Trust Board - 2 October 2025

MEETING

2 October 2025 10:00 BST

PUBLISHED

29 September 2025

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Shropshire Community Health NHS
NHS Trust

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE RAMADA HOTEL, TELFORD AT 1.00PM ON THURSDAY 7 AUGUST 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)
Executive Members (Voting)	
Ms. Sarah Lloyd	(Deputy Chief Executive & Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Clair Hobbs	(Director of Nursing)
Ms. Claire Horsfield	(Director of Operations and Chief AHP)
Executive Members (Non-Voting)	
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Ms. Rhia Boyode	(Chief People Officer)
In attendance	
Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)

Welcome

Mr Morgan welcomed all to the meeting.

Apologies and Quorum

Apologies were received from Ms Patrica Davies, Chief Executive, and Ms Cathy Purt, Non-Executive Director. The Chair in Common declared that the meeting was quorate.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 5 June 2025

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

Action Log

There were no actions outstanding

Patient Story

The Board received a presentation from a number of staff regarding the Hepatitis C scheme at HMP Stoke Heath. Every prisoner should have the opportunity to be tested for Hepatitis C, ideally on arrival. The staff reported they have approximately 8-10 arrivals each day and in 2023, the Trust had a testing rate of 23%.

The Trust implemented a pilot scheme where Health and Wellbeing Champions (HAWCs) who are prisoners, test other prisoners. The HAWCs were full trained to provide this and received a Level 2 award in health improvement following completion of this training. The scheme tested for other blood borne diseases and had been successful in picking up a number of syphilis cases. Feedback from prisoners had been good, with a significantly increased uptake in testing. The prison was the first in the country to have peer testing.

The Board praised the hard work of all involved and suggested that the pilot be written up and disseminated for wider learning.

Public Questions

Written questions had been received from two members of the public. The questions and associated response can be found in Appendix A of these minutes.

Chair in Common's Communication

Mr Morgan advised that Jo Williams had been appointed as Chief Executive in Common / Group Chief Executive Designate for ShropCom and the Shrewsbury and Telford Hospitals NHS Trust (SaTH) and that she would formally start the role on 1 September.

Mr Morgan sent the Boards thanks to Ms Davies, the departing Chief Executive, who would be starting her new role in Manchester in September.

Mr Morgan also informed the Board that Ian Green had started his role as STW ICB Chair and Mr Morgan expressed that he looked forward to working with Mr Green in the future.

Non-Executive Director's Communication

Mr Darbhanga had visited Whitchurch Hospital with Ms Purt and reported that the visit had been very useful. They had also visited the new medical centre in Whitchurch.

Ms Long had attended the System Finance Committee, where discussions had taken place on the financial plan and strategy. Ms Long had a visit planned to Oswestry MIU for later in the month.

Ms Barker had attended the System Quality and Performance Committee.

Chief Executive's Update

Ms Lloyd summarised the report, highlighting there had been a number of key publications since the Board had last met. The NHS 10-year plan had highlighted the three key shifts, which aligned with the Trust's strategy.

The National Oversight Framework had been published by NHSE, which allowed organisations to see how they were performing against peers through the use of benchmarking. Ms Lloyd advised that the Trust was in the process of reviewing which KPIs within the framework were relevant to the Trust.

The Urgent and Emergency Care (UEC) plan for 2025/26 had also been published. Ms Horsfield summarised the schemes proposed, which built on previous schemes.

Her Royal Highness, Princess Anne had recently visited HMP Stoke Heath and acknowledged the hard work of the team at the prison and their commitment to caring for the prisoners.

The Board discussed culture within the organisation and the longer-term transformation work, particularly when considering the move to a group model.

Patient Safety Board Oversight

Ms Ramtuhul summarised the report and noted that it was to provide the Board with assurance that the processes for managing patient safety incidents were correct and appropriate. The Patient Safety Incident Response Framework (PSIRF) had been embedded in the Trusts processes for some time and weekly incident panels took place to review all incidents that had resulted in or had potential to result in harm. Two After Action Reviews had taken place and these were embedding well as a learning response.

The Board discussed the number of incidents and noted that the Trust was around the middle of its peers, which was a good indicator as it demonstrated a good reporting culture whilst not flagging any safety concerns. It was noted that incidents reported would cover a large range of incident category, from printers not working to incidents relating to patient care. Ms Ramtuhul advised that all incidents are reviewed and dealt with and learning responses are agreed according to the level of severity.

The Board accepted the assurance provided by the update.

Group Transition Committee Terms of Reference

Ms Ramtuhul advised that the Committee was being established jointly with SaTH to oversee the development of the programme of work to move us towards a Group model and that the membership of the group would evolve over time. The current membership was focused on governance mechanisms, with a number of workstreams and this would move to include clinical leaders as appropriate as the work moved towards patient pathways.

Mr Darbhanga asked if the group would be a decision-making group, Mr Morgan confirmed it could not make binding decisions and any decisions that had previously been reserved for Board would continue to be so.

The Board approved the draft terms of reference.

QUALITY AND SAFETY

Quality and Safety Committee Chair's Report

Ms Barker summarised her report and noted that the thematic review had been on patients absconding.

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

Quality and Safety Report

Ms Hobbs advised that the report had received full assurance at the Quality & Safety Committee. Since the time of writing, there had been a further case of C-Diff, bringing the total number of cases in the year to five. A full deep clean process was in place, and the robustness of this programme was tested with regular audits. Ms Hobbs said she was confident there was nothing more that the Trust could have done to prevent these cases.

The Board accepted the assurance provided by the update.

Quarterly Mortality and Learning from Deaths Review

Dr Ganesh noted that there had been 19 deaths in the reporting period, none of which were related to Covid or learning disabilities. Of these deaths, one was unexpected, the patient had sadly died of a heart attack, which was deemed natural and explainable. There were two custodial deaths which were being investigated and further information would be bought to Board once these investigations had been concluded.

The Board

- ***Noted the report and themes detailed.***
- ***Agreed that the report provided substantial assurance that the Trust was meeting their requirements under the National Learning from Deaths 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.***

Annual Report – Infection Prevention & Control

Ms Hobbs advised that the report had received full assurance at Quality and Safety Committee and was presented at Board for final approval. The Trust had moved from enhanced support from NHS England to routine monitoring, noting the excellent progress that had been made.

Ms Lloyd welcomed the report and noted the huge impact the small Infection Prevention and Control Team had on the whole organisation.

The Board approved the report for publication.

Infection Prevention and Control Board Assurance Framework (BAF)

Ms Hobbs stated that the report had received full assurance at Quality and Safety Committee. There were two areas of non-compliance, which were identified within the report, however, there were robust action plans in place to mitigate these.

The Board approved the IPC BAF and took assurance that systems and processes were in place to comply with the 10 criterions of the Health & Social Care Act (2008).

Bi-Annual Safer Staffing Report

Ms Hobbs presented the report and advised that a confirm and challenge session had been held with the national team, who were assessing all Trusts nationally. The feedback from the national team had been positive and they had been assured around our processes.

Ms Hobbs advised that the Trust was fully safe and compliant with staffing levels and the workforce safeguards policy.

The Board

- ***Noted the benchmarking statistics within the report.***
- ***Agreed that, when reviewing the performance of the National Developing Workforce Safeguards, that we are fully compliant.***
- ***Noted that the Director of Nursing and the Medical Director confirmed that they were satisfied with the safety, effectiveness and current sustainability of staffing levels at Shropshire Community Health Trust.***

PEOPLE

People Committee Chair's Report

Ms Sargent summarised the report on behalf of Ms Purt and drew the Board's attention that the Trust's mandatory training compliance had improved recently.

Ms Boyode stated that the development of a joint People Strategy with SaTH was underway, which was very exciting step forward.

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

Integrated People Performance Report

Ms Boyode stated there had been little change since previous months. The metrics were on track, except for vacancies, with some areas showing a vacancy rate of around 30%. The People

Committee had asked for clarification around Whole Time Equivalents (WTE) and any increases, to better understand the Trust's position and this will be taken to the next Committee meeting.

The Board accepted the assurance provided by the update.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Ms Long noted that there were issues with capacity in clinical coding, and this was a national issue, and the Trust was working with partners on this. RTT waiting times had shown improvements so the Committee would continue with its routine monitoring.

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

Integrated Performance Report

Ms Lloyd summarised the report. Of the KPIs monitored through the Resource & Performance Committee, 11 measures required attention, and of these, 9 related to waiting times. The Trust continued to monitor RTT and non-RTT waits in the same way, and that there had been a sustained improvement for both lists.

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

Finance Report

Ms Lloyd advised the Board that at the end of Quarter 1, the Trust was delivering its financial plan, with a small surplus which was marginally favourable to plan. The Trust continued to forecast that it would deliver the annual plan, subject to the management of risks, which were being mitigated. It was noted that agency use was below plan, with bank use slightly more than anticipated, however, pay remained, overall, within plan.

The delivery of efficiency savings was ahead of plan, for both recurrent and non-recurrent schemes. The Trust continues to forecast delivery of the full CIP plan. Ms Lloyd advised that the teams were continuing to work hard to de-risk schemes, with 79% of schemes now listed as green and the remaining 21% as medium in terms of delivery.

Overall, the System was delivering to plan.

The Board

- ***Considered the adjusted financial position at month 3 - a surplus of £292k, compared to a planned surplus of £289k, which was a favourable variance of £3k.***
- ***Recognised that overall pay costs must remain within planned levels to ensure we deliver our financial plan, the key to which was containing bank and agency spend within our targets for the year.***
- ***Acknowledged that schemes were fully identified to deliver the annual CIP target of £5.4m with no schemes currently rated as high risk in terms of delivery.***
- ***Acknowledged that there were ongoing cost pressures in a small number of areas, plans were being developed to mitigate these pressures as far as possible.***

AUDIT

Audit Committee Chair's Report

Mr Darbhanga stated that the Committee had received the annual self-assessment of the work of the audit committee, which had not identified any issues. The draft internal audit plan had been presented by the Trust's new internal auditors, and the Anti-Fraud report had received a green self-assessment on compliance.

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

Board Assurance Framework

Ms Ramtuhul presented the Board Assurance Framework and confirmed that each Committee had reviewed the risks that sat within their remit. The report highlighted any key changes from previous versions, in particular the updates to actions to address identified gaps in controls and assurance. Ms Ramtuhul brought to the Board's attention the proposal to close the risk in relation to insufficient capital funding which had been considered and agreed by the Resource and Performance Committee.

The Board approved the Board Assurance Framework.

ANY OTHER BUSINESS – with prior agreement of the Chair

Any Other Business

Mr Morgan stated that this would be the final meeting of Ms Sargent, who was stepping down as Non-Executive Director. The Board thanked Ms Sargent for her time at ShropCom and wished her well in the future.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 2 October 2025

Shropshire Community Health NHS Trust

Chief Executive Update

October 2025

0. Reference Information

Author:	**Jo Williams, Chief Executive in Common / Group Chief Executive Designate for Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust**	**Paper date:**	**2 October 2025**
Executive Sponsor:	Jo Williams	**Paper written on:**	25 September 2025
Paper Reviewed by:		**Paper Category:**	Strategy and Leadership
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The Board is asked to ***discuss*** and ***note*** the Chief Executive's update.

2. Executive Summary

This is my first public report to the Board since starting as Chief Executive in September 2025. I want to thank the Board and all our teams for their support and warm welcome during my transition. Meetings with additional teams and services are scheduled in the coming months.

3. Recommendations

The Board is asked to:

- Discuss the contents of the report, and
- Note the contents of the report.

Chief Executive Update

October 2025

4. Main Report

4.1. OVERALL SHROPCOMM (SCHT) UPDATE

Group Model

4.1.1. Since beginning my tenure, I have dedicated most of my time to engaging with colleagues, discussing and gathering ideas, feedback, and suggestions regarding our group model, "Better Together." On Tuesday, 23 September, we achieved an important milestone when the SCHT and SaTH Boards formally approved the Case for Change in a public session.

4.1.2. Firstly, I would like to extend my gratitude to the Executive Team for their commitment and support in developing the case. It is important to acknowledge that our next step will be to establish a unified Executive leadership team across the group, and this process will be approached with care, kindness, and compassion.

4.1.3. We extend our sincere appreciation to all staff, volunteers, and stakeholders who participated in the engagement sessions and provided valuable input. Your contributions have been instrumental to this process, and we remain committed to ongoing dialogue and engagement.

Service Visits

4.1.4. On Monday 22 September, I visited the team at HMP Stoke Heath who provide support and services at the facility. I would like to acknowledge Helen, Jas, and the entire team for discussing their roles with me and outlining both opportunities and challenges in their work. The visit offered me insight into an area outside my usual experience, and I gained a greater understanding of the important service they deliver. Thank you; it was a pleasure meeting everyone. I look forward to returning in the coming months and wish to confirm that I have not forgotten the brief action list I was kindly gifted!

4.1.5. Vaccinating frontline healthcare staff is a key part of protecting people from infectious diseases including flu. Vaccination plays a vital role in protecting our staff, patients and citizens reducing the spread of disease, supporting the NHS, and keeping essential services running when they're needed most. Many of these patients are elderly, immunocompromised, or have underlying health conditions, making them more susceptible to severe outcomes from infections. Reducing the risk of transmission from staff to patients is vital in safeguarding those most at risk.

4.1.6. Vaccinating frontline staff, not only protects their own health and that of our patients, it also protects the whole of the health and social care system. Keeping our staff healthy means hospitals, clinics, and care homes can continue running safely and effectively, especially in winter when demand is higher.

4.1.7. As we commence our annual vaccination plan, I encourage all colleagues to join me and support the campaign and safeguard both themselves and others by receiving the flu vaccination.

Staff Survey

4.1.8. The annual NHS Staff Survey is one of the largest workforce surveys in the world. It's sent to over 1.3 million of our NHS people each year and is completed by over 600,000 of them. It's one of the largest workforce surveys in the world and has been conducted every year since 2003. It's run independently of NHS England and to the highest standards of quality and accuracy.

4.1.9. Your response to the staff survey is completely confidential and anonymous. After the Survey closes, everyone's answers are gathered by the Survey Co-ordination Centre that manages the survey for the NHS. It then takes time to carefully check and analyse that exceptionally large amount of anonymous data. This gives a really accurate picture of what it is like to work in the NHS, which is used by numerous different organisations, as well as your own organisation, to make things better for you, your colleagues, and our patients and service users. Participating in the survey, which takes approximately 15 minutes, will contribute to ongoing improvements within the Trust. The survey is available from 29 September to 28 November.

4.1.10. I value your perspectives, as they enable us to recognise achievements and pursue ongoing improvement, ensuring that everyone feels respected, included, and supported in their roles. By completing the survey, you help ensure that every viewpoint within our workforce is considered, in line with the People Promise: "We each have a voice that counts."

4.1.11. The Urgent and Emergency Care pathways across STW continue to face significant pressures; however, it is crucial that we maintain our focus and collaborate closely on a range of transformation initiatives with system partners. As the system UEC lead, I want to express my sincere appreciation for the resilience and commitment shown by our staff as they adapt to new processes and pathways. Thank you for your continued hard work, dedication, and professionalism.

Staff Awards

4.1.12. Congratulations to Dave Pugh, Deputy IT Services Manager for winning the Trust's Individual of the Year Award and to the Health Smiles Team for the Trust's Team of the Year Award. There is no greater accolade than being recognised by your peers and I'd like to again thank you for all that you do.

10 Year Health Plan

4.1.13. The July 2025 publication of the 10 Year Health Plan for England marked a major step for the NHS. Its focus on creating a "neighbourhood health service" to shift care from hospital to community, analogue to digital, and sickness to prevention aligns with SCHT's strategy. This plan will significantly impact our collaboration within the Group (SaTH), across our system, and with General Practice partners. The 10 Year Health Plan is designed to address the challenges confronting the NHS, as outlined in Lord Darzi's Independent Investigation of the NHS in England and Dr Penny Dash's Review of Patient Safety across the Health and Care Landscape.

4.1.14. The Plan identifies a "neighbourhood health service" as central to its three primary objectives: transitioning care from hospitals to community settings, advancing from analogue to digital solutions, and prioritising prevention over treatment. The 10 Year Health Plan encompasses a wide range of focus areas; a summary of each chapter's main elements is provided below. In the coming months, it will be essential to evaluate these key components, update our Group strategy accordingly, and establish metrics to monitor progress and success while outlining our strategic priorities.

4.1.15. From Hospital to Community: the Neighbourhood Health Service designed around you

- Improved access to GP services
- Integrated neighbourhood teams with neighbourhood contracts
- Neighbourhood health centres for every community
- Redesign of outpatients and diagnostics: Advice & Guidance services, patient-initiated follow-up, artificial intelligence -based approaches

- Redesigning urgent and emergency care – community alternatives to Emergency Department attendances

4.1.16. From Analogue to Digital: Power in Your Hands

- Transformed and expanded NHS App enabling patients to organise care around their needs and choices
- Single patient record enabling more personalised predictive care
- Use of artificial intelligence to support NHS staff and release time to care

4.1.17. From Sickness to Prevention: Power to Make the Healthy Choice

- Smoking – Tobacco and Vapes Bill to prevent access for young people
- Obesity – "moonshot" to end the obesity epidemic
- Alcohol – labelling to support healthy choices
- Support for children and young people's mental health through support teams in schools
- Focus on vaccination and screening programmes

4.1.18. A Devolved and Diverse NHS: A New Operating Model

- Strategic commissioning by ICBs – population outcomes, neighbourhood health and financial sustainability
- New wave of NHS Foundation Trusts
- Highest performing organisations to become Integrated Healthcare Organisations with responsibility and budget for health of the population
- Simpler planning, multi-year budgets and financial incentives to improve outcomes

4.1.19. A New Transparency of Quality of Care

- Strengthening transparency (public league tables), patient voice and choice including patient reported outcome and experience measures
- National investigation into maternity and neonatal services
- National Quality Board – accountability and incentives for improving quality

4.1.20. An NHS Workforce Fit for the Future

- Staff will be better treated, more motivated with better training and development opportunities
- Artificial intelligence will be "trusted assistant" for clinical staff
- Reduce sickness rates to lowest recorded in the NHS
- Minimum standards for "modern employment"
- Reduce reliance on overseas recruitment promoting local recruitment and widening participation opportunities

4.1.21. Powering Transformation. Innovation to Drive Reform

- Five transformative technologies
- Data
- Genomics
- Artificial Intelligence
- Wearable Technology
- Robotics
- To personalise care, improve outcomes, drive productivity and boost economic growth

4.1.22. A New Financial Foundation

- 2% year on year productivity expectation

- Five-year financial plans to restore financial balance
- Deconstruct block contracts
- Best practice clinical tariffs and year of care tariffs
- Move to “fair shares” funding for ICBs based on population needs
- Public private partnerships for capital investment in neighbourhood health centres

4.1.23. The 10 Year Plan for Health has been accompanied by Giving Every Child the Best Start in Life a white paper from the Department for Education that sets out the national vision for early years health and education support for children and families.

4.1.24. The policy includes a Best Start service including Best Start Family Hubs and a Best Start digital service and will be significant for future pathways for children and young people aged 0-19 years.

4.1.25. It is encouraging that the ambitions outlined in the 10 Year Plan for Health aligns with our vision, values, and ongoing collaboration with partners through the STW. However, there are now significant opportunities for us to accelerate progress and advance our initiatives. The Group model will serve as a pivotal mechanism for achieving these objectives. We will conduct a comprehensive review of our plans to ensure they are aligned with forthcoming activities.

4.1.26. This represents an exciting time for our organisation, and we have now both the responsibility and the expertise required to lead this change effectively and at pace.

4.2. SHROPSHIRE TELFORD & WREKIN (STW) INTEGRATED CARE SYSTEM (ICS) UPDATES

4.2.1. The next Integrated Care Board (ICS) Board meeting is due to be held on Wednesday 26 November 2025.

4.3. NHSE

4.3.1. A single joint executive team will be established at the Department of Health and Social Care (DHSC) and NHS England as part of the transition to one organisation. It will provide unified leadership across both organisations, bringing policy and delivery together.

4.3.2. The team will manage directors from related work areas from 3 November 2025 and will begin to combine resources.

4.3.3. The new teams can be found below.

Single joint executive team

4.3.4. The single joint executive team will comprise:

- Samantha Jones, DHSC Permanent Secretary
- Jim Mackey, CEO of NHS England
- Professor Chris Whitty - Chief Medical Officer
- Tom Riordan – Chief Operating Officer/Second Permanent Secretary
- Matthew Style - Director General, System Development
- Duncan Burton - Chief Nursing Officer for England
- Catherine Frances - Director General, Global, Public Health and Emergencies
- Professor Lucy Chappell - Chief Scientific Adviser and Director General, Science and Research
- Sally Warren - Interim Director General, Adult Social Care (recruitment to the

permanent role began in July)
- TBC - Interim Director General, Technology and Data (recruitment to the permanent role will take place during autumn)
- Elizabeth O'Mahony - Interim Director General, Finance (recruitment to the permanent role began in August)
- David Probert - Interim Director General, Performance and Delivery (and continuing as NHS England's Interim Deputy CEO)
- Jo Lenaghan - Interim Director General, People (recruitment to the permanent role began in August)
- Dr Claire Fuller and Professor Meghana Pandit - Interim Medical Directors (recruitment to the permanent role will take place during autumn)
- TBC - Interim Director General, Strategy and Healthcare Policy (recruitment to the permanent role began in July)
- TBC - Interim Director General, Commercial and Growth (recruitment to the permanent role began earlier in September)
- Joint regional teams are also being established to serve as the delivery arm of the centre, driving improvement and performance locally.

Regional leadership

4.3.5. Regional leadership is as follows:

- Louise Shepherd - Regional Director, North West
- Fiona Edwards - Regional Director, North East and Yorkshire
- Dale Bywater - Regional Director, Midlands
- Clare Panniker - Regional Director, East of England
- Caroline Clarke - Regional Director, London
- Sue Doheny - Regional Director, South West (while Elizabeth O'Mahony is NHS England's Chief Financial Officer)
- Anne Eden - Regional Director, South East (until she leaves at the end of March)
- Existing DHSC Regional Public Health Directors will begin to report into Regional Directors in the same area from 3 November, subject to appropriate consultation, while continuing to work with the Director General of Public Health and Emergencies.

National Priority Programmes

4.3.6. National Priority Programmes are also being set up to drive delivery of the government's key health priorities, drawing together teams and expertise from across the organisations and the country.

4.3.7. National Priority Programmes are led by:

- Mark Cubbon - National Priority Programme Director for Planned Care
- Sarah-Jane Marsh - National Priority Programme Director for Urgent and Emergency Care
- Duncan Burton - Interim National Priority Programme Director for Maternity, Women's Health, Children and Young People
- Dr Claire Fuller - Interim National Priority Programme Director for Neighbourhood Health
- Recruitment to the role of National Priority Programme Director for Mental Health, Learning Disability and Autism will start shortly
- Dr Amanda Doyle will continue as NHS England's National Director of Primary Care and Community Services and Glen Burley will continue as NHS England's Financial Reset and Accountability Director, both reporting to the NHS England CEO

Chief Executive Update
October 2025

5. RECOMMENDATION(S)

5.1 The Board is asked to discuss the contents of the report, and

5.2 Note the contents of the report.

Jo Williams
Jo Williams, Chief Executive in Common / Group Chief Executive Designate
Shropshire Community Health NHS Trust and
The Shrewsbury and Telford Hospital NHS Trust

26 September 2025

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of Shropshire Community Health NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	None
Comments:	Dr M Ganesh continues as Medical Director and RO
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Maintain support for RO role
Comments:	Funding support maintained
Action for next year:	Maintain support for RO role

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Maintain updated records
Comments:	GMC connect list regularly reviewed by the Responsible Officer and doctors with a prescribed connection to the designated body are promptly added when joining the organisation and removed when leaving
Action for next year:	Maintain updated records

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Completion of the Medical Appraisal and Revalidation Policy review policy review and approval process
Comments:	Policy Review completed including updated GMC professional standards and appraisal guidance
Action for next year	Monitor and review if required

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	An external audit team will be commissioned to report on medical revalidation arrangements at the trust
Comments:	An external audit was undertaken by BDO in Oct24 with all actions identified completed concluding that the Trust has a Substantial design of controls and Moderate effectiveness of controls for Clinical Staff Revalidation and Registration processes. All actions recommended have been undertaken.
Action for next year:	Monitor

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continued support of all staff needs
Comments:	Ad hoc review of medical and dental induction procedure checklist underway
Action for next year	Updated medical and dental induction procedure checklist in place to support effective induction

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work

carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue appraisal support with refresh of the Appraisal and Revalidation Policy, including more emphasis on provision of supporting evidence at appraisal for whole scope work.
Comments:	Training delivered to facilitate appraisers and appraisees use of the new portfolio to ensure effective annual appraisal, including whole scope of evidence to support all roles. Positive feedback following implementation on appraisal feedback audit and following updates.
Action for next year:	Continue appraisal support

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	NA
Action from last year:	
Comments:	
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Review of the Appraisal and Revalidation Policy completed, including more emphasis on provision of supporting evidence at appraisal for whole scope work, and updating of

	the Equality and Diversity principles and their application to appraisal and revalidation processes.
Comments:	Policy Review Completed and whole scope training update undertaken
Action for next year:	Audit appraisal quality against approved tool

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	To facilitate appraiser training where needed
Comments:	We have 4 trained appraisers for 9 attached doctors which is currently sufficient.
Action for next year:	Continue to facilitate appraiser training where needed.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	An external audit team planned to report on medical appraisal and revalidation arrangements at the trust. Reaudit of self-assessment of appraiser skills planned.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	External Audit undertaken by BDO found we had effective medical appraisal and revalidation processes in place. We provide biannual appraiser updates and training with ad hoc updates where needed. Appraisal feedback audit is completed annually with action plan agreed. External appraisal update training offered to all appraisers.
Action for next year:	Reaudit of self-assessment of appraiser skills planned now the new appraisal portfolio is implemented.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	An external audit team has been commissioned to report on medical revalidation arrangements at the trust
Comments:	An external audit was undertaken by BDO in Oct24 with all actions identified completed concluding that the Trust has a Substantial design of controls and Moderate effectiveness of controls for Clinical Staff Revalidation and Registration processes. All actions recommended have been undertaken. Annual appraisal feedback audit completed, and action plan developed, reporting to Board via Quality and Safety Committee.
Action for next year:	The trust moves to a group model with the local acute trust later this year and it is hoped this will facilitate peer review of medical revalidation and appraisal to provide assurance and feedback.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	None
Comments:	Revalidation recommendations have been undertaken or deferred in accordance with the national recommendations. There have been no non-engagement notifications and timely recommendations have been made for doctors with prescribed connections in line with their revalidation timetable.
Action for next year:	Continue

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	None
Comments:	All recommendations are promptly communicated.
Action for next year:	Continue

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Improve clarity over clinical governance for doctors working in all services, including those with a prescribed connection to another designated body, through annual role review,

	providing supporting evidence for them at their appraisal and strengthened assurance processes for the trust.
Comments:	Doctors with a prescribed connection to our organisation are supported by clear clinical governance arrangements for doctors. Some new and existing services are supported by doctors with a prescribed connection to another designated body, and the refreshed Medical Appraisal and Revalidation Policy is specific about annual role review to provide evidence to support their clinical appraisal.
Action for next year:	Ensure operational leaders are implementing annual role review in all relevant services.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	Use the roll out of the refreshed Appraisal and Revalidation Policy as an opportunity to build awareness of annual role appraisal in all services employing doctors with a prescribed connection to another designated body.
Comments:	The Medical Appraisal and Revalidation policy review has strengthened the trust systems for monitoring conduct and performance of doctors by including clearer reference to requirement to provide supporting evidence for all roles at appraisal, including annual role reviews for doctors employed in our services.
Action for next year:	Ensure operational leaders are implementing annual role review in all relevant services.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Continued support

Comments:	Ongoing positive feedback on implementation of FourteenFish appraisal portfolio ease of use
Action for next year:	Continue support

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	**Y**
Action from last year:	Ongoing review of response to concerns on case by case basis involving all involved to gain learning and further improve on our approach
Comments:	Established process in place and Policy up to date. No concerns requiring case review occurred this year.
Action for next year:	Ongoing

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Maintain awareness

Comments:	No concerns have been raised this year. However when these occur the small numbers of doctors raise challenges for reporting confidentiality. The sections of the Appraisal and Revalidation Policy relating to Equality and Diversity have been updated.
Action for next year:	Maintain awareness

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	**Y**
Action from last year:	None
Comments:	Process is via local, regional and national RO networks and keeping GMC Connect up to date, by Health Professional Alert Notices from NHS Resolution, and by RO and revalidation status for doctors not prescribed to SCHT being identified on recruitment
Action for next year:	Maintain

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	**Y**
Action from last year:	Maintain

Comments:	Mandatory training covering discrimination is provided and the Maintaining high standards of performance policy has been updated to ensure processes are fair, free from bias and discrimination. The sections of the Appraisal and Revalidation Policy relating to Equality and Diversity have been updated**.**
Action for next year:	Maintain

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	**Y**
Action from last year:	Maintain
Comments:	There are regular meetings with other ROS and CMOs from the ICB and our trust will soon be part of a group model with the local acute trust allowing closer working and support opportunities.
Action for next year:	Maintain

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Maintain
Comments:	All policies and processes for all staff groups have been reviewed in the light of the recommendations from the Messenger review to ensure compliance and consistency.

Action for next year:	Maintain

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Y**
Action from last year:	Maintain
Comments:	Thorough HR recruitment processes embedded aiming for improved timescales to recruitment with no identified issues. All pre-employment checks are undertaken in line with NHS Employers standards and national legislation. No prospective employee commences employment without satisfactory checks are in place.
Action for next year:	Maintain

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	**Y**
Action from last year:	Build on and implement the trust strategy
Comments:	The Senior leadership team, executive team and board provide a supporting environment and culture following

	wholesale review of the trust values and strategy. Establishment of multi-professional leadership forum.
Action for next year:	Maintain and build on opportunities form the move to a group model to share experience of clinical excellence.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	Monitored monthly with regard to who has undertaken the mandatory training. We report annually and publish the WDES & WRES reports.
Comments:	Policies and procedures and training are in place to support compassion, fairness, respect, diversity and inclusivity and these behaviours are proactively promoted. We introduced the Oliver McGowan training and Tier1 and 2 modules are now available. We have a workforce race equality staff network, a disability staff network and a LGBTQ+ staff network. We are an accredited Disability Confident Employer at level 2. We have a Veterans Group. The sections of the Appraisal and Revalidation Policy relating to Equality and Diversity have been updated.
Action for next year:	Monitor and maintain

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	Annual report will be completed following up on any actions from FTSU activity.

Comments:	Policies and procedures and training are in place to support the values and behaviours around openness, transparency, freedom to speak up and a learning culture and these behaviours are proactively promoted. We have Freedom to Speak up Guardian and FTSU Champions across all areas of the Trust and a FTSU e-learning training package available for all staff. Senior leaders and board are expected to complete all three modules (Speak Up, Listen Up and Follow Up) to ensure they have a full understanding of the speaking up process, including a reflective tool.
Action for next year:	Maintain

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	**Y**
Action from last year:	Maintain
Comments:	Formal policies and procedures are in place to support feedback about the organisation' professional standards processes by its connected doctors.
Action for next year:	Maintain

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	
Action from last year:	Commence collecting data on country of primary medical qualification, (or healthcare qualification for other health professionals) when concerns and complaints are brought to attention

Comments:	We have small numbers of doctors employed by the trust and fewer involved with concerns and disciplinary processes (none this year) making data to determine parity hard to interpret.
Action for next year:	Collect data on country of primary medical qualification via GMC website, (or healthcare qualification for other health professionals) when concerns and complaints are brought to attention

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	An external audit team will be commissioned to report on medical revalidation arrangements at the trust.
Comments:	An external audit team was unable to be identified. There are regular RO meetings with partner system trusts and meetings with higher level RO
Action for next year:	Explore opportunities within the new group model to ensure its professional standards processes are consistent with other organisations

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	8
Total number of appraisals completed	8
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	2
Total number of late recommendations	0
Total number of positive recommendations	2
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	8
Total number of trained case managers	10
Total number of concerns received by the Responsible Officer[2]	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
All actions outlined in the previous report have been actioned or where delayed have a plan in place to address. No new or significant risks have been identified.
Actions still outstanding
Peer review of appraisal and revalidation processes
Current issues
None

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
Monitor ongoing satisfactory processes and continue support for appraisers and appraisees. Complete update of medical and dental induction procedure checklist in place to support effective induction. Undertake an audit of appraisal quality against an approved tool. Reaudit of self-assessment of appraiser skills planned now the new appraisal portfolio is implemented. As the trust moves to a group model with the local acute trust later this year and it is hoped this will facilitate peer review of medical revalidation and appraisal to provide opportunities for assurance and feedback. Ensure operational leaders and managers are implementing annual role review in all relevant services. Collect data on country of primary medical qualification via GMC website, (or healthcare qualification for other health professionals) when concerns and complaints are brought to attention.
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
Feedback from the external audit has provided welcome assurance that our existing processes around appraisal and revalidation are robust and fit for purpose, and areas of potential weakness have been addressed. We are now moving toward a period of significant change into a group model with our acute trust, and the appointment of a Chief Executive in common. This closer working will provide opportunities for us to learn and benefit from the broader expertise of a larger trust, including opportunities for shared appraisal learning and development and to share experience of clinical excellence.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Shropshire Community Health NHS Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Dr Emily Peer
Email address:	emily.peer@nhs.net

Annual GMC Assurance Report

0. Reference Information

Author:	Dr Mahadeva Ganesh	**Paper date:**	02 October 2025
Executive Sponsor:	**Dr Mahadeva Ganesh Medical Director**	**Paper written on:**	24 September 2025
Paper Reviewed by:	Quality and Safety Committee	**Paper Category:**	Quality
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper provides the Annual GMC Assurance Statement for approval prior to submission

2. Executive Summary

2.1 Context

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although they are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer, and
c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

FTSU Report – Quarter 1 25/26

Shropshire Community Health NHS Trust

0. Reference Information

Author:	David Ballard, Freedom to Speak Up Guardian	**Paper date:**	22 Sep 25
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	11 Aug 25
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Governance
Forum submitted to:	Executive Team	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an outline of the ongoing work of the Freedom To Speak Up (FTSU) service and provides a review of the FTSU activity for Quarter 1 of 2025 - 26.

2. Executive Summary

2.1. Context

The Trust has committed to enhancing the FTSU service and the work being undertaken is reported on a regular basis to the People Committee and Trust Board. The data is collated in relation to the FTSU activity and is included in the quarterly reports to the Committee.

2.2 Summary

The self- assessment (attached at Appendix 1) shows progress from the previous quarter with there now being zero elements not compliant, compliant elements remain static:

Reporting Period	Compliant	Partially Compliant	Not Compliant
Q2 23-24	12	21	7
Q3 23-24	21	16	3
Q4 23-24	28	8	4
Q1 24-25	29	9	2
Q2 24-25	30	8	2
Q3 24 – 25	30	8	2
Q4 24 - 25	29	11	0
Q1 25 – 26	29	11	0

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

Shropshire Community Health NHS Trust

2.3 Conclusion

The Board is asked to **note** the updated position and the position with regard to the self-assessment. Progress has been limited and there is still an amount of work to complete. The assessment remains at partial assurance overall.

The Board is also asked to **note** the quarterly activity and the ongoing actions and assess if it is **assured** by the progress to date.

APPENDIX 1: SELF ASSESSMENT JUNE 2025

Summary of the expectation	Review Date	Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating (or further enhancement of evidence)
Behave in a way that encourages workers to speak up			
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up.			
Understand the impact their behaviour can have on a trust's culture	15 Oct 24	Culture and leadership programme has been completed – await feedback. Board training on FTSU completed.	
Know what behaviours encourage and inhibit workers from speaking up	15 Oct 24	Culture and leadership programme has been completed – await feedback. Board training for FTSU completed Nov 24.	
Test their beliefs about their behaviours using a wide range of feedback	15 Oct 24	NHS Staff Survey 2024 results analysed in Mar 25. There has been a 3% improvement in the People Promise theme, 'We Each Have a Voice That Counts', with improvements in each of the questions related to the theme. Notably there has been a 9.66% improvement in staff's confidence in concerns being addressed, and 6.85% improvement in staff feeling safe to speak up.	

Reflect on the feedback and make changes as necessary	~~15 Oct 24~~ 30 Sep 25	"You said we did" bulletins, Board session held on staff survey results and with wider SLT, manager toolkit issued and staff survey conversations commenced	Awaiting results of manager conversations to be fed into overarching improvement plan
Constructively and compassionately challenge each other when appropriate behaviour is not displayed	~~15 Oct 24~~ 30 Sep 25		SR leading. The 360 review is going to form part of the Well Led and Board Effectiveness review. This has been delayed; business case and approval needed. This aspect is also being explored through the work of the Culture and Leadership Programme. June 25 – The Board has indicated that it wishes to do this jointly with SaTH, an indicative quote is being taken to SaTH Board.
Demonstrate commitment to FTSU			
The board can evidence their commitment to creating an open and honest culture by demonstrating:			
There are a named Executive and non-executive leads responsible for speaking up	15 Oct 24	Director of Nursing is Executive Lead for FTSU, Harmesh Darbhanga is the Non-Executive Lead	
Speaking up and other cultural issues are included in the Board Development Programme	15 Oct 24	Culture session held in March 24 with a further session planned for July 24	Three levels of National Guardian training (dependant on role) has been recommended for inclusion in mandatory training programme for the Trust. Board have been invited to undertake their level of training.
They welcome workers to speak about their experiences in person at Board meetings	15 Oct 24	Staff stories are shared at Board on a regular basis.	

		With the new Guardian in post, they report to the People Committee on a quarterly basis.	
The Trust has a sustained an ongoing focus on the reduction of bullying, harassment, and incivility	15 Oct 24	The introduction of the FTSU online platform will provide data collection and analysis. The Trust launched its Civility and Respect Programme delivered by OD in Q1 of 24/25 which is available to all staff. The output of this training gets reported to JNP and the assurance report of People Committee	.
There is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made	~~15 Oct 24~~ 30 Sep 25		The FTSU Guardian as part of the feedback loop to individuals who use the service, will determine whether detriment has been suffered. The data for this is also captured as part of the data submitted to the NGO on a quarterly basis. The evidence of this has not been captured previously. Although there has been instances during Q1 25/26 where staff have withdrawn cases through fear of suffering detriment, to date there is no evidence that detriment has been experienced as a result of raising a concern Follow up actions to detriment being experienced has not been tested. A feedback form has been created in Q1 25/26 which will be used to assess detriment. With limited responses thus far, evidence of detriment is inconclusive.

The Trust continually invests in leadership development	15 Oct 24	The Trust offers multiple avenues for Leadership development, internal and external to the Trust, FTSU included in induction and FTSUG delivers induction. The recently appointed People Promise Manager actively supports leadership development in the Trust by championing the NHS People Promise.	
The Trust regularly evaluates how effective its FTSU Guardian and champion model is	15 Oct 24	Niche review was asked specifically to look at FTSU arrangements, whilst this was focussed on the Prison, the recommendations were Trust wide.	Ongoing assessment will form part of the work programme for the FTSU Group. This will be overseen for governance purposes at People Committee.
Have a strategy to improve your FTSU culture			
The Board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate:			
As a minimum – the draft strategy was shared with key stakeholders	~~15 Oct 24~~ 30 Sep 25	Strategy in place but out of date	New strategy needs has been socialising through extensive FTSU Comms campaign and on dedicated FTSU page on the Staff Zone.
The strategy has been discussed and agreed by the board	~~15 Oct 24~~ 31 Dec 25		FTSU Strategy has been presented at People Committee who has asked it to be socialised before presenting for approval at Board.

The strategy is linked to or embedded within other relevant strategies	15 Oct 24	New strategy links with the Culture and Engagement Strategy	
The Board is regularly updated by the Executive Lead on the progress against the strategy as a whole	~~15 Oct 24~~ 30 Sep 25		Strategy updates added to the workplan for People Committee and Board, reporting to commence once strategy signed off.
The Executive Lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	~~15 Oct 24~~ 30 Sep 25	FTSU Group is in place and meets monthly.	Quantitative measures now included at Appendix 4 and 5 of FTSU reports.
Support your FTSU Guardian			
The Executive Team can evidence they actively support their FTSU Guardian. Evidence should demonstrate:			
They have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively	15 Oct 24	The FTSUG is the OD BP and has 0.2 of his WTE allocated to FTSU work. This time allocation will continue to be monitored.	
The Guardian has been given time and resource to complete training and development	15 Oct 24	FTSUG has completed the NGO Training and attends regional and national guardianship meetings and is part of the FTSU network	
There is support available to enable the Guardian to reflect on the emotional aspects of their role	15 Oct 24	The FTSU Guardian seeks supervision from the NGO and of FTSU colleagues, most notable his counterpart at SaTH.	
There are regular meetings between the Guardian and key executives as well as the non-Executive lead.	15 Oct 24	Attendance at the monthly FTSU Network meetings includes the Exec Lead and NED sponsor.	

Individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner	15 Oct 24	There is a clear process in place for the FTSU Guardian and Champions to escalate patient safety matters and ensure FTSU cases are progressed in a timely manner	
They have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes	15 Oct 24	Data is available to FTSU Guardian as required.	
The Guardian is enabled to develop external relationships and attend National Guardian related events	15 Oct 24	The FTSU Guardian attends regional and national guardianship meetings and regularly seeks support from the FTSUG at SaTH	

Be assured your FTSU culture is healthy and effective

Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:			
That the policy is up to date and has been reviewed at least every two years	15 Oct 24	The new policy provided by the NGO was signed off by People Committee in Jan 25 and is now available on the Staff Zone.	
Reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian	~~15 Oct 24~~ 30 Sep 25	Gap analysis completed and external review of FTSU arrangements via Niche	Feedback needs to be obtained from users and analysed, use of FTSU app will support this
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate:			

Assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience.	15 Oct 24	Data is available to FTSU Guardian as required.	
You map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
You have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
You evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	~~15 Oct 24~~ 30 Sep 25	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	FTSU reporting needs to be strengthened initial reporting established but could provide greater analysis as the quantitative and qualitative data is strengthened.
The Board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	15 Oct 24	Going forward the new Guardian will attend Board to present each quarterly report.	
The Board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	~~15 Oct 24~~ 30 Sep 25		The Trust will need to review the JD of the new FTSU Guardian and due to the size of the organisation this has been added to an existing role.

The Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	15 Oct 24	Gap analysis has been completed and presented to both Audit Committee and People Committee which are attended by members of the Board	
Be open and transparent			
The Trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:			
Discussion with relevant oversight organisation	~~15 Oct 24~~ 30 Sep 25	The Board is briefed on issues reported, none have yet required discussion with oversight organisation	A healthy speaking up culture is created by Boards that are open and transparent and see speaking up as an opportunity to learn. The Board should routinely discuss challenges and opportunities presented by matters raised through speaking up.
Discussion within relevant peer networks	15 Oct 24	Access to the national FTSU network which has email forums for problem solving. FTSU System meeting attended	
Content in the trust's annual report	15 Oct 24		Overview of the Trust's FTSU has been included in 24/25's QA report that was approved at Board in June 25.
Content on the trust's website	15 Oct 24	Content on Trust's website has been refreshed and provides in-depth detail of the Trust's FTSU provision	
Discussion at the public Board	15 Oct 24	Quarterly reports to the Board	
Welcoming engagement with the National Guardian and her staff	15 Oct 24	FTSU is in communication with the NG and receives all the network	

		information / attends the network meetings	
Individual Responsibilities			
The Chair, Chief Executive, Executive Lead for FTSU, Non-Executive Lead for FTSU, HR/OD Director, Medical Director and Director of Nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	15 Oct 24	New Fit and Proper Person Framework self-assessment and appraisal documentation in place and currently being completed	

APPENDIX 2: QUARTER 1 25 / 26 FTSU ACTIVITY

FTSU Reports

There were 11 new cases raised during Q1 25 / 26, one of which remains open.

Case #	Staff Type	Issue Raised	Category	Action Taken	Outcome
23	Admin and Clerical	24 Apr 25 Leadership behaviours	Bullying and Harrassment	Support offered.	Case closed
24	Registered Nursing and Midwifery	1 May 25 Team behaviours	Patient safety and quality	Staff member moved to different team	Case closed
25	Admin and Clerical	2 May 25 Leadership behaviours	Leadership / Line Manager	Support offered	Case closed
26	Admin and Clerical	2 May 25 Team behaviours	Misconduct	Support offered	Case closed
28	Admin and Clerical	8 May 25 Team behaviour	Leadership / Line Manager	Support offered	Case closed
29	Anonymous	9 May 25 Leader behaviours	Bullying and Harrassment	Support offered by Exec Lead	Case closed
30	Registered Nursing and Midwifery	14 May 25 Flexible working request	Employee Terms and Benefits	Support offered by HR and OH	Case closed
31	Admin and Clerical	20 May 25 Manager's behaviours	Leadership / Line Manager	Support offered by Divisional lead	Case closed
32	Registered Nursing and Midwifery	2 Jun 25 Organisational culture	Patient safety and quality	Coaching offered.	Case closed

				Support provided by Exec Lead	
33	Admin and Clerical	10 Jun 25 Salary on Appointment	Employment Terms and Benefits	Support offered by HR	Case closed
34	Anonymous	11 Jun 25 Bullying	Bullying and Harrassment	Support offered by Divisional lead	Case open

FTSU Headlines, Network Meetings, and actions

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

The online FTSU platform, 'Work in Confidence', continues to be established as a resource and utilised by staff. The platform, set up in May 24, has been used by staff to raise concerns, and by the Guardian and Champions (Appendix 6) to manage cases. A quick reference guide for staff that details how to access and use the platform was added to the Staff Zone in the FTSU pages.

Additional reporting metrics has been added at Appendix 4 and 5; Concerns Raised By Channel, and Concerns Raised By Staff Group.

Closure of the National Guardians' Office

The closure of the NGO was announced during this quarter and is part of the UK Government's 10-Year Health Plan, titled *Fit for the Future*, streamlining national staff voice functions by integrating the NGO's responsibilities into NHS England.

The NGO will remain operational until 2026, after which NHS England will take over its national support and guidance functions.

Despite the closure of the NGO, the Freedom to Speak Up Guardian role will continue and remain part of the NHS Standard Contract for 2026/27:

- NHS England will oversee the national functions previously managed by the NGO.
- Guardians will still operate locally within NHS organisations, providing confidential support and guidance to staff.
- The Guardian role remains mandatory for NHS providers.
- Guardians will continue to offer safe, confidential routes for staff to raise concerns.

FTSU visits to HMP Stoke Heath

A visit to raise awareness of the FTSU service for the staff at HMP Stoke Heath was actioned. Subsequent visits are planned for Q2 25/26.

Detriment

Through conversations with staff, the FTSUG has been made aware that staff are concerned about experiencing detriment as a result of raising a concern. The NGO states, '…it is … vitally important to clearly communicate how to raise concerns, what workers can expect if they do speak up, *and how they will be protected from detrimental treatment as a result of speaking up*.' . The Guardian is aware of examples where staff have raised fear of detriment, and whether justified or not, it is clear that there is work to do in this area.

To rectify this, it is suggested that the following measures be implemented:

1. Publicly Reaffirm Commitment to a Safe Speaking-Up Culture

- Issue a statement from senior leadership explicitly affirming that **no staff member will suffer detriment** for raising concerns.
- Reference the National Guardian's Office guidance to reinforce credibility.
- Highlight the statutory protection that exists for those raising a concern.
- Include real examples of concerns that led to positive change without negative consequences.

2. Strengthen and Promote the Freedom to Speak Up (FTSU) Process

- Ensure the FTSU Guardian and Champions are visible, approachable, and well-trained.
- Promote multiple routes for raising concerns (e.g. anonymous reporting, direct to Guardian, via line manager).
- Regularly audit the FTSU process to ensure it's working as intended. First audit is planned during Q2 25/26 with MIAA.

3. Implement a Zero-Tolerance Policy on Detriment

- Update internal policies to define "detriment" clearly and outline consequences for retaliatory behaviour.
- Train managers and team leaders to recognise and prevent subtle forms of detriment, such as exclusion or negative performance reviews.

4. Monitor and Investigate Allegations of Detriment Promptly

- Investigate allegations of detriment appropriately in accordance with existing Trust policies.Offer support services (e.g. counselling, peer support) to staff who feel vulnerable after speaking up.

5. Celebrate Speaking Up

- With the agreement of those involved in a FTSU case, share anonymised stories of staff who raised concerns that led to improvements.
- Recognise and reward teams that demonstrate openness and transparency.

6. Regular Staff Engagement and Feedback

- Conduct anonymous surveys to gauge staff confidence in the speaking-up process.
- Use feedback to refine policies and address emerging concerns.

APPENDIX 3: FTSU PROJECT PLAN

FTSU Project Plan - Shropshire Community Health NHS Trust

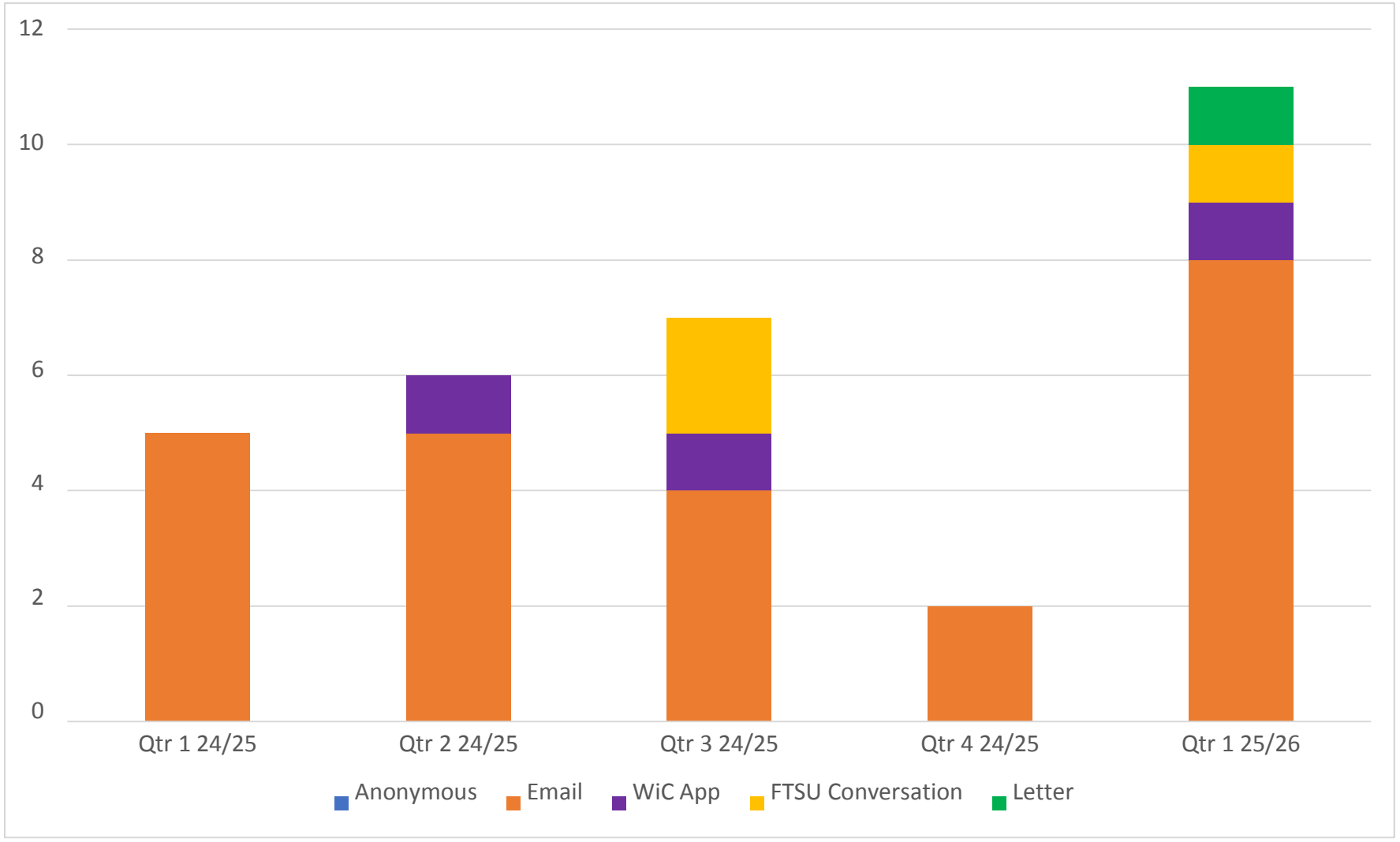
	Project Plan Deliverables	Project Lead	Start Date	Deadline	Status	Notes
1	**Set Up**					
1.1	Project plan to be drafted and approved	Project Officer	15/04/2024	25/04/2024	Completed	
1.2	FTSU Guardian to complete training & be onboarded	FTSU Guardian	15/04/2024	31/05/2024	Completed	
1.3	Comms & engagement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

2.1	Implement comms & engagement plan	Comms	01/06/2024	01/09/2024	Completed	
2.2	Update relevant staff zone & website areas	Project Officer	15/04/2024	01/10/2024	Completed	
2.3	Promotion of app; standalone bulletins, Noticeboard, Staff area's posters, Q Time, Staff/Volunteer induction, Staff Facebook group; what it is, how to register, who we are,	Comms	01/06/2024	30/06/2024	Completed	
2.4	Promotion of FTSU; Posters, What it is, who we are	Comms	01/06/2024	30/06/2024	Completed	
2.5	Recruitment call for FTSU champions in identified gaps & in staff network groups	Project Officer	01/06/2024	30/06/2024	Completed	
2.6	Ensure all FTSU champions have completed; speak up; listen up; follow up training	Project Officer	15/04/2024	01/10/2025	Ongoing	Newly appointed FTSU Admin to follow up
2.7	Create content on what is FTSU-Speaking Up, How to raise a concern etc	Project Officer	15/04/2024	24/04/2024	Completed	
2.8	FTSU Champions to attend HWB days and other event or staff meetings	Project Officer	01/06/2024	ongoing	Completed	
2.9	Host drop in sessions "about FTSUP & How to raise'	Project Officer	01/07/2024	31/07/2024	Completed	To form part of HWB days
3	**FTSU online platform – 'Work in Confidence'**					
3.1	Organisation account set up	Project Officer	15/04/2024	29/04/2024	Completed	

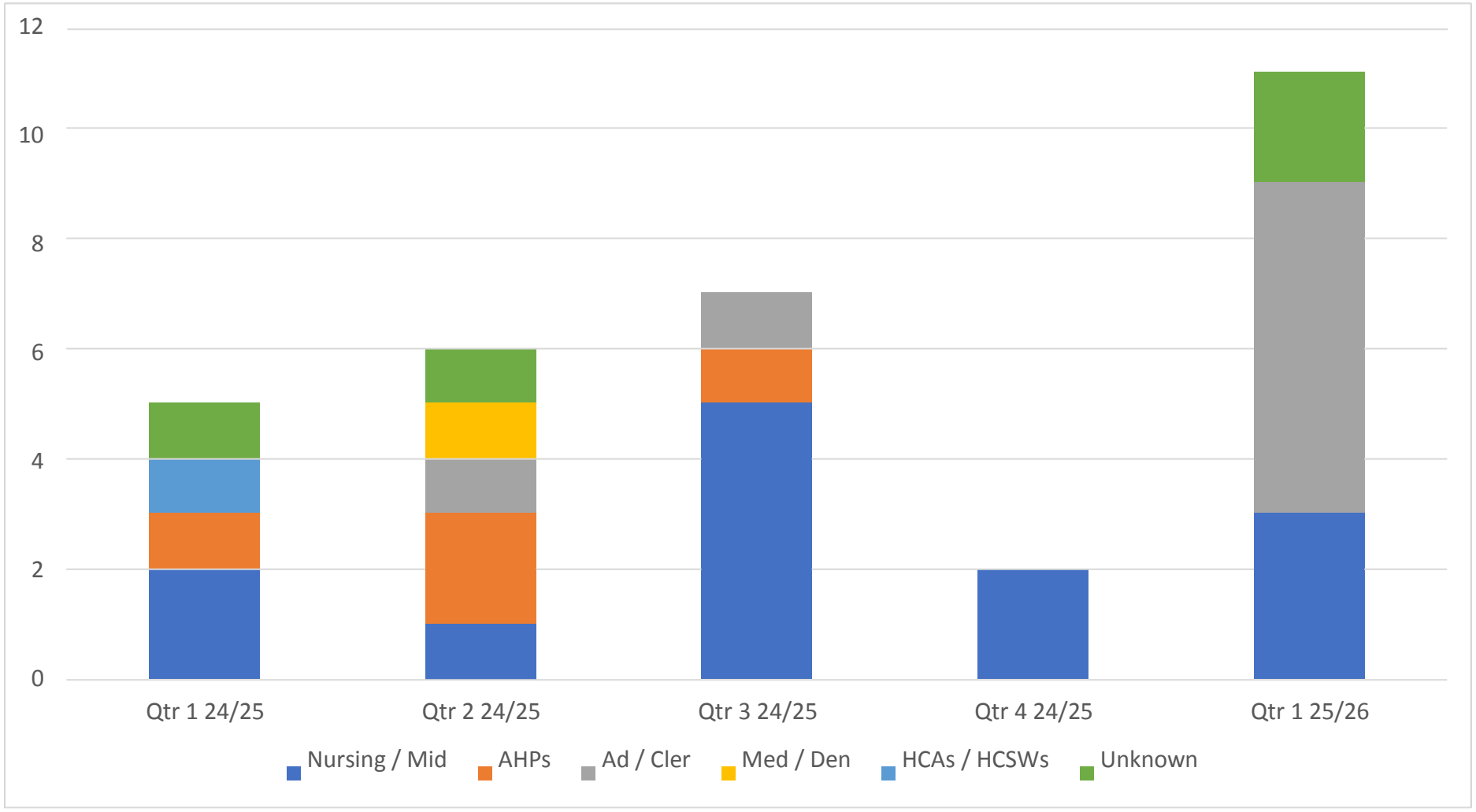
3.2	Complete admin training	Project Officer	15/04/2024	22/04/2024	Completed	
3.3	Confirm who will respond to messages (master admins)	FTSU Guardian	15/04/2024	29/04/2024	Completed	
3.4	Link with IG for considerations to be made; GDPR & Data Protection	Project Officer	01/06/2024	08/06/2024	Completed	
3.5	Confirm in app categories required	FTSU Guardian	15/04/2024	29/04/2024	Completed	
3.6	FTSU Champions to complete training	FTSU Champions	15/04/2024	30/04/2024	Completed	
3.7	Create 'dummies' guide & upload to staff zone	Project Officer	01/06/2024	14/06/2024	Completed	
3.8	Staff to self register for app (Comms)	Project Officer	01/06/2024	14/06/2024	Completed	
3.9	Add desktop link to landing page	Digital	01/06/2024	31/07/2024	Completed	
3.10	FTSU guardian / champions monitor app	FTSU Guardian	01/06/2024	ongoing	Completed	
4	**Best Practice**					
4.1	Scope adding core training for all workers to LMS & promote	Project Officer	01/06/2024	31/08/2024	Completed	Online training modules have been provided for all staff via ESR

4.2	If above approved add additional training for manager and senior leaders & promote	Project Officer	30/06/2024	31/08/2024	Completed	
4.3	Ensure a clear policy, procedure & strategy are in place	FTSU Guardian	01/06/2024	20/09/2024	Completed	New policy approved by PC in Jan 25 and is now available on the Staff Zone

APPENDIX 4: CONCERNS RAISED BY CHANNEL



APPENDIX 5: CONCERNS RAISED BY STAFF GROUP



APPENDIX 6: FREEDOM TO SPEAK UP CHAMPIONS

Shropshire Community Health NHS Trust

Safeguarding Annual Report 2024-2025

Reference Information

Author:	Sarah Rock Head of Safeguarding	**Paper date:**	2nd of October
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality and Clinical Delivery	**Paper written on:**	July 2025
Paper Reviewed by:	Sara Ellis, Deputy Director of Nursing and Quality and Deputy DIPC Safeguarding Committee Clair Hobbs, Director of Nursing, Quality and Clinical Delivery Quality and Safety Committee	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA (Freedom of Information Act) Status:**	Full

Purpose of Paper

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

This paper provides an annual update for the Trust Board on key safeguarding activities from 01 April 2024 to 31 March 2025. It aims to assure that Shropshire Community Health NHS Trust (SCHT) is fulfilling its statutory responsibilities to safeguard and promote the welfare of children, adults, and families who interact with our services, as outlined in the Children Act 1989 and 2004, and The Care Act 2014.

Staff are supported to work in partnership and to respond proportionately and appropriately to safeguarding concerns for children, young people, and adults at risk, who access services across SCHT, in accordance with their statutory duties. All safeguarding work across the Trust is underpinned by our Trust Values.

Executive Summary

Context

The Shropshire Community Health NHS Trust Safeguarding Annual Report 2024-2025 highlights the organisation's efforts and achievements in safeguarding children and adults within Shropshire, Telford & Wrekin, and Dudley. It details activity, multi-agency collaboration, training compliance, key challenges, risks, and key areas of focus for future improvements.

Summary

- A steady increase in Mental Capacity training compliance following a change in training modules has been sustained throughout this year.

- Safeguarding training compliance has been sustained at 90%, despite dips in children's training compliance in September 2024 and March 2025 due to some review of ESR staff alignment in training requirements.

- Dudley 0 – 19 service was transferred to SCHT in April 2024.

- 43 safeguarding quality visits were conducted by the Safeguarding Team providing visibility, and the opportunity for advice and support, and case discussion. There has been an investment in staff training within the Safeguarding Team to support quality and succession planning.

- Mental Capacity Audits throughout the year have shown improvement in the quality of assessments in the completion by staff.

- Safeguarding awareness sessions are now included within the Trust's Clinical Induction.

- Ask 5 Survey around Prevent was completed and gave assurance around staff awareness and knowledge of processes within the Trust

- Self-neglect posed the most common reason for adult safeguarding referrals made by the Trust.

- Health representation within Family Connect (Telford & Wrekin's First Point of Contact) and Compass Health (Shropshire First Point of Contact) has developed an integrated approach supporting service delivery across both sites.

- Initial learning from each Rapid Review within this period is disseminated to all staff using the Permission 2 Pause format and circulated through Datix and shared at Trust meetings and in supervision. In addition, all Permission 2 Pause documents are readily accessible on the Staff Zone.

- A variety of Newsletters, 7-minute briefings, learning briefings (Permission to Pause) and videos have all been produced by the Team alongside shared learning from both Partnerships which has been shared timely to meet all learning styles within the Trust and shared on the staff zone.

- There have been 165 requests for Statements of Evidence for Court.

Conclusion

The Trust Board is asked:

- To **note** the key safeguarding activities across the organisation.
- **Accept** the report as assurance that SCHT is meeting its statutory responsibilities regarding safeguarding and promoting the welfare of children, adults and families that encounter our services as set out in the Children Act 1989 and 2004 and the Care Act 2014.
- **Approve** the Annual Report

MAIN REPORT

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1. Introduction

1.1 This Annual Report provides an update on the key safeguarding activities for the period 1st April 2024 to 31st March 2025 and incorporates the work of the Safeguarding Team within Shropshire Community Health NHS Trust (SCHT).

1.2 The Annual Safeguarding Report provides an overview of the safeguarding activities and progress made over the past year. It aims to:

1.2.1 Provide assurance that SCHT is meeting its statutory responsibility regarding safeguarding and promoting the welfare of children, adults and families that encounter our services as set out in the Children Act 1989 and 2004 and the Care Act 2014.

1.2.2 Highlight key achievements and developments in safeguarding practices and identify areas for improvement and set priorities for the coming year.

2. Background

2.1 Shropshire Community Health Trust is committed to ensure safeguarding is part of core business and has a responsibility to safeguard children, young people, and adults in its care. This is a legislative requirement set out in:

2.1.1 The Children Act (1989), the Children Act (2004)

2.1.2 The Care Act (2014) and Health and Social Care Act (2022)

2.1.3 The Mental Capacity Act (2005)

2.2 In addition, the Trust is committed to ensuring safeguarding is at the heart of keeping our patients safe by complying with the responsibilities outlined in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.

2.3 The Trust is monitored by the Shropshire, Telford and Wrekin Integrated Care Board (STW ICB) and Black Country Integrated Care Board to ensure that the Trust is compliant with the duties as set out in the Safeguarding Accountability and Assurance Framework (July 2022).

3. Update on 2023-2024 Safeguarding Priorities

3.1 Safeguarding visits beyond the Community Hospitals encompassing safeguarding children to support integrated working.

3.1.1 Monthly safeguarding visits by the Nurse Specialist for Safeguarding Adults and Nurse Specialists for Safeguarding Children to the Community Hospitals continue. These visits provide visibility and awareness to clinical teams. The Nurse Specialists provide advice and support thereby supporting an integrated approach to promoting safeguarding across the Trust.

Safeguarding Visits conducted 1st April 2024 – 31st March 2025

Community Hospital/Service Area	Number of Quality Visits
Ludlow Community Hospital	7

Bridgnorth Minor Injuries Unit	6
Bishops Castle Community Hospital	5
Bridgnorth Community Hospital	5
Southeast IDT (Bridgnorth)	4
Ludlow Minor Injuries Unit	3
Whitchurch Community Hospital	3
Whitchurch Minor Injuries Unit	2
North Telford IDT	2
Sub-Acute Ward (PRH – Ward 36)	1
Sub-Acute Ward (RSH – Ward 18)	1
Oswestry Health Centre	1
Southwest IDT (Ludlow)	1
Northwest IDT (Oswestry)	1
Central IDT (South & North Shrewsbury)	1
Total	**43**

Key:

IDT = Inter Disciplinary Teams

PRH = Princess Royal Hospital (Telford)

RSH = Royal Shrewsbury Hospital (Shrewsbury)

3.2 **Integration of Dudley 0-19 including Family Nurse Partnership within Shropshire Community Health NHS Trust**

3.2.1 The Safeguarding Team have proactively worked to align Dudley 0 – 19 within SCHT supporting safeguarding compliance and governance arrangements. This has included developing relationships with Dudley Safeguarding Partnership and representation.

3.2.2 Resource to support Dudley 0 – 19 staff within the Safeguarding Team has been challenging and has been highlighted within the Safeguarding Team Risk Register.

3.3 **Development of Skills within the Workforce**

3.3.1 The Safeguarding Team has supported development of staff to enhance knowledge and skills over this year supported by Learning Beyond Registration monies.

- 1 Nurse has completed NSPCC safeguarding supervision to support her practice
- 1 Nurse has attended NSPCC Named Nurse training Level 4 training to support her continued learning
- 2 staff are completing post graduate certificates in safeguarding to support increased knowledge within the team
- 1 member of staff attended Channel Panel training ○ 1 member of staff attended Child on Parent Abuse and produced a newsletter for dissemination within Trust

3.4 **Initiate and Enable the Integration of Family Connect Staff and Compass Health Staff to Strengthen the Resilience of the Service Provision**

3.4.1 Staff within Family Connect and Compass Health now work together to ensure seamless cover across both Local Authority sites. This supports resilience when there are staff challenges.

3.4.2 A business case to reconfigure some nursing hours to Administration hours, to support Family Connect and Compass Health through a QEIA process was produced and agreed to utilise staff skills appropriately and effectively.

3.5 **Safeguarding Audit Plan**

3.5.1 The Safeguarding Team have continued to audit Mental Capacity Assessments for their quality and given timely feedback to staff. We have seen an improvement in 2024/25. Mental Capacity Audits still appear to be completed by a select number of staff and this has been highlighted.

3.5.2 The Safeguarding Team have supported 0 – 19 teams, (Telford & Wrekin and Shropshire), with their record keeping audits, including safeguarding questions to support triangulation of learning shared from Child Safeguarding Practice Reviews.

3.5.3 The Safeguarding Team have been involved with Multi Agency Case File Audits (MACFAs), within the partnership, and has disseminated the learning across the Trust.

3.6 **Provide Learning Opportunities to the Trust and Disseminate any Learning Generated through Safeguarding Partnership working**

3.6.1 The Team have been innovative in developing a variety of learning materials which include videos, voice over briefings, Permission to Pause, and 7-minute briefings to suit different learning styles. They are available on the staff-zone.
3.6.2 Eight Newsletters have been disseminated throughout the year across the Trust through the Communications Team.
3.6.3 Lunch and Learn sessions to support staff to produce a Statement of Evidence for Court have been delivered.
3.6.4 Level 3 Safeguarding Children Training has been delivered to staff who are new to the Trust or have been absent for a period of time.

4. Benefits and Challenges to Hybrid Working

4.1 Challenges of using virtual platforms and potential connectivity issues, can play a part in the quality of the experience and its effectiveness. However, hybrid working has maximised time management for the Team and the Safeguarding Partnership fostering effectiveness and efficiency.

4.2 A blended approach has allowed the Team to maximise its resources by utilising time previously allocated to travel to conduct face to face safeguarding visits supporting visibility and building relationships with the Safeguarding Team.

4.3 Challenges to staff well-being and Team cohesiveness has been made a priority through face-to-face monthly meetings and well-being catch ups within the Team.

5. Safeguarding Arrangements

5.1 The Executive Director with Safeguarding Responsibility is the Director of Nursing, Quality and Clinical Delivery.

5.2 The Head of Safeguarding role is a job share, line managed by the Deputy Director of Nursing and Quality and Deputy DIPC.

5.3 The Team continues to attend and participate in the Safeguarding Partnership sub-groups across Shropshire, Telford & Wrekin, and Dudley.

5.4 Safeguarding representation is in place at the front door systems of both local authorities; Compass Health in Shropshire and Family Connect in Telford & Wrekin. The Nurse Advisors collate and share health information from the wider health economy. A member of the Safeguarding Team has been seconded to the Dudley 0 – 19 Operational Team to support additional work around MASH, Children in Care and MARAC, which was not included within the 0 – 19 service specification. We have also supported a review of the Dudley MASH and shared our findings to support commissioning.

6. Quality and Safety

6.1 Identified learning is shared in a variety of forms to suit different learning styles including using the Permission 2 Pause template, circulated in Team Newsletters, and through Service Delivery Groups and communications.

- Permission to Pause x 9
- 7-minute briefings and other Guidance/Briefings x 7
- Videos x 2

- Newsletters x 11

6.2 Section 42 enquiries are recorded on Datix; this enables the team to monitor occurrences, identify themes, and compare with previous time periods.

6.3 Visibility and accessibility of the Safeguarding Team across operational teams is maintained by participation in Divisional Quality and Performance meetings and bronze huddles. This fosters positive relationships, familiarity, and positive working relationships within the Trust.

6.4 The Safeguarding Team has been integral in reviewing any patient safety incidents where safeguarding may have been a contributing factor. This has included being proactively involved when required with the Patient Safety Incident Response Framework (PSIRF) which supports a joined-up approach in learning from such events.

6.5 Safeguarding visits have expanded to reach specialist teams and services, providing visibility, and an opportunity for staff to receive safeguarding advice and support. Positive feedback has been received from staff regarding these visits.

6.6 Safeguarding supervision, advice and guidance is available to all Trust staff, either in groups, or through one-to-one sessions. **86** safeguarding children's supervision sessions have been delivered in this year. Different platforms are utilised to meet the needs of the practitioner in a timely manner. Thus, supporting quality by increasing practitioner confidence and developing skills around professional curiosity.

6.7 Regular safeguarding supervision is embedded for the Named Nurse, Looked after Children. This provides support to explore the challenges facing the service and its vulnerability, while maintaining the connectivity between the two teams.

6.8 Datix continues to be available to all staff which will allow us to identify trends and themes of referrals made to enable us to focus our safeguarding work. Currently themes and trends related to adult safeguarding form part of the Adult Safeguarding Dashboard which is tabled at the quarterly Safeguarding Committee. A recent change to the Datix national platform has removed a shortened Datix form. The number of Datix forms moving forward will be monitored to identify any barriers this may pose to staff completing it.

6.9 Positive working across both Shropshire, Telford & Wrekin and Dudley Partnerships including involvement in multi-agency audits, child, and adult practice reviews allows us to identify learning as a system and feed back to the organisation.

7. Training Compliance

7.1 It is mandatory that **all** SCHT staff are compliant at Level 1 and that **all** clinical staff are compliant at Level 2 for both Safeguarding Adults and Safeguarding Children training. Role specific training at levels 3 and 4 are based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Fourth edition (2019) and Adult Safeguarding Roles and Competencies for Health Staff second edition: August (2024).

7.2 The following tables demonstrate the Trust's compliance rates by month for 2024/2025:

Safeguarding Children Training

Safeguarding Children Training 1st April 2024 – 31st March 2025	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
Safeguarding Children Level 1 Training	90%	91.53	89.62	90.86	91.52	92.09	92.71	93.71	94.49	94.82	95.65	95.51	94.82
Safeguarding Children Level 2 Training	90%	91.68	91.76	93.56	93.02	92.99	89.0	90.14	92.08	93.24	94.27	93.64	93.06
Safeguarding Children Level 3 Training	90%	90.65	92.52	92.34	94.06	93.30	92.52	95.79	95.77	95.85	95.88	96.45	73.95
Safeguarding Children Level 4 Training	90 %	100	100	100	100	100	100	100	100	100	100	100	100

Safeguarding Adults Training (includes MCA/DoLS and Prevent)

Safeguarding Adults Training 1 April 2024 – 31st March 2025	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
Level 1 training for Safeguarding Adults	90%	94.6%	92.1%	93.7%	94.2%	95.2%	95.8%	96.3%	97.1%	97.2%	98%	97.8%	97.5%

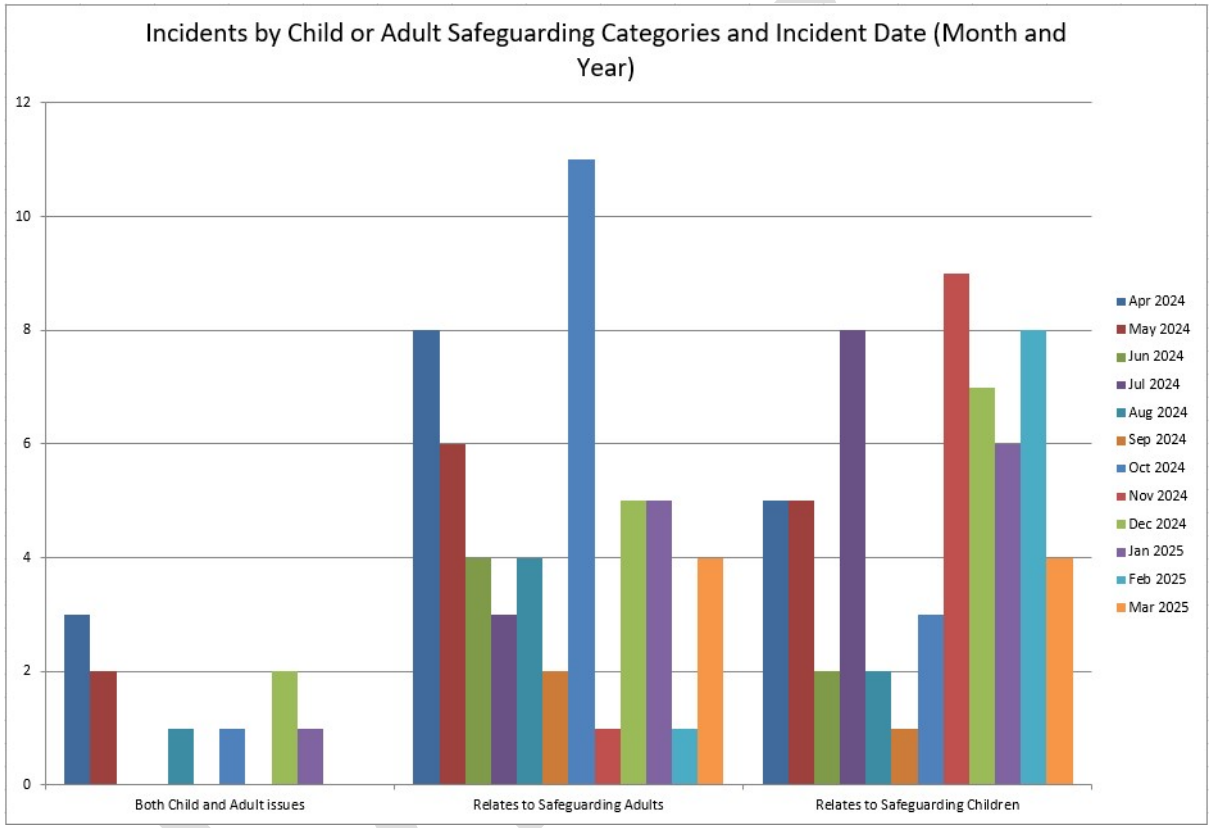
Level 2 training for Safeguarding Adults	90%	95.7%	94.6%	96.3%	95.5%	96%	93.3%	94.3%	96%	96.2%	97.2%	96.7%	96.3%
Level 3 training for Safeguarding Adults	90%	98%	98.2%	97.1%	97%	97.4%	97%	95.1%	96.5%	96.8%	98.2%	98%	73.5%
Mental Capacity Act /DoLs training	90%	86.7%	87.2%	88.2%	89.3%	92.5%	92.4%	92.8%	92.6%	92.9%	93.2%	93.2%	92.8%
Basic Prevent Awareness Training (Level 1 & 2)	85%	95.8%	95.7%	96.1%	96.4%	96.7%	97.1%	97.7%	97.7%	98.1%	98.2%	98.9%	97.8%

7.3 It should be noted that there was a reduction in compliance for Mental Capacity Act training during April – July 2024 due to competencies being reviewed, and two bespoke online modules being assigned to the electronic staff record, for practitioners to complete.

7.4 A reduction in Level 3 training compliance for Safeguarding Adults and Children in March 2025 is noted. This was due to a review of Level 3 training within the Trust, and assignment of additional clinical roles being required to undertake the level 3 competency requirements aligning with the intercollegiate document.

7.5 The Independent Inquiry into Telford Child Sexual Exploitation (IITSE) has since seen its recommendations implemented by the Telford and Wrekin Safeguarding Partnership and its partners. As a result, the Trust has added Child Sexual Exploitation (CSE) training to ESR to increase awareness across all staff groups. Monitoring of compliance with this training will become mandatory in 2025/26 through the quarterly safeguarding dashboards.

8. Adults and Children's Safeguarding Incidents Reported Through Datix System



8.1 A total of 119 safeguarding incidents were recorded in 2024-2025, which is an increase of 9% on previous year. This shows good awareness and reporting across both Adult and Children divisions and is likely due to increase in Services the Trust provides.

9. Safeguarding Adults

9.1 Section 42 Enquiries

9.1.1 There have been no Section 42 enquiries undertaken within the period 1st April 2024 – 31st March 2025.

9.2 Safeguarding Adult Reviews

9.2.1 There have been eight Safeguarding Adult Reviews (SAR) in the period covered by this Report (6 for Shropshire, and 2 for Telford & Wrekin), and nine Domestic Homicide Reviews (DHR) (6 for Shropshire, 3 for Telford & Wrekin, and one request from Cheshire Local Authority where no information was held). This compares to nine Safeguarding Adult Reviews, and twelve Domestic Homicide Reviews from the last report 1st April 2023 – 31st March 2024.

9.2.2 There has been an increase in Information Management Review (IMR) requests from both Local Authorities in association with specific SAR and DHRs. Within the time frame in this report, 4 IMRs were requested and submitted. This is a more detailed request for information and chronological review, to identify any further themes and trends from these cases.

In all of the above reviews the Safeguarding Team had varying contact with the persons in question and were involved in any requested subsequent review meetings where our input was required. Any learning identified by the Safeguarding Partnerships is shared across the Trust through Permission to Pause.

9.2.3 Emerging themes from these reviews have included Professional Curiosity, Suicide and Mental Health, Self-Neglect, and Substance Misuse. Examples of safeguarding work completed to help raise awareness around these themes can be seen below.

9.3 Shared Learning

9.3.1 Three Permissions to Pauses were created following Domestic Homicide Review meetings and Safeguarding Adult Reviews which were shared to all staff. These focused on Difficult Conversations, Professional Curiosity, and Record keeping.

9.3.2 Three newsletters were produced in September and November 2024, and March 2025; these focused on Professional Curiosity, Substance Misuse, and Self-Neglect, which were cascaded to all staff and available on the Trust's internal Staff Zone.

9.3.3 Mental Capacity Act Assessment Audit conducted in July 2024 and noted overall improvement in quality with 88% rated green, 6% amber, and 6% red, compared to previous years audit (86% green, 10% amber, and 4% red).

9.3.4 Bespoke sessions on Safeguarding Adults Awareness, and guidance around the Shropshire Safeguarding Partnership Escalation Policy were delivered to practitioners from an Inter Disciplinary Team. The sessions were all completed in May 2024.

9.3.5 Two Self–Neglect support sessions were delivered to District Nurses. These sessions provided awareness of Self-Neglect, and discussion around specific professional practice cases.

9.3.6 Domestic abuse policy reviewed, updated, and disseminated.

9.3.7 Representatives from the Safeguarding Team attended SCHT Band 4 & 5 Conference in May, and October 2024 to increase visibility and awareness of the Safeguarding Team, providing a short presentation at each conference.

9.3.8 Acknowledging the emerging theme of Professional Curiosity the Nurse Specialist for Safeguarding Adults has designed and developed a suite of video resources that have been designed for use within the Trust, to aid staff awareness around safeguarding and leadership and Professional Curiosity. Selected videos are also being utilised in the Trusts face to face clinical induction sessions.

9.3.9 **Videos can be accessed here:**

Learning Focus 2 (Safeguarding Team) How do we learn?

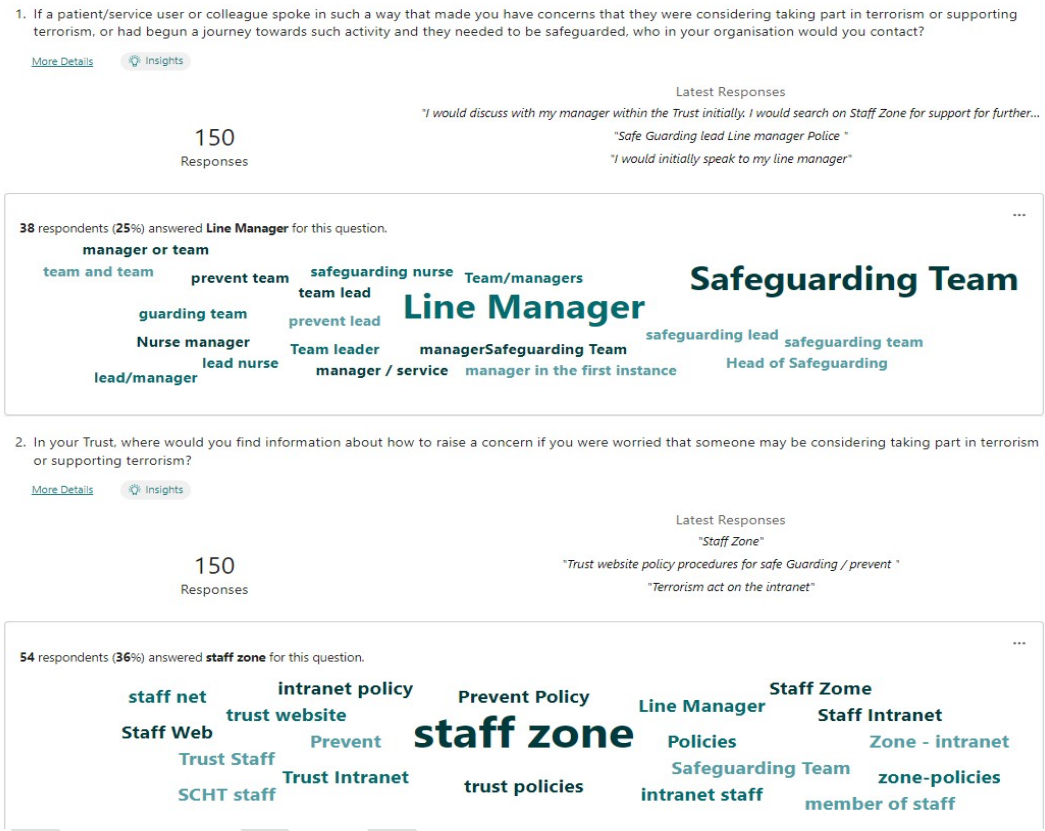
Learning Focus 3 (Safeguarding Team) Professional Curiosity

10. Prevent Duty

10.1 Prevent forms part of the Counter Terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised and drawn into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person being radicalised.

- From November 2024, the submission process was transferred to the SCHT Digital Services Team who now manage all quarterly Prevent data submissions. Prior to this, the Safeguarding Team managed all Prevent data submissions.

- Q1 and Q2 Prevent response data collected as part of a 'ask 5' snap survey, with 150 SCHT respondents completing the survey, providing assurances of Prevent awareness and process' within the trust. Examples are given below for some of the responses to questions asked:



- Within the time frame 1st April 2024 – 31st March 2025, SCHT received **23** Prevent information gathering forms, requesting additional information for both a child and an adult, relating to Prevent concerns.

Safeguarding Adult Incident Reporting

- There were 42 safeguarding adult referrals raised by SCHT within the time frame 1st April 2024 – 31st March 2025.

Quarter	Total Referrals
Q1	12
Q2	10
Q3	12
Q4	8

Themes

Neglect or acts of omission	21
Self-Neglect	7
Physical	6
Financial	3
Sexual	2
Psychological	1
Domestic Abuse	1
Organisational	1

11. Safeguarding Children

11.1 The number of children who are subjects of a Child Protection (CP) Plan has steadily decreased during the latter half of 2024/25 within Shropshire and remained fairly static throughout the year in Telford & Wrekin and Dudley. Shropshire have a simplified

referral process into Early Help withing the Local Authority which may have supported prevention at the earliest opportunity improving outcomes for children and their families.

11.2 **Telford & Wrekin Local Authority Open CP Plans**

Telford & Wrekin Local Authority	Open CP Plans as at end of month 2023/24			Open CP Plans as at end of month 2024/25		
Month	**Under 5**	**5 to 18**	**TOTAL**	**Under 5**	**5 to 18**	**TOTAL**
April	78	157	235	67	99	166
May	70	139	209	62	100	162
June	69	132	201	71	98	169
July	69	130	199	69	98	167
August	72	131	203	72	100	172
September	74	129	203	78	104	182
October	72	121	193	80	99	179
November	69	110	179	80	104	184
December	61	99	160	79	103	182

January	67	96	163	73	95	168
February	64	92	156	70	100	170
March	64	87	151	65	93	158

11.3 **Shropshire Local Authority Open CP Plans**

Shropshire Local Authority	Open CP Plans as at end of month 2023/24			Open CP Plans as at end of month 2024/25		
Month	**Under 5**	**5 to 18**	**TOTAL**	**Under 5**	**5 to 18**	**TOTAL**
April	78	162	240	69	125	194
May	84	172	256	66	124	190
June	84	173	257	67	145	212
July	72	173	245	73	144	217
August	72	164	236	74	134	208
September	76	160	236	71	136	207
October	65	155	220	62	133	195
November	66	146	212	59	134	193
December	73	137	210	59	124	183

January	72	119	191	54	119	173
February	71	117	188	59	108	167
March	71	119	190	66	108	174

11.4 **Dudley Local Authority Open CP Plans**

Dudley Local Authority	**Open CP Plans as at end of month 2024/25**		
Month	**Under 5**	**5 to 18**	**TOTAL**
April	61	189	250
May	62	188	250
June	58	194	252
July	57	200	257
August	54	213	267
September	54	207	261
October	54	203	257

November	62	191	253
December	63	182	245
January	69	198	267
February	65	190	255
March	67	177	244

11.5 **Requests for Statement of Evidence for Court**

There have been **165** requests for Statements of Evidence for Court. 79 from Shropshire, 23 from Telford & Wrekin, 56 from Dudley and 7 out of area. This is a significant increase from the previous year where the total requested was 80; there have been increases in Shropshire and Dudley operated as a new service within SCHT in 2024/25. This poses a significant resource implication to the Safeguarding Team in supporting staff. Lunch and Learn sessions have been delivered and will be continued to support confidence and competence of staff within this process.

Statement requests 2024/25					
Month	**Shropshire**	**T&W**	**Dudley**	**OOC**	**TOTAL/ MTH**
April	6	2	4		**12**
May	6	1	0		**7**
June	9	1	6		**16**
July	4	0	7		**11**

August	7	3	4	2	**16**
September	8	0	15		**23**
October	12	0	5		**17**
November	3	0	7		**10**
December	2	1	1	3	**7**
January	8	9	3		**20**
February	3	3	1		**7**
March	11	3	3	2	**19**
TOTAL/YR	**79**	**23**	**56**	**7**	**165**

11.6 **Child Safeguarding Practice Reviews**

Learning from all Rapid Reviews, Local Child Safeguarding Practice Reviews and Child Safeguarding Practice Reviews are shared with colleagues through Datix, Safeguarding Newsletters and Permission to Pause briefing papers. Themes include Professional Curiosity and Voice of the Child.

11.7 **Shropshire Safeguarding Partnership**

There have been 6 Rapid Reviews, which reviewed 10 children within this time-period (April 2024 - March 2025).

- Baby still born at 34 weeks' gestation following concealed pregnancy and previous social care involvement.
- A Looked after Child reported a sexual assault by an older adult after going missing.
- A teenager was found unresponsive by her parents and later died.
- Suspected sexual injury to toddler.
- Delayed medical attention sought for burn to foot of a toddler. Concerns of neglect were raised.
- Infant died – co sleeping and alcohol were factors within this case.

11.8 **Telford & Wrekin Safeguarding Partnership**

There has been 1 case considered for a Child Safeguarding Practice Reviews in the time-period (1st April 2024 - 31st March 2025)

11.9 **Dudley Safeguarding Partnership**

There has been 2 cases considered for Child Safeguarding Practice Reviews in the time-period (1st April 2024 – 31st March 2025)

11.10 **Shared Learning**

11.10.1 Three sessions of Level 3 Safeguarding and Protecting Children training have been delivered. It is in-house training which is available to all new staff or those who have been off work for a prolonged period. We offer MS Teams and face to face sessions throughout the year.

11.10.2 Four sessions focused on learning from CSPRs have been delivered to most of the Public Health Nurse s within Telford & Wrekin. This is bespoke in-house Level 3 Safeguarding Children training.

11.10.3 Safeguarding presentations were provided at the Shropshire Public Health Nurse conference, Dental Service Development Day training sessions.

11.10.4 The Team actively participated in the Child Safeguarding Practice Reviews within the Safeguarding Partnerships.

11.10.5 Quarterly Group Safeguarding Supervision sessions were available for all practitioners who have face to face contact with children and young people. We delivered a total of **86** Safeguarding Supervision sessions to children's staff with 14 of those sessions delivered as tripartite supervision to the Family Nurse Partnership staff.

11.10.6 Support has been provided to all staff that have been required to provide a Statement of Evidence for Court. Additional to these five Lunch and Learn sessions around statement writing have also been delivered.

11.10.7 The Team provides ad-hoc advice and guidance conversations for all Trust staff.

11.10.8 Learning is shared in a variety of formats: Permission 2 Pause templates, Newsletters, and 7-minute briefings.

11.10.9 Safeguarding information is available on Staff Zone. It is reviewed and amended to reflect changes in legislation, policies, and process and has incorporated Dudley this year.

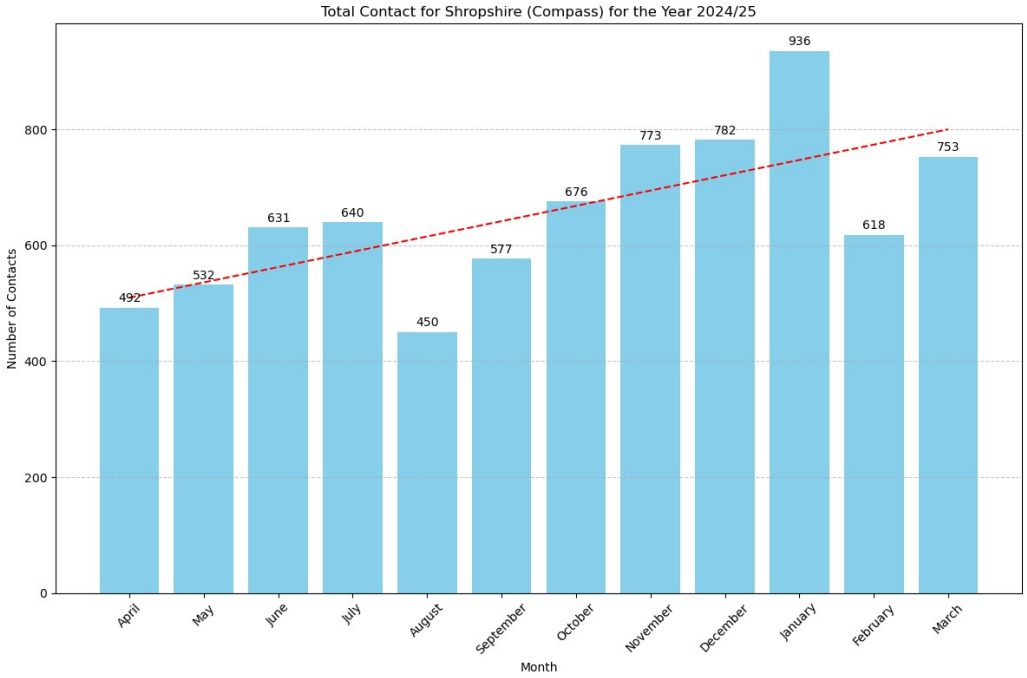
12. Family Connect and Compass Health

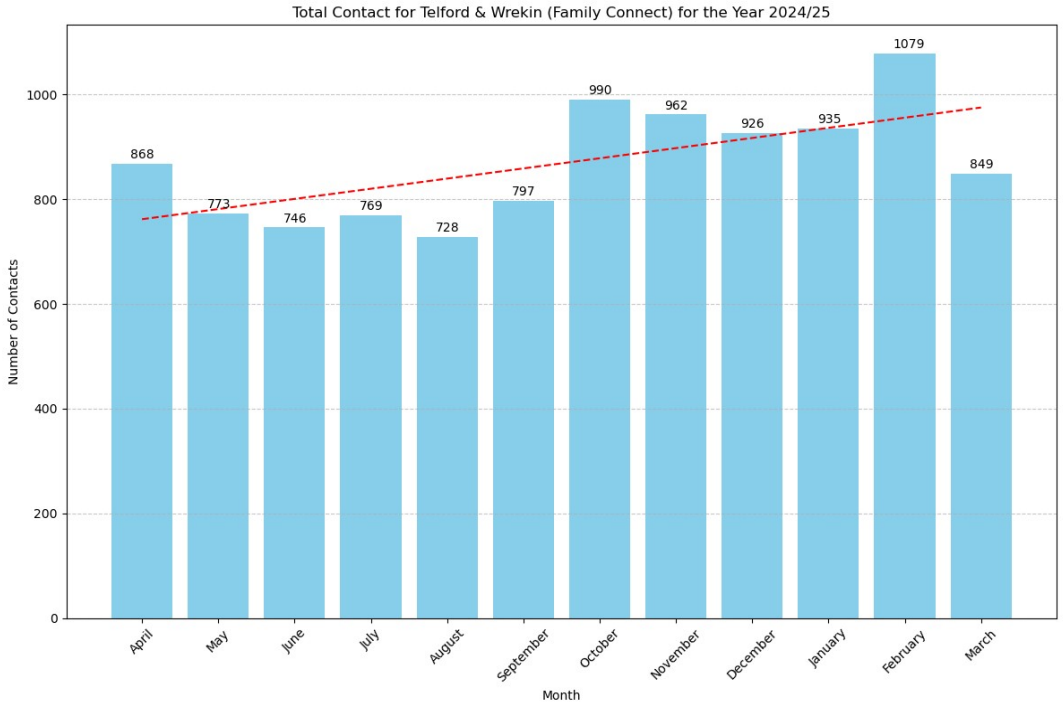
12.1 SCHT is commissioned to provide multi-agency Safeguarding Teams within Shropshire, Telford, and Wrekin. Information is shared in line with statutory guidance to Safeguard Children (Working Together to Safeguard Children 2023). Effective sharing of information between practitioners and local agencies is essential for the early identification of the need to keep children safe.

12.2 During this financial year Family Connect (FC), and Compass Health (CH) started co working to build resilience and now are known as the Multi-Agency Safeguarding Nurses (MASN). The Standard Operating Procedure (SOP) has been updated to reflect updated practice. QEIA for administration support and 35 hours' admin post created to support the Team.

12.3 The number of contacts are monitored quarterly and reported to the Safeguarding Board, Safeguarding Committee, and local Integrated Care Board (ICB). The number of contacts has increased across the year for both Local Authorities.

12.3.1 **Total Contacts for Family Connect and Compass Health**




Total Contact for Telford & Wrekin (Family Connect) for the Year 2024/25
Number of Contacts
Month
0
200
400
600
800
1000
868
773
746
769
728
797
990
962
926
935
1079
849
April
May
June
July
August
September
October
November
December
January
February
March

Shropshire health checks have increased throughout the year with strategies decreasing.

Shropshire Compass Data Overview					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Health Checks	151	147	185	289	772
Strategies	417	264	156	185	1022

Work with the Early Help and Support Team (EHAST) has helped to enable this. This has reduced the overall need for strategies to take place.

Telford & Wrekin strategies and health checks have increased each quarter with a decrease in quarter two due to the summer holidays.

Telford & Wrekin Family Connect Data Overview					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Health Checks	696	558	699	836	2789

Strategies	159	151	212	259	781

13. Looked After Children

13.1 The Looked After Children Service is situated within the Children's Division. For the purposes of this Safeguarding Annual Report, a concise summary of key activities and outcomes is provided below.

During the reporting period, the service supporting Looked after Children experienced a sustained increase in demand. This has contributed to ongoing delays in both Initial and Review Health Assessments, largely due to late receipt of essential paperwork from local authorities and workforce shortages, including the absence of a Named Doctor as recommended by national guidance.

Despite these challenges, the team has maintained strong partnership working, delivered comprehensive training, and received consistently positive feedback from children, young people, and carers. All care leavers have been offered Health Passports, and quality improvement initiatives have been implemented to enhance service delivery. Key risks remain around timely identification of health needs and compliance with statutory requirements, highlighting the need for increased resources to ensure the continued welfare and health outcomes of Looked after Children.

14. Key Risks

14.1 Challenges to our resilience within the Safeguarding Team both within Children and Adults is rated as high. Challenges that additional services have presented to a small corporate Safeguarding Team have been demanding. We are supporting a full-time secondment to Dudley 0 – 19 Operational Team to support MASH, Review Health Assessments and MARAC. We have partial back fill to mitigate this. Prioritisation of work to mitigate challenges and escalation to senior management is in place.

14.2 Safeguarding Team has limited access to Dudley 0-19 health visiting records due to different versions of electronic patient records, we do have access to School Nursing records. This has posed challenges of viewing health visiting records when

required for safeguarding investigation and gathering information. This is mitigated by accessing through Team Leads, whilst we wait for migration of RIO to our electronic record.

14.3 The Safeguarding Team has exposure to upsetting cases potentially leading to vicarious liability reflecting the complexity of cases. Mitigations and priority around 1 to 1's, Peer Supervision, Occupational Health, and Psychology Supervision if required and face to face team meetings is offered.

14.4 All risks are on the Risk Register and reviewed monthly within Team Meeting and quarterly at the Trust's Safeguarding Committee meeting with mitigations in place.

15. Safeguarding Priorities for 2025/2026

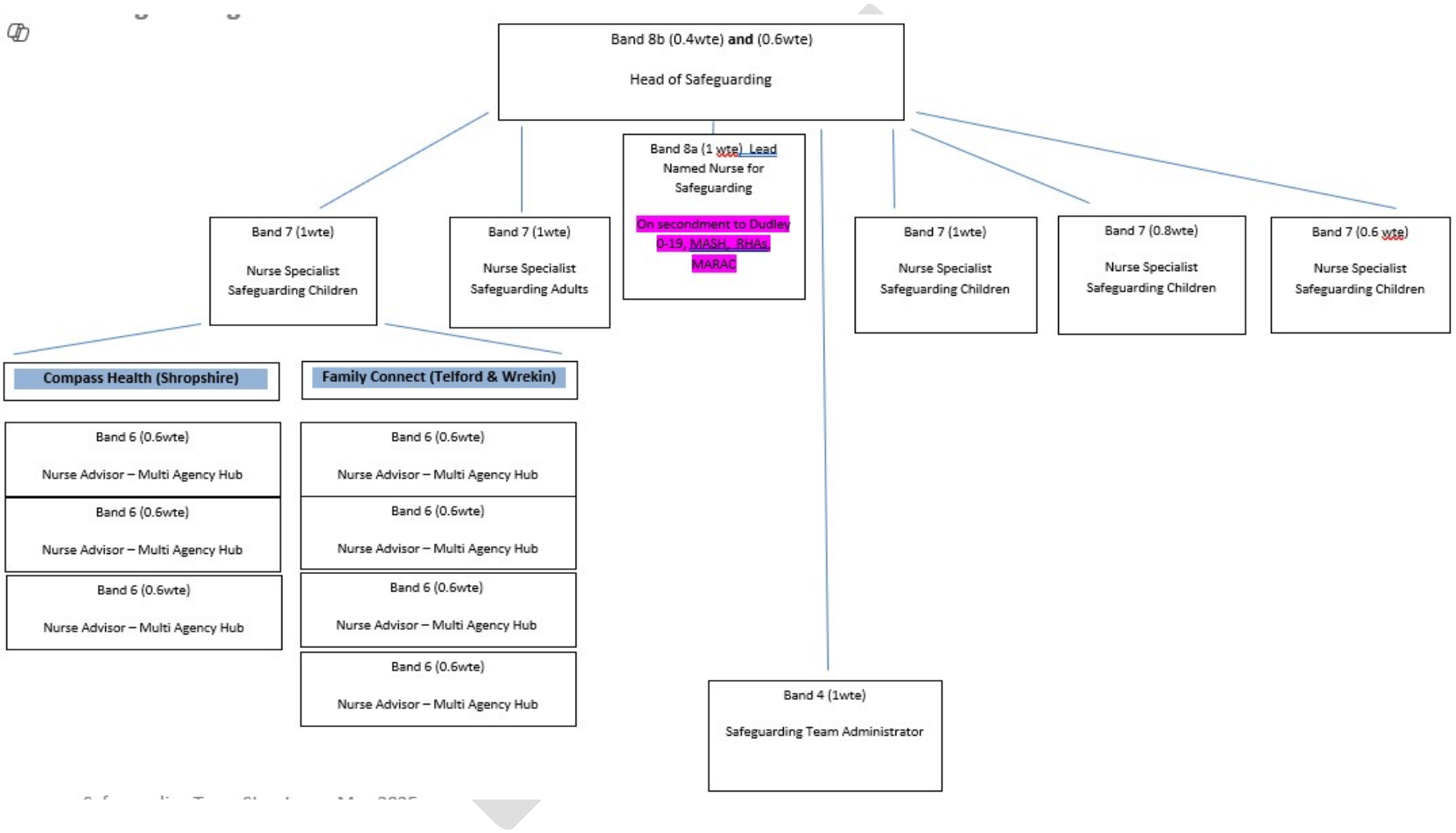
- The Safeguarding Team will have a focus on Domestic Abuse in the coming year
- Improve resilience of the Safeguarding Team by developing a more integrated model
- Continue to work with Dudley 0 – 19 to integrate practice to align with SCHT processes and recognise differences
- Align Dudley safeguarding supervision with the Trust's safeguarding model
- Develop and deliver Lunch and Learn programmes to SCHT staff to support safeguarding knowledge and competencies

16. Conclusion

The Quality and Safety Committee is asked to:

- **Note** the key safeguarding activity of the Team.
- **Accept** the report as assurance that SCHT is meeting its statutory responsibility regarding safeguarding and promoting the welfare of children, adults and families that encounter our services as set out in the Children Act 1989 and 2004 and The Care Act 2014.
- **Approve** the Annual Safeguarding Report.

Safeguarding Team Structure



Shropshire Community Health
NHS Trust

Integrated Performance Report
0. Reference Information

Authors:	Gina Billington, Head of Resourcing Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper date:**	2nd October 2025
Executive Sponsor:	Rhia Boyode, Chief People Officer SCHT & SaTH	**Paper written on:**	16th September 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 Committee 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 5 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 table below summarises each KPIs variation status as at Month 5, which has remained static with the month 4 position.

Committee	Variation concern	Variation concern of an improving nature	Both Variation and Assurance	Common Cause Variation – no significant concern	Total KPIs reviewed	Total Requiring Attention
People	0	15	0	4	**19**	**12 (63%)**

Action Plans have been developed included as Appendix 4.

2.3. Conclusion

The Committee 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 5 the total workforce is under plan by 42.9 WTE.

Both agency usage and vacancies have increased slightly in month 5. Our agency usage is 8.7 WTE over plan following a three-month trend of a reducing usage, reflecting the three-month reducing trend in vacancies.

Following a reduction in Bank usage for the three consecutive months, month 5 shows an increase and remains over plan by 19.0 WTE. This is due to the preparation for the cessation of Band 2 and Band 3 agency directive we are expecting from NHSE. August workforce unavailability increased with higher sickness absence which impacted temporary workforce spend. A review of roster practices is underway together with support and training.

As 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.

Integrated Performance Report

Plan (WTE)	Feb-25	Mar-25	Apr-25	May-25	June-25	July-25	Aug 25
Substantive	1655.16	1655.16	1689.90	1688.40	1689.80	1,694.7	1,702.2
Bank	58.00	58.00	65.90	65.9	62.9	61.4	59.6
Agency	37.12	37.12	36.50	36.5	36.2	31.7	28.7
Total	1750.28	1750.28	1792.20	1790.70	1788.90	1,787.7	1,790.5
Actual (WTE)	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**June-25**	**July-25**	**Aug 25**
Substantive	1627.49	1634.07	1617.30	1623.80	1626.70	1,631.4	1,631.6
Bank	84.63	85.46	101.00	87.7	81.6	73.4	78.6
Agency	53.17	55.20	42.70	35.6	33.7	30.2	37.4
Total	1765.29	1774.73	1761.00	1747.10	1742.10	1,735.0	1,747.6
Variance (WTE)	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**June-25**	**July-25**	**Aug 25**
Substantive	-27.67	-21.09	(72.50)	(64.50)	(63.1)	(63.3)	(70.6)
Bank	26.63	27.46	35.10	21.8	18.8	12.0	19.0
Agency	16.05	18.08	6.2	(0.9)	(2.5)	(1.4)	8.7
Total	15.01	24.45	(31.30)	(43.60)	(46.8)	(52.7)	(42.9)

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

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

Metric	Target	Feb-25	Mar-25	Apr-25	May-25	June-25	July 25	Aug 25
Appraisal	90%	87.37%	87.78%	88.00%	88.45%	88.89%	91.32%	91.05%
Leavers	9.6%	10.60%	9.86%	9.82%	9.32%	8.89%	8.04%	8.13%
Temporary Staff	3.4%	3.9%	4%	3.2%	3.1%	2.7%	2.4%	3%
Vacancies	8%	10.91%	10.56%	9.83%	9.39%	9.14%	8.82%	8.95%
Sickness	4.75%	5.32%	5.28%	5.28%	5.29%	5.32%	5.35%	5.41%

Total Shifts exceeding NHSI capped rate	No Target	63	64	49	50	56	47	64

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, **fifteen KPIs are a special cause variation 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 – **above target for the second consecutive month**
3. Leaver rate – **below target for the fourth consecutive month**
4. Mandatory Training Compliance - **above target for the third consecutive month**
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 fifth consecutive month**
12. Sickness Rate
13. Staff survey engagement theme score*
14. Total shifts exceeding NHSI capped rate
15. Total shifts on a non-framework agreement

Mandatory Training

In August 2025, Mandatory Training Compliance maintained at **96.15%**. This is the first time the KPI target of 95% has been achieved for 3 consecutive months since January 2023. There were significant improvements in Manual Handling Level 2 again saw another increase in compliance this time by 3%. In the August monthly compliance report we saw increases in compliance of 12 topics, and there was a decline in 11 topics. 8 topics had a dropped by less than 1%. However, Infection Prevention Level 2 did see a declined by over 1% and Resus

Level 3 which had a drop of over 3%, however this was due to no Resus Level 3 training taking place in August.

Appraisals

The compliance rate has been slowly increasing since February 2025. The August compliance is 1.05% **above** target. Work is continuing to ensure that this position is maintained moving forward and identified hot spot areas are being supported to ensure their outstanding appraisals are completed.

Actions to Deliver Improvements - Current Focus

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

Turnover

The Leaver rate has seen a gradual improvement with the rate continuing to fall below our target for 4 months in a row. 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.

Actions to Deliver Improvements – Current Focus

- 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.

Absence

Since March 2025 the rate continues to remain above target with marginal increases each month. Month 5 sickness rate is 5.41%. 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.

Actions to Deliver Improvements - Current Focus

- Support around health and wellbeing, resilience and flexibility to support reduction in absence levels are being implemented by the People Team.
- Implement the Health & Wellbeing Action Plan which also focusses on prevention
- Current development of our Winter ready which includes flu action plan for our upcoming flu campaign

Vacancies

Integrated Performance Report

Month 5 vacancy position is 8.95% (161 WTE) a slight rise in the reducing trend we have seen in previous months (Month 4 8.82%). Month 5 top 3 hotspots are: Community Services: (Bishops Castle, Ludlow) and Community Therapy Central, however therapies are in the process of a service review.

There is currently a focus on supporting redeployment of the RRU staff impacted by the impending de-commissioning of the service and a number of vacancies in these areas are being offered as redeployment opportunities for these staff. There are 75 WTE staff which will be supported to move to alternative roles, further supporting a reduction in our vacancy position.

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 with filming currently taking place across different locations in the Trust.
- The recruitment team have held 3 targeted recruitment events, in May, June and July to recruit bank HCA to limit the need for agency with a total of 57 offers being made on the dates of the recruitment events. A further event is planned for 26 September.

Agency Spend

Month 5 agency use is 37.4 WTE with an expenditure of £234K against a plan of 28.7 WTE and £234k, a variance of (8.7) WTE and (£534k) respectively.

Hospital Inpatients are the highest users of agency in Month 5: 20.0 WTE which is above plan (10.74 WTE) a variance of 9.26 WTE. This is an increase in the position from month 1 when the variance was 3.31 WTE.

The highest usage reason for agency in BCCH Hospital for Month 5 is: vacancies (61 shifts) followed by sickness absence. Ludlow CH shows the same data with 69 shifts for vacancies followed by sickness and high patient acuity. for 1:1 and high demand categories combined shows 43 shifts booked.

Price Cap compliance: Medical and Dental staff groups to become compliant with a current move to the regional West Midlands Price Rate Card - all agencies are now compliant with this rate.

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 September. NHSE notice is due on the cessation of Band 2 and Band 3 agency use, early indications were to cease this by the end of Q2 but as yet no formal notification has been received to date.

Actions to Deliver Improvements - Current Focus:

- Cease all HCA agency usage by end of Q3 in 25/26 (pending NHSE formal confirmation) 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 3 workers.

- Centralised Bank - additional e-roster licenses have been purchased and a high-level implementation plan is in progress. Additional staffing resources will be considered as part of the People team structure review (phase 2), in the interim, work will be undertaken to scope possible solutions for the provision of a limited centralised bank.
- 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 and this will take effect for September. Further action to monitor compliance and finalise the breakglass process.
- Actions to support reducing vacancies which includes a monthly focus on targeted hotspots and recruitment events.
- Maximise the availability of our workforce through monitoring and improving roster practices. Roster Approval Lead Times is currently 59 days, which helps increase opportunity to fill with bank.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

4. Conclusion

The Board is asked to:

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

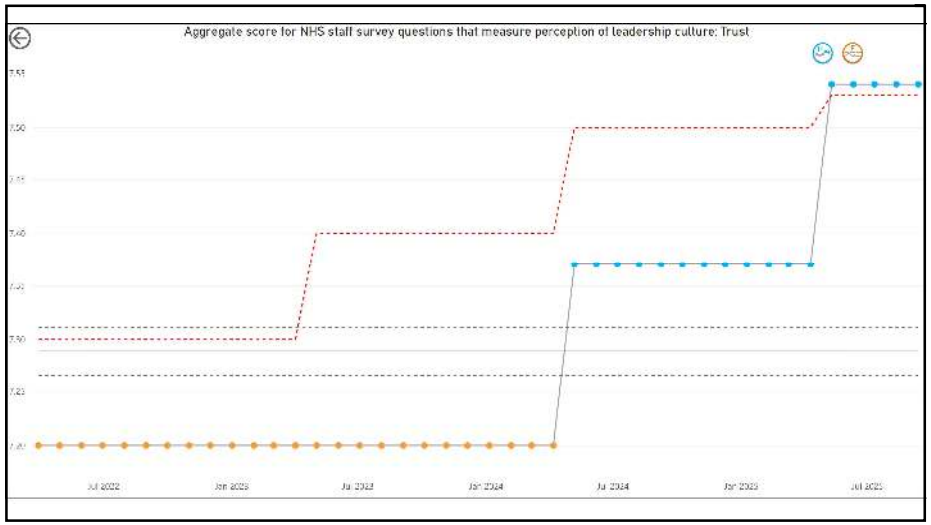
Appendix 1
People Committee – SPC Summary
Month 5 (August) 2025/2026 Performance

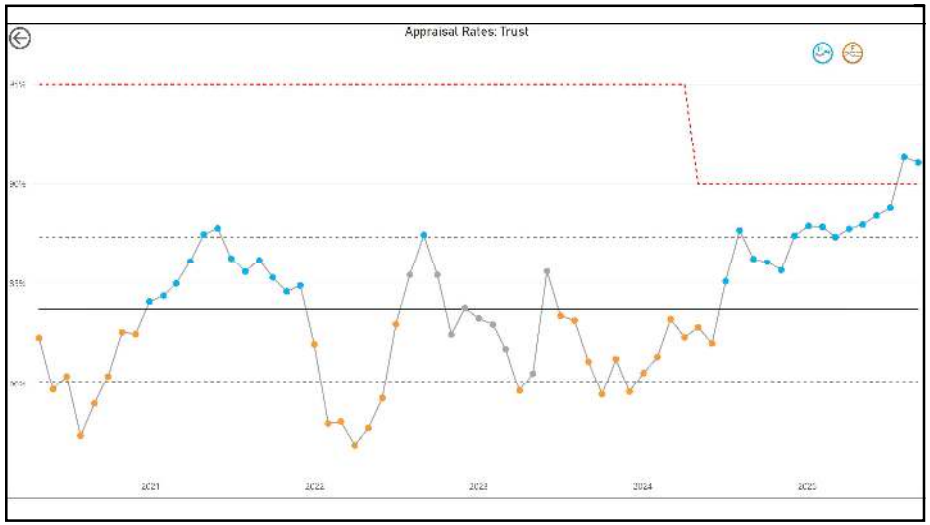
Shropshire Community Health NHS
NHS Trust

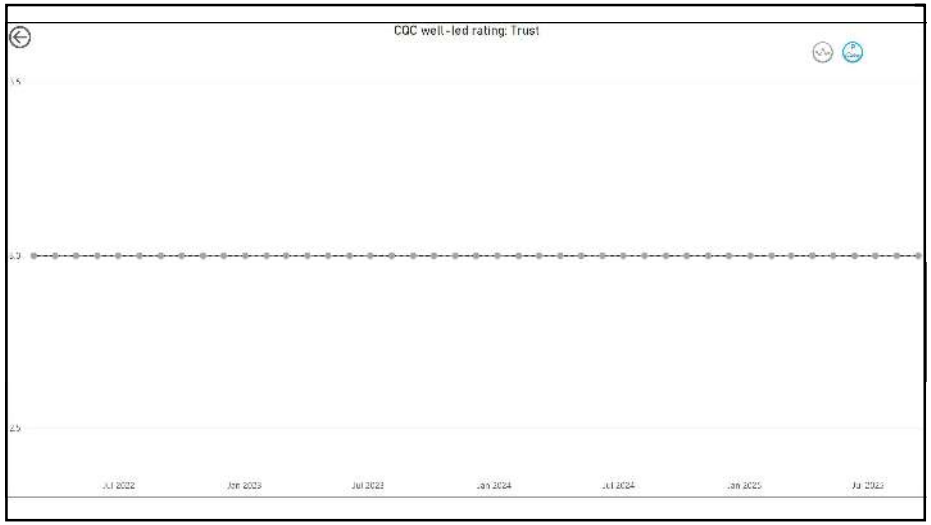
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2025-08-31	H	7.5	7.5	0.0	7.5	7.5	0.0	F
People Committee	Well Led	Appraisal Rates	2025-08-31	H	91.05%	90.00%	1.05%	89.53%	90.00%	-0.47%	F
People Committee	Well Led	CQC well-led rating	2025-08-31		Good	Good		Good	Good		P
People Committee	Well Led	Leaver rate	2025-08-31	L	8.13%	9.60%	-1.47%	8.13%	9.60%	-1.47%	F
People Committee	Well Led	Mandatory Training Compliance	2025-08-31	H	96.15%	95.00%	1.15%	96.15%	95.00%	1.15%	?
People Committee	Well Led	Net Staff in Post Change	2025-08-31		-4.05	0.00	-4.05	5.46	0.00	5.46	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-08-31	H	9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	F
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2025-08-31		72.73%	66.00%	6.73%	72.73%	66.00%	6.73%	P
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-08-31	H	4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	P
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2025-08-31	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...	2025-08-31	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...	2025-08-31	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...	2025-08-31	L	19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	F
People Committee	Well Led	Proportion of temporary staff	2025-08-31	L	3.0%	3.4%	-0.4%	2.9%	3.4%	-0.5%	F
People Committee	Well Led	Sickness Rate	2025-08-31	L	5.41%	4.75%	0.66%	5.41%	4.75%	0.66%	F
People Committee	Well Led	Staff survey engagement theme score	2025-08-31	H	7.2	7.2	0.0	7.2	7.2	0.0	F
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-08-31	L	64	0	64	53	0	53	F
People Committee	Well Led	Total shifts on a non-framework agreement	2025-08-31	L	0	0	0	0	0	0	?
People Committee	Well Led	Vacancies - all	2025-08-31		8.95%	8.00%	0.95%	9.23%	8.00%	1.23%	?

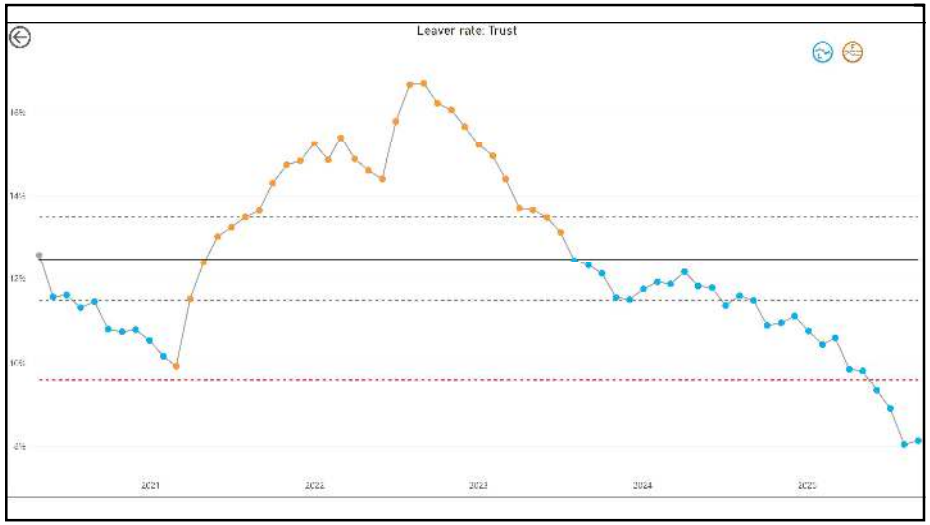
Appendix 2
People Committee
Month 5 (August) 2025/2026 Performance

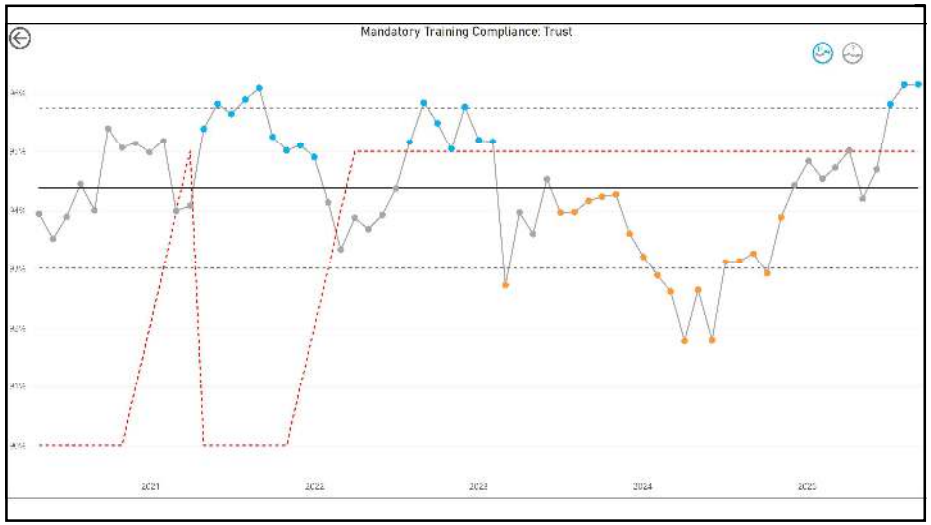
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where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

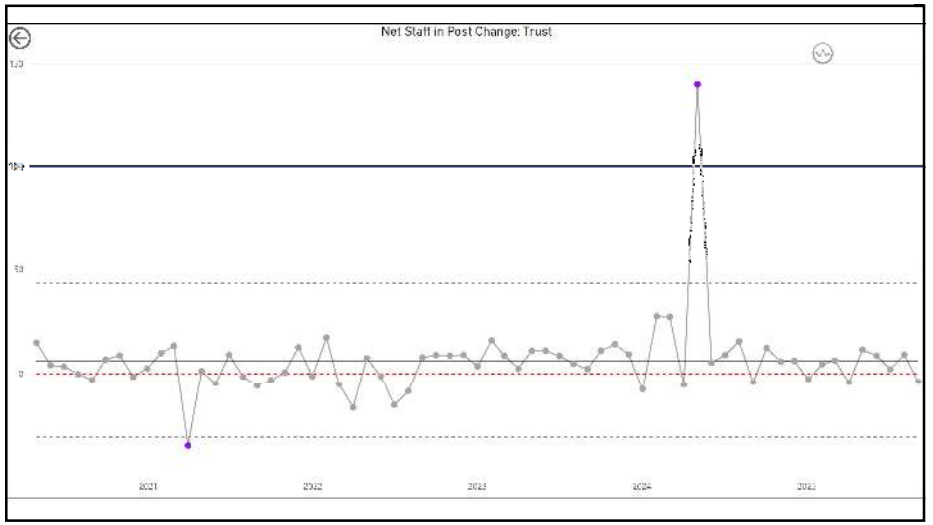

Aggregate score for NHS staff survey questions that measure perception of leadership culture: Trust

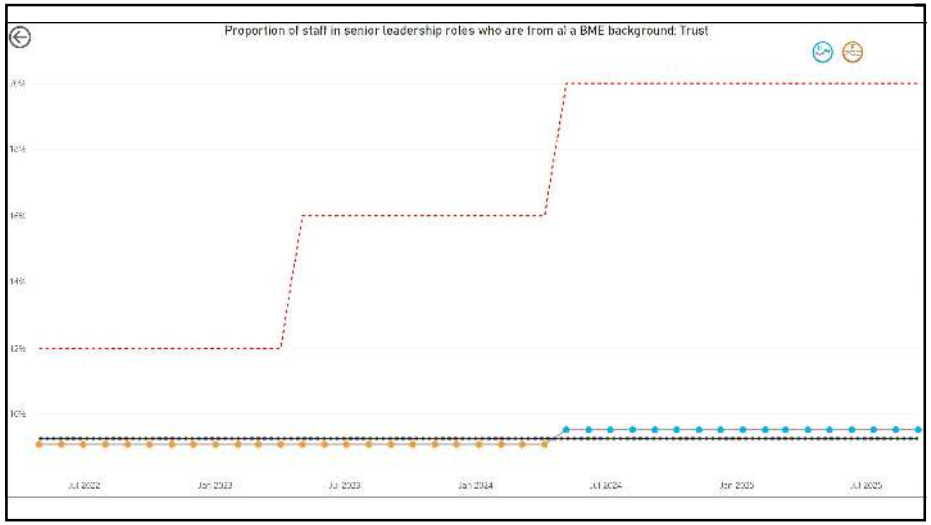

Appraisal Rates: Trust

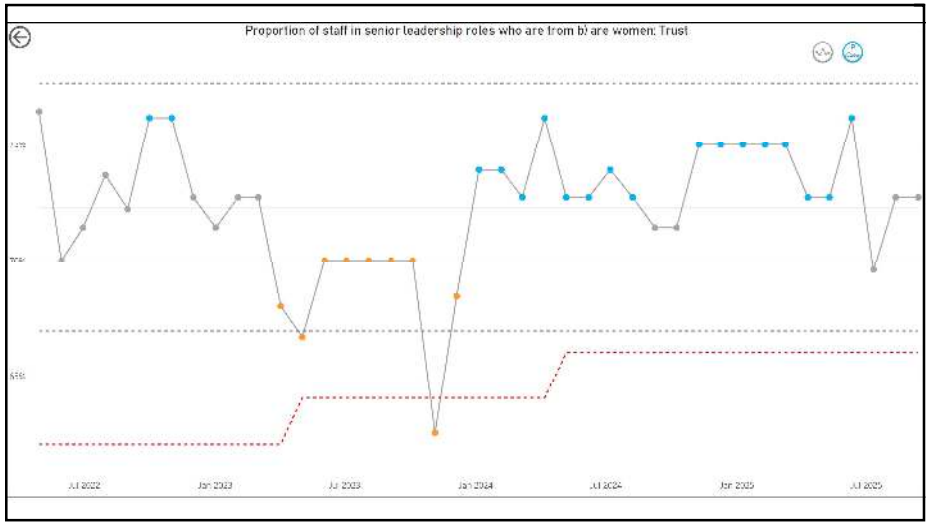

CQC well-led rating: Trust

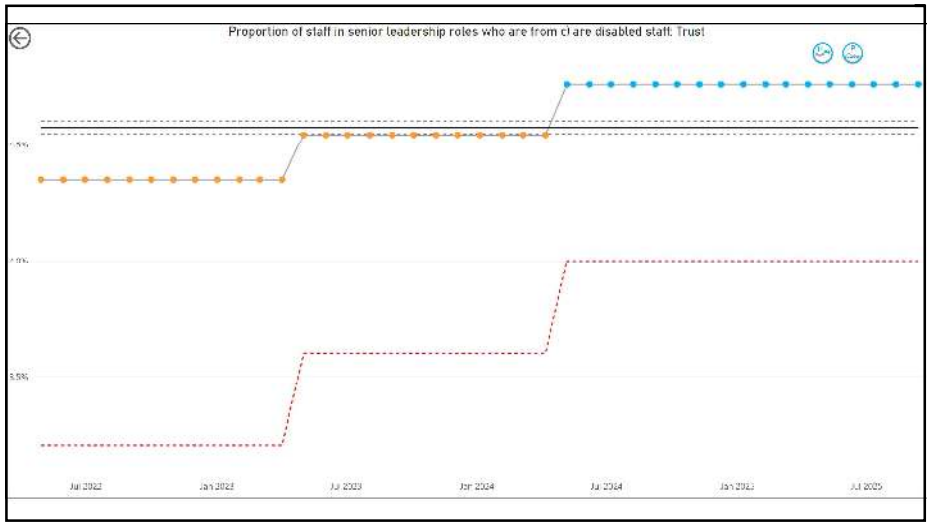

Leaver rate: Trust

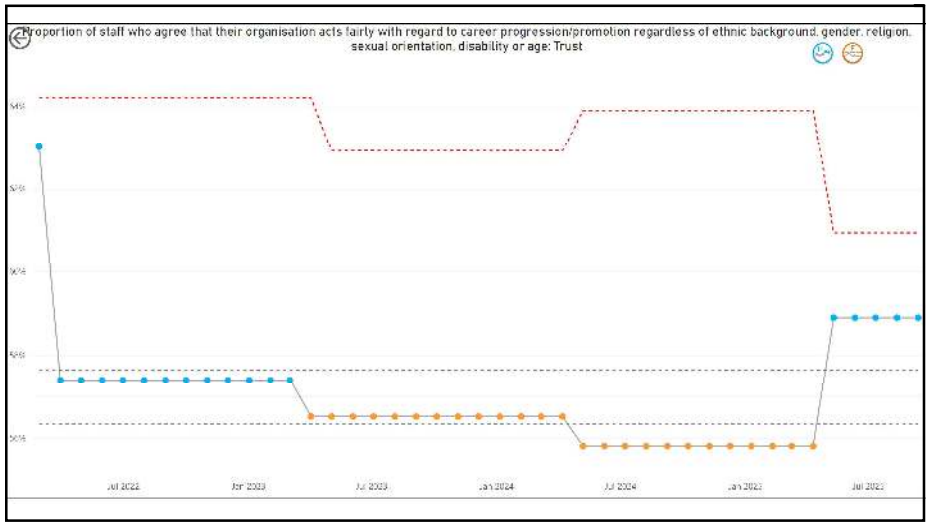

Mandatory Training Compliance: Trust

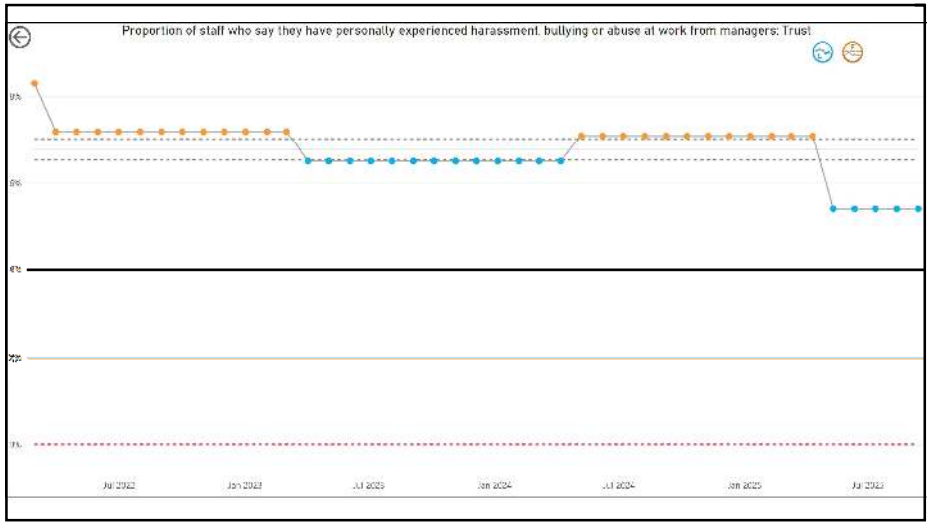

Net Staff in Post Change: Trust

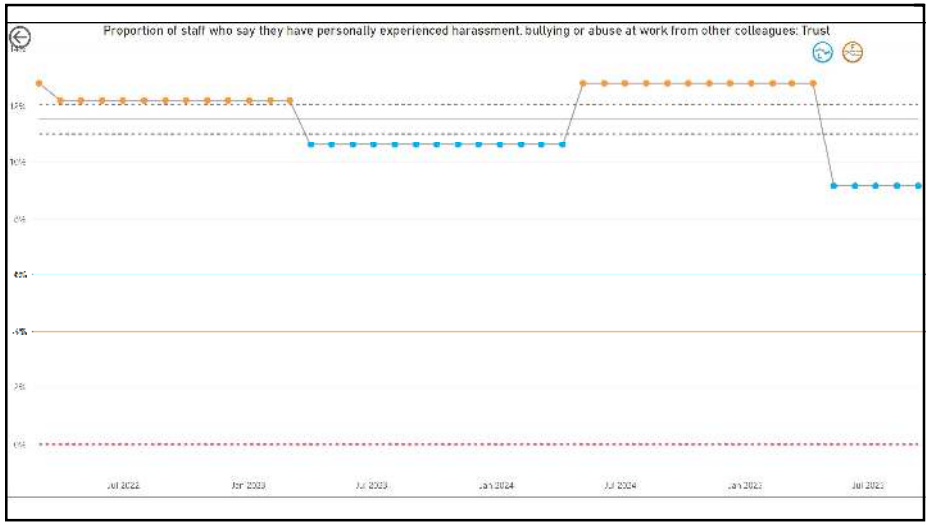

Proportion of staff in senior leadership roles who are from a) a BME background: Trust

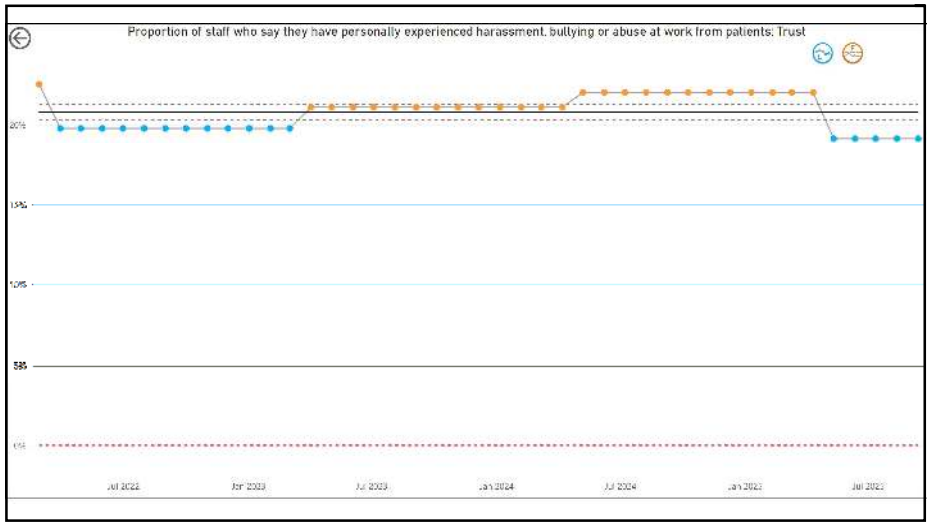

Proportion of staff in senior leadership roles who are from b) are women: Trust

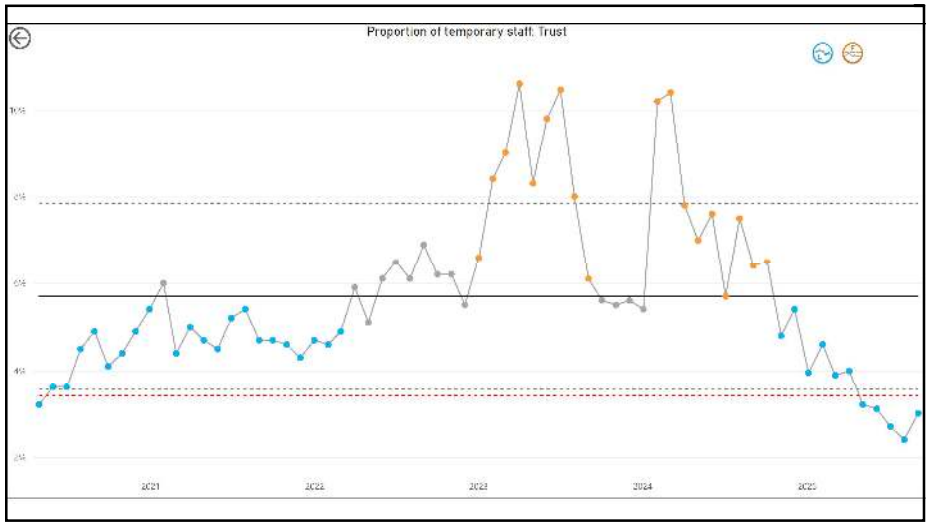

Proportion of staff in senior leadership roles who are from cl are disabled staff: Trust

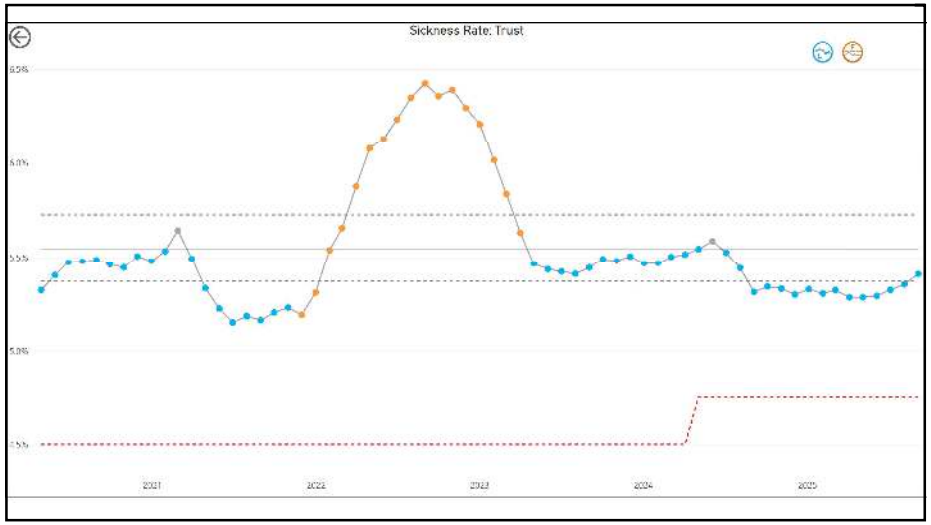

Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age: Trust

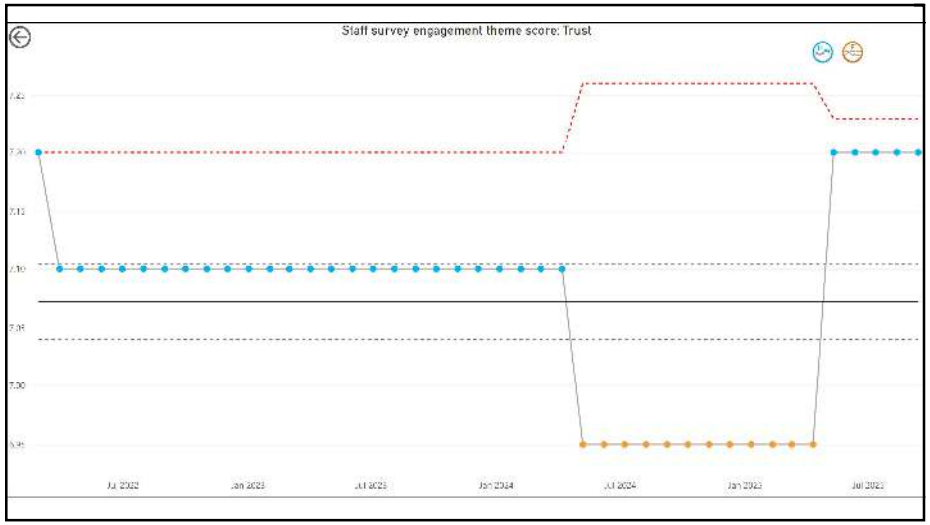

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers: Trust

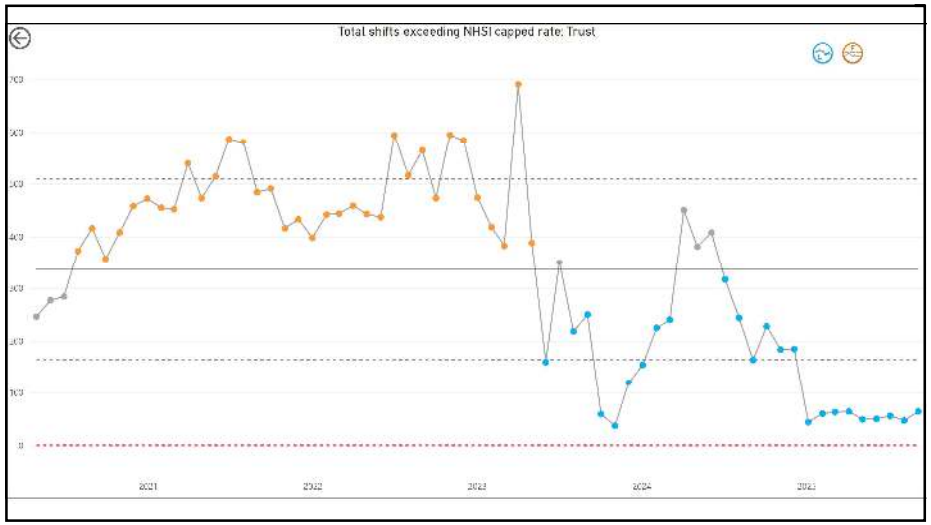

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues: Trust

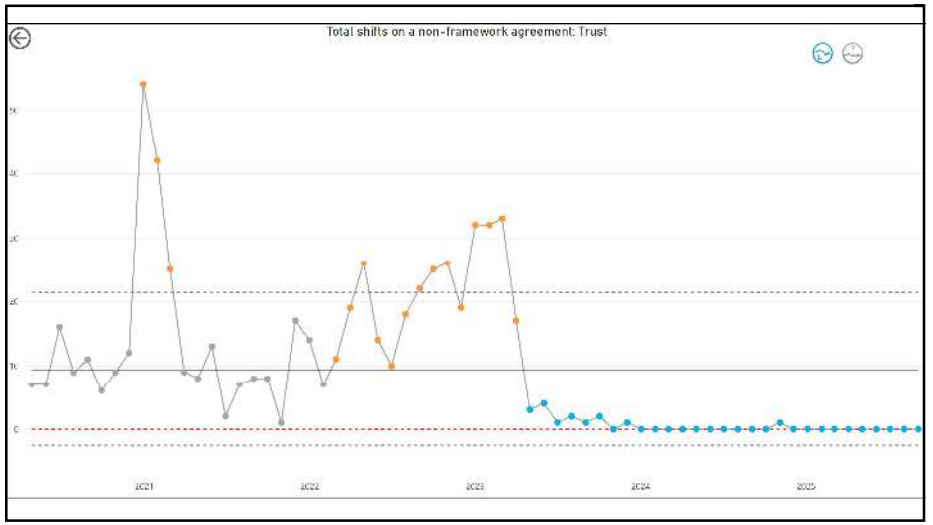

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients: Trust

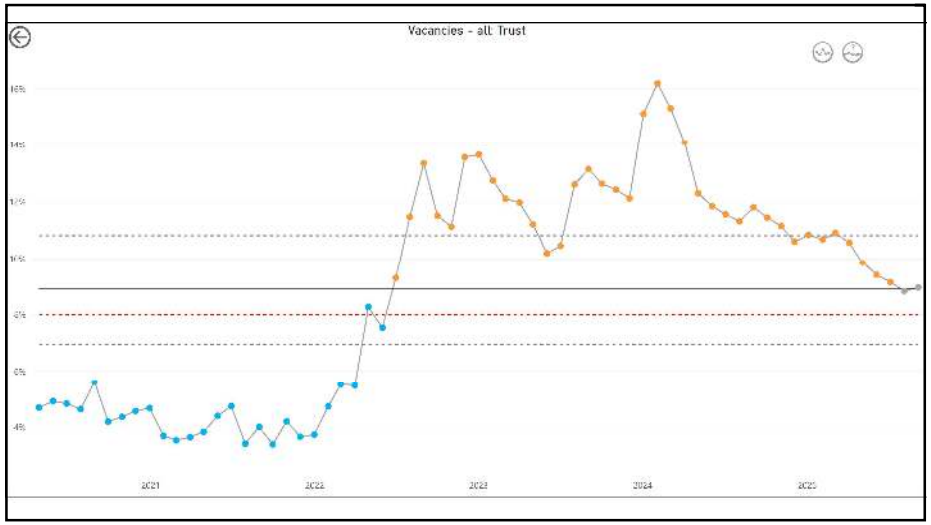

Proportion of temporary staff: Trust


Sickness Rate: Trust


Staff survey engagement theme score: Trust


Total shifts exceeding NHSI capped rate: Trust


Total shifts on a non-framework agreement: Trust


Vacancies - all: Trust

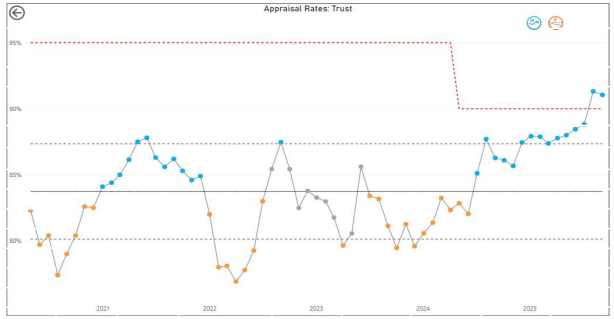
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Appraisals	%	87.78%	88.00%	88.45%	88.89%	91.32%	91.05%	89.53%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
%	89.20%	89.75%	90.00%	90.00%	90.00%	90.00%	90.00%



Reason for performance gap:	The compliance rate has been slowly increasing since February 2025. In August the compliance rate remained above our target of 90%. To remain above target we continue to send detailed appraisal reports 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 September except in exceptional circumstances. We are also focussing on ensuring those individuals coming up to the anniversary of their appraisal are appraised within the 12 months so they remain compliant. A process for monitoring progress is in place, with target support for managers and alerts and reminders to ensure completion. 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 - Whitchurch Hospital Inpatients - Band 6 has a plan for completing all outsanding appraisals supported by teh Community Services Manager	Apr-25	Sep-25	On track	To ensure appraisals are correctly inputted.
	Previous Hot spots - Planned care Wheelchair Services, Podiatry, CNRT Service lead to review and ensure completion by mid August at the latest	Jul-25	Aug-25	Complete	
	Community Services Division - Check and challenge with the Service Lead for Team Leaders to ensure that appraisals are compliant now and in the future. Now appraisal compliance is improving the check and challenge will focus on upcoming appraisals to ensure there is lapse	Mar-25	Mar-26	On Track	To ensure teams with low compliance are supported to increase their compliance rates.
	Diabetes Team - link in with Team Manager to ensure completion of outstannding appraisals (55% 4 individuals outstanding)	May-25	Sep-25	On track	Ensure appraisal compliance.
	Urgent & Emergency Care Division - (15 individuals outstanding an appraisalin teh Division) - Service Delivery Manager to work with Team Leaders to support completion by end of October at the latest.	Aug-25	Oct-25	On Track	Appraisals complete.
	Urgent & Emergency Care Division - To ensure compliance of those appraisals currently coming up for renewal these will be discussed at weekly Team Leader meetings planned in with Clinical Services Manager oversight	Aug-25	Mar-26	On track	Appraisals complete.
	Planned care Division - Clinical Services Managers will undertake a final push to ensure all appraisals are in date	Aug-25	Oct-25	On track	Appraisals complete.
	PHNS Admin team - due to absences in the team the Admin Manager will complete to ensure compliance	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	Complete	To understand any concerns around culture of the team and impact on all KPI's

Author	Fiona MacPherson	**Date**	9/16/2025
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025

Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Whitchurch Hospital Inpatients Service	34	22	64.71
825 Shropshire PHNS Admin Service	10	8	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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Leaver rate	%	9.86%	9.82%	9.32%	8.89%	8.04%	8.13%	8.13%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
%	8.84%	8.84%	8.84%	8.84%	8.84%	8.84%	8.84%

Org L6	FTE
825 Dudley CYP&F Management Services	89.82%
825 Estates Service	66.67%
825 Paediatric Phlebotomy Service	60.47%
825 Temporary Staffing Service	49.85%
825 Telford PHNS Admin Service	49.33%

Org L6 (12 months)	Leavers
825 Health Visiting Dudley Service	11
825 Bishops Castle Hospital Service	7
825 North Shropshire Community Nursing Service	7
825 South East Shropshire Community Nursing Service	7
825 Community Therapies Central Service	6
825 Recovery and Rehabilitation Unit Service	6
825 Ludlow Hospital Inpatient Service	5
825 Podiatry Service	4
825 Stoke Heath YOI Service	4
825 Whitchurch Hospital Inpatients Service	4

Leaving Reason	Leavers
Retirement Age	46
Voluntary Resignation - Work Life Balance	34
Voluntary Resignation - Relocation	21
Voluntary Resignation - Promotion	13
Voluntary Resignation - Health	9
Voluntary Resignation - Lack of Opportunities	7
Voluntary Resignation - Incompatible Working Relationships	6
Voluntary Resignation - Other/Not Known	6
End of Fixed Term Contract	4
Retirement - Ill Health	4

Reason for performance gap:

The Leaver rate has seen a gradual improvement with the rate continuing to fall below our target which has been the position for the last 4 months. 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. 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 & BIshops Castle Hospital).	Jul-25	Oct-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	Complete	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	Oct-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	Oct-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	Dec-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**	9/16/2025
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025

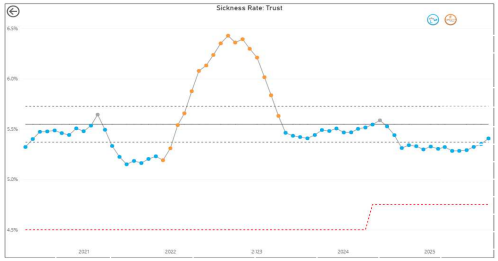
Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Sickness Rate	%	5.28%	5.28%	5.29%	5.32%	5.35%	5.41%	5.41%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
%	4.90%	4.80%	4.75%	4.75%	4.75%	4.75%	4.75%



Reason for performance gap: Since March 2025 the rate continues to remain above target and we are seeing very slight increases month on month. 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 People Team are planning for their Winty Ready capaign which includes promoting teh importance of the flu vaccination. 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. Community Therapies Central - Action plan in place - other issues also affected.	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 reach out to Ward Manager	Mar-25	Jul-25	Complete	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	Oct-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	Dec-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	Dec-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	Dec-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
UEC & Community Services division have identified peer vaccinator for the and further volunteers	Jul-25	Aug-25	Completed	Provide advice and guidance to staff their families through an online app
Launch the NHS Everything App which provides health and wellbeing advice and support inlcuding online pilates, yoga sessions etc	Jul-25	Aug-25	Completed	Ensure all staff who want a flu vaccination have easy access
Develop and implement a robust flu plan for the 2025-26 flu campaign using the data gathered from the flu survey	Mar-25	May-26	On Track	To ensure appropriate support is in place.
Work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assessment, MSK support.	Mar-25	Dec-25	On Track	To ensure menopause related absence is categorised correctly.
Raise awareness Trust wide of recording menopause related absences as menopause.	Mar-25	Dec-25	On Track	Ensure appropriate support is in place.
Cross check every month stress, anxiety and depression absences against referrals to OH to ensure compliance with the Policy.				

Author	Fiona MacPherson	**Date**	9/16/2025
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025
		Date	

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	282.00	817.17	34.51%
825 Ludlow Outpatient Service	167.39	825.61	20.27%
825 Children's Continence Service	83.27	428.53	19.43%
825 Community Therapies Central Service	790.17	5,057.96	15.62%
825 Research and Development Service	226.20	1,452.00	15.58%
825 Continence Specialist Nursing Service	352.60	2,403.07	14.67%
825 Strategy Service	169.20	1,159.70	14.59%
825 Bishops Castle Hospital Service	1,002.88	7,598.36	13.20%
825 Wound Healing Service	571.20	4,436.40	12.88%
825 Service Delivery Group - Adult Community Services Management Service	286.00	2,241.00	12.76%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Add Prof Scientific and Technic	441.21	14,667.47	3.01%
Additional Clinical Services	8,178.55	119,618.72	6.84%
Administrative and Clerical	5,680.73	124,858.89	4.55%
Allied Health Professionals	2,657.01	69,870.39	3.80%
Estates and Ancillary	687.45	17,822.16	3.86%
Medical and Dental	568.11	7,791.07	7.29%
Nursing and Midwifery Registered	13,701.28	232,852.24	5.88%
Students	33.00	3,474.00	0.95%

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	278	346	11,206.60	35.1
S13 Cold, Cough, Flu - Influenza	627	798	2,998.73	9.4
S25 Gastrointestinal problems	525	686	2,719.00	8.5
S12 Other musculoskeletal problems	118	135	2,355.19	7.4
S98 Other known causes - not elsewhere classified	150	166	2,231.00	7.0
S28 Injury, fracture	59	61	1,529.77	4.8
S17 Benign and malignant tumours, cancers	21	25	1,383.00	4.3
S11 Back Problems	68	76	1,074.30	3.4
S26 Genitourinary & gynaecological disorders	93	112	1,045.61	3.3
S15 Chest & respiratory problems	140	153	1,006.34	3.1

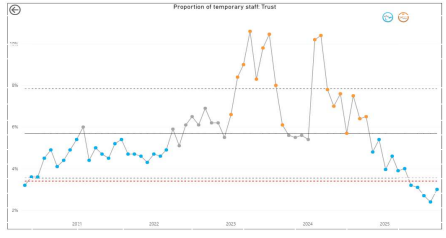
Exception Report - Action Plan

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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Prop Temporary staff	%	4.0%	3.2%	3.1%	2.7%	2.4%	3.0%	2.9%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%



Reason for performance gap:	UEC consultant recruitment has resulted in no suitably qualified applicants and this post has been reviewed by the Medical Director/ops. The Long Covid team are using a locum GP to support the service. In BCCH and LCH there is some sickness absence which is impacting on their agency and bank use. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. 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 September. NHSE notice due on the cessation of Band 2 and Band 3 agency use, early indiations were to cease this by the endof Q2 but as yet no formal notification has been received to date.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Medical and Dental and AHP staff groups to be agreed with regional NHSE group.	Apr-25	Sep-25	On Track	Reduction in price cap provision by agency, now in place for AHPs. Working towards the West Midlands Regional Price Rate Card by the end of Sep 25 for M&D. Agencies written to and advised.
	UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. JD has been reviewed - may need Royal College approval. Revised target set	Apr-25	Mar-26	On Track	Medical Director/Ops review complete and an agreed solution for this post. **22/08/25** JD reviewed and new job pack in draft. **15/9/25** Ongoing work is underway regarding the medical provision/skill mix.
	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	Mar-26	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 currently 59 days - Additional Duty %. % of assigned duties that are in addition to the budgeted demand move from current 6.7% to 3%. **15/9/25** Roster Approval Lead Time currently 59 days. Work is ongoing with further teams being implemented onto the roster system in a phased approach until March 2026
	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 at the focused interview event (see below action). 25 offers made on the day. Further events organised for June and July and September. Revised target date set as formal notification from NHSE not yet received.	Apr-25	Nov-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. **22/08/25:** Whitchurch event held on 29/7/25. 21 offers made on the day, checks ongoing and training and onboarding sessions set up in August and September.**15/09/25** July cohort: offers made to 22 bank HCSW 3 withdrawals, 10 with start dates and 9 completing onboarding. Next event: **26/9/25**
	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 16th.	Apr-25	Mar-26	On Track	**Event 16/5/25**: 21 recruited. Pre-employment checks completed (12 awaiting completion of mandatory training, 9 cleared to start). **Event 26/6/25:** 11 recruited. 1 awaiting completion of pre-employment checks, 10 undertaking mandatory training) **Event 29/7/25:** 21 recruited. Pre-employment checks ongoing. **15/9/25:** July cohort: offers made to 22 bank HCSW 3 withdrawals, 10 with start dates and 9 completing onboarding **Next event:** 26/9/25 Shrewsbury
	Roll out e-roster to all clinical staff and non-clinical bank workers.	Sep-25	Mar-26	On-track	Improved staff productivity and reduction of agency usage. Increased goverance and reporting of bank and agency bookings across the Trust.
	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. **15/9/25** Configuration documents complete, communication and migration plan in progress. IG have requested copy of Third Party DSA to ensure appropriate governance arrangements are in place
Author	Gina Billington	**Date**	9/15/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

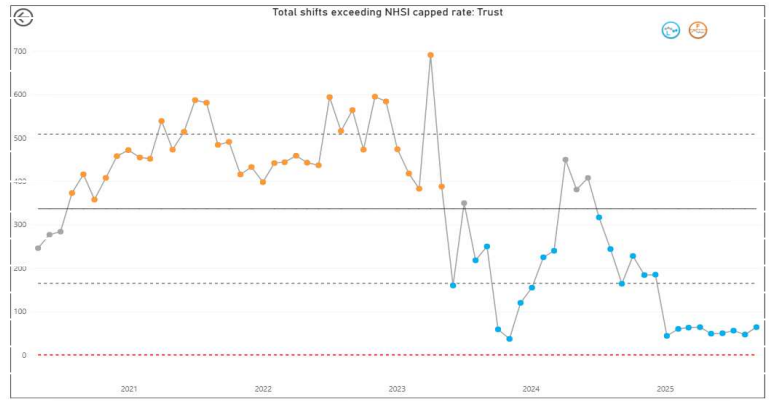
Exception Report - Action Plan

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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Shifts	Number	64	49	50	56	47	64	53
	Target	0	0	0	0	0	0	0

Trajectory	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
%	64	55	45	35	25	15	0



Reason for performance gap:	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 however there is an West Midlands agreement that all Trusts are working towards West Midlands Region Price Rate card by end of September.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Medical and Dental staff group to be agreed with regional NHSE group.	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 Sep 25. Agencies written to and advised. **15/9/25** All agencies signed up to Midlands Rate card
	Grow our bank and implement the use of centralised bank to support reduction in agency usage. Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-25	Mar-26	On Track	**Event 16/5/25**: 21 recruited. Pre-employment checks completed (12 awaiting completion of mandatory training, 9 cleared to start). **Event 26/6/25:** 11 recruited. 1 awaiting completion of pre-employment checks, 10 undertaking mandatory training) **Event 29/7/25:** 21 recruited**.** Pre-employment checks ongoing. **15/9/25:** July cohort: offers made to 22 bank HCSW 3 withdrawals, 10 with start dates and 9 completing onboarding. Next event: **26/9/25** in Shrewsbury
Author	Gina Billington	**Date**	9/15/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

Local Action Plans

Exception Report - Action Plan

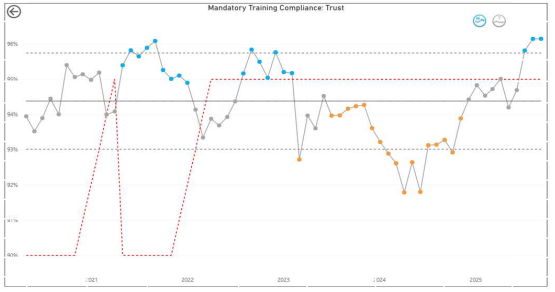
Mandatory Training Compliance

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

KPI Description	Latest 6 months	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Mandatory Training	%	95.01%	94.20%	94.69%	95.82%*	96.15%	96.15%	96.15%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

*bank IG excluded from overall compliance from June 25

Trajectory	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
%	96.60%	96.60%	97.10%	97.10%	97.60%	97.60%	98.10%



All non-compliant sectors

Sector	Substantive staff count	% Compliance
825 North East Sector	101	94.10%
825 Trust Board Sector	10	90.00%
825 Stoke Heath YOI Sector	22	86.89%
825 South East Sector	112	92.88%

August 2025 Compliance Overview

TOPIC	July Compliance		August Compliance	Variance against compliance
Corporate Induction	97.7%	▼	97.6%	-0.11%
Equality, Diversity and Human Rights - 3 Years	98.6%	▼	98.5%	-0.06%
Fire Safety - 2 Years	99.6%	▲	99.7%	0.11%
Fire Safety - High Risk - 1 Year	80.9%	▼	80.2%	-0.66%
Fraud Awareness - 3 Years	97.2%	▲	97.3%	0.10%
Health, Safety and Welfare - 3 Years	98.2%	▲	98.4%	0.26%
Infection Prevention and Control - Level 1 - 3 Years	98.7%	▼	97.7%	-0.97%
Infection Prevention and Control - Level 2 - 1 Year	97.6%	▼	96.1%	-1.57%
Information Governance and Data Security - 1 Year	97.4%	▼	97.3%	-0.16%
Moving and Handling - Level 1 - 3 Years	96.8%	▼	96.6%	-0.22%
Moving and Handling - Level 2 - 2 Years	78.6%	▲	81.6%	3.06%
NHS Conflict Resolution (England) - 3 Years	98.0%	▲	98.1%	0.10%
Patient Safety - Level 1 - 3 Years	99.4%	▲	99.5%	0.05%
Preventing Radicalisation - Prevent Awareness - 3 Years	98.1%	▼	97.8%	-0.27%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	86.0%	▲	86.3%	0.32%
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	85.8%	▲	86.2%	0.41%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	86.6%	▼	82.7%	-3.83%
Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	86.0%	▼	82.0%	-3.99%
Safeguarding Adults - Level 1 - 3 Years	98.6%	▲	98.7%	0.05%
Safeguarding Adults - Level 2 - 3 Years	98.1%	▲	98.3%	0.21%
Safeguarding Children - Level 1 - 3 Years	96.0%	▲	96.7%	0.74%
Safeguarding Children - Level 2 - 3 Years	94.0%	▲	95.5%	1.47%
The Oliver McGowan Mandatory Training on Learning Disability and Autism	98.0%	▼	98.0%	-0.06%

Reason for performance gap:

Corporate Updates – The compliance rate for August has continued to be above the 95% target, maintaining at 96.15%. We have seen a reduction in the number of topics from 14 to 10 where compliance has dropped. We have seen another drop by over 3% drop in Resuscitation - Level 3 - Adult and Paediatric, this is due to no training taking place in August. We have seen a drop in compliance for the Infection Prevention training, the Level 1 dropped by just under 1% and the Level 2 had a drop of just over 1.5%, however both are still above the 95% compliance target. Manual Handling Level 2 again increased by over 3%, taking us over the 80%, this topic has continually increased their compliance since it was introduced in April 2025.
Patient Safety Level 2, Safeguarding Children Level 3 and Level 4 and Safeguarding Adults Level 3 will be included in the monthly compliance reports from September. The positions were updated at the start of 2025, we have seen monthly increases in their compliance.

Action Plan

Action	Start Date	End Date	Status	Outcome
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	Dec-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	The ESR LM Lead has met with the new lead for Fire, where the mapping for High Risk Fire was confirmed. The positions in ESR have been updated with the updated requirements. Managers were emailed where staff were showing as non-compliant or due to expire within the next 3 months where the requirement had been added. The low compliance for High Risk Fire has been on the agenda for the newly formed Fire group, for Operational managers to ensure staff are
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	Complete	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 - 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	Dec-25	On track	Improved mandatory training compliance. Stoke Heath - Admin Team have reached the 95% Compliance Target
Community Services to implement a check and challenge session in a monthly basis to discuss hot spots for areas of low compliance	Jun-25	Dec-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	Complete	Monthly emails are sent to managers and Service Leads for topics below 95%. Improved mandatory training compliance.

Author	Catherine Morris	**Date**	9/16/2025
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025

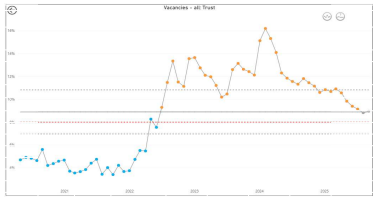
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	YTD
Vacancies	%	10.56%	9.83%	9.39%	9.14%	8.82%	8.95%	9.23%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
%	8.85%	8.70%	8.60%	8.55%	8.35%	8.30%	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 wards are de-commissioning and the focus is on redeployment of that staff in both wards. UEC are expanding their services and these vacancies will be in the process for redeployment of RRU Staff - this will be the case for all services and their vacancies. 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. Dudley C&YP Services holding vacancies whilst undertaking review of structures for managment of change.

Month 5 hotspots: Community Therapy Central is showing as a hotspot, however therapies are in the process of a service review. Dudley Health Visiting are showing as a hotspot they are holding several vacancies due to a restructure process. BCCH and LCH are continued hotspots with work ongiong with the recruitment team. There are a number of roles in these CHs which will be held for redeployment for the RRU teams. This will be the case across the Trust where roles are suitable for redeployment. This will impact on vancancy position going forward. There are a number of administrative vacancies across the Trust that have not been approved for advertisting which are 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: Work on the expansion of the UEC services is still underway. Vacancies as a result of this expansion will be held in the first instance (where suitable) for the RRU redeployment. Recruitment team managing the redeployment process with HR and operational manager.	Jul-25	Dec-25	On Track	Vacancies successfully redeployed or recruited to.
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. JD has been reviewed - may need Royal College approval. Revised target set	Apr-25	Mar-26	On Track	Medical Director/Ops review complete and an agreed solution for this post. **26/8/25** JD reviewed and new job pack in draft **15/9/25** Ongoing work is underway regarding the medical provision/skill mix.
Community Services Hotspot: Recruitment team to prioritise vacancies BCCH, LCH, Community Therapies Central, liaise with managers on shortlisting times/interview dates and follow up on successful applicants and prioritise pre-employment checks. Revised target date	May-25	Jan-26	On Track	**26/8/25** BCCH has 1.0 WTE – staff nurse with start date 26/8/25 Ludlow has 0.75 WTE Nurse associate with start date 08/09/25 Bridgnorth has 2.0 WTE vacancies in Trac, 1 wte Staff nurse at offer stage and 1 wte HCA with start date on 29/9/25 **15/9/25** b; 2.27 wte Staff Nurse 2.27 wte Healthcare Assistant *Vacancies in RRU deployment* Band 5 Nurse – in post Ludlow: 3.68 wte band 5 nurse, 1 wte with start date, 1 wte band 2 with start date 1 Nurse associate at shortlisting *Vacancies in RRU deployment*. Deputy Ward Manager: Band 6 0.8 WTE, Staff Nurse - Band 5 1.96WTE, Housekeeper: Band 2 1 WTE Community Therapies Central: Assistant Practitioner: Band 4 – 1wte at interview Occupational Therapist: Band 6 0.8 wte - advert stage *Vacancies in RRU deployment* 1 Community Physiotherapist
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. **26/8/25:** 4 posts in offer stage. **15/9/25** 1 post in VRF authorisation stage, 1 post advert closed, 5 posts in offer stage, 1 bank post in advertising
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	To meet NHSE Benchmark KPI of 40 days time to hire. **27/8/25**: Time to hire for July: 34.8 days which remains static compared to June. **15/9/25**: Time to hire for August is 42.1 days
Look at internal moves due to vacancies and identify hotspots for this movement.	Apr-25	Nov-25	On Track	Areas identified and work with managers on implications and considered for further action. Capacity issues in the team means we were unable to complete this work by the original target date of July. Revised target date set: November 25
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	**Event 16/5/25**: 21 recruited. Pre-employment checks completed (12 awaiting completion of mandatory training, 9 cleared to start). **Event 26/6/25**: 11 recruited. 1 awaiting completion of pre-employment checks, 10 undertaking mandatory training) **Event 29/7/25**: 21 recruited, Pre-employment checks ongoing. 15/9/25: July cohort: offers made to 22 bank HCSW 3 withdrawals, 10 with start dates and 9 completing onboarding. Next event: **26/9/25** Shrewsbury

Author	Rhia Boyode	**Date**	9/16/2025
Accountable Officer Approval	Gina Billington	**Date**	9/15/2025

Division	Column1	Column2	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer			30.98	2.74	8.8
Urgent Care (Adults)			215.31	16.78	7.8
Community Services (Adults)			692.1	66.14	9.6
Planned Care SDG			212.59	27.53	12.9
Children and Families Division			459.79	32.11	7.0
Chief Executive			12.84	2.00	15.6
Director of Finance and IM&T			82.29	8.68	10.5
Director of Governance			22.5	0.81	3.6
Director of People			31.91	3.16	9.9
Director of Nursing and AHPs			33.33	1.55	4.7
Medical Directorate			4.08	(0.60)	(14.7)
Total			**1,797.52**	**160.90**	**9.0**

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	1.74	12.9
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		YA255	7.2	1.00	13.9
Virtual Wards- Telford		YA257	11.04	1.28	11.6
OPAT		YA253	5.29	0.09	1.7
Urgent Community Response- Telford		TT700	12.24	(0.35)	(2.9)
Urgent Community Response- Central		TT701	7.8	0.21	2.7
Urgent Community Response- North East		TT702	4.4	0.60	13.6
Urgent Community Response- North West		TT703	5.02	0.62	12.4
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	1.04	4.2
Total			**144.63**	**13.05**	**9.0**

Children, Young People & Famili	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Shropshire PHNS Admin		WP125	9.46	1.07	11.3
Shropshire Health Visiting		WP135	45.45	0.68	1.5
Family Nurse Partnership Shropshire		WP601	5.07	0.00	0.0
Telford PHNS Admin Service		WP127	4.4	0.40	9.1
Health Visiting Telford Service		WP136	32.57	0.40	1.2
Family Nurse Partnership Telford		WP603	3.05	0.05	1.6
Dudley Health Visiting Admin Service		WP126	12	1.21	10.1
Health Visiting Dudley Service		WP205	75.27	7.15	9.5
Family Nurse Partnership Dudley Service		WP602	9.25	0.75	8.0
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	13.79	1.40	10.2
Total			**271.65**	**17.58**	**6.5**

Community Services (Adults)

Inpatient Wards	Column	Cost Cent	Budget WT	Vacancy WTE	% vacanc
Bishops Castle Hospital Ward		TW130	21.63	5.41	25.0
Ludlow Hospital Ward		TW230	34.72	6.16	17.7
Whitchurch Hospital Ward		TW330	40.46	5.16	12.8
Bridgnorth Hospital Ward		TT130	41.35	2.86	6.9
Rehab & Recovery Unit - Shrewsbury (Ward 18, Fl		YA260	50.93	12.35	24.2
Rehab & Recovery Unit - Telford (Ward 36, Fl		YA270	43.53	4.46	10.3
Total			**232.6**	**36.40**	**15.6**

Community Nursing	Column	Cost Cent	Budget WT	Vacancy WTE	% vacanc
Community Nursing - Telford North		TT530	32.42	2.42	7.5
Community Nursing - Telford South		TT900	32.38	0.12	0.4
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		TN300	29.28	0.35	1.2
Community Nursing - North West		TN800	32.01	3.15	9.7
Community Nursing - South East		TW301	31.44	3.47	11.0
Community Nursing - South West		TW300	25.11	(1.07)	(4.3)
Total			**245**	**13.14**	**5.4**

Community Therapy Services	Column	Cost Cent	Budget WT	Vacancy WTE	% vacanc
Adult Community Therapy Central		TA001	16.06	4.67	29.1
Adult Community Therapy North East		TA003	17.19	1.21	7.0
Adult Community Therapy North West		TA004	11.9	(0.03)	(0.3)
Adult Community Therapy South East		TA005	14.67	2.47	16.8
Adult Community Therapy South West		TA006	15.35	0.86	5.7
Total			**75.17**	**9.20**	**12.2**

Dental in Planned Care	Column	Cost Centr	Budget WTE	Vacancy WTE	% vacancy
Dental Central Admin		WM900	3.3	0.00	0.0
Dental Special Care and Access		WM910	30.43	2.10	6.9
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	0.63	9.8
Total			**45.72**	**4.63**	**10.1**

Planned Care	Column	Cost Centr	Budget WTE	Vacancy WTE	% vacancy
TeMS Therapy		TC231	0	0.00	#DIV/0!
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	0.30	1.6
MSST		TC250	12.97	0.90	6.9
Total			**36.86**	**1.15**	**3.1**

Planned Care	Column	Cost Centr	Budget WTE	Vacancy WTE	% vacancy
Prison Healthcare		WH200	26.82	5.85	21.8
Total			**26.82**	**5.85**	**21.8**

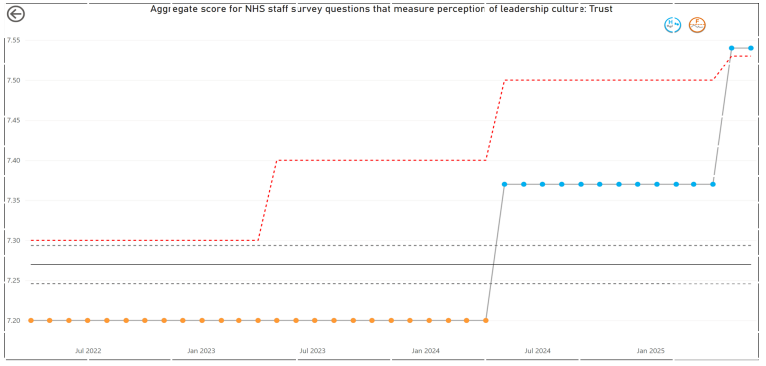
Yearly Reported KPIs

Exception Report - Action Plan

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

KPI Description	Latest 6 months	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



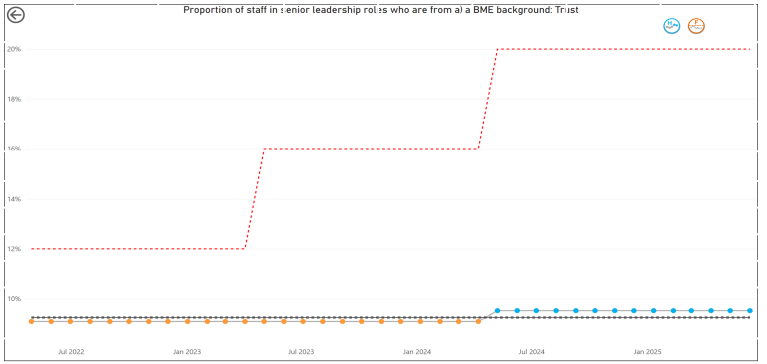
Reason for performance gap:	The target is 7.53 and we are close to this with a score of 7.54. There have been changes over the last 24 months which have included change management across leadership roles which will take time to embed and change culture. The Culture Change team has been launched with 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	Dec-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**	9/16/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

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%



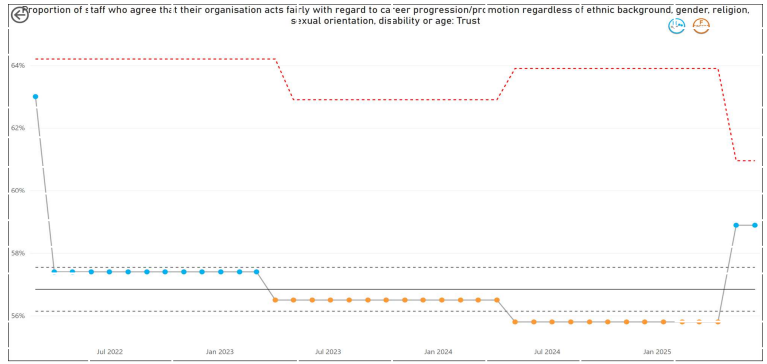
Reason for performance gap:	The WRES 2023/24 report shows our colleague representation for Asian, Mixed, Black and other minority people has increased year on year since 2020 and makes up 7.82% of our workforce. The 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, 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	Dec-25	On Track	To suppoer inclusive recruitment processes
Author	Fiona MacPherson	**Date**	9/16/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	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%



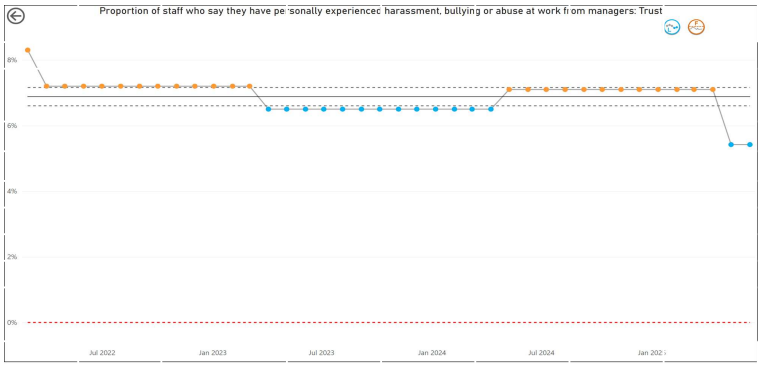
Reason for performance gap:	There was a gap of 8.1% for 2024/25 between the national average and SCHT's score, however this has decreased to 2.06%. For a period of time leadership courses have not been available internally for our staff to attend however, more recently we have been working in collaboration 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	Dec-25	On Track	Ensure recruitment processes are fair, inclusive and transparent.
	Develop and implement an inclusive recruitment toolkit.	Jan-25	Dec-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	Dec-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.
Author	Fiona MacPherson	**Date**	9/16/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	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%



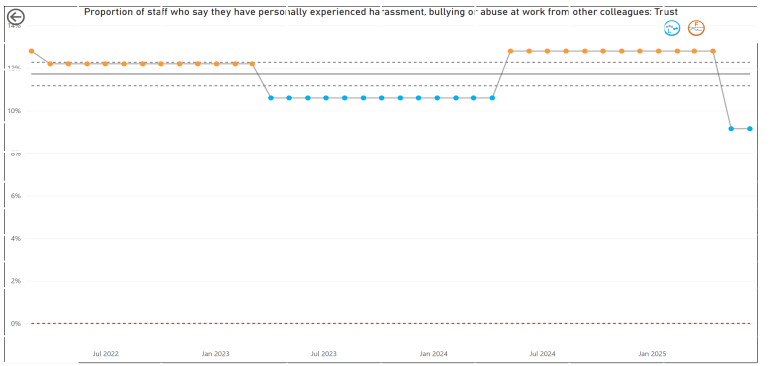
Reason for performance gap:	When reviewing the information retained by the People team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Dec-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	Dec-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	9/16/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	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%



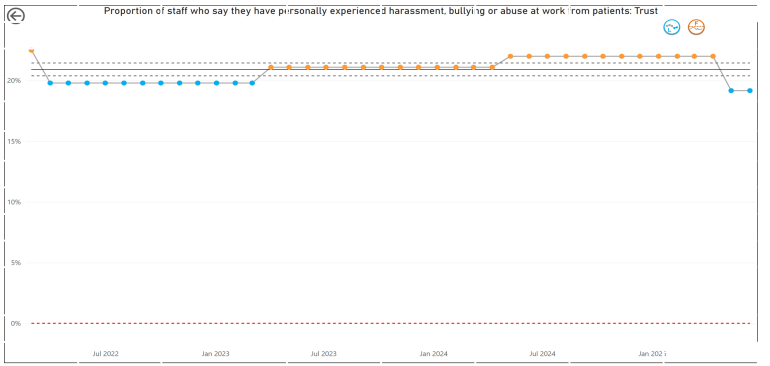
Reason for performance gap:	When reviewing the information retained by the People Team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Develop a Civility & Respect booklet to support the Civility and Respect programme.	Mar-25	Dec-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	Dec-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	9/16/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	9/16/2025		

Exception Report - Action Plan

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

KPI Description	Latest 6 months	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%



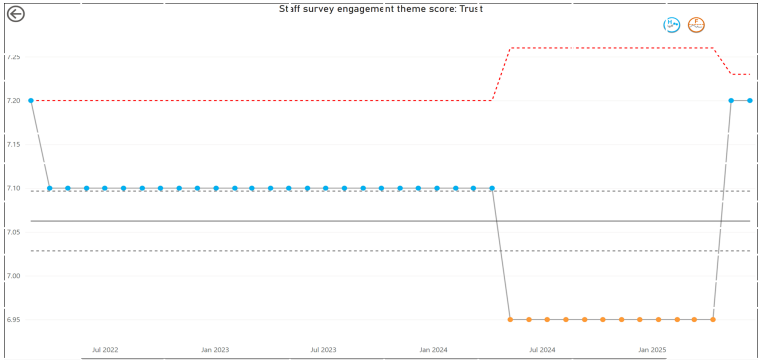
Reason for performance gap:	Staff experience bullying by patients, the aim is to raise awareness of the impact of this behaviour and support staff as required.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Launch work without fear campaign.	Mar-25	Dec-25	On Track	Raise awareness to our patients, relatives and members of the public.
	Develop nudge posters around zero tolerance.	Mar-25	Dec-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	Dec-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	Dec-25	On Track	Provides individuals with the skills to challenge inappropriate behaviour.
Author	Fiona MacPherson	**Date**	8/27/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	8/27/2025		

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**	8/27/2025		
Accountable Officer Approval	Rhia Boyode	**Date**	8/27/2025		

Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**2nd October 2025**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**24th September 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. 28 indicators are highlighted as a concern (40.6%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	0	12	0	**19**	**12 (63%)**
Quality & Safety	3	3	1	**19**	**7 (37%)**
Resource & Performance	1	8	0	**31**	**9 (29%)**

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**
  No change
- **Resource and Performance Committee**
  Urgent Care 2 hour response is no longer flagged as a variation concern.

  18 week Referral to Treatment (RTT) incomplete pathways (National target) and Proportion of patients within 18 weeks (Local target) were previously flagged as both assurance and variation concerns, now flagged as only assurance concerns

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.

Please note that the RTT measures for August 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, 9 require focused attention with 8 of the 9 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:

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

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

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

1. 18 week Referral to Treatment (RTT) incomplete pathways (National target)
2. Proportion of patients within 18 weeks (Local target)
3. Data Quality Maturity Index
4. Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
1. Total patients waiting more than 52 Weeks – All services (Local target)
2. Total patients waiting more than 65 Weeks – All services (Local target)
3. Total patients waiting more than 78 Weeks – All services (Local target)
4. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)

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

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

- No longer flagged as having a variation concern
    1. *Urgent Care 2 hour response*

- Previously flagged as both assurance and variation concern, now flagged as only an assurance concern
    1. *18 week Referral to Treatment (RTT) incomplete pathways (National target)*
    2. *Proportion of patients within 18 weeks (Local target)*

Performance Update

August 2025 position:

	Children's Services		Adult Services	
Patients Waiting	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)	Nationally Mandated Referral to Treatment (Consultant-Led Services)	Local Waiting List Management (All Services)
Over 52 weeks	0	94	51	83
Over 65 weeks	0	6	0	22
Over 78 weeks	0	1	0	2
Over 104 weeks	0	0	0	2

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

Since the last report to the Trust Board there has been improvement in the Trust's collective total for the high wait KPIs in the table above with the exception of 104 weeks (local) which has remained at 2 being reported. **However, following data validation, it is confirmed that there were zero 104 week waits in August.**

'18 week Referral to Treatment (RTT) incomplete pathways' has shown an improvement from 69.09% in July to 74.74% in August, although the August position was still being validated at the time of preparing the paper/dashboards. Further detail is included within the action plan.

The indicator for 'Proportion of patients within 18 weeks' has improved, with performance of 77.5% in August compared with 72.19% in July.

The data issue previously reported in relation to Continence products was resolved for 2024/25 data. However, a similar issue still exists for 2025/26 with data being up to date to July however August data was unavailable when preparing the dashboards; this issue has been raised and subsequently escalated with the system supplier, and the measure will be refreshed once this is resolved. This impacts the 'total activity undertaken against current year plan' KPI.

3.5 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	2025-08-31		74.74%	92.00%	-17.26%	74.74%	92.00%	-17.26%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2025-08-31	L	100.43%	100.00%	0.43%	100.43%	100.00%	0.43%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2025-08-31		71.49%	100.00%	-28.51%	71.49%	100.00%	-28.51%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2025-08-31	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2025-08-31		0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2025-05-31	H	93.0%	95.0%	-2.0%	93.0%	95.0%	-2.0%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2025-07-31		98.78%	99.00%	-0.22%	98.78%	99.00%	-0.22%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2025-08-31		1.67%	0.00%	1.67%	1.67%	0.00%	1.67%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2025-08-31		0.22%	0.00%	0.22%	0.22%	0.00%	0.22%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2025-07-31	H	94.26%	90.00%	4.26%	90.38%	90.00%	0.38%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2025-07-31	H	82.96%	90.00%	-7.04%	84.38%	90.00%	-5.62%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2025-07-31		92.62%	95.00%	-2.38%	91.43%	95.00%	-3.57%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2025-08-31	L	0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2025-08-31	H	111.65%	75.00%	36.65%	113.46%	75.00%	38.46%	?
Resource & Performance...	Responsive	Patients no longer meeting the criteria to reside	2025-08-31	L	21.4%	19.7%	1.7%	21.4%	19.7%	1.7%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2025-08-31	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...	2025-08-31	H	60.00%	92.00%	-32.00%	76.47%	92.00%	-15.53%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2025-08-31	H	77.50%	92.00%	-14.50%	77.50%	92.00%	-14.50%	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	2025-08-31		78.25%	100.00%	-21.75%	99.43%	100.00%	-0.57%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2025-08-31		122.54%	120.00%	2.54%	155.05%	120.00%	35.05%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2025-08-31	H	143.92%	103.00%	40.92%	133.70%	103.00%	30.70%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2025-08-31		2	0	2	2	0	2	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2025-08-31		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2025-08-31	L	177	0	177	177	0	177	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2025-08-31	L	51	0	51	51	0	51	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2025-08-31	L	28	0	28	28	0	28	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2025-08-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2025-08-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2025-08-31	L	3	0	3	3	0	3	F
Resource & Performance ...	Responsive	Urgent Care 2 hour response	2025-08-31		82.22%	70.00%	12.22%	82.22%	70.00%	12.22%	
Resource & Performance ...	Effective	Virtual ward bed occupancy	2025-08-31		67.09%	56.89%	10.20%	67.09%	56.89%	10.20%	

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	2025-08-31	H	6.43	6.49	-0.06	6.43	6.49	-0.06	F
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2025-08-31		0	0	0	0	0	0	?
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2025-08-31		2	0	2	2	0	2	?
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2025-08-31	H	350.00%	100.00%	250.00%	350.00%	100.00%	250.00%	?
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2025-08-31	H	100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	F
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2025-08-31	H	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	F
Quality & Safety Committee	Effective	Deaths - unexpected	2025-08-31	H	2	0	2	2	0	2	?
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2025-08-31	H	200.00%	100.00%	100.00%	200.00%	100.00%	100.00%	P
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2025-08-31		5.14	4.00	1.14	5.14	4.00	1.14	?
Quality & Safety Committee	Safe	Medication Incidents with Moderate Harm	2025-08-31		0	0	0	7	0	7	?
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2025-08-31		0	0	0	0	0	0	P
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2025-08-31	H	1	0	1	1	0	1	F
Quality & Safety Committee	Safe	Never Events	2025-08-31		0	0	0	0	0	0	P
Quality & Safety Committee	Well Led	Overall CQC Rating	2025-08-31		Good	Good		Good	Good		P
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2025-08-31		0	0	0	5	0	5	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-07-31		117%	95%	22%	117%	95%	22%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-07-31		119%	95%	24%	119%	95%	24%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-07-31	H	99%	95%	4%	99%	95%	4%	?
Quality & Safety Committee	Safe	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-07-31		103%	95%	8%	103%	95%	8%	?

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 ...	2025-08-31		7.5	7.5	0.0	7.5	7.5	0.0	
People Committee	Well Led	Appraisal Rates	2025-08-31		91.05%	90.00%	1.05%	89.53%	90.00%	-0.47%	
People Committee	Well Led	CQC well-led rating	2025-08-31		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2025-08-31		8.13%	9.60%	-1.47%	8.13%	9.60%	-1.47%	
People Committee	Well Led	Mandatory Training Compliance	2025-08-31		96.15%	95.00%	1.15%	96.15%	95.00%	1.15%	
People Committee	Well Led	Net Staff in Post Change	2025-08-31		-4.05	0.00	-4.05	5.46	0.00	5.46	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2025-08-31		9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2025-08-31		72.73%	66.00%	6.73%	72.73%	66.00%	6.73%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2025-08-31		4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2025-08-31		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...	2025-08-31		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...	2025-08-31		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...	2025-08-31		19.2%	0.0%	19.2%	19.2%	0.0%	19.2%	
People Committee	Well Led	Proportion of temporary staff	2025-08-31		3.0%	3.4%	-0.4%	2.9%	3.4%	-0.5%	
People Committee	Well Led	Sickness Rate	2025-08-31		5.41%	4.75%	0.66%	5.41%	4.75%	0.66%	
People Committee	Well Led	Staff survey engagement theme score	2025-08-31		7.2	7.2	0.0	7.2	7.2	0.0	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2025-08-31		64	0	64	53	0	53	
People Committee	Well Led	Total shifts on a non-framework agreement	2025-08-31		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2025-08-31		8.95%	8.00%	0.95%	9.23%	8.00%	1.23%	

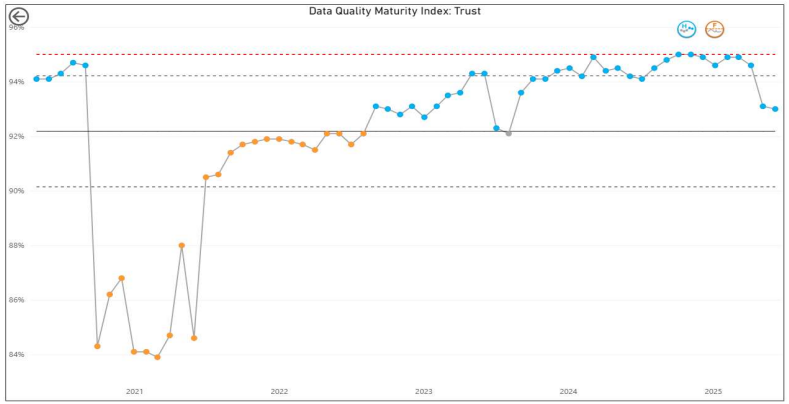
Icon Descriptions

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



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. In April 2025 there was an unexpected dip in performance, to 93.1%. This is due to the depracation of SNOMED Terms in relation to the ECDS dataset moving to a new version. We are not submitting the new version, due to our EPR not being compliant at this stage. We were not aware of this depracation until July 2025, due to delayed publication of the monthly NHSE DQ Dashboards. Since becoming aware, we have re-configured Rio to prevent the use of depracated Terms and enable the use of new Terms. This should lead to improvement from the August 25 DQMI onwards once the data has been fully validated. Data Quality Issues still being addressed relate to: 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 increased for Rehab and Recovery Units 12 months ago due to a lack of capacity for SaTH to continue to support with coding. We are currently mitigating where possible and seeking alternative arrangements. **Main Challenges:** The primary challenge affecting this metric has been 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	Stabilisation of clinical coding workforce	Nov-24	Jan-25	Off Track	**September 25 Update** Ongoing discussions to be had with external organisations. **August 25 Update** Discussions began in July and August about mutual aid from MPFT, but they are unable to assist and are instead using an external company for 100% coding. As a result, procurement options with outside providers are being considered and will continue to progress through September 25. Through the admin academy, we have now secured one individual with previous coding experience for a refresher course and another team member interested in training. Workforce is also exploring an apprentice stream via the Royal Free London Trust. **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. This has been explored previously but this means that this option can be revisited and scoped further. This month operational teams are meeting an external 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	Complete	**August 25 Update** A plan of education has been created and devised and will now be reviewed re effectiveness through DQ sub group. Raising awareness of the importance of recording ethnicity has been taking place throughout July in several mediums. Focus sessions have been delivered via the weekly huddles. Presentations have been delivered at the Divisional Performance and Quality meetings. Team leaders have been asked to include this subject in monthly one to one discussions to ensure that staff are focused to support improvements. Champions have been identified within teams to also support with this imitative. Scoping of check in kiosks have also commenced to support accurate data validation/ input at presentation of appointments. **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 needs 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 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. Some improvements 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 Ethnicity is being added through EBO to EConsent form, in time for the Flu programme to begin in September, which should help the School Aged Imms service around asking the question. Cross Team linkage and learning will take place between the SC/TW School Nurses and Dudley School Nurses who have better performance in relation to Ethnicity, to educate staff around asking the question and its impact upon Health Inequalities
	Through Data Quality sub-group and Divisional performance meetings systematically track progress against the education plan, assess the effectiveness of roll out against the trajectory to achieve 95% by January and proactively mitigate risks as they arise, focusing interventions towards specific teams requiring additional support.	Aug-25	Jan-26	On Track	**September 25 Update** For the next divisional performance meeting an agenda item there will be a slot for the Information team to discuss this KPI and support monitoring of this KPI by Team. Urgent Care division to replicate the Planned Care action plan and support teams to monitor key indicators **New Action** Team level data analysed and teams doing well (CNRT, Long Covid) asked to support with peer education and buddy teams underperforming the MIU RIO video will also be shared and 1:1 sessions with team leads and Divisional Mangers as required to address performance at team level and agree specific actions to recover.

	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	**September 25 Update** Step by step guide and data quality reports to be reviewed by Divisional Manager. Meeting to be arranged with Team Leads and one to ones with each staff member to confirm RiO recording **August 25 Update** Monthly meetings in place and continuing dedicated drill down session scheduled in month. Service lead has met with Rio training team, around the finalising of the step by step guide. Crib sheet being produced to assist staff with the key screens and flow of data entry. Service lead will ask Rio team to produce a video on how to enter the required data, which will allow monitoring of staff accessing the required guidance. **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**	09/09/2025			
Accountable Officer Approval	Claire Horsfield	**Date**	12/09/2025			

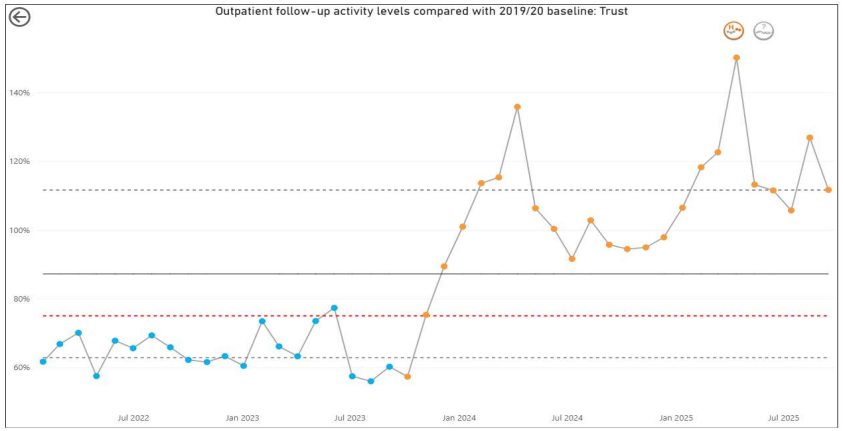
xception Report - Action Plan

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

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

KPI Description	Latest 6 months	Mar-25						
Outpatient follow-up	%	150.15%	113.1					
	Target	75.0%	75.0%					

Trajectory	Feb-25	Mar-25	Apr-25	M			
%	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 Initiat
target of 5.5% demonstrating an effective use of the pathway and best practice approach. From a local perspective SCHT are modelling a best pr
(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 overperforman
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	Aug-25 (Rounded to 0 dp)
APCS	57%
Bridgnorth Outpatients	34%
DAART	123%
Ludlow Outpatients	64%
MSST	14414%
TEMS	0%
Whitchurch Outpatients	68%

		Start Date	End Date	Status	Outcome

Action Plan	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	**September 25 Update** There continues to be improvement seen in services such as community outpatients and APCS with both now above the national target. Work continues to share learning and best practice across other services. **August 25 Update** MSST PIFU performance continues to perform well above target at 17%. Increase in PIFU utilisation in APCS sustained and a focused piece of work through community outpatients to encourage ongoing improvement. Community Outpatients in June was 7% and has increased to 8% for July. PIFU will continue to be a focus as part of the admin productivity project to help focus on increasing utilisation across other services. SALT have a plan to launch and role out PIFU aligning to their advice line in October. **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 continue to be a focus as part of the admin productivity project to help focus on increasing utilisation across other services
	Roll out PIFU across Speech and Language pathways	Oct-05	Dec-25	On Track	**September 25 Update** Meeting took place in August to review process for childrens services. Ongoing discussions to implement PIFU proceses relevant for childrens services **New August Action** On track to roll out - staff training commenced and planned for structured launch in place. Agreed October start date to support post schools returning in September.
	Roll out PIFU across Community Neuro Rehabilitation pathways	Jul-24	Jan-26	On Track	**September 25 Update** Increase in % has been maintained with August PIFU at 3.1%. Continued support and meetings throughout September to look to increase. **New August Action** Following training roll out commenced benchmark for PIFU in April was 1.8% for team July data shows improvment of 3.2% ongoing plan to achieve a 5% target.

	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		Jul-25	Dec-25	On Track	**September 25 Update** Rio configuration and data quality recovery- We are currently making ongoing progress in addressing the data quality issue identified in discharge recordings. The team leader and operational lead are actively working on this matter, with a meeting date to be confirmed. Additionally, another meeting has been scheduled with the informatics team to further discuss and resolve the issue. DAART's suitability for PIFU (Patient Initiated Follow-Up) remains undetermined, with concerns that much of its activity may be regular treatment rather than clinically appropriate follow-up therefore the next approach will be to conduct a structured clinical audit of DAART follow-up activity to determine PIFU suitability whilst ongoing work to resolve DQ. **August 25 Update** Briefing completed re utilisation of PIFU with teams and remain an agenda point in huddles and team meetings. Informatics have supported to ensure this is configured to enable recording through RIO. This month there is a data quality issue with the process and how teams are recording full discharges this has been recognised and a recovery plan is now in place working closely with the RIO team to manage the confusion in recording through training. **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**	09/09 025			
Accountable Officer Approval	Claire Horsfield	**Date**				

Exception Report - Action Plan

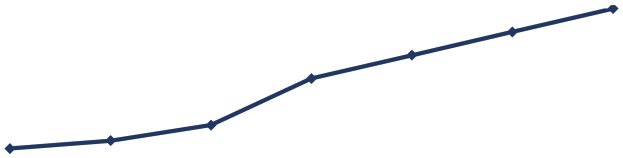
week Referral To Treatment (RTT) Incomplete Pathways

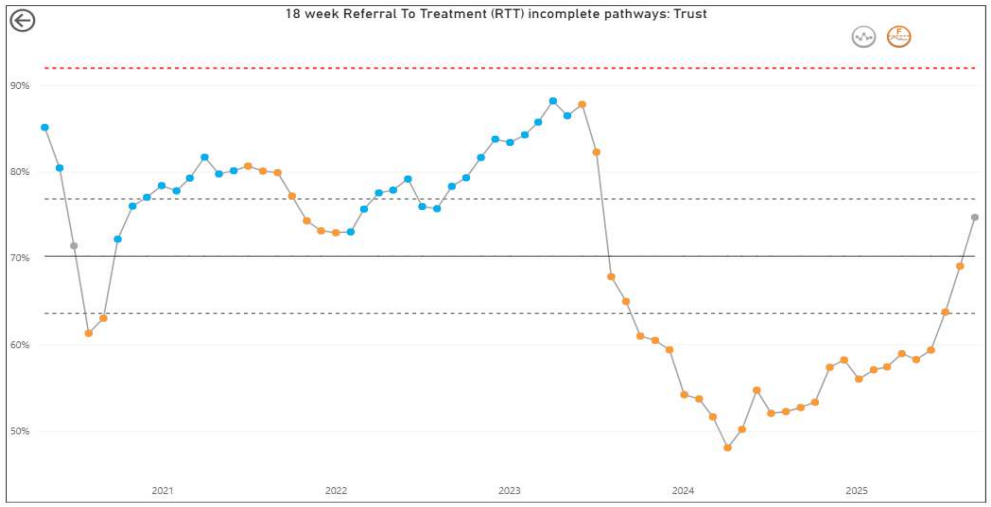
end of the month, the percentage of patients that are still waiting for treatment and are within 18 weeks

KPI Description	Latest 6 months							
RTT Incomplete Pathways	%	58.97						
	Target	92.0%						

*unvalidated

Trajectory	Apr-25	May-25	J				
%	60.5%	61.0%	62.0%				

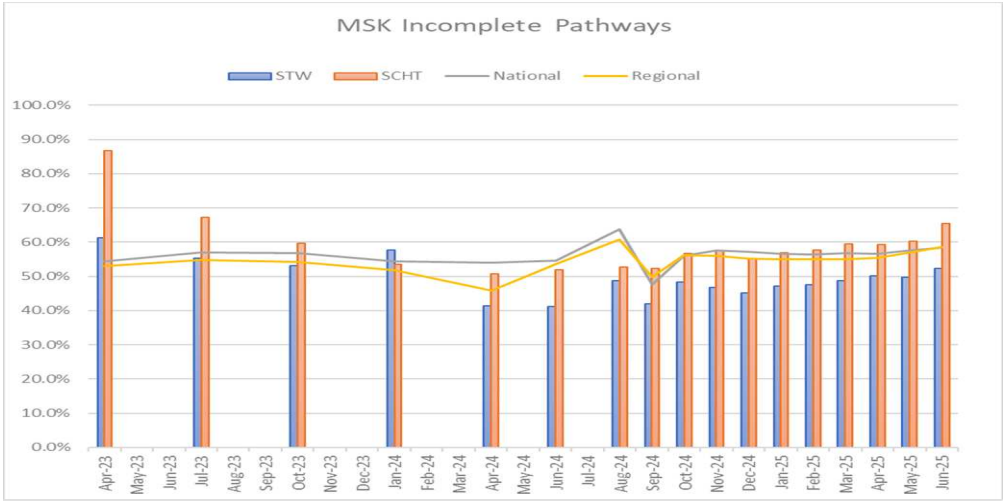




MSK Incomplete Position

	Apr-23	Jul-23	Oct-23	Jan-24	Apr-24	Jun-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-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%	50.1%	49.7%	52.3%
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%	59.2%	60.3%	65.4%
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%	56.5%	57.6%	58.4%
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%	55.4%	56.9%	58.6%

England's official statisti
This data is focused on MSK due to the size of the service and 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 5.65% with the position currently being unvalidated. Overall improvement in recovery has been seen since December 2024. 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. Current performance against the trajectory shows the achievement of 65% ahead of the March 2026 deadline. 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 super clinics. The first of these was successfully undertaken in June with circa 100 patients being seen. Further clinics have been held throughout July and August and considerably supported recovery. The clinic model has been very effective and will now be replicated and included as part of clinicians job planning as ongoing practice and as an effective waiting list initiative. 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 44 weeks and Dental is 48 weeks. Community Hospital Outpatients has a number of patients across the waiting list with 22 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 had with system partners about how to streamline and improve some these services across the system with a particular focus on ENT. NHSE Tier 1 calls are also being extended to include wider services including Dental for ongoing scrutiny.

Action Plan		**Start Date**	**End Date**	**Status**	**Comments**
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Complete	**September 25 Update** My recovery is now live which means that patients are now able to access support via the app whilst waiting for their appointments and post appointments. Strata is an ongoing piece of work that will support the service once implemented.by improving efficiency and productivity by improving admin processes, however this won't directly support adherence to RTT performance. **August 25 Update** My Recovery is live and Strata remains on track to go live by the close of August 25. **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 25.
	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25	Complete	**August 25 Update** D&C modelling revision was completed in July and showed a small improvement in capacity vs demand at Level 3. Demand into Level 3 has changed due to efficiencies made in triage and internal referral processes. This additional capacity will be utilised in the recovery of existing backlogs. Due to super clinics and revised D&C no further additional capacity is being explored. **July 25 Update** 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.

	Community outpatients: Working in partnership with SaTH re demand and capacity modelling and reviewing current SLAs to support with required capacity in Gynae, ENT and Respiratory.		Aug-25	Sep-25	On Track	**September 25 Update** SATH are supporting with taking over 30 week waits for Respiratory. ENT is an area of focus under the recovery of Planned care initiative. Following a meeting to discuss clinical pathways the Care In the Right Place Group are supporting with the system ENT transformation work th will support a left shift move into more community services closer to home. **New Action** The review and modelling for community outpatients in collaboration with SaTH has commenced in all 3 specialties working with centre managers. All current SLAs for Gynaecology. Plans for seasonal variation particularly in school holidays is being deve provide resilience across all areas. This work is also being overseen through the mon system wide Elective recovery group.
	Implementation of super clinic within existing capacity		Aug-25	Oct-25	On Track	**September 25 Update** The aim continues to be implementation during Oct 25 to achieve a business as delivery model. Working with SCHT with clinical leads within MSST to support t the future.. **New Action** Due to the success of the 18 week super clinics, learning from this will be us implementation of super clinics within routine MSST capacity. This is being from RJAH and SCHT with support from operational leads within SCHT ut from 18 weeks.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	10/0 025			
Accountable Officer Approval	Claire Horsfield	**Date**				

**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*

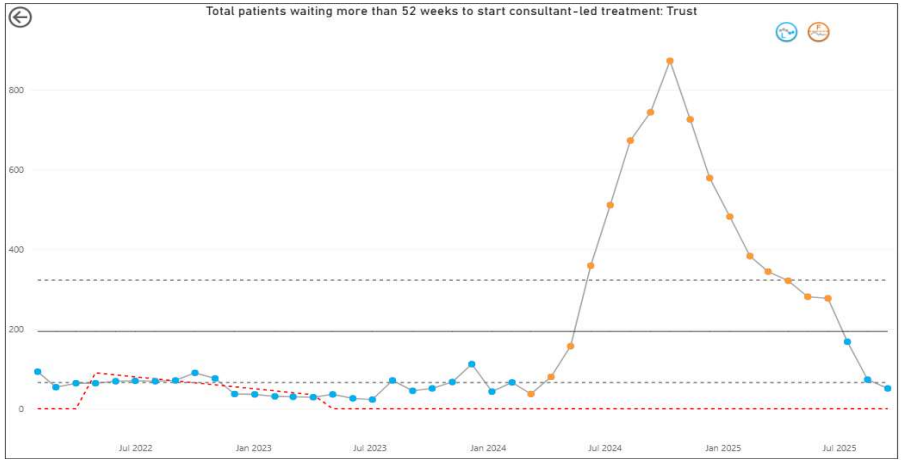
Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Mar-25	Ap					
RTT 52+ week waits	Number	321	281	2				
	Target	0	0	0				

Trajectory	Apr-25	May-25	Jun-25	Jul-25	Aug-25		
Number	150	0	230	100	30	15	



Reason for performance gap:	This is the eleventh consecutive month demonstrating improvement across the 52-week cohort. The initial aim was to achieve zero 52 weeks by the e locum APP required to support MSST, and the delays in TeMS transfer, this was not possible. The trajectory has been reviewed, stress tested and revised via superclinics, which went live in June 25 and this will then support zero 52 weeks for the MSST service by the end of October 25. The revised date for October due to ongoing challenges accessing diagnostics and capacity. Work has commenced in partnership with SaTH to work this through further, aligning to the contracted am 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 Prioritisation of long waits has been the key focus nationally and is reported at the weekly Tier 1 NHSE call. NHSE Tier 1 calls are also being extended to include wider services including Dental for ong				
		Start Date	**End Date**	**Status**	**Outcome**

Action Plan	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Complete	
	Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Comple	
	Community outpatients: Working in partnership with SaTH re demand and capacity modelling and reviewing current SLAs to support with required capacity in Gynae, ENT and Respiratory.	Aug-25	Sep-25		

	Implementation of super clinic within existing capacity		Aug-25	Oct-25	On Track	**September 25 Update** The aim continues to be implementation during Oct 25 to achieve a business as usual service delivery model. Working with SCHT with clinical leads within MSST to support the project into the future.. **New Action** Due to the success of the 18 week super clinics, learning from this will be used to support implementation of super clinics within routine MSST capacity. This is being led by clinical leads from RJAH and SCHT with support from operational leads within SCHT utilising the learning from 1 weeks.
Author	Alastair Campbell/Helen Co		/09/20			
Accountable Officer Approval			12/09/2025			

**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*

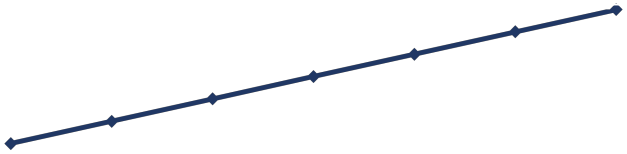
Exception Report - Action Plan

ortion of patients within 18 weeks

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

KPI Description	Latest 6 months	M						
Proportion of patients within 18 weeks	%	64.15%	6					
	Target	92.0%	92.0%					

Trajectory	Mar-25	Apr-25	May-25	Jun-25	Jul			
%	61.5%	65.0%	65.5%	66.0%	66.5%			



Reason for performance gap:	Performance has continued to improve with a further 5.32% increase, which is ahead of trajectory. Majority of acti prioritisation has been around high week waits in line with national guidance. One of the challenges with recovery from anticipated number of level 3 requirement than was originally modelled. However, the service is now stabilising. There is a accumulated demand job planning with APP's has taken place across the system to enhance productivity. Community Paediatrician services have seen improvement over time and recently due to recruitment and a change of processes for asse waiting children has reduced dramatically. As the Child Development Centre and the Community Paediatrician team are interdependent, the i improving experience for families. Children's Speech and Language services have also seen a steady improvement of waiting lists. A combination of early intervention programmes, holiday cli in CYP waiting over 52 weeks and an improvement for those waiting over 40 weeks. These initiatives will continue into the Autumn term to continue our journey t 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 E focusing on reducing and mitigating the longest waiting patients on the pathways. The deterioration 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 wil 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, Pulmonary Wheelchair Services.

	Start Date	End Date	Status	Outcome
CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	Off Track	**September 25 Update** Final outsourced appointments booked throughout September 2025. **August 25 Update** Originally, the goal was to reach zero 52-week waits by June 25. Due to delays from an external provider, the delivery deadline remains end of August, this will ensure the service remains on track for 0 65 weeks in September. A revised trajectory for 52 weeks has been completed this month and for zero 52-week waits by the end of October. **July 25 Update** Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. 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
Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Complete	**September 25 Update** My recovery is now live which means that patients are now able to access support via the app whilst waiting for their appointments and post appointments. Strata is an ongoing piece of work that will support the service once implemented.by improving efficeny and productivity by improving admin processes, however this won't directly support adherence to RTT performance. **August 25 Update** My Recovery is live and Strata remains on track to go live by the close of August 25. **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 25.
Increase APP capacity to manage spike in demand whilst D&C is complete	Feb-25	Jun-25	Complete	**August 25 Update** D&C modelling revision was completed in July and showed a small improvement in capacity vs demand at Level 3. Demand into Level 3 has changed due to efficiencies made in triage and internal referral processes. This additional capacity will be utilised in the recovery of existing backlogs. Due to superclinics and revised D&C no further additional capacity is being explored. **July 25 Update** 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.

Action P					
	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	**August 25 Update** SOGS now fully embedded in standard practice with positive feedback from clinicians. Impact now also being monitoired thropugh productivity workstreams. **July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Initial appointments using new SOG process are booked in July. Audits to take place at the end of August
	Implementation of super clinic within existing capacity	Aug-25	Oct-25	On Track	**September 25 Update** The aim continues to be implementation during Oct 25 to achieve a business as usual service delivery model. Working with SCHT with clinical leads within MSST to support the project into the future.. **New Action** Due to the success of the 18 week super clinics, learning from this will be used to support implementation of super clinics within routine MSST capacity. This is being led by clinical leads from RJAH and SCHT with support from operational leads within SCHT utilising the learning from 18 weeks.
	Diabetic Nursing and improvement plan to be established	Aug-25	Oct-25	On Track	**September 25 Update** Planned care have been invited to bring their recent experience in reviewing processes with the service in line with access policy to standardise processes. **New Action** Workshop scheduled to review pathway through admin and clinical triage. This will align with high level review of vacancy and sickness to support a recovery plan and embed a productivity workstream.
	Community outpatients: Working in partnership with SaTH re demand and capacity modelling and reviewing current SLAs to support with required capacity in Gynae, ENT and Respiratory.	Aug-25	Sep-25	On Track	**September 25 Update** SATH are supporting with taking over 30 week waits for Respiratory. ENT is an area of focus under the recovery of Planned care initiative. Following a meeting to discuss clinical pathways the Care In the Right Place Group are supporting with the system ENT transformation work that will support a left shift move into more community services closer to home. **New Action** The review and modelling for community outpatients in collaboration with SaTH has commenced in all 3 specialties working with centre managers. All current SLAs for Gynaecology. Plans for seasonal variation particularly in school holidays is being developed to provide resilience across all areas. This work is also being overseen through the monthly system wide Elective recovery group.

	QEIA to be completed re restrictive intervention for Wheelchairs and discussion with commissioners re activity on waiting list not commissioned to deliver		Aug-25	Nov-25	On Track	**September 25 Update** QEIA to be presentated at Septembers meeting. Meeting rearranged from August to September due to ICB capacity. Discussed at National Wheelchair meeting for benchmarking. West Midlands are agreeing a process to support providers and families. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	10/0 025			
Accountable Officer Approval	Claire Horsfield	**Date**				

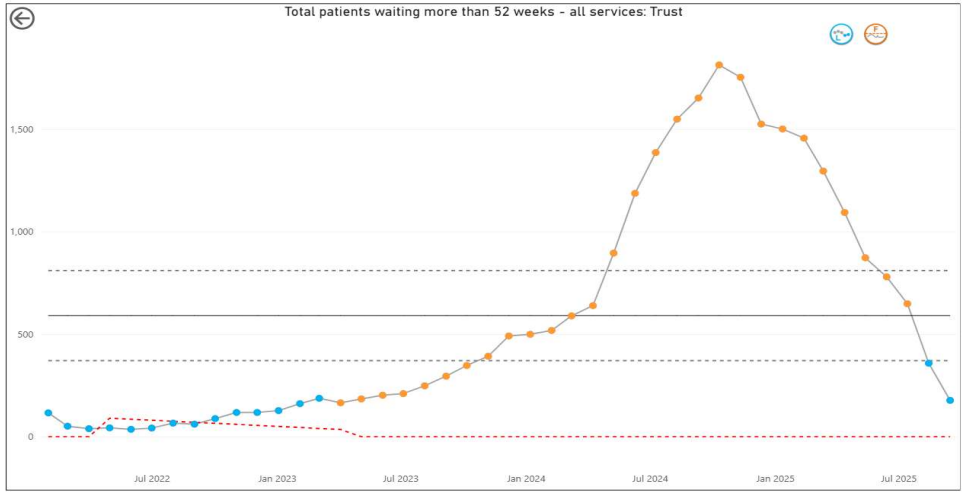
Exception Report - Action Plan

patients waiting more than 52 Weeks – All services

tients that are still waiting for an appointment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Mar						
52+ Week waits - All services	Number	1093						
	Target	0	0					

Trajectory	Aug-25	Sep-25	Oct-25	Nov-25				
Number	469	91	55	44	28			



Reason for performance gap:	The reduction of 52 weeks is on track with trajectory showing further improvement this month and ahead of productivity. A new trajectory has been provided for Sep-25 to Mar-26. CNRT have recruited a substantive Neuropsychologist who started in the service in April 25 and high week waits have sign The main challenge with recovery from a MSST perspective is a higher than anticipated number of referrals to level 3 than were origi first treatment and to manage this accumulated demand job planning with APP's has taken place across the system to enhance productiv of June 25. Community Paediatrician vacancies and an increase in the number of complex case referrals, continue to have an adverse impact on the waiting list for active recruitment. There are now only 5 children waiting to be seen at 52 weeks or above; this is a decreasing picture (4 less from last month). All vacancies been dependent upon enhanced locum support within Community Paediatrics with the assumption that this will remain. There are regular meetings with the team t has started which has increased capacity and moving forward will continue to reduce the 52 week cohort. Trajectory is 0 52 week waits by October 2025. CDC (Child Development Centre) is currently holding 24 children above 52 weeks. The trajectory for this service was due to demonstrate 0 52 weeks by July 25. Part of this was r procurement process and some capacity challanges within providers has adversely impacted the recovery plan by 3 months. Current forecasting of performance shows that improvem reduce month on month and achieve 0 52 weeks by October 2025. Speech and Language therapy also have a cohort of 51 children waiting over 52 weeks. This is an ongoing improving picture and there has been an improvement in this cohort of CYP since June 20 interventions, holiday clinics and revalidation of waiting lists has taken place over the summer. A new autumn school based intervention goes live initally in 12 high need schools during September to conti There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients, Diabetic Nursing, Interdisciplinary Teams, Community Nursing, Podiatry and Wheelchair

	Start Date	End Date	Status	Outcome
CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	Off Track	**September 25 Update** Final outsourced appointments booked throughout September 2025. **August 25 Update** Originally, the goal was to reach zero 52-week waits by June 25. Due to delays from an external provider, the delivery deadline remains end of August, this will ensure the service remains on track for 0 65 weeks in September. A revised trajectory for 52 weeks has been completed this month and for zero 52-week waits by the end of October. **July 25 Update** Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. 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
SLT Revise analysis of management of complex needs caseload	Jun-25	Sep-25	On track	**September 25 Update** Analysis and planning complete and new pathways are in situ. Complex and specialist pathways have commenced however a school based programme commences within 12 schools during September 2025. **August 25 Update** Holiday initiatives have commenced during July and running throughout August which is increasing capacity to see more complex CYP **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	Complete	**September 25 Update** My recovery is now live which means that patients are now able to access support via the app whilst waiting for their appointments and post appointments. Strata is an ongoing piece of work that will support the service once implemented.by improving efficeny and productivity by improving admin processes, however this won't directly support adherence to RTT performance. **August 25 Update** My Recovery is live and Strata remains on track to go live by the close of August 25. **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 25.

Action Plan	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25	Complete	**August 25 Update** D&C modelling revision was completed in July and showed a small improvement in capacity vs demand at Level 3. Demand into Level 3 has changed due to efficiencies made in triage and internal referral processes. This additional capacity will be utilised in the recovery of existing backlogs. Due to superclinics and revised D&C no further additional capacity is being explored. **July 25 Update** 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.
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	Community outpatients: Working in partnership with SaTH re demand and capacity modelling and reviewing current SLAs to support with required capacity in Gynae, ENT and Respiratory.	Aug-25	Sep-25	On Track	**September 25 Update** SATH are supporting with taking over 30 week waits for Respiratory. ENT is an area of focus under the recovery of Planned care initiative. Following a meeting to discuss clinical pathways the Care In the Right Place Group are supporting with the system ENT transformation work that will support a left shift move into more community services closer to home. **New Action** The review and modelling for community outpatients in collaboration with SaTH has commenced in all 3 specialties working with centre managers. All current SLAs for Gynaecology. Plans for seasonal variation particularly in school holidays is being developed to provide resilience across all areas. This work is also being overseen through the monthly system wide Elective recovery group.

	QEIA to be completed re restrictive intervention for Wheel chairs and discussion with commissioners re activity on waiting list not commissioned to deliver		Aug-25	Nov-25	On Track	**September 25 Update** QEIA to be presentated at Septembers meeting. Meeting rearranged from August to September due to ICB capacity. Discussed at National Wheelchair meeting for benchmarking. West Midlands are agreeing a process to support providers and families. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
Author	Alastair Campbell/ Helen Cooper /Gemma McIver	**Date**	10/0 2025			
Accountable Officer Approval	Claire Horsfield	**Date**				

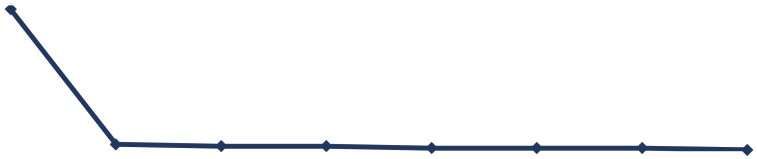
xception Report - Action Plan

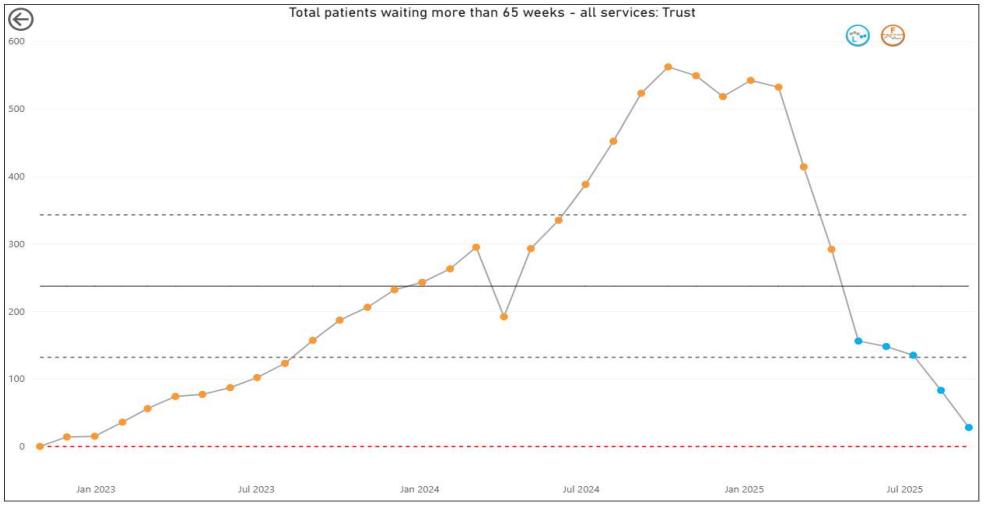
patients waiting more than 65 Weeks – All services

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

KPI Description	Latest 6 months	Mar-25						
65+ Week waits - All services	Number	292	156					
	Target	0	0					

Trajectory	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25			
Number	76	3	2	2	1			





Reason for performance gap:	Performance continues to improve and is now in line with trajectory. Rapid improvement was seen throughout March and Ap validation. With the implementation of the super clinics in MSST in July and throughout August the aim was to be back in line with A new trajectory has been provided for Sep-25 to Mar-26. Majority of activity for over 65 week waits post initial treatment still aligns to MSST, the main challenge with recovery from a MSST perspective aligns to 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 productivity. There has been an improvement in the 65 week wait position for Community Paediatrics with <5 children waiting. The trajectory for this service will have 0 65 weeks by end achieve this. CDC (Child development Centre) has reduced the 65 week waits to zero by the end of August. Speech and Language therapy have seen an improvement in over 65 weeks at the end of August. The service trajectory plans for 0 65 weeks by end of September is in place and the service are on t There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients, Interdisciplinary Teams, Community Nursing, Podiatry, Diabetic Nursing and Wheelch

	Start Date	End Date	Status	Outcome
SLT Revise analysis of management of complex needs caseload	Jun-25	Sep-25	On track	**September 25 Update** Analysis and planning complete and new pathways are in situ. Complex and specialist pathways have commenced however a school based programme commences within 12 schools during September 2025. **August 25 Update** Holiday initiatives have commenced during July and running throughout August which is increasing capacity to see more complex CYP **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.
CDC to sub contract 70 assessments to support with longest waiting children	Mar-25	Jun-25	Off Track	**September 25 Update** Final outsourced appointments booked throughout September 2025. **August 25 Update** Originally, the goal was to reach zero 52-week waits by June 25. Due to delays from an external provider, the delivery deadline remains end of August, this will ensure the service remains on track for 0 65 weeks in September. A revised trajectory for 52 weeks has been completed this month and for zero 52-week waits by the end of October. **July 25 Update** Following a procurement exercise (with external non recurrent funding) additional capacity was externally purchased as a waiting list initiative. 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	**August 25 Update** SOGS now fully embedded in standard practice with positive feedback from clinicians. Impact now also being monitoired through productivity workstreams. **July 25 Update** Revised SOG process signed off at QEIA, initial triage process commenced June 2025. Initial appointments using new SOG process are booked in July. Audits to take place at the end of August

Action Plan	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Dec-24	Complete	**September 25 Update** My recovery is now live which means that patients are now able to access support via the app whilst waiting for their appointments and post appointments. Strata is an ongoing piece of work that will support the service once implemented.by improving efficeny and productivity by improving admin processes, however this won't directly support adherence to RTT performance. **August 25 Update** My Recovery is live and Strata remains on track to go live by the close of August 25. **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 25.
	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25	Complete	**August 25 Update** D&C modelling revision was completed in July and showed a small improvement in capacity vs demand at Level 3. Demand into Level 3 has changed due to efficiencies made in triage and internal referral processes. This additional capacity will be utilised in the recovery of existing backlogs. Due to superclinics and revised D&C no further additional capacity is being explored. **July 25 Update** 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.
	Implementation of super clinic within existing capacity	Aug-25	Oct-25	On Track	**September 25 Update** The aim continues to be implementation during Oct 25 to achieve a business as usual service delivery model. Working with SCHT with clinical leads within MSST to support the project into the future.. **New Action** Due to the success of the 18 week super clinics, learning from this will be used to support implementation of super clinics within routine MSST capacity. This is being led by clinical leads from RJAH and SCHT with support from operational leads within SCHT utilising the learning from 18 weeks.

	Community outpatients: Working in partnership with SaTH re demand and capacity modelling and reviewing current SLAs to support with required capacity in Gynae, ENT and Respiratory.		Aug-25	Sep-25	On Track	**September 25 Update** SATH are supporting with taking over 30 week waits for Respiratory. ENT is an area of focus under the recovery of Planned care initiative. Following a meeting to discuss clinical pathways the Care In the Right Place Group are supporting with the system ENT transformation work that will support a left shift move into more community services closer to home. **New Action** The review and modelling for community outpatients in collaboration with SaTH has commenced in all 3 specialties working with centre managers. All current SLAs for Gynaecology. Plans for seasonal variation particularly in school holidays is being developed to provide resilience across all areas. This work is also being overseen through the monthly system wide Elective recovery group.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	10/0 025			
Accountable Officer Approval	Claire Horsfield	**Date**				

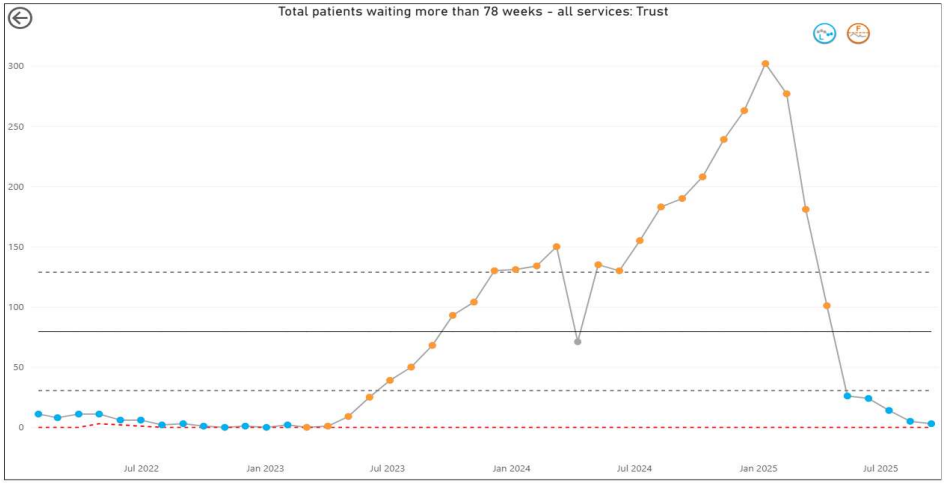
xception Report - Action Plan

patients waiting more than 78 Weeks – All services

f patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	M						
78+ Week waits - All services	Number	101						
	Target	0	0					

Trajectory	Apr-25	May-25	Jun-25				
Number	225	21	16	1			



Reason for performance gap:	The 78 week position has improved this month and is ahead of the trajectory. While overall numbers have reduced, there have been recent examples of data quality issues that trigger both the				
Action Plan		**Start Date**	**End Date**		
	Increase APP capacity to manage spike in demand whilst D&C is completed	Feb-25	Jun-25		Due t explored. **July 25 Updat** The initial findings o profiling is now more in l has been to continue to be o better understand demand and su with a workforce plan attributable to ea
	Review of data quality issues resulting in incorrect reporting of high waits and provide education for services with repeating occurances	Sep-25	Nov-25	On Track	**New Action** Information Team to compile a list of instances over the inform SDG leads and support services in reducing these in
Author	Alastair Campbell/Helen Cooper/Mark Onions/Gemma McIver	**Date**	09/09/2025		

Accountable Officer Approval	Claire Horsfield	**Date**	12/09/2025	

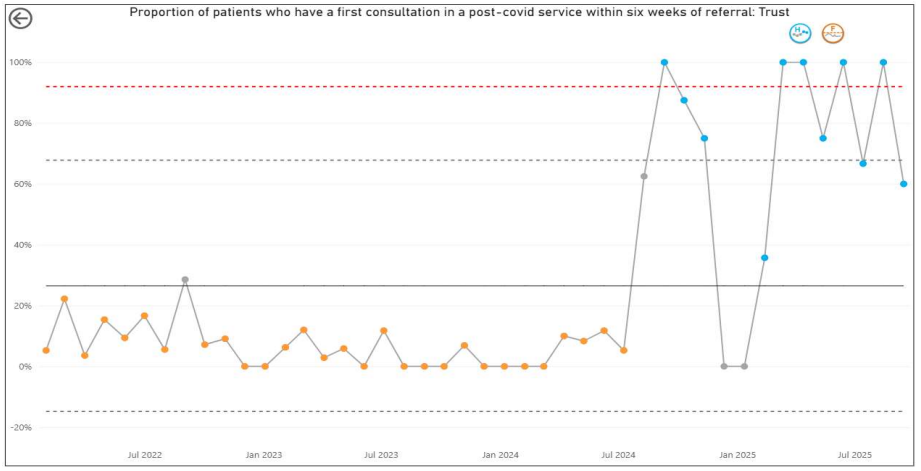
xception Report - Action Plan

rtion of patients who have a first consultation in a post-ice within six weeks of referral

ients who have an initial assessment in a Post COVID service within 6 weeks of referral

KPI Description	Latest 6 months	Mar-25	A					
Proportion of patients within 6 weeks	%	100.00%	75.00%	1				
	Target	92.0%	92.0%	92.0%				

Trajectory	Apr-25	May-25	Jun-25	Jul-25	A		
%	92.0%	92.0%	92.0%	92.0%	92.0%		



Reason for performance gap:	The service continues to be performing well overall with less than 5 patients on the waiting list over 6 weeks and this is attributa Due to the relatively small number of patients on the wating list, the reported percentages will tend to peak and trough due to the sm 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 patients still receiving active interventions in form of therapy, medical intervention, holistic advice and group work remains at C100. With patients re effectively with 95% PIFU rates to support discharge and avoid unnecessary follow up appointments, empowering patients and effectively managing clin Conversations with commissioners are live regarding future longevity and design of the service. To help ease primary care pressures and address health inequalit 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 e 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 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.

		Start Date	End Date	Status	Ou
	Implement Self-Referral	Jul-25	Sep-25	Complete	**September 25 Update** Self-referral now live. **August 25 update** Processes continue to be tested on track for planned roll out in September. due to go back to QEIA in October 25. Self referral pathway also include as part o initiative. **July 25 update** Processes being tested to ensure effective before full roll out in September. The evaluation will go to QEIA in October.

Action Plan	Roll out education programme for long covid to SCHT clinical teams and promote self referral	Jul-25	Sep-25	Complete	**September 25 Update** Team have cascaded across internal leads and within SATH. This is now completed but will be ongoing. **August 25 update** Roll out programme continues, internal comms messages sent through various forums shared with SaTH who also plan to support through September to cascade. **July 25 update** Roll out programme developed, internal comms messages drafted and plan to also share with SaTH
	Community promotion events for self referral arranged through neighbourhood meeting and networks	Jul-25	Sep-25	On track	**September 25 Update** This continues to be the plan with the team working on a timeline to implement by the end of September and the GP in the service is linking directly with Primary care. **August 25 update** Visits to community hubs, places of worship, libraries etc now diarised along side planned roadshow primary care network events throughout September. **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	**September 25 Update** Informatics supporting the service with a minor alteration and then this will go live within September 25. **August 25 update** This process is now operationalised and will be launched mid August. **July 25 update** Date for completion of this task is 31.07.25.

Author	Alastair Campbell	**Date**	10/0 2025	
Accountable Officer Approval	Claire Horsfield	**Date**		

Shropshire Community Health
NHS Trust

Performance Framework - Integrated Performance Report 2025/26 Update

Author:	Steve Price, Head of Information and Performance Assurance	**Paper date:**	2nd October 2025
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	25th September 2025
Paper Reviewed by:	RPC/QSC/People Committees	**Paper Category:**	Performance
Forum submitted to:	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?

A key governance feature of the Trust's approved Performance Management Framework is an annual review of the Trust's performance measures reported within Integrated Performance Reports (IPRs). The initial review was conducted prior to the start of 2025/26 and it was noted at the time that a further review would be conducted in-year should additional guidance be published. The NHS Oversight Framework 2025/26 was published at the end of June 2025 and this has therefore triggered the requirement for an additional review.

This paper is presented to the Trust Board for review and to agree its Key Performance Indicators (KPIs) for the remainder of 2025/26, including any recommended changes.

It is recognised that further changes may be made during 2025/26 and relevant approvals will be sought.

To ensure robust governance, any further changes; additions, redactions, or amendments to the KPIs within the IPR will be noted and agreed through utilising the IPR front sheet for the relevant Committee and Trust Board.

2. Executive Summary

2.1. Context

The purpose of this paper is to undertake a review of the IPR following the publication of the 2025/26 NHS Oversight Framework. The paper recommends continuation of many existing measures as well as recommending changes to metrics to allow alignment with internal, local and national priorities.

The KPI review has examined the new 2025/26 NHS Oversight Framework KPIs relevant to this Trust. In addition, consideration has been given to whether the former 2022/23 Single Oversight Framework measures are relevant to continue as local measures, and a review of existing local measures has also been undertaken. At this stage the 2025/26 NHS Oversight Framework does not include a full definition for all its KPI, as highlighted in the table within the appendix, and therefore further updates may be required once clarification is received from NHSE.

The paper summarises the suggested amendments and recommends new service measures with the detail included in the appendix.

2.2. Summary

The paper summarises the KPIs that will be included in each Committee's specific IPR. The appendix provides full details, for reference, should members wish to review this. Some measures are still in development or awaiting a definition and this is clearly identified where relevant. People Committee, Quality and Safety Committee and the Resource and Performance Committee have reviewed their KPIs and recommend these changes to the Trust Board for approval.

2.3. Conclusion

The Board of Directors is asked to review and approve the proposed list of key performance indicators devolved to Committees of the Board.

Updates to the Trust's IPRs may occur through the year in line with Trust requirements and in response to any changes from NHSE or other relevant guidance.

3. Main Report

In line with the Trust's Performance Management Framework, KPIs must be reviewed on an annual basis. This ensures the Board and its committees review and agree objectives and performance measures at least annually. The initial review was conducted ahead of the start of the 2025/26 financial year and, as was noted at the time, a further review would be conducted in-year should additional guidance be published. The NHS Oversight Framework 2025/26 was published at the end of June 2025, and this has therefore triggered the requirement for an additional review.

This paper is presented to the Board for review and to agree its Key Performance Indicators (KPIs) for the remainder of 2025/26, including any recommended changes.

The proposed measures outlined in this paper are a combination of the 2025/26 NHSE Oversight Framework measures and key local measures. The KPI review has examined the new 2025/26 NHS Oversight Framework KPIs relevant to this Trust. In addition, consideration has been given to whether the former 2022/23 Single Oversight Framework measures are relevant to continue as local measures, and a review of existing local measures has also been undertaken. Some of the proposed targets are nationally driven while others are based on contract arrangements or local knowledge.

At this stage the NHS Oversight Framework 2025/26 does not include a full definition for all its KPI as highlighted in the table within the appendix and therefore further updates may be required once clarification is received from NHSE and relevant approvals will be sought.

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

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

On release of further guidance or equivalent requirements, the IPR and associated KPIs for each Committee will be updated to reflect those requirements.

It is anticipated that for metrics that are reported once per annum such as the staff survey results, this requirement may be fulfilled through a single standalone report to the Committee.

Further details are included in the Appendix to allow members to review the measures, their targets, definitions and calculations. The definitions are particularly important as there will be measures that are calculated in a very specific manner e.g. 'Percentage of patients waiting over 52-weeks for community services'. This is a new measure and the definition used by NHSE is the Community Health Services SITREP which does not cover all of our services.

Note: KPIs shown in red text are those which Committees propose cease to be reported through IPRs.

4. People Committee

Local KPIs:

- Aggregate score for NHS staff survey questions that measure perception of leadership culture – to be removed, no longer an Oversight Framework KPI
- CQC well-led rating – to be removed, no longer an Oversight Framework KPI
- Leaver rate – to be removed, no longer an Oversight Framework KPI
- Proportion of staff in senior leadership roles who are from a) a BME background – to be removed, no longer an Oversight Framework KPI
- Proportion of staff in senior leadership roles who are from b) are women – to be removed, no longer an Oversight Framework KPI
- Proportion of staff in senior leadership roles who are from c) are disabled staff – to be removed, no longer an Oversight Framework KPI
- 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 – to be removed, no longer an Oversight Framework KPI
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers – to be removed, no longer an Oversight Framework KPI
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues – to be removed, no longer an Oversight Framework KPI
- 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 – to be removed, no longer an Oversight Framework KPI
- Appraisal Rates
- Bank usage (WTE)
    - *To be defined*
- Mandatory Training Compliance
- Net Staff in Post Change

- Proportion of temporary staff
- Total shifts exceeding NHSI capped rate
- Total shifts on a non-framework agreement
- Vacancies – all

2025/26 NHS Oversight Framework requirements:

- National Education and Training Survey overall satisfaction score
- NHS staff survey education and training theme score
    - *Awaiting National Definition*
- Sickness Absence Rate
- NHS staff survey engagement theme score

5. Quality & Safety Committee

Local KPIs:

- Acting to improve safety - safety culture theme in the NHS staff survey – to be removed, no longer an Oversight Framework KPI
- Category 3 Pressure Ulcers
- Category 4 Pressure Ulcers
- Complaints - (Open) % within response timescales
- Compliance with Duty of Candour
    - *In development*
- Consistency of reporting patient safety incidents – to be removed, no longer an Oversight Framework KPI
- CQC Conditions or Warning Notices
- Deaths – unexpected
- Falls per 1000 Occupied Bed Days
- Medication Incidents with moderate harm
- National Patient Safety Alerts not completed by deadline – to be removed, no longer an Oversight Framework KPI
- Never Events – to be removed
- Overall CQC Rating – to be removed, no longer an Oversight Framework KPI
- Patient Safety Incident Investigations
- Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities – to be removed, no longer an Oversight Framework KPI
- Proportion of Harm reviews completed for patients waiting over 52 weeks (local waiting lists)
    - *In development*
- Proportion of Harm reviews completed for patients waiting over 52 weeks (RTT waiting lists)
    - *In development*
- Safer Staffing - Average Fill Rate Non-Registered Nurses - Day
- Safer Staffing - Average Fill Rate Non-Registered Nurses - Night
- Safer Staffing - Average Fill Rate Registered Nurses - Day
- Safer Staffing - Average Fill Rate Registered Nurses – Night

2025/26 NHS Oversight Framework requirements:

- CQC safe inspection score (if awarded within the preceding 2 years)
  - *No CQC inspection within the last 2 years*
- NHS Staff Survey - raising concerns sub-score
- Percentage of inpatients acquiring a new pressure ulcer
  - *Awaiting National Definition*
- Rates of Healthcare Associated Infection (C-Difficile)
- Rates of Healthcare Associated Infection (E-Coli)
- Rates of Healthcare Associated Infection (MRSA)

6. Resource & Performance Committee

Local KPIs:

- Agency spend - compared to the agency ceiling – to be removed, no longer an Oversight Framework KPI
- Agency spend - Price cap compliance – to be removed, no longer an Oversight Framework KPI
- Available virtual ward capacity per 100k head of population – to be removed, no longer an Oversight Framework KPI
- CQC Conditions or Warning Notices – moved to Quality and Safety Committee
- Data Quality Maturity Index
- Financial efficiency - variance from efficiency plan
- Financial stability - variance from break-even – to be removed, no longer an Oversight Framework KPI
- New Birth Visits % within 14 days - Dudley
- New Birth Visits % within 14 days - Shropshire
- New Birth Visits % within 14 days - Telford
- Number of patients not treated within 28 days of last minute cancellation
- Outpatient follow-up activity levels compared with 2019/20 baseline – to be removed, no longer an Oversight Framework KPI
- Patients no longer meeting the criteria to reside – to be removed, replaced by new Oversight Framework KPI
- Proportion of patients spending more than 12 hours in an emergency department – to be removed, Oversight Framework KPI specific to Type 1/2
- Proportion of patients who have a first consultation in a post-covid service within six weeks of referral – to be removed, no longer an Oversight Framework KPI
- Proportion of patients within 18 weeks
- Proportion of patients within 18 weeks - Children's Services
- Total activity undertaken against current year plan
- Total diagnostic activity undertaken compared with 2019/20 baseline – to be removed, no longer an Oversight Framework KPI
- Total elective activity undertaken compared with 2019/20 baseline – to be removed, no longer an Oversight Framework KPI

- Total patients waiting more than 104 weeks to start consultant-led treatment – to be removed, no longer an Oversight Framework KPI
- Total patients waiting more than 104 weeks - all services
- Total patients waiting more than 52 weeks to start consultant-led treatment
- Total patients waiting more than 52 weeks - all services
- Total patients waiting more than 65 weeks to start consultant-led treatment
- Total patients waiting more than 65 weeks - all services
- Total patients waiting more than 78 weeks to start consultant-led treatment – to be removed, no longer an Oversight Framework KPI
- Total patients waiting more than 78 weeks - all services
- Urgent Care 2 hour response – to be removed, replaced by new Oversight Framework KPI
- Virtual ward bed occupancy

2025/26 NHS Oversight Framework requirements:

- Average number of days from discharge ready date and actual discharge date
- Difference between actual and planned 18 week elective performance
- Implied productivity level
- Percentage of patients waiting less than 18 weeks - RTT
- Percentage of patients waiting over 52 weeks for RTT
- Percentage of patients waiting over 52-weeks for community services
- Percentage of people waiting over 6 weeks for a diagnostic procedure or test
- Planned surplus/deficit
- Readmission rate band
    - *Awaiting National Definition*
- Relative difference in costs
- Under 18s elective waiting list growth
    - *Awaiting National Definition*
- Urgent community response 2-hour performance
- Variance year-to-date to financial plan

7. Summary

This paper has set out the proposed 2025/26 Integrated Performance Reports content and highlighted that updates to the Trust's IPRs may occur through the year in line with Trust requirements and in response to any changes from NHSE or other relevant guidance.

8. Conclusion

The Board of Directors is asked to review and approve the proposed list of key performance indicators devolved to Committees of the Board.

Updates to the Trust's IPRs may occur through the year in line with Trust requirements and in response to any changes from NHSE or other relevant guidance.

REFERENCE INFORMATION ONLY

Appendix – IPR Proposed 2025/26 Measures and changes

Indicator	Domain	Accountable Role	Committee	YTD (Avg / Max / Latest)	Target 25/26	Bigger or smaller	NHS OF KPI?	Definition	Changes
National Education and Training Survey overall satisfaction score	People and Workforce	Director of Nursing & Quality	People Committee	Latest	90%	Bigger is better	Y-25/26	Numerator: Positive responses Denominator: All responses Filter: the questions below: The extent to which I feel the people in charge value education and training. The overall educational experience I gained in my current or most recent practice placement / training post. Staff were welcoming, supportive and friendly throughout the practice placement or training post. How likely are you to recommend this practice placement or training post location to friends and family if they ever need the care or treatment provided there? How likely are you to recommend this practice placement or training post to friends and colleagues as a place to work or train?	New NOF Indicator as agreed with Director of Nursing and Quality

NHS staff survey education and training theme score	*People and Workforce*	*Chief People Officer*	*People Committee*	*TBC*	*TBC*	*TBC*	*Y-25/26*	*To be defined*	*Awaiting National Definition*
Sickness Rate	Well Led	Chief People Officer	People Committee	Latest	4.75	Smaller is better	Y-22/23 Y-25/26	Sickness absence rates for NHS staff in England Data source: The Electronic Staff Record (ESR) Data Warehouse Numerator Full Time Equivalent (FTE) Number of Days Sick (including non-working days) Denominator FTE Number of Days available Computation Numerator / Denominator Technical Annex doesn't state whether 12 months rolling as per leavers rate, or in month. Using rolling for consitency with leavers and PWR return	Rename KPI to align with NOF 'Sickness Absence Rate' and Change Domain to 'People and Workforce'

Staff survey engagement theme score	Well Led	Chief People Officer	People Committee	Latest	7.23	Bigger is better	Y-22/23 Y-25/26	This indicator is the NHS Staff Survey Staff theme score (summary indicator) relating to staff engagement. This theme score is comprised of 9 individual questions, which form three sub scores used to report an overall score. The theme is scored on a 0-10 scale and reported as a mean score. A higher theme score indicates a more favourable result. PP Element / Theme Subscore Q no. Question text Staff engagement Motivation q2a I look forward to going to work. Staff engagement Motivation q2b I am enthusiastic about my job. Staff engagement Motivation q2c Time passes quickly when I am working. Staff engagement Involvement q3c There are frequent opportunities for me to show initiative in my role. Staff engagement Involvement q3d I am able to make suggestions to improve the work of my team / department. Staff engagement Involvement q3f I am able to make improvements happen in my area of work. Staff engagement Advocacy q21a Care of patients / service users is my organisation's top priority. Staff engagement Advocacy q21c I would recommend my organisation as a place to work. Staff engagement Advocacy q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	Rename KPI to align with NOF 'NHS staff survey engagement theme score' and Change Domain to 'People and Workforce'

Aggregate score for NHS staff survey questions that measure perception of leadership culture	Well Led	Chief People Officer	People Committee	Latest	7.53	Bigger is better	Y-22/23 N-25/26	This indicator is the NHS Staff Survey compassionate leadership people promise element sub-score This sub-score score is comprised of 4 individual questions, used to report an overall score. The sub-score is scored on a 0-10 scale and reported as a mean score. A higher score indicates a more favourable result. Numerator Sum of individuals' scores for questions q9f-q9i Denominator Total number of individual scores for q9f-q9i KPI name change in technical annex, but using Oversight Framework main doc. Aligns with annex definition.NHS Staff Survey compassionate leadership people promise element sub-score	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework given that staff survey results are received annually.

CQC well-led rating	Well Led	Director of Governance	People Committee	Latest	3 (good)	Bigger is better	Y-22/23 N-25/26	The Care Quality Commission (CQC) inspection ratings are published by CQC. The CQC rating is based on a physical inspection, with possible ratings of: Outstanding - the service is performing exceptionally well; Good - the service is performing well and meeting CQC's expectations; Requires improvement - the service is not performing as well as it should and CQC has told the service how it must improve; Inadequate - the service is performing badly and CQC has taken action against the person or organisation that runs it. Key Lines of Enquiries (W1-W8) for which Well-led is inspected: W1: Leadership capacity and capability W2: Vision and Strategy W3: Culture W4: Governance and management W5: Management of risks, issues and performance W6: Information management W7: Engagement and involvement W8: Learning, continuous improvement and innovation	No longer a NOF KPI. Removal of KPI agreed by Director of Governance

Leaver rate	Well Led	Chief People Officer	People Committee	Latest	9.6	Smaller is better	Y-22/23 N-25/26	% of staff who have left the NHS during a 12-month period Data source: The Electronic Staff Record (ESR) Data Warehouse FTE of all staff leaving the NHS during the 12 month period FTE of all staff in post at the beginning of the 12 month period Numerator / Denominator	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer.
Proportion of staff in senior leadership roles who are from a) a BME background	Well Led	Chief People Officer	People Committee	Latest	20	Bigger is better	Y-22/23 N-25/26	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are a) from a BME background Data source: Output of annual WRES collection	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework.

Proportion of staff in senior leadership roles who are from b) are women	Well Led	Chief People Officer	People Committee	Latest	66	Bigger is better	Y-22/23 N-25/26	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are b) are women ESRData source: ESR Numerator [S071a] number of staff from denominator group who are from BME backgrounds - WRES [S071b]] number of staff from denominator group who are female – ESR [S071c] number of staff from denominator group who have a disability - WDES Denominator Number of staff at Agenda for Change band 8c + 8d + 9 + VSM. (This includes and executive board members) Computation Numerator divided by denominator multiplied by 100 i.e. 35 staff out of 100 are female: (35/100)x100=35%	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework.
Proportion of staff in senior leadership roles who are from c) are disabled staff	Well Led	Chief People Officer	People Committee	Latest	4	Bigger is better	Y-22/23 N-25/26	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are c) are disabled Data source: Output of annual WDES collection	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are

									monitored outside of the Trust Performance Framework.
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	Well Led	Chief People Officer	People Committee	Latest	60.95	Bigger is better	Y-22/23 N-25/26	This is the weighted proportion of staff who, via the NHS Staff Survey, report that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. (q15) Data source: NHS Staff Survery Numerator The weighted number of staff who responded “Yes” to the question. Denominator The weighted number of staff responding to the question, including those who answered “don’t know”. Computation Weighted percentage (numerator/denominator) - the weighted percentage of “yes” responses to this question, divided by the weighted total number of responses to the question.	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework given that staff survey results are received annually.

Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	Well Led	Chief People Officer	People Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	This indicator is q14b within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from managers The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from managers, out of those who answered the question.	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework given that staff survey results are received annually.
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	Well Led	Chief People Officer	People Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	This indicator is q14c within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from other colleagues The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from other colleagues out of those who answered the question.	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are

									monitored outside of the Trust Performance Framework given that staff survey results are received annually.
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	Well Led	Chief People Officer	People Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	This indicator is q14a within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public. The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from patients/service users, their relatives or other members of the public, out of those who answered the question.	No longer a NOF KPI. Removal of KPI agreed by Chief People Officer. No longer included in the NHS Oversight Framework and actions are monitored outside of the Trust Performance Framework given that staff survey results are received annually.

Appraisal Rates	Well Led	Chief People Officer	People Committee	Avg	90	Bigger is better	N	Compliance of substantive staff having had an apprasial in the last 12 months. Excludes staff who have started within the last 3 months	Change Domain to 'People and Workforce'
Bank usage (WTE)	*People and Workforce*	*Chief People Officer*	*People Committee*	*TBC*	*Staggered*	*Smaller is better*	*N*	*To be defined*	*New Local Indicator as agreed with Chief People Officer*
Mandatory Training Compliance	Well Led	Chief People Officer	People Committee	Latest	95	Bigger is better	N	Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only (with the exception of Information Governance which includes bank staff) Excludes new starters (1 month) and long term absence (LTS, mat,pat, adoption leave, career break etc)	Change Domain to 'People and Workforce'
Net Staff in Post Change	Well Led	Chief People Officer	People Committee	Avg	0	Plan is best	N	Net staff in post change (FTE) FTE starters in month minus FTE leavers, taken from ESR	Change Domain to 'People and Workforce'
Proportion of temporary staff	Well Led	Chief People Officer	People Committee	Avg	3.4	Smaller is better	N	Cost of agency and locum as a proportion of total staffing costs for the month expressed as a percentage	Change Domain to 'People and Workforce'
Total shifts exceeding NHSI capped rate	Well Led	Chief People Officer	People Committee	Avg	0	Smaller is better	N	Taken from total agency rule overrides section of the NHSE Monthly bank and agency collection. The number of shifts filled by on framework agencies that exceeded the price cap (cap is per shift)	Change Domain to 'People and Workforce'

Total shifts on a non-framework agreement	Well Led	Chief People Officer	People Committee	Sum	0	Smaller is better	N	Taken from total agency rule overrides section of the NHSE Monthly bank and agency collection. The number of shifts filled by off framework agencies	Change Domain to 'People and Workforce'
Vacancies - all	Well Led	Chief People Officer	People Committee	Avg	8	Smaller is better	N	Percentage of vacancies (budgeted substantive WTE minus contracted substantive WTE) over budgeted WTE.	Change Domain to 'People and Workforce'
CQC safe inspection score (if awarded within the preceding 2 years)	Patient safety	Director of Nursing & Quality	Quality & Safety Committee	Latest	Good	Bigger is better	Y-25/26	CQC safe rating if awarded within the last 24 months	Agreed to not include with Director of Nurisng and Quality as no CQC inspeciton within the last 2 years
NHS Staff Survey - raising concerns sub-score	Patient safety	Director of Nursing & Quality	Quality & Safety Committee	Latest	7.08	Bigger is better	Y-25/26	NHS staff survey sub score for the following measures: Q20a - I would feel secure raising concerns about unsafe clinical practice Q20b - I am confident that my organisation would address my concern Q25e - I feel safe to speak up about anything that concerns me in this organisation Q25f - If I spoke up about something that concerned me I am confident my organisation would address my concern For further details see Section 3.1 of NHS Staff Survey Technical Guide	New NOF Indicator as agreed with Director of Nursing and Quality

Percentage of inpatients acquiring a new pressure ulcer	*Patient safety*	*Director of Nursing & Quality*	*Quality & Safety Committee*	*TBC*	*TBC*	*TBC*	*Y-25/26*	*To be defined*	*Awaiting National Definition*
Clostridium difficile infection rate	Safe	Director of Nursing & Quality	Quality & Safety Committee	Latest	100	Smaller is better	Y-22/23 Y-25/26	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. Data source: https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure Numerator Number of incidences of Clostridium difficile Trust apportioned cases (‘Hospital-onset healthcare associated’ (HOHA) + ‘Community-onset healthcare associated’ (COHA)) OR Number of incidences of Clostridium difficile CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	Rename to align with NOF 'Rates of Healthcare Associated Infection (C-Difficile)' and Change Domain to 'Patient Safety'

E. coli bloodstream infection rate	Safe	Director of Nursing & Quality	Quality & Safety Committee	Latest	100	Smaller is better	Y-22/23 Y-25/26	12-month rolling counts of Escherichia coli (E.coli) bacteraemia by organisation and location of onset (from April 2019). Data source: https://www.gov.uk/government/statistics/e-coli-bacteraemia-monthly-data-by-location-of-onset Numerator Number of E.coli Trust apportioned cases ('Hospital-onset healthcare associated' (HOHA) + 'Community-onset healthcare-associated' (COHA)) OR Number of E.coli CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	Rename to align with NOF 'Rates of Healthcare Associated Infection (E-Coli)' Change Domain to 'Patient Safety'
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Safe	Director of Nursing & Quality	Quality & Safety Committee	Latest	0	Smaller is better	Y-22/23 Y-25/26	12-month rolling counts of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia by organisation and location of onset Numerator Number of MRSA bacteraemia (on an assigned basis) Trust apportioned cases (Hospital-onset) OR Number of MRSA bacteraemia (on an assigned basis) CCG cases (Total cases)	Rename to align with NOF 'Rates of Healthcare Associated Infection (MRSA)' and Change Domain to 'Patient Safety'
Acting to improve safety - safety culture theme in the NHS staff survey	Well Led	Director of Nursing & Quality	Quality & Safety Committee	Latest	6.49	Bigger is better	Y-22/23 N-25/26	Output from NHS Staff Survey - safe and healthy theme sub score Consistency with NHS staff survey output rather than recreating using SOF Technical Annex definitions	No longer a NOF KPI. Removal of KPI agreed by Director of Nursing and Quality

Consistency of reporting patient safety incidents	Safe	Director of Governance	Quality & Safety Committee	Latest	100	Bigger is better	Y-22/23 N-25/26	Number of months in which patient safety incidents or events were reported to the NRLS or LFPSE, by reporting trust. Data source: National Reporting and Learning System (NRLS) and its replacement, Learn from Patient Safety Events (LFPSE) Numerator Number of months in which data reported to NRLS or LFPSE within the most recent published six-month period based on reported dates Denominator Six (the most recent published six-month period based on reported dates) Computation Percentage	No longer a NOF KPI. Removal of KPI agreed by Director of Governance
National Patient Safety Alerts not completed by deadline	Safe	Director of Governance	Quality & Safety Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	Number of National Patient Safety incidents that are not reported as completed at organisations by their deadline. Data Source: Central Alerting System (CAS)	No longer a NOF KPI. Removal of KPI agreed by Director of Governance
Overall CQC Rating	Well Led	Chief Executive Officer	Quality & Safety Committee	Latest	3 (good)	Bigger is better	Y-22/23 N-25/26	The CQC (Care Quality Commission) inspection rating is published by the CQC. The trust is rated on the basis of a physical inspection. Possible ratings are outstanding, good, requires improvement and inadequate. Data source: CQC website	No longer a NOF KPI. Removal of KPI agreed by deputy Chief Executive
Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	*Well Led*	*Medical Director*	*Quality & Safety Committee*	*TBC*	*TBC*	*TBC*	*Y-22/23 N-25/26*	*In development - Definition to be established*	*No longer a NOF KPI. Removal of KPI agreed by Medical Director*
Category 3 Pressure Ulcers	Safe	Director of Nursing & Quality	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of Trust Acquired Category 3 Pressure Ulcers	Change Domain to 'Patient Safety'

Category 4 Pressure Ulcers	Safe	Director of Nursing & Quality	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of Trust Acquired Category 4 Pressure Ulcers	Change Domain to 'Patient Safety'
Complaints - (Open) % within response timescales	Responsive	Director of Nursing & Quality	Quality & Safety Committee	Avg	95	Bigger is better	N	Proportion of open complaints still within timescale. Timescales are 25 working days for single service complaints, 60 working days for complex cases	Change Domain to 'Effectiveness and experience of care'
Compliance with Duty of Candour	Safe	Director of Governance	Quality & Safety Committee	Avg	100	Bigger is better	N	In development - Percentage of incidents where Duty of Candour applies and is complied with	Change Domain to 'Patient Safety'

Deaths - unexpected	Effective	Medical Director	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of deaths in community hospitals that are categorised as unexpected Unexpected Death An unexpected death is: “Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures”. Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present then there is a requirement to begin resuscitation. The national resuscitation council has issued clear guidance for the circumstances where a patient is discovered dead and there are signs of irreversible death (Hospice UK, 2019). It is recognised that some patients may die as a result of age or fragility consequences to suffering various co-morbidities’. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition.	Change Domain to 'Patient Safety'

Falls per 1000 Occupied Bed Days	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	4	Smaller is better	N	Number of Inpatient falls in month per 1000 occupied bed days	Change Domain to 'Patient Safety'
Medication Incidents with moderate harm	Safe	Director of Nursing & Quality	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of medication incidents per month resulting in moderate harm	Change Domain to 'Patient Safety'
Never Events	Safe	Director of Nursing & Quality	Quality & Safety Committee	Sum	0	Smaller is better	N	Count of never events	Removal of KPI agreed by Director of Nursing and Quality
Patient Safety Incident Investigations	Safe	Director of Nursing & Quality	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of Patient Safety Incident Investigations commenced in month	Change Domain to 'Patient Safety'
Proportion of Harm reviews completed for patients waiting over 52 weeks (local waiting lists)	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	90	Bigger is Better	N	In development - Definition to be established. Proportion of harm reviews completed for patients waiting over 52 weeks (all local waits)	Change Domain to 'Patient Safety'
Proportion of Harm reviews completed for patients waiting over 52 weeks (RTT waiting lists)	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	90	Bigger is Better	N	In development - Definition to be established. Proportion of harm reviews completed for patients waiting over 52 weeks (RTT waits)	Change Domain to 'Patient Safety'
Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	95	Bigger is Better	N	Safer Staffing Night fill rate for Registered Nurses in the Inpatient Wards	Change Domain to 'Patient Safety'
Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	95	Bigger is Better	N	Safer Staffing Night fill rate for Non-Registered Nurses in the Inpatient Wards	Change Domain to 'Patient Safety'
Safer Staffing - Average Fill Rate	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	95	Bigger is Better	N	Safer Staffing Day fill rate for Registered Nurses in the Inpatient Wards	Change Domain to

Registered Nurses - Day									'Patient Safety'
Safer Staffing - Average Fill Rate Registered Nurses - Night	Safe	Director of Nursing & Quality	Quality & Safety Committee	Avg	95	Bigger is better	N	Safer Staffing Day fill rate for Non-Registered Nurses in the Inpatient Wards	Change Domain to 'Patient Safety'
Average number of days from discharge ready date and actual discharge date	Effectiveness and experience of care	Director of Operations	Resource & Performance Committee	Latest	Staggered target April 25-6 to 3 in March 26	Smaller is better	Y-25/26	Numerator: The number of days from discharge ready date to date of discharge Denominator: The number of patients with a delay of 1 or more days that have been discharged. Note that where the provider reports that all their discharges are on discharge ready date, i.e. the denominator is zero, the denominator is set to the total count of discharges to allow a metric value to be calculated.	New NOF Indicator as agreed with Director of Operations
Difference between actual and planned 18 week elective performance	Access	Director of Operations	Resource & Performance Committee	Latest	0	Bigger is better	Y-25/26	Planned and actual 18 week performance are compared: Numerator: Count of patients on the waiting list for less than 18 weeks Denominator: Total count of patients on the waiting list. ~~Actuals filter: Patients whose care is commissioned by non-English commissioner are excluded.~~ Calculation: the percentage point difference between actual and planned 18 week performance.	New NOF Indicator as agreed with Director of Operations
Implied productivity level	Finance and Productivity	Director of Finance	Resource & Performance Committee	Latest	100	Bigger is better	Y-25/26	Total units of activity in reporting period / total expenditure in reporting period Presented as a % of the same calculation for the same period in the previous year	New NOF Indicator as agreed with

									Director of Finance
Percentage of patients waiting over 52 weeks for RTT	Access	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y-25/26	Numerator: Count of patients on the waiting list for more than 52 weeks Denominator: Total count of patients on the waiting list. ~~Filter: Patients whose care is commissioned by non-English commissioner are excluded.~~	New NOF Indicator as agreed with Director of Operations
Percentage of patients waiting over 52-weeks for community services	Access	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y-25/26	Statistics » Community Health Services Waiting Lists Numerator: Count of patients on the waiting list for more than 52 weeks Denominator: Total count of patients on the waiting list	New NOF Indicator as agreed with Director of Operations
Planned surplus/deficit	Finance and Productivity	Director of Finance	Resource & Performance Committee	Latest	Staggered Target April 25 - 0.7% to March 26 - 1.9%	Bigger is better	Y-25/26	Numerator: Planned turnover Denominator: Allocation minus deficit support funding	New NOF Indicator as agreed with Director of Finance
Readmission rate band	*Effectiveness and experience of care*	*Director of Operations*	*Resource & Performance Committee*	*TBC*	*TBC*	*TBC*	*Y-25/26*	*To be defined*	*Awaiting National Definition*
Relative difference in costs	Finance and Productivity	Director of Finance	Resource & Performance Committee	Latest	0	Smaller is better	Y-25/26	Provider actual cost / provider expected cost * 100 See National Cost Collection Index (NCCI) calculation tab of NCCI dashboard for further details	New NOF Indicator as agreed with Director of Finance

Under 18s elective waiting list growth	*Improving health and reducing inequality*	*Director of Operations*	*Resource & Performance Committee*	*TBC*	*TBC*	*TBC*	*Y-25/26*	*To be defined*	*Awaiting National Definition*
Urgent community response 2-hour performance	Effectiveness and experience of care	Director of Operations	Resource & Performance Committee	Latest	National - 70	Bigger is better	Y-25/26	Numerator: Number of referrals that had a Referral to Treatment waiting time of under 120 minutes. Denominator: Number of standard urgent community response referrals received.	New NOF Indicator as agreed with Director of Operations
Variance year-to-date to financial plan	Finance and Productivity	Director of Finance	Resource & Performance Committee	Latest	100	Bigger is better	Y-25/26	Numerator: Actual surplus/deficit Denominator: Planned surplus/deficit	New NOF Indicator as agreed with Director of Finance
Proportion of patients spending more than 12 hours in an emergency department	Responsive	Director of Operations	Resource & Performance Committee	Sum	1.99	Smaller is better	Y-22/23 N-25/26	The number of patients that spend more than 12hrs between arrival and admissions, transfer or discharge, as a proportion of total attendances Numerator Sum of attendances where difference between arrival and departure time is greater than 12 hours Denominator Sum of attendances Computation Numerator/Denominator * 100	No longer a NOF KPI (NOF sepcifies type 1 and 2 attendances only). Removal of KPI agreed by Director of Operations

Agency spend - compared to the agency ceiling	Use of Resources	Director of Operations	Resource & Performance Committee	Latest	100	Smaller is better	Y-22/23 N-25/26	Agency spend compared to the agency ceiling Data source: Provider financial returns Numerator Agency spending Denominator Planned agency spending Computation Agency spending is calculated as a proportion of the planned agency spending. If under 100%, spending is within limit.	No longer a NOF KPI. Removal of KPI agreed by Director of Operations and Director of Finance
Agency spend - Price cap compliance	Use of Resources	Director of Operations	Resource & Performance Committee	Latest	100	Bigger is better	Y-22/23 N-25/26	Price cap compliance Data source: Temporary staffing data collection returns Numerator Compliance to price caps Denominator Compliance to price caps Computation Percentage of agency spend complying with the price cap	No longer a NOF KPI. Removal of KPI agreed by Director of Operations and Director of Finance

Available virtual ward capacity per 100k head of population	Effective	Director of Operations	Resource & Performance Committee	Latest	167 (factor to be applied)	Bigger is better	Y-22/23 N-25/26	The indicator aggregates reported virtual ward capacity – the number of patients who can be simultaneously managed within a virtual ward service – across all such existing services, and divides by the adult population (those aged 16 and over) to give a measure comparable between different geographies. Numerator Aggregate of the capacity – the number of patients who can be simultaneously managed within a given virtual ward service – across all virtual ward services. Denominator GP-registered population aged 16 and over, as of April 2022 Data published here: Patients Registered at a GP Practice, April 2022 - NHS DigitalComputation Sitrep data associated virtual ward services and their capacity with the ICS on whose behalf the service is provided. Summing across services provided to each ICS, region and nationally and dividing by relevant population figures will report the indicator at different geographic levels.	No longer a NOF KPI. Removal of KPI agreed by Director of Operations
Financial efficiency - variance from efficiency plan	Use of Resources	Director of Finance	Resource & Performance Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	This metric will measure how close the organisations are to meeting their efficiency plans as agreed in their overall financial plans. Numerator Variance from plan using recurrent achievement Denominator Efficiency plan Computation Variance from plan/plan	No longer a NOF KPI, but agreed with Director of Finance to keep as a local KPI. Change Domain to 'Finance and productivity'

									and change KPI type to local
Financial stability - variance from break-even	Use of Resources	Director of Finance	Resource & Performance Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	This indicator assesses an organisation's plan followed by how far the organisation is away from plan and breakeven plus a number of other factors which indicate whether the organisation is financially stable. In assessing stability, the latest forecast, known risks (based on local reporting if relevant), PSPP performance, run rates plus judgement as to whether or not an organisation will manage to breakeven or not will be used Data source: Financial results reported by organisations Variance from balanced plan and then variance from breakeven Allocation for ICBs and turnover for providers Variance from balanced plan Variance from breakeven/allocation (ICBs) or turnover (providers)	No longer a NOF KPI. Removal of KPI agreed by Director of Finance

Outpatient follow-up activity levels compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	75	Smaller is better	Y-22/23 N-25/26	Relative number of follow-up outpatient attendances (consultant and non-consultant led) in 2022/23 compared to baseline (2019/20*) expressed as a percentage. Numerator: Total follow-up outpatient attendances (all TFC; consultant and non-consultant led) within the period divided by the number of working days** (A) Denominator: Total follow-up outpatient attendances (all TFC; consultant and non-consultant led) in the same period for 2019/20 divided by the number of working days** (B) Computation A / B	No longer a NOF KPI. Removal of KPI agreed by Director of Operations
Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	Responsive	Director of Operations	Resource & Performance Committee	Sum	92	Bigger is better	Y-22/23 N-25/26	This indicator is the percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral. Count of initial assessments undertaken within 6 weeks of referral / Total number of assessments in the reporting period *100	No longer a NOF KPI. Removal of KPI agreed by Director of Operations

Total diagnostic activity undertaken compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	120	Bigger is better	Y-22/23 N-25/26	Numerator The number of diagnostic tests for the specified test group carried out during the month, based on monthly diagnostics data provided by NHS and independent sector organisations and reviewed and validated by NHS commissioners. This should include planned, unplanned and waiting list tests, but does not include screening. Denominator Counterfactual March 2020 activity, working day adjusted. Counterfactual calculated by applying 3-year national average growth factor from Feb-Mar to the February 2020 activity, adjusting for working days. Factor = 1.011228978	No longer a NOF KPI. Removal of KPI agreed by Director of Operations

Total elective activity undertaken compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	103	Bigger is better	Y-22/23 N-25/26	Valued weighted elective activity as a percentage of 2019/20 baseline, including effect of specialist advice. Valued activity (at HRG level) in the reporting period divided by the number of working days plus additional Specialist Advice activity that resulted in a diverted pathway (valued at average tariff for a first outpatient attendance without procedure) per working day. Where: additional Specialist Advice activity that resulted in a diverted pathway per working day = (valued Specialist Advice activity that resulted in a diverted pathway in the reporting period divided by the number of working days) – (valued Specialist Advice activity that resulted in a diverted pathway in the same period for 2019/20 divided by the number of working days) Valued activity (at HRG level) in the same period for 2019/20 divided by the number of working days. There is an exception for March 2020 which will be an estimated counterfactual. The counterfactual is: Mar-20 activity = Working days in Mar-20 * (Feb-20 / Feb-20 wd) * average (((Mar-17/Mar-17 wd)/(Feb-17/Feb-17 wd)), ((Mar-18/Mar-18 wd)/(Feb-18/Feb-18 wd)), ((Mar-19/Mar-19 wd)/(Feb-19/Feb-19 wd)) Where wd = working days This counterfactual needs to be calculated separately for each term in the weighted	No longer a NOF KPI. Removal of KPI agreed by Director of Operations and Director of Finance

								formula. Counting and coding adjustments to the baseline will be used to adjust the denominator.	

Total patients waiting more than 104 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	The number of incomplete Referral to Treatment (RTT) pathways of 104 weeks or more at the end of the reporting period.	No longer a NOF KPI. Removal of KPI agreed by Director of Operations
Total patients waiting more than 52 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.	Change Domain to 'Access'
Total patients waiting more than 78 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y-22/23 N-25/26	The number of incomplete Referral to Treatment (RTT) pathways of 78 weeks or more at the end of the reporting period.	No longer a NOF KPI. Removal of KPI agreed by Director of Operations
18 week Referral To Treatment (RTT) incomplete pathways	Responsive	Director of Operations	Resource & Performance Committee	Latest	92	Bigger is better	N-22/23 Y-25/26	Proportion of incomplete Referral to Treatment (RTT) pathways within 18 weeks at the end of the reporting period.	Was a local KPI, now included in Oversight Framework. Rename to align with NOF - 'Percentage of patients waiting less than 18 weeks - RTT' Change Domain to 'Access'

Diagnostics for Audio/Ultrasound	Responsive	Director of Operations	Resource & Performance Committee	Latest	99	Bigger is better	N-22/23 Y-25/26	DM01 statutory return - Percentage of patients waiting within 6 week standard	Rename to align with NOF 'Percentage of people waiting over 6 weeks for a diagnostic procedure or test' and Change Domain to 'Improving health and reducing inequality'
CQC Conditions or Warning Notices	Responsive	Chief Executive Officer	Resource & Performance Committee	Sum	0	Smaller is better	N	CQC Conditions or Warning Notices imposed	Change Committee to 'Quality and Safety' and change Domain to 'Effectiveness and experience of care'
Data Quality Maturity Index	Effective	Director of Operations	Resource & Performance Committee	Latest	95	Bigger is better	N	NHSE Published performance rating the completeness and validity of provider datasets	Change Domain to 'Finance and Productivity'
New Birth Visits % within 14 days - Dudley	Caring	Director of Operations	Resource & Performance Committee	Avg	90	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Dudley)	Change Domain to 'Access'
New Birth Visits % within 14 days - Shropshire	Caring	Director of Operations	Resource & Performance Committee	Avg	90	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Shropshire)	Change Domain to 'Access'

New Birth Visits % within 14 days - Telford	Caring	Director of Operations	Resource & Performance Committee	Avg	95	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Telford)	Change Domain to 'Access'
Number of patients not treated within 28 days of last minute cancellation	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Number of daycase/inpatients cancelled on same day as admission, not treated within 28 days of surgical date	Change Domain to 'Access'
Patients no longer meeting the criteria to reside	Responsive	Director of Operations	Resource & Performance Committee	Latest	Staggered target April 25- 24.6% to 16.4% in March 26	Smaller is better	N	Percentage of beds occupied by patients no longer meeting the criteria to reside Numerator - The average (daily number/number of days in month) number of patients remaining in hospital who no longer meet the criteria to reside but remain in hospital. Denominator - The average number of beds occupied (daily OBD/days in month)	Removal of KPI agreed by Director of Operations - KPI to be replaced with 'Average number of days from discharge ready date and actual discharge date'
Proportion of patients within 18 weeks	Responsive	Director of Operations	Resource & Performance Committee	Latest	92	Bigger is better	N	Proportion of patients still on a new waiting list, waiting less than 18 weeks - all services as of end of month	Change Domain to 'Access'
Proportion of patients within 18 weeks - Children's Services	Access	Director of Operations	Resource & Performance Committee	Latest	92	Bigger is better	N	Proportion of patients (children) still on a new waiting list, waiting less than 18 weeks - all children's services as of end of month	New local Indicator as agreed with Director of Operations
Total activity undertaken against current year plan	Effective	Director of Operations	Resource & Performance Committee	Sum	100	Bigger is better	N	Proportion of activity delivered against seasonally adjusted plan	Change Domain to 'Finance and Productivity'
Total patients waiting more than 104 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 104 weeks - all services as of end of month	Change Domain to 'Access'

Total patients waiting more than 52 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 52 weeks - all services as of end of month	Change Domain to 'Access'
Total patients waiting more than 65 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 65 weeks - all services as of end of month	Change Domain to 'Access'
Total patients waiting more than 65 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	The number of incomplete Referral to Treatment (RTT) pathways of 65 weeks or more at the end of the reporting period.	Change Domain to 'Access'
Total patients waiting more than 78 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 78 weeks - all services as of end of month	Change Domain to 'Access'
Urgent Care 2 hour response	Responsive	Director of Operations	Resource & Performance Committee	Latest	70	Bigger is better	N	The percentage of 2-hour UCR referrals meeting the 2-hour standard. The two-hour urgent community response standard is 120 minutes or less between clock start and clock stop. Numerator - Of the number of 2-hour UCR referrals received (in month)the number which had a UCR care contact within 2-hours Denominator - the number of 2-hour UCR referrals received (in month)	Removal of KPI agreed by Director of Operations - KPI to be replaced with 'Urgent community response 2-hour performance'
Virtual ward bed occupancy	Effective	Director of Operations	Resource & Performance Committee	Latest	80.24	Bigger is better	N	Number of VW occupied bed days in month over Number of VW available bed days in month	Change Domain to 'Finance and Productivity'

Shropshire Community Health NHS Trust

Month 5 2025/26 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	2 October 2025
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	24 September 2025
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance in August (month 5) 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 31 August 2025 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £666k adjusted surplus as at month 5 compared to the planned surplus of £649k, which is a small favourable variance of £17k.

Key areas for consideration are:

- **Agency -** spend is £1,121k after five months of the financial year; this is £216k 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 £1,755k after five months of the financial year; this is £559k adverse to plan. The variance is due mainly to a higher level of vacancies than planned and prioritising bank staff over agency to cover clinical shifts. 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 5 2025/26 Financial Performance

- **CIP** delivery at month 5 is £2,022k, which is £58k 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 its high risk schemes and the medium risk schemes account for 15% of forecast delivery at £786k. **The Trust must deliver the CIP target in full to deliver the financial plan.**

- **Cost pressures –** the year to date position is impacted by cost pressures in Prison Healthcare, Rehab and Recovery Units (RRUs,) the Wheelchair service and unplanned inpatient escalation beds. Mitigating actions have begun to reduce a number of these pressures from month 5. **The Trust must mitigate all current and arising cost pressures during the year to deliver the financial plan**.

- **Risk** – At month 5 the Trust is reporting all financial risks are fully mitigated on the basis that we are relatively 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 4; this reflects the continued de-risking of our CIP programme and reductions in a number of cost and income risks.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 5 is a surplus of £666k compared to the planned surplus of £649k, which is a favourable variance of £17k.
- **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 15% of schemes rated as medium risk and 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 in place or being developed to mitigate these pressures as far as possible.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.
- **Consider** the NHSE updates in particular the key role that Finance Committees and Boards will have in challenging and assuring underlying positions.

Month 5 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 Income and Expenditure at adjusted financial performance level. This excludes several technical accounting adjustments and is the level at which performance is reported to and managed by NHSE.

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 5.

Financial Performance against Plan (£k)	M05 Plan	M05 Actual	M05 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast	Annual Variance
(Surplus)/ Deficit In Year	(195)	(204)	(9)	(649)	(666)	(17)	(2,000)	(2,000)	0
Underlying Position	(115)	(114)	1	(247)	(297)	(50)	(932)	(932)	0
Agency Expenditure	234	235	1	1,337	1,121	(216)	2,939	2,939	0
Bank Expenditure	225	340	115	1,196	1,755	559	2,736	2,736	0
Cost Improvement Programme	461	474	13	1,964	2,022	58	5,359	5,359	0
Capital Expenditure	210	43	(167)	1,804	1,201	(603)	4,975	4,975	0

3.2. Adjusted Financial Performance – favourable variance to plan £17k

The adjusted financial position at month 5 is a surplus of £666k compared to the planned surplus of £649k which is a favourable variance of £17k. Further details on the underlying position are set out in section 3.2.10.

Table 1 summarises the position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(54,191)	(54,296)	(105)
Expenditure excl. adjusting items	53,542	53,629	87
Adjusted financial performance total	**(649)**	**(666)**	**(17)**
Adjusting items	55	57	2
Retained (surplus) / deficit	**(594)**	**(609)**	**(15)**

Table 1: Income and Expenditure (surplus) / deficit position as at 31 August 2025

Month 5 2025/26 Financial Performance

3.2.1. Income – favourable variance to plan £105k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System income	(42,119)	(42,134)	(15)
Non-system income	(12,072)	(12,162)	(90)
Total income	**(54,191)**	**(54,296)**	**(105)**

Table 2: Income Summary as at 31 August 2025

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).

National planning guidance for 2025/26 confirmed that there is no additional funding available for elective activity beyond that included in ICB allocations. SCHT elective/variable income plan is consistent with the STW ICB allocation. Our internal reporting indicate that elective activity is overperforming against plan, however due to the cap on funding, variable income is assumed to be in line with plan as at month 5.

3.2.2. Expenditure – adverse variance to plan £89k

Table 3 shows a summary of expenditure by key categories.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	37,108	36,130	(978)
Bank	1,196	1,755	559
Agency	1,337	1,121	(216)
Total Pay	**39,641**	**39,005**	**(636)**
Supplies & Services Clinical	4,492	4,955	463
Prison Escorts and Bedwatch	109	198	89
Drugs	637	604	(32)
Premises	3,924	3,938	14
Travel	701	596	(105)
Other	4,093	4,389	296
Total Non-Pay	**13,956**	**14,681**	**725**
Total Expenditure	**53,597**	**53,686**	**89**

Table 3: Expenditure Summary as at 31 August 2025

3.2.3. Pay – favourable variance to plan £636k

The overall pay position is a favourable variance of £636k. 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 clinical shifts wherever possible, to avoid the use of agency staff. The pay spend also includes £74k temporary staffing to cover unfunded inpatient escalation beds. This overspend is currently offset by underspends elsewhere within the position.

Month 5 2025/26 Financial Performance

Bank spend was £340k in August, an increase of £12k compared to the previous month and £115k adverse to plan. The year to date position is now £559k adverse to plan. This represents 4.5% of total pay compared to our plan of 3.0%. The overspend is due to higher level of vacancies than planned and escalation costs of £37k. The target is £2,736k, 3% of the overall pay plan. It is of note that after five months of the financial year, 64% of the annual Bank financial plan has been spent.

Agency spend was £235k in August, an increase of £42k compared to the previous month and £1k adverse to plan. The year to date position is now £216k favourable to plan, after allowing for £37k escalation costs. This represents 2.9% of total pay compared to our plan of 3.4%. The underspend is due mainly to the mix of staff weighted towards lower paid and below plan usage from month 2 due to rigorous controls. The target for the Trust in 2025/26 is £2,939K, 3.1% of total pay cost.

The vacancy rate in August was 8.95% (a reduction from 10.9% in March 2025), which equates to 161 WTE vacancies, however it should be noted that there were 116 WTE of temporary staff (79 bank and 37 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 – adverse variance to plan £725k

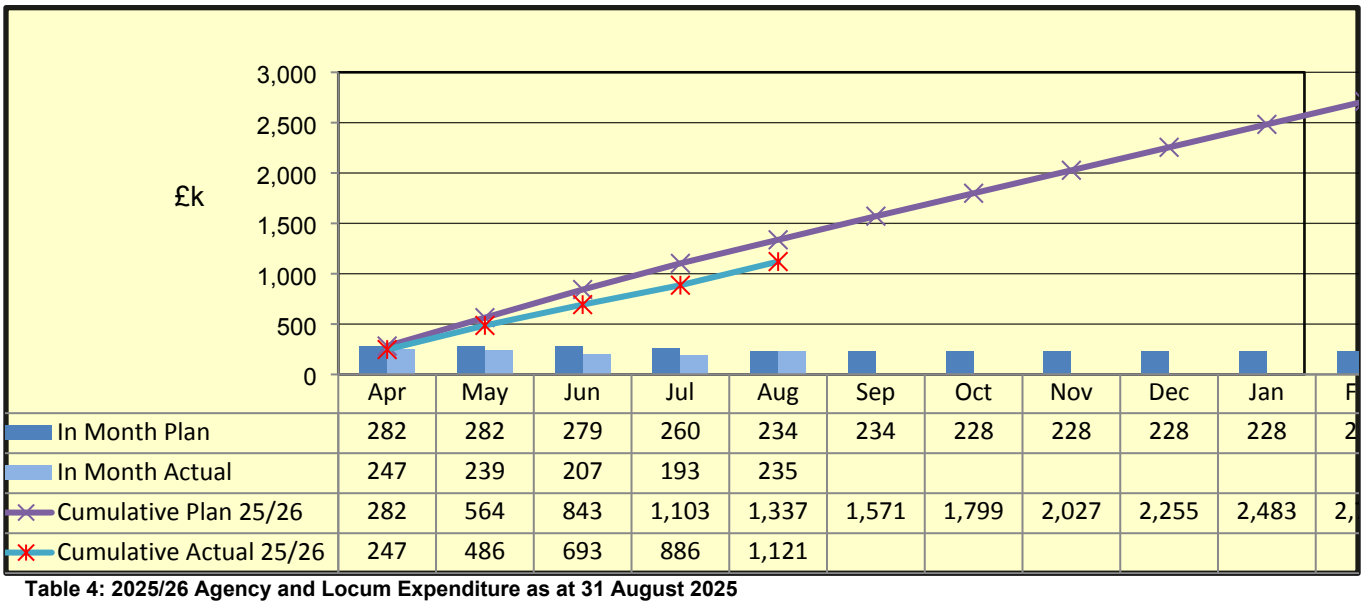
There are continuing cost pressures in the Prison Healthcare service, the Wheelchair service and the RRUs which are the key reasons for the non-pay overspend. We have mitigating actions in place to minimise the impact on the Trust's financial position and are seeking additional measures to reduce these areas of pressure.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £216k

Table 4 shows agency spend is £1,121k compared to the plan of £1,337k, which is a favourable variance of £216k. 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.

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 additional pressures during the autumn and winter period.

Month 5 2025/26 Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	F
In Month Plan	282	282	279	260	234	234	228	228	228	228	2
In Month Actual	247	239	207	193	235						
Cumulative Plan 25/26	282	564	843	1,103	1,337	1,571	1,799	2,027	2,255	2,483	2,
Cumulative Actual 25/26	247	486	693	886	1,121						

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

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 £2,022k as at month 5, which is £58k favourable to plan.

	Plan YTD £k	Actual YTD £k	Variance YTD £k
Recurrent	1,286	1,318	32
Non-recurrent	678	704	26
TOTAL	**1,966**	**2,022**	**58**

Table 5: 2025/25 CIP delivery as at 31 August 2025

Recurrent delivery as at Month 5 is £1,318k, which is £32k favourable compared to the recurrent plan of £1,288k. Non-recurrent CIP delivery is £704k, which is £26k favourable to plan.

Positive progress is being made in relation to the delivery risk of our CIP. At month 5, 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 have a value of £786k at month 5, a reduction of £345k on month 4 position.

Recurrent / Non Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total Forecast £k	Total Plan £k	Full Year Effect CIP £k
Recurrent	2,933	641	0	0	3,574	3,574	3,574
Non Recurrent	1,640	145	0	0	1,785	1,785	-
	4,573	**786**	**0**	**0**	**5,359**	**5,359**	**3,574**
Recurrent	55%	12%	0%	0%	67%		
Non Recurrent	30%	3%	0%	0%	33%		
	85%	**15%**	**0%**	**0%**	**100%**		

Table 6: CIP 2025/26 full year breakdown as at 31 August 2025

Month 5 2025/26 Financial Performance

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 31 August 2025 is shown in Table 7.

	31 July 25 Balance £k	31 August 25 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,398	42,110	(288)
Inventories	205	205	0
Non-current assets for sale	0	0	0
Receivables	5,095	3,016	(2,079)
Cash	28,849	30,318	1,469
Payables	(15,461)	(14,397)	1,064
Provisions	(3,761)	(3,742)	19
Lease Obligations on Right to Use Assets	(11,324)	(11,317)	7
TOTAL ASSETS EMPLOYED	**46,001**	**46,193**	**192**
Retained earnings	36,634	36,826	192
Other Reserves	9,367	9,367	0
TOTAL TAXPAYERS' EQUITY	**46,001**	**46,193**	**192**

Table 7: Statement of Financial Position as at 31 August 2025

- Receivables (amounts we are owed) decreased by £2,079k due mainly to receipts from Local Authority
- Payables (amounts we owe) decreased by £1,064k due mainly to deferred income movements and payment of NHS invoices.
- Cash increased by £1,469k largely because of the above changes.

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

3.2.8. Capital Expenditure

The 2025/26 plan is to spend £4,975k which comprises operational capital of £2,818k and IFRS 16 lease capital of £2,157k. NHSE guidance now allows flexibility on how our overall capital allocation is spent. Our forecast outturn is to fully utilise our capital funding in year.

At Month 5 actual spend was £1,201k compared to planned spend of £1,804k, an underspend of £603k, as shown in Table 8, which is mainly due to slippage on leases. Capital expenditure is expected to come back in line with planned levels during quarter 3.

Capital Expenditure	Annual Plan £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Operational capital	2,818	787	663	(124)
IFRS 16 leases	2,157	1,017	538	(479)
	4,975	**1,804**	**1,201**	**(603)**

Table 8: 2025/26 Capital Expenditure as at 31 August 2025

Month 5 2025/26 Financial Performance

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 5 is £50k 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 £370k which is £33k adverse to plan mainly due to a small number of cost pressures, which are assumed to be non-recurrent issues.

The underlying position is a key area of focus for NHSE which they expect Trust Boards and Committees to monitor. Our forecast outturn and financial risk assessment is overseen through the Resource and Performance Committee at each of its meetings.

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

	YTD Actual £k			Forecast £k		
	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Income	(54,085)	(211)	(54,296)	(128,930)	(506)	(129,436)
Pay	39,495	(489)	39,006	95,243	(806)	94,437
Non-pay	14,294	330	14,624	32,755	244	32,999
Adjusted financial position	**(297)**	**(370)**	**(666)**	**(932)**	**(1,068)**	**(2,000)**
Plan	(247)	(403)	(649)	(932)	(1,068)	(2,000)
Variance (favourable)/adverse	**50**	**(33)**	**17**	**0**	**0**	**0**

Table 9: 2025/26 Underlying financial position as at 31 August 2025

3.2.10. Forecast Outturn and Financial Risk

We have reviewed current and relevant information relating to our financial performance for the remainder of the year and we are forecasting that we are likely to deliver our 2025/26 financial plan, subject to mitigation of our key financial risks.

The level of financial risk has reduced since month 4; this reflects reduction in the cost risk as the year progresses. 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

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

3.2.12. NHSE Update

NHSE are undertaking a number of reviews and actions to strengthen financial position and support the 10-year health plan. The key areas are summarised below.

Month 5 2025/26 Financial Performance

Deconstruction of Block Payments - to support the NHS's strategic shift toward neighbourhood health services, the 10-year health plan calls for the deconstruction of block payments in urgent, emergency, mental health, and community services. Systems are required to undertake an impact assessment on contract baselines for deconstructing the blocks. This will inform the design of future financial frameworks and ensure transparency in funding.

The impact assessment is an opportunity for ICBs and providers to work jointly to understand and reach agreement on how their current 2025/26 block contract values compare to an activity/price assessment basis. However, there will be no changes to contracts in 2025/26, and the outcome of the impact assessment should not in any way impact on delivery of the 2025/26 plans.

We are in the process of completing our assessment based on national prices provided by NHSE or locally agreed prices where national price is not available.

Underlying Position – The 2025/26 exit underlying position will be the starting point for the medium-term plans (MTPs) and so a robust, consistent assessment of this key financial metric is essential.

The 10 year health plan sets out the requirement for all NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly. In practice, this translates to a required underlying surplus of 3% and nationally this will require a considerable improvement in current underlying positions.

The next step in moving to a robust assessment of the underlying position for the MTPs and to establishing a trajectory to the required 3% underlying surplus is to establish a set of national principles. The application of these principles will improve the consistency of the assessment of the underlying financial position.

NHSE expectation is that organisations' finance committees and Boards will have a key role in challenging and assuring underlying positions. The nationally consistent set of principles will be key to the assurance processes within organisations internal governance arrangements.

Grip and Control Self-Assessment – each organisation is required to reassess their grip and control measures to ensure they are still being applied and are effective. SCHT are in the process of reviewing our grip and control measures which will be independently assess by our internal auditors during November.

Capital Flexibility – to enhance the incentives for delivering strong revenue performance, NHSE is considering introducing adjustments to the capital regime that provide targeted freedoms and flexibility for high-performing systems and providers.

Under the proposal Providers in tier 1 and 2 that delivered a surplus in 2024/25 (excluding deficit funding) would have the flexibility to invest capital equivalent to their surplus in 2024/25, over the financial years 2025/26 and 2026/27. This capital would have to be directed toward projects that demonstrably improve revenue outcomes.

3.2.13. 2026/27 Planning

The following diagram below shows the timeline for 2026/27 planning round has significantly reduced compared to previous years with a draft submission due in November and a final submission in December.

Month 5 2025/26 Financial Performance

Other differences compared to previous years include:

- The plan will be for 5 years
- Providers will submit their own individual plans separately from the ICB
- Planning framework has been released but further planning guidance and tools are expected during October.
- The Board Assurance Template is expected to be extended.

To allow time for the plan submissions to be reviewed and approved at Board, extraordinary Board and/or Resource and Performance Committee meetings may be required.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 5 is a surplus of £666k compared to the planned surplus of £649k, which is a favourable variance of £17k.
- **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 15% of schemes rated as medium risk and 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 in place or being developed to mitigate these pressures as far as possible.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.
- **Consider** the NHSE updates in particular the key role that Finance Committees and Boards will have in challenging and assuring underlying positions.

Green Plan 2025-2028

0. Reference Information

Author:	Richard Best - Associate Director of Estates	**Paper date:**	02 October 2025
Executive Sponsor:	Sarah Lloyd - CFO	**Paper written on:**	24 September 2025
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Use of resources
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper provides the 2025-2028 Green Plan for review and approval.

2. Executive Summary

2.1 Context

This paper presents the Green Plan for 2025-2028 for review and approval. This Plan was reviewed by the Resource and Performance Committee on 24 September and is recommended to the Trust Board for approval following minor amendments.

Green Plan 2025 – 2028

This 2025-2028 Green Plan builds on our existing Green Plan and the Trust's Energy Management Policy to reflect recent changes in legislation, and it aligns to the Shropshire, Telford and Wrekin Integrated Care System Green Plan and Integrated Care Board contractual requirements. Additionally, it reflects recent changes in legislation. The breadth of this plan also recognises an updated national view in relation to Net Zero expectations.

Our 2025-2028 Green Plan provides an action plan for the next 3 year, across a number of enabling areas, with over 30 actions.

Regular progress updates will continue to be presented to the Resource and Performance Committee and Trust Board as required.

2.2 Conclusion

The Trust Board is asked to **consider and approve** the Trust's 2025-2028 Green Plan, following recommendation by the Resource and Performance Committee.

3. Main Report

3.1 Green Plan 2025-2028

Our Green Plan 2025-2028 builds on both our existing Green Plan, which ran from 2022, and the Trust's Energy Management Policy. Through our work in this area to date, the Trust's directly influenceable Carbon Footprint has reduced by 36.7% since the NHS introduced its Net Zero pledge in 2020.

Our updated Pan aligns to the Shropshire, Telford and Wrekin Integrated Care System Green Plan and Integrated Care Board contractual requirements. Additionally, it reflects recent changes in legislation.

To support delivery of our updated Plan, we have expanded the key enablers in line with the national view from the 'Greener NHS Unit', and these now include:

- Adaption
- Digital Transformation
- Estates and Facilities
- Food and Nutrition
- Leadership and Workforce
- Medicines
- Supply Chain and Procurement
- Sustainable Models of Care
- Travel and transport

Our Green Plan 2025-2028 explains our approach under each these enablers and provides an action plan covering the 3 year period. Progress will be measured and reported regularly through Committee and the Trust Board.

3.4 Recommendation

The Trust Board is asked to **consider and approve** the Trust's 2025-2028 Green Plan, following recommendation by the Resource and Performance Committee.

Shropshire Community Health
NHS Trust

‘Green Plan Phase 2’
Our Sustainable Development Strategy 2025-2028

Building on our 2022-2025 performance to deliver a Net Zero Health Service

Contents

1. Introduction and Context

It is now widely recognised that climate change is a serious threat to life, our health, and our wellbeing. As one of the world's largest organisations the NHS has an absolute imperative to act to make a real and sustainable difference.

In 2008 the Climate Change Act set national targets for the reduction of carbon emissions in England, against a 1990 baseline, establishing the NHS Carbon Footprint.

Climate change threatens the health of the population and the ability of the NHS to deliver its essential services in both the near-term and longer term.

For this reason, in 2020 the NHS became the first national health system in the world to commit to decarbonise its operations, setting a clear target for net zero by 2045 for its total carbon footprint, with an 80% reduction by 2036 to 2039. This commitment gained legislative footing with the Health and Care Act (2022).

The objectives set out in with the '*Delivering a Net-Zero NHS'* report, expanded on the existing NHS Carbon Footprint, and established the NHS Carbon Footprint Plus. This now covers the full scope of emissions from the NHS and the Greenhouse Gas Protocol (GHGP) and supports international comparison and transparency:

Scope	Description	Examples
GHGP Scope 1: Direct Emissions	Direct emissions from sources that are owned or controlled by the NHS	• Direct fuel/energy use e.g. natural gas • Fuel used from institution owned vehicles • Anaesthetic Gases
GHGP Scope 2: Electricity Indirect Emissions	Emissions from the generation of purchased electricity consumed by the NHS	• Purchased electricity
GHGP Scope 3: Other Indirect Emissions	Emissions that are a consequence of the activities of the NHS, but occur from sources not owned or controlled by the NHS	• Construction, Water, waste, land-based travel, commuting (both staff and students) • Food and catering

2. Purpose

Shropshire Community Health NHS Trust (SCHT) recognises its role as an anchor institution and is taking ambitious action, as noted in its original Trust Board approved Green Plan 2022-2025, to tackle the twin challenges of climate change and air pollution. Indeed, many of the actions to cut carbon emissions also reduce air pollution which leads to direct and quantifiable impacts on health while also addressing health inequality.

Our carbon reduction strategy has been developed in response to the need for NHS services to take action on climate change and sets out our ambitions to deliver a net zero NHS service in our Trust. The table below provides a further breakdown of how services are delivered across the GHCP scope of emissions.

	Delivery of care	Personal travel	Supply chain	Commissioned
Scope 1	• On-site fossil fuel use • Anaesthetic gases • NHS fleet and leased vehicles			
Scope 2	• Purchased electricity			
Scope 3	• Water and waste • Metered dose inhalers • Business travel	• Staff commute	• Pharmaceuticals and chemicals • Medical equipment • Non-medical equipment • Business services • Food and catering • Other procurement	• Commissioned health services
Non-Protocol*		• Patient travel • Visitor travel		

Although SCHT is not the largest NHS organisation in Shropshire, Telford and Wrekin and Dudley, we improve the lives of the local population for generations through positive action on the environment.

3. Shropshire Community Health Trust Green Plan

This 2025-2028 Green Plan builds on our existing Green Plan and the Trust's Energy Management Policy to reflect recent changes in legislation, and it aligns to the Shropshire, Telford and Wrekin Integrated Care System (STW ICS) Green Plan and Integrated Care Board contractual requirements. Additionally, it reflects recent changes in legislation relating to the Clinical Waste Strategy, national standards for healthcare food and drink, and the Net Zero travel and transport strategy. As a result, SCHT has:

- Reviewed our Green ambitions and the enablers to achieve these
- Publicly set our commitment to sustainable development
- Demonstrated how we expect to meet our legislative requirements
- Described how we will evaluate our impact
- Set out how we will monitor and assure against delivery of this strategy

4. Our core aims, ambitions and objectives

We continue working towards the two key targets set out by NHS England:

- **To ensure the emissions we control directly (the NHS Carbon Footprint) are net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032**
- **To ensure the emissions we can influence (our NHS Carbon Footprint Plus) are net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039**.

In addition to these targets, SCHT also committed to:

i. Reduce the carbon impact of NHS related travel and transport
ii. Improve our Estates and Facilities to meet Net Zero
iii. Move to a model of sustainable procurement
iv. Co-design new models of care and health delivery innovation

5. Our Green Ambitions – Enablers and Areas for 2025 – 2028

The key enablers to support the delivery of our updated Green Plan have broadened in line with the 2025 national review. These enablers have been identified by the Greener NHS Unit and are the nine areas of focus within a Green Plan.

1. Leadership and Workforce:
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and transport.
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaption

This plan sets actions for each of these areas of focus, describing our approach and the broad objectives for each of these enablers over the next three years.

1. Leadership and Workforce

System collaboration and partnership working is an essential part of our approach to sustainability. In preparing the Green Plan we have engaged with Shropshire, Telford and Wrekin and Dudley partners and NHS regional forums, sharing ideas and comparing progress.

Community healthcare creates specific environmental challenges and necessitates innovation around sustainable models of care. As a community provider, the Trust owns or leases space in a high number of premises and accesses more. The reduction of our carbon footprint not only requires decarbonising our estates, but also extensive liaison with third-party landlords. Furthermore, much of our patient care is delivered by clinicians in patient homes, meaning green transport strategies are essential.

During 2025 - 2028 we will:

Leadership

- Develop and strengthen our strategic plans with system partners across Shropshire Telford and Wrekin and Dudley. Continue to play an active and leading role in ICS Green groups and regional forums, delivering on the respective ICS sustainability priorities
- Build sustainability into all our strategies, plans, and investment decisions
- Learn from others in healthcare and beyond
- Clearly communicate our plan and progress to staff, patients and communities
- Continue to align our Green plan with the aims of the anchor institution programme
- Deliver on all contractual requirements

Engagement of Staff and Community

- Involve staff, patients, and our local communities to help us meet our goals
- Educate staff about how to improve home energy efficiency through the Trust website and social media
- Develop a network and involvement of green champions
- Strengthen our sustainability training offer for staff and increase participation rates
- Address the matters of environmental concern to staff
- Embed principles of sustainability within training placements and apprenticeships

2. Sustainable Models of Care

SCHT is committed to creating and embedding sustainable models of care and ensuring our operations and estates are as efficient, sustainable, and as resilient as possible. Increasingly, these plans focus on joint working and integrating services to provide better care for our patients. The Trust is committed to this agenda and has worked actively to integrate core community services in localities to improve care delivery.

During 2025- 2028 we will:

- Worked closely with our clinical leads to align Green initiatives with the Trust's clinical strategy.
- Continue to monitor and reduce the use of metered dose inhalers (MDIs) where clinically appropriate, noting that whilst we expect some future reduction, figures may plateau (reflecting saturation in the system, patient choice and the introduction of lower hydrofluoroalkane propellant MDIs on the market)
- Improve Green spaces to facilitate staff access for rest breaks and one to one meetings, together with patient benefits.
- Identify and map projects with the objective of reducing clinical waste (for example, PPE, packaging, medicines)
- Explore utilisation of sterilisation and re-use of equipment across more services, noting this is current practice in the dental service
- Move towards electronic health resources for families, including health questionnaires, birth packs and letters for our children's services
- Continue to work on initiatives, including hybrid working, which reduce staff travel journeys and journey time
- Further engage clinicians and patients to identify and deliver sustainable models of care across the Trust including patient self-care models; quality improvement methodologies to streamline services and improve patient outcomes (hence reducing health resource utilisation and associated carbon footprint)

3. Digital Transformation

The Trust deploys information technology to support staff to work efficiently in their roles. This means we can work in a more agile, paper free manner, to reduce environmental impact.

Over the past three years we have adopted digital innovations in patient care. However, we are also recognising digital systems use significant amounts of energy, and the environmental impact of digital has been considered and will continue to be monitored.

During 2025 - 2028 we will:

- Develop and implement a move away from paper-based patient records for them to be held digitally
- Implement a project to convert to electronic patient appointment letters in all settings
- Implement an office desktop energy saving scheme
- Where appropriate, offer virtual appointments in addition to face to face to facilitate patient choice, ensuring we are not excluding patients who do not have access to such technology, or who would prefer to be seen face to face.
- Implement Electronic Prescription Service (EPS) to reduce the number of paper prescriptions in primary care.
- Move towards implementation of an Electronic Prescribing and Medicines Administration (EPMA) system for patient care (mainly bedded services) in line with the national data strategy and improving patient safety
- Explore the implementation of electronic forms for requests such as blood tests to reduce paper usage
- Implement more digital care models, where appropriate for our patient demographic learning from ICS partners
- Continue to develop agile working protocols, which reduce staff travel journeys and journey time
- Implement a patient self-scheduling tool to reduce the number of patient letters sent
- Meet all sustainability requirements of the Digital Maturity Assessment
- Assess the energy and environmental impact of digital tools to ensure they support our pathway to Net Zero
- Streamline the use and increase repurpose of electronic equipment such as phones and laptops as well as ensuring environmental disposal

4. Travel and Transport

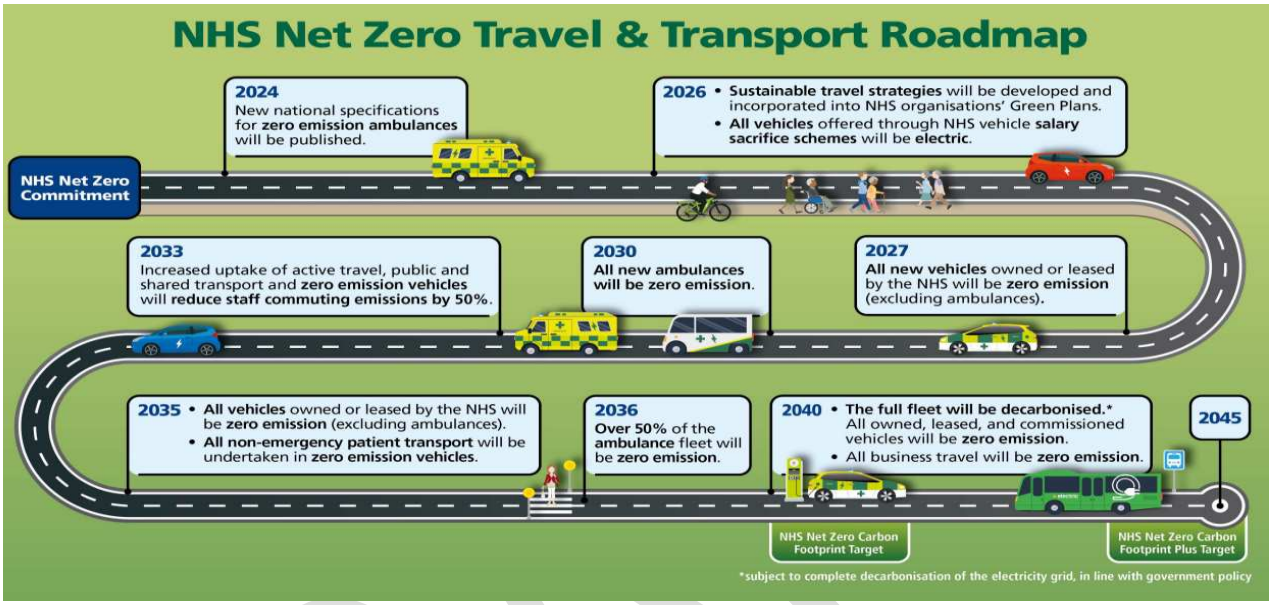
The NHS generates around 3.5% of all journeys in the UK, resulting in a travel-related carbon footprint of 3.5 million tonnes of CO2e every year. SCHT's travel and transport falls into four areas:

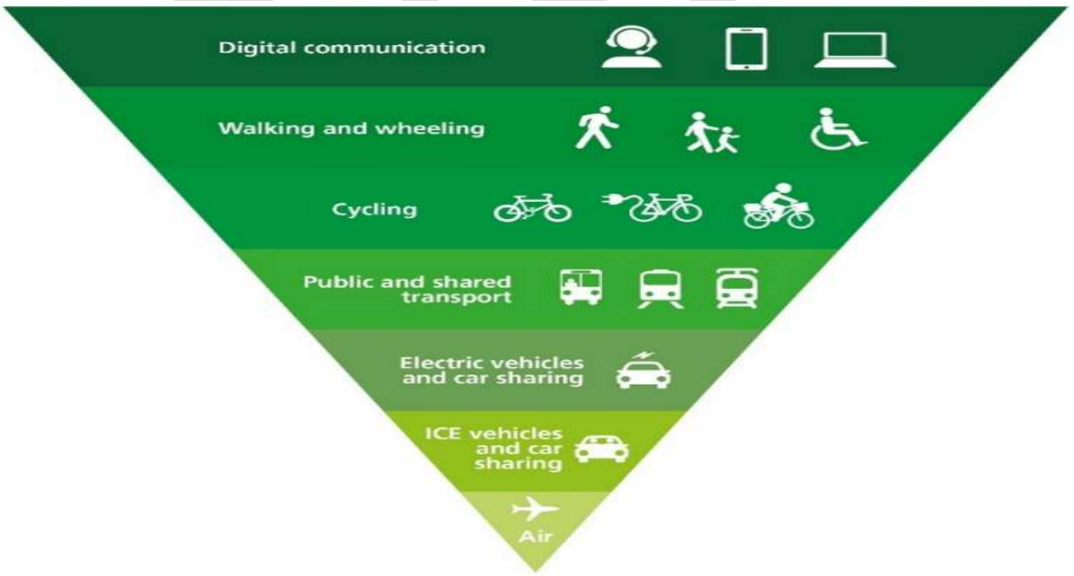
- Staff commuting
- Staff business travel (e.g., between sites, patient visits, meeting travel)
- Patient travel to appointments
- Logistics – supplies delivery

As a community Trust staff business travel is particularly significant and whilst pursuing sustainability, we need to ensure that our staff are well supported with their travel needs. Over the past two years we have made progress in the transition to low carbon travel. In April 2023, the Trust converted its vehicle lease schemes so that all new leases are Low Emission Vehicles (LEV) as we transition to electric or ultra-low emission vehicles only. The Trust's staff salary sacrifice scheme has been extended to cover vehicles recently to assist in promoting environmentally friendly alternatives.

An NHS Net Zero Travel and Transport Strategy was published in October 2023 which provides a clear timeline to achieve the commitments in Delivering a Net Zero National Health Service for travel and transport emissions. The diagram below shows the roadmap from the strategy that we will follow.

To support this transition, SCHT will work with system partners to make all travel more sustainable.





The diagram above shows the sustainable travel hierarchy with the least sustainable mode at the bottom in light green.

During 2025 - 2028 we will:

Develop an integrated sustainable travel strategy that supports staff and follows or exceeds the roadmap set out in the NHS Net Zero Travel Strategy.

Staff commuting and business travel

- Develop and implement a Transport & Travel Policy
- Reduce the impact of motor vehicle travel by encouraging green travel options (e.g. cycles, walking, car sharing, carbon-efficient vehicles, bus fare subsidies)
- Improve guidance to staff on the most sustainable ways to travel
- Maintain and promote the Trust bike trial and cycle scheme and carry out audits on cycle usage
- Instigate a car share database and aim to increase the number of car sharers each year.
- Continue to improve cycle storage as well as shower and changing facilities
- Move faster towards converting existing Trust vehicle leases to electric vehicles
- Work to influence our landlords to install appropriate electric vehicle charging points at our premises
- Explore the use of government buildings such as local Council sites as additional hot desk areas for domiciliary staff so they do not need to return all the way to their base office

Patient Travel

- Explore options to reduce travel to clinics where remote consultation is clinically appropriate.
- Increase the deployment of patient self-care options
- Work with our patient transport provider to:
    - Increase the number of hybrid/electric vehicles used
    - Schedule journeys more efficiently

Logistics

- Review the approach to ordering and logistics to assess whether the number of deliveries can be reduced
- Review suppliers to the Trust to implement “Just In Time” scheduling
- Review own storage arrangements so that the number of deliveries can be optimised
- Ensure sustainability of supplier vehicle fleet is included as part of procurement criteria
- Review the current equipment supply arrangements to increase efficiency and reduce environmental impact

5. Estates and Facilities

The Trust is committed to reducing the environmental impact of all our estate. We have embarked on a programme of energy efficiency and heat decarbonisation in line with national guidance.

We have made significant progress over the last three years including:

- Energy saving schemes, for example, boiler controls and insulation in our freehold estate.

- Solar PV arrays have been installed at three of our Freehold properties, two Community Hospitals and one Health Clinic and have generated over 325,000 kW of electricity consumed internally.

  The graph of the 3 PV arrays across the Trusts freehold estate demonstrates the highs and lows associated with the British seasons.

- Converting lighting to LED (Light Emitting Diode), across both freehold and leasehold properties to move towards 100% LED coverage in the areas we occupy.

We are working with NHS Property Services to better understand their plans and timetable for environmental improvements at our lease sites to ensure they fully support our own plans and targets.

SCHT recognises the value of the natural environment, which plays a key role in our health, improving patient recovery rates and patient experience. We aim to maximise the quality of, and benefits from, our green spaces across our estate but also the beautiful landscape across Shropshire Telford and Wrekin and Dudley.

During 2025 - 2028 we will:

Buildings and Energy

- We will work with others to prepare heat decarbonisation plans for all of our freehold sites with a view to replacing gas boilers with low carbon alternatives when the current heating systems come to the end of their useful life
- Work with experts to enable business cases to be submitted for both internal and external funding.
- Continue to rationalise our estate to improve the built environment whilst reducing utility costs and usage as well as reduce our carbon footprint
- Reduce our electricity usage through energy efficiency measures (excluding uplifts from the installation of heat pumps)
- Reduce our gas usage through electrification of heat for our freehold sites
- Reduce our water usage, whilst not compromising safe water systems.
- Develop a methodology and procedures to provide quarterly updates on utility consumption across our estate, including sites with NHS Property Services.
- Continue to replace standard lighting with LED lights as well as deploy smart lighting controls
- Increase on-site energy generation from renewable resources.
- Install meters and sensors in a “smart building” approach to optimise building energy efficiency

- Work with partners and the NHSE Estates team to develop simplified guidance for community NHS organisations to deliver new build and refurbishments to net-zero standards in line with NHS guidance.
- Inform and educate staff, visitors, and patients about how their actions impact upon energy and water consumption.

Waste

- Review and update our internal waste policies and procedures to embed the new NHS clinical waste strategy and achieve targets by the end of 2026/27
- Continue to improve waste and recycling facilities and signage, including sites managed by others
- Continue to select contracting companies on a range of criteria which includes environmental sustainability, such as ISO-14001 Environmental Management System accreditation for recycling packing materials and offsetting pollution
- Create a list of criteria that we expect from our waste providers, essential and desirable
- Continue to recycle wheelchairs through the Wheelchair Recycling Project and reusing unwanted items of furniture and equipment
- Recycle furniture. SCHT has worked with system partners including Local Authorities to recycle good quality furniture throughout the NHS estate
- Use our purchasing power wisely, working with suppliers to procure products that minimise packaging and offer innovative solutions to waste reduction by ensuring that this is fully integrated in tender processes
- Reduce food waste: develop a sustainable catering policy and only work with suppliers that can deliver our requirements
- Promote a culture of reuse and refurbishment of items, if cost effective, rather than buying new.

Green Spaces

- Consider how green space can be integrated into our working environment for the benefit of patients, their families and colleagues
- Use the green space improvement plans developed with Urban Green to draw up plans for all of our freehold sites
- Promote the health benefits of access to green spaces to staff, patients, and the wider community where possible
- Consider how we might repurpose unused areas to improve green space and biodiversity and create wildflower areas
- Work with staff and local community organisations to provide quality accessible urban green spaces and encourage their use
- Plant trees and ensure biodiversity through introducing ‘wild areas’ for wildflowers and to encourage insects and birds for our staff and communities to enjoy.

6. Medicines

As a community health provider, we do not use any desflurane or other volatile fluorinated anaesthetic gasses. Our dental and podiatry services do use nitrous oxide, however this is bottled and not piped. As a result, we have minimal scope 1 direct emission from anaesthetic gasses.

Our Pharmacy Team has issued guidance to clinicians on low carbon inhaler prescribing, incorporating guidance from the Integrated Care System (ICS). The Team monitors prescribing rates and carbon emissions quarterly.

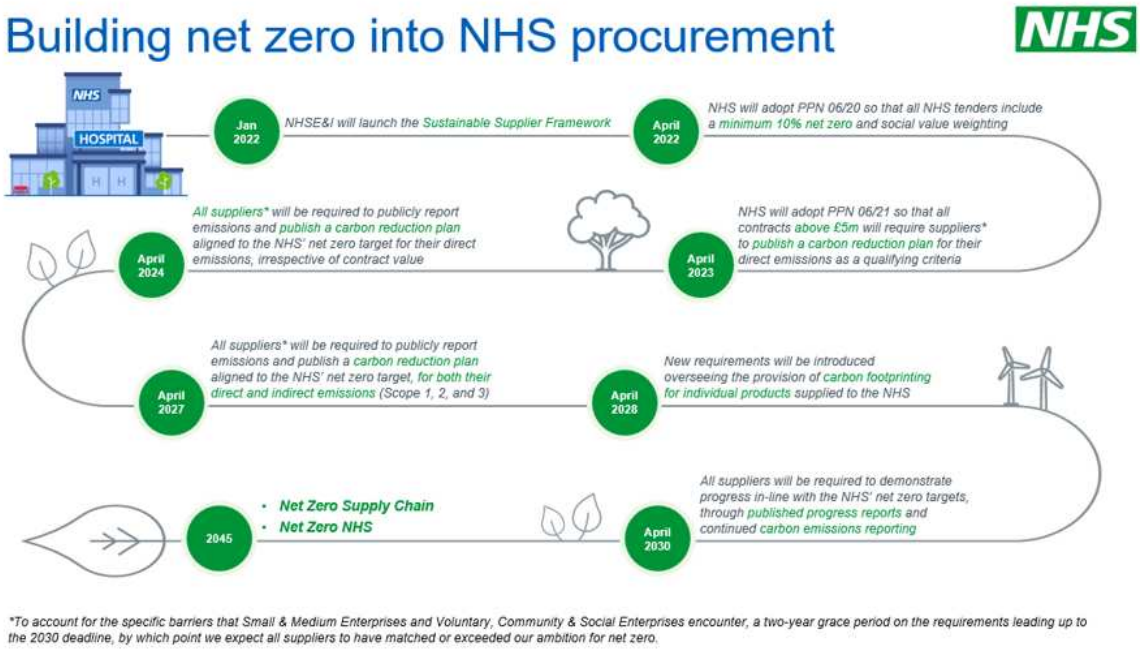
Aside from the inhaler reduction workstream there have been no specific sustainability schemes focussed on medicines in the period of our previous Green Plan.

During 2025 - 2028 we will:

- Support prescribing in line with local ICS medicines formularies. Local formularies promote prescribing of lower carbon emission inhalers where clinically appropriate.
- Continue to monitor and reduce the use of metered dose inhalers (MDIs) and switch to lower carbon alternatives where clinically appropriate.
- Actively promote disposal of all medication at pharmacies and not in domestic waste, including inhalers of all device type, expired, empty or part used and recycling of cardboard packaging. This is also in line with national incentives (NHSE Pharmacy Quality Scheme and Medicines Optimisation opportunities for ICS).
- Ensuring social value weighting applies when considering procurement for any new or renewed contracts
- Work in partnership with ICSs to improve patient care whilst reducing carbon emissions both directly and indirectly e.g. through clinical quality review projects (such as respiratory) or supporting local and national incentive schemes via clinical staff
- Work with pharmacy providers who have embedded sustainable practices as part of their medicines supply services, e.g., waste management systems, use of SMART vehicles for medicines deliveries, streamlining and centralising the number of deliveries of medication to clinical areas. Indirect options for future which may be influenced through medicines provider include reduction of plastic bags and packaging for medicine supply, change to the types of dispensing label offering a biodegradable option
- Use of clinical waste bins to segregate medicines waste for recycling or incineration in clinical areas (cardboard, glass, and plastic)
- Reducing medicines waste more broadly through tackling polypharmacy and overprescribing. E.g. reduce overprescribing of medicines including inhalers through targeted medication reviews, where clinically appropriate.

7. Supply Chain and Procurement

Supply Chain and Procurement represents by far the largest share of the Trust's total carbon footprint (NHS Footprint Plus). Our approach is to align ourselves with the NHS Supplier roadmap launched in September 2021. The roadmap is shown in the graphic below:



Procurement colleagues have been working to standardise the product range across all areas, which supports financial sustainability and will also focus on other key elements such as a requirement for suppliers to deliver Social Value as part of providing their services.

Shropshire Health Procurement Service has a dedicated Carbon Reduction Policy (CRP) that clearly outlines the process for managing CRPs in tenders. This includes the introduction of mandatory questions asking bidders to demonstrate their commitment to Net Zero, which is in 'addition' to the inclusion of a minimum 10% weighting on net zero and social value in NHS procurements tender scoring. This has been a requirement since April 2022.

During 2025 - 2028 we will:

- Continue to implement the NHS supplier procurement roadmap including the requirement that all suppliers (irrespective of contract value) will be required to publish a carbon reduction plan.
- Continue to standardise the Trust's product range whilst accepting exceptions may exists across differing patient cohorts.
- Review and comment upon carbon reduction plans received from suppliers
- Ensure sustainability criteria are included in all supplier tenders. This will be in the main requirements specification and not just in the Social Value section.
- Continue to include sustainability criteria in the 10% Social Value section of tenders and review the responses.
- Proactively review our supplies, medicines, and medical equipment to look for opportunities to reduce packaging and waste (particularly plastic waste).
- Continue to re-deploy medical devices from services where they are not being used to services where they are needed.

8. Food and Nutrition

We provide food services at the premises where we have bedded services. These services are provided by our own catering teams at three of our community hospitals whilst catering at the fourth site is provided by a neighbouring partner organisation.

In all cases the Trust seeks to ensure, through its supplier partnership that:

- Food waste is minimised, including ensuring electronic meal ordering systems are in place
- Food waste, where it does occur, is properly disposed of
- Food options are healthy and balanced and include vegetarian options.

During the course of our new Green Plan we plan to increase our focus on food and nutrition to ensure we comply with all Greener NHS targets

9. Adaptation

Climate change is one of the biggest public health threats and challenges that we face. Extreme weather conditions, such as flooding and heatwaves, are becoming more frequent and severe. This section considers how our organisation's infrastructure, services, procurement, local communities, and colleagues are prepared for the impacts of climate change.

The Trust is part of a wider NHS system that must consider the following risks relating to climate change:

- People/population risks, e.g., changes to disease patterns, changes to the health needs of population, social and community impacts including vulnerable communities, migration, and mental health
- System risks, e.g., resilience to normal ways of protecting health and delivering care, business continuity, workforce and service delivery including training requirements
- Infrastructure risks, e.g., buildings, transport, supply chain, getting to essential services as user or staff, resource use, scarcity and continuity including energy, food and water
- Risks posed by specific event, e.g., heat, cold, floods, air quality.

During 2025 - 2028 we will

- Finalise our Climate Adaptation plan
- Follow NHS policy guidance for climate adaption as it is issued
- Continue to update our extreme weather policy and resilience action plans, including reviewing and updating the Heat Wave Plan
- Improve estates to ensure insulation for cold weather and cooling for hot weather
- Integrate our climate adaptation work with the mainstream estates works programme

6. Monitoring Progress and Reporting

The structure of this document is aligned to that of the Greener NHS guidance. Progress against the objectives will be reported to the Resource and Performance Committee bi-annually and to the Board annually.

As objectives are achieved, they may be replaced by a new objective to ensure continual improvement in our environment and sustainability performance and reflect our ever-changing services. The Trust's Annual Report will provide a summary of sustainability progress and carbon footprint reduction.

7. Communication

We have a large, geographically spread and diverse body of staff. Our approach involves maintaining high quality and regular communications across a variety of channels and continually reviewing and learning from what we do. We will look to implement and maintain a communications plan for all of the requirements that fall under this Strategy and promote a Greener Shropshire Telford and Wrekin and Dudley over the coming months and years.

We understand from staff feedback in our annual corporate services satisfaction survey that it is not always possible to reach all staff via news items on the intranet or via email and we will look at other ways of providing information.

Patient and public communications will primarily be by the Trust website but may also include specific promotional events or posters.

8. Risk

Sustainability risks fall into two categories, the long-term risks relating to the overall progress with our Strategy and our annual programme plan delivery risks. The former are logged on Datix and monitored in line with the Trust risk strategy. The annual programme risks are monitored at a programme level through monthly Trust project reporting.

The following describes the key longer-term delivery risks.

- **Delivery Failure**

  Due to competing priorities for management time, there is a risk that Green/Sustainable targets do not fully deliver our ambitions. We will mitigate this risk by seeking to align the Trust priorities with the Sustainability agenda and ensuring careful review of progress.

  SCHT is reliant upon third parties to deliver elements of this plan. In particular we are reliant on landlords to decarbonise the estate where we hold leases as this forms part of our carbon footprint. To mitigate this risk, we are establishing working groups with our key landlords such as NHS Property Services.

  Another key area of delivery risk is the capacity of our estates team as many of the projects we need to deliver require estates team support and we looking to mitigate this through working more closely with partner organisations.

- **Finance**

  To deliver the commitments in this plan we will need appropriate funding in place. There is a risk that NHS capital allocations will be insufficient to meet our requirements within the timescales set out. To mitigate this risk, we will continue to apply to grant funding sources such as the Public Sector Decarbonisation Fund (PSDS), noting that this is a competitive bid process.

- **Not meeting carbon reduction targets**

  Due to the nature of the Trust's services, our absolute carbon emissions may increase as the intensity of our activities increases and the estate grows. To account for this, we will always normalise assessment emissions. (e.g., per £m revenue, per patient contact, per bed day or per m2)

- **Non-compliance with legislation or contractual requirements**

  Due to the size, scale, rural and complex nature of our organisation, there is a risk we may not comply with all legislation. We will mitigate this risk through systems, training, and auditing of activities against the relevant requirements.

- **Climate change**

  The risks to the organisation from climate change will be outlined in our Climate Change Adaptation Plan. These include risks to buildings, staff, health and wellbeing. Maintaining and delivering our plan is vital to address these risks.

- **Reputation**

  Our reputation for Sustainability is paramount to our performance. We remain committed to taking a lead in this area and delivering our Plan monitored through a robust reporting structure.

9. Finance

Effectively managing environmental performance can bring financial benefits. Energy, carbon, and transport costs are rising and there are a number of ways we can manage the impact of this. The Trust's approach to funding its Green Plan will partly be by realising cost savings from:

- Driving down utility and waste costs by procuring more efficiently, investing in metering and monitoring to identify opportunities to reduce consumption
- Managing the way, we use energy and water on site – educating staff on best practice and quickly responding to issues such as leaks and overheating.

However, it is recognised that in some circumstances, we will deploy solutions that will not deliver a short-term financial return on investment. For example, the installation of heat pumps to replace gas boilers is likely to have a very long period of pay back, however these investments are necessary due to the requirements for sustainability and their overall value for money from creating a healthier environment for our communities.

Shropshire Community Health NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**2 October 2025**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	26 September 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 on actions being taken to address identified control / assurance gaps
- The risk in relation to quality team capacity has been reduced as the vacancies have been recruited to and the risk has met its target risk rating and is therefore recommended for closure
- The risk in relation to internal governance and operational oversight arrangements for system programmes has been reduced following discussion at the Resource and Performance Committee

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	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	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	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	-	-	-	CLOSED	4
3.2	Quality Team Capacity	Oct 24	-	-	12	12	12	12	12	12	12	12	12	12	4	↓	4
3.3	Completion of actions linked to learning response	May 25	-	-	-	-	-	-	-	-	-	12	12	12	12	↔	4
3.4	Demand exceeds capacity	Apr 22	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	15	15	15	15	15	15	15	15	15	15	15	↔	10
4.2	Internal governance and operational oversight	Sep 23	15	15	15	15	15	15	15	15	15	15	15	15	9	↓	5

Board Assurance Framework

	arrangements for system programmes																
4.1	Operational capacity to undertake all programmes of work	Sep 23	20	15	15	15	15	15	15	15	15	15	15	15	15	↔	10
4.2	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	15	15	15	15	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	12	12	12	12	12	12	12	12	12	12	12	12	↔	8
5.3	Costs exceed plan	Apr 22	12	12	12	12	12	12	12	12	16	16	16	16	16	↔	6
5.4	Insufficient capital funding	Sep 24	-	9	9	9	9	9	9	9	9	9	9	-	-	CLOSED	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: September 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: September 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

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2	Scoping of collaborative working options	Director HR and OD	~~June 2025~~ Sept 2025	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

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: September 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	Has been presented to Executive Team with ongoing discussion regarding next steps

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: September 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:

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

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Review of management of change policy	Director of HR	~~July 2025~~ Sept 2025	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: September 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 have been agreed by the People Committee and going to October Board for final approval

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: September 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 further training being rolled out
- 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 **RECOMMENDED FOR CLOSURE**

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	1↓	1
Total	16	12↓	4

Risk Details:

Opened:	October 2024
Reviewed Date:	September 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:

- ~~N/A~~

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	2↓	1
Total	16	8↓	4

Risk Details:

Opened: May 2025

Reviewed Date: September 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
- ✓ Quarterly board oversight report

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:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Further PSIRF training to be rolled out	Director of Governance / Director of Nursing	Oct 2025	Learning needs analysis updated with costings and went to Patient Safety Committee in Septemberand approved .- action to be closed
C3	No of trained staff to be increased	Director of Goverannce / Director of Nursing	Jan 2026	Dates being arranged with provider and nominations for the training being sought

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
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	Policy complete and Harms proforma added to RiO. Training not required – forms self-explanatory with harm definitions in place.
C2	Audit to be undertaken to assess consistency and identify areas for training	Director of Operations / Director of Governance / Director of Nursing	~~Sept 2025~~ Dec 25	Monthly reporting from RiO to assess numbers of harm proformas being completed by service area.
A1	Director of Governance and Director of Nursing to review reporting and tracking	Director of Governance and Director of Nursing	~~Sept 2025~~ Dec 25	KPIs been agreed at QSC and Board – awaiting team to adjust reporting from Q3

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:	September 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	Complete and now business as usual in teams that are utilising temporary staff
C3	Explore options of third party NHS bank staff provider	Director of HR	Sept 2025	Exploring with NHSP
C3	Implementation of ETOC programme	Director of Nursing	Oct 2025	Improvement plan in place with national support – complete.
C3	Targeted recruitment campaigns for HCAs	Director of HR	Dec 2025	

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: September 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 of change completed and to continue due to success
- Re-sequencing of Directory of Services enacted to re-direct flow away from EDs
- Active partners with ICB in neighbourhood model, leading on the MDT workstream
- Investment in expansion of Community UEC services secured, eg RR to midnight, CTH and integrated front door

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: September 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	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 - completed

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

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

System programmes are taken through system governance and don't have links into the Trust's governance and operational oversight arrangements, potential for risks to not be identified and mitigated from a Trust perspective when SROs sit outside of the organisation

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	3↓	5
Likelihood	4	3	1
Total	20	9	5

Risk Details:

Opened:	September 2023
Reviewed Date:	September 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:

- C2: Alignment of risk management across the system

Gaps in Assurance:

- A2: Alignment of risk management across the system

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C2/A2	Amendment to Risk Management Strategy to include the management of system risk	Director of Governance	December 2025	Meeting with governance leads in the system has taken place and Chief Business Officer for ICB is drafting a proposal for consideration

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: September 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

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: September 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:

- C3: New standards require assessment and revision to systems and processes to ensure compliance
- C4: Gaps with clinical coding impacting on DSPT compliance

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C3	Full DSPT compliance to be achieved	Director of Governance	~~June 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:	September 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:

- C3: Exploring opportunities to share expertise with system partners

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Digital workstream for shared services to be progressed	Director of Finance	March 2026	Project initiation document has been completed and reporting for workstream is being overseen by Shared Services Group

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: September 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

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	Update has been provided to Execs, plan in place to bring this back on track, discussions are underway with Unions
A1	Review of National Oversight Framework	Director of Finance	September 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. Completed

Shropshire Community Health
NHS Trust

SCHT Winter Plan 2025/26
0. Reference Information

Author:	**Gemma McIver** – Deputy Director of Operations	**Paper date:**	3/10/2025
Executive Sponsor:	**Claire Horsfield** Director of Operations & Chief AHP	**Paper written on:**	27/08/2025
Paper Reviewed by:	**Executive Team Meeting 26/8/25** **Public Board 4/9/25** **Quality & Safety Committee 25/9/25**	**Paper Category:**	Strategic
Forum submitted to:	Public Board	**Paper FOIA Status:**	

1. Purpose of Paper

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

This paper provides the Board with the Trust's Winter Plan for 2025/26 for information and assurance.

NHSE have requested that for 2025/26 all ICB & Provider Boards formally approve a Board Assurance Statement this is included within the conclusion of the plan

2. Executive Summary

- The SCHT Winter Plan aims to ensure resilient, high-quality care during winter 2025/26 through careful planning, increased service capacity, and robust leadership.
- Priorities include high vaccination uptake (Flu and COVID-19), strong infection prevention and control, demand management, discharge profiling, use of data to support decision making and Trust wide dedicated planning to proactively prepare for winter pressures.
- Director of Operations & Chief AHP will act as the required Trust designated Winter Director.
- Operational planning will use real-time data monitoring and stress-testing to respond to increased demand both internally and at a system level.
- Detailed learning from 2024/25 has been included to evidence how past experiences have informed current planning and confirm readiness for winter pressures across all divisions and key corporate areas.
- To meet NHSE timelines the plan gained full assurance at Private Board in September, pending Regional NHSE Winter Assurance Visit (4/9/25) and Winter Exercise Testing (17/9/25). These have since occurred and positive feedback upon the plan received.
- In addition, the plan and approved QEIA were received by Quality & Safety Committee on 25/9/25 where ongoing oversight of effectiveness and learning will occur to feed into next years plan

2.3 Conclusion

The Board is asked to

- **accept** the report as information of resilient winter planning against the guidelines

Shropshire Community Health Trust (SCHT): Winter Plan 2025/26

3.1 Purpose

The National Director of Urgent and Emergency Care & Operations from NHSE wrote to Chairs & CEOs on 14th July to ask for Board assurance on this year's winter plans: "While NHS England does not need the detail, we do need assurance that your Board has robustly tested the key lines of enquiry to make sure patients can access the care they need this winter." Both ICBs and Trusts are required to submit Board Assurance Statements to NHSE national team by 30th September.

This Winter Plan sets out SCHT's approach to managing anticipated pressures for the 2025/26 winter season. It aims to ensure high-quality, resilient care for our communities through proactive prevention, robust data-led planning, decisive leadership, and operational preparedness. The plan describes the Trust's strategy to increase capacity in affected services, support staff, and enhance patient care while ensuring quality and safety. It focuses on reducing winter-related risks, particularly for SCHT as a community healthcare provider in both urban and rural areas.

3.2 National Winter 2025/26 – Expectations for Planning, Preparedness, and Assurance

3.2.1 SCHT will deliver against NHS England's priorities, as outlined in the Board Assurance Statements and communications from NHSE in June and July 2025:

- **Vaccination Coverage:** Ensure high uptake of flu and COVID-19 vaccines among staff and all eligible groups: children, adults (18–64 years at risk), and those aged 65 and over.
- **Infection Prevention and Control (IPC):** Demonstrate outbreak management, IPC surge capacity, and system-wide workforce resilience. Incorporate lessons from previous winters, especially RSV and Norovirus management.
- **Leadership and Governance:** Appoint a named Winter Director (Director-level) to coordinate planning and assurance efforts.
- **Operational Planning and Data:** Provide clear data trajectories on demand, capacity, vaccination rates, IPC, and workforce resilience. Stress-test plans with winter exercises and surge scenarios (August/September).
- **Board Assurance:** Boards must evidence how previous learning informs current plans, manage risk amid system changes, and confirm readiness for anticipated pressures.

3.2.2 The NHS 10-year plan (published July 3rd 2025) has also included a focus on winter resilience. The plan specifically references enhancing Rapid Response services in time for Winter and locally this is a fundamental element to this year's plan. Aligning to the NHS 10 year position the system wide aim for 25/26 winter readiness is to migrate and avoid care from within the acute hospitals to the community to better manage winter pressures wherever clinically possible.

3.3 Maintaining Quality and Safety

SCHT faces increased winter risks, including spikes in respiratory illnesses, rural access barriers, staff shortages, and supply chain pressures. Proactive measures and a comprehensive Quality Equality Impact Assessments (QEIA) underpin the 25/26 plan, ensuring interventions protect high-risk groups and maintain care quality throughout the season.

3.4 Governance and Assurance Framework

3.4.1 Board Assurance: The requirements for Board Assurance are outlined in the Board Assurance Statement. This is included within the conclusion of the Winter Plan and cross referenced to enable full Board level assurance that SCHT have a robust plan in place for delivery, resilience and Winter readiness. The plan will therefore cross reference each of the below standards.

- Governance
- Plan content and delivery
- Prevention
- Capacity

3.4.2 Oversight of the plan: The Winter Plan will be submitted to the Quality and Safety Committee for assurance and review. Typically, this process occurs prior to consideration by the Trust Board however given time frames for Board Assurance to be provided to NHSE by mid-September this year this can not be achieved.

The evaluation of the 24/25 Winter Plan effectiveness was presented to the Quality & Safety Committee (Q&S) in May, enabling the committee to triangulate findings, track lessons learned, and embed improvements into future planning. This approach has been integral in the writing of the 25/26 plan as it has ensured that the lessons from 24/25 can aid decision-making, and learning is systematically reviewed and integrated, driving continuous enhancement of our approach to winter planning and resilience as a Trust for 25/26.

3.4.3 System input: In alignment with its commitment to collaborative system working, the intentions of SCHT's Winter Plan has been co-designed and actively shared with system partners through the Urgent and Emergency Care (UEC) Delivery Group. This process ensures that Executive oversight is embedded at the system level, fostering shared responsibility and transparency across all stakeholders. Executive oversight via the UEC Delivery Group further bolsters assurance mechanisms, allowing for coordinated responses to emerging risks and supporting seamless integration of operational practices throughout the winter period.

3.4.4 Accountable Winter Executive: The Trust has identified the Director of Operations and Chief AHP as the Executive accountable for the winter period. The core responsibilities of this role will include overseeing planning and delivery, monitoring impact and risks, ensuring effective communication and decision-making, and maintaining Board assurance on the Trust's readiness and resilience throughout the season.

3.5 Surge readiness and pressure mitigation.

3.5.1 OPEL utilisation: A key tool underpinning our surge readiness is the use of OPEL (Operational Pressures Escalation Levels) scores. These scores are used across the system and monitored to assess pressures across essential acute and community services, providing an objective framework for triggering escalation protocols when thresholds are met. The OPEL framework enables early identification of emerging risks, facilitates proactive deployment of resources, and supports transparent communication between operational teams and leadership at both a local and system level.

By embedding OPEL monitoring into daily huddles and decision-making, the Trust ensures that responses to fluctuating demand remain timely, proportionate, and evidence-driven. This structured use of OPEL scores enhances cross-system coordination which is overseen by the SCC (System Control Centre) and supports rapid recovery actions.

3.5.2 Escalation process: As a Trust SCHT feed directly into the SCC Operational, Tactical, and Strategic Command process during periods of escalation which is determined through OPEL levels. This provides a familiar, clear and structured framework for governance and resilience at a system level all year round but is utilised more readily in Winter when pressures arise.

Table 1 below outlines the hierarchy of decision-making, communication, and responsibility across the Trust at each trigger within OPEL. This is further complimented by a range of escalation cards. The escalation cards serve as rapid reference tools used at service level, specifying roles, responsibilities, and mandatory responses tailored to each stage of pressure or risk. The use of the cards has been stress tested and forms the backbone of the Trust's winter resilience. The cards along with Business Continuity Plans are familiar to operational teams who use them daily and stress test them annually as part of system readiness.

3.5.3 Proactive demand management Locally the demand profiles have been aligned to OPEL to ensure that there is a coordinated and joined up approach to pressures both internally and locally. Table 2 shows a breakdown of data aligned to each element of the demand profiles for both community and acute, as depending on where pressures are presenting will align to our internal responses. Each operational metric acts as a vital early warning signal, reflecting the real-time pressures experienced across the Trust's acute and community settings. By closely monitoring indicators such as staffing levels, bed occupancy, ambulance arrivals, flow rates, and patient acuity, operational teams can proactively identify emerging stress points that may precede a surge in demand. This granular surveillance supports timely interventions—enabling the Trust to deploy resources, adjust workflows, and implement preventative measures before pressures escalate further. Importantly, these metrics do not operate in isolation; rather, they are aggregated and systematically assessed to generate the OPEL score and response

High level actions have been provided however it is important to note that these are further strengthened and underpinned through the escalation action cards that all teams have access to.

Table 1 – Response to OPEL

Command Structure	OPEL Level	Demand Level	Meetings	Responsibilities	Required decision makers in hours	Required decision makers out of hours
Operational Command	1	Baseline demand	**Operational** level forums/calls: Care Transfer Hub call, operational leadership huddle, Site Safety Meetings.	Implementing policies and procedures at service level, managing resources, and responding to immediate issues as they arise.	Clinical Service Managers Operational Service Leads	Senior Manager On-Call
Tactical Command	2-3	Moderate Demand	**Tactical** system calls implemented by SCC	Analyse data, coordinate interventions, and deploy resources to meet evolving challenges, overseeing surge responses and mitigation strategies, forward planning.	Clinical Divisional Managers and/or Deputy Director of Operations	Senior Manager On Call & Director On Call
Strategic Command	4 Critical Incident	Extreme Demand	**Strategic** command calls implemented by SCC	Sets the vision and priorities for the organisation whilst in surge/pressure formulating policy, making major decisions, and ensuring long-term resilience and compliance with regulatory standards. Strategic command provides oversight and assurance, enabling the organisation to anticipate risks and allocate resources accordingly.	Director of Operations and Chief AHP Director of Nursing and Clinical Delivery CEO	Senior Manager On Call & Director On Call Other senior managers as required

Table 2 – Demand Management through OPEL

	SCHT	SaTH	Agreed high level actions
Baseline Demand	• Community Bed Occupancy >85-92% • No longer meeting criteria to reside >5-15% • Virtual Ward Occupancy >80-90% • Community nursing caseload v's scheduled (percentage) >85-95% or >100-105% • Intermediate care contacts vs scheduled (percentage) >85-95% or >100-105% • UCR 2-Hour response (percentage) >70-80%	• Average ambulance handover since midnight (minutes) 15-30mins • Current 4-hour ED performance percentage (percentage) >78-95% • Current ED majors and resus occupancy (percentage) >80-90% • Current median time to treatment since midnight (minutes) >60-120 minutes • Patients in ED over 12 hours (percentage) >2-5% • Patients in ED referred to service (percentage) >2-5% • Bed occupancy (percentage) >85-92% • Patients no longer meeting Criteria to Reside (percentage) 10-15% • Patients discharged (percentage) >20-30% • Beds closed due to infection prevention control (percentage) >0.5-2.5%	• Ensure key workforce in place across all core services • Business as usual actions • Standard processes in place to support daily rhythm of flow including Care Transfer Hub (CTH) calls and Community No Criteria to Reside Senior Review. Routine escalation of any delays across CTH, Community Hospitals, Rapid Response and Virtual Ward • Attendance at SaTH site calls and long stay meetings • Utilise all opportunities for rehabilitation in own homes and Virtual Ward. • Ensure all patients have an Expected Date of Discharge (EDD) in Community Hospitals and TOC (Transfer of Care) completion is within 24 hours across Acute and Community settings. • Identify patients for discharge tomorrow or later in week (including weekend discharge planning) in community, Virtual Ward and acute settings through CTH escalate any low activity re discharges to understand impact on flow. • Early identification of patients across community and acute settings to community Interdisciplinary Teams, discharge support teams to identify those suitable for move to social care/ care home or home. • Identify early, any rising issues which could affect an upward trend in escalation level – escalate as appropriate.
Moderate Demand	• Community Bed Occupancy >92-98% • No longer meeting criteria to reside >15- 25%%	• Average ambulance handover since midnight (minutes) 30-60mins	• Identify where community teams have capacity, prioritising supported discharge over routine patient need • Caseload reviews of Virtual Ward to create additional flow • Additional support at any extraordinary patient long stay meetings within acute

	• Virtual Ward Occupancy >90-95% • Community nursing caseload vs scheduled (percentage) >75-85% or >105-110% • intermediate care contacts vs scheduled (percentage) >75-85% or >105-110% • UCR 2-Hour response (percentage) >60-70%	• Current 4-hour ED performance percentage (percentage) >60-78% • Current ED majors and resus occupancy (percentage) >90-100% • Current median time to treatment since midnight (minutes) >120-240 minutes • patients in ED over 12 hours (percentage) >5-10% • Patients in ED referred to service (percentage) >5-8% • Bed occupancy (percentage) >92-98% • Patients no longer meeting Criteria to Reside (percentage) 15-20% • Patients discharged (percentage) >10-20% • Beds closed due to infection prevention control (percentage) >2.5 -5 %	• Full senior review of every patient across Community Hospitals • Review demand for any additional escalation beds • Flex Community Hospital admission criteria; discuss with SaTH on an individual patient basis for appropriate transfer for discharge or admission avoidance. • Flex, where safe, admission times to Community Hospitals on a case by case basis • Inform relevant Senior managers to request help in NCTR avoidance. • Communicate current position to relevant Senior Leads, Locality Managers, Corporate Teams, Ward Managers, Duty Manager & Director On Call to support with managing any increasing demands. • Expedite discharges/transfers of care with internal and external partners. Ensure early booking of transport to prevent delays. • In Community Hospitals support to safely and comfortably sit patients out due for discharge same day to enable early transfer of patients.
Extreme Demand	• Community Bed Occupancy >98% (All additional beds open) • No longer meeting criteria to reside >25% • Virtual Ward Occupancy >95% • Community nursing caseload vs scheduled (percentage) ≤75% or >110%	• Average ambulance handover since midnight (minutes) >60mins • Current 4-hour ED performance percentage (percentage) <60% • Current ED majors and resus occupancy (percentage) >100% • Current median time to treatment since midnight (minutes) >240 minutes	• Communicate position urgently to dedicated Winter Executive Lead. • All non-essential meetings and training to be stood down to maximise available clinical staff • Ensure staffing is adequate with appropriate skill mix to manage situation – Consider Bank & Agency where necessary. Move staff to critical areas of service delivery as per business continuity • Relevant local service Business Continuity Plans initiated where appropriate. • All routine patient visits stood down and where clinically safe community staff redeployed to support community UEC pathways

	• Intermediate care contacts vs scheduled (percentage) ≤75% or >110% • UCR 2-Hour response (percentage) ≤60%	• patients in ED over 12 hours (percentage) >10% • Patients in ED referred to service (percentage) >8% • Bed occupancy (percentage) >98% • Patients no longer meeting Criteria to Reside (percentage) >20% • Patients discharged (percentage) <10% • Beds closed due to infection prevention control (percentage) >5 %	• Consider releasing clinical staff from corporate teams and other services to support community and community hospitals e.g. IPC, Diabetes Nurses, Quality Team and Clinical Education • Case by case review of acute IV patients for care in community settings and Virtual Ward • Consider enhanced deployment of SCHT bank HCAs to support gaps in domiciliary care provision • Consider extending MIU hours and Xray provision if a clear benefit to managing system demand • Redeploy Care Home MDT to support early discharge of any care home patients in community or acute hospitals. • Enhanced clinical in reach (therapies) to support a full discharge to assess model

3.6 EPRR (Emergency Preparedness, Resilience and Response)

3.6.1 System-Wide Exercises Throughout the year at Trust and system level multi-disciplinary teams have conducted scenario-based planning to test the system and organisations responsiveness against a range of winter hazards, with a particular focus on respiratory surges, workforce shortfalls, and supply chain interruptions. This learning and testing have enabled Business Continuity Plans to be strengthened and operational confidence in delivery. The Trust is leading on organisational testing in relation to the National Tier 1 exercise PEGASUS on pandemic outbreak management scheduled for September, October and November with further revision of Trust arrangements following earlier exercising this year (SOLARUS AND TANGRA).

The Trust has also undertaken some place-based winter exercising with services in Dudley and as a result, has strengthened collaboration with West Midlands Local Resilience Forum and Dudley ICB, for best intelligence and reporting.

There was a regionally-led winter exercise on 17th September with both internal and external follow up events 19th/20th September in place to review outcomes of the exercise and further incorporate any lessons learnt into internal business continuity plans.

Throughout periods of extreme weather conditions in 24/25, at both system and organisational level, debriefs have taken place and provided valuable insights that have further strengthened future responses and forward planning. The main elements that are vital when managing a winter hazard that will be enacted as part of operational delivery, preparedness and readiness are

- **Timely Communication**: Rapid information sharing between teams is critical. Delays in relaying weather warnings or operational updates can hamper response efforts.
- **Resource Flexibility**: The need for adaptable workforce deployment and flexible resource allocation becomes apparent during surges, enabling swift adaptation to changing conditions – escalation cards support with this, and redeployment plans/mutual aid access is built into all teams' Business Continuity Plans.
- **Enhanced Surveillance and Data Use**: Real-time monitoring of key metrics (such as admissions, staff availability, community scheduled visits and bed status) supports proactive decision-making and rapid mobilisation of resources.
  Enhanced monitoring of the Met Office Hazard Manager system, Environment Agency Flood Alerts and River Flood alerts, use of the NHS England Adverse Weather Toolkit and collaboration with County Council colleagues to produce a Rapid Catchment Flood action card to proactively support rural community service delivery.
- **Collaborative Working**: Multi-agency debriefs reinforce the importance of joined-up working with system partners, providing a holistic overview and coordinated response to wide-scale disruptions.
- **Staff Welfare and Resilience**: Prioritising staff wellbeing by ensuring rest periods, support mechanisms, and safe working environments has helped to maintain operational effectiveness during extended periods of strain.
- **Clear Communication with the Public**: Transparent, accessible updates to patients and the public manage expectations and reduce anxiety during periods of uncertainty. The Senior Leadership/Director On-Call Team have completed a refresh in media training during August to support incident response and this will potentially be valuable working through winter challenges.
- A robust hot spot map has been developed working with neighbourhoods to understand areas of vulnerability and challenged access in times of snow or flooding

this is then used to support forward planning and to align with fire and rescue and other emergency services if needed to gain vital access and maintain those most at risk in the communities during extreme weather conditions.

- Community Nursing and Children's Teams have applied an alert to vulnerable individuals on RiO so that in times of extreme conditions or pressures on a service a clinical prioritisation and risk tool can be applied to support vital interventions and manage any access delays. This has been rigorously tested in Exercise TOLLARD in 2025.

3.6.2 Monitoring Weather conditions this is proactively monitored using guidance and alert systems provided by the Met Office. Real-time notifications of adverse weather—such as snow, flooding, or high winds—are disseminated directly to operational teams and leadership via secure channels and huddles arranged if required. These alerts are integrated into daily briefings and response protocols, enabling rapid evaluation of potential impacts and timely escalation when thresholds are met. As soon as a Met Office alert is issued, business continuity plans as required are initiated in readiness checks, review vulnerable areas highlighted in the hot spot map, and coordinate with community partners to ensure that critical services remain accessible. This process ensures a swift, informed response to evolving risks and reinforces overall system resilience during periods of severe weather.

The Trust has developed and tested a 'support desk' approach in extreme weather which reviews weather and travel data, transport partners capabilities and tries to triage requests for 4x4 vehicles to a minimum. 4x4 vehicle support is then allocated via response partners capabilities with the assurance that only urgent requests which cannot be addressed another way, are processed.

3.6.3 Industrial action When facing potential industrial action, the approach will centre on maintaining operational stability, ensuring patient safety, and prioritising transparent communication with all stakeholders. Proactive scenario planning will be leveraged to anticipate areas most at risk, using real-time surveillance tools and hot spot mapping to support service continuity. Collaborative multi-agency working will play a critical role, drawing on mutual aid agreements and redeployment plans embedded in business continuity strategies to mitigate disruptions from workforce shortfalls. Much of this has been successfully stress tested throughout 24/25. Clear communication channels will be established both internally and with the public, addressing concerns and managing expectations throughout periods of industrial action. SCHT will approach this where appropriate through system partners and the ICB. Senior leadership will provide visible oversight, enact defined escalation protocols and ensure that critical services are prioritised, while lessons learnt from previous challenges inform a structured, responsive approach.

The Trust is active in the EPRR Risk structures and regularly reports back on any proactive intelligence on potential industrial action. Using the statutory pre-ballot window to plan the response with partner agencies.

3.7 Lessons Learnt from 2024/25

3.7.1 Action following 24/25: An evaluation of winter planning and operational effectiveness was conducted and formally shared with Quality and Safety Committee in May, ensuring oversight and continuous improvement was embedded into 25/26.

A key finding from 24/25 was as a system there remains an overreliance on bedded capacity which does not provide the best patient pathways and is not conducive to the requirements of the 10-year plan. In addition to this the utilisation of Temporary Escalation Spaces (TES)

highlighted logistical challenges, prompting the establishment of a clear TES Standard Operating Procedure (SOP) for future emergencies, in line with NHSE guidance, and a wide acknowledgment from the system that a move away from bedding in unconventional areas cannot be a reliance and should be mitigated as much as possible for 25/26.

Evaluations at Trust Level and System Level through the Urgent Care Delivery Board further evidenced robust initiatives such as senior clinical in reach, Virtual Ward, Rapid Response overperformance, and Care Transfer Hub strengthened system resilience for 24/25.

The expansion in proven community-based solutions tested last year throughout Winter to improve sustainability, performance, safety, quality, and readiness for winter is being led by SCHT under the UEC improvement workstream maximising community UEC pathways.

Evaluation of last year's plan and winter impact at Trust level evidenced improved elective care, financial delivery against the CIP (Cost Improvement Programmes) and children's services even under pressure. To build further upon this success for 25/26 dedicated leadership will remain at the forefront of each division, with a strong focus on managing clear roles and responsibilities across all teams. Senior leaders will provide visible oversight, supported by defined escalation protocols, to guarantee that safe core business is preserved even when winter presents pressures. This will be key to avoid duplication and ensure a structured response to UEC surge as outlined in the OPEL and command protocols above.

3.8 Workforce Delivery Model

3.8.1 Workforce management support: SCHT will deploy dynamic rostering through use of e-roster, cross-training, escalation policies, and wellbeing initiatives to maintain staff resilience throughout the winter periods. The Agency Scrutiny Panel and Workforce Team will oversee agency and temporary staffing, prioritise recruitment, and support retention and redeployment as needed. Vacancy 'hotspots' are identified monthly and prioritised to support timely recruitment to posts will continue. Targeted recruitment events are held where 'hard to recruit' vacancies are identified and throughout the summer this has targeted areas required to be 'winter ready.'

3.8.2 Wellbeing Support and Absence Management

The Trust has in place a Health and Wellbeing (H&WB) action plan which has been developed by undertaking an assessment of our Staff Survey results, our H&WB survey results and our sickness absence data. The actions identified support our workforce to remain well, focussing on preventative measures and/or recovery to stay in and/or return to work.

There is a robust sickness absence management policy to guide managers in how to support and manage staff experiencing ill health and/or periods of sickness absence; this is in addition to the requirement for line managers to hold an annual wellbeing conversation with their staff.

The Trust has a wide range of health and wellbeing support available to individuals which is advertised regularly through wellbeing bulletins and on Staff Zone. Each year, the Occupational Health and Wellbeing Team, and People Team run health and wellbeing days across multiple Trust locations.

Absences can rise during winter, so strategies must be in place to ensure adequate cover and staff wellbeing. Business Continuity Planning has addressed staffing absences across all clinical teams to the 30% planning assumptions within the National Risk Register Annex B. These planning assumptions, when aligned to Business Impact Assessments, ensure that services can operate at pre-determined acceptable levels, during a staffing disruption. Plans also

articulate staffing alliances and skill mixes, so that when further resources are required, they are the most suitable staffing solutions for the service.

3.9. Workforce Flu Vaccinations

3.9.1 Encouraging uptake As a Trust we strongly encourage all staff and volunteers to have the Flu vaccine. To support in delivering the campaign for 25/26, a survey was launched in July relating directly to Flu vaccination. The information gathered will be invaluable in shaping this year's campaign to ensure that everyone who wishes to receive a Flu vaccination can do so.

Following lessons learnt from 24/25 the Occupational Health Team will schedule an increased number of Health and Wellbeing days to promote vaccine uptake as well as increasing the number of drop-in clinics across STW and Dudley. There will also be a number of 'Know your Numbers' events during the flu vaccine campaign to try and offer an incentive and educate individuals on the importance of flu vaccination. Vaccines will be available across 18 different SCHT bases to support easy accessibility across all workforce groups and this will also be supported by a number of peer vaccinators. Covid and Flu vaccines are overseen by the Director of Nursing/Director for Infection Prevention & Control at IPC Committee and at People Committee

3.9.2 Target In 24/25 780 staff were vaccinated (51% of all frontline staff and 52% of all staff). The internal vaccination plan for staff this year has built a trajectory, target and milestone plan to achieve 60% of all staff vaccinated. This exceeds the ask from NHSE of a 5% improvement from 24/25.

3.10 Public Health Vaccination

3.10.1 Community Vaccination Operational Plan: The threat of COVID-19 remains present, particularly with the potential for seasonal surges and the emergence of new variants. The below outlines a high-level strategy for COVID-19 vaccinations, focusing on protecting vulnerable populations, maintaining healthcare system resilience, and supporting community well-being.

The announced and authorised cohorts eligible for a COVID-19 vaccine in Autumn/Winter 2025 are:

- Residents in a care home for older adults
- All adults aged 75 years and over
- Persons aged 6 months and over who are immunosuppressed

The vaccines that will be supplied by NHSE for the Autumn/Winter programme are the Pfizer-BioNTech mRNA (Comirnaty) vaccines.

There is good site coverage across Shropshire Telford & Wrekin through pharmacy and primary care. In areas where there is insufficient capacity Shropshire Community Health Trust lead upon the delivery of satellite or pop-up clinics.

Where the Trust are administering vaccine we will offer a mix of appointment-based and walk-in options to maximise accessibility. Extended hours, weekend availability, and flexible scheduling for those with work or caregiving responsibilities will be available.

The COVID-19 programme will run from 1st October 2025 to 31st January 2026. However, most COVID-19 vaccinations are aimed to be completed by 19th December 2025 in line with NHSE guidance. The winter vaccination plan is to vaccinate a minimum of 8,500 people during this campaign throughout STW.

3.11 Infection Prevention and Control (IPC)

3.11.1 IPC workforce: The IPC Team now known as the Infection Prevention Education and Advisory Team (IPEAT) have been strengthened with the addition of 1 WTE Band 6 Infection Prevention Nurse to allow for prompt response, and early advice and guidance to seasonal infection surges.

3.11.2 Mask Wearing and FIT testing: The Deputy Director for IPC will review and update the Trust wide mask wearing risk assessment in September, this will be approved by Director of Nursing/Director for Infection Prevention & Control at IPC Committee, then cascaded to all clinical and non-clinical staff ready for Winter. Targeted fit testing training has taken place throughout the summer for all relevant staff groups particularly targeting Dental, MIU's UCR and Virtual Ward due to lower compliance rates last year. Fit testing training is recorded on spreadsheets and accessible at divisional level. All relevant PPE stock and flow is in place for periods of high demand.

3.11.3 IPC Campaign: IPEAT will launch their winter campaign, *Protecting Patients Starts with You – Be Winter Ready*, across our Community Hospitals, following the NHS England winter planning letter. The campaign focuses on strengthening outbreak management and ensuring teams are well-prepared for the challenges of the winter season.

All teams will receive the correct outbreak documentation to support consistent and efficient reporting across sites and early escalation. To build confidence in managing outbreaks, IPEAT will deliver realistic scenario-based training based on previous experiences. The campaign will also include guidance on when staff should avoid coming into work and respiratory testing protocols for both patients and staff. The team will also promote good respiratory hygiene among staff and help educate patients on best practices.

A dedicated MS Teams channel between IPEAT, Care Transfer Hub and Community Hospital wards is in place to support patient flow and early decision making. Also to provide detail in relation to risk based escalation planning and cohorting.

3.11.4 Managing Outbreaks: Learning will be embedded from Winter 24/25 with regards to the prolonged Norovirus outbreaks with enhanced cleaning after any patient with diarrhoea symptoms whether samples are positive or negative for the virus. Touchpoint cleaning will be in place.

Strengthened messaging to visitors and public advising not to attend if they are experiencing symptoms will be done through a variety of different formats and channels to reinforce expected behaviours.

Training on compliance with annual hand hygiene compliance will continue to be monitored at IPC Committee via the Director of Nursing/Director for Infection Prevention & Control.

3.12 Operational Readiness - Urgent & Emergency Care and Adults Divisions

3.12.1 Service Expansion: Five areas have been identified for service expansion to develop community pathways, following established models and previous winter schemes in 2024/25. These include:

- Urgent Community Response (two-hour response)
- Enhancing the Care Transfer Hub to improve discharge pathways; Care Transfer Hub facilitate efficient referrals, discharges, and better alignment with community and social care resources so that patients receive appropriate care in a timely manner.
- Front door coordination and redirection to community pathways
- Two-hour domiciliary care response and bridging service

Ahead of winter, a plan is being implemented to expand the above services and close the RRU's, aiming to support reinvestment and reduce reliance on bedded capacity, particularly for frail and vulnerable patients. By strengthening the Urgent Community Response Teams and enhancing the Care Transfer Hub, this will support enhanced avoidance of unnecessary admissions but also facilitates swifter, more coordinated discharges - ensuring patients are cared for in the most appropriate environment.

3.12.2 Bedded Escalation Spaces: The Trust has an Escalation SOP designed to increase capacity during periods of high demand, this includes TES (Temporary Escalation Space) to further expand hospital capacity if required in extreme pressure. At system level, the focus is to maximise community capacity and promote alternatives to an Emergency Department attendance and to facilitate early discharge to individual homes whenever feasible migrating away from a previous over reliance of bedded capacity.

3.12.3 In Reach: Workforce integration with SaTH and flexible working deployment will always be essential as part of surge management and the integration of therapies workstream will continue to accelerate throughout winter providing a more agile and integrated therapy workforce across 7 days. Following lessons learnt in 24/25 the approach to any additional in reach this year will be coordinated and panned through the establishment of the Front Door Team. This will reduce duplication and provide a dedicated response reducing risk of diluting community roles to the acute which can have an adverse impact on patient safety and system flow.

3.12.4 Remote Monitoring: The adoption of digital tools for remote monitoring (Luscii) through UCR and Virtual Wards alongside roll out of Point of Care Testing (POCT) will further enhance winter readiness for 25/26. Embedding Luscii throughout the year will enable real-time tracking of patient health, especially for those with RSV and Norovirus, and supporting prompt intervention from Community Teams This not only ensures vulnerable patients remain safely monitored at home but also frees up acute beds for those in greatest need. By integrating digital solutions into discharge planning and ongoing care, the Trust will be better equipped to manage surges, deliver continuity of care, and maintain efficient patient flow throughout the winter season.

3.12.5 Complex Discharge Profiles Acute: As lead provider of the Care Transfer Hub seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with Local Authorities for the number of P0, P1, P2 and P3 discharges.

Targets aligned for Winter for complex acute discharge are detailed below and overseen by the UEC Delivery Group and System Control Centre (these have been agreed at a system level).

Pathway	Percentage
P0	50% increase from current base line (8%)
P1	75%
P2	22%
P3	3%

In addition to the above the following targets have also been agreed at a system level to deliver improved patient experience, outcomes, reduce risk of deterioration and enhance flow for winter:

- Reduce number of NCTR/Discharge Ready patients in hospital wards to <10% of the bed base (STW only) from 120 to 60

- Reduce NCTR LoS (STW only) from 3 to 2 days
- Complex discharge % / or average number of complex discharge from 19% to 15%
- Reduce average LOS of complex discharge LOS from 16 days to 12 days
- Increase % of NCRT discharges on same day as NCRT P1 to 90%
- Increase % of NCRT discharges on same day as NCRT P2 to 50%
- Reduced variation of/demand for Complex Discharge across 7 days from 70% to 15%

3.12.6 Complex Discharge Profiles Community (P2): Using system-level analysis and aligning with The Trust operational plan, winter targets and discharge profiles for community hospitals have been set. While the community hospitals continue to prioritise the 'home first' approach, increased complexity and frailty of patients does mean fewer patients go to pathway 3, raising demand on P2. This shift enables more rehab opportunities and independence, though some patients still require Care Homes after discharge.

At trust level these percentages have been further profiled through the operational planning rounds to align to predicted activity and overlapped with system seasonality trends this enables operational leads to have a proactive response to periods of increased demand/flow. This also provides a daily discharge target over a 7-day period.

Pathway	Percentage
P0	10%
P1	56%
P2	2%
P3	18%
Readmission to acute	14%

3.12.7 Minor Injury Units

To improve pathways by further utilising alternatives to ED there is a phased roll out of Adastra to enable direct booking from General Practice, 111 and Single Point of Access to our 4 MIUs.

3.12.8 OPAT (Outpatient Parenteral Antimicrobial Therapy) & DARRT (Diagnostics, Assessment & Access to Rehabilitation & Treatment)

There is an established IV pathway to support vulnerable individuals with long term conditions to stay in their own home. PIFU has been launched within DARRT to ensure capacity is used effectively to enable patient pathways to be supported and capacity released for first appointments.

3.12.9 CMDU (Covid Medicines Delivery Unit)

The CMDU service will continue to provide treatment for patients at highest risk in the community to support them to remain safe and well at home particularly over winter.

3.13 Operational Readiness - Planned Care Division

3.13.1 Planned care delivery for RTT and non RTT reportable services: both areas have shown consistent progress throughout 2024/25 and into 2025/26. The Trust is on schedule to meet the national target of 65% RTT compliance by March 2026. High week waits have declined, with a plan in place to achieve zero 52-week waits by October 2025 and to continue reducing wait times throughout the winter across all service areas.

Elective delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand including on diagnostic services. Trajectories have been adjusted to mitigate seasonal variation and ongoing recovery milestones have been identified.

Analysing seasonal trends over the last 3 consecutive years has enabled the Planned Care Division to apply proactive planning for minimising disruption and safeguarding waiting list recovery and planned care over winter. It has involved scenario modelling, resource management, and the adoption of flexible, patient-centred approaches. This has been applied to the creation of superclinics across the MSST service, a review of annual leave plans for all clinicians during peak periods, a focus on children's dental lists in school holidays and preparation throughout summer and additional strategies to manage waiting lists across Speech and Language Therapy.

3.13.2 Digital: The launch of the digital solution earlier this year My Recovery will greatly support the MSST service going into Winter. The digital platform will act as a central hub for both patients and clinicians—enabling personalised care plans, symptom tracking, and two-way communication between care teams and families. Through secure portals, patients can access recovery resources, monitor their rehabilitation progress, and receive tailored advice on exercise, nutrition, and medication adherence. This will help maximise clinic utilisation and prevent avoidable non elective presentation through a preventative proactive platform avoiding crisis points.

3.13.3 Manging Planned Care Demand at System Level: Where required SCHT are working with system partners (SaTH and RJAH) to ensure ring-fencing capacity for planned care. This has involved promotion of community-based provision for example community outpatient and day surgery units to support with releasing theatre space and capacity in the acute to enhance flow and safety at a system level across winter.

3.13.4 The Long Covid Service: Research has demonstrated that patients who have Long Covid have increased risk during the winter period. To relieve pressures on Primary Care and address health inequalities the service has launched a self-referral pathway to enable patients to refer directly into the service to get support and interventions.

Patients remain within the service on average for 6 months. The service then utilises PIFU (Patient Initiated Follow Up) effectively with rates of 95% to support discharge and avoid unnecessary follow up appointments, empowering patients and effectively managing clinic utilisation. The self-referral model will allow patients to seamlessly re-enter the service enabling appropriate support in a timely manner.

3.14 Operational Readiness – Children & Young People (CYP) Division

3.14.1 Expanding Services The CYP Division are charged with safeguarding the health and wellbeing of some of the most vulnerable members of our local communities, especially during peak periods of Respiratory Syncytial Virus (RSV) and other seasonal illnesses. They offer expert Nursing care to children and young people in both home and community settings, enabling early intervention and reducing unnecessary hospital admissions.

- Rapid response for acute illness, particularly RSV, minimising escalation to secondary care.
- Ongoing support for children and young people living with chronic or complex health needs, preventing crisis presentations.
- Flexible deployment of staff to hotspots identified through real-time data analysis, ensuring resources are directed where they are most needed.

3.14.2 Partnership working: The CYP Division has a strong collaboration with Social Services across Shropshire, Telford and Dudley this ensures a holistic approach to child health. This partnership-driven model addresses the wider determinants of health, such as social, emotional, and educational support, which are particularly crucial during winter when families may face additional stressors.

- Integrated care planning with social workers, school nurses, and community practitioners to support children at risk.
- Joint visits and shared case management for the most vulnerable, including those in foster care or experiencing safeguarding concerns.
- Close liaison with education providers to align health interventions with school-based programmes, maximising coverage and support.

3.15 Corporate Response Readiness

3.15.1 Planning and Financial Framework

SCHT is on track to deliver a CIP target for 25/26, overseen by the CIP Delivery Group and the Finance Recovery Group.

Key winter financial activities to maintain financial accountability throughout winter include:

- Payroll: Timely and accurate payment for staff, supporting surge activity.
- Purchase Ledger: Prompt and correct supplier payments.
- Sales Ledger: Accurate invoice management.
- Statutory Financial Reporting: Monthly reports for Trust Board, STW ICS, and NHS.
- Financial Planning: Production during the planning cycle.
- Agency staff oversight and reduction, with support from the Workforce Team.

3.15.2 Estates

The Associate Director of Estates overseas the planned, routine and emergency repair and general maintenance of trust buildings coordinating with contractors and maintenance plans as required. Estate repairs vital to mitigating impacts of adverse weather of heating etc will always be prioritised throughout Winter.

During the winter period the Estates Team will:

- Ensure the gritting contract is in place to ensure that car parks and footpaths we hold responsibility for are gritted when required.
- Oversee all Winter estate maintenance: lighting, heating, gritting, generator checks, gutter cleaning, tree surveys.
- Work with contractors as required to safely maintain building infrastructure.
- Ensure that resilient equipment Uninterrupted Power Supplies (UPS) (through IT department) and generators have been serviced and tested to provide coverage to essential areas so core services can be maintained.
- Ensure all heating and lighting systems are serviced and maintained
- Liaise with supply chain to request their contingency plans if required.

3.15.3 Communications

A communication strategy will keep all stakeholders informed, fostering collaboration across regional boundaries and within the Trust's workforce. By embedding a culture of continuous learning and improvement, the organisation aims not only to respond to challenges but also to anticipate and reduce the impact of seasonal risks wherever possible.

The Communication Team have strong, established links with IPEAT to share key messages and learning and manage the rise of winter illnesses. They will work closely with Vaccination Teams and have a robust communications plan in place to raise awareness of the importance of winter vaccinations, how to book and how to seek advice for people who are unsure. Communications will promote vaccines through all channels, including social media. The Communication Team will act as the main conduit through to the ICB to offer broadcast opportunities at local clinics to help build awareness of the importance of vaccination. Real people will be utilised in our strategy and leaders and vaccinators encouraged to share their reasons for getting vaccinated. National assets to promote winter messaging across our internal and external channels will be utilised.

SaTH and SCHT are forming an integrated Communications Team, which provides opportunities for shared learning and increased resilience in both teams. This will enable winter communications plans to be aligned and ensure messaging is consistent, timely and encourages action across teams. Through the system Stronger Together campaign awareness will be raised that urgent and emergency care is everyone's responsibility, and we can all support teams to manage pressure this Winter. Working with SaTH and the wider ICS partners, we will be sharing regular updates internally and externally on the work happening through the Winter Plan to manage winter pressures, including any new community services. This includes taking part in the ICBs campaigns, including the Think Which campaign in Winter and promoting this across all channels. Opportunities to share advice and support from our clinical/professional teams, for example Minor Injury Units, to help our communities manage winter illnesses and know which service to use when will be sought.

3.15.4 Quality and Safety

The Quality and Safety Committee and Trust Board will continue to receive a monthly integrated quality report that gives oversight of key quality metrics including safer staffing fill rates to identify emerging themes and trends.

There are twice daily safer staffing meetings to assess patient acuity and dependency and identify potential gaps in the service and provide mitigations to ensure patient safety is always maintained, this can include use of temporary staffing workforce or redeployment of staff.

The Director of Infection Prevention and Control (DIPC), chairs the Infection Prevention Control Committee, where a monthly report on healthcare-acquired infections and outbreaks is presented. The committee also discusses key lessons learned and monitors improvement actions.

3.16 Business Intelligence

3.16.1 Informing Response Operational planning is a key element for the Trust and falls part of the local system and national process in line with national guidance. The Performance Framework details the Trusts approach to performance which includes monthly performance workshops where action plans are developed in a collaborative style workshop including both operational and support service colleagues. As a Trust we have ensured readiness for seasonal variation, enabling operational teams to anticipate and prepare for known seasonal trends. This has been particularly paramount within planned care services to model a deliverable trajectory of improvement, vaccination services to manage temporary workforce demands, community nursing, ward areas, Rapid Response and Virtual Ward have robust plans in place to anticipate demand using historical and real-time data, with escalation plans for surges.

3.16.2 Planed events to manage seasonal peaks: Where known peaks are anticipated and prevention is paramount as a community Trust, we have planned Community MADE (Multi Agency, Discharge Event) particularly around bank holidays.

3.16.3 OPEL Triangulation: Daily through the use of OPEL and system wide data shared through SCHT's data warehouse the system SCC will link directly with The Trust to provide daily surveillance of ambulance activity, single point of access demand, admissions (acute and community), discharges (acute and community), open beds, virtual wards, discharge flow. As required, this will collate and support weekly trend analysis to inform capacity planning and resource allocation at a system level and enable a constant agile approach to manage surge and evaluating impact of any interventions.

3.16.4 Access to information: Below details processes or reporting routes to support operational services to respond during times of pressure and surge:

- Information reports are provided to service areas on both routine and ad-hoc basis with some reports as frequent as daily
- Specific Key Performance Indicators (KPIs) under the Performance Framework are available in Power BI with many available as drill down to service level.
- Collaborative working within the system to support demand and capacity at both elective and non-elective workstreams
- Review and development of planning templates with seasonal variation including areas such as UCR 2 Hour and Virtual Ward

3.16.5 Understanding impact of new/expanded services: The new UEC maximising community pathways services will need to demonstrate impact and ongoing benefits realisation. The impact metrics have been agreed and from point of phased implementation mechanisms both internally and externally have been established to capture the planned impact and reported at a system level.

3.16.6 Patient experience: data will continue to be gathered through a variety of channels, this information is regularly reviewed by dedicated teams, who identify trends, concerns, and opportunities for enhancing patient care. The data is overseen through reports to Quality & Safety Committee which triangulate complaints and incidents and reported ultimately to Board.

During periods of significant surge this is vital to understand impact of extreme pressure on services and patient experience and intelligence will be collated to make rapid improvements if required through the Winter, share and promote areas of good practice and use intelligence to support the 26/27 Winter Plan.

3.17 On call arrangements

3.17.1 Rotas: Schedules for on call for experienced On-call Managers and Directors will be carefully reviewed and optimised to ensure maximum decision-making capacity is available during periods of predicted highest demand, including weekends. This proactive approach guarantees resilient leadership and swift escalation routes, enabling timely responses to emerging pressures and safeguarding seamless patient care throughout the winter months.

To further bolster resilience and communication under extreme pressure, the implementation of WhatsApp groups for both On-call Managers and Directors are in place and structured buddy systems has proven invaluable. This communication platform enables rapid, secure information sharing among On-call Managers and Directors, facilitating real-time updates, coordinated responses, and immediate escalation of emerging issues as well as advice and support.

3.17.2 Ward Manager Rota: Throughout winter there will be additionality of a dedicated Ward Manager at weekends. At times of heightened winter pressure, when admissions typically surge, the accessibility of an experienced Ward Manager ensures continuity of leadership and effective coordination of Multidisciplinary Teams. This role is pivotal in maintaining patient flow, proactively managing discharge planning, and addressing emerging operational pressures before they escalate.

3.17.3 Expanding senior decision makers out of hours: Investment into the Care Transfer Hub has also provided additional leadership capacity during evenings and weekends going into Winter, ensuring that critical decision-making expertise and coordination are available throughout extended hours for the system. This expansion allows for more responsive management of patient pathways, greater oversight of discharge processes, and timely escalation of issues as they arise outside of standard daytime operations. As a result, patients benefit from smoother transitions of care and multidisciplinary teams remain well-supported, even during peak demand periods.

3.18 Conclusion

As SCHT prepares for the challenges of winter 2025/26, this Winter Plan demonstrates a comprehensive, proactive approach rooted in robust governance, collaborative system working, and continuous learning. From surge readiness mechanisms and strengthened community pathways to focused workforce strategies and dynamic communication, every facet of planning is designed to safeguard safe, high-quality care throughout the Winter. The integration of data-driven decision-making, digital innovations, and lessons learned from prior winters ensures resilience and adaptability in readiness of anticipated pressures.

The Board is asked to

- **accept** the report as information of resilient winter planning against the guidelines

Shropshire Community Health NHS Trust

Annex B – Board Assurance Statement for NHS Trusts
Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	YES	4/9/25 Private Board
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	YES	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	YES	Evidence: 3.4.3, 3.5.1, 3.5.2, 3.5.3, 3.6.1, 3.6.2, 3.12.1, 3.12.3, 3.12.5, 3.12.6, 3.13.3, 3.15.3, 3.16.2, 3.16.3
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	YES	Evidence 3.6.1
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	YES	Evidence: 3.4.4: The Trust has identified Director of Operations and Chief AHP as the Executive accountable for the winter period.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	YES	See listed evidence references in Section B
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	YES	Evidence: Supporting QEIA, 3.3, 3.4.2, 3.5.1, 3.5.3, 3.7.1, 3.11, 3.12.2, 3.15.4
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	YES	Evidence: 3.13.1, 1.13.3

Provider CEO name	Date	Provider Chair name	Date
Jo Williams	4/9/25	Andrew Morgan	4/9/25

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Section B: 25/26 Winter Plan Checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1.There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	YES	Evidence 3.9.2
Capacity		
1.The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	YES	Evidence 3.5
2.Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	YES	Evidence: 3.17
3.Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	YES	Evidence: 3.12.5, 3.12.6
4.Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	YES	Evidence: 3.13
Infection Prevention and Control (IPC)		
1.IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	YES	Evidence: 3.11
2.Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	PARTIAL	Evidence: 3.11.2 (Not evidenced through ESR, however evidenced in a central repository held by IPEAT & Divisions and overseen by IPCC)
3.A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	YES	Evidence 3.11
Leadership		
1.On-call arrangements are in place, including medical and nurse leaders, and have been tested.	YES	Evidence: 3.17
2.Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	YES	Evidence 3.5, 3.16.3