identified up to November 2024; 11 following delays to first appointment, 2 due to delayed follow up appointments in Rheumatology, 1 due to patient choice delay to commence medication and 1 due to delay of referral onward. 14 cases have been reviewed by the Clinical Lead who has agreed with the assessment of moderate harm and 1 is currently under review. These cases have been escalated to the governance team for discussion at weekly panel meeting.

The service is routinely conducting a review of 10% of the harm proformas completed which equates to 84.

The below table and charts display the number of harm proformas completed and percentages of low and no harm - over a 12-month period.

18 week RTT	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Harm proformas completed	481	495	506	513	517	528	537	544	550	586	699	844
Number of low harm	104	105	107	109	111	114	114	116	118	127	134	143
Number of moderate harm	5	6	6	7	7	8	8	9	10	13	14	15
Percentage of no harm	77.34%	77.58%	77.66%	77.39%	77.18%	76.90%	77.28%	77.03%	76.73%	76.10%	78.83%	81.27%
Percentage of low harm	21.62%	21.21%	21.15%	21.25%	21.47%	21.59%	21.22%	21.32%	21.46%	21.68%	19.17%	16.94%
Percentage of moderate harm	1.04%	1.21%	1.19%	1.36%	1.35%	1.51%	1.50%	1.65%	1.81%	2.22%	2.00%	1.80%

The current harms policy has been reviewed and has been approved at Quality and Safety Committee. Outcomes of harms reviews will be reviewed at Divisional Governance meetings with escalation to Patient Safety Incident Panel. The Deputy Director of Nursing will work with the informatics team to review how we can report harm reviews completed in SPC format going forwards.

Shropshire Community Health
NHS Trust

Complaints and PALS Annual Report 2023/2024

0. Reference Information

Author:	Mark Crisp and Natalie Hughes, Complaints/PALS/FOI Managers	**Paper date:**	19 November 2024
Executive Sponsor:	Shelley Ramtuhul Trust Secretary & Director of Governance	**Paper written on:**	19 November 2024
Paper Reviewed by:	Previous Quality and Safety Committee	**Paper Category:**	Governance
Forum submitted to:	Quality and Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

The purpose of this paper is to provide the Quality and Safety Committee with an annual report on Complaints and PALS enquiries received during 2023/2024 and in turn to provide assurance that the associated investigations, learning, actions, and service improvements are clearly documented. That the follow-up work with patient experience and service user feedback is planned or completed; and that there is evidence of the operational teams and Quality Improvement team working together to deliver service change and improvements.

2. Executive Summary

2.1 Context

This paper provides information on the number of complaints and PALS enquiries received during 2023/2024 including a breakdown of cases by Divisions, Services and subjects. It includes information on handling performance and changes that have been made as a consequence of complaints.

2.2 Summary

- The number of complaints rose significantly and PALS enquiries decreased in comparison to the previous year.
- The total number of complaints received was 110 with TeMS Consultants receiving the most, 11 complaints, followed by Bridgnorth Hospital with 10 complaints.
- ‘Quality of care’ (32) accounted for 29.1% of the complaints received.

2.3. Conclusion

The Quality and Safety Committee is asked to:

- Note the information contained in the report.
- Accept assurance of the work undertaken relating to complaints and PALS enquiries during 2023/2024.

Complaints and PALS Annual Report 2023/2024

Complaints/PALS Annual Report 2023/24

1. Introduction

This report provides an analysis of Complaints and Patient Advice and Liaison (PALS) enquiries received between 1 April 2023 and 31 March 2024. The report meets the annual complaints report requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The table below shows the differences in totals received between 2022/23 and 2023/24.

	2022/23	2023/24	% Difference
Complaints	71	110	+54.9%
PALS enquiries	144	117	-18.75%
Compliments	574	619	+7.8%

The number of complaints received rose significantly and PALS enquiries decreased whilst the number of compliments received increased slightly.

With regards to complaints, we are guided by the person's wishes as to how they would like their concerns to be handled i.e. as a formal complaint or informally under PALS. In the case of concerns handled informally under PALS, support is provided directly by service managers in resolving matters locally.

2. Complaints

Table 1 – Complaints by Services and Division

	Adult Services Division	Children & Young People's Service Delivery Group	TEMs and Outpatients Division	Total
Bridgnorth Hospital	10	0	0	10
Bridgnorth MIU	4	0	0	4
Bridgnorth Outpatients Clinic	0	0	1	1
Central Shropshire Health Visiting	0	3	0	3
Clinical Governance	0	0	0	1
Community Neuro Rehab Team	1	0	1	2
Consultant Out-patient Clinics	0	0	3	3
CTS – ALL Children's Therapies (clinical)	0	3	0	3
CTS Child Development Centres (clinical)	0	1	0	1
CTS Children's Speech & Language Therapy	0	3	0	3
CTS Community Paediatrics (clinical)	0	6	0	6
Long Covid	0	0	1	1
Ludlow Hospital	3	0	0	3
Ludlow MIU	2	0	0	2

Complaints and PALS Annual Report 2023/2024

Ludlow Physiotherapy	0	0	1	1
MSST	0	0	1	1
North East Community Team	5	0	0	5
North Shropshire Health Visitors	0	1	0	1
North West Community Team	2	0	0	2
Oswestry Health Centre	1	0	0	1
Oswestry Minor Injuries Unit (MIU)	3	0	0	3
Podiatry – Clinic	0	0	2	2
Rapid Response and Virtual Ward South East	1	0	0	1
Recovery and Rehab Ward 18 RSH	1	0	0	1
Shrewsbury North Community Team	3	0	0	3
Shrewsbury South Community Team	5	0	0	5
Shropshire Dental Services	0	4	0	4
Shropshire Respiratory Service	1	0	0	1
Shropshire School Nursing	0	1	0	1
South East Community Team	2	0	0	2
Stoke Heath Prison	5	0	0	5
Telford North Community Team	1	0	0	1
Telford School Nursing	0	1	0	1
Telford Wound Healing Service	1	0	0	1
TEMS Consultants	0	0	11	11
TEMS Physiotherapy	0	0	2	2
TEMS RJAH	0	0	1	1
TEMS SATH	0	0	1	1
TW Respiratory Service	2	0	0	2
Wheelchair Services	0	2	0	2
Whitchurch Hospital	3	0	0	3
Whitchurch MIU	2	0	0	2
Covid 19 Vaccination RJAH Oswestry	0	1	0	1
Covid 19 Vaccination Mobile Units (BUS)	0	1	0	1
Total	58	27	25	110

*Please note that the hierarchy in our Complaints recording system (Datix) is different to our current divisional structures, we anticipate that this will be resolved through an upgrade to the recording system.

TeMS Consultants received the most complaints (11) followed by Bridgnorth Hospital (10).

TeMS Consultants

Of the 11 complaints received, 4 related to ‘Appointment’, 3 to ‘Quality of Care’, 2 to ‘Waiting Times’ and 1 each in respect of ‘Communication’ and ‘Staff Attitude’. 4 complaints were partly upheld.

Complaints and PALS Annual Report 2023/2024

Bridgnorth Hospital

Of the 10 complaints received, 6 related to 'Quality of Care', 2 to 'Discharge Arrangements, and 1 each to 'Communication' and 'Other'. 1 complaint was upheld and 4 were partly upheld.

See section 7 for information about changes made as a result of complaints.

2.1 Complaints by outcome

Table 2 below shows the outcome status for complaints where they were either upheld or partly upheld. The Trust takes learning from all complaints, and categorises them as upheld, partly upheld or not upheld in order to satisfy Department of Health reporting requirements. The categorization is reviewed with input from relevant staff.

Table 2 – Complaints outcome status

	Complaint Not Upheld	Complaint partly upheld	Complaint Upheld	Total
Bridgnorth Hospital	3	4	1	8
Bridgnorth MIU	1	0	0	1
Bridgnorth Outpatients Clinic	1	0	0	1
Central Shropshire Health Visiting	1	1	0	2
Community Neuro Rehab Team	1	0	0	1
Consultant Out-patient Clinics	1	2	0	3
CTS - ALL Children's Therapies (clinical)	0	1	0	1
CTS Child Development Centres (clinical)	0	0	1	1
CTS Children's Speech & Language Therapy	1	0	0	1
CTS Community Paediatrics (clinical)	1	2	2	5
Long Covid	1	0	0	1
Ludlow Hospital	1	0	1	2
Ludlow MIU	1	0	1	2
Ludlow Physiotherapy	1	0	0	1
MSST	1	0	0	1
North East Community Team	0	2	1	3
North Shropshire Health Visitors	1	0	0	1
North West Community Team	2	0	0	2
Oswestry Minor Injuries Unit (MIU)	1	1	0	2
Podiatry - Clinic	1	0	1	2
Recovery and Rehab Ward 18 RSH	1	0	0	1
Shrewsbury North Community Team	1	0	2	3
Shrewsbury South Community Team	0	3	1	4
Shropshire Dental Services	0	2	0	2
Shropshire Respiratory Service	1	0	0	1
Shropshire School Nursing	1	0	0	1
Stoke Heath Prison	2	0	0	2
Telford School Nursing	1	0	0	1
Telford Wound Healing Service	0	1	0	1
TEMS Consultants	1	4	0	5
TEMS Physiotherapy	0	1	0	1
Whitchurch Hospital	1	1	0	2
Whitchurch MIU	1	1	0	2
Covid 19 Vaccination RJAH Oswestry	1	0	0	1
Covid 19 Vaccination Mobile Units (BUS)	0	1	0	1
Total	31	27	11	69

This year the combined total of complaints partly upheld and upheld was 27 and 11 respectively – this represented 34.5% of the total number of complaints received during the year.

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2.2 Complaints by subjects

Subject	Adult Services Division	Children & Young People's Service Delivery Group	TEMs and Outpatients Division	Total
Access to services	4	1	1	6
Appointment	5	9	6	20
Communication	6	8	4	18
Confidentiality	1	0	0	1
Discharge Arrangements	4	0	0	4
Other	3	1	0	4
Quality of Care	24	2	6	32
Staff attitudes	10	3	5	18
Waiting Times	0	3	3	6
Total	57	27	25	109

Similar to 2022/2023, 'Quality of Care' was the subject area under which most complaints (32) were received followed by 'Appointment' (20) and 'Communication' and 'Staff attitudes' with 18 each.

The 32 complaints where 'Quality of Care' was the primary subject were spread across 19 different service areas. The services that received the most complaints under this category were Bridgnorth Hospital Hospital (6), followed by Shrewsbury South Community Team, Stoke Heath Prison, and TeMS Consultants with 3 each. Further detail on the 'Quality of Care' category has been added to the quarterly reports provided to the Trust's Patient Experience Committee.

2.3 Response performance

2.3.1 96 (87.3%) out of the 110 complaints received were acknowledged within 3 working days of receipt.

2.3.2 67 (60.9%) out of the 110 complaints received were replied to within 25 working days or 60 working days (in the case of complex complaints) of receipt.

2.4 Parliamentary and Health Service Ombudsman (PHSO)

One complaint relating to Bridgnorth Community Hospital (BCH) was investigated by the Local Government and Social Care Ombudsman's Office (LGSO) and was found to be upheld. The Trust has complied with the recommendations made by the LGSO's Office confirming that following our investigation of the complaint, the importance of appropriate communication with, and involvement of, patients and their families and/or carers during planning for post-discharge support was reiterated to the relevant staff at BCH. The learning from the complaint was also shared with the Ward Managers at our other Community Hospitals to ensure that this was also raised with the relevant staff within those Hospitals.

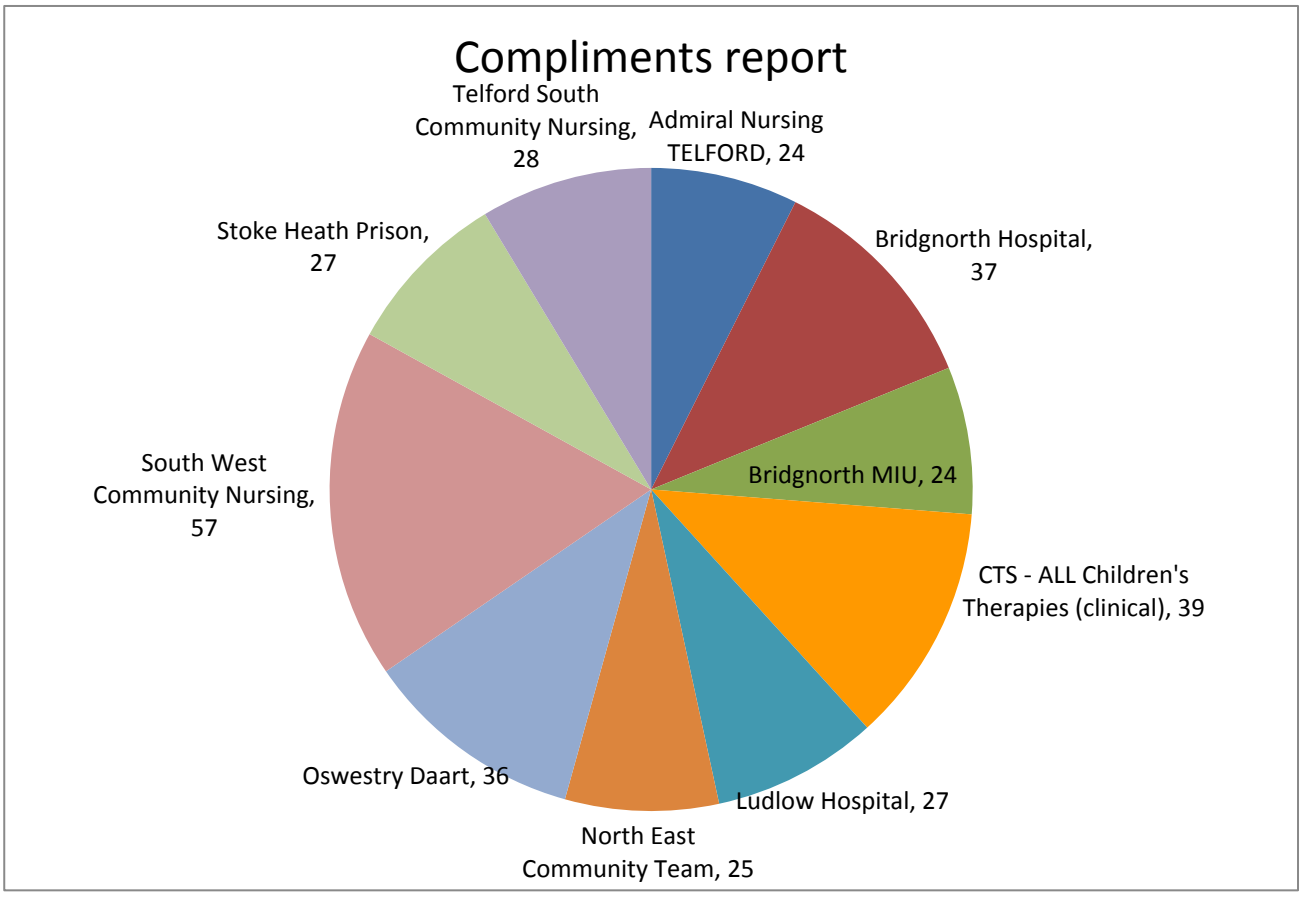
No complaints are currently being considered by the PHSO.

Complaints and PALS Annual Report 2023/2024

3. Compliments

A total of 619 compliments were received, an increase of 7.8% on the previous year. Service leads continue to be asked to remind their services of the importance of recording their compliments using the data capture form in Datix as this helps to provide context alongside complaints and PALS data.

The chart below shows the top 10 most complimented areas:



Some of the comments received included;

- *"I cannot thank you and your manager enough for all you have done for my xxxx, honestly, you've all been fantastic and it's so nice to see my xxxx getting around the home more with this wheelchair, it's changed xxxx life."*
- *"I cannot praise your district nurses enough, they have managed to heal the wounds so well that dressings are no longer required."*
- *"On behalf of myself and the family, I would like to say a huge thank you for the wonderful care you gave xxxx, during xxxx last days at home."*

- *"Thank you so much for helping xxxx with xxx speech. xxxx has enjoyed xxx sessions and is sad to be leaving."*
- *"You helped and looked after me when I was in need and at my lowest, I'll never forget that."*
- *"I have had reason to attend MIU two or three times over the past couple of years and the service is unfailingly amazing."*
- *"To all the staff, Thank You is too small a gratitude. Thanks for all the support, care and smiles that have helped my recovery. You are amazing."*

4. Patient Advice and Liaison Service (PALS)

The PALS service deals with a range of enquiries each year. The types of enquiry and actions required are varied, including, signposting patients to services, comments about services and liaising between patient and services to solve service delivery problems. The service frequently helps patients through processes, improving the quality of the service delivered, and resolves issues before they turn into formal complaints.

The service dealt with 117 enquiries last year, a decrease of 18.75% on the previous year. The table below shows the PALS enquiries received by service:

	Adult Services Division	Children & Young People's Service Delivery Group	TEMs and Outpatients Division	Total
Admiral Nursing TELFORD	1	0	0	1
APCS Oswestry ENT	0	0	1	1
APCS Shrewsbury ENT	0	0	1	1
Bishops Castle Hospital	1	0	0	1
Bridgnorth Hospital	3	0	0	3
Bridgnorth Physiotherapy	0	0	1	1
Central Rehabilitation Pathway	1	0	0	1
Central Telford Health Visiting	0	1	0	1
Childrens Community Nursing	0	1	0	1
Community Neuro Rehab Team	0	0	1	1
Consultant Out-patient Clinics	0	0	1	1
Continence Nursing	2	0	0	2
Covid 19 Vaccination Service	0	0	2	2
CTS Child Development Centres (clinical)	0	1	0	1
CTS Children's Occupational Therapy (clinical)	0	2	0	2

CTS Children's Physiotherapy	0	1	0	1
CTS Children's Speech & Language Therapy	0	6	0	6
CTS Community Paediatrics (clinical)	0	3	0	3
Diabetes Nursing	2	0	0	2
Long Covid	0	0	2	2
Ludlow Hospital	2	0	0	2
North East Community Team	2	0	0	2
North West Community Team	1	0	0	1
Oswestry Minor Injuries Unit (MIU)	2	0	0	2
Pain Management	0	0	1	1
Podiatry - Clinic	0	0	3	3
Podiatry - Domiciliary Visit	0	0	1	1
Recovery & Rehab Ward 36, PRH	2	0	0	2
Recovery and Rehab Ward 18 RSH	1	0	0	1
Shrewsbury North Community Team	3	0	0	3
Shropshire Dental Services	0	4	0	4
Stoke Heath Prison	1	0	0	1
TEMS Consultants	0	0	8	8
TEMS RJAH	0	0	1	1
Wheelchair Services	0	3	0	3
Whitchurch Hospital	3	0	0	3
Whitchurch MIU	1	0	0	1
Total	28	22	23	73

*The above table excludes contacts received by PALS relating to other organisations

The areas that stand out are:

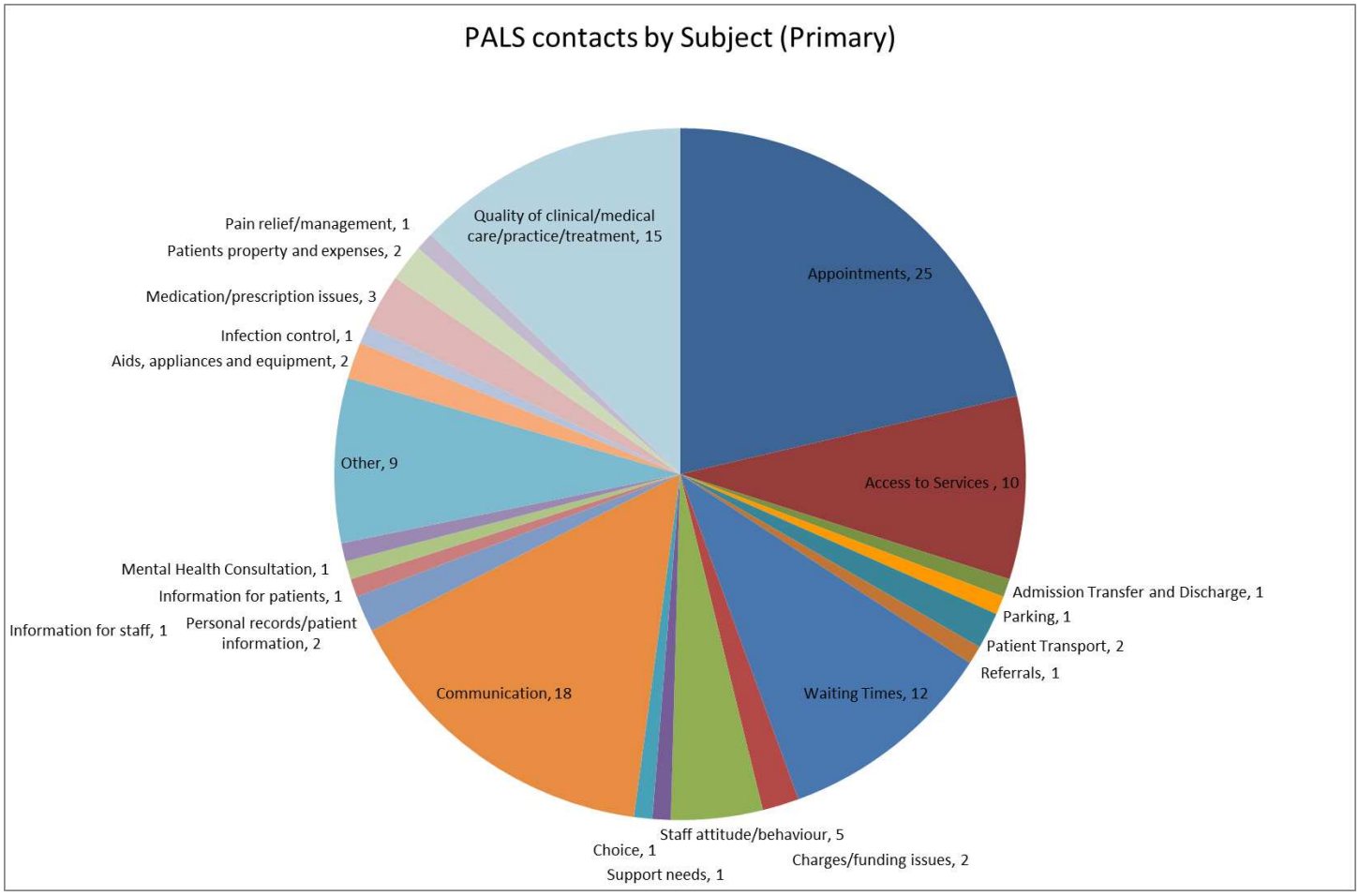
- TeMS Consultants (8). These contacts related to appointments including length of wait and communication.

- Children's Speech and Language Therapy (SaLT) (6). These contacts related mainly to length of wait for SaLT.

4.1 PALS subjects

'Appointments', 'Communication', and 'Quality of clinical/medical care/practice/treatment' were the most enquired about subjects under PALS. The chart below shows the 23 subject areas where we received enquiries under PALS:

Complaints and PALS Annual Report 2023/2024



5. What does the summary of Complaints and PALS tell us?

Appointments/Access to Services

The PALS service is an appropriate vehicle for resolving issues when they occur. In most instances services are responsive and the enquirer is happy with the outcome. In all cases any problems are reported to service managers and they are involved in the resolution.

Similar to the previous year, the most enquiries received by PALS related to 'Appointments' with a combined total of 25.

Communication

This category contains many different forms of communication, including the lack of, or quality of, advice given. It also refers to communication between organisations and health professionals, staff and degree of patient involvement. Again in all cases the relevant service is involved in the resolution. A total of 18 enquiries related to 'Communication'.

6. Sharing lessons learned

The following are means by which complaints and PALS are shared in the Trust so lessons can be learned:

- Quality and Safety Committee
- Patient Experience Committee
- Service Delivery Group Quality and Safety meetings
- Team meetings

We will continue to develop methods to ensure that the lessons are shared and learned more widely with all team members.

7. What have we changed as a result of complaints?

The majority of complaints and PALS received relate to an individual's requirements and the action for the service is to resolve these requirements to the complainant's satisfaction. It is important that issues raised are discussed within teams so that practice can be reflected upon and necessary service changes or improvements made.

The following provide examples of some of the changes made and actions we have taken as a result of complaints received into the Trust.

Learning themes	Actions taken and planned
Communication	It was acknowledged that the patient's Vascular referrals should have been followed up, this issue has been shared with the clinical team regarding ownership of referrals to ensure that there is clear process in place for referrals to be followed up and that any outstanding actions are shared at clinical handovers and safety huddles.
	Apology given that process wasn't followed properly with regards to communicating concerns about child's health and wellbeing with the child's parent before escalating concerns. This has been discussed with the staff member involved to ensure they are clear that unless sharing the information with a parent/guardian would put a child at greater risk, then all efforts should be made to contact the parent/guardian prior to escalation.
	The member of staff was asked to write a piece of reflection to understand how things could have been done differently. They were also asked to attend an advanced communication course to support their communication with patients, carers and families.
	We have looked at and are working on some of our communication pathways as we recognise they need to be less complicated, but also to enable our administration teams to signpost correctly first time.
	Reply sent advising that language in correspondence relating to 'problem' will be changed to 'background'.

	Estates Department has been requested to provide more prominent signage in the centre as this would've prevented delay in attending appointment. Apology given for staff member's comment and assurance given that they have reflected on this.
	It was acknowledged that clinicians should introduce themselves at appointments. The manager has spoken to the Team and other services they manage to reinforce the positive message this simple act can have.
	Leaflet being provided to patients, carers and families to inform them of the possibility that their visit may be cancelled or rescheduled due to the current high pressure on the service. Details will also be included on the actions we are taking to expand our workforce capacity, self-care information and indicators of when to contact the service to be reviewed to safety net our patients. We will also be working with our Information Technology and Quality Team colleagues to explore digital solutions to informing patients, carers and families of when visits are cancelled.
Processes	It was acknowledged that the patient's Vascular referrals should have been followed up, this issue has been shared with the clinical team regarding ownership of referrals to ensure that there is clear process in place for referrals to be followed up and that any outstanding actions are shared at clinical handovers and safety huddles.
	Preadmission/transfer status regarding risks associated with confusion is being reviewed with our system partners to ensure that we have accurate clinical information for handover between care providers and that this supports us with an informed decision regarding accepting the patient into our care and being able to meet the individual's needs and maintain safety.
	A breakdown in process has been shared with the Administration and Clinical Teams to reduce the likelihood of this happening in the future.
	We acknowledged and apologised that the correct procedure was not followed with regards to the patient's valuables being logged into the ward safe. Assurance was given that that this has been discussed with the Ward Team and a reminder has been issued to all staff about the patient valuables policy (Finance Procedure I17: Patients' Property – Cash & Valuables) which includes ensuring a receipt is provided when items are returned to patients or their family/carers.
	Explanation given regarding treatment provided to the patient, including attempts made in requesting ENT to review the patient. As a result of the complaint a process has now been put in place to enable Nurses to request a second opinion if they feel their concerns and the concerns of the family are not being taken seriously.

8. Future Plans

Complaints and PALS Annual Report 2023/2024

8.1 **Complaints and the Patient Safety Incident Response Framework (PSIRF).** The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There will be occasions where the complaints we receive will need to be investigated as a Patient Safety Incident, the outcome of the investigation will inform our response to these complaints and we will ensure that the requirements of both the Complaints process and PSIRF are satisfied in undertaking this.

We are reviewing our Complaints process to align it with the principles of PSIRF and our complaints Investigating Officers will be provided with Patient Safety Incident Investigation training to ensure consistency of approach in undertaking investigations.

Further information regarding PSIRF is available at NHS England » Patient Safety Incident Response Framework.

8.2 **Complaints actions monitoring.** We have recently introduced a more robust system for monitoring actions that have been identified following the investigation of complaints. A weekly 'Complaints Actions Tracker' is now produced and is accessible to senior managers within the Trust to be able to review progress. The Complaints Team is responsible for monitoring progress of the actions and liaising with service managers where appropriate to ensure their completion.

8.3 **Triangulation of information and reporting.** Information relating to complaints themes, actions and response performance are included as part of the wider Governance Team's recently revised monthly report to the Quality & Governance Divisional Meetings with services within the Trust. This contributes to the triangulation of information provided to services particularly with regards to the wider area of Patient Experience and in turn opportunities for service improvements.

Shropshire Community Health
NHS Trust

Patient Safety Incident Response Plan

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**6 February 2025**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	31 January 2025
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	People Committee	**Paper FOIA Status:**	

1. Purpose of Paper

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

The Board is asked to ***consider and approve*** the Trust's Patient Safety Incident Response Plan which outlines how the Trust will respond to different types of patient safety incident to ensure effective oversight, management and improvement.

2. Executive Summary

The Trust implemented the Patient Safety Incident Response Framework (PSIRF) at the end of 2023 and has operated it's patient safety systems under this for the last 12 months. As part of the transition to PSIRF the Trust formally outlined it's planned response to patient safety incidents in the Patient Safety Incident Response Plan and this was ratified by the Board.

At 12 months since implementation of PSIRF the Response Plan has been reviewed, taking into account the types of incidents that have been reported and reviewed by the Patient Safety Incident Panel.

The Patient Safety Incident Response Plan is presented for ratification with the following suggested changes:

- Reference to the Patient Safety Incident Panel which has now been embedded and is operating well under the Trust's Patient Safety Incident Framework.
- Transfer of responsibilities from the Patient Safety Working Group to the Patient Safety Incident Panel to oversee the weekly reporting and management of patient safety incidents.
- Inclusion of a specific response for incidents relating to deteriorating patients as this has been noted as a theme by the Patient Safety Incident Panel.

The revised Response Plan has been presented and approved at Quality and Safety Committee for onward presentation to the Board for final approval.

Conclusion

The Board is asked to ***consider and approve*** the updated Patient Safety Incident Response Plan.

Shropshire Community Health NHS Trust

Patient Safety Incident Response Plan

Ratification date: ~~02/11/2023~~

Review date: ~~02/11/2024~~

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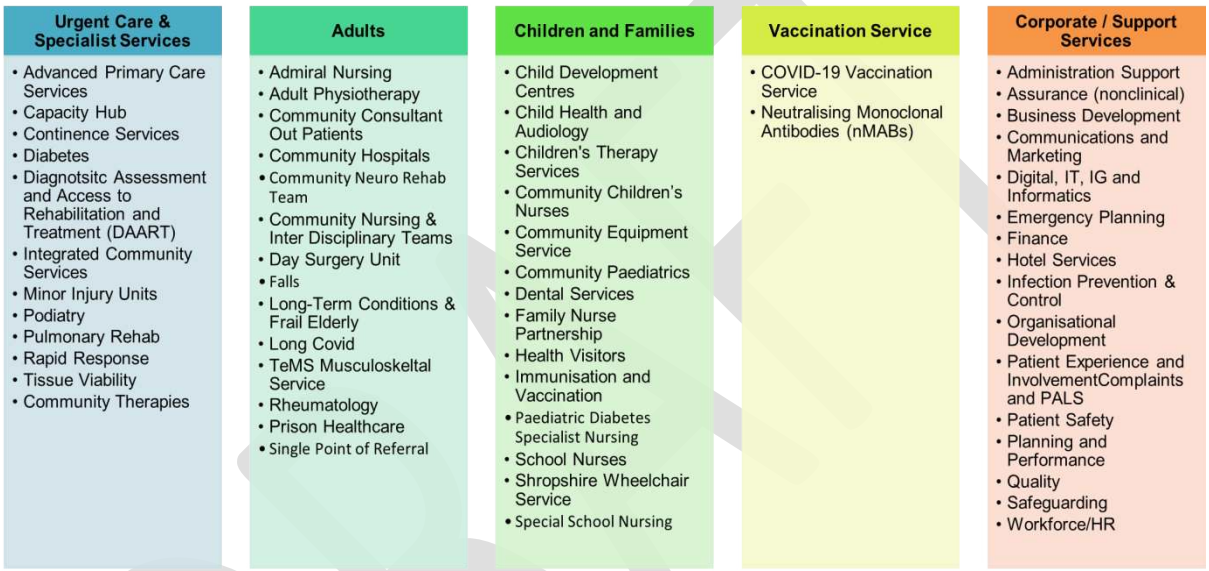
Introduction

This patient safety incident response plan sets out how Shropshire Community Health NHS Trust (SCHT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services



The SCHT Patient Safety Incident Response will cover the services outlined above.

Defining our patient safety incident profile

Stakeholder Engagement

A project group was established in January 2023, to implement the Patient Safety Incident Response Framework. To establish the group key stakeholders were identified as the following:

- Director of Governance (SRO, Executive lead, Co-chair)
- Head of Patient Safety & Patient Safety Specialist (Co-Chair)
- Associate Director of Operations
- Project Manager – Strategy
- Service Delivery Group Leads (*SDG managers should identify operational leads from their teams to attend the meetings*).
- Clinical Service Managers – (TeMS, OP, APCS)
- Service Leads (Tissue Viability, Diabetes, Respiratory, Virtual Wards & Rapid Response, Vaccination Service)
- Falls Prevention Team Leader
- AHP Lead (Adults AHP Professional Lead and Workforce Lead)
- Clinical Quality Leads (Adult nursing, Children & Families)
- Medical Leads - Medical Director and/or Associate Medical Directors
- Medicines Management - Chief Pharmacist / Medicines Safety Officer
- Head of Governance & Risk
- Complaints/PALS/FOI Manager
- Patient Safety Partners
- Patient Representatives
- Head of Safeguarding
- Quality Facilitator
- Associate Director of Workforce
- Head of Digital Services
- Communications Officer

Data Sources

The group used a variety of sources to identify the safety incident profile, reviewing information from the previous two to three years. This included:

- Datix incident profiles
- Key performance indicators
- Reported Serious Incidents or Never Events
- Patient experience data
- Clinical Audit
- Trust Risk Registers

Since this the introduction of PSIRF in December 2023, the Trust has had in place a Patient Safety Incident Panel that meets on a weekly basis to review safety incidents.

This group is made up of:

- Director and Deputy Director of Nursing
- Medical Director
- Director of Governance
- Associate Director of Governance / Patient Safety Officer
- Governance Manager / Patient Safety Lead
- Other Governance Team members as appropriate
- Clinical staff as relevant to the incidents being considered

In addition, the meeting is attended by the Quality Lead for the ICB to provide independent input and support from a system perspective.

Defining our patient safety improvement profile

The Trust is developing strong governance processes across the Clinical divisions and the Governance Team and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, and partner agencies.

The Trust Quality and Safety Committee will retain oversight of quality improvement measures and safety improvement plans. Its' subcommittee, the Patient Safety Committee will ensure that the clinical divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues.

The Trust has a Clinical and Quality Strategy that describes our approach to improvement including:

- Identifying our starting position
- Identify and monitor improvement measures
- Aligning to our strategic objectives

The recommendations from our Patient Safety Investigations and Patient Safety thematic reviews will flow through these processes linking them in directly to the Trusts Quality Improvement work.

Our patient safety incident response plan: national requirements

There are several national priorities outlined by NHS England and those outlined below are considered applicable to this Trust.

National priorities require an external escalation, where the Trust may need to contribute to an investigation. A locally led Patient Safety Incident Investigation (PSII) may be required dependent upon the circumstances surrounding the patient safety event.

Patient safety incident type	Required response	Anticipated improvement route
National Priorities		
Incidents meeting the national Never Events criteria 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
A patient death thought more likely than not due to problems in care, as indicated by NHS England Learning from Deaths guidance. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
Incident in Screening Programmes	Patient Safety Incident Investigation / After Action Review / Thematic Review (if applicable)	Organisational Safety Improvement Plan
Child Death should be reviewed to the Child Death Review Panel	Review by Child Death Review Panel Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Death of persons with Learning Disabilities, need to be referred to the Learning Disability Mortality Review (LeDeR) programme.	Referral to Learning Disability Mortality Review Programme Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Safeguarding, under the following categories must be	Referral to Local Authority Safeguarding Lead	Organisational Safety Improvement Plan

referred to local authority safeguarding lead. ○ babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. ○ adults (over 18 years old) are in receipt of care and support needs from their local authority. ○ If the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	Patient Safety Incident Investigation / After Action Review (if applicable)	
Information Governance	Report to ICO if SI criteria met Investigation using PSIRF methodology / After Action Review	Organisational Safety Improvement Plan

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response*	Anticipated improvement route
Transfer of Care Pathways	Datix investigation and MDT (multidisciplinary team) and multi-organisational review, reporting findings to the Patient Safety ~~Working Group.~~Incident Panel	Co-production of safety improvement actions managed on a local/organisational safety improvement plan to feed into any wider system improvement plans.
Pressure Ulcers	Case by case review of all Cat 3 and 4 pressure ulcers by Safety Panel and	Use the theme identified to focus the required quality improvement, monitored

	proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	through the organisational safety improvement plan
Falls	Case by case review of all falls resulting in significant harm and/or meeting RIDDOR by Safety Panel and proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Medication Events	Case by case review of all medication events by Medicines Safety Group and escalation to Patient Safety Incident Panel of any incidents resulting in significant harm and proportionate response determined. Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Deteriorating Patient	Case by case review of all incidents of deteriorating patient and escalation of any incidents resulting in significant harm to the Patient Safety Panel for a proportionate response to be determined. Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitoried through the organisational safety improvement plan.

Assessment of incidents outside of the identified priorities	Proportionate response dependent upon the circumstances surrounding the patient safety event	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.

*The Systems Engineering Initiative for Patient Safety (SEIPS) model will be used as a framework to guide all learning responses.

Infection Prevention and Control Board Assurance Framework

0. Reference Information

Author:	Sara Ellis-Anderson, Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	6th of February 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce and Director of IPC	**Paper written on:**	14th of November 2024
Paper Reviewed by:	Infection Prevention and Control Committee	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The Trust Board is asked to **note** the current self-assessment of the IPC BAF and gain **assurance** that systems and processes are in place to comply with the 10 criterions of the Health and Social Care Act (2008) recognising the mitigating actions outlined for those key lines of enquiry that are partially compliant.

2. Executive Summary

2.1 Context

The National Infection Prevention and Control (IPC) Board Assurance Framework ('the IPC BAF') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others.

The purpose of the IPC BAF is to provide an assurance structure for Trust Boards against which the organisation can effectively self-assess compliance against the 10 criterion with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

2.2 Summary

- The IPC BAF has been reviewed quarterly by the Deputy DIPC and by members of IPC, Estates, Clinical Education, Health and Safety and Pharmacy teams.
- Out of a total of 55 key lines of enquiry (KLOEs) the self-assessment has identified 44 fully compliant KLOEs with associated evidence and 11 partially compliant KLOEs.
- Since the last review Four KLOEs (2.7, 3.1, 7.2 and 8.3) have moved from partially compliant to fully compliant.
- Several partially compliant KLOEs relate to Facilities and cleanliness and FFP3 fit mask testing compliance
- Mitigating actions have been identified for partially compliant KLOEs with identified gaps in assurance. These are monitored through the IPC Improvement plan which is monitored through IPC Committee.
- It should be noted that in the next review KLOE 1.3 will move to fully compliant with the Trust achieving LFPSE compliance

2.3 Conclusion

The Trust Board is asked to **approve** the IPC BAF.

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by clicking here.

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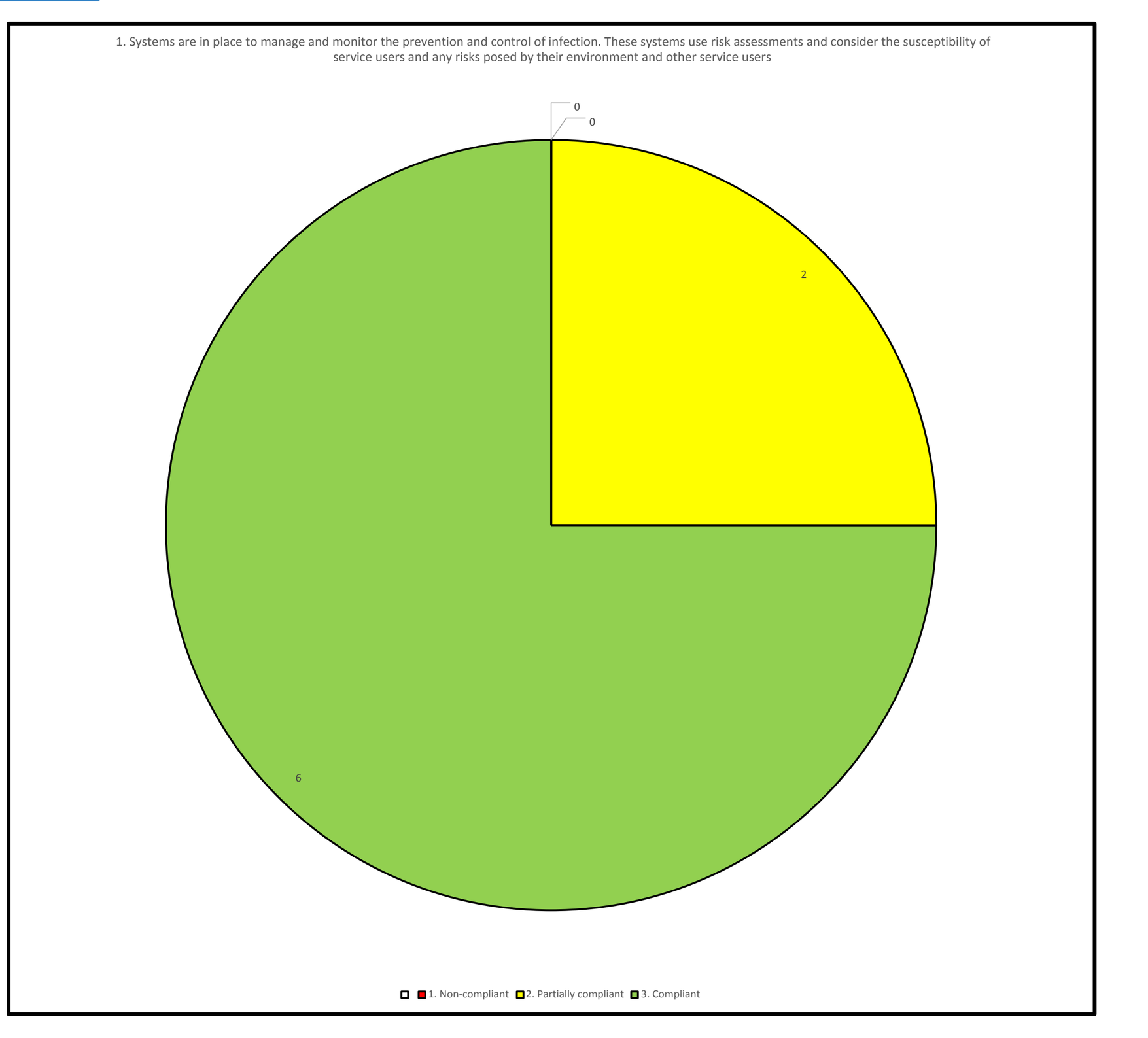
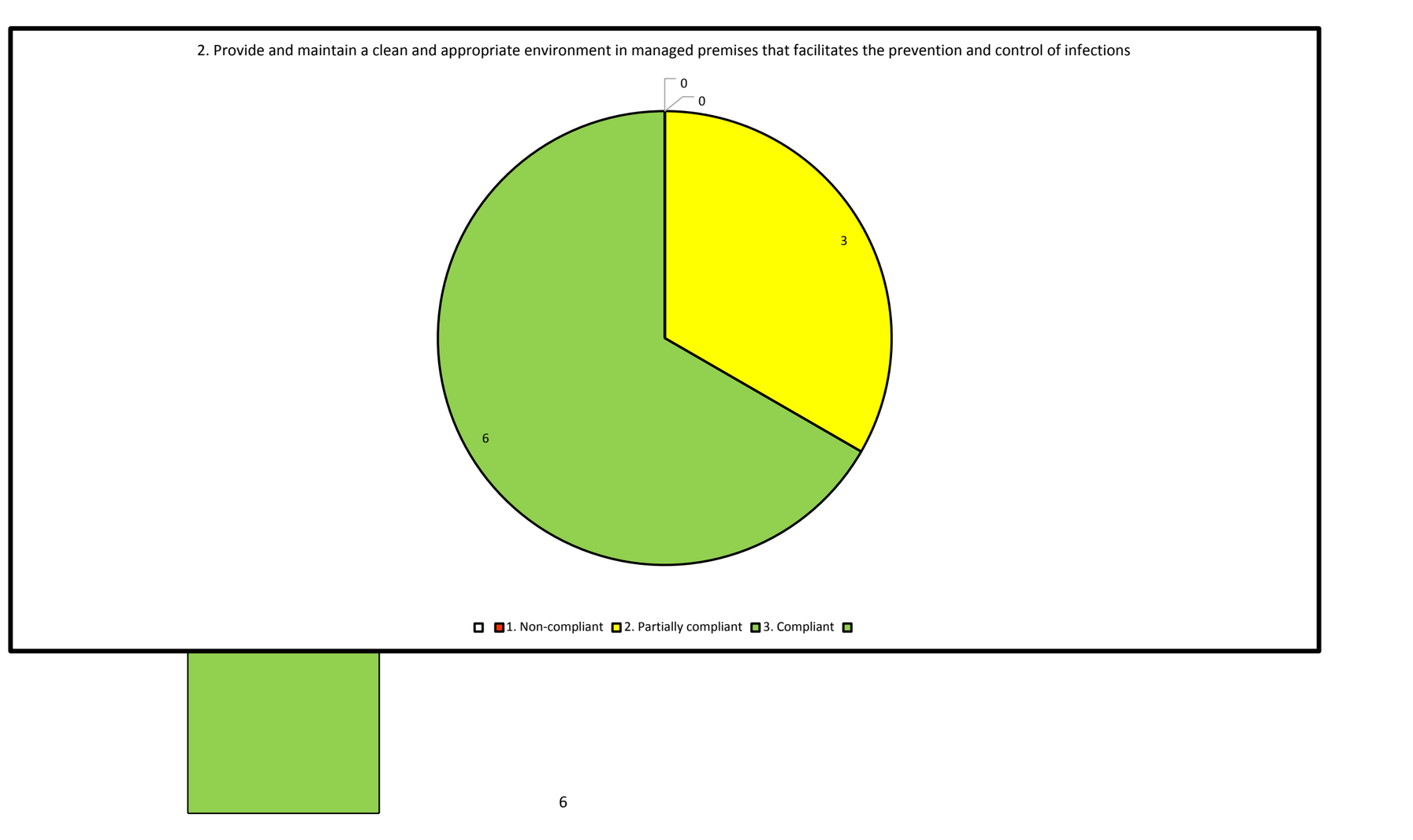
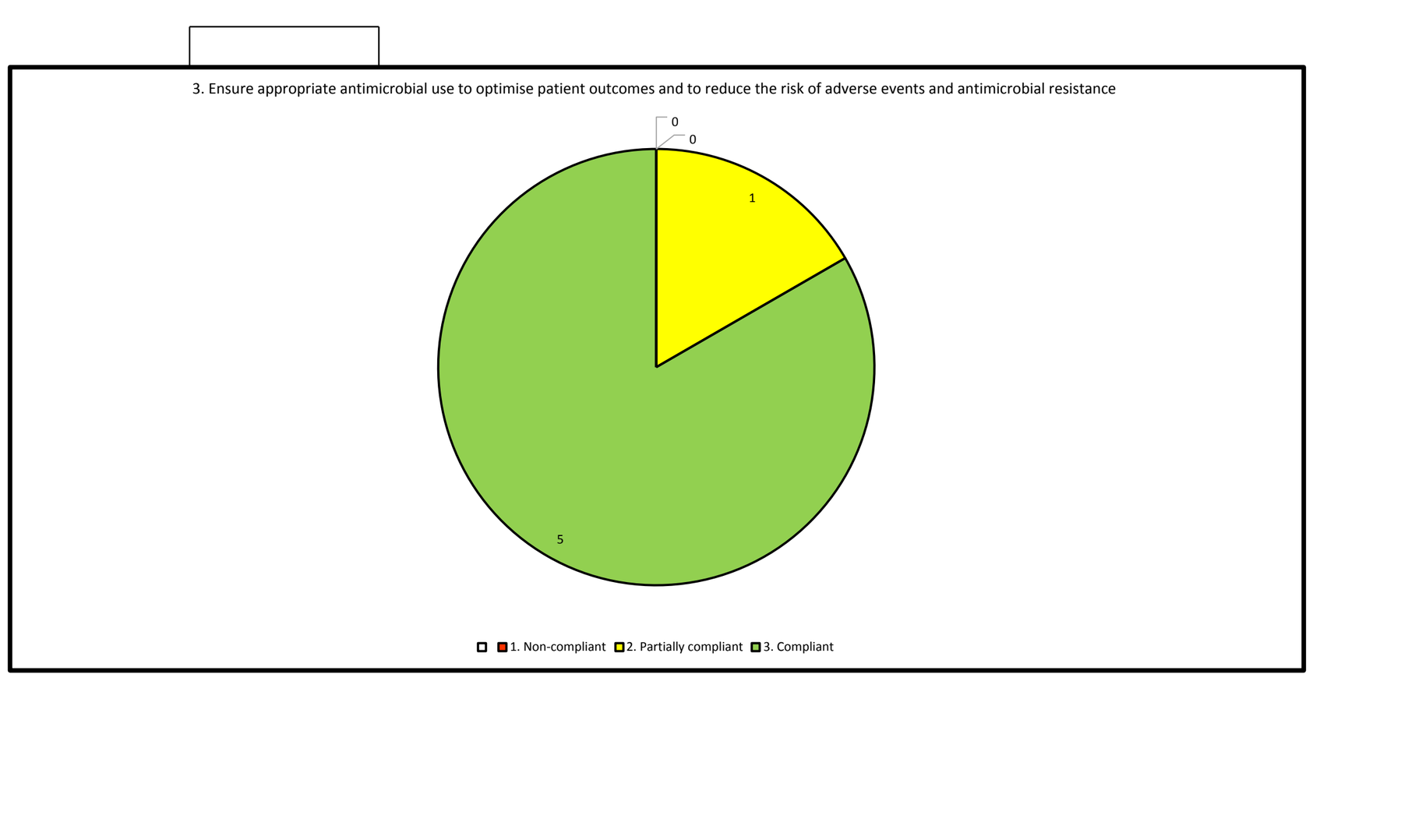
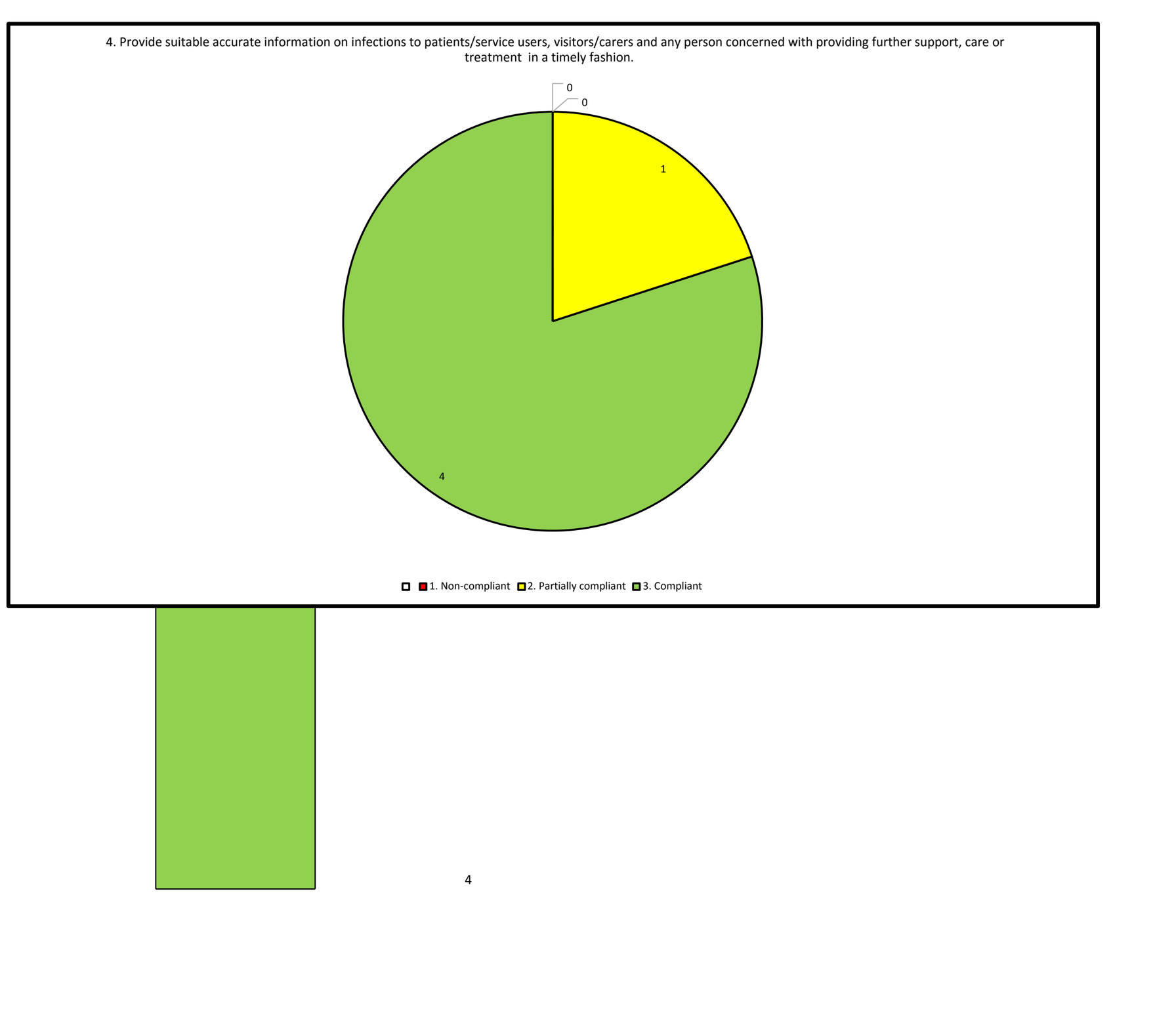
Infection Prevention and Control board assurance framework v2.0

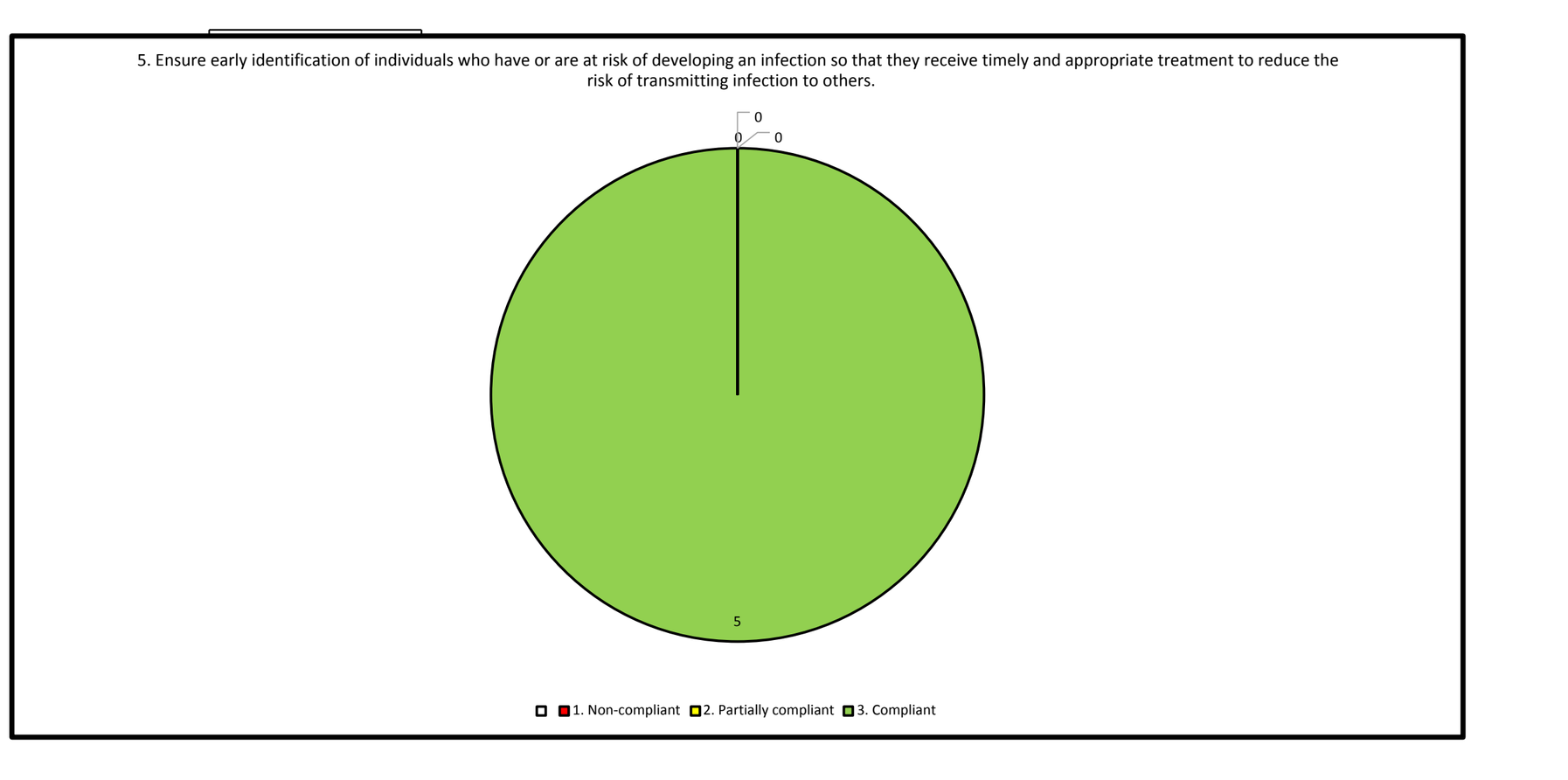
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Lead	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Organisational or board systems and process should be in place to ensure that:							
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Formal IPC Governance structure in place (evidence on IPC QMS).					3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks . There is no digital system for surveillance at present but alerts are on RiO. This is captured on the IPC Risk Register. Chief Pharmacist is responsible for antimicrobial stewardship reporting through IPC Committee.					3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Consistent high levels of Incident Reporting per month, traning provided on the System to new users, Datix actively used to progress an investigation. LFPSE implentation underway. Workforce and Staff Specific Risks in place across all Risk Registers.	Trust is not LFPSE compliant	Governance Support Officer and Senior Governance Manager currently covering some aspects of Datix administration in extension to existing responsibilities.	Learning from Patient Safety Framework (LFPSE) transition in progress with new Datix system purchased.	Director of Governance	2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC Quality Assurance Audits (QAAs) cover SIPC elements from each section of the NIPCM. SCHT IPC policies are aligned to the NIPCM. In addition, environmental and practice self audits are conducted by operational teams and an annual Sharps Audits by Daniels. Results and actions are monitored at IPCOG and IPCC through unit reports.					3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Targets set locally by ICB. Surveillance data is monitored through IPC report to IPCC. Local antimicrobial resistance patterns are reviewed by Consultant Microbioligist which influences local antimicrobial guidelines. Outbreaks and serious incidents are monitored and managed through outbreak meetings, Datix, PIRs. All are contained in the IPC report to IPCC.					3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC Team budget in place. SLA agreement with MPFT for Estates PPM and upgrading. Ops are responsible for cleaning and report compliance against National Cleaning Standards 2021 through IPCC. IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks. There is no digital system for surveillance Chief Pharmacist is responsible for antimicrobial stewardship reporting through IPC Committee. IPC responsibilities are captured in all JD's (IPC Improvement plan)		Manual process for surveillance remains in place until digital solution is implemented. This is not a gap in assurance, this is an improvement.	ICNet - budget is not secured for this but Digital Services are aware. This is captured on the IPC Risk Register and on the ICS IPC risk register monitoried by the ICB.		3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff IPC responsibilities are detailed in their job description. IPC training is included in induction. IPC e-learning module through ESR: Annually for clinical, 3 yearly for non clinical. Ad hoc face to face IPC training for wards, IPC training for domestic staff, IPC training for volunteers. IPC link practitioners for all services who disseminate training provided by IPC team. Quarterly campaigns covering updates and areas identified as requiring additional support. Annual Hand Hygiene assessments are recored and reported monthly at IPCC	ANTT is not included in mandatory training or competency checks.	There is an ongoing review of statutory and mandatory training requirements including capturing results on ESR to monitor compliance. This links to serial 6.6 This action is included on the IPC Quality Improvement Plan.		Associate Director for Workforce, Education & Professional Standards	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Patients are assessed on admission for Infection risks and placed appropriorately according to the Isolation Risk Assessment Tool. Individual cases are discussed with IPC or Consultant Microbiologist on call. Heirarchy of Controls is completed for all outbreaks and included as a standing agenda item at Outbreak Meetings. General IPC Risks are logged on Datix with mitgations and monitoring outlined. Systems to monitor alert organisms and Post Infection Review (PIR) system is in place. In the forthcoming year, PIRs will be updated and aligned to PSIRF (Patient Safety Integrated Review Framework).			A digital solution to surveillance would enhance risk assessments (ICNet).	Deputy DIPC	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
System and process are in place to ensure that:							
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Responsibility for cleanliness and compliance against National Cleaning Standards (CS) 2021 is with the Operational Team. DIPC receives cleanliness reports through IPCC and can escalate or challenge operational leads on standards of cleanliness. The Director of Operations has overall Trust responsibility for delivering the National Cleaning Standards 2021	No Facilities Lead or Cleaning Lead in community settings. GP practices and social care settings do not follow CS 2021. This gap in assurance is due to current legislation.	MyAudit supports cleanliness audit cycle. Cleaning compliance in buildings where SCHT are tenants are audited by operational leads to highlight and escalate areas of concern in non-Trust owned buildings	Action is included on IPC Improvement Plan.	Claire Horsfield, Director of Operations	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE audits are conducted by the Patient Experience team and reported through the Patient Experience Committee, Chaired by DDIPC. The IPC team are members of the PLACE audit.					3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Roles and responsibilities for cleaning in community hospitals is agreed	Cleaning of patient care equipment in satellite clinics and where SCHT are tenants is clearly defined but not the environment.	Serial 2.1	Risk on Risk Register	Claire Horsfield, Director of Operations	2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Quarterly Water Safety Group attended by Estates, MPFT (SLA in place) Authorised Engineer for water is contracted to conduct annual water safety audit and attends Water Safety Group monitoring compliance with action plan. There is a Ventilation Authorised Engineer under contract and the Associate Director of Estates has full oversight of remedial works to achieve compliance. PAM completed in line with mandatory reporting. Ventilation is a standing agenda item on the H&S Group.			Ventilation Safety Group to be established in 2025.		3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	SLA agreement with MPFT for Estates PPM and upgrading, MPFT policies for Estates are adopted. New building and refurbishment policy is approved and in place		Formal signed Contract in place between partnerStanding Operating Procedure for Management of the Trusts Estate linked to the SLA with the maintainer of or non NHS PS esate. Both parties have appointed the same Water AE and have aligned processes and procedures noting the SLA identiifes the follwoing of the maintainers processes and policies noting they themselves are an NHS Provider. Monthly uodates are provided to IPC with support provided directly by the maintainer into IPC directly. Quarterly meetings are conducted with NHS PS with local "BUG" meetings hosted by NHS PS with site leads. Documenation and evidence is available via the maintenance providers CAFM system MICAD	IPC Team have requested priority list to be included. Action is included on IPC Improvement Plan.	Richard Best, Associate Director of Estates	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen contract in place and monitored by Operational team to ensure quality of items and adequate supply and provision at ward level. Issues with linen are reported through DATIX.		Purchase of mobile linen storage units have been approved by IPC.	IPC to audit compliance until assurance is achieved. Linen storage is included in the QAA	Locality/Ward Managers Claire Horsfield, Director of Operations	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste management budget holder is the Associate Director or Estates, with repsonsibilty delegated to service leads and teams at an operational level. The Premises ssurance Model is used to monitor performance noting the use of datix in the event of individual issues as they arise. Domestic Waste is managed under an SLA with Veolia as procured by the system led by SaTH Clinical Waste is managed via an SLA with a partner NHS Trust and is provided under contract by Tradebe NHS PS provide waste services a spart of their managed estate			Waste provider is SRCL at Ludlow, and provided via the landlord NHS PS, the bins are removed secured and locked and transported from site to the processing site process observed at site level with photographic evidence. In that process the bins are swapped for clean empty ones therefore avoiding the mixing of waste. At Bridgnorth, the service is provided by Tradebe as a shared contract with another NHS Provider the bins remain in situ and the backs are transported in amongst other waste from other sites.	Richard Best, Associate Director of Estates	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Dental instruments are processed in line with guidance and policy Endoscopy equipment is processed in line with guidance and policy and reported through IPCC		Contracts in place with specialist providers contracted via the SLA and are audited by the Decon AE	Discussions underway with Partner NHS provider to enter in formal discussions for the contract moving forward		3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Each Community Hospital has a lead for food hygiene. Food Hygiene policy is in place and up to date. Food hygiene training is provided by external contracted provider. IPC team review ward kitchens, microwaves, fridges included in the QAA.	There is no overall Trust Food Hygiene lead	The gap in role has been escalated to the Operational Leads and captured on the IPC Improvement Plan.		Claire Horsfield, Director of Operations	2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Systems and process are in place to ensure that:							
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements.			Nominated lead in post. JD to be updated.	Susan Watkins, Chief Pharmacist	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Antimicrobial stewardship is formally reported to the IPCC Chair and onwards to the Board via an IPCC Chair's report					3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Antimicrobial stewardship is the responsibility of the DIPC who sits on the Board					3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements. NICE guidance is utilised and shared with clinicians.	Having access to ePMA would further support reviews and enable more efficient review of patient compliance	Pharmacy team on site at the prison and community hospitals a minimum of 5 days per week. PGDs have criteria which provides maximum course lengths and roots for escalation.		Susan Watkins, Chief Pharmacist	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •total antimicrobial prescribing. •broad-spectrum prescribing. •intravenous route prescribing. •treatment course length.	Prescribing and AMS use data is presented to the IPC Committee for ratificaiton which demonstrates any patterns in prescribing behaviour. Informaiton is provided from all services using antibioitics					3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	All prescribers that work within SCHT meet with a member of the pharmacy team and they are supported with safe prescribing and maintainance of AMS. This includes agency staff as well as permanent. PGDs can only be used by staff that have bene signed off as competent, this means there is little use of PGDs by agency which provides the required robustness.					3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion							
Systems and processes are in place to ensure that:							
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPC develop patient and staff information leaflets are reviewed by Patient representatives. For new and emerging health threats, the IPC Team request dissemination of information through communication channels.					3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	IPC develop patient and staff information leaflets in line with policies. Head of Quality is lead on Accessible Information Standard for the Trust.		The IPC Team utilise online acessible information software to assess compliance prior to publishing.		Director of Governance	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	IPC policies are aligned to NIPCM and criterion 9 avaiable on StaffZone intranet. The IPC information and Governance systems support dissemination of IPC information from floor to Board. The IPC Annual Report includes information on IPC, compliance with the H&SCA including AMR. This is published on the SCHT Internet page.					3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	IPC develop and publish patient, contractor and staff information leaflets. These are reviewed and aligned to the NIPCM and NHSE/UKHSA guidance. SOPS on specific actions, e.g. Covid screening, outbreak managent, isolation, are available to staff via the intranet and disseminated through communication channels. OHD and Medicines Managent produce communications around campaigns e.g. antimicrobials, vaccinations, which include desk-top banners, newsletters and communication releases.					3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Information on infection status of patients is requested and conferred prior to admission. Patient admission assessment and pre-transfer checklists are completed by capacity hub and ward teams. Admission documentation includes IPC status.	Catheter Passports are not consistently in use across the system.	Current system remains in place until digital surviellance is implemented. Work is in progress to implement a revised Catheter Passport.	There is no digital system for surveillance - serial 1.6 A full review of invasive devices training and managment, VIP scores and obtaining blood culture protocols will be required if the Trust Service/Transformation Plan moves to providing sub-acute care	IPC Team and Continence Service Director of Operations	2. Partially compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.							
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:							
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	All patients are screened for MRSA on admission in line with guidance for Community in-patient areas. Isolation audit and check lists are employed by teams. Identification of signs/symptoms of infection are included in SOPs e.g Respiratory symptoms, diarrhoea and vomiting			Emergence of organisms of significance is monitored by the IPC Team Lead. Potential screening requirements are reviewed. Currently requirement for CPE screening is under review.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patients are assessed during their stay for signs and symtpoms of infection. SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Non-compliance due to risk assessment is recored on DATIX.					3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Information on infection status of patients is requested and conferred prior to admission in a pre-handover checklist. Admission documentation includes IPC status.			There is no digital system for surveillance, however, ICNet is awaiting implementation - serial 1.6		3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Respiratory Symptoms posters are in place across SCHT premises.					3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak Policy is in place and followed. External stakeholders are invited to outbreak meetings. CQC are informed through submission of a Statuty Notification Regulation 18 (2 (g)) 2009. Outbreak SOPs (respiratory and diarrhoea & vomiting) are in the on-call folder for IPC guidance in out-of-our period.					3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection							
Systems and processes are in place to ensure:							
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	On-line corporate induction includes required IPC elements. E-learning mandatory IPC training Levels 1 and 2 provided according to role. IPC have regualt 2 hour slot on clinical skills week for face to face clinical induction			Serial 1.7 for ANTT		3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Clearly defined IPC roles and responsibilities are embedded in the JD's of all new and existing roles throughout the Trust. Locality Managers and Site Managers are aware of their resposibility for Estate and IPC. Areas that require improvement are captured on individual IPC Improvement Plans reviewed at IPCOG and during IPC QAA. Training and IPC practice compliance is recored and reported through Unit/SDG reports to IPCC overseen by the DIPC.					3. Compliant
6.3	Monitoring compliance and update IPC training programmes as required.	IPC training compliance is a Trust KPI monitored at Q&SC. A bespoke training package for Healthcare Support Workers for the System has been reviewed and updated					3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	A link to the NIPCM Donning and Doffing is embedded within our Standard Infection Control Precautions policy. IPC Team regularly audit compliance during visits.	Clinical staff are required to be fit-tested to x2 types of FFP3 mask.	See serial 6.5	Fit mask testers have now been trained for SCHT	Service Director, Deputy Director of Operations	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Records of compliance are currently kept locally by each Service, and enquiries have been made to keep records centrally on ESR - this has been added to the Risk Register	Clinical staff are required to be fi-tested to x2 types of FFP3 mask. The Trust currently have limited or no in-date FFP3 fit testing staff, H&S are currently exploring external providers for this service.	Staff who are untested for a mask, are advised not to deliver care in areas where there are AGPs being conducted.	Fit mask testers have now been trained for SCHT	Service Director, Deputy Director of Operations	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Clinical Skills that involve medical device insertion has a comptency document that the clinician completes in practice following the initial training, for example Venepuncture & cannulation.	Competencies are currently not linked to role. Competency records are not held digitally.	The clinical competency library is held on Staffzone. Line mangers are responsible to ensure their staff are appropriately trained and indivdual paper records are held locally.	Role Speciific Training and Competencies are to be recored on ESR.	Associate Director of People	2. Partially compliant
Systems and processes are in place in line with the NIPCM to ensure that:							
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Serial 5.1 and 5.2. Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Admissions and transfers that require isolation are allocated and agreed prior, to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required.					3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Serial 5.2 SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Admissions and transfers that require isolation are allocated and agreed prior to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required. Non-compliance due to risk assessment is recorded on DATIX. Avian flu and zoonotic disease capability is covered by action cards informed by the Incident Management Team having an IPC lead as its subject matter expert. Any other general clinical decisions would fall to the Ops/Clinical teams as part of their business as usual and escalation processes.				EPRR Senior Lead	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICPs and TBP Policy is in place aligned to the NIPCM. Signage for precautions are in place and displayed. Compliance is monitored through QAA and spot checks. Results are reported through IPCC and SDG reports.			Redesign of isolation posters are in progress which reflect the NIPCM. This is not a gap in assurance as is an improvement.	IPC Team	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Onward care facilities are advised of patients that require isolation.					3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate							
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:							
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Laboratory specimens are obtained by registered practitioners or HCSW who have had appropriate training and are delegated to complete the task. In the absence of national accrediation training, staff complete the LFD test SOP and competency check.			There is no nationally recognised acrediation system for LFD testing. Staff follow laboratory protocol and SCHT policy when obtaining respiratory Panel PCR, MRSA screen and other specimens.		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	All lab results are reported via SaTH Review system. IPC receive a weekly 'Alert Organism' list from the SaTH labs.	There is currently no system which automatically adds an alert to the patients records.	Identification of positive results is carried out by IPC staff accessing results in a timely manner.	ICNet - serial 1.6		2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SCHT utilise SaTH laboratories for all microbiology and IPC services. The SLA does not specify turnaround times. SaTH laboratories process SCHT samples in line with their own sampling.		If samples are to be processed rapidly, individual cases are discussed with the Microbiology team. In the event of late sample results and an issue arising as a result, SCHT will raise an NHS 2 NHS concern and discuss with SaTH laboratory service manager.	SCHT samples are processed in an equitable manner with all samples from the STW system. Including a specified turnaround time within the SLA is not deemed to impact on the current service and therefore not required. This has not been transferred to the IPC Improvement Plan.	IPC Team	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	MRSA swabbing on admission as per Trust Policy and compliance is monitored monthly by the IPC Team as an IPC KPI - threshold of 97% YTD. Swabbing guidance flowcharts are shared and in place with in-patient areas.					3. Compliant
8.5	Patients/service users who develop symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Swabbing guidance flowcharts in place in all in-patient areas, as per national swabbing guidance.					3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	The IPC team have access to consultant microbiologist advice 24/7 when needed. Clinical teams also have access to microbiologist advice as required. IPC cover including outbreaks is included in the SLA.					3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	SCHT follow policy: Collection, Packaging, Handling, Storage and Transport of Laboratory Specimens.					3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	IPC policies are aligned to NIPCM and criterion 9. IPC policy tracker is reviewed at IPC Committee as per the workplan. IPC receive reports from operational teams on IPC Compliance at IPCOG and IPCC. IPC team conduct regular ad hoc and targeted audits to triangulate and verify self-audit findings. Infection Incidents are reported through DATIX. Post Infection Reviews are conducted for all HAI. Outbreak sare managed and reported as serial 5.5.					3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:							
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Team Leads and Line amangers carry out this assessment. Referrals are made to OHD.			Any issues that are identified are then notified to Occupational Health and further information and assessment is carried out		3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	All staff who have an exposure incident are encouraged to contact Occupational Health. They will have an initial assessment by one of the advisors and a plan will be agreed following Trust policy. If the issue happens at the weekend or out of hours the employee can access one of the Sharps Incident Boxes located around the county that contains instructions on what bloods are needed and can access the policy as well as immediate first aid procedures. The incident should also be reported via DATIX.			DATIX summary reports are sent out daily by the Governance Team to senior leads, the DDIPC and DIPC for oversight. Sharps incidents are followed up by H&S Team		3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	All staff who have or may have a patient facing role are seen by Occupational Health before or very soon after commencement in role and a full immunisation check is carried out that includes TB, Hepatitis B, Measles, Rubella and Varicella. Any outstanding vaccines are offered or, in the case of Measles and Rubella blood tests are offered and results followed up					3. Compliant
		Any person carrying out Exposure Prone Procedures or anyone new to the NHS is asked to undertake a blood test to check for Hep b, Hep C and HIV – this is validated by photographic ID; again any issues are followed up and advise and support offered to the individual and the manager/trust.					3. Compliant

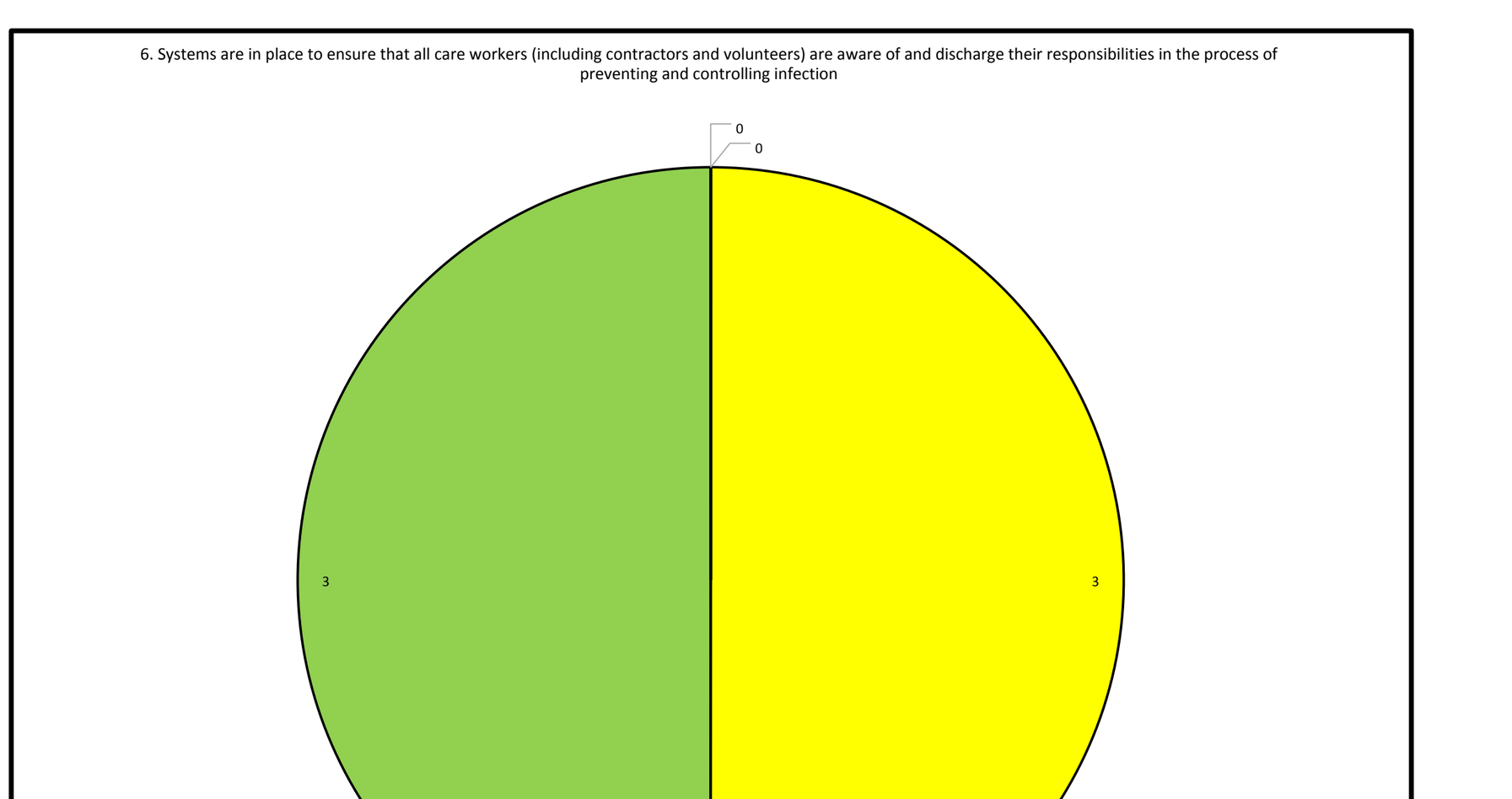


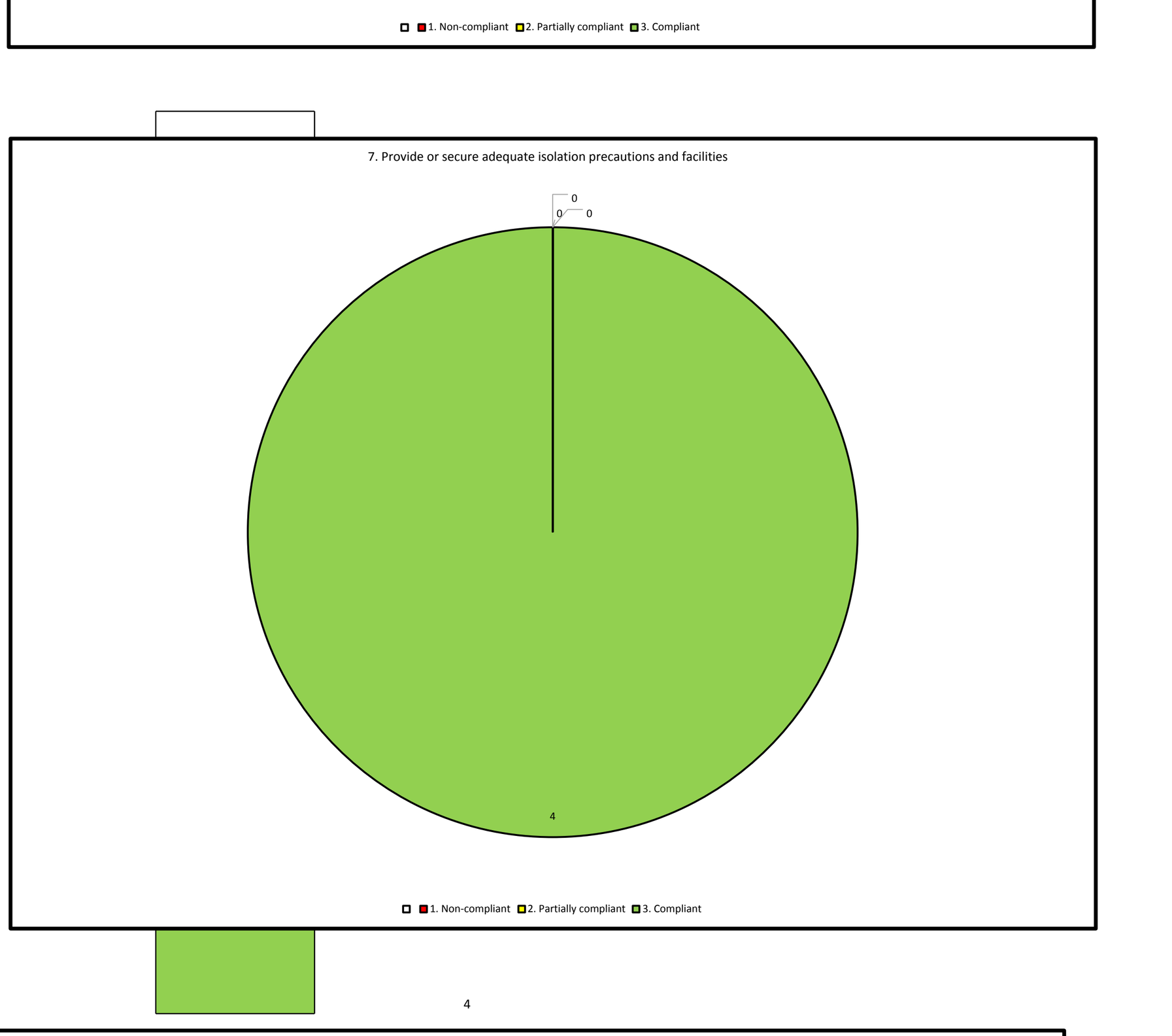


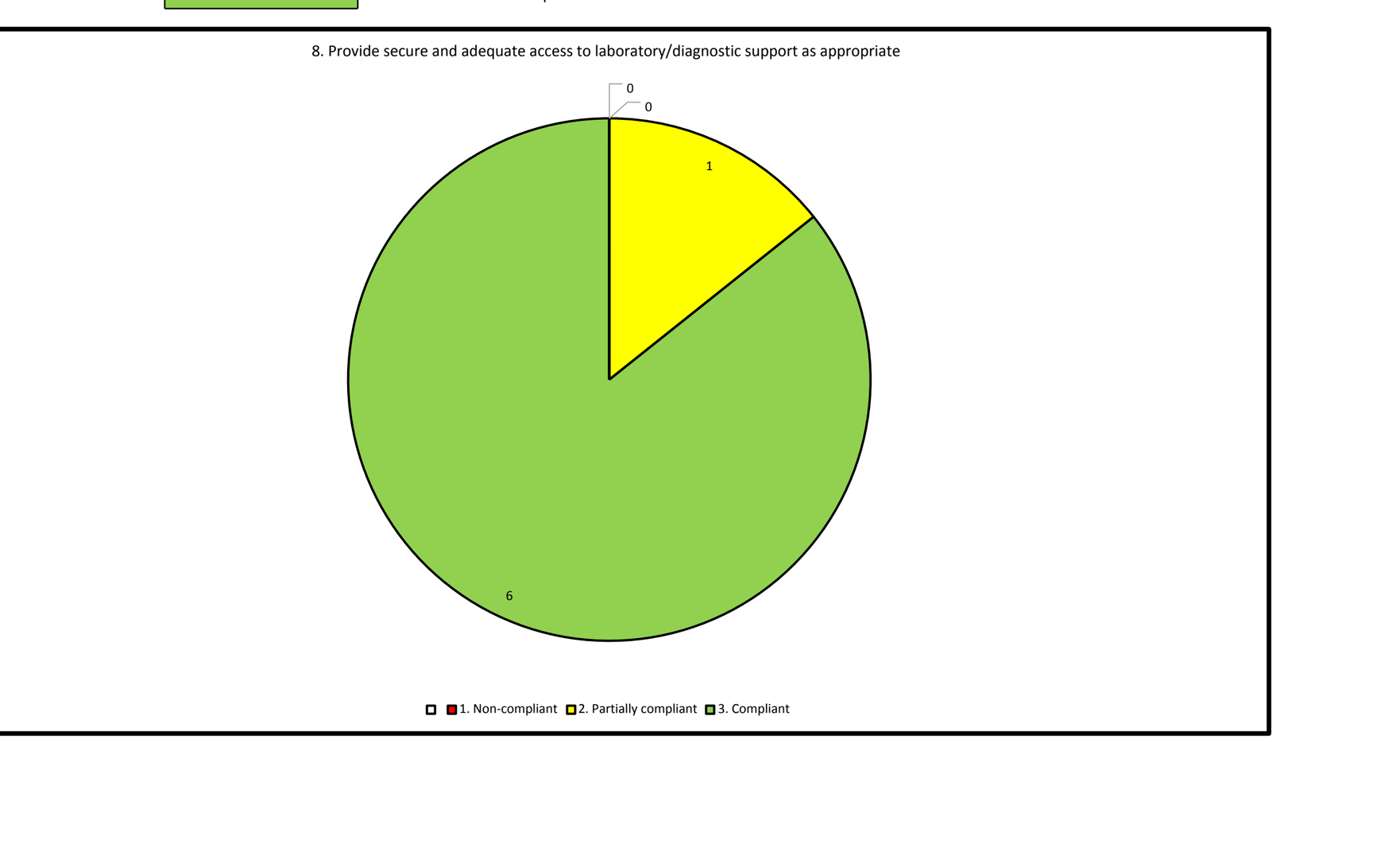


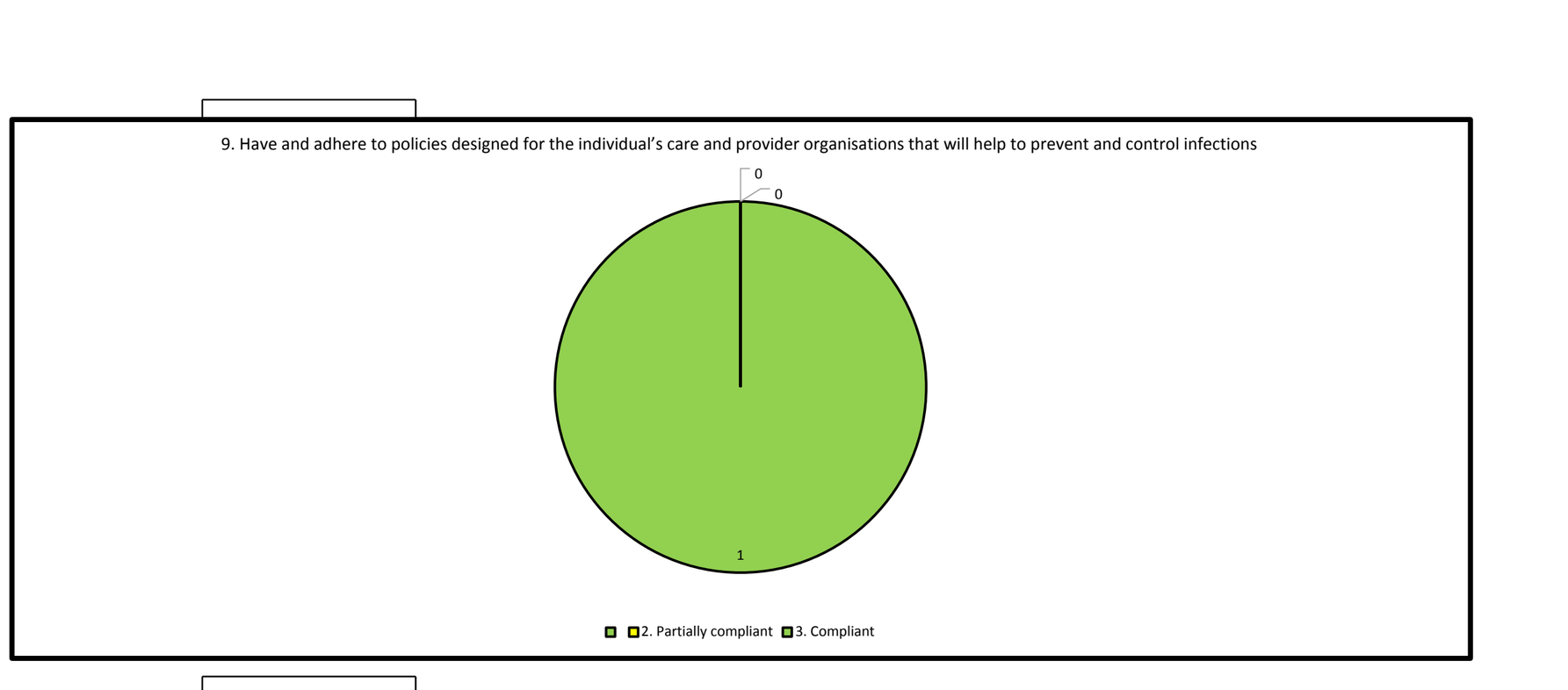


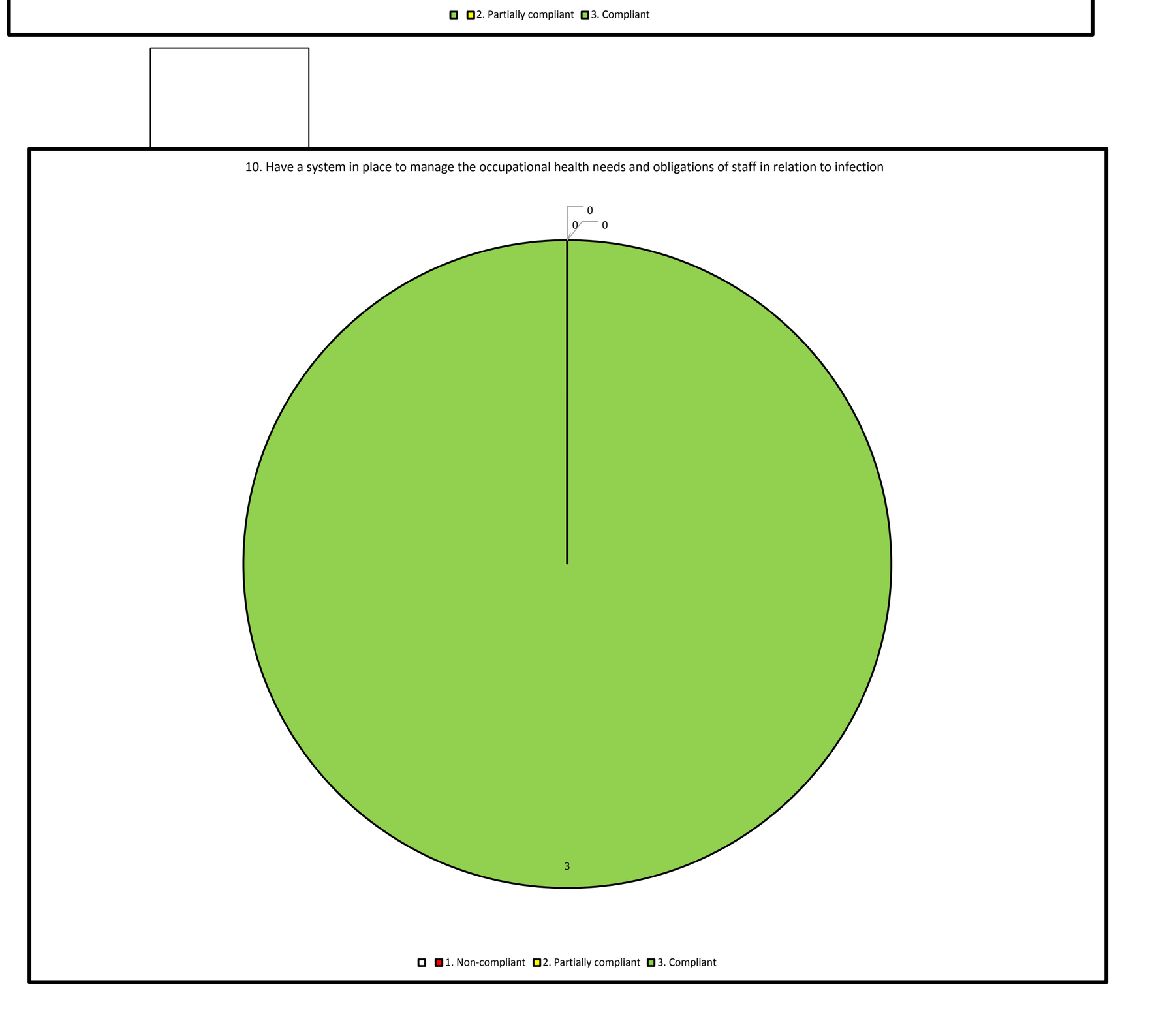




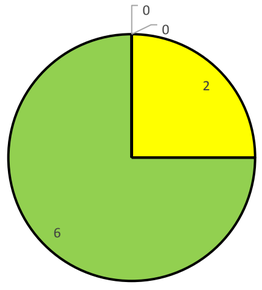




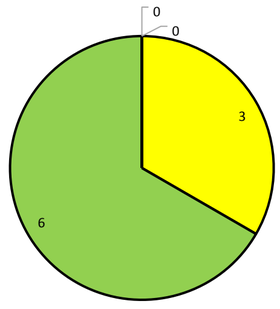




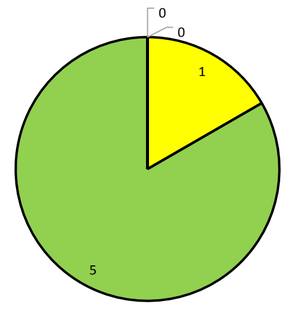
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



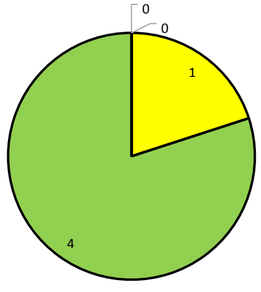
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



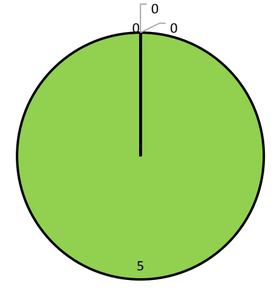
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



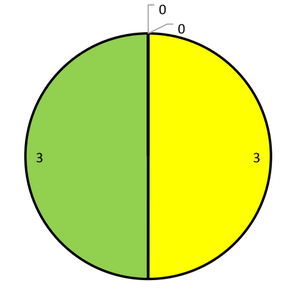
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



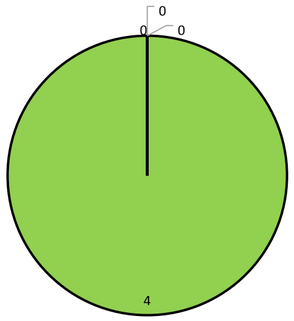
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



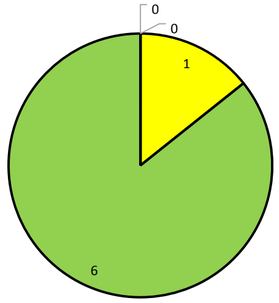
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



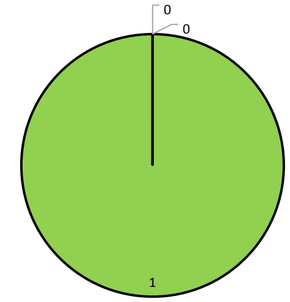
7. Provide or secure adequate isolation precautions and facilities



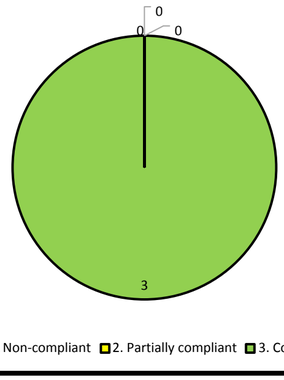
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

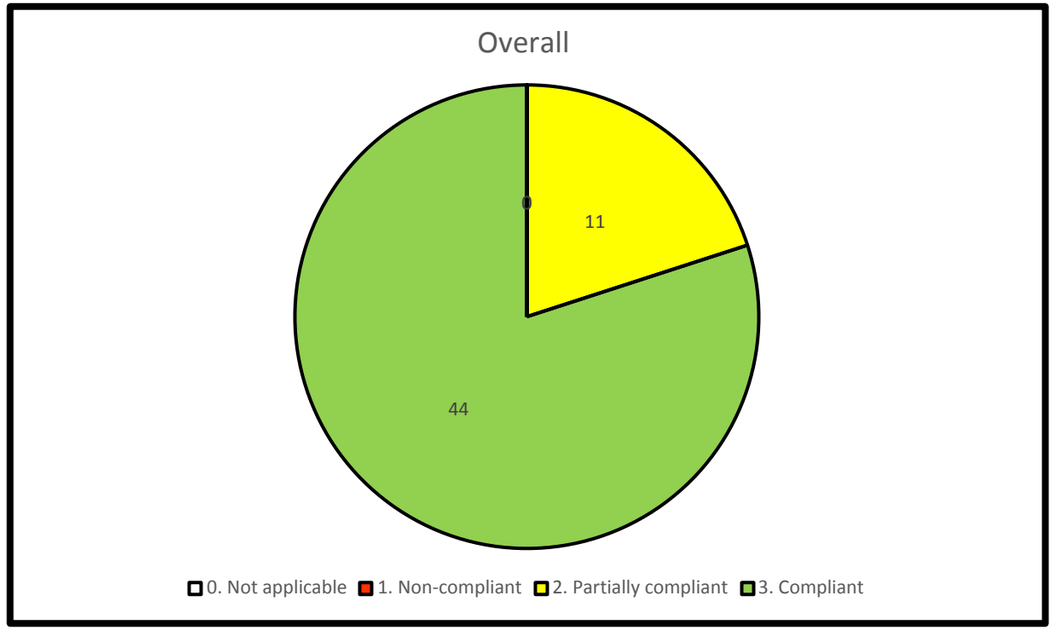


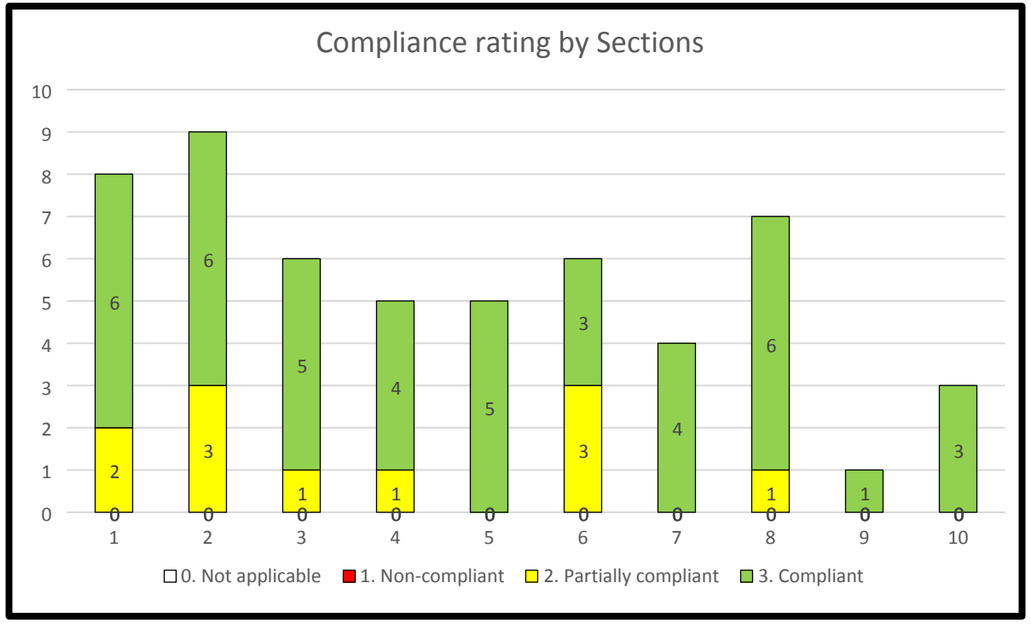
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections



10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection




Overall
0
11
44
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
10
9
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0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

Shropshire Community Health
NHS Trust

Performance Update
0. Reference Information

Author:	Jen Deakin, Fiona MacPherson Gina Billington Heads of Service	**Paper date:**	21 January 2025
Executive Sponsor:	Rhia Boyode, Chief People Officer SCHT & SATH	**Paper written on:**	21 January 2025
Paper Reviewed by:	Simon Balderstone, Deputy Chief People Officer / Interim Workforce Operations Director	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

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

2. Executive Summary

2.1 Context

This report focuses on the key areas of performance relevant to Trust Board, including a review of performance against the month 9 workforce plan position. The KPI's throughout the report are key drivers of performance, which underpin the delivery of the 24/25 workforce plan.

2.2 Summary

The key points for Board to consider are:

- The table below summarises the number of KPIs highlighted as a concern.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	1	7	5	**19**	**13 (73.7%)**

Action Plans have been developed by the Heads of People, Resourcing and Workforce and included as Appendix 4.

The Board 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. SPC charts and icon descriptions are included in the appendices should members wish to review further.

Performance Update
2.3. Conclusion

The Board is asked to:

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

3. Main Report

3.1 Introduction

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

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

3.2 Summary of key points in report

The workforce plan for 2024/25 set a 33 WTE increase from the start of the year, which incorporated an 81 WTE increase in substantive workforce. This included the transfer of the 0-19 Dudley Children's Services. The target set to reduce agency usage was a 42% reduction, to be offset with increases in the permanent workforce. At month 9 the total workforce is over plan by 4.26 WTE.

Our agency usage is 7.74 WTE over plan driven by additional usage in Community Nursing where agency is being used to cover staff absences (maternity, long term sickness and recruitment to vacancies), and an increase in timed medications impacting on workload. Escalation beds have been opened and spend on agency may remain high in the CHs and RRUs, dependent on these winter pressures.

Bank usage has been above planned levels and is expected to remain above plan to the end of year, however given the costs are comparative to substantive workforce this is not expected to create a cost pressure and overall, we are expecting to deliver against our planned levels for total workforce.

Month 9 Position

Plan (WTE)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Substantive	1607.9	1618.9	1635.5	1641.2	1647.5	1648.5	1654.1	1654.15	1653.85
Bank	58.0	58.0	58.0	58.0	58.0	58.0	58.0	58.0	58.00
Agency	89.4	71.3	54.6	51.1	44.7	43.7	38.1	38.13	38.43
Total	1755.3	1748.2	1748.1	1750.3	1750.3	1750.3	1750.3	1750.28	1750.28
Actual (WTE)	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**
Substantive	1573.9	1586.2	1589.7	1598.0	1594.3	1603.3	1621	1632.02	1626.52
Bank	79.7	67.1	77.0	66.0	67.7	70.0	71	79.6	81.85

Performance Update

Agency	64.0	49.1	41.7	43.6	46.7	44.3	48.68	44.27	46.17
Total	1717.6	1702.3	1708.5	1707.6	1708.7	1717.6	1735	1755.89	1754.54
Variance (WTE)	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**
Substantive	-34.0	-32.7	-45.8	-43.2	-53.2	-45.2	-33.1	-22.1	-27.33
Bank	21.7	9.1	19.0	8.0	9.7	12.0	13.0	21.6	23.85
Agency	-25.4	-22.2	-12.9	-7.5	2.0	0.6	10.6	6.1	7.74
Total	-37.7	-45.8	-39.7	-42.7	-41.5	-32.6	-9.5	5.6	4.26

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

- Appraisals
- Leaver rates
- Vacancies
- Temporary staffing
- Absence management
- Price cap compliance

There are 19 performance indicators reported in this period as described in Appendix 1, and 13 of these require focused attention.

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

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

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

One KPI is a variation concern only – special cause variation of a concerning nature.

1. Vacancy rate

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

1. Aggregate score for NHS staff survey questions that measure perception of leadership culture*
2. Appraisal Rates
3. Leaver rate
4. Proportion of staff in senior leadership roles who are from a) a BME background*
5. Proportion of temporary staff
6. Sickness Rate
7. Total shifts exceeding NHSI capped rate

Performance Update

Five KPI are an assurance concern and a variation concern - the process is not capable and will fail the target without process redesign.

1. Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age*
2. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers*
3. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues*
4. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives, or other members of the public*
5. Staff survey engagement theme score*

The list of KPIs which are of concern is relatively unchanged from the last report to the Board, with only 1 change to note;

- Mandatory Training Compliance is no longer flagged as having a variation concern.

Metric	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Appraisal	90%	87.7%	86.27%	86.10%	85.67%	87.44%	87.92%
Leavers	9.6%	11.59%	11.48%	10.89%	10.95%	11.11%	10.76%
Temporary Staff	3.4%	7.5%	6.4%	6.5%	4.8%	5.4%	4%
Vacancies	8%	11.32%	11.81%	11.45%	11.15%	10.59%	10.84%
Sickness	4.75%	5.44%	5.31%	5.34%	5.33%	5.30%	5.33%
Total Shifts exceeding NHSI capped rate	No Target	244	164	228	184	185	44

There has been a slight improvement with appraisals, leavers and temporary staffing, a significant improvement with total shifts, but vacancies and sickness have increased. This is evident in the chart above and the charts within the appendices.

Appraisals

Appraisal compliance has remained relatively static since August, however since November we have seen an increase. Appraisal training sessions are continuing for staff and managers to attend, and support is being provided to areas with lower compliance rates.

Performance Update

Turnover

The Leaver rate has seen a gradual improvement since April but still below target by 1.16%. Our leavers rate has decreased in December A deep dive is being undertaken in relation to hot spots for leavers in terms of reasons, leavers with less than 12 months service etc to establish any bespoke support required for teams. The main driver of the turnover is retirement. We are providing workshops to staff to increase the awareness of flexible retirement options to support people to work longer before full retirement and encourage more flexible options. Our leavers policy has also been updated to provide various methods for completion of exit interviews as a consequence of this we have already seen an increase in completion of exit interviews.

Absence

Our absence rate is on an overall decreasing trend; however, we have seen a slight increase in December. We regularly review the application of our new Policy and provide support where required to ensure it is being applied consistently. We have a suite of offers from a HWB perspective in particular the roll out of our HWB days. The People Team supported by the Occupational Health team are rolling out workshops on how to complete a stress risk assessment. Work is being undertaken on ensuring timely Occupational Health referrals by Line Managers. We are continuing with our flu vaccination programme until the end of March 2025. We will be sending out a HWB survey to gather feedback on our HWB offer so we can tailor this to the needs of our staff.

Vacancies

Collaborative support from SaTH recruitment team to cover the team's vacancy has been reviewed and SaTH are unable to continue with this support. The team are operating with a 0.5 WTE vacancy, with only 1.5 WTE in the small team.

Due to an internal decision at SaTH regarding delivery and attendance at training across their Trust, the SaTH recruitment team are unable to continue to support this. The team continue to deliver recruitment training for recruiting managers and to offer drop-in sessions. New dates for this year are in place. This will support managers to manage their vacancies and reduce the number of queries to the recruitment team.

Agency Spend

Agency Price Cap compliance has continued to improve with a week on week fall in the number of shifts booked above price cap. We issued letters to all our agencies regarding price cap compliance and future bookings with the aim of 100% compliance by 31 March 2025.

In December only 44 shifts were above price cap compared to 185 shifts in November. We continue this work by focusing on both volume reductions and price of agency.

The focus will be on filling vacancies where we are using agency, so we can reduce demand and on reducing the price of agency by improving price cap compliance and maximising bank efficiency. This will be supported by moving to a central bank function and potentially utilising the National bank scheme where it makes sense to use.

Performance Update

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Board is asked to:

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

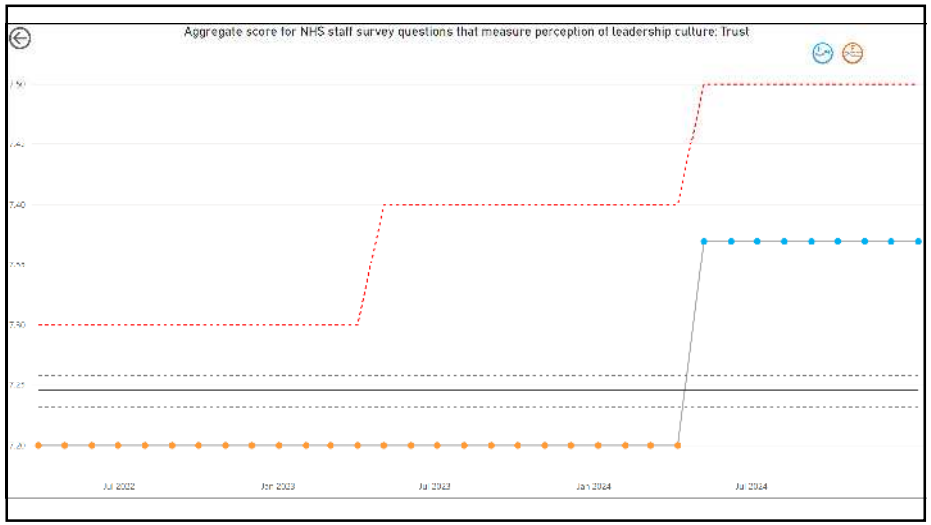
Appendix 1
People Committee – SPC Summary
Month 09 (December) 2024/2025 Performance

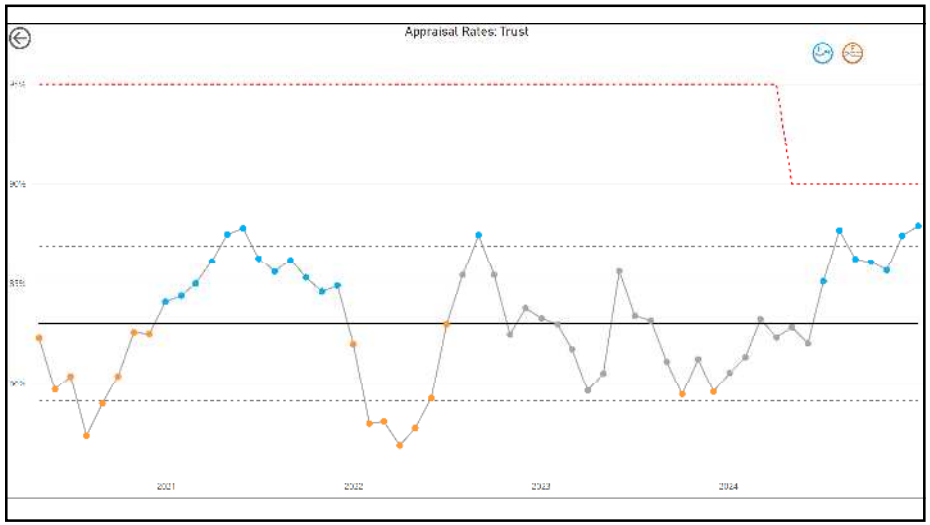
Shropshire Community Health NHS
NHS Trust

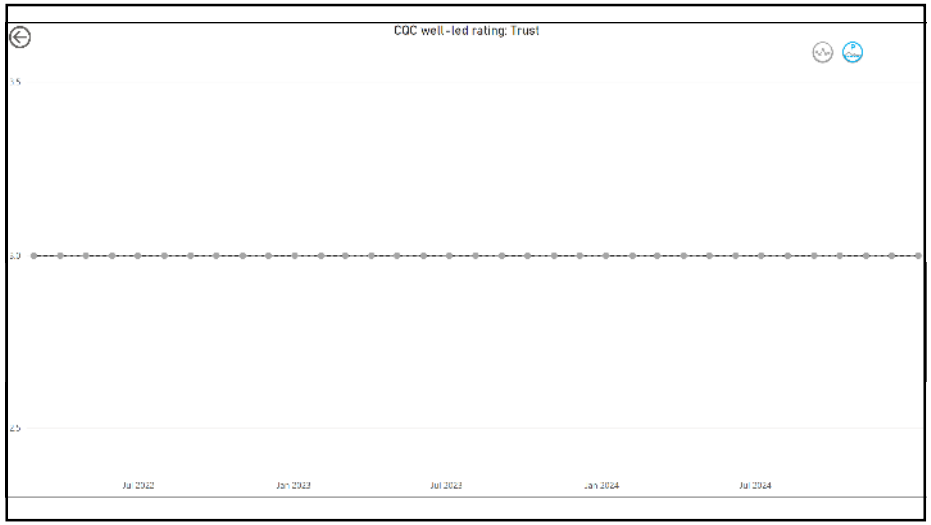
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2024-12-31	H	7.4	7.5	-0.1	7.4	7.5	-0.1	F
People Committee	Well Led	Appraisal Rates	2024-12-31	H	87.92%	90.00%	-2.08%	85.68%	90.00%	-4.32%	F
People Committee	Well Led	CQC well-led rating	2024-12-31		Good	Good		Good	Good		P
People Committee	Well Led	Leaver rate	2024-12-31	L	10.76%	9.60%	1.16%	10.76%	9.60%	1.16%	F
People Committee	Well Led	Mandatory Training Compliance	2024-12-31		94.83%	95.00%	-0.17%	94.83%	95.00%	-0.17%	?
People Committee	Well Led	Net Staff in Post Change	2024-12-31		-2.77	0.00	-2.77	20.77	0.00	20.77	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-12-31	H	9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	F
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-12-31		75.00%	66.00%	9.00%	75.00%	66.00%	9.00%	P
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-12-31	H	4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	P
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2024-12-31	L	55.80%	63.90%	-8.10%	55.80%	63.90%	-8.10%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31	H	7.1%	0.0%	7.1%	7.1%	0.0%	7.1%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31	H	12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31	H	22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	F
People Committee	Well Led	Proportion of temporary staff	2024-12-31		4.0%	3.4%	0.6%	6.1%	3.4%	2.7%	F
People Committee	Well Led	Sickness Rate	2024-12-31	L	5.33%	4.75%	0.58%	5.33%	4.75%	0.58%	F
People Committee	Well Led	Staff survey engagement theme score	2024-12-31	L	7.0	7.3	-0.3	7.0	7.3	-0.3	F
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-12-31	L	44	0	44	239	0	239	F
People Committee	Well Led	Total shifts on a non-framework agreement	2024-12-31	L	0	0	0	1	0	1	?
People Committee	Well Led	Vacancies - all	2024-12-31	H	10.84%	8.00%	2.84%	11.43%	8.00%	3.43%	?

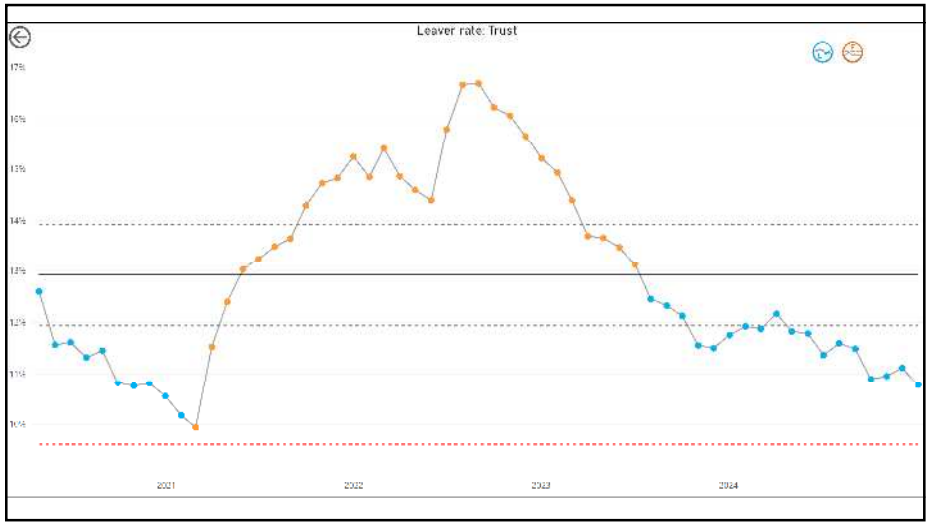
Appendix 2
People Committee
Month 09 (December) 2024/2025 Performance

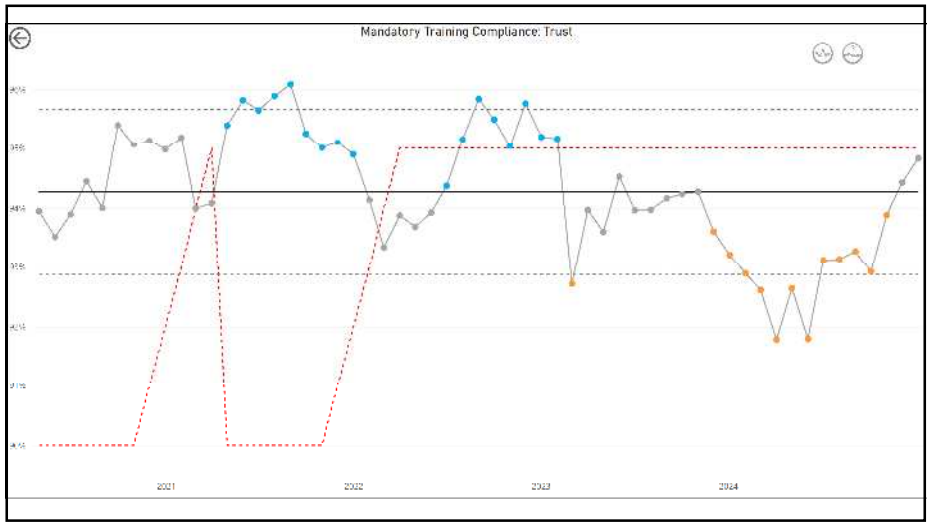
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where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

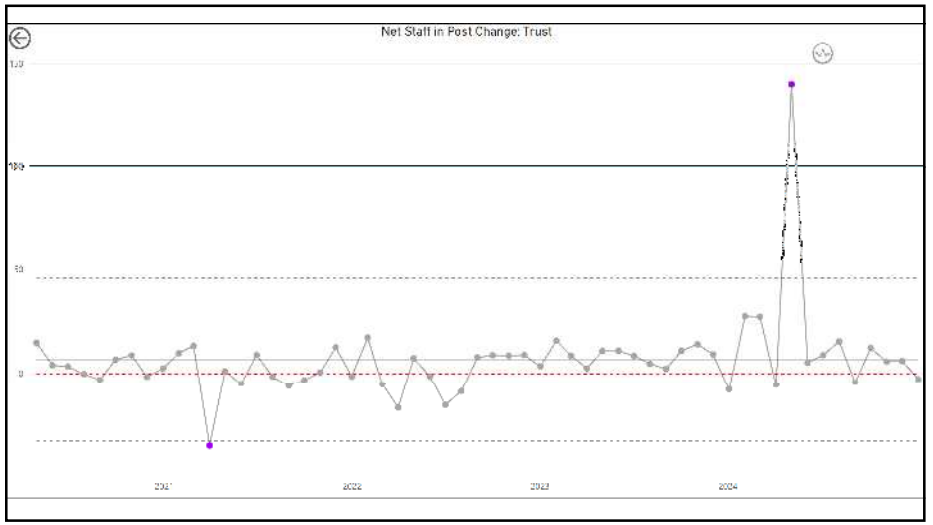

Aggregate score for NHS staff survey questions that measure perception of leadership culture: Trust
7.40
7.50
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

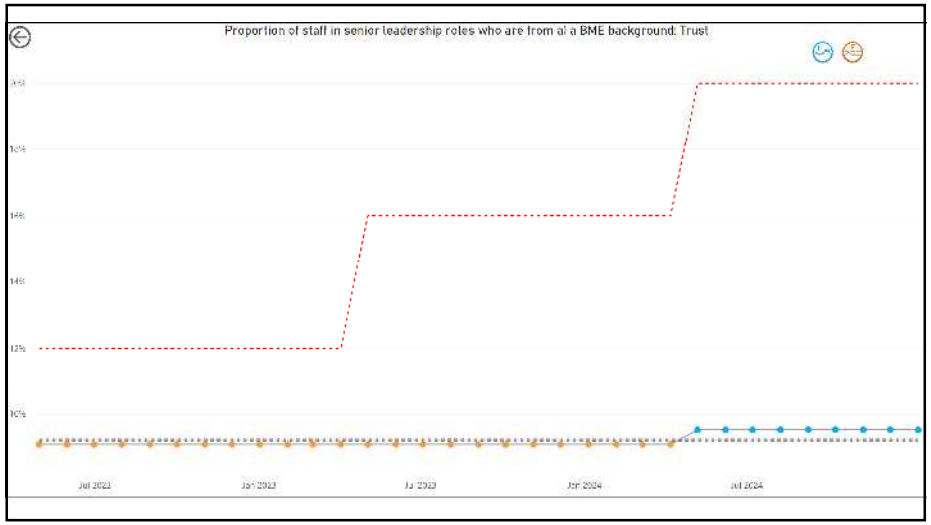

Appraisal Rates: Trust
90%
85%
2021
2022
2023
2024

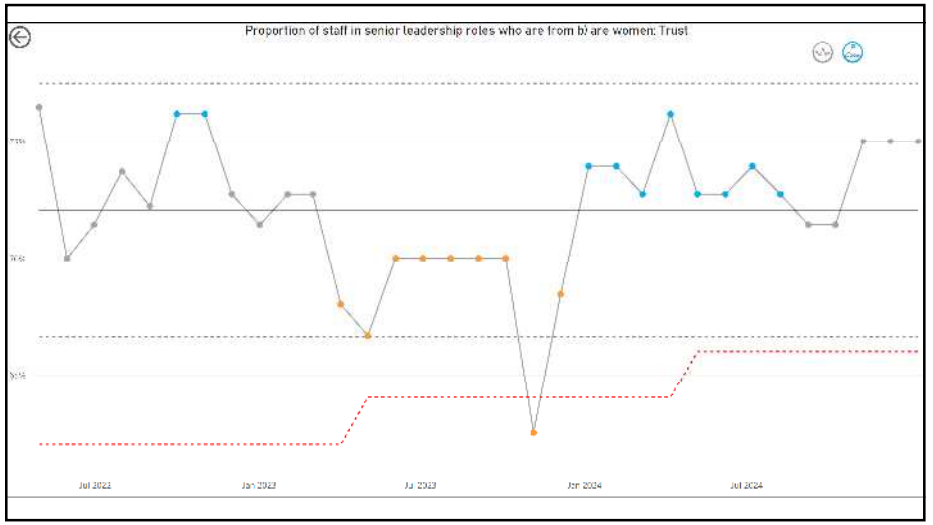

CQC well-led rating: Trust
2.0
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

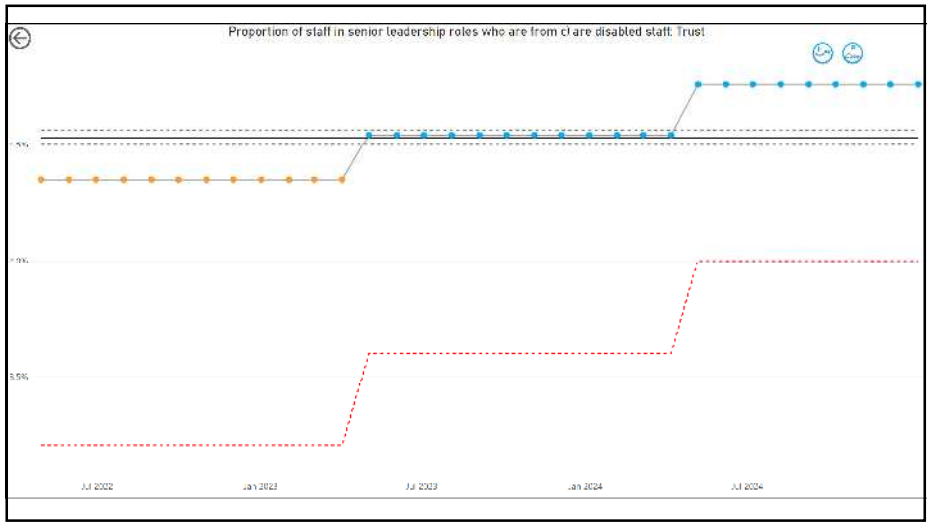

Leaver rate: Trust
17%
16%
15%
14%
13%
12%
11%
10%
2021
2022
2023
2024

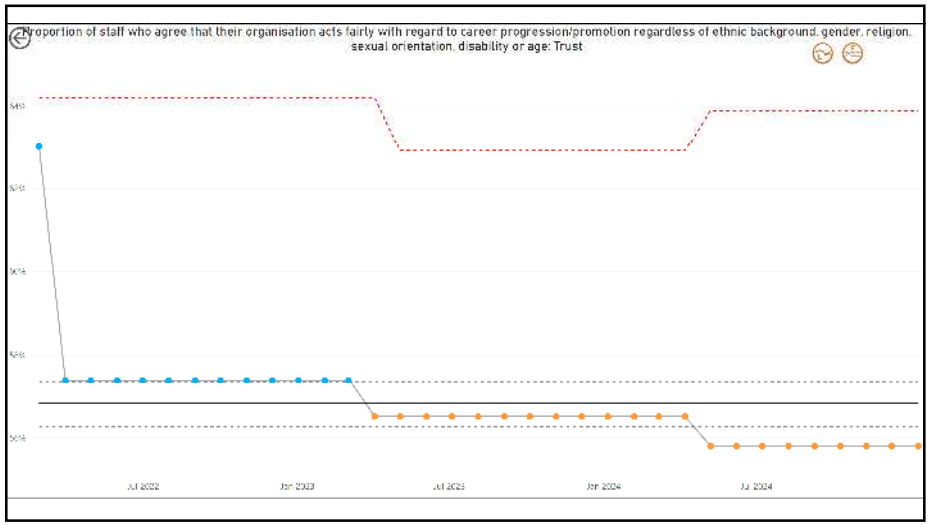

Mandatory Training Compliance: Trust

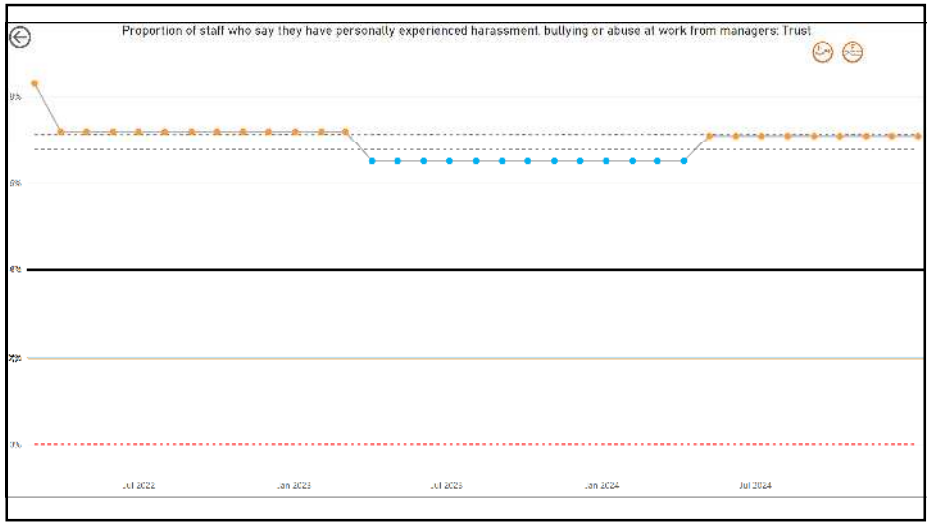

Net Staff in Post Change: Trust

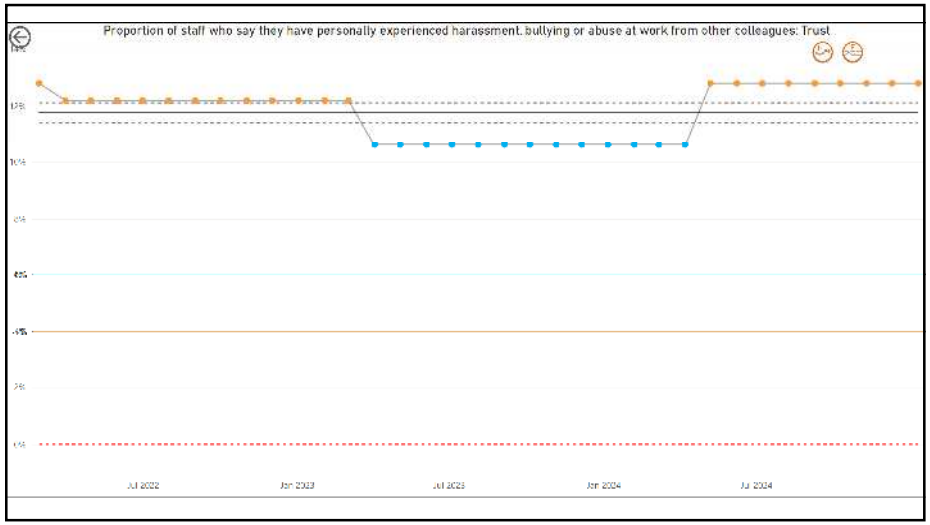

Proportion of staff in senior leadership roles who are from a) a BME background: Trust

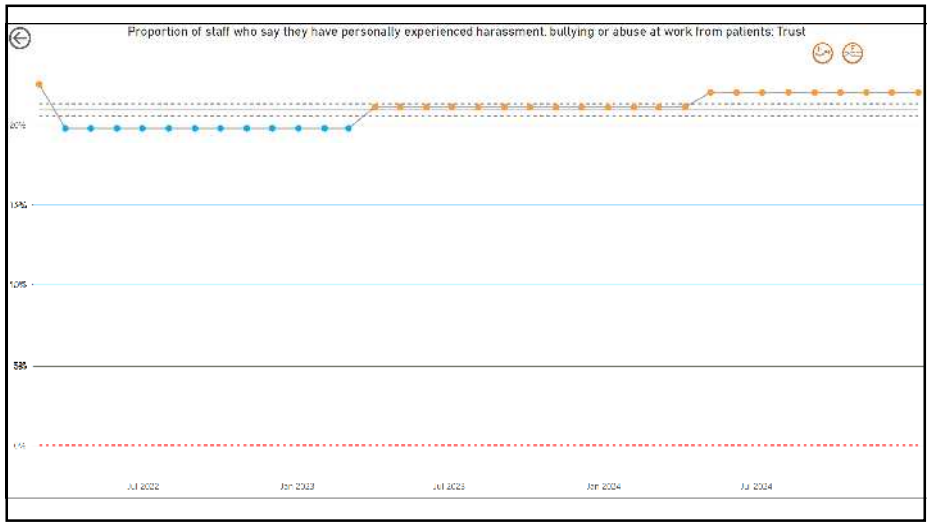

Proportion of staff in senior leadership roles who are from b) are women: Trust

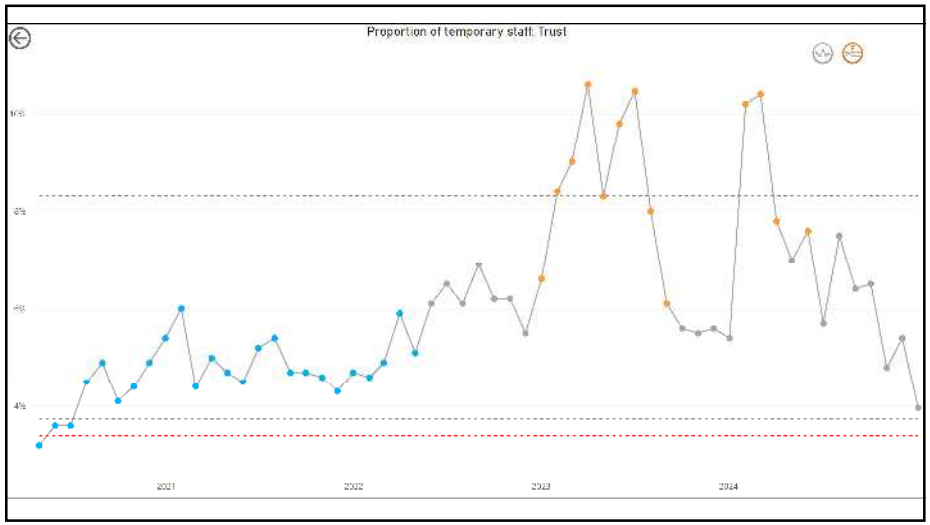

Proportion of staff in senior leadership roles who are from cl are disabled staff: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

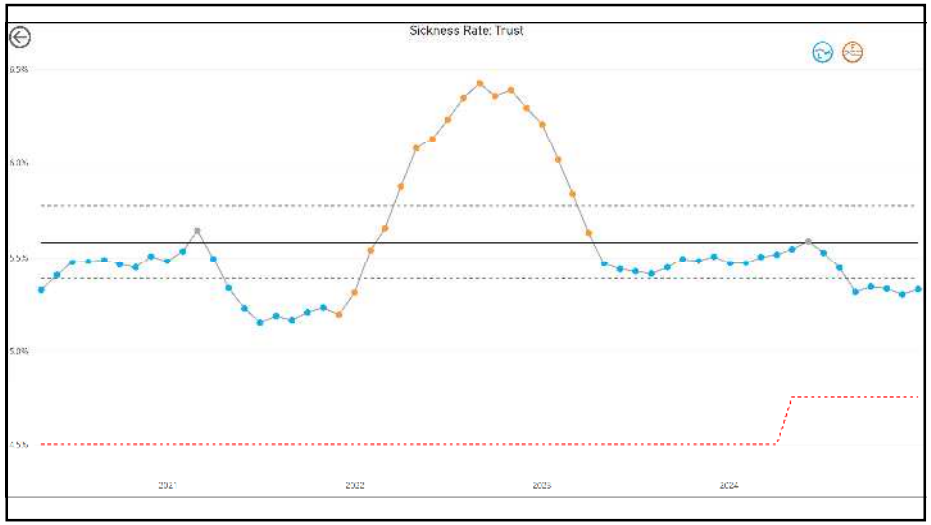

Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

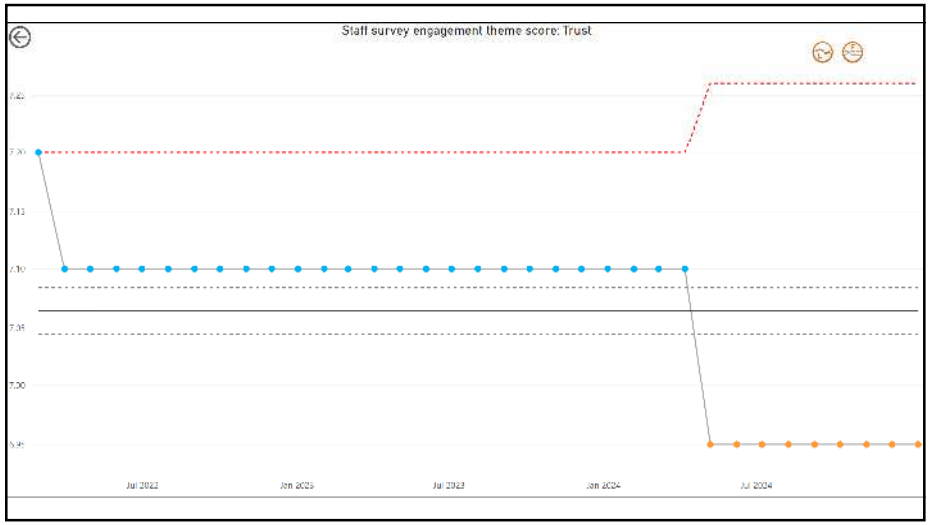

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

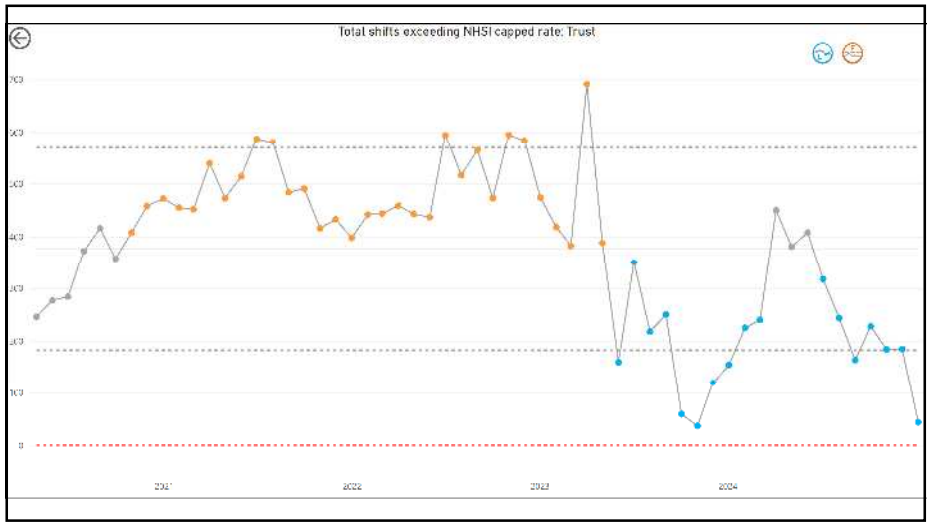

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024


Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024

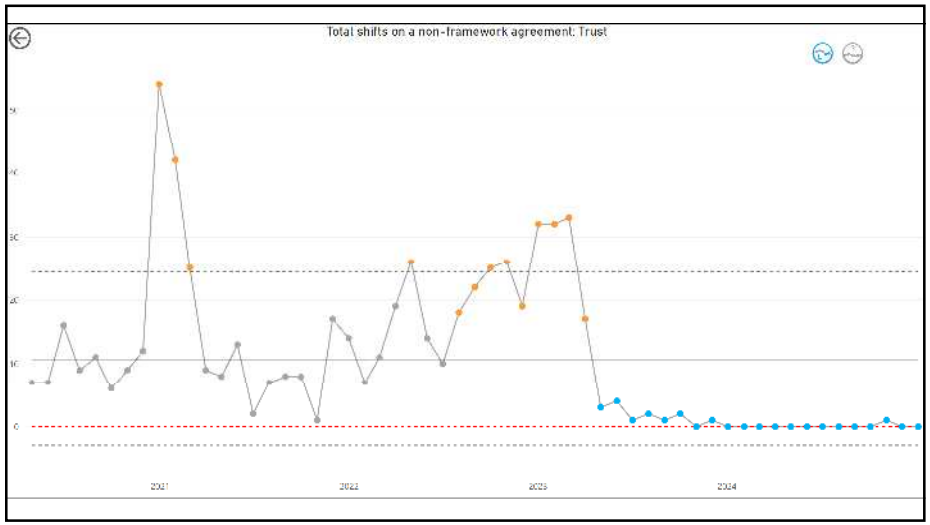

Proportion of temporary staff: Trust
2021
2022
2023
2024


Sickness Rate: Trust
2021
2022
2023
2024

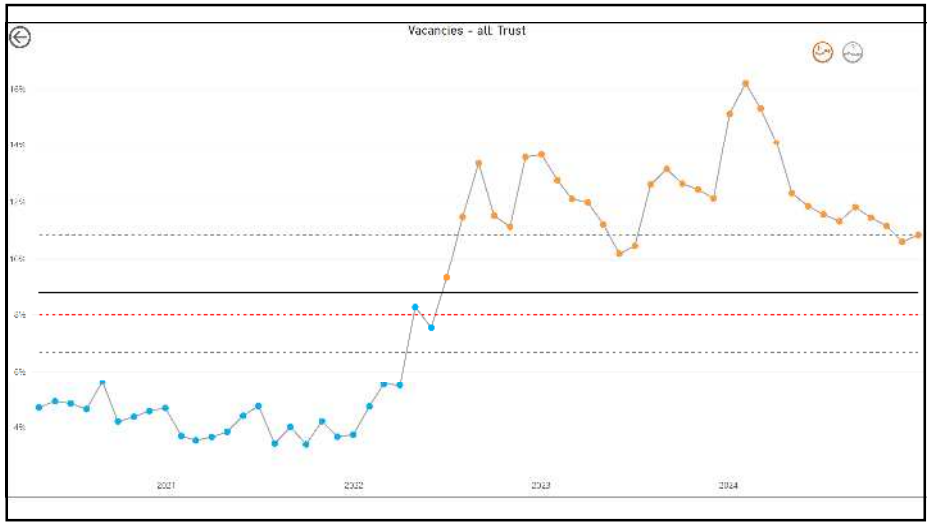

Staff survey engagement theme score: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024


Total shifts exceeding NHSI capped rate: Trust

21


Total shifts on a non-framework agreement: Trust

22


Vacancies - all: Trust

23

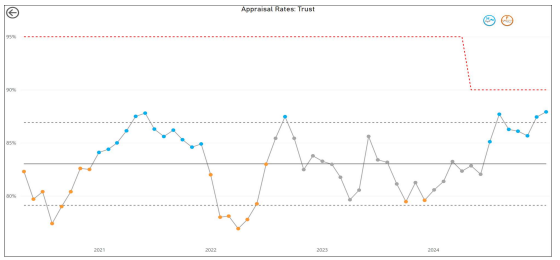
Exception Report - Action Plan

Appraisal Rates

Compliance of substantive staff having had an appraisal in the last 12 months

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Appraisals	%	87.70%	86.27%	86.10%	85.67%	87.44%	87.92%	85.68%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	88%	88%	89%	89%	90%	90%	91%



Reason for performance gap:	Corporate Updates - There has been a gradual improvement in the appraisal rate from the beginning of the year, with a slight reduction between August into October. There has been an increase in December. The December compliance is 2.08% below target with 6 out of 13 divisional teams below 90% completed. There is a level of corelation between departments with higher vacancies, higher levels of sickness and low appraisal completion rates. Support and intervention is required in these areas. The focus is on setting a plan for the services with the lowest completion rates and to set dates for completion by the end of January. A process for monitoring progress in place, with target support for managers and alerts and reminders to ensure completion. Operational Updates - Adult Community SDG - some appraisals have not been carried out due to long term absence within the management team. Bishops Castle and Ludlow, some appraisals have not been carried out due to gaps within the management team. Therapies have had a lack of consistent operational management support over the past 6 months. Urgent Care SDG - team leader sickness has led to low appraisal compliances in some teams. Cultural change regarding mindset for appraisal compliance - mentor and support from SLs. Planned - inconsistency in management support.			
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Adult Community SDG - Therapies, Ludlow and Management team will have targeted support from Divisional Manager to improve compliance	Jan-25	Ongoing	Not Started	To ensure teams with low compliance are supported to increase their compliance rates.
	Workforce & Digital Team to review appraisal recording for return for retire and return staff and when returnees from mat leave should be included in reporting.	Jan-25	Mar-25	Not Started	To ensure compliance reports are capturing the relevant staff.
	Adult Community SDG - Sally Stubbs to support RRU ward manager with appraisal compliance.	Dec-24	Ongoing	On Track	To support ward manager with completing outstanding appraisals.
	Urgent Care - EK to contact service managers each month regarding non-compliant staff and offer support if needed. Weekly UEC huddles also to be used for escalation.	Dec-24	Ongoing	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
	Planned Care and CYP&F - monthly escalation meetings process.	Dec-24	Ongoing	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
	Target Corporate areas with low compliance to ensure areas that have less clinical impact are running at 100% compliance which will support overall numbers.	Nov-24	Ongoing	On Track	Introduce Corporate discussions to ensure compliance (and recovery) against key workforce metrics.
	Stoke Health increased staffing to support greater capacity to complete appraisals.	Oct-24	Dec-24	On Track	Plans in place to recover appraisal position due to increased substantive staff position.
	People team to support areas of low compliance to develop recovery plans for their appraisal compliance.	Oct-24	Ongoing	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
	Review reports available for appraisal compliance to enable teams to monitor appraisal compliance.	Oct-24	Dec-24	Complete	Ensure Managers have the information easily available to support compliance.
	Monthly Professional Standards & Absence People team meetings with Clinical Services Manager & Divisional Service Managers to discuss appraisal and other workforce metrics to support compliance and look at interventions to improve appraisals, including service specific appraisal plans, identifying who conducts the appraisal and when it will be completed.	May-24	Ongoing	Complete	In place and ongoing. These meetings discuss hot spots and what support us required from a the People team to increase compliance.
	Provide regular appraisal training for staff and managers to support improved approach to appraisal process enhancing the experience for employees and setting clear expectations of the importance of the appraisal and completing when due.	Jan-24	Ongoing	Complete	In place and ongoing. These sessions are reviewed and if fully booked additional dates are added as required. Bespoke sessions are also arranged e.g. Dudley 0-19 service.

Author	Fiona MacPherson	**Date**	1/20/2025
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025

Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 75%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Community Therapies Central Service	14	10	71.43
825 Recovery and Rehabilitation Unit Service	11	6	54.55
825 Advanced Care Planning Service	15	11	73.33
825 Community Therapies South East Service	11	7	63.64
825 Bishops Castle Hospital Service	10	6	60.00
825 Stoke Heath YOI Service	19	11	57.89
825 Virtual Wards Service	35	23	65.71

SDGs and Divisions of 10+ staff	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	40	37	92.50
825 Finance Division	26	24	92.31
825 Governance Division	18	15	83.33
825 Medicines Management Division	21	19	90.48
825 Nursing and Quality Division	12	10	83.33
825 Operations Directorate Management Division	12	12	100.00
825 People and OD Division	25	22	88.00
825 Safeguarding Children Division	10	9	90.00
825 Service Delivery Group - Adult Community Services Division	606	535	88.28
825 Service Delivery Group - CYP&F Shropshire Services Division	335	311	92.84
825 Service Delivery Group - Planned Care Division	185	154	83.24
825 Service Delivery Group - Urgent Care Division	138	106	76.81
825 Trust Board Division	11	11	100.00

Exception Report - Action Plan

Leaver rate

Percentage of staff who have left the Trust during a 12-month period

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Leaver rate	%	11.59%	11.48%	10.89%	10.95%	11.11%	10.76%	10.76%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	11.4%	11.5%	11.3%	11.0%	10.7%	10.5%	10.3%

Reason for performance gap:	Corporate Updates - The Leaver rate has seen a gradual improvement since April but still above target by 1.16%. The main drivers of the turnover is retirement which based on the age profile is likely to remain over coming years. Initiatives to support more flexible retirement may support people to work longer before full retirement and encourage more retire and return. The second highest reason for leaving is related to work life balance. Health and wellbeing support and initiatives to support more flexibility in how people work are underway to support retention. One of the teams with the highest leaver rate (Community Equipment Delivery Team) TUPE'd to an alternative provider on 1 April 2024.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review the leavers information in relation to incompatible working relationships to establish next steps.	Nov-24	Jan-25	Not Started	To evaluate any further support required for teams.
	Review and monitor leavers with less than 12 months service.	Nov-24	On-going	Not started	Ensure new starters are receiving appropriate onboarding processes, 30, 60, 90 day conversations.
	Review staff survey information for areas with high leaver rate to establish any patterns.	Nov-24	Jan-25	Not started	Establish if there are any areas of correlation with staff survey in the areas of higher leaver rate.
	Review the leavers information in relation to work life balance to establish next steps alongside flexible working requests recorded on ESR.	Oct-24	Jan-25	In progress	To evaluate the reasons for work life balance as a reason for leaving and develop further support as required.
	Roll out Stay Conversation and 30, 60, 90 day conversations workshops in particular targeting areas with high leaver rates	Sep-24	On-going	In progress	Workshops for stay and 30, 60,90 day conversations have been developed to include supporting compassionate conversations. These were advertised in October 2024.
	Refresh and update our Leavers Policy to include various methods for completing exit questionnaires which includers, paper copy, MS Forms, ESR & electronic version	Jul-24	Nov-24	Complete	The updated Policy is currently going through the policy approval process with the aim to be completed in November 2024.
	Appointment of People Promise Manager.	Jul-24	Jul-25	Complete	The People Promise Manager is working on different projects aligned to our staff survey results. In particular they are working on a change programme and awards week.
	Raise awareness of Pension awareness sessions which cover flexible retirement options.	Jul-24	On going	Complete	Ensure staff are fully informed about their options in relation to flexible retirement including retire and return.
	Monthly Professional Standards and Absence team meetings with Clinical Services Manager & Divisional Service Managers to discuss leavers and other workforce metrics compliance to provide support where possible.	May-24	On-going	Complete	Hot spot area are discussed along with required support.
	Develop and launch a flexible working campaign to raise awareness around work life balance	Apr-24	Jul-24	Complete	Ongoing campaign in place with updated flexible working policy.
	Undertake a HWB Survey including questions around work life balance	Jan-25	Mar-25	In progress	To gather information to understand what staff would like to see in terms of HWB and achieving a work life balance
	Develop and launch flexible working survey along with recording flexible working on ESR and flexible working workshops	Apr-24	Jul-24	Complete	Flexible working survey has been published and currently analysing the results to inform next steps.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Leaving Reason	Leavers
Retirement Age	55
Voluntary Resignation - Work Life Balance	31
Employee Transfer	21
Voluntary Resignation - Relocation	16
Voluntary Resignation - Health	12
Voluntary Resignation - Promotion	12
End of Fixed Term Contract	10
Voluntary Resignation - Incompatible Working Relationships	8
Voluntary Resignation - To undertake further education or training	6
Voluntary Resignation - Lack of Opportunities	5

Org L6	Leavers
825 Community Equipment Delivery Service	21
825 Health Visiting Dudley Service	10
825 North Shropshire Community Nursing Service	10
825 MSK Shropshire & Telford (MSST) Service	9
825 Ludlow Hospital Inpatient Service	7
825 Recovery and Rehabilitation Unit Service	7
825 Shropshire Physiotherapy Service	6
825 South East Shropshire Community Nursing Service	6
825 Health Visiting Shropshire Service	5
825 Shrewsbury Community Nursing Service	5
825 Specialist Nursing Diabetes Adults Service	5

Staff Group	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Add Prof Scientific and Technic	2	1.20	4.35%	3.14%
Additional Clinical Services	35	27.17	9.32%	8.89%
Administrative and Clerical	63	53.49	15.54%	15.56%
Allied Health Professionals	24	18.08	10.84%	10.10%
Estates and Ancillary	7	6.60	8.86%	13.21%
Medical and Dental	2	0.83	6.25%	3.86%
Nursing and Midwifery Registered	71	56.43	10.49%	10.07%
Students	0	0.00	0.00%	0.00%

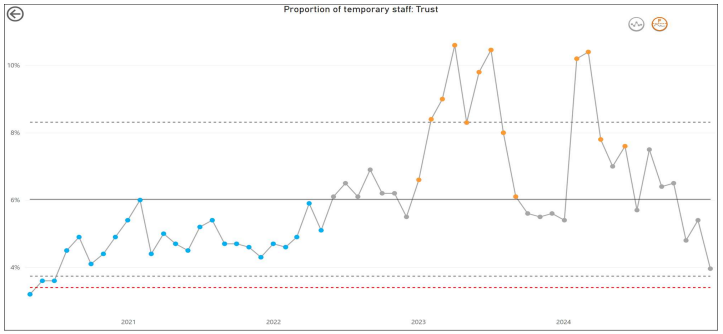
Exception Report - Action Plan

Proportion of temporary staff

Cost of agency and locum as a proportion of total staffing costs for the month expressed as a percentage

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Prop Temporary staff	%	7.5%	6.4%	6.5%	4.8%	5.4%	4.0%	6.1%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	4.0%	4.0%	4.0%	4.0%	4.0%	1.0%	1.0%



Reason for performance gap:	Corporate Updates - Community Nursing is currently using agency above plan due to high levels of unavailability: staff absences (maternity, long term sickness and recruitment to vacancies). Additionally in Telford there is an increase in patient timed medications which has resulted in a higher use of agency. This is under review with the operational teams. Escalation beds have been opened and spend on agency may remain high in the CHs and RRUs, dependent on these winter pressures. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. NHSE have launched a new programme aiming to improve price cap compliance for agencies across the Midlands which will support improvement in price by setting target dates for reduction over the coming months. The Trust has price cap compliance in place for nursing with the aim for specialist nursing areas to be compliant by the end of March 25.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Operational agency scrutiny meetings take place fortnightly.	Unknown	Unknown	On-going	Challenge on timescales for the use of agency in ops teams and their strategies to manage.
	Check and Challenge meetings commenced October 24 - run by clinical lead (Assos. Director of Workforce and Professional standards) to ensure efficient and effective use of e-roster to show transparency in shift management by roster creators and maintainers.	Oct-24	Unknown	On-going	Monthly meetings identify any issues and the processes required to rectify to reduce agency.
	Implement price reductions for agency in line with NHSE price cap compliance programme.	Oct-24	Mar-25	In progress	Reduced price of agency shifts and consistency across system and region.
	New temporary staffing policy in draft for consultation process including flowcharts on bank and agency approval process for clarity.	Oct-24	Nov-24	Complete	Policy published on staff zone.
	Community nursing - some recruitment outstanding due to the issue of PINs by the NMC. Anticipated issue is end of October however this is subject to the NMC. The recruitment team remain in contact with these individuals. There are currently only 3 Nursing Associate PINs now outstanding.	Sep-24	Oct-24	Complete	NQ's received PINS and commenced employment.
	Paediatrics - recruitment complete Speciality Doctor start date 31/10/24.	Feb-24	Nov-24	Complete	Reduction in locum use from November 2024.
	R & R Ward 36 local Consultant - plans for this cover are not yet finalised by the operational team: an alternative model is being scoped via an SLA due to be finalised by November.	Unknown	Nov-24	Complete	Locum cover ceased. Arrangements in place via a contract.
Author	Gina Billington	**Date**	17.01.2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

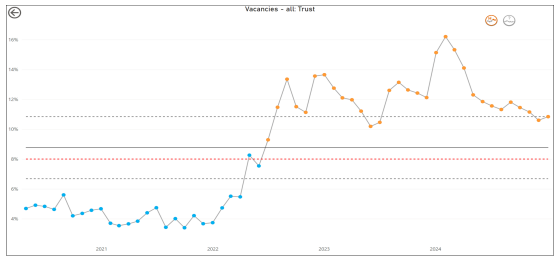
Exception Report - Action Plan

Vacancies - all

Percentage of vacancies (budgeted WTE minus contracted WTE) over budgeted WTE.

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Vacancies	%	11.32%	11.81%	11.45%	11.15%	10.59%	10.84%	11.43%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	10.0%	9.5%%	9.0%	9.0%	8.5%	8.0%	8.0%



Reason for performance gap:

Corporate Updates - The recruitment team continue to experience staff shortages due to resignation, sickness absence and annual leave and a hold on the vacancy. 3 months support from SaTH recruitment admin team has ended and the individual returned to SaTH team. Focus on the areas with vacancies that are creating demand for temporary staffing which will be across in patient areas.

Operational Updates - Adult Community SDG - RRU Shrewsbury have some posts held whilst not operating at 32 beds - no current plans to open the remaining beds due to no additional space. North Shrewbury Community Nursing team have high vacancies due to a number of staff returned from maternity leave on reduced hours (flexible working).

Action Plan

	Start Date	End Date	Status	Outcome
Review provision of collaborative support to team.	Jan-25	Jan-25	Complete	SaTH unable to continue support at this time.
Meet with finance, check financial reports and align with what budget should be, and review workforce plan. Take vacancies to VRF. Some vacancies have been filled.	Dec-24	Jan-25	In progress	
Recruitment policy in draft to commence the consultation stage. Includes new flowcharts and toolkit for managers.	Oct-24	Nov-24	In progress	To ensure managers are up to date with recruitment processes and provides the tools for them to recruit.
Recruitment managers training - collaborative delivery with SaTH.	Sep-24	On-going	Complete	Recruiting managers trained and aware of the processes involved in recruitment to aid in the appropriate recruitment processes and time lines. To reduce the number of queries received by the recruitment team. **17 January 2025:** SaTH not able to continue with collaboration due to internal decision - sessions will take place with SCHT team only
Drop-in sessions taking place with the ESR team for managers to attend covering ESR queries, recruitment and Trac queries. Annual plan in progress.	Sep-24	On-going	On-going	To support managers in the processes involved in addressing vacancies.
Increase the number of pre-employment check slots available for successful applicants to book within a 2 week window. Write to all successful applicants reminding them to book in and the documents they need to bring.	Jul-24	Sep-24	Complete	Pre-employment checks: November- slots available- 42 / slots booked - 31 December- slots available- 38 / slots booked - 26 January- slots available- 39 / slots booked- 29 (to date)
Recruitment continue to review their processes to ensure timely recruitment.	Apr-24	On-going	On-going	Time to hire December 24 is 43.2 working days. There are currently 29 applicants with start dates in January
RRU consultant vacancy - operational plan in place to ensure medical cover is in place.	Unknown	Nov-02	Complete	Contracted solution in place 1/12/24
Community nursing - some recruitment outstanding due to the issue of PINs by the NMC. Anticipated issue is end of October however this is subject to the NMC. The recruitment team remain in contact with these individuals.	Sep-24	Oct-24	Complete	NQ's receive PINS and commence employment.
Gain approval to recruit to resignation of the team. Collaborative support to cover the vacancy sought from SaTH.	Jul-24	Sep-24	Complete	Approval gained from VRF panel. Support from SaTH commenced 30/9/24 to be reviewed in January 25.

Author	Gina Billington	**Date**	1/17/2025
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025

Division	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer	33.32	1.93	5.8
Urgent Care (Adults)	191.31	36.44	19.0
Community Services (Adults)	741.86	76.28	10.3
Planned Care SDG	214.64	29.73	13.9
Children and Families Division	453.79	30.51	6.7
Chief Executive	12.64	2.00	15.8
Director of Finance and IM&T	84.57	12.39	14.7
Director of Governance	22.5	2.72	12.1
Director of People	33.86	2.96	8.7
Director of Nursing and AHPs	33.71	3.80	11.3
Medical Directorate	3.18	(0.90)	(28.3)
Total	**1825.38**	**197.86**	**10.8**

Inpatient Wards	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward	21.63	3.04	14.1
Ludlow Hospital Ward	35.72	6.31	17.7
Whitchurch Hospital Ward	41.13	3.90	9.5
Bridgnorth Hospital Ward	41.35	4.06	9.8
Rehab & Recovery Unit - Shrewsbury (Ward 18, RSH)	53.84	15.72	29.2
Rehab & Recovery Unit - Telford (Ward 36, PRH)	45.52	8.19	18.0
Total	**239.19**	**41.22**	**17.2**

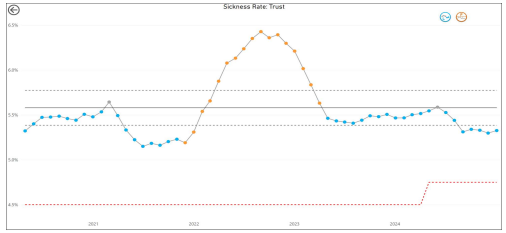
Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Sickness Rate	%	5.44%	5.31%	5.34%	5.33%	5.30%	5.33%	5.33%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	5.3%	5.3%	5.2%	5.1%	5.0%	4.9%	4.9%



Reason for performance gap: Corporate Updates - Overall sickness has reduced since April with a slight increase in December. The rate continues to remain above target. The main drivers are stress, anxiety and depression conditions. Support around health and wellbeing, resilience and flexibility are critical to support reduction in absence levels and are being implemented by the People Team. Seasonal conditions such as cold and flu are also a significant reason for sickness, our continued vaccination campaign will provide a level of mitigation.

Action Plan

	Start Date	End Date	Status	Outcome
Adult Community SDG - analysis of gender/age/sickness reason	Jan-25	On-going	In progress	To better understand the detail behind absences and what bespoke support needs to be put in place
ESR Workforce Team to send comms out about not using 'S98 - other known causes - not elsewhere classified' unless there isn't a relevant absence reason to select.	Jan-25	Jan-25	Complete	Digital Team will review in 6 months time to ensure absences
Admin Academy - aligning to people promise themes.	Jan-25	Ongoing	In progress	To support admin staff - health and wellbeing workstream to include mentoring, mutual aid, protected time, admin network and learning passport
Conduct HWB survey to support the ongoing implementation of the HWB action plan.	Jan-25	Jan-25	In progress	This survey will gather views/ideas/feedback on the HWB offer and what staff would like to see.
Targeted support for areas with high MSK absence.	Nov-24	Jan-25	In progress	MSK is the second highest reason for absence and we are looking at preventative actions as well as curative.
Develop online Physio drop in sessions for staff to discuss any MSK issues	Feb-25	May-25	In progress	To provide staff with the opportunity to discuss any issues as a preventative measure to absence
Work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, MSK support.	Oct-24	On-going	In progress	To ensure appropriate support is in place.
Cross check all stress, anxiety & depression absences to ensure appropriate referrals have been completed. If not educate relevant Line Managers.	Sep-24	On-going	In progress	Ensure appropriate referrals are being undertaken. Areas where these are not being completed the People team will support with education.
Roll out Wellbeing Conversations training.	Jul-24	On-going	In progress	To provide managers and staff with a framework to have wellbeing conversations. These sessions are scheduled until December 2024 with further dates to follow for 2025.
Roll out HWB days to include flu vaccination and other services.	Oct-24	Dec-24	Complete	The HWB days include flu vaccinations, health checks, physio and signposting to key HWB support.
Launch personal resilience sessions for staff and managers.	Sep-24	Dec-24	Complete	To provide staff and managers with the tools to ensure they look after their staff and own wellbeing.
Implement HWB working group with attendees committing to being HWB Champions.	Sep-24	On-going	Complete	The HWB working group members act as champions and gather views of their teams, colleagues to feed into the work around HWB.
Refresh and update Stress and Staff Support Policy.	Jul-24	Oct-24	Complete	Ensure the policy is fit for purpose and provides managers with the tools and guidance to support staff.
Develop workshops to support managers to complete the stress risk assessment.	Jul-24	On-going	In place	To provide managers with the support to undertake risk assessments appropriately.
Monthly People team meetings with Clinical Services Manager & Divisional Service Managers to discuss appraisal compliance and support where possible.	May-24	Ongoing	In place	Hot spot areas, timely referrals are discussed and explored as required .

Author	Fiona MacPherson	**Date**	1/20/2025
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025

Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	262	335	11,285.98	37.2
S13 Cold, Cough, Flu - Influenza	665	843	3,190.44	10.5
S12 Other musculoskeletal problems	119	132	2,378.04	7.8
S25 Gastrointestinal problems	469	599	2,101.74	6.9
S28 Injury, fracture	59	60	1,513.55	5.0
S98 Other known causes - not elsewhere classified	80	88	1,320.65	4.4
S15 Chest & respiratory problems	165	185	1,224.95	4.0
S26 Genitourinary & gynaecological disorders	88	102	1,097.57	3.6
S17 Benign and malignant tumours, cancers	18	27	1,055.80	3.5
S11 Back Problems	80	86	955.19	3.1

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Wound Healing Service	773.20	4,327.00	17.87%
825 Single Point of Referral Service	440.49	2,590.77	17.00%
825 Community Therapies Central Service	857.49	5,898.06	14.54%
825 Dudley CYP&F Management Services	107.00	810.47	13.20%
825 Community Respiratory Service	844.67	6,559.64	12.88%
825 Research and Development Service	127.00	994.00	12.78%
825 Bishops Castle Hospital Service	630.16	5,213.44	12.09%
825 Falls Service	263.28	2,274.07	11.58%
825 Special School Nursing Service	151.45	1,351.66	11.20%
825 North Shropshire Community Nursing Service	2,071.31	20,301.94	10.20%

Org L7	Absence FTE	Available FTE	Absence FTE %
825 CYP Nurse Management Team	107.00	275.00	38.91%
825 MSK Rheumatology Team	189.40	507.00	37.36%
825 Dental Advice Line Team	12.00	49.60	24.19%
825 Compass Health Team	50.40	273.80	18.41%
825 Telford Wound Healing Service Clinical Team	727.20	3,961.00	18.36%
825 Single Point of Referral Team	440.49	2,590.77	17.00%
825 Shropshire Community Respiratory Clinical Team	779.53	5,354.28	14.56%
825 Adult Community Therapy Central Team	857.49	5,898.06	14.54%
825 Community Children's Nursing Admin Team	113.91	824.24	13.82%
825 Community Nursing Team - North East	1,254.13	9,212.64	13.61%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Add Prof Scientific and Technic	390.08	14,270.18	2.73%
Additional Clinical Services	8,117.52	118,626.87	6.84%
Administrative and Clerical	5,147.60	125,687.68	4.10%
Allied Health Professionals	2,280.09	65,783.72	3.47%
Estates and Ancillary	808.83	17,719.01	4.56%
Medical and Dental	483.75	7,800.47	6.20%
Nursing and Midwifery Registered	13,084.38	215,893.06	6.06%
Students	28.00	3,731.00	0.75%

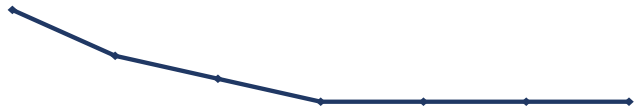
Exception Report - Action Plan

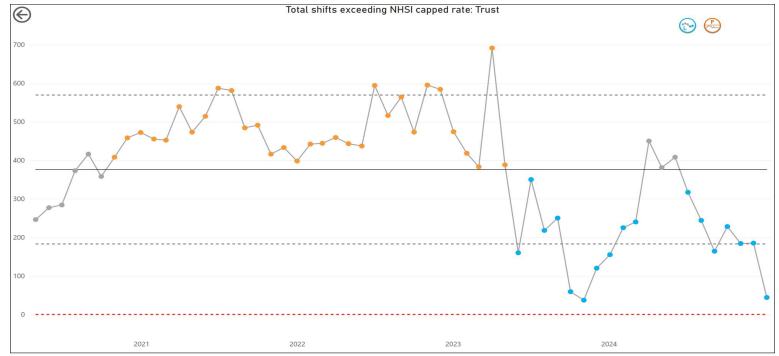
Total shifts exceeding NHSI capped rate

The number of shifts filled by on framework agencies that exceeded the price cap (cap is per shift)

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Shifts	Number	244	164	228	184	185	44	239
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	40	20	10	0	0	0	0





Reason for performance gap:	Corporate Updates - Demand for agency workers and market rates is contributing to high price of agency shifts above price cap. The NHSE price cap programme and the work already undertaken across our system will improve price cap compliance through a targeted strategy working collaboratively to set rate reductions over the coming months. We are aiming to get to a position of 100% price cap compliance by 31 March 25.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Phase 2 of price cap compliance negotiations: system and regional groups established and agreed letters sent to agencies regarding price cap compliance. Letters sent Oct 24 price cap compliance for general nursing agency from December 1. Phased plan in progress for Specialist Nursing, AHPs and Medical.	Oct-24	Dec-24	On-going	Reduction in price cap provision by agency. January 5: currently standing at 98% of shifts compliant with price cap. Non-compliant shifts are Specialist Nursing, AHP and Medical.
	Agency scrutiny meetings held weekly with Ops and temp staffing and recruitment.	Oct-24	Dec-24	On-going	Challenge on timescales for the use of agency in ops teams and their strategies to manage. Frequency of meetings have now been reduced to fortnightly.
	Check and Challenge meetings commenced October 24 - run by clinical lead (Assos. Director of Workforce and Professional standards) to ensure efficient and effective use of e-roster to show transparency in shift management by roster creators and maintainers.	Oct-24	Unknown	On-going	Monthly meetings identify any issues and the processes required to rectify to reduce agency.
	Determine phased approach and reductions in rate and work collaboratively on the development of a rate reduction schedule to bring down rates gradually over coming months.	Jul-24	Mar-25	Complete	Approach agreed.
	New temporary staffing policy in draft for consultation process including flowcharts on bank and agency approval process for clarity.	Oct-24	Nov-24	Complete	Policy published on staff zone.

Author	Gina Billington	**Date**	1/17/2025
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025

Local Action Plans

Exception Report - Action Plan

Mandatory Training Compliance

Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only (with the exception of Information Governance which includes bank staff)

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Mandatory Training	%	93.14%	93.28%	92.92%	93.89%	94.43%	94.83%	94.83%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	94.83%	93.00%	93.20%	93.40%	93.60%	94.00%	94.30%

Reason for performance gap:

Corporate Updates - All topics with the exception of 2 have increased in their overall compliance.

The 2 topics to have a drop in compliance in December are Fire Safety and Information Governance and Data Security. There was an issue with these 2 national eLearning packages over the Christmas period. The issues were resolved very quickly following the Bank Holiday and completions have since recording correctly. This was a national issue where staff could not play the eLearning packages.

As of January 2025, Resuscitation Level 3 Adults and Paediatric Immediate Life Support (ILS) will be included in the monthly compliance reports. The training requirements were only added in September 2024 and there has been a steady increase in compliance (Sept 24 46.3%, Nov 62.6%, Dec 69.8%) but will reduce the overall compliance figure when fully integrated into the monthly compliance reports.

Operational Updates - Planned care - Stoke Heath don't have access to computers other than in the manager's office.

Action Plan

	Start Date	End Date	Status	Outcome
Adult Community SDG - potential to over roster so that MT can be completed at a dedicated time (ST)	Jan-25	Mar-24	Not Started	To ensure teams with low compliance are supported to increase their compliance rates.
CFYP - to review what IT is allowed in the office at Stoke Heath and potential to over roster so that MT can be completed at a dedicated time (HC)	Jan-24	Mar-24	Not Started	To ensure teams with low compliance are supported to increase their compliance rates.
Admin Academy - aligning to people promise themes.	Jan-25	Ongoing	Not Started	To support admin staff - health and wellbeing workstream to include mentoring, mutual aid, protected time, admin network and learning passport.
Stoke Health increased staffing to support greater capacity to complete mandatory training.	Oct-24	Dec-24	In Progress	Nov 2024 - Stoke Health are still promoting the completion of mandatory training. This is also being monitored within Children & Families and Planned Care Performance Divisional Meeting. Oct 2024 - Plans in place to recover mandatory training position due to increased substantive staff position.
High Risk Fire.	Jul-24	Feb-25	In Progress	Dec 2024 - RWT do not have the capacity to support. Estates & Facilities (EFM) Compliance Manager has been through Interview and the job has been offered to a successful applicant. E&F Manager has also agreed to review positions and advise which positions would require the training. Nov 2024 – Still waiting for RWT to come back following the meeting. There is a vacancy for Estates & Facilities (EFM) Compliance Manager, the Fire Safety Manager is part of this role. Oct 2024 - SCHT have arranged a meeting with RWT in November to discuss RWT providing a fire service for SCHT. Sept 2024 -SCHT should not have a fire safety manager, RWT provide a fire service for SaTH. SCHT's estate's manager is contacting MPFT to enquire about their fire service (as they are similar org). High risk fire (HRF) completions are recorded on ESR. If the HRF objectives meet the CSTF objectives, staff who are required to complete the HRF training will not need to complete the standard fire safety training. There are also discussions over fire warden training and who should complete this, who would provide the training and how it is recorded in ESR.
Safeguarding Training - Position Review.	Jul-24	Jan-25	In Progress	Dec 2024 – Updates have taken place and final review to be sent back to the Safeguarding Team. Nov 2024 - Safeguarding Children – 1st Review has taken place. Been sent back to the Safeguarding Team for confirmation of updates. Sept 2024 - The mapping review has commenced and is currently with the Safeguarding Team to review.
An Inter Authority Transfer (IAT) working group has been set up to investigate the process for core skill training framework (CSTF) training to be transferred to the learning record for new starters who have completed this training in their previous NHS organisation.	Jul-24	Dec-24	In Progress	Dec 2024 – Confirmation from ESR that the consent does not transfer from Trac to ESR after initial interface. ESR working with Trac with regards to updating interfaces. Nov 2024 – We have now established a link with SaTH, to ensure anyone completing training at SaTH will have their training transferred to SCHT, as SaTH does not use ESR. The IAT working group continues to meet to and new processes have been put in place until we receive confirmation from TRAC on how the IAT flag is undated. Sept 2024 - To ensure where staff are moving from one NHS organisation to SCHT their CSTF training is transferred so they only need to complete any new or expired topics and removes the need to duplicate training.
To implement a process to remind core ESR learner users to update training attendance status in ESR.	Sep-24	On-going	Complete	The ESRLM Team now send weekly emails to teams responsible for updating training statuses in ESR for attendance at face to face training, this reminder is to ensure attendance is captured in the monthly compliance reports.
Appraisal and Mandatory Training Compliance Targets Briefing paper update.	Jun-24	Dec-24	In Progress Task 1 Complete Task 2 Complete Task 3 Complete Task 4 Complete Task 5 Complete	Oct 2024 - Task 3 complete • The ESR course catalogue and classes have been audited and updated following national best practice. The introduction of the ESR Learning Admin Working Group ensures all ESRLM admin users are given best practice guides and any new updates on ESR. All new staff who have ESRLM access are given training to ensure best practice is followed. Sept 2024 - Task 1 Training Completions • All existing training completions have been received and recorded in ESR. Task 2 ESR Access • Core user ESR access has been audited and updated where required and training has been given to the relevant staff who manage training in ESR. Task 3 Existing ESR Course Catalogue • The ESR course catalogue has been audited and updated following national best practice. Task 4 Competency Requirements • Best practice is being followed by using national competencies, this allows us to accurately record training completions and supports the Enabling Staff Movement Strategy by reducing the duplication of mandatory training when staff move between roles in the NHS. Task 5 Review of Statutory and Mandatory Training Needs Analysis • A formal review of the statutory and mandatory training needs analysis (TNA) is currently being conducted, the TNA process will be used to determine the range of risk related training required and the groups of staff that are required to undertake the training. In conducting the TNA, the Trust will consider: •Statutory training requirements •Mandatory training government requirements •Mandatory role essential training that the Trust has identified in respect of its service delivery and risks.
Resuscitation Training Level 3.	Jun-24	Sep-24	Complete	The resuscitation training requirements have been reviewed, with the introduction of Level 3 for certain areas, positions will be updated with these changes.
Manual Handling for People Handlers training.	Jun-24	Sep-24	Complete	Clinical Education have identified the ESR positions that are required to complete the training. With support from IBM, these positions will be updated in ESR over the next 2 months, so staff will have the correct training requirements.
Monthly Professional Standards & Absence People team meetings with Clinical Services Manager & Divisional Service Managers to discuss mandatory training and other workforce metrics to support compliance.	May-24	On-going	Complete	In place and ongoing. These meetings discuss hot spots and what support us required from a the People team to increase compliance.
All positions have current training requirements attached.	Mar-24	Sep-24	Complete	These updates will impact the overall Trust's compliance figures, this is due to more staff being reported on via the compliance reports that were not previously included, therefore reducing compliance figures. Comms have been sent out to inform managers and staff. The ESRLM Lead will also be linking in with departments to ensure ESR is maintained correctly, and training is being awarded in the correct manner.
Review completions in ESR.	Mar-24	Jun-24	Complete	Confirms have been updated to attended or did not attend. If updated to attended this will have made a positive impact on compliance. If did not attend, this will not have made any impact on compliance.
Backlog of training completions to be updated in ESR.	Mar-24	Mar-24	Complete	The backlog of training completions for Local Fire training and Basic Life Support has been completed, this has made a positive impact on training compliance.
400+ Oliver McGowan (OM) training completions errors have been identified.	Mar-24	Mar-24	Complete	All OM training completions have been corrected, this has made a positive impact on training compliance.
New ESR Learning Management (ESRLM) Lead appointed.	Dec-23	Mar-24	Complete	ESRLM started 18 March and will be working with HR, Divisional managers and the Subject Matter Experts to ensure ESR is set up correctly and maintained to ensure accurate compliance data.

Author	Jen Deakin	**Date**	1/20/2025
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025

All non-compliant sectors

Sector	Substantive staff count	% Compliance
825 Stoke Heath YOI Sector	25	82.66%
825 Governance Sector	20	88.85%
825 Operations Directorate Management Sector	13	90.45%
825 Medical Sector	3	90.91%
825 South West Sector	134	91.10%
825 Central Sector	104	91.68%
825 Strategy Sector	4	92.31%
825 Trust Board Sector	11	93.04%
825 North West Sector	195	93.39%
825 Service Delivery Group - CYP&F Management Sector	5	93.88%
825 Urgent and Emergency Care Sector	125	93.98%
825 Childrens Psychology Sector	9	94.34%
825 Finance Sector	26	94.67%
825 Shropshire PHNS 0-19 Sector	104	94.69%
825 South East Sector	136	94.75%
825 Telford Sector	45	94.90%
825 Clinical Services - CYP&F Sector	20	94.93%

TOPIC	October Compliance		November Compliance	Variance against compliance
Mandatory Topics (All Staff)				
Corporate Induction	83.6%	▲	95.8%	1.26%
Equality, Diversity and Human Rights	97.8%	▲	98.2%	0.44%
Fire Safety	93.2%	▲	93.9%	0.66%
Fire Safety - High Risk	82.2%	▼	81.9%	-0.28%
Fraud Awareness	95.5%	▲	96.1%	0.60%
Health, Safety and Welfare	97.6%	▲	98.0%	0.44%
Infection Prevention and Control	97.6%	▲	98.3%	0.70%
Infection Prevention and Control - Level 2	96.1%	▲	97.1%	1.02%
Information Governance and Data Security	92.0%	▲	93.1%	1.07%
Moving and Handling - Level 1	97.0%	▲	97.1%	0.12%
NHS Conflict Resolution	97.1%	▲	97.7%	0.61%
Patient Safety - Level 1	97.5%	▲	98.4%	0.87%
Preventing Radicalisation - Prevent Awareness	97.7%	▲	97.8%	0.06%
Resuscitation - Level 2 - Adult Basic Life Support	74.1%	▼	73.0%	-0.12%
Resuscitation - Level 2 - Paediatric Basic Life Support	74.9%	▼	73.2%	-0.72%
Safeguarding Adults - Level 1	96.8%	▲	97.2%	0.88%
Safeguarding Adults - Level 2	94.4%	▲	96.0%	1.65%
Safeguarding Children - Level 1	93.7%	▲	94.5%	0.78%
Safeguarding Children - Level 2	90.1%	▲	92.1%	1.94%
The Oliver McGowan	94.0%	▲	95.4%	1.37%

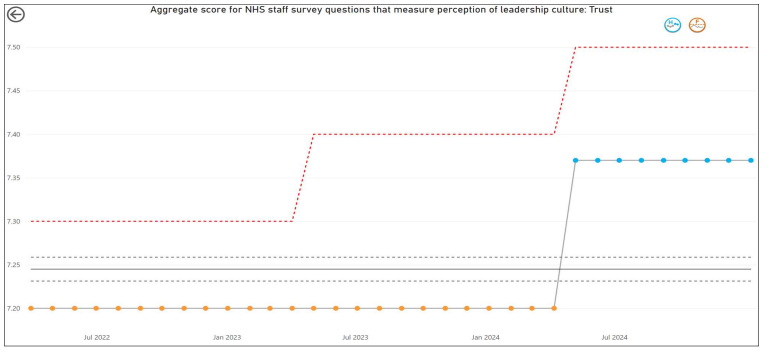
Yearly Reported KPIs

Exception Report - Action Plan

Aggregate score for NHS staff survey questions that measure perception of leadership culture

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Aggregate score for NHS staff survey questions	Number	7.4	7.4	7.4	7.4	7.4	7.4	7.4
	Target	7.5	7.5	7.5	7.5	7.5	7.5	7.5

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	7.4	7.4	7.4	7.4	7.4	7.4	7.4



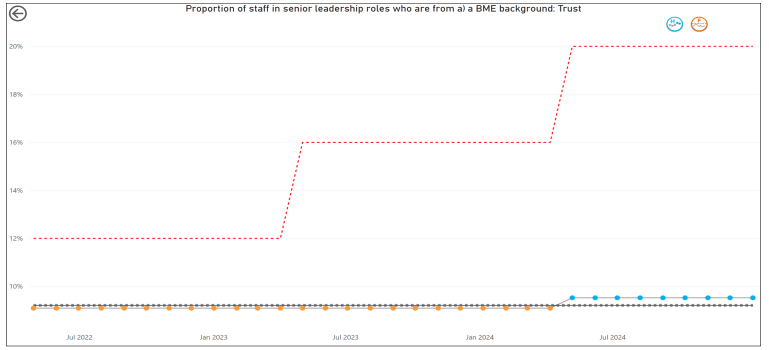
Reason for performance gap:	The national average is 7.5 and we are close to this with a score of 7.4. There have been changes over the last 24 months which have included change management across leadership roles which will take time to embed and change culture. The culture change team has been launched and will support changing this score over time.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Undertake Cultural Maturity Audit.	Oct-24	Jan-25	In progress	To understand further the culture of the Trust.
	Implement Culture Change Team.	Oct-24	Ongoing	In place	Make a difference: drive meaningful change across ShropCom to enhance employee experience, review our culture and leadership behaviours, bring 'The People Promise' alive, and improve the care we provide to our patients and communities.
	Commence discovery phase of the culture and leadership change programme.	Nov-24	Ongoing	In progress	Make a difference: drive meaningful change across ShropCom to enhance employee experience, review our culture and leadership behaviours, bring 'The People Promise' alive, and improve the care we provide to our patients and communities.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Exception Report - Action Plan

Proportion of staff in senior leadership roles who are from a BME background

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of staff in senior leadership roles	Number	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52
	Target	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%



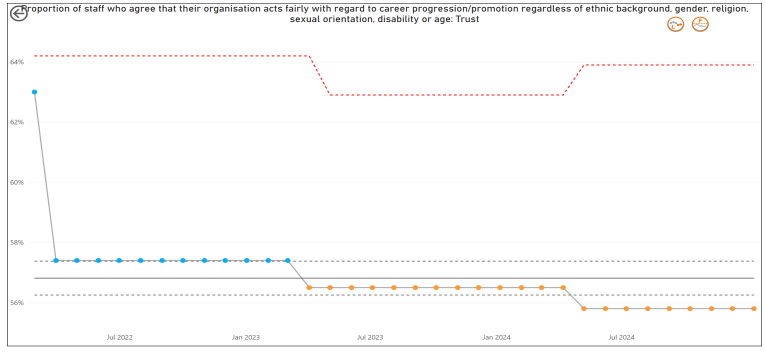
Reason for performance gap:	The WRES 2023/24 report shows our colleague representation for Asian, Mixed, Black and other minority people has increased year on year since 2020 and makes up 7.82% of our workforce. The 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, Mixed, Black, and other minority people as 3.3%. The population by ethnicity for Telford and Wrekin in the 2021 census was White people 88.2% and Asian, Black, Mixed and other minority people 11.8%. While this indicates our senior leadership workforce is over representative when compared to our local Shropshire community, we do recognise that our senior leadership workforce is not representative compared to our local Telford & Wrekin community.					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Nov-24	Ongoing	In progress	Ensure recruitment processes are fair, inclusive and transparent.	
	Work in collaboration with SaTH to offer places on the Galvanise Leadership Course for Ethnic Minority Staff.	Aug-24	Ongoing	In place	Ensure staff have the opportunity to access leadership courses.	
	Explore Scope for Growth conversations	Nov-24	Feb-25	Not Started		
Author	Fiona MacPherson	**Date**	1/20/2025			
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025			

Exception Report - Action Plan

Proportion of staff who agree that their organisation acts fairly with regards to career progression

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of staff who agree that their organisation	Number	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%
	Target	63.90%	63.90%	63.90%	63.90%	63.90%	63.90%	63.90%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%



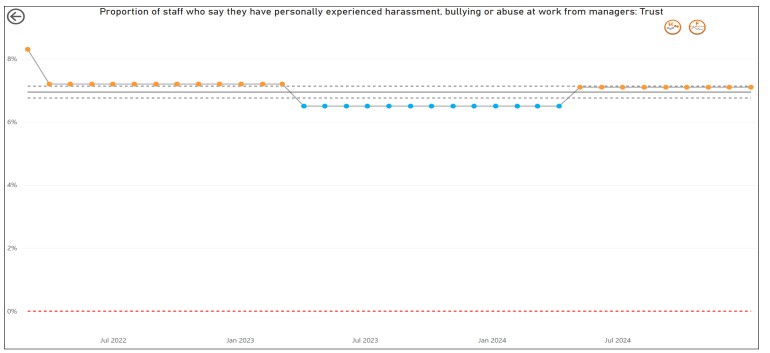
Reason for performance gap:	There is a gap of 8.1% between the national average and SCHT's score. For a period of time leadership courses have not been available internally for our staff to attend however, more recently we have been working in collaboration with SaTH and places have been offered to our staff on their leadership courses.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Nov-24	Ongoing	In progress	Ensure recruitment processes are fair, inclusive and transparent.
	Work in collaboration with SaTH to offer places on the Galvanise Leadership Course for Ethnic Minority Staff and other leadership courses.	Aug-24	Ongoing	In place	Ensure staff have the opportunity to access leadership courses.
	Work with the Workforce Race Equality Network to understand development needs and how their careers can be supported.	Nov-24	Mar-25	Not Started	Ensure support is appropriate and meets individual's needs.
	Publicise positive staff stories around career and development opportunities.	Dec-24	Mar-25	Not started	Raise awareness of career development.
	Explore implementing 'scope for growth' conversations.	Nov-24	Feb-25	Not started	Ensure all staff have the opportunity to discuss careers aspirations.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Exception Report - Action Plan

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of staff who say they have personally	Number	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%



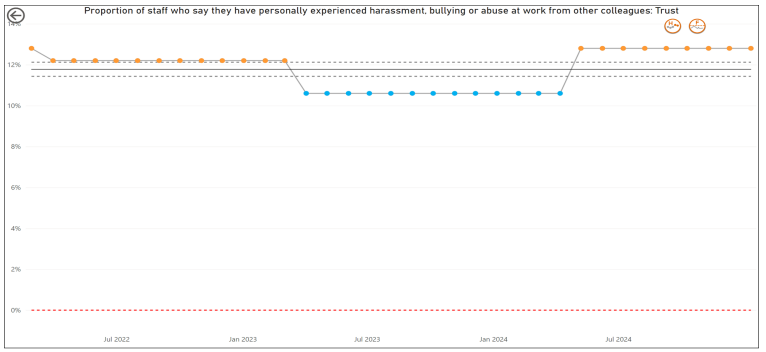
Reason for performance gap:	When reviewing the information retained by the People team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review our Dignity at Work Policy.	Oct-24	Nov-24	Complete	To ensure the Dignity at Work policy is fit for purpose.
	Develop a launch campaign to increase awareness and promote use of the Dignity At Policy.	Oct-24	Dec-24	In progress	To ensure people are aware of how to access and raise concerns.
	Raise awareness of FTSU Guardian and their role.	Jul-24	Ongoing	In progress	To ensure people are aware of how to access and raise concerns.
	Continue to roll out the civility & respect training programme.	Jul-24	Ongoing	In progress	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
	Review our staff survey results in relation to bullying and harassment raising awareness of Freedom to Speak up, Dignity at Work and Civility and Respect programme.	Nov-24	Dec-25	In progress	Targeted support for areas where bullying and harassment is reported.
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Dec-24	Mar-25	Not started	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Exception Report - Action Plan

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from colleagues

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of staff who say they have personally	Number	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%



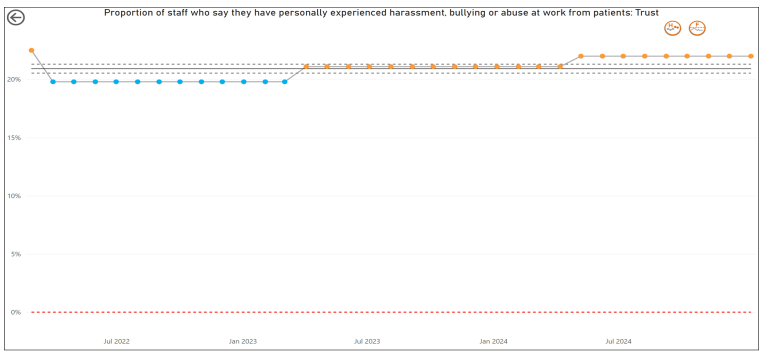
Reason for performance gap:	When reviewing the information retained by the People Team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review our Dignity at Work Policy.	Oct-24	Jan-25	Complete	To ensure the Dignity at Work policy is fit for purpose.
	Develop a launch campaign to increase awareness and promote use of the Dignity At Policy.	Oct-24	Dec-24	In progress	To ensure people are aware of how to access and raise concerns.
	Raise awareness of FTSU Guardian and their role.	Jul-24	Ongoing	On Going	To ensure people are aware of how to access and raise concerns.
	Continue to roll out the civility & respect training programme.	Jul-24	Ongoing	In progress	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
	Review our staff survey results in relation to bullying and harassment raising awareness of Freedom to Speak up, Dignity at Work and Civility and Respect programme.	Jan-25	Mar-25	Not started	Targeted support for areas where bullying and harassment is reported.
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Dec-24	Mar-25	Not started	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Exception Report - Action Plan

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of staff who say they have personally	Number	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%



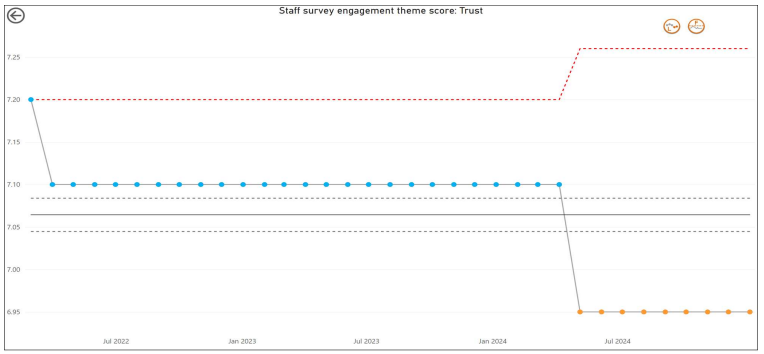
Reason for performance gap:	Staff experience bullying by patients, the aim is to raise awareness of the impact of this behaviour and support staff as required.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Launch work without fear campaign.	Dec-24	Feb-25	Not started	Raise awareness to our patients, relatives and members of the public.
	Develop nudge posters around zero tolerance.	Dec-24	Mar-25	Not started	Raise awareness to our patients, relatives and members of the public.
Author	Fiona MacPherson	**Date**	1/20/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025		

Exception Report - Action Plan

Staff survey engagement theme score

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Staff survey engagement theme score	Number	7.0	7.0	7.0	7.0	7.0	7.0	7.0
	Target	7.3	7.3	7.3	7.3	7.3	7.3	7.3

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	7.0	7.0	7.0	7.0	7.0	7.0	7.0



Reason for performance gap:	SCHT's score is close to the national average, however work continues around engagement with the appointment of the People Promise Manager and the work they are undertaking.					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	Appointment of a People Promise Manager.	May-24	Jul-24	In place	Increase awareness of the People Promise.	
	Develop a local listening promise.	Jul-24	Feb-25	In progress	visible commitment to listening.	
	Implement a reward and recognition programme to include a recognition calendar and events	Dec-24	Mar-25	In progress	To increase engagement across the Trust and enable staff to network	
Author	Fiona MacPherson	**Date**	1/20/2025			
Accountable Officer Approval	Rhia Boyode	**Date**	1/21/2025			

Shropshire Community Health
NHS Trust

Gender Pay Gap Report
0. Reference Information

Author:	**Fiona MacPherson, Head of HR Services**	**Paper date:**	6 February 2025
Executive Sponsor:	Rhia Boyode, Chief People Officer	**Paper written on:**	20 January 2025
Paper Reviewed by:	Emma Wilkins, Interim People Director (Deputy to Chief People Officer)	**Paper Category:**	Workforce
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full/Partial

1. Purpose of Paper

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

To provide the Trust Board with our Gender Pay gap report for approval. The approved data will be publicised on our website and on the online government services to ensure SCHT is compliant with its statutory obligations.

2. Executive Summary

2.1 Context

Our gender pay gap report has to be published on our website by 30 March 2025, the publication of this data must be approved by our Trust Board.

2.2 Summary

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 set out a public authority's gender pay gap reporting duties, which form part of its public sector equality duty under the Equality Act. Our gender pay data is at a snapshot date of 31 March 2024.

Key points from our gender pay gap data:

- Our gender workforce profile has remained relatively static for 8 years at 88% women and 12% men. It is reported that the gender profile of the NHS workforce as of March 2024 is 76% women and 24% men.
- Our mean gender pay gap has increased to 4.92% (an increase of **0.46% from 2023**).
- Our Median Gender Pay Gap is -5.52% in favour of women (women earn 0.93p more than men). The Office of National Statistics reports a 13.1% gender pay gap for 2024 for all employees.

Gender Pay Gap Report

- The mean pay gap equates to 0.95p in favour of men and the median pay gap equates to 0.93p in favour of women.
- Compared to our organisational gender workforce profile there are proportionately more men than women in our upper and lower pay quartile
- There is no bonus pay gap as only females are in receipt of bonus pay which is made up of only clinical excellence awards. In 2022 there was a bonus pay gap of 72.87%.

Key Priorities for gender pay gap 2025-26 (refer to appendix a for full list of priorities):

- Further enhance our flexible working offer for the workforce
- Carry out further detailed analysis of workforce data to identify patterns and trends within areas in relation to gender representation and work with divisions to address any gaps
- Analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals
- Continue to grow our staff networks to enable our staff to have their voice heard and be part of decision making for policy implementation etc.

2.3. Conclusion

The Trust Board are asked to:

1. Receive assurance and agree to publish the gender pay gap report on the SCHT website and government online services to ensure we are compliant with legislative requirements.

Gender Pay Gap Report
3.0 Main Report

3.1 INTRODUCTION

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 set out a public authority's gender pay gap reporting duties, which form part of its public sector equality duty under the Equality Act.

These duties mean that we are obliged to publish information about:

- the gender split of our workforce;
- the differences in mean and median hourly pay rates between genders;
- the gender profile of the organisation split into quartiles;
- the differences in bonus pay between genders.

The data must be published by 30 March 2025 and is at a snapshot date of **31 March 2024**.

We are required to publish the statistical information on the Gov.uk website and on our own webpages. We can add a narrative to describe the statistical information on our own webpages, we are intending to publish the detail at appendix A on our webpages.

3.2 GENDER PAY REPORTING IS DIFFERENT TO EQUAL PAY

The gender pay gap differs from equal pay.

Equal pay deals with the pay differences between **men and women who carry out the same jobs, similar jobs** or **work of equal value**. It looks at individuals. It is unlawful to pay people unequally because they are a man or a woman. Because the NHS uses structured national pay frameworks, it is highly unlikely to identify any equal pay issues.

The gender pay gap shows the differences in the **average pay between men and women.** If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are. It may be that there is an uneven distribution of genders at different levels of the organisation.

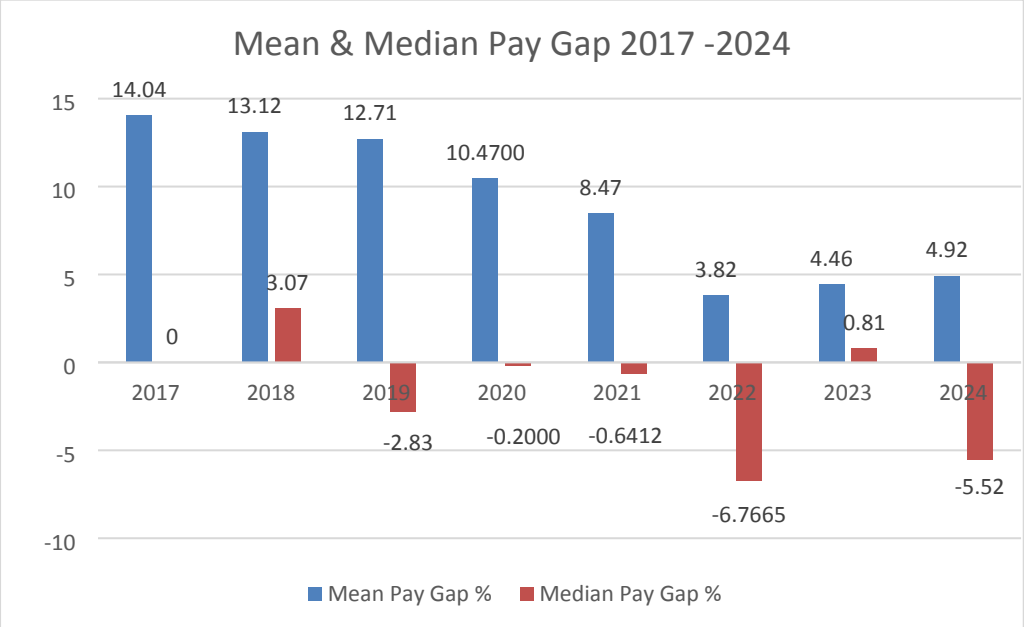
The data included at appendix A is the data that we intend to publish on the gov.uk site which is in line with our statutory duties.

3.3 COMPARISON BETWEEN OUR GENDER PAY DATA (2017-2024)

The information contained within this section provides a comparison of our gender pay data since 2017.

Gender Pay Gap Report

Measuring the Gender Pay Gap - Comparison between 2017-2024 data



In 2017 the **mean pay gap** was 14.04% which decreased to 3.82% in 2022. Since 2022 there has been a slight increase in the mean pay gap in favour of males (equivalent to 0.28p) but remains below the gap reported between 2017 -2021.

The **median pay gap** has increased from 0% in 2017 to 3.07% in 2018 but in 2019 reversed to be in favour of women. The median reversed in favour of women in 2019 which continued until 2022. In 2023 this changed to be in favour of males by 0.81% (equivalent to 0.14p). However reversed back to be in favour of women in 2024.

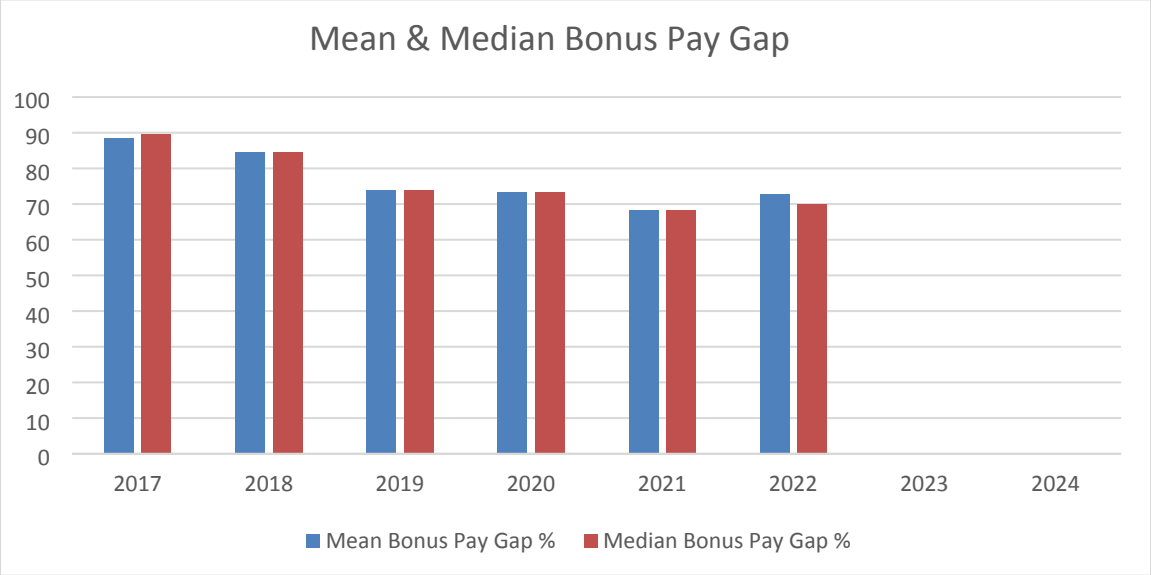
Measuring the Pay Quartiles - Comparison between 8 years of data

Between 2017 to 2022 there were proportionately more males in Quartile 1 and Quartile 4 compared to our workforce gender profile. In 2023 this changed to their being proportionately more males in upper pay quartile only. In 2024 there were proportionately more males in Quartile 1 and Quartile 4. When comparing the Quartiles there are only small changes in the percentage.

Measuring the Bonus Pay - Comparison between 31 March 2017 to 31 March 2024 data

When comparing the bonus pay from 2017 to 2024 the mean and median bonus pay gap has been gradually decreasing. In 2023 and 2024 only women received bonus pay (clinical excellence awards).

Gender Pay Gap Report



3.4 BENCHMARKING

Nationally the gender pay gap has been declining slowly over time. Over the last decade it has fallen by approximately a quarter among both full-time employees and all employees. Among all employees, the gender pay gap decreased to 13.1% in 2024, from 14.3% in 2023, and is still below the levels seen in 2019 (17.4%). *(Source: Office of National Statistics 29 October 2024).*

The Trust gender pay gap is significantly lower than the national gender pay gap.

3.5 Next steps

The Trust has maintained a low gender pay gap in recent years and will continue to build on this by (refer to appendix a for full list): -

- Further enhance our flexible working offer for the workforce
- Carry out further detailed analysis of workforce data to identify patterns and trends within areas in relation to gender representation and work with divisions to address any gaps
- Analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals
- Continue to grow our staff networks to enable our staff to have their voice heard and be part of decision making for policy implementation etc.

Gender Pay Gap Report
4.0 Conclusion

The Trust Board are asked to:

1. Receive assurance and agree to publish the gender pay gap report on the SCHT website and government online services to ensure we are compliant with legislative requirements.

Gender Pay Gap Report 2024

Reported January 2025

Introduction

The data analysis snapshot for this report is as at 31st March 2024 and is taken from the Electronic Staff Record System (ESR). The total number of employees was 1663, of which 88% were female, and 12% male, and includes all employees holding an employment contract with the Trust.

Background

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

The gender pay gap shows the differences in the **average pay between men and women**. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are. It may be that there is an uneven distribution of genders at different levels of the organisation.

Reporting Requirements

As an organisation we are required to annually report on gender pay in six different ways:

1. Mean gender pay gap – ordinary pay
2. Median gender pay gap – ordinary pay
3. Mean gender pay gap – bonus pay in the 12 months ending 31 March
4. Median gender pay gap – bonus pay in the 12 months ending 31 March
5. The proportion of male and female employees paid a bonus in the 12 months ending 31 March
6. The proportion of male and female employees in each quartile

What do we do with the information?

We use our gender pay reporting to assess:

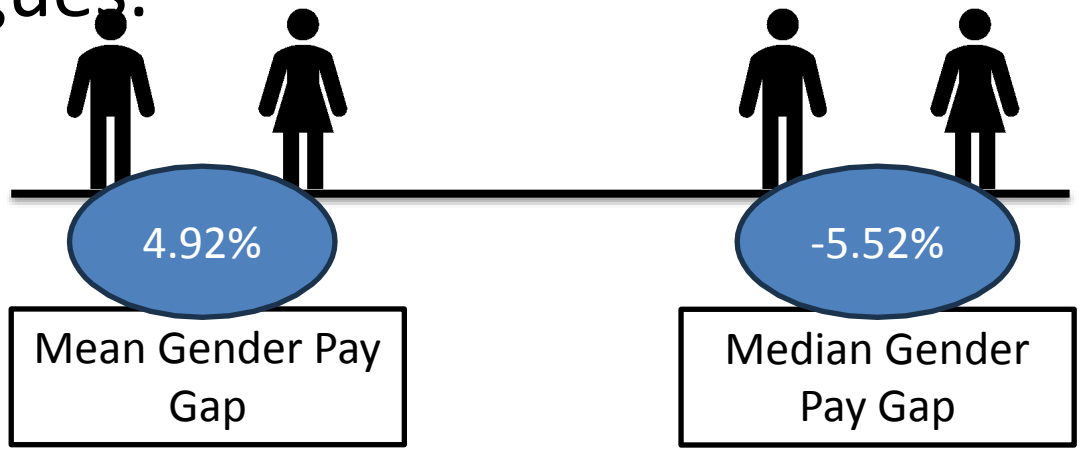
- Gender equality across our workforce
- Representation of men and women at different pay levels
- Our effectiveness in recognising and rewarding talent

Important points to note

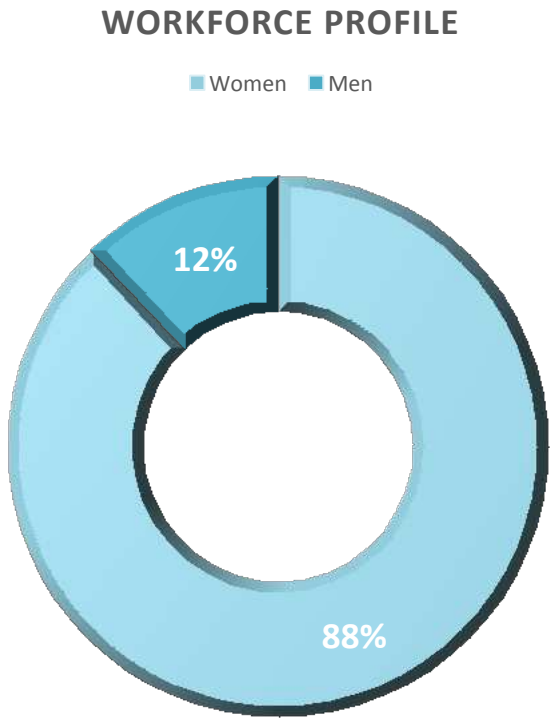
- **Gender pay gap is not the same as unequal pay.** Equal pay for equal work is a separate legal requirement.
- **Our current records do not include non-binary gender identities**. We fully acknowledge and respect the diversity of gender identities, including non-binary and transgender individuals.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

Our Headline Gender Pay Gap Data

Our mean gender pay gap is 4.92%. The median gender pay gap is -5.52%. This is inclusive of our Medical and Dental colleagues.



Our Gender Profile



Snapshot date – 31 March 2024

This chart shows our gender profile which shows a decrease of 1% in the number of female employees within our workforce (89% on 31 March 2023 compared to 88% on 31 March 2024).

Mean average Rates of Pay by Gender

This calculation is for all staff (inclusive of Medical and Dental).

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

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

Continued

Mean average Rates of Pay by Gender

This means that on average men earn £0.95 per hour more than women.

Our overall mean pay gap has fluctuated over the last 4 years but has overall reduced since reporting in 2021

	2021	2022	2023	2024
Male	£17.78	£17.50	£18.58	£19.30
Female	£16.27	£16.83	£17.75	£18.35
£ Difference	£1.51	£0.67	£0.83	£0.95
% Variance/Pay Gap	8.47%	3.82%	4.46%	4.92%

Median average Rates of Pay by Gender

This calculation is for all staff (inclusive of Medical and Dental).

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

Continued

Median average Rates of Pay by Gender

When comparing median hourly pay women earn £0.93p more than men earn.

Our overall median pay gap has in the main been in favour of women apart from in 2023 when it was in favour of men

	2021	2022	2023	2024
Male	£15.56	£15.10	£17.14	£16.76
Female	£15.66	£16.13	£17.00	£17.69
£ Difference	-£0.10	-£1.03	£0.14	- £0.93
% Variance/Pay Gap	-0.64%	-6.77%	0.81%	-5.52%

Our Gender Pay Gap Data 2024

Ordinary Pay	
Mean gender pay gap	4.92%
Median gender pay gap	-5.52%

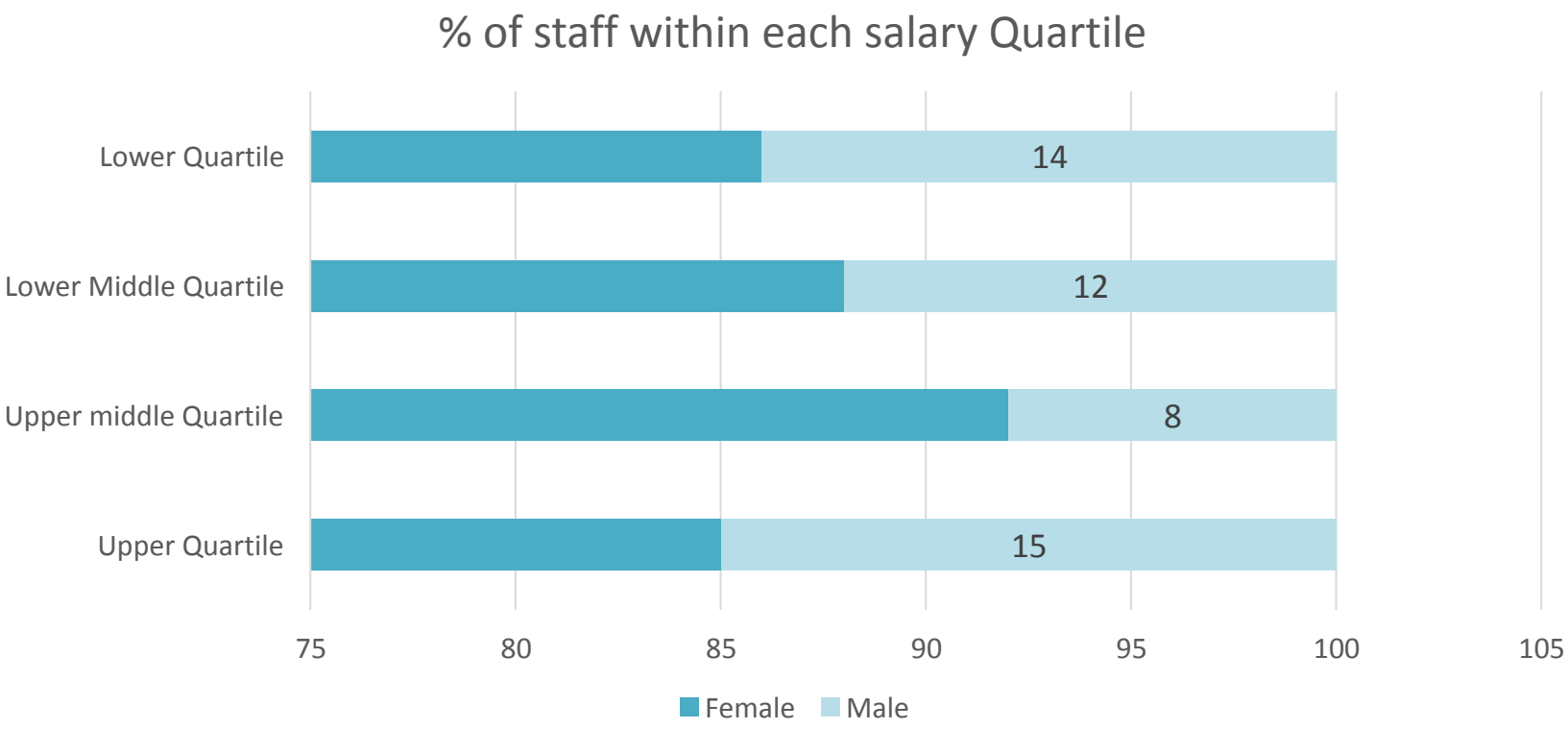
Shropcom's mean gender pay gap has increased from 4.46% in 2023 to 4.92% in 2024. The median pay gap has reversed and is now in favour of females -5.52% in 2024 (0.81% in favour of men in 2023).

The mean pay gap equates to men earning 0.95p more than women and the median equates to women earning 0.93p per hour more than men.

Bonus Pay Gap

In relation to the bonus pay gap, only female employees received bonus pay in 2024 which means there is no pay gap to report. Our last reported mean bonus pay gap was in 2022 where it was 72.87% and the median pay gap was 70% in favour of males.

The information details the % of staff within each salary quartile.



Our gender pay gap data

The information below details the % of staff within each salary quartile for 2023 and 2024:

	2024		2023	
	Male	Female	Male	Female
Lower Quartile	14	86	11	89
Lower Middle Quartile	12	88	10	90
Upper Middle Quartile	8	92	6	94
Upper Quartile	15	85	15	85

Key Priorities for 2025/26

- Continue to work with our system partners (SaTH) in offering our staff the opportunity to undertake leadership development by attending SaTH's leadership courses.
- Continue to promote our apprenticeship offer
- We are committed to an inclusive workplace and promoting equitable opportunities for all employees, to support this we are developing an inclusive recruitment toolkit and collaborating with SaTH on Safer Recruitment training.
- We are currently working towards becoming a Disability Confident Leader. As part of this work we will continue to raise awareness around our Health Passport, reasonable adjustment guidelines, access to work etc

Key Priorities for 2025/26

- Continue to grow our staff networks to enable our staff to have their voice heard and be part of decision making for policy implementation etc.
- Raising awareness of intersectionality to support staff to bring their whole selves to work through the power of support network collaboration.
- Carry out further detailed analysis of workforce data to identify patterns and trends within areas in relation to gender representation and work with divisions to address any gaps
- Analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals

Key Priorities for 2025/26

- Actively promote and champion policies to support women in the workplace including focused support for managers to implement guidance on policies e.g, • Menopause Policy, Flexible Working Policy, Fostering Friendly Policy

- Incorporate learning from stay conversations and exit interview data, identifying any trends for individuals wanting to/leaving the organisation

The End

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FTSU Report – December 2024

Shropshire Community Health NHS Trust

0. Reference Information

Author:	David Ballard, Freedom to Speak Up Guardian	**Paper date:**	24 Jan 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	31 Dec 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Governance
Forum submitted to:	People Committee & Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an outline of the ongoing work of the Freedom To Speak Up (FTSU) service. Further, the paper provides a review of the FTSU activity for Quarter 3 of 2024-25.

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 and is included in the quarterly reports to the Committee.

2.2 Summary

The self- assessment (attached at Appendix 1) shows no change from last quarter with the following assessment against requirements:

Reporting Period	Compliant	Partially Compliant	Not Compliant
Q2 23-24	12	21	7
Q3 23-24	21	16	3
Q4 23-24	28	8	4
Q1 24-25	29	9	2
Q2 24-25	30	8	2
Q3 24 – 25	30	8	2

The paper also presents the quarterly FTSU activity both in terms of updates from previous cases and any new cases reported. The quarterly report is attached at Appendix 2.

Shropshire Community Health NHS Trust

2.3 Conclusion

The Committee and Trust Board is asked to **note** the updated position and the position with regard to the self-assessment. Although there has been progress, there is still an amount of work to complete, and this assessment remains at partial assurance overall.

Further the Committee and Trust Board is asked to **note** the quarterly activity and the ongoing actions.

APPENDIX 1: SELF ASSESSMENT OCTOBER 2024

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
Behave in a way that encourages workers to speak up			
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they:			
Understand the impact their behaviour can have on a trust's culture	15 Oct 24	Culture and leadership programme has been completed	Board training specifically on FTSU scheduled for Board in Nov 24.
Know what behaviours encourage and inhibit workers from speaking up	15 Oct 24	Culture and leadership programme has been completed	Board training specifically on FTSU scheduled for in Nov 24.
Test their beliefs about their behaviours using a wide range of feedback	15 Oct 24	Staff survey, listening events programme completed with ongoing commitment to future dates	NHS Staff Survey 2024 results to be analysed in Mar 25.
Reflect on the feedback and make changes as necessary	15 Oct 24	"You said we did" bulletins, Board session held on staff survey results and with wider SLT, manager toolkit issued and staff survey conversations commenced	Awaiting results of manager conversations to be fed into overarching improvement plan
Constructively and compassionately challenge each other when appropriate behaviour is not displayed	15 Oct 24		360 appraisal to be completed by the Board. Shelley Ramtuhul to lead, to be completed by end Dec 24.
Demonstrate commitment to FTSU			
The board can evidence their commitment to creating an open and honest culture by demonstrating:			
There are a named executive and non-executive leads responsible for speaking up	15 Oct 24	Director of Nursing is Executive Lead for FTSU, Harmesh Darbhanga is the Non-Executive Lead	
Speaking up and other cultural issues are included in the board development programme	15 Oct 24	Culture session held in March with a further session planned for July.	Three levels of National Guardian training (dependant on role) has been recommended for inclusion in

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
			mandatory training programme for the Trust. Board have been invited to undertake their level of training.
They welcome workers to speak about their experiences in person at board meetings	15 Oct 24	Staff stories are shared at Board on a regular basis. With the new Guardian in post, they report to the People Committee on a quarterly basis	
The trust has a sustained an ongoing focus on the reduction of bullying, harassment, and incivility	15 Oct 24		The introduction of the FTSU online platform will provide data collection and analysis. The Trust has recently launched its Civility and Respect programme that is available to all staff.
There is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made	15 Oct 24		The FTSU Guardian as part of the feedback loop to individuals who use the service, will determine whether detriment has been suffered. The data for this is also captured as part of the data submitted to the NGO on a quarterly basis. The evidence of this has not been captured previously.
The trust continually invests in leadership development	15 Oct 24	The Trust offers multiple avenues for Leadership development, internal and external to the Trust, FTSU included in induction and FTSUG delivers induction. The recently appointed People Promise Manager actively supports leadership development in the Trust by championing the NHS People Promise.	
The trust regularly evaluates how effective its FTSU Guardian and champion model is	15 Oct 24	Niche review was asked specifically to look at FTSU arrangements, whilst this was focussed on the prison, the recommendations were Trust wide.	Ongoing assessment will form part of the work programme for the FTSU Group.

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
Have a strategy to improve your FTSU culture			
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate:			
As a minimum – the draft strategy was shared with key stakeholders	15 Oct 24	Strategy in place but out of date	New strategy has been socialised through extensive FTSU Comms campaign and FTSU has its own dedicated page on the Staff Zone.
The strategy has been discussed and agreed by the board	15 Oct 24		FTSU Strategy has been presented at People Committee who has asked it to be socialised before presenting for approval at Board. To be completed by end Feb 25.
The strategy is linked to or embedded within other relevant strategies	15 Oct 24	New strategy links with the culture and engagement strategy	
The board is regularly updated by the executive lead on the progress against the strategy as a whole	15 Oct 24		Strategy updates added to the workplan for People Committee and Board, reporting to commence once strategy signed off.
The executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	15 Oct 24	FTSU Group is in place and meets monthly.	The refreshed FTSU offer and new appointees is still becoming established, and as such sufficient data is not yet available.
Support your FTSU Guardian			
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate:			

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
They have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively	15 Oct 24	The FTSUG is the OD BP and has 0.2 of his WTE allocated to FTSU work. This time allocation will continue to be monitored.	
The Guardian has been given time and resource to complete training and development	15 Oct 24	FTSUG has completed the NGO Training and attends regional and national guardianship meetings and is part of the FTSU network	
There is support available to enable the Guardian to reflect on the emotional aspects of their role	15 Oct 24	The FTSU Guardian seeks supervision from the NGO and of FTSU colleagues, most notable his counterpart at SaTH.	
There are regular meetings between the Guardian and key executives as well as the non executive lead.	15 Oct 24	Attendance at the monthly FTSU Network meetings includes the Exec Lead and NED sponsor.	
Individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner	15 Oct 24	There is a clear process in place for the FTSU Guardian and Champions to escalate patient safety matters and ensure FTSU cases are progressed in a timely manner	
They have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes	15 Oct 24	Data is available to FTSU Guardian as required.	
The Guardian is enabled to develop external relationships and attend National Guardian related events	15 Oct 24	The FTSU Guardian attends regional and national guardianship meetings and regularly seeks support from the FTSUG at SaTH	
Be assured your FTSU culture is healthy and effective			
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:			

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
That the policy is up to date and has been reviewed at least every two years	15 Oct 24	FTSU Policy available on the Trust web, however, in keeping with the NGO directive, this is currently being replaced by the national templated policy	Completion by end Nov 24.
Reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian	15 Oct 24	Gap analysis completed and external review of FTSU arrangements via Niche	Feedback needs to be obtained from users and analysed, use of FTSU app will support this
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate:			
Assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience.	15 Oct 24	Data is available to FTSU Guardian as required.	
You map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
You have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
You evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	FTSU reporting needs to be strengthened initial reporting established but could provide greater analysis as the quantitative and qualitative data is strengthened.
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	15 Oct 24	Going forward the new Guardian will attend Board to present each quarterly report.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	15 Oct 24		The Trust will need to review the JD of the new FTSU Guardian and due to the size of the organisation this has been added to an existing role.
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	15 Oct 24	Gap analysis has been completed and presented to both Audit Committee and People Committee which are attended by all members of the Board	
Be open and transparent			
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:			
Discussion with relevant oversight organisation	15 Oct 24	The Board is briefed on issues reported, none have yet required discussion with oversight organisation	A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. The Board should routinely discuss challenges and opportunities presented by matters raised through speaking up.

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
Discussion within relevant peer networks	15 Oct 24	Access to the national FTSU network which has email forums for problem solving. FTSU System meeting attended	
Content in the trust's annual report	15 Oct 24		Overview of the Trust's FTSU is to be provided in the Trust's Annual Quality Account
Content on the trust's website	15 Oct 24	Content on Trust's website has been refreshed and provides in-depth detail of the Trust's FTSU provision	
Discussion at the public board	15 Oct 24	Quarterly reports to the Board	
Welcoming engagement with the National Guardian and her staff	15 Oct 24	FTSU is in communication with the NG and receives all the network information / attends the network meetings	
Individual Responsibilities			
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	15 Oct 24	New Fit and Proper Person Framework self assessment and appraisal documentation in place and currently being completed	

APPENDIX 2: QUARTER 3 2024 - 25 FTSU ACTIVITY

FTSU Reports

There were 5 new cases raised during Q3 of 24 – 25, one of which is open.

Notably, this quarter has seen ongoing activity regarding a case that was opened in Q2, where the subject of a concern raised submitted a SAR in a bid to identify the individual who raised the concern, along with detail regarding the case. The FTSUG expressed his concerns regarding the ethics of honouring the SAR (Q2's FTSU report), most especially as the individual raising the concern had explicitly stated they wanted to remain anonymous and *all* the detail to remain confidential. It is worth noting that other Trust's who have experienced a similar situation have stated that FTSU concerns *will not* be subject to SARs as they found that it was preventing concerns from being raised. Direction and Guidance was gained from the Trust's solicitors who have collated all the material generated throughout the case and provided a heavily redacted response.

Summary of Cases Closed and Outcome

Staff Type	Issue Raised	Category	Action Taken	Outcome
Medical and Dental	9 Oct 24 Prescribers unable to access Clinical Web Portal.	Patient Safety	Support provided by the FTSU Exec Lead. All band 6 and 7 prescribers now have access to the Portal	Case closed
Medical and Dental	14 Oct 24 Member of staff questioning recruitment process with associated concerns regarding discrimination.	Employment	Support provided by the FTSU Exec Lead.	Case open
Admin and Clerical	17 Oct 24 Staff member with concerns that their Service is overstretched	General	After raising concern and regular check-ins by the FTSUG, the staff member felt that the	Case closed

	and doesn't feel listened to		support offered by the FTSUG was enough to get them back on track	
Medical and Dental	5 Nov 24 Concern raised regarding the service provided by Medequip. 52 Datixs raised with a disproportionate amount of clinical time being spent rectifying issues	Patient Safety / Quality	Support provided by FTSU Exec Lead who followed up through Patient Safety Committee. Datixs now being carefully monitored.	Case closed
Medical and Dental	27 Nov 24 Staff member shared concern regarding a Breach of TUPE Regulations and feels their role is being purposefully eroded to that of a lower banding by their line manager.	Employment / Bullying and Harrassment	Case referred to Director of Operations and Chief AHP.	Case closed

FTSU Network Meetings and actions

The network continues to work on the Project Plan and associated actions at Appendix 3.

The online FTSU platform, 'Work in Confidence', continues to be established as a resource and utilised by staff. The platform, set up in May 24, has been actively used by staff to raise concerns, and by the Guardian and Champions (Appendix 4) to manage cases. A quick reference guide for staff that details how to access and use the platform was added to the Staff Zone in the FTSU pages.

The national FTSU policy that was provided by the National Guardians' Office was amended to reflect our Trust's FTSU contacts and has been approved by JNP. The policy is being tabled at People Committee on 29 Jan 25 for approval.

APPENDIX 3: FTSU PROJECT PLAN

FTSU Project Plan - Shropshire Community Health NHS Trust

	Project Plan Deliverables	Project Lead	Start Date	Deadline	Status	Notes
1	**Set Up**					
1.1	Project plan to be drafted and approved	Project Officer	15/04/2024	25/04/2024	Completed	
1.2	FTSU Guardian to complete training & be onboarded	FTSU Guardian	15/04/2024	31/05/2024	Completed	
1.3	Comms & engagement plan to be drafted & approved	Head of Comms	15/04/2024	31/05/2024	Completed	
1.4	Current FTSU champions to be contacted to confirm willingness to continue	Project Officer	15/04/2024	17/04/2024	Completed	
1.5	Analysis of current champions to identify organisational gaps that require FTSU champion, use staff survey data to support	Project Officer	15/04/2024	22/04/2024	Completed	
2	**Communications & Engagement**					

2.1	Implement comms & engagement plan	Comms	01/06/2024	01/09/2024	Ongoing	
2.2	Update relevant staff zone & website areas	Project Officer	15/04/2024	01/10/2024	Completed	
2.3	Promotion of app; standalone bulletins, Noticeboard, Staff area's posters, Q Time, Staff/Volunteer induction, Staff Facebook group; what it is, how to register, who we are,	Comms	01/06/2024	30/06/2024	Ongoing	
2.4	Promotion of FTSU; Posters, What it is, who we are	Comms	01/06/2024	30/06/2024	Completed	
2.5	Recruitment call for FTSU champions in identified gaps & in staff network groups	Project Officer	01/06/2024	30/06/2024	Completed	
2.6	Ensure all FTSU champions have completed; speak up; listen up; follow up training	Project Officer	15/04/2024	01/06/2024	Ongoing	
2.7	Create content on what is FTSU-Speaking Up, How to raise a concern etc	Project Officer	15/04/2024	24/04/2024	Completed	
2.8	FTSU Champions to attend HWB days and other event or staff meetings	Project Officer	01/06/2024	ongoing	Completed	
2.9	Host drop in sessions "about FTSUP & How to raise'	Project Officer	01/07/2024	31/07/2024	Completed	To form part of HWB days
3	**FTSU online platform – 'Work in Confidence'**					

3.1	Organisation account set up	Project Officer	15/04/2024	29/04/2024	Completed	
3.2	Complete admin training	Project Officer	15/04/2024	22/04/2024	Completed	
3.3	Confirm who will respond to messages (master admins)	FTSU Guardian	15/04/2024	29/04/2024	Completed	
3.4	Link with IG for considerations to be made; GDPR & Data Protection	Project Officer	01/06/2024	08/06/2024	Completed	
3.5	Confirm in app categories required	FTSU Guardian	15/04/2024	29/04/2024	Completed	
3.6	FTSU Champions to complete training	FTSU Champions	15/04/2024	30/04/2024	Completed	
3.7	Create 'dummies' guide & upload to staff zone	Project Officer	01/06/2024	14/06/2024	Completed	
3.8	Staff to self register for app (Comms)	Project Officer	01/06/2024	14/06/2024	Completed	
3.9	Add desktop link to landing page	Digital	01/06/2024	31/07/2024	Completed	
3.10	FTSU guardian / champions monitor app	FTSU Guardian	01/06/2024	ongoing	Ongoing	

4	Best Practice					
4.1	Scope adding core training for all workers to LMS & promote	Project Officer	01/06/2024	31/08/2024	In Progress	05/08 awaiting approval from ESR manager
4.2	If above approved add additional training for manager and senior leaders & promote	Project Officer	30/06/2024	31/08/2024	In Progress	05/08 awaiting approval from ESR manager
4.3	Ensure a clear policy, procedure & strategy are in place	FTSU Guardian	01/06/2024	20/09/2024	In Progress	New policy has been approved by JNP and is being tabled for consideration at PC on 29 Jan 25.

APPENDIX 4: FREEDOM TO SPEAK UP CHAMPIONS

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

0. Reference Information

Author:	Poppy Owens, Executive Assistant	**Paper date:**	6th February 2025
Executive Sponsor:	Tina Long, RPC Chair	**Paper written on:**	29th January 2025
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 27th January 2025 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Waiting times – RTT and Non RTT
    - Integrated Performance Report
    - Deep Dive Agency, Bank, Workforce
    - CIP Actions and Delivery 24/25 and 25/26 plans
    - Rehab and Recovery Benefits Realisation
    - Finance & Capital Reporting Month 9
    - Contract Monitoring Report
    - Annual Budget Setting
    - Service Development Update
    - Procurement Strategy Refresh and Quarterly Update
    - Review of BAF risks
    - Annual Meeting Evaluation Checklist Outputs
    - System Transformation Group update
    - Digital Assurance Group Minutes

2.3. Conclusion

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

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

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 27th January 2025. The meeting was quorate with four Non-Executive Director and four Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Tina Long	Non-Executive Director (RPC Chair)
Sarah Lloyd	Chief Finance Officer
Shelley Ramtuhul	Trust Secretary/Director of Governance
Claire Horsfield	Director of Operations and Chief AHP
Patricia Davies	Chief Executive Officer
Harmesh Darbhanga	Non-Executive Director
Clair Hobbs	Director of Nursing and Clinical Delivery
Jonathan Gould	Deputy Chief Finance Officer
Gemma McIver	Deputy Director of Operations
Jon Davis	Associate Director of Digital Services
Steve Price	Head of Information and Performance Assurance (part-meeting)
Simon Balderstone	Deputy Director of People Operations
Jill Barker	Non-Executive Director (Acting Chair part meeting)
Mark Mawdsley	Head of Costing and Contracting (part-meeting)
Michael Price	Procurement Manager (part-meeting)
Steve Ellis	Deputy Director of Operational Service Development
Cathy Purt	Non-Executive Director
Poppy Owens	Executive Assistant [Minutes]

3.2 Actions from the Previous Meeting

The Committee reviewed all open actions from previous meetings, and all received an update.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
7. Waiting times – RTT and Non RTT		
RTT Waits: The Committee noted there was a slight reduction in the RTT 18 week overall performance from 58% in November to 55.7% in December however this is expected to be recovered from January. There are 0 65 week waits although there remains continued risk with this position and close monitoring is in place.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

The main area of challenge across the waiting list pathway are aligned to Orthopaedics and system work is continuing in relation to this. The Committee discussed that RTT service waiting times paper frequency can be reduced moving forward, given the improved position, and as this is captured within the integrated performance report. However, papers will still be required at intervals to be confirmed. **Non RTT (All Service) waits:** The Committee acknowledged that the 78-week position has deteriorated, this is mainly aligned to TEMS, Orthopaedics and CNRT. The 65-week position has remained static but ahead of trajectory and 52-week position has improved ahead of trajectory. The Committee requested 104 week waits are reported within the executive summary, given this is an increasing number, aligned to the integrated performance report. The Committee confirmed the non RTT services waiting times paper is still required to come regularly to RPC.		
8. Integrated Performance Report		
The Committee considered that there are two performance indicator changes. The proportion of patients waiting more than 12 hours in an emergency department is no longer flagged and the total patients waiting more than 104 weeks is now flagged as a variation concern, largely relating to CNRT. The Committee discussed the assurance provided through the action plans and noted the improving position with work underway to enhance these further. It was noted that the robustness of the action plans is vital.	Full	Full assurance, however continued focus on action plan development to provide enhanced assurance.
9. Deep Dive Agency, Bank, Workforce		
The Committee considered that at month 9 we are 4 WTE over plan and our substantive staff is significantly under. We are currently operating at a 10-10.5% vacancy rate and agency WTE exceed plan, although cost is marginally below. Development of a centralised bank business case was discussed and it is noted that this will progress through the Executive team and brought back to Resource and Performance Committee when there are relevant updates.	Partial	Further development of actions required to reduce temporary staffing, focusing on underlying drivers for usage and sustainable solutions.

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

The Committee commended the Temporary Staffing Team on positive position in relation to price cap compliance for nursing staff.		
10. CIP Actions and Delivery		
The Committee heard that 2024/25 CIP delivery is exceeding plan at month 9 by £0.5m Recurrent delivery is behind plan, although this is more than offset by non-recurrent schemes which remains a focus. The full year effect of current schemes should deliver the recurrent target in full. The Committee noted that there is £1.2m identified programmes of work against the estimated 2025/26 CIP target. PIDs and QEIAs have been commenced and there will be a focussed 'PID' day on 6th February 2025. The work is progressing well and requires continued effort.	Full	Full assurance, with continued focus on 25/26 CIP development.
11. Rehab and Recovery Benefits Realisation		
The Committee received an update on the Rehab and Recovery Units which are currently running with a total of 46 beds across two sites. It was noted that the changes in performance are due to a number of service changes which happened in a relatively short period of time. There has been a clear reduction of 29.3% in No Criteria to Reside which is aligned to the RRU's and Care Transfer Hub along with reduced length of stays on frailty pathways and reduction in escalation spaces in comparison to January 2024. Benchmarking shows length of stay for PRH average is 20 days, RSH is 16 days and national average is 19.3 – 37 days. The Committee commended the positive work and suggested this is further showcased.	N/A	
12. Finance & Capital Report Month 9		
The Committee considered the financial performance, noting the favourable variance to plan of £959k for the year to date and the £3.6m forecast surplus, a favourable variance to plan of £1.8m. CIP deliver exceeds planned levels and agency spend is below plan for the year to date. Capital spend is behind plan, however recovery plans are in place. Further virtual approvals for capital spend will be shared with the Committee as required.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

13. Contract Monitoring Report		
The Committee discussed a number of contractual items, including current risks and mitigations. Work is continuing to enhance the sub-contract which is in place with SaTH for 2025/26. The Committee noted the ICB's Commissioning Intentions have just been shared and are being considered. The recently published 2023/24 National cost collection index shows a slightly increase from 99 to 103 and reviews will be undertaken to assess any areas where we appear to have costs which exceed national averages.	Full	
14. Annual Budget Setting		
The Committee acknowledged the delay budget setting timetable, due to external factors, and considered the proposal to review and agree the 2025-26 opening budget at the March Resource and Performance Committee meeting. This proposal was supported by the Committee.	N/A	
15. Service Transformation update		
The Committee received an update on the main transformation projects and supported current work with integrated neighbourhood teams.	N/A	
16. Procurement Strategy Refresh and Quarterly Update		
The Committee acknowledge the progress made to date towards identifying and delivery of 2024/25 CIP schemes and recognised the work being done for 2025-26 CIP. The Committee noted the enhanced system work, which is positive and requested a strategic update to be brought to a future meeting.	Full	Full assurance however a strategic update was requested by the Committee.
17. Review of BAF risks for R&P		
The Committee received an update on the BAF risks and objectives linked to RPC. Consideration as to whether Resource and Performance Committee BAF should continue to cover workforce is required, and SR will be reviewing this. Additionally, SR will review how we can link this to the System Integrated Improvement Plan for 2025/26. The Committee approved the BAF.	N/A	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 27th January 2025

18. Annual Meeting Evaluation Checklist Outputs		
The Committee were asked to complete the checklist in relation to effectiveness of the Resource and Performance Committee.	N/A	

3.4 Approvals

The Committee approved the updated 2024/25 BAF.

3.5 Risks to be Escalated

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

4. Conclusion

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

Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**6th February 2025**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**27th January 2025**
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The purpose of this report is to provide oversight of the key performance indicators included within the Trust's Performance Framework.

The paper is intended to provide information and assurance and consider for action.

2. Executive Summary

2.1 Context

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

This report focuses on the measures relevant to the Resource & Performance Committee and any areas of exception in relation to Quality and Safety or People Committee measures are reported separately to the Trust Board.

2.2 Summary

The key points for the Trust Board to consider are:

- There are 64 performance indicators reported in this period across all committees.
- The table below summarises the number of KPIs highlighted as a concern against each responsible committee. 32 indicators are highlighted as a concern (50%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	1	7	5	**19**	**13 (68.4%)**
Quality & Safety	2	2	4	**16**	**8 (50%)**
Resource & Performance	3	2	6	**29**	**11 (37.9%)**

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

Performance Update

Changes to the Trust's KPI flagged as a concern during the month are as follows:

- **People Committee** No change.
- **Quality and Safety Committee** The 'Medication Incidents with Harm' KPI is now flagged as a variation concern.
- **Resource and Performance Committee** The 'Total patients waiting more than 104 Weeks – All services' KPI (Local target) is now flagged as a variation concern.

Action Plans have been developed by Operational colleagues and included at Appendix 3 for the measures flagged as a concern in this report.

In a revision to the existing process, action plans were developed in a one day face to face workshop with Operational Leads and Support Services diving into the detail collaboratively. This new approach is in place for the next couple of reporting cycles and will be adapted over time to ensure maximum benefit.

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

The Board 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.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.

Performance Update

3. Main Report

3.1 Introduction

An agreed set of KPIs is in place to monitor the Trust's performance. The full list of KPIs monitored across all three of our committees is shown in Appendix 1 of this document.

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

3.2 Summary of key points in report

This report focuses on the 29 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 11 require focused attention with 10 of the 11 relating to access to services and waiting times.

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

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

Three KPI are a variation concern only – special cause variation of a concerning nature.

1. Outpatient follow-up activity levels compared with 2019/20 baseline
2. Diagnostics for Audiology and Ultrasound – DM01
3. Total patients waiting more than 104 Weeks – All services (Local target)

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

1. Data Quality Maturity Index
2. Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

Six KPI are both an assurance concern *and* special cause variation concern.

1. 18 week Referral to Treatment (RTT) incomplete pathways (National target)
2. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)
3. Proportion of patients within 18 weeks (Local target)
4. Total patients waiting more than 78 Weeks – All services (Local target)
5. Total patients waiting more than 65 Weeks – All services (Local target)
6. Total patients waiting more than 52 Weeks – All services (Local target)

The list of KPIs which are of concern is relatively unchanged from the last report to Board, with only one change to note;

- Total patients waiting more than 104 Weeks – All services (Local target) is now flagged as having a variation concern.

Performance Update

As of December 2024:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	495	1494
Patients waiting over 65 weeks	0	540
Patients waiting over 78 weeks	0	302
Patients waiting over 104 weeks	0	9

There has been improvement in total patients waiting more than 52 Weeks to start consultant-led treatment (National target) since the last report. However, all local waits are showing either a levelling off or a deterioration in December and this is more visible in the SPC charts within the action plans.

18 week Referral to Treatment (RTT) incomplete pathways has shown a deterioration from 58.23% in November to 55.72% in December, although the December position is still being validated at the time of preparing the paper/dashboards.

The indicator for 'Proportion of patients within 18 weeks' has deteriorated, with performance of 58.39% in December compared to 59.87% in November. The deterioration of this measure in November was mostly associated with the Looked After Children Nursing service and further detail is included in the action plan; validation work is being undertaken by the service and improvements are now being seen as a result of these actions.

The data issue previously reported in relation to Continence products has been resolved for November data. However, a subsequent issue for December data has been identified with only part of the month's activity available; this issue has been raised with the system supplier and the measure will be refreshed once this is resolved. This impacts total activity undertaken against current year plan.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.

Resource and Performance Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance...	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2024-12-31	L	55.72%	92.00%	-36.28%	55.72%	92.00%	-36.28%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2024-12-31	L	90.00%	100.00%	-10.00%	90.00%	100.00%	-10.00%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2024-12-31		86.11%	100.00%	-13.89%	86.11%	100.00%	-13.89%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2024-12-31	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2024-12-31		0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2024-09-30	H	95.0%	95.0%	0.0%	95.0%	95.0%	0.0%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2024-11-30	L	84.04%	99.00%	-14.96%	84.04%	99.00%	-14.96%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2024-12-31		-4.28%	0.00%	-4.28%	-4.28%	0.00%	-4.28%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2024-12-31		3.48%	0.00%	3.48%	3.48%	0.00%	3.48%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2024-11-30	H	89.56%	90.00%	-0.44%	89.68%	90.00%	-0.32%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2024-11-30	H	84.10%	90.00%	-5.90%	87.16%	90.00%	-2.84%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2024-11-30		96.67%	95.00%	1.67%	92.56%	95.00%	-2.44%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2024-12-31	L	0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2024-12-31	H	100.74%	75.00%	25.74%	98.13%	75.00%	23.13%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2024-12-31		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	P
Resource & Performance...	Responsive	Proportion of patients who have a first consultation in a post-covid ser...	2024-12-31		0.00%	92.00%	-92.00%	30.21%	92.00%	-61.79%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2024-12-31	L	58.39%	92.00%	-33.61%	58.39%	92.00%	-33.61%	F

Resource and Performance Committee - SPC Summary (continued)

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance ...	Effective	Total activity undertaken against current year plan	2024-12-31		88.22%	100.00%	-11.78%	95.41%	100.00%	-4.59%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2024-12-31		171.05%	120.00%	51.05%	158.16%	120.00%	38.16%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2024-12-31	H	125.88%	103.00%	22.88%	119.48%	103.00%	16.48%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2024-12-31	H	9	0	9	9	0	9	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2024-12-31		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2024-12-31	H	1,494	0	1,494	1,494	0	1,494	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2024-12-31	H	495	0	495	495	0	495	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2024-12-31	H	540	0	540	540	0	540	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2024-12-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2024-12-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2024-12-31	H	302	0	302	302	0	302	F
Resource & Performance ...	Effective	Virtual ward bed occupancy	2024-12-31		73.46%	73.65%	-0.19%	73.46%	73.65%	-0.19%	

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2024-12-31		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-12-31		3	0	3	3	0	3	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-12-31		8.00	0.00	8.00	8.00	0.00	8.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-12-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-12-31		97.84%	95.00%	2.84%	98.42%	95.00%	3.42%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2024-12-31		33.33%	100.00%	-66.67%	33.33%	100.00%	-66.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-12-31		1.00	0.00	1.00	1.00	0.00	1.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-12-31		5.02	4.00	1.02	5.02	4.00	1.02	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-12-31		10	0	10	51	0	51	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Never Events	2024-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-12-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-12-31		0	0	0	3	0	3	

People Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2024-12-31		7.4	7.5	-0.1	7.4	7.5	-0.1	
People Committee	Well Led	Appraisal Rates	2024-12-31		87.92%	90.00%	-2.08%	85.68%	90.00%	-4.32%	
People Committee	Well Led	CQC well-led rating	2024-12-31		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2024-12-31		10.76%	9.60%	1.16%	10.76%	9.60%	1.16%	
People Committee	Well Led	Mandatory Training Compliance	2024-12-31		94.83%	95.00%	-0.17%	94.83%	95.00%	-0.17%	
People Committee	Well Led	Net Staff in Post Change	2024-12-31		-2.77	0.00	-2.77	20.77	0.00	20.77	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-12-31		9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-12-31		75.00%	66.00%	9.00%	75.00%	66.00%	9.00%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-12-31		4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2024-12-31		55.80%	63.90%	-8.10%	55.80%	63.90%	-8.10%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31		7.1%	0.0%	7.1%	7.1%	0.0%	7.1%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31		12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-12-31		22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	
People Committee	Well Led	Proportion of temporary staff	2024-12-31		4.0%	3.4%	0.6%	6.1%	3.4%	2.7%	
People Committee	Well Led	Sickness Rate	2024-12-31		5.33%	4.75%	0.58%	5.33%	4.75%	0.58%	
People Committee	Well Led	Staff survey engagement theme score	2024-12-31		7.0	7.3	-0.3	7.0	7.3	-0.3	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-12-31		44	0	44	239	0	239	
People Committee	Well Led	Total shifts on a non-framework agreement	2024-12-31		0	0	0	1	0	1	
People Committee	Well Led	Vacancies - all	2024-12-31		10.84%	8.00%	2.84%	11.43%	8.00%	3.43%	

Icon Descriptions

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

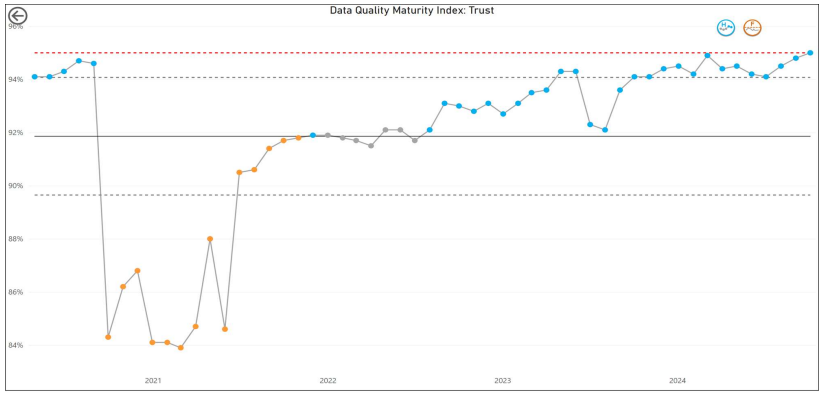
Exception Report - Action Plan

Data Quality Maturity Index

Data Quality Maturity Index as calculated by NHS England. Based on datasets submitted by SCHT

KPI Description	Latest 6 months	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	YTD
DQMI	%	94.5%	94.2%	94.1%	94.5%	94.8%	95.0%	95.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	95.0%	95.0%	94.0%	94.0%	94.0%	94.5%	95.0%



Reason for performance gap:	Performance reduced in June/July 2023 following a number of errors highlighted in the dataset submissions as the Trust implemented the new version of a dataset submission standard. The datasets have been corrected and resubmitted. Performance has gradually improved since but there are still a number of areas requiring improvement. Data quality challenges do still exist in several data items particually with Chief Complaint and Acuity for MIU, Clinical Coding for Admitted Patient Care, Ethnicity and Spoken Language. Clinical coding is now a risk also for Rehab and Recovery Units following SATH serving notice. Alternative arrangements are being sought The main area of challenge impacting this metric is in relation to compliance re-recording of ethnicity. Education to teams re importance and relevance of capturing this metric is ongoing. Challenges with admin capacity (aligned to NHSE controls) to ensure this action is completed has had an impact however working with informatics to see how certain fields that support improving data quality become mandatory for completion. There is a further risk to adherence to elements of DQMI particualy ethnicity due to the "collective action" being taken by primary care. This means services are no longer recieving proformas where some of this information would have been taken from and inputted into RIO.

	Start Date	End Date	Status	Outcome
Data Quality Sub-Group to have representation from all divisions	Jan-24	Jan-25	Off Track	Attendance logs are kept and escalations to Operational Leads will be made if there are any patterns of non attendance. Action remains open until attendance is consistent and review of diary clashes has commenced to support Operational attendance. End date was initially Sep-24 but due to importance this will be monitored until Jan-25. Attendance is still limited from Adult Community and UEC. Both divisions will work to address this and separate action listed below for Adult Community
Implementation of new Divisional performance and Quality meetings in line with new divisional structure to ensure reporting is embedded into governance structures not just reflected in the improvement group	Mar-24	Dec-24	Closed	Plans in place to include data quality as standard agenda item. Meetings are up and running with further action to include other corporate services. Separate items for Quality and Governance with further discussions required with the Governance Team. Information Analyst has attended CYP/Planned Care meetings to discuss data quality and ensure accessible and accurate dashboards are in place for each division. This action is outstanding from April with a revised time frame to be resolved now by December which ops , BI and quality are re exploring to accelerate this time line. Information Analyst booked for all divisional meetings with allocated agenda item.

Action Plan	Ethnicity data capture element need aligning with the Health Inequalities programme	Nov-24	Nov-25	On Track	Standard agenda item at the Health Inequalities Steering Group. Connected to the topic areas under the Population Health Management Core Ambassador role. DV to take the action to ensure that learning and improvements from this group are rolled out across all divisions, not worked up in silo
	Clinical Audit Tool feedback to be strengthened through SDG meetings	Jun-24	Nov-24	Off Track	Results from quarterly discussions at DQ Subgroup are being communicated back through SDG meetings. This was discussed at the workshop above and a dedicated meeting to go through an understand priority for audit actions has been completed. Review required at DQ Sub Group to ensure correct recipients for services within divisions as well as the required actions after each audit. Timetable of audit reviews to be added to the DQ Sub Group Information team to provide details of which teams are not responding, to SDG leads, for action to take forwards with service leads
	Stablisation of clinical coding workforce task	Nov-24	Jan-25	On Track	Meet with the leads involved and scope an options appraisal. Explore through admin academy any options for internal training. Planned Care and Adult Community to work together to produce impact paper, due to crossover of management vs activity
	Operations to work together to devise a plan to educate staff in the requirement to ask for Ethnicity/Spoken Language, etc and get past the "difficult" questions. Workshops in Planned Care to take 3 pronged approach (Referral/Booking/Attendance) devise plan to bring to DQ Subgroup in February Planned Care to look at whether forms can be provided in waiting areas, asking patients to complete demographics, to include Ethnicity UEC - Rolling out Triage training and will highlight Ethnicity as a key element of that, particularly around asking the "right" questions	Jan-25	Mar-25	Planned	
	MIU - Team leads are now in place and so CSM will meet on a monthly basis with Information Analyst, to understand the hotspots. CSM will then take that to team leads on a monthly basis, in order to drive improvement in required areas	Jan-25	Feb-25	Planned	
	ST to link with Jayne Carter in regard to attending DQ Subgroup going forwards, to represent Adult Community division and delegate to another rep if unavailable anytime	Jan-25	Jan-25	Planned	

Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson/Edliz Kelly	**Date**	13/01/2025	
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025	

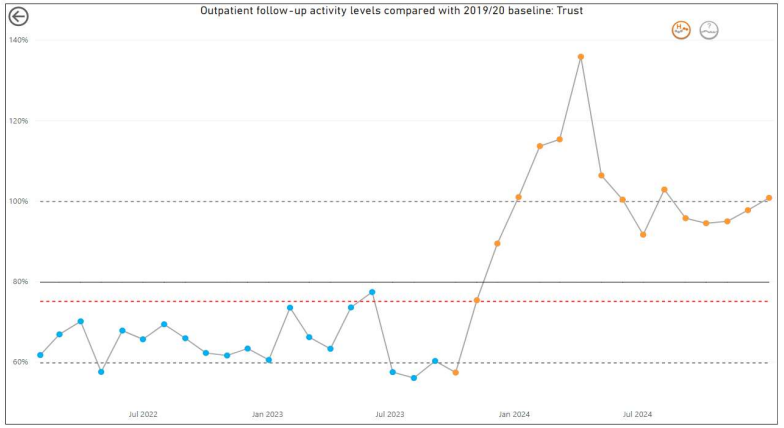
Exception Report - Action Plan

Outpatient follow-up activity levels compared with 2019/20 baseline

Outpatient follow-up activity compared with 2019/20 baseline. Calculated in line with NHSE SOF including working days comparison

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Outpatient follow-up	%	102.81%	95.68%	94.44%	94.91%	97.68%	100.74%	98.13%
	Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	86.0%	84.0%	82.0%	80.0%	99.0%	99.0%	99.0%



Reason for performance gap:

There continues to be a focus on ensuring clinically appropriate follow-up activity and the positive adherence to utilising PIFU (Patient Initiated Follow Up) across MSST. PIFU performance is currently over performing at 13.1% against the target of 5.5% demonstrating an effective use of the pathway and best practice approach. From a local persepective SCHT are modelling a best practice approach peforming consitently above the national target and also above local peers (SaTH are at 4.7% and RJAH at 4.9%)

The difficulty with this KPI is that MSST was not in existence in 19/20 so there is no baseline to compare to hence the continued demonstration of overperformance seen above. This would be similar for the TeMS service as the TeMS model is significantly different now than it was compared to 19/20.

Decision taken to alter trajectory for remainder of 2025, due to the level of MSST activity increasing and we are already more than achieving PIFU KPI's as a trust

Service	Dec-24 (Rounded to 0 dp)
APCS	125%
Bridgnorth Outpatients	56%
DAART	151%
Ludlow Outpatients	129%
MSST	12325%
TEMS	4%
Whitchurch Outpatients	44%

Action Plan

	Start Date	End Date	Status	Outcome
Review of APCS templates and new/FU ratio alongwith skill mix (medic and nurse)	Oct-24	Dec-24	Complete	Review service templates and compare data to understand impact of implementation of CNS into the model has commenced.
Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arraged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. ICB led task and finish group now in placer with full system agreement to proceed with stopping new Ortho refs by end of Dec 24 and transfer of TeMS Orth by end of Feb 25.
EK to investigate the make up of DAART Follow up activity, to understand what is being recorded, is it appropriate and can PIFU be explored and rolled out	Jan-25	Mar-25	Pending	

Author	Alastair Campbell/Helen Cooper/Mark Onions/Edliz Kelly	**Date**	13/01/2025
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025

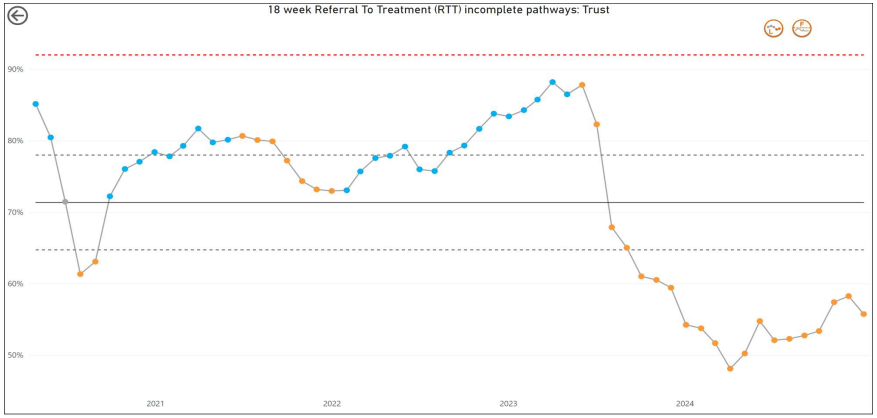
Exception Report - Action Plan

18 week Referral To Treatment (RTT) Incomplete Pathways

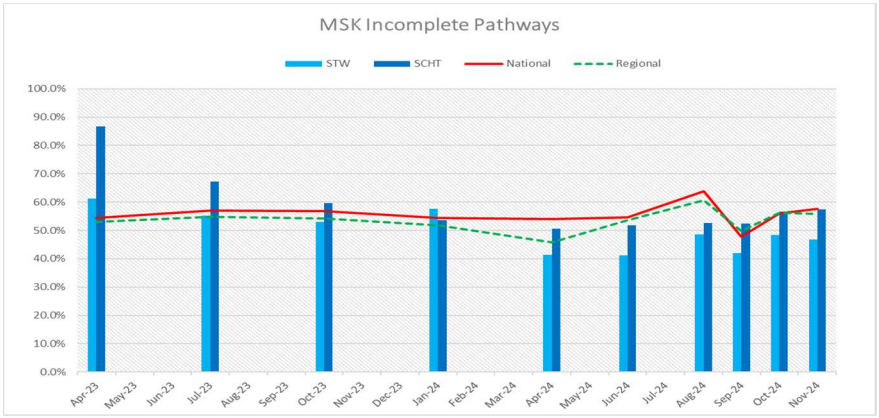
As at the end of the month, the percentage of patients that are still waiting for treatment and are within 18 weeks

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
RTT Incomplete Pathways	%	52.06%	52.26%	52.73%	53.34%	58.23%	55.72%*	55.72%*
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	62.5%	58.0%	59.0%	60.0%	60.5%	61.0%	62.0%



MSK Incomplete Position										
	Apr-23	Jul-23	Oct-23	Jan-24	Apr-24	Jun-24	Aug-24	Sep-24	Oct-24	Nov-24
STW	61.2%	55.3%	53.1%	57.6%	41.3%	41.2%	48.7%	42.0%	48.4%	46.7%
SCHT	86.8%	67.2%	59.7%	53.6%	50.7%	51.9%	52.7%	52.4%	56.7%	57.4%
National	54.4%	57.0%	56.8%	54.5%	54.0%	54.6%	63.8%	47.7%	56.0%	57.6%
Regional	53.0%	54.9%	54.3%	51.9%	45.8%	53.6%	60.7%	49.8%	56.2%	55.9%



Benchmarking:- The benchmarking data is taken from NHS England's official statistics for referral to treatment waiting times. This data is focused on MSK due to the size of the service and it's associated performance agiants RTT overal for SCHT. As the data evidences SCHT continue to perform closely with the national average and slightly above the regional average. The data also shows a continued increase in performance and significantly above the average for STW.

Reason for performance gap:

The current position has deteriorated by 2.5%. For SCHT the challenges in performance are mainly attributable to the implementation of the MSST service (80% of total activity). This is attributable to seasonality and the bank holiday period. The activity levels of patients seen in December reduced significantly for MSST.

Although mitigation was in place to manage annual leave an increase in sickness further impacted. Operational recovery has been enacted with a forecast to improve the position in line with the progress seen post November.

Internally there has been focus on recovering to the 18 weeks position however prioritisation has been around high week waits in line with national guidance. New guidance has ben published January 2025(Reforming Elective Care for Patients) which details the requirement for 65% by March 2026 and 92% March 2029. A workshop has been held to align an ongoing trajectory and plan to achieve the mandated targets.

Risks that could impact not achieving this in year are attributable to local long wait times for access to diagnostics. Current waits:
MRI (non-contrast) 30 - 31 Weeks
CT 13 – 14 weeks
Ultrasound 32- 34 Weeks
Ultrasound Injection 40- 42 Weeks
X-ray 7-8 Weeks

The other significant risk to delivery remains with the delay to the transfer of orthopaedics. The date for transfer of orthopaedics has paused 3 times locally to support system pressures. The initial plan was to transfer April 2024. A paper is being shared via the system Planned Care Delivery Group and MSK Board to support full transfer by March 2025. Progress is also reported weekly through the Tier 1 system calls to gain NHSE endorsement to ensure this time frame is enacted.

APCS is making progress and improving their position reporting 66.79% in November.

GA Dental are also showing an improving position reporting 71.72%

Community Hospital Outpatients has a number of backlog patient pathways however there activity at the end of November is at 64%. This is due to ongoing challenges with consistent capacity being provided across all SLA with the acute Trust, particularly seen within ENT and Respiratory again this is being overseen at system level and escalated through Tier 1 national calls to maintain ongoing focus and flow through the service. This is also an avenue utilised for mutual aid across the region if required.

ction Plan

	Start Date	End Date	Status	Comments
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures thsi has been further delayed. A new proposal is going through ICB in January with the plan to have full compleition by April 25. This has been overseen by Planned care delivery grup and MSK Board. SCHT have escalated impact on peformance and patient pathways through Tier 1 calls for NHSE oversight.
MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	Firsty meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.
MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	Complete	Triage audit complete and confirms change in anticipated profile of referrals entering MSST. Learning from the audit being shared amongst triage team to support reduction in urgent and level 3 referrals. The impact of this piece of work is antcipated to provide benefit in the coming months by improving the traige process folloiwng understnading of actual examples.
Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arraged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.

Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Dec-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory and working through D&C. ENT Meteing arranged fo WB 9th Dec to review D&C and options for additional support this has been rearranged on several occassions due to UEC high escalation. With no additional capacity the risk of 52 and 65 week breaches remains.ENT is a ntional challenge with national guidence and support being a focus and therefore overseen through Tier 1.
Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
Dental team linking with SATH colleagues to consider further options to increase theatre capacity.	Oct-24	Nov-24	Complete	Tom Seager liasing with SATH colleagues to review option of utilising lofthouse for Dental theatre lists.
GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.	Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including superclinics and social prescribers.
Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all availiable capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory

Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	16/01/2025
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025

**Please note that the actual performance for the month is subject to change as the validation for the national submission continued at the time of updating the action plan*

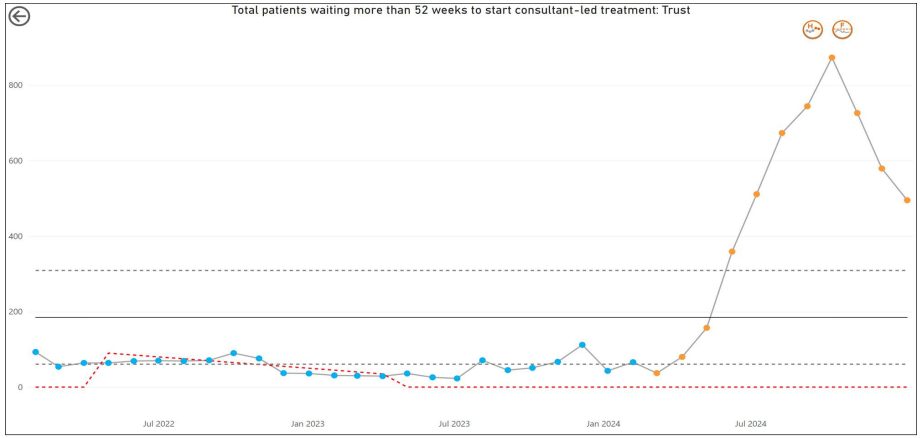
Exception Report - Action Plan

Total patients waiting more than 52 weeks to start consultant-led treatment

As at the end of the month, the number of patients that are still waiting for treatment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
RTT 52+ week waits	Number	673	744	873	726	579	495*	495*
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number	750	320	150	0	0	0	0



Reason for performance gap:	This is the third consecutive month demonstrating improvement across the 52-week cohort and we remain ahead of the planned trajectory. In terms of reportable RTT services there are now 0 52 week waits in APCS and Dental. The 52 week cohort therefore now only applies to Community Outpatients and MSST/ TEMS orthopaedics. In order to maintain consistent progress a further review of the 52-week trajectory has taken place with the revised target to reach 0 52 week waits by end of March 25 and this remains achievable. This is an internal target ahead of a nationally set target. SCHT remain the only provider in STW working on the 52-week cohort plan to hit 0 by March others are still working through 78 weeks and 65. Prioritisation of long waits has been the key focus nationally and is reported at the weekly Tier 1 NHSE E call. Although great progress can be seen potential risk to delivery remains due to local long wait times for access to diagnostics and the further delay in transfer of Orthopaedics now with the revised time frame for April 25.				
		Start Date	**End Date**	**Status**	**Outcome**
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures thsi has been further delayed. A new proposal is going through ICB in January with the plan to have full compleition by April 25. This has been overseen by Planned care delivery grup and MSK Board. SCHT have escalated impact on peformance and patient pathways through Tier 1 calls for NHSE oversight.
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	Firsty meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.

Action Plan	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	Complete	Triage audit complete and confirms change in anticipated profile of referrals entering MSST. Learning from the audit being shared amongst triage team to support reduction in urgent and level 3 referrals. The impact of this piece of work is antcipated to provide benefit in the coming months by improving the traige process folloiwng understnading of actual examples.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Dec-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory and working through D&C. ENT Meteing arranged fo WB 9th Dec to review D&C and options for additional support this has been rearranged on several occassions due to UEC high escalation. With no additional capacity the risk of 52 and 65 week breaches remains.ENT is a ntional challenge with national guidence and support being a focus and therefore overseen through Tier 1.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
	Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arraged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
	GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.	Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including superclinics and social prescribers.
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all availiable capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory

Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	15/01/2025
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025

**Please note that the actual performance for the month is subject to change as the validation for the national submission continued at the time of updating the action plan*

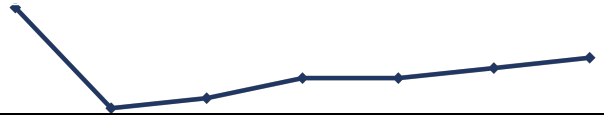
Exception Report - Action Plan

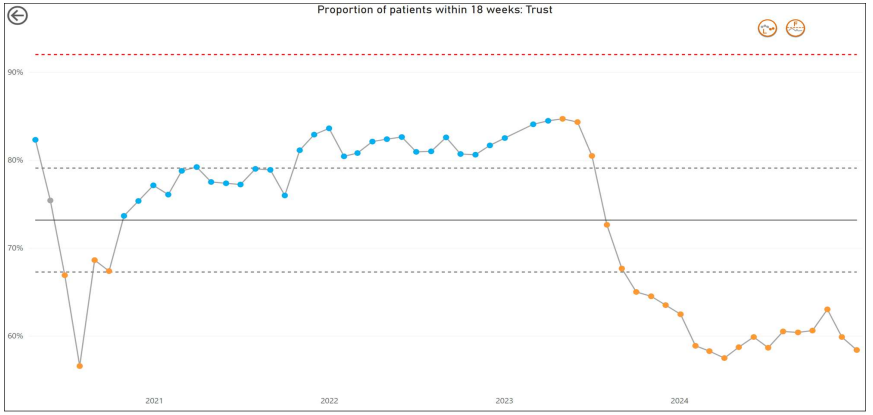
Proportion of patients within 18 weeks

The percentage of patients that are still waiting an appointment and are within 18 weeks

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of patients within 18 weeks	%	60.50%	60.39%	60.60%	63.01%	59.87%	58.39%	58.39%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	65.0%	60.0%	60.5%	61.5%	61.5%	62.0%	62.5%





Reason for performance gap:	Improvement trajectory for November was not achieved with 59.87% against the trajectory of 64.0% this further deteriorated in Dec to 58.39% and this reduction in performance has mainly been attributable to seasonality but also an increase in sickness throughout Dec impacting the number of clinics held across the month in all areas. Majority of activity aligns to MSST Internally there has been focus on recovering the 18 weeks position however prioritisation has been around high week waits in line with national guidance. The main challenge with recovery from a MSST/ TEMS perspective aligns to the delay in transfer of orthopaedics and the higher than anticipated numbers of level 3 than were originally modelled for the service. To manage this there is a high demand in the waiting lists for APP patients post their first treatment to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity with some short-term agency workforce also aligned. Community Paediatrician vacancies and sickness continue to have an adverse impact on the waiting list for Community Paediatrics in addition to the increased number of referrals for complex cases. This in turn also adversely affects the Child Development Centre waiting lists. A recruitment plan is in place to modernise the model with enhancing Specialist Nursery Nurses to support scheduling of growth skills this will then support productivity in the team and ensure the limited paediatric resource is best utilised. A locum has commenced in Jan to undertake Education, Care and Health Plans to reduce the waiting list and support the SEND agenda. Dental continues to have patients waiting above 18 weeks but improvement has been since with a reduction in the longest waiting patients. Speech and Language Therapy have had a robust recovery plan in place to mitigate particular workforce challenges attributable to sickness, maternity and vacancy. The waiting lists across all of the pathways are now clearly differentiated with prioritisation given to those children who are most clinically urgent. To support with a consistent proactive approach and ensure that long waits are prioritised it is vital that patients are aligned to the most appropriate pathways, an enhanced triage offer is required and demand and capacity modelling task is now going to progress to support ongoing recovery and embed a sustainable model. Community outpatients waiting list continues to be challenged due to a disparity between the demand and capacity and the reliance on external providers particularly with ENT and Respiratory with the teams focusing on reducing and mitigating the longest waiting patients on the pathways. LAC Nursing - Following a review, there was an amount of work the LAC service do for Children within their caseload that is not directly related to IHAs and RHAs but would be considered Commissioned activity which was not being recorded on Rio. since July the LAC Service have added Children to the waiting list which now includes their entire caseload, previously it would only include those children currently waiting for a IHA / RHA. This is now tipped into the over 18 week wait category. It does not give a true reflection of the waiting list and the information team have been looking at a way to extract the numbers of children on the caseload who are actually waiting for an IHA or RHA. Through out December a full data cleanse has taken place and an internal review of the caseload has been completed to ensure that that waiting list management is now in line with national requirements to differentiate between initial review and follow up guidance. Also, that discharge processes are fully understood to support efficiency across the service. There are other services which contribute to not meeting this performance target such as APCS, CNRT, Diabetic Nursing, Pulmonary Rehab, Bridgnorth Hospital Day case, Wheelchair Services, Adult Physio.

		Start Date	End Date	Status	Outcome
Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures this has been further delayed. A new proposal is going through ICB in January with the plan to have full completion by April 25. This has been overseen by Planned care delivery group and MSK Board. SCHT have escalated impact on performance and patient pathways through Tier 1 calls for NHSE oversight.
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	First meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	Complete	Triage audit complete and confirms change in anticipated profile of referrals entering MSST. Learning from the audit being shared amongst triage team to support reduction in urgent and level 3 referrals. The impact of this piece of work is anticipated to provide benefit in the coming months by improving the triage process following understanding of actual examples.
	Recruitment of substantive Neuropsychologist	Oct-24	Dec-24	Complete	Interviews were successful an onboarding is underway with potential start date in Jan if negotiations are successful.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	On track	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway.
	SLT to implement an enhanced Triage offer	Jan-25	Mar-25	On track	Initial plan and timescales agreed with informatics who have agreed to support.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	On track	Workshop with all SLT's scheduled to progress a consistent plan and approach
	CDC to sub contract 10 assessments to support with longest waiting children	Dec-24	Feb-25	On track	Procurement exercise in place to identify appropriate provider
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Dec-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory and working through D&C. ENT Meeting arranged of WB 9th Dec to review D&C and options for additional support this has been rearranged on several occasions due to UEC high escalation. With no additional capacity the risk of 52 and 65 week breaches remains. ENT is a national challenge with national guidance and support being a focus and therefore overseen through Tier 1.
	Dental team linking with SATH colleagues to consider further options to increase theatre capacity. Discussions with RJAH re a formal SLA too.	Oct-24	Jan-25	On track	Tom Seager liaising with SATH colleagues to review option of utilising Lofthouse for Dental theatre lists. Risk assessments being undertaken to assess suitability but confidence this will proceed and provide additional sessions to Dental. Negotiations ongoing with RJAH SLA with finances to be agreed. Currently off track from previous Nov target but revised due date as risk is minimal due to additional sessions being provided and RJAH activity continuing with waiting times reducing.

Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arranged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	On track	New Paediatrician commence in post, New locum started Dec, service review is planned and recruitment of nursery nurses in place. Job planning for all paediatricians also in place to review current plans in line with newly published guidance.
LAC Nursing service to review waiting list cohort to ensure the recorded waits are an accurate reflection	Dec-24	Dec-24	On track	Work commenced over the Christmas Period to look at rectifying/cleansing the waiting list to show the true waits rather than the whole caseload also ensure guidance re first contact and follow up are accurately and consistently applied.
Information team to support the reporting of the new waiting lists in LAC Nursing	Jan-25	Jan-25	On track	Information team will work with the service and Rio team to ensure appropriate waits are reported in line with the above action.
GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.	Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including super clinics and social prescribers.
Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all available capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory

Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	15/01/2025
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025

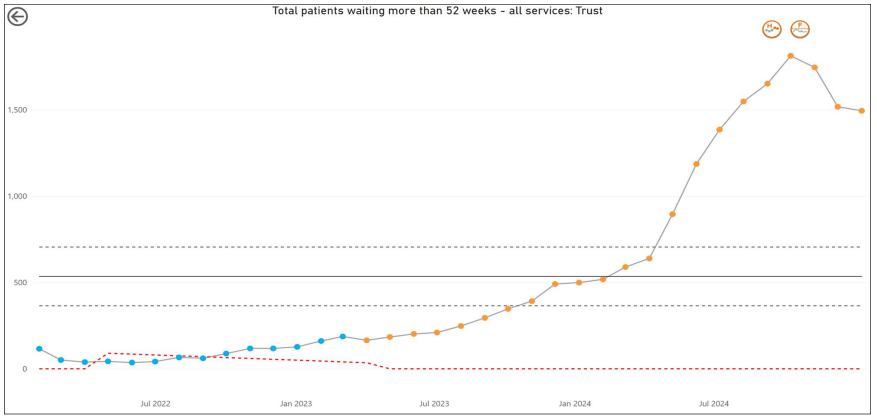
Exception Report - Action Plan

Total patients waiting more than 52 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
52+ Week waits - All services	Number	1548	1651	1812	1745	1517	1494	1494
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number	2300	1450	1350	1250	1200	1100	1000



Reason for performance gap:

The reduction of 52 weeks is a ahead of the planned trajectory by 800. An action for January is therefore to further revise the trajectory. This progress has been driven through efficiency gains with digital solutions and admin process driving productivity. Recovery has been dependent upon enhanced locum support within Paeds with the assumption that this will remain the only other element that could impact progress would be a further delay post April 25 of the orthopaedic transfer. Until this is fully supported and implemented at system level a date to recover can not be forecast.

CNRT does still have a number of patients within 52 weeks due to the last 12 months challenges with access to Psychology provision.. The service has been without substantive Psychology support for over 18 months and this is where the waits are attributable to. The service mitigated impact by securing an SLA with Circle to provide some Psychology support. This has managed to maintain and slightly reduce the high week waits but recent sickness and AL by the clinician from Circle has impacted on recovery and lead to 104 week waits. Given that Circle has not been able to provide a sustainable and reliable solution a demand and capacity review has taken place with an alignment of workforce requirements. Adverts to recruit internally for a Psychologist and Psychology Assistant have now progressed with workforce commencing end of January.

Majority of activity still aligns to MSST, the main challenge with recovery from a MSST/ TEMS perspective aligns to the delay in transfer of orthopaedics and the higher than anticipated numbers of level 3 than were originally modelled for the service. To manage this there is a high demand in the waiting lists for APP patients post their first treatment to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity with some short-term agency workforce also aligned.

Community Paediatrician vacancies and an increase in the number of complex case referrals continue to have an adverse impact on the waiting list for Community Paediatrics, mitigation in place with locums. There are 90 children waiting to be seen at 52 weeks or above this is an increasing picture. All children waiting longer than 52 weeks in Community Paediatrics are attributable to Children waiting for Schedule of Growth Skills (SOGS) appointments. This has been due to the decreased capacity of our Specialist Nursery Nurse Team and reduced admin capacity to support with managing clinics and validation. Thes vacancies have now progressed through to recruitment. There are regular meetings with the team to review the waiting list and prioritise as well as planned start dates for peadatrian and nursery nurses which will ensure capacity moving forward to continue to reduce the 52 week cohort.

CDC (Child development centre) is currently holding 62 children above 52 weeks, Locum paediatrician in place to support recovery. Out to advert for nursery nurses to support assessment process.

Speech and Language therapy have also seen an increase in over 52 weeks and now have 39 children. This is due to an increase in clinically urgent referrals and staff vacancies in the team impacting clinics. A demand and capacity piece of work is scheduled to support aligning all available workforce on a daily basis to manage appropriately clinical urgent cases and maintain capacity within the long wait cohorts to ensure progress continues. An enhanced triage tool is also being implemented to support waiting list management.

There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients, Wheelchair Services.

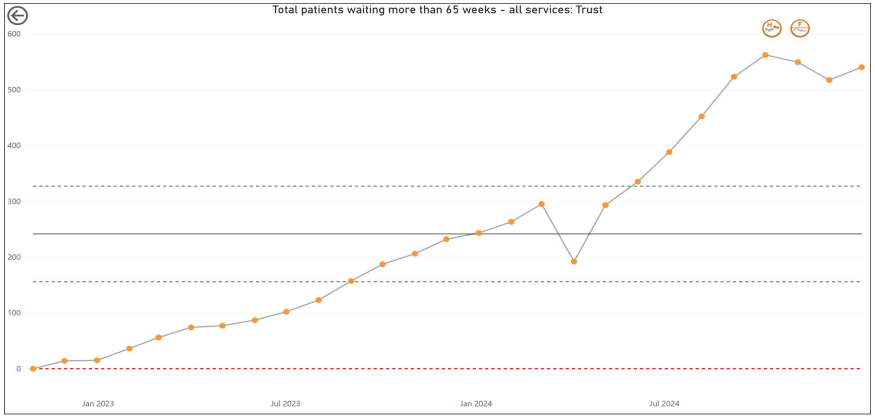
		Start Date	End Date	Status	Outcome
Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures this has been further delayed. A new proposal is going through ICB in January with the plan to have full completion by April 25. This has been overseen by Planned care delivery group and MSK Board. SCHT have escalated impact on performance and patient pathways through Tier 1 calls for NHSE oversight.
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	First meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	Complete	Triage audit complete and confirms change in anticipated profile of referrals entering MSST. Learning from the audit being shared amongst triage team to support reduction in urgent and level 3 referrals. The impact of this piece of work is anticipated to provide benefit in the coming months by improving the triage process following understanding of actual examples.
	Recruitment of substantive Neuropsychologist	Oct-24	Dec-24	Complete	Interviews were successful an onboarding is underway with potential start date in Jan if negotiations are successful.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	On track	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway.
	CDC to sub contract 10 assessments to support with longest waiting children	Dec-24	Feb-25	On track	Procurement exercise in place to identify appropriate provider
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	On track	New Paediatrician commence in post, New locum started Dec, service review is planned and recruitment of nursery nurses in place. Job planning for all paediatricians also in place to review current plans in line with newly published guidance.
	Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arranged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
	SLT to implement an enhanced Triage offer	Jan-25	Mar-25	On track	Initial plan and timescales agreed with informatics who have agreed to support.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	On track	Workshop with all SLT's scheduled to progress a consistent plan and approach
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Dec-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory and working through D&C. ENT Meeting arranged of WB 9th Dec to review D&C and options for additional support this has been rearranged on several occasions due to UEC high escalation. With no additional capacity the risk of 52 and 65 week breaches remains. ENT is a national challenge with national guidance and support being a focus and therefore overseen through Tier 1.

	GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.		Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including super clinics and social prescribers.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all available capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory
Author	Alastair Campbell/ Helen Cooper / Mark Onions/Gemma McIver	**Date**	15/01/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025			

Exception Report - Action Plan

Total patients waiting more than 65 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 65 weeks and over



KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
65+ Week waits - All services	Number	452	523	562	549	517	540	540
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number	700	500	475	450	425	400	375

Reason for performance gap:	On track in line with planned trajectory currently. For assurance recovery can be achieved but is reliant on orthopaedic transfer. Until this is fully supported and implemented at system level a date to recover can not be forecast. Paediatric Consultant capacity will also be a key area of focus with current locum usage to mitigate. SLT have sustained their improvement with 0 65 week waits. CNRT does still have a number of patients within 65 weeks due to the last 12 months challenges with access to Psychology provision.. The service has been without substantive Psychology support for over 18 months and this is where the waits are attributable to. The service mitigated impact by securing an SLA with Circle to provide some Psychology support. This has managed to maintain and slightly reduce the high week waits but recent sickness and AL by the clinician from Circle has impacted on recovery and lead to 104 week waits. Given that Circle has not been able to provide a sustainable and reliable solution a demand and capacity review has taken place with an alignment of workforce requirements. Adverts to recruit internally for a Psychologist and Psychology Assistant have now progressed with workforce commencing end of January. Majority of activity for over 65 week waits post initial treatment still aligns to MSST, the main challenge with recovery from a MSST/ TEMS perspective aligns to the delay in transfer of orthopaedics and the higher than anticipated numbers of level 3 than were originally modelled for the service. To manage this there is a high demand in the waiting lists for APP patients post their first treatment to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity with some short-term agency workforce also aligned. There has been a further deterioration in the 65 week wait position for Community Paediatrics from 27 to 29 children waiting. These are all in relation to children waiting Schedule of Growth Skills (SOGS) appointments enhancing the nursery nurse workforce will support to recover this position long term. Start dates are scheduled for January which will enhance appointment by 20 extra a month in January and then 50 in February supporting to align with the improvement trajectory. CDC (Child development Centre) now have 20 65 week waits which will be prioritised to be seen in January and they all have appointment dates. There are other services which contribute to not meeting this performance target such as, Community Hospital Outpatients.

	Start Date	End Date	Status	Outcome
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures this has been further delayed. A new proposal is going through ICB in January with the plan to have full completion by April 25. This has been overseen by Planned care delivery group and MSK Board. SCHT have escalated impact on performance and patient pathways through Tier 1 calls for NHSE oversight.

Action Plan	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	Firstly meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	Complete	Triage audit complete and confirms change in anticipated profile of referrals entering MSST. Learning from the audit being shared amongst triage team to support reduction in urgent and level 3 referrals. The impact of this piece of work is anticipated to provide benefit in the coming months by improving the triage process following understanding of actual examples.
	Recruitment of substantive Neuropsychologist	Oct-24	Dec-24	Complete	Interviews were successful an onboarding is underway with potential start date in Jan if negotiations are successful.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	On track	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway.
	SLT to implement an enhanced Triage offer	Jan-25	Mar-25	On track	Initial plan and timescales agreed with informatics who have agreed to support.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	On track	Workshop with all SLT's scheduled to progress a consistent plan and approach
	Operational and Information to conduct MSST demand and capacity modelling	Dec-24	Jan-25	On track	First meeting arranged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
	CDC to sub contract 10 assessments to support with longest waiting children	Dec-24	Feb-25	On track	Procurement exercise in place to identify appropriate provider
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	On track	New Paediatrician commence in post, New locum started Dec, service review is planned and recruitment of nursery nurses in place. Job planning for all paediatricians also in place to review current plans in line with newly published guidance.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Dec-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory and working through D&C. ENT Meeting arranged of WB 9th Dec to review D&C and options for additional support this has been rearranged on several occasions due to UEC high escalation. With no additional capacity the risk of 52 and 65 week breaches remains. ENT is a national challenge with national guidance and support being a focus and therefore overseen through Tier 1.
	GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.	Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including super clinics and social prescribers.

	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all available capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	15/01/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025			

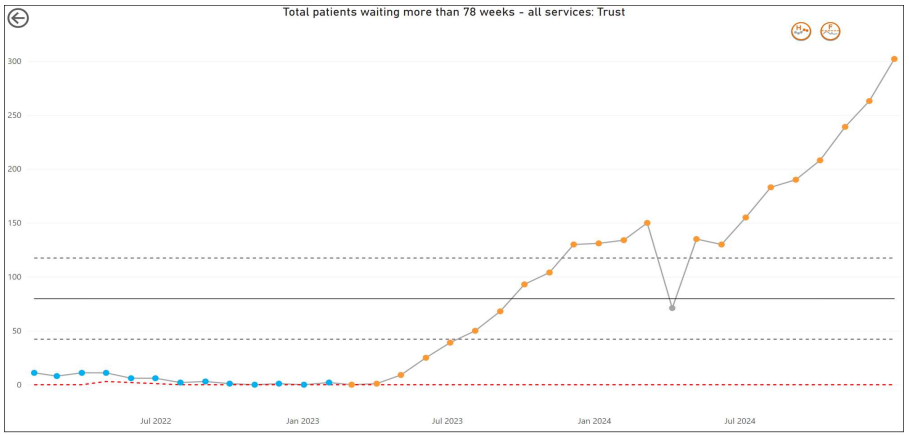
Exception Report - Action Plan

Total patients waiting more than 78 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
78+ Week waits - All services	Number	183	190	208	239	263	302	302
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number	305	300	275	250	225	200	175



Reason for performance gap:	The 78 week position is worsening as predicted due to the delay in the transfer of orthopaedics which is now due April 2025. Until this is fully supported and implemented at system level a date to recover cannot be fully forecast for assurance. Majority of activity for over 78 week waits post initial treatment still aligns to MSST, the main challenge with recovery from a MSST/ TEMS perspective aligns to the delay in transfer of orthopaedics and the higher than anticipated numbers of level 3 than were originally modelled for the service. To manage this there is a high demand in the waiting lists for APP patients post their first treatment to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity with some short-term agency workforce also aligned. Only 5 children within children's services align to 78+ cohort and all have appointments to be seen imminently it is anticipated that for January children's services will have 0 78 week waits. CNRT has also seen 78 weeks long waits within their waiting list due to significant challenges with Psychology provision which will commence recovery by end of January with the commencement of an internal psychologist and psychology assistant.				
		Start Date	**End Date**	**Status**	**Outcome**
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24 this was then revised to commence in Dec 24 with full transition by Feb 25. Due to system pressures this has been further delayed. A new proposal is going through ICB in January with the plan to have full completion by April 25. This has been overseen by Planned care delivery group and MSK Board. SCHT have escalated impact on performance and patient pathways through Tier 1 calls for NHSE oversight.
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	Complete	First meeting held and these are now ongoing monthly. Multiple PDSA's set up through this group including super clinics, rapid assessment clinics and injection blitz clinics. This is supporting an improvement methodology to deliver the planned trajectory which is clinically driven.

Action Plan	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Dec-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST. Original end date was Aug-24, now extended in line with the above. Aiming for implementation of My Recovery in Dec 24/Jan 25.
	Operational and Information to conduct MSST demand and capacity modelling		Dec-24	Jan-25	On track	First meeting arranged for 9th Dec with focus on level 3 and Urgents but incapsulating all of MSST therapy (level 2 and level 3). Once complete further actions anticipated.
	Recruitment of substantive Neuropsychologist		Oct-24	Dec-24	Complete	Interviews were successful an onboarding is underway with potential start date in Jan if negotiations are successful.
	Transition from Circle to in house provision to be completed		Jan-25	Feb-25	On track	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway.
	GIRFT (Getting it right first time) have awarded STW with some transformation non recurrent funding. An action plan to utilise this has been created.		Jan-25	Mar-25	On Track	Operational leads have linked with SaTH, who have successfully used MBI validators. The plan is to support validation of both RTT and non-RTT waiting lists. Plans are being worked up to support other projects utilising the GIRFT funding including super clinics and social prescribers.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	Job planning with all APP's and linked in with RJAH to review all available capacity and agreed a short term agency plan with SCHT and RJAH to enhance capacity for an initial 6 week period to support the revised trajectory
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	15/01/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025			

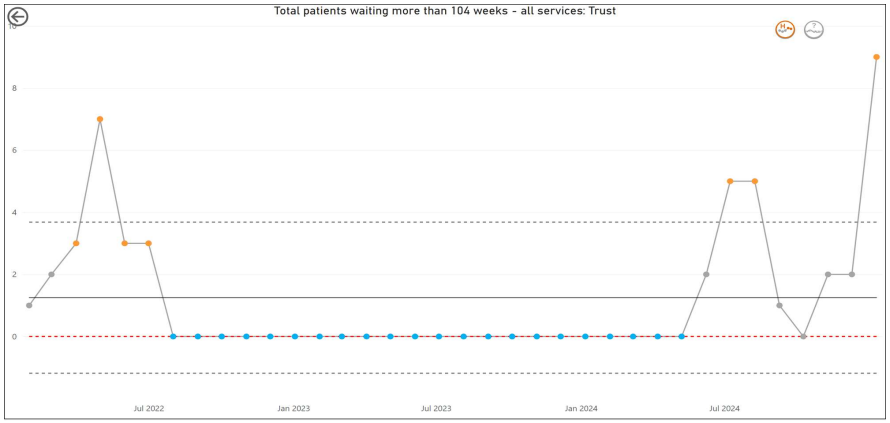
Exception Report - Action Plan

Total patients waiting more than 104 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
104+ Week waits - All services	Number	5	1	0	2	2	9	9
	Target	0	0	0	0	0	0	0

Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Number	0	2	0	0	0	0	0



Reason for performance gap:	CNRT is the only service with current 104 week waits. All of the patients have had some form of intervention elsewhere within the CNRT service but have waited 104+ for Psychology intervention. The service has been without substantive Psychology support for over 18 months. The service mitigated this by securing an SLA with Circle to provide some Psychology support but this was only possible for 0.3WTE. This has managed to maintain and slightly reduce the high week waits but recent sickness and AL by the clinician from Circle has impacted on recovery and lead to 104 week waits. Given that Circle has not been able to provide a sustainable and reliable solution a demand and capacity review has taken place with an alignment of workforce requirements. Internal adverts for a Psychologist and Psychology Assistant have now progressed with workforce commencing end of January.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review the 52 week cohort trajectory	Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	Jul-24	Complete	Psychology SLA provision agreed and implemented as of July 2024. Top 20 longest waits have either now been seen or have appointments by the end of August 2024
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	On track	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway.
	Recruitment of substantive Neuropsychologist	Oct-24	Dec-24	Complete	Interviews were successful an onboarding is underway with potential start date in Jan if negotiations are successful.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/01/2025		
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025		

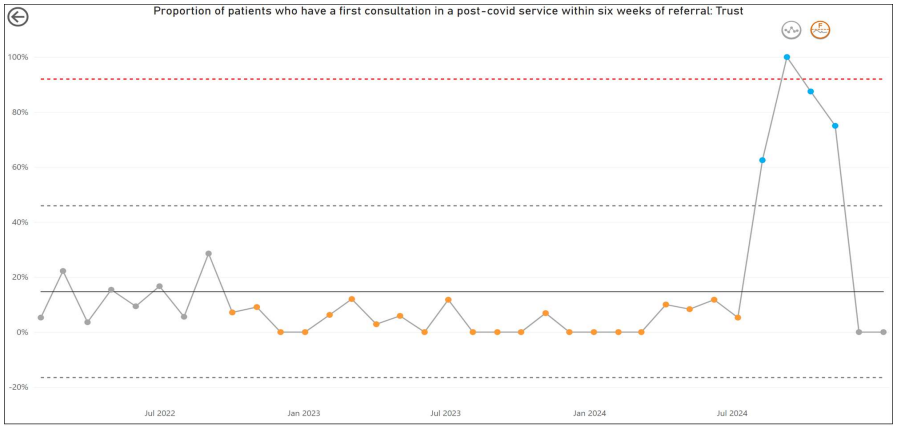
Exception Report - Action Plan

Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

The percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Proportion of patients within 6 weeks	%	62.50%	100.00%	87.50%	75.00%	0.00%	0.00%	0.00%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	40.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%



Reason for performance gap:	The service continues to be perforimng well overall depsite the percentage of patients booked within 6 weeks showing otherwise. The above KPI relates to the number of patients booked within 6 weeks and therefore will not account for the patients below 6 weeks not dated. The numbers are relatively small with currently 20 patients on the intial outcome waiting list. Of these 20, 11 are dated between 7 and 10 weeks due to some AL with the sole GP in the service. The other 9 patients are either booked within 6 weeks or not dated but below 6 weeks. All patients are triaged when the referral is recieved and provided a welcome pack which provides support whilst waiting for their appointment. Waiting times within the Long Covid Service have been a challenge since the service commenced in November 2020. NHS England had high expectations from the beginning and this was evidenced by the main reportable national key performance indicator (KPI) focusing on waiting times. The aim was for all patients to receive an initial assessment within 6 weeks of referral.Due to high demand and back log this has been a challenged KPI in Shropshire Community Health NHS trust (SCHT) due to multifactorial reasons including finance, workforce availability and high referral rates. Improvement has been demonstarted through July with a further significant step change in August following the team clearing historical backlog aligned to large demand when the service initially launched. Targeting the back log waiting list with additional clinics, a revised approach to triage and MDT approach has enabled the demand profile to now meet aligned capacity. The percentage is likely to continue fluctuate though due to the small number of patients on the waiting list. There are no major concerns with the service and it's waiting times going forward but due to the small number of patients on the waiting list there may be a little fluctuation, recently this has been due to team staff sickness and patient choice over the Christmas / New year period as well as patient cancellations due to illness. These factors have increased waits only slightly beyond the 6 week target and a high percentage of those with pending appointment are not above a 10 week wait.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Work with NHSE and primary care to scope a self referral model	Sep-24		On Hold	PDSA planning has commenced but on hold due to funding/service plan for 25/26.
	Include waiting list actual numbers and activity in update for RPC to provide context over	Nov-24	Jan-25	On track	Activity numbers included within the report
	Working with Commissioners towards planning cycle	Nov-24	Apr-25	On track	
Author	Alastair Campbell	**Date**	15/01/2025		
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025		

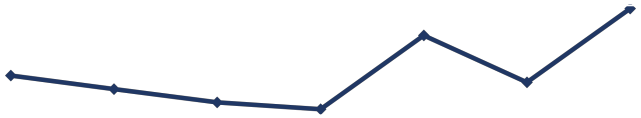
Exception Report - Action Plan

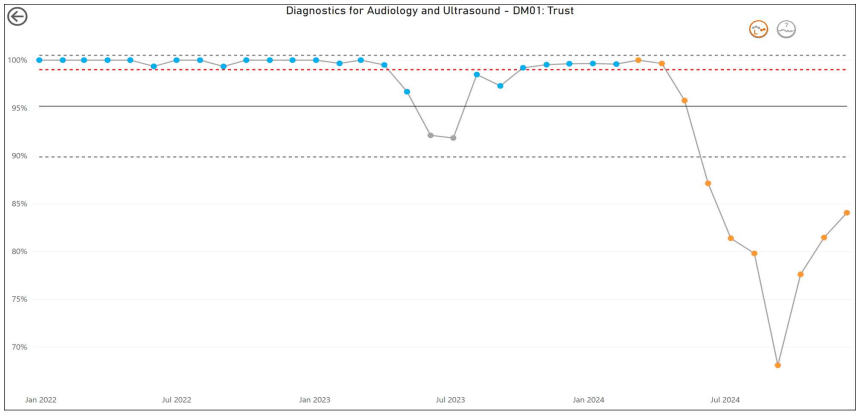
Diagnostics for Audiology and Ultrasound - DM01

DM01 statutory return - Percentage of patients waiting within 6 week standard

KPI Description	Latest 6 months	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD
DM01	%	81.36%	79.79%	68.08%	77.59%	81.45%	84.04%	84.04%
	Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Trajectory	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
%	93.0%	92.8%	92.6%	92.5%	93.6%	92.9%	94.0%





Reason for performance gap:	For Audiology we are now reporting any planned patients that are overdue for their appointment as active waits, as per National DM01 requirements. Figures are higher and there are more breaches due to this. This month improvement has been demonstrated, this is attributable to planned improvements around data cleanse, triage management of appointments and work to support clinic utilisation. Due to the changes in DM01 rules it is likely that to fully recover the position long term additional capacity is needed. This is alongside an increase in demand. The team have commenced a service review which details some demand capacity modelling and recommendations for the future. The patient facing part of the service is entirely provided by SaTH and therefore difficult to manage the capacity currently the service review will provide options to strengthen this moving forward.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review of SLA with SaTH	Jun-24	Dec-24	Off Track	Service Review Planned to support an new SLA - Service review drafted and shared with corporate colleagues for input across finance, activity and performance.
	Understanding of the national change in reporting and impact on performance - review of data quality	Oct-24	Nov-24	Complete	Deep dive arranged with national support to understand and bench mark position locally
	Demand and capacity model with SaTH to understand clinic capacity to support improvement trajectory	Oct-24	Dec-24	On track	Analysis commenced, linking with Contracts to formalise the ask
	Contract review meeting with SaTH to review recovery of performance	Dec-24	Jan-25	On track	Arranging meeting dates and attendance
Author	Mark Onions/Gemma McIver	**Date**	13/01/2025		
Accountable Officer Approval	Claire Horsfield	**Date**	20/01/2025		

Shropshire Community Health NHS Trust

Month 9 2024/25 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	6 February 2025
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	28 January 2025
Paper Reviewed by:		**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance as at month 9 and is for action and assurance.

2. Executive Summary

2.1. Context

The Trust's 2024/25 Income and Expenditure (I&E) plan is to achieve a surplus of £1,768k; this reflects the financial plan submission to NHS England (NHSE) on 12 June 2024. The Trust's 2024/25 capital expenditure plan (excluding capitalised leases) is £2,250k.

This paper summarises the Trust's financial performance for the period ended 31 December 2024 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £2,034k adjusted surplus for the year to date compared to the planned surplus of £1,075k, which is a favourable variance of £959k.

Key areas for consideration are:

- **Agency** spend to month 9 is £3,998k. This is favourable to plan by £61k. Our expectation is for agency costs to be in line with plan for the year. **Agency usage and overall pay costs must remain within planned levels to deliver the forecast surplus.**
- **CIP** performance to date is a favourable variance to plan by £495k, with actual delivery of £2,681k efficiencies. £74k of CIP schemes are currently rated as high risk in terms of delivery which is an improvement of £247k compared to the position reported at month 8. **We must deliver the CIP target in full to deliver the forecast surplus.**
- **Elective Income**. SCHT is currently reporting an overperformance compared to plan, NHSE has indicated that elective income will be capped at month 8 forecast levels and we are awaiting guidance to assess how this compares to our forecast. At month 9 we are reporting an overperformance in elective income of £1,200k compared to plan, this is in line with month 8 forecast and reflects our internal monitoring and NHSE Elective Recovery Fund (ERF) reported values. **This position is forecast to continue and underpins our improved surplus position for year-end.**

Month 9 2024/25 Financial Performance

- **Capital funding** The Capital forecast outturn is to deliver our BAU capital projects in line with plan of £2,250k. Our forecast spend on capitalised leases is £4,000k, which is an underspend of £1,135k compared to plan. The reduced spend on leases is a result of our focus on improving the utilisation of the SCHT Estate and to support management of the overall system IFRS16 allocation. **Delivery of our capital plan continues to be managed closely.**

- **Our forecast outturn** is now to deliver an improved surplus position of £3,600k compared to our original planned surplus of £1,768k as agreed at the Trust Board meeting on 5 December 2024. This will support the overall STW ICS financial position. Forecasts for all organisations across the STW ICS will be formally updated once timing is agreed with NHSE. The improvement in our forecast outturn position is largely due to ERF income overperformance which is not fully matched with cost and the additional grip and control measures that are in place. There are a number of identified risks which have been fully mitigated to date, however these and any other emerging risks will be regularly reviewed together with mitigations and potential opportunities. **Risks, mitigations and opportunities are being regularly assessed to inform our forecast.**

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 9 is a surplus of £2,034k compared to the planned surplus of £1,075k, which is a favourable variance of £959k.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3,588k with £74k of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that our capital expenditure forecast outturn is now an underspend of £1,135k relating to capitalised leases. This is due to our focus on improving the utilisation of the SCHT Estate, which includes reducing our lease commitments, and supports STW ICS to live within available funding for lease expenditure.
- **Consider** that our forecast outturn has now improved to deliver a surplus of £3,600k, which is £1,832k favourable to plan. This will be reported in our NHSE returns once a revised 2024/25 STW ICS forecast position is agreed with NHSE. There remain several risks, mitigations and opportunities which may impact upon delivery and these are closely managed.

Month 9 2024/25 Financial Performance

3. Main Report

3.1. Introduction

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

3.1.1. Summary of key points in report

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

Financial Performance against Plan (£k)	M09 Plan	M09 Actual	M09 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast	Annual Variance
(Surplus)/ Deficit	(233)	(504)	(271)	(1,075)	(2,034)	(959)	(1,768)	(3,600)*	(1,832)*
Agency Expenditure	320	288	(32)	4,059	3,998	(61)	4,898	4,898	0
Cost Improvement Programme	469	607	138	2,186	2,681	495	3,588	3,588	0
BAU Capital Expenditure	63	150	87	1,597	520	(1,077)	2,250	2,250	0

*** The updated forecast was not reported in the NHSE returns at M09. All forecasts across STW ICS will be updated when agreed with NHSE.**

3.2. Adjusted Financial Performance – favourable variance to plan £959k

The adjusted financial position is a surplus of £2,034k compared to the planned surplus of £1,075k, which is a favourable variance of £959k as summarises in Table 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(93,129)	(94,686)	(1,557)
Expenditure excl. adjusting items	92,054	92,652	598
Adjusted financial performance total	**(1,075)**	**(2,034)**	**(959)**
Adjusting items	119	100	(19)
Retained (surplus) / deficit	**(956)**	**(1,934)**	**(978)**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 31 December 2024

3.2.1. Income – favourable variance to plan £1,557k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	YTD Variance £k
System income	(69,490)	(70,740)	(1,250)
Non system income	(23,639)	(23,947)	(308)
Total income	**(93,129)**	**(94,686)**	**(1,557)**

Table 2: Income Summary as at 31 December 2024

Month 9 2024/25 Financial Performance

System income comprises of agreed block income and an element of variable income linked to the delivery of elective activity.

The Musculoskeletal Services, Shropshire and Telford (MSST) were introduced in 2023/24 and is delivering more activity than planned, resulting in additional elective income. NHSE has indicated that elective income for each system will be capped at month 8 forecast levels. We are waiting formal confirmation of the STW capped value and whilst we are not expecting any adverse impact on our forecast elective income, as our forecast is in line with month 8 STW forecast levels, this remains a risk until confirmed. At month 9 we are reporting an overperformance in elective income of £1,200k compared to plan, reflecting our internal monitoring and NHSE Elective Recovery Fund (ERF) reported values. This position is forecast to continue and underpins our improved surplus position by the year-end.

Non system income overperformance is due mainly to training income and additions to Local Authority contracts that are matched with expenditure.

3.2.2. Expenditure – adverse variance to plan £580k

Table 3 shows a summary of expenditure, by key categories, for the year to date at month 9.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	60,754	59,350	(1,404)
Bank	1,841	2,320	479
Agency	4,059	3,998	(61)
Total Pay	**66,655**	**65,668**	**(987)**
Clinical Supplies & Services	8,182	9,330	1,149
Prison Escorts and Bedwatch	197	400	204
Drugs	1,250	1,121	(128)
Premises	7,390	7,499	109
Travel	1,189	1,063	(126)
Other	3,367	4,691	1,324
Non-Pay	**21,574**	**24,105**	**2,531**
Trust wide Central Charges	3,945	2,980	(965)
Total Non-Pay	**25,519**	**27,085**	**1,566**
Total Expenditure	**92,173**	**92,753**	**580**

Table 3: Expenditure Summary as at 31 December 2024

3.2.3. Pay – favourable variance to plan £987k

The overall pay position is a favourable variance of £987k for the year to date. This is due to substantive vacancies which total £1,404k at this point in the year, largely due to the significant impact of the grip and control measures in place. The substantive pay underspend is partially offset by bank usage which is £479k overspent; bank staff (paid at substantive rates) are utilised to cover vacant shifts, wherever possible, to avoid the use of agency staff. Agency costs are £61k favourable to plan, with favourable variances in MSK, Stoke Heath Prison and GP cover in Bridgnorth and Whitchurch Hospitals almost offset by overspend on Community Nursing and Rehab & Recovery Units (RRU).

Month 9 2024/25 Financial Performance

The vacancy rate in month 9 has increased marginally to 10.8% which equates to 198 WTE vacancies compared to the month 8 position of 10.6% and 192 WTEs.

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

NHSE financial controls require all recruitment to be subject to review and approval by system partners.

3.2.4. Non-Pay and Central Charges – adverse variance to plan £1,566k

Clinical supplies and services are overspent by £1,149k for the year to date and this is largely due to:

- Out of hours medical cover costs for the RRUs are exceeding planned levels, alternative approaches to providing this medical cover are being explored.
- Secondary mental health services at Stoke Heath Prison were sourced from an alternative provider at short notice resulting in some cost pressures. Discussions are ongoing with the new provider and commissioner to identify potential mitigations, with the final outcome expected in the near future.
- Additional costs in relation to Local Authority contracts and ERF activity delivery which are offset in full by income overperformance.

The adverse variance within 'Other' non-pay is due to some CIP budgets which have not yet been allocated to relevant budget lines and charges in relation to the Rehab and Recovery Units exceeding planned levels. We made progress in allocating CIP budgets and work continues with individual budget managers to identify budget adjustments which will reduce this adverse variance.

The favourable variance for central charges relates largely to interest received on our bank balance.

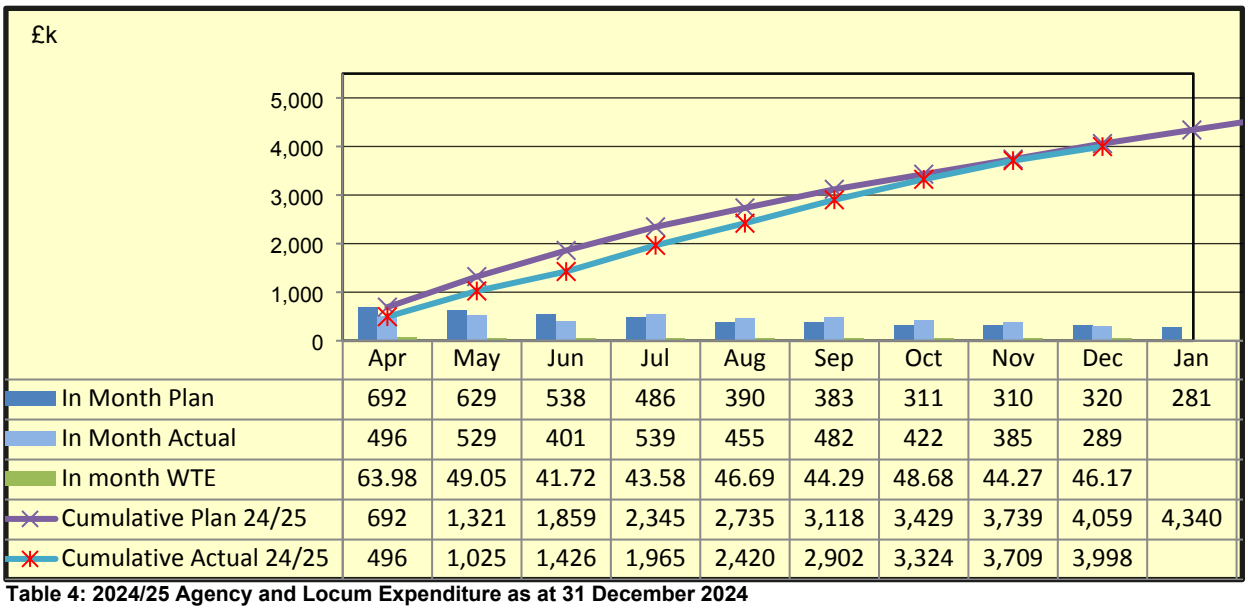
3.2.5. Agency and Locum Expenditure – favourable variance to plan £61k

Table 4 shows agency spend is £3,998k which is £61k favourable to the plan of £4,059k. The annual agency plan for 2024/25 is £4,898k.

Agency spend was £288k in December compared to £385k in November. The reduction in December was due to a change in medical provision at the RRU Wards. This results in the new contractual arrangements being reported as non-pay costs (clinical supplies and services).

44 WTE agency staff were used in December. The national agency ceiling target for the NHS in 2024/25 is 3.2% whilst STW has a cap of 6.5%. The Trust is now at 6.0% at this stage of the year which is within the STW target. Our forecast is to manage our agency costs within planned levels; however this remains challenging, particularly through the Winter period.

Month 9 2024/25 Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
In Month Plan	692	629	538	486	390	383	311	310	320	281
In Month Actual	496	529	401	539	455	482	422	385	289	
In month WTE	63.98	49.05	41.72	43.58	46.69	44.29	48.68	44.27	46.17	
Cumulative Plan 24/25	692	1,321	1,859	2,345	2,735	3,118	3,429	3,739	4,059	4,340
Cumulative Actual 24/25	496	1,025	1,426	1,965	2,420	2,902	3,324	3,709	3,998	

Table 4: 2024/25 Agency and Locum Expenditure as at 31 December 2024

The key drivers for the favourable year to date agency variance of £61k are: successful recruitment across some key services; increased bank staff usage to cover vacant shifts; and the enhanced scrutiny and controls in place. However, there is continuing pressure in Community Nursing arising from increased demand for timed medication visits, expansion of supported living establishments where demand for services tends to be greater plus high levels of maternity leave. This is resulting in the agency usage in these teams running above plan levels.

STW ICB has established a System Workforce Agency Reduction Group which includes the three providers and the ICB. We also have an internal Agency Scrutiny Group which meets weekly to scrutinise all requests for agency usage; if the request is accepted by the group, it is then submitted to the Director of Nursing for final approval. The above measures are designed to safely reduce agency spend; however, the agency reduction programme is closely monitored to take account of any patient safety risk. Quality, Equality Impact Assessments are undertaken for any changes as appropriate.

3.2.6. Cost Improvement Programme - favourable variance to plan £495k

The Trust's CIP target for 2024/25 is £3,588k which is 3.5% of the Trust's overall planned expenditure for this year. The recurrent CIP element totals £3,088k and the non-recurrent element is £500k.

Table 5 shows actual CIP recurrent delivery at month 9 is £1,783k, this is £203k adverse compared to the recurrent plan of £1,986k. However, this is mitigated by the Trust delivering £698k of non-recurrent CIP ahead of the non-recurrent CIP target. This results in an overall CIP delivery of £2,681k, which is £495k favourable to plan.

Category £k	Annual Plan £k	Year to Date £k		
	Recurrent	Plan YTD	Actual YTD	Variance (adv)/fav
Recurrent	3,088	1,986	1,783	(203)
Non-Recurrent	500	200	898	698
GRAND TOTAL	**3,588**	**2,186**	**2,681**	**495**

Table 5: CIP 2024/25 YTD Performance as at 31 December 2024

Month 9 2024/25 Financial Performance

It should be noted that our CIP is profiled more heavily towards the latter months of the year, which increases the level of risk within our plan. Had the programme been profiled evenly across the financial year, the year to date plan would have been £2,691k at month 9, an increase of £505k compared to our actual plan.

Our CIP Working Group meets weekly and is overseen by the Financial Recovery Group. The Groups are focussed on de-risking our CIP programme at pace and developing alternative schemes as potential mitigations. Progress is being made at each meeting with the value of high risk schemes reducing by £247k compared to month 8. All relevant CIP schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

Table 6 shows that we have fully identified schemes to deliver the 2024/25 CIP target of £3,588k. To date, £74k (2%) of schemes are rated 'high risk' in terms of delivery, an improvement compared to month 8, when high risk schemes made up £321k (9%) of our target.

Recurrent/Non Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total Forecast £k	Total Plan £k	Full Year Effect £k
Recurrent	2,426	190	74	-	2,691	3,088	3,105
Non Recurrent	897	-	-	-	897	500	-
	3,323	**190**	**74**	**-**	**3,588**	**3,588**	**3,105**
Risk Percentages							
Recurrent	68%	5%	2%	0%	75%	86%	
Non Recurrent	25%	0%	0%	0%	25%	14%	
	93%	**5%**	**2%**	**0%**	**100%**	**100%**	

Table 6: 2024/25 CIP by risk category

Delivery of non-recurrent savings is forecast to exceed plan as mitigation for a forecast shortfall in recurrent delivery in-year. However, the full year effect forecast of our in-year recurrent schemes is £3,105k which exceeds our annual plan.

3.2.7. Statement of Financial Position

The summarised Statement of Financial Position as at 31 December 2024 is shown in Table 7.

	30 Nov 24 Balance £k	31 Dec 24 Balance £k	Movement in Month £k
Property, Plant & Equipment	41,879	41,654	(225)
Inventories	210	210	0
Non-current assets for sale	0	0	0
Receivables	4,349	3,287	(1,062)
Cash	25,517	26,084	567
Payables	(13,064)	(11,925)	1,139
Provisions	(3,493)	(3,493)	0
Lease Obligations on Right to Use Assets	(12,209)	(12,136)	73
TOTAL ASSETS EMPLOYED	**43,189**	**43,681**	**492**
Retained earnings	34,264	34,756	492
Other Reserves	8,925	8,925	0
TOTAL TAXPAYERS' EQUITY	**43,189**	**43,681**	**492**

Table 7: Statement of Financial Position (SoFP) as at 31 December 2024

Month 9 2024/25 Financial Performance

- Receivables (amounts we are owed) decreased by £1,062k largely due to payments received for outstanding debtor invoices.
- Payables (amounts we owe) decreased by £1,139k largely due to the impact of deferred Local Authority income and other movements which are within the normal monthly range.
- Cash increased by £567k, reflecting movements in Receivables, Payables and our surplus.

All movements are within the expected monthly range and there are no exceptions to bring to the Board's attention at this time.

3.2.8. Capital Expenditure

Our 2024/25 capital expenditure allocation has two elements:

(1) Business as Usual (BAU) capital expenditure for maintenance, building projects and equipment replacement.

(2) Capital expenditure to cover additional lease obligations required by IFRS 16. The STW ICS capital allocation for IFRS 16 is less than the value required therefore we have focused on improving the utilisation of the SCHT Estate to manage lease expenditure within the system's IFRS 16 allocation.

Table 8 sets out capital expenditure for year to date compared to our plan. BAU capital spend is below planned levels due to a delay in agreeing a lease for a building where we plan to invest in further re-design. The lease has now been signed and this spend is scheduled for later in the financial year. The completion of ventilation works was also moved to later in the financial year.

Capital Expenditure	Plan £000	YTD Plan £000	YTD Actual £000	YTD Variance £000
BAU Capex	2,250	1,597	520	1,077
IFRS 16 Leases	5,135	3,888	3,956	(68)
	7,385	**5,485**	**4,476**	**1,009**

Table 8: 2024/25 Capital Expenditure as at 31 December 2024

Our BAU capital forecast outturn remains in line with the annual plan value of £2,250k. Whilst we are underspent for the year to date, delayed expenditure has been profiled later in the year and will take place in quarter 4, noting this increases the risk to delivery of our capital plan.

Our IFRS16 forecast outturn is an underspend of £1,135k due to a reduction our lease commitments. This is due to our focus on improving the utilisation of the Shropcom Estate, which includes reducing our lease commitments, and supports STW ICS to live within available funding for lease expenditure.

3.2.9. NHSE Expenditure controls

The triple lock process implemented as an additional control measure by NHSE remains in place. Non pay expenditure (excluding clinical supplies, drugs, utilities, rent and rates) above £10k is subject to the triple lock process which requires prior approval of expenditure from the relevant provider, the ICB and NHSE. There could be exceptions for emergency cases where retrospective approval will be sought.

Month 9 2024/25 Financial Performance

Other controls include improving the 'No PO No Pay' percentage, tracking the expenditure run rate and monitoring variances to the financial plan. We are continuing to focus on expenditure without a Purchase Order, by introducing further controls.

3.2.10. Forecast Outturn and Financial Risk

Our current forecast outturn is to deliver an improved surplus of £3,600k compared to the original plan of £1,768k.

The projected favourable variance of £1,832k is largely due to elective income overperformance, which is not fully matched with cost, together with the impact of the stringent controls which have been in place across the financial year in support of the overall STW ICS position. All forecasts across the STW ICS will be formally updated when agreed with NHSE.

3.2.11. 2025/26 Financial Planning

Our financial planning for 2025/26 will be informed by the system wide Medium-Term Financial Plan which has a 5-year planning horizon and will be supported by the ICB's demand and capacity review alongside the system financial strategy. The national planning guidance will also be reflected once it is available in the coming days.

The initial draft of our 2025/26 financial plan was reviewed by the Resource and Performance Committee (RPC) on 18 December and included activity, KPI performance, workforce and finance plans as a progress update. An updated version of the plan was approved RPC on 27 January. The final version will reflect national planning guidance (once received) and feedback from ICB confirm and challenges sessions. The final version is to be submitted at the end of March and is expected to be reviewed and approved by an extraordinary Board meeting in March.

3.2.12. NHSE Shared Learnings on Financial Controls and Key Themes for Improvement

There has been an increasing focus on financial delivery across the NHS in 2024/25 which is likely to continue into future years. Several systems across the country have been placed into the Investigation and Intervention (I&I) programme which is providing support to enable enhanced financial controls and identify opportunities for improvement. STW has received support through this programme, as the Board is aware.

During December 2024, NHSE circulated a number of documents sharing learning in relation to themes and observations from the I&I programme to support colleagues on the financial agenda.

The Trust's Finance Department is currently reviewing the key learning from this information to identify any further opportunities and this work will be progressed through the Financial Recovery Group.

3.2.13. 2024/25 NHSE Provider Finance Return

The Month 9 Provider Finance Return (PFR) return to NHSE was submitted on Thursday 23 January 2025 and is consistent with the information contained in this report, noting the forecast does not yet show the improved performance we expect to deliver.

Month 9 2024/25 Financial Performance

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 9 is a surplus of £2,034k compared to the planned surplus of £1,075k, which is a favourable variance of £959k.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3,588k with £74k of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that our capital expenditure forecast outturn is now an underspend of £1,135k relating to capitalised leases. This is due to our focus on improving the utilisation of the SCHT Estate, which includes reducing our lease commitments, and supports STW ICS to live within available funding for lease expenditure.
- **Consider** that our forecast outturn has now improved to deliver a surplus of £3,600k, which is £1,832k favourable to plan. This will be reported in our NHSE returns once a revised 2024/25 STW ICS forecast position is agreed with NHSE. There remain several risks, mitigations and opportunities which may impact upon delivery and these are closely managed.

Shropshire Community Health
NHS Trust

2025/26 Planning Update

0. Reference Information

Author:	Jonathan Gould, Deputy CFO	**Paper date:**	6 February 2025
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	28 January 2025
Paper Reviewed by:		**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

Purpose of Paper

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

This paper provides a planning update in relation to the development of Shropcom's 2025/26 Operational Plan.

2. Executive Summary

The process for developing our 2025/26 Operational Plan was presented to the Trust Board meeting in December 2024, and it builds on learning from our 2024/25 Operational Plan development.

Development of this plan has involved engagement with clinical and corporate teams through a series of planning workshops, it includes feedback from Executives and the wider Senior Leadership Team and considers available local and national information such as the Lord Darzi review and the STW Joint Forward Plan.

It is acknowledged that at the time of writing the 2025/26 national planning guidance and priorities has not been released. Whilst we consider our proposed Strategic Objectives and Priorities to be consistent with recent messages received from the national NHSE Team, we will undertake a further review of our plan when the national guidance is released.

All discussions held to date in relation to our Operational Plan support retaining our three overarching **Strategic Objectives** for a further year:

- Looking After Our People
- Caring for Our Communities
- Managing Our Resources

These are our longer-term objectives and are still considered to capture our areas of focus for the coming year.

Whilst our proposed 2025/26 Strategic Priorities build on the momentum from 2024/25, we are suggesting a reduced number of Priorities for 2025/26, based on learning from previous years. The five proposed **Strategic Priorities** are as follows, with further detail included within the appendix to this report:

2025/26 Planning Update

- Culture
- Attract and Retain
- Quality
- Partners
- Resources

If the proposed 'Plan on a Page' is approved by the Trust Board, work will continue to develop the interventions to deliver each Strategic Priority (the 'how') and detail the expected improved outcomes we intend to deliver for our population and people.

It is intended that the Board will be asked to review and approve Shropcom's full 2025/26 Operational Plan at its meeting in April.

3. Recommendation

The Board is asked to:

- **Approve** our 2025/26 'Plan on a Page' confirming our Strategic Objectives and Priorities, subject to any alignment required with national guidance once released.
- **Recognise** the next step is to develop the interventions which will deliver our Strategic Priorities and clearly define the expected improved outcomes our population and people can expect over the year ahead.
- **Acknowledge** that the Board will be asked to review and approve Shropcom's full 2025/26 operational plan at its meeting in April.

Planning Update – 2025/26

Proposed 2025/26 Strategic Priorities and Objectives

Trust Board

06 December 2025

Accountable Director: Sarah Lloyd, Chief Finance Officer

Introduction

- The process for developing our 2025/26 Operational Plan was presented to the Board meeting in December 2024. It follows a similar process to development of our 2024/25 Operational Plan (shown in Appendix 1).

- Development of this plan has involved engagement with clinical and corporate teams through a series of planning workshops, it includes feedback from Executives and the wider Senior Leadership Team and considers available local and national information such as the Lord Darzi review and the STW Joint Forward Plan.

- It is proposed that our three overarching **Strategic Objectives** are retained for a further year.

- We are suggesting a reduced number of Priorities for 2025/26, based on learning from previous years. The five proposed **Strategic Priorities** are detailed on the following page.

The proposed 2025/26 Strategic Priorities build on work underway in 2024/25

VISION: We will be at the heart of supporting our communities by providing fully connected services – so that everyone gets the right care, in the right place, at the right time, by the right people.

Strategic Objectives	Strategic Priorities 24/25	Strategic Priorities 25/26
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	**CULTURE** - 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
	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	**ATTRACT & RETAIN** - We will continue to establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
	We will build a valued and engaged workforce, where health and wellbeing is supported	
Care For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	**QUALITY** - We continue to support our staff to embed quality improvement methodology to improve our workforce and patient experiences.
	We will recover our services inclusively	
Managing Our Resources	We will work in partnership with others, to redesign patient pathways	**PARTNERS** - We will work in partnership with others to improve, recover and redesign patient pathways, bringing care closer to home and ensuring a focus on prevention.
	We will maximise our productivity and efficiency	**RESOURCES** - We will maximise our productivity and efficiency using technology to modernise how and where we deliver services
	We will use all available digital technologies to modernise our services and our environment	

Trust Values

- Improving Lives
- Everyone Counts
- Commitment to Quality
- Working Together for Patients
- Compassionate Care
- Respect and Dignity

Our proposed 2025/26 Operational Plan on a Page

Vision

We will be at the heart of supporting our communities by providing fully connected services – so that everyone gets the right care, in the right place, at the right time, by the right people.

Strategic Objectives	Strategic Priorities 2025/26
Looking After Our People	**CULTURE** - 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
	ATTRACT & RETAIN - We will continue to establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
Care For Our Communities	**QUALITY** - We continue to support our staff to embed quality improvement methodology to improve our workforce and patient experiences.
	PARTNERS - We will work in partnership with others to improve, recover and redesign patient pathways, bringing care closer to home and maintaining a focus on prevention.
Managing Our Resources	**RESOURCES** - We will maximise our productivity and efficiency using technology to modernise how and where we deliver services

Trust Values

- Improving Lives
- Everyone Counts
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- Respect and Dignity

Conclusion

The Board is asked to:

- **Approve** our 2025/26 ‘Plan on a Page’ confirming our Strategic Objectives and Priorities, subject to any alignment required with national guidance once released.
- **Recognise** the next step is to develop the interventions which will deliver our Strategic Priorities and clearly define the expected improved outcomes our population and people can expect over the year ahead.
- **Acknowledge** that the Board will be asked to review and approve Shropcom’s full 2025/26 operational plan at its meeting in April.

Appendix 1 - Developing the 2024/25 interventions - Recap

May 2023

The Board confirmed Shropcom's **Vision and Values**

Jan 2024

The Board confirmed Shropcom's **Strategic Objectives**

May 2024

The Board approved Shropcom's **Strategic Priorities** to be included in the 2024/25 published operational plan

'We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people.'

Trust Values

- Improving Lives
- Everyone Counts
- Commitment to Quality
- Working Together for Patients
- Compassionate Care
- Respect and Dignity

June 2024

The Board approved the 2024/25 **interventions** to deliver Shropcom's Strategic Priorities to be overseen by the relevant Committees: People; Quality and Safety; Resource and Performance.

Shropshire Community Health
NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**6 February 2025**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	30 January 2025
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The Board is asked to ***consider and approve*** the risks to delivery of the Trust's strategic objectives within its remit as cited on the Board Assurance Framework.

2. Executive Summary

The Board of Directors uses the BAF as a tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy.

The BAF has been reviewed with each Executive Lead and is presented to the Committee for consideration and approval. The Board is asked to note the following changes to the BAF since it's last presentation:

- Updates provided regarding progress against delivery of the objectives for Q2 2024/25
- Updates on actions being taken to address identified control / assurance gaps

The Committee is asked to consider the following:

- Are the risks identified correct and in line with the Board's knowledge? Are there any other risks that should be included?
- Are there adequate controls and assurances identified?
- Are appropriate actions identified to address known gaps in controls and assurances? Where actions have been identified are they on track?

Conclusion

The Committee is asked to consider and approve the Board Assurance Framework

Board Assurance Framework

BAF Risk Tracker

Ref	Risk Title	Opened	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov24	Dec 24	Jan 25	Movement in Month	Target
1.1	Workforce Team Capacity Carried forward from 23/24	Sept 23	16	16	16	16	16	16	16	16	16	16	↔	6
1.2	Principal Risk: Recruitment restrictions impact on staff morale Carried forward from 23/24	Sept 23	16	16	16	16	16	16	16	16	16	16	↔	6
4.1	Ability to transition to LFPSE	Sept 23	16	16	16	20	20	20	12	12	4		CLOSED	4
4.2	Reliance on volunteer input for key patient experience workstreams such as observe and act	Sept 23	12	12	12	12	12	12	12	12	12	12	↔	4
4.3	Quality Improvement Team Capacity	Oct 24	-	-	-	-	-	-	12	12	12	12	↔	
5.1	Demand exceeds capacity Carried forward from 23/24	Apr 22	20	20	20	16	16	16	15	15	15	15	↔	6
5.2	Potential for patient harm due to waiting times Carried forward from 23/24	Apr 23	16	16	16	16	16	16	16	16	16	16	↔	6
5.3	Operational capacity to undertake all programmes of work Carried forward from 23/24	Sep 23	20	20	20	20	20	20	15	15	15	15	↔	10
5.4	Recruitment challenges	Apr 22	16	16	16	16	16	16	16	16	16	16	↔	6
6.1	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	15	15	15	15	15	15	15	16	↔	5
7.1	Cyber attack	Sep 23	12	12	12	12	12	12	12	12	12	12	↔	6
7.2	Digital Capacity	Sep 23	20	20	20	20	20	20	12	12	12	12	↔	8
8.1	Costs exceed plan	Apr 22	20	20	20	20	20	12	12	12	12	12	↔	6
8.2	Insufficient capital funding	Sep 24	-	-	-	-	-	-	9	9	9	9	↔	6

Risk Increasing		New Risk	
Risk Decreasing		Closed Risk	

Looking after our People — OBJ 1

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive

This objective will focus on the development of the NHS long term plan – retain and transform

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 24

Reviewed Date: January 2025

Key Measures:

- ✓ Improved staff turnover
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage
- ✓ Improvement in staff survey results

Progress Update:

- Staff survey has closed with a 62% response rate – preliminary results are available but currently embargoed
- New sickness management policy has been launched and workshops have beem been held with managers to support application
- Leadership Programme launched to support managers 'Expectations of Line Managers' and collaborating with SaTH on other leadership development opportunities
- STW Temporary Staffing Task and Finish Group has been established and a regional agency reduction group established
- ACE awards have been launched as part of programme of staff recognition and second round taking place. Early planning in place for wider staff recognition and inclusive leadership programmes
- Cultural dashboards have been put in place and using BI to analyse and present staff survey results
- National Quarterly People Pulse Survey continues to be undertaken
- Wellbeing conversations being rolled out to staff
- Seasonal increase in sickness rates
- Turnover is reducing overall

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- N/A

Risks:

1.1 Workforce team capacity
1.2 Recruitment restrictions impacting on staff morale

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **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	4	2
Total	16	16	6

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

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

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

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

Gaps In Controls:

- C1: New workforce structure in the process of being put in place – will need to embed
- C2: Capacity to progress with centralised bank
- C3: Staffing vacancies in ESR team
- C4: People Promise Manager is a fixed term post with funding until Summer 2025

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Scoping of collaborative working options	Director HR and OD	January 2025	
C3	Recruitment process is underway	Director HR and OD	March 2025	
C4	Business case to be developed to ensure retention of People Promise Manager role	Director HR and OD	March 2025	

We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **BAF 1.2**

Principal Risk: Recruitment restrictions impact on staff morale

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	4	2
Total	16	16	6

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

- C3: Age profile of the organisation means high level of retirees
- C4: Response to latest staff survey (results still embargoed)

Gaps in Assurance:

- ~~A1: Staff Survey Results a year out of date~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Promotion of flexible work and retire and return	Director of HR	Ongoing	Comms has been issued about flexible working and retire and return
A1	Staff survey comms campaign	Director of HR / Director of Governance	October-November 2024	Comms campaign has commenced with weekly update on uptake to Execs and wider organisation, currently have the highest uptake for a community Trust - completed
C4	Action plans to be put in place to take forwards staff survey results	Director of HR	April 2025	

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 implementation of the NHS People Promise Exemplar Programme and the Trust's Culture and Engagement Programme

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

Culture and leadership and the flexible working programmes have both been launched. Cultural maturity audit has been completed with the initial auditor findings received and management responses due shortly. People Promise Exemplar Programme continues. Leaver rate is reducing albeit still slightly above target. Exit interview process has been reviewed to provide multiple feedback options and this has seen an initial increase in feedback.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above
Previously identified risk in relation to poor retention leading to gaps in workforce however turnover reducing so adopting a monitoring approach

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

n **OBJ 3**

Principle Objective: We will build a valued and engaged workforce, where health and wellbeing is supported

This objective will focus on the implementation of the admin academy.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

Several staff wellbeing sessions have taken place such as menopause, andropause, personal resilience. Wellbeing conversations being rolled out and health and wellbeing survey has been issued to staff. Over 300 staff have attended health and wellbeing days. The work on admin academy is continuing to embed with regular meetings, admin heroes campaign has been launched.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above

Lead Director:

Director of HR and OD

Lead Committee:

People Committee, Resource and Performance Committee

Caring for Our Communities **OBJ 4**

Principle Objective: We will support our staff to embed quality improvement methodology to improve staff and patient experiences

This objective can be broken down into the following key components; establishing a continuous quality improvement framework based on NHS impact, learning and improving patient safety and engagement, developing and implementing a clinical quality strategy, maximising return on investment of electronic prescribing management

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024
Reviewed Date: January 2025

Key Measures:

- ✓ A baseline and improvement for avoidable errors
- ✓ Increased staff training and awareness of quality improvement
- ✓ Improved patient engagement
- ✓ Improved medicines management
- ✓ Financial improvement
- ✓ Evidence of learning from patient safety events

Progress Update:

- Quality improvement framework in place and staff training and celebration events continuing
- Staff training in PSIRF compliant safety investigations completed
- Thematic reviews continue to be completed and taken through Q&S Committee
- Observe and act schedule in place
- Clinical Quality Strategy signed off by the Board
- Patient Experience Lead taking forward roll out of volunteer management software
- LFPSE compliance achieved
- Two Cohorts of after action review training has been completed

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF 4.2	Reliance on volunteer input for key patient experience workstreams such as observe and act
BAF 4.3	Quality Improvement Team capacity

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.2**

Principal Risk: Reliance on volunteer input for key patient experience workstreams such as observe and act

Loss of volunteers would impact on ability to delivery key workstreams

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Restructure of Governance Team to improve resilience including for patient experience work
- ✓ Administrative support for volunteers identified in new structure
- ✓ Board recognition for volunteers work to improve morale and retention
- ✓ Identified Patient Experience Lead overseeing volunteers with good and longstanding relationships
- ✓ Director of Governance attendance at volunteer meetings on request

Assurance: **Source of Assurance** **1**

- ✓ Patient Experience Committee

Gaps In Controls:

- C1: Lack of recruitment and retention plan for volunteers

Gaps in Assurance:

- A1: No tracking of recruitment and retention of volunteers

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Recruitment and retention plan to be devised	Director of Governance	~~December 2023~~ ~~April 2024~~ ~~October 2024~~ December 2024	Volunteers management software has been procured to support the recruitment and management of the volunteers – completed
A1	Recruitment and retention tracking to be put in place once plan devised	Director of Governance	~~January 2024~~ ~~December 2024~~ March 2025	Volunteers management software has been procured to support the recruitment and management of the volunteers and is in the process of being implemented. This will support recruitment and retention tracking.

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.3**

Principal Risk: Quality Improvement Team Capacity

Operational pressures impacting on staff engagement with QI training, ability to measure clinical quality strategy implementation

Risk Rating:

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

Risk Details:

Opened: October 2024

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Regular team meetings
- ✓ Risk based approach to prioritising quality improvement projects
- ✓ QI Training being rolled out
- ✓ Clinical Safety Officer in Quality Improvement role

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

- ✓ Quality reporting
- ✓ Oversight from Quality and Safety Committee
- ✓ Executive and Non-Executive Walkabouts

Gaps In Controls:

- C1: Uptake on training / time needed to train staff
- Vacancies

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Continued roll out of training with support from operational team to increase uptake	Director of Nursing / Director of Operations	January 2025	Training ongoing

Caring for Our Communities **OBJ 5**

Principle Objective: We will recover our services inclusively

This objective can be broken down into three key components; better understanding the needs of our population, recovering services in line with the national mandate, continuing to develop our children and young people services

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

- ✓ Improvements across CORE20PLUS metrics
- ✓ Improvement in DNA, PIFU and virtual consultations
- ✓ Increased patient access to our successful services

Progress Update:

- The Trust now has a Health Inequalities Ambassador and is encouraging more staff to express an interest to become an ambassador Health Inequalities presentation to the Board with a focus on Core20Plus.
- Health Inequality steering group has been established and reports to QSC being set up

Supporting Programmes of Work:

- OP Transformation programme
- MSK Programme

Key Assumptions

-

Risks:.3

5.1 Demand exceeds capacity
5.2 Potential for patient harm due to waiting times
5.3 Operational capacity to delivery the programmes of work
5.4 Recruitment challenges

Lack of MSST demand and capacity profiling is being worked up as a risk, also a risk in relation to data quality to support health inequalities

In addition see Risk 7.2 in relation to RTT

Lead Director:

Director for Operations / Director of Nursing

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will recover our services inclusively **BAF 5.1**

Principal Risk: Demand exceeds capacity

Inability to restore activity levels resulting in increasing waiting times and poor patient experience. Non-compliance with national oversight framework, regulatory and system scrutiny and loss of reputation, potential for loss of income if activity levels not achieved.

Risk Rating:

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

Risk Details:

Opened: April 2022

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of performance against plan for early identification of actions
- ✓ Realtime review and monitoring of waiting lists
- ✓ Internal Planning Group in place for monitoring
- ✓ Performance Board in place for oversight of delivery

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

- ✓ Resource and Performance Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee

Gaps In Controls:

- ~~C1: Gaps in service level data~~
- C2: Alignment to the newly formed System Integrated Improvement Plan

Gaps in Assurance:

- A1: Waiting for national oversight framework to enable assessment against requirements

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Service level data programme of work for improvement	Director of Operations / Director of Finance	Ongoing for 24/25	Majority of services now have drill down data available which is presented to Performance Board for the KPIs - completed
A1	KPIs to be reviewed and updated when national oversight framework published	Director of Operations / Director of Finance	TBC	This is outside of the Trust's control and the oversight framework is awaited – 24/25 update no longer being produced so action to be closed
C2	Review of SIIP actions to integrated into this risk assessment	Director of Governance / Director of Operations	February 2025	

We will recover our services inclusively **BAF 5.2**

Principal Risk: Potential for patient harm due to waiting times

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

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

Risk Details:

Opened: April 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

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 Assessment Group established to deliver process~~

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

- ✓ Quality and Safety Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee
- ✓ Patient Safety Committee established

Gaps In Controls:

- C1: Harms assessment process has only embedded in some areas

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Harms review policy to be reviewed	Director of Nursing	~~September 2024~~ November 2024	Policy has progressed through Patient Safety Committee and due to go to Quality and Safety Committee - completed
A2	Training on harms review process to be rolled out following revised policy being put in place	Director of Operations / Director of Governance / Director of Nursing	~~October 2024~~ ~~December 2024~~ March 2025	Not yet started, policy has been ratified

We will recover our services inclusively **BAF 5.3**

Principal Risk: Operational capacity to undertake all programmes of work

Potential for operational pressures to affect prioritisation of system programmes both internally and across the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	2
Total	20	15	10

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

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
- ✓ ESIST and RSP Support

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

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework
- C2: System PMO being established with uncertainty around allocation of support

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Review of governance and operational frameworks to ensure system programmes are captured	Director of Operations / Director of Governance	December 2024	Transformation oversight group established which reports to Performance Board. Completed
C1/A1	Governance leads in system to meet to work through the system governance arrangements to ensure they link and align with provider governance frameworks	Director of Governance	~~October 2024~~ March 2025	Governance leads met and ToR drafted for the SCHT led programme of Shared Services, awaiting ToRs for the other programmes and agreed way forward, escalated to CEO as SRO for the collaborative programmes
C1/A1	Streamlined governance for system operational programmes	Director of Governance	~~December 2024~~ March 2025	Plan for changes to governance framework to be approved and implemented in December 2024 – delayed by further work by system partners, regular governance meetings taking place to bring the work back on track
C2	Active member of system conversations regarding PMO changes	Director of Finance	April 2025	Ist steerco meeting has been held and work is underway to establish the shared PMO

We will recover our services inclusively **BAF 5.4**

Principal Risk: Recruitment challenges

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

Risk Rating:

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

Risk Details:

Opened: April 2022

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

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

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

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

Gaps In Controls:

C1: Electronic rostering solution to support staffing

~~C2: Sustainable solution for medical cover across all sites~~

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing Director of HR	March 2025	Collaboration with the system on e-rostering in its infancy with project plan developed ongoing but on track
C2	Options appraisal to be completed and progressed	Director of Operations / Medical Director	September 2024	Options appraisal completed and approved to go out to for bids - completed

Caring for Our Communities — OBJ 6

Principle Objective: We will work with others to redesign patient pathways

This objective will focus on optimising our community, urgent and care through early support discharge and alternatives to hospital admission

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

✓ Improved pathways through collaboration with system partners

Progress Update:

- Care Transfer Hub launched 1/10/24
- Co-location of single point of access and SCHT UCR test if change completed and to continue due to success
- Re-sequencing of Directory of Services enacted to re-direct flow away from EDs

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services
- Development of Integrated Care Coordination in system
- Development of Integrated neighbourhood Teams
- Development of Frailty pathway
- Further embedding of VW & RR pathways
-

Key Assumptions

- N/A

Risks:

6.1 Internal governance and operational oversight arrangements for system programmes

6.2 Focus on UEC diminishing capacity for community services and development of neighbourhood teams

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will work with others to redesign patient pathways

Principal Risk: Internal governance and operational oversight arrangements for system programmes

System programmes are taken through system governance and don't have links into the Trust's governance and operational oversight arrangements, potential for risks to not be identified and mitigated from a Trust perspective when SROs sit outside of the organisation

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework
- C2: Alignment of risk management across the system

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework
- A2: Alignment of risk management across the system

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Streamlined governance for system operational programmes	Director of Governance	~~December 2024~~ February 2025	Plan for changes to governance framework had originally been planned for December 2024 but this has been delayed as a result of each organisation having take this through their Boards. A workshop to finalise the detail is planned for early in the new year
C2/A2	Risk management to be aligned across the system	Director of Governance	~~December 2024~~ February 2025	Trust's risk management strategy has been updated, alignment work with other partners underway -awaiting confirmation from partners that their risk management strategies have been updated

Managing Our Resources

Principle Objective: We will use all available digital technologies to modernise our services and our environment

This objective will focus on automating manual administrative processes to increase productivity

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

✓ Demonstrable productivity improvement

Progress Update:

Co Pilot licences rolled out and being used, AI opportunities being rolled out and therefore digital modernisation is progressing well

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

7.1 Risk of cyber attack
7.2 Digital team capacity

Lead Executive

Director of Finance

Lead Committee:

Resource and Performance Committee

We will use all available digital technologies to modernise our services and our environment

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	4	2
Total	20	16	6

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

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

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

- ✓ Audit Committee Oversight
- ✓ Data Security Group

Gaps In Controls:

- ~~C2: Information asset owner compliance~~
- C3: DSPT compliance only at working to standards

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C2	Additional training and support to be put in place for information asset owners	Director of Governance	September 2024	IG Manager appointed and additional support procured via CSU to address gaps in IG team and provide support with information asset owner records and training. Forms part of DSPT Toolkit Improvement Plan. -completed
C3	Full DSPT compliance to be achieved	Director of Governance	December 2024	Improvement plan in place which is being reviewed by NHS Digital with a view to approval, this will be monitored via Audit Committee. Particular challenge with MFA compliance, IG and Digital Team working through solution, on the agenda for SLT for operational support and additional support being provided to IG team

Maximise the potential of digital technologies ensuring a core level of digitisation in every service across systems to transform the delivery of care and patient outcomes **BAF 7.2**

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	4	4
Likelihood	5	5	2
Total	20	20	8

Risk Details:

Opened: September 2023

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital strategy and programme of work in place
- ✓ Regular team meetings with oversight from Director of Finance

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

- ✓ Digital Assurance Group

Gaps In Controls:

- C1: Recruitment controls preventing appointments to vacancies
- ~~C2: Line of sight on programmes of work requiring digital input impacting on prioritisation and workload~~
- C1: Further recruitment needed

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Digital B7 Case of Need to be presented to Execs	Director of Finance	November 2023	Approved at system level and going through internal process for recruitment - completed
C2	Transformation Oversight Group to include digital input	Director of Operations	September 2024	Approved ToR in place and meetings established and reporting to Performance Board - Completed

Managing Our Resources — OBJ 8

Principle Objective: Maximise our productivity and efficiency

This objective can be broken down into three key components; delivering in year CIP and a 3-year rolling CIP plan, maximising the sustainability of our estate, implementing 24/7 single point of access (SPOA) through digital technology and process improvement

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: January 2025

Key Measures:

- ✓ Deliver £3.5m efficiencies for 2024/25, add 3 year CIP plan to the medium term financial plan
- ✓ Reduce carbon footprint and improve estate occupancy
- ✓ Improve patient access to Shropcom services

Progress Update:

Exceeding CIP target at the end of Q3
LED lighting has been installed, building management efficiencies rolled out to reduce use of fossil fuels

Supporting Programmes of Work:

- CIP Programme
- Net Zero Group
- Capital Programme

Key Assumptions:

- Operational delivery of CIP identified
- Elective activity delivery

Risks:

BAF8.1	Costs exceed plan
BAF 8.2	Capital funding insufficient

Following discussion at RPC it was agreed there would be a review of the risk of under / over performance against the contract – significant over and under performances from an activity view point but under block arrangement, impact to patients picked up through quality lens. No risk

Lead Director:

Director of Finance

Lead Committee:

Resource and Performance Committee

Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners **BAF 8.1**

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

Risk Details:

Opened: April 2022

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Use of non-recurrent schemes to allow more time to implement recurrent cost saving schemes
- ✓ CIP Delivery Group working on identifying CIP schemes
- ✓ Robust QEIA process in place
- ✓ Financial Recovery Group in place for operational oversight

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

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

Gaps In Controls:

- ~~C1: Shortfall in CIP schemes currently identified~~
- C2: Unidentified risk relating to B2/B3 review

Gaps in Assurance:

- ~~A1: Performance and Programme Board to be embedded~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Ongoing work through CIP Delivery Group feeding into Financial Recovery Group	Director of Finance	March 2024	Weekly meeting continue to take place with Executive oversight - completed
A1	Performance and Programme Board to continue to be embedded	Director of Finance / Director of Operations	September 2024	Four meetings have now taken place and continue to embed the performance framework - completed
C2	Timeline and scope of review to be outlined to inform risk assessment	Director of People	~~November 2024~~ June 2025	Timeline presented to execs to take to end of year, working through the scope of the review with initial scoping done and comms out to staff. System approach being looked at.

Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners **BAF 8.2**

Principal Risk: Insufficient Capital Funding

Potential for there to be insufficient funding for all required projects, where there are safety concerns there is potential for the Trust to breach statutory duty by exceeding capital resource limit

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	3
Likelihood	3	3	2
Total	12	9	6

Risk Details:

Opened: October 2024

Reviewed Date: January 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Capital and Estates Group in place and have reprofiled the plan with input from clinical and operational colleagues to reduce in year capital spend where possible
- ✓ System appeal to NHS England regarding the gap

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

- RPC Oversight
- Included in finance report to Board for oversight

Gaps In Controls:

- C1: Outcome of appeal to NHS awaited

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Await outcome of appeal to NHSE	Director of Finance	Dec 2024	Ongoing reporting of the issue until the outcome of the appeal is known - meetings held with system and NHSE No increase, capital funding confirmed with no increase, programme has been modified to account for this. Oversight from Capital and Esates Group

Shropshire Community Health
NHS Trust

EPRR plan approvals
0. Reference Information

Author:	Brian McMillan, EPRR Senior Lead	**Paper date:**	30th January 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing & Clinical Delivery & AEO	**Paper written on:**	12th January 2025
Paper Reviewed by:	Clair Hobbs, Director of Nursing & Clinical Delivery & AEO	**Paper Category:**	Governance
Forum submitted to:	Quality & Safety Committee & Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Quality & Safety Committee and what input is required?

This paper presents an assurance update on the EPRR workstream and the final 2024 EPRR Core Standards position.

2. Executive Summary

2.1 Context

The NHS England EPRR Core Standards assessment process guides the EPRR workplan and runs from August to August annually. The Trust submitted its annual assurance return in September 2024. The process has now been complete, and the Trusts rating and award have been approved by the ICB and NHS England. Work continues within Trust services to update Business Continuity Plans as part of the overall workplan.

2.2 Summary

The Trust submitted a Core Standard assessment of 95% - a self-assessment of compliant with 55 out of 58 standards. This was subject to a Confirm and Challenge meeting and was reduced to 91% as a final submission. This process has now been finalised and the 91% assessment was confirmed and ratified by the ICB and NHS England.

91% put the Trust in the 'Substantially Compliant' bracket. We are the only provider within the STW system to be at this level and provides assurance that the Trust is in a favourable position to health system partners.

There were no non-compliant standards. The Trust was rated partially compliant in 5 areas. These were mainly Incident Communications and testing with an additional standard on supply chain resilience being marked down. These are being worked on as part of the 2025 workstream.

The process also includes a Deep Dive, where additional quality is sought on a subject area. This year's Deep Dive was Cyber, Communications and Information Governance. The EPPR element of this is an area that requires improvement from the Trust with a rating of 1 out of 11 compliant. A Task and Finish Group has been working to address the compliance gaps although to date, all outstanding standards remain partially compliant.

EPRR plan approvals
Work has commenced on the reviews and updates required for 2025, as the assessment resets to zero each year. It is not known what this years deep dive will be.

2.3 Workstream

2025 will have a strong focus on Pandemic Preparedness. This will align to the initial findings of the COVID-19 Inquiry by Baroness Hallett. The government have introduced a series of national EPRR exercises, commencing in 2025 with a national mandatory Pandemic exercise, Exercise PEGASUS.

The remainder of the work programme is focusing on finalising current projects due to a pending change in EPRR Lead, currently going through the recruitment process.

2.3 Conclusion

The Quality and Safety Committee and Trust Board are asked to;

- **Note** the EPRR Core Standards award and request any additional information to increase **assurance** to the contents of the report and
- **Support** the delivery of the business continuity and deep dive programme.

3. Main Report

3.1 EPRR Core Standards

The NHS England EPRR Core Standards Framework is the annual assurance model for all Trusts. It sets out the minimum standards required against a number of areas of preparedness and response. For a Community Trust, it is 58 standards for full compliance.

The Trust submitted a final position of 91%. An award above 89% is banded as substantially compliant. This was an improvement on the 2023 rating of 77% and was favourable amongst regional partners.

The formal award has now been confirmed and ratified by the ICB and NHS England with the focus moving to the 2025 challenge as the score resets to zero each year.

This year's Deep Dive was Cyber, Communications and Information Governance. In particular, how those workstreams work within the EPRR and Incident Response Frameworks. The linking of this work with EPRR is not currently an area of strength for the Trust and requires improvements, Cyber Security is however known to have good assurance. Each of these areas has demonstrated effective work however it is not directly linking to the overall EPRR structures and policies as is required within the standards.

There are 11 Deep Dive standards, with the Trust compliant with 1 of the 11. Failing the Deep Dive did not directly impact on Core Standards award. A Task and Finish Group has been established to produce an internal improvement plan to address the non-compliant standards and given the high assurance, the ICB were happy to support this approach. Currently, none of the deep dive standards can be marked compliant, however the Task and Finish Group has escalated to a weekly meeting.

3.2 Business Continuity

The significant work commenced in 2024 continues currently. The work undertaken was deemed compliant but must continue to develop to maintain currency.

EPRR plan approvals

There are 120 plans have been drafted out of 133 plans required. Of these plans, 68 are approved with 58 in draft. Draft plans are in a usable state, but require the relevant service to review and sign off the arrangements. 13 plans have not yet been commenced despite various engagement methods.

Plans will need to be reviewed and approved as part of an annual cycle to remain compliant for 2025.

In addition, there is Phase 2 and 3 work which has been commenced but yet to be complete:

Phase 2 – A comprehensive list of digital systems and the teams who use each of them. This list then draws through service priorities identified within plans as well as any contingency measures to digital system disruptions.

Phase 3 – A list of geographical bases and service delivery locations. This allows more informed decision making in community disruptions and events.

The external auditors who undertook an audit in 2024, fed back to the Audit Committee that "the progress is quite something, given the capacity".

3.3 Workplan

The Trust has an EPRR workplan which is overseen by the EPRR Working Group. The EPRR focus for 2025 is Pandemic Preparedness. The introduction of a national mandated pandemic exercise (exercise PEGASUS), the first in a new series introduced by Government, follows on the from the COVID-19 inquiry by Baroness Hallett.

There will be 3 phases of the national exercise running across 9 days in September, October and November 2025. To support this, there will be 2 x regional single day exercises in April and May 2025. April sees an ICB led pandemic exercise (exercise TANGRA) and May sees a Local Resilience Forum pandemic exercise.

The Trust plan will be reviewed during a pandemic workshop on 10th March which is being supported by a wide audience of service leads from across the Trust.

3.4 Training

Training continues but is part of a 3 – year cycle. Due to the large push on training in 2024, compliance rates across the Manager on Call (Tactical) and Director on Call (Strategic) rotas is at 70%. Work is ongoing to increase this compliance rate but there will be less delivery required in 2025 than in 2024.

Due to the change in EPRR lead, current training presentations are being reviewed and updated. This should support the Trust if the new EPRR Lead initially lacks the training requirements to write and deliver courses.

3.5 Exercising

There have been a number of exercises already within this 2024/2025 reporting period. These have exceeded the number required for Core Standards with only 1 required in Q2 for full compliance. This will be a Communications Exercise and is a repeat of an exercise run in January 2025.

Other exercises undertaken since August 2024 have focused on:-

- Cyber response
- Hospital Evacuation
- Lockdown

EPRR plan approvals

- Communications cascade and incident response
- Vulnerable Persons and data sharing

3.6 EPRR Plans

EPRR plans require annual review and approval each year to ensure compliance. The majority of the plans are due for approval in the period of May – August as part of their cycle.

The EPRR Strategy and Business Continuity Strategy have both been reviewed and approved for this cycle. Depending on the recruitment timelines, this may need some priority later in the year to ensure Core Standards compliance as the number of plans could put a compliant award at risk.

There have been recently tested developments to the Evacuation and Lockdown plans which require updates and will justify an early review process. The New and Emerging Pandemics Plan will be updated following the workshop in March 2025.

Other plans which will require updates:-

- Incident Communications – dependent on a current paper on a notification tool option.
- VIP/Protected Persons Plan – needs a light touch review
- Incident Response Plan
- Mass Casualty Plan
- Mass Fatalities Plan
- Mass Countermeasures Plan
- Infectious Disease Policy – IPC led plan that has had some NHS England commentary
- Adverse Weather Plan
- CBRN / Hazmat Plan

3.7 Incidents and Exercising

There have not been any incidents since the flooding of October 2024 which was detailed in the last report.

The previous quarterly update listed 7 incidents. We are currently within the flooding / adverse weather season, however Trust services are more informed and better prepared for the impacts.

3.8 Conclusion

The Quality & Safety Committee and Trust Board are asked to:

- **Note** the EPRR Core Standards award and request any additional information to increase **assurance** to the contents of the report and
- **Support** the delivery of the business continuity and deep dive programme.