Shropshire Community Health NHS Trust

Trust Board - 5 June 2025

MEETING

5 June 2025 10:00 BST

PUBLISHED

30 May 2025

Agenda

Location	Date	Time
Oswestry Memorial Hall	5 Jun 2025	10:00 BST

	Item	Owner	Page
1	Welcome	Chair	-
2	Apologies & Quorum	Chair	-
3	Declarations of Interest	Chair	-
4	Minutes of the Previous Meeting	Chair	6
5	Action Log	Chair	13
6	Staff / Patient Story		-
7	Public Questions	Chair	-
8	Notification of Any Other Items of Business	Chair	-
9	Chair's Communication	Chair	-
10	Non-Executive Director's Communication	NEDs	-
	Strategy		-
11	Chief Executive's Report	Chief Executive	14
12	Provider License Certification	Director of Governance	20
13	Public Questions Scheme	Director of Governance	34
	Quality & Safety		-
14	Quality & Safety Committee Chair's Report	Chair of Committee	-
15	Integrated Quality & Safety Performance	Director of Nursing	36
16	Annual Quality Account	Director of Nursing	-
17	Annual Report - Research & Development and Clinical Effectivness	Medical Director	-
18	Bi-Annual Safer Staffing Review	Director of Nursing	-
19	Patient Safety Oversight Report	Director of Governance	50
	People		-

	Item	Owner	Page
20	People Committee Chair's Report	Chair of Committee	54
21	Integrated People Performance Report	Chief People Officer	61
	Resource & Performance		-
22	Resource & Performance Committee Chair's Report	Chair of Committee	-
22.1	26 March 2025		92
22.2	28 May 2025 - Verbal		-
23	Integrated Performance Report	Director of Finance	98
24	Finance Report	Director of Finance	129
25	Estates Strategy Refresh Report	Director of Finance	138
26	Delivery Against 24/25 Operating Plan	Director of Finance	146
27	25/26 Performance Framework	Director of Finance	163
	Audit		-
28	Audit Committee Chair's Report	Chair of Committee	187
29	Board Assurance Framework and Corporate Risk Register	Director of Governance	191

Contents

	Item	Page
1	Welcome	-
2	Apologies & Quorum	-
3	Declarations of Interest	-
4	Minutes of the Previous Meeting	6
5	Action Log	13
6	Staff / Patient Story	-
7	Public Questions	-
8	Notification of Any Other Items of Business	-
9	Chair's Communication	-
10	Non-Executive Director's Communication	-
11	Chief Executive's Report	14
12	Provider License Certification	20
13	Public Questions Scheme	34
14	Quality & Safety Committee Chair's Report	-
15	Integrated Quality & Safety Performance	36
16	Annual Quality Account	-
17	Annual Report - Research & Development and Clinical Effectivness	-
18	Bi-Annual Safer Staffing Review	-
19	Patient Safety Oversight Report	50
20	People Committee Chair's Report	54
21	Integrated People Performance Report	61
22	Resource & Performance Committee Chair's Report	-
22.1	26 March 2025	92
22.2	28 May 2025 - Verbal	-

	Item	Page
23	Integrated Performance Report	98
24	Finance Report	129
25	Estates Strategy Refresh Report	138
26	Delivery Against 24/25 Operating Plan	146
27	25/26 Performance Framework	163
28	Audit Committee Chair's Report	187
29	Board Assurance Framework and Corporate Risk Register	191

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE RAMADA HOTEL, TELFORD AT 10.00 AM ON THURSDAY 3 APRIL 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)

Executive Members (Non-Voting)

Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Ms. Rhia Boyode	(Chief People Officer)

In attendance

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

Welcome

Mr Morgan welcomed all to the meeting. He reminded the Board that we were in a pre-election period due to the upcoming local elections in Shropshire.

Apologies and Quorum

Apologies were received from Ms Tina Long, Non-Executive Director. The Chair in Common declared that the meeting was quorate.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 6 February 2025

Subject to the amendment of a typographical error, the minutes were agreed as an accurate record of the meeting.

Action Log

There were no outstanding actions.

Public Questions

No questions had been received.

Patient / Staff Story

The Board received a presentation from the Care Transfer Hub, focused on winter pressures. The service had played an essential role in supporting the wider System and patient flow in the acute hospital. Since the launch of the Hub on 1 October 2024, the team had been working closely with colleagues at the hospital, seeing patients and their families face to face. Jo Fothergill, the team lead at the Hub, had joined the service in July from SaTH and was able to use her experience to support the teams integration into the ward.

The team had been focusing on identifying patients early and building relationships. Trials were underway on two wards where the discharge support workers were working alongside therapy teams, with good feedback received.

The teams were multi-disciplinary and included staff from SaTH and the Local Authorities. The team based in Telford were sat within one office, which had helped with information sharing and building the sense of team, however, the team based at Shrewsbury were dispersed, which was more difficult.

Ms Lloyd asked if there was anything that the Board could do to support the team to move forward, and it was noted that the different organisations used different digital systems. Moving the Shrewsbury based team into a single space would also be very helpful.

Mr Morgan asked about other areas where Hubs were in place, the team confirmed they had visited services in Cumbria and Walsall and had taken best practice from these.

Chair in Common's Communication

Mr Morgan noted the national announcement that NHSE would be integrated back into the Department of Health. Alongside this, ICBs nationally would be required to reduce costs by 50% by October, with their role changing to strategic commissioning rather than performance management.

The national message had been for Boards to have a strong focus and accountability on delivery of plans. There was a clear expectation from the national teams that providers were expected to deliver to their plans from month 1.

The Chair thanked colleagues for their hard work in delivering the 24/25 plan and all the staff who had been involved in developing this years' plan.

Mr Darbhanga asked about the assurance functions at ICBs, Ms Davies stated that this would be done across the providers as they were better placed to do this. Mr Darbhanga additionally asked about the impact of the ICB reduction on the Trust, Ms Davies said this would be worked through.

Non-Executive Director's Update

Mr Darbhanga advised he had attended the System Finance Meeting and noted it would be a challenging year for the System.

Ms Purt had visited Whitchurch Hospital. She had spoken with staff and praised the cleanliness of the wards. She provided teams feedback at building work had not been co-ordinated so the teams were having to move multiple times.

Ms Barker had attended the System performance group. She noted that it was an ICB's Non-Executive Director, Meredith Vivan's final meeting and thanked him for his work during his time at the ICB.

Chief Executive's Update

Ms Davies summarised her report and updated the Board on the national announcement in relation to NHSE and recognised the contribution of Amanda Pritchard, the first female chief executive of NHSE. The national meeting had provided a strong message around greater productivity and accountability for delivery.

Business / Operating Plan

Ms Lloyd summarised the plan, which was presented for approval. She drew the Board's attention to the 'Plan on a Page', sets out our vision. The plan would be widely shared across the organisation. Committees would see regular milestone plans with defined benefit and an update would be provided to the Board in six months.

Ms Purt asked if there was an action in relation to staff vaccinations, Ms Boyode confirmed this was part of the action on staff sickness.

In response to a question, Ms Lloyd confirmed that the plan had been cross checked against the performance assessment framework and was consistent.

The Board approved the 2025/26 Operational Plan and the key interventions.

QUALITY, SAFETY AND PEOPLE

Quality & Safety Committee Chair's Report

Ms Barker summarised the report and noted that a number of policies had been ratified. There had been a very good discussion on violence to staff and that full assurance had been taken on patient safety incidents.

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

Integrated Quality and Safety Report

Ms Hobbs stated that the report had been reviewed thoroughly through the Quality and Safety Committee.

Ms Davies asked about safer staffing levels and noted that some work was ongoing to benchmark fill rates, Ms Hobbs confirmed that this would take place shortly.

Mr Darbhanga asked about admission criteria for high dependency patients, Ms Hobbs stated that the Trust did have an access policy however, the Trust needed to work as part of the system and the balance of patients was reviewed on a daily basis.

The Board accepted the assurance provided by the update.

Quarterly Guardian for Junior Doctor Safe Working Report

Dr Ganesh confirmed that there were no exceptions to report.

The Board accepted the assurance provided by the update.

PEOPLE

People Committee Chair's Report

Ms Sargent summarised the report and noted that there had been a good discussion on the future of the admin academy. There had been a discussion on off track KPIs that were off track and that further work was needed on the actions related to these.

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

Integrated People Performance Report

Ms Boyode discussed the national recognition that People KPIs should be standardised and that Trust's should be learning from well performing Trusts.

There was a discussion around action plans and ensuring that they had an accurate trajectory, these had recently been reviewed and would be closely monitored.

Ms Purt expressed her disappointment at the appraisal rates and noted these were vital to the culture of an organisation. Ms Boyode agreed it was disappointing, and the reasons behind why they were not completed needed to be explored.

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 processes and SPC charts.**

Annual Modern Slavery Report

Ms Ramtuhul stated that this was an annual legislative requirement for each Trust and looked back on the precious year. There were no changes from previous years, and the same measures and controls were in place.

The Board considered and approved the statement.

Staff Survey Results

The Board received a presentation from David Ballard, Organisational Development Business Partner, on the Trust's annual staff survey results. The survey was administered by Picker on the Trust's behalf. The results of the survey showed significant improvements from the previous year, and the Trust was the most improved across all comparators from Picker. The response rate was the highest in the Trust's history.

Mr Morgan expressed his thanks to the organisation and particularly Tina Long for their hard work in securing these results, which were the result of a deliberate and sustained effort. Ms Boyode additionally thanked Mr Ballard and Rebecca Smith, People Promise Manager, for their hard work on the survey.

Ms Barker welcomed the remarkable improvement and noted that appraisals played an important role in organisational culture.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Ms Lloyd, on behalf of the Chair of the Committee, summarised the meeting and noted that a number of areas received full assurance including waiting times, budget and estates compliance. There were two areas which received partial assurance; workforce and CIP as the programme had not been fully identified. It was noted that the Committee would continue to receive regular updates.

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

Performance Report

Ms Lloyd stated that of the 11 KPIs overseen by the Resource and Performance Committee which required further attention, 10 related to waiting times. It was noted that in February there had been 2 breeches in 65 week waits for the MSK service, and there had been increases in 104 week waits in all services. The Trust was now projecting to have no 52 week breeches by the end of May. The Committee received full assurance on the actions being taken. Additionally, there had been an independent review of our waiting lists and processes which determined that the processes in place were strong.

Ms Horsfield assured the Board that the 104 week breeches were all CRNT service patients, and they had all been seen by a member of the Multi-Disciplinary team and were waiting on specialist services. There were not expected to be any 104 week breeches upcoming.

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.***

Finance Report

The report presented the Financial Position until the end of February, and the Trust had delivered a surplus of £3.1m, compared to a planned surplus of £1.5m. There were no new risks to bring to the Board's attention, with all known risks mitigated. The Trust was on track to deliver a surplus of £3.6m at the end of the financial year, an improved position to support the overall system position.

Agency usage was roughly in line with plan and the capital allocation was forecast to be fully spent.

Ms Purt asked about the impact of the NHSE announcement of the elective income cap being withdrawn, Ms Lloyd confirmed that this would not impact on the 24/25 accounts as the position had already been agreed, however, there would not be a significant impact on the Trust due to the services we provide, the full detail was being worked through.

The Board

- ***Considered the adjusted financial position at Month 11 was £3,075k compared to a planned surplus of £1,534k, which was a favourable variance of £1,541k.***
- ***Acknowledged that schemes were fully identified to deliver CIP of £4,493k against the annual CIP target of £3,588k (£905k favourable to target), with minimal risk in terms of delivery.***

• Recognised that our capital expenditure forecast outturn was an underspend of £1,135k relating to capitalized leases. This was due to our focus on improving the utilization of the SCHT estate, which included reducing our lease expenditure and supported the STW ICS to live within available funding for lease expenditure.
• Considered that our forecast outturn had improved to deliver a surplus of £3,600l, which was £1,832k favourable to plan. All known risks to date had been fully mitigated and we were on track to deliver our revised forecast outturn.

Budget Setting

The report presented the Trust's opening budget for the upcoming financial year. The report had been reviewed in detailed by the Resource and Performance Committee and had been recommended to the Board for approval. In line with the Trust's Standing Financial Instructions, the Board must approve the opening budget.

The budget was based on our final plan submission to NHSE, and it was noted that the Trust was planning to deliver a surplus of £2m.

The Board noted that the budget would change throughout the year, however, it was vital that the opening position was shared with the organisation as whole as possible. Any changes to the budget would be approved in line with the Trust's scheme of delegation.

The Board
• Considered that the Resource and Performance Committee had reviewed the opening budget in detail on 26 March 2025 and had recommended it for approval by the Trust Board.
• Approved the opening 20-25/26 annual budget. The opening budget was a £2.0m surplus, in line with the financial plan approved by the Extraordinary Board Meeting on 19 March 2025.
• Recognised that the opening budgets were likely to be amended to reflect any changes agreed following review of our financial plan submission and appropriate approvals would be sought as required.
• Acknowledged a Capital Programme totalling £4.25m was included within our final plan submission, although this also remained subject to change depending on the outcome of bids for additional capital.

Annual Declaration of IG Toolkit Status

Ms Ramtuhul stated that the report was a look back on the previous year, and that for 2023/24, the submission had been made to NHSE and it had been confirmed that we had met all standards. The report for 2024/25 was being worked through, with the final submission due in June 2026.

The Board noted that the standards had been met for 2023/24.

Performance Framework – Integrated Performance Report 2025/26 Update

Each committee had reviewed its Key Performance Indicators and had recommended them for approval by the Trust Board. The KPIs needed to be agreed at the beginning of the year and could be amended as required.

It was noted that there were nationally mandated KPIs, however, these had not been reviewed in some time. The NHS Performance Assessment Framework document was currently out for consultation, and that it was expected the KPIs would be amended in light of this.

Additionally, each committee had identified local measures, which were important to us as an organisation, to look at.

The Board reviewed and approved the proposed list of key performance indicators, devolved to Committees of the Board.

Charitable Funds Committee Chair's Report

Ms Sargent summarised the report. The annual accounts and report was approved and had been submitted to the Charities Commission. The Committee had approved some changes to the approval limits, which were presented to the Board for approval in line with the scheme of delegation.

The Committee had previously discussed moving to being a fund raising organisation, however, this had been deferred, to focus on other priorities.

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

ANY OTHER BUSINESS – with prior agreement of the Chair

Any Other Business

There was none.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 5 June 2025.

Trust Board

Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
03-Apr-2025	**07/04/25 - Patient Story**	Digital solutions for information sharing within the multidisplinary team to be explored	SL	**01-Aug-2025**		ONGOING

CHIEF EXECUTIVE'S REPORT – JUNE 2025

Introduction

This report sets out issues of importance to the organisation 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 News

National News

You will have seen in my last report the announcement made by the Prime Minister and Secretary of State for Health on 13th March. To recap, the Government announced reform representing some of the most significant reshaping of the NHS nationally in a decade. The changes include bringing together the regulator for Healthcare in England (NHS England) with plans to subsume its duties within the Department for Health and Social Care (DHSC). In addition, Integrated Care Boards (ICBs) have been told they must reduce their running costs by 50% later this year. The Government also indicated corporate reductions for provider Trusts. This has since been clarified with guidance requiring provider Trusts to reduce corporate costs back to the 2018/19 baseline.

We are progressing plans to review our corporate service functions in tandem with health partners across the STW system and will share more information about this work in due course.

Local News

Very much staying with the national theme of joined up care, SCHT and SaTH are making a conscious move to bringing care closer to home through sharing a Chief Executive in common. This follows on from the appointment of the Chair in Common in October 2024 and builds on the existing joint services, with a greater focus on shifting care and delivering care across 13,000 square miles that is STW and beyond into Dudley, Wales and the wider geographies that we serve.

This is very much central to the aims of the 10-year plan and something, which is critical for an area so dispersed and of high rurality such as Shropshire.

This wider opportunity has availed itself as I am leaving the Trust. SaTH also has a vacant Chief Executive post. This will allow both Trusts, which will remain as separate organisations, to explore greater opportunities for clinical care and joined up working as part of a Group Model arrangement.

Personal

This will be my last public board before I move to my new post of Chief Executive for the two Local Care Organisations and Dental Hospital in Manchester. I begin my new role in September. The post covers community services across Manchester & Trafford and are fully integrated with social care with the focus clearly on left shift, which is very much my bag, in a city which is not dissimilar from where I grew up in Wolverhampton and areas, I have worked in. It was also the place of my youth. I spent many an hour in the Hacienda club, for those of you old enough to remember it.

I can honestly say that I have enjoyed my NHS career, and I have been blessed in having the opportunity to work in many parts of the country with fabulously skilled, committed and compassionate people in every job that I have held. ShropCom has been a real highlight. I started my clinical community career post qualification in Wales; here in Shropshire, Telford and Wrekin over 25 years ago and it has been a privilege to have returned on 1st April 2021 as the Chief Executive. Over the last 4 years we have taken what was a good organisation that provided great care into one which punches above its weight, leads transformation, steps into new ground and innovates. One that understands the value of community services, its potential, its reach and scope for delivering more skill and expertise efficiently and productively within the 500,000 beds that exist in people's homes first and foremost. There is a great team of staff whether they be clinical, operational, administrative, corporate that have ambition, commitment and motivation to continue to innovate. Thank you all for your support and compassion in the way that you deliver care. I look forward as a Shropshire resident and patient, to watching the next stage of ShropCom's development with partners and communities.

Taking Care of Our People

Staff Recognition

As previously reported, 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 within the Trust. These are bi-monthly awards, and I am pleased to announce the May winners as follows:

Award	Individual Winner	Team Winner
Agile	Stacey Worthington	Governance Team
Cohesive	Luisa Guigelmoni	Children's Asthma Nursing Team
Empowered	Janet Maila	IT / Digital Team
Totally ACE	Dave Pugh	Ward 36 Rehab & Recovery Unit

Caring for Our Communities

In my last report I wrote about the work that is ongoing to establish Integrated Neighbourhood Teams (INTs) that will support the 'left shift' from secondary to primary and community care. A workshop took place on the 16th May that involved colleagues from across all partners in STW. This highlighted the work being done by all partners across the system to facilitate that 'left shift' and to move care into Neighbourhoods. The work is being co-ordinated by the Place Partnership Boards in both Shropshire, and Telford & Wrekin, at which representatives of Shropcom play a key role.

Of particular importance is developing the Trust's working relationship with Primary Care. Members of our Senior Leadership Team met with the recently appointed co-Chairs of the STW GP Board in May to discuss areas of work linked with Neighbourhoods and the 'left shift' that can be jointly developed.

Throughout 2024/25, a system-wide UEC Improvement Plan was developed, encompassing five workstreams focused on enhancing the emergency patient pathway. The 'Alternatives to Hospital Admission' (AtED) workstream emerged as a central element of the plan.

The AtED workstream aimed to leverage appropriate services and expertise from across the system to reduce steps, handovers, referrals, and waiting times to access UEC care wherever possible outside of the acute setting. This approach sought to deliver improved and consistent patient outcomes while avoiding emergency department (ED) visits when clinically appropriate. Key achievements of this workstream during the year included:

- An increase in cases processed through the Single Point of Access (SPOA) for alternative options.
- Despite increased demand on SPOA, a 10% reduction in recommended conversions to ED was achieved.
- Enhanced responses in Category 2 incidents throughout the year.
- A 20% increase in Urgent Community Response (UCR) activity.

Following these accomplishments, the UEC Delivery Group agreed that a solid foundation for redirecting referrals from ED to alternative pathways had been established. Consequently, efforts for 2025/26 will focus on optimising community UEC pathways. The strategic objective is to shift unnecessary activities from acute settings to more appropriate community environments, enabling safer, less invasive, sustainable, and cost-effective care models to meet demand, particularly for patients with frail and complex needs.

In alignment with this objective, year two of the programme has initiated scoping demand and capacity exercises to explore how, collectively as a system, we can strengthen our community UEC offerings to further support patients locally and avoid hospital admissions whenever possible.

April marked a year since Dudley's public health nursing workforce joined our ShropCom family. In that time, we've developed a unified 0-19 service for children and families in Dudley. This integration has improved service delivery but required careful management of various factors. As we proceed with redevelopment, our focus is on collaboration, innovation, and meeting community needs. We acknowledge the challenges ahead in the

service redesign, but our workforce's support is vital. Together, we'll leverage past lessons to ensure every family in Dudley receives the necessary support to thrive.

Managing Our Resources

Like all NHS organisations, we are required to become more efficient and productive with public money year on year. We have an ambitious plan for the year, and I am proud of the commitment from staff across the organisation who continue to work to deliver this in a safe way.

Our approach to Cost Improvement Plans for 2025/26 has been strategically developed and plans were prepared in quarter 4 of 2024/25 to support delivery from month 1 of the new financial year. This involved identifying where efficiencies can be maximised and resources optimised in areas such as workforce, procurement, estate and streamlined pathways.

Our plan requires us to deliver £5.4m cost reductions plus the equivalent of £1.7m in productivity improvements in 2025/26. This is a real challenge, and we have not had to deliver at this scale before, but I know that with the continued focus and commitment from ShropCom staff we will do everything we can to meet the target.

And Finally – Good News Stories

T-Level Students

As a trust we are one of only a few Community providers supporting T-Level students. Given our success so far in this field, we have been part of a case study that will be used to show case the achievements. Gatsby are a foundation working alongside the NHS promoting T Level study and they will be recording a video with us to further promote T-Level placements for prospective future students. T levels are an important pipeline for future talent, encouraging younger students aged 16-19 to take placements in the public sector including the NHS, helping them to understand the industry and make decisions on their future career.

VE Day 80th anniversary celebrations

8 May marked the 80th anniversary of VE Day (Victory in Europe Day), throughout the week several of our colleagues marked the day by dressing up bases and providing a selection of VE day themed cakes and treats. It was great to hear the different ways staff across the Trust came together to pay tribute to the day.

London Marathon

I have been incredibly impressed and proud to hear that several of our ShropCom colleagues took part in the London Marathon to raise funds and awareness for charities close to their hearts. Abi Haylett, Health Visitor, raised £4,123 for Bliss Charity; Angela Charles, Community Respiratory Team Lead, raised over £500 for Asthma and Lung UK; and Jemma Brown, Continence Nurse Specialist Team Leader, ran on behalf of Good For Age (GFA).

International Nurses Day

We celebrated International Nurse's Day on 12th May. Throughout the week, the Trust took part in daily interviews on BBC Radio Shropshire on the Adam Green Breakfast Show with some of our nursing colleagues, as well as an interview on Greatest Hits Shropshire – Drive Time show and a feature article in Shropshire Star celebrating the day and some of our colleagues who had been nominated in our Nursing Hero campaign.

Shropshire Community Health NHS Trust

Provider Licence Declaration

0. Reference Information

Author:	Shelley Ramtuhul, Director of Governance	**Paper date:**	5 June 2025
Executive Sponsor:	Patricia Davies, Chief Executive	**Paper written on:**	22 May 2025
Paper Reviewed by:	N/A	**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 Trust Board and what input is required?

This paper presents the proposed Provider Licence Declarations for 2025 for consideration and approval.

2. Executive Summary

2.1 Context

NHS Trusts are required to give assurance that they have complied with the NHS Provider Licence, NHS Acts and have regard to the NHS Constitution. To support the Trust's self-certification, an assessment of assurances available on each aspect of the license conditions has been made.

2.2 Summary

This report provides the following:

- Self assessment undertaken against licence requirements
- Proposed declarations

2.3. Conclusion

The Trust Board is asked to **consider** the NHS Provider licence self-certification templates indicating compliance and **approve** submission of the self-certification.

Provider Licence Declaration

3. Main Report

Self-Certification for Provider Licence

The Health and Social Care Act 2012 introduced the concept of a Licence for providers of NHS services, and the NHS Provider Licence was subsequently introduced in February 2013.

Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014, but it was later confirmed that the Licence would not apply to NHS Trusts. Despite this, in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption, directions from the Secretary of State required NHSI to ensure that NHS Trusts complied with conditions equivalent to the Licence, as it deemed appropriate.

The NHS Oversight Framework (NOF) bases its oversight on the Licence and NHS Trusts are therefore legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

These conditions are:

Condition G6

Condition G6 (2) requires trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Providers must annually review whether these processes and systems are effective.

Condition CoS 7- Availability of resources (scope = next financial year 2025/26)

The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate.

Condition FT4

The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

Provider Licence Declaration

- a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
- b) comply with the following paragraphs of this Condition.

The Licensee shall establish and implement:

- a) effective board and committee structures;
- b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and clear reporting lines and accountabilities throughout its organisation

It is up to providers how they do this, but Board understanding and sign off is required. NHS England supply templates which trusts can use to confirm their compliance. Providers must have processes in place to ensure they check compliance and manage risks of non-compliance on an ongoing basis and must publish their G6 self- certification within one month following the deadline for sign-off.

There is no requirement to submit the self-certification to NHS England, but they may select some Trusts to ask for evidence that they have self-certified.

To support the Trust's self-certification, a written assessment of assurances available on each aspect of the license conditions has been prepared. The standards are the same as previous years, hence the evidence to support them is also broadly the same.

3.5 Conclusion

The Audit Committee is asked to **consider** the NHS Provider licence self-certification templates indicating compliance and **approve** submission of the self-certification to the Board for final approval**.**

Provider Licence Declaration

PREPARATION FOR SELF CERTIFICATION AGAINST PROVIDER LICENCE

SELF-ASSESSMENT May 2025

Note: References in the License to Monitor now refer to NHS England for the purpose of our assessment

Licence condition	Licence key requirement	Assurances/ Self-assessment finding
G1: Provision of information	Furnish Monitor with such information and documents as they require to exercise their function. Take reasonable steps to ensure information is accurate, complete and not misleading.	• Trust systems are in place to provide NHSE/regulators with information they require and quality assure it • Performance and Quality reporting measures are included in the local Performance Framework. • Records of meetings with NHSE and other regulators indicate appropriate information supplied when required • Audit Committee exercises its role to assure accuracy of certain Trust-wide information
G2:Publication of information	Comply with Monitor direction to publish information about NHS services	• Range of methods in place to publish this information – website, patient information material, use of accessible information standard, annual report and accounts
G3: Payment of fees to Monitor	Pay fees to Monitor	• Would meet requirement if and when arose
G4: Fit and proper persons	No person who is 'unfit' can become/remain a director or governor. Also applies to those performing similar roles eg interims and deputies	• Specific policy and Standard Operating Procedure in place • Annual background checks and annual declarations completed on relevant individuals • Arrangements reviewed and found compliant by CQC at last inspection and recently reviewed and updated in light of new FPPT Framework. • Annual submission to NHSE in line with requirement
G5: Monitor guidance	Have due regard to guidance issued by Monitor	• Regular horizon scanning for new guidance by means including NHSE bulletins and networks, horizon scanning reports by the business development team to the management team, CEO's reports to Board, external auditors reports to Audit Committee.

Provider Licence Declaration

G6: Systems for compliance with licence conditions and related obligations	Take all reasonable precautions to avoid failure to comply with the License, NHS Act or NHS Constitution	• Self assessment findings in this review indicate precautions and assurances in place to mitigate against risk of failing to comply with individual license conditions • Risk management system in place. Risk of failure to comply with legislation incl NHS Act is included on Trust corporate risk register, with associated mitigations. Trust legal advisors in place. • Wide-ranging systems for internal and external control described in Annual Governance Statement • Overarching role of Audit Committee to seek assurance on systems and compliance • Submission of statutory returns • Trust's local Performance Framework is aligned with the NHS E Oversight Framework • Monitoring of Constitution-related targets in performance reports • Submission of statutory returns
G7: Registration with the Care Quality Commission[1]	Required to be registered with CQC	• Trust has established process for CQC registration
G8: Patient eligibility and selection criteria	Required to set and publish transparent patient eligibility and selection criteria	• Covered on Trust web site - service information for patients.
G9: Application of Section 5 (Continuity of Services)	Requires trust to provide agreed Commissioner Requested Services (CRS) as contracted. Requires trust to inform Monitor where (i) change to CRS, and (ii) no agreement for extension/renewal of CRS	Not applicable

Provider Licence Declaration

P1: Recording of information	Monitor may require the trust to record information such as that related to its costs.	• Compliant with reference cost requests – the mandated national costing process with set reporting currencies • Use national tariffs for all those services where applicable • Local agreements in place with commissioners about cost recording where services are not covered by national arrangements
P2: Provision of information	As P1, but relates to provision of information	• Provide reference cost information to NHSE; see response to P1.
P3: Assurance report on submissions to Monitor	Monitor may require the trust to provide assurance that condition P2 has been complied with	• Internal assurance processes in place to cross check and assure costing information
P4: Compliance with the National Tariff	Trust can only provide services at prices that comply, or are determined in accordance, with the national tariff	• Contract monitoring reports provide evidence of our use of national tariffs for those services where they apply • Internal assurance processes in place to cross check and assure costing information
P5: Constructive engagement concerning local tariff modifications	Trust required to engage constructively with commissioners.	• Notes of contracting meetings with commissioners show engagement over arrangements for services where national tariffs do not apply eg price and activity matrix. • specific approach agreed with commissioners regarding Service Development and improvement Plans (SDIP), which will include the Price Activity Matrix (PAM)
C1: The right of patients to make choices	Requires trust to inform patient when they have a choice and where to find such	• Trust web site information • Use of RAS and TRAQs which facilitate patient choice where applicable

Provider Licence Declaration

	information regarding their choices	
C2: Competition oversight	Prohibits agreements and conduct that either have the effect, or likely to have the effect, of preventing, restricting or distorting competition	• Framework of SFI's and SO's in place, plus SLAs • Governance in place around partnerships, many of which have been under commissioner-led processes
IC1: Provision of integrated care[1]	Trust must not do anything that is detrimental to the integration of services	• Active engagement in integrated working and representation at all ICS meetings • Provision of range of services in close partnership or integration eg ICS, Out of Hospital Care
CoS1: Continuing provision of Commissioner Requested Services	Trust must not stop or change the way CRS services are provided without the agreement of the commissioner	Not applicable
CoS2: Restriction on the disposal of assets	Trust must keep an up to date register of all relevant assets used for CRS. And get Monitor approval prior to disposal of such assets when they raise a concern re on-going capability of trust	Not applicable but note that • Asset register identifies assets by service and location so links can be made
CoS3: Standards of corporate governance and financial management	Trust must have due regard to adequate standards	• Full range of systems of corporate governance and control, as described in Trust Annual Governance Statement • Internal and external audit outcomes • Oversight by Audit Committee • NHSE oversight rating with plan in place to address any areas of concern

Provider Licence Declaration

CoS4: Undertaking from the ultimate controller	Legally enforceable agreement required with parent companies to prevent their action causing a breach to licence conditions	• Currently not applicable
CoS5: Risk pool levy	May require Trust to contribute towards fund to pay for vital services if a provider fails	• Currently not applicable
CoS6: Cooperation in the event of financial stress	Trust must cooperate with Monitor under such circumstances	• Currently not applicable
CoS7: Availability of resources	Requires trust to ensure that it has the required resources available to deliver CRS.	• Not applicable

Provider Licence Declaration

Provider License Self Declaration: Assurance for Corporate Governance Statement, Condition FT4 (8) May 2024

	STATEMENT	ASSURANCES /EVIDENCE
1.	THE Board is satisfied that the Licensee applied those principles, systems and standards of good corporate governance which reasonably would be regarding as appropriate for a supplier of health care services to the NHS.	• Trust governance structure is set out in the SO's, SFI's, Schemes of Reservation and Delegation and the Risk Management Policy. Systems for internal control are set out in the Annual Governance Statement • Governance is tested by the Audit Committee through risk management, individual audits and the opinions of internal and external auditors. • The Audit Committee reports its findings to the Board after each meeting and through its Annual Report • The Trust was last inspected by the CQC in 2019 and is expecting a further CQC inspection shortly.
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.	• Horizon scanning mechanisms to review NHSE guidance, then reflected in CEO's Reports, and Governance Reports, to each Board meeting in public • Records of monthly meetings with NHSE and ICB • Regular engagement with NHSE and ICB over local arrangements and issues eg sustainability process and associated governance
3.	The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	• Clear governance structures and reporting lines/accountabilities/responsibilities documented. Structures are reviewed and updated regularly and are shared with Regulators, and published on Trust web site • Governance structures are assessed against the CQC and NHSE Well Led frameworks • The Board and supporting Committees (Audit , Quality & Safety, People Committee, Resources and Performance, Nomination and Remuneration) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. • CQC report and action plan (completed) • Board and Committees evaluate effectiveness at conclusion of business • An independent review of the Well Led" CQC standard and NHSEs Framework was carried out by GGI in 2022.

Provider Licence Declaration

4.	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the	• Detailed arrangements as described in Trust Annual Governance Statement • Clear governance structure covering these matters including Resources and Performance Committee, Quality and Safety Committee and their respective sub Committees. • External Value for Money opinion, and other relevant internal and external audits • CQC re- Inspection in 2019 No significant issues raised,
	Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.	the report is currently awaited . • Internal and external audit opinions; going concern opinion • Risk management system with risk registers at all levels, overseen ultimately by Audit Committee • Regular reviews by Board of the well-led standard, including information provision • Progress on strategies and business plans feature strongly on Board and Committee agendas; clear governance structure for the handling of business plan issues via working groups reporting to Resources and Performance Committee and from there to Board. Performance reports are organised around organisational aims. • Access to and regular briefings from legal advisors • Systems for horizon scanning reinforced by professional networks

Provider Licence Declaration

	The board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the board receives and takes in to account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the	• CQC Inspection report 2019 with rating of Good • Clinical background of a number of Board members including non-executive director with clinical background. • Quality of care considerations inbuilt to Board's work via a range of information received by Board for example, timely quality performance reports, dashboards from service delivery groups, use of quality impact assessment ,Board visits, key topic reports eg safeguarding, infection control, clinical audit reports; patient surveys; staff surveys; CQC Inspection Reports; Board Assurance Framework (BAF); • Internal Quality Review Reports and Senior Leaderships clinical teams visits • Quality and safety Committee receives comprehensive range of information • Strong record of engagement with patients, staff and stakeholders • Well-established Patient Panel acting as a conduit for feedback; evidence of "you said, we did" • CQC inspection recognised positive patient engagement activity • Range of systems for escalating and resolving quality
	Licensee including but not restricted to the systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	The Quality and Safety Committee oversees any quality issues including risk management; Incident investigation and lessons learned review meetings; complaints, deep dive reviews at Quality and safety on specific topics of concern; use of flash reports. • All risks scored above a certain level are reviewed in detail. Sources of risk include the analysis of incidents, complaints, clinical audit, concerns and claims reported throughout the Trust, the Divisional Performance Review Process, the Trust/Divisional Clinical Effectiveness Groups and other specialist committees and groups. • Enhanced governance structure approved and in the process of being implemented with a new Associate Director of Governance in place. • Quality team in place and clinical leads for quality and supporting staff

Provider Licence Declaration

6.	The Board is satisfied that there are systems to ensure that the Licensee has in plane personnel on the board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• Robust selection, appraisal, development and 'Fit and Proper' assurance processes in place for Board members which has been updated following introduction of the new FPPT framework in 2023 • Assessments of staffing in quality reports; use of tools to assess staffing; triangulation with other quality indicators • Where appropriate NEDs have suitable qualifications and backgrounds e.g. chair of Audit Committee has a financial background

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2025 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Patricia Davies	**Name**	Andrew Morgan
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2025 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Patricia Davies

Signature _____ **Name** Andrew Morgan

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A [ ] Please Respond

Shropshire Community Health
NHS Trust

Public Questions Scheme

Trust Board – 5 June 2025

0. Reference Information

Author:	**Andrew Morgan, Chair in Common**	**Paper date:**	**5 June 2025**
Executive Sponsor:	Andrew Morgan, Chair in Common	**Paper written on:**	19 May 2025
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an update scheme of public questions at Trust Board meeting held in public for the Trust, which is being submitted for approval and adoption.

2. Main Report

2.1 Introduction

The Trust has for a number of years operated a public questions scheme for its meetings that are held in public. Following the appointment of a Chair in Common in October 2024, the policy has been reviewed and refreshed and is presented to the Board for approval and adoption.

3. Conclusion

The Board of Directors is asked to approve the adoption of the updated scheme for public questions.

Public Questions at Shropshire Community Health Trust Board

Board meetings are held in public every other month on the first Thursday of the month at 10am. Meeting venues are published on the Trust's website ahead of the meeting. Meetings take place at various venues across the Trust's area to ensure that all service users are able to attend a meeting should they wish.

Submitting Your Question:

- Questions can be made in writing or via email to shropcom.publicquestions@nhs.net to be received by midday the day before the meeting
- Questions can be submitted on any matter within the powers and duties of the Trust
- If time allows after responding to written questions, the Chair will permit verbal questions on the day

At the Meeting:

- Public questions will be taken at the start of the meeting after the patient/staff story. Written questions will be taken first, followed by verbal questions if time allows.
- There will be a maximum of 30 minutes on the agenda for the public questions.
- Questions will be included in the minutes of the following meeting.
- Questions will be dealt in the order in which they were received. We will seek to give an overview of the response to the question, but a more detailed response to questions will be provided as part of the minutes which will be made available on the Trust's website and directly in writing to the person who asked them following the meeting.
- Any questions received in writing after the midday deadline will be responded to by writing to the person directly and read out at the subsequent meeting in public.
- You may attend in person to listen to the feedback, the Chair will read questions whether you are in attendance or not. It is not possible to join the meeting virtually.
- You may not ask a supplementary question and there will be no opportunity for discussion on public questions.

0. Quality and Safety Report – May 2025

Author:	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	5th of June 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	29th of May 2025
Paper Reviewed by:	Sara Ellis-Anderson – Deputy Director of Nursing and Quality and Deputy DIPC	**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

5 of the 19 Quality and Safety dashboard KPIs are showing **special cause variation of a concerning nature** in Month 1 (April)

- *Clostridium Difficile* – There has been three cases reported in April; the organisation has had 3 Hospital acquired *C-difficile* cases against a threshold of 4 YTD. Thematic reviews are scheduled quarterly.
- E-Coli bacteraemia has remained at 2 cases for the rolling 12 months. There were no cases reported in April.
- There was 1 unexpected death in April in HMP Stoke Heath, and this has been referred to the PPO for review.
- 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 in relation to the Bed Rails Safety alert and this action plan is monitored through Patient Safety Committee.
- Medicines incidents with moderate harm reported as 2 against a target of 0 for April – both incidents are linked to a PSII that has been declared due to delays in antibiotics being prescribed for an infected pressure ulcer.

3 of the 19 KPIs are showing **special cause variation of an improving nature** in Month 1 (April)

- Consistency of reporting patient safety incidents - The Trust went live for LFPSE reporting in November 2024, before that, the last upload to NRLS was in March 2024. Monthly reporting has continued, and the Trust is now at 100%
- Acting to improve safety – safety culture theme in NHS staff survey is an annual KPI that has demonstrated improvement since last staff survey data collection
- Complaints response remains at 100%

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

- In April 2025 there were 23 inpatient falls reported within our care at the Community Hospitals and Rehabilitation and Recovery Wards in comparison to 26 reported in March. This equates to a decreased rate of 5.8 falls per 1000 Occupied Bed Days (OBDs). Falls thematic reviews are presented quarterly to Patient Safety Committee.
- There was one category 4 and one category 3 pressure ulcers reported in April. PSIRF thematic reviews are being completed six monthly with improvement actions identified.
- There was one PSII declared in April 2025 relating to a category 4 pressure ulcer

Trajectories for both Falls and Medication KPIs demonstrate seasonal variation rather than month on month improvement based on analysis of last 24 months data.

Safer staffing data

- Data reporting period covers **March 2025**.
- Average fill rates for RNs were over target at 108% for day and 104% for night shift, this was due to escalation beds open on Ward 36 and Whitchurch.
- Average fill rates for non-registered workers were over target at 134% for day and 156% for night, this was due to escalation beds and higher dependency of patients requiring enhanced supervision.

Harm review data remains in the report in previous format and awaiting addition to the Quality and Safety Dashboard. This has been highlighted as a potential new KPI with a draft definition in place to add to the performance framework that will require Trust Board approval. Moderate harm incidents are reviewed as part of the Trust's weekly Patient Safety Incident Panel.

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 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	2025-04-30		6.43	6.49	-0.06	6.43	6.49	-0.06	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2025-04-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2025-04-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2025-04-30		300.00%	100.00%	200.00%	300.00%	100.00%	200.00%	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2025-04-30		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2025-04-30		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Effective	Deaths - unexpected	2025-04-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2025-04-30		200.00%	100.00%	100.00%	200.00%	100.00%	100.00%	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2025-04-30		5.80	4.00	1.80	5.80	4.00	1.80	
Quality & Safety Committee	Safe	Medication Incidents with Moderate Harm	2025-04-30		2	0	2	2	0	2	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2025-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2025-04-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Never Events	2025-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2025-04-30		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2025-04-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-03-31		134%	95%	39%	134%	95%	39%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-03-31		156%	95%	61%	156%	95%	61%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-03-31		108%	95%	13%	108%	95%	13%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-03-31		104%	95%	9%	104%	95%	9%	

Variation	Assurance			
	P	?	F	○
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.

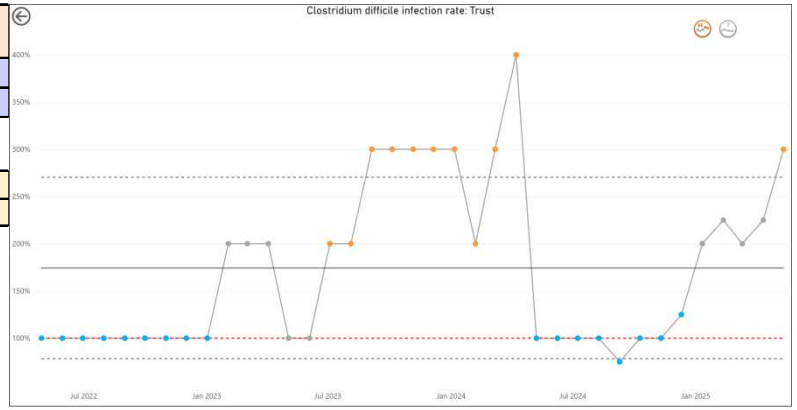
Exception Report - Action Plan

Clostidium difficile infection rate

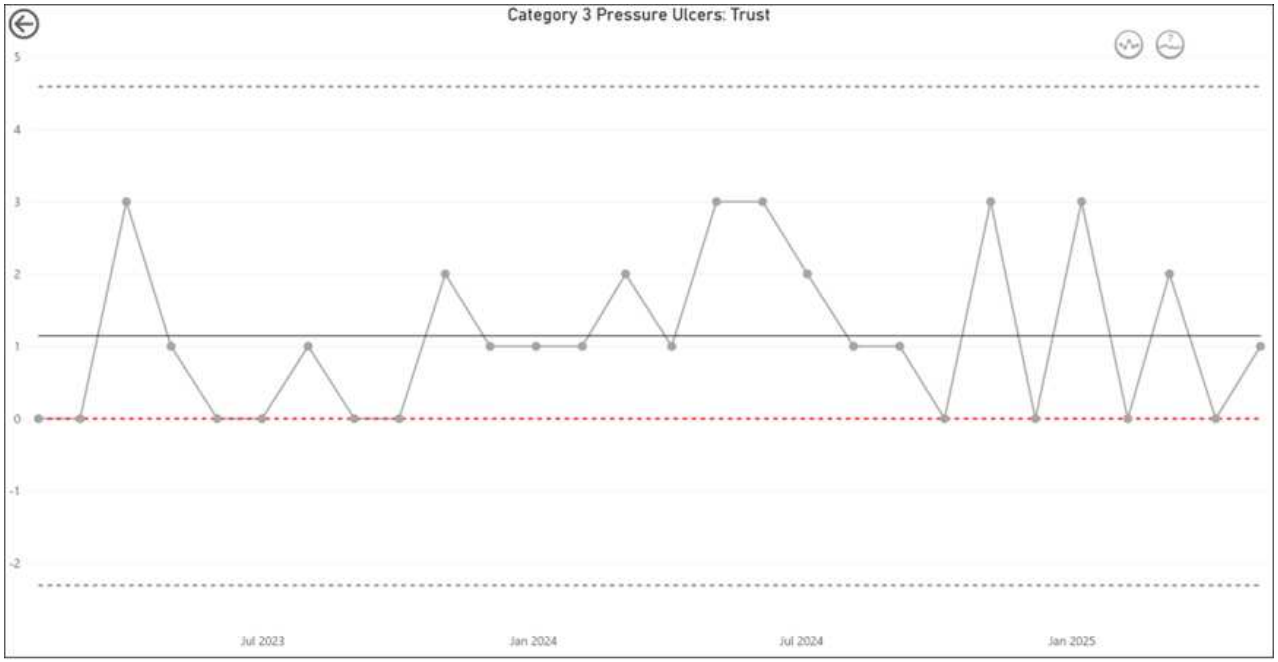
12-month rolling counts of Clostridioides difficile (C. difficile) infections by NHS organisation and prior trust exposure (from April 2019) in patients aged 2 years and over.

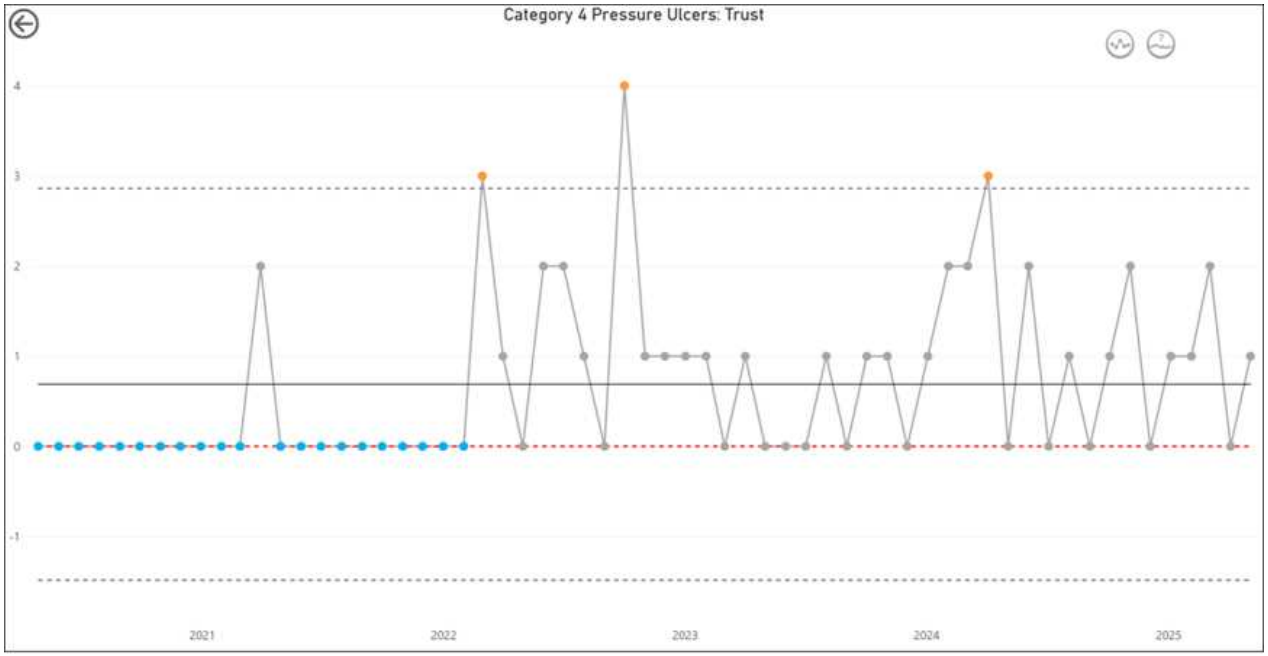
KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Clostidium difficile infection rate	Number	5	8	9	9	9	12	12
	Target	4	4	4	4	4	4	4

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number	0	0	0	0	0	0	0



Narrative/Description:	There have been three cases of C-Diff reported in April 2025. The rolling 12 months total now stands at 12 with 9 cases in 2024/25 and 3 cases YTD against an annual threshold of 4. A Post Infection Review is completed for each case with many patients having been on multiple courses of anti-biotics for other infections identified as the most probable cause. The QI and IPC Teams have carried out an initial thematic review of 8 cases to identify any areas for improvement presented at IPC Committee in March 2025 with notably 50% of the cases being re-lapses of infection that they had had previously. Futher work is also being completed by our Pharmacy team in terms of raising awareness for de-prescriping PPIs which are known to increase risk of developing C-Diff when they are used long term. Quarterly thematic reviews will continue for 25/26 to identify improvements in systems and processes required. The 9 C diff cases for 2024/2025 were: 5 in Ludlow; 1 in Bishops Castle; 1 in Whitchurch; 1 in Ward 18 RRU and 1 in Ward 36 RRU The 3 cases in April 2025 (Month 1) are: 2 in Ward 36			
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Thematic review of all C-Diff cases	Dec-24	Feb-25	Complete	Report presented at March IPCC. For Quarterly thematic reviews in 25
	Rolling annual deep clean programme for Community Hospitals and RRUs to be developed	Jan-25	Apr-25	Complete	Whitchurch has been deep cleaned in July 2024. Ludlow, BCCH and Bridgnorth have had bay by bay deep cleans following recent outbreaks. Plan in place for 25/26 for Community Hospitals.
	Flowchart to enable de-prescribing of PPIs to be written and approved at Patient Safety Committee	Feb-25	Mar-25	Complete	Approved at Patient Safety Committee February 2025
	IPC to deliver Spring Clean campaign to declutter environments and enable more effective cleaning in inpatient areas	Apr-25	May-25	Complete	Improvements noted in IPC QAA for inpatient areas in April.
	IPC team to create resources for World Hand Hygiene Day on 5th of May to promote importance of handwashing	Apr-25	May-25	Complete	
	Request Ribotyping for potentially linked cases	Apr-25	Mar-26	In progress	Will be monitored as part of quarterly thematic reviews
	Observation and mapping of deep clean process to be completed by IPC team	May-25	Jul-25	In progress	
Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	20/05/2025		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025		


Category 3 Pressure Ulcers: Trust
5
4
3
2
1
0
-1
-2
Jul 2023
Jan 2024
Jul 2024
Jan 2025


Category 4 Pressure Ulcers: Trust
4
3
2
1
0
-1
2021
2022
2023
2024
2025

Narrative/Description:	There was 1 Category 4 pressure ulcer reported in April which has been presented at PSIP. This particular incident involved a palliative patient who was approaching end of life, there were also issues with equipment delivery which resulted in deterioration of the pressure ulcer. The Tissue Viability team provides monthly support through caseload reviews, discussing complex wounds and pressure ulcers, as well as offering customised training required by the IDT teams. Additionally, "Back to Basics" virtual sessions on pressure ulcers are scheduled for all teams to update them on classification and PURPOSE T.					
Action Plan			**Start Date**	**End Date**	**Status**	**Outcome**
	Roll-out PURPOSE T implementation to community hospitals		Dec-24	Apr-25	Complete	
	Recorded training videos for Pressure Ulcer Prevention (How to complete PURPOSE T assessment, how to measure a wound etc)		Jan-25	Jun-25	In progress	First stream of videos have been filmed, second stream planned for mid June
	Bitesize Pressure Ulcer classification virtual sessions to include Q&A section on PURPOSE T		May-25	Sep-25	In progress	Training dates have gone out and staff booking onto sessions
	Revising pressure ulcer competencies in line with NWCS core corriculum		Mar-25	May-25	In progress	
	QEIA to be completed with suggestion to make Pressure Ulcer Awareness training mandatory and role specific		Mar-25	Jun-25	In progress	ESR working group meeting on 20th May 2025 agreed provisionally pending QEIA
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	20/05/2025			
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	21/05/2025			

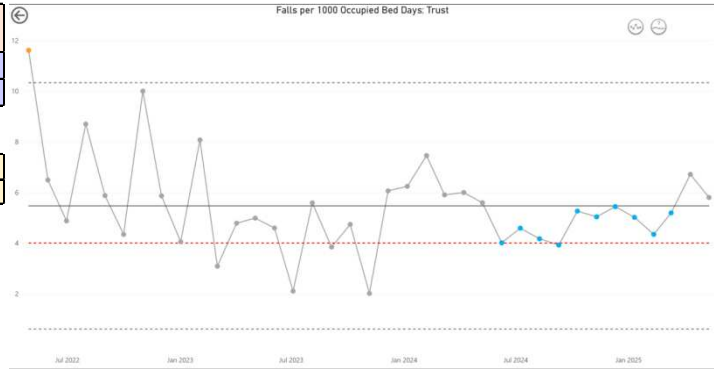
Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Falls per 1000 OBDs	Number	5.44	5.02	4.34	5.19	6.71	5.80	5.80
	Target	5	5	5	5	5	5	0

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number	4.00	4.50	4.00	4.00	4.50	4.50	4.50



Narrative/Description:

In April 2025, there were 23 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Units, marking a decrease in falls compared to M12. This translates to a rate of 5.8 falls per 1000 Occupied Bed Days (OBDs), with adjustments for duplicated falls recorded in Datix.

The fall rates for each Community Hospital site are as follows: Whitchurch (3), Ward 18 RRU (3), and Ward 36 RRU (3) reported reduced fall rates. Ludlow (1) and Bishops Castle (5) saw no change in the number of falls recorded. Bridgnorth Community Hospital experienced an increase in falls, totalling (8).

Regarding physical and psychological harm from these falls, the records indicate (Physical) No harm falls (14), Low harm falls (8), moderate harm falls (1), (Psychological) No psychological harm (20), Low Psychological harm (2), and moderate psychological harm (1). One patient attended A+E following a fall and returned to the community hospital after a head injury review.

Falls potentially attributed to patients with confusion, requiring Enhanced Patient Supervision at the time of the falls were recorded at Bishops Castle (1), Ward 18 (1), Ward 36 (1), and Whitchurch (1). Post-fall actions to increase enhanced supervision were identified and implemented.

The monthly themes show that 8 falls occurred during the day (8am-8pm) and 15 falls occurred at night (8pm-8am). The rate of unwitnessed falls remains high at 19. Ward managers are reviewing safer care data and conducting a review of the Enhanced Supervision policy to identify areas for improvement and effective individualised patient assessments.

Action Plan

	Start Date	End Date	Status	Outcome
Improving Hydration, reducing UTIs project piloting at Whitchurch. Project extended to Ludlow Community hospital .	Sep-24	~~April 2025~~ June 2025	In Progress	Delay in reporting identified from Whitchurch. Pilot project extended to Ludlow Community hospital in May 2025. In Discussion with the RIO configuration team regarding building the fluid balance form in RIO.
NEW review of products for digital falls technology and Robotic therapy animals for patients with Dementia . A demonstartion of the products is being arranged and will be evaluated at the falls task and finish group.	Jan-25	Jun-25	In Progress	Demonstration planned with RambleGuard, Ward managers, IPC , Estates and Health and Safety team June 2025. No response received from Paraseal Robotic Animal Therapy.
Falls Prevention Policy reviewed, updated and ratified by Patient Safety Committee	Jan-25	~~March 2025~~ April 2025	Complete	Falls policy final comments and amendments made. For ratification at QSC in May 2025
Heat mapping of falls locations at each inpatient site to explore potential environmental contributory factors	May-25	Jul-25	In Progress	To be collected on Datix form for ongoing monitoring within thematic reviews

Author	Sarah Venn - Clinical Lead for Quality	**Date**	15/05/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	21/05/2025

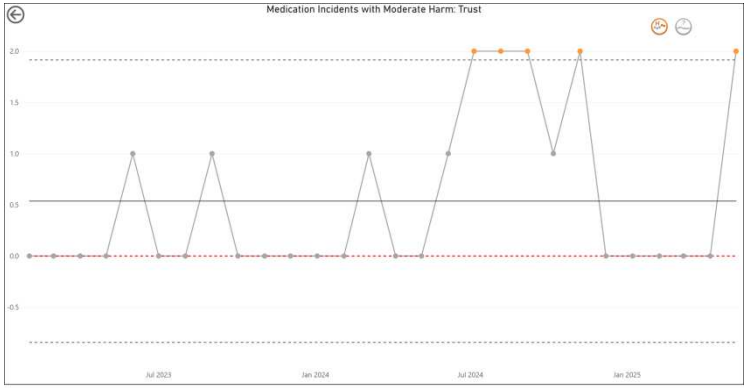
Exception Report - Action Plan

Medication Incidents with Moderate Harm

Number of medication incidents per month resulting in harm

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Medication Incidents with Harm	Number	0	0	0	0	0	2	2
	Target	0	0	0	0	0	0	0

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number	1	1	0	0	0	1	1



Narrative/Description:	All of these incidents are included in the Patient Safety Incident Response Framework (PSIRF) quarterly thematic review. **Moderate Harm** •There were 2 moderate harm incidents reported in April 2025. Both incidents were linked to PSII 2025 2071 W74827. **Low Harm** **1 x Internal** •Late administration of Tinzaparin **3 x External** •Patient dispensed OOD Dexamethasone 0.1% preservative free eye drops •Delay receiving new insulin authorisation for patient from GP •Inappropriate prescribing of antibiotics for CAP

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	Apr-25	Complete	Escalated to ICB Quality Team / Discussed at PSC on 13/02/25. ICB are completing thematic review of discharges/transfers resulting in Medication errors.
	Amendments being made to RiO RR/ VW Medication module to reduce number of RR/VW related medication incidents	Nov-24	Apr-25	Complete	technician. Pre-discharge medicines reconciliation compliance has increased to 84% and there has been an reduction in incidents as a result. Action closed but ongoing service improvement remains including pilot of medicines reconciliation module in North East team.
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	May-25	In Progress	Final changes to be agreed at community team lead meeting. Document then to be submitted to MGG for approval and PSC.
	Review and update of inpatient medicines administration chart	Apr-25	Jul-25	In Progress	Task and finish group established. No WM attendance at first meeting, LBE to identify more suitable date for group.

Author	Lucy Barrass-Evans - Medicines Safety Officer and Non-Medical Prescribing Lead	**Date**	19/05/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025

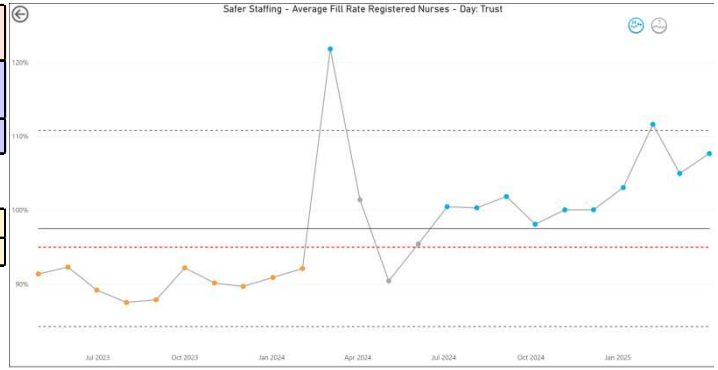
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Registered Nurses - Day: Trust

Safer Staffing - Average Fill Rate Registered Nurses - Day: Trust

KPI Description	Latest 6 months	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Safer Staffing	%			112.0%	105.0%	105.0%	108.0%	108.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:	Bishops Castle - 102.8% 2.8% for high dependancy Bridgnorth - 100.5% Ludlow - 98.5% Whitchurch - 118.6% - 18.6% for escalation beds PRH RRU Ward 36 - 110.9% 10.9% for escalation beds being opened RSH RRU Ward 18 - 105% 5% for increased demand.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
	National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submission 28th March 2025 (regional request received wc 17/3/25). application successful and launch of programme on the 12th May 2025
	Further education with the ward managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and challenge meeting to address this action
	ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
	Development of overarching improvement plan to include actions from fill rates peer review and ETOC programme	May-25	Jun-25	In Progress	
Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	07/05/2025		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025		

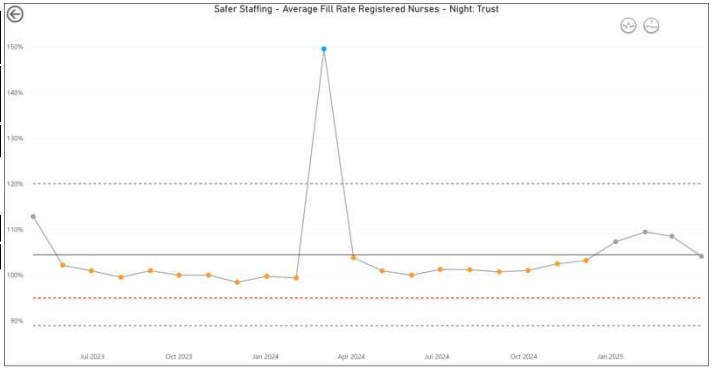
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Registered Nurses - Night: Trust

Safer Staffing - Average Fill Rate Registered Nurses - Night: Trust

KPI Description	Latest 6 months	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Safer Staffing	%			109.0%	166.0%	109.0%	104.0%	104.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:	Bishops Castle - 100% Bridgnorth - 100% Ludlow - 100% Whitchurch - 98% PRH RRU Ward 36 - 152.5% 52.5% escalation beds being opened RSH RRU Ward 18 - 99%				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
	National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submission 28th March 2025 (regional request received wc 17/3/25). Await confirmation as to whether we have been succesful in joining cohort two.
	Further education with the Ward Managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and challenge meeting to address this action
	ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
	Development of overarching improvement plan to include actions from fill rates peer review and ETOC programme	May-25	Jun-25	In Progress	

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	07/05/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025

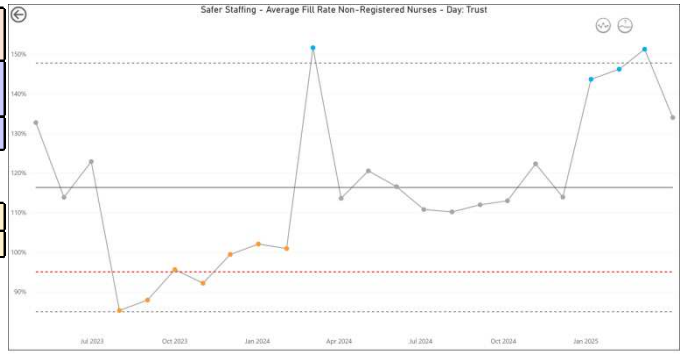
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Non-Registered Nurses - Day: Trust

Safer Staffing - Average Fill Rate Non-Registered Nurses - Day: Trust

KPI Description	Latest 6 months	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Safer Staffing	%			146.0%	151.0%	151.0%	134.0%	134.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:

Bishops Castle - 94.7% Establishment
Bridgnorth - 102.7% 2.7% one to one shifts
Ludlow - 147.4% 47% one to one shifts
Whitchurch - 151% 10% one to one shifts and 41% escalation beds being open
PRH RRU Ward 36 - 197.8% 35.5% one to one shifts and 62.3% escalation beds being opened.
RSH RRU Ward 18 - 154% 54% one to one shifts

Action Plan

	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
Review of Enhanced Supervison policy and behaviour charts to allow for more timely step down	Mar-25	Jun-25	In Progress	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submission 28th March 2025 (regional request received wc 17/3/25). Application successful launch programe on 12th May 2025
Quality Improvement Project following peer review	Apr-25	Jul-25	In Progress	To work with the Quality Team on this improvement project
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
Review of Memory and Health and Wellbeing worker role to be completed	Apr-25	Jun-25	In Progress	
Review of shift patterns for inpatient areas	Apr-25	Jun-25	In Progress	QEIA to being written to gain support for the shift patterns to change
Development of overarching improvement plan to include actions from fill rates peer review and ETOC programme	May-25	Jun-25	In Progress	

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	07/05/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025

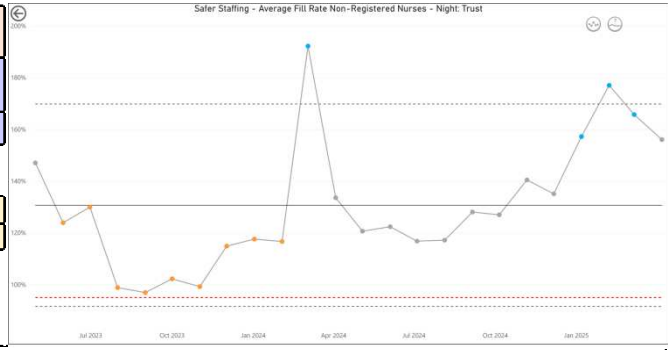
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Non-Registered Nurses - Night: Trust

Safer Staffing - Average Fill Rate Non-Registered Nurses - Night: Trust

KPI Description	Latest 6 months	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Safer Staffing	%			177.0%	166.0%	166.0%	156.0%	156.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:

Bishops Castle - 128.3% - 28.3 % one to one shitts
Bridgnorth - 112.1% - 12.1% one to one shifts.
Ludlow - 167% - 67% one to one shifts.
Whitchurch - 202% - 49% one to one shifts and 53% escalation shifts.
PRH RRU Ward 36 - 161.8% - 40% one to one shifts and 21.8% escalation shifts
RSH RRU Ward 18 - 184.7% - 84.7% one to one shifts

For January 2025 Whitchurch opened escalation beds from 25 beds to 32 and reduced to 29 on the 24th March, thus requiring further staffing outside of establishment to maintain safety, this is the same for Ward 36 that increased their beds by 3 in January 2025 and due to the lay out of the ward required above establishment to maintain safety. On the week of the 12.05.2025 both Whitchurch and Ward 36 came out of escalation

Action Plan

	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submission 28th March 2025 (regional request received wc 17/3/25). Await confirmation as to whether we have been succesful in joining cohort two.
Review of Enhanced Supervison policy and behaviour charts to allow for more timely step down	Mar-25	Jun-25	In Progress	
Quality Improvement Project following peer review	Apr-25	Jul-25	In Progress	To work with the Quality Team on this improvement project
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Review of Memory and Health and Wellbeing worker role to be completed	Apr-25	Jun-25	In Progress	
Review of shift patterns for inpatient areas	Apr-25	Jun-25	In Progress	QEIA to be written to gain support for change in shift patterns
Development of overarching improvement plan to include actions from fill rates peer review and ETOC programme	May-25	Jun-25	In Progress	

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	07/05/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/05/2025

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. 1132 harm proformas have been completed to date; with 84.02% indicating no harm and 14.31% indicating low harm and can be treated and resolved.

There have been 19 cases (1.67%) of moderate harm identified up to March 2025; 13 following delays to first appointment, 4 due to delayed follow up appointments, 1 due to patient choice delay to commence medication and 1 due to delay of referral onward. All 19 cases have been reviewed by the Clinical Lead who has agreed with the assessment of moderate harm. 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 113.

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	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Harm proformas completed	517	528	537	544	550	586	699	844	968	1064	1111	1132
Number of low harm	111	114	114	116	118	127	134	143	151	155	157	162
Number of moderate harm	7	8	8	9	10	13	14	15	15	15	15	19
Percentage of no harm	77.18%	76.90%	77.28%	77.03%	76.73%	76.10%	78.83%	81.27%	82.85%	84.00%	84.52%	84.02%
Percentage of low harm	21.47%	21.59%	21.22%	21.32%	21.46%	21.68%	19.17%	16.94%	15.60%	14.60%	14.13%	14.31%
Percentage of moderate harm	1.35%	1.51%	1.50%	1.65%	1.81%	2.22%	2.00%	1.80%	1.55%	1.40%	1.35%	1.67%

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 harms review form is now live for use of RiO and 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 with the KPI definition requiring Trust Board sign off.

0. Reference Information

Author:	Amy Fairweather, Patient Safety Lead	**Paper due date:**	5 June 2025
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	23 April 2025
Paper Reviewed by:	Shelley Ramtuhul, Director of Governance.	**Paper Category:**	Governance/Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Patient Safety Committee what input is required?

To provide the Board with assurance regarding the internal patient safety incident review and monitoring processes in place to ensure learning from any patient safety incidents, the review of themes and identification of system-based improvement actions.

Executive Summary

2.1 Context

The Trust has implemented the Patient Safety Incident Response Framework (PSIRF) into its policies and procedures. Incidents are reviewed weekly at a Patient Safety Incident Panel (PSIP) focusing on learning and improvement. PSIP ensures executive oversight, wider discussion and agreement as to the level of learning response.

It is proposed that this paper will be presented to the Board on a six monthly basis for oversight of the Trust's safety incident management and learning.

2.2 Summary

The key points of this report are:

- PSIRF offers various methods to review incidents using a systems-based approach, including Patient Safety Incident Investigations (PSII), After Action Reviews (AAR), Swarm Huddles, and Thematic Reviews aligned with Trust's priorities.
- Learning responses and actions are recorded in the Trust's Datix System and monitored by the Governance Team, reported to Service Delivery Group (SDG) and Patient Safety Committee.
- The report outlines the incidents that have been identified for a learning response and provides a status update for these.
- The report also outlines the actions taken in response to completed learning responses from October 2024 – March 2025

2.3 Conclusion

The paper is presented to the Board for assurance that the Trust has a robust internal process for reviewing and monitoring patient safety incidents, ensuring that system-based improvement actions are identified and implemented.

3. Main Report

3.1 Introduction

This report highlights the implementation of the Patient Safety Incident Response Framework (PSIRF) which offers various methods to review incidents using a systems-based approach, including Patient Safety Incident Investigations, After Action Reviews, Swarm Huddles, and Thematic Reviews aligned with the Trust's priorities. Learning responses and actions are recorded in the Trust's Datix System and monitored by the Governance Team.

3.2 System Learning Responses Commissioned in Period.

The following table outlines the learning responses commissioned over the reporting period October 2024-March 2025. Under the Trust's Policy all learning responses should be completed within 6 months where possible

PSII'S	**Opened**	**Closed**
November 2024	1 Fall at Bridgnorth Hospital W69215	Pending -Aiming for w/c 12.05.25 following presentation of report at PSIP.
March 2025	1 Pressure Ulcer North West District Nursing W74596	Pending – estimate end of June (3-6 month PSIRF timescale)
Total	2	0
AAR's	**Opened**	**Closed**
November 2024	2 W72457 and W71797 care and escalation processes of a deteriorating patient on Rehabilitation and Recovery Ward 18	Closed
February 2025	1 W73809 Integrated Care Service Therapy Equipment	Pending -date of AAR in progress
Total	2	1
Swarm Huddles	**Opened**	**Closed**
March 2025	1 W74414 Medication Incident, Telford Rapid Response	Closed
Total	1	1

3.3 Overview of actions arising from Learning Responses from commencement of PSIRF in January 2024 to March 2025.

The actions taken following incident learning responses can be summarised under the following themes:

Training

Training and competency assessments – Clinical champions to be appointed, developing a system of link nurses across the community nursing service to specialise in providing support in key areas of competence - Ongoing

Catheter Training – Increased the number of catheter training sessions available to community nursing teams with monthly supervision sessions and a further catheter course on the core clinical skills week.

Audit being undertaken across the community nursing teams to assess the effectiveness of the Trust's Staff Support Policy

Use and locating of syringe drivers – medical device training being rolled out for all staff on the RRUs who are IV trained.

Understanding of pathway for treating hyperkalaemia – identified that certain staff were not aware that treatment should be under the deteriorating patient pathway, education has taken place

Prescribing Training - All new medical staff now receive the Trust's prescribing training on induction.

Policy

Adherence to the Trust Urinary Catheter Care Policy for Adult Patients – Catheter care policy and associated SOPs signposted in the clinical induction, permission to pause bulletin issued via Datix around best catheter practice and cautioning against the use of the 'tying off method' across the Trust and audit of catheterisation practice underway and will inform further learning opportunities.

Adherence to Enhanced Supervision and Engagement Policy – the Policy is being enhanced and meetings are taking place to review the documentation with Ward Managers in real time. Review of Rio to include recording of patients level of supervision.

Documentation

Use of catheter care pathway documentation – pilot undertaken by community nurses via the catheter clinic, trials now being rolled out at the community hospitals with a plan to build the catheter care pathway document into Rio to improve record keeping.

Falls documentation has been updated and piloted with enhanced falls risk assessment and management information including actions to be taken following a patient's postural drop.

Frequency of contacts list for children under 12 months – this was received annually but has been increased to every 3 months to enable cross checking to ensure no young child / baby follow up is missed.

3.4 Internal Audit of PSIRF Processes

The Trust's internal auditors have recently undertaken an audit of the Trust's systems and processes for the management of patient safety incidents with the following conclusion:

'Overall, we have concluded substantial assurance for the control design and moderate assurance for the control effectiveness.

Control Design

The design of the PSIRF controls have been concluded as substantial as the Trust have established a clear governance structure in place to oversee the implementation of the PSIRF. This includes an incident triage meeting which takes place every other day, a weekly PSIP which reports into the Patient Safety Committee. Updates are then provided to the Quality and Safety Committee to provide assurance. The Trust have also embedded the use of Datix, with all incident actions being uploaded and tracked via the system. A Datix dashboard is in place which provides a detailed overview of the status of incidents and actions. Mandatory training compliance was high at the organisation, with 98.87% and 93.22% of staff completing the level 1 and patient safety e-learning courses. The Trust have also carried out training programmes in line with NHS England's requirements for staff who are involved with PSII and AAR.

Control Effectiveness

The effectiveness of the controls has been concluded as moderate as we could identify review of incidents at the PSIP, and reports to the Patient Safety Committee and Quality and Safety Committee were clear and detailed, with minutes highlighting engagement from the attendees. We also found incidents investigations were commissioned soon after being reported on to Datix and discussed at the PSIP. However, we did raise one medium finding regarding the following points:

- *One PSII report was not completed within 6 months from the commissioning date*
- *Eight actions which are currently open relating to PSII and PSIP have passed their due date*
- *Actions raised from the thematic review are currently not tracked via the Patient Safety Committee or monitored via Datix, as with other actions.'*

The Trust has agreed actions to address the above and these will be monitored via the Audit Committee until completion, with all actions planned for completion within three months.

4.0 Summary

The paper is presented to the Board for assurance that the Trust has a robust internal process for reviewing and monitoring patient safety incidents, ensuring that system-based improvement actions are identified and implemented to enhance patient safety.

Shropshire Community Health
NHS Trust

Chair's Assurance Report

People Committee

0. Reference Information

Author:	**Diane Davenport**	**Paper date:**	**5th June 2025**
Executive Sponsor:	Cathy Purt, Chair of People Committee Non-Executive Director	**Paper written on:**	27th May 2025
Paper Reviewed by:	Simon Balderstone, Interim Workforce Operations Director	**Paper Category:**	People
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 21st May 2025 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

- The purpose of the People Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:
    - Promote excellence in staff health and wellbeing.
    - Identify, prioritise and manage risks relating to staff.
    - Ensure efficient and effective use of resources.

- To ensure the Trust is meeting its statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans.
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues.

Chair's Assurance Report

People Committee

- To ensure that the Committee has adequate information on which to advise and assure the Board.
- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy
- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising HR issues of significance.
- To receive updates on employee relation cases in confidence and with the exclusion of attendees if deemed necessary.

2.2 Summary

The Committee met on 21st May 2025 and was quorate with 1 non-executive and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen in the grid below.

2.3. Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

People Committee

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the People Committee which met on 21st May 2025. The meeting was quorate with 1 non-Executive members and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:		
Members:		
Cathy Purt	Chair – Non-Executive Director	CP
Lisa Gibbons	Associate Director for People, Employee Relations & OH	LG
Claire Horsfield	Director of Operations & Chief AHP	CHor
Sarah Allan	Deputy Workforce Operations Director (Interim)	SA
Shelley Ramtuhul	Director of Governance/Corporate Secretary	SR
Tina Long	Non-Executive Director	TL
Simon Balderstone	Interim Workforce Operations Director	SB
Emma Wilkins	Interim People Director	EW
Jonathan Gould	Deputy Chief Finance Officer	JG
Rhia Boyode	Chief People Officer	RB – left at 10.20 a.m.
Lisa Gibbons	Associate Director of People	LG
Maggie Durrant	Head of PMO & Transformation Armed Forces Covenant Champion	MD – Item 11
Present		
Diane Davenport	Note taker	DD

Apologies:
Alison Sargent Non-Executive Director, Clair Hobbs Director of Nursing & Clinical Delivery, Jill Barker Non-Executive Director, Tracie Black Associate Director for Workforce, Education & Professional Standards

3.2 Key Agenda

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought

Chair's Assurance Report

People Committee

1.	**Review of minutes and actions from last meeting**		
	The minutes from the meetings held on 28th April 2025 were approved as a true and accurate record of the meeting. The Action log was discussed and updated.	Y	
2.	**Appropriate Behaviours & Bullying**		
	The paper provided an update on Appropriate Behaviours & Bullying, noting low incidents but emphasising that an incident is unacceptable. On going initiatives include Civility and Respect training, dignity awareness policy, local listening promise and the Culture and Leadership programme to support positive behaviour. Next steps include developing a behaviour framework aligned with the values and NHS People Promise and continue training initiatives.	Y	
3.	**Integrated Performance Report**		
	In the first month, the total workforce was 31.3% below plan. Agency staff usage increased to support community hospitals due to long term sickness, maternity leave and vacancies. Recruitment plans and exploring the National Bank are being implemented to reduce reliance on agency staff. One significant KPI variation, is the vacancy position related to gaps in clinical teams. Measures are in place to address the hotspots, including recruitment events staring in May 2025. Most metrics, including appraisals, showed an improvement. The leaver rate slightly improved, and temporary staffing met the target at 3.2%. Vacancies increased slightly, there is compliance with the framework price cap, especially in nursing. The next focus will be the AHP and medical sectors. There is a 41.72% increase in WTE and it was queried whether this would be revised given the current financial climate and CIP. Cost improvements have been incorporated, aiming for efficiencies through both pay and non pay		

Chair's Assurance Report

People Committee

	reductions. Adjustments might be required as part of the CIP and this will be reviewed. There are some teams where Appraisal rates are below 81% and it was highlighted the importance of local support from Line Managers to establish the appropriate trajectory. Detailed analyses have been conducted to understand the reasons for low compliance, set a clear trajectory and monitor progress to ensure appraisals are completed.		
4.	**Health & Well-being Action plan**		
	The Health & Well-being action plan for 2025/26 provides details of key areas of focus including: menopause support, MSK support, sickness absence management and preventative self care. The plan will be revisited due to corporate services reform. The plan to be reviewed around men's health initiatives. It was noted that MSK has one of the highest sickness rates and to check if this correlates with the Manual Handling training which has a low compliance.	Partial	The Committee agreed to the Health & Wellbeing Action plan with the request to check the support for male colleagues.
5.	**People Promise Activities**		
	There is a significant increase in employee's awareness of the People Promise and its initiatives, update on the ongoing Culture and Leadership Programme, the proposal to implement the "Each Person" platform which would streamline recognition and benefits for staff. The People Promise Manager role will cease on 30th June 2025 which is a risk to delivery of the culture work.	Partial.	Plans are being developed to ensure the momentum and continuity of the work of the People Promise Manager.
7.	**25-26 People Op Plan Deliverable & Milestones**		
	The Operational Plan Deliverables and Milestones providing details of the outcomes and descriptors to deliver the objectives was presented for approval. It was noted there will be a need to revisit the plan due to corporate services reform. The Committee approved the plan noting the need to ensure it is affordable, meets the needs of the Operational team and needs to link with the BAF for any new risks.	Partial	Review the Plan for any new risks to be included on the BAF.
8.	**Armed Forces Covenant and Veteran Aware Report**		

Chair's Assurance Report

People Committee

	The draft report for Veteran Aware re-accreditation requires final approval. Due to capacity, attendance at meetings has been challenging and actively seeking a replacement to take on the Veteran aware work. System colleagues are also finding it challenging to attend forums. It will be explored if there are any collaboration opportunities in the system. The Committee thanked Maggie Durrant for her leadership and work on the Armed Forces Covenant and Veteran aware work.		
9.	**BAF**		
	The risks relating to the 2025/26 Operational Plan to be reviewed. The two risks from last year will be carried forward into the 2025/26 BAF as still considered risks.	Partial	The Operational Plan to be reviewed.
10.	**Policy Tracker**		
	The Policy tracker if provided to give an oversight of the current position regarding the status os policies, relevant to the People Committee. The report will be provided monthly. It was emphasised that is important that policies are aligned with SaTH in light of current changes. From assurance perspective, assurance is provided on the policy process but require further assurance on the effectiveness of the process.	Partial	
11	**Any Other Business**		
	The risk relating to organisational change, including policy alignment and staff engagement to be reflected in the BAF.		

3.4 Approvals

Approval Sought	Outcome
Long Service Awards Policy	Approved – subject to checking alignment with SaTH policy.
Specialist and Speciality (SA) Drs Pay Progress Policy	Approved

4. Conclusion

Shropshire Community Health
NHS Trust

Chair's Assurance Report

People Committee

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

Shropshire Community Health
NHS Trust

Performance Update
0. Reference Information

Author:	Jen Deakin, Fiona MacPherson Gina Billington Heads of Service	**Paper date:**	5 June 2025
Executive Sponsor:	Rhia Boyode, Chief People Officer SCHT & SaTH	**Paper written on:**	14 May 2025
Paper Reviewed by:	Simon Balderstone Interim Workforce Operations Director Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The purpose of this report is to provide an oversight of the key areas of performance which are most relevant to the 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 1 workforce plan position. The KPI's throughout the report are key drivers of performance, which underpin the delivery of the 2025/26 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	12	0	**19**	**13 (73.7%)**

Performance Update

Of the 19 KP'Is, 10 are annual KPI's and are not reported monthly. The annual KPI's include Staff Survey scores that are adjusted annually and have been refreshed in the Month 1 data set. Of the remaining monthly KPI's, 7 are showing special cause variation of an improving nature. However, the data is showing that these improvements will not be sufficient to hit our current targets.

To support the development of actions to meet our targets, we are working with teams to understand the drivers of our workforce (impacting KPI's) and addressing these underlying drivers in those specific areas. There have been improvements this month in appraisals, leaver rates, temporary staffing, and vacancy rates. Sickness absence has remained at the same level as March, and mandatory training has reduced marginally below target, due to a new training module being incorporated into the reporting system.

Action Plans have been developed included as Appendix 4.

2.3. Conclusion

Trust Board is asked to:

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

3. Main Report

3.1 Introduction

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

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

3.2 Summary of key points in report

The workforce plan for 2025/26 set a 41.72 WTE increase from the start of the year, which incorporated a 34.74 WTE increase in substantive workforce. The target set to reduce agency usage was a 42% reduction, to be off set with increases in the permanent workforce. At Month 1 the total workforce is under plan by 31.30 WTE.

Our agency usage is 6.2 WTE over plan driven by additional usage in Community hospitals, where agency is being used to cover staff absences (maternity, long term sickness and recruitment to vacancies) and enhanced care where agency Healthcare Assistants are needed to meet patient needs.

Bank usage is 35.10 WTE over plan, 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.

Performance Update
Month 1 Position

Plan (WTE)	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Substantive	1654.15	1653.85	1655.16	1655.16	1655.16	1689.90
Bank	58.0	58.00	58.00	58.00	58.00	65.90
Agency	38.13	38.43	37.12	37.12	37.12	36.50
Total	1750.28	1750.28	1750.28	1750.28	1750.28	1792.20
Actual (WTE)	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**
Substantive	1632.02	1626.52	1624.74	1627.49	1634.07	1617.30
Bank	79.6	81.85	79.58	84.63	85.46	101.00
Agency	44.27	46.17	56.98	53.17	55.20	42.70
Total	1755.89	1754.54	1761.30	1765.29	1774.73	1761.00
Variance (WTE)	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**
Substantive	-22.1	-27.33	-30.42	-27.67	-21.09	(72.50)
Bank	21.6	23.85	21.58	26.63	27.46	35.10
Agency	6.1	7.74	19.86	16.05	18.08	6.2
Total	5.6	4.26	11.02	15.01	24.45	(31.30)

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

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

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

Of the KPIs that the People Committee is responsible for, 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

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

Performance Update

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 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*
6. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers*
7. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues*
8. 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*
9. Proportion of temporary staff
10. Sickness Rate
11. Staff survey engagement theme score*
12. Total shifts exceeding NHSI capped rate

The list of KPIs which are of concern has improved, with 5 moving from an assurance concern and a variation concern - to an assurance concern only.

Mandatory Training Compliance is no longer flagged as a variation concern. In March 2025, compliance reached **95.01%**—the highest level achieved since January 2023. Compliance fell to 94.2% in April following the introduction of Moving and Handling Level 2.

Metric	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Appraisal	90%	87.44%	87.92%	87.88%	87.37%	87.78%	88.00%
Leavers	9.6%	11.11%	10.76%	10.44%	10.60%	9.86%	9.82%
Temporary Staff	3.4%	5.4%	4%	4.6%	3.9%	4%	3.2%
Vacancies	8%	10.59%	10.84%	10.68%	10.91%	10.56%	9.83%
Sickness	4.75%	5.30%	5.33%	5.30%	5.32%	5.28%	5.28%
Total Shifts exceeding NHSI capped rate	No Target	185	44	60	63	64	49

There has been improvement with appraisal compliance, leavers, vacancies and temporary staffing and total shifts, however sickness has remained the same. This is evident in the chart above and the charts within the appendices.

Performance Update

Appraisals

In total, 11 teams have been identified as hot spots in relation to appraisal compliance. All 11 of these teams fall within the Operations Directorate. Each of these teams is being contacted by the People Team to establish any additional support that can be offered to enable the teams to achieve 100% compliance. These hot spots have also been highlighted to the appropriate Service Leads to ensure appropriate oversight. As part of the actions detailed in the plans provided – appraisal trajectories are included, and we plan to meet target by the end of the calendar year. Further assurance will be provided via the People Committee with regards to individual team trajectories.

Turnover

Since April, the leaver rate has gradually improved but remains 0.22% above target. 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 provide 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. A deep dive is being undertaken into Nursing and Midwifery and Administration and Clerical leavers as these are the staff groups with the highest leaver rate.

Actions to Deliver Improvements

- Implement flexible working practices - leadership development, promote benefits that are competitive across NHS. Further enhance flexible rostering practices including training in effective roster management
- Team based rostering providing greater autonomy on when and how staff work
- Use data to understand why people leave and identify departments that need support
- Focus on why people stay - connections and relationships, communities and as they participate in their professional and community life – further promote stay conversations
- Legacy mentoring, career support, new employee buddy system
- Support managers to address attrition in their teams. Educate on the range of interventions to reduce attrition
- Create a sense of belonging – culture work, EDI strategy
- Deep dive into staff survey

Absence

Our absence rate has been decreasing, although there were slight increases in December and February, we have seen a reduction in March which has remained static. From the staff survey the People Promise theme ‘We are safe and healthy’ increased from 6.13 (2023) to 6.43 (2024).

10 teams have been identified as hot spots due to the percentage of absence within the team. Deep dives are currently underway in these areas to ensure appropriate support is in place.

A review of all long-term absence cases has been undertaken, and they are all being managed appropriately.

Performance Update

A HWB Action plan for 2025/26 has been developed and is currently going through the appropriate approval route. The actions are based on the HWB survey information, staff survey data, NHS Retention Self-Assessment, absence data including top reasons and hot spot areas and the Health & Wellbeing Diagnostic Tool. The aim is to improve health and wellbeing and reduce sickness absence. All Divisions have meetings to discuss their absence and ensure appropriate support is in place. This has identified further focused support required such as training on return-to-work interviews, support with specific cases.

Stress/anxiety and depression is the highest reason for absence, on this basis the following is being implemented:

- The People Team supported by the Occupational Health team continue to roll out workshops on how to complete a stress risk assessment focussing on areas of high absence relating to stress/anxiety and depression.
- Deep dive into areas with high stress, anxiety, and depression and MSK
- A self care campaign is being developed for all staff but targeted campaigns will be for areas with high stress/anxiety and depression absence
- Mindfulness sessions for all staff in line with NICE guidelines
- Launch the Unmind app which is a AI Health and Wellbeing Tool

MSK issues is within the top 3 reasons for absence. The following actions are being implemented:

- Targeted support for areas with high MSK absence, work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, workstation assessments.
- Explore the roll out of the My Recovery app for staff in relation to MSK support

Actions to Deliver Improvements

- Address underlying drivers of absence - Targeted support for areas with high MSK absence, work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, workstation assessments.
- Deep dive into areas with high stress, anxiety, and depression and MSK
- All Divisions have meetings to discuss their absence and ensuring appropriate support is in place. This has identified further focused support required such as training on return-to-work interviews, support with specific cases.

Performance Update

Vacancies

Vacancy hotpots are identified on a monthly basis and the recruitment team take the following actions to support managers in the identified areas:

- Advise recruiting managers on advert content and other media to use for advertising (Trust social media)
- Liaise with recruiting managers on shortlisting times and interview dates to ensure these tasks are completed in a timely manner
- Follow up on interview outcomes and prioritise pre-employment checks

Month 1 hotspots are: Urgent Care (Virtual Ward and IDT), Community Services: (Bishops Castle, Ludlow & Whitchurch), Community Nursing (Telford North, Shrewsbury North) Planned Care (Stoke Heath)

The team have a series of recruitment events planned with the first one to be held on 16 May. A Working Group with operational managers and resourcing teams has been set up to support these events with regular meetings in place. Their current focus is the cessation of Band 2 and Band 3 agency workers across the Trust and the first event is targeted to Bank HCA/HCSW recruitment.

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. As at 1/4/25 we are Price Cap compliant for nursing, specialist nursing and HCA. NHSE date for price cap compliancy is 30 June 2025 for AHPs and agencies have been informed of this. Next steps will be for Medical and Dental staff groups to become compliant.

In April, the number of total shifts above the price cap decreased from 64 in March to 49 in April. The shifts that remained above price cap compliance were Medical and AHPs. The focus remains on filling vacancies where we are using agency.

Actions to Deliver Improvements:

- Reduce demand – fill vacancies where temporary staffing is being used, develop recruitment strategy for Trust, maximise use of technology, training for hiring managers monitoring of time to fill metrics, link to better hiring institute, maximise collaboration with SaTH.
- Improve availability of existing workforce, through enhancing rostering and meeting rostering KPI's further roll out of electronic rostering.
- Programme of continuous improvement workshops for roster approvers

Performance Update

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

Trust Board is asked to:

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

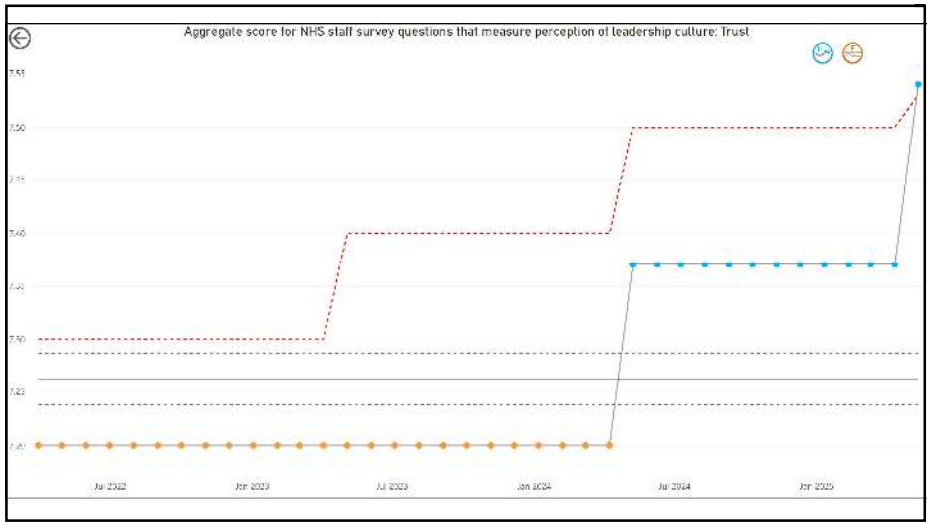
Appendix 1
People Committee – SPC Summary
Month 1 (April) 2025/2026 Performance

Shropshire Community Health NHS
NHS Trust

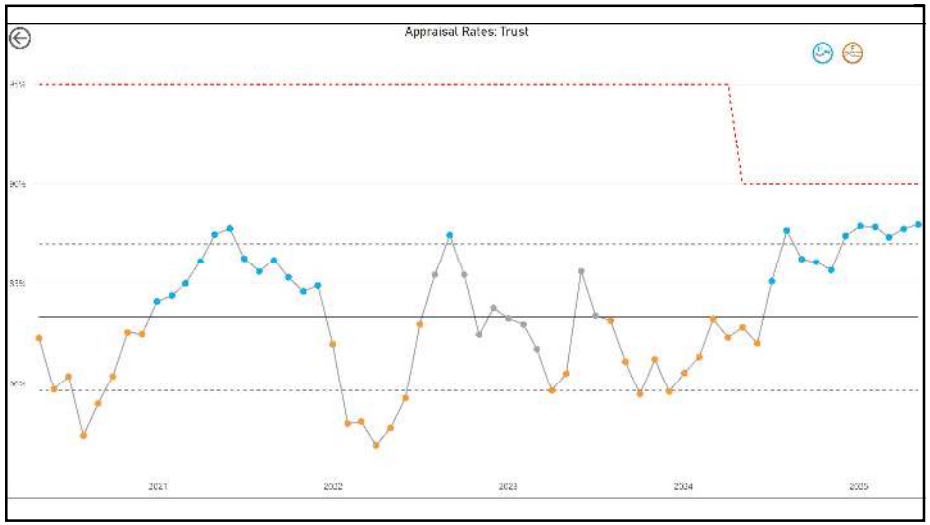
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2025-04-30		7.5	7.5	0.0	7.5	7.5	0.0	
People Committee	Well Led	Appraisal Rates	2025-04-30		88.00%	90.00%	-2.00%	88.00%	90.00%	-2.00%	
People Committee	Well Led	CQC well-led rating	2025-04-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2025-04-30		9.82%	9.60%	0.22%	9.82%	9.60%	0.22%	
People Committee	Well Led	Mandatory Training Compliance	2025-04-30		94.20%	95.00%	-0.80%	94.20%	95.00%	-0.80%	
People Committee	Well Led	Net Staff in Post Change	2025-04-30		11.48	0.00	11.48	11.48	0.00	11.48	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-04-30		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	2025-04-30		72.73%	66.00%	6.73%	72.73%	66.00%	6.73%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-04-30		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...	2025-04-30		58.89%	60.95%	-2.06%	58.89%	60.95%	-2.06%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		5.4%	0.0%	5.4%	5.4%	0.0%	5.4%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		9.2%	0.0%	9.2%	9.2%	0.0%	9.2%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	
People Committee	Well Led	Proportion of temporary staff	2025-04-30		3.2%	3.4%	-0.2%	3.2%	3.4%	-0.2%	
People Committee	Well Led	Sickness Rate	2025-04-30		5.28%	4.75%	0.53%	5.28%	4.75%	0.53%	
People Committee	Well Led	Staff survey engagement theme score	2025-04-30		7.2	7.2	0.0	7.2	7.2	0.0	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-04-30		49	0	49	49	0	49	
People Committee	Well Led	Total shifts on a non-framework agreement	2025-04-30		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2025-04-30		9.83%	8.00%	1.83%	9.83%	8.00%	1.83%	

Appendix 2
People Committee
Month 1 (April) 2025/2026 Performance

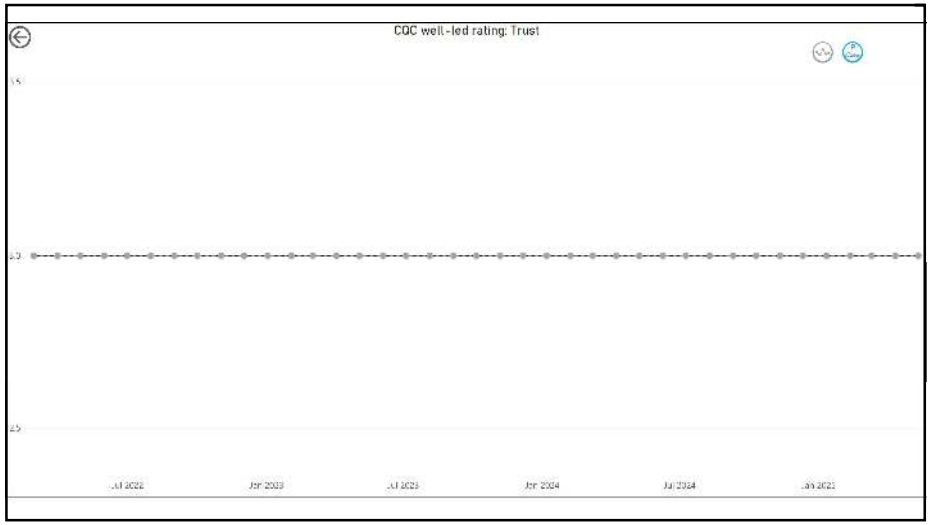
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ◯
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where 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

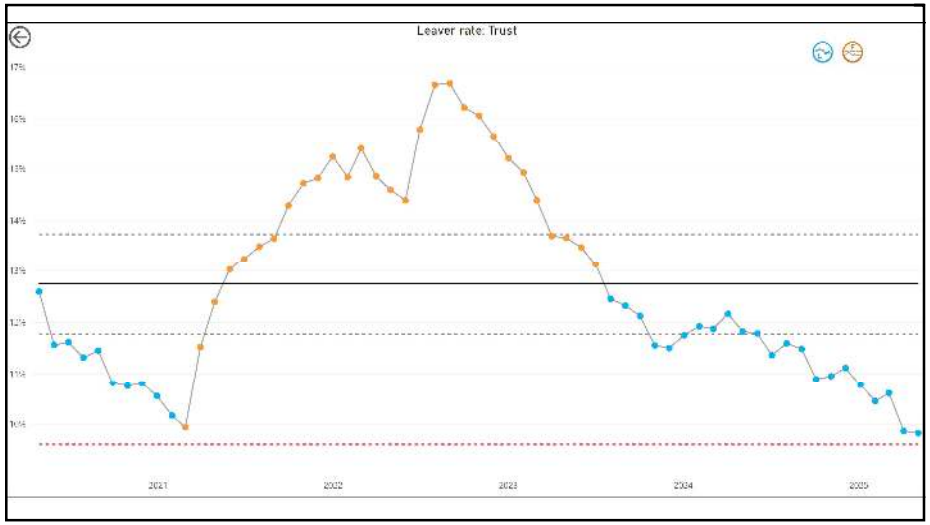
5


Appraisal Rates: Trust

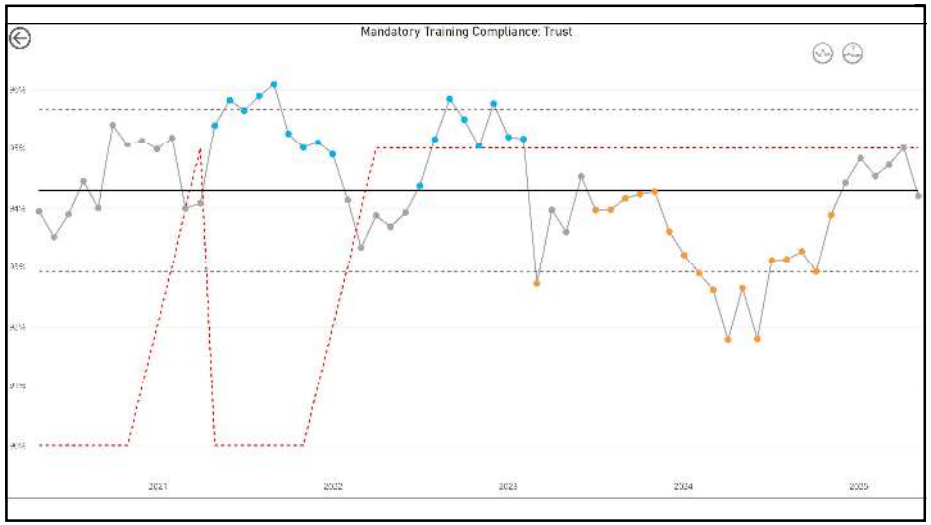
6


CQC well-led rating: Trust

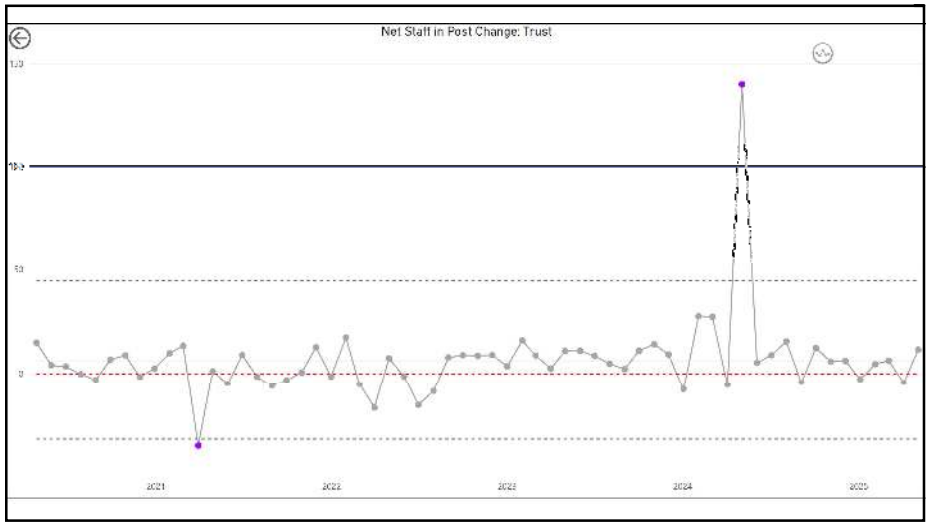
7


Leaver rate: Trust

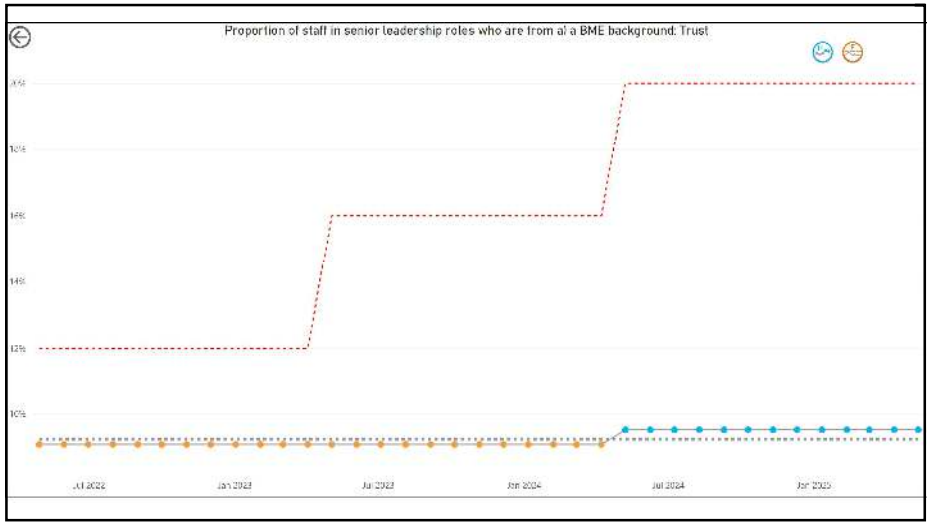
8


Mandatory Training Compliance: Trust

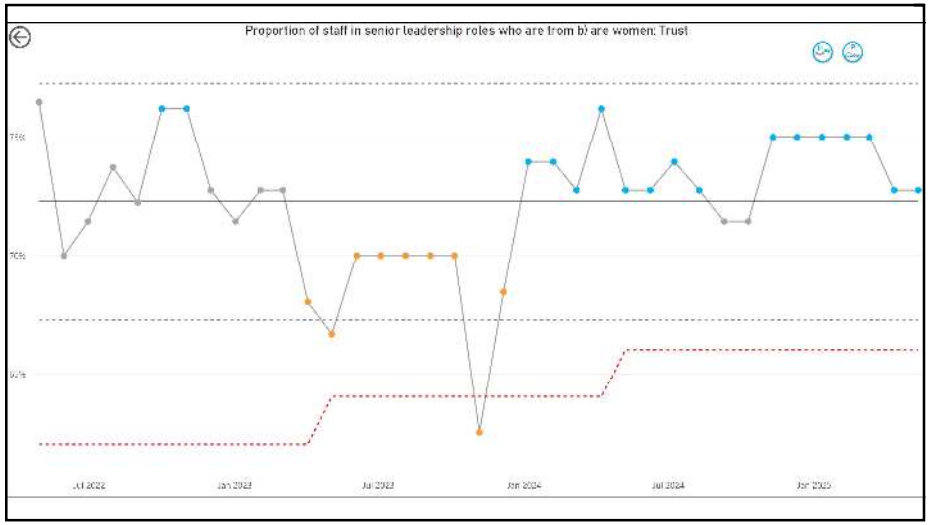
9


Net Staff in Post Change: Trust

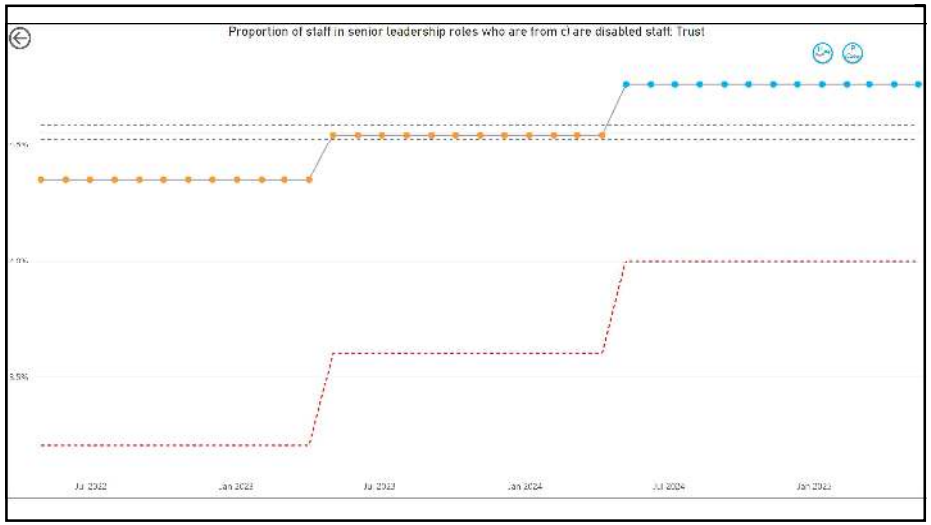
10


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

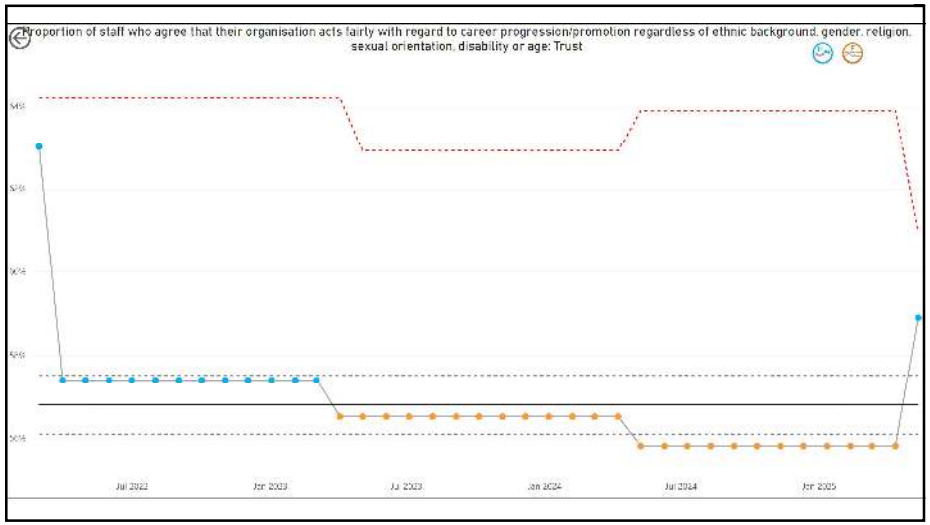
11


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

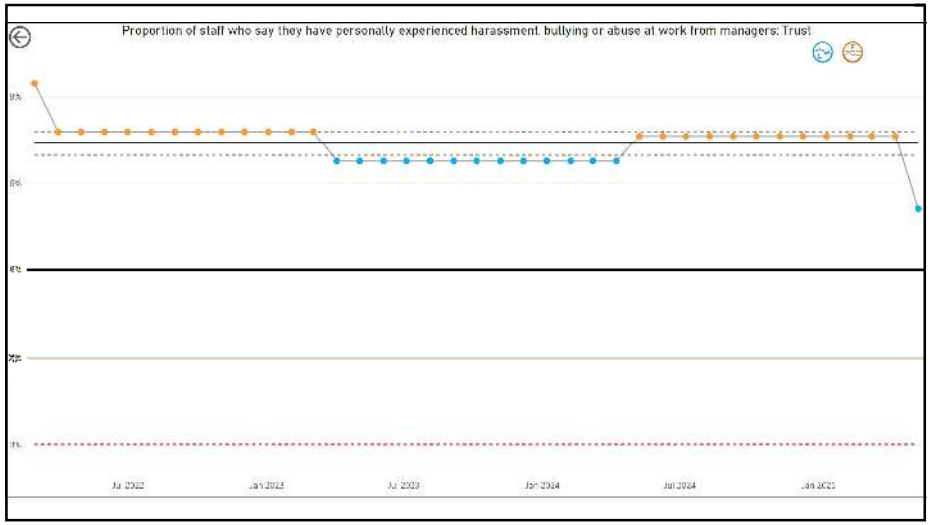
12


Proportion of staff in senior leadership roles who are from cl are disabled staff: Trust

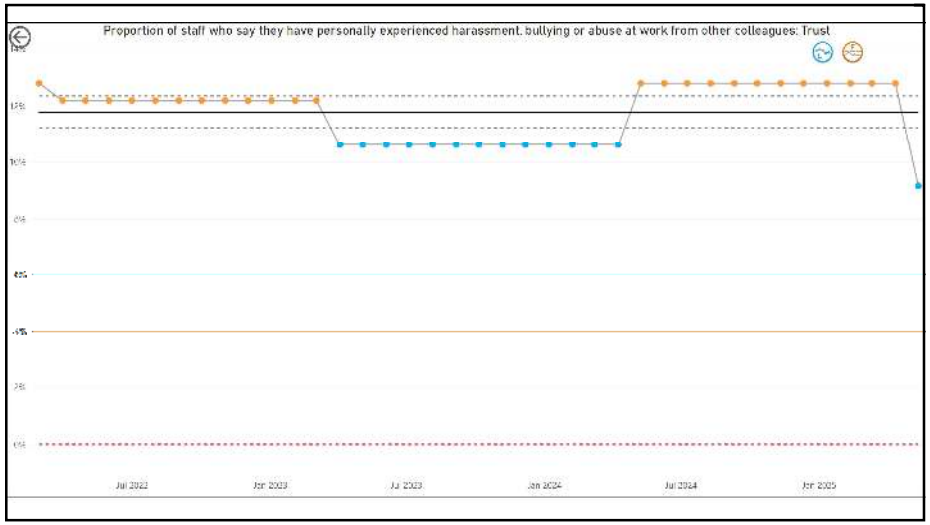
13


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

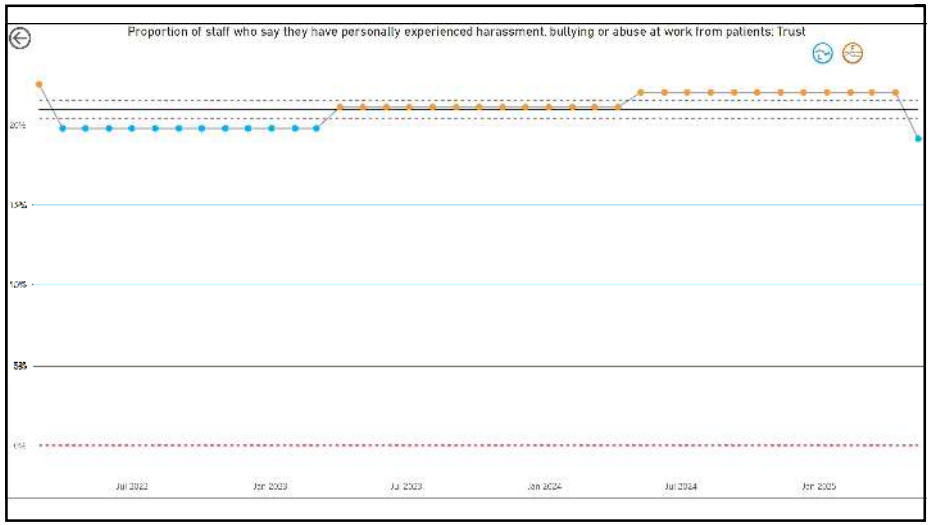
14


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

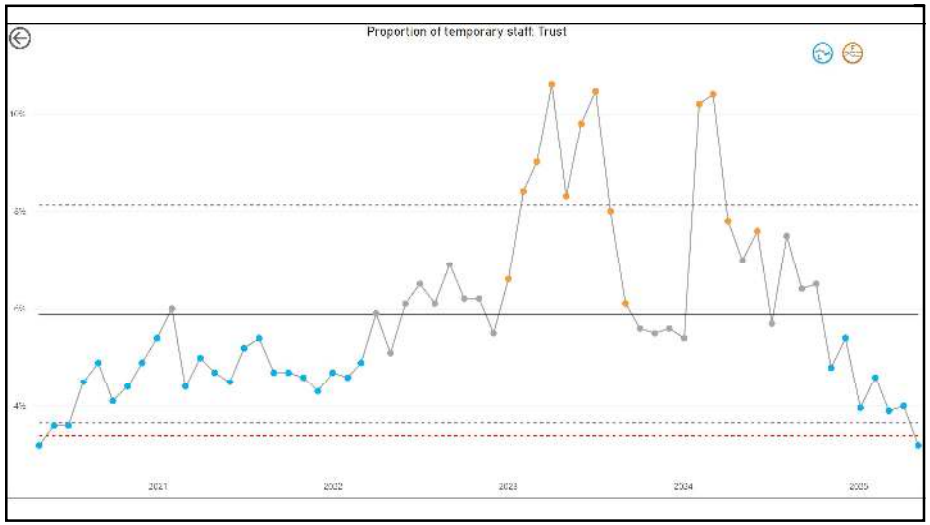
15


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

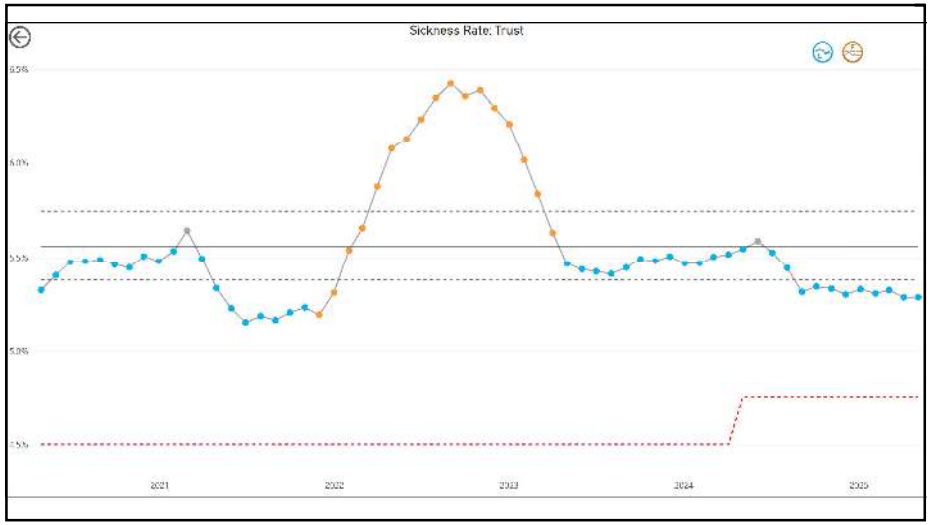
16


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

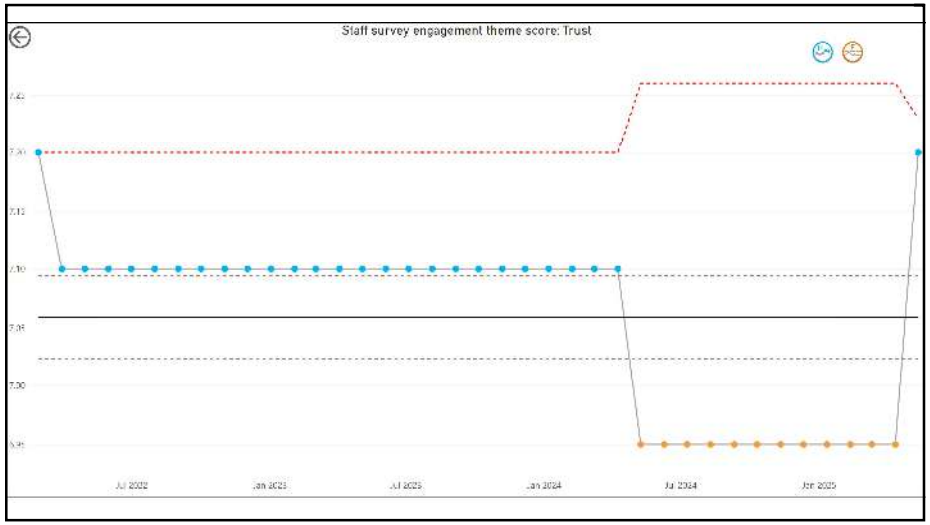
17


Proportion of temporary staff: Trust

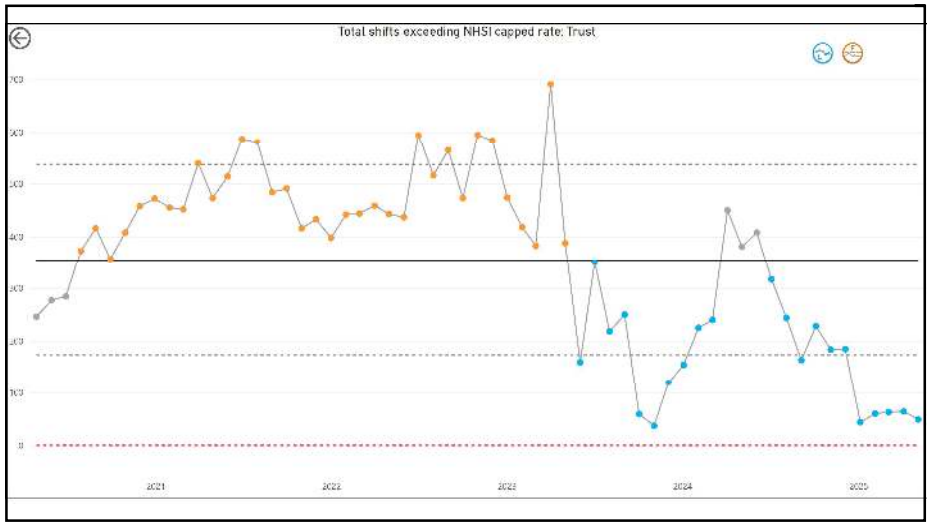
18


Sickness Rate: Trust

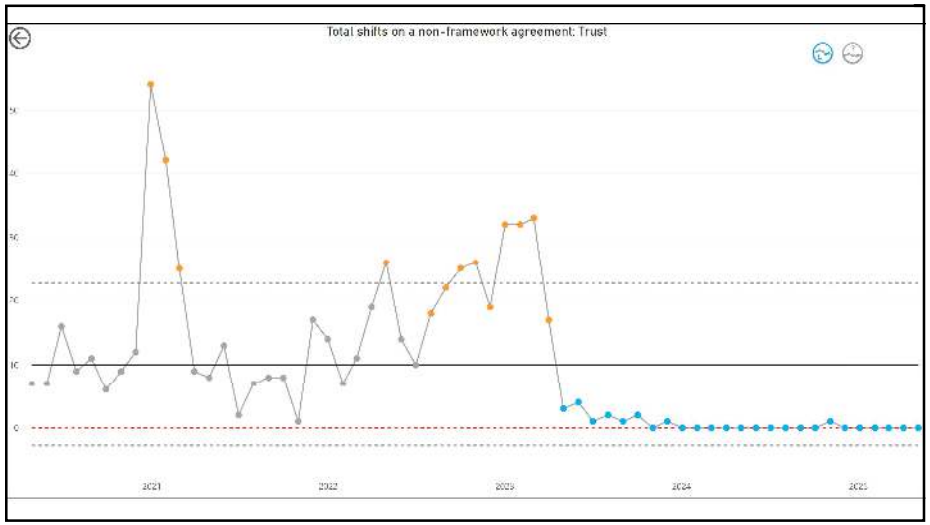
19


Staff survey engagement theme score: Trust

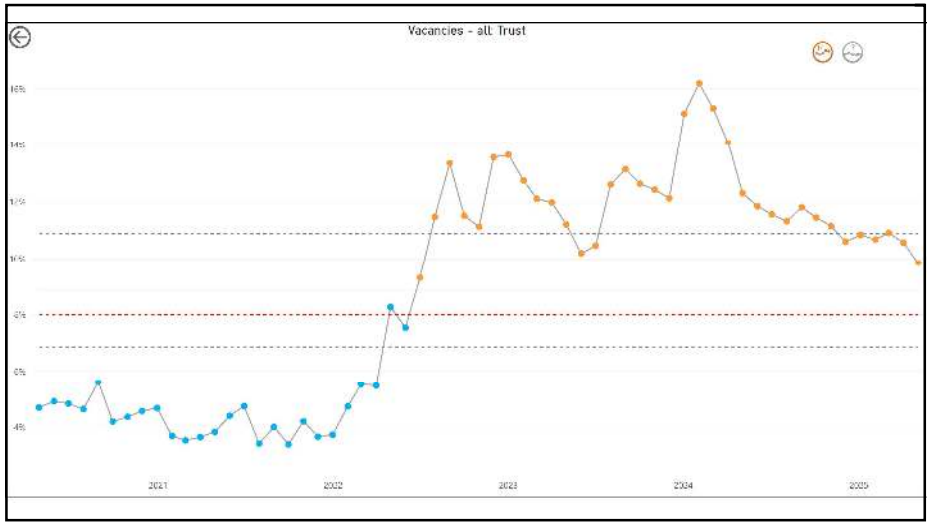
20


Total shifts exceeding NHSI capped rate: Trust

21


Total shifts on a non-framework agreement: Trust

22


Vacancies - all: Trust

23

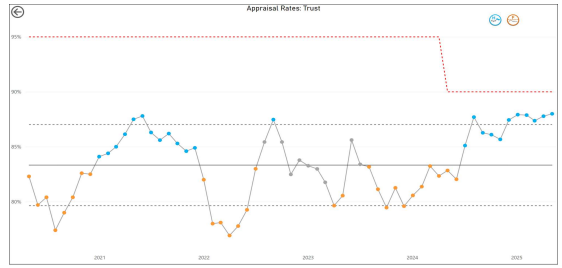
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Appraisals	%	87.44%	87.92%	87.88%	87.37%	87.78%	88.00%	88.00%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	87.95%	88.30%	88.80%	89.20%	89.75%	90.00%	90.00%



Reason for performance gap:

The rate has remained relatively static for December and January 2025 with an increase in March and April 2025. The April compliance is 2% below target. Detailed appraisal reports are sent to Managers to ensure they have sight of those appraisals out of date on ESR and regular appraisal training is in place. The focus is on setting a plan for the services with the lowest completion rates and to set dates for completion by no later than mid June. A process for monitoring progress in place, with target support for managers and alerts and reminders to ensure completion. There has been an issue with data quality in the Advance Care Planning team which is currently being resolved with teh ESR team. There has been changes in leadership which has left gaps within the Rehabilitation and Recovery Service and the South East Community Nursing team, these gaps are in the process of being covered.

Action Plan

Action	Start Date	End Date	Status	Outcome
Hot Spot - Whitchurch Hospital Inpatient Service - Additional management support has been identified to support the management on the Ward to complete appriaisals and other management tasks	May-25	May-25	On Track	To ensure there is an action plan in place to complete the outstanding appraisals for teams with low completion.
Hot Spot - Advanced Care Planning - Manager & ESR team are reviewing how the Advanced care planning team are inputting data as quality issue has been identified.	Apr-25	May-25	On Track	To ensure appraisals are correctly inputted.
Hot Spot - South East Community Team - Identify a Team leader to provide support to South East Community Nursing Team to provide support in completing appraisals.	Apr-25	May-25	On Track	Ensure appraisals completed.
Hot Spot - RRU - Cross cover from ward 36 to cover ward 18 which will support the completion of appraisals, a plan is in place to ensure all appraisals are completed by end of May 2025 with the Service Lead monitoring completion.	Mar-25	May-25	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
Hot spot - MSK Shropshire & Telford recovery plan to be developed to ensure all appraisals are completed by Mid June	May-25	Jun-25	On Track	Ensure appraisal compliance.
Hot spot - Children's Community Nurse Service recovery plan to be developed to ensure all appraisals are completed by Mid June	May-25	Jun-25	On Track	Appraisals complete.
Hot spot - Podiatry Service manager to focus on Podiatry to book all outstanding appraisals.	Apr-25	May-25	On Track	To understand the culture at Stoke Heath.
Undertake a cultural review using the Mckinsey 7s model at Stoke Heath to include the triangulation of all workforce KPI's.	Mar-25	May-25	On Track	Appraisals complete.
Hot Spot - Stoke Heath - Recovery plan for Stoke Heath to support appraisals to be undertaken. Since last month reporting the number of outstanding appraisals has decreased from 11 to 6 outstanding.	Apr-25	May-25	On track	Appraisals Completed

Author	Fiona MacPherson	**Date**	15.05.25
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25

Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance
825 DAART Service	14	8	57.14
825 Stoke Heath YOI Service	18	12	66.67
825 Urgent Community Response Service	24	17	70.83
825 Recovery and Rehabilitation Unit Service	50	37	74.00
825 Podiatry Service	27	20	74.07
825 Whitchurch Hospital Inpatients Service	36	27	75.00
825 Advanced Care Planning Service	12	9	75.00
825 South East Shropshire Community Nursing Service	20	15	75.00
825 Community Therapies Telford Service	18	14	77.78
825 MSK Shropshire & Telford (MSST) Service	29	23	79.31
825 Community Children's Nursing Service	21	17	80.95

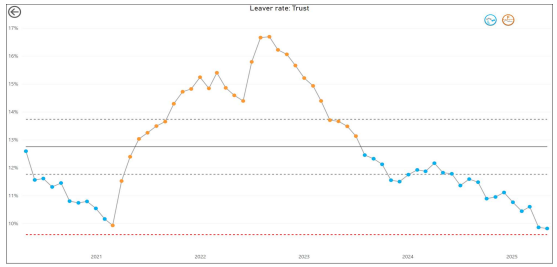
Exception Report - Action Plan

Leaver rate

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Leaver rate	%	11.11%	10.76%	10.44%	10.60%	9.86%	9.82%	9.82%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	9.81%	9.80%	9.76%	9.74%	9.72%	9.60%	9.60%



Org L6	Leavers
825 Health Visiting Dudley Service	12
825 South East Shropshire Community Nursing Service	8
825 Ludlow Hospital Inpatient Service	7
825 North Shropshire Community Nursing Service	7
825 Recovery and Rehabilitation Unit Service	7
825 5-19 School Nursing Telford Service	6
825 Health Visiting Shropshire Service	6
825 MSK Shropshire & Telford (MSST) Service	6
825 Bishops Castle Hospital Service	5
825 Bridgnorth Hospital Inpatient Service	5
825 Stoke Heath YOI Service	5
825 Virtual Wards Service	5
825 Whitchurch Hospital Inpatients Service	5

Leaving Reason	Leavers
Retirement Age	63
Voluntary Resignation - Work Life Balance	36
Voluntary Resignation - Relocation	22
Voluntary Resignation - Health	14
Voluntary Resignation - Promotion	12
Voluntary Resignation - Lack of Opportunities	8
End of Fixed Term Contract	6
Retirement - Ill Health	5
Voluntary Resignation - Pay and Reward Related	5
Voluntary Resignation - To undertake further education or training	5

Staff Group	Leavers Count	Leavers FTE	Avg FTE	FTE %
Add Prof Scientific and Technic	5	2.83	38.84	7.28%
Additional Clinical Services	38	29.13	329.78	8.83%
Administrative and Clerical	51	41.01	341.59	12.01%
Allied Health Professionals	21	17.21	186.17	9.24%
Estates and Ancillary	5	2.72	48.16	5.65%
Medical and Dental	1	1.00	20.52	4.87%
Nursing and Midwifery Registered	79	62.99	632.13	9.96%
Students	0		9.83	
Grand Total	200	156.89		

Reason for performance gap:	The Leaver rate has seen a gradual improvement since April, with a slight increase in February 2025 but a further reduction in March and April 2025 (remains above target by 0.22%). 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. Highest leavers headcount is within the Nursing and midwifery group followed closely by Administration and Clerical.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Deep dive into the leaver data for the top 2 teams with the highest leaver rate (Dudley Health Visitors & South East Community Nursing Team).	May-25	Jun-25	On Track	To understand if there is a theme around leavers and whether support is required.
	Deep dive into the leaver data for Nursing & Midwifery and Administration and Clerical Groups.	Mar-25	Jun-25	On Track	To understand if there is a theme around leavers and whether support is required.
	Review the leavers information in relation to incompatible working relationships to establish next steps.	Feb-25	Jun-25	On Track	To evaluate any further support required for teams.
	Review and monitor leavers with less than 12 months service.	Feb-25	Jun-25	On Track	Ensure new starters are receiving appropriate onboarding processes, 30, 60, 90 day conversations.
	Undertake a campaign to remind managers of the 30, 60, 90 days conversations tool in place	May-25	Jun-25	On track	Ensure 30, 60, 90 day conversations are taking place and being recorded on ESR
	Review the leavers information in relation to work life balance to establish next steps alongside flexible working requests recorded on ESR.	Feb-25	May-25	On Track	To evaluate the reasons for work life balance as a reason for leaving and develop further support as required.
	Review the staff survey data around flexible working and alongside ESR data for flexible working to provide targeted support to teams.	Apr-25	Jun-25	On Track	To ensure teams receive support to make informed decisions around flexible working requests.
	Refresh the NHS Self-Assessment Retention Tool.	Feb-25	Jun-25	On Track	Revisiting the self-assessment toll will provide us with the information to refresh our recruitment and retention action plan.
Author	Review the data gathered from the HWB survey to support the development of a HWB Action Plan for 2025/26.	Mar-25	May-25	Completed	Develop an action plan in line with information received from staff.
Accountable Officer Approval	Fiona MacPherson	**Date**	15.05.25		
	Rhia Boyode	**Date**	15.05.25		

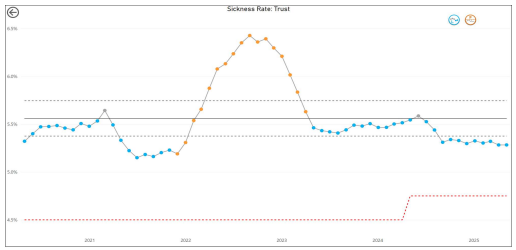
Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Sickness Rate	%	5.30%	5.33%	5.30%	5.32%	5.28%	5.28%	5.28%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	5.05%	4.95%	4.90%	4.85%	4.80%	4.75%	4.75%



Reason for performance gap: Overall sickness has overall reduced since April 2024 with a slight decrease in March and April 2025. The rate continues to remain above target but static. 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 and planning for 2025-26 campaign will provide a level of mitigation. The Managing Attendance Policy is in place and has been reviewed to ensure it is fit for purpose. As per our operational plan submission we have planned for a reducion during summer months and an increse to 5% by end of the year.

Action Plan

Action	Start Date	End Date	Status	Outcome
Adult Community SDG - ESR Workforce Team to undertake analysis of gender/age/sickness reasons.	Mar-25	Jun-25	On Track	To better understand the detail behind absences and what bespoke support needs to be put in place.
UEC to meet with HR to understand what can be done to support staff who are off with stress.	Mar-25	Jun-25	On Track	To better understand the detail behind absences and what bespoke support needs to be put in place.
Analyse data from the HWB survey to develop a HWB action plan for 2025/26 which will cross reference the NHS Retention Self Assessment, HWB Diagnostic Toolkit and absence data	Mar-25	May-25	Completed	Develop an action plan in line with information received from staff.
Implement HWB Action plan	May-25	Mar-26	On track	Enusre appropriate HWB support is implemented for staff
Targeted support for areas with high MSK absence to implement preventative measures.	Nov-24	Jun-25	On Track	MSK is the third highest reason for absence and we are looking at preventative actions as well as curative.
Develop online Physio drop in sessions with topics for discussion based on the highest MSK reasons for absence (e.g. bad back) for staff to discuss any MSK issues.	Feb-25	Jun-25	On Track	To provide staff with the opportunity to discuss any issues as a preventative measure to absence.
Deep dive into MSK absences to establish bespoke support for example workstation assessments.	Mar-25	Aug-25	On Track	Establish practices in place to ensure the appropriate equipment, knowledge and support is in place.
Review all stress, anxiety and depression absences to ensure appropriate support is in place.	Mar-25	May-25	Completed	Ensure absences are being supported appropriately.
Identify hot spot teams for stress anxiety and depression and develop action plans to establish preventative and ongoing support for those teams.	Mar-25	Sep-25	On Track	Develop action plans for teams identified as hot spots for stress anxiety and depression.
Implement sessions for staff and managers on mindfulness in line with NICE Guidelines.	Mar-25	May-25	On Track	Provide support to staff and managers on techniques to reduce stress.
Work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, MSK support.	Mar-25	May-25	On Track	To ensure appropriate support is in place.
Raise awareness Trust wide of recording menopause related absences as menopause.	Mar-25	Jun-25	On Track	To ensure menopause related absence is categorised correctly.
Cross check every month stress, anxiety and depression absences against referrals to OH to ensure compliance with the Policy.	Mar-25	Dec-25	On Track	Ensure appropriate support is in place.

Author					
Accountable Officer Approval	Fiona MacPherson	**Date**	15.05.25		
	Rhia Boyode	**Date**	15.05.25		

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	234.00	1,009.13	23.19%
825 Wound Healing Service	873.60	4,411.80	19.80%
825 Research and Development Service	208.40	1,230.60	16.93%
825 Community Therapies Central Service	873.33	5,690.02	15.35%
825 Single Point of Referral Service	376.87	2,515.96	14.98%
825 Bishops Castle Hospital Service	954.23	6,780.44	14.07%
825 Outpatient Parenteral Antimicrobial Therapy Service	175.00	1,304.40	13.42%
825 Ludlow Outpatient Service	112.01	838.73	13.35%
825 Whitchurch Hospital Inpatients Service	1,386.23	13,477.86	10.29%
825 Ludlow Hospital Inpatient Service	1,087.29	10,787.94	10.08%

Org L7	Absence FTE	Available FTE	Absence FTE %
825 Urgent Community Response - North East Team	30.00	60.00	50.00%
825 CYP Nurse Management Team	138.00	290.00	47.59%
825 Urgent Community Response - North West Team	21.20	72.00	29.44%
825 MSK Rheumatology Team	115.80	433.40	26.72%
825 Virtual Wards - North West Team	49.00	198.00	24.75%
825 Telford Wound Healing Service Clinical Team	834.60	3,957.80	21.09%
825 Ludlow Outpatient Service Clinical Team	112.01	569.40	19.67%
825 Urgent Community Response - South East Team	19.20	109.20	17.58%
825 Bishops Castle Hospital Ward	923.93	5,454.33	16.94%
825 Research and Development Team	208.40	1,230.60	16.93%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Add Prof Scientific and Technic	324.43	14,257.36	2.28%
Additional Clinical Services	8,110.56	120,880.05	6.71%
Administrative and Clerical	5,158.05	124,512.51	4.14%
Allied Health Professionals	2,476.92	67,731.11	3.66%
Estates and Ancillary	741.87	17,523.38	4.23%
Medical and Dental	336.47	7,466.22	4.51%
Nursing and Midwifery Registered	13,795.86	229,933.04	6.00%
Students	5.00	3,569.00	0.14%

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	269	337	11,246.20	36.3
S13 Cold, Cough, Flu - Influenza	660	857	3,240.52	10.5
S12 Other musculoskeletal problems	133	144	2,439.19	7.9
S25 Gastrointestinal problems	501	665	2,287.41	7.4
S98 Other known causes - not elsewhere classified	117	129	1,743.76	5.6
S17 Benign and malignant tumours, cancers	19	28	1,276.71	4.1
S28 Injury, fracture	61	61	1,254.16	4.1
S15 Chest & respiratory problems	155	170	1,094.99	3.5
S26 Genitourinary & gynaecological disorders	89	108	1,012.80	3.3
S11 Back Problems	74	81	1,004.49	3.2

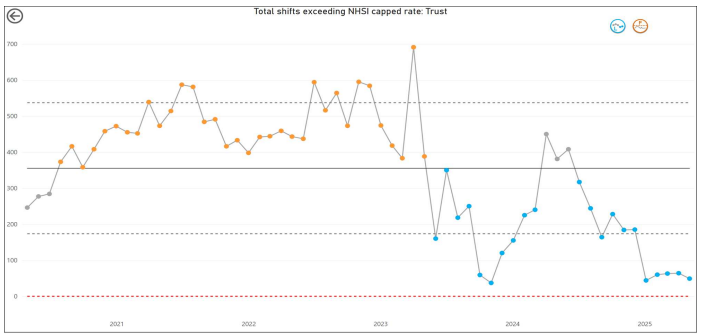
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Shifts	Number	185	44	60	63	64	49	49
	Target	0	0	0	0	0	0	0

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	49	40	35	30	25	15	0



Reason for performance gap:	Community Nursing is currently using agency above plan due to high levels of unavailability: staff absences (maternity, long term sickness and recruitment to vacancies). For Telford teams there is also an issue with patient medications. 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. Price Cap for agency nursing/HCA in place from 1 Dec 24 with specialist nursing roles in place from 1 April 25. AHP staff groups to be PCC compliant by 30 June 2025.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Medical and Dental and AHP staff groups to be agreed with regional NHSE group. *AHP now set see below*	Apr-25	Sep-25	On Track	Reduction in price cap provision by agency.
	AHP Price Cap advised to be 30 June 2025. Write to Agencies to advise of supply at these rates.	May-25	Jul-25	On track	Reduction in price cap provision by agency for AHPs.
	Maximise the availability of our workforce through monitoring and improving roster practices. Comms sent to roster approvers regarding use of roster to send unavailable shifts to bank/agency 11/3/25. Programme of continuous improvement workshops in place for roster approvers.	Mar-25	May-25	On Track	Improve assignments where the duty's grade type doesn't match the person's qualification / grade. Reduce additional shifts usage, improvement from current 2.2% to 1%.
	Grow our bank and implement the use of centralised bank to support reduction in agency usage. Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months. First event planned for May 16.	Apr-25	Mar-26	On Track	Timetable of recruitment events and venues agreed and staffing attendance identified (will need support from ops admin for some events) First event to be held on May 16.
Author	Gina Billington	**Date**	5/14/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

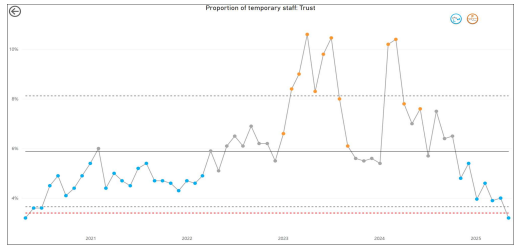
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Prop Temporary staff	%	5.4%	4.0%	4.6%	3.9%	4.0%	3.2%	3.2%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%



Reason for performance gap:	Community Nursing is currently using agency above plan due to high levels of unavailability: staff absences (maternity, long term sickness and recruitment to vacancies). For Telford teams there is also an issue with patient medications. Urgent Care: use of agency to support whilst recruiting ACP vacancy and to recruit to the bank. UEC consultant recruitment has resulted in no suitably qualified applicants and this post is to be reviewed by the Medical Director/ops. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. NHSE programme to improve price cap compliance for agencies across the Midlands to support improvement in price by setting target dates for reduction over the coming months. The Trust is price cap compliant for nursing/HCA and for specialist nursing areas. Further work on other staff groups - medical/dental and AHP will be set out by the NHSE working group for the coming months. AHP Price Cap now advised for 30/6/2025. NHSE notice on cessation of Band 2 and Band 3 agency use to be in place by 30/6/25.

Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Medical and Dental and AHP staff groups to be agreed with regional NHSE group. *AHP now set see below.*	Apr-25	Sep-25	On Track	Compliant with price cap provision by agency.
	AHP Price Cap advised to be 30 June 2025. Write to Agencies to advise of supply at these rates.	May-25	Jul-25	On track	Compliant with price cap provision by agency for AHPs.
	UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops.	Apr-25	Jun-25	On Track	Medical Director/Ops review complete and an agreed solution for this post.
	Maximise the availability of our workforce through monitoring and improving roster practices. Comms sent to roster approvers regarding use of roster to send unavailable shifts to bank/agency 11/3/25. Programme of continuous improvement workshops in place for roster approvers. Check and Challenge meetings in place with teams to review KPIs and roster efficiencies.	Mar-25	May-25	On Track	Improve assignments where the duty's grade type doesn't match the person's qualification / grade. Limited, improvement from current 2.2% to 1%. - Net Hours Balance %. The % contracted hours left unused. Currently at 5.08%, potential to reduce to align with system average 3%. - Roster Approval Lead Time. Moving from current 43 days to 48 days to help increase opportunity to fill with bank. - Additional Duty %. % of assigned duties that are in addition to the budgeted demand move from current 6.7% to 3%.
	Impending NHSE notice on cessation of Band 2 and Band 3 agency use. To set up a Working Group to include Resourcing/ops/recruitment to tap into the current plans for recruitment events. Targeted HCA/HCSW bank and substantive adverts out currently to be interviewed on May 16 at the focused interview event (see below action). Date of cessation notified by NHSE as 30/6/25. 41 bank B3 applications shortlisted and invited to interview on 16/5/25.	Apr-25	Jul-25	On Track	Working Group set up. Successfully recruit to all substantive Band 2/3 HCSW roles. To successfully recruit Band 2/3 bank roles to increase the bank pool in preparation of the cessation of agency B2/3 use.
	Grow our bank and implement the use of centralised bank to support reduction in agency usage. Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-25	Mar-26	On Track	Timetable of recruitment events and venues agreed and staffing attendance identified. First event to be held on May 16.

Author	Gina Billington	**Date**	5/14/2025
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25

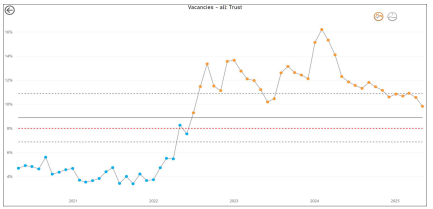
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Vacancies	%	10.59%	10.84%	10.68%	10.91%	10.56%	9.83%	9.83%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	9.50%	9.50%	9.10%	8.75%	8.30%	8.00%	8.00%



Reason for performance gap:

Corporate Updates - Focus on the areas with vacancies that are creating demand for temporary staffing which will be across in patient areas. NHSE is introducing new Time to Hire targets - 8 weeks. Recruitment team is holding a B3 0.44 WTE vacancy.

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. RR teams have been working on the staffing model and recruitment to support this is taking place over the next 4-6 weeks. UEC vacancies in process. UEC consultant recruitment has been unsuccessful - Medical Director/ops team to review. North East Shrewsbury DN are now showing a high vacancy rate due to several maternity leave absences and a reduction in hours on return on flexible hours. There are several adverts out currently to recruit to the vacancies.

Month 1 hotspots are Urgent Care (Virtual Ward and IDT), Community Services: (Bishops Castle, Ludlow & Whitchurch), Community Nursing (Telford North, Shrewsbury North) Planned Care (Stoke Heath).

Action Plan

Action	Start Date	End Date	Status	Outcome
Resourcing to undertake a deep dive into vacancy hotspots including community hospitals.	Feb-25	Mar-26	On Track	To identify areas for targeted recruitment support on a monthly basis.
Urgent Care Hotspot: Recruitment team to prioritise vacancies in UEC, Virtual Ward, IDT: liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks. - UEC vacancies, those gone through VRF, which ones have been recruited to etc to have a true picture of what vacancies are remaining.	Mar-25	Jul-25	On Track	Applicants processed and in post by Early May (subject to their notice periods). **14/5/25** 7.0 WTE vacancies on Trac, 3 in pre-interview stages, 4.8 offered (3 of which have booked start dates).
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops.	Apr-25	Jun-25	On Track	Medical Director/Ops review complete and an agreed solution for this post.
Community Services Hotspot: Recruitment team to prioritise vacancies BCCH, LCH, WCH: liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.	May-25	Jul-25	On Track	Applicants processed and in post Jul 25 (subject to their notice periods) *BCCH* has 7.44 WTE vacancies on Trac. 0.59 is in a pre-interview stage, 0.97 has a start date booked and the remaining WTE is in PEC stage. *Ludlow* has 5.46 WTE vacancies on Trac. 2.08 are in pre-interview stages and 3.38 are in PEC stage. *Whitchurch* has 3.00 WTE vacancies on Trac, 2 are in pre-interview stages and 1 has a start date booked.
Community Nursing Hotspot: Recruitment team to prioritise vacancies Telford North, Shrewsbury North: liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.	Mar-25	Jul-25	On Track	Applicants processed and in post Jul 25 (subject to their notice periods) **14/5/25.** HCA – 1 WTE perm, interviews on 15/05 – subsequent offers and PEC's will be prioritised. 6.16 WTE vacancies of which: *Telford North* - 1 in authorisation stage. *Shrewsbury North* - 1 pre-interview, 5.87 PEC, 1.64 starting. Those in offer are awaiting PINs.
Planned Care: Recruitment team to prioritise Stoke Heath vacancies: liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.	May-25	Jul-25	On Track	Applicants processed and in post Jul 25 (subject to their notice periods) 1 in authorisation, 1 in shortlisting and 1 in interview 20/5/25 (3 WTE) Recruitment Team will liaise with Recruiting M to prioritise shortlisting and interview outcome.
Recruitment policy in draft to commence the consultation stage. Includes new flowcharts and toolkit for managers. 14/5/25: Policy being revisited due to review of DBS process to align with system partners - revised target date set.	Oct-24	Sep-25	On Track	To ensure managers are up to date with recruitment processes and provides the tools for them to recruit.
Recruitment continue to review their processes to ensure timely recruitment.	Apr-25	Dec-25	On Track	Time to hire April 25 was 40.5 working days. There are currently 34 applicants with start dates in May.
Look at internal moves due to vacancies and identify hotspots for this movement.	Apr-25	Jul-25	On Track	Areas identified and work with managers on implications and considered for further action.
Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-25	Mar-26	On Track	Timetable of recruitment events and venues agreed and staffing attendance identified (will need support from ops admin for some events). First event to be held on May 16
Recruitment team to prioritise vacancies for month 12 hotspots: liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.	Apr-25	May-25	CLOSED	Recruitment team to support managers with targeted actions.

Author

Accountable Officer Approval	Gina Billington	**Date**	5/14/2025
	Rhia Boyode	**Date**	15.05.25

Division	Column1	Column2	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer			29.38	(0.06)	(0.2)
Urgent Care (Adults)			187.43	26.35	14.1
Community Services (Adults)			727.49	76.29	10.5
Planned Care SDG			212.63	30.48	14.3
Children and Families Division			452.84	26.50	5.9
Chief Executive			12.64	2.00	15.8
Director of Finance and IM&T			85.57	11.69	13.7
Director of Governance			22.5	(0.08)	(0.4)
Director of People			30.86	(0.89)	(2.9)
Director of Nursing and AHPs			33.8	5.20	15.4
Medical Directorate			4.08	(0.60)	(14.7)
Total			**1799.22**	**176.88**	**9.8**

Urgent Care (Adults)	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Single Point of Referral		TT001	8.02	0.51	6.4
Virtual Wards		YA250	13.5	3.25	24.1
OPAT		YA255	5.29	1.09	20.6
Rapid Response		TC451	0	0.00	#DIV/0!
Rapid Response - Telford		TT700	12.24	0.61	5.0
Telford Rapid Response Expansion(Central)		TT701	7.8	(0.33)	(4.2)
Integrated Discharge		TW402	27.04	6.54	24.2
Total			**73.89**	**11.67**	**15.8**

Community Services (Adults)

Inpatient Wards	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward		TW130	21.63	4.34	20.1
Ludlow Hospital Ward		TW230	34.72	6.83	19.7
Whitchurch Hospital Ward		TN130	41.13	5.30	12.9
Bridgnorth Hospital Ward		TT130	39.35	1.19	3.0
Rehab & Recovery Unit - Shrewsbury (Ward 18, RSI		YA260	51.65	15.09	29.2
Rehab & Recovery Unit - Telford (Ward 36, PRH)		YA270	43.51	7.26	16.7
Total			**231.99**	**40.01**	**17.2**

Community Nursing	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Community Nursing - Telford North		TT530	32.79	2.92	8.9
Community Nursing - Telford South		TT500	32.38	(0.08)	(0.2)
Community Nursing - Shrewsbury North		TC300	30.45	3.24	10.6
Community Nursing - Shrewsbury South		TC301	30.04	(1.34)	(4.5)
Community Nursing - North East		TN300	29.28	1.97	6.7
Community Nursing - North West		TN400	31.21	(0.58)	(1.9)
Community Nursing - South East		TW301	31.44	2.57	8.2
Community Nursing - South West		TW300	26.01	(0.42)	(1.6)
Total			**243.6**	**8.28**	**3.4**

Community Therapy Services	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Adult Community Therapy Central		TA001	16.06	4.16	25.9
Adult Community Therapy North East		TA003	17.39	2.38	13.7
Adult Community Therapy North West		TA004	12.28	0.64	5.2
Adult Community Therapy South East		TA005	14.8	3.80	25.7
Adult Community Therapy South West		TA006	15.47	1.20	7.8
Total			**76**	**12.18**	**16.0**

Children, Young People & Famili	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Shropshire PHNS Admin		WP125	9.46	0.47	5.0
Shropshire Health Visiting		WP135	45.49	0.73	1.6
Telford 0-19 Healthy Child Programme		WP140	0	0.00	#DIV/0!
Family Nurse Partnership Shropshire		WP601	5.07	0.00	0.0
5-19 School Nursing Dudley Service		WP200	33.92	1.99	5.9
5-19 School Nursing Shropshire		WP210	27.22	1.83	6.7
Dudley Health Visiting Admin Service		WP126	12	2.08	17.3
Health Visiting Dudley Service		WP205	70.47	4.98	7.1
Family Nurse Partnership Dudley Service		WP602	8.05	(2.35)	(29.2)
Total			**211.68**	**9.73**	**4.6**

Dental in Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Dental Central Admin		WM900	3.8	1.30	36.1
Dental Special Care and Access		WM910	30.43	2.50	8.2
Dental Market Drayton		WM920	3.76	1.16	30.9
Dental Craven Arms		WM930	3.01	1.94	64.5
Oral Health Improvement		WM960	6.42	1.82	28.3
Total			**47.22**	**8.72**	**18.5**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
TeMS Therapy		TC231	6.17	1.40	22.7
MSK MDT Clinic		TC232	4.27	0.00	0.0
MSK Podiatry		TC235	1	0.03	3.0
MSK Rheumatology		TC236	0	(1.00)	
TeMS Admin		TC240	18.62	3.74	20.1
MSST		TC250	12.97	(1.24)	(9.6)
Total			**43.03**	**2.93**	**6.8**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Stoke Heath YOI		WH200	26.82	5.05	18.8
Total			**26.82**	**5.05**	**18.8**

Local Action Plans

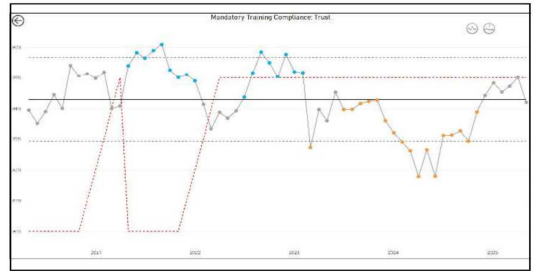
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Mandatory Training	%	94.43%	94.83%	94.53%	94.72%	95.01%	94.20%	94.20%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	94.80%	95.00%	95.30%	95.40%	95.45%	95.50%	95.60%



Reason for performance gap:	Corporate Updates – The compliance rate for April has decreased to 94.20%. For the first time, Moving and Handling - Level 2 has been included in the mandatory training figures, achieving a rate of 71.22%, which represents a 4% increase from the previous month, which is showing a positive improvement each month. Additionally, Resuscitation - Level 2 - Adult Basic Life Support and Resuscitation - Level 2 - Paediatric Basic Life Support have both experienced a decline of over 3%, which is disappointing. In accordance with the newly implemented procedure for addressing non-compliance among staff, we have observed a notable improvement in compliance for several topics, including Corporate Induction, Resus Level 3 Adult and Paediatric, and Moving & Handling Level 2, compared to the previous month. Furthermore, an additional procedure will involve including the Service Delivery Leads in email communications regarding staff non-compliance, enabling them to monitor the situation effectively.			
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Hotspot - Compliance Overview - BLS training - The Workforce Team will liaise with the SaTH OD team to request access to BLS courses conducted by SaTH. This is necessary as the room provided by SCHT's SME is unsuitable for delivering training effectively. ESRLM Team have chased SaTH to see if they are able to support with this training.	Feb-25	Apr-25	On Track	Higher BLS compliance rates among staff at SaTH sites, ensuring that mandatory training requirements are met. This improvement would enhance staff preparedness, meet regulatory and organisational standards, and contribute to safer and more effective patient care. It would also address logistical challenges that may have previously hindered training access.
	Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **Resuscitation Training, Moving & Handling Training and Corporate Induction**. The ESR Learning Management Team have identified gaps in these topics and provided managers with a detailed breakdown of non-compliance to support targeted interventions. These emails encourage managers to prioritise and allocate time for their staff to complete mandatory training	Mar-25	Jul-25	On Track	To improve overall compliance rates across Resuscitation Training, Moving & Handling Training, and Corporate Induction, ensuring staff meet mandatory training requirements. This would contribute to enhanced workforce readiness, increased operational efficiency, and alignment with organisation's compliance targets. It would also address any gaps in training that could impact service delivery or regulatory standards.
	Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **Information Governance, Safeguarding Children Level 2**. The ESR Learning Management Team have identified gaps in these topics and provided managers with a detailed breakdown of non-compliance to support targeted interventions. These emails encourage managers to prioritise and allocate time for their staff to complete mandatory training	May-25	Sep-25	On Track	To improve overall compliance rates across IG and SGC L2 ensuring staff meet mandatory training requirements. This would contribute to enhanced workforce readiness, increased operational efficiency, and alignment with organisation's compliance targets. It would also address any gaps in training that could impact service delivery or regulatory standards.
	Hotspot - Sector - Stoke Heath will utilise the rostering system to schedule staff time for completing mandatory training, which will take place at a local base. A bespoke training session for Resus has been arranged for June 2025.	Apr-25	Jul-25	On Track	Improved mandatory training compliance.
	Hotspot - All Sectors below 95% - The ESRLMS Team will contact all Sectors who have a compliance rate of below 95% to ask managers to schedule time for staff to complete their outstanding mandatory training. Detailed mandatory training reports will be provided for each of these areas.	May-25	Sep-25	On Track	Improved mandatory training compliance.
Author	Jen Deakin	**Date**	5/12/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

April 2025 Compliance Overview				
TOPIC	**March Compliance**		**April Compliance**	**Variance against compliance**
Mandatory Topics (All Staff)				
Corporate Induction |	96.8%	▲	96.8%	0.06%
Equality, Diversity and Human Rights	98.2%	▼	98.0%	-0.15%
Fire Safety	95.7%	▲	96.1%	0.45%
Fire Safety - High Risk	84.1%	▼	82.8%	-1.32%
Fraud Awareness	97.5%	▼	97.1%	-0.38%
Health, Safety and Welfare	97.9%	▼	97.9%	-0.04%
Infection Prevention and Control - Level 1	98.2%	▼	97.2%	-1.04%
Infection Prevention and Control - Level 2	97.2%	▼	96.3%	-0.95%
Information Governance and Data Security	93.1%	▼	93.0%	-0.08%
Moving and Handling - Level 1	95.9%	▲	97.1%	1.18%
Moving and Handling - Level 2	67.2%	▲	71.2%	4.07%
NHS Conflict Resolution (England)	98.3%	▼	98.2%	-0.16%
Patient Safety - Level 1	99.1%	▼	99.0%	-0.12%
Preventing Radicalisation - Prevent Awareness	97.8%	▲	98.2%	0.33%
Resuscitation - Level 2 - Adult Basic Life Support	78.4%	▼	74.7%	-3.75%
Resuscitation - Level 2 - Paediatric Basic Life Support	77.5%	▼	74.2%	-3.26%
Resuscitation - Level 3 - Adult Immediate Life Support	74.7%	▲	80.5%	5.74%
Resuscitation - Level 3 - Paediatric Immediate Life Support	73.7%	▲	79.7%	6.01%
Safeguarding Adults - Level 1	97.5%	▲	98.2%	0.65%
Safeguarding Adults - Level 2	96.4%	▲	97.2%	0.85%
Safeguarding Children - Level 1	94.8%	▲	95.3%	0.48%
Safeguarding Children - Level 2	93.1%	▲	93.3%	0.22%
The Oliver McGowan Mandatory Training	97.1%	▲	97.3%	0.20%

Sector	Substantive staff count	% Compliance
825 Stoke Heath YOI Sector	24	85.58%
825 Operations Directorate Management Sector	12	87.11%
825 South East Sector	133	90.84%
825 Clinical Services - CYP&F Sector	21	92.39%
825 North West Sector	207	92.53%
825 Trust Board Sector	11	92.73%
825 Urgent and Emergency Care Sector	184	92.86%
825 Central Sector	105	93.40%
825 North East Sector	123	93.50%
825 Telford Sector	48	93.67%
825 Service Delivery Group - CYP&F Management Sector	9	94.00%
825 Shropshire PHNS 0-19 Sector	105	94.15%
825 Planned/Elective Care Sector	144	94.23%
825 South West Sector	140	94.64%
825 Service Delivery Group - Adult Community Services Management Sector	6	94.85%
825 Medical Sector	5	94.87%

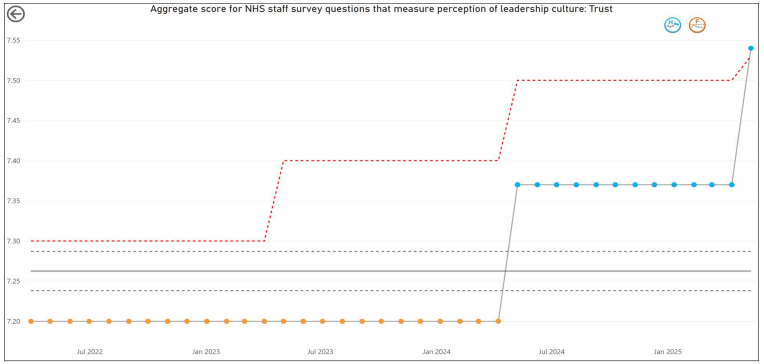
Yearly Reported KPIs

Exception Report - Action Plan

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Aggregate score for NHS staff survey questions	Number	7.4	7.4	7.4	7.4	7.4	7.54	7.54
	Target	7.5	7.5	7.5	7.5	7.5	7.53	7.53

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	7.54	7.54	7.54	7.54	7.54	7.54	7.54



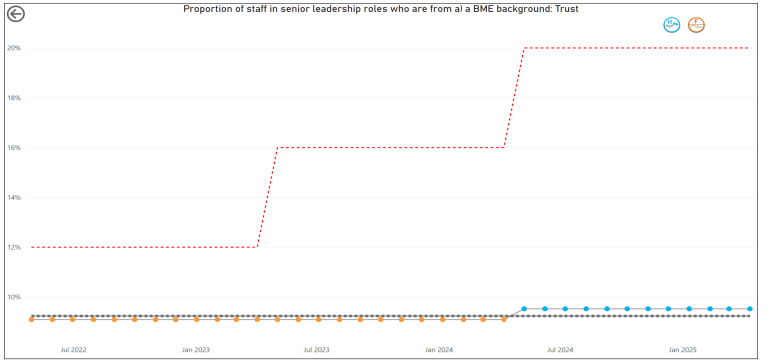
Reason for performance gap:	The target is 7.53 and we are close to this with a score of 7.54. There have been changes over the last 24 months which have included change management across leadership roles which will take time to embed and change culture. The Culture Change team has been launched with Board Conversations and Leaderhip survey will support changing this score over time. The qualittative and quatative data gathered by teh Culture Change Team will be instrumental in supporting leadership culture.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Identify and Implement actions identified from the Cultural Maturity Audit.	Mar-25	Sep-25	On Track	To implement actions where gaps have been identified through the Cultural Maturity audit.
	Commence the Culture and Leadership Programme to include Board Interviews and a Leadership survey.	Dec-24	Dec-25	On Track	To understand the culture and develop a culture action plan.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%



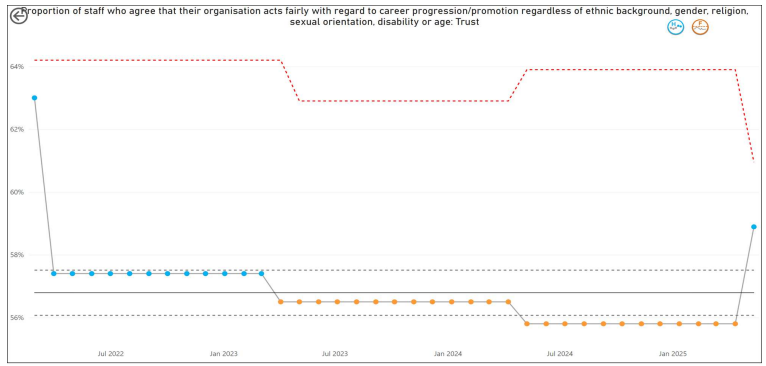
Reason for performance gap:	The WRES 2023/24 report shows our colleague representation for Asian, Mixed, Black and other minority people has increased year on year since 2020 and makes up 7.82% of our workforce. The 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, 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	**Action**	**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	Nov-25	On Track	Ensure recruitment processes are fair, inclusive and transparent.
	Develop and implement an inclusive recruitment toolkit.	Jan-25	Jun-25	On Track	17.01.2025: Toolkit in draft - to review with Trust networks.
	Explore Scope for Growth conversations.	Mar-25	Jun-25	On Track	Ensure talent management conversations take place on a regular basis to support progression.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of staff who agree that their organisation	Number	55.80%	55.80%	55.80%	55.80%	55.80%	58.89%	58.89%
	Target	63.90%	63.90%	63.90%	63.90%	63.90%	60.95%	60.95%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	58.89%	58.89%	58.89%	58.89%	58.89%	58.89%	58.89%



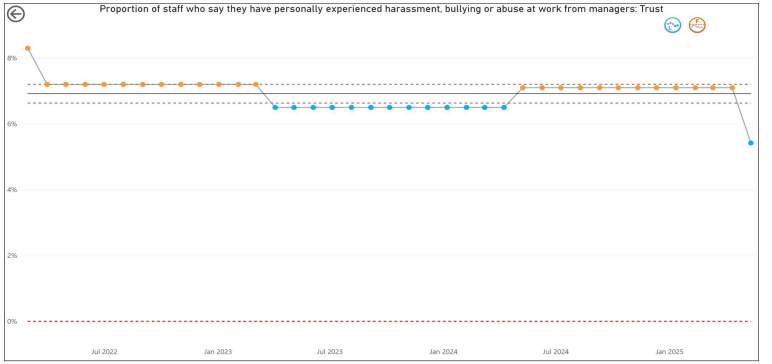
Reason for performance gap:	There was a gap of 8.1% for 2024/25 between the national average and SCHT's score, however this has decreased to 2.06%. For a period of time leadership courses have not been available internally for our staff to attend however, more recently we have been working in collaboration with SaTH and places have been offered to our staff on their leadership courses.				
Action Plan	**Action**	**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	Nov-25	On Track	Ensure recruitment processes are fair, inclusive and transparent.
	Develop and implement an inclusive recruitment toolkit.	Jan-25	Jun-25	On Track	In draft - to review with Trust networks.
	Work with the Workforce Race Equality Network to understand development needs and how their careers can be supported.	Apr-25	Jun-25	On Track	Ensure support is appropriate and meets individual's needs.
	Publicise positive staff stories around career and development opportunities.	Dec-24	May-25	On Track	Raise awareness of career development.
	Explore implementing 'scope for growth' conversations.	Mar-25	Jun-25	On Track	Ensure all staff have the opportunity to discuss careers aspirations.
	Launch cohort 2 of the Expectations of Line Managers course.	Apr-25	May-25	Completed	Provide insights into management for staff.
	Work in collaboration with SaTH to offer their masterclasses to staff.	Apr-25	May-25	Completed	Provide insights into management for staff.
	Work in collaboration with SaTH to offer their leadership courses to staff.	Apr-25	Jul-25	Completed	Leadership courses for staff.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of staff who say they have personally	Number	7.1%	7.1%	7.1%	7.1%	7.1%	5.4%	5.4%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%



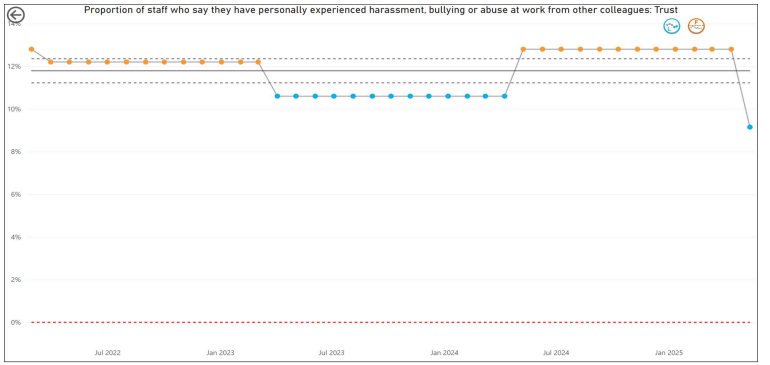
Reason for performance gap:	When reviewing the information retained by the People team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	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	May-25	Completed	Targeted support for areas where bullying and harassment is reported.
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Jun-25	On Track	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
	Explore the commencement of Active Bystander training for all staff.	Mar-25	May-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of staff who say they have personally	Number	12.8%	12.8%	12.8%	12.8%	12.8%	9.2%	9.2%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%



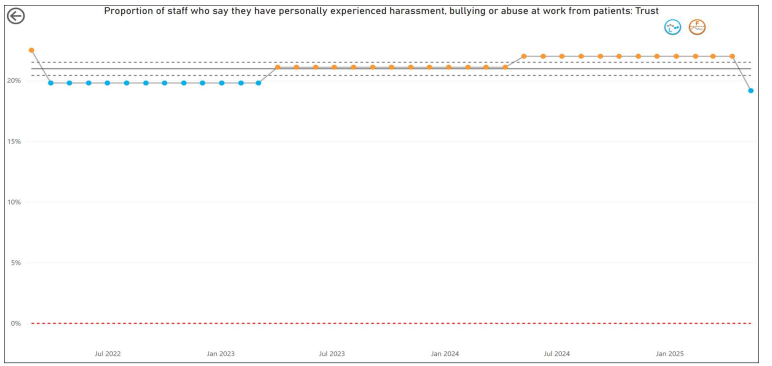
Reason for performance gap:	When reviewing the information retained by the People Team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	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	May-25	Completed	Targeted support for areas where bullying and harassment is reported.
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Jun-25	On Track	Create an environment free of bullying and harassment and raise awareness of the importance of civility and respect.
	Explore the commencement of Active Bystander training for all staff.	Mar-25	May-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of staff who say they have personally	Number	22.0%	22.0%	22.0%	22.0%	22.0%	19.2%	19.2%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%	19.2%



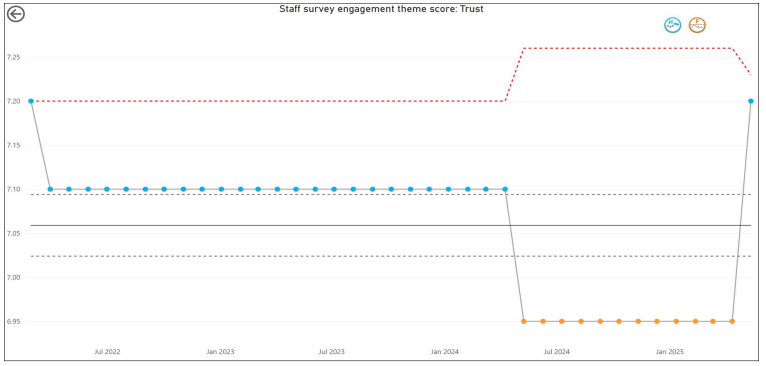
Reason for performance gap:	Staff experience bullying by patients, the aim is to raise awareness of the impact of this behaviour and support staff as required.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Launch work without fear campaign.	Mar-25	Sep-25	On Track	Raise awareness to our patients, relatives and members of the public.
	Develop nudge posters around zero tolerance.	Mar-25	May-25	On Track	Raise awareness to our patients, relatives and members of the public.
	Work with the System on EDI 90 day conversation	Apr-25	Jun-25	On Track	Raise awareness to our staff, patients, relatives and members of the public.
	Explore the commencement of Active Bystander training for all staff	Mar-25	May-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

Exception Report - Action Plan

Staff survey engagement theme score

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Staff survey engagement theme score	Number	7.0	7.0	7.0	7.0	7.0	7.2	7.2
	Target	7.3	7.3	7.3	7.3	7.3	7.23	7.23

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	7.2	7.2	7.2	7.2	7.2	7.2	7.2



Reason for performance gap:	SCHT's score is close to the national average, however work continues around engagement.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Implement a reward and recognition programme to include a recognition calendar and events	Dec-24	Jul-25	On Track	To increase engagement across the Trust and enable staff to network.
	Implement HWB action plan	May-25	Mar-26	On track	To ensure staff have the HWB support
	Roll out the Culture change Team	Dec-24	Mar-26	On track	Create an open culture
Author	Fiona MacPherson	**Date**	15.05.25		
Accountable Officer Approval	Rhia Boyode	**Date**	15.05.25		

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 2025

0. Reference Information

Author:	Stacey Worthington, Executive Assistant	**Paper date:**	5 June 2025
Executive Sponsor:	Tina Long, RPC Chair	**Paper written on:**	4th April 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 26th March 2025 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Waiting times – All Services
    - Integrated Performance Report
    - Deep Dive Agency, Bank, Workforce
    - 2025/26 CIP Progress and Actions
    - Benchmarking
    - Annual Review of Trust KPIs
    - Finance & Capital Reporting Month 11
    - Annual Budget Setting
    - Service Transformation Update
    - Planning – Operational Plan
    - Estates and Environmental Quarterly Update
    - Green Plan Update
    - Review of BAF risks
    - Annual Meeting Evaluation Checklist Outputs
    - System Transformation Group Minutes
    - Digital Assurance Group Terms of Reference
    - Contract Management Group Terms of Reference
    - Digital Assurance Group Minutes

2.3. Conclusion

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

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 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 26th March 2025. The meeting was quorate with two Non-Executive Director and three 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
Claire Horsfield	Director of Operations and Chief AHP
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
Steve Ellis	Deputy Director Operations - Service Development (part meeting)
Richard Best	Associate Director of Estates
Sam Townsend	Divisional Manager, Adult Community Services (part-meeting)
Stacey Worthington	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 – All Services		
The Committee considered improvements in waiting times across various services, noting a reduction in the reported 104-week breaches from nine to six due to data cleansing. Workforce models are being reviewed in hard-to-recruit areas, particularly community paediatrics, and the transition to in-house provision for psychology within the CNRT service. The Committee reinforced that continued collaborative working with partners is essential for delivery of seamless and equitable care to our patients.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 2025

8. Integrated Performance Report		
The Committee noted that the KPIs which were flagged as a concern were unchanged from the last report. There had been improvements in waiting times, although it was noted that there had been three 65 week RTT breaches in February. The Committee discussed the full assurance received through the action plans, noting these describe the actions to mitigate risk and improve performance.	Full	
9. Deep Dive Agency, Bank, Workforce		
The Committee considered that agency usage exceeded planned levels while bank usage was also higher than expected, attributed to lower substantive staff levels. The Workforce team is considering a national bank scheme, and a peer review on fill rates is underway due to increased patient acuity necessitating additional staffing. It was noted that action plan development is required and partial assurance was received.	Partial	Further development of actions required to reduce temporary staffing, focusing on underlying drivers for usage and sustainable solutions.
10. CIP 2025/26 Progress and Next Actions		
The Committee noted progress on developing the 2025/26 CIP programme and considered that the requirement had increased significantly through the planning process. The Trust faces an unprecedented scale of CIP and concerns were raised in relation to this. The Committee acknowledged the established governance processes but ongoing work to produce PIDs and QEIAs for the 25/26 schemes is essential at pace and therefore partial assurance only was received.	Partial	Further action required to fully develop the 25/26 CIP programme and move to delivery.
11. Benchmarking		
The Committee received benchmarking in relation to community nursing services. The teams demonstrate high productivity with increased clinical contacts and time spent with patients, despite higher costs mainly due to agency spending. The percentage of cancelled appointments was higher than some peers and this is due to urgent demands. A draft service specification is being discussed with commissioners in the near future and our staffing levels are considered to be low based on the patients we are now caring for.	N/A	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 2025

12. Annual Review of Trust KPIs		
The Committee considered the annual review of the Trust's KPIs relevant to its remit, as part of the Performance Framework. Accountable Officers had reviewed the proposed KPIs and each Committee is reviewing its 2025/26 KPIs. It was noted that there would be changes to these during the year. It was noted that the KPIs may change during the year upon receipt of updated guidance. The Committee agreed the presented KPIs and recommended these to the Trust Board for approval.	N/A	
13. Financial Performance Month 11		
The Committee considered the financial performance, noting the favourable variance to plan of £1,541k for the year to date and the £3.6m forecast surplus, a favourable variance to plan of £1.8m. CIP delivery exceeds planned levels and agency spend remains close to planned levels. Capital spend is behind plan, however recovery plans are in place. The Committee approved a lease to enable to Digital team to vacate their current accommodation subject to final confirmation through the Executive Team.	Full	
14. Annual Budget Setting		
The opening 2025/26 budgets were reviewed. These are in line with our March plan submission although it was noted further changes are possible and these will be approved in line with existing governance arrangements. Approval of the opening budget is a key element of our financial controls. The Committee recommended the opening 2025/26 annual budget to the Trust Board for approval.	Full	
15. Service Transformation update		
The Committee received an update on the main transformation projects and supported current work with integrated neighbourhood teams. It was noted that the transformation work should lead to productivity improvements and feed through to the Productivity Delivery Group.	Full	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 2025

16. Planning – Operational Plan		
The Committee noted that the approach to preparing the plan was consistent with previous years. A collaborative approach had been taken involving our teams, stakeholders and with reference to local and national priorities. There are a reduced number of strategic priorities to allow increased focus on each. Milestone plans are being developed and updates will be provided to each committee, quarterly. It was noted that partnership working is essential to delivery of this plan. The Committee reviewed the areas relevant to its remit and approved the interventions and anticipated outcomes.	Full	
17. Estates & Environment Quarterly Update		
The Committee considered a number of property vacations to support optimising the use of the estate. No new risks were identified and a continued strong relationship with the estates provider was acknowledged. The Committee was confident in the estate's management performance and the alignment with national and local strategies.	Full	
18. Green Plan Update		
The Green plan is currently being reviewed following a national refresh. The Committee noted that the Trust was on track to deliver the majority of the actions within the current plan. It was agreed that further work will be required in relation to electric vehicles and charging points.	Full	
19. Review of the BAF		
No update was presented but it was noted a full review of the BAF would be presented to the Trust Board for consideration in due course.		
20. Annual Meeting Evaluation Review Outputs		
No update was presented but it was noted an update would be provided to the Trust Board in due course.		
21-26. Minutes and Terms of Reference from sub-committees and RPC Work Plan		
The amendments to the 2025/26 work plan were presented with no further changes requested.		

Chair's Assurance Report

Resource and Performance Committee Part 1 – 26th March 2025

The Terms of Reference for the Digital Assurance Group and Contract Management Group were approved.		

3.4 Approvals

The Committee:

- Reviewed the 2025/26 KPIs within RPC's remit and recommended these to the Trust Board for approval.
- Approved lease expenditure allowing additional space at a current base, to enable the Digital team to move from their existing location as the lease nears its end.
- Reviewed the 2025/26 Opening Budgets and recommended these to the Trust Board for approval.
- Approved the 2025/26 Operational Plan Interventions and Outcomes relevant to this Committee.
- Approved the Digital Assurance Group Terms of Reference.
- Approved the Contract Management Group Terms of Reference.

3.5 Risks to be Escalated

Risks in relation to the 2025/26 CIP identification and delivery were highlighted. Additional risks in relation to workforce measures were also discussed, and these are covered through the existing 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:**	**5th June 2025**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**28th May 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 69 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. 31 indicators are highlighted as a concern (44.9%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	1	12	0	**19**	**13 (68.4%)**
Quality & Safety	4	3	1	**19**	**8 (42.1%)**
Resource & Performance	2	4	4	**31**	**10 (32.3%)**

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

There have been a number of changes to the Trust's KPIs flagged as a concern during the month, as follows:

- **People Committee**
  - *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 is now flagged as an assurance concern only*
  - *The three KPI relating to Proportion of staff who say they have personally experienced harassment, bullying or abuse at work are now flagged as an assurance concern only*
  - *Staff survey engagement theme score is now flagged as an assurance concern only*

- **Quality and Safety Committee**
  - *Clostridium difficile infection rate is now flagged as a variation concern*
  - *Deaths – unexpected is now flagged as a variation concern*
  - *Medication Incidents with Moderate Harm (new measure), flagged as a variation concern*

- **Resource and Performance Committee**
  - *Total patients waiting more than 65 Weeks – All services (Local target) is now flagged as an assurance concern only*
  - *Total patients waiting more than 78 Weeks – All services (Local target) is now flagged as an assurance concern only*
  - *Urgent Care 2 hour response (new measure), flagged as a variation concern*

Action Plans have been developed in a workshop with Operational Leads and Support Services, these are included at Appendix 3 for the measures flagged as a concern within this report.

In line with our Performance Framework and following the approval at Trust Board, the KPIs for 2025/26 are now included in the relevant committee dashboards. Those identified at the time as 'in development' will be highlighted to the relevant committee once available.

Please note that the RTT measures for April are subject to change as the validation for the national submission continued 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 three of our key 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 31 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 10 require focused attention with 9 of the 10 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:

Two 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. Urgent Care 2 hour response

Four 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
3. Total patients waiting more than 65 Weeks – All services (Local target)
4. Total patients waiting more than 78 Weeks – All services (Local target)

Four 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 52 Weeks – All services (Local target)

Performance Update

There have been a number of changes to note since the last report to Board:-

- Previously flagged as both assurance and variation concern, now flagged as an assurance concern only:
    1. *Total patients waiting more than 65 Weeks – All services (Local target)*
    2. *Total patients waiting more than 78 Weeks – All services (Local target)*

- New measure added to the performance framework, flagged as a variation concern
    1. *Urgent Care 2 hour response*

April 2025 position:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Our Services)
Patients waiting over 52 weeks	281	869
Patients waiting over 65 weeks	2	156
Patients waiting over 78 weeks	0	26
Patients waiting over 104 weeks	0	1

Since the last report to Board there has been improvement in all the high wait KPIs in the table above and this is clearly visible from the SPC charts in the appendices.

'18 week Referral to Treatment (RTT) incomplete pathways' has shown a small deterioration from 58.97% in March to 58.22% in April, although the April position was still being validated at the time of preparing the paper/dashboards. Further detail is included in the action plan.

The indicator for 'Proportion of patients within 18 weeks' has improved, with performance of 65.89% in April compared with 64.15% in March.

The data issue previously reported in relation to Continence products was resolved for 2024/25 data. However, a similar issue still exists for the start of 2025/26 with only parts of the activity available; this issue has been raised with the system supplier and the measure will be refreshed once this is resolved. This impacts the 'total activity undertaken against current year plan' KPI.

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	2025-04-30	L	58.22%	92.00%	-33.78%	58.22%	92.00%	-33.78%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2025-04-30		87.59%	100.00%	-12.41%	87.59%	100.00%	-12.41%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2025-04-30		78.14%	100.00%	-21.86%	78.14%	100.00%	-21.86%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2025-04-30	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2025-04-30		0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2025-01-31	H	94.9%	95.0%	-0.1%	94.9%	95.0%	-0.1%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2025-03-31		97.90%	99.00%	-1.10%	97.90%	99.00%	-1.10%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2025-04-30		-4.76%	0.00%	-4.76%	-4.76%	0.00%	-4.76%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2025-04-30		0.09%	0.00%	0.09%	0.09%	0.00%	0.09%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2025-03-31	H	91.75%	90.00%	1.75%	90.25%	90.00%	0.25%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2025-03-31		84.07%	90.00%	-5.93%	86.34%	90.00%	-3.66%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2025-03-31		90.07%	95.00%	-4.93%	91.82%	95.00%	-3.18%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2025-04-30	L	0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2025-04-30	H	114.03%	75.00%	39.03%	114.03%	75.00%	39.03%	?
Resource & Performance...	Responsive	Patients no longer meeting the criteria to reside	2025-04-30		21.6%	24.6%	-3.0%	21.6%	24.6%	-3.0%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2025-04-30		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...	2025-04-30	H	75.00%	92.00%	-17.00%	75.00%	92.00%	-17.00%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2025-04-30	L	65.89%	92.00%	-26.11%	65.89%	92.00%	-26.11%	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	2025-04-30		99.25%	100.00%	-0.75%	99.25%	100.00%	-0.75%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2025-04-30		138.62%	120.00%	18.62%	138.62%	120.00%	18.62%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2025-04-30	H	125.95%	103.00%	22.95%	125.95%	103.00%	22.95%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2025-04-30		1	0	1	1	0	1	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2025-04-30		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2025-04-30	H	869	0	869	869	0	869	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2025-04-30	H	281	0	281	281	0	281	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2025-04-30		156	0	156	156	0	156	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2025-04-30	L	2	0	2	2	0	2	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2025-04-30	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2025-04-30	L	26	0	26	26	0	26	F
Resource & Performance ...	Responsive	Urgent Care 2 hour response	2025-04-30	L	76.02%	70.00%	6.02%	76.02%	70.00%	6.02%	
Resource & Performance ...	Effective	Virtual ward bed occupancy	2025-04-30		73.11%	63.81%	9.30%	73.11%	63.81%	9.30%	

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	2025-04-30	H	6.43	6.49	-0.06	6.43	6.49	-0.06	F
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2025-04-30		1	0	1	1	0	1	?
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2025-04-30		1	0	1	1	0	1	?
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2025-04-30	H	300.00%	100.00%	200.00%	300.00%	100.00%	200.00%	?
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2025-04-30	H	100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	F
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2025-04-30	H	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	F
Quality & Safety Committee	Effective	Deaths - unexpected	2025-04-30	H	1	0	1	1	0	1	?
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2025-04-30	H	200.00%	100.00%	100.00%	200.00%	100.00%	100.00%	P
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2025-04-30		5.80	4.00	1.80	5.80	4.00	1.80	?
Quality & Safety Committee	Safe	Medication Incidents with Moderate Harm	2025-04-30	H	2	0	2	2	0	2	?
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2025-04-30		0	0	0	0	0	0	P
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2025-04-30	H	1	0	1	1	0	1	F
Quality & Safety Committee	Safe	Never Events	2025-04-30		0	0	0	0	0	0	P
Quality & Safety Committee	Well Led	Overall CQC Rating	2025-04-30		Good	Good		Good	Good		P
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2025-04-30		1	0	1	1	0	1	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-03-31		134%	95%	39%	134%	95%	39%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-03-31		156%	95%	61%	156%	95%	61%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-03-31	H	108%	95%	13%	108%	95%	13%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-03-31		104%	95%	9%	104%	95%	9%	?

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 ...	2025-04-30		7.5	7.5	0.0	7.5	7.5	0.0	
People Committee	Well Led	Appraisal Rates	2025-04-30		88.00%	90.00%	-2.00%	88.00%	90.00%	-2.00%	
People Committee	Well Led	CQC well-led rating	2025-04-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2025-04-30		9.82%	9.60%	0.22%	9.82%	9.60%	0.22%	
People Committee	Well Led	Mandatory Training Compliance	2025-04-30		94.20%	95.00%	-0.80%	94.20%	95.00%	-0.80%	
People Committee	Well Led	Net Staff in Post Change	2025-04-30		11.48	0.00	11.48	11.48	0.00	11.48	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-04-30		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	2025-04-30		72.73%	66.00%	6.73%	72.73%	66.00%	6.73%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-04-30		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...	2025-04-30		58.89%	60.95%	-2.06%	58.89%	60.95%	-2.06%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		5.4%	0.0%	5.4%	5.4%	0.0%	5.4%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		9.2%	0.0%	9.2%	9.2%	0.0%	9.2%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-04-30		19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	
People Committee	Well Led	Proportion of temporary staff	2025-04-30		3.2%	3.4%	-0.2%	3.2%	3.4%	-0.2%	
People Committee	Well Led	Sickness Rate	2025-04-30		5.28%	4.75%	0.53%	5.28%	4.75%	0.53%	
People Committee	Well Led	Staff survey engagement theme score	2025-04-30		7.2	7.2	0.0	7.2	7.2	0.0	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-04-30		49	0	49	49	0	49	
People Committee	Well Led	Total shifts on a non-framework agreement	2025-04-30		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2025-04-30		9.83%	8.00%	1.83%	9.83%	8.00%	1.83%	

Icon Descriptions

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.

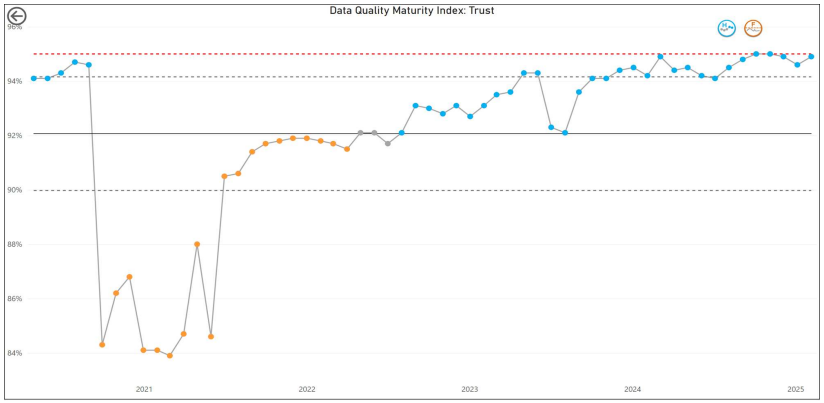
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	YTD
DQMI	%	94.8%	95.0%	95.0%	94.9%	94.6%	94.9%	94.9%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
%	94.0%	94.5%	95.0%	94.6%	94.6%	94.6%	95.0%



Reason for performance gap:

Performance Analysis:
In June/July 2023, there was a decline in performance due to multiple errors in the dataset submissions as the Trust implemented a new dataset submission standard. Although these datasets have since been corrected and resubmitted, and performance has gradually improved, several areas still need enhancement.

Data Quality Issues:
Persistent data quality issues remain in various data items, particularly in:
Chief Complaint and Acuity for MIU.
Clinical Coding for Admitted Patient Care, Rehab and Recovery Units.
Ethnicity and Spoken Language.

The risk for clinical coding has increased for Rehab and Recovery Units due to a lack of capacity for SaTH to continue to support. We are currently seeking alternative arrangements.

Main Challenges:
The primary challenge affecting this metric is compliance with recording ethnicity. Ongoing education efforts emphasise the importance and relevance of this metric. However, challenges persist due to limited admin capacity, aligned with NHSE controls, impacting the completion of this action. We are collaborating with informatics to ensure certain fields supporting data quality improvement become mandatory for completion.
There is an additional risk to adherence to DQMI elements, particularly ethnicity, due to collective action by primary care. As a result, services no longer receive proformas that previously provided some of this information, which would have been inputted into RiO

		Start Date	End Date	Status	Outcome
Action Plan	Data Quality Sub-Group to have representation from all divisions	Jan-24	Jan-25	Complete	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 due to winter pressures clashing. Both divisions are working to address this and full attendance from Ops was recorded at the March 2025 meeting. Will be monitored for April meeting with anticipated closure of this action. Representation at meetings has improved, enabling wider understanding of DQ issues and ability to disseminate through services, therefore happy to close this action
	Clinical Audit Tool feedback to be strengthened through Divisional meetings	Jun-24	Nov-24	Off Track	Results from quarterly discussions at DQ Subgroup are being communicated back through Divisional meetings. This was discussed at the workshop above and a dedicated meeting to go through and 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 Divisional Leads for action to take forwards with service leads. There is a plan to recover this action and complete by April 2025. Response rate still low as of April 25, but divisional managers copied into requests for oversight. Compliance for Planned Care is improving, will be reviewed across other areas at DQ Subgroup in May
	Stabilisation of clinical coding workforce	Nov-24	Jan-25	Off Track	Meet with the leads involved and scope an options appraisal. Explore through Admin Academy any options for internal training. Divisional Clinical Manager to take this to the April admin academy meeting. Planned Care and Adult Community to work together to produce impact paper, due to crossover of management vs activity. The plan is to review and recover this action by May 25.
	Operations to work together to devise a plan to educate staff in the requirement to ask service users regarding Ethnicity/Spoken Language, etc. 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	Jul-25	On Track	Collective agreement that a quality facilitated programme to lead the education of staff is the way forwards. Deputy DIrector of Ops has tasked SDG leads with arranging this session, supported by Quality and Information Team. Meeting to be arranged in June, where progress will be reviewed and services called to account where Ethnicity recording hasn't improved . Teams not improving will attend a one day workshop to support with planning recovery. Rio updated to change "Not Stated" to be "Patient Declined to State" to attempt to remove the over inflation of use of "Not Stated" inappropriately. MSST have carried out work to educate teams on the need to ensure demographics checked at every contact with patient. Also linked with Information Analyst to obtain detail on patients that Ethnicitiy was missing from, to work through and update.

	MIU - Team leads are now in place and so Clinical Service Manager (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	Off Track	Monthly meetings in place. Awaiting future months SUS DQ Dashboards in order to assess evidence of impact 1 team lead vacancy remains. SDG Lead will take the lead on this action and ensure that process document is available on how Rio flow should work MIU have a recovery plan in place with improvement to be evidenced by April 2025. MIU service lead has met with new MIU team leads; further work required. Information Team to review what DQ reporting is available to support completion of chief complaint and acuity. May 25 update - Performance is deteriorating at April 25. SDG lead to look at hotspots and work with team leads to understand the barriers, link with the Rio team to assess if training needed and to obtain step by step guide to how to enter relevant information, to improve these areas
Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

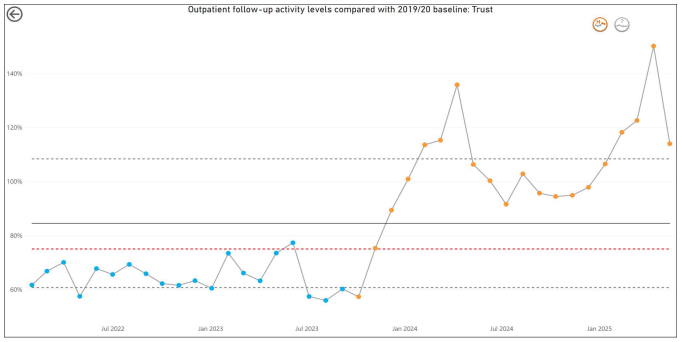
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Outpatient follow-up	%	97.87%	106.47%	118.24%	122.60%	150.15%	114.03%	114.03%
	Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Trajectory	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
%	99.0%	99.0%	99.0%	99.0%	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 perspective SCHT are modelling a best practice approach performing consistently 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 attainment of PIFU.

Service	Apr-25 (Rounded to 0 dp)
APCS	94%
Bridgnorth Outpatients	61%
DAART	128%
Ludlow Outpatients	60%
MSST	15505%
TEMS	1%
Whitchurch Outpatients	57%

Action Plan

	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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. New Referrals ceased coming into TeMS 14th February 25. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SaTH with the remaining patients to be transferred by June 25.
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 in this area to support productivity	Jan-25	Mar-25	Off track	Scoping with team commenced to explore use of PIFU. Likely that a lot of DAART activity is regular treatments and so not all interventions appropriate for PIFU. Definition of follow up activity required - review with DAART Lead. Information analyst for DAART to establish reports to support. Ops leads to review whether PIFU suits service. Review for May 25 EK linking with Emily Peer to review types of follow up activity and whether any can be administed in Primary Care

Author	Alastair Campbell/Helen Cooper/Edliz Kelly/Jade Thomas	**Date**	13/05/2025
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025

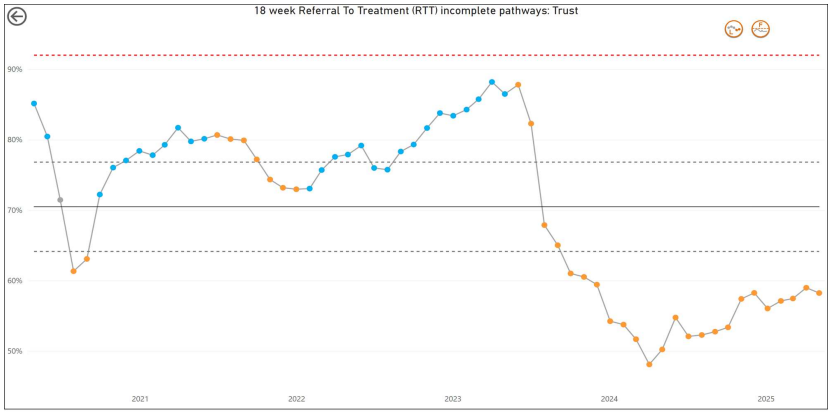
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
RTT Incomplete Pathways	%	58.23%	56.02%	57.09%	57.44%	58.97%	58.22%*	58.22%*
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

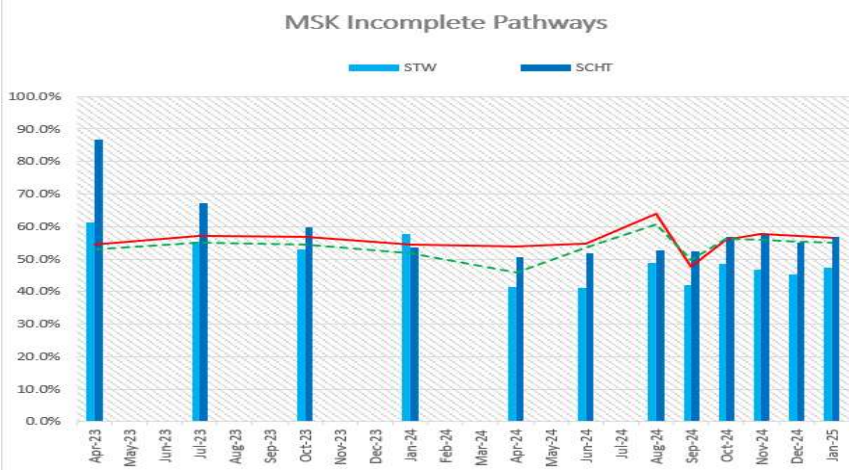
Trajectory	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
%	62.5%	58.0%	59.0%	60.0%	60.5%	61.0%	62.0%



MSK Incomplete Position

	Apr-23	Jul-23	Oct-23	Jan-24	Apr-24	Jun-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
STW	61.2%	55.3%	53.1%	57.6%	41.3%	41.2%	48.7%	42.0%	48.4%	46.7%	45.2%	47.2%
SCHT	86.8%	67.2%	59.7%	53.6%	50.7%	51.9%	52.7%	52.4%	56.7%	57.4%	55.10%	56.8%
National	54.4%	57.0%	56.8%	54.5%	54.0%	54.6%	63.8%	47.7%	56.0%	57.6%	57.1%	56.5%
Regional	53.0%	54.9%	54.3%	51.9%	45.8%	53.6%	60.7%	49.8%	56.2%	55.9%	55.2%	55.0%

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 its associated performance against RTT overall 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 decreased by approx 0.7% with the position currently being unvalidated.

Improvement in recovery has been seen since December and further improvement is expected now that the TeMS Orthopaedic service has been transferred to SaTH (closed clock FU's left to be transferred).

Factors impacting on the reduction seen between March and April will relate to the TeMS transfer with the majority of backlog 18+ patients being trasnferred to SaTH in March and the under 18 weeks being transferred in April. MBI validation has also potentially impacted with circa 600 patients being removed from the MSST pathway, again the backlog would have been prioritised with under 18 weeks to follow.

Internally there has been focus on recovering to the 18 week position however prioritisation has been around high week waits in line with national guidance. New guidance was published in January 2025 (Reforming Elective Care for Patients) which details the requirement for 65% by March 2026 and 92% March 2029. At the action plan workshop the above ongoing trajectory and plan to achieve the mandated targets in line with the Reforming Elective Care. Whilst we are currently slightly behind trajectory there remains confidence that 65% by the end of March 2026 is achievable.

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) 18-20 Weeks Improvement of 12 weeks
CT 9-10 weeks Improvement of 4 weeks
Ultrasound 7-8 Weeks Improvement of 25 weeks
Ultrasound Injection 38-40 Weeks Improvement of 2 weeks
X-ray 10-11 Weeks Deterioration of 3 weeks

The date for transfer of orthopaedics has paused 3 times locally to support system pressures. The initial plan was to transfer April 2024. It has now been agreed at the system Planned Care Delivery Group and MSK Board to support full transfer by June 2025.This transition has progressed with all new referras going directly to SaTH and a full validation excercise completed. The transfer of TeMS Orthopaedic patients started in March and circa 500 patients on the RTT pathway have been transferred to SATH. Full transfer including non-RTT and follow-up patients will likely be completed in June 25. Progress is reported weekly through the Tier 1 system calls to gain NHSE endorsement to ensure this time frame is enacted and a system wide task and finish group is in place weekly.

APCS and GA Dental continue to make progress with reducing the number of patients at the top end of the pathway with no patients waiting above 41 weeks.

Community Hospital Outpatients has a number of patients across the waiting list however the highest week waits are continuing to reduce with only 2 patients now waiting above 52 weeks. There are ongoing challenges with consistent capacity being provided across all SLA with the acute Trust, particularly seen within ENT, Respiratory and Gynaecology. Diagnostic delays has an impact on these services in community outpatients too. 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.

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 this has been further delayed. A proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. **New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 800 patients transferred to SATH with the remaining patients to be transferred by June 25.**
Align the demand and capacity findings to the current workforce model and revise a workforce plan taking into consideration current system wide configuration of resource	Feb-25	Apr-25	Complete	Arrange a workshop to share findings with BI, Ops, clinical leads and workforce to agree next steps Delay in presenting to MSST as awaiting final capacity data from all MSST specialties. **Presented in April to MSST OPs with initial findings confirming the main issue remains the backlog rather than workforce model. BI colleagues to attend in June to further review.**

Action	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). **Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.**
	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	Complete	Clinical Lead has now agreed with SaTH to utilise Lofthouse with plans being worked up and start date of April 25. 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. Conversations ongoing with provider colleagues re final sign off for SLA's but capacity is now stable and perfromance is steady with no detrimental imapct on the perfromance.
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.
	MBI validation exercise of the MSST waiting lists	Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to provide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.	Mar-25	Jun-25	On Track	MSST working with 18 weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.
	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.

Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/05/2025
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025

**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*

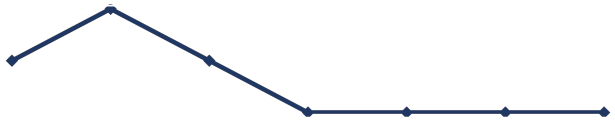
Exception Report - Action Plan

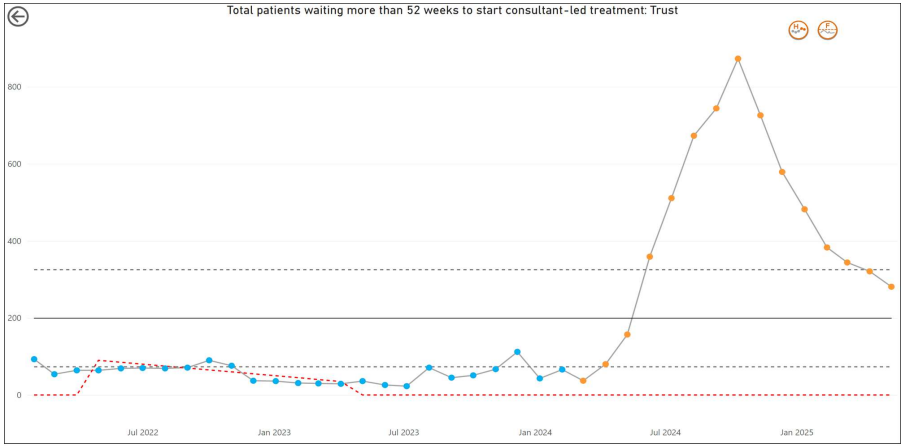
Total patients waiting more than 52 weeks to start consultant-led treatment

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
RTT 52+ week waits	Number	579	482	383	344	321	281*	281*
	Target	0	0	0	0	0	0	0

Trajectory	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Number	150	300	150	0	0	0	0





Reason for performance gap:	This is the seventh consecutive month demonstrating improvement across the 52-week cohort. The initial aim was to ahcieve zero 52 weeks by the end of March. Due to a inability to secure the additional capacity via a locum APP required to support MSST this has not been possible. The delay in TeMS Orthopaedics has equally impacted on capacity to manage this recovery. The trajectory has been reivewed and revised with the aim of implementing additional capacity for Level 3 MSST via superclinics that will then support zero 52 weeks by the end of May 25. In terms of reportable RTT services there remains 0 52 week waits in APCS and Dental. The 52 week cohort therefore now only applies to Community Outpatients and MSST with the majorty sitting within MSST. Prioritisation of long waits has been the key focus nationally and is reported at the weekly Tier 1 NHSE call.				
		Start Date	**End Date**	**Status**	**Outcome**
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. **New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SATH with the remaining patients to be transferred by June 25.** **There are now no 52+ week waits.**

Action Plan	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Dec-24	Off Track	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). **Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.**
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.
	MBI validation exercise of the MSST waiting lists		Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to provide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.		Mar-25	Jun-25	On Track	MSST working with 18weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

**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*

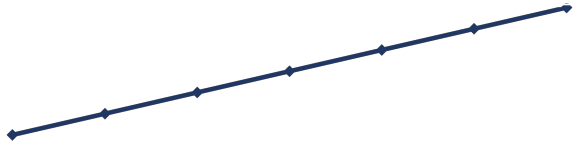
Exception Report - Action Plan

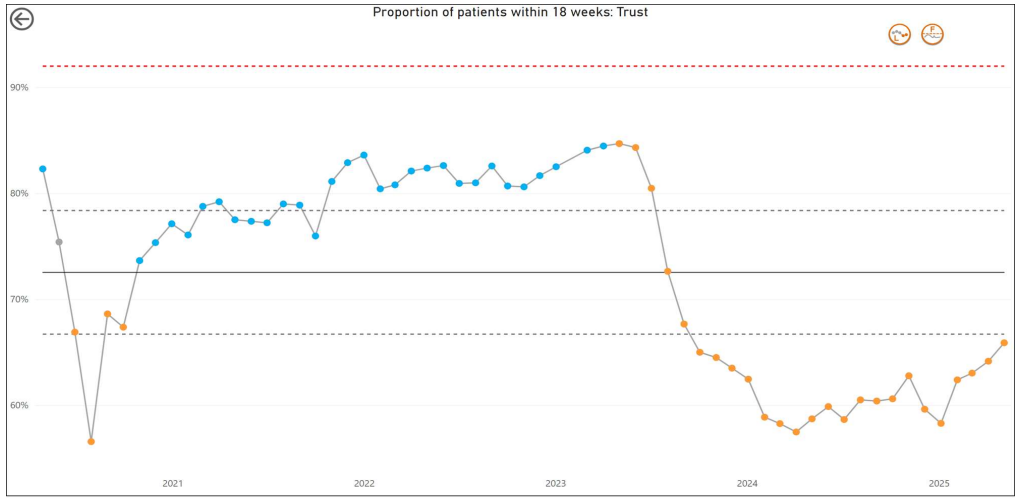
Proportion of patients within 18 weeks

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of patients within 18 weeks	%	59.62%	58.28%	62.39%	63.02%	64.15%	65.89%	65.89%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
%	61.5%	65.0%	65.5%	66.0%	66.5%	67.0%	67.5%	68.0%





Reason for performance gap:	Performance has improved with a 1.74% increase which is ahead of trajectory. 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. One of the 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 although this is now stabilising. 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 has been implemented to modernise the model with enhancing Specialist Nursery Nurses, to support scheduling of growth skills assessments. This will then support productivity in the team and ensure the limited paediatric resource is best utilised. A locum has commenced in Dec 24 to undertake Education, Care and Health Plans to reduce the waiting list and support the SEND agenda. Following a successful round of recruitment a Paediatrician has now been appointed has commenced. Successfull rectuitment to a speciality doctor post sees further addition clinical capacity to the team in May 25. Dental continues to have patients waiting above 18 weeks but improvement has been seen 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 progressing 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, Respiratory and Gynae with the teams focusing on reducing and mitigating the longest waiting patients on the pathways. There are other services which contribute to not meeting this performance target such as APCS, CNRT, LAC, Specialist Nursing Diabetes - Adults, Bridgnorth Hospital Day case, Adult Physio, Paediatric Physio, Community Children's Nursing and Paediatric Continence

		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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SATH with the remaining patients to be transferred by June 25.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	Complete	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway. Transition arrangements have started with full transition by end of March. Neuropsychologist started on 2nd April.
	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	On track	Recruitment of locum and enhancement of triage and waiting list has started. Extended additional capacity on the advice line until August 2025. The triage/validation has now started and is well underway but due to the size of the list the end date has been extended to June 25.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	Complete	Workshop with all SLT's scheduled in March to progress a consistent plan and approach.
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Procurement exercise complete and a further round of funding is available to repeat outsourcing of 70 further appointments. Impact will be seen by May with 0 children then waiting over 52 weeks. End date extended to June due to increase in assessments from 10 to 70
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.
	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	Complete	Clinical Lead has now agreed with SATH to utilise lofthouse with plans being worked up and start date of April 25. 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. Conversations ongoing with provider colleagues re final sign off for SLA's but capacity is now stable and perfromance is steady with no detrimental imapct on the perfromance.
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	Complete	New Paediatrician commence in post, New locum started Dec 24, service review is planned and recruitment of nursery nurses has been completed. Job planning for all paediatricians also in place to review current plans in line with newly published guidance. New speciality doctor to commence May 2025 to increase capacity. Improvement seen month on month with a 3% increase from Mar to April.
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.

	MBI validation exercise of the MSST waiting lists		Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to prpvide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.		Mar-25	Jun-25	On Track	MSST working with 18weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

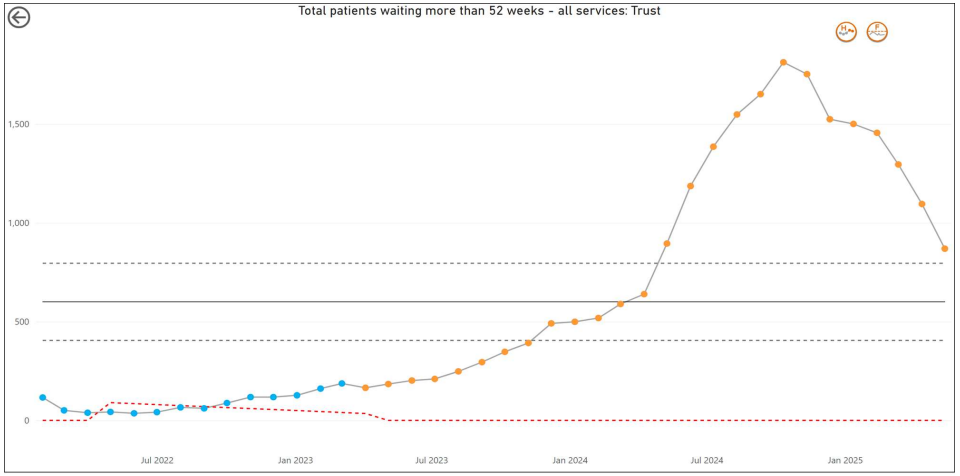
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
52+ Week waits - All services	Number	1524	1500	1455	1295	1095	869	869
	Target	0	0	0	0	0	0	0

Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Number	1200	769	669	569	469	369	269



Reason for performance gap:	The reduction of 52 weeks is on track with trajectory showing further improvement this month and ahead of 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 Community Paediatrics with the assumption that this will remain. CNRT 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. A substantive Neurposychologist started in the service in April 25 with high week wwaits reducing more quickly. 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 implementation of superclinics due within May/June. 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, however mitigation is in place with locums and active recruitment. There are 92 children waiting to be seen at 52 weeks or above this is an decreasing picture (8 less from last month). All children waiting longer than 52 weeks in Community Paediatrics are attributable to Children waiting for Schedule of Growth Skills (SOGS) appointments. This had been due to the decreased capacity of our Specialist Nursery Nurse Team and reduced admin capacity to support with managing clinics and validation. These vacancies gone through successfull recruitment. There are regular meetings with the team to review the waiting list and clinical priorities, as well as planned start dates for the new speciality Doctor (May 25) increased capacity moving forward to continue to reduce the 52 week cohort. CDC (Child Development Centre) is currently holding 59 children above 52 weeks, Locum Paediatrician in place to support recovery. Nursery Nurses continuing to support assessment processes. The trajectory for this service was due to demonstrate 0 52 weeks by July 25. Part of this was reliant on a third party to support however delays in the procurement process has adversely impacted the recovery plan by 3 months. Current forecasting of performance shows that improvements will commence from April with a plan to reduce month on month and achieve 0 52 weeks by July. Speech and Language therapy have also seen an increase in over 52 weeks and now have 93 children which has increased from March. 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. The service trajectory plans for 0 52 weeks by August. There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients, Community Nursing, Community Childrens Nursing, Podiatry, 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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SATH with the remaining patients to be transferred by June 25.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	Complete	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway. Transition arrangements have started with full transition by end of March. Neuropsychologist started on 2nd April.
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Procurement exercise complete and a further round of funding is available to repeat outsourcing of 70 further appointments. Impact will be seen by May with 0 children then waiting over 52 weeks. End date extended to June due to increase in assessments from 10 to 70
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	Complete	New Paediatrician commence in post, New locum started Dec 24, service review is planned and recruitment of nursery nurses has been completed. Job planning for all paediatricians also in place to review current plans in line with newly published guidance. New speciality doctor to commence May 2025 to increase capacity. Improvement seen month on month with a 3% increase from Mar to April.
	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	On track	Recruitment of locum and enhancement of triage and waiting list has started. Extended additional capacity on the advice line until August 2025. The triage/validation has now started and is well underway but due to the size of the list the end date has been extended to June 25.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	Complete	Workshop with all SLT's scheduled in March 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	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.
	MBI validation exercise of the MSST waiting lists	Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to prpvide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.	Mar-25	Jun-25	On Track	MSST working with 18weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.

	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.
Author	Alastair Campbell/ Helen Cooper / Mark Onions/Gemma McIver	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

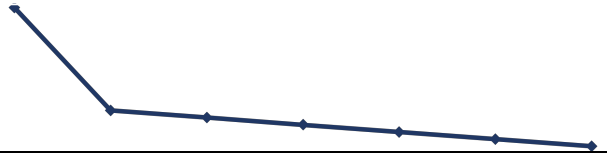
Exception Report - Action Plan

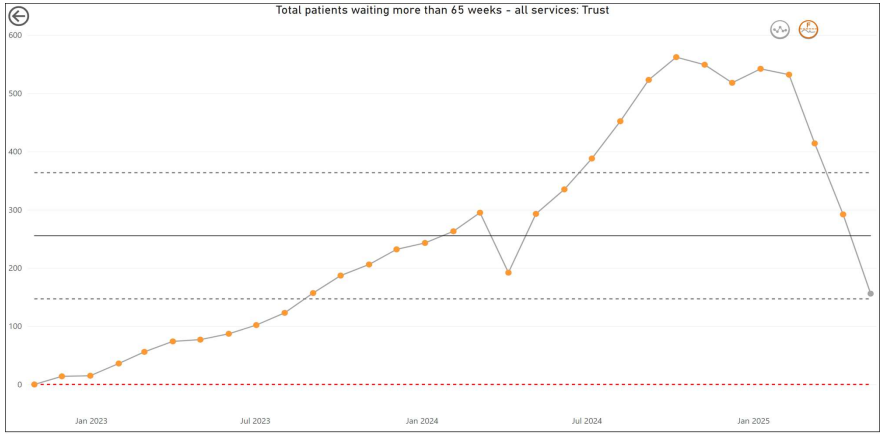
Total patients waiting more than 65 Weeks – All services

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

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
65+ Week waits - All services	Number	518	542	532	414	292	156	156
	Target	0	0	0	0	0	0	0

Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Number	425	136	116	96	76	56	36





Reason for performance gap:	Performance continues to improve ahead of trajectory. SLT have achieved zero 65 week waits during March. Wheelchairs have 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 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. The service has succesfully recurited and a new subtantive neuropsychologist has started in April providng an increase in capacity available. 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 an improvement in the 65 week wait position for Community Paediatrics with 35 children waiting. These are all in relation to children waiting Schedule of Growth Skills (SOGS) appointments which the enhanced nursery nurse workforce will continue to support the recovery of this position long term. CDC (Child development Centre) has increased from 7 to 11 65 week waits in April, however plans are being worked up for the bank holida/half term period to capture parent/schildrens in the shcool holidays. There are other services which contribute to not meeting this performance target such as, Community Hospital Outpatients.

		Start Date	End Date	Status	Outcome
Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SATH with the remaining patients to be transferred by June 25. No patients at 65+ now for TeMS.
	Transition from Circle to in house provision to be completed	Jan-25	Feb-25	Complete	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway. Transition arrangements have started with full transition by end of March. Neuropsychologist started on 2nd April.
	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	On track	Recruitment of locum and enhancement of triage and waiting list has started. Extended additional capacity on the advice line until August 2025. The triage/validation has now started and is well underway but due to the size of the list the end date has been extended to June 25.
	SLT to complete demand and capacity modelling across each element of the pathway	Jan-25	Mar-25	Complete	Workshop with all SLT's scheduled in March to progress a consistent plan and approach.
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Procurement exercise complete and a further round of funding is available to repeat outsourcing of 70 further appointments. Impact will be seen by May with 0 children then waiting over 52 weeks. End date extended to June due to increase in assessments from 10 to 70
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Apr-25	Complete	New Paediatrician commence in post, New locum started Dec 24, service review is planned and recruitment of nursery nurses has been completed. Job planning for all paediatricians also in place to review current plans in line with newly published guidance. New speciality doctor to commence May 2025 to increase capacity. Improvement seen month on month with a 3% increase from Mar to April.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.

	MBI validation exercise of the MSST waiting lists		Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to prpvide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.		Mar-25	Jun-25	On Track	MSST working with 18weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

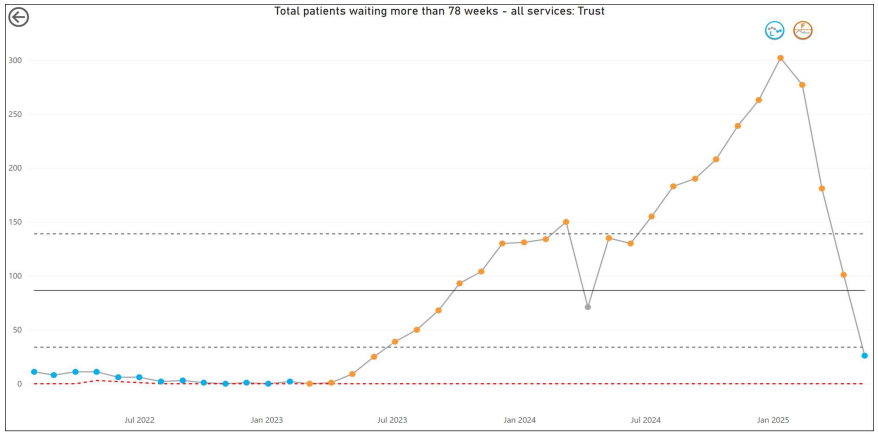
Exception Report - Action Plan

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
78+ Week waits - All services	Number	263	302	277	181	101	26	26
	Target	0	0	0	0	0	0	0

Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Number	225	21	16	11	6	1	0



Reason for performance gap:	The 78 week position has improved this month ahead of trajectory. 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. 4 children within children's services align to 78+ cohort and all have appointments to be seen in May or early June. Unfortunately the 0 78 week waits by January has not been achieved due to prioritisation of clinically urgent referrals. This is now planned to recover by end of June. 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 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. The service has succesfully recurited and a new subtantive neuropsychologist has started in April providng an increase in capacity available. 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	Complete	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 proposal was supported through Planned Care Delivery Group and MSK Board in January with assurances that completion will be delivered by April 25. A communication release has been made by ICB to support this. New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer has started with circa 500 patients transferred to SATH with the remaining patients to be transferred by June 25.

Action Plan	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Dec-24	Off Track	The digital systems proposed were My Recovery and Strata to support MSST waiting list management. Initial implementation date October this has been extended to March for My Recovery with plans in place with the operational and clinical team to commence training and roll out through February. Delays were attributable due to digital and operational capacity and competing priorities aligned with the MSK programme (particularly concentrating energy and resource on transfer of orthopaedics). Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. My Recovery was implemented late March 25 with plans to go live with STRATA in Q1 25.
	Transition from Circle to in house provision to be completed		Jan-25	Feb-25	Complete	Job planning arranged for psychologist and clinic utilisation exercise commenced to ensure on going productivity for psychology pathway. Transition arrangements have started with full transition by end of March. Neuropsychologist started on 2nd April.
	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	Complete	Operational leads through MSK transformation programme have linked with SaTH, who have successfully used MBI validators. A waiver has been signed to implement MBI. This tool will validate and ensure data quality issues are removed to support a reduced backlog and provide learning moving forward. TeMS Orthopaedics prioritised and completed 11th March with MSST completed in April.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	On Track	The initial findings of D&C have demonstrated that level 3 profiling is now more in line with original assumption. Therefore utilising APP locum in line with an enhanced triage model led by RJAH will focus on reducing legacy and will be a short term intervention.
	MBI validation exercise of the MSST waiting lists		Mar-25	Apr-25	Complete	After successful validation and completion of the TeMS waiting lists, MBI started in Mar reviewing the MSST waiting lists to ensure accurate lists and this was completed in April 25.
	MSST team working with insourcing company to prpvide additional capacity to support recovery of MSST level 3 backlog with a focus on superclinics.		Mar-25	Jun-25	On Track	MSST working with 18weeks to scope potential for an additional 8 superclinic sessions. This would potentially equate to an increase of 1500 new appointments.
	CDC and Community Paediatrics to review of factors affecting utlisation and booking horizons		Mar-25	May-25	Complete	Job planning completed for Comm Paeds which has supported an increase in activity and admin processes are being reviewed with a shift in responsibility.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	13/05/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025			

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Proportion of patients within 6 weeks	%	0.00%	0.00%	35.71%	100.00%	100.00%	75.00%	75.00%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Reason for performance gap:	The service continues to be performing well overall and the percentage of patients booked within 6 weeks this month is 75%. The drop this month is attributable to a patient that required additional information provision from primary care prior to their assessment. The lower numbers in the service currently create a view of a larger percentage drop than the context provides.The above KPI relates to the number of patients seen within 6 weeks and therefore will not account for the patients currently waiting although currently we have 4 NP's awaiing assessment and 3 have booked appts that will have them seen by week 3 of their total waiting time. The percentage is likely to continue to 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. More recently, this has been due to team staff sickness and patient choice as well as patient cancellations due to illness. We appreciate DNA's need to be managed carefully and are done so taking into consideration the circumstances and symptomology of these patients which do include mind fog, forgetfulness and overwhelming fatigue.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Implement SMS appointment reminders	Mar-25	May-25	On track	Letters are being reviewed to include the nescessary opt out statement. Once complete the SMS reminder setup can be established
Author	Alastair Campbell	**Date**	13/05/2025		
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025		

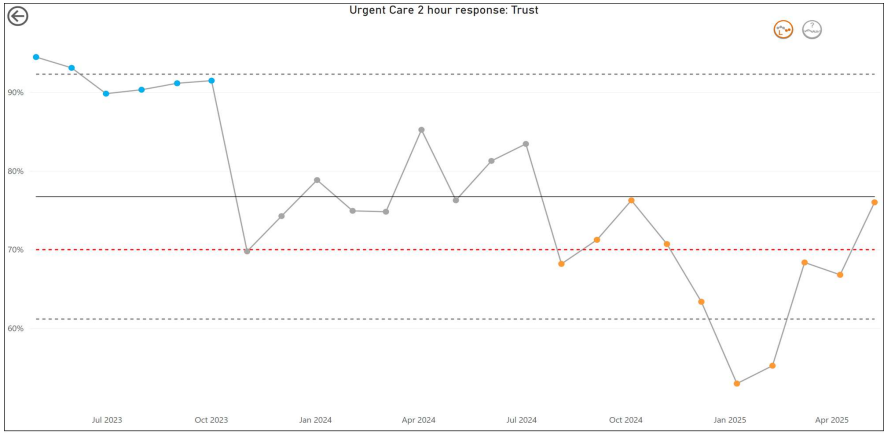
Exception Report - Action Plan

Urgent Care 2 hour response

The percentage of patients referred for an urgent care appointment who were seen within 2 hours

KPI Description	Latest 6 months	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	YTD
Urgent Care 2 hour response	%	63.38%	52.99%	55.25%	68.37%	66.81%	76.02%	76.02%
	Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

Trajectory	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%



Reason for performance gap:	Current performance is above the national 2-hour target, exceeding 70%. The decline in peformance during Summer was associated with data quality challenges. As part of the alternmatives to ED system workstream there was an increase in demand aligning to demand and capacity and how we coded our response times. Even when we did not hit the national target,100% of activity was responded to in 4 hours. The rejection rate has also been consitently low. We have worked with NHSE as recording against 2 hours criteria has been a national challenge and with an internal improvment plan we can now demonstrate a recovery.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	To arrange a meeting with the UEC Operations and Business Intelligence Lead from NHSE to get their advice on recording rejected referrals due to clinical capacity in the CSDS.	Mar-25	Apr-25	Complete	It is recommended by NHSE to track rejections due to clinical capacity in local systems for service planning and improvement. The UEC Operations and Business Intelligence Lead for NHSE has requested the national team to consider including clinical capacity as a rejection reason in the fast data flow (FDF).
	To confirm the ICB service review date, outcome and recommendations re future commissioning intentions on emergency falls since the pilot EMED project ended April 2025.	May-25	Jun-25	On track	Awaiting response from ICB re the named commissioner leading on project evaluation and outcomes
	Embed a validation process to review information for submission on weekly report for CSM aside from the daily DQ report to team leads.	May-25	Jul-25	On track	Data quality report are being sent to Team leads on daily basis to action data quality issue as they arise. Final validation via CSM and UEC leads prior to submission
	Productivity review for UCR, data review of service contacts versus establishment to meet the demand of the service.	May-25	Jul-25	On track	Data analysis will provide an insight to the current activity v plan, workforce v demand and enable a drill down of the UCR demand and capacity based on contract value / workforce/activity
	Task and Finish group to be mobilised to review the operational processes and working practices between Care Home MDT and UCR to support improve in care home referrals to UCR services and 2 hour UCR response times, PDSA to be completed	Jun-25	Aug-25	On track	PDSA recommendations to be implemented to support the 2 hour response times for UCR
Author	Sarah Robinson / Edliz Kelly		13/05/2025		
Accountable Officer Approval	Claire Horsfield	**Date**	19/05/2025		

Shropshire Community Health NHS Trust

Month 1 2025/26 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	5 June 2025
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	28 May 2025
Paper Reviewed by:	Resource and Performance Committee	**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 at month 1 and is for action and assurance.

2. Executive Summary

2.1. Context

The Trust's 2025/26 Income and Expenditure (I&E) plan is to achieve a surplus of £2,000k; this reflects the financial plan submission to NHS England (NHSE) on 30 April 2025. The Trust's 2025/26 capital expenditure plan is £4,975, which comprises operational capital of £2,818k and IFRS 16 lease capital of £2,157k.

This paper summarises the Trust's financial performance for the period ended 30 April 2025 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £68k adjusted surplus for month 1 compared to the planned surplus of £74k, which is a small adverse variance of £6k.

Key areas for consideration, at this early stage of the financial year, are:

- **Agency -** spend was £247k in April, this is favourable to plan by £35k. However, agency spend is planned to reduce to £228k per month from month 7 which will require a sustained reduction from current levels. Agency remains a key area of external scrutiny, and the Agency Scrutiny Group is focused on reducing agency spend as far as possible, without compromising patient safety. **Agency usage will need to remain within planned levels to deliver the financial plan.**

- **Bank pay** spend was £394k in April, £144k adverse to plan. The overspend is due to higher level of vacancies than planned and staffing of unplanned escalation beds. Bank pay will also be a key area of external scrutiny this financial year, and the Vacancy Control Pannel is focused on reducing Bank spend as far as possible, without compromising patient safety. **Bank usage will need to remain within overall planned pay levels to deliver the financial plan.**

Month 1 2025/26 Financial Performance

- **CIP** delivery at month 1 was £352k, £10k favourable to plan due to overperformance on non-recurrent schemes. Delivery of the Trust's £5,359k annual cost reduction **t**arget for 2025/26 remains a significant financial risk. 29% of the full year target is rated as high risk in terms of delivery and teams are working at pace to de-risk schemes and deliver the CIP target. **To deliver our planned financial position for 2025/26 we must deliver our CIP target in full.**

- **Cost pressures –** there are ongoing cost pressures in a small number of services, plus as a result of opening unplanned escalation beds; teams are developing plans to mitigate these pressures. **The Trust will need to mitigate all current and arising cost pressures during the year to deliver the 2025/26 planned financial position**.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 1 is a surplus of £68k compared to the planned surplus of £74k, which is an adverse variance of £6k.
- **Recognise** that overall pay costs must remain within planned levels to ensure we deliver our financial plan, the key to which is containing bank and agency spend within our target for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m although 29% of identified schemes are rated as high risk in terms of delivery.
- **Acknowledge** that there are ongoing cost pressures in a small number of areas plans are being developed to mitigate these pressures as far as possible.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.

Month 1 2025/26 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 I&E 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)	M01 Plan	M01 Actual	M01 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast	Annual Variance
(Surplus)/ Deficit In Year	(74)	(68)	6	(74)	(68)	6	(2,000)	(2,000)	0
Underlying Position	13	(18)	(31)	13	(18)	(31)	(932)	(932)	0
Agency Expenditure	282	247	(35)	282	247	(35)	2,939	2,939	0
Bank Expenditure	250	394	144	250	394	144	2,736	2,736	0
Cost Improvement Programme	342	352	(10)	342	352	(10)	5,359	5,359	0
Capital Expenditure	0	241	0	0	241	0	2,818	2,818	0

3.2. Adjusted Financial Performance – adverse variance to plan £6k

The adjusted financial position for month 1 is a surplus of £68k compared to the planned surplus of £74k which is an adverse variance of £6k. Table 1 summarises the position. The underlying position is set out in section 3.2.12.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(10,663)	(10,677)	(15)
Expenditure excl. adjusting items	10,589	10,609	20
Adjusted financial performance total	**(74)**	**(68)**	**6**
Adjusting items	10	6	(4)
Retained (surplus) / deficit	**(64)**	**(62)**	**2**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 30 April 2025

3.2.1. Income – favourable variance to plan £15k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System Income	(8,384)	(8,387)	(3)
Non system Income	(2,279)	(2,290)	(12)
Total Income	**(10,663)**	**(10,677)**	**(15)**

Table 2: Income Summary as at 30 April 2025

Month 1 2025/26 Financial Performance

System income comprises of agreed block income, variable income linked to the delivery of elective activity plus non-recurrent funding from Shropshire, Telford and Wrekin (STW) ICB.

Data for elective activity is not yet available; therefore, income is assumed to be in line with plan for month 1 reporting.

3.2.2. Expenditure – adverse variance to plan £17k

Table 3 shows a summary of expenditure by key categories.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	7,273	7,095	(178)
Bank	250	394	144
Agency	282	247	(35)
Total Pay	**7,805**	**7,736**	**(69)**
Supplies & Services Clinical	1,026	1,056	30
Prison Escorts and Bedwatch	22	28	6
Drugs	119	120	1
Premises	811	778	(33)
Travel	139	123	(16)
Other	281	437	156
Non-Pay	**2,397**	**2,542**	**144**
Trust-wide Central Charges	396	337	(59)
Total Non-Pay	**2,794**	**2,879**	**85**
Total Expenditure	**10,599**	**10,615**	**17**

Table 3: Expenditure Summary as at 30 April 2025

3.2.3. Pay – favourable variance to plan £69k

The overall pay position is a favourable variance of £69k. This is due mainly to pay underspends on our substantive vacancies. The substantive pay underspend is partially offset by Bank usage which is £144k overspent; Bank staff (paid at substantive rates) are utilised to cover vacant shifts wherever possible, to avoid the use of agency staff.

Agency spend was £247k in April, £35k favourable to plan. This represents 3.2% of total pay compared to plan of 3.6%. The underspend is due mainly to the skill mix of agency staff utilised being weighted towards the lower pay scales. The target for the Trust in 2025/26 is £2,939K, 3.2% of the Trust's total pay budget.

April's pay costs include £34k (Bank £11k, Agency £23k) to cover unfunded inpatient escalation beds. This overspend is currently offset by underspends elsewhere within the position, but a mitigation is required to ensure that this unplanned cost does not result in a risk in relation to delivery of our financial plan.

The vacancy rate in April 2025 was 9.83% which equates to 177 WTE vacancies, however it should be noted that temporary staffing of 144 WTE (Bank 101 WTE, Agency 43 WTE) were utilised during the month the majority of which covered clinical vacancies.

Month 1 2025/26 Financial Performance

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 £85k

Further budget realignment for CIP will be finalised in month 2 which will partly reduce the non-pay overspend.

However, there are continuing cost pressures in Prison Healthcare and Rehabilitation and Recovery Units budgets which are the key reasons for the non-pay overspend. Plans to mitigate these overspends are being developed and will be reported to the Resource and Performance Committee for oversight.

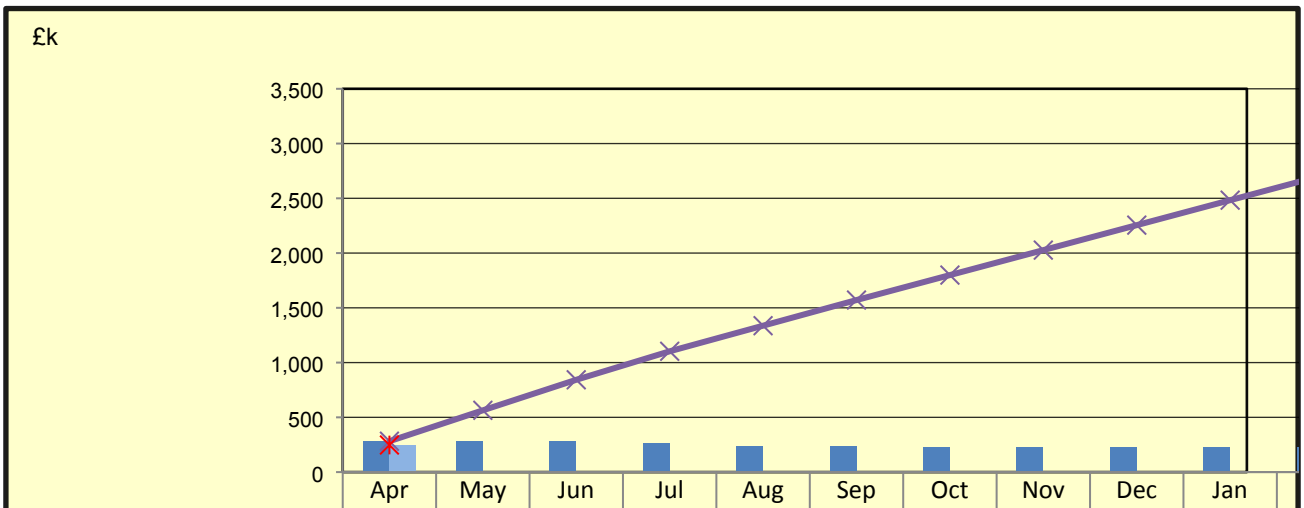
Budget realignment for CIP is to be finalised in month 2 and this will impact variances in the 'Other' and 'Trust-wide Central Charges' categories.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £35k

Table 4 shows agency spend is £247k compared to the plan of £282k, which is a favourable variance of £35k. The underspend is due mainly to the skill mix of agency staff utilised being weighted towards the lower pay scales. Month 1 agency spend includes £23k to cover unfunded escalation beds at Whitchurch Inpatient Ward and Telford RRU, and we are working with system partners to find a clinically safe solution that will remove this cost pressure.

Agency cost represents 3.2% of the Trust's total pay against a plan of 3.6% for April.

The agency target for the year is £2,939k with a spend profile that reduces to £228k per month from month 7. To achieve our agency target a sustained reduction from current levels will be required by month 7, noting that this covers the Autumn and Winter period.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
In Month Plan	282	282	279	260	234	234	228	228	228	228
In Month Actual	247									
Cumulative Plan 25/26	282	564	843	1,103	1,337	1,571	1,799	2,027	2,255	2,483
Cumulative Actual 25/26	247									
In month WTE	43									

Table 4: 2025/26 Agency and Locum Expenditure

Month 1 2025/26 Financial Performance

3.2.6. Cost Improvement Programme 2025/26

The Trust's CIP target for 2025/26 is £5,359k comprising £3,574k of recurrent savings and £1,785k of non-recurrent savings. This value is 4.4% against our opening recurrent cost base or 5.3% when we take account of the service areas upon which we cannot apply a CIP.

Detailed reporting of delivery and the forecast against the target will commence in month 2, and this month's update presents the current summary position only.

Table 5 shows overall CIP delivery of £352k in April which is £10k favourable to plan.

Recurrent delivery in April is £220k, which is £11k adverse compared to the recurrent plan of £231k. However, this is mitigated by the Trust delivering £21k of non-recurrent CIP in excess of the non-recurrent CIP target.

	Month 1 Plan YTD £k	Month 1 Actual YTD £k	Month 1 Variance YTD £k
Recurrent	231	220	(11)
Non-recurrent	111	132	21
TOTAL	**342**	**352**	**10**

Table 5: 2025/25 CIP delivery as at 30 April 2025

The CIP plan becomes increasingly challenging as the monthly savings value increases each month for the first 7 months. It is therefore vital that we do not fall behind the plan in any month as recovering this position will be difficult.

We have put in place an executive-led Productivity and Efficiency Oversight Group which reports to the Financial Recovery Group. The Group's remit includes focusing on de-risking and delivery of the 2025/26 CIP programme at pace. All relevant CIP schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

3.2.7. Statement of Financial Position

The summarised Statement of Financial Position (SoFP) for period ended 30 April 2025 is shown in Table 6.

	31 Mar 25 Balance £k	30 Apr 25 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,878	42,729	(149)
Inventories	205	205	0
Non-current assets for sale	0	0	0
Receivables	3,068	6,037	2,969
Cash	27,074	25,430	(1,644)
Payables	(11,889)	(13,475)	(1,586)
Provisions	(3,981)	(3,981)	0
Lease Obligations on Right to Use Assets	(11,770)	(11,299)	471
TOTAL ASSETS EMPLOYED	**45,585**	**45,646**	**61**
Retained earnings	36,217	36,278	61
Other Reserves	9,368	9,368	0
TOTAL TAXPAYERS' EQUITY	**45,585**	**45,646**	**61**

Table 6: Statement of Financial Position (SoFP) as at 30 April 2025

Month 1 2025/26 Financial Performance

- Receivables (amounts we are owed) increased by £2,969k due mainly to some quarter 1 invoices yet to be paid
- Payables (amounts we owe) increased by £1,586k due mainly to movements in our deferred income
- Cash decreased by £1,644k as a result of the above changes.

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

The plan for 2025/26 is to spend £4,975k which comprises operational capital of £2,818k and IFRS 16 lease capital of £2,157k. These plans have been agreed with the ICS and submitted to NHSE as part of the Trust's financial plan.

In Month 1 actual spend was £241k compared to £0 spend in the plan. This is mainly due to LED lighting at Whitchurch. This is planned expenditure and forecast within our annual plan.

Table 7 sets out capital expenditure for year to date compared to our plan.

Capital Expenditure	Plan £000	YTD Plan £000	YTD Actual £000	YTD Variance £000
BAU Capex	2,818	0	241	241
IFRS 16 Leases	2,157	0	0	0
	4,975	**0**	**241**	**241**

Table 7: 2025/26 Capital Expenditure as at 30 April 2025

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.

3.2.10. Productivity

The Trust overall efficiency improvement target for 2025/26 is £7.1m, £5.4m of which is cash releasing CIP (referenced in para 3.2.6) and £1.7m is for non-cash releasing productivity improvements.

We have identified key areas that will be targeted to deliver productivity improvement, and we are at the early stages of developing delivery plans. The new fortnightly Productivity Development Group is focussing on completing productivity improvement plans to ensure that £1.7m has been identified for delivery in 2025/26. The Financial Recovery Group will also provide further oversight of all productivity schemes.

3.2.11. Underlying Financial Position

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

The underlying position at month 1 is a surplus of £18k which is £31k favourable to plan.

Month 1 2025/26 Financial Performance

The underlying position is planned to improve each month for the first 7 months due mainly to the profiling of CIP delivery. The months ahead will become increasingly challenging, therefore it is vital that we do not fall behind our recurrent plan in any month as recovering any shortfall will be difficult.

The non recurrent position is a surplus of £50k which is £37k adverse to plan due mainly to escalation costs and Prison Health cost pressures, which are assumed to be non-recurrent issues.

Table 8 shows the underlying and non-recurrent position for the month and full year.

	YTD Plan £k	YTD Actual £k	Variance £k	Annual Plan £k	Forecast £k	Variance £k
Recurrent/underlying (surplus)/deficit	**13**	**(18)**	**(31)**	**(932)**	**(932)**	**0**
Non-Recurrent (surplus)/deficit	(87)	(50)	37	(1,068)	(1,068)	0
Adjusted financial performance total	**(74)**	**(68)**	**6**	**(2,000)**	**(2,000)**	**0**

Table 8: 2025/26 Underlying Position as at 30 April 2025

This position will be reported each month, so the Board has sight of our recurrent position and any variances which affect this.

3.2.12. Forecast Outturn and Financial Risk

Detailed reporting on our forecast outturn will commence from month 3.

As at month 1 the Trust is reporting risks totalling £6,771k with full mitigation at this stage. Risks are summarised in Table 9.

Summary	High	Medium	Total
Additional cost	2,572	1,050	3,622
Excess inflation	0	0	0
CIP	1,233	1,102	2,335
Income	0	814	814
TOTAL	**3,805**	**2,966**	**6,771**

Table 9: 2025/26 Risk Summary as at 30 April 2025

Additional cost relates primarily to cost of growth not covered by productivity (£1.6m), potential pay pressures in relation to agency, escalation and national insurance cost increase (£1.5m) and cost & volume estates contract costs (£0.3m).

The CIP risk relates to 100% of the value of high-risk schemes (£1.2m) and 50% of the value of medium risk schemes (£1.1m) although we continue to de-risk this position, overseen through our Financial Recovery Group.

Income risk covers potential shortfall in Covid vaccination income (£0.5m) and elective income underperformance (£0.3m).

Whilst all risks are currently shown as mitigated, we will continue to assess these risks and our mitigations to update our forecast and the Trust Board, as necessary.

3.2.13. Monthly Monitoring Return to NHSE

Full monitoring returns to NHSE will resume from month 2 in line with the national timetable.

Month 1 2025/26 Financial Performance

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 1 is a surplus of £68k compared to the planned surplus of £74k, which is an adverse variance of £6k.
- **Recognise** that overall pay costs must remain within planned levels to ensure we deliver our financial plan, the key to which is containing bank and agency spend within our target for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m although 29% of identified schemes are rated as high risk in terms of delivery.
- **Acknowledge** that there are ongoing cost pressures in a small number of areas plans are being developed to mitigate these pressures as far as possible.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.

Estates Strategy Progress Update

Author:	Richard Best, Associate Director of Estates	**Paper date:**	05/06/2025
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	22/05/2025
Paper Reviewed by:		**Paper Category:**	Governance/Quality and Safety/Finance
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 an update on progress against the Trust's agreed Estates Strategy, and it provides information and assurance on the provision of a sustainable and safe estate.

2. Executive summary

The Trust's approved Estates Strategy runs from 2022/23 to 2027/28. The Strategy is reviewed annually to ensure it reflects and material changes in circumstances and to respond to demands.

The Strategy is based on seven objectives including: 'our estate as an enabler'; 'functional suitability' and 'value for money' in support of the Trust's commitment to Right Care, Right Place, Right People, Right Time.

Delivery of this Strategy is overseen through the Trust's Capital and Estates Group and the Resource and Performance Committee. Good progress is being made in relation to delivery of the agreed Strategy. The following areas underpin delivery of our Strategy and are therefore included within this update report:

- External cost and performance benchmarking. Available benchmarking demonstrates strong performance.
- Compliance. Continued improvement is evidenced through the use of external information.
- Changes in size, usage, and age profile. Our utilisation is improving, and the overall age of our estate is reducing.
- Ten year investment plan. Whilst capital resources are limited, we focus on the highest priority areas including backlog maintenance, our Green agenda and ensuring thriving community sites.
- National Trends. Lord Dharzi's report describes the national trends and capital expenditure restrictions and the NHS 10 year plan publication may result in changes to our own Strategy.
- Risks. Key risks include increasing maintenance costs due to the age and utilisation of our estate and limited access to capital funding.

2.3. Recommendations

The Board is asked to:

- **Acknowledge** the good progress to date towards delivery of our Estates Strategy
- **Consider** the assurances provided in relation to compliance and cost
- **Note** our Estates Strategy may require updating following publication of the NHS 10 year plan

3. Main Report

3. Introduction

The Trust's approved Estates Strategy runs from 2022/23 to 2027/28. The Strategy is reviewed annually to ensure it reflects and material changes in circumstances and to respond to demands. This report provides an update on progress against delivery of the current Strategy.

3.1. Delivery against Estates Strategy

Delivery of the Estates Strategy is overseen through the Trust's Capital and Estates Group and the Resource and Performance Committee.

The Strategy contains seven core objectives and good progress is being made across all areas. A summary of recent progress is contained within Appendix 1 of this report.

Examples of delivery are contained within the summary and key areas of improvement since the last update to the Trust Board which include vacation of a number of properties and optimising the use of our remaining estate.

3.2 Cost and Performance Benchmarking

The Trust continues to demonstrate strong performance in relation to the cost of its estate when compared to our Peer Groups as demonstrated through National Performance Reports such as the Estates Return Information Collection (ERIC) and Patient-Led Assessment of the Care Environment.

The cost of ShropCom's Estate and Facilities provision is £408/m2 which is 15% lower than our peer group average for the last 3 years and Appendix 2 includes further details.

Whilst most areas of benchmarking indicate strong performance, there are a small number of areas which suggest we have opportunity for improvement namely in relation to our space utilisation. This is a key area of focus through our Estates Optimisation Group and recent examples of improvements include: increasing utilisation by continuing to vacate sites: agreeing direct leases with landlords to reduce costs; and closer management of maintenance costs as the impact of more wear and tear increases.

In addition, reducing the cost of our estate supports delivery of the Trust's Cost Improvement Programme. Over the past two years, £385k has been safely delivered as a contribution towards our efficiency targets, with further plans in place for the coming year.

3.3 Compliance

The Trust's estate is 'Fit for Purpose', as defined in the National Premises Assurance Model (PAM) collections across England. This provides assurance to the Trust Board in relation to our estate and a summary position is included within Appendix 3.

This data demonstrates consistent improvements in our estate; in 2022 22% of our estates and facilities process were categorised as good and this has improved markedly to 58% in 2024. This improvement is a considerable achievement considering the age of our estate.

Whist our performance remains strong, there are of course areas of focus for the coming years, in particular in relation to our Soft Facilities Management. These include adhering to all Food standards regulations, implementing National Cleaning Standards and making improvements to Fire Safety procedures. These areas of focus also inform our estates plan.

3.4 Changes in Size, Usage and Age Profile

Optimising the use of our estate remains a key area of focus, as does reducing the overall age of our properties, where appropriate to do so. ShropCom has:

- ✓ Reduced our operating area by 3.8%, from 29,091 m^2 to 27,974 m^2 in 2024/25
- ✓ Improved utilisation of clinical space by 6.5%
- ✓ Reduced the number of properties from which we operate to 67, although as a community provider we remain focused on delivering services locally.
- ✓ Reduced the age of our estate; 20% of our estate is now less than 20 years old compared to 15% in 2022.

As noted previously within this report, the Trust remains focused on increasing space usage through our Estates Optimisation Group, which is well attended by clinical and operational leads.

3.5 10 Year Investment Plan

Our investment plans remain focused on developing modern, thriving community healthcare facilities across our localities, co-locating with partners where appropriate to do so.

Our capital funding is agreed with partners across Shropshire, Telford and Wrekin ICS, within the limits set by NHS England, and our focused investment of limited capital resources has resulted in improvements in compliance as noted earlier within this report. We also explore opportunities to access any available additional funding streams.

In addition to investing to improve compliance and reducing backlog maintenance requirements, we also invest in decarbonisation and have recently been successful in securing funding for the purchase and installation of additional solar panels. We are currently working with NHS England to further develop our Decarbonisation Plan.

3.6 National Trends

The findings of the Lord Dharzi report published in September 2024 describe the challenges in relation to the NHS estate, including its age and restricted capital funding. NHS England is expected to hold event in the Autumn to provide clarity on the national 10 year plan to inform future Estates Strategies.

In addition, STW's Estates and Physical Infrastructure Strategy remains under review, and it is reviewed each quarter at the System-Led Strategic Estates Group Meeting.

ShropCom will review its Strategy to ensure it aligns to both the System Strategy and the 10 year plan, when the information is published.

3.7 Risks

We continue to carefully manage with our estate. Key risks relate to the growing cost of maintenance due the age of the age of the estate and its increasing utilisation. Access to capital funding remains a risk and we await the publication of the NHS 10 year plan to assess if this may result in additional opportunities in relation to access to capital funding.

4. Recommendations

The Board is asked to:

- **Acknowledge** the good progress to date towards delivery of our Estates Strategy
- **Consider** the assurances provided in relation to compliance and cost
- **Note** our Estates Strategy may require updating following publication of the NHS 10 year plan

Appendix 1

Summary Progress against Shropshire Community Health NHST Trust Estates Strategy Objectives

Objective	Description	Progress

1. Estates as an Enabler	Clinical need will determine our estate.	**Headline: An increase in direct leases has reduced rental costs and enabled more flexible use of our estate**
		• Using direct leases:
		  ○ to enable the development of Children and Families service base to increase capacity for patient care
		  ○ to support the development of a Community Hub in Telford.
		  ○ to deliver increased activity for clinical services and co-location of teams.
		  ○ to enable co-location of our Digital team

2. Functional Suitability	Properties are maintained effectively to provide safe and fit for purpose environment.	**Headline: Estates management KPIs are consistently achieving over 90% compliance ratings** • £1.1m estates improvements during 2024/25 • NHSE and MPFT achieve over 93% of agreed KPIs, demonstrating our properties are safe and well maintained. • Management of the ShropCom Estate is informed by the national NHS Premises Assurance Model and data collection alongside national guidance, ensuring our estate is compliant for patients, staff and visitors
3. Sustainability	Ensuring our estate supports reducing its impact on the environment	**Headline: We self-generated 178 megawatt hours of electricity last year from our investment in solar panels** • Solar panels have been installed at Whitchurch, Bridgnorth Community Hospital and Hadley Health Centre and are generating green electricity. • Boiler and controls upgrade at Bridgnorth Community Hospital and Wellington Medical Practice to increase the efficient use of fuel and heating Controls upgrade at Bishops Castle Community Hospital. • Controls upgrade is planned for Whitchurch Community Hospital in 2025/26. • Installed LED lighting in Bishop Castle, Monkmoor and Halesfield to reduce the electricity demand with Whitchurch Community Hospital to be upgraded in 2025/26. • Further investment is planned this year for modern insulation and equipment to support ShropCom's Green plan.

4. Location	Review locations based on service needs	**Headline: Clinical and operational teams have influenced investment schemes of £1.1m in 2024/25** • Systematic reviews of our buildings are clinically and operationally led to ensure a focus on service need. • Proposals to change or update locations are managed via the Estates Optimisation Group (EOG) which include Clinical and Quality representatives. • Locations are reviewed to consolidate where necessary to increase capacity and access for patients across fewer, more modern, locations. • All proposed changes are subject to the outcome of a Quality & Equality Impact Assessment.
5. Flexibility	Work with clinical services to provide an estate that meets their service needs	**Headline: Three sites have been remodelled to respond to service user needs** • Our Estates Capital Investment Programme is reviewed with clinical leads to understand needs and prioritise. • Our Procurement process adheres to our SFIs and incorporates staff and service user views as appropriate. For example, improvements to layout of clinic and office space to accommodate co-location of teams in Bridgnorth.
6. Value for Money	Balancing clinical need, productivity, and cost	**Headline: External benchmarking shows the cost of our estate per square metre remains below the average cost of other community providers for the fourth year.** • Quarterly Contract Management Meetings are used to review and amend planned maintenance programmes to focus on statutory and mandatory requirements at each site. • Our capital investment approval process includes a Value For Money assessment for each proposal. Digital solutions are providing more options to improve the productivity of the estate. • All capital schemes are evaluated at the Capital and Estates Group with Clinical, Operational, Procurement, Finance and Estates team input.
7. Partnerships	Collaboration with internal and external stakeholders	**Headline: We are gaining value from working in partnership with other organisations.** • Our Estates lead worked with ST&W ICS estates leaders to develop the STW Infrastructure Strategy and prioritise investment. We remain fully connected to the One Public Estate work programme and have increased our leased space at Local Authority locations, recognising the benefits of co-location. • MPFT and NHSPS provide insight for estates planning from their experience across the NHS. Our Associate Director of Estates chairs the Healthcare Estates and Facilities Management Association for the West Midlands to promote closer working and integration across organisations.

Appendix 2

SCHT Estates Performance as per Model Health System between 31st March 2022 to 31st March 2024

Trust Type (ERIC)

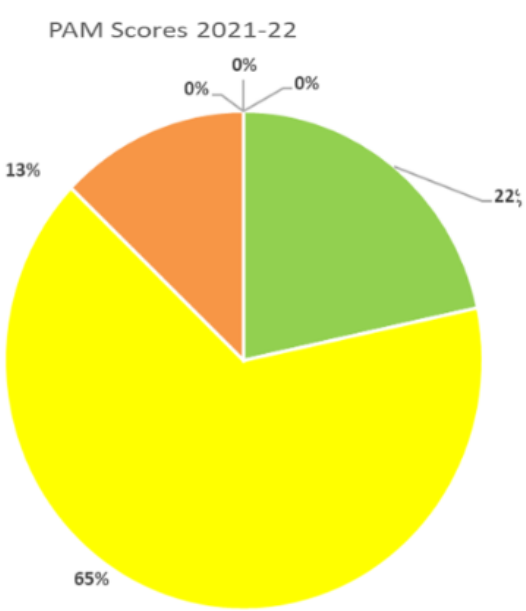
Date Period	2023/24		2022/23		2021/22	
Cost to Eradicate Backlog Maintenance	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Total backlog maintenance costs (£)	£5.46m	£9.25m	£3.10m	£3.29m	£3.55m	£2.59m
Total backlog maintenance (£ per m2)	£187.62/m2	£218.72/m2	£108.03/m2	£103.69/m2	£113.44/m2	£77.46/m2
Critical Infrastructure Risk	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Total critical infrastructure risk (£)	£2.94m	£3.97m	£2.05m	£867.02k	£2.78m	£538.12k
Critical infrastructure risk (£ per m2)	£100.97/m2	£106.08/m2	£71.34/m2	£29.35/m2	£88.96/m2	£21.91/m2

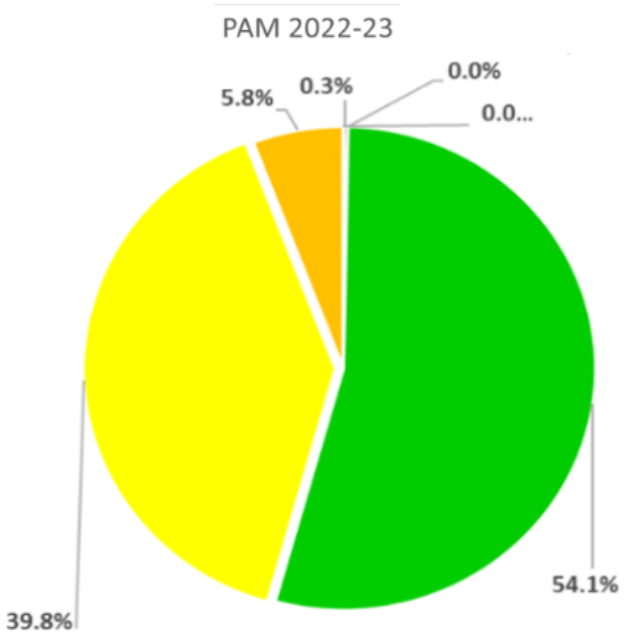
Date Period	2023/24		2022/23		2021/22	
Cost to Eradicate Backlog Maintenance	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Total backlog maintenance costs (£)	£5.46m	£9.25m	£3.10m	£3.29m	£3.55m	£2.59m
Total backlog maintenance (£ per m2)	£187.62/m2	£218.72/m2	£108.03/m2	£103.69/m2	£113.44/m2	£77.46/m2
Critical Infrastructure Risk	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Total critical infrastructure risk (£)	£2.94m	£3.97m	£2.05m	£867.02k	£2.78m	£538.12k
Critical infrastructure risk (£ per m2)	£100.97/m2	£106.08/m2	£71.34/m2	£29.35/m2	£88.96/m2	£21.91/m2

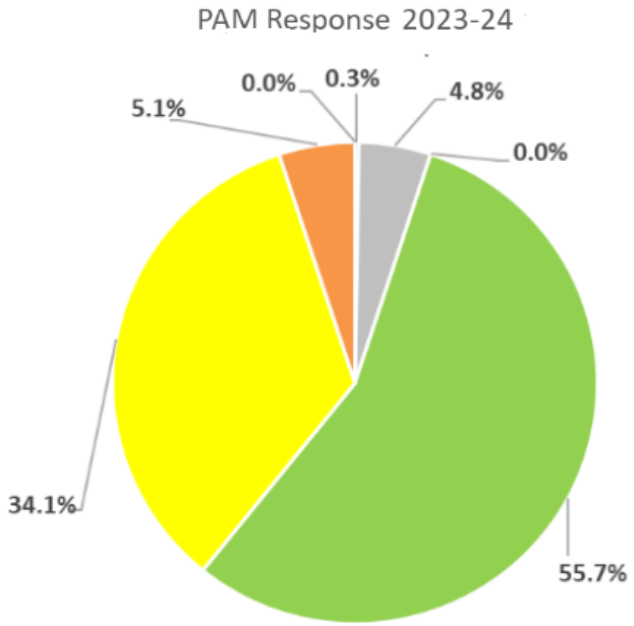
Date Period	2023/24		2022/23		2021/22	
Space usage - Clinical	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Amount of clinical space (%)	57.78%	64.72%	63.48%	64.07%	57.78%	64.72%
Space usage - Non-clinical	Provider value	Peer median	Provider value	Peer median	Provider value	Peer median
Amount of non-clinical space (%)	42.22%	35.28%	36.52%	35.93%	42.22%	35.28%
General administration space (%)	10.77%	7.63%	8.53%	9.72%	10.77%	7.63%

Appendix 3

Estates and Facilities Compliance as Demonstrated through the Premises Assurance Model







The pie charts summarise the improvements in the Premises Assurance Model scores over the last 3 years. Overall improvement is evident in all categories, noting there have been changes to the questions requiring a response.

1.	Outstanding
2.	Good
3.	Requires minimal improvement
4.	Requires moderate improvement
5.	Inadequate

Shropshire Community Health NHS Trust

2024/25 Operational Plan Delivery

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	05 June 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	26 May 2024
Paper Reviewed by:		**Paper Category:**	Planning
Forum submitted to:	Trust Board (Public)	**Paper FOIA Status:**	Full

Purpose of Paper

1.1. Why is this paper going to Resource and Performance committee and what input is required?

This paper provides an end of year performance update in respect of delivery of our 2024/25 Operational Plan which was approved by the Trust Board in June 2024.

2. Executive Summary

2.1. Context

Each year the Trust Board approves our Operational Plan which sets out our strategic priorities for the year ahead. These priorities are the key areas of focus for the entire organisation and describe to our patients, the public and our partners where we intend to focus our resources.

We monitor performance against our Operational Plan through our Committees throughout the year and our Board Assurance Framework considers the key risks in relation to delivery of these strategic priorities.

Our 2024/25 Operational Plan included 3 Strategic Objectives and 8 Strategic Priorities and set out an ambitious programme of delivery.

This update presents the outcomes in relation to delivery of our 2024/25 Plan and learning for the year ahead and it shows that ShropCom has much to be proud of as we have delivered a significant amount of development and transformation, and a range of benefits are evident.

3. Conclusion

The Board is asked to:

- **Recognise** the excellent progress made in delivering the Trust's 2024/25 Operational Plan
- **Consider** the benefits delivered to patients, the public and our people through delivering the 2024/25 Operational Plan
- **Acknowledge** the lessons learnt as we progress our 2025/26 plans.

Planning Update:

2024/25 Operational Plan Outcomes

Trust Board 05 June 2025

Accountable Director: Sarah Lloyd, Chief Finance Officer

Contents

1. 2024/25 Operational Plan - Context
2. 2024/25 Operational Plan - Delivery
3. Achievements
4. Challenges and lessons learned for 2025/26

Appendix 1 – How outcomes were achieved

2024/25 Operational Plan - Context

Each year the Trust Board approves our Operational Plan which sets out our strategic priorities for the year ahead. These priorities are the key areas of focus for the entire organisation and describe to our patients, public and our partners where we intend to focus our resources.

We monitor performance against our Operational Plan throughout the year and our Board Assurance Framework considers the key risks in relation to delivery of these strategic priorities.

Our Operational Plan is developed using feedback from:

- Front-line staff and service leads
- Members of the Board
- National planning guidance
- Partner organisations

2024/25 Operational Plan - Context

Our 2024/25 Operational Plan was summarised in our 'Plan on a Page' format and shared widely. It is shown on the following page and presents:

- Our **Vision**
- Our **3 Strategic Objectives**
- Our **8 Strategic Priorities**

Our 2024/25 Operational Plan was ambitious. It included 16 important interventions designed and chosen to positively impact on 20 key outcomes. **This update presents the outcomes of this work and learning for the year ahead**.

2024/25 Plan on a Page

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
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive
	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
	We will build a valued and engaged workforce, where health and wellbeing is supported
Caring For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways
Managing Our Resources	We will maximise our productivity and efficiency
	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

2024/25 Operational Plan – Delivery

The Board received an update on delivery of our 2024/25 Operational Plan in December 2024, which included supporting narratives from each SRO demonstrating all interventions were on track.

This report and the appendix set out the end of year performance against our Plan and describe the benefits delivered.

Whilst not all of our ambitions were delivered in full, it is clear ShropCom has made excellent progress delivering its plan and therefore a wide range of benefits to patients and our staff.

2024/25 Operational Plan Achievements

Key successes in 2024-25

- **Our People Benefits** We improved staff survey results, reduced sickness and reduced use of agency. Our Admin. workforce were supported and empowered through the Admin Academy.
- **Digital innovation** We improved the use of digital apps to reduce staffing administrative time on patient bookings and consent forms. Foundations are in place to extend automation. We increased our use of virtual consultations.
- **Improved patient pathways** through collaboration with system partners resulting in increased activity for MIUs, Rapid Community Response and step-down Virtual Ward.
- **Clinical Quality Strategy** was updated and approved, including a strategy implementation plan, and updated governance systems, policies and procedures to achieve compliance.

Outcomes achieved

Intervention	End of Year Status	Outcomes
Implement Admin Academy	Expected Q3 25/26	• Reduced use of agency (Apr 24: £282k, March 25: £228k) • Improved staff survey results (2024 compared to 2023: 36% of scores significantly better, 64% no significant difference, NO scores significantly worse)
Better understanding the needs of our populations	Complete	• Integrated Neighbourhood team (INT) pilot underway • ShropCom leading the Shropshire INT accelerator group. • Health Inequalities Steering group established to prioritise services to improve CORE20PLUS metrics
Recovering Elective Services in line with national mandates	Complete	• Improved DNA rates, increased PIFU and virtual consultations, and achieved key waiting list target.
Continuing to develop our Children and Young People's Services	Complete	• Improved patient access to SCHT services (% of patients seen within 18 weeks - April 24: 57%, March 25: 66%)
Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	Complete	• Improved pathways through collaboration with system partners has increased activity for MUI, Rapid Community Response and step-down Virtual Ward.
Delivering in-year Cost Improvement Programme (CIP) and a 3-year rolling CIP plan delivery	Complete	• Exceeded £3.5m efficiency target for 2024/25 • Added 3-yr CIP plan to the medium-term financial plan, supported by our 10-year capital plan
Maximising the sustainability of our Estates	On Track	• Further reduction in carbon footprint from continued investment in solar panels and LED lighting • Improved occupancy by vacating more sites
Implementing 24/7 Single Point of Access (SPoA) through digital, technological and process improvement	Complete	• A reduction in staff time spent on patient bookings and completing patient consent forms. • Infrastructure in place to extend automation and further increase productivity in 2025/26
Automating manual administrative processes to increase productivity	Complete	

Outcomes achieved

Intervention	End of Year Status	Outcomes
Establishing a continuous quality improvement framework based on NHS Impact	Completed	• Acting to improve safety metric continues to improve • Out of the 12 defined aims within the QI framework, 8 have been fully achieved and 4 are in progress
Learning and Improving Patient Safety and Engagement	Completed	• Approved Clinical Quality Strategy • Clinical Quality Strategy implementation plan in place • Updated governance systems, policies and procedures to achieve compliance.
Developing and implementing Clinical Quality Strategy	Completed	
Maximising Return On Investment (ROI) of Electronic Prescribing Management (ePMA)	Expected 2026/27	• To deliver VfM by continuously improving medicine management, lowering risk, reducing usage and reducing cost.
Develop NHS Long term workforce plan – Train, Retain and Transform	On Track	• Improved sickness absence (April 24, 5.5%, Mar 25, 5.3%) • Improved Staff Turnover (April 24, 11.8%, Mar 25, 9.9%)
Implement NHS People Promise Exemplar Programme	On Track	
Implement the Culture and Engagement Programme	On Track	

Further detail on how the outcomes were achieved is provided in Appendix 1

2024/25 Operational Plan Challenges and Lessons Learnt for 2025/26

Challenges in 2024-25

- Some interventions in the operational plan are still to be completed and will move to business as usual or rolled forward into 2025/26 as they are finalised and embedded.
- The increased NHSE/ICB requirements for 2025/26 planning round and additional external scrutiny for efficiency planning reduced the amount of time for some teams to deliver elements of the operational plan.
- Some of the metrics to illustrate the benefits achieved by the operating plan were not developed in time to fully capture the 'before and after'.

Lessons learnt for 2025-26

- Consider how simplifying the number of interventions and linked outcomes for the 2025-26 Operational Plan will further improve focus and delivery
- Further improve how the outcomes are measured to illustrate what has been achieved

Recommendation

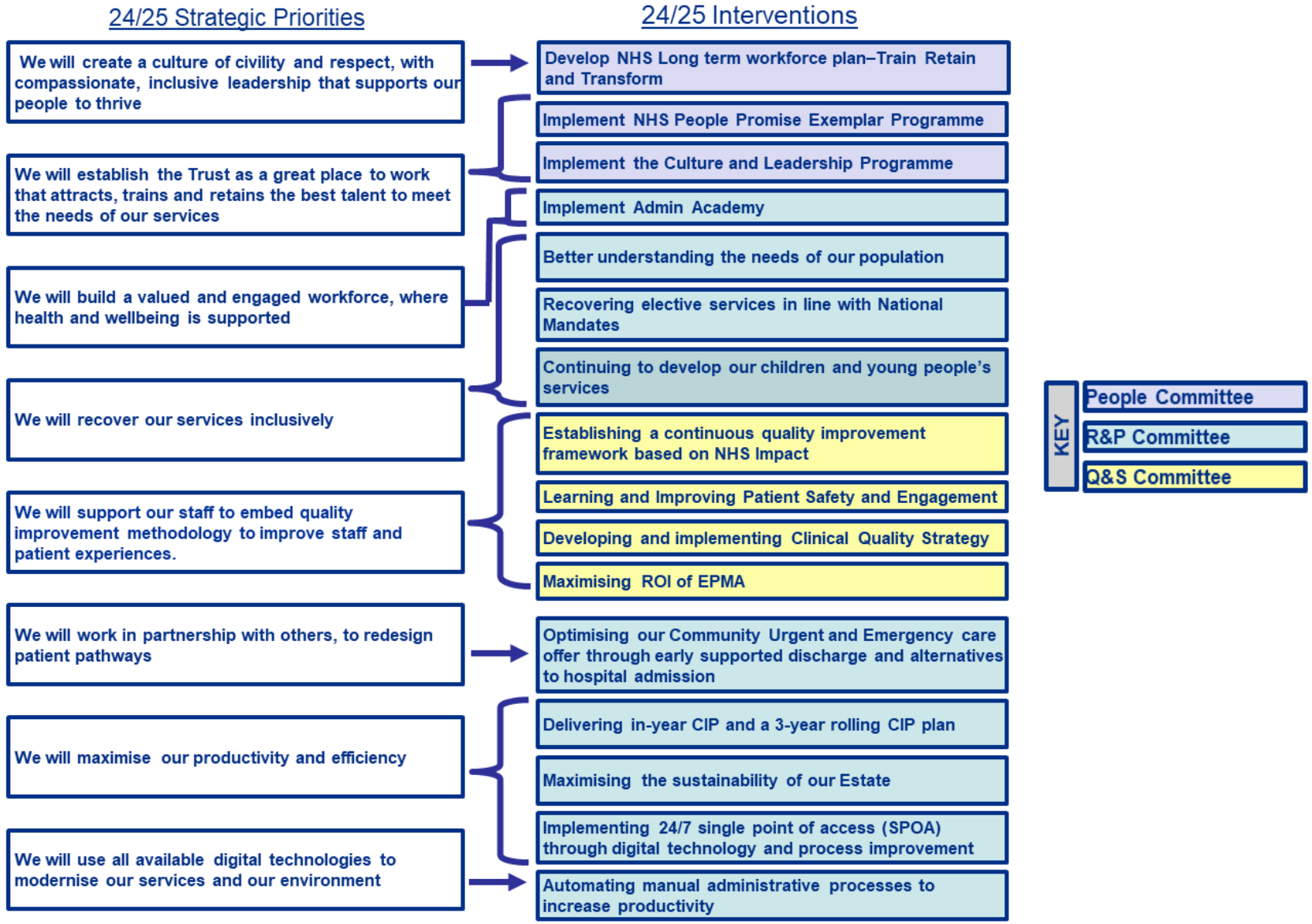
The Board is asked to:

- **Recognise** the excellent progress made in delivering the Trust's 2024/25 Operational Plan
- **Consider** the benefits delivered to patients, the public and our people through delivering the 2024/25 Operational Plan
- **Acknowledge** the lessons learnt as we progress our 2025/26 Operational Plans

Appendix 1

The diagram opposite shows how our agreed interventions supported delivery of our Strategic Priorities.

The next 4 slides provide further detail on how the interventions were delivered and outcomes achieved.



Appendix 1: Status and Narrative Update – full-year review

Intervention	End of Year Status	Narrative (high level)
Implement Admin Academy	Expected Q3 25/26	Significant progress has been achieved, including enhanced collaboration across the Trust and a reduction in bank and agency usage. Five Task and Finish groups have been established to focus on the development of a shared bank, training opportunities, mutual aid/setting up SPOA to build resilience, apprenticeships, and an administrative network. However, full completion the project is currently behind schedule while team capacity and PMO support is being arranged.
Better understanding the needs of our populations	Complete	The Health Inequalities steering group has been established and is now fully embedded, reporting directly to the Quality and Safety Committee . The HI Steering Group provides essential support to CORE20PLUS Ambassadors and their engagement projects. The Integrated Neighbourhood Teams (INT) project is being developed in collaboration with Primary Care and other system partners, contributing to the 2025/26 Strategy and Interventions. A pilot INT site is currently being developed in North West Shropshire in partnership with the North Shropshire Primary Care Network, with an initial focus on Diabetes.
Recovering Elective Services in line with national mandates	Complete	The introduction of SMS text notifications has successfully reduced Did Not Attend (DNA) rates. The Patient Initiated Follow-Up (PIFU) program has been expanded, and virtual consultations have been effectively embedded into our services. We have met the national target of eliminating 65-week waits by May 2024.
Continuing to develop our Children and Young People's Services	Complete	Success of our Children and Young People's Services is recognised. This is the reason for number of clear opportunities being offered to grow the service further to increase access to this care.
Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	Complete	The optimisation of community pathways is now integrated with the system Urgent and Emergency Care (UEC) workstreams to enhance UEC community pathways. Detailed implementation plans, project initiation documents, metrics, and key performance indicators are outlined in the program. The review and streamlining of the Urgent Community Response and Virtual Ward triage models have been enhanced by surgical pathways and the winter scheme community in-reach. The Care Transfer Hub implementation program is currently under review, with the project review expected to be completed by Q1 2025/26. Operational planning and priorities are set in line with UEC plans, with the System Discharge Alliance leading the system work.
Delivering in-year Cost Improvement Programme (CIP) and a 3-year rolling CIP plan delivery	On Track	The project is complete now that Month 12 and year-end positions show in-year full delivery . CIP schemes have been identified to deliver the 3-year rolling CIP plan and the 3-year rolling plan is expected to be finalised by Q3 2025/26

Appendix 1: Status and Narrative Update – full-year review

Intervention	End of Year Status	Narrative (high level)
Maximising the sustainability of our Estates	On Track	The Shropshire, Telford & Wrekin Integrated Care Board (ICB) has re-convened its Climate Change Group, which meets quarterly. The existing Green Plan is currently under review and is expected to be completed by 31st July 2025, covering the three-year cycle requested by NHS England for 2025-2028. Updates to the Green Plan will be provided to the Resource Planning Committee (RPC) at least annually. Existing ventilation systems at Whitchurch and Bridgnorth have been upgraded, with modern equipment that is more energy-efficient. Plans to install digital energy monitoring have been completed. SCHT is investing in LED lighting across Bishop Castle and Halesfield 6, with completion of these schemes anticipated by the end Q2. The estimated carbon reduction based on current usage is around 18 tonnes. Additionally, plans are progressing to deliver LED lighting across Whitchurch during 2025-26, which could reduce its carbon footprint by an estimated 58 tonnes per annum. Three non-mandatory sustainability courses are available on ESR, to support teams identifying more carbon reduction opportunities. Procurement is supporting system-wide programs for energy purchasing and waste management, both of which are expected to commence in Q1 of 2025-26. While financial benefits are expected, carbon reduction is also a central focus, due to anticipated regulatory changes within the waste and recycling sector.
Implementing 24/7 Single Point of Access (SPoA) through digital, technological and process improvement	Complete	The phased implementation is in place. The RiO Virtual Assistant (VA), which facilitates online appointment management for patients, has been successfully launched within MSST and other areas of the Trust. The technical deliverables required for this deployment have been successfully deployed. Additionally, a Patient Engagement Portal (PEP) has been procured and this new technology will build upon and incorporate the VA technology as it is deployed. It will enable patient correspondence to be accessed through a digital portal integrated with the NHS App. The capability to conduct virtual consultations integrated with RiO and the PEP will also be included in the scope of this technology rollout.
Automating manual administrative processes to increase productivity	Complete	CoPilot has been successfully deployed at scale across various staff groups, generating significant benefits and productivity improvements in several areas. Robotics was implemented in particular use cases; without further investment in the necessary staff to support this technology, the scale and future expansion of productivity improvements will remain constrained.

Appendix :1 Status and Narrative Update – full-year review

Intervention	End of Year Status	Narrative (high level)
Establishing a continuous quality improvement framework based on NHS Impact	Completed	The Quality Improvement (QI) framework has been approved and outcomes are being monitored by the Patient Safety Committee. Out of the 12 defined aims within the QI framework, 8 have been fully achieved and 4 are in progress. The successful launch of the QI framework was supported by a targeted communications campaign and the development of the QI page on the staff zone, offering staff a range of tools and information on QI. The Trust has exceeded the target of at least ten staff attending the 1-day QI fundamentals training in Q3 (September 2024 – December 2024), with a total of 20 additional staff booked for the training sessions. To date, the Trust has completed and presented 4 QI projects, with the aim of achieving 10 projects delivered this year
Learning and Improving Patient Safety and Engagement	Completed	Significant work has been completed to update the governance systems, policies, and procedures. The governance team is working closely and collaboratively with all services and the quality improvement team to ensure that our learning responses are monitored and managed effectively. A communications and training plan has been successfully delivered.
Developing and implementing Clinical Quality Strategy	Completed	The Clinical Quality Strategy was approved by Trust Board with 4 Clinical Quality Ambitions defined. Delivering Safe Integrated Care (Starting well, staying well and dying well), Listening to and supporting the patient voice, Learning and improving together, and Delivering equitable and sustainable services. The Quality Strategy is on staff zone and public facing webpage. 25/26 interventions will include the implementation and delivery of this strategy.
Maximising Return On Investment (ROI) of Electronic Prescribing Management (ePMA)	Expected 2026/27	A business case for ePMA was written and shared with Deputy Directors and a paper was discussed at Q&S Committee. Positive feedback was given and clear engagement for the desire and need for ePMA to be implemented. EPMA remains a priority and work is now focussing on securing the right resources and delivery team to maximise the positive impact on patient care.

Appendix 1: Status and Narrative Update – full-year review

Intervention	End of Year Status	Narrative (high level)
Develop NHS Long term workforce plan – Train, Retain and Transform	On Track	We continue to work with Team Leaders to support them in developing team actions based on the staff survey data. We have offered Call to Action sessions where managers find out more about their results and our refreshed Managers Toolkit. Corporate actions from the staff survey results are being developed alongside targeted support for areas that are showing as a hot spot. We have worked in collaboration with SaTH to offer our staff the opportunity to attend their leadership courses which includes the Galvanise course for Ethnic Minority Staff and masterclasses.
Implement NHS People Promise Exemplar Programme	On Track	A number of workstreams aligned to the People Promise continue including wellbeing conversations, menopause support, FTSU promotion, flexible working campaign, reward and recognition including Long Service Awards, ACE Awards and informal recognition and awareness day promotion, the Culture and Leadership Programme, We also continue to work with our system partners, in SATH and RJAH to deliver on retention activities and bring policies and procedures in line, where appropriate. Current workstreams include Flexible working, STAY conversations & Menopause. Progress so far includes recording a webinar on flexible working that can be shared system wide for employees and sharing of menopause resources and exploring the option to establish a system wide network of champions. A repeat survey in January 2025 was undertaken to measure and review the impact of the People Promise agenda over the past 6 months. This saw a number of improvements in employees being aware of the People Promise (PP) and the associated initiatives: 42% increase in employees knowing what the PP is; 18% increase in employees being aware of initiatives across SCHT that are aligned to the PP; 20% increase in employees feeling the PP represents their workforce.
Implement the Culture and Engagement Programme	On Track	The Culture Change Team continue to deliver on the Discovery phase of the Culture & Leadership Programme. Board Conversations commenced in March and the Leadership Behaviours Survey has been shared to all employees. Currently we have completed 10/13 Board Conversations, and the Leadership Behaviours Survey is at 285 responses and closes on 11th April. Analysis of both these evidence-based tools will commence when all data has been reviewed and will be collated in a report for wider sharing. The next tools to be completed will include focus groups and gathering patient experience. All of our planned Health & Well-being days have taken place and the feedback has been positive. Flexible working workshops have continued. We now use ESR for flexible working requests which enables the data to be analysed and support put in place for those teams where approval rates are lower. A flexible working survey has been completed and the data gathered will inform our next flexible working campaign. A financial wellbeing survey has been conducted; the data will be analysed and an action plan developed. A Health and Well Being (HWB) survey has been conducted which will inform the HWB action plan alongside information gathered from the HWB diagnostic framework and the Retention Self Assessment. Continuing to make ShropCom a diverse and inclusive place to work we have developed reasonable adjustment guidelines, Health passport and associated guidance, access to work guidance and a neuro diverse guidance which will be launched with associated workshops.

Shropshire Community Health
NHS Trust

Performance Framework Update

0. Reference Information

Author:	Steve Price, Head of Information & Performance Assurance	**Paper date:**	05 June 2205
Executive Sponsor:	Sarah Lloyd, Director of Finance	**Paper written on:**	28th May 2025
Paper Reviewed by:	Resource & Performance Committee	**Paper Category:**	Performance
Forum submitted to:		**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 report presents the Trust's updated Performance Framework. The paper is to provide information and assurance and to consider for approval.

This paper was reviewed at the Trust's Resource and Performance Committee in May, and it recommends this Framework to the Trust Board for approval.

2. Executive Summary

2.1 Context

In line with best practice, the Trust's Performance Framework has recently been reviewed, and a small number of changes have been made. Key changes include refreshing the Key Performance Indicators, to reflect those recently approved by the Trust Board, and minor wording changes.

3. Main Report

3.1 Introduction

The Trust's Performance Framework has been reviewed with only minor changes made including the introduction of a number of new KPIs as noted below. These have been reviewed through our committees and were approved by the Trust Board in April.

Safe	Medication incidents with moderate harm	New KPI to replace 'medication incidents with harm'	Director of Nursing & Quality
Safe	Proportion of Harm reviews completed for patients waiting over 52 weeks (local waiting lists)	New KPI in development	Director of Nursing & Quality
Safe	Proportion of Harm reviews completed for patients waiting over 52 weeks (RTT waiting lists)	New KPI in development	Director of Nursing & Quality
Responsive	Patients no longer meeting the criteria to reside	New indicator as agreed with Director of Ops	Director of Operations
Responsive	Urgent care 2 hour response	New indicator as agreed with Director of Ops	Director of Operations

Our approach to performance management remains unchanged and the Framework is appended to this report. Performance action plan workshops continue to be received well, taking place monthly with corporate and operational stakeholders and focusing on the highest impact actions to enhance performance. These action plans are also designed to provide assurance to Committees.

As we progress through the year, it is likely further revisions to the Performance Framework will be required as anticipated national guidance is published, such as the NHS Performance Assessment Framework which is currently out for consultation. Despite this, it remains important to complete our annual review of the Trust's Performance Framework due to its importance in relation to the governance arrangements for key aspects of performance reporting and management across the organisation.

Any alterations to our Framework will be presented to the Board for further approval.

3.2 Conclusion

The Trust Board is asked to:

- **Consider** the updated Performance Framework and if any amendments are required in order to provide adequate assurance to the Board in relation to how performance is managed
- **Approve** the Trust's updated Performance Framework
- **Note** that our Framework is likely to require updating following publication of the National Performance Assessment Framework later in the year.

Shropshire Community Health
NHS Trust

Performance Management Framework

Date: 05 June 2025
Version: 1.63

Author	Chief Finance Officer
Owner	Chief Finance Officer
Client	Chair of Trust Board

Document History

Version	Date	Changes
1.0	09/09/2016	Updated to incorporate Single Operating Framework (SOF) – Consultation
	09/09/2016	Updated to reflect current reporting position
	09/09/2016	Updated to include development section
	07/10/2016	Updates to Business Planning and Delivery of Objectives
	07/10/2016	List of measures added from NHSI SOF
	07/10/2016	Update to section 3 following publication of SOF
1.1	15/09/2017	Update to Monthly Performance Assessment (Recovery Plans)
	15/09/2017	Integrated Dashboard with updated measures / measures by type
1.2	08/06/2018	Update to section 3 following Nov' 2017 SOF Publication
	08/06/2018	Review of appendix 1 and 3 following SOF revision
	08/06/2018	Update to Performance Review Cycle
1.3	18/11/2022	Review and refresh following external review.
1.4	11/01/2023	Final updates following review of measures against SOF requirements.
1.5	24/02/2023	Adjustments identified by Board 02/02/23 before wider circulation and implementation
1.6	10/07/2024	Updated to refer to: the Trust Performance Board and Performance Spectrum; references to action plans; definitions relating to monitoring and exceptions under NHSE Making Data Count; Director Titles; Committee KPI annual review; Updated diagrams and appendices
1.61	02/08/2024	KPI Appendix updated to reflect feedback from Board, incorrect owner for Never Events KPI
1.62	20/05/2025	KPI Appendix updated to reflect KPI base for 2025/26 following the KPI review and approval. Minor wording changes.
1.63	05/06/2025	Minor wording changes following RPC feedback

Distribution Record

Version	Date	Distributed to:
1.0	07/10/2016	Resource & Performance Committee (RPC)
	21/10/2016	Approved at RPC with minor changes needed
1.1	15/09/2017	Resource & Performance Committee (RPC)
1.2	18/06/2018	Resource & Performance Committee (RPC)
1.3	18/11/2022	Executive Team Meeting
	06/12/2022	Senior Leadership Team
1.4	23/01/2023	Resource & Performance Committee (RPC)

1.4	02/02/2023	Trust Board
1.5`	March/July 2023	Across organisation via SLT
1.6	July 2024	Executive Team meeting and SLT
1.6	01/08/2024	Trust Board
1.62	28/05/2025	Resource and Performance Committee
1.63	05/06/2025	Trust Board

1. Introduction

1.1. The Trust's Performance Management Framework (PMF), Board Assurance Framework (BAF) and other wider governance arrangements when combined, are integral to the Trust's governance framework. The Framework is designed to enable a full and comprehensive implementation of strategic and operational plans, including the delivery of quality and financial improvement programmes.

1.2. The Performance Management Framework (PMF) aims to foster a culture of responsibility and accountability at all levels in the Trust and helps teams and staff to understand the roles they play in successful delivery of the Trust's objectives. The PMF specifies the structure, systems and processes used to embed a performance management culture in the Trust and identifies the responsibilities for performance management.

1.3. A devolved accountability structure is in place at the Trust, managed through the Performance Framework. The underlying principles of this Framework are to ensure that delivery of the Trust's strategy and corporate objectives are managed in a systematic way from 'Community/Ward to Board' and 'Board to Community/Ward'.

2. Objectives of the Performance Management Framework

2.1. The PMF sets out the systems and processes through which the organisation will support teams and manage the delivery of our strategic and operational goals, as well as ensuring that the regulatory and statutory requirements that apply to the Trust are met (including those outlined in the NHS Constitution).

2.2. The PMF drives the implementation of best practice performance assurance processes throughout the organisation, aligned to our Board committees, ensuring that:

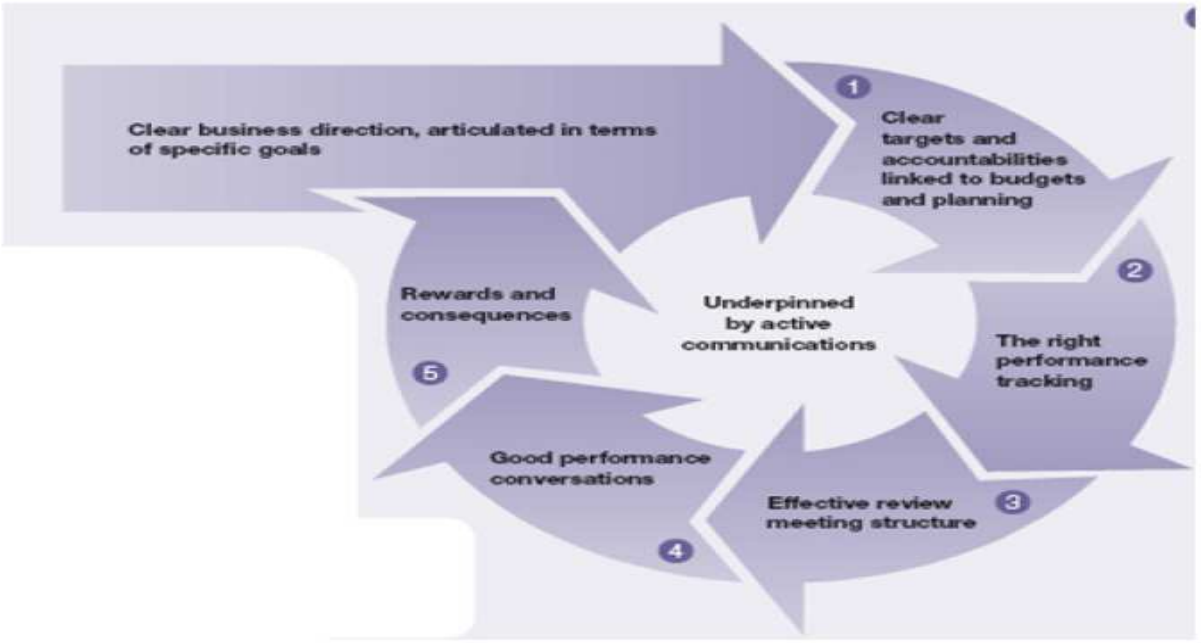
- Accountability arrangements are in place across the organisation to drive the delivery of all agreed objectives, targets, and standards. Performance is seen as a continuous process which is embedded in all aspects of organisational activity.
- Agreed performance objectives and targets are Specific, Measurable, Agreed, Realistic and Time bound (SMART) and transparent measurements are set to monitor performance.
- Timely information is available to enable appropriate understanding, monitoring, and assessing of the Trust's quality and performance, prompting appropriate action to be taken if performance is forecast to fall below set objectives and targets.

- Staff, teams, and Committees understand their roles and responsibilities and are supported and motivated to deliver, with a clear line of sight between their contributions and the overall success of the Trust.
- Action plans are developed as soon as risks to the achievement of required targets or standards and/or barriers to effective performance are identified.

3. Key Management Principles

3.1. The following key management principles underpin this framework:

- ***Focused on improvement -*** All teams and staff members are encouraged to embrace a culture of continuous performance improvement and to speak up with suggestions and concerns. Initial interventions will focus on recovery to sustain improvement and will include actions to address the root causes of issues.
- ***Transparent*** – Clear and pre-determined performance measures and interventions. Teams and individuals will understand how performance is being assessed and what to expect if performance falls below acceptable levels.
- ***Consistent*** - Clear accountabilities through a uniform approach across SCHT, at different levels of the organisation and across different departments will ensure that all parties are clear of where accountabilities lie.
- ***Proactive -*** Delivery focused on improved performance through an integrated and action-oriented approach, with thresholds for intervention that identify underperformance at an early stage so that it can be swiftly addressed.
- ***Proportionate -*** Performance management interventions and action are related to the scale of risk and maintains an appropriate balance between challenge and support.



4. The Performance Spectrum

4.1. The spectrum of performance stretches from unacceptable at one extreme, to outstanding or world class performance at the other, as illustrated:

Breach of requirements and/or multiple KPI targets across multiple domains	Non-compliance of requirements, not meeting several KPI targets, selected improvement standards or failure to meet improvement targets	Compliance with requirements, adoption of improvement standards and performance against KPI targets	Exceeding KPI targets, benchmarking and continued improvement
← **Unacceptable**	**Requires Improvement**	**Good**	**Outstanding** →

(the spectrum of performance must be measured in terms of metrics, targets and standards)

4.2. The Executive Team, through the Trust Performance Board, will assess how each Division is performing against the necessary Key Performance Indicators, using the dashboards and slides presented.

4.3. Where an exception occurs, the Executive Team will require assurance in the form of actions plans to evidence the reason for the performance gap and the associated actions required to improve performance.

4.4. Divisions and Corporate Services will attend the Trust's Performance Board on a rolling basis, however frequency may be increased at the discretion of the Executive Team, should there be particular areas of concern.

5. Link to Executive Director Roles and Responsibilities

5.1. Board of Directors

- The Board is required to ensure that the Trust always remains compliant with the relevant conditions of its NHS Provider License and has regard to the NHS Constitution.
- The Performance Management Framework works in conjunction with the Board Assurance Framework to provide the Board of Directors with the assurance required in relation to the full and comprehensive implementation of strategic and operational plans.
- The Board has overall accountability for the implementation of the Performance Management Framework.

5.2. Chief Executive

- The Board delegates responsibility for delivery of the objectives, targets and standards outlined in the Trust's Strategy and Operational Plan to the Chief Executive. The Chief Executive, supported by the Executive Directors, ensures that the associated activities are carried out efficiently, effectively, and economically and in a manner appropriate for the proper conduct of public affairs.
- This Performance Management Framework describes the governance arrangements through which the Chief Executive delegates and manages the delivery of those responsibilities.

5.3. Chief Finance Officer

- The CFO has delegated responsibility for the leadership, development, and implementation of the Performance Management Framework.

5.4. Divisional Leads, Directorate Leads & Divisional Meetings

- The management teams are responsible for ensuring services are delivered in line with commissioning requirements and meet the required safety and quality standards, financial targets, and regulatory requirements.
- Drive professional and managerial responsibility in delivering key performance indicators and promoting leadership across the Trust to deliver the performance agenda.

Responsibilities include ensuring that:

- The Performance Management Framework is implemented within their own sphere of responsibility.
- Steps are taken to secure resources for the implementation of associated controls following risk assessment.
- Targets for KPIs are agreed, communicated, and delivered.
- Governance arrangements to underpin the Performance Management Framework are in place.
- Services within their remit perform to the required standards/targets and maximise their potential.

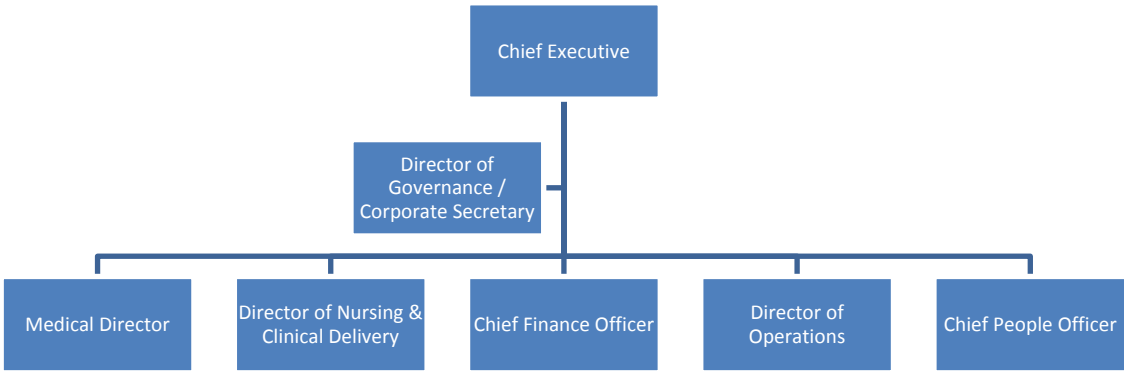
The management teams should

- Acknowledge and reward excellent performance.
- Analyse service performance regularly, establishing variances, trends and discrepancies or gaps.
- Scrutinise the root cause of the above and act upon this to eliminate continued issues by developing actions plans to recover.
- Implement improvement plans as appropriate.
- Escalate to the executive team, via the Trust Performance Board, areas of significant risk or opportunity.
- Divisional meetings are accountable for delivering performance targets within their respective Divisions. To ensure the efficient operation of the Performance Framework, Divisional meetings will need to ensure suitable time is available for the review of performance information and the preparation for Performance Board.
- Each Division will have its own Integrated Performance Report (IPR), which reflects the content of the Trust Board's IPR with the addition of drill down KPIs.

6. Performance Management Roles and Responsibilities

6.1. The Trust's Performance Management Framework describes how the Chief Executive delegates responsibility for the delivery of strategic and operational plans, targets, and objectives. There are two main ways in which those responsibilities are delegated – through line management structures and through a small number of management meetings.

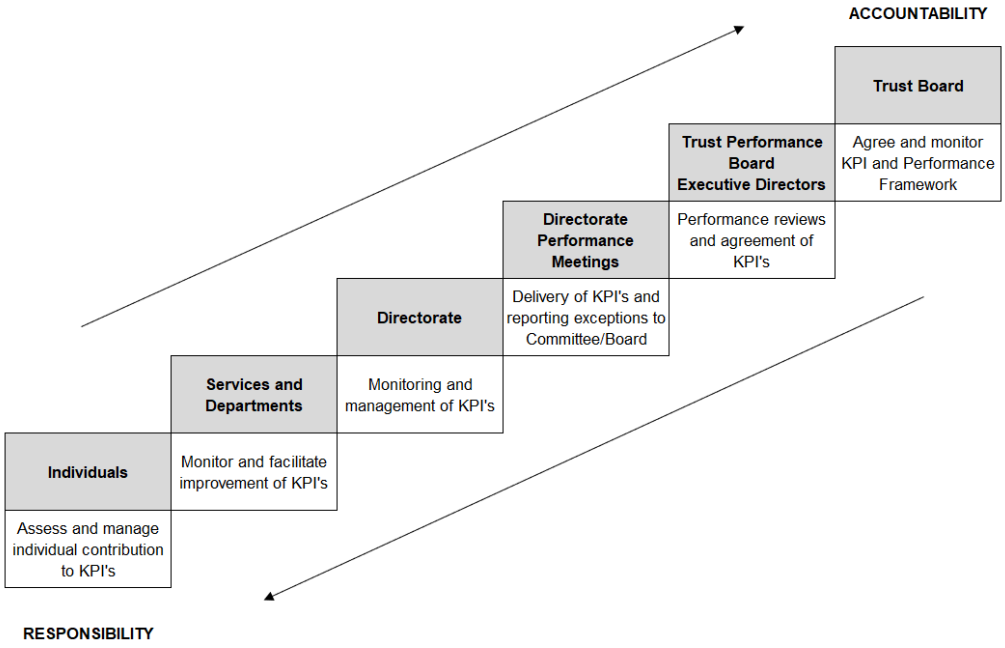
6.2. The primary way in which responsibilities are delegated is through the Trust's line management structure to individuals, and then through to relevant members of their teams.



6.3. The Executive Directors have individual responsibility for delivering the objectives that relate directly to their role, and for supporting their colleagues to deliver their objectives. Also, they are collectively responsible for delivering the Operational Plan objectives as a team.

7. Responsibilities and Accountabilities

7.1. To deliver the Performance Management Framework a stepped approach to performance management is required which clearly specifies roles, accountabilities, and responsibilities. It is essential that key targets, programmes, projects, and actions are disaggregated throughout the Trust and hierarchy to ensure delivery of targets at every level and across the organisation as a whole; to understand what is expected of them and the part they play in the overall success of the Trust.



8. Line Management Responsibilities

8.1. Responsibility for most of the Trust's performance objectives and targets is cascaded through to relevant line managers on an annual basis (or more frequently if required).

8.2. Line managers are responsible for delivery of their agreed targets in accordance with the key principles and approach outlined in this framework. Line management responsibilities include ensuring that:

- Teams and staff members have a clear understanding of their role, responsibilities, and performance targets (with individual targets agreed and documented through the appraisal process).
- Teams and staff members work in an environment that embraces feedback and learning and staff members are encouraged to speak up about issues and concerns.
- Performance delivery is actively and proactively managed.
- Performance issues and risks are captured, managed and escalated where appropriate.
- Excellent performance is recognised and rewarded.

9. Sub-Committee Responsibilities

9.1. A number of Sub-Committees support the Board and Executive Team in effectively discharging their obligations by taking responsibility for the delivery of agreed objectives and targets.

9.2. Directorate meetings and Sub-Committees are responsible for the delivery of relevant directorate and/or functional objectives and targets within their areas of accountability.

9.3. Various other forums also play an important role in taking responsibility for the delivery of specific objectives and targets and in securing wider organisational buy-in to plans and developments.

9.4. A review of sub-committees and other groups will be undertaken, with the aim of:

- Clarifying scope and alignment of scope to support plan objectives
- Improving effectiveness and efficiency
- Ensuring right people attend and right governance structures are in place

10. Performance targets, objectives and KPIs

10.1. The Trust's strategic and operational plans are updated on an annual basis (or more frequently if required) in accordance with the Trust's planning cycle.

10.2. The Trust's performance targets, objectives and KPIs are also updated on an annual basis (linked to the content of strategic and operational plans) and may be further updated during the financial year if needed.

10.3. Agreed performance targets, objectives and KPIs are cascaded to relevant line managers or to accountable Committees.

10.4. Effective and supportive performance management mechanisms are key to an organisation being 'well led' and are essential to the delivery of strong and consistent performance.

11. Performance monitoring and escalation

11.1. The Chief Finance Officer, and supporting personnel, monitors and assesses all aspects of the delivery of strategic and operational plan targets, having the following key responsibilities:

- Providing assurance that all statutory, regulatory, quality, operational, workforce, financial and project targets, objectives and KPIs are fully understood and have been assigned to an appropriate Executive Director, managerial lead, and assurance committee.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target (single version of the truth), proactively supporting projections to the end of the plan year.
- Driving consistency and alignment of performance dashboards and reports at all levels (including Trust Board) – using 'exception-based' reporting wherever possible.
- Constructively challenging performance delivery against agreed targets and recommending action(s) where appropriate.
- Reviewing performance against comparative benchmarks to recognise areas of good performance and identify areas where further improvement is needed.

11.2. All Directorate meetings and Sub-Committees are required to formally review progress against performance objectives and targets at least once a month (more frequently if required) and confirm that those targets are still expected to be delivered.

11.3. If a Directorate meeting and/or Sub-Committee forecasts that it is unlikely to be able to deliver the agreed objectives and/or targets at any point, then the associated issue(s) and/or risk(s) should be formally escalated to the next layer of the Trust's accountability matrix (N.B. escalation of an issue does not transfer the responsibility for delivery).

11.4. If a Directorate meeting or Sub-Committee or individual's performance regularly falls below the required levels, more formal escalation processes may be instigated (e.g., Performance Action Plans).

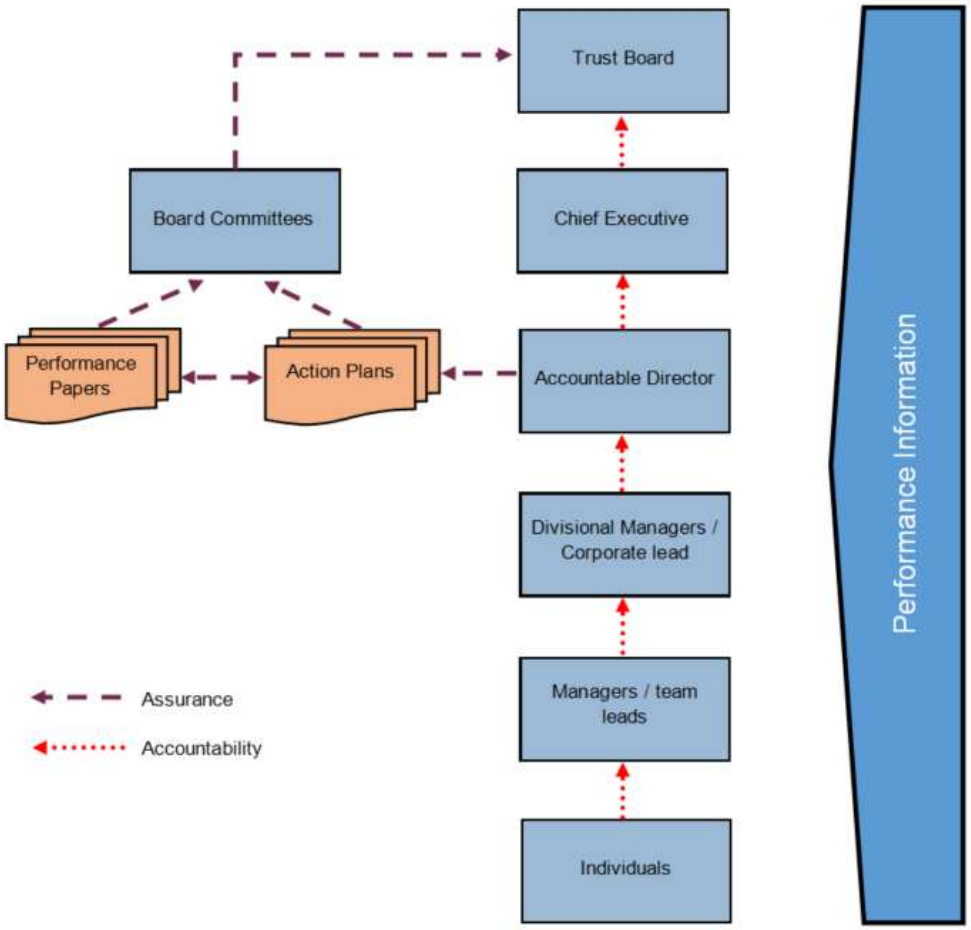
11.5. The Executive Team will meet regularly (monthly) with management teams to review performance and progress. The focus and content of those meetings will vary depending on the current performance levels and the level of assurance provided by the directorate management team.

11.6. Performance will be monitored and displayed in line with NHS England's Making Data Count guidance including the use of Statistical Process Control Charts (SPC).

11.7. The dashboards will include icons that highlight whether there are areas of concern from a variation or assurance perspective in line with this guidance. An example of the dashboards that are to be used by each Committee is in Appendix 4

11.8. Action plans will be developed for each Committee as a minimum for the indicators that have been identified as having a variation or an assurance concern. The action plan template is included as Appendix 5

11.9. The action plans will be developed by the appropriate lead and approved by the Accountable Director for the relevant indicator. This forms the basis of the exception reporting to Committee.



12. Recognition and Reward

12.1. Where objectives are delivered and/or performance is exceeded the Trust actively seeks to recognise and reward that good performance.

12.2. Recognising stable and/or good performance of a Directorate may be provided through a reward of time, in not attending the Trust Performance Board as frequently.

12.3. The successes of Directorates and other functions in delivering key elements of the Trust's Operational Plan, will be routinely reported, and celebrated as part of monthly communication processes.

12.4. There are a wide variety of routes through which performance is currently recognised and rewarded, including:

- Staff and team communication
- ACE awards
- Long Service awards

13. Trust Board

13.1. The Board provides leadership and direction to the organisation and will receive regular reports assuring them of the quality and performance of services. This Performance Management Framework will form part of the assurance to the Board of Directors regarding achieving the performance objectives as detailed in the Board Assurance Framework (BAF).

13.2. The Board approves the annual operating plan ensuring it meets the Trust's overall strategic direction and NHSE's planning guidance together with the NHS Long Term Plan and ICS developments.

13.3. Agree the annual objectives including the accountable director ensuring the required outcomes key to delivery can be measured by key performance indicators.

13.4. The Board will state the risks to the Trust should an outcome not be delivered (through the Board Assurance Framework).

13.5. The Board assesses the performance of the Trust monthly via the Performance reports from each committee, these include NHSE Making Data Count dashboards and action plans for each Committee where assurance or variation is being flagged as a concern.

13.6. The key performance indicators presented to Board are aligned with the NHSE Oversight Framework. The data included in the IPR is underpinned by a robust rolling data quality programme which is overseen by the Audit Committee.

13.7. The Board may request that an appropriate Committee carries out 'deep dives' into certain performance indicators to ensure an appropriate level of granular review is carried out.

14. Board Committees

14.1. Board Committees provide an additional layer of independent assurance over and above organisational assurance processes, helping the Board to ascertain whether the PMF is operating effectively.

14.2. The responsible Committee for each indicator will approve definitions including targets that will drive the exception reporting process for the year. Any exception reported will include an understanding of the cause of variation as part of the action plan to rectify performance.

14.3. Indicators will be allocated to committees as follows:

- Safe – Quality and Safety Committee and People Committee
- Caring - Quality and Safety Committee and People Committee
- Responsive – Resources and Performance Committee and Quality and Safety Committee
- Effective - Resources and Performance Committee and Quality and Safety Committee
- Well Led - Resources and Performance Committee and People Committee

14.4. Board Committees provide an additional mechanism for Non-executive Directors to hold Executive Directors to account by testing the level of assurance available to support reported progress towards delivery of operational plan objectives.

14.5. Board Committees will routinely review performance reports but may also, from time to time and as necessary, undertake more in-depth assessments of aspects of performance delivery (where significant, this may involve establishing additional time-limited sub-committees or groups).

14.6. The effectiveness of the Board Committees will be reviewed annually or more frequently if required.

Shropshire Community Health
NHS Trust

Appendices - Performance Management Framework

Appendix 1 – Integrated Performance KPI Accountability

People Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership culture	SOF 22/23	Director of People and OD
Well Led	Appraisal Rates	Existing KPI	Director of People and OD
Well Led	CQC well-led rating	SOF 22/23	Director of Governance
Well Led	Leaver rate	SOF 22/23	Director of People and OD
Well Led	Mandatory Training Compliance	Existing KPI	Director of People and OD
Well Led	Net Staff in Post Change	Existing KPI	Director of People and OD
Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	SOF 22/23	Director of People and OD
Well Led	Proportion of staff in senior leadership roles who are from b) are women	SOF 22/23	Director of People and OD
Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	SOF 22/23	Director of People and OD
Well Led	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	SOF 22/23	Director of People and OD
Well Led	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	SOF 22/23	Director of People and OD
Well Led	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	SOF 22/23	Director of People and OD
Well Led	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	SOF 22/23	Director of People and OD
Well Led	Proportion of temporary staff	Existing KPI	Director of People and OD
Well Led	Sickness Rate	SOF 22/23	Director of People and OD
Well Led	Staff survey engagement theme score	SOF 22/23	Director of People and OD
Well Led	Total shifts exceeding NHSE capped rate	Existing KPI	Director of People and OD
Well Led	Total shifts on a non-framework agreement	Existing KPI	Director of People and OD
Well Led	Vacancies - all	Existing KPI	Director of People and OD

Quality & Safety Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	SOF 22/23	Director of Nursing & Quality
Safe	Category 3 Pressure Ulcers	Existing KPI	Director of Nursing & Quality
Safe	Category 4 Pressure Ulcers	Existing KPI	Director of Nursing & Quality
Safe	Clostridium difficile infection rate	SOF 22/23	Director of Nursing & Quality
Responsive	Complaints - (Open) % within response timescales	Existing KPI	Director of Nursing & Quality
Safe	Compliance with Duty of Candour	Existing KPI in development	Director of Governance
Safe	Consistency of reporting patient safety incidents	SOF 22/23	Director of Governance
Effective	Deaths - unexpected	Existing KPI	Medical Director
Safe	E. coli bloodstream infection rate	SOF 22/23	Director of Nursing & Quality
Safe	Falls per 1000 Occupied Bed Days	Existing KPI	Director of Nursing & Quality
Safe	Medication Incidents with moderate harm	New KPI to replace Medication incidents with harm	Director of Nursing & Quality
Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SOF 22/23	Director of Nursing & Quality
Safe	National Patient Safety Alerts not completed by deadline	SOF 22/23	Director of Governance
Safe	Never Events	Existing KPI	Director of Nursing & Quality
Well Led	Overall CQC Rating	SOF 22/23	Chief Executive Officer
Safe	Patient Safety Incident Investigations	Existing KPI	Director of Nursing & Quality
Well Led	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	SOF 22/23 in development - definition to be established	Medical Director
Safe	Proportion of Harm reviews completed for patients waiting over 52 weeks (local waiting lists)	New KPI in development - requested by Deputy Director of Nursing and Quality and Deputy DIPC	Director of Nursing & Quality
Safe	Proportion of Harm reviews completed for patients waiting over 52 weeks (RTT waiting lists)	New KPI in development - requested by Deputy Director of Nursing and Quality and Deputy DIPC	Director of Nursing & Quality
Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	Existing KPI	Director of Nursing & Quality
Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	Existing KPI	Director of Nursing & Quality
Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	Existing KPI	Director of Nursing & Quality
Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	Existing KPI	Director of Nursing & Quality

Resource & Performance Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Responsive	18 week Referral To Treatment (RTT) incomplete pathways	Existing KPI	Director of Operations
Use of Resources	Agency spend - compared to the agency ceiling	SOF 22/23	Director of Operations
Use of Resources	Agency spend - Price cap compliance	SOF 22/23	Director of Operations
Effective	Available virtual ward capacity per 100k head of population	SOF 22/23	Director of Operations
Responsive	CQC Conditions or Warning Notices	Existing KPI	Chief Executive Officer
Effective	Data Quality Maturity Index	Existing KPI	Director of Operations
Responsive	Diagnostics for Audio/Ultrasound	Existing KPI	Director of Operations
Use of Resources	Financial efficiency - variance from efficiency plan	SOF 22/23	Director of Finance
Use of Resources	Financial stability - variance from break-even	SOF 22/23	Director of Finance
Caring	New Birth Visits % within 14 days - Dudley	Existing KPI	Director of Operations
Caring	New Birth Visits % within 14 days - Shropshire	Existing KPI	Director of Operations
Caring	New Birth Visits % within 14 days - Telford	Existing KPI	Director of Operations
Responsive	Number of patients not treated within 28 days of last minute cancellation	Existing KPI	Director of Operations
Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	SOF 22/23	Director of Operations
Responsive	Patients no longer meeting the criteria to reside	New Indicator as agreed with COO	Director of Operations
Responsive	Proportion of patients spending more than 12 hours in an emergency department	SOF 22/23	Director of Operations
Responsive	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	SOF 22/23	Director of Operations
Responsive	Proportion of patients within 18 weeks	Existing KPI	Director of Operations
Effective	Total activity undertaken against current year plan	Existing KPI	Director of Operations
Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	SOF 22/23	Director of Operations
Effective	Total elective activity undertaken compared with 2019/20 baseline	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 104 weeks - all services	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 104 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 52 weeks - all services	Existing KPI	Director of Operations

Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 65 weeks - all services	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 78 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 78 weeks - all services	Existing KPI	Director of Operations
Responsive	Urgent Care 2 hour response	New Indicator as agreed with COO	Director of Operations
Effective	Virtual ward bed occupancy	Existing KPI	Director of Operations

Appendix 2 – Lead Executive Director for Board Committees

Board Committee	Lead Executive Director
Quality and Safety Committee	Director of Nursing & Clinical Delivery and Medical Director
People Committee	Director of People and Organisational Development
Resource & Performance Committee	Chief Finance Officer
Audit Committee	Director of Governance
Remuneration Committee	Director of Governance
Charitable Funds Committee	Chief Finance Officer

Appendix 3 – Performance Delivery Meetings & Governance

Meeting	Frequency	Who	Report
Board of Directors	Monthly	Chair - Chair Trust Board	Trust level Integrated Performance Report Annual objective review (quarterly) Committees to review all Committee KPIs and present a performance overview through the Chair's report.
Execs/SLT	Monthly	Chair – CEO Execs Meeting	Trust level Integrated Performance Report and review of Trust operational performance review meeting Execs to review Directorate KPIs.
Execs	Weekly	Chair – CEO Execs Meeting	Key performance indicators weekly exceptions e.g. patient safety incidents, infection control, waiting times targets, activity and financial performance
Trust Performance Board	Monthly	Chair – Chief Finance Officer Execs, Directorate Management Team	Trust level Integrated Performance Report, unit exception reporting, strategic updates, financial performance, key risks, actions plans
Directorate Meetings	Monthly	Chair – Directorate Lead	Key performance metrics for directorate, departments and services. Performance against corporate objectives, strategic updates, unit scorecard exception reporting, financial performance, key risks, action plans and update of participation in organisational development programmes

Appendix 4 - Framework

Shropshire Community Health NHS Trust

Board of Directors (BoD)

The BoD holds the Executive Directors to account for delivery of plan targets and objectives.

The BoD receives progress/performance reports.

The BoD delegates assurance activities (focused on the areas identified in the Board Assurance Framework).

The BoD receives 'independent' assurance from Board Committees

The Executive Directors manage performance delivery by delegating responsibility through line management structure and to a number of responsible teams /Directorates

Principles underpinning the Performance Management Framework

- Ensuring all operational, financial and project targets, objectives and KPIs are fully understood and have been assigned to an appropriate unit owner.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target.
- Driving consistency and alignment of performance information and reports at all levels – exception based reporting were possible.
- Constructively challenge performance delivery against agreed targets, confirming escalation criteria and recommending timely actions where appropriate.

Board Committees

Board Committees:
Audit Committee
Quality and Safety Committee
Resource and Performance Committee
People Committee

Other Board Committees:
Remuneration Committee
Charitable Funds Committee

Additional Time-Limited Committees:

Shropshire Community Health
NHS Trust

Appendix 5 – Dashboard Example

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	2024-05-31		6.1	6.4	-0.3	6.1	6.4	-0.3	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-05-31		2	0	2	2	0	2	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-05-31		4.00	0.00	4.00	4.00	0.00	4.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-05-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-05-31		98.16%	95.00%	3.16%	98.77%	95.00%	3.77%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30		83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-05-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-05-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Serious Incidents (reported)	2024-05-31		0	0	0	0	0	0	

Shropshire Community Health
NHS Trust

Appendix 6 – Action Plan Template

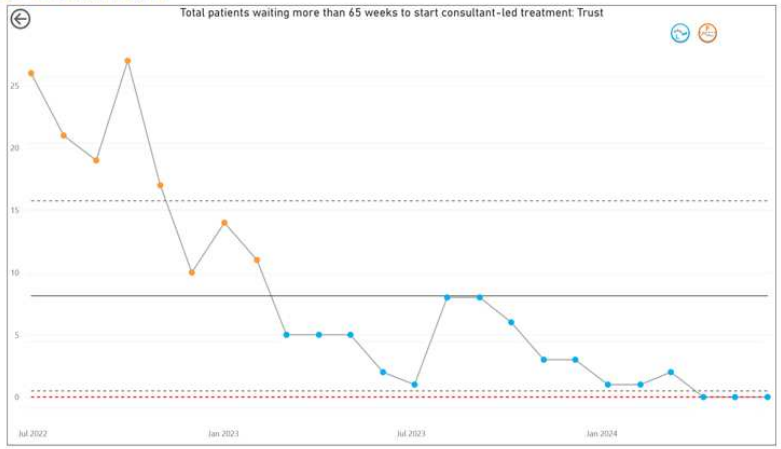
Exception Report - Action Plan

Total patients waiting more than 65 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 65 weeks and over

KPI Description	Latest 6 months	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
RTT 65+ week waits	Number	1	1	2	0	0	0	0
	Target	0	0	0	0	0	0	0

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Number	3	0	0	0	0	0	0



Reason for performance gap:					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
Author		**Date**			
Accountable Officer Approval		**Date**			

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Audit Committee – May 2025

0. Reference Information

Author:	Stacey Worthington	**Paper date:**	28 May 2025
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	28 May 2025
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit Committee meeting held on 28 May 2025 for assurance purposes. The Audit Committee is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

The Committee met on 28 May 2025 and was quorate with 3 Non-Executive Directors and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen within the main report.

2.3. Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Audit Committee – May 2025

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Audit Committee which met on 28 May 2025. The meeting was quorate with 3 non-Executive and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Harmesh Darbhanga	Chair – Non-Executive Director
Tina Long	Non-Executive Director
Jill Barker	Non-Executive Director
Sara Ellis-Anderson	Deputy Director of Nursing
Shelley Ramtuhul	Director of Governance
Sarah Lloyd	Director of Finance
Stacey Worthington	Executive Assistant / Corporate Office Manager (Minute Taker)
Gill Richards	Associate Director of Governance
Gurpreet Dulay	Internal Audit
Richard Anderson	External Audit
Harry Jones	Apprentice PA (Shadowing)
Apologies:	
Cathy Purt (Non-Executive Director), Clair Hobbs (Director of Nursing)	

3.2 Actions from the Previous Meeting

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

AGENDA ITEM / DISCUSSION		ASSURED (Y/N)	ASSURANCE SOUGHT
3.	**DECLARATIONS OF INTEREST** None declared.	N/A	
4.	**REVIEW OF THE ACTION LOG** The Committee reviewed the action log and noted the actions that could be removed.	FULL	
6.	**BOARD ASSURANCE FRAMEWORK** Committee noted the report and the updates provided. It was noted that risks removed from the BAF did not mean that they were not a risk, but that they were not a risk related to the Trust's overall strategic objectives for the year.	FULL	

Chair's Assurance Report

Audit Committee – May 2025

7.	**RISK MANAGEMENT REPORT** Report discussed and noted. A review of the information included in the report going forward would take place, as Datix improvements had been made, so information could be presented in a more user friendly format. Number of risks opened and closed per quarter to be added to the report going forward.	FULL	
11.	**DSPT** Verbal report provided. Noted that there was still significant work to do against the 47 new outcomes we are required to measure against. Risk that we may not meet the deadline and that an improvement plan would be needed, this was not an unusual picture nationally.	PARTIAL	
12.	**LOSSES AND COMPENSATION REPORT** Learning in relation to the losses to be circulated widely around the Trust to ensure that all learning is embedded.	FULL	
14.	**SCHEME OF DELEGATION** Due to the national requirement for NHS Trusts to reduce their costs, it had been agreed that individual directors would be required to review any spend above £50k for a trial period of three months.	N/A	
17.	**INTERNAL AUDIT REPORTS** The Committee reviewed and discussed the internal audit reports.	FULL	
18.	**EXTERNAL AUDIT PROGRESS REPORT** External Auditors were on track to complete the Value for Money Audit by 13 June, two weeks ahead of schedule. There were no significant concerns to bring to the Committees attention.	FULL	

Chair's Assurance Report

Audit Committee – May 2025

4. Risks to Escalate

There were no risks to escalate.

5. Conclusion

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

Looking after our People — OBJ 1

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

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

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2025

Key Measures:

Sustained improvement compared to 24/25 across:

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

Progress Update:

- NHS E recognition for the improvement in all elements of the people promise in the staff survey results
- Key people measures and trajectories agreed by the Board and will be reported via People Committee going forward

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- People promise resource available

Risks:

1.1 Workforce team capacity Carried forward from 24/25

1.2 Recruitment restrictions impacting on staff morale and wellbeing Carried forward from 24/25

In addition the People Committee identified that delivery of this objective may be impacted by the significant changes taking place at national, system and local level and agreed a risk assessment of this should be undertaken and included in the BAF going forward

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

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

Principal Risk: Workforce Team Capacity

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: May 2025

Source of Risk: Internal Risk Assessment

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 being developed
- C2: Capacity to progress with centralised bank
- C3: Staffing vacancies in ESR team – being mitigated and will be addressed through new structure
- C4: People Promise Manager is a fixed term post with funding until Summer 2025 – being addressed through new structure

Gaps in Assurance:

- Volume of reports going to People Committee minimises impact of assurance

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Scoping of collaborative working options	Director HR and OD	June 2025	Collaborative working is underway with further opportunities being scoped, with benefits to be realised in 25/26.
C4	Business case to be developed to ensure retention of People Promise Manager role	Director HR and OD	June 2025	Business case was rejected but new structure to address the gap

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

Principal Risk: Recruitment restrictions impact on staff morale and wellbeing

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: May 2025

Source of Risk: Internal Risk Assessment

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~~
- A2: Board interview feedback to be shared

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Promotion of flexible work and retire and return	Director of HR	Ongoing	Comms has been issued about flexible working and retire and return
C4	Action plans to be put in place to take forwards staff survey results	Director of HR	June 2025	Managers toolkit in place, local and corporate level improvement plans being worked on
A2	Board interview feedback to be shared with Exec Team before onward submission to the Board	Director of HR	June 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 NHS Long Term Workforce Plan development and benefits realisation from the Admin Academy

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2025

Key Measures:

Sustained improvement compared to 24/25 across:

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

Progress Update:

- Key people measures and trajectories agreed by the Board and will be reported via People Committee going forward

Supporting Programmes of Work:

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

Key Assumptions:

- People Promise Resource

Risks:

Risks 1.1 and 1.2 as above

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Caring for Our Communities — OBJ 3

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

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

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025
Reviewed Date: May 2025

Key Measures:

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

Progress Update:

- Staff training in PSIRF compliant safety investigations d AARs completed with possibility of funding further training via CPD being explored
- 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
- Work on new Datix system has commenced
- Internal audit of PSIRF completed with no major flags
- Patient Safety Oversight Board report put in place

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF 3.1	Reliance on volunteer input for key patient experience workstreams such as observe and act Recommended for closure
BAF 3.2	Quality Improvement Team capacity Carried forward from 24-25
BAF 3.3	Completion of actions linked to learning responses NEW
BAF 3.4	Demand exceeds capacity Recommended for closure
BAF 3.5	Potential for patient harm due to waiting times Carried forward from 24-25
BAF 3.6	Recruitment challenges Carried forward from 24-25

In addition, internal audit picked up a risk relating to the tracking of actions following thematic reviews and this has been addressed by adding the actions to Datix for follow up and monitoring by the Governance Team

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home **BAF 3.1**

Principal Risk: Reliance on volunteer input for key patient experience workstreams such as observe and act **RECOMMENDED FOR CLOSURE**

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: May 2025

Source of Risk: Internal Risk Assessment

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:

- N/A

Gaps in Assurance:

- ~~A1: No tracking of recruitment and retention of volunteers~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
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. New system in place - Commpleted

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home **BAF 3.2**

Principal Risk: Quality Improvement Team Capacity **CARRIED FORWARD FRO 2024/25**

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: May 2025

Source of Risk: Internal Risk Assessment

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
- C2: 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
C2	Recruitment to quality posts	Director of Nursing	July 2025	Recruitment completed awaiting start dates

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

Principal Risk: Completion of actions linked to learning responses NEW

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

Risk Rating:

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

Risk Details:

Opened: May 2025

Reviewed Date: May 2025

Source of Risk: Internal Audit

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

- C1: Divisional governance reporting still embedding
- C2: Complaints action reporting not as mature

Gaps in Assurance:

- A1: Board oversight

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Review of PSIRF reporting at Divisional Governance meetings with Director of Nursing and Associate Director of Governance, Deputy Director of Nusing.	Director of Governance / Director of Nursing	June 2025	Reporting has been put in place but this should be reviewed to assess opportunity to strengthen further in light of internal audit finding
C2	Process for monitoring of complaints actions to be brought in line with the process for incidents	Director of Governance	July 2025	Actions have been logged on Datix and reporting has commenced
A1	Board Oversight Report to be put in place	Director of Governance	June 2025	Draft report went to Board in April, full report to go to Public Board in May and to continue on a quarterly basis

Principle Objective: We will continue to support our staff to embed quality improvement methodology to improve staff and patient experiences in bringing care closer to home **BAF 3.4**

Principal Risk: Demand exceeds capacity RECOMMENDED FOR CLOSURE

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:	Internal Risk Assessment
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	

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

Principal Risk: Potential for patient harm due to waiting times CARRIED FORWARD FROMM 2024/25

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:	May 2025
Source of Risk:	Internal Risk Assessment
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 proforma on Rio with audit capability

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

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

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	Divisional Leads to take process forward	Director of Nursing / Director of Operations	July 2025	Deputy director of Nursing has cascaded new policy and requested divisional leads to take forward
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~~ May 2025	Not yet started, policy has been ratified

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

Principal Risk: Recruitment challenges CARRIED FORWARD FROM 24/25

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: May 2025

Source of Risk: Internal Risk Assessment / External Guidance and Controls

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~~
C2: Lack of centralised bank
C3: Cessation of HCA agency without mitigations

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
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 for medical cover in community hospitals to be completed and progressed	Director of Operations / Medical Director	September 2024	Options appraisal completed and approved to go out to for bids - completed
C3	Explore options of third party NHS bank staff provider			Exploring with NHSP
C3	Implementation of ETOC programme			Launch event attended and project group being established

Caring for Our Communities **OBJ 4**

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention

This objective will focus on implementing integrated neighbourhood (INT) schemes – Phase 1 and partnership management prioritisation and approach

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2025

Key Measures:

- ✓ Evidence of left shift of work and care to community services
- ✓ Strengthened relationships with system partners in developing INT model
- ✓ Identify key partners beyond ICS and LA support SCHT in delivering its Strategy through delivering against critical success factor for these relationships

Progress Update:

- 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:

4.1 Operational Capacity to undertake all programmes of work Carried forward from 2024/25

4.2 Internal governance and operational oversight arrangements for system programmes Carried forward from 2024/25

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention **BAF 4.1**

Principal Risk: Operational capacity to undertake all programmes of work **CARRIED FORWARD FROM 2024/25**

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: May 2025

Source of Risk: Internal risk assessment

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~~ May 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~~ May 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	As of April system PMO is up and running and will continue to evolve - completed

Principle Objective: We will work in partnership to constantly improve, recovery and redesign patient pathways and prevention **BAF 4.2**

Principal Risk: Internal governance and operational oversight arrangements for system programmes CARRIED FORWARD FROM 2024/25

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:	May 2025
Source of Risk:	Internal Risk Assessment / Integrated System Improvement Plan
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 - Completed
C2/A2	Risk management to be aligned across the system	Director of Governance	~~December 2024~~ ~~February 2025~~ June 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 — OBJ 5

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

This objective will focus on delivering an in year CIP and 3 year rolling CIP plan, achieving digital maturity (DCF) and the ten year sustainability plan annual goals

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: May 2025

Key Measures:

- ✓ Delivery of the financial efficiency targets sustained through attainment of both in year and updated rolling CIP schemes
- ✓ Demonstrable productivity improvements through automation
- ✓ Demonstrable improvement in patient access, quality of care and reduced risks
- ✓ Continued improvements in our environmental efficiency and sustainability against clear goals from central government
- ✓ Demonstrating a financial return on investments

Progress Update:

- Co Pilot licences rolled out and being used, AI opportunities being rolled out and therefore digital modernisation is progressing well
- Datix Cloud bring rolled out to improve the collation and use of patient safety data to inform quality improvements
- E-community investment has been prioritised

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

5.1 Risk of cyber attack Carried forward from 2024/25
5.2 Digital team capacity Carried forward from 2024/25
5.3 Costs exceed plan Carried forward from 2024/25
5.4 Insufficient Capital Funding Recommended for closure

Lead Executive

Director of Finance

Lead Committee:

Resource and Performance Committee

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services **BAF 5.1**

Principal Risk: Cyber attack CARRIED FORWARD FROM 2024/25

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: May 2025

Source of Risk: Internal Risk Assessment

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: New standards require assessment and revision to systems and processes to ensure compliance

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	June 2025	Standards met for 2023-24, 24-25 baseline has been submitted with identified challenges being worked through with DSPAG oversight

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services **BAF 5.2**

Principal Risk: Digital Team capacity

Lack of capacity results in programmes of work being paused or delayed, loss of momentum with digital agenda, staff unsupported with digital service needs. Potential to impact on improvement with RTT

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	5	5	2
Total	20	20	8

Risk Details:

Opened: September 2023

Reviewed Date: May 2025

Source of Risk: Internal Risk Assessment / Vacancy Rate

Corporate Risk Register

Controls:

- ✓ Digital strategy and programme of work in place
- ✓ Regular team meetings with oversight from Director of Finance
- ✓ ~~Prioritisation undertaken with clinical leads~~

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~~
- C1: Exploring opportunities to share expertise with system partners

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

Principle Objective: We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services **BAF 5.3**

Principal Risk: Costs exceed plan CARRIED FORWARD FROM 2024/25

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	4 ↑	2
Total	20	16↑	6

Risk Details:

Opened: April 2022

Reviewed Date: May 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 Transformation Group oversight
- ✓ KPI Metrics
- ✓ Value for Money audit

Gaps In Controls:

- C2: Unidentified risk relating to B2/B3 review
- C3: Unfunded overperformance in relation to inpatient activity / increased dependency of patients

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
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.
C3	Mitigating actions to be explored with the ICB	Director of Finance	July 2025	CEO has written to ICB CEO outlining the risks

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 5.4**

Principal Risk: Insufficient Capital Funding RECOMMENDED FOR CLOSURE

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: May 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	No increase, capital funding confirmed with no increase, programme has been modified to account for this. Oversight from Capital and Esates Group