Shropshire Community Health NHS Trust

Trust Board - 7 August 2025

MEETING

7 August 2025 10:00 BST

PUBLISHED

1 August 2025

Agenda

Location	Date	Time
The Ramada Hotel, Telford	7 Aug 2025	10:00 BST

Contents

Shropshire Community Health NHS Trust

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE RAMADA HOTEL, TELFORD AT 10.00 AM ON THURSDAY 5 JUNE 2025

PRESENT

Chair and Non-Executive Members (Voting)

Mr. Andrew Morgan	(Chair in Common)
Ms. Tina Long	(Non-Executive Director and Vice Chair)
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)
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)

In Attendance

Mr. Simon Balderstone	(Deputy Chief People Officer)

Welcome

The Chair in Common welcomed all members to meeting and the staff and public present

Apologies and Quorum

Apologies were received from Ms Sarah Lloyd, Director of Finance. The Chair in Common declared that the meeting was quorate.

Declarations of Interest

Ms Cathy Purt declared she had been re-elected as member of Whitchurch Town Council and had been nominated as Chair of the Health and Social Care Committee.

Minutes of the Meeting held on 3 April 2025

Subject to the amendment of the date to 2025 not 2024, the minutes were agreed as an accurate record of the meeting.

Patient Story

Julie Roper, Clinical Services Manager across Urgent Care Portfolio attended to share with the Board a patient story from the virtual ward. The Virtual Ward (VW) team is a multi-disciplinary team of professionals who provide acute care to patients in the community in their own homes.

The Board were informed that there were 5 pathways – frailty, respiratory, cardiology, general medical pathway and the recently implemented surgical pathway, with patients accessing the service both stepping down from hospital and preventing patients having to go in.

The Board heard the story of a 21 year old lady, who had been admitted to SaTH for a kidney infection, optimised on treatment and sent home for monitoring. She was initially seen by the VW team for 3 days consecutively and wished to return to work, the team did an initial assessment and she was able to return to work whilst still receiving care, supported by twice daily telephone calls and remote monitoring. During these calls, it was noted the her blood pressure had started to drop and heart rate increased, these findings were escalated back into acute trust and she was readmitted to hospital.

The team had reflected on what could have been done differently to prevent readmission, but noted that we didn't recognise the ability to see the deterioration earlier, current EPR doesn't give ability to track trends, put in place a hard copy of the NEWS score, the team didn't escalate early enough to put in further interventions. New remote monitoring intervention LUCII – can continuously remotely monitor, patient can input info via an app and system will alert anything outside of acceptable parameters. Will also alert if the patient does not enter any information. Gives patient the ability to take ownership of their own care

Mr Morgan commented on the huge amount of work and the alignment of this work to the three shifts being promoted nationally; digital, left shift and prevention.

Ms Sargent asked how the team ascertained whether a patient is suitable to use the technology, Ms Roper said that the team would always see the patient face to face first, so that an assessment could be undertaken, which would take into account any extended family or wider support available for the digital solution.

Ms Barker asked if learning and reflections had been shared across the whole system? Ms Roper confirmed that a permission to pause was conducted and had been shared widely.

Public Question Scheme

Ms Ramutuhul presented the proposed changes to the handling of public questions. The main changes included accepting verbal questions on the day if time permits and questions were not limited to the agenda but to anything within the powers and duties of the Trust

The Board approved the adoption of the updated scheme for public questions

Public Questions

Ms Ramuthul confirmed that three questions had been received from members of the public which she summarised as follows:

Whether the Board are aware that the Shropshire Admiral Nurse service is still not listed in their website and only the Telford service is listed. There was a concern raised that this would mean that Shropshire people cannot find out about this service.

Ms Ramtuhul advised that the website has been checked and it was clear that the service was available to patients registered with a GP in Shropshire and Telford and Wrekin, however, it was noted that the service location listed was Telford. This has been raised with the team and was in the process of being updated.

Could the Board explain please why bereaved families who have raised concerns of the care their relatives have received at the End of their Life are not involved in the learning from deaths review and not informed of any outcome of this review or informed of any learnings taken from this outcome?
I would appreciate clarification of how the Trust ensures that families are involved in Learning in Death reviews and under what circumstances are families excluded?

It was confirmed that all unexpected deaths were reviewed by the Learning from Deaths Panel and then referred to PSIP and family engagement would be via this process. Expected deaths do not include family but the Trust would look at how this was addressed further.

How does the Trust ensure that it upholds the Nolan Principles when handling complaints and ensures that it responds to concerns with honesty and integrity

Ms Hobbs summarised the complaints process once a complaint had been received in the Trust. Any complaint response was reviewed by Ms Hobbs to ensure it was open and transparent and she would challenge at this stage if she did not feel this was happy. The Chief Executive would provide the final sign off for all complaints.

Patient Safety Oversight Report

The Board received a presentation on the Patient Safety Oversight report, which included the recent changes made by the Trust to deliver the PSIRF plan. The overview report would include the types of incidents that have occurred and the Trust's response, which would include any themes of learning.

Clinical Governance now sat within the wider Governance team, which was showing real benefits.

Ms Long asked how patients and carers were involved in the process, it was confirmed that there was a patient experience lead in post, who attended the patient safety panel and was working on the processes in place to strengthen them.

Board were assured regarding the robust internal processes for reviewing and monitoring patient safety incidents, ensuring that system-based improvement actions are identified and implemented to enhance patient safety.

The Board noted the report and the assurances within, that the Trust had a robust internal process for reviewing and monitoring patient safety incidents, ensuring that system-based improvement actions are identified and implemented.

Chair in Common's Report

Mr Morgan stated that the Chief Executive in Common position was out for advertisement, which would be the Group Chief Executive Designate. A series of engagement sessions were underway with staff and system partners. The final interviews would take place in July.

Mr Morgan summarised the national and regional meetings he had attended. There had been Local Elections in May in Shropshire and Mr Morgan provided his congratulations to the new Leader of Shropshire Council, Cllr Heather Kidd, Liberal Democrat. Cllr Bernie Bentick had been appointed as the Cabinet Member responsible for Health. Ian Green had been appointed as the new Chair of Shropshire, Telford & Wrekin ICB and would start this role on 1 July.

Finally, Mr Morgan noted that Ms Davies would be leaving the Trust at the end of August to take up a role in Manchester. He thanked Ms Davies for her work at the Trust and for the population we serve.

Non Executive Directors Communications

Ms Long had attended the System financial committee which had focussed on the system financial strategy and plan. She had also visited Bishops Castle Community Hospital recently, which had been very positive, with good patient feedback received.

Ms Barker had attended the System quality and performance committee and noted that she welcomed the joint discharge piece of work being done.

Mr Darbhanga had attended a planning and strategy visit and had discussed staff concerns on the group model. Mr Morgan recognised that the group model was being conflated with the corporate service cuts.

Ms Purt had attended the opening of the Whitchurch medical centre, which had been renamed as the Clayton Medical Centre. She had also chaired the Strategy and Prevention committee for the ICB.

Chief Executive's Reports

Ms Davies summarised her report, highlighting the national news on NHS reform and reduction of corporate costs. The Trust was working with partners to look at integrated shared services to ensure resilience while achieving reduction in cost.

Ms Davies congratulated the winners of the ACE awards and noted that each demonstrated the huge respect peers have for their colleagues.

Provider License Certification

Ms Ramuthul presented the draft certification, which had been presented to Audit Committee.

The Board approved the certification and authorised the signatory by the Chief Executive and Chair in Common.

Quality and Safety Committee Chair's Report

Ms Barker presented the report. Committee received the quality account, a comprehensive report on the paediatric psychology, had a detailed conversation around fire safety at community hospitals. There had been good progress with policies although there were some high risk policies still outstanding to be prioritised.

Ms Long asked about fire safety, Ms Hobbs confirmed that working with the fire service all staffing levels had been reviewed.

The Board noted that the meeting had taken place and the assurances obtained.

Integrated Quality and Safety Performance Report

Ms Hobbs summarised the report and noted there had been 12 cases in the year to date, all of which had been deemed as unavoidabld. Ms Davies stated that there was more work to do at a System level on testing to understand typing, which had been escalated to the System quality meeting. The Board asked for their concerns to be highlighted.

The Board accepted the report.

Annual Quality Account

Ms Hobbs advised that the Account due to be submitted to NHS England at the end of June.

Ms Long stated it was a positive report and showed the achievements on the quality front.

The Board noted the report.

People Committee Chair's Report

Ms Purt presented the report and highlighted that there had been partial assurance for health and wellbeing action plan, as the Committee felt there should be more for male colleagues. There was also partial assurance on the people operational plan the deliverables and milestones, with further work needed on affordability.

Ms Davies picked up the importance of promoting men's health, a huge amount has been done on women's health and particularly around menopause, and it was important that men's health be promoted too.

The Board noted that the meeting had taken place and the assurances obtained.

Workforce Report

Mr Balderstone summarised the report and noted that it set out the KPIs that underpin delivery of the workforce plan. Agency usage was slightly over plan, which had been linked to enhanced care and escalation, however, overall there had been an underspend on

agency, demonstrating the positive actions that had been taken, such as the price cap compliance.

There remained a variation concern in relation to mandatory training, which had been improving and last month hit target. Appraisal rates had increased but were still slightly short of target.

The Board considered the performance across relevant indicators to date and discussed the actions taken to mitigate any risks to either the resources available to the Trust or to the Trust's performance.

RPC Chairs Report

Ms Long presented the paper which was in relation to the March Committee. Full assurance had been obtained on all items considered, with exception of the deep dive for agency usage, as the Committee would like to see the expected impact of the actions.

Ms Long verbally updated the Board on the which had held the previous week, most items had received full assurance and there had been a good report on waiting times for all services. The agency deep dive remained at partial assurance.

There had been a significant shift in relation to CIP, assurance regarding the programme and that processes had been followed but recognised the challenges.

Ms Long asked about QEIAs for CIP schemes, Ms Davies confirmed that each scheme had a QEIA, which was managed through the PSIP process. Ms Horsfield advised that QEIAs with higher risks could go through the QEIA panel, which was agreed.

The Committee noted that the meetings had taken place and the assurances obtained.

Integrated Performance Report

Ms Ramtuhul summarised the report on behalf Ms Lloyd. Ms Horsfield stated that there had been two 65 week breaches, both of which were in MST and she confirmed that both patients have been seen. There had been one reported 104 breach, however, this was a data quality issue so no patient attached to this. All waiting times showed improvements.

Ms Purt asked if patients waiting over 65/78 were for specific services, it was noted that the majority of people waiting this long sat in MSST and some in CNRT.

The Board:

- **Considered the Trust's performance to date and the actions 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 assurances provided to the Board in relations to the actions being taken to improve performance.**

Financial Report

Ms Ramtuhul summarised the report of Ms Lloyd.

Ms Purt asked if we had checked our CIP against SaTH's to ensure that there were no unintended consequences. Ms Horsfield confirmed that a firm red line had been drawn that identified there should be no harm to patients and no consequences for partner

organisations. There was a System group which would look at schemes where there was a potential for an impact elsewhere.

The Board:

- **Considered the adjusted financial position at month 1 was a surplus of £66k, compared to the planned surplus of £74k, which was an adverse variance of £6k.**
- **Recognised that overall pay costs must remain within planned levels to ensure we deliver our financial plan, the key of which was containing bank and agency spend within our target for the year.**
- **Acknowledged that schemes were now fully identified to deliver the annual CIP target of £5.4m, although 29% of identified schemes were rated as high risk in terms of delivery.**
- **Acknowledged that there are ongoing cost pressures in a small number of areas, plans were being developed to mitigate these pressures as far as possible.**

Estates Strategy Update

The report was presented and Mr Morgan noted that there would be further benefits to the Trust when exploring the Group Model.

The Board:

- **Acknowledged the good progress to date towards delivery of our Estates Strategy.**
- **Considered the assurances provided in relation to compliance and cost.**
- **Noted that our Estates Strategy may require updating following publication of the NHS 10 year plan.**

Delivery Against 24/25 Operational Plan

The Board noted the end of year performance against the 2024/25 Operational Plan. The plan was developed following feedback from staff, members of the Board, national planning guidance and partner organisations.

Key achievements in 2024/25 included improved staff survey results, reduced sickness and use of agency.

The Board:

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

25/26 Performance Report

The paper had been reviewed through the Resource and Performance Committee and had been recommended for approval by the Trust Board.

The Board:

- **Considered the updated Performance Framework and if any amendments were required in order to provide adequate assurance to the Board in relation to how performance is managed.**
- **Approved the Trust's updated Performance Framework.**

- **Noted that our Framework is likely to require updating following publication of the National Performance Assessment Framework later in the year.**

Audit Committee Report

Mr Darbhanga summarised the report.

The Board noted that the meeting had taken place and the assurances gained.

BAF

Ms Ramtuhul summarised the report.

CHIEF EXECUTIVE'S REPORT – AUGUST 2025

Introduction

1. This paper provides an update on issues of importance to the organisation which have arisen since the last public Board meeting on 5 June 2025 and are not covered 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

   The Board is asked to consider the contents of this report.

National and Local News

National News

2. There have been a number of publications over the last two months which I would like to bring to the Board's attention.

2.1 On 3 July '**Fit for the Future: 10 Year Health Plan for England'** was published; this is an important document which sets out the plan for the future of the NHS.

Fit for the future: 10 Year Health Plan for England

The key messages from the plan are summarised below:

- The 10 Year Health Plan sets out a bold, ambitious and necessary new course for the NHS.
- It seizes the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients and better value for taxpayers.
- The Government is fundamentally reinventing its approach to healthcare, so that it can guarantee the NHS will be there for all who need it for generations to come.
- Through the *three shifts*, care will be personalised, more power will be given to patients, and the best of the NHS will be available to all.

The Three Shifts

From hospital to community; transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home.

From analogue to digital; creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide.

From sickness to prevention; shifting to preventative healthcare by making healthy choices easier—banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families.

Whilst the plan sets out ambitions for the next 10 years, much of it is anticipated to deliver more quickly, with the following planned by 2028/29.

HOSPITAL TO COMMUNITY

Same-day digital and telephone GP appointments will be available and calls to GPs will be answered more quickly – ending the 8am scramble.

A GP led Neighbourhood Health Service with teams organised around groups with most need.

Neighbourhood Health Centres in every community; increased pharmacy services and more NHS dentists.

Redesigning outpatient and diagnostic services.

Redesigning urgent and emergency care, allowing people to book into UEC services before attending via the NHS App or NHS 111.

People with complex needs will have the offer of a care plan by 2027 and the number of people offered a personal health budget will have doubled.

Patient-initiated follow-up will be a standard approach.

ANALOGUE TO DIGITAL

The NHS App will be the front door to the NHS, making it simpler to manage medicines and prescriptions, check vaccine status and manage the health of your children.

'HealthStore' to access approved health apps: Enabling innovative SMEs to work more collaboratively with the NHS and regulators.

A Single Patient Record will mean patient information will flow safely, securely and seamlessly between care providers.

Digital liberation for staff with the scale of proven technology to boost clinical productivity.

SICKNESS TO PREVENTION

Health Coach will be launched to help people take greater control of their health, including smoking and vaping habits later this year.

New weight loss treatments and incentive schemes to help reduce obesity.

The Tobacco and Vapes Bill will be passed, creating the first smoke-free generation.

Women will be able to carry out cervical screening at home using self-sample kits from 2026.

2.2 In addition to the transformative 10 year plan, in early June the **Urgent and Emergency Care Plan for 2025/26** was published.

NHS England » Urgent and emergency care plan 2025/26

This sets out how all system partners are required to work collaboratively to improve the effectiveness of urgent and emergency care pathways. It is based on seven priorities for improvement including:

- ambulance handover times
- waiting times in A&E
- access for children
- and tackling delayed discharges.

We already work closely with system partners to deliver improvements across Urgent and Emergency Care pathways and will continue to implement key programmes of work aimed at delivering these priorities. This work also aligns to the system's Winter plan which will be presented to the Trust Board in September for review and approval.

2.3 On 26 June 2025, NHSE published its **Oversight Framework for 2025/26** which includes a revised approach to the oversight of Integrated Care Boards (ICBs), trusts, and foundation trusts and builds the foundations for the ten-year health plan. This is a one-year framework which will be reviewed again in 2026/27.

NHS England » NHS Oversight Framework 2025/26

The Framework reiterates the government's focus on granting high-performing providers additional freedoms, with a commitment to review the incentives available. The new Framework is underpinned by a scoring approach to performance and this score is strongly influenced by benchmarking against other trusts.

Metrics relevant to an organisation will be assigned a score and this will influence the overall segmentation of that organisation. A financial override will limit providers in deficit, or in receipt of deficit funding, to segment 3 or below. In addition to these short-term and operationally focused metrics, there are contextual measures focused on medium-term goals which do not contribute to the scoring but will inform how NHSE responds to the segmentation.

Due to the current changes across ICBs, their scores will not be introduced until 2026/27. Where providers are part of a provider collaborative or group model, they will be measured as an individual Trust and not as a wider group.

The Framework introduces an additional fifth segment to better identify those organisations most in need of support. Provider capability ratings will inform NHSE's improvement response to ensure support is directed to those organisations that are unable to improve on their own.

It is anticipated that the initial segments will be published in late August or September and will then be presented for discussion to the Trust Board.

Local News

2.4 Board members will be aware of the Resident Doctors strike action between 25-30 July. Whilst this was not anticipated to have a significant direct impact on the delivery of care within ShropCom, plans were in place to maintain safe levels of patient care and support System partners to help minimise the impact on wider services.

2.5 Neighbourhood Health is central to the Government's ambitions within the 10 Year Plan. NHSE has invited systems across the country to apply for phase one of the National Neighbourhood Health Implementation Programme. This programme will gather and disseminate learning to create exemplars and support Places to embed the culture and capability required to deliver a Neighbourhood Health service.

ShropCom is actively involved in this work, together with key local stakeholders, and has confirmed its commitment to advancing this programme.

Looking After Our People

3. In early July, close to the day that the NHS celebrated its 77th birthday, I had the pleasure of attending our long service awards with many other members of the Trust Board.

Together, we celebrated colleagues who have worked for the NHS for 25 or, in some cases, 40 years! We presented almost forty people with their awards and there were many others who sadly could not join us on the day to celebrate. We heard a little about each person and their incredible contributions to the NHS, and their combined service totalled 1,100 years, which is staggering.

Thank you to all our amazing people who serve the NHS with such commitment and dedication, it is appreciated.

Caring for Our Communities

4. It has recently been confirmed that the Rehabilitation and Recovery wards at RSH and PRH will close later this year, and the estate will be returned to Shrewsbury and Telford Hospital NHS Trust for their use. There will be significant investment in community-based urgent and emergency care services. These services have been co-designed with partners and build on existing community pathways, learning from previous Winter schemes and aim to deliver the right care, in the right place, at the right time, by the right person.

   This investment supports the national and local strategic shift from hospital-based care to community care and ShropCom will deliver the following:

   - An extended Urgent Care Response service, including medical model
   - Integrated Community Front door in both EDs
   - Expansion of the Care Transfer Hub
     - System Manager role
     - Extended discharge planning
     - Additional therapy cover over weekends
   - Two hour domiciliary care service to support complex flow and allow swift discharge from Emergency Departments

   Mobilisation plans are in place, and the Board will be updated on progress to deliver the services and the benefits realised following a period of establishment.

Managing Our Resources

5. We heard recently that our Digital team and School Aged Immunisation Service won a national Health Service Journal Digital award for 'unlocking productivity and efficiency.'

   These are competitive awards, so it is a tremendous achievement and very well deserved. It is a great example of ShropCom teams working together to improve service user experience and delivery through digital innovation. Well done to everyone involved!

Good News Stories

6. We had a Royal visit at Stoke Heath Prison by HRH Princess Anne in July. She was there in her capacity as patron of the Butler Trust, a charity which celebrates excellence in UK prisons, probation, youth justice and escort services. During her visit she took time to meet with members of the Healthcare Team and received with delight one of the first jars of honey created through the recent food behind bars initiative. Princess Anne openly acknowledged the team's hard work and commitment to caring for prisoners.

0. Reference Information

Author:	Amy Fairweather, Patient Safety Lead	**Paper due date:**	7th August 2025
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	14th July 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 that Shropshire Community Health NHS Trust (SCHT) has a robust internal Patient Safety Incident review and monitoring process to ensure that we learn from any patient safety incidents, review themes and identify system-based improvement actions in ensuring patient safety.

Executive Summary

2.1 Context

The Trust has implemented the Patient Safety Incident Response Framework (PSIRF) into its policies and procedures. Incidents are reviewed at Patient Safety Incident Panel (PSIP) on a weekly basis where moderate harm and/or those that have an unexpected level of risk and/or potential for learning and improvement. PSIP ensures executive oversight, wider discussion and agreement as to the level of learning response.

This is the second oversight report of this nature.

2.2 Summary

The key points of this report are:

- PSIRF offers various methods to review incidents using a systems-based approach. These include 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.

3. Main Report

3.1 Introduction

System Learning Responses Commissioned in Period.

Learning responses commissioned over reporting period April 2025-June 2025.

Patient Safety Incident Investigations Commissioned (PSII) PSII'S	Opened	Closed / Progress Update
April 2025	1 Pressure Ulcer Shrewsbury South Community Nursing Team W74827	Investigation is underway -working towards 3-6 month PSIRF timescale i.e. on or before 9.10.25
May 2025	2 Declarations The first being a consolidated investigation into two medication incidents on Ward 36 R & R Ward and Whitchurch Ward W75768 & W75969). The second being a Pressure Ulcer under Whitchurch Hospital, W75946	Investigations underway – working towards 3-6 month PSIRF timescale i.e on or before 19.11.25 and 30.11.25 respectively.
June 2025	2 Declarations. The first being a review into a post custody death at HMP Stoke Heath, W73749. The second relating to management of Patients' diabetes whilst under Whitchurch Ward, W75899)	Investigation underway – working towards 3-6 month PSIRF timescale i.e on or before 12.12.25 and 19.12.25 respectively.
Total	5	0

AAR's	Opened	Closed
May 2025	1 W75803 -Joint with SaTH - involves transfer/treatment of a patient with C-Diff	Pending -date of AAR diarised for 16.07.25
June 2025	1 W75723 Joint with SaTH involves the suitability of transfer and escalation of an orthopaedic patient.	Pending -date of AAR in progress, have consulted SaTH as to availability
Total	2	0
Swarm Huddles	Opened	Closed
May 2025	1 W75800 relating to three separate incidents where patient and /or members of the public had tripped over cabling relating to a mobile breast screening unit, installed at the rear of the Bridgnorth MIU site, under care of Shrewsbury and Telford Hospitals (SaTH)	Closed
Total	1	1

3.2 Overview of actions arising from Learning Responses

Documentation

Updates to Electronic Patient Record RIO to enable the recording of a patient's supervision level to support effectively staffing each shift.

Agree on system-level documentation to ensure ease of use across prescribing and administering

ISBAR Tool Template: Develop for referrals between teams.

Ensure compliance with Trust's Records and Documents Management Policy and Data Protection Policy.

Review Adult Prescription & Administration Record

Patient Care

Strengthen working with the Hospice

E-Obs Implementation: Use mobile devices to collect and store patient observations.

Production Boards/Whiteboards: Display in each inpatient setting to prompt staff about clinical assessments.

Review Meetings: Bi-monthly with MPFT regarding patients who DNA (Do Not Attend) appointments.

Training

Arrange scenario-based training sessions for Community Teams over the summer.

In-house workshops on Enhanced Supervision Framework.

Review with End of Life (EOL) working group to build practice, competencies, and skills matrix.

Risk Management

Access to risk assessments completed by third parties relating to ShropCom sites.

Policy / Procedure

SOP for Mobile Units: Develop and approve standard operating procedures for notification and placement on SCHT sites.

Enhanced Supervision Policy: Revision linked with the 90-day ETOP programme, review by end of August 2025.

4. Conclusion

This reports on the Trust's work under the Patient Safety Incident Response Framework (PSIRF). The framework 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.

During the reporting period from April -June 2025, several learning responses were commissioned, including investigations into repeated trips, 2 x pressure ulcers, and 2 x medication incident as well as a custody death. Actions arising from these investigations have been documented, with oversight from the Governance team to ensure follow up and completion.

The report provides assurance that SCHT 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

The Shrewsbury and Telford Hospital NHS Trust

Better Together

Looking to the future

Draft Group Transition Committee (GTC)

Terms of Reference

1. Authority

The Group Transition Committee is established as a joint committee by the Trust Boards of both Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (ShropCom). The Standing Orders and Standing Financial Instructions of the Trust Boards and the Group Partnership Working Agreement, as far as they are applicable, shall apply to the committee and any of its established groups, either jointly or individually.

The Group Transition Committee holds only those powers as delegated in these terms of reference and will report to each Board.

The Group Transition Committee is authorised to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within its terms of reference. This includes referral of matters for consideration to another board committee or other relevant group.

2. Purpose of the Committee

The Group Transition Committee exists to scrutinise the robustness of and provide assurance to each Board on the development and delivery of a group model, the integration agenda and strategic aims and objectives for the benefit of our population.

The Group Transition Committee will be the lead committee for oversight of the development of the group model assurance document and the associated governance to develop a programme of integration focussed on the hospital transformation programme, the local care programme and shared services.

The committee will work with the other board committees to ensure that full oversight of the areas of responsibility is covered.

3. Membership

The members of the committee are:

(Chair) Non-Executive Director (Chair of SaTH and ShropCom)

Non-Executive Director (Vice Chair SaTH)

Non-Executive Director (Vice Chair ShropCom)

Chief Executive (SaTH)

Chief Executive (ShropCom)

Director of Strategy and Partnerships (SaTH)

Director of Finance (ShropCom)

Director of Governance (SaTH)

Director of Governance (ShropCom)

Director of Workforce and OD (SaTH & ShropCom)

Director of Communications (SaTH)

4. Attendance and Quorum

The committee will be quorate when four of the membership are present. This must include two Non-Executive Directors, and an Executive Director from each organisation.

By exception a deputy may attend on behalf of a member with the Chair's prior agreement.

If the Chair is unable to attend an alternative Chair will be nominated from one of the Organisations' Vice Chairs

Members should attend at least 75% of meetings each financial year but should aim to attend all.

The Chief Executive is the Executive Lead for the committee.

Other attendees may be invited to attend the meetings as appropriate.

5. Frequency

The committee will meet monthly for the first 12 months of establishment and will then be reviewed by each Board.

6. Specific Duties

The Group Transition Committee will:

• Consider and agree the strategic objectives of integration for onward approval of each Board

• Evaluate any risks associated with the delivery of strategic objectives and provide assurance to each Board that these risks are being effectively controlled and managed. If necessary, escalate such risks to ensure that timely and appropriate mitigation measures are implemented.

• Oversee the development of the outline, and subsequently, the full business case for a group model between SaTH and ShropCom

• Where appropriate the committee may request for deep dives to be undertaken to further understand any opportunities and risks of integration and any actions required

• Seek and receive assurance that all appropriate actions are being taken to ensure full participation in integration initiatives to support the move towards a group model

• Ensure that key enablers to the delivery of the integration agenda are carefully considered and included in the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer-term strategy, vision and values for the group.

• Review and provide assurance to the Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

• Agree and oversee the programme of work and establish any task and finish groups required to support its agenda.

7. Administrative support

The committee will be jointly supported administratively by the EAs of the Chief Executive for each organisation.

The committee will operate using a work plan to inform its core agenda.

Topical / emerging issues will be added to the agenda as required.

The agenda will be agreed with the committee chair and Executive lead prior to the meeting.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.

Items which miss the deadline for inclusion on the agenda may be added with permission from the chair.

Minutes will be taken at all meetings and circulated to members within 5 working days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The chair of the committee shall report to the Board of each organisation after each meeting and provide an upward report on assurances received, escalating any concerns where necessary.

The committee will, where necessary, advise the Audit & Risk Committees of the adequacy of assurances available and contribute to the Annual Governance Statements.

The committee will refer any necessary issues outside its terms of reference, as appropriate, to the relevant board committee or other relevant group.

9. Monitoring effectiveness and Compliance with Terms of Reference

The committee will complete an annual review of its effectiveness and provide an annual report to each Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The committee is established for an initial period of 12 months.

The Terms of Reference for the committee will be reviewed annually by the committee and submitted to each Board for approval and, together with the work plan, will be reviewed at each meeting of the committee to ensure they remain fit for purpose. The committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved by:

Next Review Date:

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality & Safety Committee Thursday 31st July 2025

0. Reference Information

Author:	**Jessica Donegan, Executive Assistant**	**Paper date:**	**7th August 2025**
Executive Sponsor:	Jill Barker, Non-Executive Director (Chair)	**Paper written on:**	31st July 2025
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Clinical Delivery & Quality	**Paper Category:**	Quality & Safety
Forum submitted to:	Quality & Safety Committee	**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 Quality & Safety Committee meeting held on 31st July 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 Summary

- Committee received an update on the actions from the Fuller report, following phase one of the inquiry, which was released November 2023,
- Committee agreed that the NHS resolution report would now be presented on a bi-annual basis as opposed to the quarterly updates that it had been receiving
- The recommendations for the Bi-Annual Quality dashboard were approved by committee
- The Fire Safety Group Terms of Reference were approved

2.2 Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Quality & Safety committee which met on 31st July 2025. The meeting was Quorate, with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair) Clair Hobbs, Director of Nursing, Clinical Delivery & Quality (Executive Lead)

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Tina Long, Non-Executive Director Claire Horsfield, Director of Operations & Chief AHP Shelley Ramtuhul, Director of Governance & Company Secretary Dr Ganesh, Medical Director Sara Elis-Anderson, Deputy Director of Nursing & Quality Clare Walsgrove, Head of Quality (observing) Sharon Simkin, Clinical Quality Lead ICB Jessica Donegan, Executive Assistant/Minute Taker
Apologies:
Cathy Purt, Non-Executive Director Alison Sargent, Non-Executive Director

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Integrated Quality & Safety Performance Report		
CHob presented the integrated quality and safety performance report, highlighting that all flagged actions are on track. She noted there were no C. Diff cases in June, but one occurred in July, bringing the total to five against a threshold of four, with ongoing deep cleans, Housekeeper hours and Ribo typing as mitigation. One unexpected death in June for a Community Team was attributed to natural causes, and two significant incidents—a death in custody and a diabetic incident at Whitchurch Hospital—are undergoing full PSII. Committee members discussed the need for greater assurance regarding deaths in custody, with TL requesting a comprehensive report on deaths, learning, and embedded actions for September. CHob confirmed this is in progress, and SR added that a thematic review is being commissioned with Solicitors. DrG assured the Committee of appropriate healthcare management in the Prison, while the Chair and CHor discussed benchmarking. TL also sought an update on	Full Assurance	

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the bed rail alert, with CHob explaining the risk-based approach being taken.		
2. PSII & DoC report		
SR presented the usual report detailing patient safety incidents (PSIs) and learning responses, noting that despite the pressure from the volume of cases, all investigations are on track and within the six-month completion timeframe. She highlighted that deaths in custody have been addressed, with a meeting planned with solicitors to review these cases and consider a thematic review, leveraging their existing involvement, she concluded by inviting questions on the report. During the discussion, the Chair inquired about the reporting of duty of candour, to which SR responded that it is completed as standard for all relevant cases and agreed it could be made more explicit in the report. TL sought clarification on the "permission to pause" and the bed alert incident, with SR confirming the incident was not related to required alert actions and was an issue with Mediquip. SEA explained that "permission to pause" is a method to disseminate key learning or information across the organisation, prompting staff to pause their work to read and learn from the information.	Full Assurance	Full assurance was taken on the basis that going forward Duty of Candour is explicitly highlighted within the report.
3. Policy Tracker		
SR reported that the policy tracker is improving, with fewer overdue policies and a forward look now in place to anticipate upcoming reviews. The process now includes early chasing and preparation for policies due for review, aiming to reduce the number of overdue items. It was clarified that some items on the high-risk policy list but not on the overdue list are actually guidelines, not policies, and noted that the food hygiene policy has only just become overdue, explaining its absence from the overdue list. CHob commented that a couple of overdue policies had been brought to PSC for approval but were not ready to be signed off, with work ongoing to complete them by September. SR acknowledged the high volume of policies coming through	Full Assurance	The committee agreed that the policy tracker should be a regular item on the meeting agenda unless there is nothing to report.

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Committees and suggested a separate meeting might be needed to handle the workload. TL raised concern about the Stoke Heath constant observation policy being significantly out of date and asked if it could be prioritised for review and completion, to which SR agreed and CHob acknowledging the Divisional Clinical Lead had been spoken to in this regard. The Chair noted that the deteriorating patient and risk of sepsis policy was not on the overdue list, and SR explained it is likely categorised as a guideline rather than a policy. SEA clarified that the high-risk policies have a forward look and that the deteriorating patient policy is not overdue yet but is coming up for review in the next three months.		
4. QSC related BAF risks & Corporate Risk Register		
SR shared the QSC-related Board Assurance Framework (BAF) risks paper, highlighting that the quarter one position for delivery of objectives related to quality improvement was assessed as green, indicating the team is on track. Four risks linked to this objective were discussed: quality improvement team capacity, completion of actions linked to learning responses from the PSIRF audit, potential for patient harm due to waiting times, and recruitment challenges. It was noted that actions have been updated with no overdue items at the time of reporting. She also highlighted the closure of the risk around demand and capacity, explaining that the risk has shifted from restoring pre-COVID activity levels to managing increased post-COVID demand, impacting waiting times and patient experience. The wording of this risk was updated in consultation with CHor. Actions for this risk include implementing a harm assessment policy and auditing the consistency of its application. Another risk discussed was the recovery and redesign of patient pathways and prevention, also marked green for quarter one, with no overdue actions. Two linked risks were operational capacity to undertake all programmes of work and internal governance and operational oversight arrangements for system programmes, which will be addressed through group work and shared services initiatives. SEA added that a Rio report on harm reviews had been completed, noting that 214	Partial Assurance	

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harm proformas were completed under the new format since May.		
5. Corporate Risk Register		
SR discussed and shared on screen the five corporate risks, noting that all are overdue for review and will be followed up outside the meeting. The risks include challenges in therapy recruitment, which has been on the register for several years and will be reviewed to determine if it remains at the current risk level; the impact of industrial action, which needs updating to reflect the current context; the risk of patient harm and poor experience due to temporary escalation spaces in use on Ward 36, with CHob advising not to close this risk until the RRU's hand over; rescheduled and cancelled visits, which is a long-standing problem that needs to remain on the register; and the single point of referral risk for UEC, which also needs review. Additional risks mentioned include Housekeeper capacity across inpatient wards and the effect of agency staffing on service delivery in the people management sector, which may no longer be a risk and could potentially be closed. The Chair inquired about the frequency of the Board Assurance Framework (BAF) reports, to which SR responded that the BAF will come every month as a standing report to the Committee. DrG suggested that when presenting the BAF, it would be useful to triangulate the risks by showing what harm the risk could have posed or is still posing, and what mitigations have been put in place until the risk is removed. SR confirmed that the detail is included in the report, with risks assessed based on impact and likelihood, existing controls, and further mitigating actions. CHob commented that it is great to see the Coporate Risk Register now in a manageable state and suggested comparing the current Corporate Risk Register with the previous version to ensure all necessary items have been transferred or moved appropriately.	Partial Assurance	
6. NHS Resolutions report		
CHob commented that the NHS Resolution report had already been discussed at Patient Safety Committee, where it was well received. She highlighted that the report offers strong	Full Assurance	The Chair commented that quarterly reporting

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assurance, particularly as system partners have seen an increase in claims while the Trust has seen a decrease. CHob also praised Amy Fairweather for her excellent work in this area. SR agreed, noting that she keeps the process running smoothly. She added that the Governance Team now ensures any claim indicating harm is taken through the patient safety process, providing extra assurance. SR also mentioned that learning from claims can be challenging due to the time lag, but the team is now more proactive in this area.		might not be sufficient to see significant changes, and the Committee agreed to move the NHS Resolution report to six-monthly reporting.
7. Quarterly Mortality Learning from Deaths report		
DrG reported a total of 19 deaths in the quarter, with one unexpected death in May involving a patient under virtual ward care with multiple co-morbidities. The Medical Examiner confirmed the cause as extreme heart disease and failure, requiring no further investigation, and no additional learning was identified. There were also two custodial deaths. Initial findings indicate that nothing more could have been done from the health team's side, and the Trust is awaiting PPO (Prisons and Probation Ombudsman) reports for further learning. SR is taking these cases to Solicitors for further thematic review. Additionally, there were four deaths related to frailty, and none related to learning disabilities in Community Hospitals and Virtual Wards. Opportunities for improvement were identified, including one patient not receiving their preferred place of death and a couple of cases where respect forms were not completed. Good practices included open access for visitors for end-of-life care, maintaining patient safety and dignity, and most patients now having respect forms completed and improved symptom management. TL asked for more details about the Whitchurch case, and DrG responded that a deeper review is needed to determine if the staff were temporary or if other factors were involved. SR suggested coordinating with Lindsey Leach, Senior Governance Manager, to track actions through the Datix system, and SEA offered to track actions through the palliative and end-of-life care group. The Chair emphasised the importance of following up on missed opportunities for improvement and questioned whether further understanding is	Partial Assurance	The chair requested a deep dive into Whitchurch in October.

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needed regarding several serious incidents at Whitchurch. CHob acknowledged ongoing concerns at Whitchurch and mentioned efforts to address issues related to leadership and culture. CHob also requested that for further assurance relevant actions to address issues of learning should be included in future reports and actions monitored via the End-of-Life Steering Group.		
8. Annual IPC Report		
SEA presented the annual IPC (Infection Prevention and Control) report for 2024/25, structured around the 10 criteria of the Health and Social Care Act. She noted that the contents page dates need updating from 2023/24 to 2024/25. The report highlighted a significant number of audits completed, annual hand hygiene assessments consistently above 95%, and the achievement of the MRSA screening target at 97%. However, challenges included 11 outbreaks during the year, with two norovirus outbreaks lasting several weeks, and exceeding the C. Diff threshold with nine cases against a target of four. The report also detailed achievements against the IPC strategy and outlined focus areas for the coming year, with external assurance received from NHSE and ICB colleagues. TL and the Chair praised the IPC annual report, describing it as excellent and among the best received. TL expressed strong approval for it to go to the Trust Board, acknowledging the challenges faced but emphasising the positives. The Chair supported the report's progression to the Trust Board, with the only amendment being to update the dates on the contents page. She also suggested that the report should include an increased focus on identifying people at risk of developing an infection, particularly regarding C. Diff, for the next year.	Full Assurance	Approved by committee to go to Board
9. IPC BAF		
SEA presented the IPC BAF (Infection Prevention and Control Board Assurance Framework), noting that it had been reviewed by a multidisciplinary group and is now on version five. Out of 54 key performance indicators, 38 are fully compliant and 14 are partially compliant. No further detailed content or the full text of the BAF was included in the transcript.	Full Assurance	Committee were happy to approve the IPC BAF for onward submission to Trust Board.

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TL asked for clarification about the food hygiene training, specifically whether any training was happening across the organisation, as she had read it as if there was none. SEA clarified that staff had received training, but some refresher training was overdue. TL confirmed that her concern was about ensuring no one was handling food without training and was satisfied with the explanation.		
10. Fuller Update		
SEA provided an update on the Fuller Inquiry, explaining that this was an update to the original paper. Phase One of the inquiry was published in November 2023, and out of the 17 recommendations, five are not applicable to the organization due to the lack of an HTA licence or mortuary management responsibilities. Phase Two of the inquiry was launched in early February 2024, but the final report has not yet been published. An interim report was released, but it was only relevant to the funeral sector. The paper presented updates on the Phase One recommendations and actions relevant to the organization, detailed in Appendix A, with six actions completed and three in progress. The chair thanked SEA for the comprehensive report. TL asked whether any of the three amber (in progress) actions in the Fuller report carried significant risk for the organization until completed. SEA responded that she did not think so, explaining that further assurance was being sought on external contractors' DBS checks, but current processes ensure no one is unaccompanied in mortuaries and CCTV is in place, so high-risk actions have been completed. It was confirmed that when the final Phase Two report is published, a final report will be brought to the Committee for an update.	Full Assurance	
11. Thematic review of Patient Absconsion		
It was confimed that the thematic review on patient absconsion had already been discussed at the Patient Safety Committee, where there was thorough satisfaction with the actions Ian is proposing. CHob noted that the review will return to the Committee in a few months. CHob also mentioned the Wander Guard system referenced in the report, stating she had asked	Full Assurance	

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Ian Gingell, to pause purchasing batteries for it while CHor and SEA's teams assess whether it is still the right solution for these types of patients. SR highlighted that the thematic review was prompted by two cases at Bishop's Castle, noting that historically, there had been a good track record except for these isolated incidents. She concluded that this provides assurance, as there have been no further incidents since, suggesting the organisation is effectively managing this area. CHob added that the team at Bishop's Castle has received significant support and training around patient absconsion, which should prevent such incidents from happening again. Sharon include ICB title inquired about the recommendations and action timelines, and CHob responded that a further report with comprehensive details is scheduled to come back to the Committee. The Chair concluded that the Committee is satisfied with the thematic review, with the understanding that the recommendations and actions will be revisited in future meetings.		
12. Fire Safety Group Update		
The Fire Safety Group has met and established administrative processes, including the ability to produce minutes and a Chair's report, aligning with other reporting Committees. Estates work required for fire safety is on track, with either completion or scheduled dates for outstanding items. SR has met with the fire service multiple times, with another meeting scheduled to conclude their audit and receive findings. The Fire Service is reportedly comfortable with the current state of the buildings. Staffing and evacuation drills have been reviewed and completed, with staffing increased where necessary, and the fire service is satisfied with these measures. A challenge remains in identifying the responsible person for fire safety management in each building and ensuring they have the appropriate training, with a plan expected by the next meeting.	Full Assurance	Full assurance taken on the basis that a briefing note would be circulated to the committee following the meeting with the fire service to conclude their audit and receive findings. An extraordinary meeting may be scheduled in August dependant on the outcome of the upcoming meeting with the Fire Service.

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The fire safety policy has been reviewed and updated, but several supporting protocols are missing, which Rob Lamb is prioritising for completion by autumn. Governance has been strengthened by establishing the Fire Safety Group, with responsibilities now moved to the governance team and tracked in Datix. Lindsey Leach, has developed a dashboard for fire safety, providing a one-stop oversight tool. SR expressed confidence in the Trust's position ahead of the Fire Service meeting and thanked the operational and governance teams for their efforts. The Chair questioned the appropriateness of the Fire Safety Group reporting to the Quality and Safety Committee, but SR explained that it provides the necessary level of assurance given recent regulatory concerns. CHob agreed with this structure, and Ganesh raised concerns about practical fire safety at the frontline, which Shelley acknowledged, stating that efforts are ongoing to ensure every building has a nominated, trained person responsible for fire safety. The Chair suggested receiving virtual assurance in the meantime, and Shelley agreed to provide a briefing note after the upcoming fire service meeting.		
13. Chairs Reports		
Infection Prevention & Control CHob highlighted Susan Watkins, the Chief Pharmacist, for consistently providing exemplary assurance through her reports. CHob raised an ongoing concern about uniform compliance, urging colleagues to call out non-compliance during visits, as she frequently notices issues. She mentioned a specific point about self-audits, where one division failed to complete audits because the Housekeeper was absent to remind them. CHob found this unacceptable, emphasising that qualified Nurses should know their responsibilities and proceed without reminders. She concluded that, apart from these points, there was full assurance on most matters and nothing else to escalate. CHob also noted that there was no ICB member present at the meeting. **Clinical Effectiveness Committee**	Full Assurance Full Assurance	

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DrG reported that some audits had been completed and would be presented at the next meeting. The audit data showed improvements in pressure ulcer and malnutrition, while other areas were lagging but expected to improve. He discussed a new software tool called AMAT, which had been demonstrated to the audit lead, Michelle Bramble. The tool was praised for its capabilities in capturing audits, tracking, and learning, and the executive team would review it for potential adoption. The Committee agreed on the importance of a structured process to review audit outcomes, which the AMAT system would support. DrG also noted an expression of interest from research staff to join the group and had invited them, believing their participation would be useful. TL asked about the low number of audits regarding lower limb assessments from a CQUIN perspective and whether this should be addressed by the Q&S or another subgroup. CHob responded that the details would come through the CQUIN report. CHor commented on the need for flexibility in standardising clinical documentation audits for different professional groups. The Chair asked if there were enough operational people in the Clinical Effectiveness meeting, and DrG responded that audit topics are discussed in their SDGS groups, with clinical leads co-opted as needed. CHob emphasised the need to review Committee membership to ensure the right people are present for effective assurance. CHor highlighted the importance of having clinical leads in the Committee and supported bringing the research and innovation team into the forum. **Patient Safety Committee** The meeting was lengthy and heavy, partly because it is now held bimonthly to free up capacity for busy staff. Full assurance was given in most areas, but only partial assurance was given on the NEWS2 audit, which was disappointing. CHob was not satisfied with the action plan, noting the actions were not SMART and would not deliver the needed improvements. The audit will be brought back to the next Committee and then to QSC for further assurance.	Full Assurance	

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A resuscitation meeting paper was submitted, but no one was present to answer questions, so the Chair refused to accept it and requested the responsible person attend the next Committee. Additionally, a serious case involving a patient and their mother who died in a house fire was discussed, highlighting learning points around emollients, air mattresses, and professional inquisitiveness in the home environment. Due to its sensitivity, this powerful story is proposed to be shared with the Board in a private session.	Full Assurance	
Health & Safety Committee The report covered the June meeting, where one reportable RIDDOR incident and 15 health and safety incidents were discussed, with no needle stick injuries reported. The Fire Safety Group terms of reference were approved but later decided to be sent to the Quality and Safety Committee instead. Additionally, the asbestos policy was approved. SR mentioned that the HSE is currently at RJAH, conducting checks on skin conditions and needle stick injuries, primarily in the occupational health space. Ian noted that similar reviews are being conducted across organisations as part of routine spot checks by the HSE. SR emphasised that the absence of needle stick injuries is positive and that the HSE visits are routine rather than triggered by specific issues, although there is a possibility they may visit this organisation as well. The Chair inquired about the progress on the bed rails alert and when the work would be concluded to which she was informed there is a risk-based approach and ongoing work through a system group.	Full Assurance	
CQC Steering Group The main topic discussed was the recent CQC engagement meeting, which CHobb had already briefed the Committee on. There was concern about the patient and public information policy and the length of time it is taking to complete, noting it is a joint policy with SaTH and is on the QSC policy tracker. CHob commented that the statement of purpose, which the Exec signed off, is now out for consultation with Divisional managers. CHob clarified that if there are suggested		

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amendments, it will need to come back to Execs before going to CQC, as the report currently reads like it will go straight to CQC after divisional managers review it. CHob also referenced last month's QSC, where Nicola Dixon presented on briefcases and noted that 31 areas hadn't accessed them. CHob asked SEA to escalate to Execs if, after the next CQC meeting, there are still services that haven't accessed briefcases, so action can be taken to support them. **Learning from Deaths** This was not discussed as it had all previously been discussed in the Learning from Deaths Quarterly Mortality report.	Full Assurance	
14. Bi-Annual Quality Dashboard Review		
SEA provided an update on the quality indicators for all four Community Hospitals, following up on the Bishops Castle Improvement plan, covering the period from January to June 2025. She acknowledged concerns about Whitchurch, noting a significant increase in reported incidents and three patient safety investigations commissioned. The top three incident types at Whitchurch in June were pressure ulcers, medication, and staffing/workload, with the medicine safety officer supporting improvement work on missed doses and signatures. Across the four hospitals, there were 17 acquired pressure ulcers, mostly category 2, with one category 4 at Whitchurch, which is a PSI. There has been significant improvement in the completion of pressure ulcer and nutrition risk assessments. Falls remained largely consistent, but SEA recommended future reports drill down to ward level and use SPC format for better trend analysis. IPC audit improvements were seen at Bridgnorth and Whitchurch, but Ludlow showed a decline in compliance in the last two months. Housekeeper recruitment and standardisation need prioritisation. Patient experience data has been strengthened, now including a drill down of inpatient survey questions, with a theme around communication and discharge prompting a request for a deep dive. The Committee was asked to note the information, gain assurance that processes are in place to monitor quality	Full Assurance	The Chair suggested that it might be beneficial for one of the Community Hospital Managers to present the progress they've made against these recommendations at a future meeting, framing this as a development opportunity for the managers. Committee approved the recommendations.

metrics, and approve the recommendations at the end of the report. TL commented on the inpatient surveys, asking for a breakdown by Community Hospital for clearer data presentation.		
15. Approvals		
Learning from Deaths Terms of Reference - Amendments were made to the membership, - DoN will be included within the membership - Deputy Director of Nursing is to be removed from the membership and will act as a deputy to the DoN if needed - Non-Executive Director was removed from the membership Committee approved following the amendments **Fire Safety Group ToR** Approved		
16. Meeting Evaluation and AOB		
Following concerns that were raised at the last Committee about ShropDoc cover ending out of hours cover on the RRUs, work has been ongoing to resolve the issue. CHob confirmed that a solution has been found and SaTH colleagues will support out-of-hours cover for the RRU's during the interim period, so the risk is now resolved.		

4. Approvals

Item:	Status:
Learning from Deaths Terms of Reference	Approved
Fire Safety Group Terms of Reference	Approved

5. Conclusion

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

0. Quality and Safety Report – July 2025

Author:	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	6th August 2025
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	21st of July 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 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 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 3 (June)

- *Clostridium Difficile* – There has been no further cases reported in June. The organisation has had 4 Hospital-onset healthcare associated (HOHA) *C-difficile* cases YTD. Thematic reviews are scheduled quarterly. Actions for improvement are ongoing with a specific focus on cleanliness.
- E-Coli bacteraemia has remained at 2 cases for the rolling 12 months. There were no cases reported in June.
- There was 1 unexpected death in June; a patient was found in their home by a community team. On further investigation, the Coroner did not require any further investigation and death was attributable to natural causes.
- 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.
- There were two Category 4 pressure ulcers reported in June. All appropriate actions were taken, and both cases were discussed at PSIP.

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

- In June 2025 there were 20 inpatient falls reported within our care at the Community Hospitals and Rehabilitation and Recovery Wards compared to 23 in May. There is a minor discrepancy with the rate of falls per occupied bed days and discussions are being held with the information team to review the way we measure falls data. Falls thematic reviews are presented quarterly to Patient Safety Committee. Falls related to new onset confusion and cognitive impairment amounted to 7 cases, constituting 35% of the total falls this month.
- There were zero category 3 pressure ulcers reported in June.
- There were zero medication incidents resulting in patient harm reported in June.
- There were 2 PSII's declared for June 25. The first involves review of a January ligature death occurring at HMP Stoke Heath and further receipt of initial PPO findings shared through Health and Justice Commissioners. The second relates to treatment and management of a diabetic patient at Whitchurch Hospital.

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 **May 2025** and is an improving picture.
- Average fill rates for RNs were over target at 103% for day and 104% for night shift, this was due to escalation beds open on Ward 36.
- Average fill rates for non-registered workers were over target at 125% for day and 139% 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 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	2025-06-30		6.43	6.49	-0.06	6.43	6.49	-0.06	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2025-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2025-06-30		3	0	3	3	0	3	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2025-06-30		300.00%	100.00%	200.00%	300.00%	100.00%	200.00%	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2025-06-30		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2025-06-30		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Effective	Deaths - unexpected	2025-06-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2025-06-30		200.00%	100.00%	100.00%	200.00%	100.00%	100.00%	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2025-06-30		5.83	4.00	1.83	5.83	4.00	1.83	
Quality & Safety Committee	Safe	Medication Incidents with Moderate Harm	2025-06-30		0	0	0	6	0	6	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2025-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2025-06-30		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Never Events	2025-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2025-06-30		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2025-06-30		2	0	2	5	0	5	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-05-31		125%	95%	30%	125%	95%	30%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-05-31		139%	95%	44%	139%	95%	44%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-05-31		103%	95%	8%	103%	95%	8%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-05-31		104%	95%	9%	104%	95%	9%	

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.

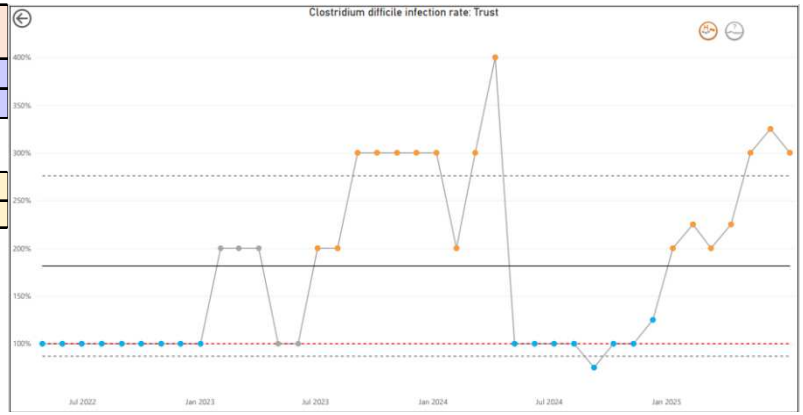
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Clostidium difficile infection rate	Number	9	9	9	12	13	12	12
	Target	4	4	4	4	4	4	4

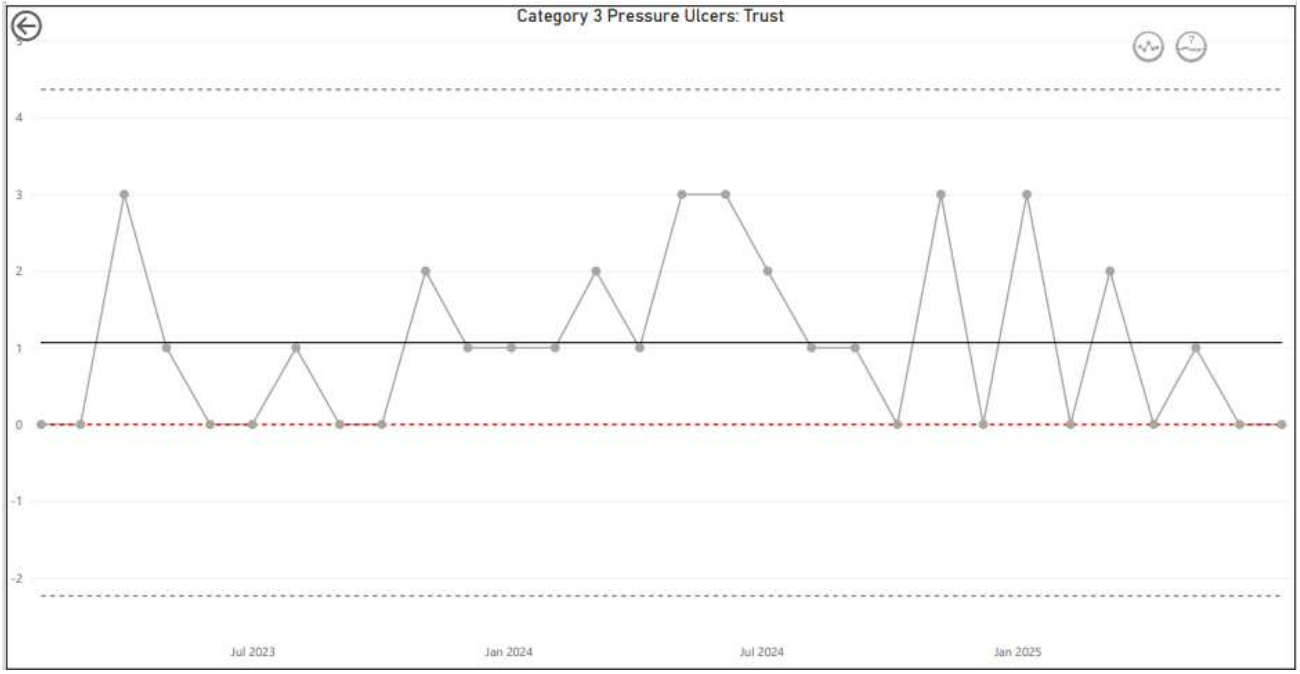
Trajectory	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number	0	0	0	0	0	0	0

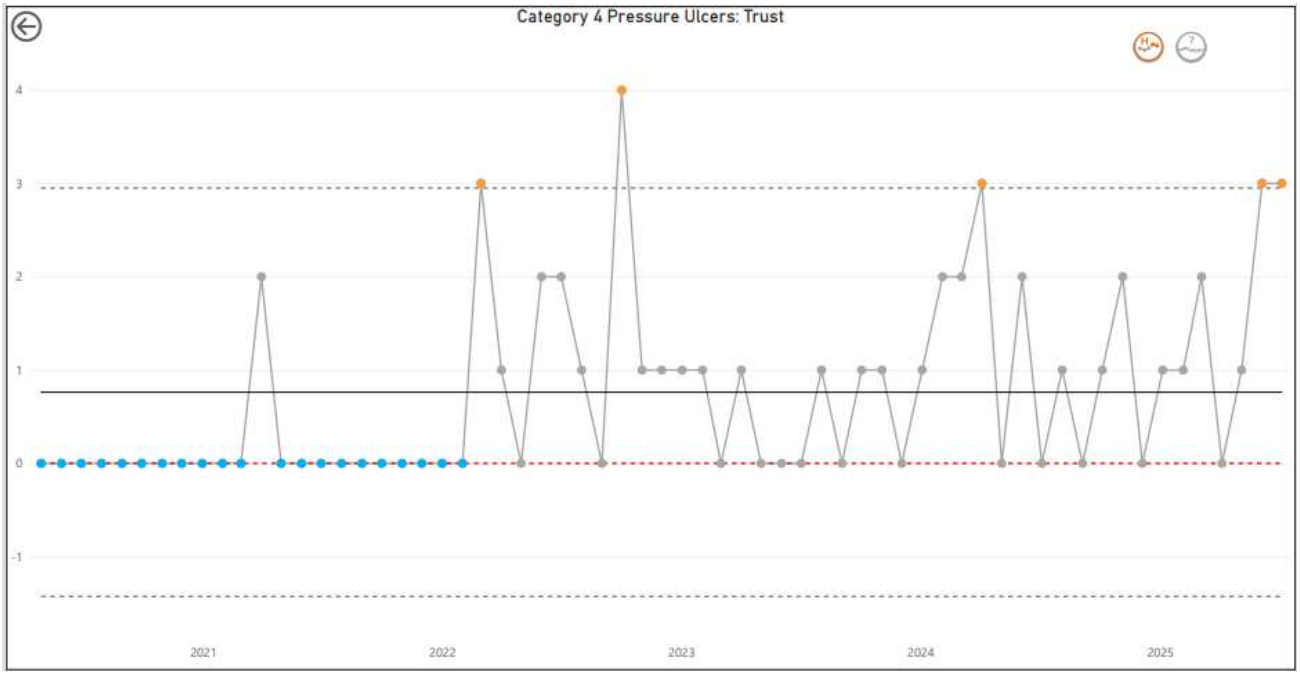


Narrative/Description:	There has been zero C-Diff cases reported in June. The rolling 12 months total now stands at 12 and there have been 4 cases YTD against an annual threshold of 4. A Post Infection Review is completed for each case with many patients having been on multiple courses of anti-biotics for other infections identified as the most probable cause. Quarterly thematic reviews will continue for 25/26 to identify improvements in systems and processes required. The four cases YTD for 2025/26 are: April: Ward 36 x 2 and Ludlow x 1 May: Ludlow x 1

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.
	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	Complete	
	Increase number of Housekeeper hours available across the Community Hospitals	Jun-25	Aug-25	In progress	Paper went to IPCC April 2025 demonstrating need for standardisation and increase of Housekeeper hours available on each inpatient ward. Discussions taking place with Divisional Clinical Managers to implement.
	Create visual aids (videos or posters) on how to clean key pieces of equipment (i.e. beds)	Jun-25	Aug-25	In progress	

Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	21/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025


Category 3 Pressure Ulcers: Trust
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 were two category 4 pressure ulcers developed in service in June 2025, both of which are to be presented at PSIP. 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. The graph refers to three category 4 pressure ulcers however when assessed one was not developed in service. The data and graph will be adjusted for future reports.					
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	May-25	Complete	Completion date for videos is 16th May
	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	Jul-25	In progress	
	QEIA to be completed with suggestion to make Pressure Ulcer Awareness training mandatory and role specific		Mar-25	~~01/06/2025~~ Aug 2025	In progress	
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	18/07/2025			
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	21/07/2025			

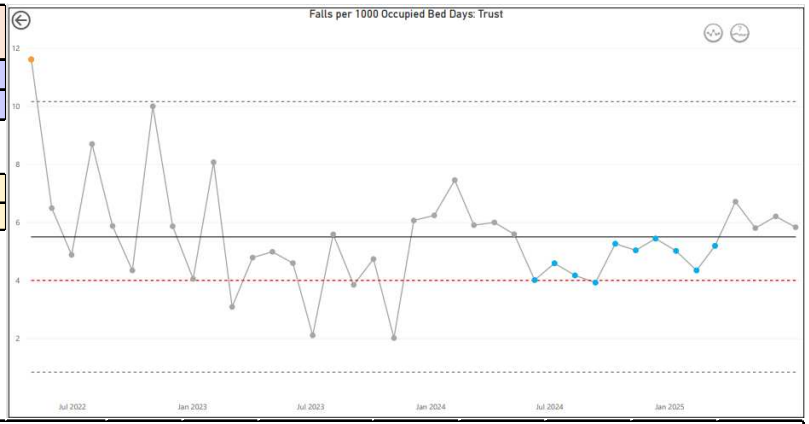
Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Falls per 1000 OBDs	Number	4.34	5.19	6.71	5.19	5.27	5.36	
	Target	4	4	4	4	4	4	0

Trajectory	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number	4.50	4.00	4.50	4.50	4.50	4.50	4.50



Narrative/Description:

In June 2025 there were 20 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Units. This equates to a rate of 5.36 falls per 1000 Occupied Bed Days (OBDs). The number of falls and OBD reflects the removal of duplicated falls recorded in Datix.
The number of falls per individual Community Hospital site is as follows: a reduced falls rate at RRU PRH Ward 36 (1). Number of patient falls remained static at Bridgnorth (3), Bishops Castle (5), RRU RSH Ward 18 (3), Whitchurch (6) and Ludlow (3). The Community Hospital sites with the highest number of falls per 1000 OBDS, were Bishops Castle (10.8) followed by Whitchurch (9.8). The indicated level of harm recorded is falls recorded as no harm/injury, (4), Low harm falls (14), moderate harm, falls (2) with injuries including head injury/lacerations and bruising.
The new mandatory field in Datix includes detailed contributory factors linked to each individual fall. It was noted that (3) patients had a new onset of confusion or change in medical condition, which contributed to their falls. (4) patients had a diagnosis of confusion related to cognitive impairment. Two falls were related to continence, occurring when patients were mobilising from the bay to the bathroom. Additionally, (6) falls occurred in bathrooms.
The data collected this month reveal that 14 falls occurred during the daytime (between 8 am and 8 pm), whereas (6) falls took place at night (between 8 pm and 8 am). There were (15) unwitnessed falls recorded. There were 7 falls linked to new onset confusion or cognitive impairment, accounting for 35% of all falls, with 5 occurring unwitnessed. This issue is currently being addressed through the development of the ETOC project.

Action Plan

	Start Date	End Date	Status	Outcome
Improving Hydration, reducing UTIs pilot in Ludlow Community hospital .	Sep-24	~~01/07/2025~~ Sept 2025	In Progress	Slight delay in project due to staff sickness in Ludlow . However , Jug lids have been ordered and training has commenced with an aim to go live from 1st August .
Digital falls equipment pilot at Brignorth and Whitchurch community hospital	Jan-25	Jul-25	In Progress	Pilot of chair, bed and toilet sensors commencing July 15th at Whitchurch and 16th at Bridgnorth Community Hospital. Results of pilot will feed into August QSC report.
NEW Re-invigorated Project re: Dementia friendly environment standardisation.	Jun-25	rolling programe - first site by end of year	In Progress	Ludlow Dinham ward assessed on 30/6/2025 with the Alzheimer's Society Dementia Friendly Environment checklist. Project Lead now allocated to Admiral Nurses Cheryl Scarrott; Emma Butler and QI faciliator is Hayley Grice, Clinical Lead for Quality and Holly Grainger, IPC Nurse.
Review and update of Enhanced Supervision Policy	Apr-25	~~01/06/2025~~ Aug-25	In Progress	ETOC programme is underway , a new policy will be developed and shared on completion of the project.

Accountable Officer Approval			
Sarah Venn - Clinical Lead for Quality	**Date**	09/07/2025	
Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	21/07/2025	

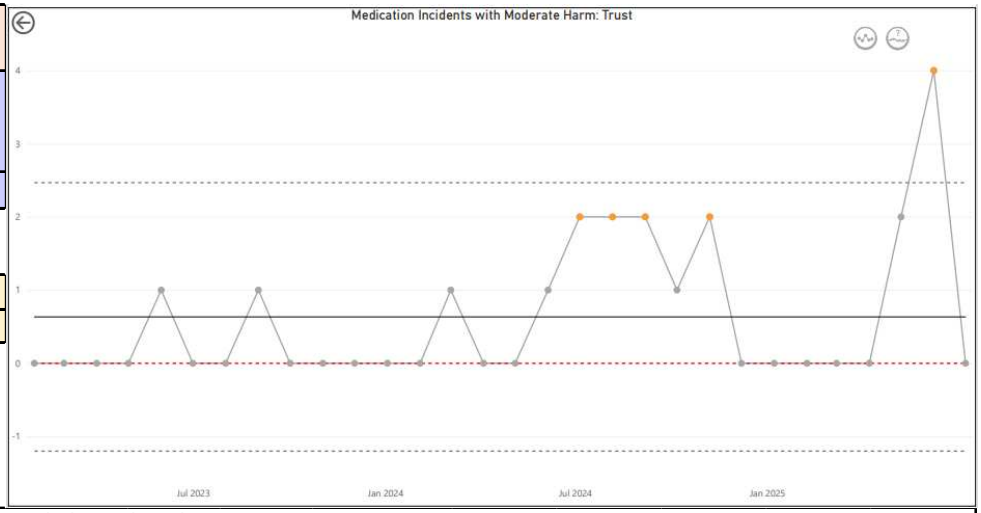
Exception Report - Action Plan

Medication Incidents with Moderate Harm

Number of internal medication incidents per month resulting in moderate harm

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Medication Incidents with Moderate Harm	Number				2	4	0	6
	Target	0	0	0	0	0	0	0

Trajectory	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number	2	5	5	5	5	6	6



Narrative/ Description:	All of these incidents are included in the Patient Safety Incident Response Framework (PSIRF) quarterly thematic review. **There were no moderate harm incidents reported in June 2025.**

Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Oct-25	In Progress	LBE has now set up T&F group to finalise documentation due to document not being approved at team leader meeting (it was reported that the document would not suit all district nursing services).
	Review and update of inpatient medicines administration chart	Apr-25	Sep-25	In Progress	Final changes submitted to printers by SW on 7/7/25. Awaiting final draft.

Author	Lucy Barrass-Evans - Medicines Safety Officer and Non-Medical Prescribing Lead	**Date**	08/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025

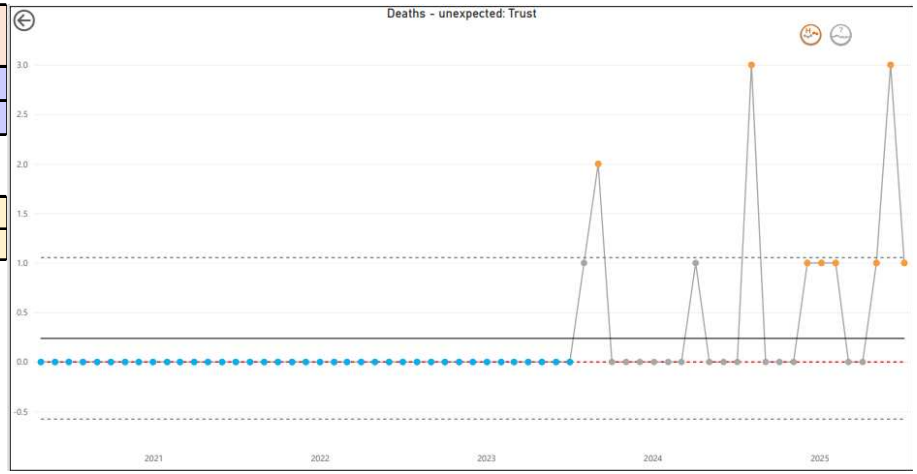
Exception Report - Action Plan

Deaths - Unexpected

Deaths - Unexpected

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Deaths - unexpected	Number	1	0	0	0	3	1	3
	Target	0	0	0	0	0	0	0

Trajectory	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number	0	0	0	0	0	0	0



Narrative/Description:	In accordance with the Trust's Learning from Deaths Policy, all deaths that are unexpected are required to be added to the Trust's Incident Reporting System and a Learning from Death Review Completed. There was 1 unexpected death recorded in June of a patient found in their home by a Community team. On further investigation, the Coroner did not require any further investigation and death was attributable to natural causes. No problems in care identified through discussion at Patient Safety Incident Panel.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	The Trust's Learning from Death Policy was ratified at January's Patient Safety Committee and formally approved at January's Quality and Safety Committee.		Jan-25	Complete	
Author	Amy Fairweather - Patient Safety Officer	**Date**	10/07/2025		
Accountable Officer Approval	Dr Mahadeva Ganesh	**Date**	21/07/2025		

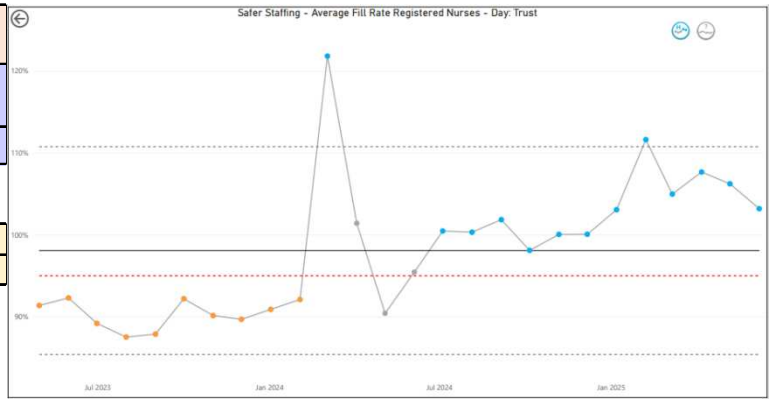
Exception Report - Action Plan

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

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

KPI Description	Latest 6 months		Jan-25	Feb-25	Mar-25	Apr-25	May-25	YTD
Safer Staffing	%		112.0%	105.0%	108.0%	106.0%	103.2%	103.2%
	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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



Narrative/Description:	Bishops Castle - 102% Bridgnorth - 98% Ludlow - 101% Whitchurch - 90% PRH RRU Ward 36 - 109% 9% for escalation beds being opened RSH RRU Ward 18 - 104% 4% High acuity

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. Have bee approved for the ETOC programme.
	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	

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	14/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025

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		Jan-25	Feb-25	Mar-25	Apr-25	May-25	YTD
Safer Staffing	%		109.0%	109.0%	104.0%	108.0%	103.9%	103.9%
	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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 - 148% 48% escalation beds being opened RSH RRU Ward 18 - 100%

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	

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	14/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025

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		Jan-25	Feb-25	Mar-25	Apr-25	May-25	YTD
Safer Staffing	%		146.0%	151.0%	134.0%	137.0%	125.1%	125.1%
	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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

Narrative/Description:

Bishops Castle - 110%	10% one to one shifts
Bridgnorth - 104%	4% for one to one shifts
Ludlow - 98%	
Whitchurch - 134%	34% one to one shifts
PRH RRU Ward 36 - 182%	22% one to one shifts and 60% escalation beds being opened.
RSH RRU Ward 18 - 136%	36% 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	Jul-25	In Progress	Reivew underway and will be completed by end of July 2025
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.
Quality Improvement Project following peer review	Apr-25	Jul-25	Complete and ongoing	meeting held to commence work on ETOC quality improvement
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	Aug-25	In Progress	Under review
Review of shift patterns for inpatient areas	Apr-25	Jul-25	Complete	shift patterns reviewed and paper to JNP

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	17/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025

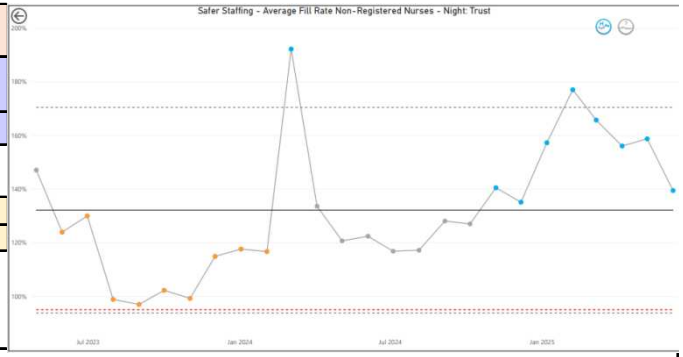
Exception Report - Action Plan

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		Jan-25	Feb-25	Mar-25	Apr-25	May-25	YTD
Safer Staffing	%		177.0%	166.0%	156.0%	159.0%	139.4%	139.4%
	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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



Narrative/Description:

Bishops Castle - 122% 22% one to one shifts
Bridgnorth - 106% 6% one to one shifts
Ludlow - 118% 18% one to one shifts
Whitchurch - 159% 41% one to one 18% escalation beds being opened
PRH RRU Ward 36 - 160% 31% one to one 29% escalation beds being opened
RSH RRU Ward 18 - 167% 67% one to one shifts

Action Plan

bridgnorth	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	Jul-25	In Progress	Policy being reviewd and charts reviewed will be completed by end of July 2025
Quality Improvement Project/ETOC following peer review	Apr-25	Jul-25	In Progress	Work commenced on Quality 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	Aug-25	In Progress	Under review
Review of shift patterns for inpatient areas	Apr-25	Jun-25	Complete	Shift patterns reviewed and to process to LD at all sites with flexiblity included for staff not wishing to go to LD

Author	Tracie Black, Associate Director for Nursing Workforce and Professional Standards	**Date**	14/07/2025
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21/07/2025

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. 1293 harm proformas have been completed to date; with 85.46% indicating no harm and 13.00% indicating low harm and can be treated and resolved.

There have been 20 cases (1.54%) of moderate harm identified up to April 2025; 14 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 20 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 129.

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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Harm proformas completed	537	544	550	586	699	844	968	1064	1111	1132	1212	1293
Number of low harm	114	116	118	127	134	143	151	155	157	162	168	168
Number of moderate harm	8	9	10	13	14	15	15	15	15	19	20	20
Percentage of no harm	77.28%	77.03%	76.73%	76.10%	78.83%	81.27%	82.85%	84.00%	84.52%	84.02%	84.50%	85.46%
Percentage of low harm	21.22%	21.32%	21.46%	21.68%	19.17%	16.94%	15.60%	14.60%	14.13%	14.31%	13.85%	13.00%
Percentage of moderate harm	1.50%	1.65%	1.81%	2.22%	2.00%	1.80%	1.55%	1.40%	1.35%	1.67%	1.65%	1.54%

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.

Shropshire Community Health NHS Trust

Learning from Deaths 2025-6 Q1 Report

Reference Information

Author:	Lindsey Leach, Senior Governance Manager Amy Fairweather, Patient Safety Officer	**Paper date:**	31st July 2025
Executive Sponsor:	Dr Mahadeva Ganesh, Medical Director	**Paper written on:**	01st July 2025
Paper Reviewed by:	Dr Mahadeva Ganesh, Medical Director	**Paper Category:**	Governance/Quality and Safety
Forum submitted to:	Learning from Deaths Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Quality & Safety Committee, and what input is required?

To provide the Learning from Deaths Committee with assurance that Shropshire Community Health NHS Trust (SCHT) has a robust internal Learning from Deaths review process to ensure that we learn from any patient deaths and ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services.

To meet the National Learning from Deaths Framework requirement to collect and publish data to monitor trends in patients' deaths within the Trust and report quarterly to the Trust Public Board meeting.

To provide an update on work to learn from deaths beyond that required by statute and the emergent system (ICS) approach to Learning from Deaths.

2. Executive Summary

2.1 Context

This report provides the Quality & Safety Committee with assurance that the Trust is meeting its requirements under the National Learning from Death Framework and the Learning from Deaths in relation to patients who have died within our direct care. This report also notes how SCHT is learning from these deaths and the impact of this work, with the aim of providing high quality, integrated and personalised care.
This includes our wider ambition both to demonstrate impact of learning from Community Hospital deaths but also to learn from deaths in the wider community (where patients are in the direct care of another organisation, but we have been involved in their care) and play a part in evolving a system approach to learning from deaths.

2.2 Summary

The key points of this report are:

- Nineteen deaths were reported for Q1 2025-26 across Community Hospitals, Recovery and Rehabilitation Wards and Virtual Ward.

Learning from Deaths 2025-6 Q1 Report

- No patients had COVID-19 recorded as their primary cause of death in Q1.
- There were no reported deaths of Autistic People or people with a diagnosis of Learning Disability in Q1.
- All Deaths across the Trust's Community Hospital and Recovery and Rehabilitation Wards are referred to The Medical Examiner Service for independent review of the Cause of Death.

In addition to exploring and responding locally to learning from each Community Hospital death, the following theme continues to be addressed and impact demonstrated through our Learning from Deaths Lessons Learnt Improvement Plan:

- Improving inter-organisational collaboration for Learning from Deaths. Child Deaths and End of Life care including systems for promoting continuity of care.

2.3. Conclusion

The Quality and Safety Committee is asked to:

- Note the report and themes detailed.
- Agree the level of assurance provided by this report, proposing substantive assurance that the Trust are meeting their requirements under the National Learning from Death Framework including learning from deaths in relation to patients who have died within our direct care and in addition taking opportunities to learn from all deaths within our direct care and in the wider Community Services.

3. Main Report

3.1 Introduction

The Trust's Learning from Deaths process is covered in the Learning from Deaths Policy and details the processes we undertake to carry out a review or investigation of a death of a patient under our direct care (Community Hospitals, Virtual, Recovery and Rehabilitation Wards and HMP/YOI Stoke Heath). We are also willing to be involved in any investigation of a patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation. It is acknowledged that, for patients not under our direct care, we will sometimes have to rely on those other organisations to notify us of a patient's death as there is currently no national system in place that will notify us directly. It is noted that we do carry out Learning from Deaths Level 1 reviews in the Community when instigated by our Teams.

3.2 Community Hospital and Sub-Acute Ward Deaths

Local Learning from Deaths Level 1 reviews are carried out on every patient death within the Community Hospitals and, since January 2024, in the two Recovery and Rehabilitation Wards (RSH Ward 18 and PRH Ward 36), and since April 2025, in Virtual Wards. These reviews are

Learning from Deaths 2025-6 Q1 Report

written by the staff involved in the care and treatment of the Patient and reviewed by Clinical Governance and the Medical Director.

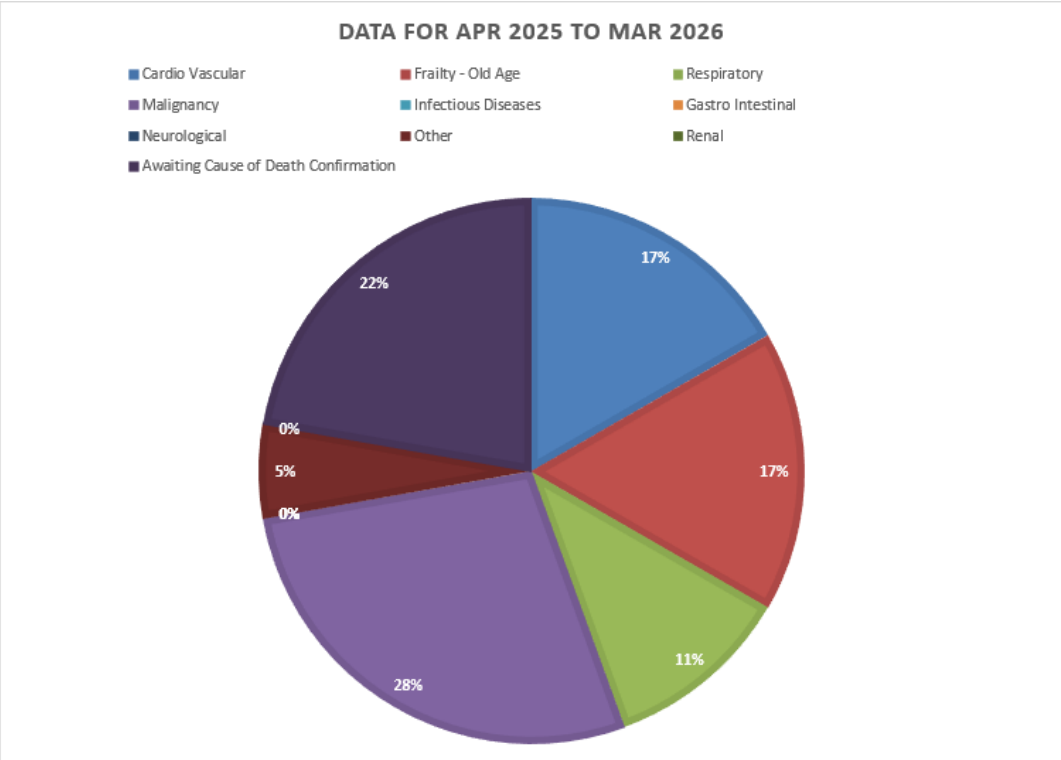
Patient deaths reported in Community Hospitals, Recovery and Rehabilitation Wards, and Virtual Ward are shown below:

No. Episodes	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total for 25/26	Grand Total
Bishops Castle	1	1	1										3	261
Bridgnorth	1												1	416
Ludlow		4	1										5	455
Whitchurch		3	1										4	523
SubAcute RSH18													0	10
SubAcute PRH36													0	5
Virtual Wards	3	3											6	6
Total	5	11	3	0	0	0	0	0	0	0	0	0	19	1676

Data is updated continuously and reported quarterly within the Trust to the Learning from Deaths Committee and to the Public Board in accordance with the national framework guidance.

3.3 Causes of Death

The main causes of deaths within Community Hospitals, Recovery and Rehab Wards and Virtual Ward for Quarter 1 of the year 2025-26 were Malignancy (5 deaths), Frailty – Old Age (3 deaths) and Cardio Vascular (3 deaths). The highest cause of death so far for 2025-26 is Malignancy as depicted in the graph shown below, and representing 28% of the deaths recorded for this financial year.



Learning from Deaths 2025-6 Q1 Report

3.4 Unexpected deaths

There was one unexpected death in Q1 for Community Hospitals, Recovery and Rehabilitation Wards, and Virtual Ward.

The patient had been referred to Virtual Ward by her GP due to breathing/respiratory concerns and seen on 02/05/2025, with known Heart Failure and Mental Health issues, noted to be very anxious and distressed on the first visit. During the seven days the patient was under our care, she stabilised, and her discharge/physiotherapy referral was underway by 09/05/2025.

Virtual Ward was contacted by the patient's GP on 13/05/2025 to advise that the patient had been found deceased on 11/05/2025 and the cause of death was to be determined. The Virtual Ward team at this time hadn't seen the patient for six days due to the patient being processed for discharge and a physiotherapy referral. The cause of death for the patient was confirmed as 1a) Ischaemic Heart Disease and 2) Frailty of old age following a post-mortem.

The case was presented at the Trust's Patient Safety Incident Panel (PSIP) on 04/06/2025 where the panel required further information regarding the cause of death (which was not know at this time) and whether there was a requirement for coroner involvement. Due to the confirmed cause of death later received, there was no further action required by the team.

To note, an unexpected death in the Community Nursing Team occurred in June 2025 whereby a patient on our caseload was found at home deceased when the team came to visit for a pre-arranged appointment. This has been captured within the Trust's KPI figures for June 2025, however would not be included within the graphs and overall data captured within this report.

3.5 COVID-19

No patients had COVID-19 recorded as their primary cause of death on the death certificate for Q1.

4.0 Deaths in Custody

There were two Deaths in Custody reported in Q1.

The first patient had been found in their cell in the Segregation and Reintegration Unit (SRU) by officers and found to have a ligature around their neck. Attempts to resuscitate had been undertaken by the Prison Officers until the Paramedic and ambulance staff arrived. On-site GP pronounced death.

The second patient was found in their cell on the wing by officers and found to have a large amount of vomit in their airway. Attempts to resuscitate had been undertaken by the Prison Officers until the Paramedic and ambulance staff arrived. the air ambulance doctor pronounced death approximately 1 hour and 15 minutes from the point of notification.

Both deaths have been reported to the Prison and Probation Service in accordance with Procedure for their Clinical Review of the Patient's care and treatment.

Learning from Deaths 2025-6 Q1 Report

5.0 Deaths of People with a Learning Disability and Autistic People (LeDeR)

LeDeR is responsible for facilitating local reviews of deaths of people with learning disabilities (aged 4 to 74 inclusive) and autistic people registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death. There were no deaths of patients with a formal learning disability diagnosis in the Community Hospitals, Virtual Wards and Rehabilitation and Recovery Wards in Q1.

6.0 Learning and Good Practice

The Trust takes the opportunity to learn from each Level 1 Learning from Death Review and these learning points are discussed and shared at the quarterly meetings. This section of the report brings together all the lessons and observations made throughout the year.

7.0 Opportunities to improve across the system:

- Reports reflect that some patients were not in their preferred place of death however this was due to fast deterioration and team's being unable to organise preferred place of death within the time and funding available.
- Reports reflect an increase in RESPECT forms not being completed.
- There was one death at Whitchurch where some of the staff were unfamiliar with End of Life care which resulted in a reluctance to give prescribed medication.

8.0 Good practice to share:

- Reports reflect prompt access to End-of-Life side room with open access for visitors for their privacy and Patient's dignity.
- Involvement of Families in End-of-Life care plan conversations
- Reports reflect Medications given in a timely manner for any symptom management.
- Reports reflect that RESPECT was in place.

9.0 Conclusion

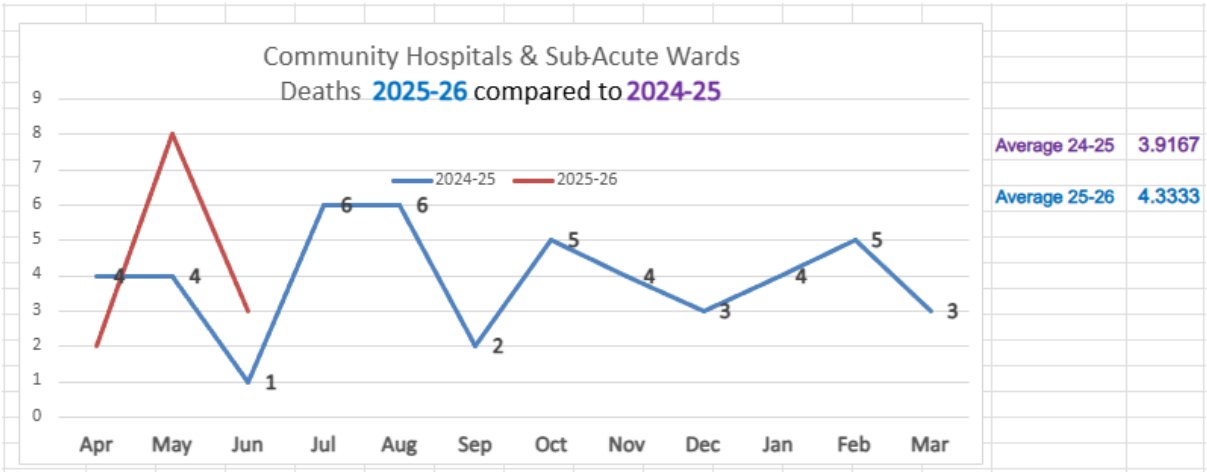
The Learning from Death Group are asked to:

- Note the mortality data and themes detailed.
- Agree the level of assurance provided by this report, proposing substantive Assurance that the Trust are meeting their requirements under the National Learning from Death Framework including Learning from Deaths in relation to patients who have died within our direct care. The Trust continues to take opportunities to learn from all deaths within our direct care and in the wider Community Services.

Learning from Deaths 2025-6 Q1 Report

LIST OF APPENDICES

Appendix 1: Deaths in Community Hospitals



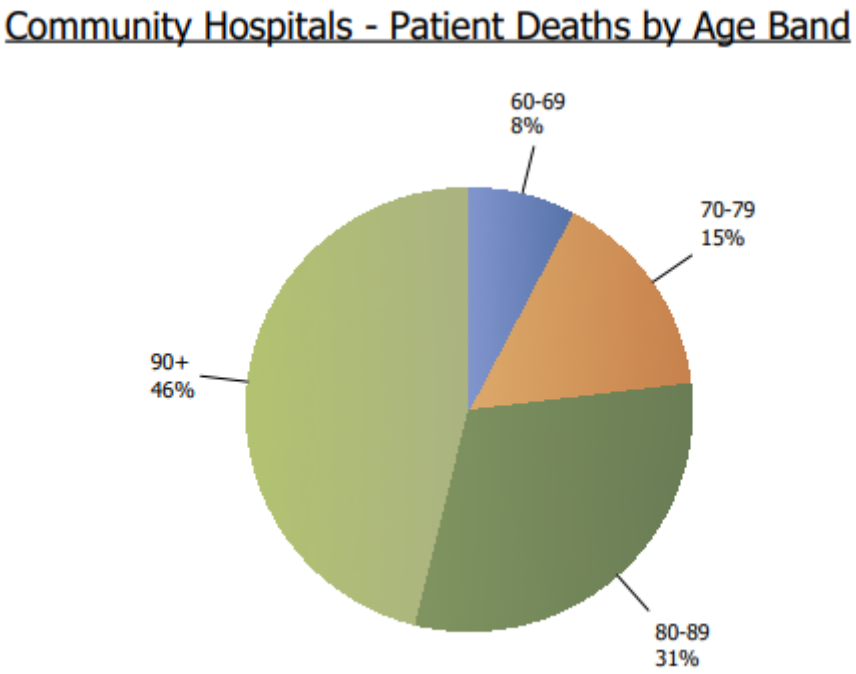
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	total
2024-25	4	4	1	6	6	2	5	4	3	4	5	3	47
2025-26	2	8	3										13

Appendix 2: Hospital Mortality Monthly Report

Community Hospitals - Patient Deaths by Age Band

No. Episodes		Apr-25	May-25	Jun-25	Total
60-69	Ludlow		1		**1**
	Total for 60-69		**1**		**1**
70-79	Bishops Castle	1			**1**
	Whitchurch		1		**1**
	Total for 70-79	**1**	**1**		**2**
80-89	Bishops Castle		1		**1**
	Ludlow			1	**1**
	Whitchurch		1	1	**2**
	Total for 80-89		**2**	**2**	**4**
90+	Bishops Castle			1	**1**
	Bridgnorth	1			**1**
	Ludlow		3		**3**
	Whitchurch		1		**1**
	Total for 90+	**1**	**4**	**1**	**6**
Total		**2**	**8**	**3**	**13**

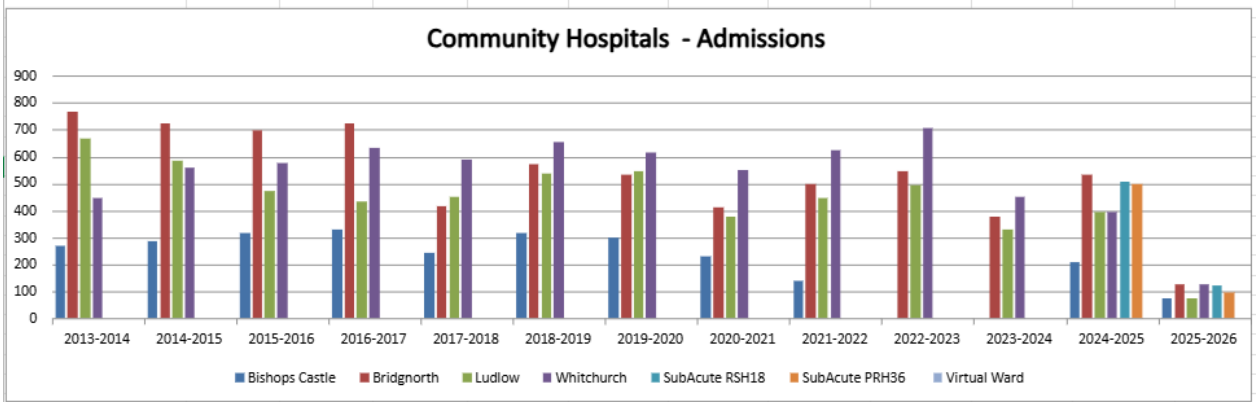
Learning from Deaths 2025-6 Q1 Report

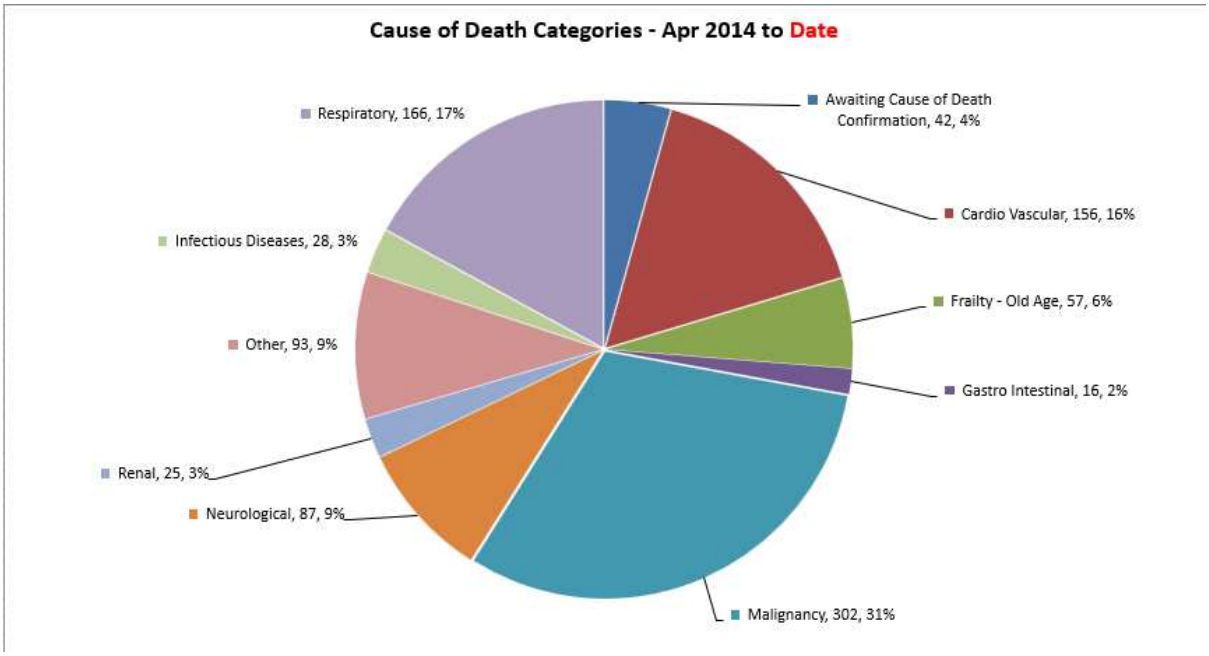


Learning from Deaths 2025-6 Q1 Report

Community Hospitals - Admissions

Community Hospital	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	Totals
Bishops Castle	271	288	318	328	245	317	299	232	139	0	0	211	75	**2,723**
Bridgnorth	767	722	696	722	416	570	534	412	500	545	378	534	125	**6,921**
Ludlow	668	583	474	434	451	537	548	379	448	495	330	396	75	**5,818**
Whitchurch	445	560	576	632	589	653	617	549	623	708	453	393	127	**6,925**
SubAcute RSH18	0	0	0	0	0	0	0	0	0	0	0	507	122	**629**
SubAcute PRH36	0	0	0	0	0	0	0	0	0	0	0	499	95	**594**
Virtual Ward	`	0	0	0	0	0	0	0	0	0	0	0		**0**
Total	**2,151**	**2,153**	**2,064**	**2,116**	**1,701**	**2,077**	**1,998**	**1,572**	**1,710**	**1,748**	**1,161**	**2,540**	**619**	**23,610**

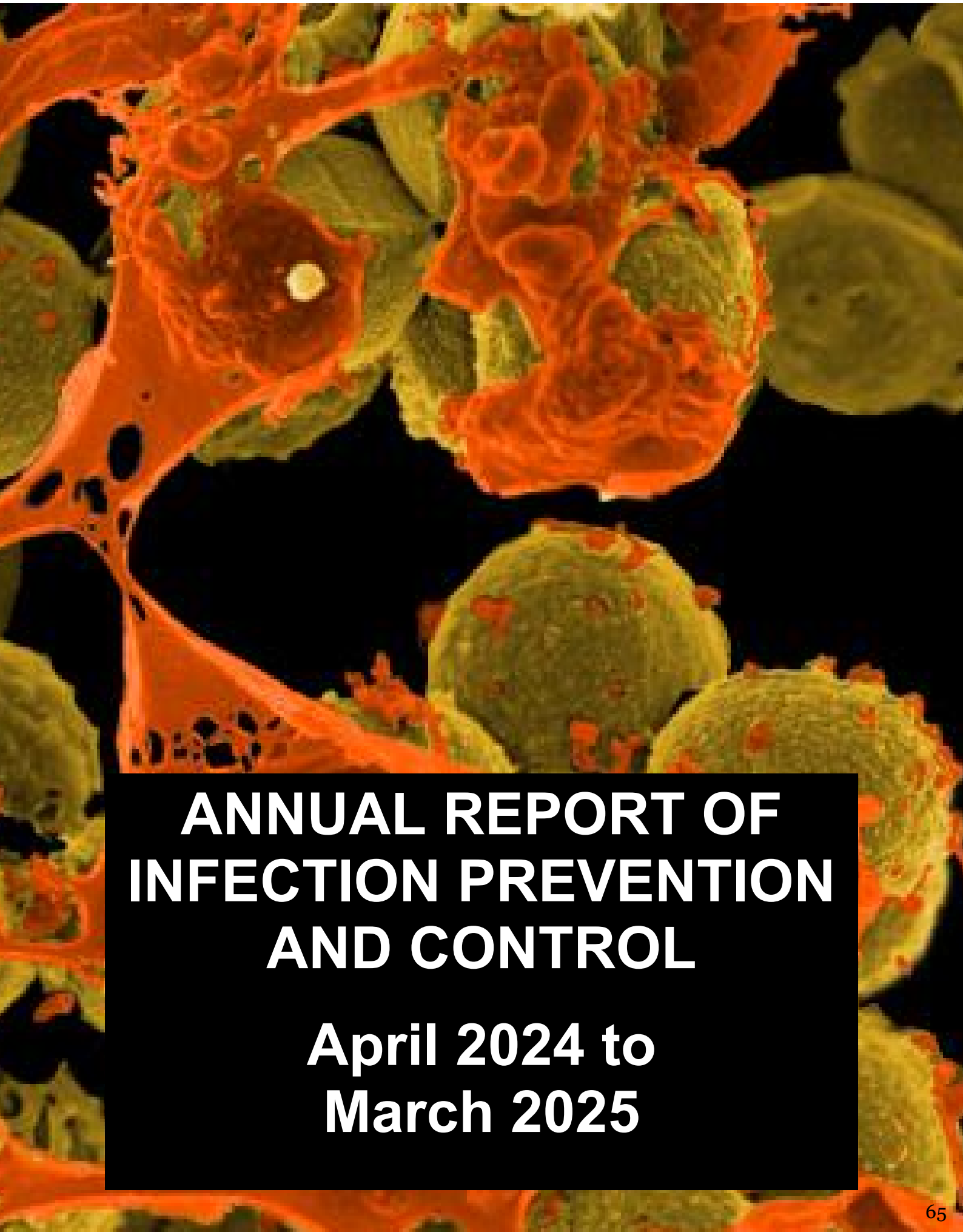




Learning from Deaths 2025-6 Q1 Report

													Grand Total from 2020
Hospital	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	
Bridgnorth	0	0	0										7
Bishops Castle	0	0	0										0
Ludlow	0	0	0										13
Whitchurch	0	0	0										52
Sub-Acute Wards	0	0	0										0
Virtual Ward	0	0	0										0
Grand Total	0	0	0										**72**

Shropshire Community Health
NHS Trust



ANNUAL REPORT OF INFECTION PREVENTION AND CONTROL

April 2024 to March 2025

Table of Contents

Foreword by Clair Hobbs, Director of Infection Prevention and Control

As Director of Nursing and Director of Infection Prevention and Control (DIPC), this annual report summarises the infection prevention and control work that has been undertaken for the year 2024/25.
It is my honour to present this annual report, which reflects our unwavering commitment to safeguarding the health and well-being of our patients, staff, and community. This document serves as a comprehensive guide to our infection prevention strategies, protocols, and achievements.

Infection prevention and control are critical components of healthcare, and our team has worked tirelessly to implement best practices, innovative solutions, and continuous improvements. Our efforts have not only reduced the incidence of healthcare-associated infections but also enhanced the overall quality of care.

This document highlights our journey through 2024-25, the challenges we have faced, and the successes we have achieved. It is a testament to the dedication, expertise, and collaboration of our IPC Team and our operational colleagues. I hope it serves as a valuable resource for healthcare professionals and inspires continued excellence in infection prevention and control.

I extend my heartfelt gratitude to all those who have contributed to our success and to those who will continue to uphold our high standards in the future.

Clair Hobbs, Director of Nursing, Quality and Clinical Delivery and Director of Infection Prevention and Control

Introduction

Who We Are and What We Do

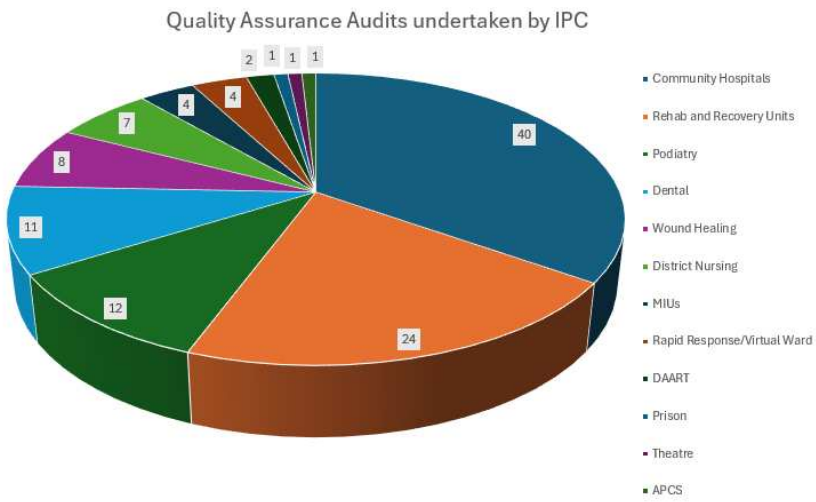
Shropshire Community Health NHS Trust (SCHT) provides a range of community and community hospital services for the people of Shropshire, Telford and Wrekin, serving a population of around 506,000 people. and some services to people in surrounding areas, including Dudley's Family Nurse Partnership, School Nursing and Health Visiting Services which joined SCHT in April 2024.

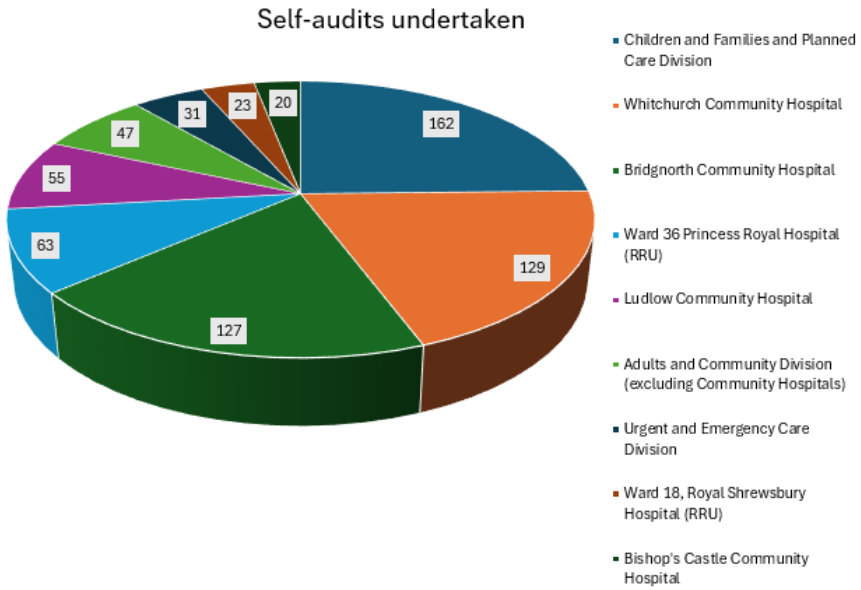
Shropshire is a mostly rural, diverse county with over a third of the population living in villages, hamlets and dispersed dwellings, a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England. As over a third of our population live rurally, our services are on the main organised geographically to enable us to be as responsive as possible to meet the needs of our service users, their carers and families. SCHT serves its population throughout life, with a wide range of services including but not limited to; 0-19s Services, Community Therapy and Nursing, Urgent Care such as Minor Injury Units and Virtual Ward, Outpatients and Community Inpatient Wards. As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to transform the provision of our services by working in partnership with others to meet the needs of those served.

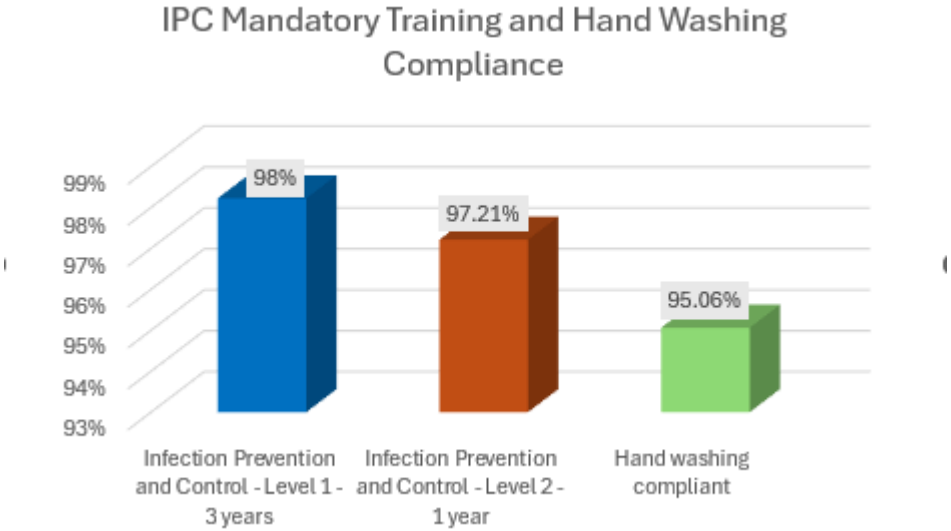
This annual report outlines the activities of SCHT relating to Infection Prevention and Control (IPC) for the year from April 2024 to March 2025 and discusses the arrangements SCHT have in place to reduce the spread of infections. It also reviews governance arrangements, policies and procedures relating to monitoring and surveillance, the environment, cleaning, audit and education. The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised December 2022), which sets out 10 criteria of which a registered provider must be compliant. This sets the framework on which we base our annual programme that is monitored at SCHT's Quality and Safety Committee and IPC Committee (IPCC). The prevention and management of infection is the responsibility of all staff working in SCHT and is an integral element of patient safety programmes. The aim of the IPC Team is to maintain organisational focus and collaborative working to ensure continued compliance with IPC practices, and to actively contribute to quality improvement and safer patient care.

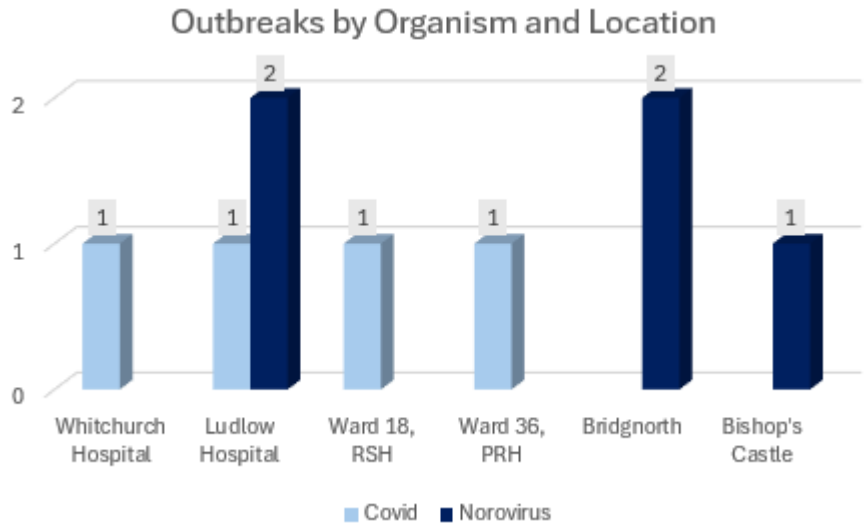
Key Achievements of 2024/25

Our year in numbers









MRSA Bacteraemia and *Clostridioides difficile* cases in SCHT in 2024/25

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Threshold
Healthcare Associated Infections – KEY: Green – below threshold Red – above threshold														
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridioides difficile	0	0	1	0	0	1	0	2	2	2	0	1	9	4

MRSA Screening on admission to SCHT inpatient areas 2023/24

Percentage of inpatients screened for MRSA on admission to Community Hospitals – KEY: Green – above 97% Red – below 97%														
	Apr-24	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Total**	**Threshold**
Average over Trust	98%	96%	92%	99%	99%	99%	98%	94%	97%	95%	97%	97%	97%	97%

Key Achievements

The Trust launched their first IPC strategy in January 2023 and the IPC team have continued to deliver against the four ambitions set out; integrated working, education and training, digital technology and enhanced engagement.

Our IPC Team key achievements for 2024/25 were:

Ambition 1: Integrated Working	
Collaborate with other providers across Shropshire Telford and Wrekin to consolidate our approach to IPC.	• IPC team have attended and contributed to Shropshire, Telford and Wrekin (STW) system IPC and Antimicrobial Resistance (AMR) group regularly. • IPC team have contributed to system wide C-difficile improvement plan sharing SCHT stool chart as best practice example. • Outbreak meetings have been extended to system partners where applicable to ensure shared learning. • IPC team have offered advice/support and peer reviews to the Hospice. • Continued to build relationships with Telford College and offered regular teaching sessions on Healthcare Support Worker Academy
To establish relationships with local higher education establishments	• 3 out 5 IPC team members have completed Quality Improvement (QI) fundamentals course • IPC team member has successfully completed MSc module in IPC to ensure alignment to IPC National Education Framework • Community Nursing Specialist Practitioner Qualification (SPQ) students have spent time with the IPC team as part of their leadership course • IPC have developed and deliver IPC education session at core clinical skills week as part of clinical induction
Participate in the system wide Antimicrobial Group partnership contributing to the worldwide antimicrobial resistance campaign.	• IPC team have attended and contributed to STW system IPC and AMR group regularly. • IPC team in conjunction with Pharmacy team an education campaign to promote AMR awareness
Participate and support in local EPRR exercises	• IPC team members have participated in local EPRR exercises • Participated in Incident Management Teams (IMTs) for iGAS and Avian Flu to support the wider community.

Ambition 2: Education and Training	
Innovate our approach to education, creating a sustainable future for the IPC workforce. This will include implementing the IPC National Education Framework and ensuring that IPC training for our staff is fit for purpose and meets the new guidance set out in the Health and Social Care Act.	• IPC team member has successfully completed MSc module in IPC to ensure alignment to IPC National Education Framework • Community Nursing SPQ students have spent time with the IPC team as part of their leadership course • IPC have developed and deliver IPC education session at core clinical skills week as part of clinical induction

IPC team members to attend Quality Improvement fundamentals course	• 3 out 5 IPC team members have completed QI fundamentals course

Ambition 3: Digital Technology	
Harness technology to make IPC accessible and responsive. This includes implementing software platforms to enhance our audit and reporting and surveillance software increasing and maximising our response to risks of infections.	• My Audit software module has been purchased and designed for IPC Quality Assurance Audits in Community Hospital inpatient wards.

Ambition 4: Enhanced Engagement and Involvement	
Ensure IPC has Board to floor involvement. This includes enhanced communications, introducing IPC campaigns and engaging with all staff on IPC Roadshows.	• IPC Campaigns have included: o Back to Basics o AMR o Winter Well • IPC Quality Assurance Audit themes presented at IPCC
Ensure approach is aligned with the organisation Patient Safety Incident Response Framework and promote the use of After Action Reviews following outbreaks or HAIs	• Implemented use of SBAR (Situation, Background, Assessment, and Recommendation) reports for rapid learning following outbreaks aligned to PSIRF
Engage with Quality Improvement team to deliver identified Quality Improvement projects	• IPC team have worked with QI team on several improvement projects: o Hydration to reduce incidence of Urinary Tract Infections (UTIs) o Visual Infusion Phlebitis (VIP) document and Intravenous (IV) policy update to ensure early removal of peripheral vascular access devices

The Criteria of the Health and Social Care Act (2008: revised 2022)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

NHS England (NHSE)'s Health and Social Care Act (H&SCA) guidance, builds on the previous H&SCA code of practice and contains statutory guidance about compliance with the registration requirement relating to IPC, including cleanliness. The H&SCA and regulations are law and must be complied with. The Care Quality Commission (CQC) has enforcement powers that it may use if registered providers do not comply with the law.

Any gaps in compliance and actions to address these are captured on the overarching Trust IPC Improvement Plan.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

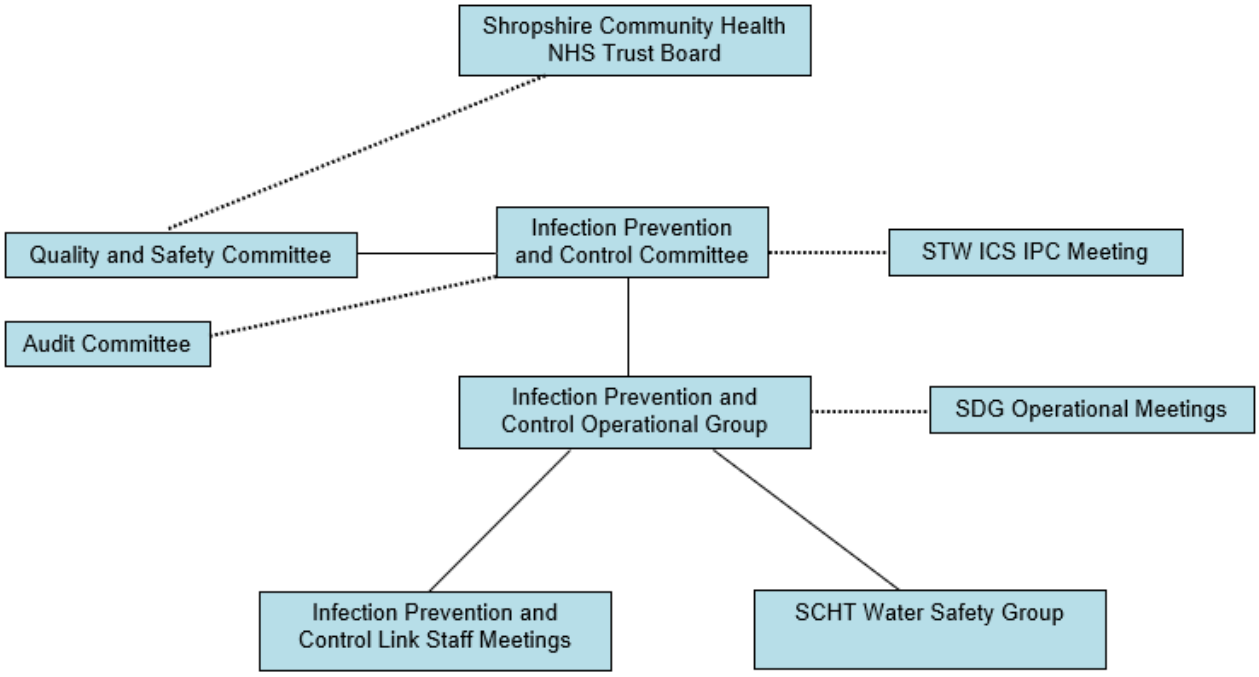
Duties, arrangements and assurance

The SCHT Board and ultimately the Chief Executive carries responsibility for ensuring that systems and resources are available to implement and monitor compliance with IPC and is a vital component of Quality and Safety. The Director of IPC (DIPC) provides oversight and assesses assurances on IPC (including cleanliness), the built environment and antimicrobial stewardship reported to the Trust Board. The responsibilities of the DIPC are discharged by the Deputy Director for IPC who is responsible and manages IPC for the Trust. All managers and clinicians must ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff is expected to demonstrate commitment to reducing the risk of Healthcare Associated Infections (HAI) through the application of standard IPC measures aligned to the National IPC Manual. The IPC Team provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC. Reports on all IPC activity are submitted through a series of operational Groups, Committees and to Private and Public Board for oversight and assurance purposes.

Governance and Assurance Arrangements for 2024/25

Shropshire Community Health NHS Trust

Infection Prevention and Control Governance Framework



The Infection Prevention and Control Team

The Trust's DIPC is Clair Hobbs, who is also Director of Nursing, Quality and Clinical Delivery, and reports directly to the Chief Executive.

Deputising for the DIPC and leading the IPC Team and IPC programme, is Sara Ellis-Anderson, in the role of Deputy Director of Nursing and IPC. Sharon Toland is the Clinical Lead Nurse for IPC. Ian McCabe and Eve Sampson are IPC Nurses and Holly Grainger also joined the Team in March 2025. Admin Support is provided by Alison Davies.

SCHT's committed IPC Team are very clear on the actions necessary to deliver and maintain patient safety and quality of care. Equally, it is recognised IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC Team utilises a proactive approach to engage with staff to develop systems and processes that lead to sustainable and reliable improvements in applying IPC practices.

Infection Prevention and Control Service

- Director of IPC (also Director of Nursing, Quality and Clinical Delivery) (1.0 WTE)
- Deputy Director of IPC (also Deputy Director of Nursing and Quality) (1.0 WTE)
- Clinical Lead Nurse, IPC (1.0 WTE)
- IPC Nurse (1 WTE)
- IPC Nurse (1 WTE)
- IPC Nurse (0.6 WTE)
- IPC Secretary (0.8 WTE)

SCHT has a Service Level Agreement for specialist support from a Consultant Microbiologist at Shrewsbury and Telford NHS Trust (SaTH) to act as SCHT's IPC Doctor. Medical microbiology support is provided 24 hours a day, 365 days a year through on-call arrangement. SCHT also seek advice from the UK Health Security Agency (UKHSA) and NHSE when required.

Trust Board – SCHT's performance against the MRSA Bacteraemia, Clostridioides Difficile Infection (CDI) national reduction thresholds are included in the monthly Integrated Quality Report. The IPC Board

Assurance Framework (IPC BAF) is completed and presented at the SCHT Public Board Meetings bi-annually and this IPC Annual Report is presented annually at the Public Board.

Infection Prevention and Control Committee (IPCC) – Membership is multi-disciplinary and includes representation from the operational and quality directorates, estates department, medicines management, Integrated Care Board (ICB) IPC Nurse IPC Nurse and SaTH IPC Doctor. The meeting is chaired by the DIPC. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

Quality and Safety Committee (QSC) – SCHT's performance against the MRSA Bacteraemia, CDI national reduction thresholds are included in the integrated quality report. IPCC Chair reports, the IPC Board Assurance Framework and the IPC Annual report are presented to Quality and Safety Committee meetings.

Infection Prevention and Control Operational Group (IPCOG) Meeting – Primary membership is from higher risk areas within the Trust, such as Community Hospitals, dental services and podiatry as well as Health and Safety, Quality Improvement, EPRR and Estates representatives. Team leaders from other services are invited to join if they have any IPC issues to discuss and/or address or where IPC audits fall below expected standards and improvement plans are required. The meeting is chaired by the Deputy DIPC and meets monthly. The TOR and membership are reviewed every year to ensure responsibility for IPC continues to be embedded across the organisation.

Outbreak/infections review – Chaired by either DIPC or Deputy DIPC, this is a monthly meeting to discuss any alert organisms or outbreaks to establish whether there were any lapses in care or lessons to be learned and shared. Attendance is by invitation and may include Ward Manager or representative, SaTH IPC Doctor, prescribing Doctor, pharmacist and ICB IPC Nurse. PIRs or after action reviews are prepared and discussed and actions and findings disseminated.

Learning from Deaths Meeting – The membership is multi-disciplinary and includes representation from the operations and quality directorates, IPC and medical directorate.

SCHT Water Safety Group – The membership is multi-disciplinary and has representatives from Midlands Partnership Foundation NHS Trust (MPFT) and an Authorising Engineer and is chaired by the Deputy DIPC. The TOR and governance structure is reviewed every two years. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, Automated Endoscope Reprocessor (AER) and capital developments and reports to the QSC. The annual SCHT Water Safety audit was undertaken in October 2024. The Deputy Director of IPC is also a member of the MPFT Operational Water Safety Group for Shropshire chaired by MPFT to oversee operational delivery of Water Safety.

Integrated Care System IPC Meeting/IPC and Anti-Microbial Resistance Group – These System groups aim to ensure a strategic overview across the local health economy and SCHT is represented by the Clinical Lead Nurse for IPC.

In addition to the meetings mentioned above, the IPC Team also attend other regular and ad hoc meetings where specialist IPC knowledge is required.

Infection Prevention and Control Link Staff – All IPC link staff and their line managers are asked to sign a Roles and Responsibilities agreement. Our IPC link staff support the operational delivery of IPC practice ensuring high standards of quality and patient safety in relation to IPC. Our IPC link staff are also responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

Divisional Clinical Managers, Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders – Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of

cleanliness. Our leaders are responsible for ensuring the IPC link staff are supported in performing their role and have appropriate time and resources to do this effectively.

Organisational Development Team – Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which include IPC. Training compliance is reported monthly to the QSC. The IPC Team participates in Core Clinical Skills weeks, providing clinical staff with a general overview of infection prevention and control, encompassing the importance of embedding standard IPC precautions into practice to prevent the transmission of infection.

Roles and Responsibilities of all Staff – All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow standard IPC precautions at all times and are familiar with IPC policies, procedures and guidance relevant to their area of work and this responsibility is included in all SCHT job descriptions.

Alert Organism Surveillance and Management and Healthcare Associated Infection (HAI)

All organisms of IPC significance are monitored by the IPC Team and are termed Alert Organisms. The local acute Trust, whose microbiology laboratory process specimens from SCHT patients, submit data on SCHT's behalf on MRSA Bacteraemia, MSSA Bacteraemia, Escherichia coli (E.coli) Bacteraemia infections and CDI to UKHSA, as part of the national mandatory surveillance programme for HAIs.

SCHT does not have nationally set thresholds for reducing HAIs. These thresholds are set for acute Trusts and ICBs. However, SCHT recognises it does have a responsibility in contributing to the overall reduction thresholds of Shropshire and Telford & Wrekin ICB and therefore agree local infection thresholds.

Healthcare Associated Infections in SCHT 2023/24

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	Threshold
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridoides difficile	0	0	1	0	0	1	0	2	2	2	0	1	9	4
E-coli Bacteraemia	0	0	0	0	0	1	0	0	0	0	0	1	2	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella spp	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CPE Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VRE Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Green – under or equal to threshold
Red – exceeding threshold

MRSA Bacteraemia Trust Threshold

In the event of a patient contracting an MRSA Bacteraemia whilst under the care of SCHT, the Trust would review the case through a Patient Safety Investigation to identify any potential lapses in care or any common themes that may have contributed to the infection.

Clostridioides difficile Infection (CDI) Thresholds

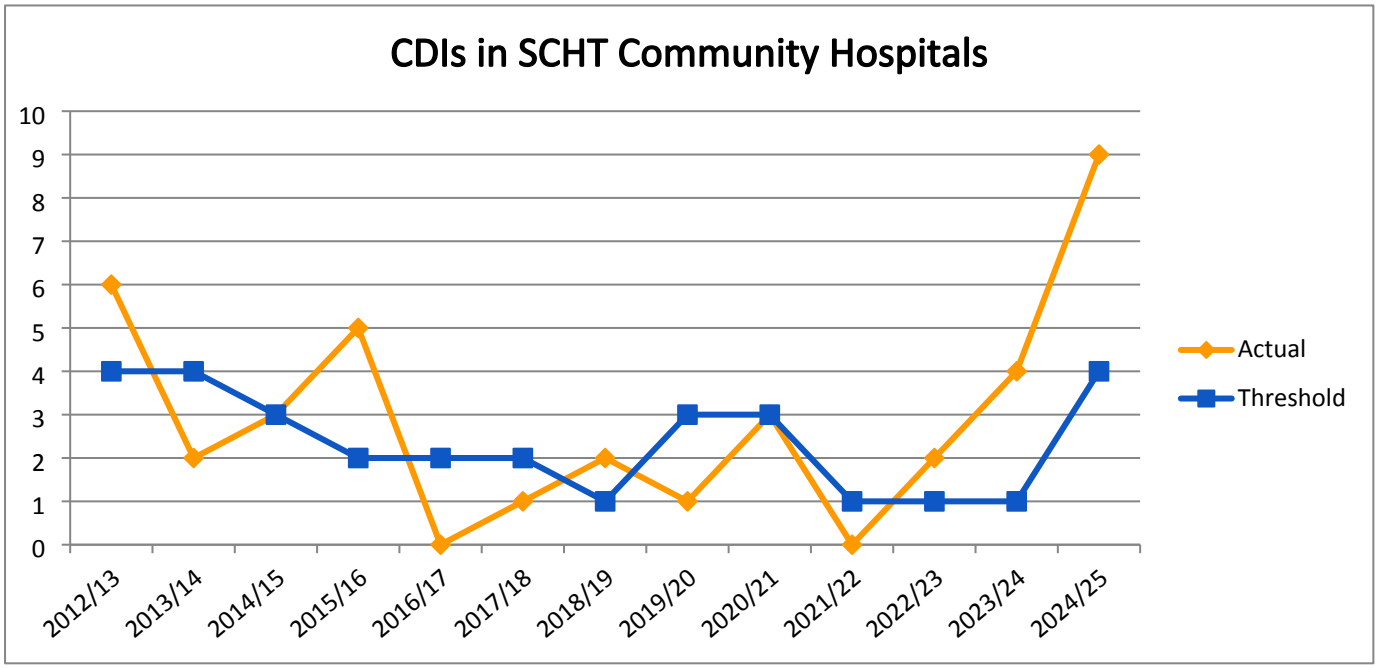
The local threshold set for SCHT was to have no more than four cases of CDI diagnosed post 48 hours after admission in the community hospitals attributed to SCHT.

There were nine incidences of CDI attributed to SCHT in 2024/25. Each case is reviewed to identify learning and discussed at the monthly Outbreak/HAI meeting. A thematic review was completed of all the cases which noted all patients had previous admissions in SATH and total hospitalisation exceeded four weeks in all cases. Four of the cases were relapses and had previously had CDIs. Eight out of the nine patients had antibiotics in the 3 months prior to identification with CDI.

The IPC Annual Programme continues to focus on key actions to reduce the number of CDI cases which includes appropriate antibiotic prescribing and advice, with the earliest detection of CDI and prompt isolation of all patients with diarrhoea. The IPC team have worked alongside the pharmacy team to introduce a guide to de-prescribing Proton Pump Inhibitor (PPI) medication which can be a risk factor in patients developing CDI with its long term use. SCHT IPC team have contributed to a Shropshire Telford and Wrekin (STW) collaborative CDI improvement plan to share best practice and learning in response to the increased incidence being seen across all system providers during 2024/25.

The graph shows the cases of CDI diagnosed in SCHT Community Hospitals since 2012/13 against the threshold set by the commissioners.

Incidences of CDI in SCHT since 2012/13



CDI 30-day Mortality Rate

The Consultant Microbiologist at SaTH monitors the local health economy CDI mortality data which includes patients in SCHT. There were no deaths attributed to CDI at our Community Hospitals in 2024/25.

Periods of Increased Incidence (PII)

Since April 2010, all Trusts have been asked to report PII of infections on the Trust's electronic incident reporting system, Datix. SCHT reported no PII during 2024/25.

Other Alert Organism Surveillance and Management

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia.

Mandatory reporting of all MSSA bacteraemia commenced in January 2011. There is currently no target associated with MSSA bacteraemia incidence. SCHT continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance scheme.

Carbapenemase-producing Enterobacteriaceae (CPE)

CPE are Gram negative bacteria which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics, are ineffective. CPE continues to be included in the SCHT revised Prevention and Control of Multi-Resistant Gram-Negative Bacteria policy and advice is included in the Guide to Multi Resistant Gram-Negative Bacteria information leaflets available to all staff, patients and visitors.

Glycopeptide-Resistant Enterococci (GRE) also known as Vancomycin-Resistant Enterococci (VRE)

In all cases of GRE/VRE, IPC recommend source isolation for all community hospital patients as prevention of transmission is through effective transmission-based precautions.

Extended Spectrum Beta-Lactamase (ESBL) including Escherichia *coli.* and *Klebsiella/AmpC Beta-Lactamase*

Within the Community Hospitals the most common site for these bacteria is in patients' urine. Upon notification of a positive result, the IPC Team contact the ward to discuss isolation, other precautions and if treatment is required.

SCHT recorded two incidences of patients contracting E.coli bacteraemia whilst inpatients in the Community Hospitals.

Investigation from the IPC team established that the first patient had no invasive devices and no breaks in skin identified that could have provided a possible route of infection. It was agreed that the Trust should develop a policy for staff taking blood cultures to identify how blood cultures are taken, and how this is documented.

The second patient to be diagnosed with an E.coli bacteraemia had a catheter in situ after a fall. An After Action Review was carried out which highlighted the requirement for greater discussion with patients around catheter use and for Trials Without Catheters to be considered. As a result of this, questioning the use of indwelling devices has been introduced to daily huddles within wards.

Outbreaks

An outbreak of infection is described as two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample and are linked through a common exposure, personal characteristics, time or location.

The table below summarises the outbreaks declared in SCHT community hospitals during 2024/25.

Total outbreaks declared in SCHT in 2024/25

Hospital/Team	Date	Causative Organism
Royal Shrewsbury Hospital (RSH), Ward 18	05/09/2024	COVID-19
Whitchurch	17/09/2024	COVID-19/ respiratory
Ludlow	02/10/2024	COVID-19
Princess Royal Hospital (PRH), Ward 36	02/10/2024	COVID-19
Bridgnorth	15/12/2024	Norovirus
Ludlow	12/12/2024	Norovirus
Bishops Castle	28/12/2024	Norovirus
Bridgnorth	10/01/2025	Norovirus
Ludlow	03/01/2025	Norovirus

SCHT has continued to follow and adhere to National Guidance regarding COVID-19. In each of the outbreaks, whether for COVID-19 or Norovirus, the IPC Team conducted Quality Ward Walks to offer guidance on patient management and placement, adherence to control measures and advised the use of

a range of tools designed to assist in the care and monitoring of affected patients. Daily discussions were conducted with operational colleagues and ward teams. Close monitoring in this way meant that the disruption to patients and SCHT services and teams was kept to a minimum.

Internal and external outbreak meetings were held on declaration of an outbreak with the ICB, UKHSA and NHSE, and the Care Quality Commission were notified of any disruption of services.

The Trust witnessed Norovirus outbreaks lasting > 20 days in some instances. Indications showed there were examples of patients transferred into re-opened beds that then become symptomatic having incubated the virus prior to transfer. In response the Trust increased the length of time before cleaning and re-opening beds from 48 hour to 72 hours with the understanding this can be risk assessed on a case-by-case basis if there are extreme system pressures.

Auditing Programme

Auditing is the mainstay of the systems we use to manage and monitor the prevention and control of infection and a summary of our audits is provided below.

Hand Hygiene Assessments

Effective and timely hand decontamination is acknowledged as the most important way of preventing and controlling infections. The IPC Team continued its concerted efforts to ensure that hand hygiene compliance remained a high priority.

Training on the importance of hand hygiene, being “bare below the elbow” and the World Health Organisation (WHO) “5 moments for hand hygiene”, was provided locally to new clinical staff on induction and was reinforced by members of the IPC Team at all IPC training events, during clinical visits and whilst auditing.

Assessments to monitor effective hand washing are undertaken by all new staff within one week of commencement of employment, and annual assessments undertaken for existing staff, including students on placement. Hand washing assessments are included in clinical areas’ reports to the IPCC meeting.

IPC Quality Assurance Audits

In total 115 audits were undertaken by the IPC Team. The objectives of the audits were to inform services of their level of compliance to the National Infection Prevention and Control Manual (NIPCM), local policy and procedures and allow improvements to be made based upon the findings. It also identified target areas for IPC training.

Common themes identified within these audits were Estates remedial works required, missed moments of hand hygiene, inappropriate use of and compliance with Personal Protective Equipment (PPE) and cleanliness of equipment.

As well as audits undertaken by the IPC Team, IPC have encouraged the use of the self-audit/checklist by ward staff and community staff to monitor ongoing IPC compliance. Any issues identified are addressed immediately to ensure safety for the individual patient, other patients, and staff, and for assurance as all self-audits are reported through IPC Committee meetings.

331 self-audits were undertaken at the Community Hospitals by ward staff – 127 at Bridgnorth Community Hospital, 20 at Bishop’s Castle Community Hospital, 55 at Ludlow Community Hospital and 129 at Whitchurch Community Hospital. A total of 86 self-audits were undertaken at the two Rehabilitation and Recovery Units (RRUs) – 63 at Ward 36, PRH and 23 at Ward 18, RSH.

Self-audits were also undertaken in non-inpatient areas. These monitored areas such as the environment, cleaning standards and the condition and cleanliness of equipment, 47 such self-audits were undertaken in the Adults and Community Division, 31 in Urgent and Emergency Care Division and 162 in Children and Families and Planned Care Division.

External Audit

Following the Associate Director of IPC for NHSE in the Midlands visit in April 2023 when recommendations included a long-term review of bed spacing at Whitchurch Hospital, a review of the cleaning provision at Oswestry and identification and replacement of damaged equipment such as foot stools, leg troughs and pressure cushions, a revisit was conducted on the 13th of June 2024.

The visit to the Trust took place over one day and covered three sites: Ward 36 at Princess Royal Hospital, Whitchurch Community Hospital and Oswestry Health Centre. The day commenced with a presentation delivered by the DIPC, Deputy DIPC and the IPC team where the current position and the changes that have been made to IPC and to the governance structure since the previous visit were outlined.

The Trust were previously assessed as **enhanced monitoring and support** on the NHSE - Midlands Infection Prevention and Control (IPC) internal escalation matrix. The Trust have been re-assessed against this matrix following the visit in June and it was confirmed that the Trust were assessed as **routine monitoring and support**, this reflects the significant work that has taken place and the improvements in the governance and assurance processes.

Sarah Game, the Infection Prevention and Control Nurse Specialist at NHS Shropshire, Telford and Wrekin ICB, visited Bishop's Castle Community Hospital on 25 July 2024, two weeks after the hospital had reopened to patients. Her follow up report indicated many good areas of practice and had only a few minor suggestions to improve.

Criterion 2 – The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The 2025 cleaning standards encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results. The 2025 standards reflect modern methods of cleaning, IPC and other changes since the last review and important considerations for cleaning services during a pandemic; and emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

All hospital wards have a hospital cleaning schedule and charter specific to the ward clearly displayed. Key policies for this criterion are in place.

- Quality reviews and IPC audits are undertaken in all areas that include general cleanliness.
- Monthly cleaning scores for sites maintained by MPFT are reported to the IPCC meeting.
- Formal assessments using Patient Led Assessment of the Care Environment were re-established and were reported through the Patient Experience Group.
- IPC Team continue to advise on refurbishment or redevelopment and new build projects to ensure IPC is adequately considered at all stages in line with Health Technical Memorandum and Health Building Notes.
- All laundry is reprocessed at Elis Laundry Services via a contract agreement with Mid Cheshire Hospitals NHS Foundation Trust. Compliance evidence against the contract specifics is reviewed by the Trust and auditing of the laundry facilities is shared with colleagues from RJAH.
- The Central Sterilising Services Department (CSSD) in Telford, operated by SaTH, undertakes most of the decontamination of reusable instruments for SCHT.
- The SCHT dental service is compliant with the “essential quality” requirements contained in the Health Technical Memorandum 01-05 – Decontamination in Primary Care Dental Practices and use the NHSE Dental Audit tool to monitor IPC.
- An automated audit reporting system is now used for completion and monitoring of cleaning audits at the Community Hospitals.

Water Safety

SCHT Water Safety Group meets quarterly with representatives from MPFT and NHS Property Services (NHS PS) and reports through IPCC. The Trust employs an Authorised Engineer who conducts an annual audit, and an action plan is developed to address any issues arising. The Group monitors and manages water risks, especially around Legionella and Pseudomonas, flushing regimens, annual disinfection and capital developments.

Criterion 3 – Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance

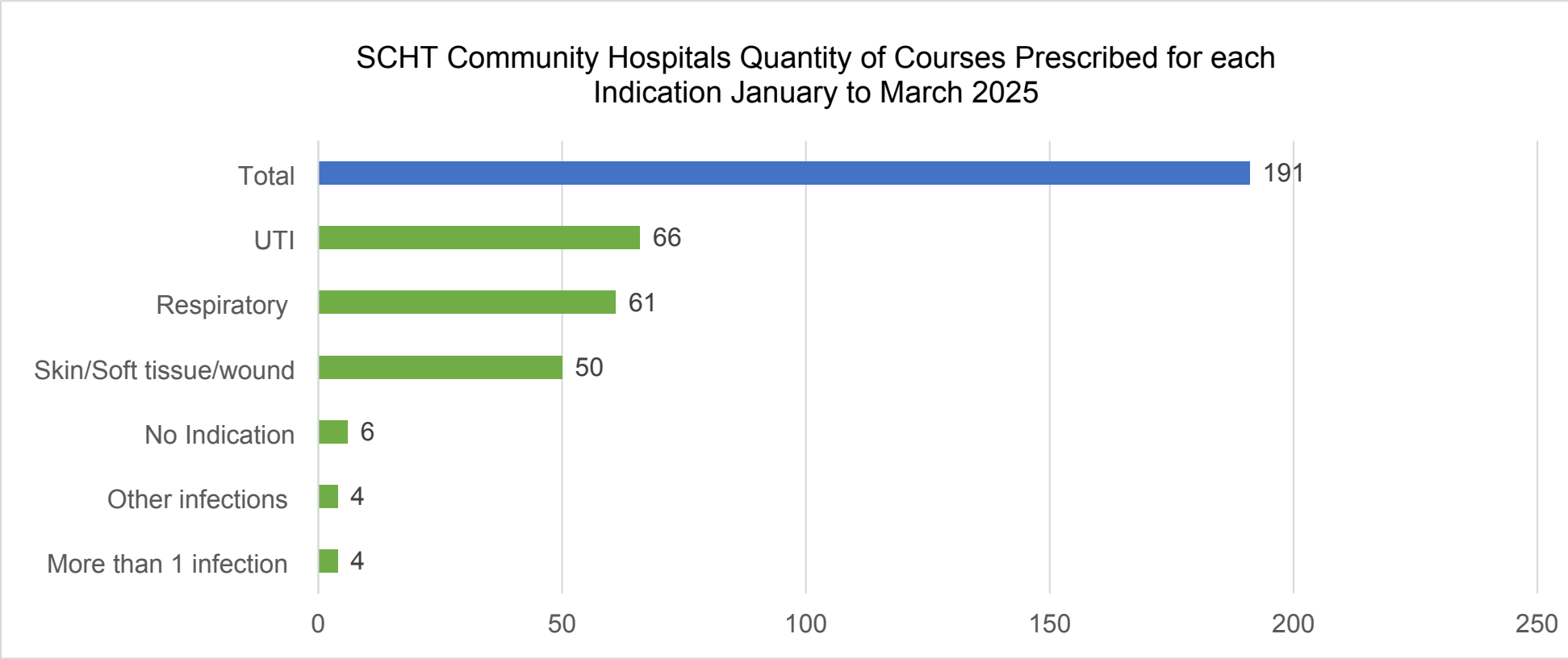
Medicines Management Report

The Trust follows local prescribing guidelines and has access to a community antibiotic policy. All non-medical prescribers have an induction competency assessment with a Pharmacist which includes antimicrobial prescribing. Ward Pharmacy Technicians review all prescription charts daily and advise on antimicrobial stewardship.

Antimicrobial prescribing and administration occur across various services within the Community Trust, including Prisons, Community Hospitals, non-medical prescribers, Virtual Wards, and Dental Services, among others.

Community Hospitals:

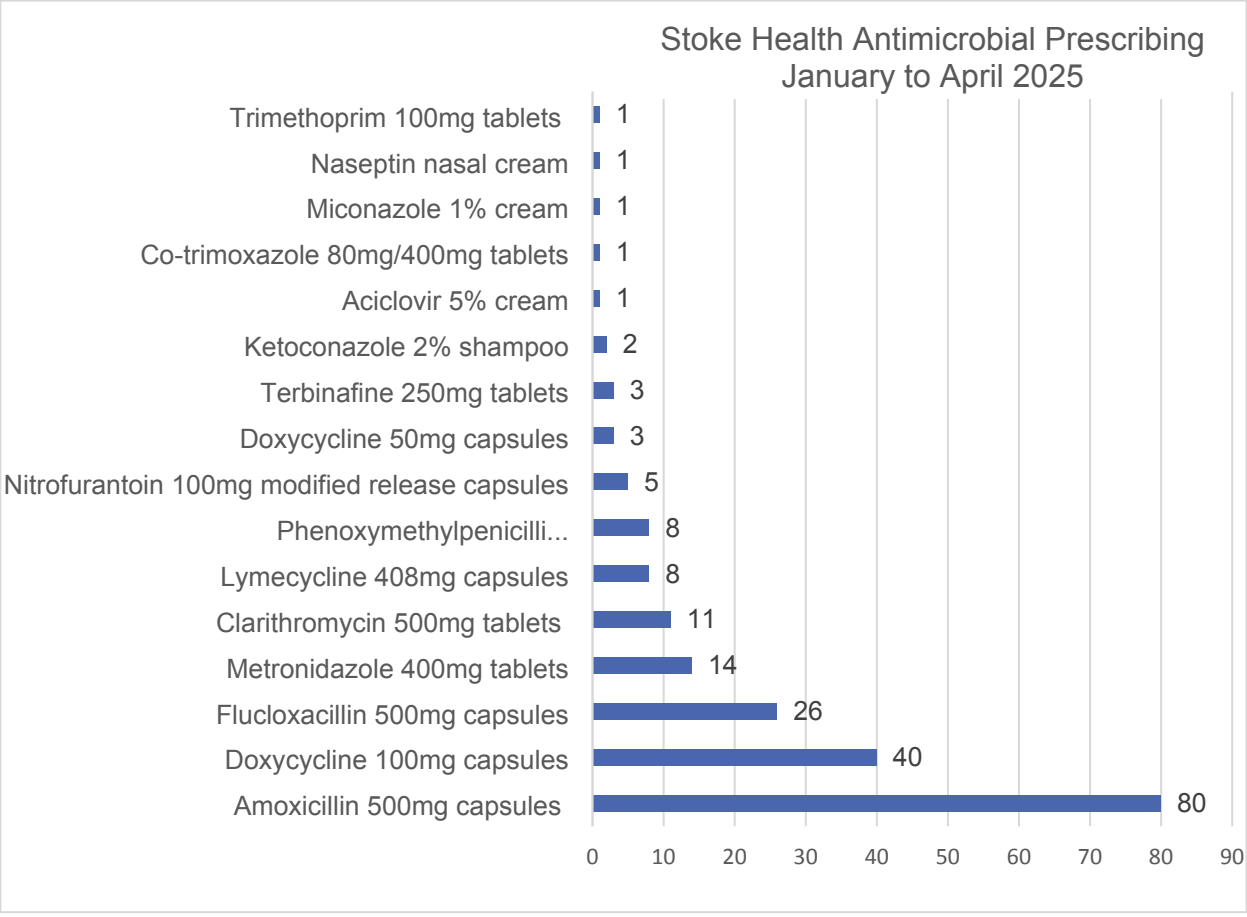
- Antimicrobial prescribing is monitored electronically daily by a designated member of the Clinical Medicines Management Team.
- The Lead Pharmacy Technician oversees antimicrobial stewardship (AMS) within the Community Hospitals, actively monitoring prescribing practices and ensuring adherence to guidelines. They regularly review data and provide reports to the Infection Prevention and Control (IPC) Committee quarterly, contributing to efforts to optimise antimicrobial use and improve patient outcomes.
- The lead Pharmacist for Community Hospitals conducts daily team huddles for Pharmacy staff. These meetings reinforce the antimicrobial stewardship (AMS) message and emphasise the importance of reviewing antimicrobial prescriptions. Technicians are reminded to check each patient's drug chart daily, flagging any antimicrobial prescribing for further clinical review. The Pharmacist then assesses prescriptions against Eolas Medical to ensure compliance with local guidelines.
- Ward Pharmacists review antimicrobial prescriptions to ensure compliance with local guidelines. If a prescription does not align with these standards, they challenge it and document the outcome in the patient's record. This includes noting whether the prescription was adjusted or recording the prescriber's justification for maintaining the original treatment.



- A spreadsheet is also used to monitor antimicrobial use. The spreadsheet is used to record initiation of antibiotics along with the indication, chosen antibiotic, dose and course length as assurance. This is reviewed daily by the Lead Pharmacist for Community Hospitals and Minor Injury Units (MIUs). Any queries are relayed back to the specific hospital team.
- Any prescribed antibiotic courses are recorded in each patient's RiO record, including the prescriber's name, the indication for treatment, and any relevant microbiology results. This documentation supports auditing efforts and ensures prescribing decisions align with clinical guidelines.
- The System Eolas Medical is the reference source used to provide the most up to date information on resistance patterns.
- The use of Intravenous (IV) antibiotics occurs in one Community Hospital only (Whitchurch Rehab), however, use is low.

Prison Healthcare:

- The electronic patient record in prison (SystmOne) allows reporting on antibiotic use. Antibiotic prescriptions are scrutinised and verified as clinically indicated.
- Antibiotic prescribing within HMP Stoke Heath averages 34 acute prescriptions per month. The majority are for skin related conditions. Over the past six months, antimicrobial use for acne treatment has declined due to an NHS England initiative aimed at educating prisoners on the risks of long-term antimicrobial use.
- The prison GP has a good understanding of anti-microbial stewardship. The electronic prescribing system facilitates adherence to formulary as the dose and the number of tablets (course length) are automatically populated from the formulary.
- Antibiotic audits are extracted from the SystmOne software and shared with the Infection Prevention and Control (IPC) Committee to provide assurance to the Director of Infection Prevention and Control (DIPC), ensuring oversight of antimicrobial prescribing practices and compliance with guidelines.
- A report is produced and shared with the prison team at the bi-monthly Prison Medicines Management Meetings. This report highlights any instances of prescribing that fall outside of local guidelines, ensuring that prescribing practices can be reviewed and adjusted to align with best practices and antimicrobial stewardship principles.



The Prison receives remote support from another pharmacist within the SCHT team, who clinically screens prescribing on SystmOne. This Pharmacist plays a key role in antimicrobial stewardship by

reviewing prescriptions and challenging any antimicrobial prescribing that does not align with Eolas Medical or NICE guidelines.

Dental Services:

- The Dental Service is supported by a member of the Medicines Management Team. They monitor the prescribing of antibiotics at all five dental clinics; these include Oswestry, Market Drayton, Castle Foregate, Craven Arms and Dawley Telford.
- Antibiotic prescribing will generally occur during working hours. Clinics which are specifically set up for emergencies such as Castle Foregate have the highest rate of antibiotic prescribing. In these clinics, antibiotic prescribing can be 50% of all prescribing.
- Most of the prescriptions continue to be metronidazole and amoxicillin which is in line with Eolas Medical guidance.
- Antibiotics are only recommended if there are signs of severe infection, systemic symptoms or high risk of complications.

The antimicrobials recommended for the treatment of dental infections are as follows:

  - First Line-Amoxicillin 500mg TDS or Penicillin V 500mg-1g QDS for up to 5 days
  - Penicillin allergy-Clarithromycin 500mg BD for 5 days
  - Severe infection-add Metronidazole 400mg TDS for 5 days or if allergy, Prescribe Clindamycin alone 300mg QDS for 5 days.

- Clinics, which predominantly have a special care role, prescribe the least number of antibiotics.

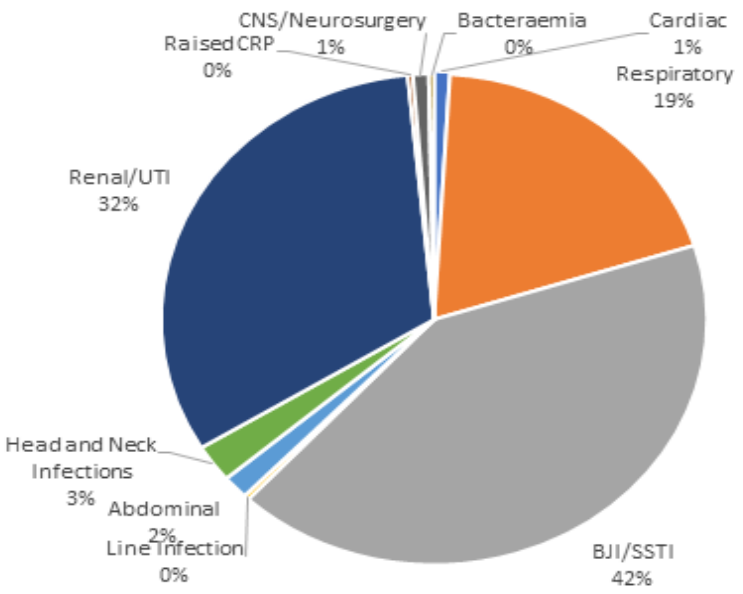
Patient Group Directions (PGDs):

- Patient Group Direction (PGD) are used to provide antibiotics to patients under strict criteria, e.g., in Minor Injury Units.
- PGDs when reviewed are checked against evidence-based references such as NICE guidance and the Shropshire, Telford, and Wrekin local antimicrobial guidelines (Eolas)
- All PGDs for supply of an antimicrobial have microbiology approval before publishing.

OPAT:

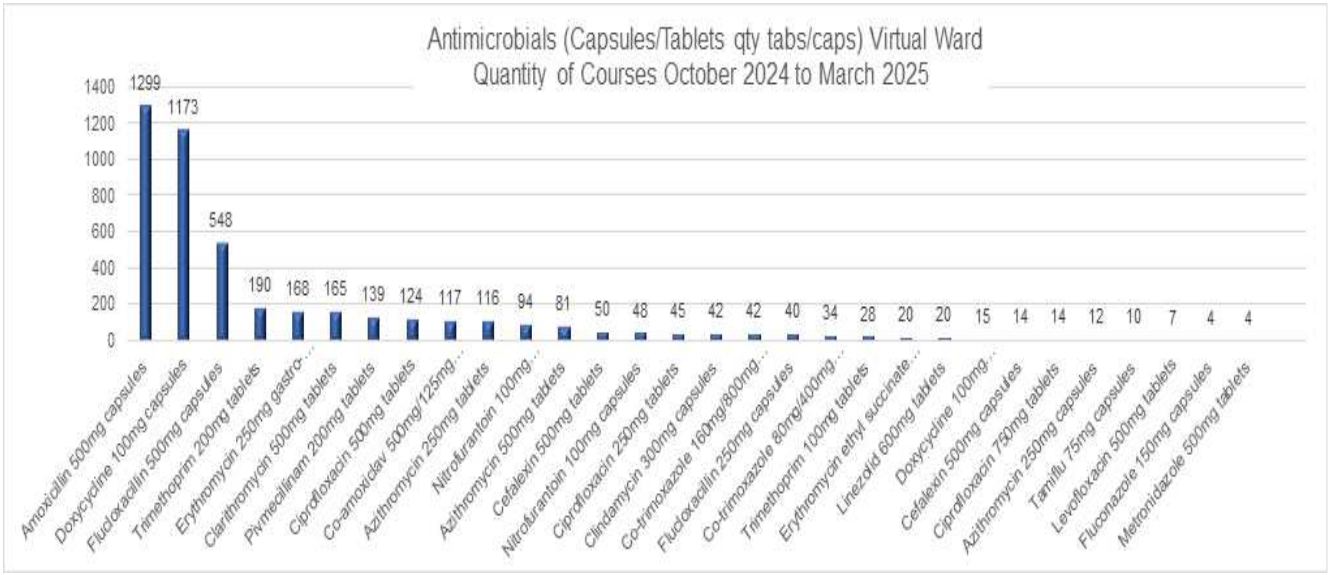
- Outpatient Parenteral Antimicrobial Therapy (OPAT) refers to outpatient or community-based management of an infection via the administration of an intravenous (IV) antimicrobial while residing at home. Patients are managed without admission or may transition to OPAT following hospitalisation. By minimising hospital stay, OPAT is increasingly recognised as a cost-efficient management strategy for a variety of patients requiring either short- or medium- to long-term IV antimicrobial therapy, while also reducing pressures on the acute hospitals by reducing the need for hospital admissions.
- The main antibiotics prescribed by OPAT are, Ceftazidime, Ceftriaxone, Ertapenem and Teicoplanin this is mainly due to their OD/BD regimes as these are logistically easier to manage by the team. Antibiotics are prescribed either on a PSD or an authorisation to administer form by the prescribers in the OPAT team.
- Since the service was created in Nov 2023, 4372 bed days have been saved.
- From launch to March 2025 referrals into the service are predominately from Shrewsbury and Telford Hospital NHS Trust (SaTH) and these equate to 70%, 19% from GP, 6% from another hospital, 3% Virtual Ward/ Diagnostics, Assessment and Access to Rehabilitation and Treatment (DAART), 2% pre-OPAT launch.

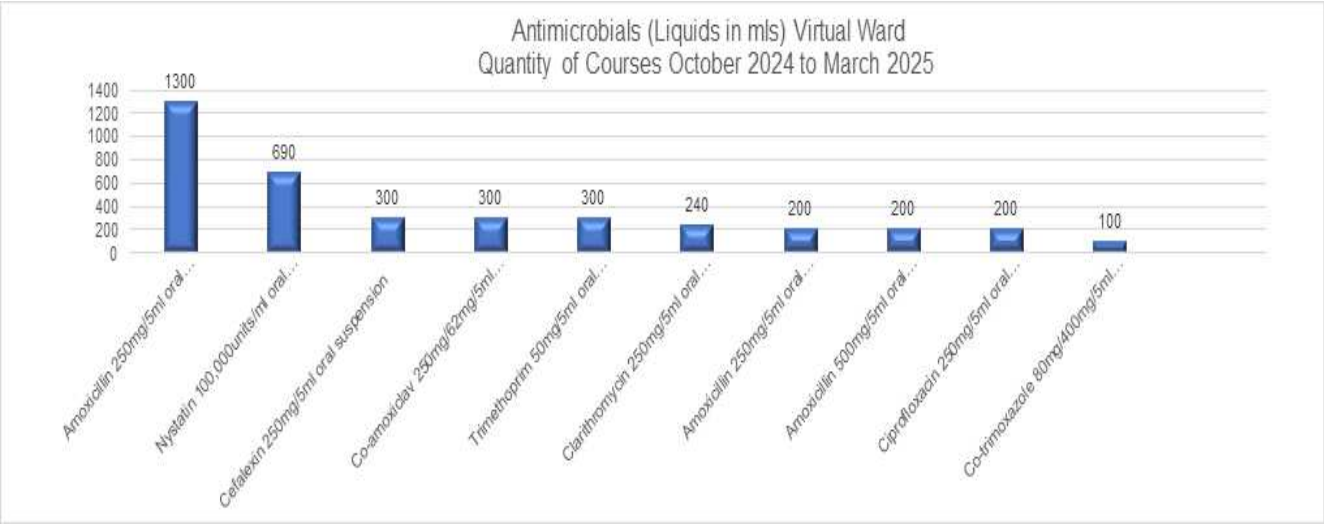
Indications treated by OPAT launch to March 2025



Virtual Ward:

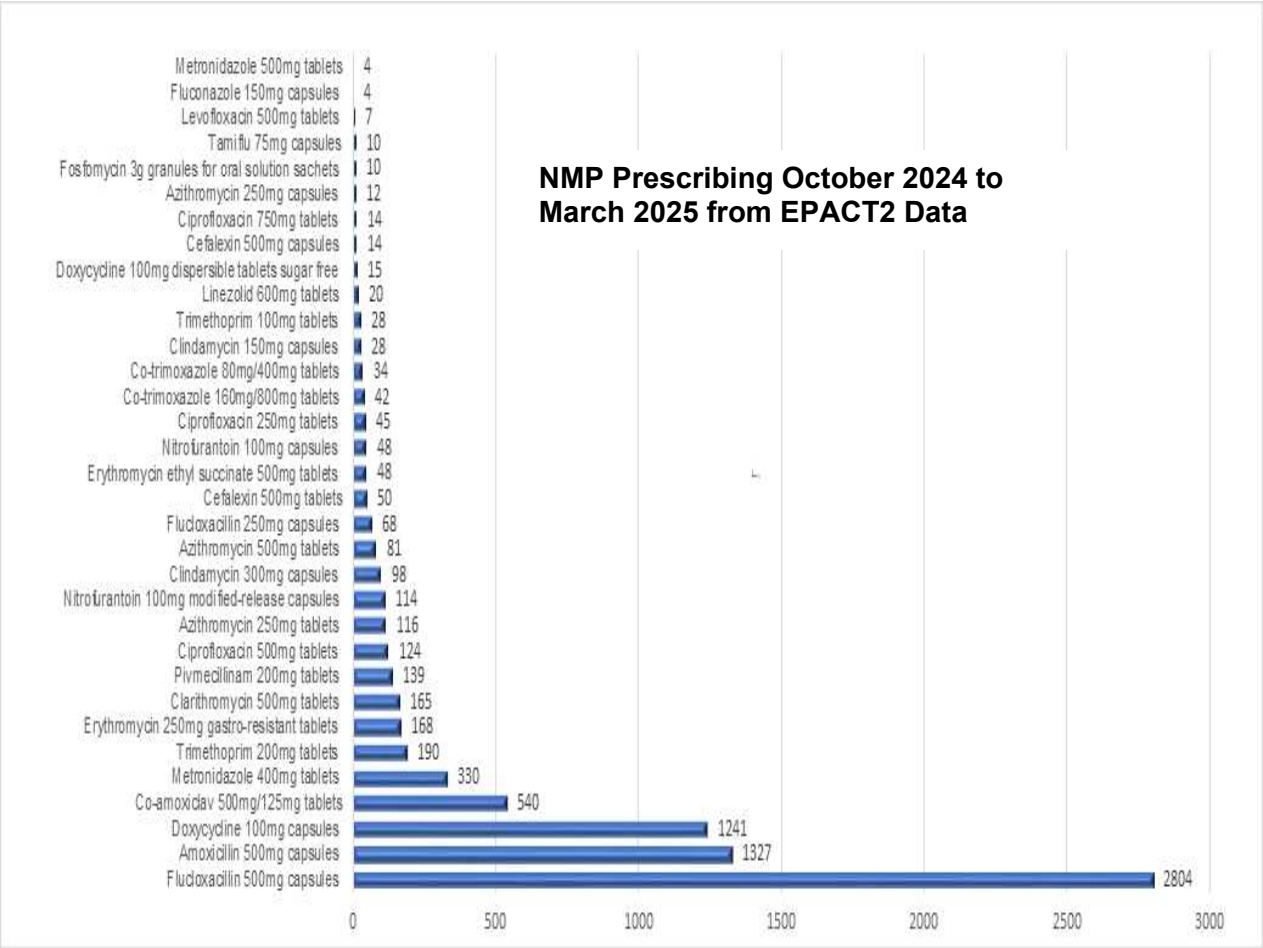
- Virtual Ward (VW) allows patients to access hospital-level care in familiar surroundings at home, safely to speed up recovery while freeing up hospital beds for patients that are more in need.
- There is a mixture of Non-Medical Prescribers (NMPs) and Doctors working within this service. All antibiotics prescribed are either provided by OPAT for IV or on FP10 prescription for oral medicines.
- Antibiotics are prescribed to patients following agreed pathways that mirror guidance in Eolas Medical or via OPAT with medication then being supplied via SaTH Pharmacy.
- Antimicrobials are prescribed under the direction of microbiology, the Virtual Ward Consultant or Virtual Ward GP.
- The Principal Pharmacist in Virtual Ward clinically screens all patient records to ensure that they are following local antibiotic guidance.





Community Nursing:

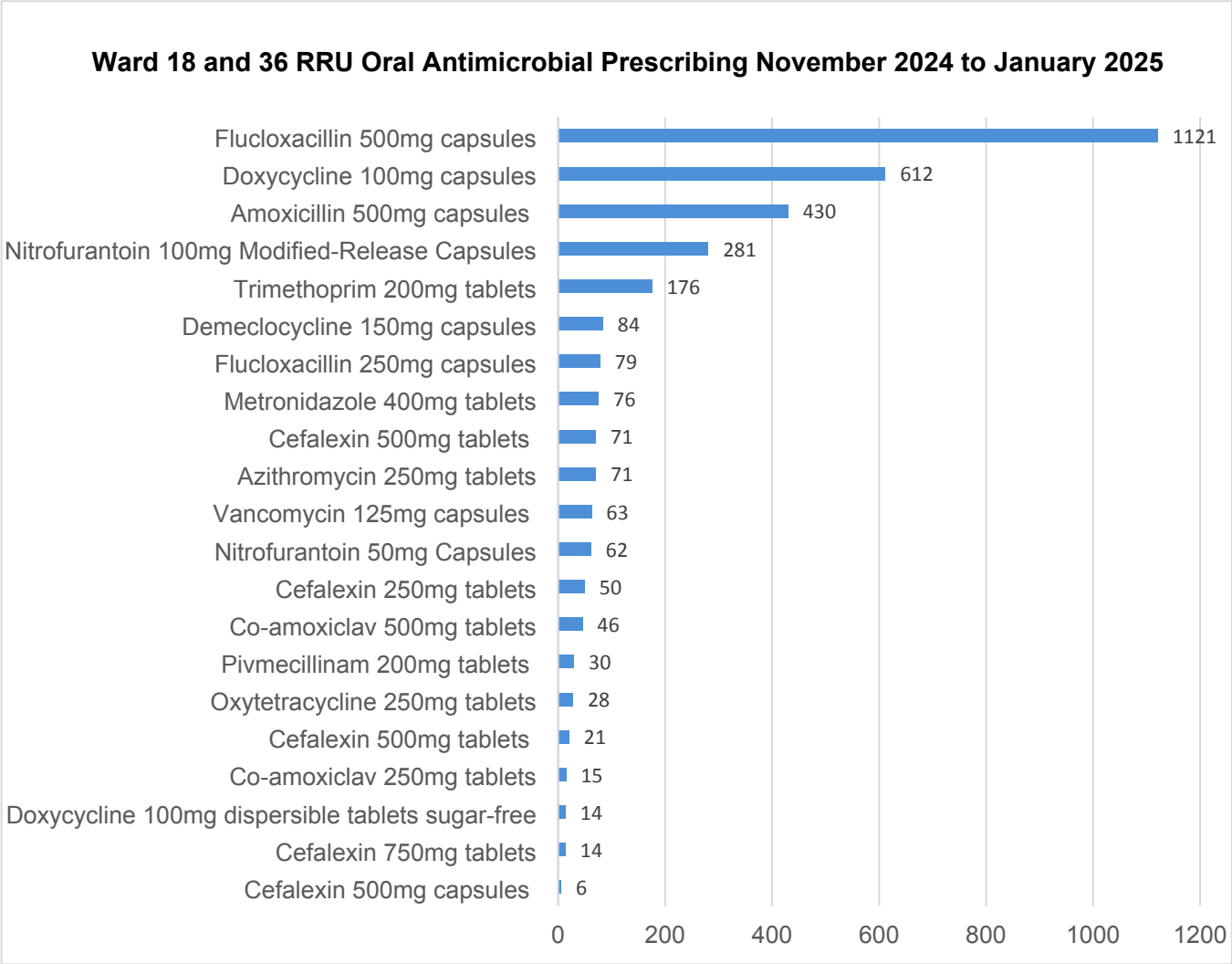
- With the introduction of OPAT, the number of IV antibiotics prescribed by Community Nurses has been reduced. Non-medical prescribing is monitored via ePACT2 data by the Trust's Medicines Management team and the Integrated Care Board.
- Appropriate justification for prescribing is sought where necessary.
- There are 169 NMPs working for SCHT consisting of Nurses, Health Visitors, Paramedics, Physiotherapists, Pharmacists and a Podiatrist.
- Indications for prescribed antibiotics routinely present as UTI, respiratory, wound infections and cellulitis / bites.



Recovery and Rehabilitation Units:

- In January 2024, SCHT opened two new wards which are based within the Acute Hospitals (SaTH), with one being on the Royal Shrewsbury Hospital (RSH) site and the other at the Princess Royal Hospital (PRH) in Telford.

- Antimicrobial data is provided to the Lead Pharmacy Technician in spreadsheet format, where it is carefully reviewed to identify any anomalies. The validated data is then shared with the Infection Prevention and Control (IPC) Committee to ensure oversight and assurance.



- This graph shows the quantity of tablets, capsules prescribed on Ward 18 and Ward 36 for oral antimicrobials Nov 2024 to Jan 2025
- The top four oral antibiotics seen on RRU Wards 18 and 36 are Flucloxacillin, Doxycycline, Amoxicillin and Nitrofurantoin.

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The Pharmacy Department managing the units are employed by SaTH.

Summary:

- Frameworks to reduce HAIs are being developed to prevent HCA LRTIs and UTIs in collaboration with the IPC team and are currently being trialed within our Community Hospitals.
- The Medicines Management Team are active in ensuring compliance with the Antimicrobial Stewardship.
- The Medical Director will support the medicines management team by challenging prescribing when identified by SCHT Pharmacy that it is outside of guidance and there is no microbiology to support the request.
- Any issues with the prescribing undertaken by SCHT are highlighted at the Trusts Infection, Prevention and Control Committee meetings.

Lisa Pascall, Lead Pharmacy Technician - AMS and Vaccination Services
Susan Watkins - Chief Pharmacist, SCHT

Criterion 4 – The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion

Communication regarding appropriate guidelines has continued to be a key requirement in the provision of care, the instigation of IPC initiatives as well as public and visitor safety as we moved to "business as usual" introducing a traffic light system for wearing masks and face coverings in our hospitals, visits and clinics.

The Communications Team are invited to attend IPC outbreak meetings if these may result in media interest because of the nature or impact of the outbreak. The Communications Team also provides the support and guidance and to prepare proactive and reactive media statements where required.

The IPC Team Secretary is responsible for updating the IPC Team intranet site and for the production of staff and visitors' leaflets. IPC updates are also provided to Team leads and an IPC newsletter is designed, sent to all staff and published on the intranet.

As in Criteria One, SCHT report on all Alert Organism monitoring and surveillance through IPCC meetings and Quality and Safety Committees. Our IPC Annual Report is a public document and available to view or download on our Trust website. Details of Alert Organism cases and MRSA screening compliance are also published on the intranet and the public website.

Criterion 5 – That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people

The IPC Team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of IPC; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organism surveillance and managing outbreaks of infection.

MRSA Screening

In addition to the local infection thresholds, a compliance threshold of 97% for MRSA screening for in-patients on admission was agreed with the ICB. Compliance results are reported monthly to the Quality and Safety Committee and IPC Committee with oversight by the DIPC to ensure good practice is shared and action plans are completed and show improvement.

MRSA Screening Compliance for in-patient areas

We aim to screen at least 97% of patients on admission for MRSA each month. For 2024/25, our MRSA screening compliance score was 97.3%, just above the 97% target. Work continues to ensure that this figure is maintained or improved for 2025/26 which includes supporting our clinical teams with digital solutions to form filling and helping reduce the amount of paperwork on admission to our Community Hospitals.

Month	Bishops Castle	Bridgnorth	Ludlow	Whitchurch	PRH	RSH	Overall Trust
Apr-24	Not open	100%	100%	100%	97%	92%	98%
May-24	Not open	100%	100%	100%	97%	87%	96%
Jun-24	Not open	100%	94%	95%	100%	76%	92%
Jul-24	100%	100%	97%	97%	100%	100%	99%
Aug-24	100%	100%	100%	97%	100%	98%	99%
Sep-24	87%	100%	100%	100%	100%	100%	99%
Oct-24	85%	100%	100%	98%	100%	100%	98%
Nov-24	91%	100%	86%	93%	100%	94%	94%
Dec-24	91%	100%	93%	100%	95%	100%	97%

Jan-25	94%	98%	95%	100%	94%	91%	95%
Feb-25	93%	100%	96%	97%	96%	100%	97%
Mar-25	92%	100%	93%	95%	100%	100%	97%
Year End	93%	100%	96%	98%	98%	95%	97%

Figures are rounded up or down to nearest whole number.

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

The Trust has information and processes in place to ensure that its staff, including agency staff, contractors, and volunteers, are able to meet the requirements of this criterion.

All clinical staff receive induction and updated training and education in current IPC practices. IPC mandatory training for clinical staff was delivered via e-learning and 98% of clinical staff were up to date with mandatory Level 2 IPC training as of March 2025.

The IPC team have been engaging with the Clinical Education team and have a regular 2-hour training session being delivered to SCHT staff as part of the clinical induction week programme. The IPC team also support the Shropshire Telford and Wrekin (STW) Healthcare Support Worker (HCSW) academy by delivering IPC training to new HCSW staff that have been recruited.

Other systems in place include:

- SCHT job descriptions include IPC compliance alongside mandatory training to show that responsibility for IPC is delegated to every member of staff.
- “IPC working with patients in community hospitals” information booklet developed with the Feedback Information Group, provides IPC advice and information for all volunteers working with SCHT.
- An IPC information leaflet for health professional staff is available and is given to all temporary and agency staff as part of their local induction.
- IPC Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in the Community Hospitals.
- Information leaflet for contractors working in Community Hospitals.
- Monthly hand hygiene observational audits tools include volunteers and students.

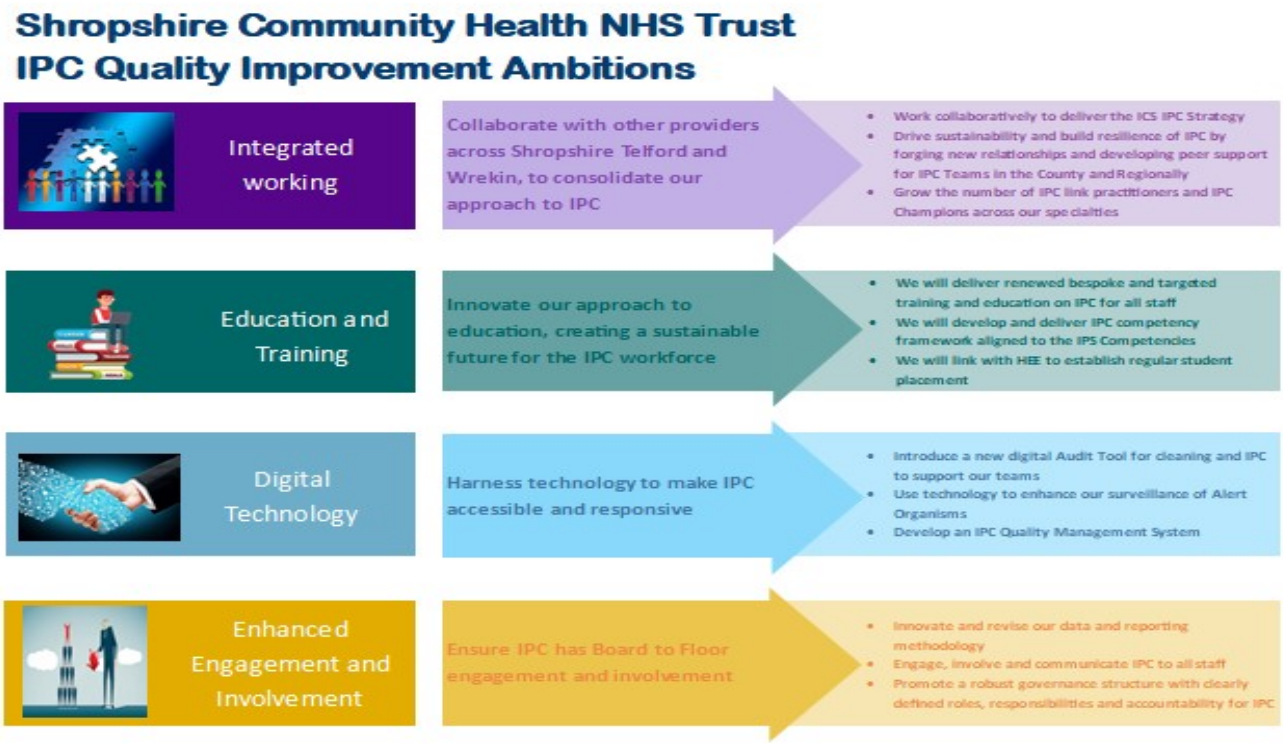
It is important that the Trust can demonstrate that responsibility for IPC is effectively devolved to all groups involved with delivering care and that we have the arrangements in place to inform relevant authorities and System partners of outbreaks or incidents relating to infection. Surveillance of Alert Organisms is covered under Criteria 1.

- Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.
- Responsibilities of groups and of staff are included in all SCHT IPC policies.
- IPC Link Staff Roles and Responsibilities for both community and Community Hospitals has been revised and updated. The IPC link staff receive additional training in IPC and act as a resource and role model and liaise between their clinical area and the IPC team.
- The IPC Self-audit programme encourages teams to own IPC practices and compliance as part of their day to day work.

- IPC Team access SaTH
- Laboratory IT systems to allow enhanced alert organism surveillance and on notification, the IPC team report all outbreaks and incidents of infection to the CQC, ICB, UKHSA and NHSE.

SCHT IPC Ambitions were launched in January 2023 and a report on progress against the milestones has been updated through the IPC report received at IPCC and the IPC annual report.

Figure: SCHT IPC Ambitions



The IPC Team have maintained 100% compliance with their own mandatory training programme and personal development reviews that support increasing knowledge and skills to assist in the delivery of improved quality of care. IPC Nurses have revalidated with the Nursing and Midwifery Council.

Criterion 7 – The provision or ability to secure adequate isolation facilities

The Trust has robust isolation policies in place and has single room accommodation available to isolate patients when this is required. The Trust is also able to implement cohort isolation processes within the current estate and this process has been assured by NHSE Deputy Director of IPC. The Isolation policy includes an Isolation Risk Assessment Tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis.

Criterion 8 – The ability to secure adequate access to laboratory support as appropriate

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The IPC Team have a good working relationship with our IPC Doctor who is the Consultant Microbiologist at SaTH. Medical microbiology support is provided by SaTH 24 hours a day, 365 days a year and the Trust is currently fully compliant with this criterion.

Criterion 9 – That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections

The Trust has many policies and Standard Operating Procedures (SOPs) in place to ensure it meets the requirements of this criterion. The IPC Team have a rolling programme to update and review policies and

compliance with the programme is monitored through IPCC. In addition, policies are updated prior to review date if national guidance changes to ensure they reflect up to date, evidence based, best practice. All policies are ratified and approved through SCHT governance arrangements.

Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

Occupational Health Report 2024/25

Once again Occupational Health have offered advice and support to trust employees and managers with regards to management of sickness absence, staff health and wellbeing and immunisations -- advice has also been offered around staff working with and being in contact with infectious diseases and viruses with help and support from the IPC team especially with regards to staff being in work or returning to work.

Between March 2024 and March 2025, Occupational Health have supported with 18 needlestick/splash/scratch or human bite injuries and have been part of conversations around managing dog bites.

The team have almost completed the Measles project that has seen all patient facing staff records being checked for evidence of immunity to Measles either by serology testing or vaccination and, where needed, staff have been offered appointments to update the information held on record to ensure the safety of both staff and their patients.

A second project has been started that looks at Pertussis or Whooping Cough – guidance suggested that the first phase of the project should look at maternity staff and those working in Neonatal Units but after discussion it was decided that our health visiting staff should be vaccinated if not already and this programme has been started.

Health and Wellbeing days for staff have been offered at 6 sites that included cholesterol and blood pressure checks and a stand from the IPC team that promoted staying well in winter.

Our 2024/25 Flu campaign was not as successful as in previous years with us vaccinating 51% of staff but our data and figures reflected those from around the country and despite our figures being lower than previous seasons we were still within the top quarter across the region.

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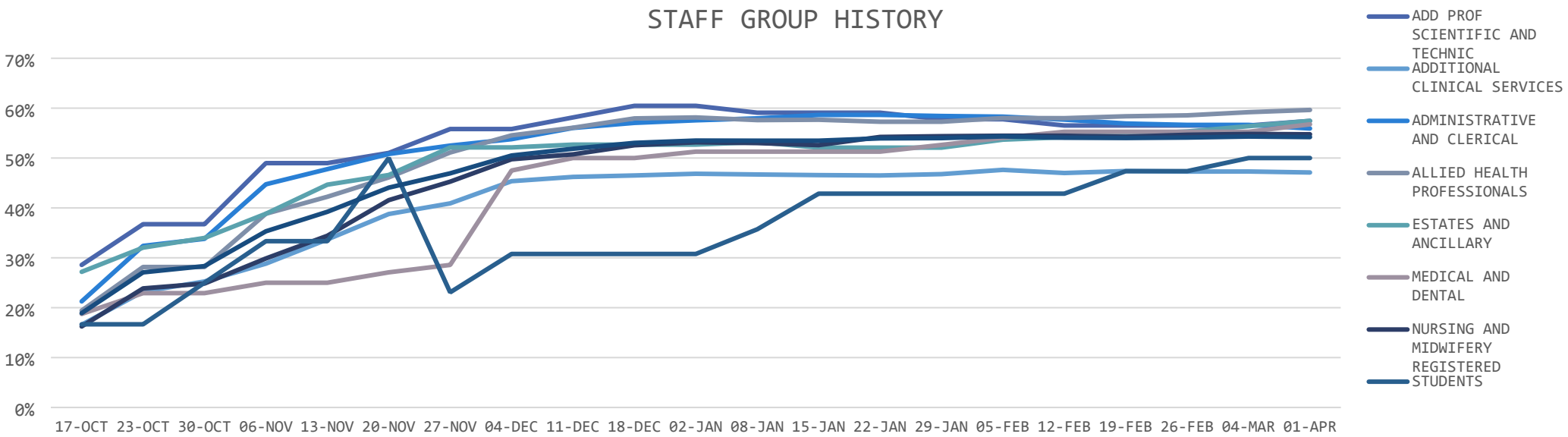
Measles



Occupational Health are currently working to assess the Measles status of any staff who have a patient facing role. They are looking at staff needing 2 x MMR Vaccines or Measles Serology as proof of immunity. The Health Protection Agency suggest that having had 2 x MMR Vaccines offers 95% efficacy. Each staff member with neither vaccines or serology recorded are being offered serology testing but we are noting that there is a high percentage who are ignoring their invitation to attend – when they are invited to attend they are being sent information from The UK Health Security Agency as reference.

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Looking Forward to 2025/26

An Overview of Infection Prevention and Control Programme

The key aim in 2025/26 will be to continue to prevent HAI and to provide education and support to SCHT staff to enable prompt management and control of infections. This will include meeting thresholds and to evidence compliance with the Health and Social Care Act through completing the IPC BAF. In addition, we will strive to achieve the IPC objectives and four ambitions in our IPC Strategy.

Our focus will be to:

Ambition 1: Integrated Working

- Collaboration with providers to continue with particular focus on CDI and AMR for next 12 months
- Support and contribute to Emergency Preparedness, Resilience and Response (EPRR) exercises and Pandemic planning

Ambition 2: Education and Training

- Develop scenario-based teaching for IPC
- Corporate student placements to be offered
- Develop IPC educational resources that are accessible such as videos to support bite-size learning

Ambition 3: Digital Technology

- Contribute to development of digital quality dashboard to display key IPC metrics at ward/department level
- IPC reports to develop use of SPC charts to enable overview of themes and trends
- Enhance digital communications for dissemination of key messages through use of IPC WhatsApp group

Ambition 4: Enhanced Engagement and Involvement

- Continue collaboration with QI team with specific focus on:
    - Catheter care
    - Mouth Care
- Develop method for reward and recognition of excellent IPC practices
- Re-design brand of IPC team to focus on education and advise.

Conclusion

The IPC Annual Report 2024-25 highlights significant achievements and ongoing efforts in infection prevention and control within the Shropshire Community Health NHS Trust. Despite challenges from increased CDI cases and Norovirus outbreaks, the Trust has demonstrated resilience and effective management. The positive outcome of the NHS England inspection further validates the Trust's commitment to maintaining high standards of infection control.

Over the past year, the IPC Team has conducted numerous audits that underpin the Trust’s robust governance arrangements, ensuring floor-to-board support for Infection Prevention and Control initiatives. These audits have provided valuable insights and themes to drive improvements and maintain high-quality standards.

The IPC Team has worked collaboratively with various departments across the organisation, including EPRR, Occupational Health, Pharmacy, Estates, Quality Improvement, and Operational teams, to ensure the safety of patients, staff, and the public for 2024/25. They have conducted several educational and awareness campaigns ensure IPC remains a key focus.

The IPC team has clearly defined key areas of focus for the 2025/26 period in alignment with the IPC Quality Ambitions. The IPC Team remains committed to delivering these objectives while ensuring the provision of a safe and effective IPC service for the Trust.

Glossary of Terms

AMR	Antimicrobial Resistance
Bacteraemia	A bloodstream infection
CDI	*Clostridioides difficile* infection. *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
COVID-19	Coronavirus disease
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
E.coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ePACT2	Prescription database for authorised users
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HAI	Healthcare Associated Infection
H&SCA	Health and Social Care Act
ICB	Integrated Care Board. Previously known as the Clinical Commissioning Group.
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
MPFT	Midlands Partnership NHS Foundation Trust
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NHSE	NHS England
NMP	Non Medical Prescriber
NICE	National Institute for Health and Care Excellence
OPAT	Outpatient Parenteral Antimicrobial Therapy

Outbreak	Two or more persons with the same signs, symptoms in time place and space.
PGD	Patient Group Direction
PII	Period of Increased Incidence
PPE	Personal Protective Equipment e.g. gloves, aprons and goggles
PRH	Princess Royal Hospital
PSD	Patient Specific Direction
QI	Quality Improvement
QSC	Quality and Safety Committee
RRU	Rehab and Recovery Unit
RSH	Royal Shrewsbury Hospital
SaTH	Shrewsbury and Telford Hospital NHS Trust
SBAR	Situation, Background, Assessment, and Recommendation
SCHT	Shropshire Community Health NHS Trust
TOR	Terms of Reference
UKHSA	United Kingdom Health Security Agency

Acknowledgements and Further Information

Thank you for reading the IPC Annual Report for 2023/24.

If you require any further information about IPC in SCHT please email the team at Shropcom.IPCTeam@nhs.net or visit our webpage at https://www.shropscommunityhealth.nhs.uk/safehands

This report was prepared by SCHT's IPC team:

Clair Hobbs – Director of Nursing and Workforce and Director of Infection Prevention and Control
Sara Ellis-Anderson – Deputy Director of Infection Prevention and Control
Sharon Toland – Clinical Lead Nurse, Infection Prevention and Control
Ian McCabe – Infection Prevention and Control Nurse
Eve Sampson – Infection Prevention and Control Nurse
Holly Grainger - Infection Prevention and Control Nurse
Alison Davies – Infection Prevention and Control Team Secretary

In conjunction with:

Susan Watkins – Chief Pharmacist,
Lisa Pascall, Lead Pharmacy Technician – AMS and Vaccination Services
Helen Russell – Occupational Health Advisor

References

Department of Health: The Health and Social Care Act 2008

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

NHSE: National Infection Prevention and Control Manual

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

National Standards of Healthcare Cleanliness 2021

B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

80. Reference Information

Author:	**Tracie Black Associate Director for Workforce Education and Professional standards**	**Paper date:**	**6th August 2025**
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	June 2025
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Workforce, Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The aim of this paper is to provide advice and assurance to the Trust Board regarding the provision of Safer Nurse Staffing and adherence to national policy.

2. Executive Summary

2.1 Context

NHS provider Boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing that will support safe, effective, caring, responsive and well-led care.

2.2 Summary

- The Community Safer Staffing tool was introduced to the Trust in January 2023, however at the beginning of 2024 the National Team paused the tool due to issues with the efficacy of the tool. It has now been re-launched with some changes. Data collection will be undertaken from June 2025.
- The service specification review continues in the Community District Nursing Team with Commissioners however to date no changes have been agreed.
- The updated SNCT tool for inpatient areas has added 2 further categories 1C/D this allows us to capture patients requiring enhanced supervision, which in this data collection has increased from June 2024.
- The Trust continues to see increased need for enhanced care for our patients across all inpatient wards which has increased the use of agency staff as staffing establishment does not include any uplift for enhanced care.
- The Trust has been successful on securing a place on to the NHSE second cohort of the National programme for Enhanced Therapeutic Observation and Care Collaborative (ETOC). This programme will help us understand how we can support our patients with enhanced care needs whilst reducing the need for extra staffing for all patients.
- Safe care is being used in all inpatient areas. Safe care provides staff with live visibility of staffing levels matching with patient demand, it can highlight areas with short workload-based care hours. It allows for the acuity and dependency of patients to be visible daily so wards can demonstrate how dependant their area is at all times. A

weekly report is circulated to the team to monitor consistency of inputting data; this is also monitored and challenged at the monthly e-roster Check and Challenge meetings.

- Five of the six inpatient areas now have a second set of data however due to the launch of the ETOC Programme and two of the wards having escalation beds opened no recommendations should be made for change.
- Vacancy rates in our Community Hospitals have increased from June 2024 from 13.08 WTE to 25.41 WTE, this included all 4 inpatient areas and the Rehabilitation and Recovery Units (RRUs). All vacancies are in various stages of the recruitment process.
- The inpatient wards have seen an increase in patients needing enhanced supervision, this alongside escalation beds being open on Ward 36 and Whitchurch has adversely impacted agency usage.
- The Trust is aware that NHSE will serve notice that all agency Band 2/3 will stop, this will have an impact on the safer staffing of the wards and as a Trust will need to find ways to mitigate this risk.
- Bishops Castle Community Hospital (BCCH) reopened the inpatient facility in July 2024 to 16 beds and so undertook the data collection for January 2025.
- The Workforce Safeguard Gap analysis action plan now has all 14 actions fully completed and so the Trust is now fully compliant.

2.3. Conclusion

The report shows us that benchmarking statics continue to be roughly 50:50 RN to HCA and we continue to see the RN to HCA ratio change when we have additional staff for enhanced care but when we triangulate with quality and safety metrics and red flags there are no concerns regarding safe staffing.

When reviewing the performance of the National Developing Workforce Safeguards, we are fully complaint. (Attachment 1)

The Director of Nursing and Medical Director confirm they are satisfied with the safety, effectiveness and current sustainability of staffing levels at Shropshire Community Heath Trust.

3. Main Report

3.1 Introduction

NHS Provider Boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing that will support safe, effective, caring, responsive and well-led care.

Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2021) sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

It is well documented that ensuring adequate Registered Nurse (RN) staffing levels in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress, reduction in patient mortality and improved quality and safety metrics.

The Developing Workforce Safeguards national policy (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and builds on the National Quality Board (2016) guidance. It identifies that NHS Trusts must ensure the below three components are used in their safe staffing processes:

- Evidence based tools and data.
- Professional judgement
- Outcomes

Of which this paper confirms that we have adopted this triangulated approach. The Trust has a Workforce Safeguards Gaps analysis action plan which has 14 recommendations of which we are fully complaint (see attachment 1).

The Trust commenced using the validated inpatient tool (SNCT) in June 2023 once the required licence had been received, this tool is used widely in other Community Hospitals. The inpatient tool was updated in 2023 and released for use in 2024.The January 2025 data is the second set of data using this updated tool. The National Community Safer Staffing tool was introduced nationally in January 2023 but was paused in early 2024 by the National Team whilst further checks are undertaken and has now been relaunched, and so data collection will be undertaken in June 2025. This report outlines the Second set of data using the refreshed tool for the community inpatient wards and the RRUs captured via this validated, evidence-based method.

4.0 Nurse to Patient ratio – Inpatient wards

4.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for.

4.2 It should be noted that this method may not always accurately reflect the needs of the individual patient as their dependency on nursing input may differ at various points. Nevertheless, the Royal College of Nursing (RCN) ‘Mandatory Nurse Staffing Levels’ (2012) and NICE ‘Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals’ (2014) suggest Acute inpatient wards must have a planned Registered Nurse (RN) to patient ratio of no more than 1: 8 during the day. We acknowledge that these recommendations are for acute wards, but the community wards work to these numbers also alongside professional judgement as the model of care moves towards a more sub-acute specialty. The ratios are followed due to the number of beds within each inpatient area, making it difficult to reduce further. At present there is no national guidance of Nurse-to-patient ratios for night duty however professional judgement of the Director of Nursing (DoN) who is also a National CNO Safer Staffing Fellow is 1:13.

4.3 Table 1 shows the average RN: Patient ratio at Shropcom during January 2025 for our community and RRU inpatient areas It demonstrates that during January 2025 all community and RRU inpatient wards met the national acute requirement of an overall 1:8 for day shifts at the time of the data collection although it should be noted this national guidance is based on acute inpatient facilities.

Table 1: Actual Average RN: Patient ratio during January 2025

Hospital	RN: Patient Ratio- Day Shift
Ludlow	1:8.4
Bridgnorth	1:8.3
Whitchurch	1:8.3
BCCH	1:7.2
Ward 36	1:8
Ward 18	1:8.3

4.4 At Whitchurch the bed base was reduced to 25 beds In August 2024 due to IPC issues, however due system pressures the beds were opened for escalation to 29 beds on the 28.11.24 and then to 32 beds on 20.12.2024 and reduced to 29 beds 24.01.25. For the January 2025 data collection, the ward was open to 32 beds up to the 24.11.2025 then 29 beds. Ward 36 beds base is 20 beds but has the ability to increase to 23 beds (3 side rooms) in escalation and on the 16th of December 2024 these beds were opened and a further 3 beds put into the bays (as temporary escalation spaces) making a total of 26 beds, the beds were decreased on 16th January 2025 to 23 beds and remain at 23. So, for data collection half of the month was at 26 beds and half was 23 beds.

4.5 Nursing Associates (NA) are used in the Trust but have not yet been written into National Policy to be included into the Registered numbers, as yet this policy has not been launched however in the updated SNCT tool it includes NA in the Registered Nurse (RN) count. The use of NA to the Trust is becoming embedded to many of our areas but to ensure safety, professional judgement is applied with triangulation of quality and safety data as a standard daily expectation of leaders and managers. It is to be noted that within the Trust the count the qualified NA in the RN ratios.

4.6 Actual versus planned staffing numbers for January 2025 showed that for 4 inpatient wards and the 2 RRUs 81.66% of all shifts (both RN and HCSW) were covered by substantive staff; this is an increase from 78.6% on June 2024 data. (BCCH not in % as ward not opened) 3.8% were filled by Agency staff and 15% were shifts filled by Bank staff. This demonstrates that the fill rate was over 100% and this is due to the need for enhanced care supervision and escalation beds being opened.

5.0 Safer Nursing Care Tool (SNCT)

5.1 The SNCT is an evidence-based tool that is recommended by NICE to measure individual patient acuity and dependency. It is proposed that using SNCT offers greater understanding regarding if actual hours match required hours.

5.2 The SNCT tool was updated in 2023, and the data collection period has changed from 20 days to 30 days now including the weekends. The twice-yearly data collection continues (January & June). The tool collects individual patient acuity and dependency and in the updated version 2023 there has been 2 new categories added which will monitor the use of enhanced care required by patients these are categories 1C and 1D. The data collection is undertaken by the trained senior Nurses in each team.

5.3 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. It

should be used as part of professional judgement and patient outcomes as is the case with this review.

5.4 The Trust gained its licence in early 2023 but due to the refresh of the tool this data collection is the 2 set of data collected, we will continue to collect 2 sets per year, as this allows us to understand our adherence to the national standards and offer the Board greater assurance.

5.5 Training is in place for staff undertaking the SNCT data collection and will continue. Safe care is now being used in all inpatient areas, with weekly reports on compliance and compliance is discussed in the monthly Check and Challenge Roster meetings.

5.6 Bridgnorth has 25 beds with the daily average at 23.91 patients at the time of the data collection. (See appendix 1 for the SNCT score). The staffing split is 43:57 RN to HCA. The data also suggests that and additional 5.30 WTE is required for the 1c & 1d patients. The agency/bank usage for January 2025 was 8.00 WTE which covered enhanced supervision and vacancy gaps.

Beds 25	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	5.5	0.26	16.50	1.65	RN 15.53 HCA 20.29	RN 23.82 HCA 15.88

5.7 Ludlow has 24 beds with the daily average at 23.34 patients at the time of the data collection. The staffing split is 50:49 RN to HCA. The data suggests that an additional 11.11 WTE is required for the 1c and 1d patients. With the actual Establishment at 30.22 there is a deficit of 8.52 WTE without the consideration of enhanced care. The agency/bank usage for June 2024 was 24.32 WTE this was a mixture of RN and HCA to cover enhanced care patients and vacancy.

Beds 24	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	5.35	0.03	17.00	3.46	RN 15.21 HCA 14.99	RN 23.24 HCA 15.50

5.8 Whitchurch has 25 beds but due to escalation they were on 32 beds until the 24th of January 2025 when they dropped down to 29 beds. with the daily average at 29.03 patients at the time of the data collection. The staffing split is 42:57 RN to HCA. The split is less than 50:50 due to the escalation beds being opened and having more HCA on the ward to support the care of the extra patients.

When we look at the results of the data collection it suggests the ward needs 47.11 WTE to run the ward which would be an increase of 12.46 WTE and suggests that the ratio of RN to HCA needs to change. It further recommends 6.42 WTE for enhanced patients. **It needs to be noted that the staffing recommendations is based on escalation beds being opened which was an increase of 7 patients so**

not a true reflection of the establishment of the ward. The agency/bank usage for January 2025 was 19.60 WTE which covered escalation beds being opened and enhanced care patients.

Beds 32/29	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	5.65	0.03	20.35	2.00	RN 14.67 HCA 19.79	RN 28.27 HCA 18.84

5.9 Bishops Castle reopened in July 2024 and has 16 beds with the daily average at 13.82 patients at the time of the data collection. The staffing split is 59:39. The agency/bank in January 2025 was 14.00 WTE this was to support vacancy and sickness.

Beds 16	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	6.73	0.16	6.93	0.0	RN 11.24 HCA 7.49	RN 15.80 HCA 6.14

5.10 Ward 36 has 20 beds however on 26th December the ward opened 6 escalation beds then reduced to 23 beds on the 16th of December 2024 and have remained at 23 beds. The daily average of 23.18 patients at the time of the data collection. The staffing split is 54:46 RN to HCA. The data suggests a further 6.10 WTE for the 1c/1d patients. The agency/bank usage for June 2024 was 26.60 WTE which was cover for the enhanced care patients and vacancy and escalation beds being opened and so the recommendation for increased staffing is not a reflection of established staffing

Beds 26	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	5.35	0.03	17.45	1.96	RN 21.17 HCA 16.50	RN 23.24 HCA 15.50

5.11 Ward 18 has 26 beds with a daily average was 24.34 patients at the time of the data collection. The staffing split is 56:44 WTE. The data would suggest an increase of 1.07 WTE. It further suggests 11.11 WTE for enhanced care patients. The agency/bank usage for January 2025 was 24.32 WTE which covered vacancy and enhanced care.

Beds 24	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	5.35	0.03	17.00	3.46	RN 15.21 HCA 14.99	RN 23.24 HCA 15.50

5.12 The community Wards and RRU have seen an increase in the need for enhanced care for our patients, which is seen in the increased 1c patients, and this is not isolated to our Trust but a national picture. NHSE have introduced a programme called the Enhanced Therapeutic Observation and Care Collaborative (ETOC) to help support Trust work differently to support our patients without always increasing staff. They have just launched their second cohort, and we have been successful in being included in this cohort.

5.13 Due to Whitchurch and Ward 36 wards being opened to escalation beds and 1 ward only having 1 set of data, at this present time we should not make recommendations for change but should maintain monitoring. Staffing is monitored on a daily basis with risk being assessed.

5.14 The gold standard for skill mix of staff would be 70% RN to 30% (Royal College of Nursing 2012) HCA linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of Care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021). Within the Community Wards the skill mix is often circa 50:50. It is to be noted that when benchmarking, most Trusts including acute Trusts, do not reach the standard of 70:30, the aim is to work towards increasing the Nurse-to-patient ratio on a trajectory to eventually get to 60% and that the 60% would include NAs. This is the professional judgement of the Director of Nursing. The data collection recommendations are based on a 60:40 skill mix.

5.15 The cost to the Trust in January 2025 for substantive RN/HCA staff was **418,204K** with an additional bank cost of **104,721K** and an agency cost of **164,441K**, which is a total additional cost of **269,162k** for staffing in January 2025. (see Table below)

Table 2 staffing costs for January 2025

	Cost for January 2025					
Site	Substantive RN	Substantive HCA	Bank RN	Bank HCA	Agency RN	Agency HCA
Whitchurch Hospital Ward	68,737	49,484	7,093	9,827	16,019	22,155
Bridgnorth Hospital Ward	61,502	59,784	2,763	6,882	272	9,062
Bishops Castle Hospital Ward	42,700	18,390	508	5,315	20,318	7,588
Ludlow Hospital Ward	37,908	41,820	11,057	6,261	15,797	31,751
Rehab & Recovery Unit - Shrewsbury (Ward 18, RSH)	57,368	40,156	12,826	14,646	9,043	13,271
Rehab & Recovery Unit - Telford (Ward 36, PRH)	59,833	43,212	10,747	16,796	6,893	12,272

6.0 Community Safer Care Tool (CNSST)

6.1 The data for the CNSST has not been included following national instruction to pause it's use whilst further testing is undertaken. The tool has now been updated and launched, and so training is being undertaken, and the next data collection will take place in July 2025 and this data will be included in the next report.

7.0 Fill rates for inpatient wards

7.1 Trusts are required to collate and report staffing fill rates for external data submission to NHSE monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA.

7.2 The position for January 2025 Source (January 1st – 31st January 2025) is shown in table 2.

Table 3 – Fill rates (January 2025)

	Day		Night	
Hospital Site	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	101.2%	106.5%	106.5%	123.1%
Ludlow	101.6%	177%	107.7%	205.2%
Whitchurch	114.1%	145.8%	101.1%	238.1%
BCCH	120.2%	99.7%	112.2%	105.0%
Ward 36	143.2%	222.8%	152.6%	202%
Ward 18	109.6%	136.9%	100.1%	158.3%

7.3 We can see from the table that the fill rates for both RN and HCA are predominately over the 100% fill rates. HCA day and night shifts were higher than planned to maintain ongoing management and safety for patients requiring enhanced supervision. For Whitchurch and RRU Ward 36 have had escalation beds opened which has been and increase maximum of 13 beds. This is particularly noticeable at both Whitchurch and Ludlow where they have seen high numbers of patients needing enhanced supervision.

7.4 Fill rates do not take into account the skill mix within an area including what percentage of this fill was temporary staff, all of which are contributing factors to quality and safety within the clinical environment.

7.5 Bed occupancy rates reported for January 2025 were 95.4%. This breakdown for bed occupancy at each site as 92.3% Bridgnorth, 98.1% Ludlow, and 96.7%, Whitchurch, Ward 36 PRH, 96.9% and Ward 18 RSH 94.7%.

7.6 For the 4 community inpatient areas, 5 shifts were reported in January 2025 as 100% RN agency staff. These were in relation to 4 shifts at Ludlow all for night duty and

staff on shift were regular agency to Ludlow and 1 shift at BCCH again RN for night shift.

7.7 All 6 ward areas were above the 90% fill rate for both days and nights in January 2025.

8.0 Care Hours per Patient Day (CHPPD)

8.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Insight-Model Hospital website. SCHT data is available on the Model Hospital site and on performing benchmark analysis, for the last quarter (January 2025) the average overall for our Trust is 6.6 care hours per patient day (CHPPD), compared to with average of other similar community NHS trusts of 7.3 (as shown in table 3). This data cannot be viewed in isolation and when triangulating with other data and professional judgement and quality and safety indicators there is not a cause for concern. CHPPD will continue to be monitored monthly. In table 3 you can see that the Trust sits in the 3rd quartile, and this remains a consistent picture.

Table 4 - Model Hospital Benchmarking table

Organisation Name	CHPPD - overall
Derbyshire Community Health Service Foundation Trust	11.4
Kent Community Health NHS Foundation Trust	7.8
Central London Community Healthcare	7.5
Hertfordshire Community	7.4
Overall average	7.3
Leeds Community Healthcare NHS Trust	7.3
Shropshire Community Health	6.6
Norfolk Community Health and Care	6.8
Sussex Community	6.5
Bridgwater Community Healthcare	5.8

8.2 Table 4 shows the rolling care hours per day for the last year. Care hours per patient day are calculated by dividing the total number of nursing hours on a ward by the number of patients in beds at midnight. The calculation provides the average number of care hours available each patient on the ward and thus there is variation each month and for each ward.

Table 5– Care hours per patient day – total staffing

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Bridgnorth	6.7	6.7	6.7	6.4	6.9	6.7	6.20	7.26	6.61	6.40	6.05	6.86	6.5
Ludlow	8.3	8.3	7.0	7.3	7.5	6.85	6.39	6.61	6.05	6.45	6.41	7.77	7.11
Whitchurch	6.4	6.4	6.2	6.3	6.1	6.41	6.90	6.81	6.65	6.25	6.43	6.43	7.10
BCCH							6.88	6.37	5.96	6.20	7.63	6.3	6.67
RRU Ward 36						6.0	6.70	6.46	6.32	6.20	6.07	6.71	6.10
RRU Ward 18						5.9	6.20	5.61	5.92	5.62	4.94	6.27	6.03

9.0 Incidents

9.1 During January 2025 there were 4 reported staffing issues, 2 at ward 18 and 1 at ward 36 and 1 at Ludlow, on review these all related to bank/agency staff not turning up for a variety of reasons. No harm to patients occurred.

9.2 During January 2025 there were 5 occasions that the Community inpatient wards had 100% RN agency on night duty, 4 were at Ludlow and 1 at BCCH. There were no harms reported due to the 100% agency.

9.3 During January 2025 there were 19 inpatient falls reported which occurred across 5 of our inpatient areas which equates to a rate of 4.34 falls per 1000 Occupied Bed Days (OBDs)

9.4 Table 6 below shows the rolling year for falls, when we triangulate the data for falls in January 2025 in all areas staffing was not recorded or datixed as being attributed.

Table 6 – Falls Data

Year		M1 April	M2 May	M3 June	M4 July	M5 Aug	M6 Sept	M7 Oct	M8 Nov	M9 Dec	M10 Jan
2022/23	Falls	26	15	11	21	12	10	24	14	10	18
	Falls/ 1000 OBDs	11.46	6.69	5.18	9.01	5.35	4.29	9.87	5.79	4	7.29
2023/24	Falls	11	11	5	14	9	13	5	15	17	25
	Falls/ 1000 OBDs	4.56	4.5	2.15	5.84	3.79	5.43	1.97	6.09	6.67	7.11
2024/25	Falls	16	14	17	17	15	21	17	22	22	19
	Falls/ 1000 OBDs	4.31	3.58	4.65	4.19	3.92	5.26	5.04	5.44	5.02	4.34

10.0 Red Flags (Appendix 2)

10.1 There are 6 elements to the Nice Red Flags (see appendix 2), these include:

1. Omission in providing medication

2. Delay of more than 30 minutes in providing pain relief

3. Patients vital signs not assessed in line with care plan

4. Delay or omission of regular checks on patients to ensure care needs are met as outlined in the care plan

5. A shortfall of more than 8 hours or 25% (whichever is reach first) of registered nurse time available compared to the actual requirement of the shift.

6. Less than 2 Registered Nurses present on a ward during any shift

10.2 Table 7 shows the monthly metrics that are captured that relate to red flags. This metrics are reviewed in Quality and Safety Committee and actions are taken when metrics are not compliant.

10.3 Datix is used to monitor any delays in pain relief, vital signs not being assessed and delays or omissions or regular check on patients. In January 2025 there were no datixes relating to these.

10.4 In line with safer staffing requirement, red flags are reported where there is a shortfall of more than 8 hours or 25% (whichever is reached first) of RN time available compared with the actual requirement for the shift or where fewer than two RNs are present on a ward during any shift. There have not been any incidents for any of the inpatient wards in January 2025.

10.5 When we review the incidents in table 7 for January 2025, we can see 6 incidents relating to workload resource incidents, this were reviewed and all relate to bank/agency not attending shift and although further support sort, part of shift left short, no harm to patient documented. There were no PSII or Pressure Ulcers in January 2025. There were 6 medication incidents, 1 at Ludlow, 1 at Whitchurch and 4 at Bridgnorth. All incidents were related to storage and labels and not due to staff error or staffing. January 2025 there were 18 falls, and when triangulated staffing was not a contributing factor.

Table 7 - Monthly Quality data

Bishops Castle	**Aug-24**	**Sept-24**	**Oct -24**	**Nov-24**	**Dec-24**	**Jan-25**
Number of patient Safety incident investigation (PSII)	0	0	0	0	0	0
Number of Falls	4	8	0	0	5	2
Number of Category ¾ pressure ulcers in Service	0	0	0	0	0	0
Workload Resource Incidents	2	0	0	0	0	1
Medication Incident	3	2	5	1	3	0
Bridgnorth	**Aug-24**	**Sept-24**	**Oct -24**	**Nov-24**	**Dec-24**	**Jan-25**
Number of patient Safety incident investigation (PSII)	0	0	0	0	0	0
Number of Falls	6	5	3	0	3	6
Number of Category ¾ pressure ulcers in Service	0	0	0	0	0	0
Workload Resource Incidents	2	0	1	0	0	0
Medication Incident	5	2	2	1	0	4

Ludlow	**Aug-24**	**Sept-24**	**Oct -24**	**Nov-24**	**Dec-24**	**Jan-25**
Number of patient Safety incident investigation (PSII)	0	0	0	0	0	0
Number of Falls	1	4	1	1	4	5
Number of Category ¾ pressure ulcers in Service	0	0	0	0	0	0
Workload Resource Incidents	4	0	0	0	1	0
Medication Incident	5	4	3	4	4	1
Whitchurch	**Aug-24**	**Sept-24**	**Oct -24**	**Nov-24**	**Dec-24**	**Jan-25**
Number of patient Safety incident investigation (PSII)	0	0	0	0	0	0
Number of Falls	2	1	2	9	11	4
Number of Category ¾ pressure ulcers in Service	0	0	0	0	0	0
Workload Resource Incidents	1	1	2	0	0	2
Medication Incident	3	1	2	0	9	1
RRU ward 36	**Aug-24**	**Sept-24**	**Oct -24**	**Nov-24**	**Dec-24**	**Jan-25**
Number of patient Safety incident investigation (PSII)	0	0	0	0	0	0
Number of Falls	2	0	4	5	5	0
Number of Category ¾ pressure ulcers in Service	0	0	0	0	0	0
Workload Resource Incidents	0	0	0	0	0	0
Medication Incident	4	0	0	1	0	0
RRU ward 18	Aug-24	Sept-24	Oct -24	Nov-24	Dec-24	Jan-25
Number of patient Safety incident investigation (PSII)	**0**	**0**	**0**	**0**	**0**	**0**
Number of Falls	**2**	**0**	**4**	**3**	**2**	**1**
Number of Category ¾ pressure ulcers in Service	**0**	**0**	**0**	**0**	**0**	**0**
Workload Resource Incidents	**0**	**0**	**0**	**0**	**1**	**3**
Medication Incident	**0**	**0**	**0**	**0**	**0**	**0**

11.0 Risks to Safer Staffing

11.1 NHSE have given all Trusts a directive to reduce costs for both agency and bank in this next financial year. The Trust has robust plans in place to monitor and approve

both bank an agency, however we have been told by NHSE that we must cease the use of agency for band 2/3 by around September 2025. This will pose a risk to the staffing in our community wards as due to the demographic of our ward areas it is not easy to pull from other and so reliance on bank and agency is high.

11.2 Work is being undertaken to increase the bank so ensure that we have sufficient temporary staffing when gaps occur.

11.3 The Trust is moving to a centralised bank as this will help to move staff to the areas of gaps as at present bank workers only work in one ward and it is not easy to be flexible.

11.4 The Trust has commenced the NHSE ETOC programme that will help us work with our staff to find better ways to care for our patients with enhanced care needs, this will involve training programmes for staff and working together as an MDT to ensure safe and effective care for our patient. This work should enable us to reduce our dependency on Agency/bank staff for enhanced care patient needs without impacting patient safety.

12.0 Recommendations available to review and accept

12.1 To continue to embed the twice-yearly data collection tool for the Community inpatient areas.

12.2 To relaunch the Community District Nursing teams staffing tool in the July 2025 data collection.

12.3 To continue to monitor the E-roster Safe Care weekly to ensure consistent compliance.

12.4 To introduce E-community to the District Nursing teams. This is IT system that links with E-roster, some of benefits of this product are:

> Improved fairness of allocation process
>Avoids staff being given unachievable workload due to the inclusion of travel time.
>Completion of visits in real time
> Reports and daily panning screen allow for the prediction of skills gaps and changes in service demands, identifies pressure points and under -utilised workforce
> Dynamically redeploy staff based on patient needs
> Provide robust data

12.5 Due to the NHSE directive to stop the use of agency for band 2/3 in our inpatient wards by September 2025 we need to monitor the effect this has on safer staffing and need to escalate concerns in an appropriate manner.

12.6 Montor the work undertaken on the ETOC programme and what effect that has on the need for enhanced supervision staffing for patients and patient safety.

12.7 Work continues on the recruitment and retention plan, to support the Trust in filling the vacancy gaps thus improving overall safer staffing substantive numbers.

12.8 For the inpatient data collection, the January 2025 is the second set data with the refreshed tool with the exception of BCCH which is their first data collection. However, with escalation beds being opened and the Trust about to undertake the ETOC programme the data does not show a true picture and so is difficult to make recommendation on changes to establishment. Mitigations are in place and risk remains well controlled with daily staffing checks to maintain safety. The Director of Nursing is comfortable that existing staffing and processes that are in place is maintaining patient and staff safety during this time.

12.9 Consideration in the future should be taken to the cost of bank and agency that is being used for staffing gaps, enhanced care and escalation beds as for January 2025 the additional cost staffing was 262,162K, which equates to 25.04% bank and 39.03% totally 64.36%. It may be more cost effective to add additional substantive staff to the establishment. The cost for an RN is 42,575k and HCA 30,903K (mid-point-including on costs). This would give 6.3 WTE RN or 8.7 WTE HCA and would then significantly reduce agency/bank costs in the following months. This consideration should be measured once the 90-day ETOC cycle has been completed, and a further review of June data has taken place.

13.0 Revalidation of Registered Nurses/Pharmacy/ HCPC registered staff

13.1 Registered Nurses get notification from the NMC regarding their revalidation at the 100 and 60 days prior to revalidation and emails via ESR at 12, 8 and 4 months.

13.2 HCPC registrants receive notification from the HCPC regarding their renewal 2 months prior to renewal and emails via ESR at 3 and 1 month.

13.3 Registered Pharmacy staff receive notification from GPhC regarding their revalidation 2 months prior to revalidation and emails via ESR at 3 and 1 month

13.4 Whilst the Trust puts reminders in place for staff it is the responsibility of the registrant to ensure that their registration is valid at all times.

13.5 The Trust has 642.02 WTE which equates to 900 individual Registered Nurses and Registered Nursing Associates that need to renew their PIN by paying their annual fee and revalidate every 3 years. In the last 12 months March 2024 to March 2025 there has been 3 occasions where staff have failed to revalidate, immediate action was taken, and all 3 staff did not work without a current pin number.

13.6 The Trust has 194.53 WTE and 5.75 WTE Psychology Professional registered with the HCPC. Re-registration takes place on a biannual basis for each profession, whereby the registrant both pays their annual fee and completes a self-declaration of adherence to professional standards. In the last 12 months, April 2024 to March 2025, Dietitians, Podiatrists and Psychology Practitioners have renewed their registration, there have been no occasions where staff have failed to re-register.

13.7 The Trust has 25.4 WTE Pharmacy staff which equated to 19 Pharmacists and 15 Pharmacy Technicians registered with GPhC. Revalidation takes place on an annual

basis, whereby the registrant both pays their annual fee and revalidates. In the last 12 months, April 2024 to March 2025, there have been zero occasions where staff failed to revalidate.

14.0 Conclusion

The report shows us that benchmarking statics continue to be roughly 50:50 RN to HCA and we continue to see the RN to HCA ratio change when we have additional staff for enhanced care but when we triangulate with quality and safety metrics and red flags there are no concerns regarding safe staffing.

When reviewing the performance of the National Developing Workforce Safeguards, we are fully complaint. (Attachment 1).

The Director of Nursing and Medical Director confirm they are satisfied with the safety, effectiveness and current sustainability of staffing levels at Shropshire Community Heath Trust.

Supporting Literature

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Appendices

Appendix 1 – Inpatient Decision matrix

Level 0	Care requirements may include the following

(Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	• Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • Early Warning Score is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATERPOTENTIAL to deteriorate.	Care requirements may include the following: • Increased level of observations and therapeutic interventions • Early Warning Score - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation / invasive monitoring • Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living	Care requirements may include the following • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff(provided from within ward budget)as per local policy
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway and protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Respiratory or CNS depression / compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection

Appendix 2

Red Flags (NICE2021)

1	Unplanned omission in providing patient medications.
2	Delay of more than 30 minutes in providing pain relief.
3	Patient vital signs not assessed or recorded as outlined in the care plan
4	Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: — Pain: asking patients to describe their level of pain level using the local pain assessment tool. — Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. — Placement: making sure that the items a patient needs are within easy reach. — Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
5	A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
6	Less than 2 registered nurses present on a ward during any shift.

Attachment 1 – Workforce safeguards gap analysis

	Developing Workforce Safeguards Gap analysis action plan
Executive Sponsors	Clair Hobbs - Director of Nursing & Clinical Delivery
Responsible Officers	Tracie Black - Associate Director for Workforce, Education and Professional Standards
Corporate Nursing Review	01.06.2025
Report signed by (Executive Lead)	Clair Hobbs Director of Nursing & Clinical Delivery

Developing Workforce Safeguards Action Plan

ID	Recommendation	Site	Compliance	Actions required	Deadline	Status
	Recommendations 1 & 2 1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safer staffing governance. 2. Trusts must ensure the 3 components are used in their sfaer staffing processes (evidence based tools, professional judgement and patient outcomes).	Trust	**Fully compliant ↑**	SOP in progress for annual calendar for training, data collection and inter-rater reliability checks being organised for completeness in regards to the bi-annual staffing process.	30.03.2025	Delivered
				Training on acuity and dependency ratings delivered by National Team. All community staff to be trained and band 7 and 6 to be trained in the inpatient areas.	30.06.2023	Delivered ongoing monitoring
				Ensure yearly renewal of safer Nursing Care Tool licence	30.05.2023	Delivered
	Recommendations 3, 4 & 5 Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement.	Trust	**Fully compliant ↑**	Director of Governance to add statement to future annual governance statement.	31.03.2024	Delivered ongoing monitoring
				Biannual staffing reviews will have been reviewed and statement from the Director of Nursing regarding assurances in relation to safer staffing.	30.05.2023	Delivered ongoing monitoring
	Recommendation 6 As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Trust	**Fully compliant ↑**	Additional training with senior staff on acuity and dependency.	30.05.2023	Delivered ongoing monitoring
				A further full biannual staffing review to take place in June 2023.	20.05.2023	Delivered
				Organisational wide process for vacancy oversight from department/ward upwards	31.01.2024	Delivered ongoing monitoring
				Development of a local Safer Staffing Policy which includes establishment setting and will note the requirement to have QEIAs for all changes to staffing establishments – signed off by the Director of Nursing.	31.06.2024	Delivered
				Commence an inaugural Safer Nursing Care Tool assessment in the Community Hospitals	31.06.2023	Delivered ongoing monitoring
				Commence an inaugural Safer Nursing Care Tool assessment in the Community District Nursing Teams	31.01.2023	Delivered ongoing monitoring

Not yet sta	PRH	Weekly
In progress	RSH	Bi-weekly
Delivered	Both	Monthly
Delivered c	Trust	Adhoc
Overdue		

Shropshire Community Health
NHS Trust

Integrated People Performance Report
0. Reference Information

Authors:	Gina Billington, Head of Resourcing Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper date:**	7 August 2025
Executive Sponsor:	Rhia Boyode, Chief People Officer SCHT & SaTH	**Paper written on:**	28 July 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 this 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 People Committee, including a review of performance against the month 3 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 Trust Board to consider are:

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

Committee	Variation concern	Assurance concern of an improving nature	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	1	15	0	**19**	**16 (84.2%)**

There have been improvements this month in appraisals, leaver rates, temporary staffing, mandatory training, and vacancy rates. Sickness absence and total shifts exceeding NHSI capped rates have slightly increased compared to month 2 but are special cause variations of an improving nature that will pass the target if nothing changes.

Integrated People Performance Report

Action Plans have been developed included as Appendix 4.

2.3. Conclusion

The Board is asked to:

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

3. Main Report

3.1 Introduction

The full list of KPIs to be reviewed 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 3 the total workforce is under plan by 46.80 WTE.

There is a difference in 20 substantive WTE between the current plan and the submitted plan due to non-recurrent services/funding, which was confirmed post submission, however this aligns to changes within the Finance plan.

Our agency usage is 2.5 WTE under plan predominately due to a reduction of 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 18.8 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.

Month 3 Position

Plan (WTE)	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June-25
Substantive	1655.16	1655.16	1655.16	1689.90	1688.40	1689.80
Bank	58.00	58.00	58.00	65.90	65.9	62.9
Agency	37.12	37.12	37.12	36.50	36.5	36.2

Integrated People Performance Report

Total	1750.28	1750.28	1750.28	1792.20	1790.70	1788.90
Actual (WTE)	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**June-25**
Substantive	1624.74	1627.49	1634.07	1617.30	1623.80	1626.70
Bank	79.58	84.63	85.46	101.00	87.7	81.6
Agency	56.98	53.17	55.20	42.70	35.6	33.7
Total	1761.30	1765.29	1774.73	1761.00	1747.10	1742.10
Variance (WTE)	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**June-25**
Substantive	-30.42	-27.67	-21.09	(72.50)	(64.50)	(63.1)
Bank	21.58	26.63	27.46	35.10	21.8	18.8
Agency	19.86	16.05	18.08	6.2	(0.9)	(2.5)
Total	11.02	15.01	24.45	(31.30)	(43.60)	(46.8)

All NHS Trusts are being asked to reduce costs, improve productivity and create a sustainable workforce with less reliance on temporary workforce. To address these challenges an Integrated Workforce Strategy is being developed to provide a clear direction for the Trust identifying what and when workforce is needed, how it will be used and understand why it is needed. The Integrated Workforce Strategy will consider the following:

- Review of national and local context
- Workforce profile
- Workforce challenges and risks
- Future service developments
- Demand and Supply analysis
- Actioning planning

The development of the strategy will involve all stakeholders including Operational and Clinical leads with clear links to our financial and operational plans.

Integrated People Performance Report

There are several workforce KPI's 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

Fifteen KPIs are an assurance concern only – all of these KPI's are now of an improving nature and will pass or continue to pass the target if nothing changes.

1. Aggregate score for NHS staff survey questions that measure perception of leadership culture*
2. Appraisal Rates
3. Leaver rate – **below target for the second consecutive month**
4. Mandatory Training Compliance - b**elow target for the second time since March 2025**
5. Proportion of staff in senior leadership roles who are from a) a BME background*
6. Proportion of staff in senior leadership roles who are from c) are disabled staff*
7. 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*
8. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers*
9. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues*
10. 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*
11. Proportion of temporary staff – **below target for the second consecutive month**
12. Sickness Rate
13. Staff survey engagement theme score*

Integrated People Performance Report

14. Total shifts exceeding NHSI capped rate
15. Total shifts on a non-framework agreement

In June 2025, Mandatory Training Compliance significantly increased from 94.69% in May to **95.82%**. This is the second time the KPI target of 95% has been achieved since March 2025. There were significant improvements in Resus Level 2 (increased their compliance by over 3%) and Resus Level 3 (increased their compliance by over 2%). Manual Handling Level 2 again saw another increase in compliance this time by 3.73%. In the June monthly compliance report only 1 topic had a drop in their compliance, and this was a very small decrease from 0.05%. This month, a significant change has been implemented: Fire eLearning will now be renewed every two years instead of annually. This adjustment is in response to a request from NHSE to align renewal periods with national recommendations.

Metric	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June-25
Appraisal	90%	87.88%	87.37%	87.78%	88.00%	88.45%	88.89%
Leavers	9.6%	10.44%	10.60%	9.86%	9.82%	9.32%	8.89%
Temporary Staff	3.4%	4.6%	3.9%	4%	3.2%	3.1%	2.7%
Vacancies	8%	10.68%	10.91%	10.56%	9.83%	9.39%	9.14%
Sickness	4.75%	5.30%	5.32%	5.28%	5.28%	5.29%	5.32%
Total Shifts exceeding NHSI capped rate	No Target	60	63	64	49	50	56

Appraisals

The compliance rate has been slowly increasing since February 2025. The June compliance is 1.11% below target. With the implementation of the Community Services SOP the Community Therapies teams have increased their compliance and are no longer a hot spot. It should be noted that the Community Services Division has gaps in operational management.

Actions to Deliver Improvements - Current Focus

- Detailed appraisal reports are sent to Managers to ensure they have sight of those appraisals out of date on ESR and regular appraisal training is in place. The focus is on setting a plan for the services with the lowest completion rates and to set dates for completion by no later than end of July except in exceptional circumstances.
- A process for monitoring progress is in place, with target support for managers and alerts and reminders to ensure completion.
- There has been changes in leadership which has left gaps and access to ESR being problematic within the Rehabilitation and Recovery Service, there is a recovery plan in place to complete all appraisals.

Integrated People Performance Report
Turnover

The Leaver rate has seen a gradual improvement with the rate continuing to fall below our target. The main driver of the turnover is retirement which based on the age profile is likely to remain over coming years and the second highest reason for leaving is related to work life balance. Highest leavers headcount is within the Nursing and midwifery group followed closely by Administration and Clerical.

Actions to Deliver Improvements – Current Focus

- Implement flexible working practices - initiatives to support more flexible retirement may support people to work longer before full retirement and encourage more retire and return.
- Health and wellbeing support and initiatives to support more flexibility in how people work are underway to support retention.
- The South East Community Nursing Service is a hot spot however a new Team Leader, a change of base and ways of working have been implemented which will hopefully have a positive impact on leaver rates.

Absence

Since March 2025 the rate continues to remain above target but relatively static. Month 3 sickness rate is 5.32%. The main drivers are stress, anxiety and depression conditions. 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 reduction during summer months and an increase to 5% by the end of the year.

Actions to Deliver Improvements - Current Focus

- Support around health and wellbeing, resilience and flexibility to support reduction in absence levels and are being implemented by the People Team.
- Implement the Health & Wellbeing Action Plan

Vacancies

Month 3 vacancy position is 9.14% (164 WTE) a reduction compared to Month 1 which was 9.83% (177 WTE). Month 3 hotspots are: Community Services: (Bishops Castle, Ludlow & Whitchurch), Community Nursing (Telford North and South and Shrewsbury North and South).

Actions to Deliver Improvements - Current Focus

- Focussing recruitment efforts by prioritising recruitment hotspot areas. The recruitment team are liaising with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks.
- Development of a trust recruitment video continues
- The recruitment team have held 2 targeted recruitment events, in May and June to recruit bank HCA to limit the need for agency with a total of 36 offers being made on

the dates of the recruitment events. A further event is planned for 29th July at Whitchurch Hospital.

Agency Spend

Month 3 agency use is 33.7 WTE with an expenditure of £73.6K against a plan of 36.2 WTE and £92.4k, a variance of 18.8 WTE and £18.8k respectively.

Hospital Inpatients and Community Nursing are the highest users of agency in Month 3 with both areas being above plan: 0.62 WTE and 0.2 WTE variance which is a much-reduced position from month 1 when the variance was 3.31WTE and 3.20WTE respectively.

As at 30/6/25 we are Price Cap compliant (PCC) for nursing, specialist nursing, HCA and AHP staff groups. Next steps will be for Medical and Dental staff groups to become compliant with a current move to the regional West Midlands Price Rate Card by the end of July.

Actions to Deliver Improvements - Current Focus:

- Cease all HCA agency usage by end of Q2 in 25/26 including identifying initiatives to address the demand and supply of enhanced care. This includes the implementation of NHSP National Bank. A Working Group has been established to identify any further actions and support required due to the cessation of Band 2 and Band workers.
- Centralised Bank - funding has been approved for the additional e-roster licenses for the bank staff module of e-roster. There is however, no additional staffing resources identified at this stage which will mean that a fully functioning centralised bank may not be possible. Consideration is being made as part of the People team structure review of how this may be appropriately resourced / mitigated. Without sufficient resourcing the provision of a central bank would be limited. This would need managers to undertake some of the tasks associated with a centralised bank e.g. monitoring and ensuring mandatory training.
- Improve absence management practices reducing sickness by 1% across high use agency teams.
- Price Cap Compliance - All nursing, specialist nursing, HCA and AHP providers are supplying at price cap rates. Medical and Dental will follow the West Midlands Regional Rate card later in this year, a date yet to be agreed.
- Implement changes to recruitment practices and introduce recruitment plans to support reducing vacancies with an expected improvement of 25% improvement from current vacancy position.
- Maximise the availability of our workforce through monitoring and improving roster practices. Check and Challenge meetings are held monthly with rostered areas managers. We have seen an improvement in Roster Approval Lead Times, which have increased from 43 days to 50 days, which helps increase opportunity to fill with bank.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

Integrated People Performance Report

The Board is asked to:

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

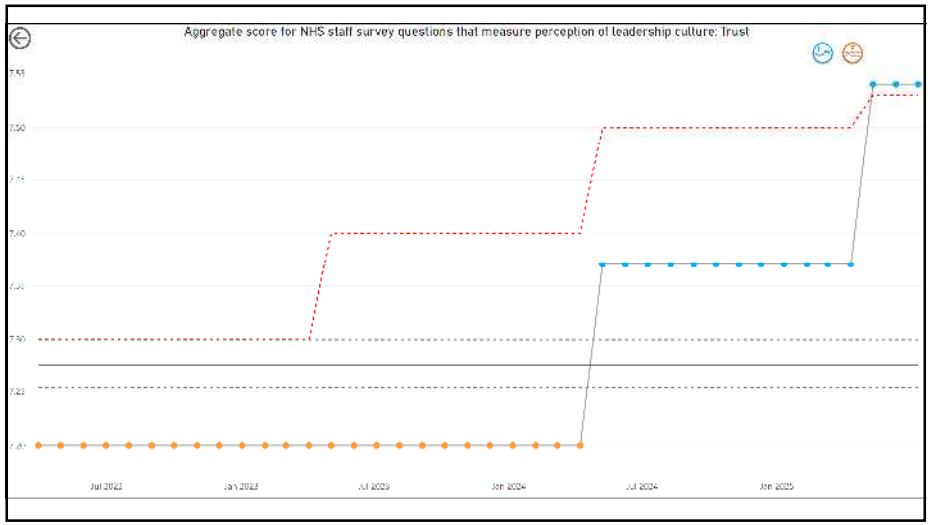
Appendix 1
People Committee – SPC Summary
Month 3 (June) 2025/2026 Performance

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 ...	2025-06-30		7.5	7.5	0.0	7.5	7.5	0.0	
People Committee	Well Led	Appraisal Rates	2025-06-30		88.82%	90.00%	-1.18%	88.42%	90.00%	-1.58%	
People Committee	Well Led	CQC well-led rating	2025-06-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2025-06-30		8.89%	9.60%	-0.71%	8.89%	9.60%	-0.71%	
People Committee	Well Led	Mandatory Training Compliance	2025-06-30		95.82%	95.00%	0.82%	95.82%	95.00%	0.82%	
People Committee	Well Led	Net Staff in Post Change	2025-06-30		2.08	0.00	2.08	7.42	0.00	7.42	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-06-30		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	2025-06-30		69.57%	66.00%	3.57%	69.57%	66.00%	3.57%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-06-30		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...	2025-06-30		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...	2025-06-30		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...	2025-06-30		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...	2025-06-30		19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	
People Committee	Well Led	Proportion of temporary staff	2025-06-30		2.7%	3.4%	-0.7%	3.0%	3.4%	-0.4%	
People Committee	Well Led	Sickness Rate	2025-06-30		5.32%	4.75%	0.57%	5.32%	4.75%	0.57%	
People Committee	Well Led	Staff survey engagement theme score	2025-06-30		7.2	7.2	0.0	7.2	7.2	0.0	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-06-30		56	0	56	52	0	52	
People Committee	Well Led	Total shifts on a non-framework agreement	2025-06-30		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2025-06-30		9.14%	8.00%	1.14%	9.45%	8.00%	1.45%	

Appendix 2
People Committee
Month 3 (June) 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.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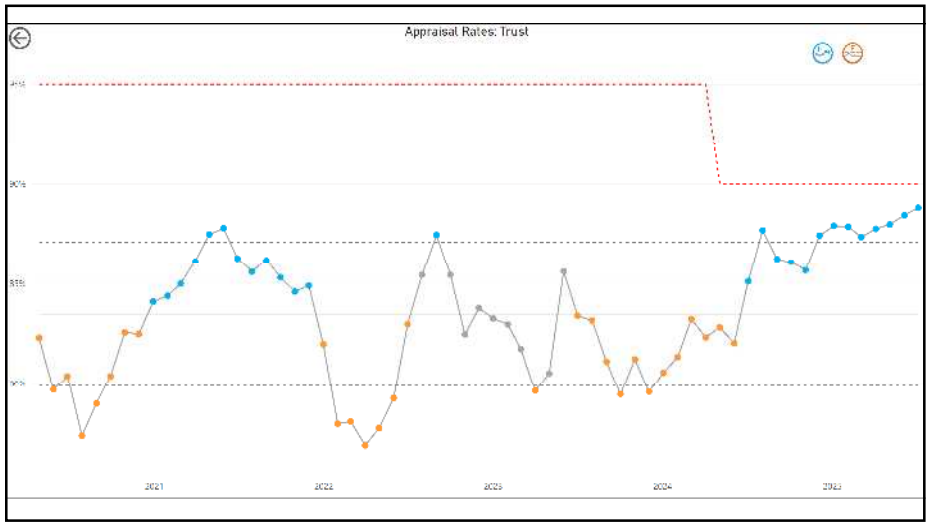
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025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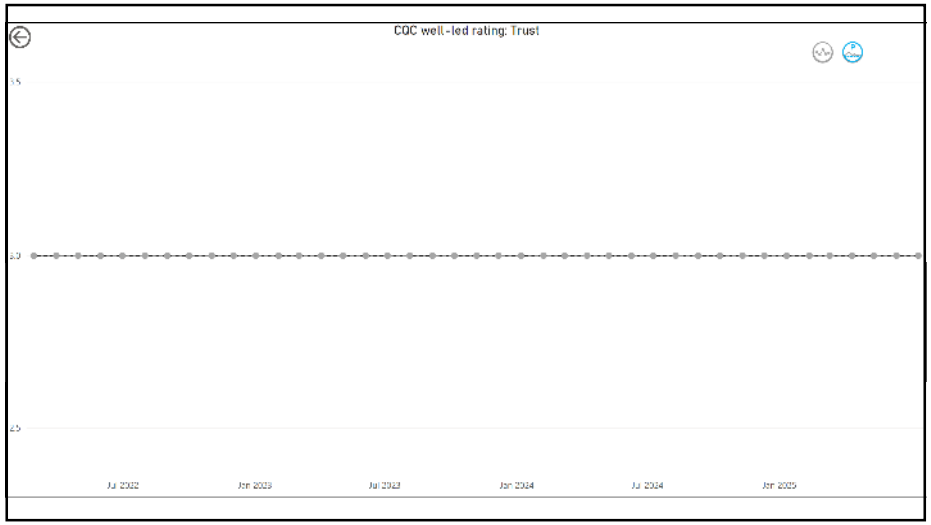
2021
2022
2023
2024
2025


CQC well-led rating: Trust
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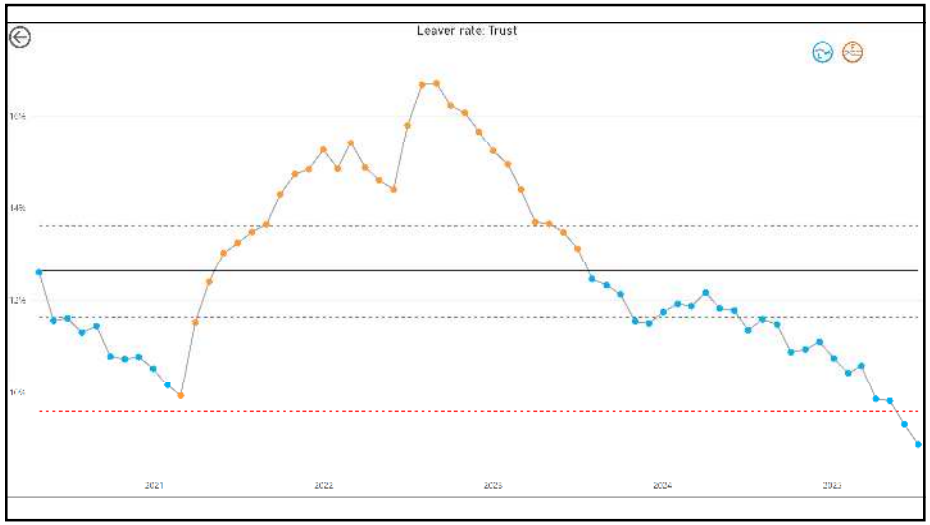
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025


Leaver rate: Trust
2021
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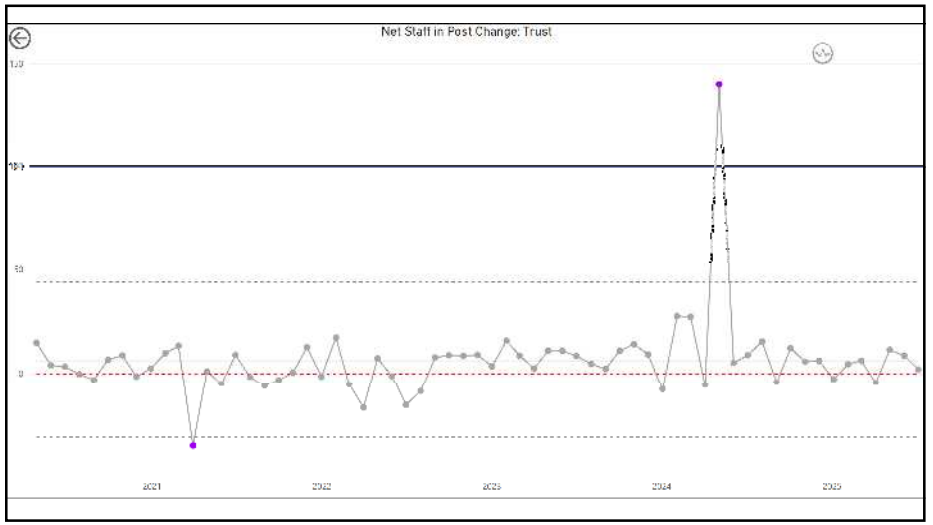
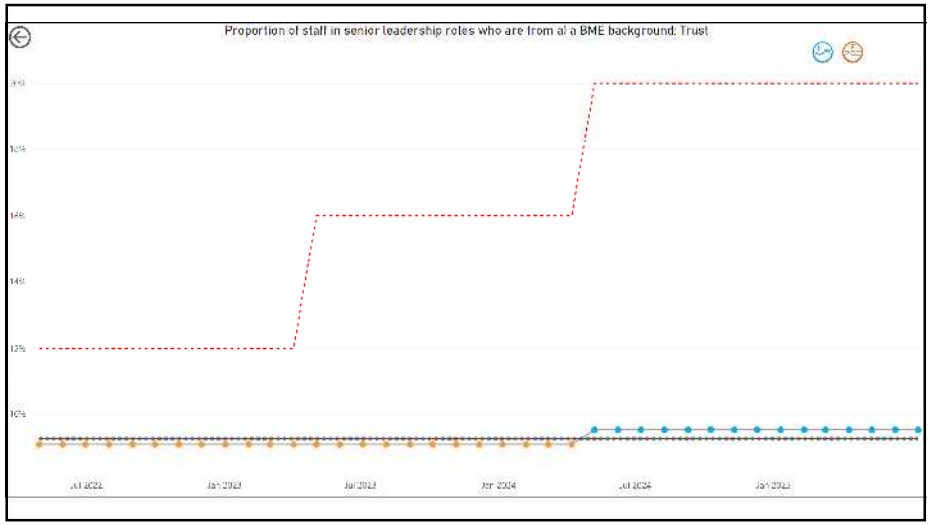
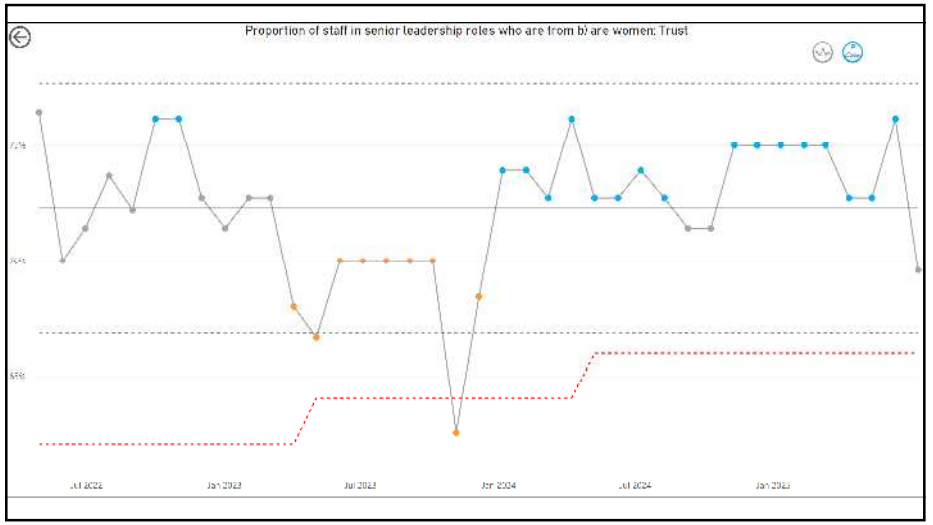
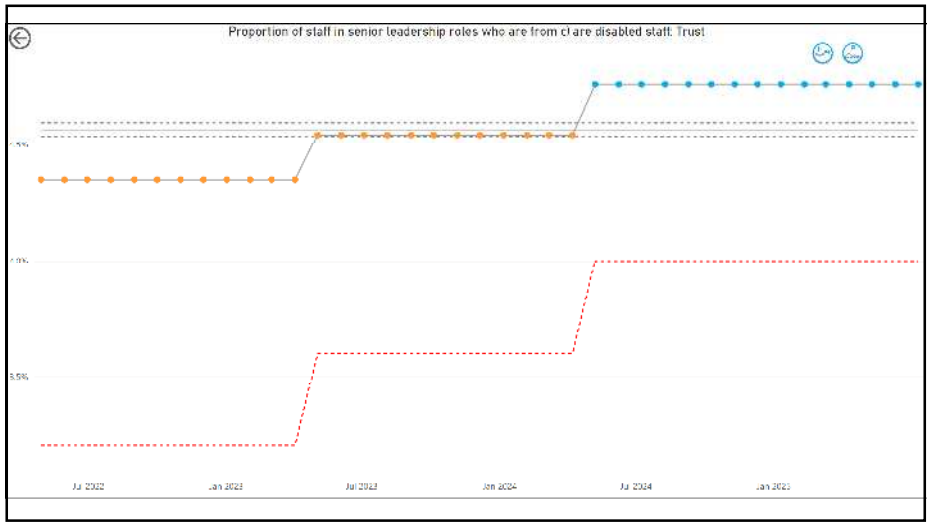
2024
2025

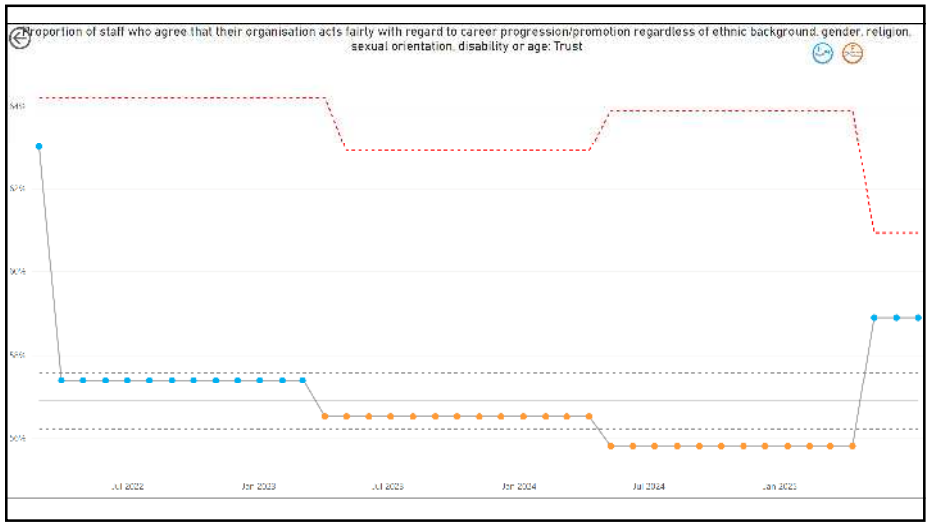

Mandatory Training Compliance: Trust

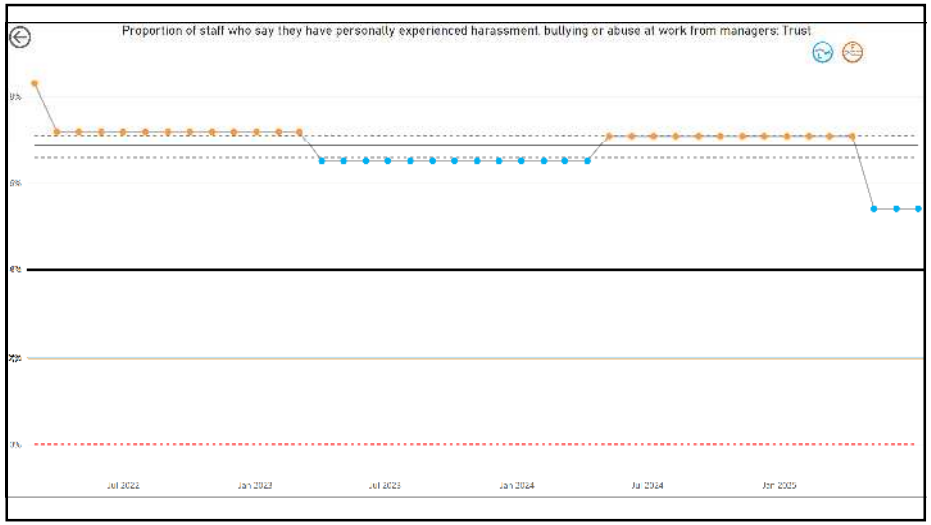

Net Staff in Post Change: Trust

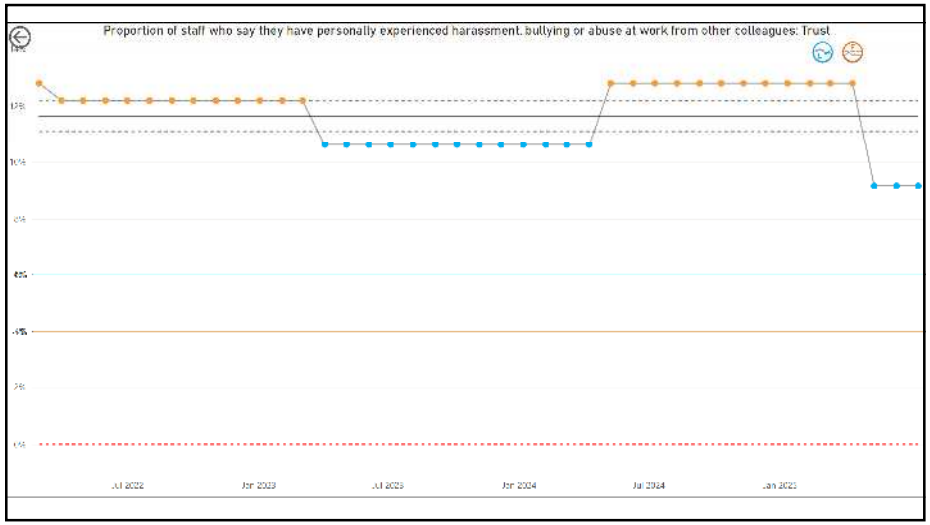

Proportion of staff in senior leadership roles who are from a) a BME background: Trust

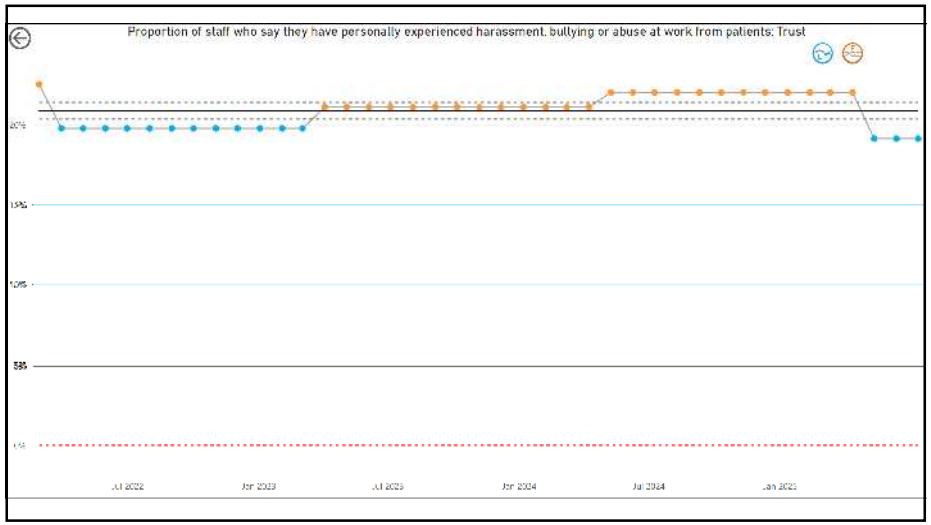

Proportion of staff in senior leadership roles who are from b) are women: Trust

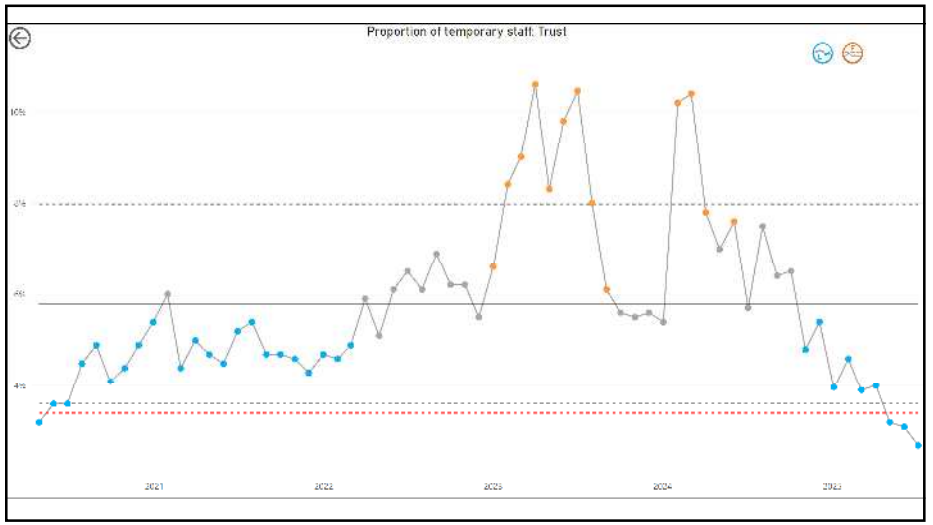

Proportion of staff in senior leadership roles who are from cl are disabled staff: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025

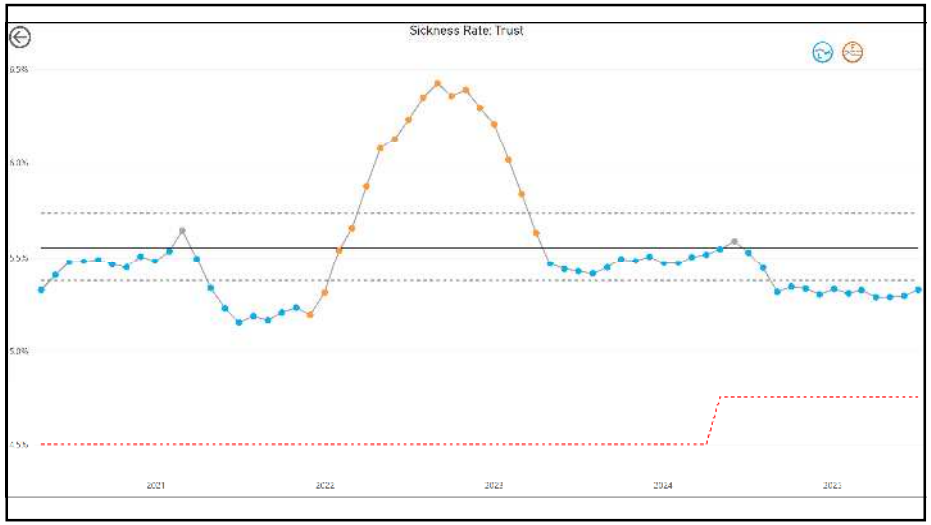

Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025

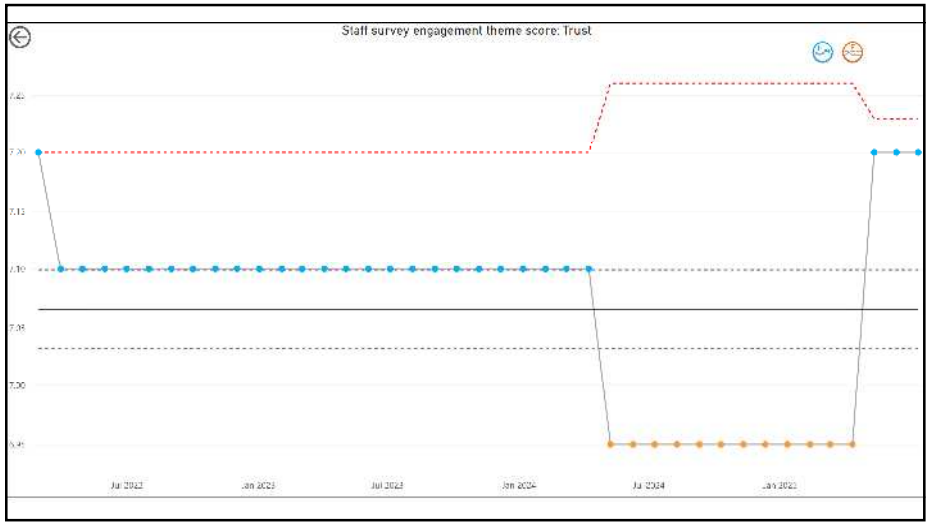

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025

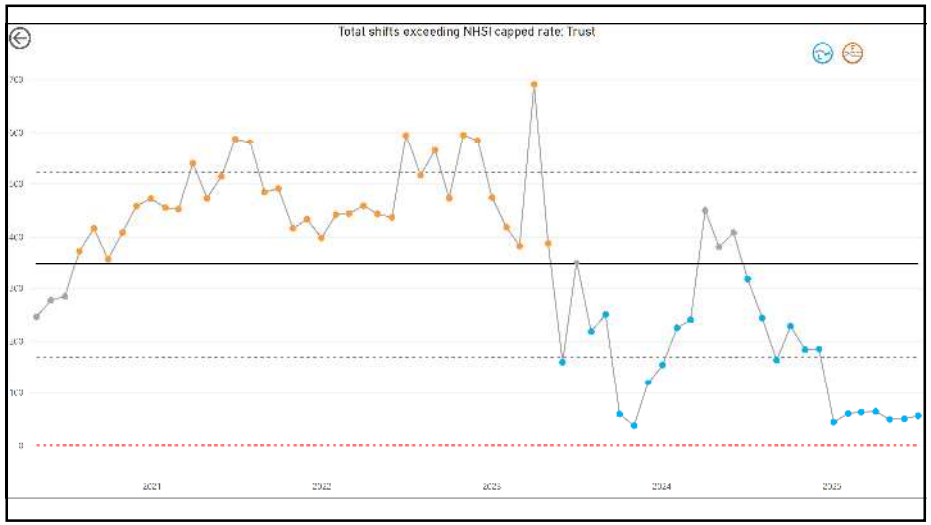

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues: Trust
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025

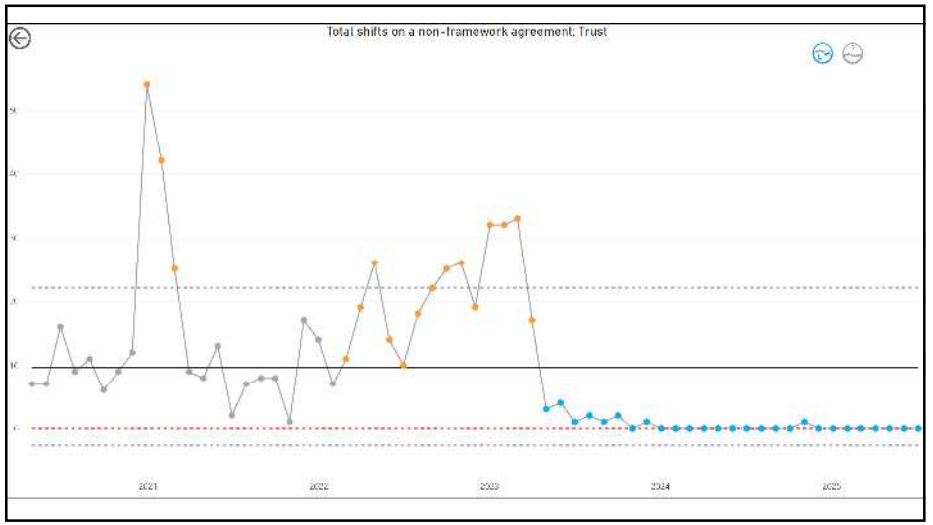

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients: Trust

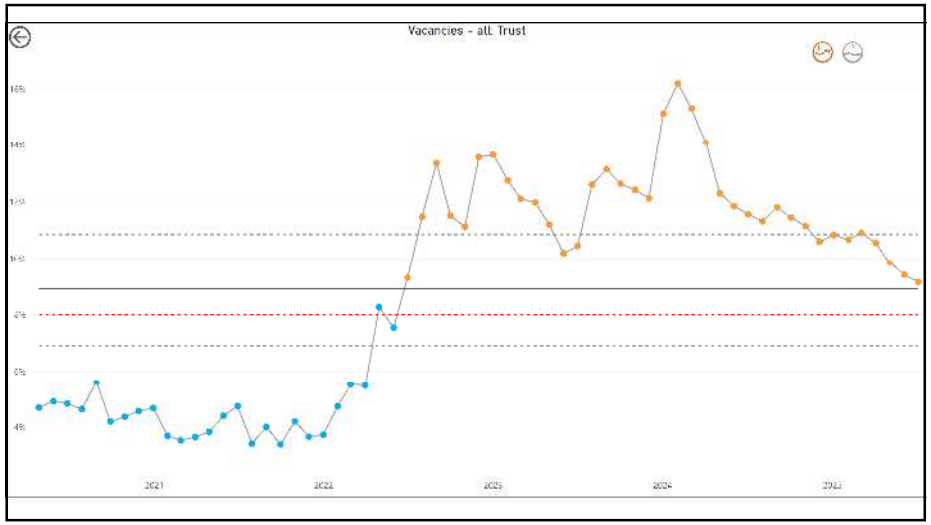

Proportion of temporary staff: Trust


Sickness Rate: Trust


Staff survey engagement theme score: Trust


Total shifts exceeding NHSI capped rate: Trust
2021
2022
2023
2024
2025


Total shifts on a non-framework agreement: Trust
2021
2022
2023
2024
2025


Vacancies - all: Trust
2021
2022
2023
2024
2025

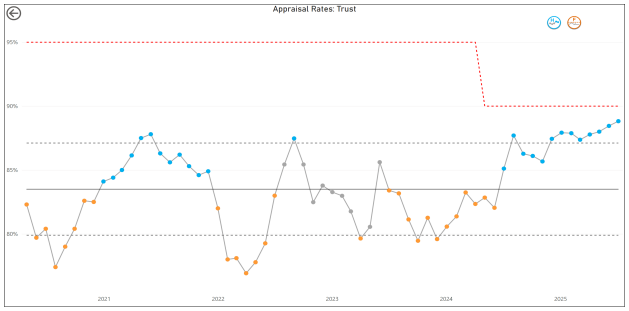
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Appraisals	%	87.88%	87.37%	87.78%	88.00%	88.45%	88.89%	88.42%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
%	88.80%	89.00%	89.20%	89.75%	90.00%	90.00%	90.00%



Reason for performance gap:	The compliance rate has been slowly increasing since February 2025. The June compliance is 1.11% 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 end of July except in exceptional circumstances. A process for monitoring progress is in place, with target support for managers and alerts and reminders to ensure completion. There has been changes in leadership which has left gaps and acces to ESR been problematic within the Rehabilitation and Recovery Service, there is a recovery plan in place to complete all appraisals. With the implementation of the Community Services SOP the Community Therapies teams have increased their compliance and are no longer a hot spot. It should be noted that the Community Services Division has gaps in operational management.

Action Plan

Action	Start Date	End Date	Status	Outcome
Hot Spot - Shrewsbury Community Nursing Team (predominantly this is the South team 12 out of the 14 outstanding). A proportion are people who have returned from maternity leave and now on annual leave; these will be completed when individuals return. The Team Leader is relatively new in post and being supported as required	May-25	Jul-25	On Track	To ensure there is an action plan in place to complete the outstanding appraisals for teams with low completion.
Hot Spot - Ludlow Hospital Hotel Services - Renewed focus by Hotel Services Manager following urgent review of H&S procedures on site completed by end of July	Apr-25	Sep-25	On Track	To ensure appraisals are correctly inputted.
Hot Spot - Ludlow Hospital inpatient services, Deputy Ward Managers to complete outstanding appraisals and undertake a look forward to ensure all appraisals remain in date	Apr-25	Jul-25	On Track	Ensure appraisals completed.
Hot spots - Planned care Wheelchair Services, Podiatry, CNRT Service lead to review and ensure completion by mid August at teh latest	Jul-25	Aug-25	On track	Ensure appraisals completed.
Check and challenge with the Service Lead for Team Leaders to ensure that appraisals are compliant now and in the future.	Mar-25	Mar-26	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
Hot Spot - RRU - From a trend perspective RRU has an improving picture, however, they remain a hot spot. Clinical Services Manager to support completion of outstanding appraisals with all appraisals to be completed by mid July 2025 with the Service Lead	May-25	Jul-25	On Track	Ensure appraisal compliance.
CCN Improving picture as a hot spot last month A recovery plan to be developed to ensure appraisals are completed by mid July (Mid July is due to the reason of Special School holiday period)	May-25	Jun-25	On Track	Ensure appriasal compliance
Hot spot - South East Community Nursing Team, this is an improving picture overall (4 oustanding). Clinical Services Manager will support Team Leader to complete final appraisals	Mar-25	Aug-25	On Track	Appraisals complete.
Hot spot - Wheelcahir services (3 outstanding appraisalsI), discuss with Clinical Services Manager to ensure completion	Jul-25	Aug-25	On Track	
Service Lead to share worsening trend details with relevant services	Jul-25	Dec-25	On track	Teams can identify if they are improving with their compliance
Undertake a cultural review using the Mckinsey 7s model at Stoke Heath to include the triangulation of all workforce KPI's.	Apr-25	Aug-25	On track	To understand any concerns around culture of the team and impact on all KPI's

Author			
Accountable Officer Approval	Fiona MacPherson	**Date**	18.07.25
	Rhia Boyode	**Date**	18.07.25

Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Recovery and Rehabilitation Unit Service	60	41	68.33
825 Shrewsbury Community Nursing Service	57	42	73.68
825 Wheelchair Service	12	9	75.00
825 Enhanced Care Home Service	13	10	76.92
825 Community Neuro Rehabilitation Service	14	11	78.57
825 Ludlow Hospital Inpatient Service	33	26	78.79
825 Ludlow Hospital Hotel Service	24	19	79.17
825 South East Shropshire Community Nursing Service	20	16	80.00
825 Podiatry Service	25	20	80.00

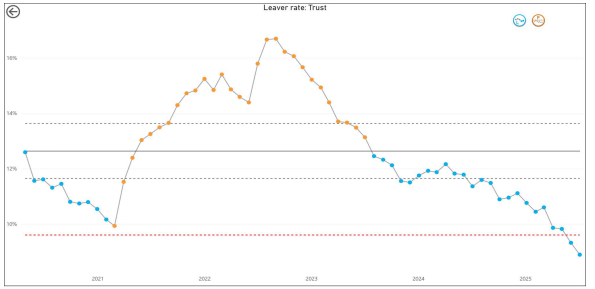
Exception Report - Action Plan

Leaver rate

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

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Leaver rate	%	10.44%	10.60%	9.86%	9.82%	9.32%	8.89%	8.89%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
%	8.84%	8.84%	8.84%	8.84%	8.84%	8.84%	8.84%



Reason for performance gap: The Leaver rate has seen a gradual improvement with the rate continuing to fall below our target. The main driver 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. The South East Community Nursing Service is a hot spot however a new Team Leader, a change of base and ways of working have been implemented which will hopefully have a positive impact on leaver rates.

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 & RRU).	Jul-25	Sep-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	Sep-25	On Track	To understand if there is a theme around leavers and whether support is required.
A cultural review has been commissioned at Stoke Heath along with additional clinical leadership	Feb-25	Aug-25	On Track	To evaluate any further support required for teams.
Review and monitor leavers with less than 12 months service.	Feb-25	Dec-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	Dec-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	Aug-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	Aug-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	Sep-25	On Track	Revisiting the self-assessment tool will provide us with the information to refresh our recruitment and retention action plan.

Author	Fiona MacPherson	**Date**	18.07.25
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25

Org L6	FTE
825 Paediatric Phlebotomy Service	92.86%
825 Whitchurch Outpatient Service	88.76%
825 Dudley CYP&F Management Services	85.96%
825 Temporary Staffing Service	69.12%
825 Estates Service	50.00%
825 Telford PHNS Admin Service	49.33%
825 Occupational Health Service	48.48%
825 Community Therapies Central Service	43.01%
825 Children's Continence Service	37.50%
825 Non-Executive Directors Service	36.36%

Org L6	Leavers
825 Health Visiting Dudley Service	11
825 Recovery and Rehabilitation Unit Service	7
825 South East Shropshire Community Nursing Service	7
825 Bishops Castle Hospital Service	6
825 Community Therapies Central Service	6
825 5-19 School Nursing Telford Service	5
825 Bridgnorth Hospital Inpatient Service	5
825 Health Visiting Shropshire Service	5
825 Ludlow Hospital Inpatient Service	5
825 MSK Shropshire & Telford (MSST) Service	5
825 Podiatry Service	5
825 Stoke Heath YOI Service	5

Leaving Reason	Leavers
Retirement Age	53
Voluntary Resignation - Work Life Balance	36
Voluntary Resignation - Relocation	23
Voluntary Resignation - Promotion	12
Voluntary Resignation - Health	11
Voluntary Resignation - Lack of Opportunities	7
End of Fixed Term Contract	6
Voluntary Resignation - Incompatible Working Relationships	6
Voluntary Resignation - Other/Not Known	5
Voluntary Resignation - Pay and Reward Related	5

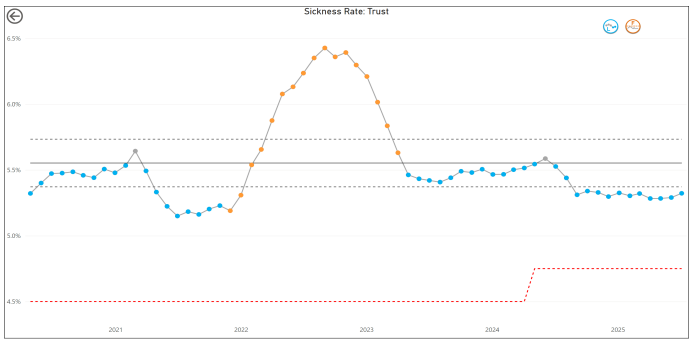
Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Sickness Rate	%	5.30%	5.32%	5.28%	5.28%	5.29%	5.32%	5.32%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
%	5.10%	5.00%	4.90%	4.80%	4.75%	4.75%	4.75%



Reason for performance gap:	Since March 2025 the rate continues to remain above target but relatively 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. 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 reduction during summer months and an increase to 5% by end of the year.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Adult Community SDG - Inpatient services are a worsening trend over last 12 months. Deep dive into absence on inpatient wards to see what interventions would prevent and reduce length of absence	Jul-25	Nov-25	On Track	To better understand the detail behind absences and what bespoke support needs to be put in place.
	People Team to work with the new Team Leader at BCCH to support and ensure relevant support is in place	Mar-25	Jul-25	On Track	To better understand the detail behind absences and what bespoke support needs to be put in place.
	Hot spot Dudley CYP&F Management Services - moving FNP to correct place on ESR as reporting structure is incorrect. People Team to work with FNP to ensure appropriatre support is in place	May-25	Aug-25	On Track	To ensure the structure in ESR is correct and support is in place
	Implement HWB Action plan	May-25	Mar-26	On track	Ensure appropriate HWB support is implemented for staff
	Targeted support for areas with high MSK absence to implement preventative measures.	Nov-24	Dec-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	Aug-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.
	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	Sep-25	Completed	Provide support to staff and managers on techniques to reduce stress in line with NICE Guidelines
	Work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, MSK support.	Mar-25	May-26	On Track	To ensure appropriate support is in place.
	Raise awareness Trust wide of recording menopause related absences as menopause.	Mar-25	Dec-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	Fiona MacPherson	**Date**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	270.60	902.48	29.98%
825 Ludlow Outpatient Service	168.01	832.23	20.19%
825 Research and Development Service	230.80	1,340.40	17.22%
825 Wound Healing Service	739.40	4,424.00	16.71%
825 Community Therapies Central Service	854.83	5,393.35	15.85%
825 Single Point of Referral Service	345.77	2,566.53	13.47%
825 Continence Specialist Nursing Service	321.27	2,403.07	13.37%
825 Bishops Castle Hospital Service	988.49	7,491.08	13.20%
825 Children's Continence Service	52.27	412.00	12.69%
825 Outpatient Parenteral Antimicrobial Therapy Service	172.00	1,433.60	12.00%

Org L7	Absence FTE	Available FTE	Absence FTE %
825 CYP Nurse Management Team	138.00	229.00	60.26%
825 Child Development Centre Admin Team	61.00	177.64	34.34%
825 Ludlow Outpatient Service Clinical Team	168.01	569.40	29.51%
825 Urgent Community Response - North West Team	58.80	218.40	26.92%
825 Urgent Community Response - North East Team	43.00	182.00	23.63%
825 MSK Rheumatology Team	80.20	396.80	20.21%
825 Urgent Community Response - South East Team	64.24	318.24	20.19%
825 CYPF Operational Management Team	132.60	673.48	19.69%
825 Ludlow Hospital Radiology Team	54.42	296.20	18.37%
825 Telford Wound Healing Service Clinical Team	700.40	3,909.00	17.92%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Additional Clinical Services	8,286.24	120,109.20	6.90%
Nursing and Midwifery Registered	13,652.76	231,733.39	5.89%
Medical and Dental	444.27	7,717.37	5.76%
Estates and Ancillary	758.34	17,641.44	4.30%
Administrative and Clerical	5,245.05	124,691.34	4.21%
Allied Health Professionals	2,549.88	68,967.68	3.70%
Add Prof Scientific and Technic	368.95	14,398.70	2.56%
Students	32.00	3,508.00	0.91%

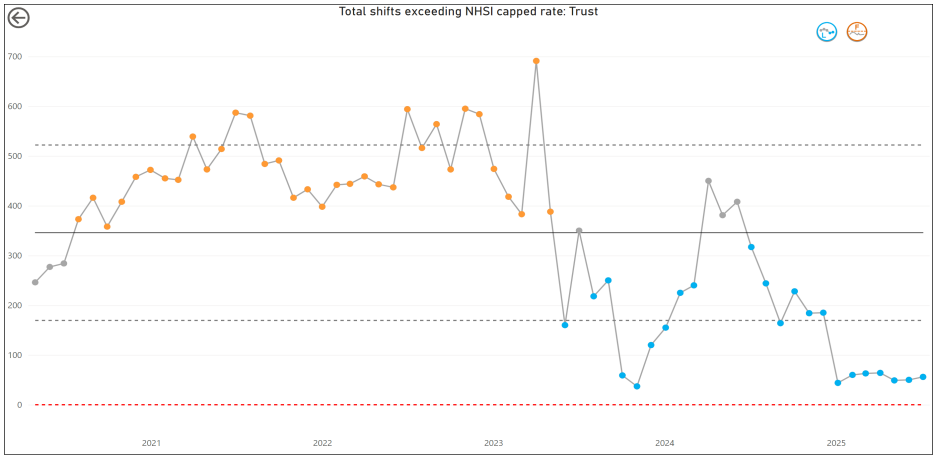
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Shifts	Number	60	63	64	49	50	56	52
	Target	0	0	0	0	0	0	0

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
%	56	50	40	30	25	20	0



Reason for performance gap:	For Telford teams there is an issue with patient medications which is being worked through to ensure a reduction in agency usage. Demand for medical 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, specialist nursing roles and AHP all in place. We have not yet been advised by NHSE of a date for price cap compliance for medical and dental staff but working towards West Midlands Region Price Rate card by end of July.			
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. Working towards the West Midlands Regional Price Rate Card by the end of July.
	AHP Price Cap advised to be 30 June 2025. Write to Agencies to advise of supply at these rates. 10/6/25 Letters sent to agencies.	May-25	Jul-25	Completed	Reduction in price cap provision by agency for AHPs. Currently only 1 AHP in place and agency will provide at PCC from 1 July. Due to end mid August.
	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 held on May 16. **11/06/25** 25 Bank HCA recruited, 6 with start dates. **14/7/25**: Ludlow event held 25/6/25 13 Bank HCA offered. A total of 15 from cohort 1 commenced shifts in June, 1 further to commence in July and 7 others who are being followed up by the recruitment team to complete their onboarding. **Next event**: Whitchurch 29/7/25

Author	Gina Billington	**Date**	7/14/2025
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25

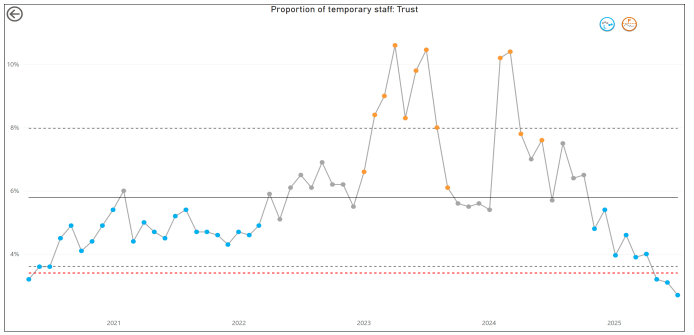
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Prop Temporary staff	%	4.6%	3.9%	4.0%	3.2%	3.1%	2.7%	3.0%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

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



Reason for performance gap:	For Telford teams there is an issue with patient medications which is being worked through to ensure a reduction in agency usage. UEC consultant recruitment has resulted in no suitably qualified applicants and this post is being reviewed by the Medical Director/ops. The Long Covid team are using a locum GP to support the service. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. he 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, specialist nursing roles and AHP all in place. We have not yet been advised by NHSE of a date for price cap compliance for medical and dental staff but working towards West Midlands Region Price Rate card by end of July. NHSE notice due on the cessation of Band 2 and Band 3 agency use to be advised, working on this 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	Reduction in price cap provision by agency. Working towards the West Midlands Regional Price Rate Card by the end of July.
	AHP Price Cap advised to be 30 June 2025. Write to Agencies to advise of supply at these rates.	May-25	Jul-25	Completed	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. JD currently being reviewed by Medical Director - may need Royal College approval.	Apr-25	Jul-25	Off 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	Jul-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). 41 bank B3 applications shortlisted and invited to interview on 16/5/25. 25 offers made on the day. Further events organised for June and July.	Apr-25	Sep-25	On Track	Working Group set up. To successfully recruit Band 2/3 bank roles to increase the bank pool in preparation of the cessation of agency B2/3 use. Timetable of recruitment events and venues agreed and staffing attendance identified (will need support from ops admin for some events) First event held on May 16. **11/06/25** 25 Bank HCA recruited, 6 with start dates. **14/7/25**: Ludlow event held 25/6/25 13 Bank HCA offered. A total of 15 from cohort 1 commenced shifts in June, 1 further to commence in July and 7 others who are being followed up by the recruitment team to complete their onboarding. **Next event**: Whitchurch 29/7/25
	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 held on May 16. **11/06/25** 25 Bank HCA recruited, 6 with start dates. **14/7/25**: Ludlow event held 25/6/25 13 Bank HCA offered. A total of 15 from cohort 1 commenced shifts in June, 1 further to commence in July and 7 others who are being followed up by the recruitment team to complete their onboarding. **Next event: Whitchurch 29/7/25**
	Implement the use of NHSP national bank to reduce agency use. Targeted work by NHSP to convert current agency workers to the NHSP bank.	Jun-25	Sep-25	On Track	Reduction in the use of agency. Increased levels of bank workers available.

Author	Gina Billington	**Date**	7/14/2025
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25

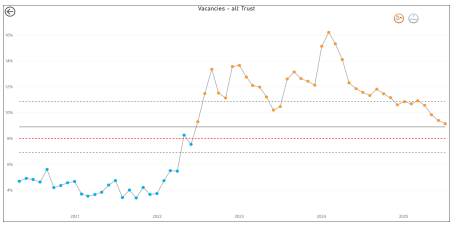
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Vacancies	%	10.68%	10.91%	10.56%	9.83%	9.39%	9.14%	9.45%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
%	9.14%	9.10%	8.75%	8.30%	8.00%	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. Adult Therapy Central are being supported by the AHP lead on a skills mix review to inform future recruitment. Stoke Heath are reviewing the mental health offer working with MPFT on a model.

Month 2 Hotspots: Updates below. Month 3 hotspots: Adult Community therapies are in the process of a service review and although Dudley Health Visiting are showing as a hotspot they are holding several vacancies due to a restructure process. There are a number of administrative vacancies across the Trust that have not been approved for advertising which is impacting on the vacancy position.

Action Plan

Action	Start Date	End Date	Status	Outcome/Update
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	Complete	Applicants processed and in post July (subject to their notice periods). **13/6/25:** 12.31 WTE vacancies on Trac, 3.51 WTE in pre-interview stages, 1 WTE at interview 1.8 WTE at offer, 6 WTE with start dates booked. 14/7/25 : Urgent Care: 2 in offer, 8 with start dates. BCCH,BN, Ludlow & W'church: 1 at advertising, at interview, 9 in offer, 3 starting. Community Nursing: 9 in offer, 2 started, 2 with start dates, 2 in interview stage, 3 in advertising. Stoke Heath: 1 starting, 1 shortlist, 1 in interview stage and 1 in advertising.
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. 11/06/2025 - JD being reviewed by Medical Director to inlcude reference to the planned move to a Group Model. This may then require Royal College input.	Apr-25	Jun-25	Off 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) **14/7/25** BCCH has 5.18 WTE – 4 staff nurses & 2 HCAs vacancies on Trac. 2 WTE have a start date booked in July, 2.59 WTE at offer stage and 0.59 at interview. Ludlow has 4 WTE vacancies on Trac. 1 at shortlisting stage and 3 WTE at offer stage(2 HCAs & 1 RN B5) Bridgnorth has 1.25WTE vacancies in Trac 1 at offer stage & 1 with a start date in July WCH has 1 WTE with a start date in July
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	Complete	Applicants processed and in post Jul 25 (subject to their notice periods) **14/7/25** : 1 HCA – 0.96 WTE perm at longlisting, 1 wte Nurse associate, started, 9 RCNs (8.24 WTE) at shortlisting, 5.64 at offer stage, 1.8 at interview & 0.8 at longlisting. 1 wte matron B7 at offer. 2 wte caseload holder; 1 at offer & 1 at longlisting. vacancies of which: Telford North & South – 2 WTE at offer stage, 1 wte at interview Shrewsbury North & South - 3.64 WTE at offer stage
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. Service Lead to ensure all vacancies have been processed.	May-25	Oct-25	On Track	Applicants processed and in post Jul 25 (subject to their notice periods) **13/6/25:** Total of 5.2 WTE in recruitment stage 2 posts (3 WTE) in shortlisting and 3 posts (2.2 WTE) at offer; Recruitment Team will prioritise pre-employment checks.
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.	Jun-25	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 June 25 was 43.2 working days. There are currently 25 applicants with start dates in July.
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 held on May 16. **11/06/25** 25 Bank HCA recruited, 6 with start dates. **14/7/25**: Ludlow event held 25/6/25 13 Bank HCA offered. A total of 15 from cohort 1 commenced shifts in June, 1 further to commence in July and 7 others who are being followed up by the recruitment team to complete their onboarding. **Next event: Whitchurch 29/7/25**

Author	Gina Billington	**Date**	7/14/2025
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25

Division	Column1	Column2	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer			28.18	(2.26)	(8.0)
Urgent Care (Adults)			186.93	24.97	13.4
Community Services (Adults)			729.98	70.16	9.7
Planned Care SDG			213.08	29.21	13.7
Children and Families Division			459.15	32.05	7.0
Chief Executive			12.64	2.00	15.8
Director of Finance and IM&T			82.14	6.14	7.5
Director of Governance			22.5	(0.19)	(0.8)
Director of People			32.86	1.11	3.4
Director of Nursing and AHPs			33.33	1.55	4.7
Medical Directorate			4.08	(0.60)	(14.7)
Total			**1,795.87**	**164.14**	**9.1**

Urgent Care (Adults)	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Single Point of Referral		TT001	8.02	0.51	6.4
Virtual Wards- Management		YA250	13.5	3.25	24.1
Virtual Wards- Central		YA251	11.2	1.20	10.7
Virtual Wards- North East		YA252	8	1.34	16.8
Virtual Wards- North West		YA253	9.38	1.48	15.8
Virtual Wards- South East		YA254	7.8	0.23	2.9
Virtual Wards- South West		YA256	7.2	1.00	13.9
Virtual Wards- Telford		YA257	11.04	1.28	11.6
ORAT		YA255	5.29	0.09	1.7
Urgent Community Response- Telford		TT700	12.24	(0.39)	(3.2)
Urgent Community Response- Central		TT701	7.8	0.57	7.3
Urgent Community Response- North East		TT702	4.4	0.60	13.6
Urgent Community Response- North West		TT703	5.02	1.62	32.3
Urgent Community Response- South East		TT704	4.5	1.86	41.3
Urgent Community Response- South West		TT706	4.5	0.20	4.4
Care Transfer Hub		TW402	24.74	5.24	21.2
Total			**144.63**	**20.08**	**13.9**

Community Services (Adults)

Inpatient Wards	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward		TW130	21.63	6.54	30.2
Ludlow Hospital Ward		TW230	34.72	7.56	21.8
Whitchurch Hospital Ward		TN130	40.41	6.11	15.1
Bridgnorth Hospital Ward		TT130	41.35	1.86	4.5
Rehab & Recovery Unit - Shrewsbury (Ward 18, RSH)		YA260	50.93	12.45	24.4
Rehab & Recovery Unit - Telford (Ward 36, PRH)		YA270	43.51	6.26	14.4
Total			**232.55**	**40.78**	**17.5**

Community Nursing	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Community Nursing - Telford North		TT530	32.79	1.80	5.5
Community Nursing - Telford South		TT500	32.38	0.72	2.2
Community Nursing - Shrewsbury North		TC300	31.32	3.78	12.1
Community Nursing - Shrewsbury South		TC301	31.04	0.95	3.1
Community Nursing - North East		TN200	29.29	0.15	0.5
Community Nursing - North West		TN400	32.01	2.51	7.8
Community Nursing - South East		TW301	31.44	3.47	11.0
Community Nursing - South West		TW300	25.11	(1.07)	(4.3)
Total			**245.37**	**12.31**	**5.0**

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	17.19	0.21	1.2
Adult Community Therapy North West		TA004	11.9	(0.03)	(0.3)
Adult Community Therapy South East		TA005	14.8	3.00	20.3
Adult Community Therapy South West		TA006	15.35	1.88	12.2
Total			**75.3**	**9.22**	**12.2**

Children, Young People & Families	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Shropshire PHNS Admin		WP125	9.46	0.47	5.0
Shropshire Health Visiting		WP135	45.45	0.69	1.5
Family Nurse Partnership Shropshire		WP601	5.07	0.00	0.0
Telford PHNS Admin Service		WP127	4.4	1.00	22.7
Health Visiting Telford Service		WP136	32.57	0.17	0.5
Family Nurse Partnership Telford		WP603	3.05	(0.55)	(18.0)
Dudley Health Visiting Admin Service		WP126	12	1.17	9.8
Health Visiting Dudley Service		WP205	75.27	10.27	13.6
Family Nurse Partnership Dudley Service		WP602	9.35	(0.85)	(9.1)
5-19 School Nursing Dudley Service		WP200	33.92	2.04	6.0
5-19 School Nursing Shropshire		WP210	27.22	2.43	8.9
5-19 School Nursing Telford		WP220	13.99	1.60	11.4
Total			**271.75**	**18.44**	**6.8**

Dental in Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Dental Central Admin		WM900	3.6	0.30	8.3
Dental Special Care and Access		WM910	30.43	2.30	7.6
Dental Market Drayton		WM920	3.56	0.96	27.0
Dental Craven Arms		WM930	2.01	0.94	46.8
Oral Health Improvement		WM960	6.42	1.62	25.2
Total			**46.02**	**6.12**	**13.3**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
TeMS Therapy		TC231	6.17	0.40	6.5
MSK MDT Clinic		TC232	4.27	0.00	0.0
MSK Podiatry		TC235	1	(0.05)	(5.0)
MSK Rheumatology		TC236	0	0.00	
TeMS Admin		TC240	18.62	1.10	5.9
MSST		TC250	12.97	0.10	0.8
Total			**43.03**	**1.55**	**3.6**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Prison Healthcare		WH200	26.82	5.05	18.8
Total			**26.82**	**5.05**	**18.8**

Local Action Plans

Exception Report - Action Plan

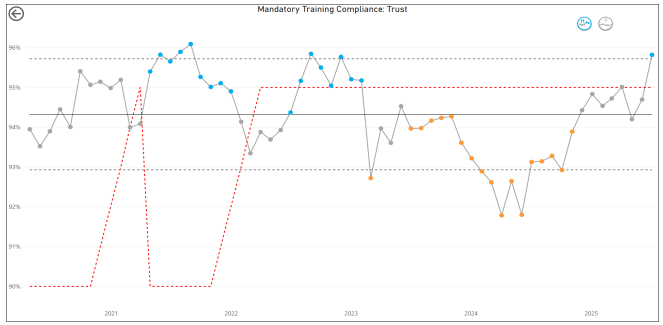
Mandatory Training Compliance

Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Mandatory Training	%	94.53%	94.72%	95.01%	94.20%	94.69%	95.82%*	95.82%*
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

*bank IG now excluded from overall compliance

Trajectory	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
%	95.85%	95.90%	95.90%	95.95%	95.95%	96.00%	96.00%



Reason for performance gap:	Corporate Updates – The compliance rate for June has increased to 95.82%, we have reached over 95% compliance since the introduction Moving and Handling Level 2 in April 2025. We have made a significant change to Fire and Information Governance. Following the recommendation from NHSE to align our renewal with national guidence, Fire has now changed from being renewed on an annual basis to every 2 years. Information Governance has also been bought in line with all other topics, Bank Staff are no longer being included in the monthly compliance figures. This will still be monitored by the Governance Team outside of the compliance report. We have seen improvement in all topics with the exception of 2, Fraud which has had a very small drop (0.05%) and High Risk Fire. This is still being reviewed by the Estates department, with regards the possibly change to Fire Warden. There has been significant improvement with regards to the Resus Training, Resus Level 2 Adults and Paediatrics have increased by over 3% and Resus Level 3 Adults and Paediatrics have increased by over 2%. We are continuing to adhere to the newly implemented procedures for addressing non-compliance, and we have observed improvements in these areas. We will persist with this process, to ensure we maintain the 95% compliance rate. Additionally, we will monitor all other areas, and any that fall below the 95% compliance threshold will also receive notifications regarding non-compliance.

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	Jul-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 - ESRLMS to focus efforts on improving compliance rates for **High Risk Fire**. The Associate Director of Estates has attended Mandatory Training Group with proposal that High Risk Fire is replaced with Fire Warden Training.	Apr-25	Dec-25	On Track	Mandatory Training Group asked for a Business Case to be put forward with the various options and costings available for High Risk Fire and Fire Warden, to be taken to the execs for final approval. Fire Warden would be for all locations in the trust with 5 or more staff. Currently High Risk Fire is for Community Hospitals only
	Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **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 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 - Compliance Overview - ESRLMS to focus efforts on improving compliance rates for **Information Governance**. The ESR Learning Management Team has identified that bank staff are currently being included in compliance for Information Governance (IG). As no other topic includes bank staff, this should be monitored separately. It is recommended that IG compliance be aligned with all other mandatory topics.	Jun-25	Sep-25	Completed	Bank Staff have now been removed from the compliance figures. To improve overall compliance rates across IG 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.
	Community Services to implement a check and challenge session in a monthly basis to discuss hot spots for areas of low compliance	Jun-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**	18.07.25
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25

All non-compliant sectors

Sector	Substantive staff count	% Compliance
825 Trust Board Sector	11	88.48%
825 Stoke Heath YOI Sector	19	92.49%
825 Operations Directorate Management Sector	11	92.61%
825 South East Sector	114	93.46%
825 North West Sector	203	93.56%
825 North East Sector	102	93.72%
825 Telford Sector	44	93.98%
825 Central Sector	100	94.73%
825 Service Delivery Group - Adult Community Services Management Sector	5	94.94%

June 2025 Compliance Overview

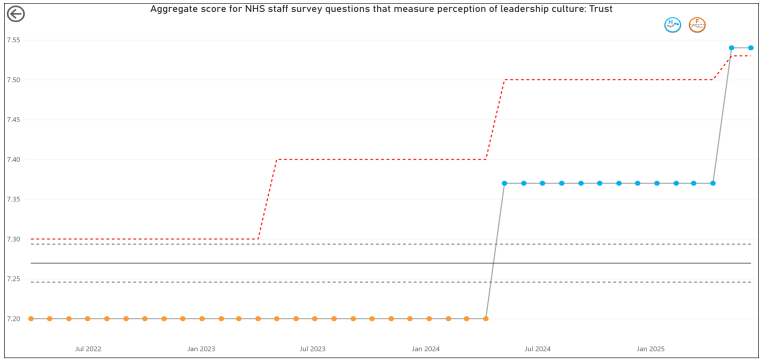
TOPIC	May Compliance		June Compliance	Variance against compliance
Corporate Induction	97.3%	▲	97.7%	0.39%
Equality, Diversity and Human Rights - 3 Years	98.2%	▲	98.7%	0.49%
Fire Safety - 2 Years		▲	99.7%	99.68%
Fire Safety - High Risk - 1 Year	85.1%	▼	84.0%	-1.14%
Fraud Awareness - 3 Years	97.5%	▼	97.5%	-0.05%
Health, Safety and Welfare - 3 Years	98.3%	▲	98.4%	0.11%
Infection Prevention and Control - Level 1 - 3 Years	97.5%	▲	98.8%	1.30%
Infection Prevention and Control - Level 2 - 1 Year	96.2%	▲	98.1%	1.88%
Information Governance and Data Security - 1 Year	93.9%	▲	98.0%	4.10%
Moving and Handling - Level 1 - 3 Years	96.9%	▲	97.0%	0.12%
Moving and Handling - Level 2 - 2 Years	72.6%	▲	76.3%	3.73%
NHS Conflict Resolution (England) - 3 Years	97.8%	▲	98.1%	0.28%
Patient Safety - Level 1 - 3 Years	99.2%	▲	99.5%	0.27%
Preventing Radicalisation - Prevent Awareness - 3 Years	97.7%	▲	98.0%	0.23%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	76.9%	▲	80.0%	3.15%
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	76.4%	▲	79.7%	3.30%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	85.7%	▲	88.6%	2.85%
Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	85.5%	▲	88.5%	2.97%
Safeguarding Adults - Level 1 - 3 Years	98.1%	▲	98.5%	0.49%
Safeguarding Adults - Level 2 - 3 Years	98.1%	▲	98.2%	0.15%
Safeguarding Children - Level 1 - 3 Years	95.4%	▲	95.8%	0.40%
Safeguarding Children - Level 2 - 3 Years	94.0%	▲	94.1%	0.08%
The Oliver McGowan Mandatory Training on Learning Disability and Autism P	97.7%	▲	97.9%	0.17%

Exception Report - Action Plan

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

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

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



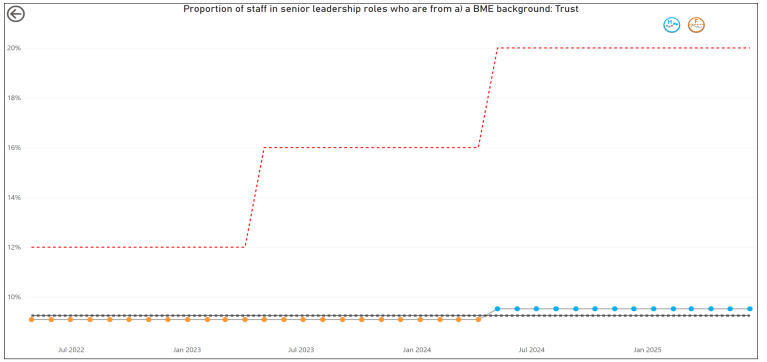
Reason for performance gap:	The target is 7.53 and we are close to this with a score of 7.54. There have been changes over the last 24 months which have included change management across leadership roles which will take time to embed and change culture. The Culture Change team has been launched with Board Conversations and Leadership survey will support changing this score over time. The quantitative and qualitative data gathered by the 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**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

Exception Report - Action Plan

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

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



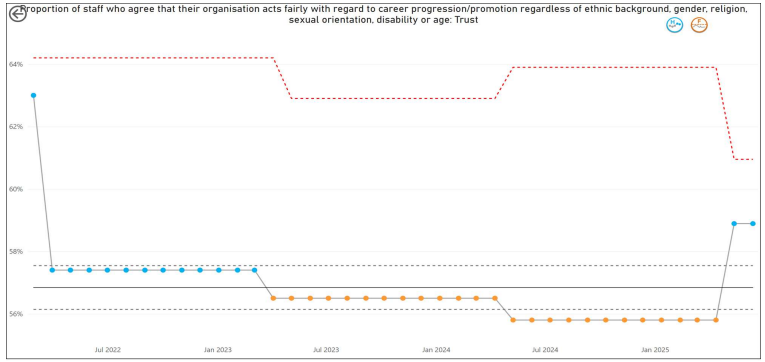
Reason for performance gap:	The WRES 2023/24 report shows our colleague representation for Asian, Mixed, Black and other minority people has increased year on year since 2020 and makes up 7.82% of our workforce. The 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, 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	Sep-25	On Track	To suppoer inclusive recruitment processes
	Explore Scope for Growth conversations.	Mar-25	Aug-25	On Track	Ensure talent management conversations take place on a regular basis to support progression.
Author	Fiona MacPherson	**Date**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

Exception Report - Action Plan

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

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

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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	Sep-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	Aug-25	On Track	Ensure support is appropriate and meets individual's needs.
	Publicise positive staff stories around career and development opportunities.	Dec-24	Dec-25	On Track	Raise awareness of career development.
	Explore implementing 'scope for growth' conversations.	Mar-25	Aug-25	On Track	Ensure all staff have the opportunity to discuss careers aspirations.
Author	Fiona MacPherson	**Date**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

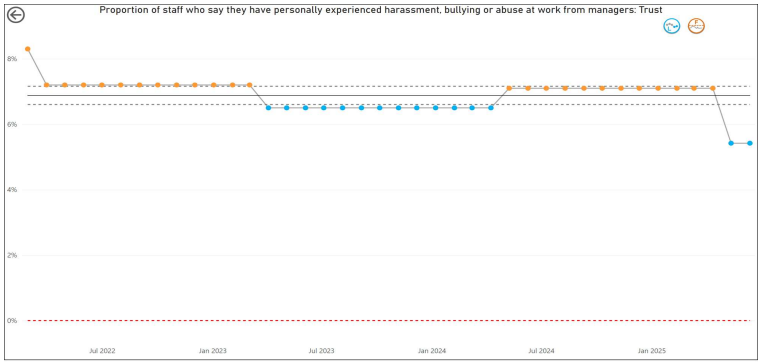
Yearly Reported KPIs

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

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



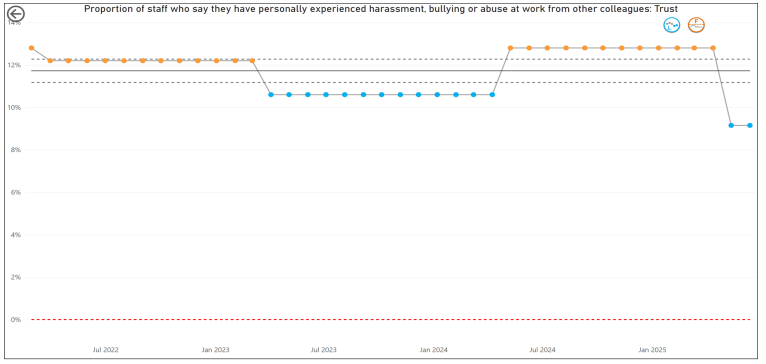
Reason for performance gap:	When reviewing the information retained by the People team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Oct-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	Oct-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	16.6.25		
Accountable Officer Approval	Rhia Boyode	**Date**	16.6.25		

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

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



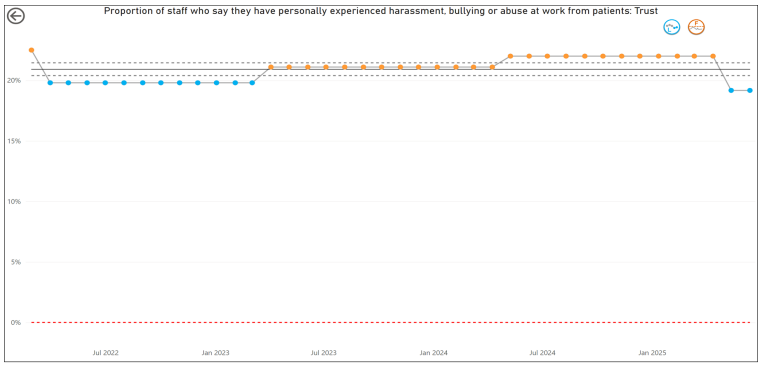
Reason for performance gap:	When reviewing the information retained by the People Team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Oct-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	Oct-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

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

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



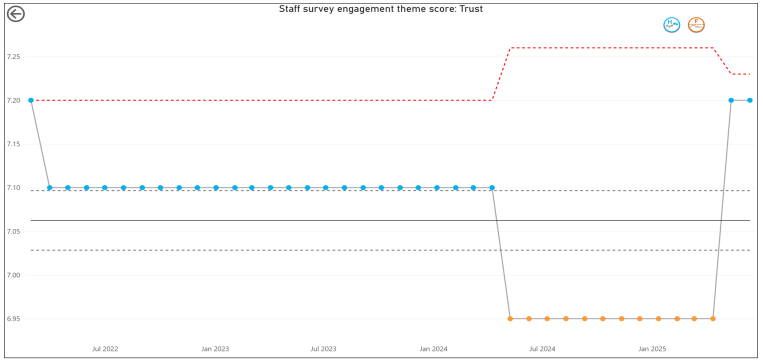
Reason for performance gap:	Staff experience bullying by patients, the aim is to raise awareness of the impact of this behaviour and support staff as required.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Launch work without fear campaign.	Mar-25	Sep-25	On Track	Raise awareness to our patients, relatives and members of the public.
	Develop nudge posters around zero tolerance.	Mar-25	Aug-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	Aug-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	Aug-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

Exception Report - Action Plan

Staff survey engagement theme score

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

Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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	Completed	To increase engagement across the Trust and enable staff to network.
	Implement HWB action plan	May-25	Dec-25	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**	18.07.25		
Accountable Officer Approval	Rhia Boyode	**Date**	18.07.25		

Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**7th August 2025**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**23rd July 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. 32 indicators are highlighted as a concern (46.4%), 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	3	5	3	**31**	**11 (35.5%)**

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 the following changes to the Trust's KPIs flagged as a concern during the month:

- **People Committee -** No change.
- **Quality and Safety Committee**
  1. *Medication Incidents with Moderate Harm is no longer flagged as a variation concern*
- **Resource and Performance Committee**
  1. *Financial efficiency – variance from efficiency plan is now flagged as a variation concern*
  2. *Total patients waiting more than 52 Weeks to start consultant-led treatment (National target) was previously flagged as both assurance and variation concern, now flagged as only an assurance concern*

Action Plans have been developed in a workshop with Operational Leads and Support Services and are included at Appendix 3 for the measures flagged as a concern within this report, with the exception of Financial efficiency – variance from efficiency plan.

The variation concern for 'Financial efficiency – variance from efficiency plan' was impacted by 2024-25 recurrent delivery; although recurrent delivery was below plan in year this was offset by non-recurrent schemes. In addition, the full year effect of recurrent schemes was marginally in excess of plan. The 2025/26 recurrent position is slightly favourable to plan and so an action plan has not been developed at this stage.

Please note that the RTT measures for June are subject to change as the validation for the national submission continued at the time of preparing 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, 11 require focused attention with 9 of the 11 relating to access to services and waiting times.

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

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

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

1. Outpatient follow-up activity levels compared with 2019/20 baseline
2. Urgent Care 2 hour response
3. Financial efficiency – variance from efficiency plan

Five 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)
5. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)

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

1. 18 week Referral to Treatment (RTT) incomplete pathways (National target)
2. Proportion of patients within 18 weeks (Local target)
3. Total patients waiting more than 52 Weeks – All services (Local target)

There have been two changes to note since the last report to Board:-

- Now flagged as having a variation concern
    1. *Financial efficiency – variance from efficiency plan*

- Previously flagged as both assurance and variation concern, now flagged as only an assurance concern
    1. *Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)*

Performance Update

June 2025 position:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Our Services)
Patients waiting over 52 weeks	168	648
Patients waiting over 65 weeks	0	135
Patients waiting over 78 weeks	0	14
Patients waiting over 104 weeks	0	0

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 an improvement from 59.38% in May to 63.42% in June, although the June 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 68.07% in June compared with 66.29% in May.

The data issue previously reported in relation to Continence products was resolved for 2024/25 data. However, a similar issue still existed for the start of 2025/26 with April and May being up to date but only part of June data being available when the dashboards were created. This issue has been previously raised and subsequently escalated with the system supplier. The issue, as of 23rd July, has now been resolved and the measure will be refreshed for the next reporting cycle. This impacts the 'total activity undertaken against current year plan' KPI. This measure has also been refreshed as a discrepancy was identified. The refresh has had no impact on the making data count icons.

3.3 NHS Oversight Framework

On 26 June 2025, NHS England published the NHS Oversight Framework for 2025/26 which is the first publication since the NHS Oversight Framework for 2022/23.

The Oversight Framework for 2025/26 is a one year framework and will be reviewed in 2026/27, taking into account the 10 Year Plan. The 2025/26 framework includes Integrated Care Boards (ICBs), NHS trusts and foundation trusts. The new framework is underpinned by a scoring approach to performance and this score is strongly influenced by benchmarking against other trusts.

The domains within the framework have also been reviewed and the metrics now fall under a number of domains:

- Access to services
- Effectiveness and experience of care
- Patient Safety
- People and Workforce
- Finance and productivity and
- Improving health and reducing inequality (non-scoring).

Performance Update

Due to the changes within ICBs, their score will not be introduced until 2026/27. Where providers are part of a provider collaborative or group model, they will be measured as a trust and not as a wider group. It is anticipated that the scores for organisations will be published in late August/September.

An assessment in relation to the application of this Framework is underway and a proposal to amend the Trust's KPIs to fully reflect it will be presented through committees and Trust Board for approval, as required by our Performance Framework.

3.4 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.5 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	2025-06-30	L	63.77%	92.00%	-28.23%	63.77%	92.00%	-28.23%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2025-06-30	L	74.19%	100.00%	-25.81%	74.19%	100.00%	-25.81%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2025-06-30	~	73.53%	100.00%	-26.47%	73.53%	100.00%	-26.47%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2025-06-30	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2025-06-30	~	0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2025-03-31	H	94.6%	95.0%	-0.4%	94.6%	95.0%	-0.4%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2025-06-30	~	99.47%	99.00%	0.47%	99.47%	99.00%	0.47%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2025-06-30	H	0.17%	0.00%	0.17%	0.17%	0.00%	0.17%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2025-06-30	~	1.35%	0.00%	1.35%	1.35%	0.00%	1.35%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2025-05-31	H	87.46%	90.00%	-2.54%	89.08%	90.00%	-0.92%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2025-05-31	~	86.34%	90.00%	-3.66%	85.10%	90.00%	-4.90%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2025-05-31	~	93.24%	95.00%	-1.76%	91.52%	95.00%	-3.48%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2025-06-30	L	0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2025-06-30	H	104.56%	75.00%	29.56%	109.65%	75.00%	34.65%	?
Resource & Performance...	Responsive	Patients no longer meeting the criteria to reside	2025-06-30	L	20.8%	21.3%	-0.5%	20.8%	21.3%	-0.5%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2025-06-30	L	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...	2025-06-30	H	66.67%	92.00%	-25.33%	80.00%	92.00%	-12.00%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2025-06-30	L	68.07%	92.00%	-23.93%	68.07%	92.00%	-23.93%	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	2025-06-30		89.08%	100.00%	-10.92%	98.59%	100.00%	-1.41%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2025-06-30		306.06%	120.00%	186.06%	161.80%	120.00%	41.80%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2025-06-30	H	127.21%	103.00%	24.21%	124.94%	103.00%	21.94%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2025-06-30		0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2025-06-30		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2025-06-30	H	648	0	648	648	0	648	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2025-06-30	L	168	0	168	168	0	168	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2025-06-30	L	135	0	135	135	0	135	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2025-06-30	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2025-06-30	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2025-06-30	L	14	0	14	14	0	14	F
Resource & Performance ...	Responsive	Urgent Care 2 hour response	2025-06-30	L	69.96%	70.00%	-0.04%	69.96%	70.00%	-0.04%	
Resource & Performance ...	Effective	Virtual ward bed occupancy	2025-06-30		69.34%	63.81%	5.53%	69.34%	63.81%	5.53%	

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	2025-06-30	H	6.43	6.49	-0.06	6.43	6.49	-0.06	F
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2025-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2025-06-30	H	3	0	3	3	0	3	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2025-06-30	H	300.00%	100.00%	200.00%	300.00%	100.00%	200.00%	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2025-06-30	H	100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	F
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2025-06-30	H	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	F
Quality & Safety Committee	Effective	Deaths - unexpected	2025-06-30	H	1	0	1	1	0	1	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2025-06-30	H	200.00%	100.00%	100.00%	200.00%	100.00%	100.00%	P
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2025-06-30		5.83	4.00	1.83	5.83	4.00	1.83	
Quality & Safety Committee	Safe	Medication Incidents with Moderate Harm	2025-06-30		0	0	0	6	0	6	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2025-06-30		0	0	0	0	0	0	P
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2025-06-30	H	1	0	1	1	0	1	F
Quality & Safety Committee	Safe	Never Events	2025-06-30		0	0	0	0	0	0	P
Quality & Safety Committee	Well Led	Overall CQC Rating	2025-06-30		Good	Good		Good	Good		P
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2025-06-30		2	0	2	5	0	5	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-05-31		125%	95%	30%	125%	95%	30%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-05-31	H	139%	95%	44%	139%	95%	44%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-05-31	H	103%	95%	8%	103%	95%	8%	
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-05-31		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 ...	2025-06-30	H	7.5	7.5	0.0	7.5	7.5	0.0	F
People Committee	Well Led	Appraisal Rates	2025-06-30	H	88.82%	90.00%	-1.18%	88.42%	90.00%	-1.58%	F
People Committee	Well Led	CQC well-led rating	2025-06-30		Good	Good		Good	Good		P
People Committee	Well Led	Leaver rate	2025-06-30	L	8.89%	9.60%	-0.71%	8.89%	9.60%	-0.71%	F
People Committee	Well Led	Mandatory Training Compliance	2025-06-30	H	95.82%	95.00%	0.82%	95.82%	95.00%	0.82%	?
People Committee	Well Led	Net Staff in Post Change	2025-06-30		2.08	0.00	2.08	7.42	0.00	7.42	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-06-30	H	9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	F
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2025-06-30		69.57%	66.00%	3.57%	69.57%	66.00%	3.57%	P
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-06-30	H	4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	P
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2025-06-30	H	58.89%	60.95%	-2.06%	58.89%	60.95%	-2.06%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-06-30	L	5.4%	0.0%	5.4%	5.4%	0.0%	5.4%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-06-30	L	9.2%	0.0%	9.2%	9.2%	0.0%	9.2%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2025-06-30	L	19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	F
People Committee	Well Led	Proportion of temporary staff	2025-06-30	L	2.7%	3.4%	-0.7%	3.0%	3.4%	-0.4%	F
People Committee	Well Led	Sickness Rate	2025-06-30	L	5.32%	4.75%	0.57%	5.32%	4.75%	0.57%	F
People Committee	Well Led	Staff survey engagement theme score	2025-06-30	H	7.2	7.2	0.0	7.2	7.2	0.0	F
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-06-30	L	56	0	56	52	0	52	F
People Committee	Well Led	Total shifts on a non-framework agreement	2025-06-30	L	0	0	0	0	0	0	?
People Committee	Well Led	Vacancies - all	2025-06-30	H	9.14%	8.00%	1.14%	9.45%	8.00%	1.45%	?

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.

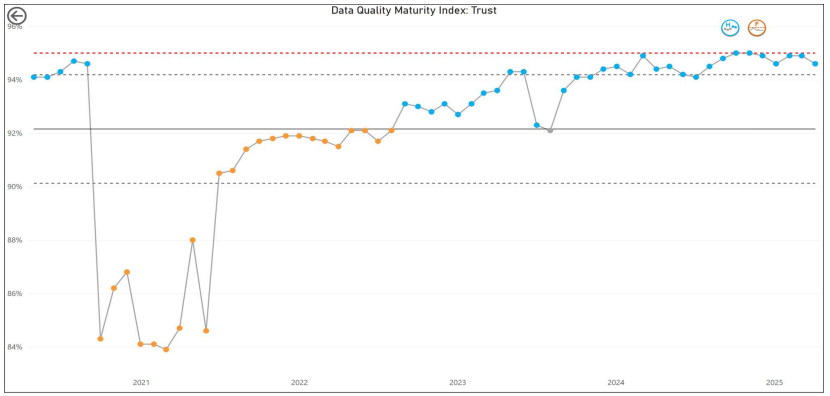
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
DQMI	%	95.0%	94.9%	94.6%	94.9%	94.9%	94.6%	94.6%
	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%	94.6%



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.
The Plan is to achieve the 95% target by the end of quarter 2 and all individual action plans align to this deadline. In addition to this however it is vital that as well as reaching target education sessions take place to support teams to understand the importance of good data quality and in particular how this relates to health inequalities.

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	Clinical Audit Tool feedback to be strengthened through Divisional meetings	Jun-24	Nov-24	Complete	Results from quarterly discussions at DQ Subgroup are now a standing agenda item through Divisional meetings which ensures DQ specific actions at Divisional and Service level are collated and tracked. A focused meeting with senior operations leads and BI has taken place this month and reviewed both high-performing and underperforming areas. Targeted actions were developed, and a follow-up meeting is scheduled in six weeks to monitor progress and provide support as needed to drive improvement. Compliance for Planned Care is improving, and they have made considerable progress with their recovery plan this is now to be shared across other areas and at DQ Subgroup in May, to replicate and drive improvement further.
	Stabilisation of clinical coding workforce	Nov-24	Jan-25	Off Track	**July 25 Update** This month admin academy has again been approached to scope options for internal training and uptake was not successful. Job descriptions and person specifications have been reviewed for external advertising and will go through VRF for consideration. As well as a further attempt to recruit conversations have also been held this month with MPFT who outsource coding. This has been explored previously but this means that this option can be revisited and scoped with procurement. This month operational teams are meeting the company used by MPFT to explore feasibility, cost and time frames for implementation. If successful a procurement process will then commence mid August.
	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	Jan-25	Jul-25	On Track	**July 25 update** A session has taken place in June as part of the recovery action plans to provide a quality facilitated programme to lead the education of staff in the way forwards and understand importance of ethnicity reporting. This need to expand as a rolling piece of work and currently ops are working with Comms to provide a comms message to go out mid August. 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. Teams this month have been informed of importance of this and auditing has taken place to understand where teams are using these domains incorrectly and support provided to correct. Improvements in June have been seen in MSST following the work completed 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 Ethnicity was missing from, to work through and update. Included on core scripts when seeing patients of questions to ask. MSST are also continuing to align My Recovery to assist with sending out questions to patients as part of their work around FFT, etc. Working with Rio team to look at the use of EBO and whether that can populate Ethnicity as part of Demographic checks and pull of information. CYP&F have developed champions to promote the importance of Data Quality, including Ethnicity, which includes attending DQ Subgroup on a rota basis and cascading issues from the performance meetings through team meetings, etc. This will be rolled out to all divisions by end of July.

	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	**July 25 Update** Monthly meetings in place. Awaiting future months SUS DQ Dashboards in order to assess evidence of impact. A step by step guide is now in draft and will be disseminated to all teams to share with relevant staff. A drill down session with further education has also been arranged for August.
Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas	**Date**	09/07/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	15/07/2025			

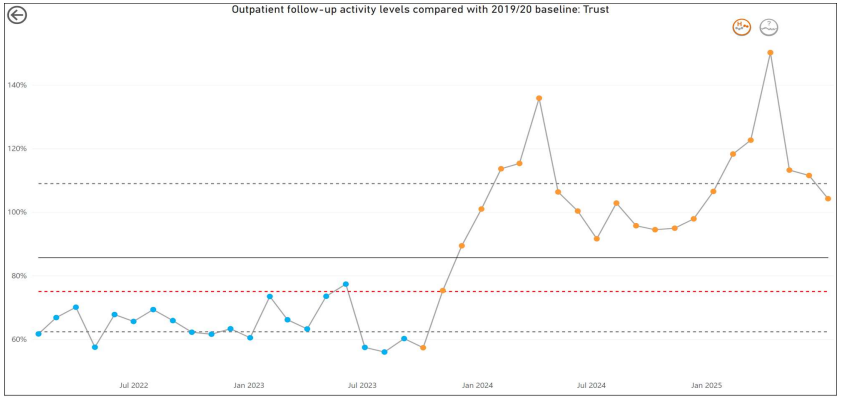
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Outpatient follow-up	%	118.24%	122.60%	150.15%	113.18%	111.49%	104.56%	109.65%
	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 overperforming at 16.7% 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	Jun-25 (Rounded to 0 dp)
APCS	71%
Bridgnorth Outpatients	57%
DAART	85%
Ludlow Outpatients	77%
MSST	15225%
TEMS	0%
Whitchurch Outpatients	31%

Plan

	Start Date	End Date	Status	Outcome
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	**July 25 Update** New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer was completed on the 12th June.
Continue to focus on rolling out PIFU across wider services and utilise the learning from other teams. Significant progress has been made in MSST which has helped support increase utilisation in other services, such as APCS and community outpatients.	Jun-25	Sep-25	On Track	**July 25 Update** Significant increase already starting to be seen in APCS (now at 14%) and an increase within areas of community outpatients. PIFU will cotninue to be a foucs as part of the admin productivity project to help focus on increasing utilisation across other services.

Action	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	**July 25 Update** This month briefing taken place with team re options to use PIFU and working with informatics to ensure this is a recorded field through RIO. Definition of follow up activity shared with team to support improvement in data capture. Information analyst for DAART to establish reports to support and provide feedback loop to the teams in terms of performance. Plan also established this month with Daart clinical lead re feedback and discharge back to primary care to support follow up in most appropriate setting.
Author	Alastair Campbell/Helen Cooper/Edliz Kelly/Jade Thomas	**Date**	09/07/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	15/07/2025			

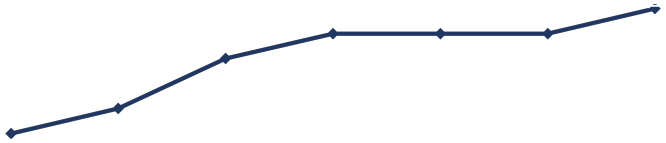
Exception Report - Action Plan

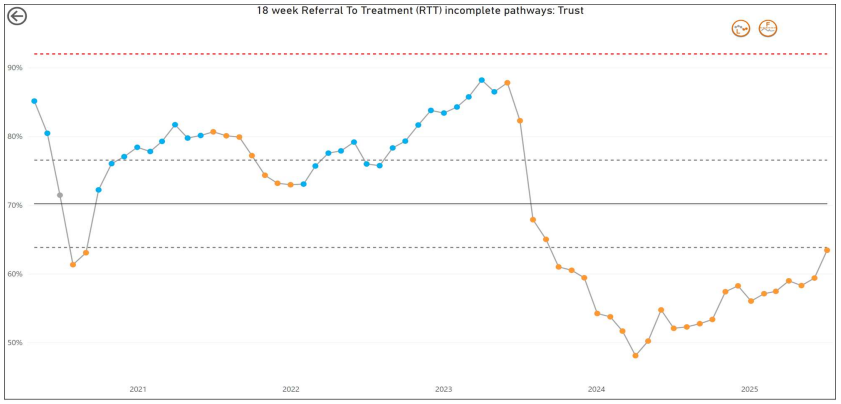
18 week Referral To Treatment (RTT) Incomplete Pathways

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
RTT Incomplete Pathways	%	57.09%	57.44%	58.97%	58.28%	59.38%	63.42%*	63.42%*
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

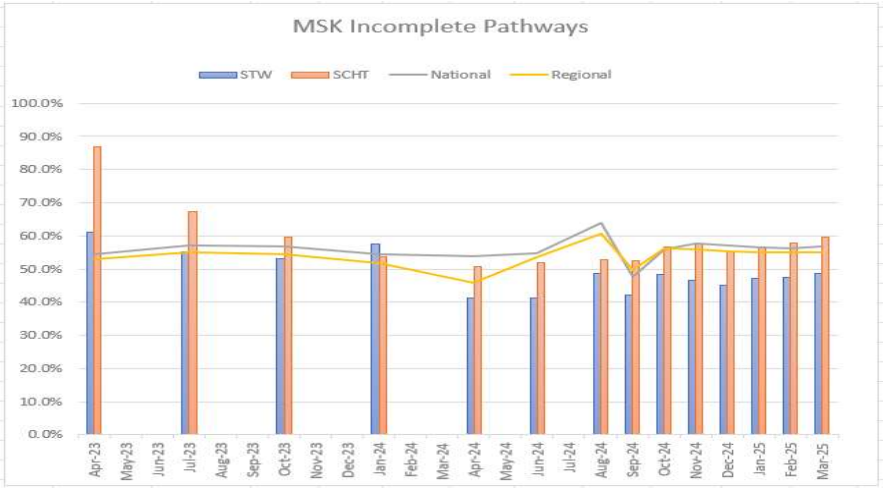
Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
%	60.5%	61.0%	62.0%	62.5%	62.5%	62.5%	63.0%





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	Feb-25	Mar-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%	47.5%	48.7%
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%	57.7%	59.5%
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%	56.3%	56.7%
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%	55.1%	55.1%

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 improved by 4.04% with the position currently being unvalidated. Overall improvement in recovery has been seen since December. 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. Current performance against the trajectory provides a high level of confidence that 65% by the end of March 2026 is achievable. Following initial delays the transfer of the TeMS orthopaedics service has now been completed. MSST has experienced ongoing issues with capacity within Level 3 which is the highest contributing factor to the risk of 52 weeks and overall RTT performance. Demand and capacity modelling shows that capacity meets demand however this does not account for the current backlog. Work has been ongoing to increase capacity with the use of an insourcing company to support recovery of this backlog through superclinics. The first of these was succesfully undertaken in June with circa 100 patients being seen. There are plans for further dates through to September. APCS and GA Dental continue to make progress with reducing the number of patients at the top end of the pathway. APCS longest wait is 38 weeks and Dental is 39 weeks. Community Hospital Outpatients has a number of patients across the waiting list with 8 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 and Respiratory. 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. Discussions continue to be have with system partners about how to streamline and approve some these serices across the system with particualr focus on ENT.

Action Plan		**Start Date**	**End Date**	**Status**	**Comments**
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	**July 25 update** New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer was completed on the 12th June.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.
	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	Complete	**July 25 update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	09/07/2025
Accountable Officer Approval	Claire Horsfield	**Date**	15/07/2025

**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

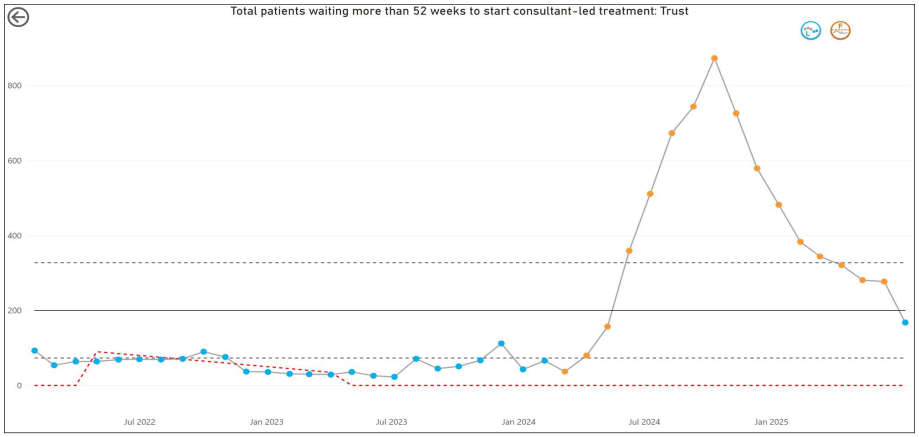
Total patients waiting more than 52 weeks to start consultant-led treatment

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
RTT 52+ week waits	Number	383	344	321	281	277	168	168
	Target	0	0	0	0	0	0	0

*unvalidated position

Trajectory	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Number	150	300	150	0	230	100	80



Reason for performance gap:	This is the ninth 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 and the dealys in TeMS transfer this was not possible. The trajectory has been reivewed, stress tested and revised with the aim of implementing additional capacity for Level 3 MSST via superclinics that went live in June and will then support zero 52 weeks for the MSST service by the end of October. The revised date for October will support to mitigate the ongoing risk of 52 week breachesl in August due to ongoing challenges accessing diagnostics and capacity.Work has commenced in partnership with SaTH to work this through further aligning to the contracted amount of sessions, additional clinics as appropriate and a combined plan to support and streamline diagnostic access. 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**
Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 Update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.

Action Plan	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	Complete	**July 25 update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase APP capacity to manage spike in demand whilst D&C is complete		Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	09/07/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025			

**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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Proportion of patients within 18 weeks	%	62.39%	63.02%	64.15%	65.89%	66.29%	68.07%	68.07%
	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 continued to improve with a further 1.78% 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. There is a high demand in the waiting lists for APP patients post their first treatment and 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. Following a successful round of recruitment a Paediatrician has now been appointed has commenced. Successfull recruitment to a speciality doctor post sees further addition clinical capacity to the team in May 25. 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. The deteriation in performance Diabetic nursing is due to sickness, vacancies and use of temporary staffing to meet demand, there will be a focused piece of improvement work that will be operationally led to look at triage, follow-ups and more productive ways of working. There are other services which contribute to not meeting this performance target such as APCS, Dental, CNRT, Continence, Bridgnorth Hospital Day case, Adult Physio, Paediatric Physio, Interdisciplinary Teams, Pulmonary Rehab and Wheelchair Services.

		Start Date	End Date	Status	Outcome
Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	**July 25 Update** New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer was completed on the 12th June.
	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	Complete	**July 25 Update** 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 commenced. June 25.
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. **July 25 Update** The intention was to have 0 52 weeks by end of June however due to a delay in the external provider going live the end date for delivery has been extended to end of July with a plan to have 0 65 week waits by close August and 0 65 by close of September.
	Increase capacity to deliver SOGS to all children waiting over 52 weeks and release clinical time for Comm Paediatricians to manage waits	Apr-25	Aug-25	Complete	**July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Intitial appointments using new SOG process are booked in July. Audits to take place at the end of August
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 Update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.
	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	Complete	**July 25 Update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 Update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	09/07/2025
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025

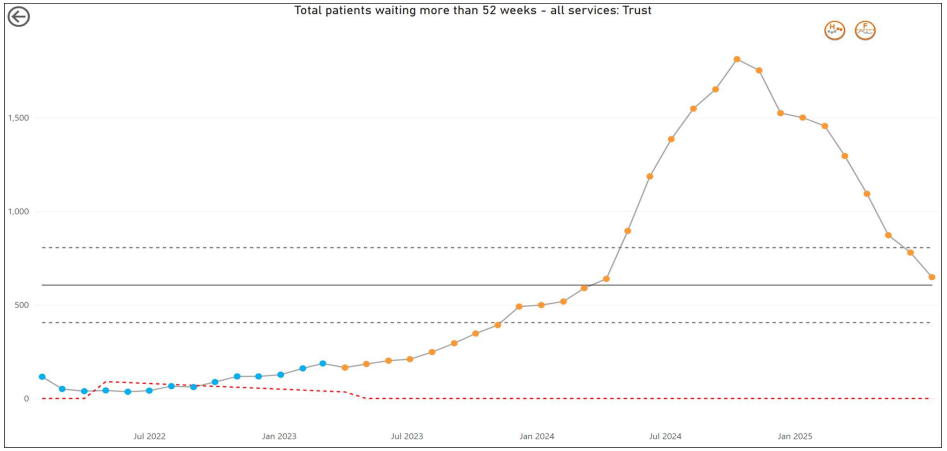
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
52+ Week waits - All services	Number	1455	1295	1093	872	779	648	648
	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 in line with trajectory. This progress has been driven through efficiency gains with digital solutions and admin process driving productivity. CNRT have a number of patients within the 52 weeks KPI 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. 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 Neurpsychologist started in the service in April 25 with high week waits 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. There is a high demand in the waiting lists for APP patients post their first treatment and 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. The superclinics started at the end of 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 59 children waiting to be seen at 52 weeks or above this is an decreasing picture (13 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. Recovery has been dependent upon enhanced locum support within Community Paediatrics with the assumption that this will remain. There are regular meetings with the team to review the waiting list and clinical priorities, new speciality Doctor has started with increased capacity moving forward to continue to reduce the 52 week cohort. Trajectory is 0 52 week waits by October 2025 CDC (Child Development Centre) is currently holding 40 children above 52 weeks. 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 June with a plan to reduce month on month and achieve 0 52 weeks by November. Speech and Language therapy also have a cohort over 52 weeks and now have 93 children. This is due to an increase in clinically urgent referrals and staff vacancies in the team impacting clinics. A demand and capacity piece of work has been completed leading to some reduction of waits within certain caseloads. An enhanced triage tool is also being implemented to support waiting list management. The service trajectory plans for 0 52 weeks by November. There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients, APCS, Diabetic Nursing, Interdisciplinary Teams, Community Nursing, Podiatry, Pulmonary Rehab and Wheelchair Services

		Start Date	End Date	Status	Outcome
Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Complete	**July 25 Update** New Referrals ceased coming into TeMS 14th February. MBI validation of TeMS has been completed and transfer was completed on the 12th June.
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. **July 25 Update** The intention was to have 0 52 weeks by end of June however due to a delay in the external provider going live the end date for delivery has been extended to end of July with a plan to have 0 65 week waits by close August and 0 65 by close of September.
	Increase capacity to deliver SOGS to all children waiting over 52 weeks and release clinical time for Comm Paediatricians to manage waits	Apr-25	Aug-25	Complete	**July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Intitial appointments using new SOG process are booked in July. Audits to take place at the end of August
	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	Complete	**July 25 Update** 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 Revise analysis of management of complex needs caseload	Jun-25	Sep-25	On track	**July 25 update** Revised triage has reduced the waiting list for waits between 41 and 52 weeks due to their pathway journeys. The complex pathways have seen an increase due to capacity and specialism of staff. Renewed triage on complex pathways with a view for holiday initiatives are being planned.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.
	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	Complete	**July 25 update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 Update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.

Author	Alastair Campbell/ Helen Cooper /Gemma McIver	**Date**	09/07/2025
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025

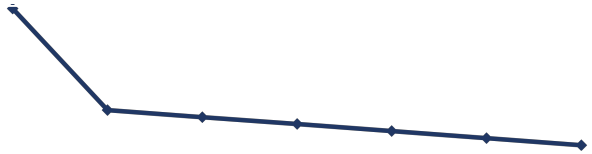
Exception Report - Action Plan

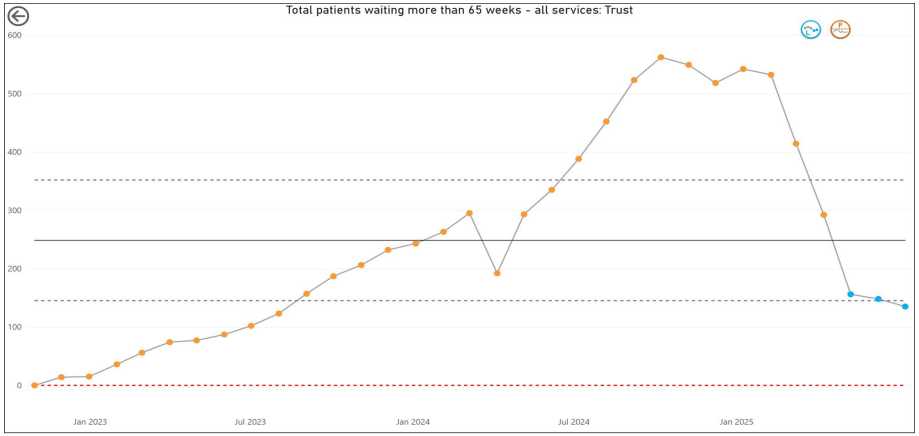
Total patients waiting more than 65 Weeks – All services

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

KPI Description	Latest 6 months	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
65+ Week waits - All services	Number	532	414	292	156	148	135	135
	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 but is not in line with trajectory. Rapid imporvement was seen throughout March and April due to the transfer of TeMS Orthopaedics and increased activity within MSST due to clinical validation. With the implementation of the super clinics in MSST in June and the plan for July and August the aim is to be back in line with trajecotry by end of August. 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. 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 waits and clinical need being priority enabling the high waits to significantly reduce.The trajectory for this service will have 0 65 weeks by end of November.At service leve they are on track to achieve this. Just over half 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. There is a high demand in the waiting lists for APP patients post their first treatment and to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity. There has been an improvement in the 65 week wait position for Community Paediatrics with 27 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. The trajectory for this service will have 0 65 weeks by end of September.At service leve they are on track to achieve this. CDC (Child development Centre) has decreased from 18 to 9 65 week waits in June. Nursery Nurses continuing to support assessment processes. The trajectory for this service will have 0 65 weeks by end of August at service leve they are on track to achieve this. Speech and Language therapy have seen a decrease in over 65 weeks and now have 1 which has decreased from 4 in May. 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 has been completed in month leading to a reduction in overall waits. An enhanced triage tool has also being implemented to support waiting list management. The service trajectory plans for 0 65 weeks by end of July and the service are on track.

		Start Date	End Date	Status	Outcome
Action Plan	SLT to implement an enhanced Triage offer	Jan-25	Jun-25	Complete	**July 25 update** 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 Revise analysis of management of complex needs caseload	Jun-25	Sep-25	On track	**July 25 Update** Revised triage has reduced the waiting list for waits between 41 and 52 weeks due to their pathway journeys. The complex pathways have seen an increase due to capacity and specialism of staff. Renewed triage on complex pathways with a view for holiday initiatives are being considered
	CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	On track	Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. **July 25 Update** The intention was to have 0 52 weeks by end of June however due to a delay in the external provider going live the end date for delivery has been extended to end of July with a plan to have 0 65 week waits by close August and 0 65 by close of September.
	Increase capacity to deliver SOGS to all children waiting over 52 weeks and release clinical time for Comm Paediatricians to manage waits	Apr-25	Aug-25	On track	**July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Intitial appointments using new SOG process are booked in July. Audits to take place at the end of August
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 Update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.
	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	Complete	**July 25 Update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 Update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	09/07/2025
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025

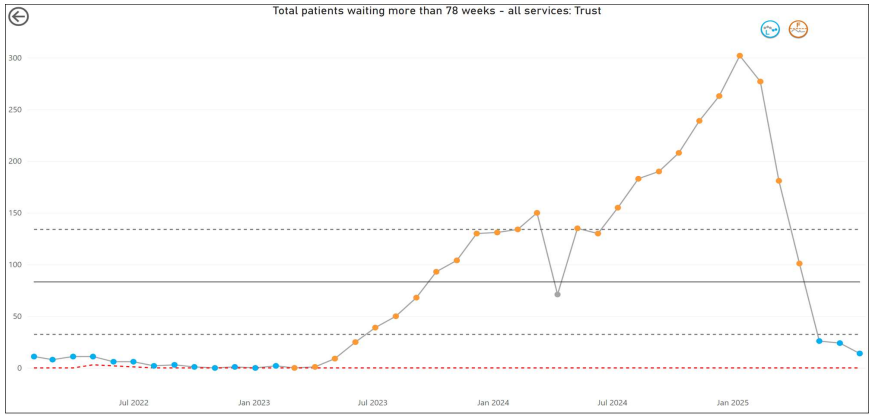
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
78+ Week waits - All services	Number	277	181	101	26	24	14	14
	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 and is ahead of the trajectory. The main challenge with recovery from a MSST 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. There is a high demand in the waiting lists for APP patients post their first treatment and to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity. 7 children within children's services align to 78+ cohort and all have appointments to be seen by early September, the harms process has been adhered to. There are other services which contribute to not meeting this performance target such as, Community Hospital Outpatients.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Off Track	**July 25 Update** The digital systems proposed were My Recovery and Strata to support MSST waiting list management. The Initial implementation date was October this was extended to March for My Recovery which is now live. Strata (referral management system) was the initial digital plan for MSST as part of the transformation programme. Strata currently in process of User Accepting Testing and it will go live August.
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Off Track	The initial findings of D&C completed in Q4 have demonstrated that level 3 profiling is now more in line with original assumption. Therefore, the focus has been to continue to be on reducing long waits and overall waiting lists to better understand demand and supporting a long-term sustainable service with a workforce plan attributable to each Level 2 and 3. **July 25 Update** D&C modelling will be revised in July to assess impact. Additional hours have been planned by Level 3 and Level 2 staff to support recovery through to September as part of the super clinics waiting list initiative.

	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	Complete	**July 25 Update** MSST have implemented 18 weeks a company who will provide 8 super clinic sessions working with MSST clinicians to (ensure good governance) from July to September. This will equate to an increase of 1500 new appointments. The first super clinic was completed 27th June with circa 100 patients being seen.
	Increase capacity to deliver SOGS to all children waiting over 52 weeks and release clinical time for Comm Paediatricians to manage waits		Apr-25	Aug-25	On track	**July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Intitial appointments using new SOG process are booked in July. Audits to take place at the end of August
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	09/07/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	15/07/2025			

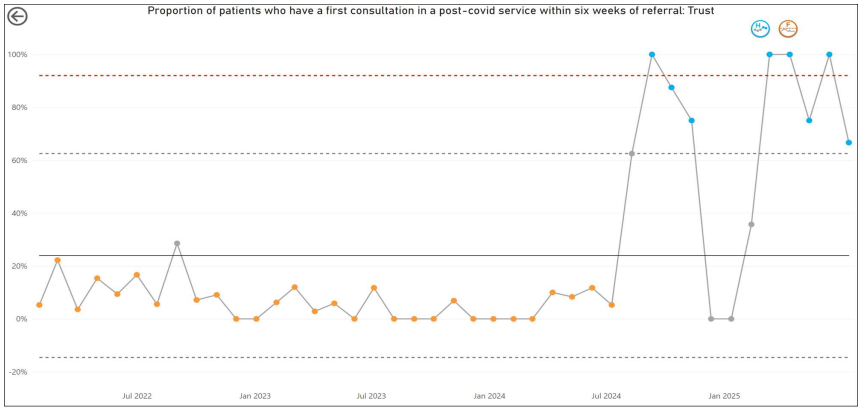
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Proportion of patients within 6 weeks	%	35.71%	100.00%	100.00%	75.00%	100.00%	66.67%	80.00%
	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 with only 1 patient on the waiting list over 6 weeks and this is attributable to patient choice.
This small number of patients on the wating list will therefore reduce movement of the reported percentages making performance often appear far from target when this is only attributable to less than 5 patients.

The service has seen a considerable drop in demand and high levels of DNA's (Did not Attend). Current referrals are on average 5 a week for same period this time last year the service were working at around 20 a week. The current case load of patients still receiving active interventions in form of therapy, medical intervention, holistic advice and group work remains at C100. With patients reamaining on the service on average for 6 months. The service then utilise PIFU (Patient initiated follow up) effectively with 95% PIFU rates to support discharge and avoid unnecessary follow up appointments, empowering patients and effectively managing clinic utilisation.

Conversations with commissioners are live regarding future longevity and design of the service. To help ease primary care pressures and address health inequalities, shown by research to affect long COVID risks and experiences—the service has launched a self-referral pathway. The referral pathway will be available to all but will specifically also target through dedicated comms and community events those for example with lower socio-economic groups, females and ethnic minorities more likely to have a higher prevalence for long covid. Learning from this targeted health population support will then be taken to support other services as appropriate.

Digital is also fundamental to the self-referral process and reducing the levels of DNA's as such the SMS service is continuing to develop. Self-referral will be accessed on the Elaro's digital platform which is an app, as well as via telephone for those less comfortable with accessing IT or smart phone technology. An evaluation will be completed after a three-month pilot to support with longer term plans for the service.

on Plan

	Start Date	End Date	Status	Outcome
Implement Self-Referral	Jul-25	Sep-25	On track	**July 25 update** Processes being tested to ensure effective before full roll out in September. The evaluation will go back to QEIA in October.
Roll out education programme for long covid to SCHT clinical teams and promote self referal	Jul-25	Sep-25	On track	**July 25 update** Roll out programme developed, internal comms messages drafted and plan to also share with SaTH

Acti	Community promotion events for self referall arranged through neighbourhood meeting and networks	Jul-25	Sep-25	On track	**July 25 update** Plans to vist community hubs, places of workship, libraries etc and also roadshow primary care network events.
	Implement SMS appointment reminders	Mar-25	May-25	Off track	Letters are being reviewed to include the necessary opt out statement. Once complete the SMS reminder setup can be established. **July 25 update** Date for completion of this task is 31.07.25.

Author	Alastair Campbell	**Date**	12/06/2025
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025

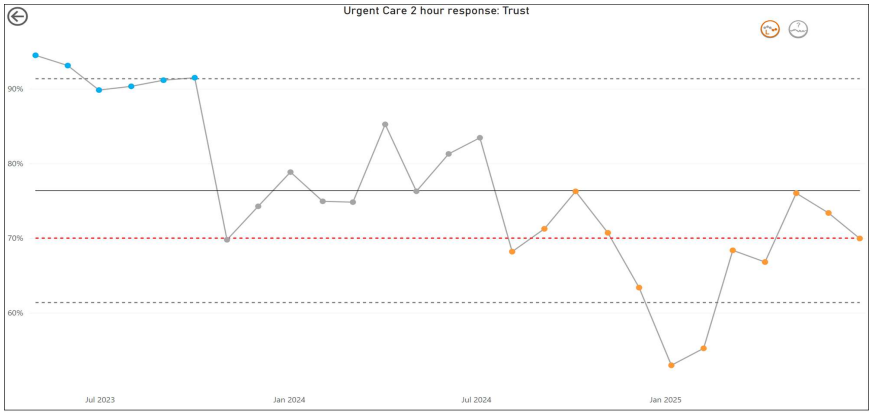
Exception Report - Action Plan

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD
Urgent Care 2 hour response	%	55.25%	68.37%	66.81%	76.02%	73.37%	69.96%	69.96%
	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:	Internal data indicates that we are very close to achieving the 70% target. Nationally when the data has been reported by NHSE the performance is considerably above at 88%. This is being reported through the national dashboard and places SCHT at the 2nd quartile in terms of performance. As a Trust (with other Trusts) we are actively working with NHSE to understand the difference in internal/ external reporting and how the first and second scheduled submissions impact against internal performance reporting. This is a national challenge. Current performance is above the national 2-hour target and although internal data indicates that we are underperforming marginally NHSE are confident with the validation and current high level of performance against the national target. Internally there is a plan to scope how we can align our reporting to the national platform. Although performance is in a good position it has declined throughout the Summer which was attributed to data quality challenges, seasonality and the change in the out of hours contract. It is important to note that even when the national target was not met, 100% of activities were responded to within 4 hours evidencing overall effectiveness of the service to avoid admissions. The rejection rate has also remained consistently low and praised at a regional level.

	Start Date	End Date	Status	Outcome
To confirm the ICB service review date, outcome and recommendations regarding future commissioning intentions on emergency falls since the pilot EMED project ended April 2025.	May-25	Jul-25	On track	**July 25 Update** Awaiting response from ICB re the named commissioner leading on project evaluation and outcomes. Monitor rejection rate to determine impact on loss of the service.
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	Complete	**July 25 Update** Data quality reports 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

Action Plan	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 **July 25 Update** Initial review of SPC against certain measures has been conducted with CSM and Information Team. Further scoping required for understanding whether a full D&C Model is required.
	It has been observed that differences have been found between national and local data reporting. The Information Team has been assigned to reconcile internal Urgent Community Response (UCR) data with national datasets. This involves identifying discrepancies, validating data accuracy, and supporting decision-making through improved data integrity. The team will extract and compare datasets, perform detailed field-level checks, and document findings. The outcome will be a reconciled dataset, a summary of discrepancies, and recommendations to enhance future reporting processes.	Jul-25	Aug-25	On Track	**July 25 Update** The Information Team will start the process. Operationsal Lead has met with BI colleagues to begin discussing the issue. Information Team have reviewed the datasets and carried out reconcilliation between local data and the national benchmarking. The KPI included in the Performance Framework is based on the number of UCR 2 Hour referrals and the percentage that then receive a response in 2 hours. The national benchmarking is a different approach that focuses on a retrospective view with performance based on those 2 hour UCR referrals seen in month and the percentage of those within 2 hours This measure was introduced locally and now that the new Oversight Framework is published, it will be reviewed accordingly. Further detail behind the new definition has been requested from NHSE
	A Task and Finish group will be mobilised to review the operational processes and working practices between the Care Home MDT and UCR. The aim is to support improvement in care home referrals to UCR services and achieve 2-hour UCR response times. Additionally, a PDSA will be developed to increase the referral rate from the care home team to UCR.	Jun-25	Aug-25	On track	**July 25 Update** PDSA recommendations to be implemented to support the 2 hour response times for UCR. Care Home MDT has moved to UCR division and therefore alignment will be a seamless process.

Author	Sarah Robinson / Edliz Kelly	**Date**	16/07/2025	
Accountable Officer Approval	Claire Horsfield	**Date**	16/07/2025	

Shropshire Community Health NHS Trust

Month 3 2025/26 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	7 August 2025
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	21 July 2025
Paper Reviewed by:	Resource & 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 the Trust Board and what input is required?

This paper presents key financial information in relation to our financial performance as at month 3 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 £4,975k, 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 June 2025 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £292k adjusted surplus for month 3 compared to the planned surplus of £289k, which is a small favourable variance of £3k.

Key areas for consideration are:

- **Agency -** spend is £693k after three months of the financial year; this is £150k favourable to plan. The reduced agency spend is due to continuing controls and scrutiny and prioritising bank staff use to cover clinical shifts. The agency plan becomes more challenging as the year progresses and sustaining this position is therefore important. Agency remains a key area of external scrutiny, and the Agency Scrutiny Group is focused on maintaining agency spend within plan without compromising patient safety. **Agency usage must remain within overall planned pay levels to deliver the financial plan.**

- **Bank pay** spend is £1,087k after three months of the financial year; this is £348k adverse to plan. The overspend is due to a higher level of vacancies than planned and staffing of unplanned escalation beds. Bank pay is a key area of external scrutiny this financial year, and the Vacancy Control Panel is focused on reducing bank staff spend as far as possible without compromising patient safety. **Bank usage must remain within overall planned pay levels to deliver the financial plan.**

Month 3 2025/26 Financial Performance

- **CIP** delivery at month 3 is £1,090k, £34k favourable to plan. Delivery of the Trust's £5,359k annual cost reduction target for 2025/26 remains a significant financial risk; although the Trust has now de-risked all high risk schemes and the medium risk schemes reduced by £357k in month 3 to £1,133k. **The Trust must deliver the CIP target in full to deliver the financial plan.**

- **Cost pressures –** there are ongoing cost pressures in Prison Healthcare, Rehab and Recovery Units (RRUs) and unplanned inpatient escalation beds and teams have developed plans to mitigate these pressures where possible. **The Trust must mitigate all current and arising cost pressures during the year to deliver the financial plan**.

- **Risk** – At month 3 the Trust is reporting all financial risks are fully mitigated on the basis that we are early in the financial year and have sufficient time to develop and deploy mitigating actions as required. The level of financial risk has reduced since month 2; this is largely in relation to the continued de-risking of our CIP programme.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 3 is a surplus of £292k compared to the planned surplus of £289k, which is a favourable variance of £3k.
- **Recognise** that overall pay cost must remain within planned levels to ensure we deliver our financial plan, the key to which is containing bank and agency spend within our targets for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m with no schemes currently 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.

Month 3 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 as at Month 3.

Financial Performance against Plan (£k)	M03 Plan	M03 Actual	M03 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast	Annual Variance
(Surplus)/ Deficit In Year	(138)	(140)	(2)	(289)	(292)	(3)	(2,000)	(2,000)	0
Underlying Position	(58)	(89)	(31)	(48)	(102)	(54)	(932)	(932)	0
Agency Expenditure	279	207	(72)	843	693	(150)	2,939	2,939	0
Bank Expenditure	239	343	104	739	1,087	348	2,736	2,736	0
Cost Improvement Programme	372	377	5	1,056	1,090	34	5,359	5,359	0
Capital Expenditure	100	259	159	100	615	515	2,818	2,818	0

3.2. Adjusted Financial Performance – favourable variance to plan £3k

The adjusted financial position at month 3 is a surplus of £292k compared to the planned surplus of £289k which is a favourable variance of £3k. Table 1 summarises the position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(32,200)	(32,323)	(122)
Expenditure excl. adjusting items	31,911	32,030	119
Adjusted financial performance total	**(289)**	**(292)**	**(3)**
Adjusting items	32	32	(0)
Retained (surplus) / deficit	**(257)**	**(261)**	**(4)**

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

3.2.1. Income – favourable variance to plan £122k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System income	(25,153)	(25,160)	(8)
Non system income	(7,048)	(7,162)	(115)
Total income	**(32,200)**	**(32,323)**	**(122)**

Table 2: Income Summary as at 30 June 2025

Month 3 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 ICB (STW ICB).

Data for elective activity is not yet available; therefore, variable income is assumed to be in line with plan for month 3 reporting.

3.2.2. Expenditure – adverse variance to plan £119k

Table 3 shows a summary of expenditure by key categories.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	21,981	21,561	(420)
Bank	739	1,087	348
Agency	843	693	(150)
Total Pay	**23,563**	**23,341**	**(222)**
Supplies & Services Clinical	2,737	3,025	288
Prison Escorts and Bedwatch	66	109	44
Drugs	354	340	(14)
Premises	2,412	2,321	(91)
Travel	421	352	(69)
Other	1,302	1,562	260
Non-Pay	**7,292**	**7,709**	**417**
Trust-wide Central Charges	1,088	1,012	(76)
Total Non-Pay	**8,381**	**8,721**	**341**
Total Expenditure	**31,943**	**32,062**	**119**

Table 3: Expenditure Summary as at 30 June 2025

3.2.3. Pay – favourable variance to plan £222k

The overall pay position is a favourable variance of £222k. This is due mainly to pay underspends linked to substantive vacancies. The substantive pay underspend is partially offset by bank spend; bank staff (paid at substantive rates) are utilised to cover vacant shifts wherever possible, to avoid the use of agency staff. Pay spend also includes £66k temporary staffing to cover unfunded inpatient escalation beds. This overspend is currently offset by underspends elsewhere within the position, but mitigation is required to ensure that this unplanned cost does not result in a risk in relation to delivery of our financial plan.

Bank spend was £343k in June, £104k adverse to plan. Year to date bank spend is £1,087k, £348k adverse to plan, and represents 4.7% of total pay compared to plan of 3.1%. The overspend is due to higher level of vacancies than planned. The annual plan is £2,736k, 2.9% of the overall pay plan. It is of note that after 3 months of the financial year, 40% of the annual Bank financial plan has been spent.

Agency spend was £207k in June, £72k favourable to plan. Year to date agency spend is £693k, £150k favourable to plan, and represents 3.0% 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 agency annual plan is £2,939K, 3.2% of the Trust's total pay budget.

Month 3 2025/26 Financial Performance

The vacancy rate in June was 9.14%, a reduction from 10.9% in March 2025, which equates to 164 WTE vacancies, however it should be noted that there were 116 WTE of temporary staff (82 bank and 34 agency) utilised during the month with the majority covering clinical vacancies.

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.

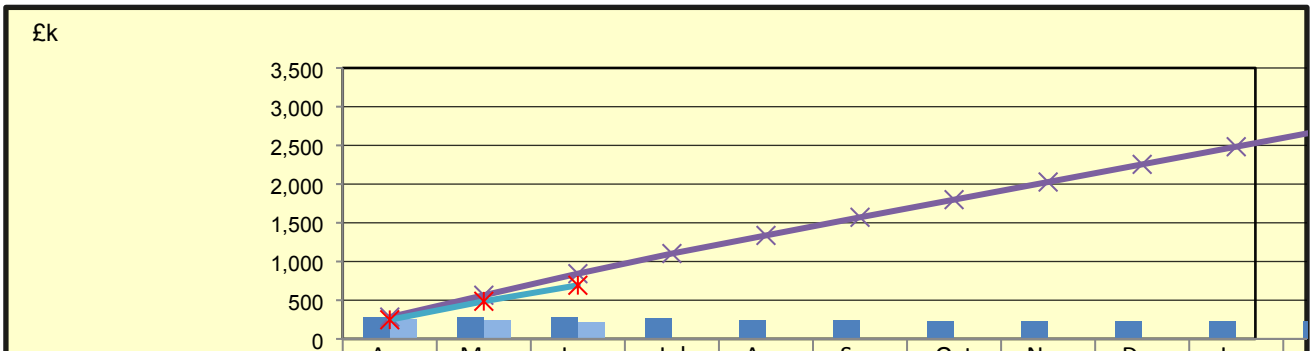
3.2.4. Non-Pay and Central Charges – adverse variance to plan £341k

There are continuing cost pressures in the Prison Healthcare service and the RRUs which are the key reasons for the non-pay overspend. We are continuing to pursue the identified mitigations to minimise the impact on the Trust's financial position.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £150k

Table 4 shows agency spend is £693k compared to the plan of £843k, which is a favourable variance of £150k. The underspend is due mainly to continuing controls and scrutiny on request for agency usage and prioritising bank use ahead of agency staff to cover clinical shifts. The favourable position is also influenced by the skill mix of agency staff utilised being weighted towards the lower pay scales. Agency workers were employed to cover unfunded escalation beds, and we are working with system partners to find a clinically safe solution that will remove this cost pressure.

The target for the year is £2,939k with monthly expenditure decreasing to £228k from month 7. The favourable position will need to be maintained as far as possible since there is no allowance for the added pressures of 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	239	207							
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	486	693							

Table 4: 2025/26 Agency and Locum Expenditure

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.

Table 5 shows overall CIP delivery of £1,090k as at month 3, which is £34k favourable to plan.

Month 3 2025/26 Financial Performance

	Plan YTD £k	Actual YTD £k	Variance YTD £k
Recurrent	698	717	19
Non-recurrent	358	373	15
TOTAL	**1,056**	**1,090**	**34**

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

Recurrent delivery as at Month 3 is £717k, which is £19k favourable compared to the recurrent plan of £698k. Non-recurrent CIP delivery is £373k, which is £15k favourable to plan.

Positive progress is being made in relation to the delivery risk of our CIP. At month 3, Table 6 shows that we have fully identified schemes to deliver the 2025/26 CIP target and that all high risk schemes in terms of delivery have been de-risked. The focus now is de-risking medium risk schemes which reduced by £357k in month 3 to £1,133k.

Recurrent / Non Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total Forecast £k	Total Plan £k	Full Year Effect CIP £k
Recurrent	2,943	631	0	0	3,574	3,574	3,574
Non Recurrent	1,285	500	0	0	1,785	1,785	-
	4,228	**1,131**	**0**	**0**	**5,359**	**5,359**	**3,574**
Risk Percentages							
Recurrent	55%	12%	0%	0%	67%		
Non Recurrent	24%	9%	0%	0%	33%		
	79%	**21%**	**0%**	**0%**	**100%**		

Table 6: CIP 2025/26 full year breakdown

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 June 2025 is shown in Table 7.

	31 May 25 Balance £k	30 June 25 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,557	42,422	(135)
Inventories	205	205	0
Non-current assets for sale	0	0	0
Receivables	3,901	3,175	(726)
Cash	27,166	27,936	770
Payables	(12,928)	(12,772)	156
Provisions	(3,800)	(3,800)	0
Lease Obligations on Right to Use Assets	(11,384)	(11,322)	62
TOTAL ASSETS EMPLOYED	**45,717**	**45,844**	**127**
Retained earnings	36,350	36,477	127
Other Reserves	9,367	9,367	0
TOTAL TAXPAYERS' EQUITY	**45,717**	**45,844**	**127**

Table 7: Statement of Financial Position as at 30 June 2025

Month 3 2025/26 Financial Performance

- Receivables (amounts we are owed) decreased by £726k due mainly to payment of outstanding contractual payments
- Payables (amounts we owe) decreased by £156k which is in line with usual monthly movements
- Cash increased by £770k largely as a result of the above changes.

All movements are within the expected monthly range and there are no exceptions to bring to Trust Board's attention currently.

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 were submitted to NHSE as part of the Trust's financial plan.

At Month 3 actual spend was £721k compared to planned spend of £1,117k. This is mainly due a lease still progressing through the legal process as at month 3. This lease is now forecast to complete in Month 4. Table 8 sets out capital expenditure for the year to date compared to our plan.

Capital Expenditure	Annual Plan £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Operational capital	2,818	100	615	515
IFRS 16 Leases	2,157	1,017	106	(911)
	4,975	**1,117**	**721**	**(396)**

Table 8: 2025/26 Capital Expenditure as at 30 June 2025

3.2.9. 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 year to date position at month 3 is £54k favourable to plan. The favourable variance is due mainly to recurrent CIP and income overperformance. The months ahead will become increasingly challenging, therefore it is vital that we do not fall behind against our recurrent plan in any month as recovering any shortfall will be difficult.

The non recurrent year to date position is a surplus of £190k which is £51k adverse to plan mainly due to escalation costs and a small number of cost pressures, which are assumed to be non-recurrent issues; these pressures were partly mitigated by non-recurrent pay savings.

Table 9 shows the underlying and non-recurrent position year to date and full year.

	YTD Plan £k	YTD Actual £k	Variance £k	Annual Plan £k	Forecast £k	Variance £k
Recurrent/underlying financial performance	**(48)**	**(102)**	**(54)**	**(932)**	**(932)**	**0**
Non-recurrent financial performance	(241)	(190)	51	(1,068)	(1,068)	0
Adjusted financial performance total	**(289)**	**(292)**	**(3)**	**(2,000)**	**(2,000)**	**0**

Table 9: 2025/26 Underlying financial position as at 30 June 2025

T

Month 3 2025/26 Financial Performance

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

3.2.10. Forecast Outturn and Financial Risk

At this early stage of the financial year, a summary forecast has been prepared which indicates that the Trust should deliver its financial plan, subject to mitigating financial risks.

At month 3 the Trust is reporting all financial risks are fully mitigated on the basis that we are early in the financial year and have sufficient time to develop and deploy mitigating plans as required.

The level of financial risk has reduced since month 2; this is largely in relation to the continued de-risking of our CIP programme. Our forecast outturn and financial risk assessment is overseen through the Resource and Performance Committee at each of its meetings.

3.2.11. Monthly Monitoring Return to NHSE and NHS Oversight Framework

The Provider Financial Return (PFR) was submitted to NHSE on 15 July 2025 in line with the national timetable.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 3 is a surplus of £292k compared to the planned surplus of £289k, which is a favourable variance of £3k.
- **Recognise** that overall pay cost must remain within planned levels to ensure we deliver our financial plan, the key to which is containing bank and agency spend within our targets for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m with no schemes currently 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.

Shropshire Community Health
NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**7 August 2025**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	30 July 2025
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

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

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

- Updates are provided in relation to delivery of the objectives as at Q1
- Updates are provided on actions being taken to address identified control / assurance gaps
- The risk in relation to insufficient capital funding has been considered by the Resource and Performance Committee and is recommended for closure
- The Audit Committee requested a colour coding for the actions to assist with oversight of the completion:

Completed	
On track	
Missed original deadline but new deadline agreed with Committee and on track to hit the new deadline	
Overdue	

The Board is asked to consider the following:

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

Conclusion

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

Board Assurance Framework

BAF Risk Tracker

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

Board Assurance Framework

4.1	Operational capacity to undertake all programmes of work	Sep 23	20	20	20	15	15	15	15	15	15	15	15	15	15	↔	10
4.2	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	15	15	15	15	15	15	15	15	15	15	15	↔	5
5.1	Cyber attack	Sep 23	12	12	12	12	12	12	12	12	12	12	12	12	12	↔	6
5.2	Digital Capacity	Sep 23	20	20	20	12	12	12	12	12	12	12	12	12	12	↔	8
5.3	Costs exceed plan	Apr 22	20	20	12	12	12	12	12	12	12	12	16	16	16	↔	6
5.4	Insufficient capital funding	Sep 24	-	-	-	9	9	9	9	9	9	9	9	9	9	CLOSE	6

Risk Increasing		New Risk	
Risk Decreasing		Closed Risk	

Looking after our People — OBJ 1

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

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

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2025

Reviewed Date: July 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
- Action plans in place for all KPIs
- Wellbeing offering to staff continues and a focus in staff briefing on staff wellbeing and signposting

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- People promise resource available

Risks:

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

Lead Director:

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: July 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:

- A1: 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~~ Sept 2025	Collaborative working is underway with further opportunities being scoped, with benefits to be realised in 25/26. Management of change in progress, deadline extended to allow for consultation
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 – close action
A1	Review of agenda / workplan	Director HR and OD / Director of Governance	June 2025	Completed

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: July 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

Gaps in Assurance:

- 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~~ Sept 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~~ Sept 2025	

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

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

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

Risk Rating:

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

Risk Details:

Opened:	September 2023
Reviewed Date:	July 2025
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	

Controls:

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

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

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

Gaps In Controls:

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

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
A1	Ongoing staff engagement	Director of Governance	July 2025	Comms has been issued about flexible working and retire and return - completed
C1	Review of management of change policy	Director of HR	~~July 2025~~ Sept 2025	Management of change policy has been reviewed by the Executive Team and is going to JNP for consultation before final approval at People Committee

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: July 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, 1.2 and 1.3 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: July 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 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
- Falls reduced for the last two months
- Medication incidents have remained static
- Assessments for pressure ulcer damage included in CQUIN and improvements being seen

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF 3.2	Quality Improvement Team capacity
BAF 3.3	Completion of actions linked to learning responses
BAF 3.5	Potential for patient harm due to waiting times
BAF 3.6	Recruitment challenges

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

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

Principal Risk: Quality Improvement Team Capacity

Operational pressures impacting on staff engagement with QI training, ability to measure clinical quality strategy implementation

Risk Rating:

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

Risk Details:

Opened: October 2024

Reviewed Date: June 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	Number of trained staff has exceeded plan – close action
C2	Recruitment to quality posts	Director of Nursing	July 2025	Recruitment completed and post holders have started – close action

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

Principal Risk: Completion of actions linked to learning responses

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

Risk Rating:

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

Risk Details:

Opened: May 2025

Reviewed Date: July 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
- C3: Capacity of staff training in PSIRF to lead investigations

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 - completed
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 - completed
A1	Board Oversight Report to be put in place	Director of Governance	June 2025	Draft report went to Board in April, full report went to Public Board in May and to continue on a quarterly basis - completed
C3	Further PSIRF training to be rolled out	Director of Governance / Director of Nursing	Oct 2025	Enquiries being made with training supplier for 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 3.5**

Principal Risk: Potential for patient harm due to waiting times

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

Risk Rating:

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

Risk Details:

Opened: April 2023

Reviewed Date: July 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
- C2: Consistency of application of policy across all areas

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
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 – Completed
C2	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~~ Sept 2025	Not yet started, policy has been ratified
C2	Audit to be undertaken to assess consistency and identify areas for training	Director of Operations / Director of Governance / Director of Nursing	Sept 2025	
A1	Director of Governance and Director of Nursing to review reporting and tracking	Director of Governance and Director of Nursing	Sept 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 3.6**

Principal Risk: Recruitment challenges

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

Risk Rating:

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

Risk Details:

Opened:	April 2022
Reviewed Date:	July 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: 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~~ Oct 2025	Collaboration with the system on e-rostering in its infancy with project plan developed ongoing but on track
C3	Explore options of third party NHS bank staff provider	Director of Nursing / Director of HR	Sept 2025	Exploring with NHSP
C3	Implementation of ETOC programme	Director of Nursing	Oct 2025	In discovery phase to look at the data and then action plan to be developed

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: July 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 with planned expansion in Q3
- 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
- Active partners with ICB in neighbourhood model, leading on the MDT workstream

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services
- Development of Integrated Care Coordination in system
- Development of Integrated neighbourhood Teams
- Development of Frailty pathway
- Further embedding of VW & RR pathways
-

Key Assumptions

- N/A

Risks:

4.1 Operational Capacity to undertake all programmes of work

4.2 Internal governance and operational oversight arrangements for system programmes

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

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

Principal Risk: Operational capacity to undertake all programmes of work

Potential for operational pressures to affect prioritisation of system programmes both internally and across the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	2
Total	20	15	10

Risk Details:

Opened: September 2023

Reviewed Date: July 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

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	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	MSK, UEC and Shared Services Forums established with reports into Trust via Programme Board - Completed
C1/A1	Streamlined governance for system operational programmes	Director of Governance	~~December 2024~~ May 2025	As above, plus System Transformation Group now in place. - completed
C1	Chairs report from System Transformation Group to feed into Trust Governance	Director of Governance	August 2025	Went to RPC in August and will continue to go to that Committee

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:	July 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	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	MSK, UEC and Shared Services Forums established with reports into Trust via Programme Board - 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 aligned with RJAH. SaTH and ICB sighted on the changes required to complete full alignment across the system – completed as ShropCom action completed

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: July 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 and a deployment programme is established
- Established CIP and productivity workstreams, on track for Q1

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

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

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: July 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
- ✓ Board Cyber training completed

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~~ Dec 2025	Submission of standards not met due to one area of weakness relating to clinical coding, improvement plan in place with expectation DSPT standards will be met by Dec 2025

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: July 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

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

- ✓ Digital Assurance Group

Gaps In Controls:

- C1: Recruitment controls preventing appointments to vacancies
- 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

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: July 2025

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Use of non-recurrent schemes to allow more time to implement recurrent cost saving schemes
- ✓ Productivity and Efficiency Group working on identifying additional CIP schemes, and de-risking existing 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 and Digital Group oversight
- ✓ System Finance Committee 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:

- A1: National oversight framework has only just been released and requires review for impact on performance dashboards overall including financial performance

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. Update has been provided to Execs, plan in place to bring this back on track
C3	Mitigating actions to be explored with the ICB	Director of Finance	July 2025	CEO has written to ICB CEO outlining the risks and a response has been received. Financial risk assessment is updated each month, including internal mitigations. Risks are flagged internally and discussed with system partners each month.- Completed
A1	Review of National Oversight Framework	Director of Finance	August 2025	The national Oversight Framework was released in July and is being reviewed for presentation to RPC. Proposals to amend Performance dashboards will be presented to each committee by September.

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

Infection Prevention and Control Board Assurance Framework

0. Reference Information

Author:	Sara Ellis-Anderson, Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	7th of August
Executive Sponsor:	Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce and Director of IPC	**Paper written on:**	20th of June 2025 updated 1st of August 2025
Paper Reviewed by:	Infection Prevention and Control Committee and Quality and Safety Committee	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- The IPC BAF has been reviewed by the Deputy DIPC and by members of IPC, Estates, Clinical Education, Health and Safety and Pharmacy teams.
- Version 5 has updated KLOES highlighted in beige for ease of reference.
- Out of a total of 54 key lines of enquiry (KLOEs) the self-assessment has identified 38 fully compliant KLOEs with associated evidence and 14 partially compliant KLOEs.
- There are 2 KLOEs that are non-compliant:
    - KLOE 2.9 Food Hygiene training is commensurate with the duties of staff – there is currently a gap on training provision, and this is being proposed through a shared service agreement with SATH. All catering staff have received food safety training but currently 6 staff are overdue their refresher course.
    - KLOE 6.5 All identified staff are fit tested as per HSE requirements and records are kept. IPC team and operational teams are implementing central records of staff trained
- Since the last review six KLOEs (2.2, 2.5, 2.6, 2.7, 2.8 and 5.2) have moved from Green to Amber with improvement actions identified
- Since the last review one KLOE (2.3) have moved from partially compliant to fully compliant.

- Mitigating actions have been identified for partially compliant KLOEs with identified gaps in assurance. These are monitored through the IPC Improvement plan which is monitored through IPC Committee.

2.3 Conclusion

The Trust Board is asked to **approve** the IPC BAF and gain **assurance** that systems and processes are in place to comply with the 10 criterions of the Health and Social Care Act (2008).

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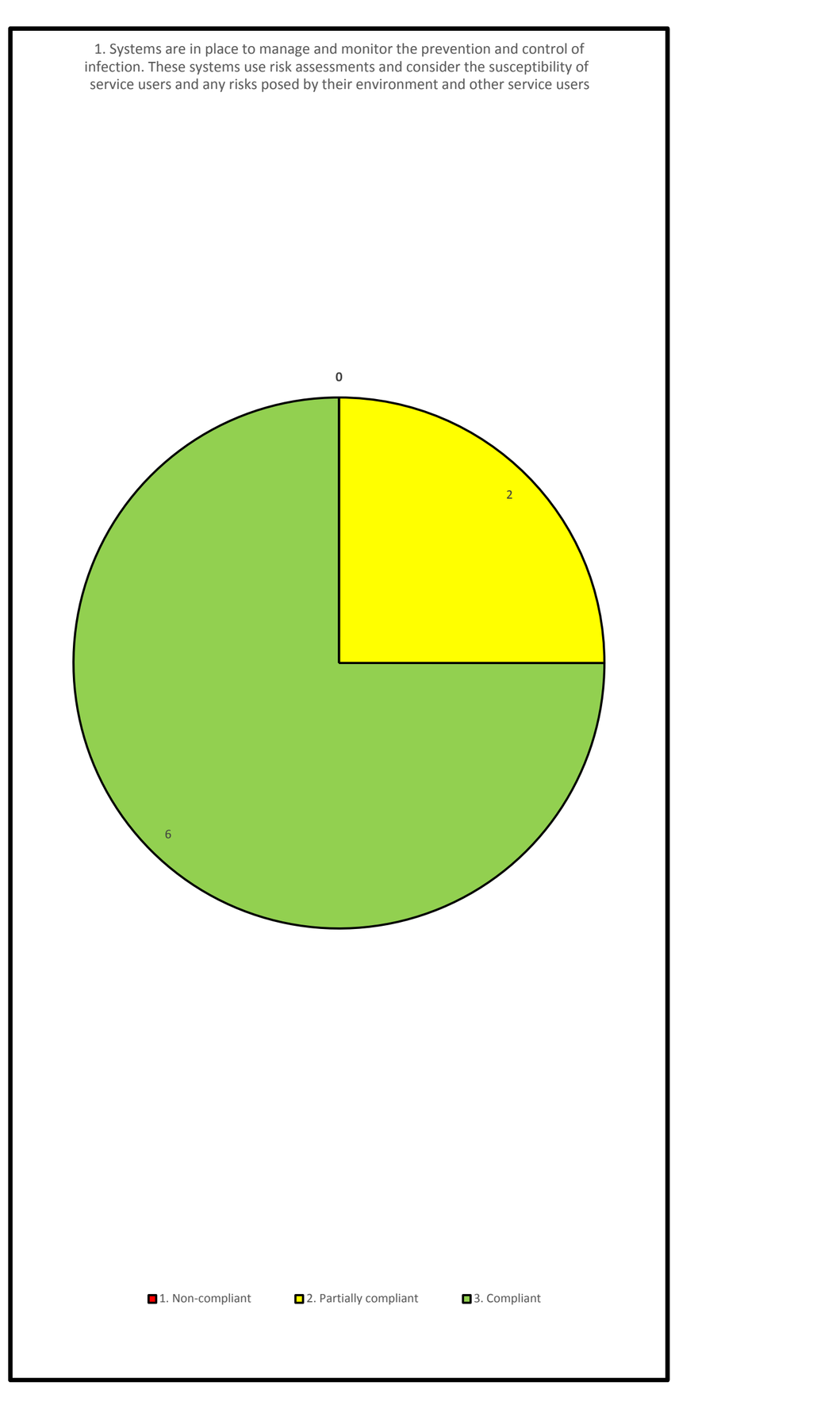
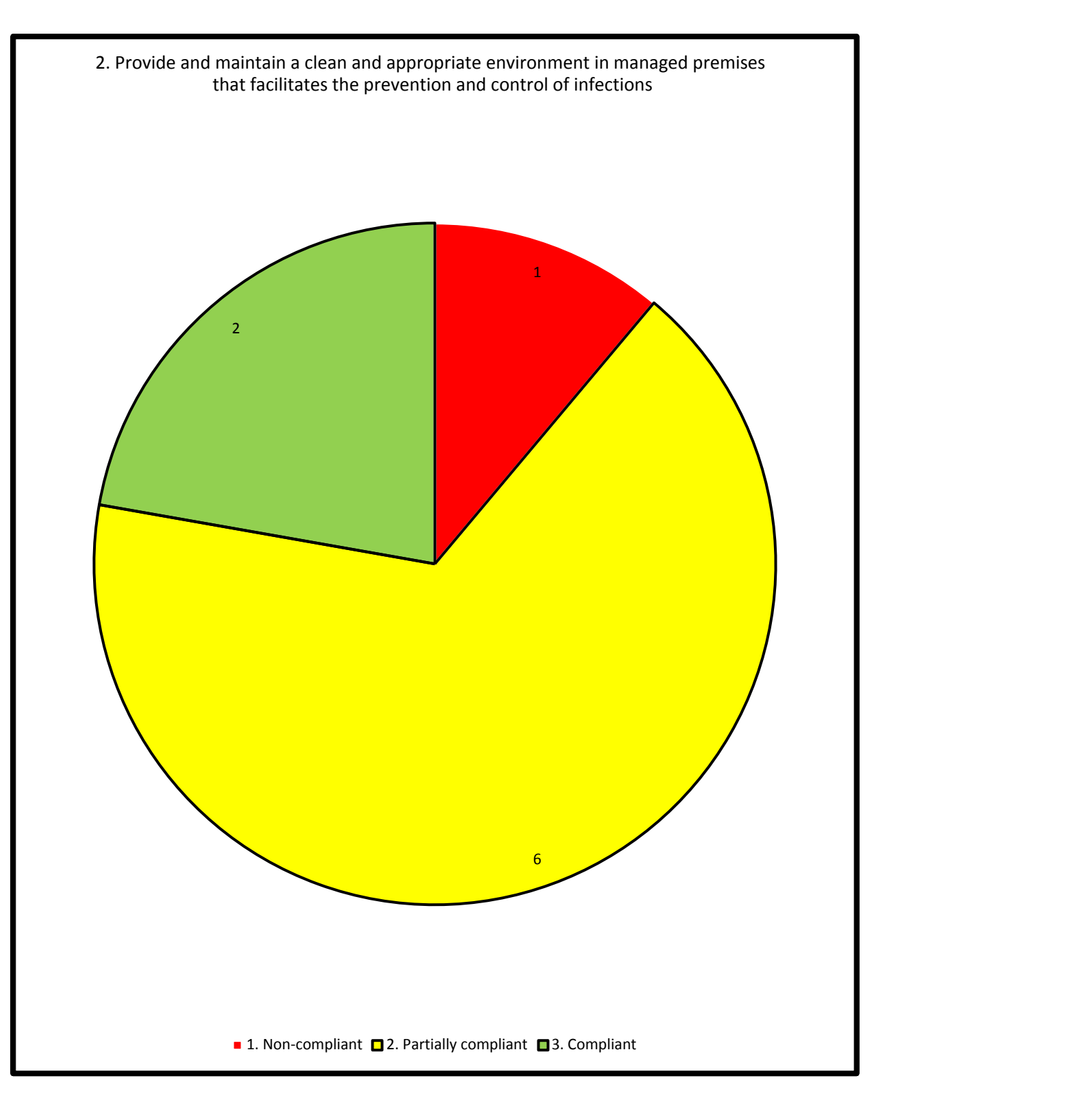
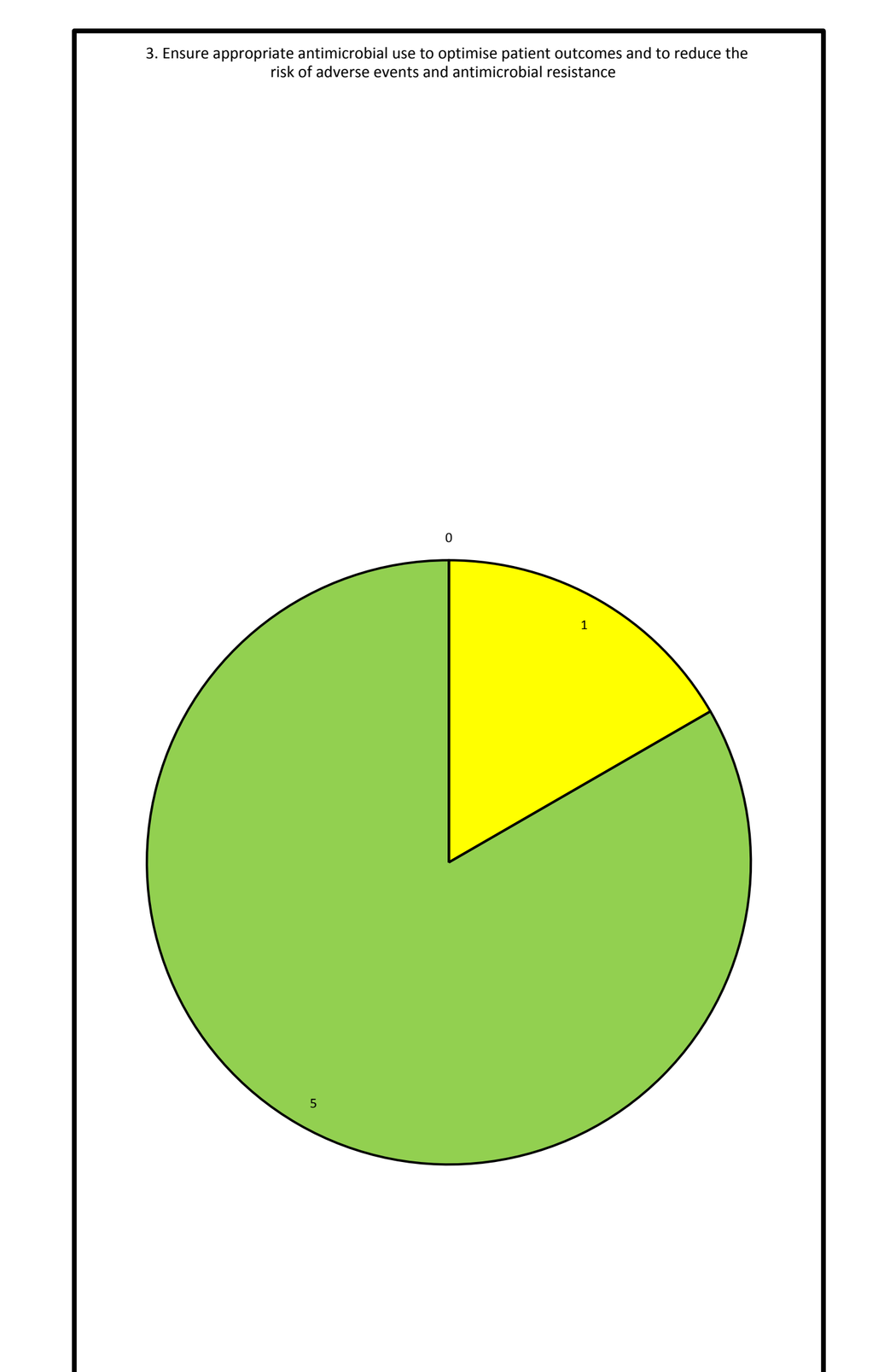
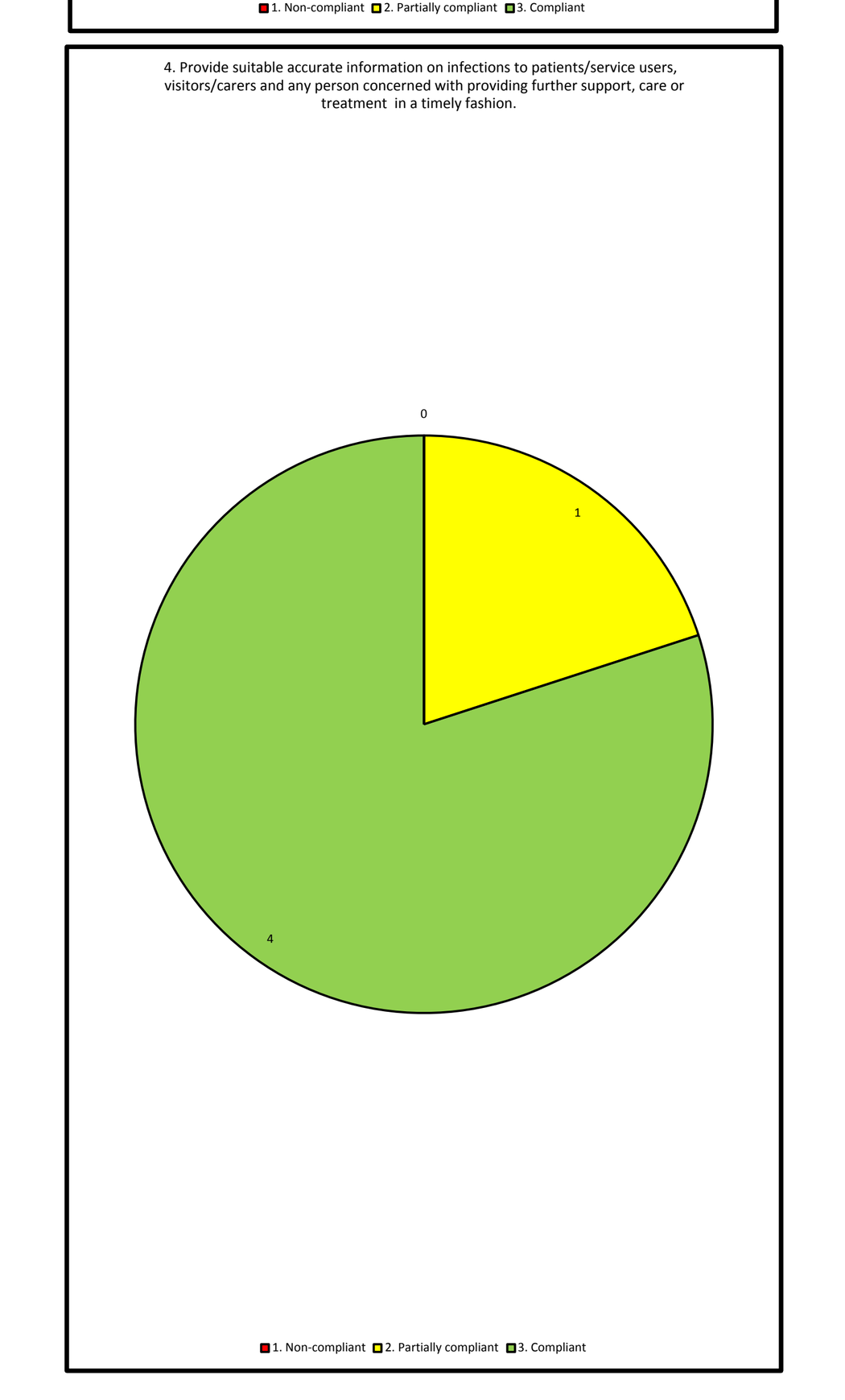
IPC Board Assurance Framework - version 5

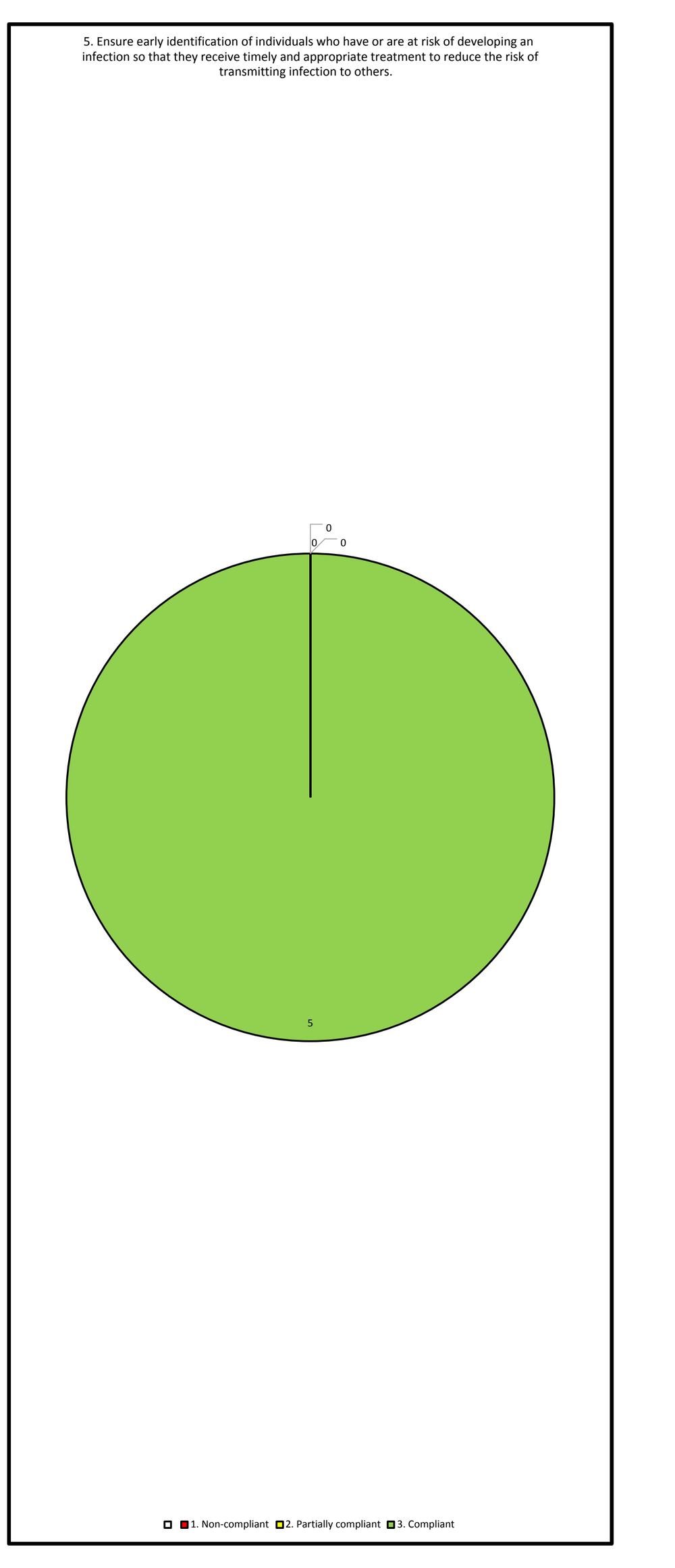
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Lead	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Organisational or board systems and process should be in place to ensure that:							
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Formal IPC Governance structure in place (evidence on IPC QMS).					3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks . There is no digital system for surveillance, however, ICNet is					3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Consistent high levels of Incident Reporting per month, traning provided on the System to new users, Datix actively used to progress an investigation. LFPSE implentation complete. Workforce and Staff Specific Risks in place across all Risk Registers.	IPC Datix dashboard to be available to all IPC Team.	DDPIC has access to all incidents and risks. Incident data reported at IPCC through divisional reports.		Director of Governance	2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC Quality Assurance Audits (QAAs) cover SIPC elements from each section of the NIPCM. SCHT IPC policies are aligned to the NIPCM. In addition, environmental and practice self audits are conducted by operational teams and an annual Sharps Audits by Daniels. Results and actions are monitored at IPCOG and IPCC through unit reports.					3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Targets set locally by ICB. Surveillance data is monitored through IPC report to IPCC. Local antimicrobial resistance patterns are reviewed by Consultant Microbioligist which influences local antimicrobial guidelines. Outbreaks and patient safety incidents are monitored and managed through outbreak meetings, Datix, PIRs. All are contained in the IPC report to IPCC.					3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC Team budget in place. SLA agreement with MPFT for Estates PPM and upgrading. Ops are responsible for cleaning and report compliance against National Cleaning Standards 2021 through IPCC. IPC Team have an annual programme approved through IPC Committee that includes audit, alert organism surveillance, outbreaks. There is no digital system for surveillance.		Manual process remains in place until ICNet implemented. This is not a gap in assurance, this is an improvement.	ICNet - This is captured on the IPC Risk Register and on the ICS IPC risk register monitoried by the ICB.		3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff IPC responsibilities are detailed in their job description. IPC training is included in induction. IPC e-learning module through ESR: Annually for clinical, 3 yearly for non clinical. Ad hoc face to face IPC training for wards, IPC training for domestic staff, IPC training for volunteers. Annual Hand Hygiene practical assessment for all patient facing staff. IPC link practitioners for all services who disseminate training provided by IPC team. Education campaigns covering updates and areas identified as requiring additional support.	ANTT is not included in mandatory training or competency checks.	Staff requiring ANTT training have been identified. Training is being rolled out.		Associate Director of People	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Patients are assessed on admission for Infection risks and placed appropriately according to the Isolation Risk Assessment Tool. Individual cases are discussed with IPC or Consultant Microbiologist on call. Heirarchy of Controls is completed for all outbreaks and included as a standing agenda item at Outbreak Meetings. General IPC Risks are logged on Datix with mitgations and monitoring outlined. Systems to monitor alert organisms and Post Infection Review (PIR) system is in place. In the forthcoming year, PIRs will be updated and aligned to PSIRF (Patient Safety Integrated Review Framework).			A digital solution to surveillance would enhance risk assessments (ICNet).		3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
System and process are in place to ensure that:							
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Responsibility for cleanliness and compliance against National Standards of Healthcare Cleanliness (NSHC) ~~2021~~ 2025 is with the Operational Team. DIPC receives cleanliness reports through IPCC and can escalate or challenge operational leads on standards of cleanliness. The Director of Operations has overall Trust responsibility for delivering the National Standards of Healthcare Cleanliness 2021 2025	No consistent reports received on compliance with the NSHC 2025~~1~~ audit in line with all elements, e.g Audit cycle is incomplete. No Facilities Lead or Cleaning Lead in community settings. GP practices and social care settings do not follow CS ~~2021~~ 2025. This gap in assurance is due to current legislation.	MyAudit software in process of implementation which will support audit cycle. Facilities Lead has been advertised. Cleaning compliance in buildings where SCHT are tenants are audited by operational leads to highlight and escalate areas of concern in non-Trust owned buildings	Action is included on IPC Improvement Plan.	Claire Horsfield, Director of Operations	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE audits are conducted by the Patient Experience team and reported through the Patient Experience Committee, Chaired by DDIPC. The IPC team are members of the PLACE audit.	Governance needs strengthening wth Annual Report to Board.	Actions monitored through Patient Experience Committee		Clair Hobbs, Director of Nursing	2. Partially compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Roles and responsibilities for cleaning in community hospitals is agreed	Cleaning of patient care equipment in satellite clinics and where SCHT are tenants is clearly defined but not the environment.	Serial 2.1		Claire Horsfield, Director of Operations	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Quarterly Water Safety Group attended by Estates, MPFT (SLA in place) Authorised Engineer for water is contracted to conduct annual water safety audit and attends Water Safety Group monitoring compliance with action plan. There is a Ventilation Authorised Engineer under contract and the Associate Director of Estates has full oversight of remedial works to achieve compliance. PAM completed in line with mandatory reporting. Ventilation is a standing agenda item on the H&S Group.	Need to receive water records from SaTH for wards 18 and 36 and DAART.				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	SLA agreement with MPFT for Estates PPM and upgrading, MPFT policies for Estates are adopted. Building and Refubishment SOP has been published	MPFT and NHS PS to provide their annual PPM programme	Formal signed Contract in place between partner Standing Operating Procedure for Management of the Trust's Estate linked to the SLA with the maintainer of or non NHS PS esate. Both parties have appointed the same Water AE and have aligned processes and procedures noting the SLA identiifes the following of the maintainers processes and policies noting they themselves are an NHS Provider. Monthly updates are provided to IPC with support provided directly by the maintainer into IPC directly. Quarterly meetings are conducted with NHS PS with local "BUG" meetings hosted by NHS PS with site leads. Documenation and evidence is available via the maintenance providers CAFM system MICAD	IPC Team have requested PPM priority list and frequencies to be included. Action is included on IPC Improvement Plan.	Richard Best, Associate Director of Estates	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen contract in place and monitored by Operational team to ensure quality of items and adequate supply and provision at ward level. Issues with linen are reported through DATIX.	Linen storage in clinical areas (Whitchurch, Ludlow and Bishop's Castle) are not compliant with HTM 01-04 as linen cupboards have unvarnished wooden slats.	Hotel Services Leads to raise jobs to replace wooden slats. Purchase of mobile linen storage units have been approved by IPC. IPC QAA includes compliance with linen storage	IPC to audit compliance until assurance is achieved. Linen storage is included in the QAA	Locality/Ward Managers Claire Horsfield, Director of Operations	2. Partially compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste management budget holder is the Associate Director or Estates, with repsonsiblity delegated to service leads and teams at an operational level. The Premises ssurance Model is used to monitor performance noting the use of datix in the event of individual issues as they arise. Domestic Waste is managed under an SLA with Veolia as procured by the system led by SaTH Clinical Waste is managed via an SLA with a partner NHS Trust and is provided under contract by Tradebe NHS PS provide waste services a spart of their managed estate	Not all areas label their clinical waste bags with the ward/department. No desgnated lead for waste in the Trust.	Waste provider is SRCL at Ludlow, and provided via the landlord NHS PS, the bins are removed secured and locked and transported from site to the processing site process observed at site level with photographic evidence. In that process the bins are swapped for clean empty ones therefore avoiding the mixing of waste. At Bridgnorth, the service is provided by Tradebe as a shared contract with another NHS Provider the bins remain in situ and the backs are transported in amongst other waste from other sites.	Review commenced around clinical waste and will be taken forward to provide more robust assurance. Pharmaceutical Waste sits outside of the Estates Lead responsibility and is managed via Pharmacy	Richard Best, Associate Director of Estates	2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Dental instruments are processed in line with guidance and policy Endoscopy equipment is processed in line with guidance and policy and reported through IPCC	No appointed authorised engineer for decontamination.	Contracts in place with specialist providers contracted via the SLA and are audited by the Decon AE	Discussions underway with Partner NHS provider to enter in formal discussions for the contract moving forward		2. Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Each Community Hospital has a lead for food hygiene. Food Hygiene policy is in place and up to date. IPC team review ward kitchens, microwaves, fridges included in the QAA. RRU housekeepers have food hygiene training.	There is no overall Trust Food Hygiene lead. Food hygiene training not available at present.	Progressing discussions with SaTH re shared services agreement.	Operational review in progress. Facilities lead will be responsible when appointed. Post has been advertised.	Claire Horsfield, Director of Operations	1. Non-compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Systems and process are in place to ensure that:							
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements. Chief Pharmacist and Lead Pharmacist for AMS in post. Pharmacist for the Virtual Ward has a background in managing AMS			Meeting arranged within region to develop SCHT staff appropriately and create a network	Susan Watkins, Chief Pharmacist	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Antimicrobial stewardship is formally reported to the IPCC Chair and onwards to the Board via an IPCC Chair's report					3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Antimicrobial stewardship is the responsibility of the DIPC who sits on the Board	Lead Pharmacist in AMS to represent Trust at system wide AMS group.		Check with Chief Pharmacist whether Lead Pharmacist for AMS has dedicated time in job description.		3. Compliant
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	The medicines management team work closely with prescribers to ensure antimicrobial prescribing is appropriate, meets criteria for indication, denotes a course length and this meets the expected requirements. NICE guidance is utilised and shared with clinicians.	Having access to ePMA would further support reviews and enable more efficient review of patient compliance. Now have greater visibility of prescribing data now but do not have assurance for RRUs. Not able to insist SCHT pharmacy provides this. AMS not included in mandatory training.	Pharmacy team on site at the prison and community hospitals a minimum of 5 days per week. PGDs have criteria which provides maximum course lengths and roots for escalation.	Start Smart, Then Focus - to determine whether this is part of the AMS audits.	Susan Watkins, Chief Pharmacist	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Prescribing and AMS use data is presented to the IPC Committee for ratificaiton which demonstrates any patterns in prescribing behaviour. Information is provided from all services using antibioitics					3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	All prescribers that work within SCHT meet with a member of the pharmacy team and they are supported with safe prescribing and maintainance of AMS. This includes agency staff as well as permanent. PGDs can only be used by staff that have bene signed off as competent, this means there is little use of PGDs by agency which provides the required robustness.					3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion							
Systems and processes are in place to ensure that:							
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPC develop patient and staff information leaflets are reviewed by Patient representatives. For new and emerging health threats, the IPC Team request dissemination of information through communication channels.					3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service	IPC develop patient and staff information leaflets in line with policies.		The IPC Team utilise online accessible information software to assess compliance prior to publishing.		Director of Governance	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	IPC policies are aligned to NIPCM and criterion 9 avaiable on StaffZone intranet. The IPC information and Governance systems support dissemination of IPC information from floor to Board. The IPC Annual Report includes information on IPC, compliance with the H&SCA including AMR. This is published on the SCHT Internet page.					3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	IPC develop and publish patient, contractor and staff information leaflets. These are reviewed and aligned to the NIPCM and NHSE/UKHSA guidance. SOPS on specific actions, e.g. Covid screening, outbreak managent, isolation, are available to staff via the intranet and disseminated through communication channels. OHD and Medicines Managent produce communications around campaigns e.g. antimicrobials, vaccinations, which include desk-top banners, newsletters and communication releases.					3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Information on infection status of patients is requested and conferred prior to admission. Patient admission assessment and pre-transfer checklists are completed by capacity hub and ward teams. Admission documentation includes IPC status.	Catheter Passports are not consistently in use across the system.	Current system remains in place until digital surveillance is implemented.	There is no digital system for surveillance although Rio is being used where possible. A full review of invasive devices training and managment, VIP scores and obtaining blood culture protocols will be required if the Trust Service/Transformation Plan moves to providing sub-acute care	IPC Team and Continence Service Director of Operations	2. Partially compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.							
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:							
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	All patients are screened for MRSA on admission in line with guidance for Community in-patient areas. Isolation audit and check lists are employed by teams. Identification of signs/symptoms of infection are included in SOPs e.g Respiratory symptoms, diarrhoea and vomiting			Emergence of organisms of significance is monitored by the IPC Team Lead and DDIPC. Potential screening requirements are reviewed.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	Patients are assessed during their stay for signs and symtpoms of infection. SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Non-compliance due to risk assessment is recored on DATIX.	No isolation care plan or daily review mechanism in place.	IPC team to develop document to assess isolaton. Rio team to be notified. Review isolation SOP against national guidance		Sara Ellis-Anderson, Deputy Director of Nursing and Deputy DIPC	2. Partially compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Information on infection status of patients is requested and conferred prior to admission in a pre-handover checklist. Admission documentation includes IPC status.			There is no digital system for surveillance, however, ICNet is awaiting implementation - serial 1.6		3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Respiratory Symptoms posters are in place across SCHT premises.					3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak Policy is in place and followed. External stakeholders are invited to outbreak meetings. CQC are informed through submission of a Statuty Notification Regulation 18 (2 (g)) 2009. Outbreak SOPs (respiratoy and diarrhoea & vomiting) are in the on-call folder for IPC guidance in out-of-our period.					3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection							
Systems and processes are in place to ensure:							
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	On-line corporate induction includes required IPC elements. E-learning mandatory IPC training Levels 1 and 2 provided according to role.			Serial 1.7 for ANTT		3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Clearly defined IPC roles and responsibilities are embedded in the JD's of all new and existing roles throughout the Trust. Locality Managers and Site Managers are aware of their resposibility for Estate and IPC. Areas that require improvement are captured on individual IPC Improvement Plans reviewed at IPCOG and during IPC QAA. Training and IPC practice compliance is recored and reported through Unit/SDG reports to IPCC overseen by the DIPC.					3. Compliant
6.3	Monitoring compliance and update IPC training programmes as required.	IPC training compliance is a Trust KPI monitored at Q&SC. A bespoke training package for Healthcare Support Workers for the System has been reviewed and updated					3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	A link to the NIPCM Donning and Doffing is embedded within our Standard Infection Control Precautions policy. IPC Team regularly audit compliance during visits.	All clinical staff are required to be fit-tested to x2 types of FFP3 mask. The Trust currently have limited or no in-date FFP3 fit testing staff, H&S are currently exploring external providers for this service.	See serial 6.5	Work ongoing to arrange for Train the Trainer sessions to have a tester in teams to provide local fit mask training.	Service Director, Deputy Director of Operations	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Records of compliance are currently kept locally by each Service, and enquiries have been made to keep records centrally on ESR - this has been added to the Risk Register	No regular reporting on fit mask testing compliance.	Fit testers trained across the organisation. List of staff requiring training to be reviewed and operational leads to ensure compliance		Service Director, Deputy Director of Operations	1. Non-compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Clinical Skills that involve medical device insertion has a comptency document that the clinician completes in practice following the initial training, for example Venepuncture & cannulation.	Competencies are currently not linked to role. Competency records are not held digitally.	The clinical compentency library is held on Staffzone. Line mangers are responsible to ensure their staff are appropriately trained and indivdual paper records are held locally.	Role Speciific Training and Competencies are to be recorded on ESR.	Associate Director of Workforce and Professional Standards	2. Partially compliant
7. Systems and processes are in place in line with the NIPCM to ensure that:							
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Serial 5.1 and 5.2. Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Admissions and transfers that require isolation are allocated and agreed prior, to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required.			Incidents recorded on Datix system if handover information on IPC status differs from clinical presentation		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Serial 5.2 SOP for isolation and risk assessment tool is in place. Isolation and cohorting is in line with SCHT SOP and on an assessment of individual need. This is documented. Admissions and transfers that require isolation are allocated and agreed prior to ensure correct patient placement and TBP are available. Guidance on patient placement is through IPC or microbiologist on-call if required. Non-compliance due to risk assessment is recorded on DATIX. Avian flu and zoonotic disease capability is covered by action cards informed by the Incident Management Team having an IPC lead as its subject matter expert. Any other general clinical decisions would fall to the Ops/Clinical teams as part of their business as usual and escalation processes.			New and Emerging Pandemic Plan being written and tested in 2025/26	EPRR Senior Lead	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICPs and TBP Policy is in place aligned to the NIPCM. Signage for precautions are in place and displayed. Compliance is monitored through QAA and spot checks. Results are reported through IPCC and SDG reports.			Redesign of isolation posters are in progress which reflect the NIPCM. This is not a gap in assurance as is an improvement.	IPC Team	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Information on infection status of patients is requested and conferred prior to admission or discharge in a pre-handover checklist which includes IPC status. Onward care facilities are advised of patients that require isolation.					3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate							
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:							
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Laboratory specimens are obtained by registered practitioners or HCSW who have had appropriate training and are delegated to complete the task. In the absence of national accrediation training, staff complete the LFD test SOP and competency check.			There is no nationally recognised accreditation system for LFD testing. Staff follow laboratory protocol and SCHT policy when obtaining respiratory Panel PCR, MRSA screen and other specimens		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	All lab results are reported via SaTH Review system. IPC receive a weekly 'Alert Organism' list from the SaTH labs. SaTH labs will telephone results through - this is evidenced in patient notes.	Results are not manually added to patient record on Rio by ward staff	Manually added to Rio by IPC staff.			2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SCHT utilise SaTH laboratories for all microbiology and IPC services. The SLA does not specify turnaround times. SaTH laboratories process SCHT samples in line with their own sampling.	Turnaround times not specified in the SLA.	If samples are to be processed rapidly, individual cases are discussed with the Microbiology team. In the event of late sample results and an issue arising as a result, SCHT will raise a PPF concern and discuss with SaTH laboratory service manager.	SCHT samples are processed in an equitable manner with all samples from the STW system. Including a specified turnaround time within the SLA is not deemed to impact on the current service and therefore not required. This has not been	IPC Team	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	MRSA swabbing on admission as per Trust Policy and compliance is monitored monthly by the IPC Team as an IPC KPI - threshold of 97% YTD.					3. Compliant
8.5	Patients/service users who develop symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Swabbing guidance flowcharts in place in all in-patient areas, as per national swabbing guidance.					3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	The IPC team have access to consultant microbiologist advice 24/7 when needed. Clinical teams also have access to microbiologist advice as required. IPC cover including outbreaks is included in the SLA.					3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	SCHT follow policy: Collection, Packaging, Handling, Storage and Transport of Laboratory Specimens.					3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	IPC policies are aligned to NIPCM and criterion 9. IPC policy tracker is reviewed at IPC Committee as per the workplan. IPC receive reports from operational teams on IPC Compliance at IPCOG and IPCC. IPC team conduct regular ad hoc and targeted audits to triangulate and verify self-audit findings. Infection Incidents are reported through DATIX. Post Infection Reviews are conducted for all HAI. Outbreaks are managed and reported as criterion 5.5. SBARs are completed after outbreaks and reported at monthly outbreak meetings to			All policies refer to NIPCM and list of A-Z pathogens is linked on staffzone		3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:							
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Team Leads and Line amangers carry out this assessment. Referrals are made to OHD.			Any issues that are identified are then notified to Occupational Health and further information and assessment is carried out		3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	All staff who have an exposure incident are encouraged to contact Occupational Health. They will have an initial assessment by one of the advisors and a plan will be agreed following Trust policy. If the issue happens at the weekend or out of hours the employee can access one of the Sharps Incident Boxes located around the county that contains instructions on what bloods are needed and can access the policy as well as immediate first aid procedures. The incident should also be reported via DATIX.			DATIX summary reports are sent out daily by the Governance Team to senior leads, the DDIPC and DIPC for oversight. Sharps incidents are followed up by H&S Team and are included in the KPI metrics reproted through Q&SC.		3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	All staff who have or may have a patient facing role are seen by Occupational Health before or very soon after commencement in role and a full immunisation check is carried out that includes TB, Hepatitis B, Measles, Rubella and Varicella. Any outstanding vaccines are offered or, in the case of Measles and Rubella blood tests are offered and results followed up					3. Compliant
		Any person carrying out Exposure Prone Procedures or anyone new to the NHS is asked to undertake a blood test to check for Hep b, Hep C and HIV – this is validated by photographic ID; again any issues are followed up and advise and support offered to the individual and the manager/trust					3. Compliant

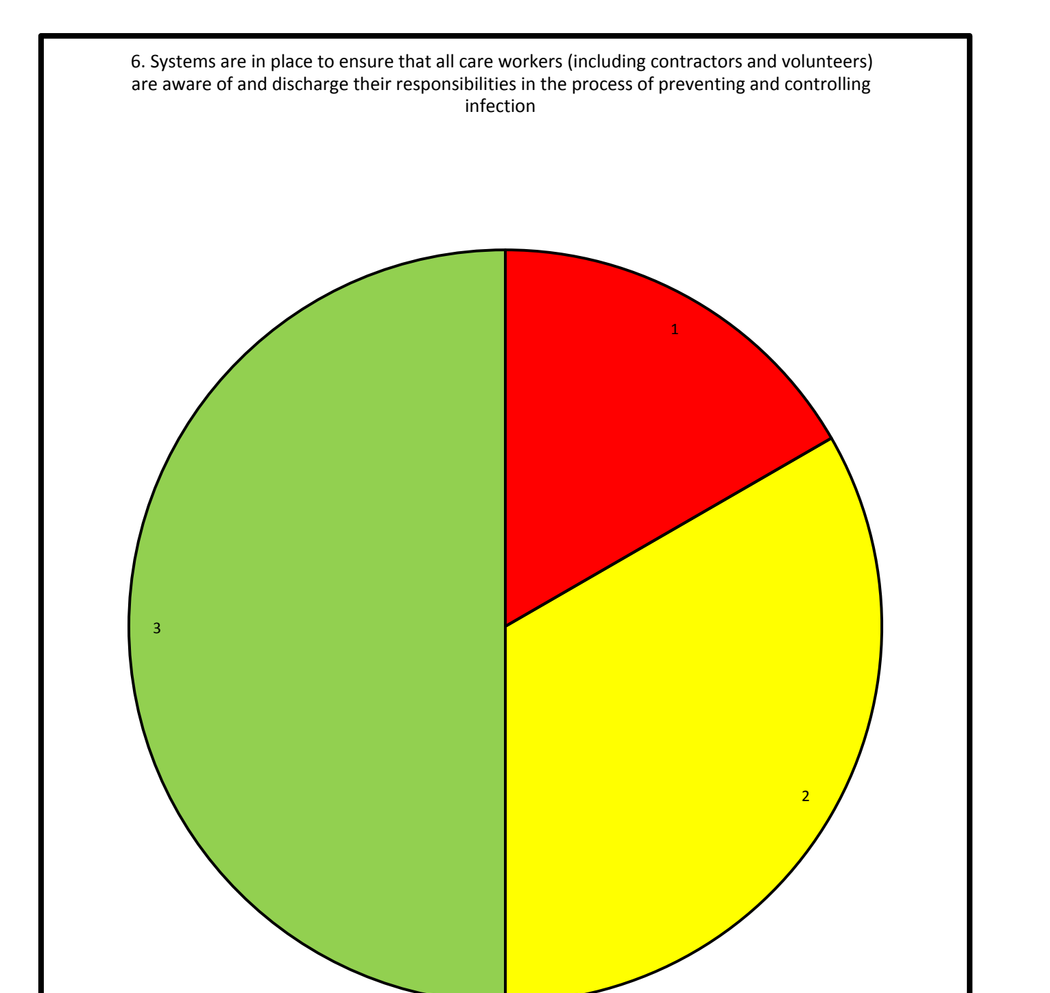


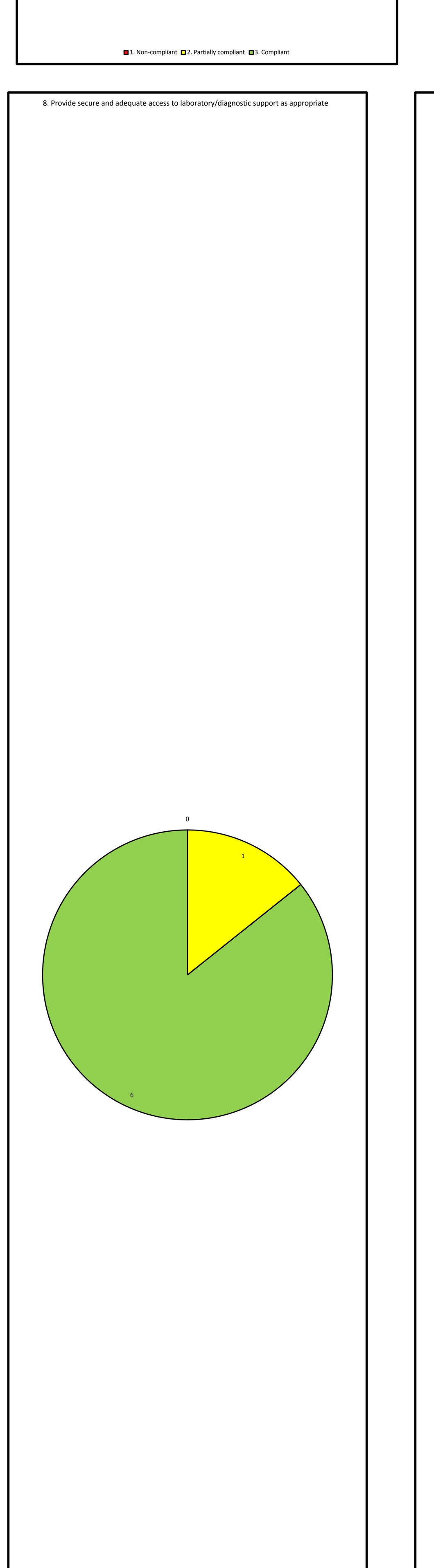


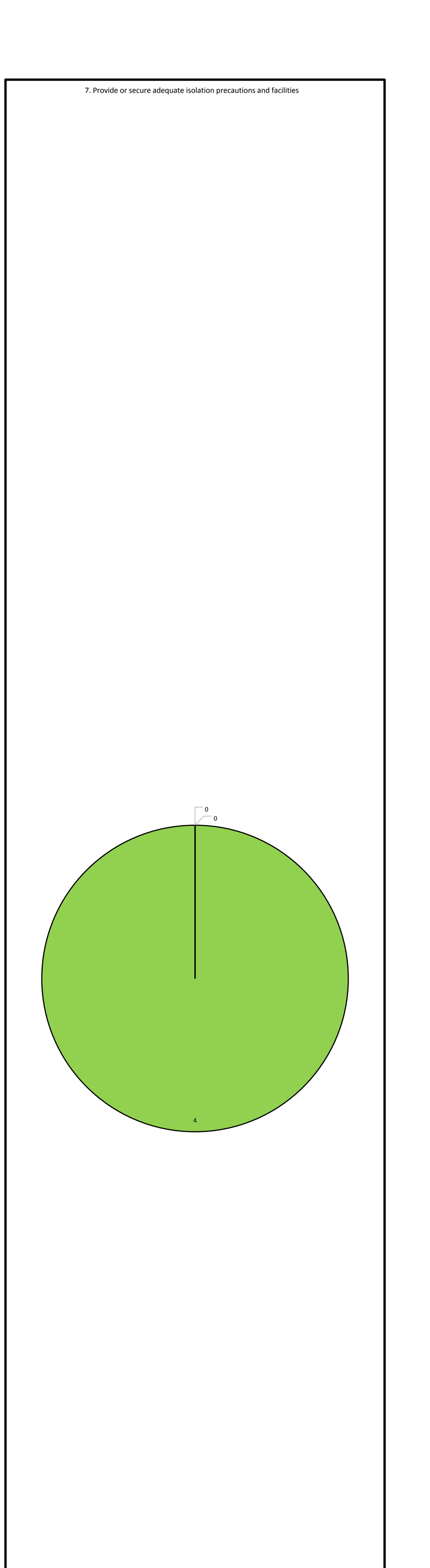


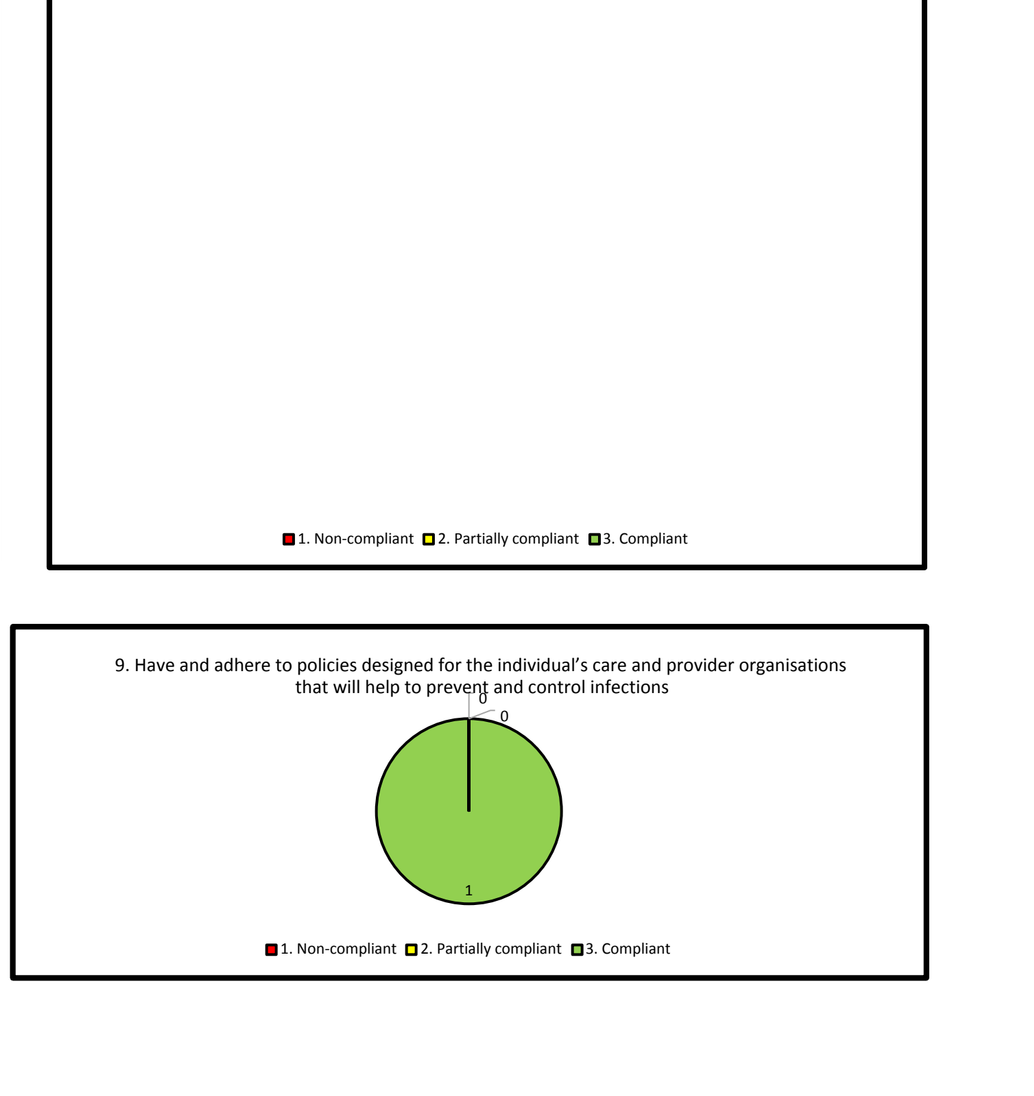


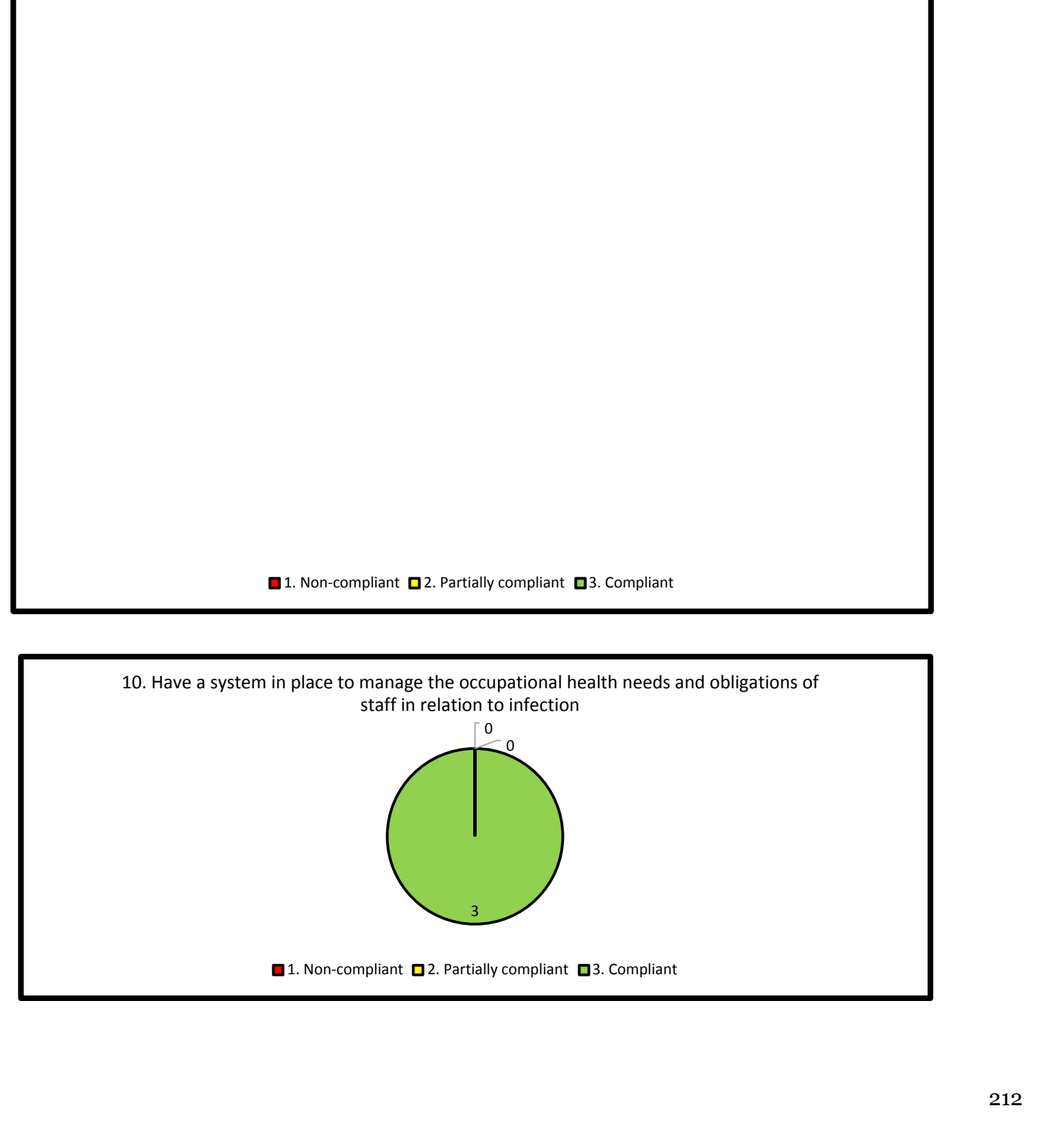












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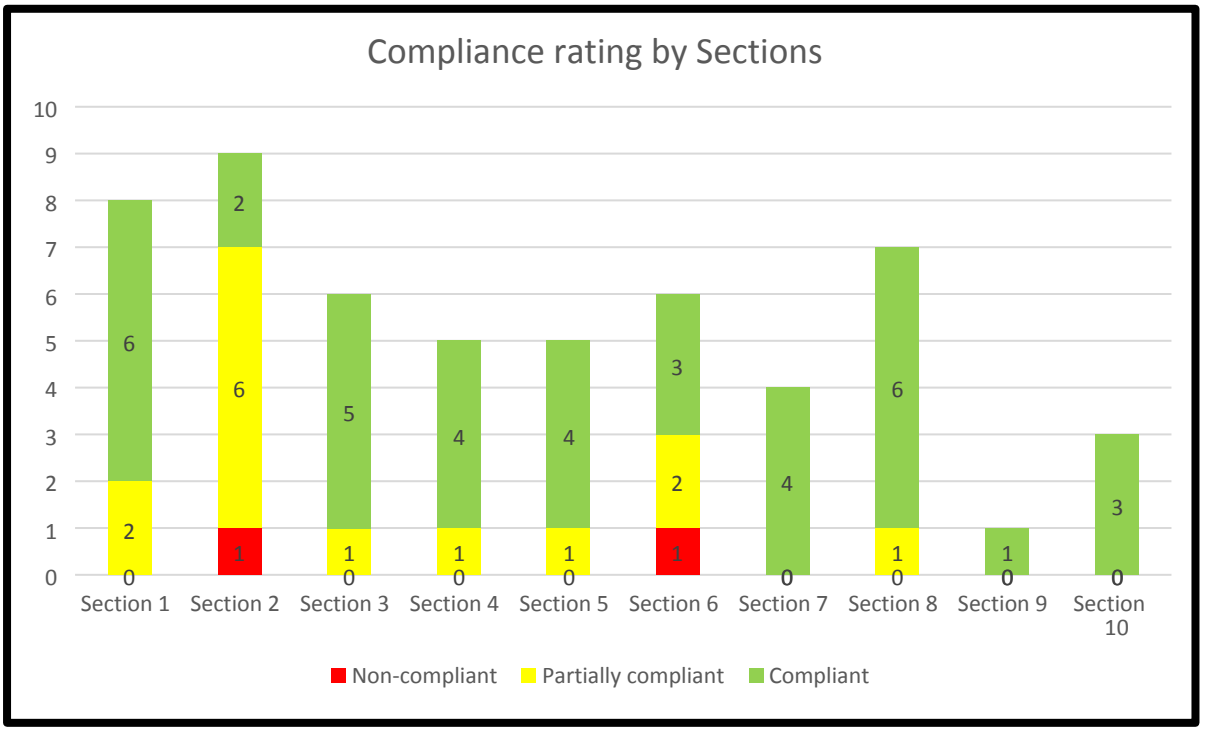

	Non-compliant	Partially compliant	Compliant
Section 1	0	2	6
Section 2	1	6	2
Section 3	0	1	5
Section 4	0	1	4
Section 5	0	1	4
Section 6	1	2	3
Section 7	0	0	4
Section 8	0	1	6
Section 9	0	0	1
Section 10	0	0	3
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