Shropshire Community Health NHS Trust

# Trust Board - 4 December 2025

MEETING

4 December 2025 10:00 GMT

PUBLISHED

28 November 2025

# Agenda

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# MINUTES OF THE PUBLIC BOARD MEETING

## HELD AT THE RAMADA HOTEL, TELFORD AT 10.00 AM ON THURSDAY 2 OCTOBER 2025

## PRESENT

| | |
|---|---|
| **Chair and Non-Executive Members (Voting)** | |
| **Mr. Andrew Morgan** | (Group Chair) |
| **Ms. Tina Long** | (Non-Executive Director and Vice Chair) |
| **Mr. Harmesh Darbhanga** | (Non-Executive Director) |
| **Ms. Cathy Purt** | (Non-Executive Director) |
| **Executive Members (Voting)** | |
| **Ms. Jo Williams** | (Group Chief Executive) |
| **Ms. Sarah Lloyd** | (Director of Finance) |
| **Dr. Mahadeva Ganesh** | (Medical Director) |
| **Ms. Clair Hobbs** | (Director of Nursing) |
| **Ms. Claire Horsfield** | (Director of Operations and Chief AHP) |
| **Executive Members (Non-Voting)** | |
| **Ms. Shelley Ramtuhul** | (Company Secretary/Director of Governance) |
| **Ms. Rhia Boyode** | (Chief People Officer) |
| **In attendance** | |
| **Ms. Stacey Worthington** | Executive Personal Assistant (to take the minutes of the meeting) |

### Welcome

Mr Morgan welcomed all to the meeting. He welcomed Ms Williams, the new Group Chief Executive, to her first Board meeting. He expressed the Board's thanks and appreciation to Ms Patricia Davies, the previous Chief Executive and wished her well for the future.

### Apologies and Quorum

Apologies were received from Ms Jill Barker, 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 7 August 2025

The minutes were agreed as an accurate record of the meeting.

### Public Questions

No questions from the public had been received in advance of the meeting, and, in line with the Trust's scheme for public questions, the Chair asked if there were questions from the floor.

Mr David Tooley asked a question regarding vaccinations, and the importance of vaccines in the winter plan. Ms Hobbs confirmed that vaccine fatigue was a national concern, however, the local winter vaccine programme had begun earlier in the week and was progressing well. The Board was advised that vaccines would be strongly encouraged for the workforce and every effort would be made in making sure they were as accessible for them as possible.

Mr David Sandbach asked a question in relation to clinical visits in homes, and if the Trust expected to see an increase in number of visits in the upcoming year. It was agreed that the Trust was expecting an increase number of clinical visits in homes, however, there was not a target forecast.

**Staff Story**

Anna, from the Whitchurch Community Therapy Team, a physiotherapist, attended the Board to share a patient story. The patient was a wheelchair user following an accident years earlier, who unfortunately had started to deteriorate in the previous few months, the therapy team supported the patient, including training her carers to support with exercises. The patient was re-referred to the service several months later, and the carers retrained to support her with exercises. The patient had contacted the team with her thanks and support.

The Board noted that the team had provided a real partnership approach with the patient, understanding what was important to her and acting as an advocate for her. The Board discussed how the Trust could further support with prevention work, such as digital solutions for carers so that they had access to the required exercises.

**Chair's Communication**

Mr Morgan thanked staff for their work in relation to the Annual General Meeting which had taken place two weeks earlier and noted the huge range of services the Trust provided.

Simon Whitehouse had been formally appointed as the Chair of the ICB Cluster covering Shropshire, Telford and Wrekin, Stoke and Staffordshire. The Chair of the Cluster had previously been announced as Ian Green.

**Non-Executive Director Communications**

Ms Purt stated that she had visited Dudley 0-19 Services and discussed how the Trust could make them feel closer to ShropCom. She noted that she had chaired the ICB Strategy meeting, where green plans had been discussed.

Ms Long had visited Oswestry MIU, which was busy. The staff are very passionate and discussed how they wished to work more closely with the A&Es and raised concerns regarding the limited hours of X-ray provision. She had also visited the DAART service and Whitchurch Hospital.

**Chief Executive's Report**

Ms Williams thanked all staff across the Trust for being some welcoming and engaging. She had recently visited HMP Stoke Heath and noted that the environment was very different from anywhere else.

The winter plan, which was included later in the agenda for this meeting, was the most skewed towards community services she had seen in her career. The national shift towards prevention was clear through the winter planning process.

**QUALITY, SAFETY AND PEOPLE**

**Quality & Safety Committee Chair's Report**

Ms Hobbs summarised the report on behalf of Ms Barker. The Committee continued to see improvement in policies for approval and received a number of thematic reviews, including C-Difficile, falls and medicines management.

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

**Integrated Quality and Safety Report**

Ms Hobbs advised that the report had received full assurance at Committee. The Trust had now reached six C-Diff cases in the year, above our threshold, however, reviews showed that there was

nothing that could have been done to prevent these cases, although we would continue to look for improvements. There had been two category 4 pressure ulcers within the community teams, these were being investigated and would be presented to Committee in due course.

Mr Darbhanga asked about the deaths reported, Ms Hobbs confirmed that an after action review had been completed and it was not considered that the death could have been avoided had the patient been in an acute setting, a full investigation was being completed on the other death; there were no indicators at the moment that this could have been avoided.

In response to a question, Ms Hobbs confirmed that no patients were disadvantaged if they were unable to use the technology needed to be a virtual ward patient.

***The Board accepted the assurance provided by the update.***

**Annual GMC Assurance Report**

Dr Ganesh presented the report, which was a statutory requirement for all Trusts. The Trust had completed all doctors appraisals on time and there had been no concerns raised. An external audit of the process had concluded there was full assurance and our policies were fit for purpose.

Mr Dabhanga asked about difference between ShropCom and SaTH policies, Dr Ganesh confirmed that this was a national policy, however, we could always learn from each other in terms of implementation of the policy.

The Board asked about oversight for dentists, Dr Ganesh confirmed that dentists did not go through the same formal revalidation process as doctors, however, they could be included in the report going forward.

***The Board approved the report and authorized the Chief Executive to sign on the Trust's behalf for submission to the GMC.***

**Freedom to Speak Up Report**

Mr David Ballard, Freedom to Speak Up Guardian, attended the Board to present this item. He provided a summary of the activity taken in relation to FTSU over the last year. He detailed that 11 complaints had been received, which varied over a range of categories of concern.

Mr Ballard discussed the number of issues raised by admin and clerical staff, which would need to be monitored going forward. He had visited HMP Stoke Heath to raise awareness of FTSU amongst the staff there, regular visits would take place to the prison going forward.

There had been some press reports highlighting staff members concerns around detriment, he provided assurance around this and noted that the ongoing culture and OD work would support with this assurance. There was no evidence that anyone who had submitted a concern had suffered any detriment as part of raising a concern.

The Board asked about the recent announcement of the closure of the National Guardians Office, this would not affect the provision or importance of FTSU across the Trust and the function would continue to be a statutory requirement.

Mr Darbhanga noted that he was the Non-Executive Director FTSU Champion and was happy to talk to any member of staff with concerns.

***The Board***

- ***Noted the updated position and the position with regard to the self-assessment.***
- ***Noted the quarterly activity and the ongoing actions.***

Mr Ballard left the meeting at 11.10am.

**Safeguarding Annual Report**

The report had been approved by the Quality & Safety Committee and was presented to the Board for final approval. The report was a statutory responsibility and listed the key achievements over the last year.

Ms Purt asked about Dudley staff and their access to training. Ms Hobbs confirmed that the staff had access to training and supervision as Shropshire based staff.

***The Board***
- ***Noted the key safeguarding activities across the organization.***
- ***Accepted the report as assurance that SCHT was meeting its statutory responsibilities regarding safeguarding children, adults and families that encounter our services as set out in the Children's Act 1989 and 2004.***
- ***Approved the Annual Report.***

## PEOPLE

**People Committee Chair's Report**

The Committee received partial assurance in relation to mandatory training, further work was needed to resolve competencies between Trusts and a renewed focus on resuscitation training. There had been a good discussion on the flu vaccine programme and an update on the Culture programme. Appraisal rates were at 90% and the focus of the next piece of work would be around sickness.

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

**Integrated People Performance Report**

There had been significant progress with the KPIs reviewed by the People Committee, with a sustained improvement shown. There had been an updated national framework for People related KPIs, which would require review to ensure that these were embedded within the Trust's indicators.

There had been significant improvement in the number of appraisals completed and the Board expressed their thanks to staff across the Trust to achieve this. The next focus would be around staff sickness, particularly in relation to mental health and MSK; preventative work would be central to progressing this.

It was noted that an update report on the Culture Programme would be provided to the Trust Board shortly.

Mr Darbhanga asked if there were any key areas of concern with vacancies, particularly if we were using agency to manage any gaps. Ms Boyode confirmed that there were no particular areas of concern, there were areas where there was higher temporary staffing use but this was always managed safely, and there was a detailed recruitment plan.

***The Board accepted the assurance provided by the update.***

## RESOURCE AND PERFORMANCE

**Resource and Performance Committee Chair's Report**

Ms Long advised that the Committee received full assurance on all items presented. The Trust was delivering to plan and waiting times were progressing well. The Trust's digital strategy was coming to an end, and a discussion had taken place between the Trust and SaTH on key themes to ensure any future strategy was right for the Group.

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

**Performance Report**

Of the indicators reviewed by the Resource and Performance Committee, there were 9 indicators which required further attention, of which 8 related to waiting times. At the request of the Board, waiting times had been separated into children's and adult services. There had been significant improvements across all waiting lists. Ms Lloyd additionally noted that the 2 reported 104 week waits identified within the report were a data quality issue and there were no 104 breaches.

The other KPI which required attention related to data quality, and this would be the next focus for the Committee.

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

**Performance Framework Update**

The Trust completed a review of the performance measures on an annual basis, which had been completed prior to the start of the financial year. The NHS Oversight Framework 2025/26 had been published in June and therefore, an additional review was required. The Board was required to sign off any amendments to the KPIs, and each of the proposed amendments had been reviewed by the relevant committee.

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

**Finance Report**

The Trust remained on track and was delivering a surplus of £666k at the end of August. The Trust continued to forecast delivering its plan, with a surplus of £2m at year end. The level of risk was reducing each month, with no new risk to bring to the Board's attention. The Trust was making good progress with its efficiency programme, with 85% of schemes now identified as green, with the remaining 15% as amber.

Pay was on track, with slightly higher than anticipated bank usage. Capital spending was slightly behind plan, due to issues with receiving permission from a landlord for some works.

***The Board***

- ***Considered the adjusted financial position at month 5 was a surplus of £666k, compared to a planned surplus of £649k, which was a favourable variance of £17k.***
- ***Recognised that overall pay costs must remain with planned levels to ensure we deliver of 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.l4m, with 15% of schemes rated as medium risk and 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 in place or being developed to mitigate these pressures as far as possible.***
- ***Considered the NHSE updates, in particular the key role that Finance Committees and Boards will have in challenging and assuring underlying positions.***

**Green Plan Update**

The NHS had been the first health care system in the world to make a commitment to decarbonisation, with the ShropCom Board signing off its green plan in 2022. The Trust had delivered in excess of this plan, and it was now time to update and refresh the plan.

The new plan was ambitious and extensive, one of the key aims was supporting patients to not travel if it was not clinically necessary by using digital solutions.

Ms Purt welcomed the inclusion of food and nutrition within the plan, this was a vital part of the service we provide to our patients.

***The Board considered and approved the Trust's 2025-2028 Green Plan, following recommendation by the Resource and Performance Committee.***

## GOVERNANCE

**Board Assurance Framework**

The report recommended the closure of two risks; quality team capacity as vacancies had been recruited to and internal governance and operational oversight for system programmes as the line of oversight had been developed.

***The Board approved the Board Assurance Framework.***

**Winter Planning**

This item had been approved at a previous Board meeting held in private session and was presented for information only.

***The Board noted the Winter Plan.***

## ANY OTHER BUSINESS – with prior agreement of the Chair

**Any Other Business**

There was none.

## DATE OF FUTURE MEETING

**Date of Future Meeting**

10am – 1.00pm, Thursday 4 December 2025

Shropshire Community Health
NHS Trust

# Group Chief Executive Report

## Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Jo Williams<br>Group CEO | **Paper date:** | 4 December 2025 |
| **Executive Sponsor:** | Jo Williams<br>Group CEO | **Paper written on:** | 27 November 2025 |
| **Paper Reviewed by:** | Jo Williams<br>Group CEO | **Paper Category:** | Strategic |
| **Forum submitted to:** | Public Trust Board | **Paper FOIA Status:** | |

## 1.0 Purpose

The Board is asked to note the contents of the report and to take assurance where appropriate.

## 2.0 Executive Summary

This paper provides an update regarding some of the most noteworthy events and updates since the last Public Board from the Group Chief Executive's position, this includes an overall update, SCHT news and wider NHS updates

## 3.0 Shropshire Community Services Update (SCHT)

**3.1** The system has continued to experience substantial pressures within urgent and emergency care. SCHT has consistently supported partners in addressing increased demand while remaining committed to expanding community services. I wish to express my sincere gratitude to all teams for their dedication and perseverance in achieving the key milestones set out in the Winter plan. Several initiatives have been introduced, including extending the Urgent Community Response team hours to midnight daily, assigning Integrated Front Door practitioners at PRH and RSH Emergency Departments from 08:00–20:00 every day, and expanding Care Transfer Hub and Therapy Hours to 08:00–20:00, seven days a week.

**3.2** In recent weeks, I have had the opportunity to visit various services within the trust, such as the District Nursing Team in Dudley and Ludlow Community Hospital. Additional visits are scheduled in the next few weeks to include all services.

Without exception, all staff members I have encountered have welcomed the visit and appreciated the opportunity to highlight both the strengths of their services and the challenges that should inform our future planning. I look forward to collaborating with the team to address these challenges while ensuring that their perspectives remain central to the ongoing development of our Group model.

3.3 Thank you to everyone who joined the Group Model staff engagement session on Wednesday, 19 November 2026, at AFC Telford. The session covered a range of topics, including our strategy for new models of care that support the NHS 10 Year Plan—this approach aligns with our Group model goals and underscores that our culture remains vital to our progress. It was a valuable opportunity to exchange ideas and collaboratively co-design some of our workstreams, identifying how we can together enhance pathways for both patients and staff. Additional sessions are scheduled for the coming weeks, focusing on smaller, specific staff groups and services so we can agree on actions and plan next steps.

## 4.0. Shropshire Telford & Wrekin (STW) Integrated Care System updates

4.1 The public board meeting was held on Wednesday 26 November 2025. NHS STW Board Meetings - NHS Shropshire, Telford and Wrekin

4.2 On Wednesday, 26 November 2025, the system welcomed Sir Professor Chris Whitty, Chief Medical Officer (CMO) for England, the UK government's Chief Medical Adviser, and head of the public health profession. Sir Chris met with senior leaders to gain insight into our current initiatives and how they are being implemented within a rural community. He expressed his gratitude for the opportunity to meet everyone and commended the enthusiasm and exemplary work demonstrated across our system.

## 5.0 NHSE

5.1 The Model Region Blueprint for NHS regional teams has now been published. It sets out a high-level mandate for the seven regions and articulates their purpose, core functions and activities. It is anticipated that there will be a Chair and CEO role each region, but that they will not be independent organisations.

They will be part of DHSC in the future. We know that some functions are still being considered, especially workforce, education and training. The Model Region Blueprint also informs the detailed design work that is taking place as part of the DHSC/NHSE transformation programme over the coming weeks and months.

Regions will essentially have three key objectives:

1. The first of those objectives is to provide strategic leadership of regional health systems. This means that regions will lead local reform, oversee investment and the reconfiguration of local services; support innovation; and ensure an effective leadership strategy and talent pipeline to get the best from our people. Regions will do this by developing and overseeing implementation of the regional medium-term strategic plan and leading regional implementation of the NHS planning framework. They will support innovation and system development and lead local digital transformation to ensure effective data and analytics capability. Regions will also oversee strategic plans for service and organisational change, set leadership strategy and develop the workforce through training and education.

2. The second objective will be to performance manage and oversee local commissioners and providers. This means regions will have holistic oversight of performance in line with national frameworks, ensure Board and leadership capability, as well as identify 'early warnings' and manage risk. To achieve this, regions will have oversight of provider and commissioner performance.

3. The final objective will be to have a regional approach to improvement, support and intervention. This means regions will support systems and trusts to deliver high quality and sustainable care, develop capability, and address underperformance. This will be achieved by regions providing improvement support, intervening to address challenged performance or providers, and developing commissioning capability and professional leadership.

## 6.0 RECOMMENDATION(S)

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

**6.2** Note the contents of the report.

Shropshire Community Health
NHS Trust

# Group Chief Executive Report

Jo Williams

Group Chief Executive

Shropshire Community Health NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

27 November 2025

## 0. Quality and Safety Report – October 2025

| | | | |
|---|---|---|---|
| **Author:** | Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC | **Paper date:** | 4th of December 2025 |
| **Executive Sponsor:** | Clair Hobbs, Director of Nursing, Quality & Clinical Delivery | **Paper written on:** | 20th November 2025 |
| **Paper Reviewed by:** | Clair Hobbs, Director of Nursing, Quality & Clinical Delivery | **Paper Category:** | Quality and Safety |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

**1.1.**

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

## 2. Executive Summary

### 2.1 Context

The report aims to:

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

### 2.2 Summary

4 of the 16 Quality and Safety dashboard KPIs are showing **special cause variation of a concerning nature** in Month 7 (October)

- *Clostridium Difficile* – There has no further cases in October. The organisation has had 6 Hospital-onset healthcare associated (HOHA) *C-difficile* cases YTD against a threshold of 4. Thematic reviews are scheduled quarterly. Actions for improvement are ongoing with a specific focus on cleanliness and decontamination of equipment.
- There were 2 unexpected deaths in October. One Virtual Ward patient and one on RRU, both were unexpected but explainable and will be discussed at the Learning from Deaths meeting.
- Safer Staffing for RN Day fell below the expected standard of 95%, this was due to staffing being reduced to align with the bed reduction on RRU. All areas maintained safer staffing numbers with at least 2 RN on duty.
- There was 1 patient that developed a Category 4 Pressure Ulcer in service, deteriorating from a category 3. The case was discussed at PSIP with no further actions for the team, patient was non-concordant and self-neglect pathway commenced with all appropriate action taken to support the patient.

1 KPI has shown a deterioration with complaints response in October falling to 72% with 13 out of the 17 complaints meeting the deadline for response against a target of 95%. The governance team management of

change was completed at the end of October 2025. As part of this there was a transition and handover period during October that contributed to the timeliness of handling complaints and meeting deadlines.

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

- In October 2025 there were 12 inpatient falls reported within our care. The falls per 1000 occupied bed days has fallen for the second consecutive month to 3.60 and is below our target of 4.0. Falls thematic reviews are presented quarterly to Patient Safety Committee with ongoing improvement work focussing on digital technology and SWARM huddles to capture more timely learning.
- There were zero category 3 pressure ulcers reported in October
- There were zero medication incidents with harm
- A PSII was commissioned in October in connection with the SAIS vaccination incident, and a comprehensive briefing paper was presented to both the Quality and Safety Committee and the Trust Board demonstrating immediate safety actions taken.

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

Safer staffing data

- Data reporting period covers **September 2025**
- Average fill rates for RNs were at 94% for day and 99% for night shift
- Average fill rates for non-registered workers were over target but an improving picture at 110% for day and 109% for night, this was due to a higher dependency of patients requiring enhanced supervision. It is notable that the use of staff for additional one to ones was minimal in both Ludlow and BCCH due to the additional staffing in place due to fire safety.

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

## 2.3. Conclusion

The Quality and Safety Committee is asked to:

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

## Quality and Safety Committee - SPC Summary

| Committee | Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality & Safety Committee | Patient Safety | Category 3 Pressure Ulcers | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Quality & Safety Committee | Patient Safety | Category 4 Pressure Ulcers | 2025-10-31 | | 1 | 0 | 1 | 1 | 0 | 1 | |
| Quality & Safety Committee | Effectiveness and experience of care | Complaints - (Open) % within response timescales | 2025-10-31 | | 72.73% | 95.00% | -22.27% | 91.43% | 95.00% | -3.57% | |
| Quality & Safety Committee | Effectiveness and experience of care | CQC Conditions or Warning Notices | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Quality & Safety Committee | Patient Safety | Deaths - unexpected | 2025-10-31 | | 2 | 0 | 2 | 2 | 0 | 2 | |
| Quality & Safety Committee | Patient Safety | Falls per 1000 Occupied Bed Days | 2025-10-31 | | 3.72 | 4.00 | -0.28 | 3.72 | 4.00 | -0.28 | |
| Quality & Safety Committee | Patient Safety | Medication Incidents with Moderate Harm | 2025-10-31 | | 0 | 0 | 0 | 8 | 0 | 8 | |
| Quality & Safety Committee | Patient Safety | NHS Staff Survey - raising concerns sub-score | 2025-10-31 | | 6.83 | 7.08 | -0.25 | 6.83 | 7.08 | -0.25 | |
| Quality & Safety Committee | Patient Safety | Patient Safety Incident Investigations | 2025-10-31 | | 1 | 0 | 1 | 7 | 0 | 7 | |
| Quality & Safety Committee | Patient Safety | Rates of Healthcare Associated Infection (C-Difficile) | 2025-10-31 | | 325.00% | 100.00% | 225.00% | 325.00% | 100.00% | 225.00% | |
| Quality & Safety Committee | Patient Safety | Rates of Healthcare Associated Infection (E-Coli) | 2025-10-31 | | 100.00% | 100.00% | 0.00% | 100.00% | 100.00% | 0.00% | |
| Quality & Safety Committee | Patient Safety | Rates of Healthcare Associated Infection (MRSA) | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Quality & Safety Committee | Patient Safety | Safer Staffing - Average Fill Rate Non-Registered Nurses - Day | 2025-09-30 | | 110% | 95% | 15% | 110% | 95% | 15% | |
| Quality & Safety Committee | Patient Safety | Safer Staffing - Average Fill Rate Non-Registered Nurses - Night | 2025-09-30 | | 109% | 95% | 14% | 109% | 95% | 14% | |
| Quality & Safety Committee | Patient Safety | Safer Staffing - Average Fill Rate Registered Nurses - Day | 2025-09-30 | | 94% | 95% | -1% | 94% | 95% | -1% | |
| Quality & Safety Committee | Patient Safety | Safer Staffing - Average Fill Rate Registered Nurses - Night | 2025-09-30 | | 99% | 95% | 4% | 99% | 95% | 4% | |

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

Harm Proformas have been completed for all new patients seen over 52 weeks as an essential, but also for follow up patients if the clinician deems necessary. 1500 harm proformas have been completed to date; with 86.80% indicating no harm and 11.73% indicating low harm and can be treated and resolved.

There have been 22 cases (1.47%) of moderate harm identified up to Aug 2025; 16 following delays to first appointment, 4 due to delayed follow up appointments, 1 due to patient choice delay to commence medication and 1 due to delay of referral onward. All 22 cases have been reviewed by the Clinical Lead who has agreed with the assessment of moderate harm. These cases have been escalated to the governance team for discussion at weekly panel meeting.

The service is routinely conducting a review of 10% of the harm proformas completed which equates to 150.

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

| 18 week RTT | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm proformas completed | 699 | 844 | 968 | 1064 | 1111 | 1132 | 1212 | 1293 | 1348 | 1428 | 1464 | 1500 |
| Number of low harm | 134 | 143 | 151 | 155 | 157 | 162 | 168 | 168 | 169 | 175 | 176 | 176 |
| Number of moderate harm | 14 | 15 | 15 | 15 | 15 | 19 | 20 | 20 | 21 | 21 | 22 | 22 |
| Percentage of no harm | 78.83% | 81.27% | 82.85% | 84.00% | 84.52% | 84.02% | 84.50% | 85.46% | 85.97% | 86.35% | 86.48% | 86.80% |
| Percentage of low harm | 19.17% | 16.94% | 15.60% | 14.60% | 14.13% | 14.31% | 13.85% | 13.00% | 12.54% | 12.25% | 12.02% | 11.73% |
| Percentage of moderate harm | 2.00% | 1.80% | 1.55% | 1.40% | 1.35% | 1.67% | 1.65% | 1.54% | 1.50% | 1.40% | 1.50% | 1.47% |

The current harms policy has been reviewed and has been approved at Quality and Safety Committee. Outcomes of harms reviews will be reviewed at Divisional Governance meetings with escalation to Patient Safety Incident Panel. The harms review form is now live for use of RiO and the Deputy Director of Nursing will work with the informatics team to review how we can report harm reviews completed in SPC format going forwards with the KPI definition requiring Trust Board sign off.

Shropshire Community Health
NHS Trust

# Learning from Deaths 2025-6 Q2 Report

## Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Lindsey Leach, Senior Governance Manager<br>Amy Fairweather, Patient Safety Officer | **Paper date:** | 4th of December 2025 |
| **Executive Sponsor:** | Dr Mahadeva Ganesh, Medical Director | **Paper written on:** | 7th October 2025 |
| **Paper Reviewed by:** | Dr Mahadeva Ganesh, Medical Director | **Paper Category:** | Governance/Quality and Safety |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

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

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

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

## 2. Executive Summary

### 2.1 Context

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

### 2.2 Summary

The key points of this report are:

- Twenty deaths were reported for Q2 2025-26 across Community Hospitals, Recovery and Rehabilitation Wards and Virtual Ward. This is comparative to 14 deaths for Q2 2024-5. The comparative increase can be attributed to the onboarding of Virtual Ward which accounted for 6 Deaths this period.

# Learning from Deaths 2025-6 Q2 Report

- No patients had COVID-19 recorded as their primary cause of death in Q2.

- The causes of Death for the 20 Patients this quarter are
- There were no reported deaths of Autistic People or people with a diagnosis of Learning Disability in Q2.
- All Deaths across the Trust's Community Hospital and Recovery and Rehabilitation Wards are referred to The Medical Examiner Service for independent review of the Cause of Death.

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

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

**2.3. Conclusion**

The Board is asked to:

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

# Learning from Deaths 2025-6 Q2 Report

## 3. Main Report

### 3.1 Introduction

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

### 3.2 Community Hospital and Sub-Acute Ward Deaths

Local Learning from Deaths Level 1 reviews are carried out on every patient death within the Community Hospitals and, since January 2024, in the two Recovery and Rehabilitation Wards (RSH Ward 18 and PRH Ward 36), and since April 2025, in Virtual Wards. These reviews are written by the staff involved in the care and treatment of the Patient and reviewed by Clinical Governance and the Medical Director.

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

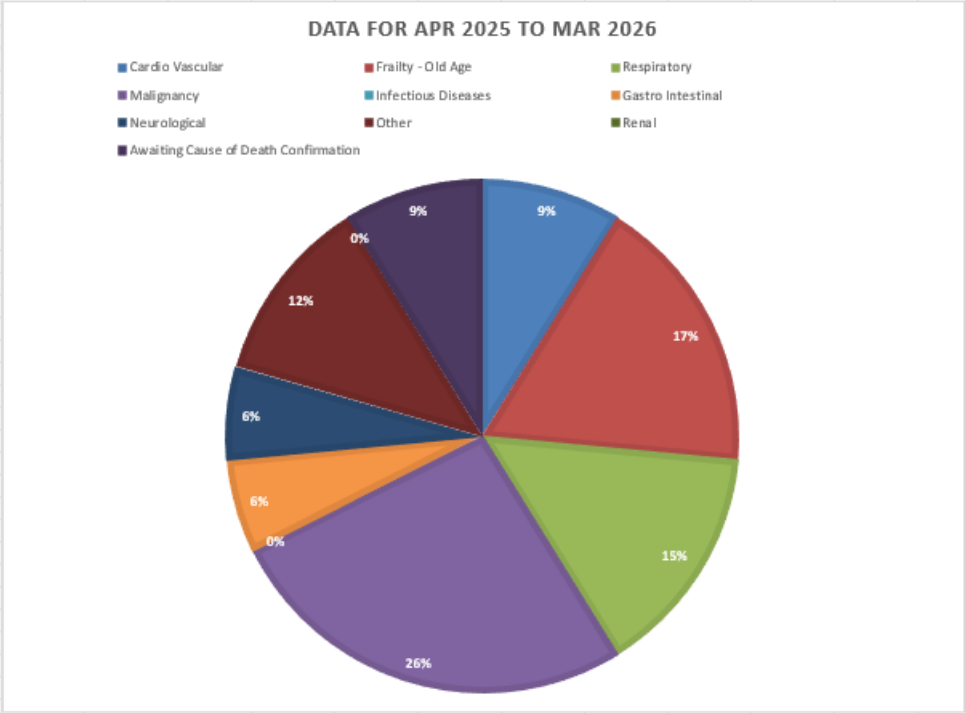
| No. Episodes | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Total for 25/26 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bishops Castle | 1 | 1 | 1 | | 2 | 5 | | | | | | | 10 | 268 |
| Bridgnorth | 1 | | | | | 1 | | | | | | | 2 | 417 |
| Ludlow | | 4 | 1 | 2 | | 2 | | | | | | | 9 | 459 |
| Whitchurch | | 3 | 1 | | | 1 | | | | | | | 5 | 524 |
| SubAcute RSH18 | | | | | | 1 | | | | | | | 1 | 11 |
| SubAcute PRH36 | | | | | | | | | | | | | 0 | 5 |
| Virtual Wards | 3 | 3 | | 3 | 2 | 1 | | | | | | | 12 | 12 |
| **Total** | 5 | 11 | 3 | 5 | 4 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 39 | 1696 |

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

### 3.3 Causes of Death

The causes of deaths within Community Hospitals, Recovery and Rehab Wards and Virtual Ward for Quarter 2 of the year 2025-26 were Malignancy (4 deaths), Frailty – Old Age (3 deaths), Other (3 deaths), Respiratory (3 deaths) and Cardio Vascular (3 deaths) Neurological (2 deaths). Gastro-Intestinal (1 death). The highest cause of death so far for 2025-26 is Malignancy as depicted in the graph shown below, and representing 26% of the deaths recorded for this financial year.

# Learning from Deaths 2025-6 Q2 Report




### 3.4 Unexpected deaths

There were three unexpected deaths in Q2 for Community Hospitals, Recovery and Rehabilitation Wards, and Virtual Ward:

**W77682** - The patient had been transferred to Virtual Ward via SaTH PRH medical escalation for monitoring of bilateral cellulitis on 28/07/2025 and seen by the team on 29/07/2025, with known lower limb cellulitis, asthma, HTN, T2DM and AF. The patient was monitored and found to have worsening renal function and AKI 3; however the patient was reluctant to be admitted to the acute and attempts for completion of the RESPECT form were made, however the patient did not want to engage. The patient later agreed to admission to the acute and this was arranged via CCC and an ambulance within a 2-hour window on the evening of 29/07/2025. The ambulance arrived at the patient's home at 06:54am the next morning, where the patient was found to be deceased.

The case was escalated and reviewed at PSIP on 29/09/2025 where the raising of a PPF with WMAS was advised for the ambulance delay.

**W77821** – The patient had been referred to Virtual Ward by her GP due to shortness of breath (treated as CA Pneumonia) and chronic leg ulcers on 08/08/2025, however was not seen before being admitted to the acute and then discharged to VW on 11/08/2025. Patient had known Chronic leg ulcer, T2DM on insulin with retinopathy and neuropathy, Osteoarthritis, non-alcoholic fatty liver disease, obstructive sleep apnoea, probable obesity hypoventilation syndrome, angina, TIA, PH, new heart failure, CKD stage 1, anaemia and gastritis. The patient

was seen on 12/08/2025 and assessed, an MDT review took place on 13/08/2025, with follow up for the patient booked for 14/08/2025. On 14/08/2025, the patient was uncontactable, with the team attending her home unannounced to find that the patient had passed away the evening before.

The case was escalated and reviewed at PSIP on 03/09/2025 where an After Action Review (AAR) was commissioned. This is still underway and will follow the PSIRF process.

**W78445** - The patient had been referred to Virtual Ward by his GP due to shortness of breath and seen on 02/09/2025, with known constipation, CKD3, Tricuspid valve regurgitation, left ventricular diastolic dysfunction, PVD, AAA, HF, AF, mitral regurgitation, HTN, hyperlipidaemia and anaemia. The patient had been seen on the same day of referral to VW, safety netting advice provided, and bloods reviewed. Admission arranged via CCC to the acute in a 2-hour window. However, the ambulance crew were diverted due to another emergency, therefore delaying the transfer for the patient. On arrival of the ambulance crew, the patient was in peri-arrest and declared deceased. VW have recognised that though there was early identification of a deteriorating patient, they missed the opportunity to complete the RESPECT form with the patient and their family.

The case was escalated as part of the incident triage process, the LfD Level 1 form was shared with the Medical Director and Deputy Director of Nursing, and the team have been advised to raise a PPF with WMAS regarding the ambulance delay in this incident. The case has been referred to the coroner with a preliminary cause of death of congestive heart failure.

### 3.5 COVID-19

No patients had COVID-19 recorded as their primary cause of death on the death certificate for Q2.

Though there were no reported deaths as mentioned above, it is key to note that there was one death reported within the community (Covid-19 Vaccination Team) which was reported in Q2 but happened within Q1. The patient received the Covid-19 vaccination, became unwell and subsequently passed away; the coroner's report indicates a link to the vaccine as part of cause of death. The patient is also documented to have had a learning disability. The incident was discussed at PSIP on 20/08/2025 and agreed to follow the coroner's process and any learning from the incident to be shared with the relevant teams.

## 4.0 Deaths in Custody

There were zero Deaths in Custody reported in Q2.

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

LeDeR is responsible for facilitating local reviews of deaths of people with learning disabilities (aged 4 to 74 inclusive) and autistic people registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death. There were no deaths of patients with a formal learning disability diagnosis in the Community Hospitals, Virtual Wards and Rehabilitation and Recovery Wards in Q2.

# Learning from Deaths 2025-6 Q2 Report

To note, please see 3.5 for the Covid-19 death which involved a patient with a learning disability.

## 6.0 Learning and Good Practice

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

## 7.0 Opportunities to improve across the system:

- Reports reflect that where ambulances were required for transfer of the patients to the acute, this had been delayed.
- Reports reflect an increase in patients' non-compliance with transfer to the acute once deterioration identified, leading to delays in their care.
- Reports reflect an increase in End-of-Life care plans not being completed.
- There was one death under VW where there was a delay in the initiation of the syringe driver due to the local community nursing team unfamiliar with how to start one, due to new members joining the team.

## 8.0 Good practice to share:

- Patient wishes have been followed with their preferred place for End-of-Life, with families being local to the location.
- Involvement of Families in End-of-Life care plan conversations
- Reports reflect Medications given in a timely manner for any symptom management.
- Reports reflect that RESPECT form was completed and in place.
- There has been an increase in recognition and identification of deterioration for a patient, especially across the UCR/VW services.

## 9.0 Conclusion

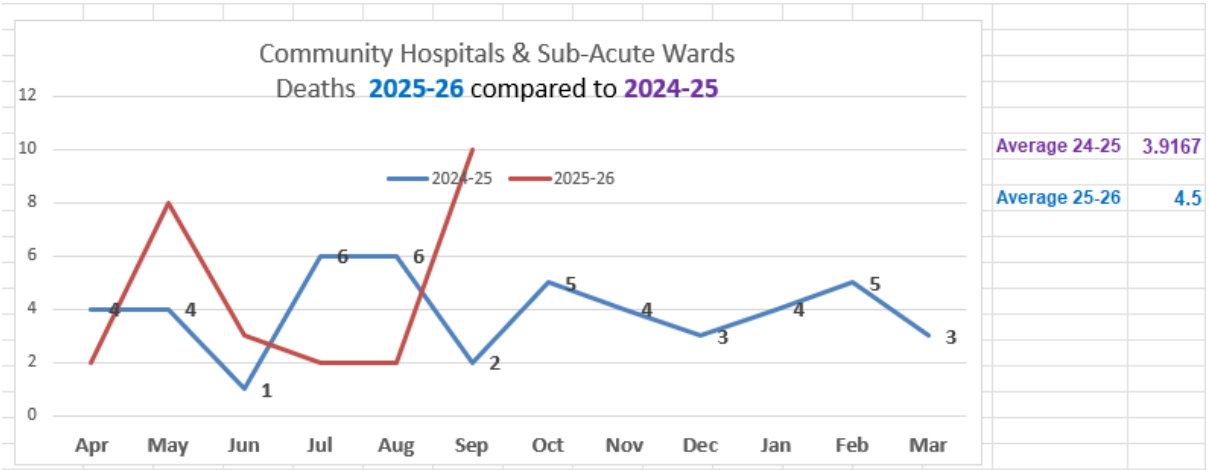
The Learning from Death Group are asked to:

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

# Learning from Deaths 2025-6 Q2 Report

## LIST OF APPENDICES

### *Appendix 1: Deaths in Community Hospitals*



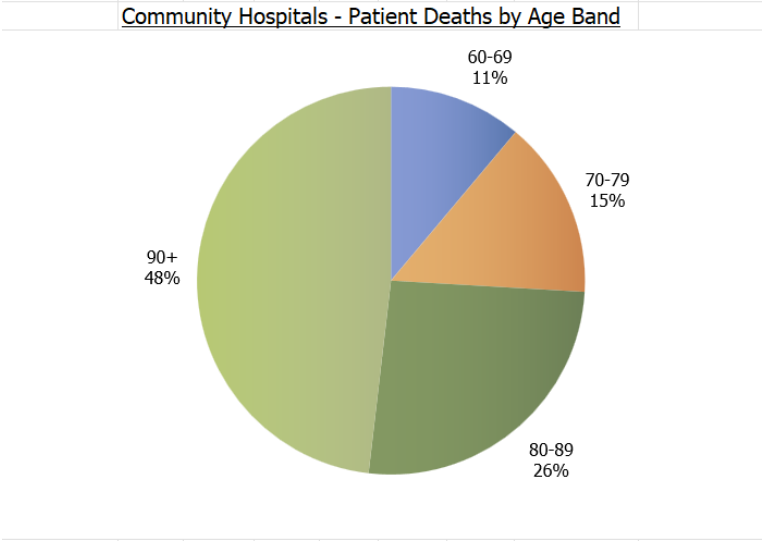

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024-25 | 4 | 4 | 1 | 6 | 6 | 2 | 5 | 4 | 3 | 4 | 5 | 3 | 47 |
| 2025-26 | 2 | 8 | 3 | 2 | 2 | 10 | | | | | | | 27 |

### *Appendix 2: Hospital Mortality Monthly Report*

Community Hospitals - Patient Deaths by Age Band

| No. Episodes | | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Total |
|---|---|---|---|---|---|---|---|---|
| 60-69 | Bishops Castle | | | | | | 1 | **1** |
| | Ludlow | | 1 | | | | | **1** |
| | Whitchurch | | | | | | 1 | **1** |
| | **Total for 60-69** | | **1** | | | | **2** | **3** |
| 70-79 | Bishops Castle | 1 | | | | | 1 | **2** |
| | Bridgnorth | | | | | | 1 | **1** |
| | Whitchurch | | 1 | | | | | **1** |
| | **Total for 70-79** | **1** | **1** | | | | **2** | **4** |
| 80-89 | Bishops Castle | | 1 | | | | 1 | **2** |
| | Ludlow | | | 1 | 1 | | 1 | **3** |
| | Whitchurch | | 1 | 1 | | | | **2** |
| | **Total for 80-89** | | **2** | **2** | **1** | | **2** | **7** |
| 90+ | Bishops Castle | | | 1 | | 2 | 2 | **5** |
| | Bridgnorth | 1 | | | | | | **1** |
| | Ludlow | | 3 | | 1 | | 1 | **5** |
| | Sub-Acute RSH | | | | | | 1 | **1** |
| | Whitchurch | | 1 | | | | | **1** |
| | **Total for 90+** | **1** | **4** | **1** | **1** | **2** | **4** | **13** |
| **Total** | | **2** | **8** | **3** | **2** | **2** | **10** | **27** |

# Learning from Deaths 2025-6 Q2 Report



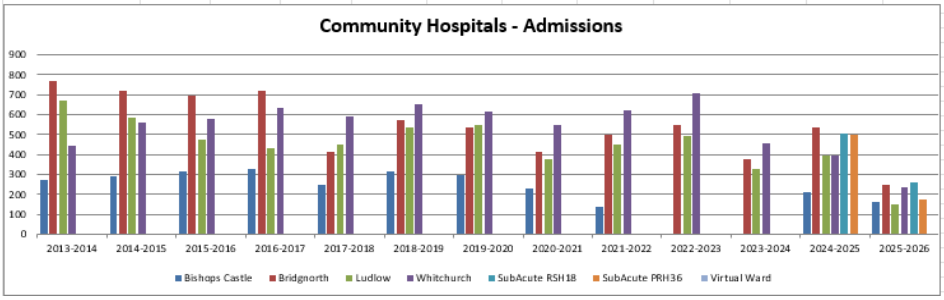

8

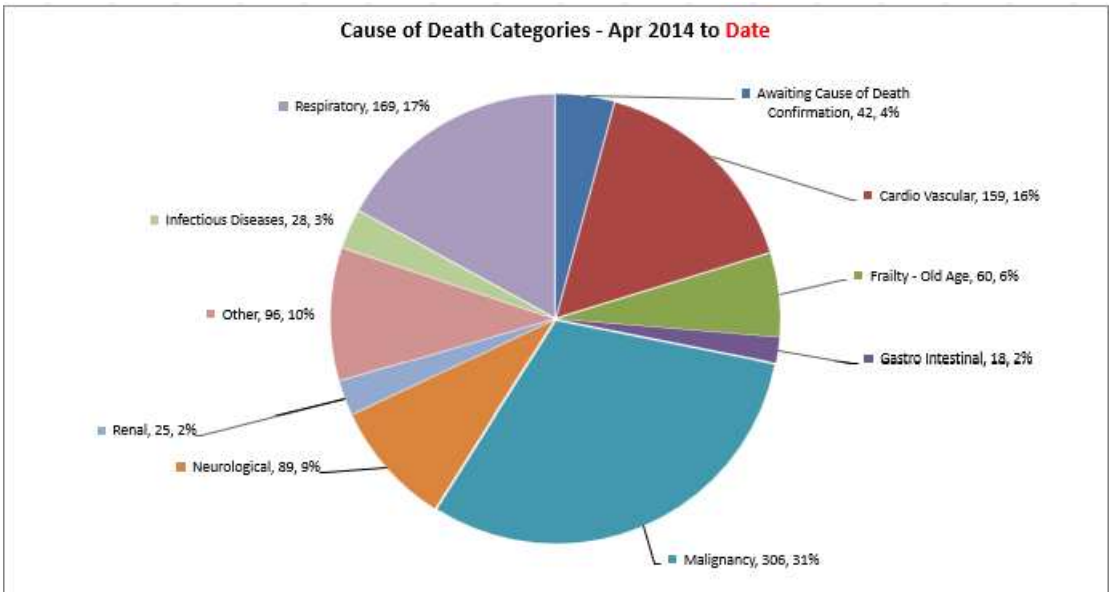
# Learning from Deaths 2025-6 Q2 Report

**Community Hospitals - Admissions**

| Community Hospital | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2018-2019 | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 | 2023-2024 | 2024-2025 | 2025-2026 | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bishops Castle | 271 | 288 | 318 | 328 | 245 | 317 | 299 | 232 | 139 | 0 | 0 | 211 | 162 | 2,810 |
| Bridgnorth | 767 | 722 | 696 | 722 | 416 | 570 | 534 | 412 | 500 | 545 | 378 | 534 | 247 | 7,043 |
| Ludlow | 668 | 583 | 474 | 434 | 451 | 537 | 548 | 379 | 448 | 495 | 330 | 396 | 152 | 5,895 |
| Whitchurch | 445 | 560 | 576 | 632 | 589 | 653 | 617 | 549 | 623 | 708 | 453 | 393 | 236 | 7,034 |
| SubAcute RSH18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 507 | 260 | 767 |
| SubAcute PRH36 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 499 | 173 | 672 |
| Virtual Ward | ` | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Total | 2,151 | 2,153 | 2,064 | 2,116 | 1,701 | 2,077 | 1,998 | 1,572 | 1,710 | 1,748 | 1,161 | 2,540 | 1,230 | 24,221 |

**Note:** Day Cases Admissions not included in this data reporting




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

Shropshire Community Health
NHS Trust

Dentist Appraisal Assurance Report

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Tom Seager | **Paper date:** | **Date of meeting** |
| **Executive Sponsor:** | Dr Ganesh, Medical Director | **Paper written on:** | 19/11/2025 |
| **Paper Reviewed by:** | N/A | **Paper Category:** | Governance/Quality and Safety |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

This paper presents a synopsis of the dentist appraisal process and an assurance to the Board of community dental service compliance with contractually obligated appraisal.

## 2. Executive Summary

### 2.1 Context

The community dental service has been asked to give clarification to Board around the dentist appraisal process.

Additional clarification has been sought in relation to organisational compliance to dental appraisal for M&D staff (non-agenda for change).

### 2.2 Summary

- Dentist Appraisal follows a contractually obligated approach prescribed by the salaried dental service contract (NHS, 2008) and the Appraisal Guidance document (NHS Employers, 2024)
- All dentists receive annual appraisal from their line manager in line with contractual requirements
- All dentists are currently in date with their appraisal review for 25/26

### 2.3. Conclusion

The Quality and Safety Committee is asked to note the dentist appraisal (M&D staff) process and to acknowledge compliance with the contractual requirements for appraisal.

## 3. Main Report

### 3.1 Introduction

Dentist appraisal has been a contractually obligated annual requirement since the implementation of the Salaried (Community) Dental Service (2008) contract.

Dentist Appraisal Assurance Report

All dental professionals including Dentists are professionally registered with the General Dental Council in the United Kingdom.

Dentist registration with the General Dental Council is not contingent on a revalidation process unlike the process for doctors.

**Dental Professional Registration Renewal Obligations**

Maintenance of registration with the general dental council is subject to three criteria:

- Payment of the annual retention fee before 31st December of the calendar year
- Confirming that the dentist has appropriate indemnification in place
- Completion of 100 hours of verifiable Continuing Professional Development within each 5 year cycle

The CPD carried out by a dentist must be classified as “enhanced”- meeting a set of criteria outlined by the GDC and aligned to set development outcomes, with clear aims and objectives, and learning content. Dentist’s must complete reflective feedback for each enhanced CPD session completed.

CPD carried out by the dentist should be aligned to the dentist’s personal development plan which should reflect their development plan for the current 5 year CPD cycle.

Further recommendations are considered advisory by the general dental council including:

- Highly recommended CPD in medical emergencies, disinfection, and radiography and radiation protection
- Recommended CPD in legal and ethical issues, complaints, oral cancer early detection, safeguarding children and young people, safeguarding vulnerable adults.

Appraisal

As discussed the community dental appraisal and job planning process is contractually defined. The framework for this process is rigid and defined by a template which is within the salaried dental service contract for dentists.

In June 2024, NHS Employers in partnership with the British Dental Association published an Appraisal guidance document. This provides further information about dentist appraisal lacking in the original contract.

The appraisal documentation is split into four sections:

• section A relates to personal information

• section B should contain the evidence which the dentist intends to use to demonstrate their progress towards or maintenance of the band specific competencies

• section C is for the documentation of the appraisal interview. This is divided into the same subheadings as the competency framework

• section D is for the documentation of any agreed actions and personal development plan.

Dentist Appraisal Assurance Report

The documentation outlines both employer and employee responsibilities within the dentist appraisal process and stresses that failure to engage or comply with the appraisal process will be regarded as a disciplinary measure.

Organisational Responsibilities

The dentist must be appraised by a senior dentist or the Clinical Director of the Community Dental Service and the outcomes of the appraisals should be shared with the clinical director.

The Chief Executive will be accountable to the board for overseeing the appraisal process. They should ensure and confirm to the board that:

- Annual appraisals have been conducted for all dentists
- Any issues arising out of appraisals and being managed appropriately and action taken where necessary
- Personal development plans are in place for dentists

**Dentist appraisal status 2025/26**

There is a current headcount of 14 dentists employed by Shropshire Community Health NHS Trust. All dentists have had appraisals carried out as outlined in the processes above as this is a contractual obligation. (Exception would be made for any individuals absent for reasons of maternity leave)

### 3.3 Key Risks

No risks are associated with the dental appraisal process.

### 3.4 Recommendations

Acknowledge that dental appraisal is carried out in line with the contractual obligations of the salaried dental service (community dental service) contract (2008)

### 3.5 Conclusion

The Board is asked to be assured of the dental appraisal process and organisational adherence to this.

The Board is asked to assure the CEO and board that dentist appraisals have been completed in 2024/26 in accordance to the dentists' contractual obligations.

## 80. Reference Information

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

## 1. Purpose of Paper

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

The aim of this paper is to provide advice and assurance to the Board regarding the provision of Safer Nurse Staffing and adherence to national policy for June 2025.

## 2. Executive Summary

### 2.1 Context

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

### 2.2 Summary

- The Community Safer Staffing tool was introduced to the Trust in January 2023, however at the beginning of 2024 the National Team paused the tool due to issues with the efficacy of the tool. Following a refresh this has now been relaunched with some changes. Data collection will be collected in January 2026
- The updated Safer Nursing care Tool (SNCT) tool for inpatient areas has added 2 further categories 1C/D this allows us to capture patients requiring enhanced supervision.
- The Trust continues to see increased need for enhanced care for the safety of our patients across all inpatient wards which has increased the use of agency staff as staffing establishment does not include any uplift for enhanced care.
- The Trust has been successful on securing a place on to the NHSE second cohort of the National programme for Enhanced Therapeutic Observation and Care Collaborative (ETOC). The programme commenced in May 2025 with an improvement plan developed which is monitored at Patient Safety Committee to ensure progress is being achieved.
- Safe care is now embedded in inpatient areas. Safe care provides staff with live visibility of staffing levels matching with patient demand, it can highlight areas with short workload-based care hours. It allows for the acuity and dependency of patients to be visible daily so wards can demonstrate how dependant their area is at all times. A weekly report is circulated to the team to monitor consistency of inputting data; this is also monitored and challenged at the monthly e-roster Check and Challenge meetings.
- The six inpatient areas now have a second set of SNCT data, and it is apparent there is a need to increase the establishment to support the enhanced care patients.

- The ICB made the decision to decommission the Rehabilitation and recovery Units (RRU) and so both wards will close at the end of November 2025 with all staff being redeployed to other areas of the Trust.
- The Trust has been served notice that all agency Band 2/3 is to cease and from November 2025 no new agency can be booked although the Trust can break glass until the end of January 2026. This change will potentially impact on the safer staffing of the wards and as a Trust will need to find ways to mitigate this risk.
- Bishops Castle Community Hospital (BCCH) reopened the inpatient facility in July 2024 to 16 beds however due to fire restrictions has now reduced beds to 14.
- Ludlow community Hospital have reduced their beds to 19 from 24 due to the fire risks recently identified
- The Workforce Safeguard Gap analysis action plan now has all 14 actions fully completed and so the Trust is now fully compliant.
- Due to fire regulations BCCH, Ludlow and Whitchurch have increased the staffing by 1 HCA on night duty, this is a cost pressure to the Trust as this increase has not been added to the establishment.

### 2.3. Conclusion

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

When reviewing the performance of the National Developing Workforce Safeguards, we are fully complaint.

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

## 3. Main Report

### 3.1 Introduction

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

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

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

The Developing Workforce Safeguards national policy (2018) identifies that NHS Trusts must ensure the below three components are used in their safe staffing processes:

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

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

The Trust commenced using the validated inpatient tool (SNCT) in June 2023 once the required licence had been received, this tool is used widely in other Community Hospitals. The inpatient tool was updated in 2023 and released for use in 2024.The June 2025 data is the second set of data using this updated tool. The National Community Safer Staffing tool was introduced nationally in January 2023 but was paused in early 2024 by the National Team whilst further checks are undertaken however due to number of staff that need to trained, the data collection will be undertaken in January 2026. This report outlines the Second set of data using the refreshed tool for the community inpatient wards and the RRUs captured via this validated, evidence-based method.

**4.0 Nurse to Patient ratio – Inpatient wards**

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

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

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

**Table 1: Actual Average RN: Patient ratio during June 2025**

| Hospital | RN: Patient Ratio- Day Shift |
|---|---|
| Ludlow | 1:6 |
| Bridgnorth | 1:8.3 |

| | |
|---|---|
| Whitchurch | 1:8.3 |
| BCCH | 1:7 |
| Ward 36 | 1:7 |
| Ward 18 | 1:8.6 |

4.4 At Whitchurch the bed base has reduced to 25 beds but does have the ability to increase to 29 beds for escalation. For June 2025 data collection the ward was open to 25 beds.

4.5 Nursing Associates (NA) are used in the Trust and the updated SNCT tool it includes NA in the Registered Nurse (RN) count. The use of NA to the Trust is now embedded to many of our areas but to ensure safety, professional judgement is applied with triangulation of quality and safety data as a standard daily expectation of leaders and managers. It is to be noted that within the Trust we do count the qualified NA in the RN ratios.

4.6 Actual versus planned staffing numbers for June 2025 showed that 71% of all shifts (both RN and HCSW) were covered by substantive staff. This rate is lower than January 2025 data of 81.66% due to the vacancies at BCCH and Ludlow, 11.3% were filled by Agency staff and 17% were shifts filled by Bank staff. This demonstrates that the fill rate was over 100% and this is due to the need for enhanced care supervision and escalation beds being opened at ward 36.

**5.0 Safer Nursing Care Tool (SNCT)**

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

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

5.3 Following the update on the SNCT tool in 2023, and the data collection period has changed is now 30 days and includes the weekends. The twice-yearly data collection continues (January & June). The tool collects individual patient acuity and dependency and in the updated version 2023 with the added categories 1C and 1D that enables us to monitor the use of enhanced care required by patients. The data collection is undertaken by trained senior Nurses in each team.

5.4 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. It should be used as part of professional judgement and patient outcomes as is the case with this review.

5.5 The Trust gained its licence in early 2023 but due to the refresh of the tool this data collection is the 3rd set of data collected, we will continue to collect 2 sets per year, as this allows us to understand our adherence to the national standards and offer the Board greater assurance.

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

5.7 Bridgnorth has 25 beds with the daily average at 23.13 patients at the time of the data collection. The staffing split is 43:57 RN to HCA. The data also suggests that and additional 2.99 WTE is required for the 1c & 1d patients.

| Beds 25 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment Based on 60:40 |
|---|---|---|---|---|---|---|
| | 10.70 | 0.00 | 11.50 | 0.93 | RN 15.53<br>HCA 20.29 | RN 20.60<br>HCA 13.74 |

5.8 Ludlow has reduced its bed occupancy from 24 to 19 due to fire regulations. The daily average at 18.64 patients at the time of the data collection. The staffing split is 50:49 RN to HCA. The data suggests that an additional 5.29 WTE is required for the 1c and 1d patients. With the actual Establishment at 28.40 there is a deficit of 1.00 WTE without the consideration of enhanced care.

| Beds 19 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment Based on 60:40 |
|---|---|---|---|---|---|---|
| | 4.76 | 0.36 | 8.76 | 4.76 | RN 15.21<br>HCA 14.99 | RN 17.64<br>HCA 11.76 |

5.9 Whitchurch has 25 beds with a daily average of 24.58 at the time of data collection. The staffing split is 51:49 RN to HCA. With the establishment of 34.46 the data suggests a deficit of 5.34 and it also suggests a further 6.30 for 1c/d patients.

| Beds 25 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment Based on 60:40 |
|---|---|---|---|---|---|---|
| | 6.00 | 0.06 | 16.56 | 1.96 | RN 14.67<br>HCA 19.79 | RN 23.88<br>HCA 15.92 |

5.10 Bishops Castle beds have been reduced to 14 due to Fire regulations. The daily average at 10.87 patients at the time of the data collection. The data suggests an additional 1.80 WTE is required for the 1C/D patients. The staffing split is 50:50. With the actual establishment of 18.73 the staffing is sufficient without consideration for enhanced care.

| Beds 14 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment |
|---|---|---|---|---|---|---|
| | 6.93 | 0.0 | 3.30 | 0.56 | RN 11.24<br>HCA 7.49 | RN 9.47<br>HCA 6.31 |

5.11 Ward 36 had 20 beds however due to opening escalation the ward was open to 23 beds at the time of data collection. The daily average of 21.41 patients at the time of the data collection. The staffing split is 54:46 RN to HCA. The data suggests a further 3.82 WTE for the 1c/1d patients. With the actual establishment of 39.23 the data suggests the staffing is sufficient without the consideration of enhanced care.

| Beds 23 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment |
|---|---|---|---|---|---|---|
| | 3.22 | 0.00 | 17.00 | 1.19 | RN 21.17<br>HCA 16.50 | RN 22.52<br>HCA 15.01 |

5.12 Ward 18 had 26 beds with a daily average was 24.80 patients at the time of the data collection. The staffing split is 56:44 WTE. The data would suggest an increase of 9.03 WTE. It further suggests 8.35 WTE for enhanced care patients.

| Beds 26 | Level 0 | Level 1a | 1B | 1C | Actual Establishment | Suggested Establishment |
|---|---|---|---|---|---|---|
| | 5.35 | 0.03 | 17.00 | 3.46 | RN 15.21<br>HCA 14.99 | RN 25.51<br>HCA 17.01 |

5.13 Due to the increasing need for enhanced care for our patients, in May 2025 the Trust enrolled onto the National Enhanced Therapeutic Observation and Care Collaborative. We have produced an improvement action plan, that is monitored at Patient Safety Committee, to ensure progression of the programme.

5.14 The SNCT data suggests that all of the community wards need an increase in establishment to support the enhanced care needs of our patients. It is also important to note that with the National directive of the cessation of band 2/3 HCSW by the end of January 2026, wards would not be able to maintain safety for our enhanced care patients.

5.15 The cost to the Trust in June 2025 for substantive RN/HCSW staff was **565,093K** with an additional bank cost of **125,070K** and an agency cost of **80,137K**, which is a total additional cost of **205,207k** for staffing in June 2025. The additional costs were to cover the increase staffing at Ludlow, BCCH and Whitchurch at night for the fire risk, to cover the additional staff required for enhanced care, escalation beds being opened and high-level sickness. (see Table below)

**Table 2 staffing costs for June 2025**

| | Substantive RN | Substantive HCA | Bank RN | Bank HCA | Agency RN | Agency HCA |
|---|---|---|---|---|---|---|
| WH | 57,749 | 49,990 | 8,132 | 14,989 | 11,909 | 10,497 |
| BH | 59,888 | 59,509 | 6,408 | 7,492 | 1,613 | 1,361 |
| BCCH | 34,079 | 15,965 | 4,867 | 11,917 | 11,582 | 6,951 |
| LH | 37,364 | 37,742 | 9,852 | 12,496 | 12,497 | 8,255 |
| RRU- RSH | 63,780 | 46,427 | 14,440 | 12,668 | 2,975 | 11,092 |
| RRU- PRH | 58,828 | 43,772 | 9,485 | 12,324 | - | 1,405 |

## 6.0 Community Safer Care Tool (CNSST)

6.1 The data for the CNSST has not been included following national instruction to pause it's use whilst further testing is undertaken. The tool has now been updated and launched, and so training is being undertaken, and the next data collection will take place in January 2026, and this data will be included in the next report.

## 7.0 Fill rates for inpatient wards

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

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

**Table 3 – Fill rates (June 2025)**

Key

| |
|---|
| **90-100%** |
| **Over 100%** |

| | | | | |
|---|---|---|---|---|
| | **Day** | | **Night** | |

| Hospital Site | Average fill rate – Registered nurses (%) | Average fill rate – care staff (%) | Average fill rate – Registered nurses (%) | Average fill rate – care staff (%) |
|---|---|---|---|---|
| **Bridgnorth** | 98.6% | 104% | 100% | 106% |
| **Ludlow** | 101.8% | 98.9% | 101.3% | 118.9% |
| **Whitchurch** | 90.3% | 134.5% | 98.9% | 159.9% |
| **BCCH** | 100% | 110% | 100.% | 122% |
| **Ward 36** | 109.8% | 182% | 148% | 160.3% |
| **Ward 18** | 104% | 136% | 100% | 167% |

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

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

7.5 Bed occupancy rates reported for January 2025 were 95.4%. This breakdown for bed occupancy at each site as 96.3% Bridgnorth, 97.7% Ludlow, 83.10% BCCH and 95.5 Whitchurch, Ward 36 PRH, 96.9% and Ward 18 RSH 94.7%.

7.6 For the 4 community inpatient areas, 2 shifts were reported in June 2025 as 100% RN agency staff. These were in relation to 1 shift at Ludlow all for night duty and staff on shift were regular agency to Ludlow and 1 shift at BCCH again RN for night shift.

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

**8.0 Care Hours per Patient Day (CHPPD)**

8.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Insight-Model Hospital website. SCHT data is available on the Model Hospital site and on performing benchmark analysis, for the last quarter (June 2025) the average overall for our Trust is 6.8 care hours per patient day (CHPPD), compared to with average of other similar community NHS trusts of 7.5 (as shown in table 3). This data cannot be viewed in isolation and when triangulating with other data and professional judgement and quality and safety indicators there is not a cause for concern. CHPPD will continue to be monitored monthly. In table 3 you can see that the Trust sits in the 3rd quartile, and this remains a consistent picture.

**Table 4 - Model Hospital Benchmarking table**


| Organisation Name | CHPPD - overall |
|---|---|
| Derbyshire Community Health Service Foundation Trust | 11.6 |
| Kent Community Health NHS Foundation Trust | 8.1 |
| Lincolnshire Community | 7.0 |
| Hertfordshire Community | 7.5 |
| Average for Community Trust | 7.5 |
| Norfolk community | 7.3 |
| East Suffolk | 6.9 |
| Shropshire community Health | 6.8 |
| Sussex Community | 6.5 |
| Bridgwater Community Healthcare | 6.6 |

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

**Table 5– Care hours per patient day – total staffing**

| | Jun-24 | Jul-24 | Aug-24 | Sept-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Bridgnorth** | 6.7 | 6.2 | 7.26 | 6.61 | 6.40 | 6.05 | 6.86 | 6.5 | 6.1 | 5.4 | 5.8 | 7.6 | 7.4 |
| **Ludlow** | 6.85 | 6.33 | 6.61 | 6.05 | 6.45 | 6.41 | 7.77 | 7.11 | 7.1 | 7.7 | 6.4 | 6.5 | 6.7 |
| **Whitchurch** | 6.41 | 6.90 | 6.81 | 6.65 | 6.25 | 6.43 | 6.43 | 7.10 | 7.2 | 7.2 | 6.6 | 6.7 | 7.1 |
| **BCCH** | | 6.88 | 6.37 | 5.96 | 6.20 | 7.63 | 6.3 | 6.67 | 6.6 | 7.3 | 6.7 | 6.5 | 6.7 |
| **RRU Ward 36** | 6.0 | 6.70 | 6.46 | 6.32 | 6.20 | 6.07 | 6.71 | 6.10 | 6.2 | 6.7 | 6.7 | 6.4 | 6.5 |
| **RRU Ward 18** | 5.9 | 6.20 | 5.61 | 5.92 | 5.62 | 4.94 | 6.27 | 6.03 | 6.3 | 6.1 | 6.5 | 5.5 | 5.9 |

**9.0 Incidents**

9.1 During June 2025 there were 7 reported staffing issues, 3 at ward 36, 3 at Ludlow and 1 at BCCH, on review these were related to last minute sickness and although agency was requested, they were not able to cover, also bank/agency staff not turning up for a variety of reasons. No harm to patients occurred.

9.2 During June 2025 there were 2 occasions that the Community inpatient wards had 100% RN agency on night duty, 1 at Ludlow and 1 at BCCH. There were no harms reported due to the 100% agency.

9.3 During June 2025 there were 20 inpatient falls reported which occurred across 5 of our inpatient areas which equates to a rate of 5.36 falls per 1000 Occupied Bed Days (OBDs).

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

**Table 6 – Falls Data**

| Year | | M6 Sept | M7 Oct | M8 Nov | M9 Dec | M10 Jan | M11 Feb | M12 Mar | M1 April | M2 May | M3 June |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **2024/25** | **Falls** | 21 | 17 | 22 | 22 | 19 | 17 | 26 | 23 | 23 | 20 |
| | **Falls/ 1000 OBDs** | 5.26 | 5.04 | 5.44 | 5.02 | 4.34 | 5.19 | 6.71 | 5.80 | 5.27 | 5.36 |

**10.0 Red Flags (Appendix 2)**

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

1. Omission in providing medication

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

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

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

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

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

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

10.3 Datix is used to monitor any delays in pain relief, vital signs not being assessed and delays or omissions or regular check on patients. In June 2025 there were 3 datixes relating to 2 missed doses at Whitchurch and 1 missed dose at Ludlow, no harm to patients and appropriate action taken.

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

10.5 When we review the incidents in table 7 for June 2025, we can see 7 incidents relating to workload resource incidents, this were reviewed related to bank/agency/last minute sickness not attending shift and although further support sort, part of shift left short, no harm to patient documented. There was 1 PSII for Whitchurch in June 2025 that relates to a diabetic medication which is currently under investigation. There were 16 medication incidents, 3 at BCCH,1 at Ludlow, 9 at Whitchurch, 1 at Bridgnorth and 2 at RRU ward 18. These incidents were related to a variety of reasons including 3 omissions of medication, which caused no harm to patients, other issues were antibiotics prescribed not in line with antimicrobial prescribing and issues with medication charts out of hours. These were dealt with safely and do not relate to staffing. June 2025 there were 20 falls, and when triangulated staffing was not a contributing factor.

**Table 7 - Monthly Quality data**

| **Bishops Castle** | **Feb-25** | **March-25** | **April-25** | **May-25** | **June-25** | **July -25** |
|---|---|---|---|---|---|---|
| Number of patient Safety incident investigation (PSII) | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Falls | 1 | 7 | 5 | 5 | 6 | 1 |
| Number of Category ¾ pressure ulcers in Service | 0 | 0 | 0 | 0 | 0 | 0 |
| Workload Resource Incidents | 0 | 0 | 2 | 0 | 1 | 0 |
| Medication Incident | 0 | 2 | 3 | 3 | 3 | 14 |
| **Bridgnorth** | Feb-25 | March-25 | April -25 | May-25 | June-25 | **July - 25** |
| Number of patient Safety incident investigation (PSII) | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Falls | **7** | **4** | **8** | **5** | **2** | **5** |
| Number of Category ¾ pressure ulcers in Service | 0 | 0 | 0 | 0 | 0 | 0 |
| Workload Resource Incidents | **0** | **1** | **0** | 0 | 0 | **1** |
| Medication Incident | **0** | **1** | **0** | **0** | **1** | 4 |
| **Ludlow** | **Feb-25** | **Mar-25** | **Apr-25** | **May-25** | **June -25** | **Jul- 25** |
| Number of patient Safety incident investigation (PSII) | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Falls | **2** | **1** | 1 | **4** | **3** | **1** |
| Number of Category ¾ pressure ulcers in Service | 0 | 0 | 0 | 0 | 0 | 0 |
| Workload Resource Incidents | **0** | **3** | **1** | **3** | **3** | **4** |
| Medication Incident | **1** | **2** | **1** | **0** | **1** | **0** |
| **Whitchurch** | **Feb-25** | **Mar-25** | **Apr-25** | **May-25** | **June -25** | **Jul- 25** |
| Number of patient Safety incident investigation (PSII) | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Falls | 2 | 1 | 2 | 9 | 11 | 4 |
| Number of Category ¾ pressure ulcers in Service | 0 | 0 | 0 | 0 | 0 | 0 |
| Workload Resource Incidents | 1 | 1 | 2 | 0 | 0 | 2 |
| Medication Incident | 3 | 1 | 2 | 0 | 9 | 1 |
| **RRU ward 36** | **Feb-25** | **Mar-25** | **Apr-25** | **May-25** | **June -25** | **Jul- 25** |
| Number of patient Safety incident investigation (PSII) | 0 | 0 | 0 | 1 | 0 | 0 |
| Number of Falls | 1 | 5 | 3 | 6 | 6 | 2 |
| Number of Category ¾ pressure ulcers in Service | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Workload Resource Incidents | 0 | 0 | 8 | 0 | 3 | 0 |
| Medication Incident | 0 | 2 | 1 | 0 | 0 | 1 |
| RRU ward 18 | **Feb-25** | **Mar-25** | **Apr-25** | **May-25** | **June -25** | **Jul- 25** |
| Number of patient Safety incident investigation (PSII) | **0** | **0** | **0** | **0** | **0** | **0** |
| Number of Falls | **2** | **5** | **2** | **4** | **3** | **5** |
| Number of Category ¾ pressure ulcers in Service | **0** | **0** | **0** | **0** | **0** | **0** |
| Workload Resource Incidents | **0** | **0** | **0** | **0** | **0** | **0** |
| Medication Incident | **0** | **2** | **0** | **0** | **2** | **0** |

## 11.0 Risks to Safer Staffing

11.1 NHSE have given all Trusts a directive to reduce costs for both agency and bank in this next financial year. The Trust has robust plans in place to monitor and approve both bank an agency; however, we have been given notice by NHSE that we must cease the use of booking new agency for band 2/3 from 1st November 2025 and cease all use by January 2026. This will pose a risk to the staffing in our community wards as due to the demographic of our ward areas it is not easy to pull from other and so reliance on bank and agency is high.

11.2 Work has been undertaken to increase the bank to enable us to have sufficient temporary staffing when gaps occur. We have an ongoing recruitment campaign to ensure temporary staffing numbers are maintained at a level that is sufficient to support the Trust.

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

11.4 The Trust has engaged with National Health Service Professionals(NHSP) and will go live on the 9th December 2025, this will allow agency staff to move over to NHSP and still earn a similar rate as on the agency but staff working for NHSP is logged as bank not agency, so this will support the Trust with the cessation of agency for Band 2/3

11.4 As we work through the action plan for the ETOC programme we should be able to work with our staff to find better ways to care for our patients with enhanced care needs. The education programme is now in place, and this will support staff to work together to ensure safe and effective care for our patient. This work should enable us to reduce our dependency on Agency/bank staff for enhanced care patient needs without impacting patient safety.

## 12.0 Recommendations available to review and accept

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

12.2 To undertake the first data collection for Community District Nursing teams staffing tool in the January 2026 with the CNSST.

12.3 Whilst the data suggests that changes in establishment are required for both ward establishment and for enhanced care at this time this would not be a recommendation due to the Change in demographic with the RRU closing and the increased capacity in the Urgent Care Response (UCR) opening hours increasing to 6am to 12 midnight this will allow more patients to be seen away from hospital care, as well as the ETOC programme the Trust should monitor these changes for the next 6 to 12 months and to see how these changes affect our patient cohort and then make a recommendation if change is required.

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

12.5 To introduce E-community to the District Nursing teams. This is IT system that links with E-roster. There have been delays with the introduction of this product due to issues with IT integration. We are working through these issues and should be able to go live early in the new year.

12.5 NHSE have now given written notice to the Trust that agency cannot be booked after the 1st November 2025 however they will be able to break glass, but this will be recorded and sent to NHSE monthly and so we will need to monitor what effect this will have on safer staffing.

12.6 The ETOC programme will present at Patient Safety Committee bimonthly to demonstrate work against the plan and to demonstrate improvement in supporting patients with enhanced needs.

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

12.8 For the inpatient data collection, the June 2025 is the 3rd set data with the refreshed tool with the exception of BCCH which is their second data collection. It would seem appropriate to increase the establishment to support the staffing increase for fire risks at Ludlow, Bishops Castle and Whitchurch and also to support the enhanced care for patients as demonstrated in the data collection. Whilst there has been some over recruitment at Whitchurch and Bridgnorth due to reallocation of staff from the RRU closure, this will not cover all areas as Ludlow and BCCH have not had any over recruitment

12.9 Consideration should be taken to the cost of bank and agency that is being used for staffing gaps, enhanced care and escalation beds as for June 2025 the additional cost staffing was 205,207K. It may be more cost effective to add additional substantive staff to the establishment. The cost for an RN is 42,575k and HCA 30,903K (mid-point-including on costs). This would give 4.81 WTE RN or 6.63 WTE HCA and would then significantly reduce agency/bank costs in the following months. This is particularly important due to the cessation of Band 2/3 HCSW by January 2026.

**13.0 Revalidation of Registered Nurses/Pharmacy/ HCPC registered staff**

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

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

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

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

13.5 The Trust has 642.02 WTE which equates to 900 individual Registered Nurses and Registered Nursing Associates that need to renew their PIN by paying their annual fee and revalidate every 3 years. In the last 12 months June 2024 to June 2025 there has been 4 occasions where staff have failed to revalidate, immediate action was taken, and all 4 staff did not work without a current pin number.

13.6 The Trust has 194.53 WTE Paramedics, Speech and Language Therapists and Occupational Therapists and 5.75 WTE Psychology Professional registered with the HCPC. Re-registration takes place on a biannual basis for each profession, whereby the registrant both pays their annual fee and completes a self-declaration of adherence to professional standards. In the last 12 months, June 2024 to October 2025, there have been 2 occasion where a staff member did not complete their re-registrations within the deadline for their profession. Trust policy was followed with both members of staff, with one returning to the register within 48 hours of the deadline. At no time did the staff member work as their registered profession whilst not on the HCPC register.

13.7 The Trust has 25.4 WTE Pharmacy staff which equated to 19 Pharmacists and 15 Pharmacy Technicians registered with GPhC. Revalidation takes place on an annual basis, whereby the registrant both pays their annual fee and revalidates. In the last 12 months, June 2024 to June 2025, there have been zero occasions where staff failed to revalidate.

**14.0 Conclusion**

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

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

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

**Supporting Literature**

Aiken, LH., Sloane, D., Griffiths, P. Rafferty, A.M., Bruyneel, L., McHugh, M., Maier, C.B.,

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National Institute for Health and Clinical Excellence (2014) *Clinical guideline 1: Safe staffing for nursing in adult in patient wards in hospitals*. London, Department of Health. Overview | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE

National Quality Board (2016) *Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time.* NQB, London 2904770 NQB Guidance v1_2_with links A (england.nhs.uk)

NHSI. (2021) *Developing Workforce Safeguards. Supporting providers to deliver high quality care through safe and effective staffing.* London: NHSI. Publication Code: CG 84/18. Developing-workforce-safeguards.pdf (england.nhs.uk)

Royal College of Nursing (2012). *Mandatory Nurse Staffing Levels.* London: RCN.

## Appendices

Appendix 1 – Inpatient Decision matrix

| | |
|---|---|
| Level 0<br>(Multiplier =0.99* ) Patient requires hospitalisation<br>Needs met by provision of normal ward cares. | Care requirements may include the following<br>• Elective medical or surgical admission<br>• May have underlying medical condition requiring on-going treatment<br>• Patients awaiting discharge<br>• Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly<br>• Regular observations 2 - 4 hourly<br>• Early Warning Score is within normal threshold.<br>• ECG monitoring<br>• Fluid management<br>• Oxygen therapy less than 35%<br>• Patient controlled analgesia<br>• Nerve block<br>• Single chest drain<br>• Confused patients not at risk<br>• Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence |
| Level 1a (Multiplier =1.39* )<br>Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATERPOTENTIAL to deteriorate. | Care requirements may include the following:<br>• Increased level of observations and therapeutic interventions<br>• Early Warning Score - trigger point reached and requiring escalation.<br>• Post-operative care following complex surgery<br>• Emergency admissions requiring immediate therapeutic intervention.<br>• Instability requiring continual observation / invasive monitoring<br>• Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly<br>• Arterial blood gas analysis - intermittent<br>• Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains<br>• Severe infection or sepsis |
| Level 1b<br><br>(Multiplier = 1.72*) Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living | Care requirements may include the following<br>• Complex wound management requiring more than one nurse or takes more than one hour to complete.<br>• VAC therapy where ward-based nurses undertake the treatment<br>• Patients with Spinal Instability / Spinal Cord Injury<br>• Mobility or repositioning difficulties requiring the assistance of two people<br>• Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)<br>• Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome<br>• Patients on End of Life Care Pathway<br>• Confused patients who are at risk or requiring constant supervision<br>• Requires assistance with most or all activities of daily living<br>• Potential for self-harm and requires constant observation<br><br>• Facilitating a complex discharge where this is the responsibility of the ward-based nurse |
| Level 1c<br>Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety | • Patients requiring arm's length or continuous observation as per local policy |
| Level 1d<br><br>Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety | • Patients requiring arm's length or continuous observation by 2 or more members of staff(provided from within ward budget)as per local policy |
| Level 2 (Multiplier = 1.97*)<br><br>May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit | • Deteriorating / compromised single organ system<br>• Post operative optimisation (pre-op invasive monitoring) / extended post-op care.<br>• Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure<br>• First 24 hours following tracheostomy insertion<br>• Requires a range of therapeutic interventions including:<br>• Greater than 50% oxygen continuously<br>• Continuous cardiac monitoring and invasive pressure monitoring<br>• Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium<br>• Pain management - intrathecal analgesia<br>• CNS depression of airway and protective reflexes<br>• Invasive neurological monitoring |
| Level 3 (Multiplier = 5.96*)<br><br>Patients needing advanced respiratory support and / or therapeutic support of multiple organs. | • Monitoring and supportive therapy for compromised / collapse of two or more organ / systems<br><br>• Respiratory or CNS depression / compromise requires mechanical / invasive ventilation<br>• Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection |

Appendix 2

Red Flags (NICE2021)

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

Shropshire Community Health
NHS Trust

**EPRR plan approvals**
## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Brian McMillan, EPRR Senior Lead | **Paper date:** | 4TH December 2025 |
| **Executive Sponsor:** | Clair Hobbs, Director of Nursing & Clinical Delivery & AEO | **Paper written on:** | 6th November 2025 |
| **Paper Reviewed by:** | Steve Ellis, Deputy Director of Operational Service Development & Patient Safety Committeee | **Paper Category:** | Governance |
| **Forum submitted to:** | Patient Safety Committee | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

Following requirements to approve strategic EPRR documents at Trust Board, this paper presents the revised versions for approval by Trust Board.

## 2. Executive Summary

### 2.1 Context

The Trust maintains 2 strategic EPRR documents – the EPRR Policy and the Business Continuity Policy. Both documents were historically approved by the Patient Safety Committee until 2024 when the NHS England Core Standards for EPRR required both documents to be Board approved annually.

The requirement is for both documents to be signed off by the Trust Board, rather than a group or individual through delegated authority schemes.

### 2.2 Summary

The EPRR Strategy (V7) is the overarching strategic document that structures our EPRR arrangements. It addresses all aspects of EPRR delivery and references the response plans and arrangements required for compliance.

The document itself is considered compliant and is reviewed and approved annually. It was previously approved by Trust Board on 5th December 2024. The Strategy is within the bundle for approval.

The Business Continuity Strategy (V10) is the overarching strategic document that structures the Trust's business continuity management system. It details our plan phases, roles and responsibilities and aligns to ISO 22313 and the NHS England Business Continuity Toolkit.

The document itself is considered compliant. It was included in the 2023/2024 audit by BDO auditors that went to Audit Committee. It was previously approved on 5th December 2024. Attached to the Document is an Annex 1 – Business Impact Assessment. This has recently been comprehensively reviewed and streamlined.

**EPRR plan approvals**
The strategy is contained within the bundle for review.

**2.3 Conclusion**

The Board are asked to:

- **review** and **approve** both documents as part of their annual approval cycle.

# EPRR Annual Board Report

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | **Brian McMillan, EPRR Senior Lead** | **Paper date:** | **4th** December 2025 |
| **Executive Sponsor:** | Clair Hobbs, Director of Nursing & Accountable Emergency Officer | **Paper written on:** | November 2025 |
| **Paper Reviewed by:** | Steve Ellis, Dep. Dir. Operational Service Development | **Paper Category:** | Governance |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

This paper presents an update on the Trusts Emergency Preparedness, Resilience and Response (EPRR) function for Board scrutiny and assurance.

## 2. Executive Summary

### 2.1 Context

The Trust is required to annually update the Board on a number of different aspects of Emergency Planning and Business Continuity issues to provide adequate assurance of its resilience and response capabilities.

The contents of the report include updates required within the NHS Core Standards Framework (2022).

### 2.2 Summary

Trust response capabilities continue to evolve, with business continuity management systems introduced in 2024/25 now maturing and enabling services to be more resilient to disruption than previously.

The Trust has been rated similarly to 2024 in its annual assurance process for EPRR and is building towards the next assurance piece which will have a more robust confirm and challenge process and have newer standards than previously.

### 2.3. Conclusion

The Trust Board is asked to:

- **Note** the contents of this report
- **Note** the core standards compliance award of **Substantially Compliant**, and
- **Accept** this report as assurance of the Trust's EPRR capabilities.

## 3. Main Report

### 3.1 Introduction

The Trust has a duty to prepare for incidents and disruptive events and to put arrangements in place to continue service delivery throughout disruptive events. It also must collaborate with other responding agencies to support a multi-agency response where required.

The statutory duties for the Trust are contained within the Civil Contingencies Act 2004 and the Health and Social Care Act 2012. Additionally, the NHS Core Standards Framework 2022 set out a number of minimum standards across the entire EPRR agenda and the Trust is measured against these standards annually. The Core Standards for EPRR are a robust measurement tool for organisational resilience.

Many of the Trust structures and processes were introduced in 2023 and have been developing since that time. The Trust is now on a sound footing with its internal arrangements and has good collaborative relationships with partner agencies locally and regionally where we deliver out of area services.

### 3.2 NHS Core Standards for EPRR

The standards cover 10 x domains across the spectrum of EPRR:-

1. Governance
2. Risk
3. Plans
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10. CBRN

Each domain has a number of standards, totalling 58 across all domains. Each standard has a number of evidential requirements.

Standards are assessed as:-

- Fully compliant – meets all standard and evidential requirements
- Partially compliant – fails to meet all requirements and is on a work programme for the following 12 months
- Non-compliant – fails to meet the standard and will not be made compliant within 12 months

The resulting assessment is then given an award based on the percentage achieved. Only fully compliant standards count towards the award.

- Fully compliant – 100% of the standards met.
- Substantially compliant – 89 – 99% of the standards met.
- Partially compliant – 77 – 88% of the standards met
- Non-compliant – less than 77% of the standards met.

This year's award was **Substantially Compliant**, with an assessment of 52/58 or **89%.** There were no 'non-compliant' standards. This was similar to last year's award, although the partially compliant standards have differed this year.

A breakdown of the partially compliant standards is detailed below.

#17 Lockdown Plan – Inability to currently lockdown the sites due to estates constraints and communication gaps. Work ongoing to resolve these issues and building towards a Live exercise in 2026 to test the capability and a build a new response plan for all sites.

#34 Incident Communications – A new plan has been created following Group Modelling with the Communications Team. However, Incident Communications has yet to be tested and there are some initial elements of the plan that need to be worked through within the next 12 months.

#35 Communication with stakeholders – There remains a gap in capability to rapidly communicate with staff and geographical groups across the Trust during an incident. Work is ongoing to develop a means to do this that avoids reliance on the Trust network or manual telephone cascades.

#49 Data Security Protection Toolkit – The Trust achieved a rating of 'Approaching compliance' with the DSPT, pending a small piece of remedial work. This was not enough for compliance with the standard this year.

#53 Business Continuity supplier resilience – The assurance of supply chain and contractual resilience and their links to priority services is not where it needs to be. The Procurement and Contracts Team are system wide. The Trust has developed an approved solution but it has not been implemented to date. This now features on the system wide workplan for 2026 with the ICB leading the implementation of the agreed solution.

#65 CBRN PPE compliance – FFP3 fit mask testing compliance rates need to improve. An improvement plan has been implemented by the Infection Prevention Education and Advice Team to increase compliance rates over the next 12 months.

### 3.2 Resources and Structure

This year, amendments have been made to the EPRR structure and work undertaken to increase resilience in the service.

The main EPRR Working Group has been reduced and is now a smaller group of 4 main attendees of a more senior nature, led by the Accountable Emergency Officer and Director of Operations. Other attendees are co-opted in by the Chair as required by the workstream or subject area. This has led to a far greater understanding of EPRR amongst senior colleagues and greater engagement with work programmes.

Work has taken place to identify alternative leads for elements of the EPRR function in the absence of the EPRR Senior Lead. These are outlined below:-

- Risk (including attendance at LRF Risk workshops) - Deputy Director for Operational Service Development
- EPRR systems (including Resilience Direct, Hazard Manager, etc) - Business Support Officer, Operations
- Decontamination – Ludlow Minor Injury Unit Team Lead

The Deputy Director for Operational Service Development has taken line management responsibility for the EPRR Senior Lead role and joined the EPRR Working Group, providing more strategic involvement in planning arrangements and exercises, and a more resilient day to day service than in previous years.

The Board can have assurance that the EPRR Service currently has sufficient resources within the current system delivery model.

**3.3 Response Plans**

The Trust maintains a suite of Incident Response Plans and documents aligned to these, to complement and support our incident response and recovery capabilities.

There are 3 strategy documents –

1. EPRR Strategy – updated and requires Board approval on a separate paper
2. Business Continuity Strategy – updated with renewed priority activities and requires Board approval on a separate paper
3. EPRR Risk Strategy – risks reviewed and added to Datix for 2025

There are then a number of mandated response plans

1. Incident Response Plan
2. Adverse Weather and Health Plan
3. Lockdown Plan – pending significant re-write following planned live exercise in 2026
4. Evacuation and Shelter Plan – has had numerous tests in 2025
5. Mass Casualty Plan
6. Mass Countermeasures Plan
7. Mass Fatalities and Excess Deaths Plan
8. VIP / Protected Persons Plan
9. CBRN / Hazmat Plan
10. New and Emerging Pandemics Plan – tested as part of a national exercise
11. Infectious Disease Plan – sits with IPC Committee

In addition, there are some non-statutory plans which have been created due to risks to services:

1. Digital Response Plan – due to be mandated for 2026
2. Fuel Disruption Plan
3. Outline Power Outage Plan
4. Training and Exercising Policy

All plans have been reviewed and approved for 2025. In addition, 114 business continuity plans have been reviewed and tested as part of the overall arrangements.

### 3.4 Summary of Incidents and Business Continuity disruptions

There have been no incidents declared or escalated service disruptions throughout 2025. Services are more resilient with service level business continuity plans.

### 3.5 Training and Exercising

The Trust is required to have a 24/7 on call capability to respond to incidents. This is enabled through our Manager and Director on Call staff. They are required to be trained to National Occupational Standards and to maintain their competency through exercising.

The On-Call training compliance dipped slightly during 2025, due to a large turnover of the on-call cadre but has been restored again to over 70% for both cohorts. In addition to the internal training pathway, there is a mandatory training course run by NHS England, which has not been available throughout 2025 due to a review of the course. It is now back online, and staff are being encouraged to book places given the backlog regionally.

With the Manager on Call staff, there are 10 x courses measured and 19 applicable staff. Current compliance against all courses on the pathway is – 133/190 (70%)

With the Director on Call staff, there are 10 x courses measured and 18 applicable staff. Current compliance against all courses on the pathway is – 146/180 (77%)

### 3.6 Exercising

The Trust must deliver a set number and type of exercises within its programme. The minimum required is;

- 2 x communication tests per year. One in hours and one out of hours.
- 1 x business continuity exercise per year
- 1 x desktop exercise per year
- 1 x CBRN (Chemical, Biological, Radiological & Nuclear) exercise on reviewing the CBRN plan
- 1 x command post exercise every 3 years
- 1 x live exercise every 3 years

Over the last 12 months, the Trust has conducted a number of internal exercises and supported partners in their exercise efforts. Subject matters covered and delivery methods are listed below:-

- Severe Weather (desktop)
- Communication Exercises (6 x desktop)
- IT outage (desktop)
- Severe Weather (Command Post)
- Pandemic Response (3 x Command Post and 1 x workshop)
- Waste Fire (desktop)
- Lockdown (desktop)
- Evacuation and Shelter (5 x live exercises and 1 x workshop

Partner exercises supported have included:-

- Waste Fire
- Vulnerable Persons
- Marauding Terrorist Firearms Attack
- Power Outage
- RAAC incident

The Trust has also taken part in a national 'Tier 1' exercise from Central Government. Spread across September, October and November. Exercise PEGASUS was a pandemic virus exercise across multiple national response layers. The Trust had a full Incident Team on each phase of the exercise to test our New and Emerging Pandemics Plan. Learning from the exercise will be incorporated into documents from 2026.

The Trust has a requirement to conduct a 'live' exercise every 3 years. The live 'bedpush' exercises conducted in 2025 were not sufficient to discharge this requirement. The Trust is in the early stages of planning a live 'Lockdown' exercise for May 2026. Partners are supporting the exercise including NHS England national leads.

The exercise will be conducted with all services running and will minimise any disruption to patients.

### 3.7 Business Continuity Management System

The Trust has undertaken significant work to improve our Business Continuity Management System (BCMS) in the last 12 months. We have taken the Trust from a position in April 2023 of having only 6 non-compliant plans and no central capability, to now having 114 plans across each team or service within the Trust – achieving 90% compliance in the Core Standard domain in the last 2 years.

Every clinical team has a compliant plan. Over 250 training courses have been delivered to support teams to maintain and review their own arrangements. Many plans are now on their second annual update and have been tested locally.

This work is driving increased resilience across the organisation as teams better understand their priorities, risks and mitigations. Less disruptions are being escalated and the teams are much more responsive to resilience planning documents regarding planned outages.

In addition to the standard plans, the Trust is developing 2 x sub streams of BCMS. One is a comprehensive digital reference document detailing teams with critical services and their IT dependencies and workarounds. The second is a geographic reference document of teams bases and service areas to enable a better response to a non-Trust incident impacting a particular geographic area.

Plans will continue to mature now, with only minor amendments required.
To accompany the latest version of the Business Continuity Strategy, all services have reviewed the list of priority activities annexed to the plan. It has been an important step in maturing our Business Continuity Management Systems this year.

### 3.9 Lessons Identified

Detailed below are the lessons identified through various exercises undertaken in the past year and the expected outcome and RAG status.

| Source | Learning Identified | Owner | Type | Expected Outcome | Target Date | Status |
|---|---|---|---|---|---|---|
| Ex Chetton Feb 2025 | On Call staff were not all able to access Resilience Direct to upload agency updates and access documentation. Some were not confident in using the system and some had not registered for use of the system. | Deputy Director of Operational Service Delivery | Incident Support | All On Call staff to be instructed to register for a Resilience Direct account and to be encouraged to do some RD training if they are not confident in its use. | Feb-25 | On-call capability now included on the TNA. |
| Ex Chetton Feb 2025 | The loggist activation card is in the On Call Handbook and in the Incident Response Plan. Despite this, the participants are regularly reporting they don't know how to do this. This is evidencing a lack of use of the on-call documents. | EPRR Senior Lead | Incident Support | The loggist / Command Support Role activation card to be refreshed and discussed in the On Call Forum. It will be recorded as a separate document on MS Teams | Feb-25 | Refreshed and included in training materials. Mentioned regularly in the Ops Huddle and will be addressed in the next on call forum. |
| Ex Pegasus Phase 1 | PPE stock knowledge is really challenging and when it did come through it is clear the current procurement push model is leaving resilience gaps. | DIPC/ Deputy DIPC | PPE stock | DIPC/IPEA Committee to consider PPE stock in the context of the national urgent request that we could not respond to within time, to link in with proposed CIP project for PPE Stores | Dec-25 | Ongoing discussions on central stock storage |

| | | | | | | |
|---|---|---|---|---|---|---|
| Exercise Pegasus Phase 1 | Lack of place-based considerations in the multi-agency setting means Trust responders have to keep this to their forefront and keep pushing it within the agendas. | EPRR Lead | Place based care | EPRR lead will include reference to this in the Incident Response Plan, Tactical and Strategic Commanders Action Cards and in training materials. | Dec-25 | Included in materials and has been addressed in West Mercia and West Midlands LRF debriefs from Pegasus |
| Exercise Pegasus Phase 1 | The multi-agency notification and alert system failed again and needs a regional review with health partners. There may be some internal considerations if the PAM is only going out by email. | EPRR Lead | Notifications | The system wide EPRR group and ICB lead are following this up with LRF secretariat to explore other options. | Dec-25 | Challenged with LRF lead and confirmed the failing is at the point of contact with the ICB. The call is going through, but not being cascaded. Trust EPRR lead still has a workaround until this is resolved. |
| Exercise Pegasus Phase 1 | Lack of confidence in Incident Communications support and capability | EPRR Lead / Comms Lead | Communications | New Incident Communications Plan and Toolkit produced. Team in early stages of Group Modelling. DDOSD to follow up discussions with Head of Communications and face to face involvement in Phase 3 to be undertaken | Dec-25 | Further issues in Phase 2, addressed ahead of a further test in Phase 3. Will pick up with a specific debrief with the new comms lead and review of Trust plan |

| | | | | | | |
|---|---|---|---|---|---|---|
| Exercise Pegasus Phase 1 | It was identified that there are services in Staffordshire that would require similar arrangements and action cards to the Black Country Services. | EPRR Senior Lead | Place based care | EPRR lead to ensure an Action Card is produced in a similar way to the Dudley Incident Action Card | Dec-25 | New action card being built |
| Exercise Pegasus Phase 2 | PPE stock knowledge is not easily available across all services, with no HCID PPE stock | EPRR Lead / DIPC | EPRR Working Group | EPRR Committee to consider PPE stock in the context of the national urgent request that we could not respond to within time, to link in with proposed CIP project for PPE Stores | Dec-25 | National issue across all organisations, currently being worked through. Pending feedback from national team on Pegasus expectations |
| Exercise Pegasus Phase 2 | FFP3 compliance is low, particularly when widened out beyond high-risk teams | EPRR Lead / DIPC | EPRR Working Group | consider FFP3 compliance which is tightening in the 2026 EPRR Core Standards. | Dec-25 | IPC currently looking at an improvement plan with Operational teams |

### 3.10 Summary

To borrow a Government EPRR assurance term that was significant in the Manchester Arena Inquiry, the Trust has a good 'grip' on EPRR currently. Improvements have been identified and will continue to be worked on throughout the 2026 reporting period. The Board can be assured that there is a commitment to EPRR and Business Continuity within the Trust and a commitment to working in collaboration with partners in line with our statutory duties.

2026 will be a significant year, building towards our Live Exercise in May.

### 3.11 Conclusion

The Trust Board is asked to:

- **Note** the contents of this report
- **Note** the core standards compliance award of **Substantially Compliant**, and
- **Accept** this report as **assurance** of the Trust's EPRR capabilities.

Shropshire Community Health NHS Trust

# SCHT Business Continuity Strategy V10.1

| **Document Details** | |
|---|---|
| Title | **Business Continuity Strategy V10** |
| Trust Ref No | 2034-84110 |
| Main points the document | Set out how the Trust manages its Business Continuity Management Systems |
| Who is the document aimed at? | All managers and employees of Shropshire Community Health NHS Trust |
| Owner | EPRR Senior Lead |
| Approval Process | |
| Who has been consulted in the development of this plan? | Locality Clinical Managers, Communications, SDG Managers, Business Continuity Leads, EPRR working group, Patient Safety Committee, STW ICB, NHS England Regional EPRR team |
| Approved by | Trust Board |
| Approval Date | |
| Initial Equality Impact | Yes |
| Full Equality Impact | No |
| Lead Director | Accountable Emergency Officer |
| Category | Operations |
| Sub-category | Business Continuity |
| Review date | November 2025 |
| **Distribution** | |
| Who the policy will be distributed to | All staff, held electronically on Microsoft Teams and Staff zone with a resilient copy on Resilience Direct. Paper copy in the Incident Control Room at Halesfield 6. |
| Method | Teams and email alert to all affected groups.<br><br>Highlight item in Trust communications and BC Training |
| Keywords | Business Continuity, Business Impact Assessment,<br><br>ISO 22301:2019, ISO 22313:2020 |
| **Document Links** | |
| Required by CQC | Yes |
| Other | NHS National contract NHS E EPRR Core Standards, ISO 22313, Business Continuity Institute Good Practice Guidelines, NHSE BC toolkit 2023 |

| **Amendments History** | | |
|---|---|---|
| No | | |
| V8.1 | Brian McMillan | Inclusion of RTO/MPToD. Updated NHSE AT to ICB on call. Inclusion of ISO 22313. Inclusion of National Planning Assumptions and Cat 2 partners statutory obligations. Inclusion of alert/warning intel systems for weather disruption and of mapping capability for floods and fuel disruption. Inclusion and explanation of Recovery Time Objectives. |
| V9.0 | Brian McMillan | Wholesale review and redrafting to follow national template within the NHS England BC Toolkit 2023 |
| V9.1 | Brian McMillan | Amendment to include procurement and audit details following consultation |
| V9.2 | Brian McMillan | Annual review |
| V9.3 | Brian McMillan | Review following EPRR Core Standards – amendment to approval process. Document now reviewed and approved by Trust Board |
| V10 | Brian McMillan | Annual review and substantial review of the Trust BIA. Moved to an annex of this plan to ease ongoing BIA reviews. |
| V10.1 | Brian McMillan | Organisational BIAs reviewed by EPRR task and finish group |

# 1. Contents



# 2. Scope

2.1 This document has been developed to support SCHT with the management of its Business Continuity Management System. Maintaining an effective business continuity management system is a statutory requirement of the Trust.

2.1.1 The document is aligned to the following standards and references:

- ISO 22301:2019 – Business continuity management system requirements
- ISO 22313:2020 – Societal security – Business continuity systems – Guidance
- BCI Good Practice Guidelines (2018)
- Civil Contingencies Act 2004
- Health And Social Care Act 2022
- The NHS Act 2006
- Duty to maintain business continuity plans within the Civil Contingencies Act 2004
- NHS EPRR Core Standards Framework
- NHS Standard contract (SC30)
- NHS England business continuity Toolkit 2023

2.1.2 Under the Civil Contingencies Act 2004 and the Health and Social Care Act 2022, all NHS organisations have a duty to put in place business continuity arrangements. The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) is the assurance framework for these requirements. This requires that services should be maintained to pre-determined levels during any disruption or recovered to these levels as soon as possible.

2.1.3 ISO 22313 is the best practice standard for business continuity strategies. ISO 22301 is the best practice standard for business continuity plans. The NHS England Business Continuity Toolkit 2023 aligns to the standards and is designed to help NHS organisations, and providers of NHS funded care, to prepare for, respond to and recover from unexpected and disruptive incidents. It also provides a structure for the Trust to align with and as a result, highlights key areas that must be adopted as part of the Plan, Do, Check, Act (PDCA) cycle.

2.1.4 A Business Continuity Management (BCM) system provides a holistic management process that identifies potential threats to NHS organisations and the impact on business operations those threats, if realised, might cause.

2.1.5 Business Continuity guidance requires ownership, commitment and reviews by senior leadership and top management. NHS England have articulated in November 2024, that this must be the Board and not a sub-Committee or delegated individual. From this point, the Strategy will be annually reviewed and approved by the Trust Board.

## 3. Objectives

3.1 This document is designed to support the development of business continuity arrangements. In addition, to support the implementation of a business continuity management system, exercising of plans and auditing.


3.1.1 In order to maximise the benefits of a successful BCMS, we need to continually use the PDCA cycle.

3.1.2 The BCM toolkit is derived from The Plan, Do, Check, Act (PDCA) cycle. SCHT will refer to this cycle, to drive continual improvements in planning and raising the standard of business continuity preparedness as per NHS toolkit guidance.

| | |
|---|---|
| **Plan** | • Establish the BCMS strategy system<br>• Review the Organisational Business Impact Assessment<br>• Develop Training for Operational Teams<br>• Establish a documentation system that follows the NHSE template<br>• Plan with Teams, Localities and Sites |
| **Do** | • Undertake Team level Business Impact Analysis<br>• Implementation of Team level plans<br>• Create an exercise programme.<br>• Develop a lessons register |
| **Check** | • Schedule management reviews<br>• Undertake internal audits.<br>• Exercise plans |
| **Act** | • Debrief<br>• Implement corrective actions.<br>• Ensure Continuous improvement measures.<br>• Share good practice and lessons identified |

3.1.3 Each plan will identify prioritized activities within the Team / Locality or Organisation and shall focus on the following key areas –

- Disruption or loss of staffing
- Disruption or loss of operating premises (including power and utilities)
- Disruption or loss of information and data
- Disruption or loss of ICT systems
- Disruption or loss of suppliers

- Requirements for ongoing patient care

3.1.4 Functions will be prioritised using a Business Impact Assessment (BIA). Maximum Permitted Time of Disruption (MPToD) and Recovery Time Objectives (RTO) are used to identify the timeframes of expected and required recovery, therefore informing an organisations risk register or decision maker of further risk or potential impact. They have a secondary role of providing a clear escalation point from the local management to the Trust senior leadership.

3.1.5 Where mitigation measures, known as 'design solutions' are identified, these shall be aligned to the Recovery Time Objective identified. Design solutions are the mitigations and workarounds that already exist or would be locally used to mitigate the impacts. Where there are no design solutions, this becomes the focus of the incident management team, to maintain priority services.

3.1.6 The Trust will have Team level plans for all Trust Services and Teams. These shall escalate up to Locality level plans, which in turn will inform the Organisational level business continuity plan. By designing the business continuity system in this fashion, subsidiary plans can be used in isolation to manage a small local incident or to escalate to a major/critical or significant business continuity incident which may have a wider organizational impact.

# 4. Purpose

4.1 This document will support the trust to provide factual evidence of robust planning and preparation. The BCMS process is required as part of the EPRR assurance, or other commissioning activities at NHS England regional or lower level (ICB).

4.1.1 Having a robust BCM system provides assurance to the trust and commissioning bodies such as the ICB/NHS England that we can respond, recover and learn from incidents, whilst trying to maintain services and our reputation.

## 4.2. Individual Roles within the strategy

- **Accountable Emergency Officer** – Board Level Executive Director responsible for the Trust EPRR programme including BCMS. Must be trained in the Principles of Health Command Strategic level training.
- **Emergency Planning Senior Lead** – Lead individual for supporting the review, maintenance, training, exercising and guidance on BCMS planning. Must be CBCI qualified and hold a level 3 teaching certification.
- **Team or Service Business Continuity Lead** – Local service leads responsible for maintenance, review and exercising of local operational level (service or team) BC plans. Must have undertaken BC awareness training to develop knowledge of the NHS England BC toolkit.
- **Locality business continuity lead** – Lead individual for a locality site, usually a Community Hospital, accommodating a range of teams/services. Must have undertaken BC awareness training to develop knowledge of the NHS England BC toolkit.

# 5. Risk Assessment

5.1 Business Continuity risks sit within the overall EPRR risk strategy framework. The Trust operates a corporate risk register of identified risks to the organisation. This escalates to a corporate Board Assurance Framework (BAF) that documents higher scored risks. Separate to that, the EPRR function operates an EPRR risk overview, to have sight of emerging EPRR threats, events and intelligence that are not yet impacting upon the organisation. The EPRR working group have oversight of emerging risks and can escalate them to the corporate register or BAF as appropriate.

5.1.1 Within the EPRR risk framework, business continuity plans will identify local issues that may pose a risk to service delivery. These are issues outside of the standard disruption categories that each plan considers and will look in more detail as local issues that may impact a team. Additionally, they may be single points of failure identified through reviews of service business continuity arrangements. Where these are identified, a 'design solution' will be detailed to provide mitigation in that circumstance. Gaps where mitigation is not possible, will escalate via the EPRR working group to the corporate register or BAF as required. This prevents the Corporate Risk structure having to review all business continuity plans and EPRR risks on the National Security Risk Assessment and Community Risk Registers.

# 6. Business Impact Analysis

6.1 The BIA will break each Service down into component parts, referred to as functions or activities and will focus on these rather than roles or risks. The BIA will then RAG rate the functions to visually demonstrate how each Service will suspend, alter, contract and expand to mitigate the disruption and continue service delivery where possible. Each Function shall identify a Recovery Time Objective (RTO) and Maximum Permitted Time of Disruption (MPToD) as well as details of the organisational risk that a failure to restore the activity within that Service would bring.

6.1.1 Where a function has been RAG rated via the BIA, all interdependencies will be mapped to that RAG status. This ensures that Estates, IT and data priorities align to the activity and clinical priority. Where gaps exist, due to contractual or response constraints, mitigating design solutions will be developed for the intervening gap period.

6.1.2 The Trust's current strategic organisational BIA is attached at Appendix A.

# 7. Business Continuity Plans

7.1 Plans will be in place across 3 levels – Organisational, Locality and Team Level. *(This deviates from the common Divisional level plan for NHS organisations. However, due to the geographical spread of services within SCHT, disruption happens in localities, not divisions)* Specific risk-based plans may also be created if a system or location poses a risk to multiple services and requires detailed arrangements to be explored.

7.1.1 Plans will cover the following categories of disruption – listed with design solutions where possible. The categories of disruption are identified within the NHSE EPRR Core Standards Framework. Other categories may be added where local risks are identified, and existing workarounds are identified.

Loss or disruption to:-

- People
- Premises
- Utilities including IT
- Information and Data
- Supply chain
- Service, resulting in compromised patient care

7.1.2 The EPRR working group shall have oversight of the annual BCMS audit and improvement plans. The group will monitor actions and taskings and shall report to the Trust Patient Safety Committee quarterly and the Quality and Safety Committee biannually on the overall resilience of the Trust BCMS.

7.1.3 Assurance on BCMS will be a key feature of the annual EPRR Board report. The Trust's Annual Board report shall also contain a commitment to business continuity and EPRR within it.

7.1.4 The Audit Committee shall have responsibility for the programme of external audit. This schedule includes BCMS. Where BCMS is identified for external audit, the EPRR Senior Lead shall work with the Auditors and report back to the Audit Committee on recommendations and audit reports.

# 8. Training

8.1 Training in Business Continuity Awareness will follow the NHS England BC Toolkit presentation (2023). This will be provided in a classroom environment where possible to all business continuity leads to support their role in maintaining and testing their own plans.

8.1.2 Business Continuity Awareness training will also be provided to all On Call managers and Directors as part of the Trust's approved training pathway within the EPRR Training and Exercising Policy. Training will be delivered by the EPRR Senior Lead who is CBCI and Level 3 AET qualified.

8.1.3 Training will be recorded in the Trusts EPRR Training Needs Analysis and shall be reported to the Patient Safety Committee. Training compliance and feedback shall also form part of the annual EPRR report to the Trust board.

8.1.4 Training evaluation forms shall be used following each training session to review delivery and ensure continual improvement of training materials and delivery. Training materials and the pathway are aligned to the National Occupational Standards and the Minimum Occupational Standards for On Call.

# 9. Exercising

9.1 The Trust is required to undertake a minimum of one desktop exercise each year, with 3 yearly command post and live exercises.

9.2 The Trust will carry out a minimum of 1 desktop exercise each year which will focus on several service business continuity plans. The expectation is that local plan owners carry out more localised exercising of plans throughout the year with an overarching desktop carried out centrally by the EPRR Senior Lead.

9.3 All business continuity exercises shall have a post exercise report to highlight any actions and improvement plans, or to highlight good practice. These will be shared with the EPRR Senior Lead who can collate these centrally within the Trust and have oversight of action plan compliance.

9.4 Reporting on Trust exercises will be a standing item for the EPRR working group and shall be escalated to the Patient Safety Committee.

# 10. External Suppliers and Contractor

10.1 The Trust are system participants in a Shropshire, Telford & Wrekin Procurement and Contract Management Team. As part of the Contract Management policy, regular contract and performance review meetings will take place in accordance with the pre-assigned supplier risk classification level and these meetings will involve the continuous tracking of contracts or innovations mutually agreed with gold level suppliers.

10.1.1 All meetings will be chaired by the Contract and SRM lead and conducted using the standard Contract Review Meeting template with actions followed up as agreed. Minutes of meetings and agreed actions and results will be electronically communicated to all stakeholders following each meeting and recorded by the Contract and SRM team and uploaded on to ATAMIS as part of monitoring and tracking overall performance metrics.

10.1.2 The Contract Review Meeting template has been designed to ensure key contract management topics are fully covered.

10.1.3 A summary of some of the key topics are detailed below:

- Supplier Performance and KPI review
- Sustainability / Social Values
- Market Intelligence
- Carbon reporting where applicable
- CIP (Savings & Cost Avoidance)
- Continuous Improvement & innovation Opportunities Financial - Regular Invoicing Review and Supplier Financial Health (Health Check)
- Risk Management
- Business Continuity, Disaster Recovery and Exit Plan
- 3rd Party Subcontractors
- Contract CCN / Amendments
- AOB

10.2 The Contract and SRM team will schedule monthly check-in meetings with procurement leads to review current performance and challenges and to discuss and identify any revised changes or new risks.

10.3 Currently, the Contracts management process does not link back to Service level BIA's. This does not allow interrogation of contracts for single points of failure that underpin priority activities. To try to resolve this, business continuity training highlights to service leads that they need to review current supply chain to identify risks to priority services from supply chain disruption.

# 11. Governance & Audit

## 11.1 Governance

The approval mechanism for BCMS plans is as follows:-

**For team/service level plans** – these will be reviewed by the service structure and approved by their internal governance route. The plan must be shared with the EPRR Senior Lead as part of the consultation as this role is the Trusts subject matter expert in business continuity.

**For Locality level plans** – these will be reviewed by the EPRR Senior Lead with the relevant Clinical Site Lead.

**For Organisational level plans** – These shall be maintained by the EPRR Senior Lead and reviewed via the Patient Safety Committee following consultation with the EPRR working group, before being approved by Trust Board annually.

## 11.2 Audit

11.2.1 The EPRR Senior Lead shall direct where internal audits should take place, having regard to

- Quality of business continuity risk register entries
- A significant change in practice or recent significant incident
- Imminent new EPRR impact
- Requests from Local Business Continuity Leads

11.2.2 Where the structure makes it possible auditors will be provided from peer services – for example, Ludlow Hospital will provide a peer auditor to Bridgnorth who will provide a peer auditor to Whitchurch who will in in turn provide a peer auditor to Ludlow. In other cases the peer auditor should be a Business Continuity Lead or a member of the Quality Team.

11.2.3 The Trust's audit regime for EPRR will work in tandem with the review regime described in Section 13 of this Strategy ie the audit will make reference to the most recent and next planned review. Audits will be conducted by sampling.

11.2.4 Audits shall be conducted routinely as internal exercises and the Trust shall make provision for a regular external audit at a frequency to be confirmed by the Trust Board but at the least every 3 years.

- Audits at Organisational level will be approved by the Audit Committee and then signed off by the Accountable Emergency Officer
- Audits at Locality/Service level will be approved and then signed off by the EPRR Senior Lead
- The audit for a Service will address continuity of priority activities, if identified
- The data collection (paper/electronic/portal) elements will be decided by a member of the EPRR Working Group and a relevant clinical/administrative professional depending on the activity to be audited.
- Audits will be separate from the Emergency Preparedness Exercise regime, although areas for audit may be identified through an EPRR exercise.

11.2.4 Audit reports and action plans, once signed off, shall be considered at first by the EPRR working group and included in the Group's reports to the Audit Committee and Board report. Significant findings will be shared Trust wide via EPRR Group submissions to the Audit Committee.

10.2.5 An Audit Log and management responses will be maintained by the EPRR Working Group
10.2.6 Audit reports and Action Plans shall be stored as described in Section 10.3 of this Strategy.
The EPRR Senior Lead shall maintain an overview of the Actions arising from each audit to ensure oversight at a senior level.

### 11.3 Documentation Control

11.3.1 BC plans will be version controlled via the normal Trust route, with annual reviews triggering a new version and smaller reviews being numbered with decimal reviews, e.g 1.1.
Plans will be retained locally by the Business Continuity Lead in addition to the locally stored plans. They will also be stored electronically on the Trust servers and accessed via the EPRR Team channel. A resilient copy will be stored on Resilience Direct within the Business Continuity folder on the system.

11.3.2 The Incident Control Room will hold a hard copy of the BC Strategy, Organsational level plan and Locality Plans. Due to the difficulty in maintaining accurate plans, team plans will not be held centrally in paper format but will be accessible electronically.

11.3.3 Business Continuity plans will be protective marked as Official. Where external contractual details are included within the plans, they will be protective marked as Official – Sensitive Commercial.

11.3.4 Historical plans will be tracked in the version control section and placed in an archive folder. They shall be removed when the retention period has expired.

## 12. Communication

12.1 Business Continuity works best when it is an embedded culture within the Teams and they have a good understanding of their plans as they are locally maintained, reviewed, and tested.
Trust strategic documents – the Business Continuity Strategy, the Organisational and Locality Level Plans, will be centrally stored and reviewed. These documents will be communicated via the Trusts

Manager and Director on Call network and Divisional Operations Groups and Huddles to ensure all response roles know the plans and their locations.

12.1.2 Smaller Team/Ward/Service plans will be locally held and communicated within the Service network. However, this will be coordinated via the Trust Senior EPRR lead with a centrally stored copy on a resilience system.

# 13. Review of BCMS

13.1 The Trust BCMS shall have 2 levels of review:

User reviews shall be conducted by the team/service that owns the plan and shall be conducted by locally based staff. Any actions resulting from the review shall be coordinated with the EPRR Senior Lead for evidence and assurance purposes.
Management Reviews shall be conducted by the EPRR Senior Lead. This forms part of the ongoing Business Continuity audit tool maintained by the EPRR Senior Lead to evidence the Trusts statutory obligations and EPRR Core Standards requirements.

13.2. All reviews will form part of the EPRR Annual report to Board and shall be regularly reviewed as part of the EPRR working group arrangements.

# APPENDIX A – Organisational BIA (Levels 1 and 2 only –last reviewed in November 2025)

| Ref | Funtion | Team | RTO | MPTD | Risk/Consequence of a continued disruption |
|---|---|---|---|---|---|
| 01 | Responding to medical emergencies | Prison Service | 1 hour | 4 Hours | Risk to patient safety |
| 02 | Administer medications | | 1 hour | 4 Hours | Compromised patient care |
| 03 | Prescribing of medications | | 1 hour | 4 Hours | Compromised patient care |
| 04 | Prison escort to urgent external appointments | | 1 hour | 4 Hours | Risk to patient safety |
| 05 | Assessment of new patients to establishment | | 1 hour | 4 Hours | Inability to identify patient needs and patients at risk |
| 06 | Administering Methodone | | 1 hour | 4 Hours | Currently delivered by NSCHT, possibly moving to another provider, however during a disruption SCHT would be held responsible for delivery of this service. Would compromise patient safety and prison stability |
| 07 | Patient Mental Health delivery | | 1 hour | 4 Hours | Currently delivered by NSCHT, possibly moving to another provider, however during a disruption SCHT would be held responsible for delivery of this service. Would compromise patient safety and prison stability |
| 08 | Complex patient visits | | 2 hrs | 8 hrs | Compromised patient care as these visits are for higher complexity, including mental health impacts and safeguarding |
| 09 | Safeguarding support – virtual and f2f | | 4 hrs | 8hrs | Risk to patients, family, staff and other parties engaging with the patient |
| 10 | 24/7 inpatient care | All wards | 1 hour | 1 hour | Statutory, financial, reputational and compromised patient care |
| 11 | Urgent treatments | All MIU | 1 hour | 1 hour | Compromised patient care and impact to flow across the system |
| 12 | MIU Referrals | Bridgnorth xray | 2 hours | 4 hour | Compromised patient care |
| 13 | Transportation of blood samples to hospital pathology | Childrens Phlebotomy | 2 hours | 4 hours | Blood samples will not get to pathology for testing<br>Delay in transportation may not provide viable for reliable results<br>Repeat appointments may be needed<br>Delay in blood results being available for GPs to determine treatment plans |

| | | | | | |
|---|---|---|---|---|---|
| 14 | Ongoing incident support | EPRR | **4 hours** | 8 hours | Lack of specialist advice and support to incident structures. Lack of system access and support during incidents<br>Statutory and reputational risk |
| 15 | Safeguarding contact from professionals / safeguarding contacts with clients | FNP Dudley | **4 hrs** | 1 day | Will need triaging for priority. If high priority there could be risk to patient care and safety, reputational, statutory risk |
| 16 | Duty Nurse role | LAC | **4 hours** | 4 hrs | Loss of service would impact on patient care and wellbeing |
| 17 | 24/7 inpatient care | Ludlow Ward | **1 hour** | 1 hour | Statutory, financial, reputational and compromised patient care |
| 18 | Urgent treatments | Ludlow MIU | **1 hour** | 1 hour | Compromised patient care and impact to flow across the system |
| 19 | Urgent treatments | Oswestry MIU | **1 hour** | 1 hr | Compromised patient care and impact to flow across the system- including missing safeguarding concerns. |
| 20 | Catering for the ward | Ludlow Hotel Services | **1 hours** | 4 hrs | Compromised patient care |
| 21 | Provision of Trust mortuary capacity | Mortuary provision | **1 hour** | 4 hrs | Impact to patient dignity. Reliance on funeral directors to move deceased in local events |
| 22 | Child notification update onto system (temporary arrangement at present) | Safeguarding | **4hrs** | 8 hrs | Statutory risk to the Trust |
| 23 | Oxygen service triage nurse to deal with any urgent oxygen patients/ urgent palliative oxygen requests. | | **4 hrs** | 8 hrs | Significant impact to patient outcomes and significant impact to other NHS services. Increased admissions to hospital |
| 24 | Admission avoidance nurse – going out to patients that have been triaged to help prevent their admission into hospital | | **4 hrs** | 8 hrs | Significant impact to patient outcomes and significant impact to other NHS services. Increased admissions to hospital |

| | | | | | |
|---|---|---|---|---|---|
| 25 | UCR Triage | | **30 minutes** | 2 hrs | Compromised patient care and risk to patient safety and loss of life, reputational damage.<br>Knock on effect to other emergency services |
| 26 | Catering for the ward | Whitchurch Hotel Services | **1 hours** | 4 hours | Compromised patient care |
| 27 | Urgent treatments | Whitchurch MIU | **1 hour** | 1 hour | Compromised patient care and impact to flow across the system- including missing safeguarding concerns |
| 28 | Rapid Response<br>2 hour response | Virtual Ward and Rapid Response | **2 hrs** | 4 hrs | Compromised patient care and risk to patient safety and loss of life, reputational damage.<br>Knock on effect to other emergency services |
| 29 | Outbreak Management | Infection Prevention Education and Advice | **4 hours** | 8 hrs | Compromised patient care and risk of worsening outbreak |

Amber activity – Close of play tomorrow (up to 48 hrs MPTD)

| | | | | | |
|---|---|---|---|---|---|
| 30 | Palliative /urgent home visits | | 8 hours | 2 days | Compromised patient care. |
| 31 | Safeguarding contacts | FNP Shropshire | 24 hrs | 24 – 36 hrs | Risk to patient care and safety, reputational, statutory risk |
| 32 | Safeguarding contacts | Health Visitor Service | 24 hours | 24 – 36 hrs | Compromised patient care, reputational and statutory risk |
| 33 | Provision of mutual aid capacity or capacity during Mass Fatalities incident | Mortuary provision | 24 hrs | 3 days | Inability to support partner organisations with capacity.<br>Reputational risk |
| 34 | Safeguarding adults | Safeguarding | 24hrs | | Statutory risk and patient safety risk |
| 35 | Advice calls | | 24hrs | | Reputational risk – inability to support patients and families |
| 36 | CDS and Sexual Health | | 24 hrs | 48 hours | Compromised patient care, reputational and financial risk |
| 37 | Safeguarding contacts | | 24 hrs | 48 hrs | Compromised patient care, reputational and statutory risk |

| | | | | | |
|---|---|---|---|---|---|
| | | School Nursing Service | | | |
| 38 | Daily triage referrals | Tissue Viability | 1 – 2 days 1 day | 2 days | Compromised patient care through lack of advice and planned visits |
| 39 | CYPT access, via telephone/email/ MS Teams, including management of referrals - urgent onward referrals, Triage | Childrens Physio therapy | 4 hrs | 24 hrs | **Risk:** patients and staff can't contact the service and referrals are missed/delayed.<br>**Consequences:**<br>Interrupted/delayed patient care<br>Potential impact on wellbeing and health outcomes<br>Staff – lost time; reduced efficiency |
| 40 | CYPT Priority New Appts - Urgent and high Patients | | 4 hrs | 24 hrs | **Risk:** Delayed Discharges<br>Compromising patient care and safety<br>CYP unable to access education setting<br>**Consequences:**<br>Impact on treatment and psychological wellbeing<br>Increased physical and mental health risks<br>Impact on integrated care |
| 41 | CYPT: Priority planned clinical contacts for all caseloads.<br>• Respiratory Service<br>• Equipment needs – standing frames, walking aids and other postural equipment review, replace/repair/new/competency/coaching and sign off.<br>EHC planned contacts | | | | **Risk:** missed appointments compromising patient care and safety.<br>**Consequences:**<br>Impact on treatment and psychological wellbeing<br>Increased physical and mental health risks<br>Impact on integrated care<br>Potential safeguarding risks increased<br>Potential legislation under Statutory Provisions. |
| 42 | ECHNA notifications | | | | **Risk**: Delays in assessment for ECHN's compromising access to education and provision of support for CYP<br>**Consequences**<br>Impact on treatment and psychological wellbeing<br>Increased mental health risks ·<br>Impact on integrated care<br>Potential safeguarding risks increased<br>Reputational damage in relation to SEND statutory performance indicators |

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| 42 | In reach service (x1 nurse PRH x1 nurse RSH daily) to facilitate the early supported discharge of patients within SaTH that have an admitting diagnosis of exacerbation of COPD/Bronchiectasis | Shropshire Community Respiratory | 24 hrs | 48hrs | Increased stay within the acute hospital setting, patient not supported on discharge by community team resulting increased risk of readmission. Increased impact to other services |
| 43 | Urgent oxygen safety check for patient within Shropshire or telford patients with a diagnosis of COPD/Bronchiectasis that are registered housebound patients | | 24 hrs | 48hrs | Increased safety risk to patient, increased risk to healthcare professionals, increased risk to the community. Fire and safety risk. Increased impact to other services |
| 44 | Palliative /urgent home visits | | 8 hours | 2 days | Compromised patient care. |
| 45 | Support to MIU | | 8 hrs | 24 hours | Impact to MIU flow and patient throughput |
| 46 | Portering services – ordering medical gases, post, deliveries | Whitchurch Hotel Services | 8 hours | 24 hours | Could have some disruption, but potential risk with changing of medical gases as only the porters can do this. There is a temporary back up supply which could be switched. |
| 47 | Palliative /urgent home visits | | 8 hours | 2 days | Compromised patient care. |
| 48 | Patient face to face appointment's high priority wound care | Wound Healing | 1 day | 2 days | Compromised patient care, impact on other NHS services |
| 49 | Reactive fire risk assessments | Estates | 24 hrs | 2 -3 days | Requires liaison with external parties |

Trust Priority Activities – need to be running by close of play today (8hr RTO)

| Ref | Funtion | Team | RTO | MPTD | Risk/Consequence of a continued disruption |
|---|---|---|---|---|---|
| 01 | Responding to medical emergencies | Prison Service | 1 hour | 4 Hours | Risk to patient safety |
| 02 | Administer medications | | 1 hour | 4 Hours | Compromised patient care |
| 03 | Prescribing of medications | | 1 hour | 4 Hours | Compromised patient care |
| 04 | Prison escort to urgent external appointments | | 1 hour | 4 Hours | Risk to patient safety |
| 05 | Assessment of new patients to establishment | | 1 hour | 4 Hours | Inability to identify patient needs and patients at risk |
| 06 | Administering Methodone | | 1 hour | 4 Hours | Currently delivered by NSCHT, possibly moving to another provider, however during a disruption SCHT would be held responsible for delivery of this service. Would compromise patient safety and prison stability |
| 07 | Patient Mental Health delivery | | 1 hour | 4 Hours | Currently delivered by NSCHT, possibly moving to another provider, however during a disruption SCHT would be held responsible for delivery of this service. Would compromise patient safety and prison stability |
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| 13 | Transportation of blood samples to hospital pathology | Childrens Phlebotomy | 2 hours | 4 hours | Blood samples will not get to pathology for testing<br><br>Delay in transportation may not provide viable for reliable results |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Repeat appointments may be needed<br><br>Delay in blood results being available for GPs to determine treatment plans |
| 14 | Ongoing incident support | EPRR | **4 hours** | 8 hours | Lack of specialist advice and support to incident structures. Lack of system access and support during incidents<br><br>Statutory and reputational risk |
| 15 | Safeguarding contact from professionals / safeguarding contacts with clients | FNP Dudley | **4 hrs** | 1 day | Will need triaging for priority. If high priority there could be risk to patient care and safety, reputational, statutory risk |
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| 22 | Child notification update onto system (temporary arrangement at present) | Safeguarding | **4hrs** | 8 hrs | Statutory risk to the Trust |
| 23 | Oxygen service triage nurse to deal with any urgent oxygen patients/ urgent palliative oxygen requests. | | **4 hrs** | 8 hrs | Significant impact to patient outcomes and significant impact to other NHS services. Increased admissions to hospital |
| 24 | Admission avoidance nurse – going out to patients that have been triaged to help prevent their admission into hospital | | **4 hrs** | 8 hrs | Significant impact to patient outcomes and significant impact to other NHS services. Increased admissions to hospital |

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Amber activity – Close of play tomorrow (up to 48 hrs MPTD)

| | | | | | |
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| 32 | Safeguarding contacts | Health Visitor Service | 24 hours | 24 – 36 hrs | Compromised patient care, reputational and statutory risk |

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| 33 | Provision of mutual aid capacity or capacity during Mass Fatalities incident | Mortuary provision | 24 hrs | 3 days | Inability to support partner organisations with capacity.<br>Reputational risk |
| 34 | Safeguarding adults | Safeguarding | 24hrs | | Statutory risk and patient safety risk |
| 35 | Advice calls | | 24hrs | | Reputational risk – inability to support patients and families |
| 36 | CDS and Sexual Health | School Nursing Service | 24 hrs | 48 hours | Compromised patient care, reputational and financial risk |
| 37 | Safeguarding contacts | | 24 hrs | 48 hrs | Compromised patient care, reputational and statutory risk |
| 38 | Daily triage referrals | Tissue Viability | 1 – 2 days 1 day | 2 days | Compromised patient care through lack of advice and planned visits |
| 39 | CYPT access, via telephone/email/ MS Teams, including management of referrals - urgent onward referrals, Triage | Childrens Physio therapy | 4 hrs | 24 hrs | **Risk:** patients and staff can't contact the service and referrals are missed/delayed.<br>**Consequences:**<br>Interrupted/delayed patient care<br>Potential impact on wellbeing and health outcomes<br>Staff – lost time; reduced efficiency |

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| 40 | CYPT Priority New Appts - Urgent and high Patients | | 4 hrs | 24 hrs | **Risk:** Delayed Discharges<br>Compromising patient care and safety<br>CYP unable to access education setting<br>**Consequences:**<br>Impact on treatment and psychological wellbeing<br>Increased physical and mental health risks<br>Impact on integrated care |
| 41 | CYPT: Priority planned clinical contacts for all caseloads.<br>• Respiratory Service<br>• Equipment needs – standing frames, walking aids and other postural equipment review, replace/repair/new/competency/coaching and sign off.<br>EHC planned contacts | | | | **Risk:** missed appointments compromising patient care and safety.<br>**Consequences:**<br>Impact on treatment and psychological wellbeing<br>Increased physical and mental health risks<br>Impact on integrated care<br>Potential safeguarding risks increased<br>Potential legislation under Statutory Provisions. |
| 42 | ECHNA notifications | | | | **Risk**: Delays in assessment for ECHN's compromising access to education and provision of support for CYP |

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| | | | | | **Consequences**<br>Impact on treatment and psychological wellbeing<br>Increased mental health risks ·<br>Impact on integrated care<br>Potential safeguarding risks increased<br>Reputational damage in relation to SEND statutory performance indicators |
| 42 | In reach service (x1 nurse PRH x1 nurse RSH daily) to facilitate the early supported discharge of patients within SaTH that have an admitting diagnosis of exacerbation of COPD/Bronchiectasis | Shropshire Community Respiratory | 24 hrs | 48hrs | Increased stay within the acute hospital setting, patient not supported on discharge by community team resulting increased risk of readmission. Increased impact to other services |
| 43 | Urgent oxygen safety check for patient within Shropshire or telford patients with a diagnosis of COPD/Bronchiectasis that are registered housebound patients | | 24 hrs | 48hrs | Increased safety risk to patient, increased risk to healthcare professionals, increased risk to the community. Fire and safety risk. Increased impact to other services |
| 44 | Palliative /urgent home visits | | 8 hours | 2 days | Compromised patient care. |
| 45 | Support to MIU | | 8 hrs | 24 hours | Impact to MIU flow and patient throughput |

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| 46 | Portering services – ordering medical gases, post, deliveries | Whitchurch Hotel Services | 8 hours | 24 hours | Could have some disruption, but potential risk with changing of medical gases as only the porters can do this. There is a temporary back up supply which could be switched. |
| 47 | Palliative /urgent home visits | | 8 hours | 2 days | Compromised patient care. |
| 48 | Patient face to face appointment's high priority wound care | Wound Healing | 1 day | 2 days | Compromised patient care, impact on other NHS services |
| 49 | Reactive fire risk assessments | Estates | 24 hrs | 2 -3 days | Requires liaison with external parties |

Shropshire Community Health NHS
NHS Trust

| Document Details | |
|---|---|
| **Title** | Emergency Preparedness, Resilience and Response (EPRR) Strategy v7 |
| Trust Ref No | 2271-84159 |
| Main points the document covers | This strategy provides a framework within which the Trust can comply with EPRR and business continuity requirements. The purpose of the guidance is to make the Trust ready and able to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained. |
| Who is the document aimed at? | All staff |
| Owner | Brian McMillan, EPRR Senior Lead |
| **Approval process** | |
| Who has been consulted in the development of this policy? | EPRR Working Group, STW ICB, NHS England Regional, Patient Safety Committee |
| Approved by (Committee/Director) | Trust Board & Trust Accountable Emergency Officer |
| Approval Date | 5th December 2024 |
| Initial Equality Impact Screening | Yes |
| Full Equality Impact Assessment | No |
| Lead Director | Clair Hobbs, Director of Nursing & Clinical Delivery - and Accountable Emergency Officer |
| Category | Operations |
| Subcategory | EPRR |
| Review date | 23rd October 2025 |
| **Distribution** | |
| Who the policy will be distributed to | ALL STAFF |
| Method | Email, staff zone, EPRR Teams Channel, Resilience Direct |

| | | |
|---|---|---|
| Keywords | | EPRR, Business Continuity, On Call |
| **Document Links** | | |
| Required by CQC | | Yes |
| Other | | Civil Contingencies Act 2004, Health and Social Care Act 2012 and the NHS Standard Contract (SC30) |
| **Amendments History** | | |
| No | Date | |
| 1 | November 2021 | New policy created and approved by Resource and Performance committee |
| 2 | August 2022 | Updated version of policy to include wider elements of EPRR to comply with NHS England core standards assurance framework |
| 3 | October 2022 | Updated elements to align with new NHSE EPRR Framework |
| 4 | April 2023 | Full review by EPRR lead to include further areas of EPRR and remove appendices where duplicated. |
| 5 | July 2023 | Complete re-write following NHS England EPRR Core Standards guidance. Written to be more focused and direct in terms of Trust undertakings. |
| 5.1 | August 2023 | August 2023 Revised following NHS England consultation |
| 5.2 | July 2024 | Annual review. Revision of EPRR roles, including AEO, CBRN team and EPRR Support Roles |
| 6 | July 2024 | Approved annual review |
| 6.1 | November 2024 | Post Core Standards amendment to the approval route – from Patient Safety Committee to Board approval. |
| 6.2 | August 2025 | Updated to reflect local EPRR structure changes |
| 7 | October 2025 | Approved annual review – amendment to support role staff |

# Contents

## 1 Introduction / Purpose

This Strategy outlines the Trust's commitment to EPRR and provides the framework for maintaining and assuring readiness. It aligns to the NHS EPRR Core Standards framework (2022). The EPRR Strategy and will be reviewed annually against the standards, ensuring it aligns to any changes. In providing this assurance, the Trust also complies with its requirements under the Civil Contingencies Act 2004, Health and Social Care Act 2022 and the NHS Standard Contract (SC30).

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must evidence they can effectively respond to major, critical and business continuity incidents and disruptions whilst maintaining services to patients.

The NHS England Board has a statutory requirement to formally assure itself of its own, and the NHS in England's, EPRR readiness. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care, and the Secretary of State for Health and Social Care.

The NHS England EPRR Core Standards framework sets the minimum standards in emergency preparedness. They provide a common reference point for all organisations and are reviewed annually, including an annual 'deep dive' on a particular area of response. Providers of NHS funded services complete an assurance self-assessment based on these core standards.

## 2 Process

The NHS England EPRR framework assurance return is carried out annually between July and September. The standards are released in July - August annually. The standards require evidence of plans, policies and response arrangements and are a minimum expected standard of the Trust.

This strategy will be reviewed annually following the release of the standards to ensure that any developing requirements are captured. It also provides an opportunity to ensure gaps in Trust arrangements can be addressed and prioritised. Any subsequent guidance releases throughout the year may also trigger a revision of the EPRR Strategy.

This strategy is therefore an undertaking of the Trust's commitment to its emergency preparedness duties and an assurance tool for the Trust's Accountable Emergency Officer, Trust Executives and Board.

The Trust's Patient Safety Committee and the Trust Quality and Safety Committee shall be the governance and approval route for EPRR documents, with the EPRR and Business Continuity Strategies being approved by Board. The EPRR Core Standards state within the 'suggested evidence' that the EPRR Policy, or Strategy, must be approved by the Board with

Board reports and minutes as required evidence. This requirement triggered sign off amendments from Version 6.1.

## 2.1 Trust EPRR undertakings

The organisation works under a single EPRR structure.

**AEO** The organisation has a single Accountable Emergency Officer (AEO) who has the statutory responsibility for EPRR delivery. The AEO must be a Board Level Director with voting rights. This is currently the Director of Nursing & Clinical Delivery, Clair Hobbs.

The AEO must engage with the Local Health Resilience Partnership and provide assurance to the Trust Board at least annually, on all matters relating to EPRR and the Trusts level of preparedness.

The AEO now chairs the EPRR working group following changes in July 2025.

(In incidents of sickness or absence, the AEO role shall be formally deputised or an interim put in place during the cover period)

**EPRR Senior Lead**

The organisation has an EPRR Senior Lead who will be responsible for day-to-day maintenance of the EPRR functions, response and plans on behalf of the AEO**.** This includes day to day business continuity management, training and exercising programmes, debriefs and all matters relating to emergency preparedness and response.

The EPRR Senior Lead shall also engage with LRF subgroups as required, ensuring multi-agency plans are consulted and contributed to, lessons are captured and EPRR risks are captured**.** The EPRR Senior Lead is currently Brian McMillan.

(In incidents of sickness or absence, the EPRR Senior Lead shall be deputised by the Deputy Director of Operational Service Development – Steve Ellis)

Further sector specific skills are highlighted in the On Call Handbook, with alternative staff trained to fulfil them in the absence of the EPRR Senior Lead.

**Deputy Director of Operational Service Development**

The EPRR Senior Lead is managed by the Deputy Director of Operational Service Development and has day to day oversight of the EPRR delivery.

**Command Support Team**

The Command Support Team are individuals within the organisation who provide ad hoc resilience to the EPRR Senior Lead function, particularly during incident response. The Support role comprises an individual who has knowledge and experience of EPRR systems that support an Incident Management Team – Laura Bradshaw and Holly Grainger. This team works together when required, to support the Trusts Incident response arrangements.

**CBRN Teams**

The Trust has CBRN teams based in each Minor Injuries Unit who are responsible for maintaining the Trusts capability to respond to a CBRN or Hazmat event. (Chemical, Biological, Radiological, Nuclear incidents). The team are trained by the EPRR Senior Lead and are familiar with the Trusts CBRN/Hazmat plan. Trust training includes clinical staff in the MIU's and front of house teams and staff who are most likely to have contact with a contaminated patient. Collaboratively, they maintain an initial operating response to chemical responses.

**On Call Staff**

The organisation maintains a 24/7 response capability at a strategic and tactical level. The strategic role is the Director on Call and the tactical role is the Manager on Call. These roles are held by competent experienced post holders capable of delivering incident response to any incident affecting the health economy.

All on call role holders shall be trained in line with the Trust EPRR Training and Exercising Policy. Training materials align to National Occupational Standards and training requirements align to role identifiers within the Minimum Occupational Standards for EPRR.

All on call role holders shall maintain their record of training and exercising and Continuous Professional Development and this shall be linked to the Trusts EPRR Training Needs Analysis.

**Loggists**

The Trust maintains a 24/7 loggist capability. It is the responsibility of the EPRR Senior Lead to train and maintain the loggist capability. Loggists will be deployed to support the Incident Response arrangements.

Loggists differ from Command Support as they are only trained in Incident Logging. Command Support are trained loggists but also have other skills – such as Resilience Direct, Mapping, Hazard Manager, etc.

**EPRR Working Group**

The Trust has an EPRR Working Group comprising of the Accountable Emergency Officer, Director of Operations and Deputy Director of Operational Service Development. Other multi-disciplinary leads from the Trust can be co-opted in as required. The EPRR working group are responsible for reviewing, engaging and consulting on Emergency Planning documents , EPRR Risks and the EPRR workplan. They have authority to approve EPRR action cards and lessons register, however approval of formal response plans sits with the Patient Safety Committee. Strategic EPRR documents are approved at Trust Board.

The Group will drive engagement in EPRR across the organisation by contributing to plans, training, exercising and lessons. The group shall have Emerging EPRR risks as a standing item on their agenda and shall escalate any identified risks at the appropriate trigger, to the Trusts Risk Assurance Group.

**Patient Safety Committee**

The Trust has a Patient Safety Committee who meet to consider matters across the Trust. Emergency Planning reports directly to this group to increase engagement and provide Executive level assurance. EPRR reports to the Patient Safety Committee at least quarterly.

The Committee are responsible for approval of EPRR documents. The Chair of the Committee is the Trust's Accountable Emergency Officer.

**Quality and Safety Committee**

The Trust Quality and Safety Committee will receive EPRR reports at least 6-monthly for oversight and assurance. The Committee shall receive assurance reports on all matters of EPRR, including Business Continuity.

**EPRR Workplan**

The organisation shall have an approved annual work plan that identifies EPRR workstreams, priorities and gaps. As the Core Standards assessment provides a reference point for, and underpins the essential competencies of EPRR, it shall inform and form the basis of the annual work plan, ensuring that annual priorities align to a fully compliant state of preparedness.

The annual work plan shall be approved by the EPRR Working Group and should include as a minimum:

- Emergency Plan reviews
- Business Continuity Management
- Training oversight and action plans
- Exercising oversight, post exercise reporting and action plans
- Debriefing and Lessons identified
- Consideration of emerging risks and intelligence
- Mitigation or escalation of identified risks
- Reviews of incidents
- Multi-agency commitments throughout the planning cycle

The EPRR Senior Lead shall produce an annual report, highlighting the results of the Core Standards assessment as well as any priority work streams and lessons identified.

The report shall be approved by the AEO for reporting to the Board and the report, including the results of the Core Standards assessment shall be publicised on the Trust website.

The report must also provide a summary of the incidents and events throughout the previous year and any lessons or good practice which is identified. Assurances on the EPRR resources shall be included in the report to provide assurance to the Board on the Trust's overall preparedness state.

## 2.2 Response Arrangements

The organisation will maintain a 24/7 response capability at Strategic and Tactical level. This will include a capability to respond to internal incidents and incidents that affect the wider health economy and Local Resilience Partnership organisations. On Call staff shall be clear in how their on-call role sits within a wider Health and/or multi-agency response to an incident. Other roles across the organisation support the EPRR response structure such as Business Continuity Leads, Communications, Estates, IT, Loggists and Command Support.

Management of an incident shall be from the Incident Control Centre. The primary Incident Control Centre is located at:-

**The Aldridge Room, Halesfield 6, Telford, TF7 4BF**

With alternative sites being located at:-

- **Trust HQ, Mount McKinley, Anchorage Avenue, Shrewsbury**, SY2 6FG
- **Trust Community Hospitals – Bridgnorth, Ludlow, Whitchurch and Oswestry Health Care.**

The Incident Command Centres will be regularly tested and details captured in the Trusts Incident Command Centre booklet.

The EPRR Senior Lead, Manager on Call or Director on Call shall be responsible for establishing an Incident Control Centre when this is deemed necessary for Incident Response, preparation or standby.

The Trust is committed to debriefing during and following any incident to continually improve its Incident Response capabilities and to capture good practice. Debriefs conducted will be formally recorded in Debrief or Post Exercise Reports and any lessons or good practice captured will be entered into the Trust Lessons Register. This will be maintained on behalf of the AEO for consideration by the Trust. The EPRR Working Group will have oversight of the Lessons Register.

The Incident Control Rooms shall be checked every 3 months to ensure the equipment within them is maintained and ready for use. The EPRR Lead shall maintain a log of the Incident Control Room audits.

The Organisation shall maintain a 24/7 loggist capability, to ensure that decisions, actions and rationales can be properly captured and recorded. The loggists' training will form part of the Annual Training review.

The additional Command support roles – Resilience Direct, mapping, Met Office Hazard Manager users, Genasys Operators, Operational JESIP roles and debriefers are not specifically required through Core Standards – although they are referenced in the Minimum Occupational Standards for EPRR. They are seen locally as a support tool to enable the Incident Management Team to have greater capability, particularly in situational awareness. To ensure training and competency compliance the training records shall be maintained on the Training Needs Analysis.

The organisation shall support local health economy groups by sending appropriate representatives. These include Local Health Resilience Partnership (LHRP), Local Health Protection Group (LHPG) and any Local Resilience Forum or County Emergency Planning Groups including the Risk Awareness Working Group (RAWG). Attendance at LHRP shall be by the Accountable Emergency Officer, or approved Deputy.

**Plans**

The organisation has a number of emergency plans in place, supported by plans and guidance from within National and Regional Health partners, UK Health Security Agency and the Local Resilience Forum partners.

Plans are reflective of national guidance and risk assessments, as well as national planning assumptions and are developed in collaboration with other affected partner agencies. They must be version controlled, reviewed regularly and be available in hard copy as well as electronic form. Plans shall promote the Joint Decision Model used in JESIP and shall identify the support streams and escalation models available to local decision makers.

Plans will be developed with the Trust EPRR working group, who maintain oversight of plan review dates and are standard consultees on all new policies. Maintenance of the plans shall include its entire cycle to include testing, training, exercising and review of the plans.

The Core Standards return will identify the minimum requirement for relevant emergency plans for the Trust. This list is not exhaustive as local risks, operational service delivery and lessons identified from incident response may identify a local need for further specific plans. The Core Standards plan requirements will be updated annually and new plans written where required.

The plans will be approved on behalf of the AEO and signed off through the Patient Safety Committee.

### 2.3 Debriefs

The Trust is committed to debriefing during and following any incident to continually improve its Incident Response capabilities and to capture good practice. The Trust will ensure that the following types of debrief are conducted;

• **Hot debrief** – immediately following each incident or component shift by the Incident lead at the time

• **Structured debrief** – Conducted within 3 weeks of the incident by an independent party. Commissioned within a scope agreed by the Accountable Emergency Officer and shall include all other agencies involved. This debrief will usually be conducted by the EPRR Senior Lead, partner agencies EPRR Lead or NHS England / Local Resilience Forum trained debriefers. (Where external colleagues facilitate the debrief on behalf of the Trust, it is the Trust's responsibility to provide a scribe and to draft the debrief report for the Accountable Emergency Officer. The report shall be complete within 1 week of the debrief)

• **Wellbeing / diffuse debriefs** – conducted by the EPRR Senior Lead or suitably trained staff member. Shall be conducted where a need is identified and will follow the TRiM model (Trauma Risk Management). This debrief aims to diffuse any ongoing wellbeing concerns and allow staff the chance to offload concerns relating to the incident response. It shall not generate any formal reporting due to the confidential nature of the debrief.

Debriefs conducted will be formally recorded in Debrief Reports and any lessons or good practice captured will be entered into the Trust Lessons Register by the Trust EPRR Senior Lead. This will be maintained on behalf of the AEO for consideration by the Trust. The EPRR Working Group will have oversight of the Lessons Register and where required, can escalate lessons, risks and good practice to the Trust Risk Group and the Patient Safety Committee.

## 2.4 Business Continuity Management

The Trust is committed to Business Continuity Management and shall have a Business Continuity Management System (BCMS) in place. Plans shall be written for service level, locality level and organisation level processes and be focused on

identification of prioritised activities, identifying how the organisation will respond to ensure continuity of service delivery for the duration of a disruption.

The plans shall identify the difference between a Business Continuity Incident, Critical Incident and Major Incident. It shall identify the different response levels and each trigger point for escalation.

The Business Continuity plans shall be reviewed and tested annually as a minimum, or following a change of structure, key personnel or after activation of a business continuity plan.

The plans shall be written in line with the appropriate guidance (ISO 22301) and be reviewed by the relevant team Business Continuity Leads. The Business Continuity Plans will support the Business Continuity Strategy which is written in line with guidance (ISO 22313) and the NHS Business Continuity Toolkit. The Trust's Business Continuity Strategy shall be approved by the Trust Board and shall contain a summary of the organisational business impact assessment and priority services.

On call staff shall have Business Continuity Management awareness training included as part of their annual training pathway. This will be extended to business continuity leads, service leads and other identified staff. Exercising of business continuity plans will be at both service and organisational level and will target weaknesses within service delivery.

Audits of business continuity plans shall be maintained as an ongoing audit assurance tool by the EPRR Senior Lead. Assurance shall be fed back to the EPRR working group. Improvement Plans shall be overseen by Audit Committee and will be reported to the Board.

Audit Committee also have the overall assurance process and work with external auditors – MIAA, to audit different areas of the Trust Service. This shall include periodic external audits of the Trusts Business Continuity planning arrangements.

The Trust shall use a key performance indicator of 80% of plans to be reviewed and approved and all plans to have an embedded Business Impact Assessment.

The Trust shall use the tools and templates within the 2023 Business Continuity Toolkit provided by NHS England.

The annual EPRR report shall include details on the status of the Business Continuity Plans, including any feedback and lessons identified from any business continuity plan activations or exercises.

**Risk**

The organisation has an existing EPRR Risk strategy and corporate Risk Register. The Risk Register has a process for recording, escalating and monitoring risk and mitigation measures that affect the organisation.

The Risk Register will incorporate EPRR based risks identified from the National and Community Risk Registers where there are sufficient local impacts. The trigger for an EPRR Risk triggering the corporate risk register is not based on scoring, but on potential, likely or actual risks to the Trust.

Additional Risk information will be taken from the Local Health Resilience Partnership (LHRP) as well as from the Local Resilience Forum's Risk Assessment Working Group (RAWG). Intelligence from the Resilience Direct Joint Operational Learning (JOL online), the West Mercia Resilience Forum multi-agency Intelligence Cell (MAIC) and the UKHSA notifiable disease system (NOIDS) will also feed in to ensure escalating risks are captured.

The risk register will identify local control and assurance measures for EPRR risks, documented in the relevant emergency and business continuity plans.
The Risk Register has an assurance sign off process through Patient Safety Committee following review by the EPRR Working Group.

## 2.5 Training and Exercising

The organisation will have a training and exercise programme and this is identified In the Trust's EPRR Training and Exercising Policy. The Training pathway for on call staff will be captured by the Trust's EPRR Training Needs Analysis (TNA). The TNA will provide the necessary assurance that training has been delivered across the Strategic, Tactical and EPRR supportive roles.

Training will follow a pathway to ensure on call staff meet and maintain the desired standard and competencies for their roles. In addition to this pathway, any additional training identified by Trust staff will be included on the TNA.

Training will be aligned to the National Occupation Standards and Minimum Occupations Standards for EPRR. The organisation will have an exercise programme annually. The programme will build on the requirement for the organisation to actively take part in in-house and multi-agency exercises to test its preparedness. Exercises must include:-

• a six-monthly communications test
• annual table top exercise
• live exercise at least once every three years
• command post exercise every three years.

Each exercise will include a post exercise report, documenting any lessons identified and further training or review from the use of the associated planning documents.

The organisation will host and support multi-agency exercising where possible and will represent the Trust and Health Economy roles as exercise opportunities become available.

## 3 Associated Documents

- The Civil Contingencies Act 2004
- NHSEI Core Standards for EPRR
- The Health and Social Care Act 2012
- NHS Standard Contract SC30
- ISO 22301:2019 Security and Resilience

## 4 Duties

The Accountable Emergency Officer (or deputy) will attend a minimum 75% of Local Health Resilience Partnership (LHRP) meetings annually, when in place. The EPRR Senior Lead shall ensure attendance and deputise where required to ensure information and intelligence is not missed.

## 5 Document retention periods

Trust EPRR documents will be retained in line with NHS guidelines and as follows:

| Category | Examples | Minimum retention period | Final action |
|---|---|---|---|
| Incidents (declared) | Decision logbook, on-call logbook, incident-related documents including plans and organisational structures<br>Paper and electronic records | 30 years | Review, archive or destroy under confidential conditions |
| Exercise | Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |
| On-call (routine – non-Major Incident) | Decision log, on-call log, handover records<br>Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |
| EPRR | Incident response plans, guidance, standard operating procedures, core standards for assurance<br>Electronic records | 30 years | Review, archive or destroy under confidential conditions |
| EPRR | Information sharing protocols, memorandum of understanding, service-level agreements<br>Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |
| EPRR | LHRP and sub-group minutes, papers, action logs<br>Risk registers<br>Electronic records | 30 years | Review, archive or destroy under confidential conditions |

## 6 Implementation

This document is an assurance tool that aligns how the Trust delivers its emergency planning duties, to the minimum standards set by NHS England. By continually reviewing our plans, risks and standards, the Trust is committed to continual improvement of our response and recovery capabilities.

Shropshire Community Health
NHS Trust

# Chair's Assurance Report

People Committee

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | **Diane Davenport** | **Paper date:** | **4th December 2025** |
| **Executive Sponsor:** | Cathy Purt, Chair of People Committee Non-Executive Director | **Paper written on:** | 27/11/2025 |
| **Paper Reviewed by:** | Rhia Boyode, Chief People Officer | **Paper Category:** | People |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 24th November 2025 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

## 2. Executive Summary

### 2.1 Context

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

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

# Chair's Assurance Report

People Committee

- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy

- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.

- To assure and provide advice to the Board on any arising HR issues of significance.

- To receive updates on employee relation cases in confidence and with the exclusion of attendees if deemed necessary.

### 2.2 Summary

The Committee met on 24th November 2025 and was quorate with 1 non-executive and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen in the grid below.

### 2.3. Conclusion

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

Shropshire Community Health NHS Trust

# Chair's Assurance Report

People Committee

## 3. Main Report

### 3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the People Committee which met on 27th October 2025. The meeting was quorate with 1 non-Executive members and 2 Executive members. A full list of the attendance is outlined below:

**Chair/ Attendance:**

| **Members:** | | |
|---|---|---|
| Cathy Purt | Chair – Non-Executive Director | CP |
| Rhia Boyode | Chief People Officer | RB |
| Jill Barker | Non-Executive Director | JB |
| Claire Horsfield | Director of Operations & Chief AHP | CHor |
| Shelley Ramtuhul | Director of Governance | SR |
| **In attendance** | | |
| Teresa Boughey | Non-Executive Director (SaTH) | TB |
| Rosi Edwards | Non-Executive Director (SaTH) | RE |
| Wendy Nicholson MBE | Non-Executive Director (SaTH) | WN |
| Jonathan Gould | Deputy Director of Finance (Shropcom) | JG |
| Jo Williams | Chief Executive in Commong | JW |
| John Jones | Executive Medical Director (SaTH) | JJ |
| Simon Balderstone | Interim Director of People (Operations) (SaTH) | SB |
| Deborah Bryce | Head of Corporate Governance & Compliance (SaTH) | DB |
| Nigel Lee | Director of Strategy and Partnerships (SaTH) | NL |
| Fleur Blakeman | NHSE Intensive Support Director | FB |

**Apologies:**

Lisa Gibbons Associate Director for People, Employee Relations and Occupational Health, Emma Wilkins Interim People Director, Paula Gardner Chief Nursing Officer, Jennie Rowlands Deputy Medical Director, Heidi Fuller Associate Non-Executive Director

### 3.2 Key Agenda

| Agenda Item / Discussion | | Assured (Y/N) | Assurance Sought |
|---|---|---|---|
| 1. | **Review of minutes and actions from last meeting** | | |

# Chair's Assurance Report

People Committee

| | | | |
|---|---|---|---|
| | The minutes from the meetings held on 27th October 2025 were approved as a true and accurate record of the meeting.<br><br>The Action log was discussed and updated. | Y | |
| 2. | **Freedom to Speak Up (FTSU) Report Quarter 2 25/26** | | |
| | An update was provided of the Shropcom FTSU activity for Quarter 2 25/26. The Trust are now compliant in 34 out of 40 self-assessment areas, with six partially compliant and none non-compliant, and the main focus going forward is on culture and behaviours.<br><br>There were eight cases raised in quarter 2, mostly related to inappropriate staff and leadership behaviours, with five cases still open and ongoing investigations.<br><br>A MIAA Audit found substantial assurance for the Freedom to Speak Up Service, with good internal controls and consistent application, and the Audit will be present to the Audit Committee in February 2026.<br><br>Staff feedback has indicated they would recommend the service to other staff members.<br><br>There has been a refresh of the FTSU project plan, and all actions completed, exception of Item 2.5 in relation to training for FTSU Champions.<br><br>The FTSU update will now be picked up as part of the Group People Committee. | Y | |
| 3. | **Freedom to Speak Up Audit** | | |
| | Provided for information. | | |
| 4. | **Shropcom Policies for Approval** | | |
| | Updated Temporary Staffing and Agency Policy<br><br>Agency Worker – Break Glass – Standard Operating Process<br><br>Updated Work Experience Policy | | |

# Chair's Assurance Report

People Committee

| | | | |
|---|---|---|---|
| | Performance Maintaining High Standards (Non-Medical)<br><br>The Committee Approved all of the Policies | | |
| 5. | **Any Other Business** | | |
| | None raised | | |

### 3.4 Approvals

| Approval Sought | Outcome |
|---|---|
| Updated Temporary Staffing and Agency Policy | Approved |
| Agency Worker – Break Glass – Standard Operating Process | Approved |
| Updated Work Experience Policy | Approved |
| Performance Maintaining High Standards (Non-Medical) | Approved |

### 4. Conclusion

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

Shropshire Community Health
NHS Trust

# Integrated Performance Report
## 0. Reference Information

| | | | |
|---|---|---|---|
| **Authors:** | Gina Billington,<br>Head of Resourcing,<br>Fiona MacPherson,<br>Head of People Services<br>Sarah Allan,<br>Deputy Workforce Operations Director (Interim) | **Paper date:** | 4th December 2025 |
| **Executive Sponsor:** | Rhia Boyode, Chief People Officer SCHT & SaTH | **Paper written on:** | 18th November 2025 |
| **Paper Reviewed by:** | Simon Balderstone,<br>Interim Workforce Operations Director<br>Sarah Allan,<br>Deputy Workforce Operations Director (Interim) | **Paper Category:** | Performance |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

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

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

## 2. Executive Summary

### 2.1 Context

This report focuses on the key areas of performance relevant to Trust Board, including a review of performance against the month 7 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 7.

| 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** | 2 | 6 | 0 | 2 | **10** | **6 (60%)** |

Action Plans have been developed included as Appendix 4.

### 2.3. Conclusion

The Board is asked to:

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

## 3. Main Report

### 3.1 Introduction

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

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

### 3.2 Summary of key points in report

The workforce plan for 2025/26 set a 41.72 WTE increase from the start of the year, which incorporated a 34.74 WTE increase in substantive workforce. The target set to reduce agency usage was a 42% reduction, to be off set with increases in the permanent workforce. At month 7 the total workforce is under plan by 13.5 WTE and we are expecting to deliver against our planned levels for total workforce.

Agency usage has decreased in Month 7 with Bank usage increasing. Our agency usage is 7.0 WTE over plan following a three-month trend of a reducing usage (May – July), and increases in August and September, with a decrease in Month 7. Vacancy levels have decreased - a continuing trend since April 25 and is the lowest it has been in this financial year to date.

Hospital Inpatients are the highest users of agency in Month 7: 15.1 WTE which is above plan (9.37 WTE) a variance of 5.79 WTE. This is an increase in the position from month 1 when the variance was 3.31 WTE.

Following a reduction in Bank usage for the three consecutive months, month 7 shows an increase however it remains over plan by 25.8 WTE.

September workforce unavailability increased with higher annual leave impacting temporary workforce spend. September's workforce unavailability increased by 4% to 27%. A review of roster practices is underway together with support and training.

## Integrated Performance Report

### Month 7 Position

| Plan (WTE) | Apr-25 | May-25 | June-25 | July-25 | Aug 25 | Sep 25 | Oct 25 |
|---|---|---|---|---|---|---|---|
| Substantive | 1689.90 | 1688.40 | 1689.80 | 1694.7 | 1702.2 | 1700.73 | 1671.14 |
| Bank | 65.90 | 65.9 | 62.9 | 61.4 | 59.6 | 57.8 | 55.70 |
| Agency | 36.50 | 36.5 | 36.2 | 31.7 | 28.7 | 28.7 | 27.28 |
| Total | 1792.20 | 1790.70 | 1788.90 | 1787.7 | 1790.5 | 1787.2 | 1754.12 |
| **Actual (WTE)** | **Apr-25** | **May-25** | **June-25** | **July-25** | **Aug 25** | **Sep 25** | **Oct 25** |
| Substantive | 1617.30 | 1623.80 | 1626.70 | 1631.4 | 1,31.6 | 1635.14 | 1,624.84 |
| Bank | 101.00 | 87.7 | 81.6 | 73.4 | 78.6 | 76.8 | 81.54 |
| Agency | 42.70 | 35.6 | 33.7 | 30.2 | 37.4 | 37.8 | 34.28 |
| Total | 1761.00 | 1747.10 | 1742.10 | 1735.0 | 1747.6 | 1749.7 | 1,740.66 |
| **Variance (WTE)** | **Apr-25** | **May-25** | **June-25** | **July-25** | **Aug 25** | **Sep 25** | **Oct 25** |
| Substantive | (72.50) | (64.50) | (63.1) | (63.3) | (70.6) | (65.6) | (46.30) |
| Bank | 35.10 | 21.8 | 18.8 | 12.0 | 19.0 | 19.0 | 25.84 |
| Agency | 6.2 | (0.9) | (2.5) | (1.4) | 8.7 | 9.1 | 7.00 |
| Total | (31.30) | (43.60) | (46.8) | (52.7) | (42.9) | (37.5) | (13.46) |

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

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

**Integrated Performance Report**

| Metric | Target | Apr-25 | May-25 | June-25 | July 25 | Aug 25 | Sep 25 | Oct 25 |
|---|---|---|---|---|---|---|---|---|
| Appraisal | 90% | 88.00% | 88.45% | 88.89% | 91.32% | 91.05% | 87.81% | 87.28% |
| Temporary Staff | 3.4% | 3.2% | 3.1% | 2.7% | 2.4% | 3% | 3.9% | 3.9% |
| Vacancies | 8% | 9.83% | 9.39% | 9.14% | 8.82% | 8.95% | 8.65% | 7.46% |
| Sickness | 4.75% | 5.28% | 5.29% | 5.32% | 5.35% | 5.41% | 5.48% | 5.52% |
| Total Shifts exceeding NHSI capped rate | No Target | 49 | 50 | 56 | 47 | 64 | 64 | 108 |

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, six KPIs are a special cause variation of an improving nature and will pass or continue to pass the target if nothing changes, 2 are a special cause variation of a concerning nature where the process is not capable and will fail without process redesign and 2 are a common cause variation with no significant change.

1. Appraisal Rates - improving
2. Mandatory Training Compliance - improving
3. National Education and Training Survey overall satisfaction score - concerning
4. Net Staff in Post Change – no significant change
5. Proportion of temporary staff - improving
6. Sickness Rate - concerning
7. Staff survey engagement theme score - improving
8. Total shifts exceeding NHSI capped rate - improving
9. Total shifts on a non-framework agreement - improving
10. Vacancy rate - no significant change

## Integrated Performance Report

### Appraisal Rates

The compliance rate has been slowly increasing since February 2025. The September and October compliance rates have dropped below target. Currently the compliance rate stands at 87.28%. This reduction in compliance is mainly due to the reporting parameters changing to only reporting on performance appraisal. As the reporting parameters have changed a piece of work is ongoing to ensure all previous appraisal discussions that are not recorded as performance appraisal on ESR are recorded appropriately. Work is continuing to ensure 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.
- Reviewing those appraisals that have been recorded incorrectly on ESR to ensure that they are recorded as performance appraisals

### Mandatory Training

The compliance rate for October improved to 96.42%. After three consecutive months of decline in Infection Level 1, Infection Level 2, and Information Governance, these areas demonstrated increased compliance this month. Only two mandatory requirements—Fire Safety and Safeguarding Children Level 3—experienced a decrease in compliance; however, the reduction was minimal, with the largest decline being just 0.2%. Several areas have shown three continuous months of improvement, including Fraud Awareness, Resuscitation Level 2 (Adult and Paediatric), Moving and Handling Level 2, and Safeguarding Adults Level 3. Notably, Resuscitation Level 3 (Adult and Paediatric) recorded an improvement exceeding 7%. No subjects have experienced three consecutive months of decline.

DNA – High Risk Fire – 47. Spaces not used 25 (2 in Ludlow and 23 in Bridgnorth)
DNA – Resus Level 2 – 4
DNA – Resus Level 3 – 0
DNA – Moving and Handling Level 2 – 15. Spaces not used 19 (2 classes yet to be updated)

High Risk Fire has been set to reach 95% compliance by April 2026. High Risk Fire Trajectory - Oct 2025 - Target - 75%. Actual - 77%.
Nov 2025 - 77%, Dec 2025 - 82%, Jan 2026 - 89%, Feb 2026 - 91% and Mar 2026 - 95%. Consideration will be made in terms of DNA in our trajectory and a focus to improve DNA an action for future reporting.

There were 47 DNA's during October for High-Risk Fire Training at Bridgnorth and Ludlow locations. There are sessions planned for Ludlow and Whitchurch in November and Whitchurch and Oswestry for December. Awaiting dates for 2026 from High-Risk Fire Areas, this will be raised in the Health & Safety Committee meeting taking place in November.

## Integrated Performance Report

Plans are being put in place to look at where there has been continuous non-compliance for 3 months or longer and where training has not been completed previously.

Where topics are below 95% compliance, managers are receiving an email informing them they have one or more staff who are non-compliant. Staff are also receiving emails (where there is an active email address in ESR) where they are non-compliant. They will also get an email if they are expiring in the next 3 months, so they can plan their completion prior to expiring.

### Absence

Since March 2025 the rate continues to remain above target with marginal increases each month. Month 7 sickness rate is 5.52%. 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. The action plans now include a breakdown of short term and long term sickness absence showing a reduction in long term at month 7 and an increase in short Term, with overall levels consistent with previous months.

### Review of Long-Term absence Cases

A recent review of long-term sickness absence cases in October 2025 has taken place. An overview of the findings are as follows:

- In October 2025, 54 staff were recorded as absent due to long-term sickness.
    - 6 have returned to work or left the organisation.
    - 7 have planned return or exit dates in November.
    - As of 14 November 2025, 41 staff remain on long-term sickness, with 3 having planned returns/exits by mid-January 2026. This leaves 38 with no scheduled return or exit date.
- Stress (mainly due to personal reasons) is the leading cause of long-term sickness absence, followed by musculoskeletal (MSK) issues and cancer.
- Most cases are being managed in line with the Trust's Managing Attendance Policy, with reasonable adjustments as required under the Equality Act.

### Data Insights from the long absence case review

- Long-term absence rate in September 2025 was 3.31% (down from 3.83% in August), while short-term absence increased to 2.77% (from 1.68%).
- The average number of long-term sickness cases over the past year is 51, with a slight reduction in Q2, particularly in September 2025
- Breakdown by duration (October 2025):
    - 20+ weeks: 11 staff
    - 10–20 weeks: 14 staff
    - 5–10 weeks: 24 staff
    - 4–5 weeks: 5 staff.
- The majority of cases are in the Operational Directorate, with Adult Community Services and CYP Shropshire divisions most affected.

## Integrated Performance Report

### Opportunities for Improvement in terms of long-term absence management

- Timely referral to Occupational Health by line managers.
- Prompt and accurate recording of absences.
- Improved communication between line managers and the People Team.
- Ensuring correct categorisation of absence reasons.

### 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
- Deep dive into MSK absences has identified that the main MSK issues relate to back, shoulder and neck pain. Work is underway with the MSK Physio team to develop videos to focus on prevention of absence in these areas
- Delivering our Winter ready campaign which includes flu action plan for our flu campaign (at week 7 current flu vaccination uptake is 40%)
- Implement the opportunities for improvement identified above

### Vacancies

Month 7 vacancy position is 7.46% (131.2 WTE) a reduction on month 6 position (8.64%, 155 WTE). Month 7 top 3 hotspots are: Community Hospitals: (Bishops Castle, Ludlow, Whitchurch), Community Nursing and Stoke Heath Prison. The Prison vacancy rate remains high at 20.27% (6.55 WTE) however they have completed their review of the mental health provision, and those roles are now coming through to advert. They currently have 3.6 WTE in the recruitment process, some of which are from the previous month due to the time taken to complete the recruitment process.

To date all of the affected RRU staff have been 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 5 targeted recruitment events, in May, June, July and September to recruit bank HCA to limit the need for agency with a total of 77 offers being made on the dates of the recruitment events with a total of 63 progressing through to appointment.
- Rolling bank recruitment events are being scoped with ops and the recruitment team.

## Integrated Performance Report

### Agency Spend

Month 7 agency use is 34.28 WTE with an expenditure of £307.5K against a plan of 27.3 WTE and £228k, a variance of (7.0) WTE and (£79k) respectively.

Hospital Inpatients are the highest users of agency in Month 7: 15.1 WTE which is above plan (9.37 WTE) a variance of 5.79 WTE. This is an increase in the position from month 1 when the variance was 3.31 WTE.

Price Cap compliance: All staff groups are compliant with NHSE price cap compliance with the exception of Medical and Dental staff groups who are compliant with the Regional West Midlands Price Rate Card.

NHSE notice on the cessation of Band 2 and Band 3 agency use: this has now been formalised with no further bookings for agency B2 and B3 from 1 November 2025 and complete cessation of those already booked by the end of January 2026.

Our work towards mitigation of this change of agency rules has been in previous months with 5 targeted recruitment events resulting in 63 new Band 2 HCAs joining the bank.

In Month 7 the Temporary staffing team booked Bank HCA shifts for both B2 and B3 for all teams on the e-roster system:

•The highest reason for booking B2 HCAs was vacancies

•The highest reason for booking B3 HCAs was sickness absence.

•Both vacancies and sickness absence were the 2 highest reasons for requesting shift fill

The Temporary Staffing team booked bank HCAs across the 4 CHs and the 2 RRUs:

•117 HCA shifts – covered by agency

•297 Shifts were covered by bank HCAs

•101 of these shifts were covered by the Bank HCAs appointed via the recruitment events that have taken place

**Actions to Deliver Improvements - Current Focus:**

- Cease all HCA agency usage by end of January 2026 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.
- Fast tracking any HCA's going through recruitment for bank and permanent roles
- Review fill rates and any mitigations to move HCA's to fill gaps where we are using agency at moment
- Communication with agency workers to transition to SCHT bank
- Support from SaTH to cover short term gaps whilst we switch off agency.

- Centralised Bank - 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 is being 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 NHSE price cap rates. Medical and Dental will follow the West Midlands Regional Rate card until NHSE advise of the new Price Cap. Further action to monitor compliance and finalise the break glass process is underway.
- 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 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.

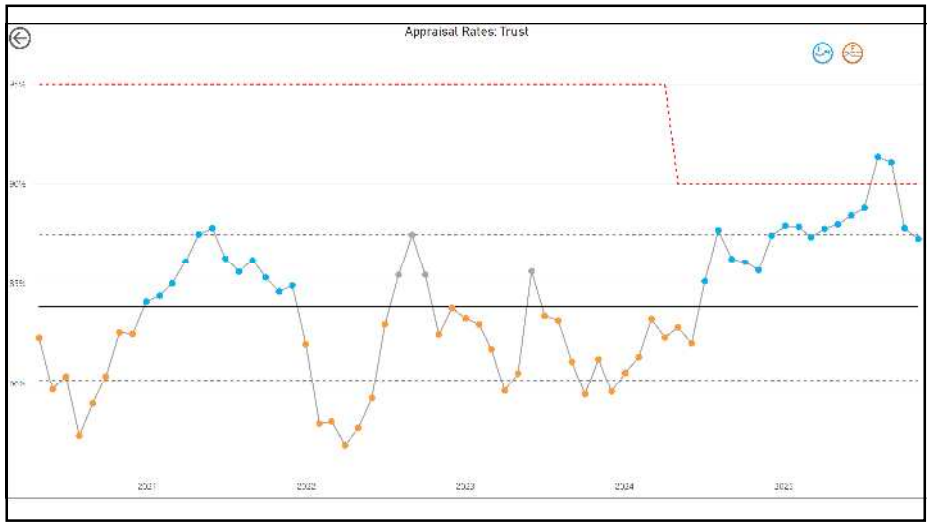
**Appendix 1**
People Committee – SPC Summary
Month 7 (October) 2025/2026 Performance

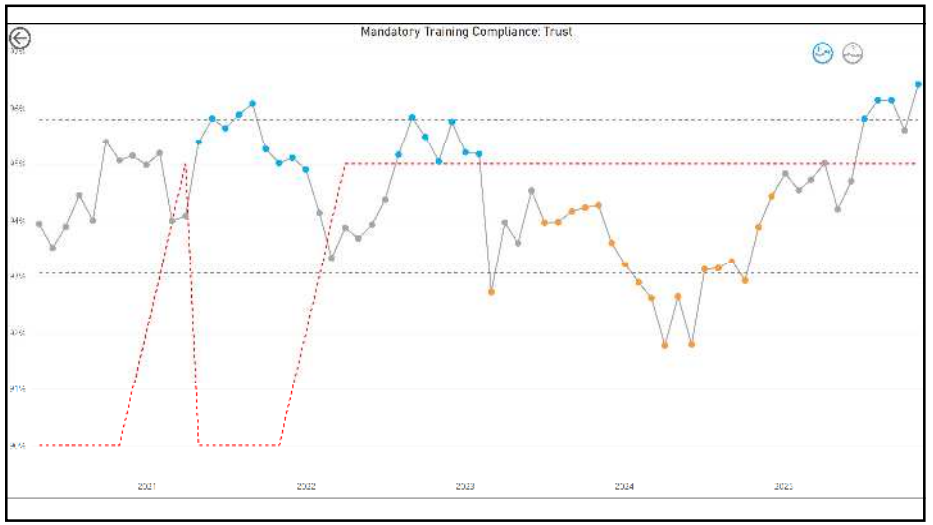
Shropshire Community Health NHS
NHS Trust

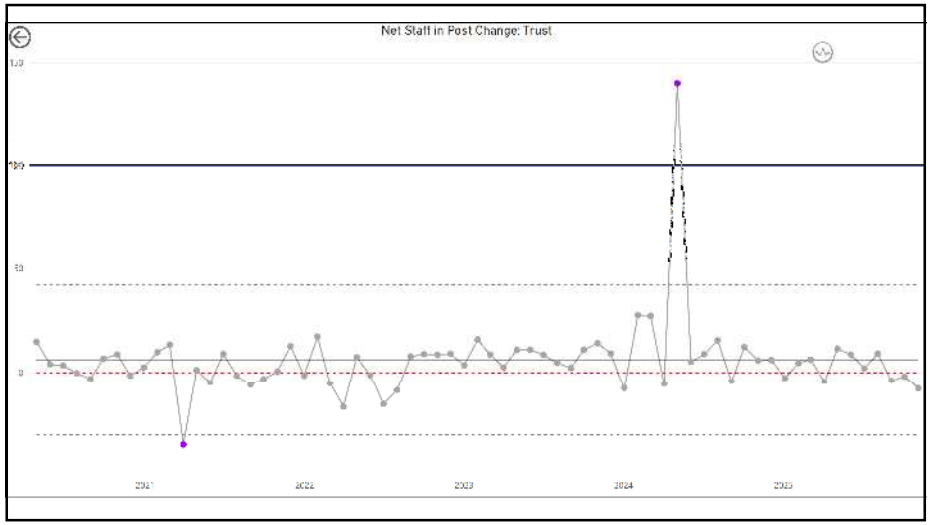
| Committee | Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| People Committee | People and Workforce | Appraisal Rates | 2025-10-31 | H | 87.28% | 90.00% | -2.72% | 88.96% | 90.00% | -1.04% | F |
| People Committee | People and Workforce | Mandatory Training  Compliance | 2025-10-31 | H | 96.42% | 95.00% | 1.42% | 96.42% | 95.00% | 1.42% | ? |
| People Committee | People and Workforce | National Education and Training Survey overall satisfaction score | 2024-12-31 | L | 88.06% | 90.00% | -1.94% | 88.06% | 90.00% | -1.94% | F |
| People Committee | People and Workforce | Net Staff in Post Change | 2025-10-31 | | -8.13 | 0.00 | -8.13 | 2.48 | 0.00 | 2.48 | |
| People Committee | People and Workforce | NHS staff survey engagement theme score | 2025-10-31 | H | 7.2 | 7.2 | 0.0 | 7.2 | 7.2 | 0.0 | F |
| People Committee | People and Workforce | Proportion of temporary staff | 2025-10-31 | L | 3.9% | 3.4% | 0.5% | 3.2% | 3.4% | -0.2% | F |
| People Committee | People and Workforce | Sickness Absence Rate | 2025-10-31 | H | 5.52% | 4.75% | 0.77% | 5.52% | 4.75% | 0.77% | F |
| People Committee | People and Workforce | Total shifts exceeding NHSI capped rate | 2025-10-31 | L | 108 | 0 | 108 | 63 | 0 | 63 | F |
| People Committee | People and Workforce | Total shifts on a non-framework agreement | 2025-10-31 | L | 0 | 0 | 0 | 1 | 0 | 1 | ? |
| People Committee | People and Workforce | Vacancies - all | 2025-10-31 | | 7.46% | 8.00% | -0.54% | 8.89% | 8.00% | 0.89% | ? |

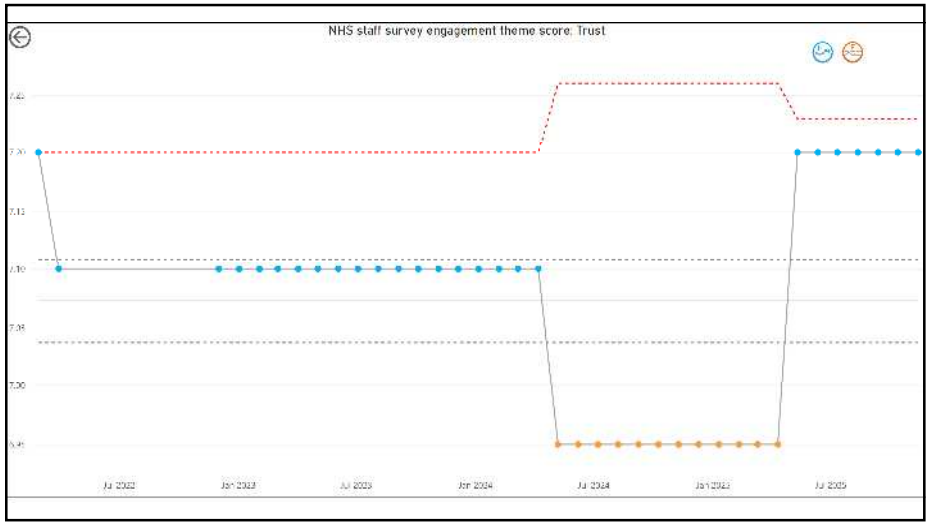
**Appendix 2**
People Committee
Month 7 (October) 2025/2026 Performance

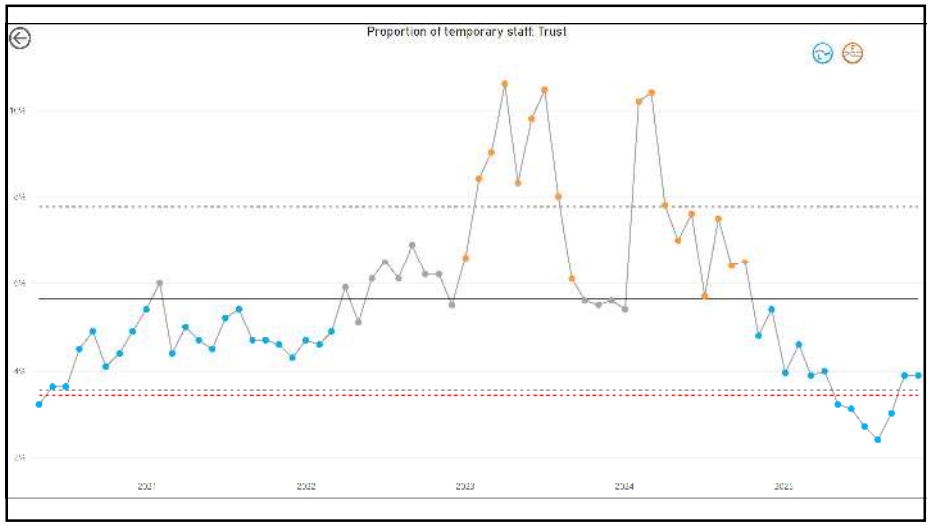
| Variation \ Assurance | P | ? | F | |
|---|---|---|---|---|
| H | Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.<br><br>This process is capable and will consistently **PASS** the target if nothing changes. | Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.<br><br>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**.<br><br>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**.<br><br>Assurance cannot be given as there is no target. |
| L | Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**.<br><br>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**.<br><br>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**.<br><br>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**.<br><br>Assurance cannot be given as there is no target. |
| | Common cause variation, **NO SIGNIFICANT CHANGE**.<br><br>This process is capable and will consistently **PASS** the target if nothing changes. | Common cause variation, **NO SIGNIFICANT CHANGE**.<br><br>This process will not consistently HIT OR MISS the target as the target lies between process limits. | Common cause variation, **NO SIGNIFICANT CHANGE**.<br><br>This process is not capable and will **FAIL** the target without process redesign. | Common cause variation, **NO SIGNIFICANT CHANGE**.<br><br>Assurance cannot be given as there is no target. |
| H | Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**.<br><br>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**.<br><br>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**.<br><br>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**.<br><br>Assurance cannot be given as there is no target. |
| L | Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**.<br><br>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**.<br><br>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**.<br><br>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**.<br><br>Assurance cannot be given as there is no target. |
| | | | | Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning.<br><br>Assurance cannot be given as there is no target. |
| | | | | Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning.<br><br>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.<br><br>Assurance cannot be given as there are no process limits. |

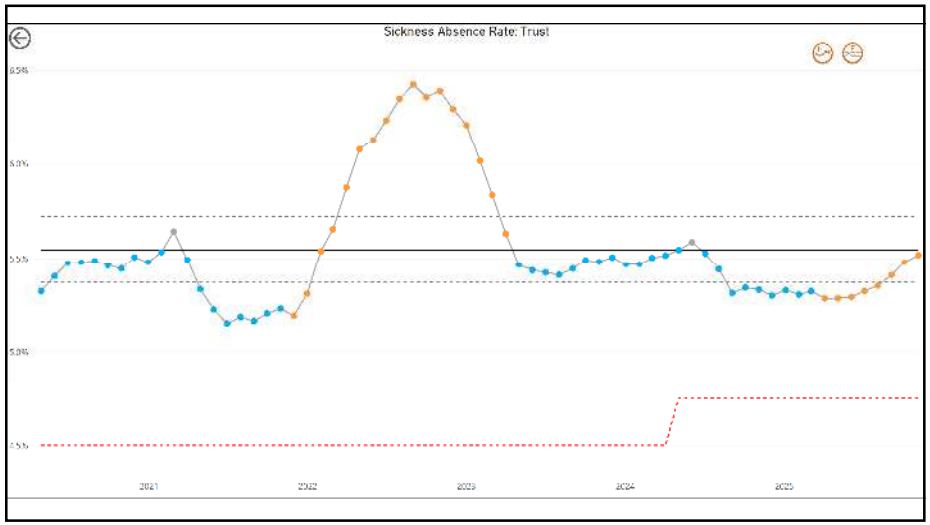

Appraisal Rates: Trust

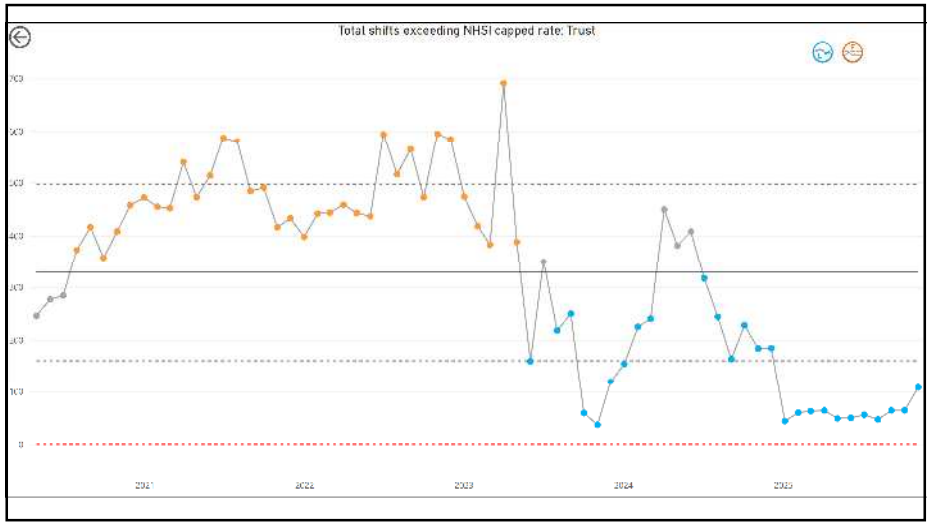

Mandatory Training Compliance: Trust

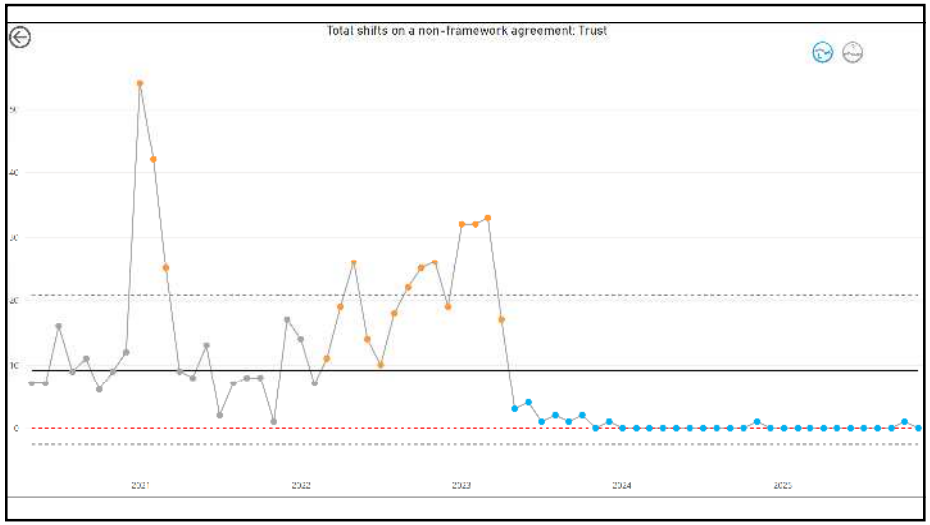

Net Staff in Post Change: Trust

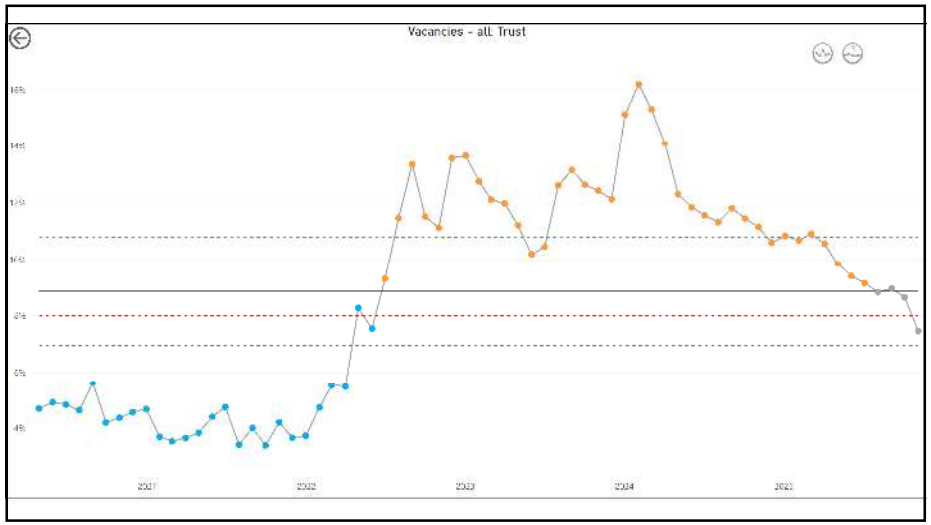

NHS staff survey engagement theme score: Trust


Proportion of temporary staff: Trust


Sickness Absence Rate: Trust


Total shifts exceeding NHSI capped rate: Trust


Total shifts on a non-framework agreement: Trust


Vacancies - all Trust

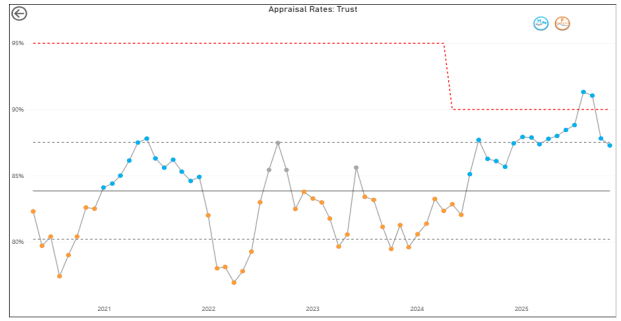
**Exception Report - Action Plan**

## Appraisal Rates

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Appraisals | % | 88.45% | 88.89% | 91.32% | 91.05% | 87.81% | 87.28% | 89.24% |
| | Target | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 87.00% | 88.00% | 89.00% | 89.00% | 89.00% | 90.00% | 90.00% |




**Reason for performance gap:**

The compliance rate has been slowly increasing since February 2025. In September the compliance rate slightly dropped and again in October to 87.28%. This reduction in compliance is mainly due to the reporting parameters changing to only reporting on performance appraisal. As the reporting parameters have changed a piece of work is ongoing to ensure all prevoius appraisal discussions that are not recorded as performance appraisal on ESR are recorded appropriately. 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 the end of December 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.

**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 the Community Services Manager. Allocated 8a Clinical Manager to implement specfic imrovement actions across a range of metrics | Apr-25 | Nov-25 | On track | To ensure appraisals are undertaken and correctly inputted. |
| **Community Services Division -** Check and challenge with the Service Lead for Team Leaders. Review appraisal recording to ensure they are recorded as performance appraisal. 109 appraisals are coming out of compliance over the course of the next 3 months. | Mar-25 | Mar-26 | On Track | To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place |
| **Urgent & Emergency Care Division -** SDG Manager implementing an escalation process. The escalation process will start with the Clinical Services Manager confirming a date when appraisals require completion, if not completed by this date escalation to the Services Delivery Manager who will make contact directly with the Line Manager. . Service Lead will get all Team Leaders to check how appraisals have been recorded as a performance appraisal to ensure they are within the correct parameters. Monthly newsletter to Division to include importance of appraisals and ensuring individuals also take ownership of ensuring their appraisal is completed in time alongside teh Team Leader. (This approach and any communications will be shared with other Divisions) | Aug-25 | Jan-26 | On Track | Appraisals complete and both staff and Line Managers are reminded of the importance of appraisals. Foster a culture of accountability for staff and Line Managers. |
| **Hot spots -** All hot spots will be shared with the relevant Clinical Services Manager to flag compliance rate and ensure they support their Team Leaders with maintaining comolaince | Nov-25 | Dec-25 | On track | Ensure compliance is achieved and CSM's support Line Manager to foster a culture of accountability |
| **Hot Spot MIU Service** - Identify MIU areas that are oustanding appraisals and Operational Lead will link with relevant CSM and ensure dates are booked in for appraisal conversations | Aug-25 | Nov-25 | Completed | Appraisals complete. |
| **Planned care Division** - Clinical Services Managers will undertake a final push to ensure all appraisals are in date and recorded correctly on ESR. Last month Planned Care Division was at 86.3% now at 87.75% so minor improvement. The Operational Lead will ensure focus is particularly on Podiatry (9 outstanding), MSST (5 outstanding), Stoke Heath (4 outstanding). MSST and Stoke Heath will be completed by end of December. 4 appraisals will be completed for Podiatry by end of December with remiaing 5 for end January. Over the next 3 months there are 43 individuals coming out of compliance which will be booked in advance of the expiry date | Oct-25 | Jan-26 | On track | Ensure all appraisals are up to date and those coming out of compliance are planned in |
| Moving forward ensure all pre booked appraisal dates are populated in ESR to enable a report to be generated from ESR of appraisal data to enable senior oversight and oversight at Performance Workshop of a monthyl basis | Nov-25 | Apr-26 | On track | To ensure senior oversight of appraisals providing assurance that appraisals are booked in advance |
| **CYP & F Services (Dudley & Shropshire)** (9 outstanding for Dudley, 47 outstanding for Shropshire). Operational Lead to work with Team Leaders to create a trajectory for 100% compliance which includes those appraisals expiring in the next 3 months (70 expiring for Shropshire and 36 for Dudley) | Nov-25 | Mar-26 | On track | Ensure meaningful appraisals are completed and a plan is in place for all appraisals coming out of compliance |

| | | | |
|---|---|---|---|
| **Author** | Fiona MacPherson | **Date** | 11/18/2025 |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 |

| SDGs and Divisions of 10+ staff | Assignment Count | Reviews Completed | Reviews Completed % |
|---|---|---|---|
| 825 Digital Division | 44 | 37 | 84.09 |
| 825 Finance, Strategy and Estates Division | 32 | 31 | 96.88 |
| 825 Governance Division | 17 | 8 | 47.06 |
| 825 Medicines Management Division | 14 | 13 | 92.86 |
| 825 Nursing and Quality Division | 10 | 10 | 100.00 |
| 825 Operations Directorate Management Division | 11 | 9 | 81.82 |
| 825 People and OD Division | 26 | 24 | 92.31 |
| 825 Safeguarding Children Division | 11 | 11 | 100.00 |
| 825 Service Delivery Group - Adult Community Services Division | 629 | 552 | 87.76 |
| 825 Service Delivery Group - CYP&F Dudley Services Division | 141 | 132 | 93.62 |
| 825 Service Delivery Group - CYP&F Shropshire Services Division | 337 | 290 | 86.05 |
| 825 Service Delivery Group - Planned Care Division | 204 | 179 | 87.75 |
| 825 Service Delivery Group - Urgent Care Division | 202 | 168 | 83.17 |

| Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%) | Appraisals Required | Appraisals In-Date | % Compliance |
|---|---|---|---|
| 825 Digital Application Support Service | 10 | 8 | 80.00 |
| 825 Whitchurch Hospital Hotel Service | 24 | 18 | 75.00 |
| 825 Whitchurch Hospital Inpatients Service | 41 | 33 | 80.49 |
| 825 North Shropshire Community Nursing Service | 56 | 44 | 78.57 |
| 825 Shrewsbury Community Nursing Service | 56 | 44 | 78.57 |
| 825 South East Shropshire Community Nursing Service | 25 | 18 | 72.00 |
| 825 Bishops Castle Hospital Service | 15 | 12 | 80.00 |
| 825 Community Paediatrics Service | 12 | 9 | 75.00 |
| 825 Shropshire PHNS Admin Service | 10 | 6 | 60.00 |
| 825 Child Development Service | 10 | 7 | 70.00 |
| 825 Paediatric Physiotherapy Service | 11 | 8 | 72.73 |
| 825 5-19 School Nursing Telford Service | 14 | 11 | 78.57 |
| 825 Podiatry Service | 27 | 18 | 66.67 |
| 825 Stoke Heath YOI Service | 19 | 15 | 78.95 |
| 825 Community Respiratory Service | 19 | 15 | 78.95 |
| 825 MIU Service | 27 | 21 | 77.78 |
| 825 Urgent Community Response Service | 28 | 21 | 75.00 |
| 825 Virtual Wards Service | 61 | 47 | 77.05 |

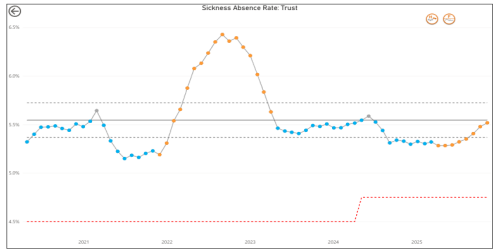
**Exception Report - Action Plan**

## Sickness Rate

Percentage of staff absent over a rolling 12-month period

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Sickness Rate | % | 5.29% | 5.32% | 5.35% | 5.41% | 5.48% | 5.52% | 5.52% |
| | Target | 4.75% | 4.75% | 4.75% | 4.75% | 4.75% | 4.75% | 4.75% |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 5.50% | 5.20% | 5.00% | 5.00% | 4.80% | 4.75% | 4.75% |

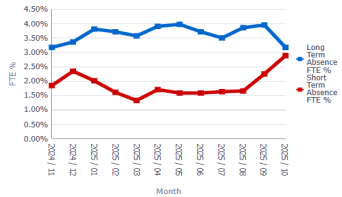



**Reason for performance gap:**

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. We have seen a reduction in long term absence and an increase in short term absence with cold cough flu being the second highest reason for absence. Cold cough flu are generally prevalent during Autumn and Winter months 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 have commenced their Winter Ready campaign which includes promoting the importance of the flu vaccination, know your numbers and HWB days. In week 7, our flu vaccination uptake stands at 40% compared to 44% at the same time last year. 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. A review of all long term absences has been undertaken, a total of 54 individuals hit the trigger for long term absence in October 2025. 16 of those individuals are returning to work or leaving the orgnaisation with the remaining 38 individuals being managed under the Managing Attendace Policy taking into account their personal circumstances and reasonable adjustments under the Equality Act.

| Absence Reason | Headcount | Abs Occurrences | FTE Days Lost | % |
|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 283 | 361 | 11,119.50 | 34.0 |
| S13 Cold, Cough, Flu - Influenza | 664 | 834 | 3,042.08 | 9.3 |
| S25 Gastrointestinal problems | 535 | 678 | 2,920.31 | 8.9 |
| S12 Other musculoskeletal problems | 118 | 139 | 2,497.11 | 7.6 |
| S98 Other known causes - not elsewhere classified | 163 | 182 | 2,313.39 | 7.1 |
| S28 Injury, fracture | 62 | 65 | 1,631.77 | 5.0 |
| S17 Benign and malignant tumours, cancers | 20 | 23 | 1,433.00 | 4.4 |
| S26 Genitourinary & gynaecological disorders | 103 | 123 | 1,181.56 | 3.6 |
| S11 Back Problems | 66 | 77 | 1,158.41 | 3.5 |
| S15 Chest & respiratory problems | 137 | 152 | 1,008.49 | 3.1 |

| Org L6 | Absence FTE | Available FTE | Absence FTE % |
|---|---|---|---|
| B25 Dudley CYP&F Management Services | 254.60 | 740.72 | 34.37% |
| B25 Ludlow Outpatient Service | 166.45 | 569.40 | 29.23% |
| B25 Children's Continence Service | 97.47 | 444.80 | 21.91% |
| B25 Research and Development Service | 245.40 | 1,561.80 | 15.71% |
| B25 Telford & Wrekin Paediatric Physiotherapy Team (DO NOT USE) | 133.93 | 919.87 | 14.56% |
| B25 Workforce Systems Service | 161.00 | 1,108.00 | 14.53% |
| B25 Whitchurch Hospital Inpatients Service | 1,766.97 | 13,125.60 | 13.46% |
| B25 Strategy Service | 144.70 | 1,092.60 | 13.24% |
| B25 Continence Specialist Nursing Service | 317.20 | 2,403.07 | 13.20% |
| B25 Community Therapies Central Service | 623.52 | 4,822.50 | 12.93% |




**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 | Dec-25 | On Track | To better understand the detail behind absences and what bespoke support needs to be put 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 one of the highest reason for absence and we are looking at preventative actions as well as curative. |
| A deep dive into MSK absences has highlighted that the main causes for MSK absences relate to neck, shoulder and back pain. Work with the MSK Physio team to develop appropiate videos around prevention with the MSK team initally focussing on these common absence reasons | Feb-25 | Jan-26 | On Track | To prevent absences around MSK |
| 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. |
| Review all long term absence cases to ensure management is in line with Managing Attendance Policy and next steps are planned with each case - share with the Executive Team for assurance | Nov-25 | Nov-25 | Completed | Ensure the appropriate support and management of all long term absence cases |
| Implement the opportunities for improvement identified in the long term absence review of absence cases that was shared with teh Executive Team | Nov-25 | Jan-26 | On track | Ensure opportunities for improvement are implmented to support teh management of long term absence |
| Community Services Division - Ensure long terms absence is managed in line with the Managing attendance policy | Oct-25 | Nov-25 | Completed | To ensure policy compliance |
| **UEC Division** -. Within urgent care 10% of absences are recorded as other Known causes. Operational Lead will check to ensure this is most appropriate category. 42% of absence is recorded as stress - Operational lead will communicate the current workshops (Meditation and stress management and ensure where appropriate stress risk assessments are undertaken). 9% cancer, gastro 14%, MSK 2%, Monthly newsletter will inlcude preventative support and also a reminder to Line managers in terms of support available and importance of prompt support for staff | Oct-25 | Dec-25 | On Track | Provide staff with appropriate support |
| Long Term Absence Workshop to be scheduled in January 2026 with Operational Leads, People Services and Deputy Director of Operations to review long term absence cases ensuring appropriate support is in place and redeployment offers can be discussed. At this workshop consider how moving forward redeployment opportunities can be explored with the relevant stakeholders | Nov-25 | Jan-26 | On track | To provide an overview of long term absence cases raising awareness of redeployment opportunities and assurance the appropriate support is in place |
| **Planned care w**ithin planned care 41% of absence is atributable to stress and 19% is MSK related. Review the absence hot spots provide appropriate bespoke support to hot spot teams | Nov-25 | Jan-26 | On track | To provide relevant and taregtted support to teams to support the reduction of absence |
| Ensure Line Managers and Team Leaders are supported to create a positive working enviornment. This can be through ACE Award nominations, using the moment that matters cards or providing teams with a safe space to raise any concerns or issues | Nov-25 | Mar-26 | On track | Creat a positive working enviornment as a supportive and positive workplace can reduce stress and improve job satisfaction, lowering the risk of sickness absence. |
| Undertake a regular flexible campaign to raise awareness of flexible working and the benefits of flexible working | Nov-25 | Mar-26 | On track | Flexibility can help employees balance work and personal commitments, reducing stress and the likelihood of sickness absence. |
| Monitor annual leave to provide assurance that appropriate annual leave has been taken and is booked - (55% leave taken in Operations). Operations to have a focussed drive to ensure all leave is booked in by end of December supported by a comms campaign to encourage staff to plan and book their remaining leave | Nov-25 | Jan-26 | On track | To ensure all staff take time away from work to rest and recuperate |
| Review of short term absence to provide assurance that short term absence is being managed in line with the triggers within the Managing Attendance Policy. Include a review of short term absence hot spots to understand any themes or patterns emerging | Nov-25 | Jan-26 | On track | To ensure the application of the Managing Attendance Policy and support to staff who have short term absence |
| Develop and implement a robust flu plan for the 2025-26 flu campaign using the data gathered from the flu survey | Aug-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 | Provide staff with appropriate support |
| Raise awareness Trust wide of recording menopause related absences as menopause. | Mar-25 | Dec-25 | On Track | To ensure menopause related absence is categorised correctly. |
| Cross check every month stress, anxiety and depression absences against referrals to OH to ensure compliance with the Policy. | Mar-25 | Mar-26 | On Track | Ensure appropriate action is being undertaken in line with Managing Attendance Policy |

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|---|---|---|---|
| **Author** | Fiona MacPherson | **Date** | 11/18/2025 |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 |
| | | **Date** | |

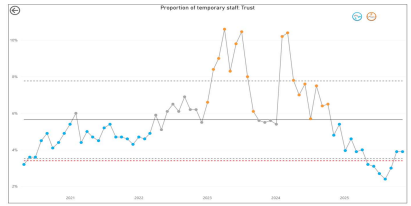
**Exception Report - Action Plan**

## 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 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Prop Temporary staff | % | 3.1% | 2.7% | 2.4% | 3.0% | 3.9% | 3.9% | 3.2% |
| | Target | 3.4% | 3.4% | 3.4% | 3.4% | 3.4% | 3.4% | 3.4% |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 3.90% | 3.90% | 3.80% | 3.80% | 3.70% | 3.60% | 3.40% |




| | |
|---|---|
| **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 with the Consultant JD with the Royal College for approval. 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. Hospitals remains high users of agency. 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 and we are compliant wih the the West Midlands Region Price Rate card for medical and dental staff . NHSE have now confirmed the cessation of Band 2 and Band 3 agency use and no further bookings can be made. All bookings in place will cease at the end of January 2026. |

**Action Plan**

| Action | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|
| **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. **14/9/25:** Ops continuing to review - support from resourcing has been offered.**15/10/25** Ops working on updating the jd and reviewing the medical offer. **13/11/25.** Medical Director/Ops review complete and an agreed solution for this post. New Consultant JD with the Royal College for approval prior to being able to advertise. Resourcing are supporting Ops managers with the writing a Speciality Dr jd and a GPwER jd. Speciality Dr jd will also require Royal College Approval. |
| 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. **14/10/25** % contracted hours left unused 5.36%, % additional duties 3.19%, Roster Approval Lead Time partial 54 days – Full 49 days **13/11/25** Currently 89 teams are live on e-roster with a further 21 teams scheduled up to 31/3/26. Roster approval lead time - full approval = 54 days, Partial approval 59 days. % contract hours unused 2%, % hours additional duties 6%. |
| 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. Notification received 30/11/25. See action below on grow our own bank. | Apr-25 | Nov-25 | Completed | 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 13/11/25** No new bookings for B2/3 from 1/11/25 with all pre-booked shifts to end by 31 Jan 26. |
| Grow our bank and implement the use of centralised bank to support reduction in agency usage and relieve pressure on teams where covering sickness absence . 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 | **13/11/25: Event 16/5/25** *Shrewsbury:* 25 offers - 14 started, 5 withdrawn, 6 waiting completion supernumary shifts/training **Event 26/6/25** *Ludlow* 13 offers - 8 started, 4 withdrawn, 1 waiting completion of supernumary shifts/training **Event 29/7/25** *Whitchurch* - 21 offers - 7 started, 5 withdrawn, 9 waiting completion supernumary shifts/training **Events 3/10 & 24/10** *Shrewsbury:* 18 offers - 7 awaiting completion supernumary shifts/training, 11 in pre-employment checks |
| 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. **13/11/25**: Implementation plan in place: 89 teams on e-roster with 21 teams planned for implementation until March 2026 - 3 outstanding teams for April implementation. |
| Implement the use of NHSP national bank to reduce agency use. Targeted work by NHSP to convert current agency workers to the NHSP bank. New Revised end date. | Jun-25 | Dec-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 **14/10/25**: IG confirmed arrangements meet requirements. API requested for switch on. **13/11/25** APIs switched on and NHSP setting up on e-roster. Lead in times being |
| Deep dive into the reasons for booking temporary staffing | Oct-25 | Mar-26 | On Track | To ensure managers use the correct reason for booking temporary staffing using the roster system to improve the reporting of booking reasons that in turn will enable the resourcing team and ops senior managers to identify any trends with staffing productivity. |

| | | | |
|---|---|---|---|
| **Author** | Gina Billington | **Date** | 11/13/2025 |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 |

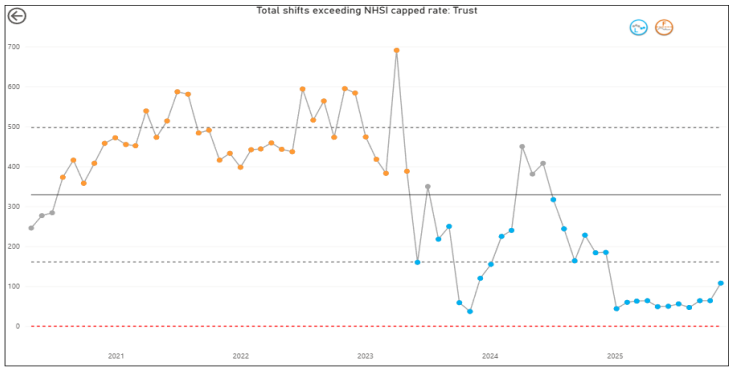
**Exception Report - Action Plan**

## 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 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Shifts | Number | 50 | 56 | 47 | 64 | 64 | 108 | 63 |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 108 | 90 | 90 | 80 | 60 | 40 | 20 |




| | | | | |
|---|---|---|---|---|
| **Reason for performance gap:** | 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 or the new rates for medical and dental staff however we are compliant with the West Midlands Region Price Rate card (this is slightly higher than the current NHSE rate). We are currently supplying Medical staff to: Long Covid, Virtual Ward, Integrated Front Door, Paeds, Stoke Heath Prison | | | |
| **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 | Complete | 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 | **13/11/25:** **Event 16/5/25** *Shrewsbury*: 25 offers - 14 started, 5 withdrawn, 6 waiting completion supernumary shifts/training **Event 26/6/25** *Ludlow* 13 offers - 8 started, 4 withdrawn, 1 waiting completion of supernumary shifts/training **Event 29/7/25** *Whitchurch* - 21 offers - 7 started, 5 withdrawn, 9 waiting completion supernumary shifts/training **Events 3/10 & 24/10** *Shrewsbury:* 18 offers - 7 awaiting completion supernumary shifts/training, 11 in pre-employment checks |
| | Expansion of UEC: medical staffing reviewed requirement for Consultant, Speciality Dr and GP. | Oct-25 | Mar-26 | On Track | **13/11/25.** New Consultant JD with the Royal College for approval prior to being able to advertise. Resourcing are supporting Ops managers with writing a Speciality Dr jd and a GPwER jd. Speciality Dr jd will also require Royal College Approval. |
| **Author** | Gina Billington | **Date** | 11/13/2025 | | |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 | | |

# Local Action Plans

**Exception Report - Action Plan**

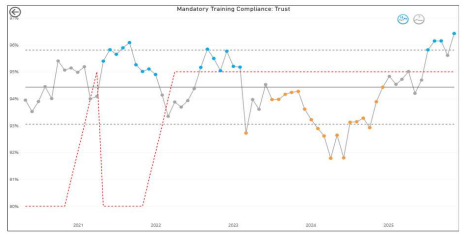
## Mandatory Training Compliance

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Mandatory Training | % | 94.69% | 95.82%* | 96.15% | 96.15% | 95.71% | 96.42% | 96.42% |
| | 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 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 |
|---|---|---|---|---|---|---|---|
| % | 96.60% | 96.60% | 97.10% | 97.10% | 97.60% | 97.60% | 98.10% |




October 2025 Compliance Overview

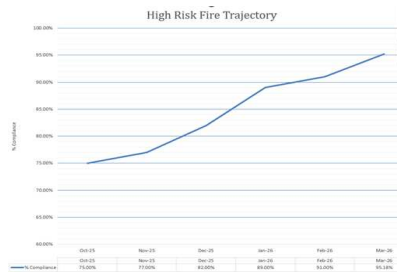
| TOPIC | September Compliance | Movement | October Compliance | Variance against compliance |
|---|---|---|---|---|
| Conflict Resolution | 97.9% | ▲ | 98.6% | 0.70% |
| Corporate Induction | 97.5% | ▲ | 97.6% | 0.09% |
| Equality, Diversity and Human Rights | 98.8% | ▲ | 99.1% | 0.27% |
| Fire Safety - High Risk | 82.4% | ▲ | 76.8% | 14.38% |
| Fire Safety | 99.7% | ▼ | 99.7% | -0.01% |
| Fraud Awareness | 97.4% | ▲ | 97.8% | 0.36% |
| Health, Safety and Welfare | 98.2% | ▲ | 98.8% | 0.53% |
| Infection Prevention and Control - Level 1 | 97.1% | ▲ | 97.4% | 0.31% |
| Infection Prevention and Control - Level 2 | 95.2% | ▲ | 97.0% | 1.78% |
| Information Governance and Data Security | 97.0% | ▲ | 97.5% | 0.42% |
| Moving and Handling - Level 1 | 96.9% | ▲ | 97.4% | 0.52% |
| Moving and Handling - Level 2 - 2 Years | 62.5% | ▲ | 64.2% | 1.71% |
| Oliver McGowan Training Elearning | 97.6% | ▲ | 98.0% | 0.37% |
| Patient Safety - Level 1 | 98.4% | ▲ | 99.6% | 0.16% |
| Patient Safety - Level 2 | 96.9% | ▲ | 97.1% | 0.24% |
| Preventing Radicalisation - Prevent Awareness | 97.7% | ▲ | 98.2% | 0.48% |
| Resuscitation - Level 2 - Adult Basic Life Support | 86.8% | ▲ | 88.9% | 2.08% |
| Resuscitation - Level 2 - Paediatric Basic Life Support | 80.8% | ▲ | 82.4% | 1.63% |
| Resuscitation - Level 3 - Adult Immediate Life Support | 73.4% | ▲ | 80.8% | 7.39% |
| Resuscitation - Level 3 - Paediatric Immediate Life Support | 72.8% | ▲ | 81.7% | 8.89% |
| Safeguarding Adults - Level 1 | 98.2% | ▲ | 98.6% | 0.48% |
| Safeguarding Adults - Level 2 | 98.0% | ▲ | 98.3% | 0.29% |
| Safeguarding Adults Level 3 | 95.3% | ▲ | 96.3% | 1.02% |
| Safeguarding Children - Level 1 | 96.2% | ▲ | 96.6% | 0.41% |
| Safeguarding Children - Level 2 | 94.0% | ▲ | 94.2% | 0.22% |
| Safeguarding Children Level 3 | 92.7% | ▼ | 92.5% | -0.20% |
| Safeguarding Children Level 4 | 100.0% | - | 100.0% | 0.00% |
| Overall Mandatory Training Compliance | 95.6% | ▲ | 96.4% | 0.81% |

**Reason for performance gap:**

Corporate Updates – The compliance rate for October improved to 96.42%. After three consecutive months of decline in Infection Level 1, Infection Level 2, and Information Governance, these areas demonstrated increased compliance this month. Only two mandatory requirements—Fire Safety and Safeguarding Children Level 3—experienced a decrease in compliance; however, the reduction was minimal, with the largest decline being just 0.2%. Several areas have shown three continuous months of improvement, including Fraud Awareness, Resuscitation Level 2 (Adult and Paediatric), Moving and Handling Level 2, and Safeguarding Adults Level 3. Notably, Resuscitation Level 3 (Adult and Paediatric) recorded an improvement exceeding 7%. No subjects have experienced three consecutive months of decline.
DNA – High Risk Fire – 47. Spaces not used 25 (2 in Ludlow and 23 in Bridgnorth)
DNA – Resus Level 2 – 4
DNA – Resus Level 3 – 0
DNA – Moving and Handling Level 2 – 15. Spaces not used 19 (2 classes yet to be updated)
DNA - Corporate Induction - 5. Spaces not used 26
Where topics are below 95% compliance, managers are receiving an email informing them they one or more staff who are non-compliant. Staff are also receiving emails (where there is an active email address in ESR) where

**Action Plan**

| Action | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|
| **Hotspot - Compliance Overview** - Ops Teams to focus efforts on improving compliance rates for **Resuscitation Training**. 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 | Tasked to reach 95% compliance by April 2026 for Resus Level 2 and Level 3, it will be discussed at the November Performance Meetings to reach an agreement for the Trajectory for the coming months. During October we had 2 sessions where their was no attendance and 2 sessions where we only had 1 person to attend. There were 4 people who DNA'ed. Please note it is not a requirement for staff to book through ESR, so there may be people who had planned on attending, but didn't attend which we would not know about.<br>Managers are emailed where they have staff who are non-compliant with Resus Level 2 and Level 3. Where staff have an active email email address, are also emailed where they are non-compliant. An email is also sent to those who are due to expire in the next 3 months, so they can plan their attendance.<br>To improve overall compliance rates across Resuscitation Training, 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 | High Risk Fire Trajectory - Oct 2025 - Target - 75%. Actual - 77%.<br>Nov 2025 - 77%, Dec 2025 - 82%, Jan 2026 - 89%, Feb 2026 - 91% and Mar 2026 - 95%.<br>There were 47 DNA's during October for High Risk Fire Training at Bridgnorth and Ludlow locations. There are sessions planned for Ludlow and Whitchurch in November and Whitchurch and Oswestry for December. Awaiting dates for 2026 from High Risk Fire Areas, this will be raised in the Health & Safety Committee meeting taking place in November.<br>Managers are emailed where they have staff who are non-compliant with High Risk Fire. Where staff have an active email email address, are also emailed where they are non-compliant. An email is also sent to those who are due to expire in the next 3 months, so they can plan their attendance.<br>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.<br>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 booking on to ensure their compliance. |
| **Hotspot - Compliance Overview** - ESRLM to focus on improving compliance where there has been a continuation of non-compliance. | Oct-25 | Apr-26 | On track | ESRLM reported on staff who have been non-compliant for 3 months or longer or have never completed the training. This report has been sent to Tracie Black (Associate Director for Workforce, Education & Professional Standards and) and Sarah Allan (Deputy Workforce Operations Director (Interim))<br>Further investigation will be done on number of people who are non-compliant for multiple topics and which topics have high rate of continued |
| 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.<br>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 |
| **Hotspot - Compliance Overview** - ESRLMS to focus efforts on improving compliance rates for **Infection Prevention Level 1 and Level 2 and Information Governance**. The Subject Leads have been invited to the Mandatory Training Group as we have seen 3 continuous months of decline in compliance. Currently still remain above the 95% compliance. | Oct-25 | Dec-25 | Completed | To see a stop in declining compliance and see an improvement in compliance. |
| **Hotspot - Compliance Overview** - ESRLMS to focus efforts on improving compliance rates for **Safeguarding Children Level 2 and Safeguarding Children Level 3**. The Subject Leads have been invited to the Mandatory Training Group as we have seen the compliance drop below the 95% target. | Oct-25 | Dec-25 | On track | Managers are emailed where they have staff who are non-compliant with Safeguarding Children Level 2 and Safeguarding Children Level 3. Where staff have an active email email address, are also emailed where they are non-compliant. An email is also sent to those who are due to expire in the next 3 months, so they can plan their completion.<br>Improved mandatory training compliance. |
| Community Services to implement a check and challenge session on a monthly basis to discuss hot spots for areas of low compliance | Jun-25 | Dec-25 | On track | Improved mandatory training compliance. |




| | | | |
|---|---|---|---|
| **Author** | Catherine Morris | **Date** | 11/18/2025 |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 |

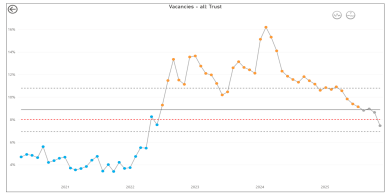
**Exception Report - Action Plan**

## Vacancies - all

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Vacancies | % | 9.39% | 9.14% | 8.82% | 8.95% | 8.65% | 7.46% | 8.89% |
| | Target | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 7.46% | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% | 8.0% |




**Reason for performance gap:**

Corporate Updates - Focus on the areas with vacancies that are creating demand for temporary staffing which will be across inpatient areas. NHSE is introducing new Time to Hire targets - 40 days/8 weeks. Recruitment team is holding a B3 1.00 WTE vacancy.

Operational Updates - RRU wards now decommissioned and all individual now redeployed or employed elsewhere, no redundancies have been made. UEC are expanding their services and a number of these vacancies have been filled by RRU redeployees. Remaining vacancies now underway. UEC consultant recruitment has been reviewed and 3 medical posts now required. Dudley C&YP Services holding vacancies whilst undertaking review of structures for managmenet of change. RRU still on the establishment for vacancy reporting and UEC is not yet on - this will affect the vacacny position once updated.

Month 7 hotspots: Community Nursing, CH's (BCCH, LCH and Whitchurch) and Stoke Heath (have completed their review of mental health provision) are hotspots with work ongiong with the recruitment team. There are a number of administrative vacancies across the Trust that have not been approved for advertisting which are impacting on the vacancy position in admin teams.

**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 managers. | Jul-25 | Dec-25 | On Track | Vacancies successfully redeployed or recruited to. **13/11/25**: working with ops managers on medical jds - see below update. |
| **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. **14/9/25**: Ops continuing to review - support from resourcing has been offered. **13/11/25.** New Consultant JD with the Royal College for approval prior to being able to advertise. Resourcing are supporting Ops managers with the writing a Speciality Dr jd and a GPwER jd. Speciality Dr jd will also require Royal College Approval. |
| **Vacancy Hotspots:** Recruitment team to prioritise vacancies in hotspot areas and 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 | **13/11/25**<br>**Community Nursing:** Starting: 0.96 HCSW, Longlisting: 0.8 Staff nurse shortlisting: 1.0 HCSW<br>interview: 1.0 Staff Nurse and 1.0 HCA<br>**CHs:**<br>Starting 1.0 Staff nurse<br>Longlisting: 6.31 HCA, 1 x housekeeper<br>Shortlisting 2 x Deputy Ward managers, 2.95 staff nurse<br>**Stoke Heath:**<br>Starting 1 .0 Sister.<br>Longlisting: 1.0 Primary Care nurse, 0.6 GP<br>In offer: 1.0 nurse |
| **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 | Completed | **15/10/2025:**<br>Band 6 General Nurse – 1.12 WTE, awaiting authorisation.<br>Prison Adult Nursing Sister – 1 WTE, awaiting confirmation of start date.<br>Staff Nurse – 2 WTE, 1 starting in October, 1 awaiting prison vetting.<br>Prison Mental Health Team Leader – 1 WTE, awaiting outcome of EOI for redeployment.<br>Prison GP – 0.60 WTE, JD requires review. **13/11/25:** see above vacancy status following review of mental health provision |
| 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 | Jan-26 | On Track | To ensure managers are up to date with recruitment processes and provides the tools for them to recruit. **14/10/25** New revised date due to timing of consultation and relevant committees. |
| 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 **15/10/25:** time to hire 40.99 days **13/11/25** Time to hire 36.4 days |
| Look at internal moves due to vacancies and identify hotspots for this movement. | Apr-25 | Dec-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 **13/11/25** Due to increased capacity issues and the RRU redeployment project we were unable to complete this work. Revised target date: 31 December 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 | **13/11/25:**<br>**Event 16/5/25** *Shrewsbury:* 25 offers - 14 started, 5 withdrawn, 6 waiting completion supernumary shifts/training<br>**Event 26/6/25** *Ludlow* 13 offers - 8 started, 4 withdrawn, 1 waiting completion of supernumary shifts/training<br>**Event 29/7/25** *Whitchurch* - 21 offers - 7 started, 5 withdrawn, 9 waiting completion supernumary shifts/training **Events 3/10 & 24/10** *Shrewsbury:* 18 offers - 7 awaiting completion supernumary shifts/training, 11 in pre-employment checks |

| | | | |
|---|---|---|---|
| **Author** | Gina Billington | **Date** | 11/13/2025 |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 |

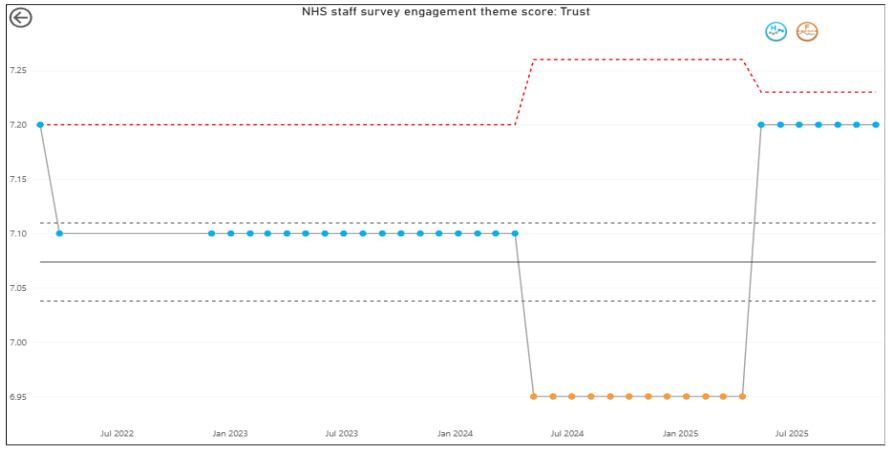
# Yearly Reported KPIs

**Exception Report - Action Plan**

## NHS Staff survey engagement theme score

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Staff survey engagement theme score | Number | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 |
| | Target | 7.3 | 7.3 | 7.3 | 7.3 | 7.23 | 7.23 | 7.23 |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 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** | 11/18/2025 | | |
| **Accountable Officer Approval** | Rhia Boyode | **Date** | 11/18/2025 | | |

Shropshire Community Health
NHS Trust

## Performance Update

| | | | |
|---|---|---|---|
| **Author:** | Steve Price, Head of Information and Performance Assurance Operational Leads & Jon Davis Associate Director of Digital Services. | **Paper date:** | **4th December 2025** |
| **Executive Sponsor:** | Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations | **Paper written on:** | **26th November 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 53 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. 23 indicators are highlighted as a concern (43.4%), although there are interdependencies across many of these.

| Committee | Variation concern | Assurance concern | Both Variation and Assurance | Total KPIs reviewed | Total Requiring Attention |
|---|---|---|---|---|---|
| **People** | 0 | 4 | 2 | **10** | **6 (60%)** |
| **Quality & Safety** | 3 | 1 | 1 | **16** | **5 (31.3%)** |
| **Resource & Performance** | 1 | 10 | 1 | **27** | **12 (44.4%)** |

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**
  *Category 4 Pressure Ulcers and Safer Staffing - Average Fill Rate Registered Nurses - Day are now flagged as a variation concern*

- **Resource and Performance Committee**
  *Variance year-to-date to financial plan is now flagged as a variation concern.*

Action Plans have been developed in a workshop with Operational Leads and Support Services and are included at Appendix 3 for the measures flagged as a concern within this report, with the exception of 'Variance year-to-date to financial plan'; this KPI is achieving target but is flagged as special cause variation due to historical performance and SPC calculations.

At the request of the Resource & Performance Committee, more detail has been provided in the action plan for Data Quality Maturity Index.

**Please note that the RTT measures for October are subject to change as the validation for the national submission continued at the time of preparing the 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.
- **Approve** the changes to the measures referenced in the report.
- **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus.

**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 27 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 12 require focused attention with 10 of the 12 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. Variance year-to-date to financial plan

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

1. Percentage of patients waiting less than 18 weeks - RTT
2. Percentage of patients waiting over 52-weeks RTT
3. Proportion of patients within 18 weeks
4. Percentage of patients waiting over 52-weeks for community services
5. Data Quality Maturity Index
6. Total patients waiting more than 52 Weeks – All services
7. Total patients waiting more than 65 Weeks – All services
8. Total patients waiting more than 78 Weeks – All services
9. Total patients waiting more than 52 Weeks to start consultant-led treatment
10. Average number of days from discharge ready date and actual discharge date

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

1. Proportion of patients within 18 weeks - Children's Services

There has been one change to note since the last report to the Trust Board:-

- Now flagged as having a variation concern
    1. *Variance year-to-date to financial plan*

## Performance Update

### October 2025 position:

| | Children's Services incl. Dental | | Adult Services | | Total | |
|---|---|---|---|---|---|---|
| Patients Waiting | Nationally Mandated Referral to Treatment (Consultant-Led Services) | Local Waiting List Management (All Services) | Nationally Mandated Referral to Treatment (Consultant-Led Services) | Local Waiting List Management (All Services) | Nationally Mandated Referral to Treatment (Consultant-Led Services) | Local Waiting List Management (All Services) |
| 52+ weeks | 0 | 38 | 20 | 39 | 20 | 77 |
| 65+ weeks | 0 | 10 | 0 | 3 | 0 | 13 |
| 78+ weeks | 0 | 1 | 0 | 1 | 0 | 2 |
| 104+ weeks | 0 | 0 | 0 | 1 | 0 | 1 |

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

Since the last report to Board there has been improvements in many of the high waits in the table above with the exception of 65+ weeks and 78+ weeks for local waits. The appended plans describe the actions being taken and the trajectories for improvement. **The local 104+ week wait has been confirmed as a data quality issue and this will affect the other local wait KPI also.**

'Percentage of patients waiting less than 18 weeks - RTT' has shown an improvement from 80.47% in September to 82.46% in October, although the October position was still being validated at the time of preparing the paper/dashboards. Further detail is included in the action plan.

The indicator for 'Proportion of patients within 18 weeks' has improved, with performance of 82.14% in October compared with 79.73% in September.

The data issue previously reported in relation to Continence products is not yet fully resolved. Data is up to date to September however October data was incomplete when preparing the dashboards; this issue has been 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.

As previously referenced, changes to our KPI are anticipated through the year. The proposed changes are listed below and **require approval** from the Trust Board in line with our governance arrangements:-

- New Birth Visits % within 14 days – Telford and Wrekin. New contract is being finalised with a target of 90% and the KPI adjusted to reflect this. This is consistent with the Dudley and Shropshire Council KPI contractual targets.
- Planned surplus/deficit. Change to methodology to be consistent with National Oversight Framework dashboards. NOF are using annual rather than in month values.

## Performance Update

### 3.3 National Oversight Framework

Following the national release of the Oversight Framework scores, we are reviewing our performance in relation to peers and assessing if further efforts can be applied to particular KPIs in order to improve individual domain scores.

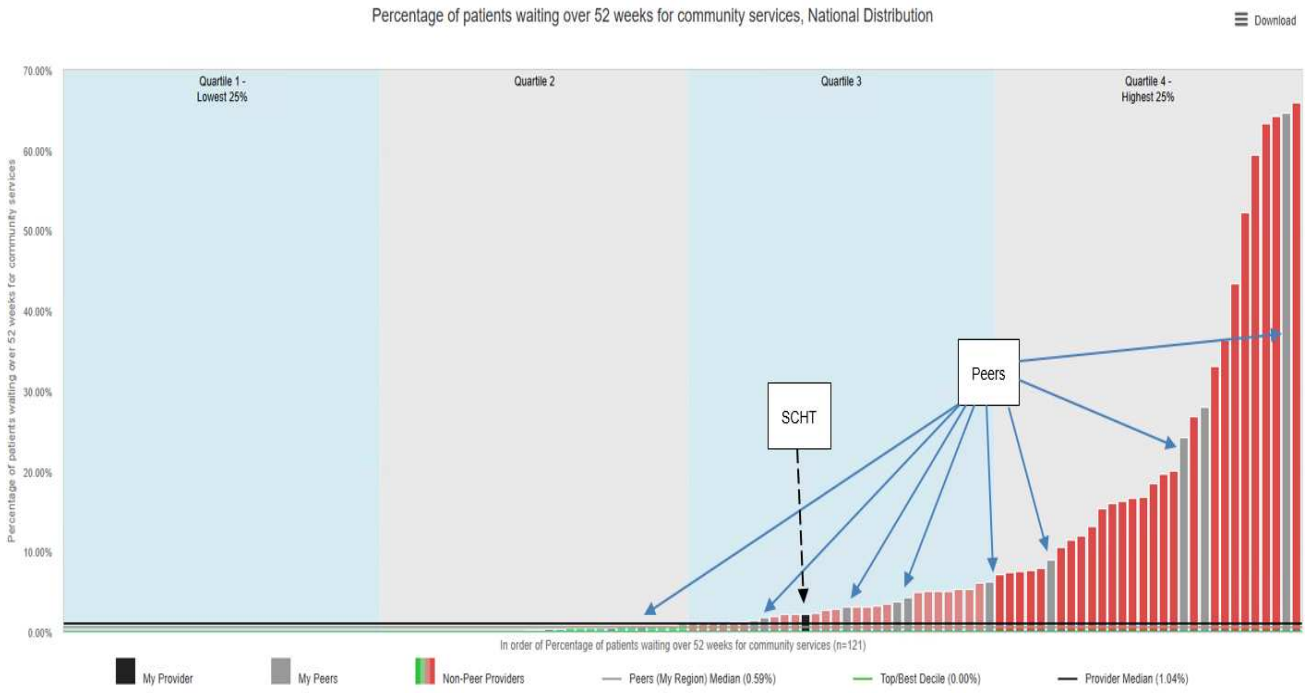
SCHT performs well across many domains within the Oversight Framework, which is reflected in the positive overall NOF score of 2. Organisations rated as 1 are reported as the best performing and organisations rated as 4 requiring the most support.

There are two areas within the NOF where SCHT is shown as below average in recent data:

- Percentage of patients waiting over 52 weeks for community services (Resource and Performance Committee remit)
- Sickness absence rate (People Committee remit)

Both of the above KPIs are already flagged as a concern within our performance reporting, and details in relation to the actions being taken to improve this performance are shown within the relevant action plan, and assurance is gained through the relevant committees.

**Percentage of Patients Waiting for Community Services**




It is proposed that information in relation to our Oversight Framework performance is included within future board papers, as relevant.

## Performance Update

### 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.
- **Approve** the changes to the measures referenced in the report.
- **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus.

# APPENDICES FOR PERFORMANCE REPORT - FOR REFERENCE

## Resource and Performance Committee - SPC Summary

| Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Effectiveness and experience of care | Average number of days from discharge ready date and actual discharge date | 2025-10-31 | | 6.9 | 4.0 | 2.9 | 6.9 | 4.0 | 2.9 | F |
| Finance and Productivity | Data Quality Maturity Index | 2025-07-31 | H | 94.6% | 95.0% | -0.4% | 94.6% | 95.0% | -0.4% | F |
| Access | Difference between actual and planned 18 week elective performance | 2025-10-31 | | 19.46 | 0.00 | 19.46 | 19.46 | 0.00 | 19.46 | |
| Finance and Productivity | Financial efficiency - variance from efficiency plan | 2025-10-31 | H | 1.53% | 0.00% | 1.53% | 1.53% | 0.00% | 1.53% | ? |
| Finance and Productivity | Implied productivity level | 2025-10-31 | | 109.21% | 100.00% | 9.21% | 109.21% | 100.00% | 9.21% | ? |
| Access | New Birth Visits % within 14 days - Dudley | 2025-09-30 | H | 92.07% | 90.00% | 2.07% | 90.71% | 90.00% | 0.71% | ? |
| Access | New Birth Visits % within 14 days - Shropshire | 2025-09-30 | H | 86.67% | 90.00% | -3.33% | 85.40% | 90.00% | -4.60% | ? |
| Access | New Birth Visits % within 14 days - Telford | 2025-09-30 | | 88.24% | 95.00% | -6.76% | 90.90% | 95.00% | -4.10% | ? |
| Access | Number of patients not treated within 28 days of last minute cancellation | 2025-10-31 | L | 0 | 0 | 0 | 0 | 0 | 0 | ? |
| Access | Percentage of patients waiting less than 18 weeks - RTT | 2025-10-31 | H | 82.46% | 92.00% | -9.54% | 82.46% | 92.00% | -9.54% | F |
| Access | Percentage of patients waiting over 52-weeks for community services | 2025-10-31 | L | 0.82% | 0.00% | 0.82% | 0.82% | 0.00% | 0.82% | F |
| Access | Percentage of patients waiting over 52-weeks RTT | 2025-10-31 | L | 0.25% | 0.00% | 0.25% | 0.25% | 0.00% | 0.25% | F |
| Improving health and reducing inequality | Percentage of people waiting over 6 weeks for a diagnostic procedure or test | 2025-09-30 | | 100.00% | 99.00% | 1.00% | 100.00% | 99.00% | 1.00% | ? |
| Finance and Productivity | Planned surplus/deficit | 2025-10-31 | H | 1.57% | 0.00% | 1.57% | 1.57% | 0.00% | 1.57% | P |
| Access | Proportion of patients within 18 weeks | 2025-10-31 | H | 82.14% | 92.00% | -9.86% | 82.14% | 92.00% | -9.86% | F |
| Access | Proportion of patients within 18 weeks - Childrens Services | 2025-10-31 | L | 71.98% | 92.00% | -20.02% | 71.98% | 92.00% | -20.02% | F |
| Finance and Productivity | Relative difference in costs | 2024-03-31 | | 102.52% | 100.00% | 2.52% | 102.52% | 100.00% | 2.52% | |

# Resource and Performance Committee - SPC Summary (continued)

| Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Finance and Productivity | Total activity undertaken against current year plan | 2025-10-31 | | 88.58% | 100.00% | -11.42% | 100.13% | 100.00% | 0.13% | |
| Access | Total patients waiting more than 104 weeks - all services | 2025-10-31 | | 1 | 0 | 1 | 1 | 0 | 1 | |
| Access | Total patients waiting more than 52 weeks - all services | 2025-10-31 | L | 77 | 0 | 77 | 77 | 0 | 77 | F |
| Access | Total patients waiting more than 52 weeks to start consultant-led treatment | 2025-10-31 | L | 20 | 0 | 20 | 20 | 0 | 20 | F |
| Access | Total patients waiting more than 65 weeks - all services | 2025-10-31 | L | 13 | 0 | 13 | 13 | 0 | 13 | F |
| Access | Total patients waiting more than 65 weeks to start consultant-led treatment | 2025-10-31 | L | 0 | 0 | 0 | 0 | 0 | 0 | |
| Access | Total patients waiting more than 78 weeks - all services | 2025-10-31 | L | 2 | 0 | 2 | 2 | 0 | 2 | F |
| Effectiveness and experience of care | Urgent Community Response 2-hour performance | 2025-08-31 | | 92.50% | 70.00% | 22.50% | 92.50% | 70.00% | 22.50% | |
| Finance and Productivity | Variance year-to-date to financial plan | 2025-10-31 | L | 117.51% | 100.00% | 17.51% | 117.51% | 100.00% | 17.51% | |
| Finance and Productivity | Virtual ward bed occupancy | 2025-10-31 | | 73.61% | 80.24% | -6.63% | 73.61% | 80.24% | -6.63% | |

# Quality and Safety Committee - SPC Summary

| Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety | Category 3 Pressure Ulcers | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Patient Safety | Category 4 Pressure Ulcers | 2025-10-31 | H | 1 | 0 | 1 | 1 | 0 | 1 | |
| Effectiveness and experience of care | Complaints - (Open) % within response timescales | 2025-10-31 | | 72.73% | 95.00% | -22.27% | 91.43% | 95.00% | -3.57% | |
| Effectiveness and experience of care | CQC Conditions or Warning Notices | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | P |
| Patient Safety | Deaths - unexpected | 2025-10-31 | H | 2 | 0 | 2 | 2 | 0 | 2 | |
| Patient Safety | Falls per 1000 Occupied Bed Days | 2025-10-31 | | 3.72 | 4.00 | -0.28 | 3.72 | 4.00 | -0.28 | |
| Patient Safety | Medication Incidents with Moderate Harm | 2025-10-31 | | 0 | 0 | 0 | 8 | 0 | 8 | |
| Patient Safety | NHS Staff Survey - raising concerns sub-score | 2025-10-31 | H | 6.83 | 7.08 | -0.25 | 6.83 | 7.08 | -0.25 | F |
| Patient Safety | Patient Safety Incident Investigations | 2025-10-31 | | 1 | 0 | 1 | 7 | 0 | 7 | |
| Patient Safety | Rates of Healthcare Associated Infection (C-Difficile) | 2025-10-31 | H | 325.00% | 100.00% | 225.00% | 325.00% | 100.00% | 225.00% | F |
| Patient Safety | Rates of Healthcare Associated Infection (E-Coli) | 2025-10-31 | | 100.00% | 100.00% | 0.00% | 100.00% | 100.00% | 0.00% | |
| Patient Safety | Rates of Healthcare Associated Infection (MRSA) | 2025-10-31 | | 0 | 0 | 0 | 0 | 0 | 0 | P |
| Patient Safety | Safer Staffing - Average Fill Rate Non-Registered Nurses - Day | 2025-09-30 | | 110% | 95% | 15% | 110% | 95% | 15% | |
| Patient Safety | Safer Staffing - Average Fill Rate Non-Registered Nurses - Night | 2025-09-30 | | 109% | 95% | 14% | 109% | 95% | 14% | |
| Patient Safety | Safer Staffing - Average Fill Rate Registered Nurses - Day | 2025-09-30 | L | 94% | 95% | -1% | 94% | 95% | -1% | |
| Patient Safety | Safer Staffing - Average Fill Rate Registered Nurses - Night | 2025-09-30 | | 99% | 95% | 4% | 99% | 95% | 4% | |

# People Committee - SPC Summary

| Domain | Metric | Latest Date | Variation | Month Value | Month Target | Month Variance | YTD | YTD Target | YTD Variance | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| People and Workforce | Appraisal Rates | 2025-10-31 | H | 87.28% | 90.00% | -2.72% | 88.96% | 90.00% | -1.04% | F |
| People and Workforce | Mandatory Training  Compliance | 2025-10-31 | H | 96.42% | 95.00% | 1.42% | 96.42% | 95.00% | 1.42% | ? |
| People and Workforce | National Education and Training Survey overall satisfaction score | 2024-12-31 | L | 88.06% | 90.00% | -1.94% | 88.06% | 90.00% | -1.94% | F |
| People and Workforce | Net Staff in Post Change | 2025-10-31 | - | -8.13 | 0.00 | -8.13 | 2.48 | 0.00 | 2.48 | |
| People and Workforce | NHS staff survey engagement theme score | 2025-10-31 | H | 7.2 | 7.2 | 0.0 | 7.2 | 7.2 | 0.0 | F |
| People and Workforce | Proportion of temporary staff | 2025-10-31 | L | 3.9% | 3.4% | 0.5% | 3.2% | 3.4% | -0.2% | F |
| People and Workforce | Sickness Absence Rate | 2025-10-31 | H | 5.52% | 4.75% | 0.77% | 5.52% | 4.75% | 0.77% | F |
| People and Workforce | Total shifts exceeding NHSI capped rate | 2025-10-31 | L | 108 | 0 | 108 | 63 | 0 | 63 | F |
| People and Workforce | Total shifts on a non-framework agreement | 2025-10-31 | L | 0 | 0 | 0 | 1 | 0 | 1 | ? |
| People and Workforce | Vacancies - all | 2025-10-31 | - | 7.46% | 8.00% | -0.54% | 8.89% | 8.00% | 0.89% | ? |

# Icon Descriptions

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

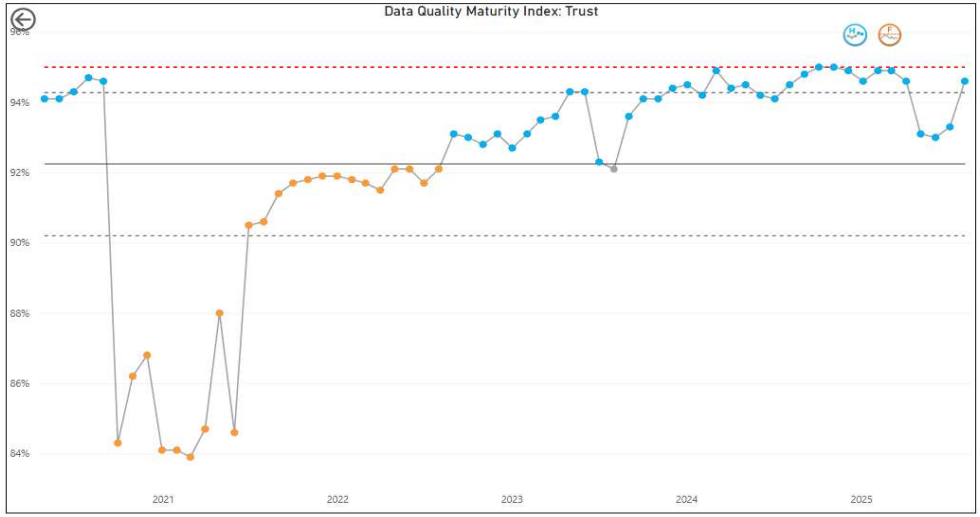
**Exception Report - Action Plan**

## Data Quality Maturity Index

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

| KPI Description | Latest 6 months | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| DQMI | % | 94.9% | 94.6% | 93.1% | 93.0% | 93.3% | 94.6% | 94.6% |
| | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |

| **Trajectory** | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|
| % | 94.6% | 94.6% | 94.7% | 94.7% | 94.7% | 94.8% | 94.8% |




| | |
|---|---|
| **Reason for performance gap:** | The target for DQMI is 95% and July has seen an improvement in line with the planned trajectory. Part of the reason for decline previously has been aligned to a dataset change in April 2025 where 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 was intended to then lead to improvement from the August 25 DQMI onwards once the data has been fully validated.<br><br>The Plan is to achieve the 95% target by the end of quarter 4 and all individual action plans align to this deadline. The main element impacting this metric currently has been compliance with accurately recording ethnicity, spoken language, MIU chief complaint, MIU acuity, MIU discharge and Clinical Coding. Ongoing education efforts emphasise the importance and relevance of these metrics with dedicated areas to target focusing heavily on data capture, clinical coding and MIU. Informatics have supported services in understanding areas that require improvement and the impact to DQMI .<br><br>There is an ongoing risk to meeting DQMI requirements, especially for recording ethnicity, because primary care no longer provides proformas that previously supplied this vital information for input into RiO following Industrial Action. The below action plans are however designed to mitigate this as much as possible. |

| | | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|---|
| Action Plan | **Oversight of improvement plan:** Through Data Quality Sub-Group and Divisional Performance Meetings progress is systematically tracked to assess the effectiveness of the education plan 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 | **November 25 Update**<br>The Health Inequalities and Data Quality Session with the Planned Care Teams has taken place, The focus of the meeting this month was for the DAART ethnicity which has remained at around 65% to have targeted intervention. The learning from the initial improvements in MIU DQ will now be taken forwards by same team lead into the DAART team to drive next stages of improvement roll out.<br><br>**October 25 Update**<br>Business Intelligence Lead has been contacted and agreed to provide a Health Inequalities and Data Quality Session to the Planned Care Teams. There will be a particular focus on understanding the importance of asking the relevant questions at every contact with a patient and ensuring EPR system is updated accordingly<br><br>**September 25 Update**<br>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<br><br>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. |
| | **Area 1 - Clinical Coding:**<br><br>Stabilisation of clinical coding workforce | Nov-24 | Jan-25 | On Track | **November 25 Update**<br>Recruitment plans continue to progress and bank utilisation continues. If able to recruit, plan will be to have individuals in post by Jan -25 Those who have applied for courses remained prepared to commence in January<br><br>**October 25 Update**<br>Job descriptions and person specifications have been reviewed for external advertising and will go through VRF for consideration for Coders and we have 2 applications for individuals to commence coding courses in January. The service continues to utilise bank.<br>Operational teams have worked with Procurement to complete a tender exercise with the market to further scope and secure additional support to manage back log.<br><br>**September 25 Update**<br>Ongoing discussions to be had with external organisations.<br><br>**August 25 Update**<br>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.<br>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. |
| | Targeted approach to clinical coding to provide change in KPI performance | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>Implemented - ongoing monitoring to understand how this impacts performance commenced<br><br>**October 25 Update**<br>Team to be briefed and plan implemented with immediate effect |

| | | | | | |
|---|---|---|---|---|---|
| | Identify Short Term funding and procure an external company to code backlog | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>The team have worked with finance colleagues and procurement and have started working with a company who will support with reducing the backlog of coding. Awaiting implementation date.<br><br>**October 25 Update**<br>Complete a procurement exercise in month |
| | **Area 2 - Ethnicity:**<br>All services have been reviewed through performance days. Those where the biggest impact to improve overall ethnicity improvement can be targeted will have core actions now included as part of RPC action plans for oversight and scrutiny to ensure that areas that will significantly support an improvement in performance are visible. | Oct-25 | Oct-25 | Complete | **November 25 Update**<br>Review of data has shown little improvement despite the focus and plans in place. Further exploration of potential digital/AI solutions that could support improvement to be supported by Head of Planning.<br><br>**October 25 Update**<br>individual actions with the most significant impact are now listed below that will drive the expected improvement trajectories and also improve Spoken Language performance alongside at service level. |
| | SC and TW School Nursing are challenged with Ethnicity compliance. Dudley School Nursing is performing 20% better and so service lead will link the Dudley team lead in with SC & TW leads in order to share learning and actions around how their position could be improved | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>School Nursing in TW and SC has improved by 4% to reach 72%, requirement to be at 85% by January. Team leads from Dudley, SC and TW have linked together and shared learning in place to drive this forwards.<br><br>**October 25 Update**<br>Set trajectory for School Nursing to improve to 85% in line with Dudley by January 2026. |
| | Community Hospital Outpatients Appt Letter currently contains Ethnicity question to patients, which should be populated into RiO at appt check in. Spoken Language will be added to the letter as well, through contact with Rio Configuration Team and message will be re-enforced to reception staff and linking HCA's into process, to check letter when patient arrives at appt and ensure Rio is updated | Oct-25 | Feb-26 | On Track | **November 25 Update**<br>The letter has been written and will be Rio configured following ratification with a plan to go live first week in December.<br><br>**October 25 Update**<br>Current performance = Bridgnorth (39%), Ludlow (53%), Whitchurch (67%). Trajectory to improve to 90% by February 2026 |
| | MSST to implement a trajectory to recover to 90% by February 2026, to continue recent improvement of 10% over last 12 months, including drilling down to organisational level across SaTH and RJAH to assess education and learning requirement across all that impact upon MSST. | Oct-25 | Feb-26 | On Track | **November 25 Update**<br>All performance data disseminated across teams and improvement plan established at team level this will be overseen by data quality group for support and updated in team meetings.<br><br>**October 25 Update**<br>Performance data will be systematically shared with the team to ensure transparency and collective responsibility. The improvement trajectory must be owned at the team level, with clear actions and plans developed and agreed upon during team meetings and DQMI will now be a standard agenda item. This collaborative approach will enable regular progress reviews and foster accountability for delivering against the new revised set target. |
| | Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April | Oct-25 | Apr-26 | On Track | **November 25 Update**<br>Review of admin processes in Diabetes Nursing is taking place over the next month and recording of Ethnicity and Spoken Language will be included in that review, which will include the additional admin capacity.<br><br>**October 25 Update**<br>Alignment of admin process with SPR to strengthen reliance and vacancy offered to redeployment in the RRU's to support to manage the gap. |

| | | | | | |
|---|---|---|---|---|---|
| | Pulmonary Rehab - Targeted workshop has taken place and demonstrable impact seen in last month improvement from 54% to 67%. Trajectory to continue improvement to 90% by April 26 | Oct-25 | Apr-26 | On Track | **November 25 Update**<br>Performance has deteriorated in November to 60%, down by 6.3%. Review of admin processes in Pulmonary Rehab is taking place over the next month and recording of Ethnicity and Spoken Language will be included in that review. Dedicated meeting to support planned and admin post to be shared at VRF panel.<br><br>**October 25 Update**<br>Performance will continue to remain visible at the team level and will be regularly shared through team meetings. A local action plan is in place, ensuring team-wide ownership and collective responsibility for outcomes. |
| | Admiral Nurses Telford - Showing decline in performance on Ethnicity recording month on month. Trajectory to improve performance back to 90% position by Apr-26 | Nov-25 | Apr-26 | On Track | **November 25 Update**<br>Team leads for Shropshire and Telford to be linked together, with Shropshire performance at 97% in order to ensure shared learning takes place and actions taken forwards by Telford team lead to improve recording across both teams. |
| | Implement self-check in at reception areas across appropriate Outpatient estate, to include link to Rio and mandating of Ethnicity and Spoken Language population on screen, in line with the 10 year plan to move to Digital where possible | Jan-26 | Apr-26 | On Track | **November 25 Update**<br>MPFT exploring procurement to provide the ability to integrate RIO with a check-in solution. Digital to look at possibility of shared project. Funding to implement the equipment has been identified.<br><br>**October 25 Update**<br>A workshop will be held with Operations and Digital teams to plan the roll-out of the preferred product. Further actions and timelines will be provided for November update to support roll out of the plan. |
| | **Area 3 - MIU:**<br>MIU DQ Issues - Weekly Task and finish group for MIU dedicated to improving DQMI performance | Oct-25 | Apr-26 | On Track | **November 25 Update**<br>Performance in Acuity and Chief Complaint have improved by 16% in October 25, showing initial effects of this action. There will be a 3 month lag before any impact on DQMI is seen. Discharge information is similar to last month at 75%. Action to continue to drive improvement in performance in all DQ areas, celebrating the initial improvement but highlighting the need for further improvement to meet the 90% trajectory<br><br>**October 25 Update**<br>Band 8a to chair, 14 dedicated actions aligned to improve position with a trajectory to achieve 95% by April 26 MIU Data Quality, which drills down to unit and individual level, will be shared weekly with team leads for targeted celebration and improvement where required |
| | MIU recruiting to receptionist at Ludlow, which will support improved data capture | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>Recruitment process continuing. From 22nd October also agreed to have reception cover in all units, which will assist with data inputting at patient check in points, for non clinical elements<br><br>**October 25 Update**<br>Post presented to VRF agreed and commenced recruitment process |

| | | | |
|---|---|---|---|
| **Author** | Alastair Campbell/Helen Cooper/Wendy Hallows/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas | **Date** | 11/11/2025 |
| **Accountable Officer Approval** | Claire Horsfield | **Date** | 18/11/2025 |

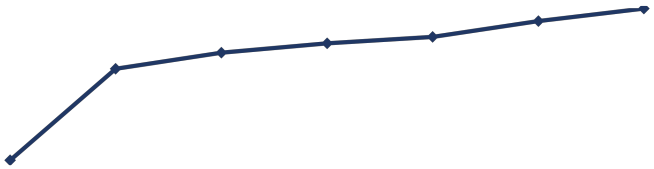
**Exception Report - Action Plan**

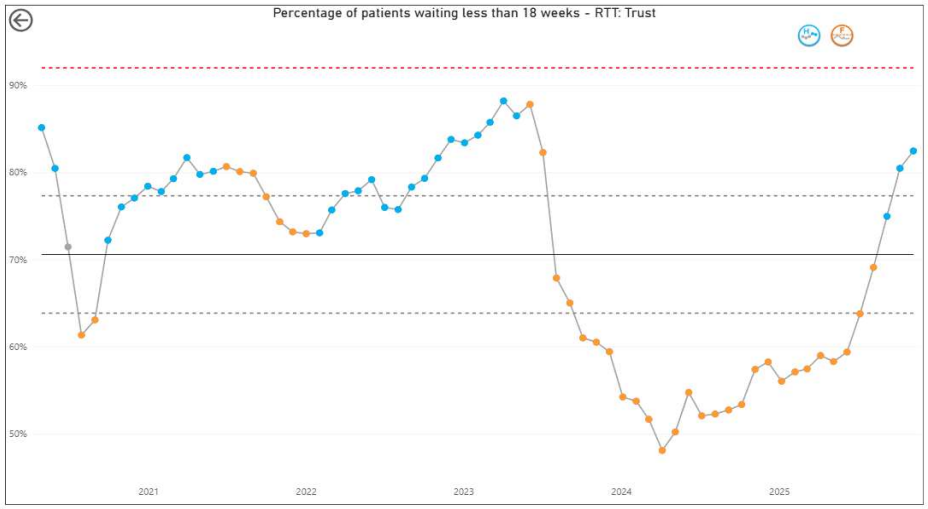
## Percentage of Patients waiting less than 18 weeks - RTT

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

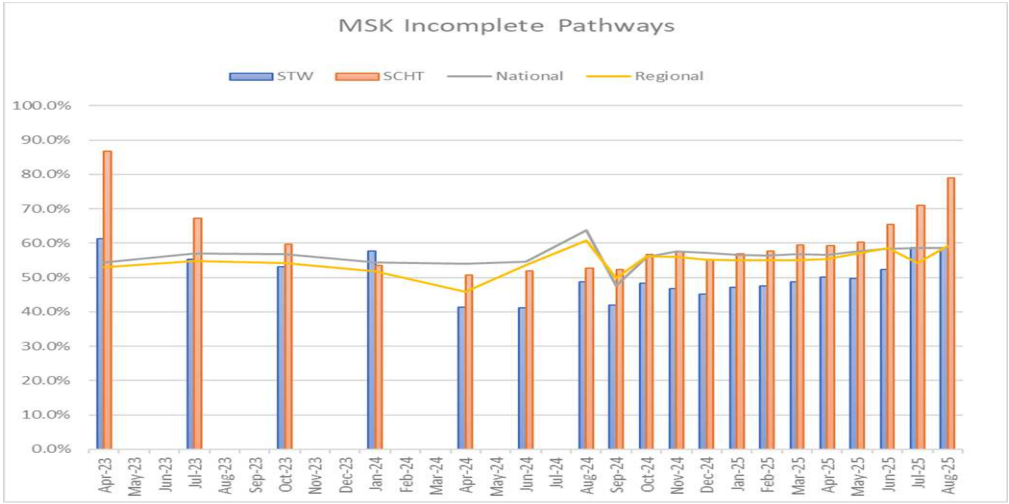
| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| RTT Incomplete Pathways | % | 59.38% | 63.77% | 69.09% | 74.95% | 80.47% | 82.46*% | 82.46*% |
| | Target | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |

| Trajectory | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|
| % | 68.0% | 82.5% | 85.0% | 86.5% | 87.5% | 90.0% | 92.0% |






| 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 | Jul-25 | Aug-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% | 58.7% | 58.7% |
| SCHT | 86.8% | 67.2% | 59.7% | 53.6% | 50.7% | 51.9% | 52.7% | 52.4% | 56.7% | 57.4% | 55.10% | 56.8% | 57.7% | 59.5% | 59.2% | 60.3% | 65.4% | 71.1% | 78.9% |
| 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% | 58.6% | 58.6% |
| 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% | 54.2% | 59.1% |




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

| | |
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| **Reason for performance gap:** | Overall improvement in recovery has been seen since December 2024 and continued to improve in October by 1.99% with the position currently being unvalidated.<br><br>There has been focus on recovering 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 and therefore a revised trajectory has been produced. This aims to achieve 18 weeks by April 2026.<br><br>Work has been ongoing to increase capacity within MSST with the use of an insourcing company to support recovery of backlog through super clinics. These clinics ran from June- September. The plan is to secure continued support from 18 Weeks Support Ltd up until the end of March 2026 initially with a planned implementation in December 2025. 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.<br><br>There are ongoing challenges with consistent capacity being provided across the SLA with the acute Trust for Community Hospital Outpatient clinics, particularly seen within ENT and Respiratory. Diagnostic delays have an impact on these services in community outpatients too, however is supported and managed on a case by case basis through direct conversations with SaTH to support longest waits and clinically urgent . This is also being overseen at system level and escalated through Tier 1 national calls to maintain ongoing focus and flow through the service. NHSE Tier 1 calls are also being extended to include wider services including Dental for ongoing scrutiny.<br><br>There are other services which contribute to not meeting this performance target such as APCS and Dental |

| **Action Plan** | **Start Date** | **End Date** | **Status** | **Comments** |
|---|---|---|---|---|
| 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 | Complete | **November 25 Update**<br>ENT capacity provided throughout October with ongoing work around demand and capacity being worked through as business as usual.<br><br>**October 25 Update**<br>Progress has been made with ENT, and arrangements for additional capacity to be provided throughout October via an insourcing company supported via SATH. This will go live 18th October.<br>SATH Respiratory continuing to provide support for new patients above 30wks with an offer of appointments within SATH. Additional discussions with insourcing company re other options to further support recovery including Respiratory, Gynaecology and T&O.<br><br>**September 25 Update**<br>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. |
| Implementation of super clinic within existing capacity | Aug-25 | Nov-25 | On track | **November 25 Update**<br>The future plan for MSST is to have consistent super clinic clinic models as part of business as usual and this is being incorporated into job planning.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |

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|---|---|---|---|---|---|
| | Working with SaTH for a long term resolution to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |
| | Re-Implementation of super clinics via 18 weeks | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>The plan remains to re-implement super clinics via the 18 weeks company and additional clinics provisionally scheduled for December.<br><br>**New Action**<br>Working with 18 weeks to re-implement previous process around super clinics. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |

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|---|---|---|---|---|
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | |
| **Accountable Officer Approval** | Claire Horsfield | **Date** | 17/11/2025 | |

**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*

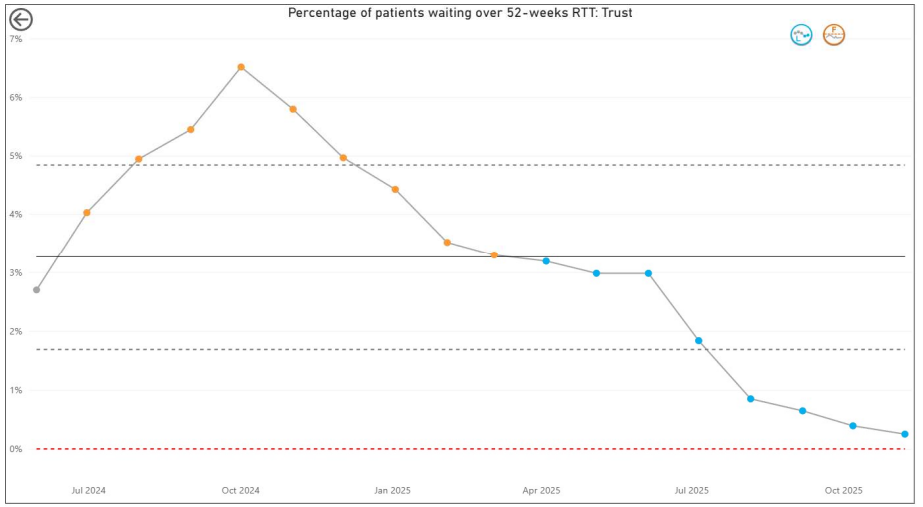
**Exception Report - Action Plan**

## Percentage of Patients waiting over 52 weeks - RTT

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Percentage of Patients waiting over 52 weeks - RTT | % | 2.98% | 1.84% | 0.85% | 0.65% | 0.39% | 0.25%* | 0.25%* |
| | Target | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

| **Trajectory** | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|
| % | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

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|---|---|
| **Reason for performance gap:** | This is the thirteenth consecutive month demonstrating significant improvement across the 52-week cohort ahead of the national target.<br><br>In terms of reportable RTT services there are now 0 52 week waits in APCS and Dental.<br><br>MSST service had 5 52 week waits all with dates to be seen in month November<br><br>Community Hospitsl Outpatients now hold the majority of breaches (15) with the main challenge seen within ENT and then respiratory service. As laid out below are plans to achieve zero 52 weeks through additional capacity with a revised target of the end of November.<br><br>Prioritisation of long waits has been the key focus nationally and is reported at the weekly Tier 1 NHSE call. |

| | | Start Date | End Date | Status | Comments |
|---|---|---|---|---|---|
| Action Plan | 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 | Complete | **November 25 Update**<br>ENT capacity provided throughout October with ongoing work around demand and capacity being worked through as business as usual.<br><br>**October 25 Update**<br>Progress has been made with ENT, and arrangements for additional capacity to be provided throughout October via an insourcing company supported via SATH. This will go live 18th October.<br>SATH Respiratory continuing to provide support for new patients above 30wks with an offer of appointments within SATH. Additional discussions with insourcing company re other options to further support recovery including Respiratory, Gynaecology and T&O.<br><br>**September 25 Update**<br>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. |
| | Implementation of super clinic within existing capacity | Aug-25 | Nov-25 | On track | **November 25 Update**<br>The future plan for MSST is to have consistent super clinic clinic models as part of business as usual and this is being incorporated into job planning.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |
| | Working with SaTH a long term resolution is required to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Re-Implementation of super clinics via 18 weeks | | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**New Action**<br>Working with 18 weeks to re-implement previous process around super clinics. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | | | |
| **Accountable Officer Approval** | Claire Horsfield | **Date** | 17/11/2025 | | | |

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

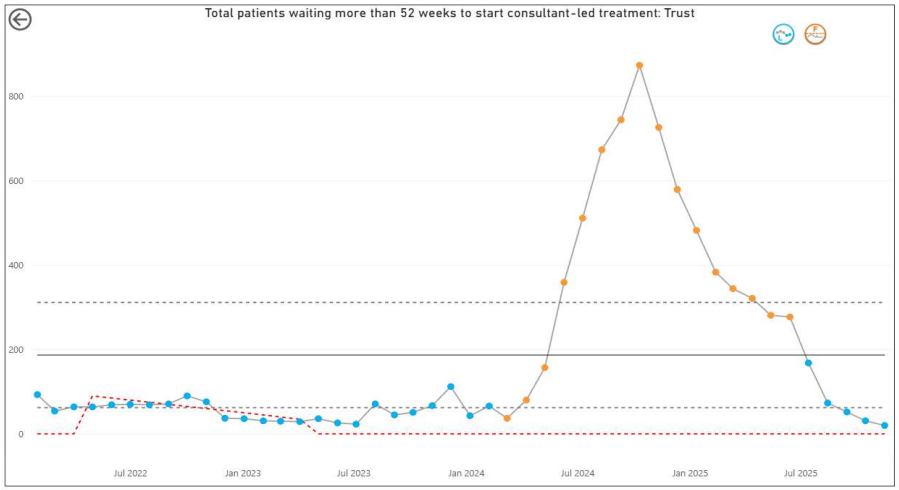
**Exception Report - Action Plan**

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

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| RTT 52+ week waits | Number | 277 | 168 | 73 | 52 | 31 | 20* | 20* |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trajectory | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|
| Number | 15 | 0 | 0 | 0 | 0 | 0 | 0 |

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|---|---|
| **Reason for performance gap:** | This is the thirteenth consecutive month demonstrating significant improvement across the 52-week cohort ahead of the national target.<br><br>In terms of reportable RTT services there are now 0 52 week waits in APCS and Dental.<br><br>MSST service had 5 52 week waits all with dates to be seen in month November<br><br>Community Hospitsl Outpatients now hold the majority of breaches (15) with the main challenge seen within ENT and then respiratory service. As laid out below are plans to achieve zero 52 weeks through additional capacity with a revised target of the end of November.<br><br>Prioritisation of long waits has been the key focus nationally and is reported at the weekly Tier 1 NHSE call. |

| | | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|---|
| Action Plan | 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 | Complete | **November 25 Update**<br>ENT capacity provided throughout October with ongoing work around demand and capacity being worked through as business as usual.<br><br>**October 25 Update**<br>Progress has been made with ENT, and arrangements for additional capacity to be provided throughout October via an insourcing company supported via SATH. This will go live 18th October.<br>SATH Respiratory continuing to provide support for new patients above 30wks with an offer of appointments within SATH. Additional discussions with insourcing company re other options to further support recovery including Respiratory, Gynaecology and T&O.<br><br>**September 25 Update**<br>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. |
| | Implementation of super clinic within existing capacity | Aug-25 | Nov-25 | On Track | **November 25 Update**<br>The future plan for MSST is to have consistent super clinic clinic models as part of business as usual and this is being incorporated into job planning.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |
| | Working with SaTH a long term resolution is required to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Re-Implementation of super clinics via 18 weeks | | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**New Action**<br>Working with 18 weeks to re-implement previous process around super clinics. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | | | |
| **Accountable Officer Approval** | Claire Horsfield | **Date** | 17/11/2025 | | | |

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

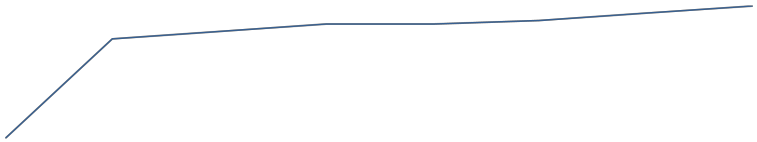
**Exception Report - Action Plan**

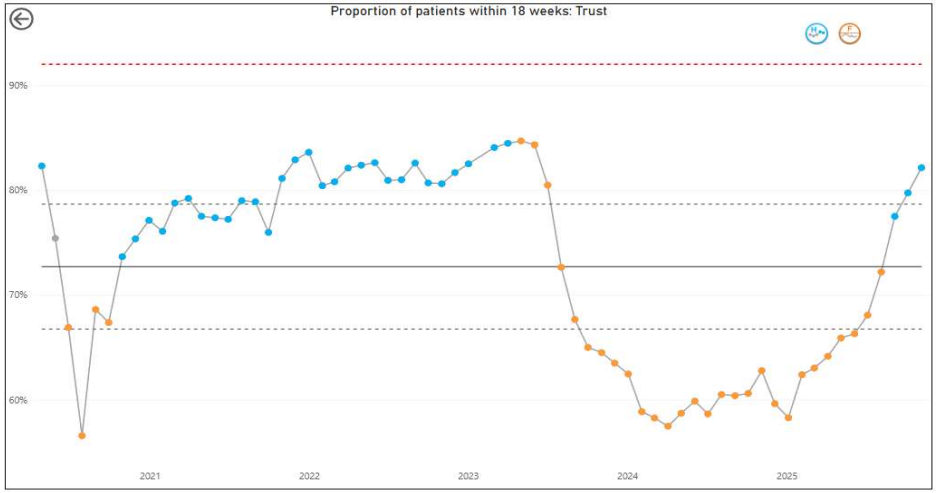
## Proportion of patients within 18 weeks

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Proportion of patients within 18 weeks | % | 66.29% | 68.07% | 72.19% | 77.50% | 79.73% | 82.14% | 82.14% |
| | Target | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |

| Trajectory | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 |
|---|---|---|---|---|---|---|---|---|
| % | 67.5% | 81.0% | 82.0% | 83.0% | 83.0% | 83.5% | 84.5% | 85.5% |





| | |
|---|---|
| **Reason for performance gap:** | Performance has continued to improve with a further 2.41% increase, which is ahead of trajectory.<br><br>The focus has been on reducing long waits in line with national guidance, particularly within MSST services. Recovery efforts have been hampered to date by delays in orthopaedics transfers and more level 3 demand than initially modelled, the position is now stabilising following several waiting list initiatives and demand and capacity modelling . High demand persists for APP patients after their first treatment, so job planning across the system has been implemented to enhance productivity.<br><br>Community Paediatrician services have seen improvement aligned to recruitment and a change of processes for assessment enhancing productivity. Despite the increased number of referrals, the numbers for high waiting children have reduced dramatically. As the Child Development Centre and the Community Paediatrician team are interdependent, the implementation of a modernised service is increasing productivity and improving experience for families.<br><br>Children's Speech and Language services have also seen a steady improvement of waiting lists. A combination of early intervention programmes, holiday clinics and revalidation of waiting lists has resulted in a drop in CYP waiting over 52 weeks and an improvement for those waiting over 40 weeks. These initiatives are continuing into the Autumn term to enable the team to reach the 18 week target.<br><br>Wheelchair services waits appear to be deteriorating however a challenge has been made to the service regarding how the waits are categorised and measured. All patients waiting over 30 weeks for wheelchairs have been assessed, seen and most have their equipment. However if a patient requires an accessory or modification they have historically remained on the open waiting list. Support has been sought from national team re reporting, and a workshop is in place to refine data capture points and accuracy of metrics to treatment.<br><br>CDC (Child Development Centre) is currently holding 10 (improvement of 6) children above 52 weeks. The trajectory for this service was due to demonstrate 0 52 weeks by July 25. Part of this was reliant on a third party to support, however, delays in the procurement process and some capacity challenges within providers has adversely impacted the recovery plan by 3 months. Current forecasting of performance shows that improvements commenced from June with a plan to reduce month on month and achieve 0 52 weeks by October 2025. However, as there remains a small number of 52 weeks waits the service is now aiming to reduce this to zero by the end of December 2025.<br><br>Children's Physiotherapy has been challenged over the last 12 months due to long term absences and attrition. Active recruitment has been undertaken however it has been a challenge to recruit to specialised posts. Mutual aid has been exhausted internally and with SaTH. MSST has supported with taking some CYP aged between 16 and 18 years olds. To address this demand and capacity work has been undertaken and an exercise for clinic utilisation. Additional clinic space is being sought to meet demand and a full workforce review and recruitment drive is being implemented to ensure recovery of the waiting list position and stabilisation of the service.<br><br>Community outpatients waiting list continues to be challenged due to a disparity between the demand and capacity and the reliance on external providers particularly with ENT, Respiratory and Gynae with the teams focusing on reducing and mitigating the longest waiting patients on the pathways in partnership with SaTH.<br><br>One area identified as requiring attention this month is Diabetic nursing, which has experienced a dip in performance due to staff sickness, vacancies and reliance on temporary staff to meet demand. To address this, a focused improvement programme has been implemented, led by operational teams, specifically targeting triage processes, follow-up procedures and exploring more efficient working practices. This dedicated approach is expected to deliver measurable improvements in service delivery and patient experience, providing assurance that robust actions are in place to support recovery in this area.<br><br>There are other services which contribute to not meeting this performance target all with individual recovery plans in place: such as APCS, Dental, CNRT, Continence, Bridgnorth Hospital Day case, Adult Physio, Pulmonary Rehab, CIC Nurses. |

| | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|
| CDC to sub contract 70 assessments to support with longest waiting children | Mar-25 | Jun-25 | Complete | **November 25 Update.**<br>20 further subcontracting appointments were booked during November. This action is now closed with a new action opened below.<br><br>**October 25 Update**<br>All the subcontracted appointments have been delivered. However due to some financial availability further subcontracted appointments are going to be booked for October and November.<br><br>**September 25 Update**<br>Final outsourced appointments booked throughout September 2025.<br><br>**August 25 Update**<br>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.<br><br>**July 25 Update**<br>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 |
| Due to additional funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026. | Nov-25 | Feb-26 | On Track | **New action**<br>20 further appointments to be procured via private providers during December 25 and January 26. |
| Implementation of super clinic within existing capacity | Aug-25 | Nov-25 | On track | **November 25 Update**<br>The future plan for MSST is to have consistent super clinic clinic models as part of business as usual and this is being incorporated into job planning.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |

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| Action Plan | Diabetic Nursing and improvement plan to be established | Aug-25 | Oct-25 | Complete | **November 25 Update**<br>There has been an increase in activity last month due to some immediate actions being implemented. Start dates for vacancies are now in place with additional bank admin approved to support recovery from December.<br><br>**October 25 Update**<br>Workshop completed and areas of improvement have been identified. Gaps in admin capacity were acknowledged so 1 WTE is now out to recruitment to release clinical time. This will increase clinic capacity and clinic utilisation.<br><br>**September 25 Update**<br>Planned care have been invited to bring their recent experience in reviewing processes with the service in line with access policy to standardise processes.<br><br>**New Action**<br>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 | Complete | **November 25 Update**<br>ENT capacity provided throughout October with ongoing work around demand and capacity being worked through as business as usual.<br><br>**October 25 Update**<br>Progress has been made with ENT, and arrangements for additional capacity to be provided throughout October via an insourcing company supported via SATH. This will go live 18th October.<br>SATH Respiratory continuing to provide support for new patients above 30wks with an offer of appointments within SATH. Additional discussions with insourcing company re other options to further support recovery including Respiratory, Gynaecology and T&O.<br><br>**September 25 Update**<br>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. |

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| | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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. |
| | Recruitment of additional speech and language therapist within CNRT to support improvement in SLT waiting times. | Oct-25 | Feb-25 | On Track | **November 25 Update**<br>Post was approved and has been out to advert wiht no suitable candidates. Team will readvertise.<br><br>**New Action**<br>The SLT waiting list has been slowly increasing despite previous recruitment. Therefore the service has had an additionally role as part of a workforce redesign approved and this will go out to advert in October 25. |
| | New initiatives to be delivered during Autumn term to manage the demand for SLT services. Roll out of the Super penguin on line intervention for teachers and parents is underway to facilitate first line support. A new schools programme commenced in September to facilitate more CYP being able to access interventions within schools. | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway<br><br>**New Action**<br>Testing for the super-penguin initiative commenced in Sept 25. A QEIA was approved in Sept 25 regarding the new SLT service offer within schools and this commenced mid-September in four schools with the highest needs. |
| | Children's Physiotherapy services to complete capacity and demand piece of work and align to productivity. Clinical utilisation to be assessed and improved. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Liaised with Head of AHPs and D&C analysis has commenced. Clinical utilisation analysis being undertaken by the single point of access manager.<br><br>**New Action**<br>Recruitment team supporting to accelerate recruitment to vacant posts. Building work is on schedule within Coral House which will increase clinic capacity for this team. The works are due to be completed by Dec 25. |
| | An estate realisation exercise to be undertaken to ensure adequate clinical space is available for CYP therapy clinics. Any additional clinical space requirements to be sourced. | Nov-25 | Dec-25 | On Track | **New action**<br>Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025 |

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| | Job planning for Community Paediatricians has just been completed. In conjunction with case load validation demand and capacity is being tested to assess needs of the communities and the ability of the team to meet demand. | Oct-25 | Dec-25 | Complete | **November 25 Update**<br>Job plan has been completed. Single point of access has been implemented. Realigned the weighting of the caseloads. Impact of changes to be monitored<br><br>**New Action**<br>Caseload validation has commenced. Job plans with Medical Director for sign off. QEIA to be written for skill mixing options. |
| | Working with SaTH a long term resolution is required to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |

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| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | |
| **Accountable Officer Approval** | Claire Horsfield | **Date** | 17/11/2025 | |

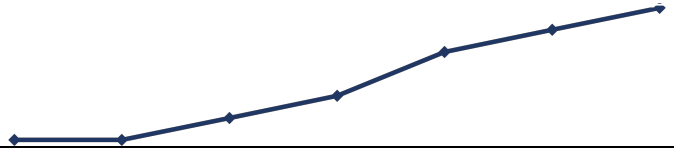
**Exception Report - Action Plan**

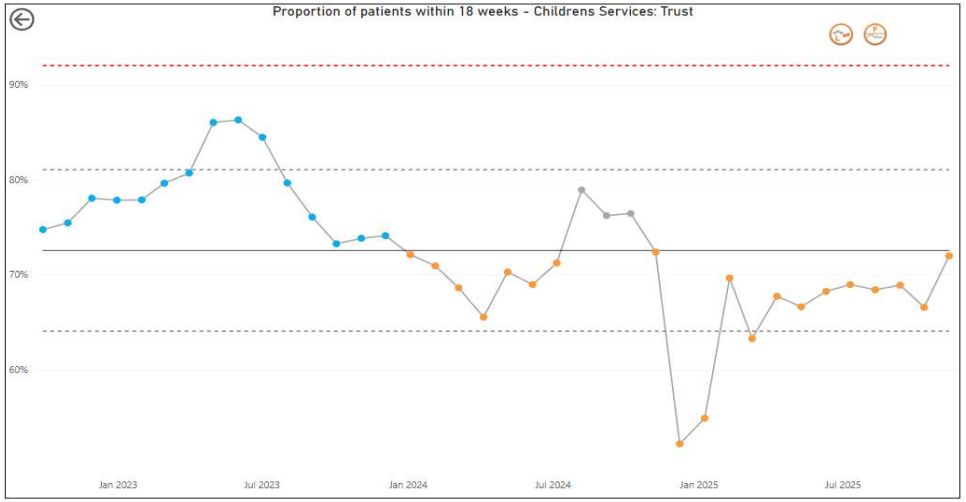
# Proportion of patients within 18 weeks - Children's Services

The percentage of patients that are still waiting an appointment and are within 18 weeks - Children's Services including Oral Surgery

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Proportion of patients within 18 weeks - Children's Services | % | 68.23% | 68.94% | 68.40% | 68.88% | 66.56% | 71.98% | 71.98% |
| | Target | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 |
|---|---|---|---|---|---|---|---|---|
| % | 67.0% | 67.5% | 67.5% | 68.0% | 68.5% | 69.5% | 70.0% | 70.5% |



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| **Reason for performance gap:** | Community Paediatrician services have seen improvement aligned to recruitment and a change of processes for assessment enhancing productivity. Despite the increased number of referrals, the numbers for high waiting children have reduced dramatically. As the Child Development Centre and the Community Paediatrician team are interdependent, the implementation of a modernised service is increasing productivity and improving experience for families.<br><br>Children's Speech and Language services have also seen a steady improvement of waiting lists. A combination of early intervention programmes, holiday clinics and revalidation of waiting lists has resulted in a drop in CYP waiting over 52 weeks and an improvement for those waiting over 40 weeks. These initiatives are continuing into the Autumn term to enable the team to reach the 18 week target.<br><br>Wheelchair services waits appear to be deteriorating however a challenge has been made to the service regarding how the waits are categorised and measured. All patients waiting over 30 weeks for wheelchairs have been assessed, seen and most have their equipment. However if a patient requires an accessory or modification they have historically remained on the open waiting list. Support has been sought from national team re reporting, and a workshop is in place to refine data caption points and accuracy of metrics to treatment.<br><br>CDC (Child Development Centre) is currently holding 10 (improvement of 6) children above 52 weeks. The trajectory for this service was due to demonstrate 0 52 weeks by July 25. Part of this was reliant on a third party to support, however, delays in the procurement process and some capacity challenges within providers has adversely impacted the recovery plan by 3 months. Current forecasting of performance shows that improvements commenced from June with a plan to reduce month on month and achieve 0 52 weeks by October 2025. However, as there remains a small number of 52 weeks waits the service is now aiming to reduce this to zero by the end of December 2025.<br><br>Children's Physiotherapy has been challenged over the last 12 months due to long term absences and attrition. Active recruitment has been undertaken however it has been a challenge to recruit to specialised posts. Mutual aid has been exhausted internally and with SaTH. MSST has supported with taking some CYP aged between 16 and 18 years olds. To address this demand and capacity work has been undertaken and an exercise for clinic utilisation. Additional clinic space is being sought to meet demand and a full workforce review and recruitment drive is being implemented to ensure recovery of the waiting list position and stabilisation of the service.<br><br>Oral Surgery has faced challenges over the past 12 months, primarily regarding access to appropriate theatre space. However, by working in partnership with SaTH, we have begun to see improvements in theatre allocation and service delivery. While there are still occasions where theatre slots are arranged at short notice or adjustments are needed due to overruns in other services, ongoing collaboration and regular discussions are helping to address these issues and drive continued progress.<br><br>There are other services which contribute to not meeting this performance target such as CIC Nurses |

| | | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|---|
| Action Plan | Children's Physiotherapy services to complete capacity and demand piece of work and align to productivity. Clinical utilisation to be assessed and improved. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Liaised with AHP lead and D&C analysis has commenced. Clinical utilisation analysis being undertaken by the single point of access manager.<br><br>**New Action**<br>Recruitment team supporting to accelerate recruitment to vacant posts. Building work is on schedule within Coral House which will increase clinic capacity for this team. The works are due to be completed by Dec 25. |
| | An estate realisation exercise to be undertaken to ensure adequate clinical space is available for CYP therapy clinics. Any additional clinical space requirements to be sourced. | Nov-25 | Dec-25 | On Track | **New action**<br>Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025 |
| | Working with SaTH a long term resolution is required to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |
| | CDC to sub contract 70 assessments to support with longest waiting children | Mar-25 | Jun-25 | Complete | **November 25 Update.**<br>20 further subcontracting appointments were booked during November. This action is now closed with a new action opened below.<br><br>**October 25 Update**<br>All the subcontracted appointments have been delivered. However due to some financial availability further subcontracted appointments are going to be booked for October and November.<br><br>**September 25 Update**<br>Final outsourced appointments booked throughout September 2025.<br><br>**August 25 Update**<br>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.<br><br>**July 25 Update**<br>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 |
| | Due to additional funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026. | Nov-25 | Feb-26 | On Track | **New action**<br>20 further appointments to be procured via private providers during December 25 and January 26. |

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| | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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. |
| | New initiatives to be delivered during Autumn term to manage the demand for SLT services. Roll out of the Super penguin on line intervention for teachers and parents is underway to facilitate first line support. A new schools programme commenced in September to facilitate more CYP being able to access interventions within schools. | | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway<br><br>**New Action**<br>Testing for the super-penguin initiative commenced in Sept 25. A QEIA was approved in Sept 25 regarding the new SLT service offer within schools and this commenced mid-September in four schools with the highest needs. |
| | Job planning for community paediatricians has just been completed. In conjunction with case load validation demand and capacity is being tested to assess needs of the communities and the ability of the team to meet demand. | | Oct-25 | Dec-25 | Complete | **November 25 Update**<br>Job plan has been completed. Single point of access has been implemented. Realigned the weighting of the caseloads. Impact of changes to be monitored<br><br>**New Action**<br>Caseload validation has commenced. Job plans with Medical Director for sign off. QEIA to be written for skill mixing options. |
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | | | |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 | | | |

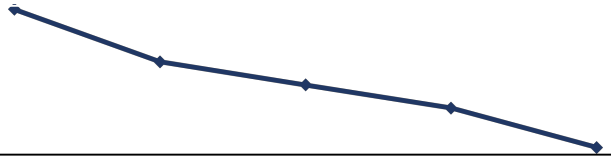
**Exception Report - Action Plan**

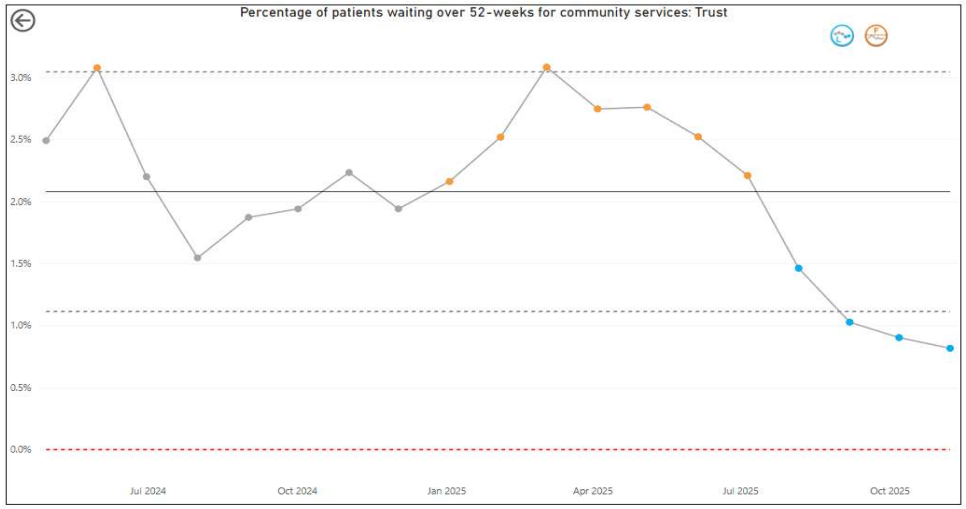
# Percentage of patients waiting over 52-weeks for community services

The percentage of patients that are still waiting an appointment and are over 52 weeks

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Percentage of patients waiting over 52-weeks for community services | % | 2.52% | 2.21% | 1.46% | 1.03% | 0.90% | 0.82% | 0.82% |
| | Target | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

| **Trajectory** | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|
| % | - | 0.68% | 0.55% | 0.35% | 0.26% | 0.17% | 0.02% |



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| **Reason for performance gap:** | There has been consistent and significant improvement in reducing 52 weeks over a sustained period.<br><br>Community Paediatrician vacancies and an increase in the number of complex case referrals, continue to have an adverse impact on the waiting list for Community Paediatrics. However mitigations are in place with a locum and active recruitment. There are now <5 children waiting to be seen at 52 weeks or above; this is a decreasing picture. All vacancies within the team has gone through successful recruitment. Recovery has been dependent upon enhanced locum support within Community Paediatrics with the assumption that this will remain. There are regular meetings with the team to review the waiting list and clinical priorities. A new speciality Doctor has started which has increased capacity and moving forward will continue to reduce the 52 week cohort. Trajectory was 0 52 week waits by October 2025 however the service ended with a small number at 52 week wait. The aim is this will be resolved by the end of November.<br><br>Children's Speech and Language services have also seen a steady improvement of waiting lists. A combination of early intervention programmes, holiday clinics and revalidation of waiting lists has resulted in a drop in CYP waiting over 52 weeks and an improvement for those waiting over 40 weeks. These initiatives are continuing into the Autumn term to enable the team to reach the 18 week target.<br><br>Wheelchair services waits appear to be deteriorating however a challenge has been made to the service regarding how the waits are categorised and measured. All patients waiting over 30 weeks for wheelchairs have been assessed, seen and most have their equipment. However if a patient requires an accessory or modification they remain on the open waiting list. A secondary report has been compiled to compare referral to first appointment. This is being validated and reported in Decembers action plans. In addition we have a number of children waiting for restrictive intervention. Discussions have commenced with commissioners and local authority as this is purely an allocation of equipment with no clinical assessment therefore should not be coming to the Wheelchair services.<br><br>There are other services which contribute to not meeting this performance target such as Diabetic Nursing, Interdisciplinary Teams and Pulmonary Rehab. |

| | | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|---|
| | SLT Revise analysis of management of complex needs caseload | Jun-25 | Sep-25 | Complete | **October 25 update**<br>Analysis and planning is complete. new pathways and service delivery model is now live.<br>**September 25 Update**<br>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.<br>**August 25 Update**<br>Holiday initiatives have commenced during July and running throughout August which is increasing capacity to see more complex CYP<br>**July 25 Update**<br>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. |
| | Diabetic Nursing and improvement plan to be established | Aug-25 | Oct-25 | Complete | **November 25 Update**<br>There has been an increase in activity last month due to some immediate actions being implemented. Start dates for vacancies are now in place with additional bank admin approved to support recovery from December.<br><br>**October 25 Update**<br>Workshop completed and areas of improvement have been identified. Gaps in admin capacity were acknowledged so 1 WTE is now out to recruitment to release clinical time. This will increase clinic capacity and clinic utilisation.<br><br>**September 25 Update**<br>Planned care have been invited to bring their recent experience in reviewing processes with the service in line with access policy to standardise processes.<br><br>**New Action**<br>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. |

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| **Action Plan** | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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. |
| | An estate realisation exercise to be undertaken to ensure adequate clinical space is available for CYP therapy clinics. Any additional clinical space requirements to be sourced. | Nov-25 | Dec-25 | On Track | **New action**<br>Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025 |
| | Recruitment of additional speech and language therapist within CNRT to support improvement in SLT waiting times. | Oct-25 | Feb-25 | On Track | **November 25 Update**<br>Post was approved and has been out to advert with no suitable candidates. Team will readvertise.<br><br>**New Action**<br>The SLT waiting list has been slowly increasing despite previous recruitment. Therefore the service has had an additionally role as part of a workforce redesign approved and this will go out to advert in October 25. |
| | New initiatives to be delivered during Autumn term to manage the demand for SLT services. Roll out of the Super penguin on line intervention for teachers and parents is underway to facilitate first line support. A new schools programme commenced in September to facilitate more CYP being able to access interventions within schools. | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway<br><br>**New Action**<br>Testing for the super-penguin initiative commenced in Sept 25. A QEIA was approved in Sept 25 regarding the new SLT service offer within schools and this commenced mid-September in four schools with the highest needs. |
| | Job planning for community paediatricians has just been completed. In conjunction with case load validation demand and capacity is being tested to assess needs of the communities and the ability of the team to meet demand. | Oct-25 | Dec-25 | Complete | **November 25 Update**<br>Job plan has been completed. Single point of access has been implemented. Realigned the weighting of the caseloads. Impact of changes to be monitored<br><br>**New Action**<br>Caseload validation has commenced. Job plans with Medical Director for sign off. QEIA to be written for skill mixing options. |

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| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 |

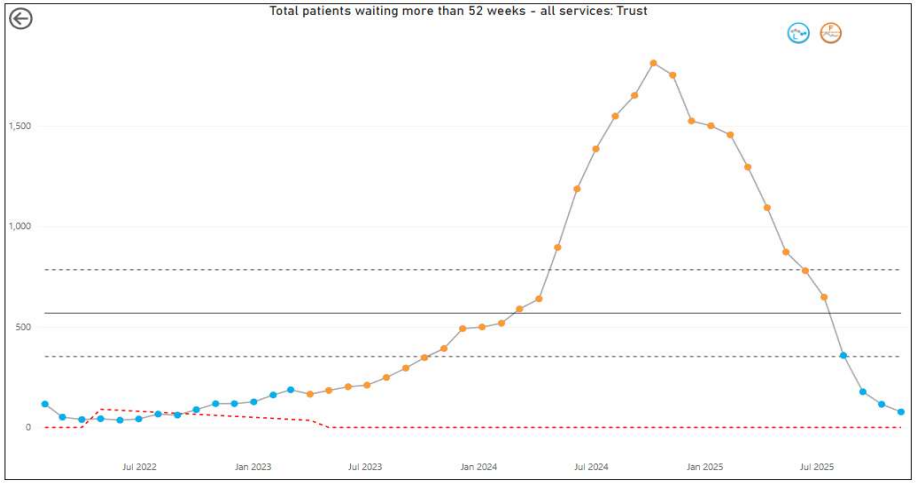
**Exception Report - Action Plan**

## Total patients waiting more than 52 Weeks – All services

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| 52+ Week waits - All services | Number | 779 | 648 | 358 | 177 | 115 | 77 | 77 |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trajectory | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|
| Number | 469 | 91 | 55 | 44 | 28 | 21 | 14 | 2 |

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| **Reason for performance gap:** | There has been consistent and significant improvement in reducing 52 weeks over a sustained period. This progress has been mainly driven through efficiency gains with digital solutions and admin process driving productivity. A new trajectory was provided for Sep-25 to Mar-26, the reduction of 52 weeks is slightly off track with this new trajectory.<br><br>The main challenge with recovery from a MSST perspective is a higher than anticipated number of referrals to level 3 than were originally modelled for the service. There is a high demand in the waiting lists for APP patients post their first treatment and to manage this accumulated demand job planning with APP's has taken place across the system to enhance productivity with implementation of super clinics due within June/July. The super clinics started at the end of June 25.<br><br>Community Paediatrician vacancies and an increase in the number of complex case referrals, continue to have an adverse impact on the waiting list for Community Paediatrics. However mitigations are in place with a locum and active recruitment. There are now <5 children waiting to be seen at 52 weeks or above; this is a decreasing picture. All vacancies within the team has gone through successful recruitment. Recovery has been dependent upon enhanced locum support within Community Paediatrics with the assumption that this will remain. There are regular meetings with the team to review the waiting list and clinical priorities. A new speciality Doctor has started which has increased capacity and moving forward will continue to reduce the 52 week cohort. Trajectory was 0 52 week waits by October 2025 however the service ended with a small number at 52 week wait. The aim is this will be resolved by the end of November.<br><br>CDC (Child Development Centre) is currently holding 10 (improvement of 6) children above 52 weeks. The trajectory for this service was due to demonstrate 0 52 weeks by July 25. Part of this was reliant on a third party to support, however, delays in the procurement process and some capacity challenges within providers has adversely impacted the recovery plan by 3 months. Current forecasting of performance shows that improvements will commence from June with a plan to reduce month on month and achieve 0 52 weeks by October 2025. However there remains a small number of 52 weeks therefore the service is now aiming to reduce this to zero by the end of December 2025. The weighting of the caseload has been re-aligned to ensure that more feedback slots are now availbale which will support the recovery by the end of December.<br><br>Children's Speech and Language services have also seen a steady improvement of waiting lists. A combination of early intervention programmes, holiday clinics and revalidation of waiting lists has resulted in a drop in CYP waiting over 52 weeks and an improvement for those waiting over 40 weeks. These initiatives are continuing into the Autumn term to enable the team to reach the 18 week target.<br><br>Wheelchair services waits appear to be deteriorating however a challenge has been made to the service regarding how the waits are categorised and measured. All patients waiting over 30 weeks for wheelchairs have been assessed, seen and most have their equipment. However if a patient requires an accessory or modification they remain on the open waiting list. A secondary report has been compiled to compare referral to first appointment. This is being validated and reported in Decembers action plans. In addition we have a number of children waiting for restrictive intervention. Discussions have commenced with commissioners and local authority as this is purely an allocation of equipment with no clinical assessment therefore should not be coming to the Wheelchair services.<br><br>Community outpatients waiting list continues to be challenged due to a disparity between the demand and capacity and the reliance on external providers particularly with ENT, Respiratory and Gynae with the teams focusing on reducing and mitigating the longest waiting patients on the pathways.<br><br>There are other services which contribute to not meeting this performance target such as Diabetic Nursing, Interdisciplinary Teams and Pulmonary Rehab. |

| | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|
| CDC to sub contract 70 assessments to support with longest waiting children | Mar-25 | Jun-25 | Complete | **November 25 Update.**<br>20 further subcontracting appointments were booked during November. This action is now closed with a new action opened below.<br><br>**October 25 Update**<br>All the subcontracted appointments have been delivered. However due to some financial availability further subcontracted appointments are going to be booked for October and November.<br><br>**September 25 Update**<br>Final outsourced appointments booked throughout September 2025.<br><br>**August 25 Update**<br>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.<br><br>**July 25 Update**<br>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 |
| Due to additional funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026. | Nov-25 | Feb-26 | On Track | **New action**<br>20 further appointments to be procured via private providers during December 25 and January 26. |
| SLT Revise analysis of management of complex needs caseload | Jun-25 | Sep-25 | Complete | **October 25 update**<br>Analysis and planning is complete. new pathways and service delivery model is now live.<br>**September 25 Update**<br>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.<br>**August 25 Update**<br>Holiday initiatives have commenced during July and running throughout August which is increasing capacity to see more complex CYP<br>**July 25 Update**<br>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. |

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|---|---|---|---|---|---|
| | Implementation of super clinic within existing capacity | Aug-25 | Oct-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |
| | Diabetic Nursing and improvement plan to be established | Aug-25 | Oct-25 | Complete | **November 25 Update**<br>There has been an increase in activity last month due to some immediate actions being implemented. Start dates for vacancies are now in place with additional bank admin approved to support recovery from December.<br><br>**October 25 Update**<br>Workshop completed and areas of improvement have been identified. Gaps in admin capacity were acknowledged so 1 WTE is now out to recruitment to release clinical time. This will increase clinic capacity and clinic utilisation.<br><br>**September 25 Update**<br>Planned care have been invited to bring their recent experience in reviewing processes with the service in line with access policy to standardise processes.<br><br>**New Action**<br>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. |

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|---|---|---|---|---|---|
| **Action Plan** | 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 | Complete | **November 25 Update**<br>ENT capacity provided throughout October with ongoing work around demand and capacity being worked through as business as usual. Due to this piece of work there is a new action to support the ongoing recovery of Gynaecology and Respiratory. Action complete.<br><br>**October 25 Update**<br>Progress has been made with ENT, and arrangements for additional capacity to be provided throughout October via an insourcing company supported via SATH. This will go live 18th October.<br>SATH Respiratory continuing to provide support for new patients above 30wks with an offer of appointments within SATH. Additional discussions with insourcing company re other options to further support recovery including Respiratory, Gynaecology and T&O.<br><br>**September 25 Update**<br>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. |
| | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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. |
| | An estate realisation exercise to be undertaken to ensure adequate clinical space is available for CYP therapy clinics. Any additional clinical space requirements to be sourced. | Nov-25 | Dec-25 | On Track | **New action**<br>Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025 |
| | Recruitment of additional speech and language therapist within CNRT to support improvement in SLT waiting times. | Oct-25 | Feb-25 | On Track | **November 25 Update**<br>Post was approved and has been out to advert with no suitable candidates. Team will readvertise.<br><br>**New Action**<br>The SLT waiting list has been slowly increasing despite previous recruitment. Therefore the service has had an additional role as part of a workforce redesign approved and this will go out to advert in October 25. |

| | | | | | |
|---|---|---|---|---|---|
| | New initiatives to be delivered during Autumn term to manage the demand for SLT services. Roll out of the Super penguin on line intervention for teachers and parents is underway to facilitate first line support. A new schools programme commenced in September to facilitate more CYP being able to access interventions within schools. | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway<br><br>**New Action** |
| | Job planning for community paediatricians has just been completed. In conjunction with case load validation demand and capacity is being tested to assess needs of the communities and the ability of the team to meet demand. | Oct-25 | Dec-25 | Complete | **November 25 Update**<br>Job plan has been completed. Single point of access has been implemented. Realigned the weighting of the caseloads. Impact of changes to be monitored<br><br>**New Action**<br>Caseload validation has commenced. Job plans with Medical Director for sign off. QEIA to be written for skill mixing options. |
| | Working with SaTH a long term resolution is required to agree theatre provision for oral surgery which provides enough resource to meet demand. The original SLA would provide this if the theatres can be allocated. | Oct-25 | Dec-25 | On Track | **November 25 Update**<br>Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provsion improving and SaTH scoping plan to reach full SLA if this can not be delivered then mitigation will be formalising current arrangments with RJAH.<br><br>**New Action**<br>To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA. |
| | Re-Implementation of super clinics via 18 weeks | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**New Action**<br>Working with 18 weeks to re-implement previous process around super clinics. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |

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|---|---|---|---|---|
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 | |

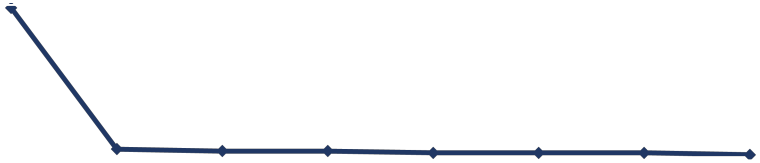
**Exception Report - Action Plan**

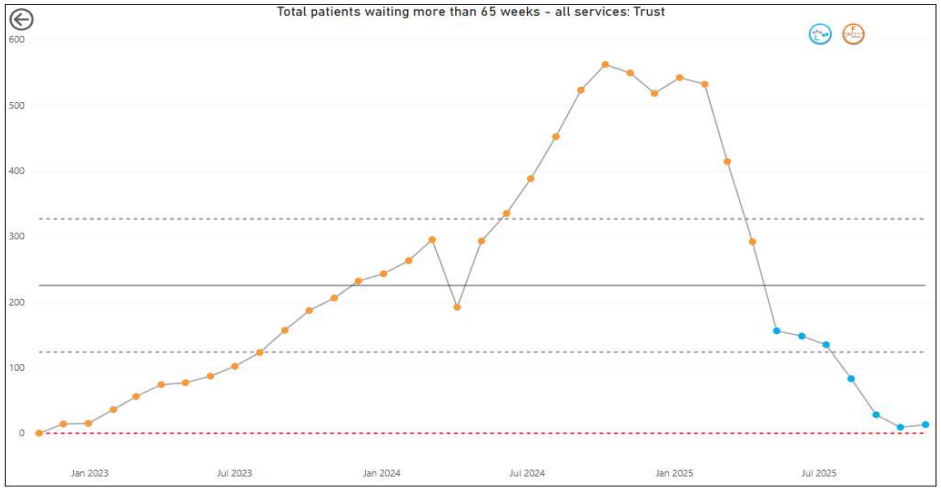
## Total patients waiting more than 65 Weeks – All services

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| 65+ Week waits - All services | Number | 148 | 135 | 83 | 28 | 9 | 13 | 13 |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trajectory | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|
| Number | 76 | 3 | 2 | 2 | 1 | 1 | 1 | 0 |






| Reason for performance gap: | |
|---|---|
| | Performance continued to improve up until this month where we have seen an increase in 65 weeks of 4 patients. This is primarily due to the wheelchairs service and more specifically the restrictive interventions pathway. Rapid improvement was seen throughout March and April due to the transfer of TeMS Orthopaedics and increased activity within MSST due to clinical validation. With the implementation of the super clinics in MSST in July and throughout August the aim was to be back in line with trajectory by end of August 25.<br><br>A new trajectory was provided for Sep-25 to Mar-26 with assumption a plan would be in place for the RI pathway in Wheelchairs<br><br>Wheelchair services waits appear to be deteriorating however a challenge has been made to the service regarding how the waits are categorised and measured. All patients waiting over 30 weeks for wheelchairs have been assessed, seen and most have their equipment. However if a patient requires an accessory or modification they remain on the open waiting list. A secondary report has been compiled to compare referral to first appointment. This is being validated and reported in Decembers action plans. In addition we have a number of children waiting for restrictive intervention. Discussions have commenced with commissioners and local authority as this is purely an allocation of equipment with no clinical assessment therefore should not be coming to the Wheelchair services.<br><br>There are other services which contribute to not meeting this performance target such as Interdisciplinary Teams |

| | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|
| SLT Revise analysis of management of complex needs caseload | Jun-25 | Sep-25 | Complete | **October 25 update**<br>Analysis and planning is complete. new pathways and service delivery model is now live.<br>**September 25 Update**<br>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.<br>**August 25 Update**<br>Holiday initiatives have commenced during July and running throughout August which is increasing capacity to see more complex CYP<br>**July 25 Update**<br>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 | Complete | **November 25 Update.**<br>20 further subcontracting appointments were booked during November. This action is now closed with a new action opened below.<br><br>**October 25 Update**<br>All the subcontracted appointments have been delivered. However due to some financial availability further subcontracted appointments are going to be booked for October and November.<br><br>**September 25 Update**<br>Final outsourced appointments booked throughout September 2025.<br><br>**August 25 Update**<br>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.<br><br>**July 25 Update**<br>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 |
| Due to additional funding the CDC subcontracting initiative has been extended. A further 20 appointments have been procured to be delivered by end of Jan 2026. | Nov-25 | Feb-26 | On Track | **New action**<br>20 further appointments to be procured via private providers during December 25 and January 26. |

| | | | | | |
|---|---|---|---|---|---|
| Action Plan | Implementation of super clinic within existing capacity | Aug-25 | Oct-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**October 25 Update**<br>Learning has taken place through understanding the outsourcing models approach and this has provided a template for future in house super clinics. Job plans and approach are being worked up to support this as business as usual. Due to success of insourcing and positive patient feedback operations are working with finance to scope feasibility of adding additional super clinics through November and December.<br><br>**September 25 Update**<br>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. |
| | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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. |
| | An estate realisation exercise to be undertaken to ensure adequate clinical space is available for CYP therapy clinics. Any additional clinical space requirements to be sourced. | Nov-25 | Dec-25 | On Track | **New action**<br>Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025 |
| | New initiatives to be delivered during Autumn term to manage the demand for SLT services. Roll out of the Super penguin on line intervention for teachers and parents is underway to facilitate first line support. A new schools programme commenced in September to facilitate more CYP being able to access interventions within schools. | Oct-25 | Jan-26 | On Track | **November 25 Update**<br>In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway<br><br>**New Action**<br>Testing for the super-penguin initiative commenced in Sept 25. A QEIA was approved in Sept 25 regarding the new SLT service offer within schools and this commenced mid-September in four schools with the highest needs. |
| | Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients. | Nov-25 | Dec-25 | On Track | **New Action**<br>The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks. |

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|---|---|---|---|---|---|---|
| | Additional typing and administrative support is being explored to support the increase in clinical activity planned and current RTT services (APCS, Community Outpatients and MSST). | | Nov-25 | Dec-25 | On Track | **New Action**<br>The additional administrative capacity needs to be in place to give the green light to the additional clinical capacity being planned. Overtime, additional hours, recruitment and outsourcing are all being worked through. |
| **Author** | Alastair Campbell/Helen Cooper/Gemma McIver | **Date** | 11/11/2025 | | | |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 | | | |

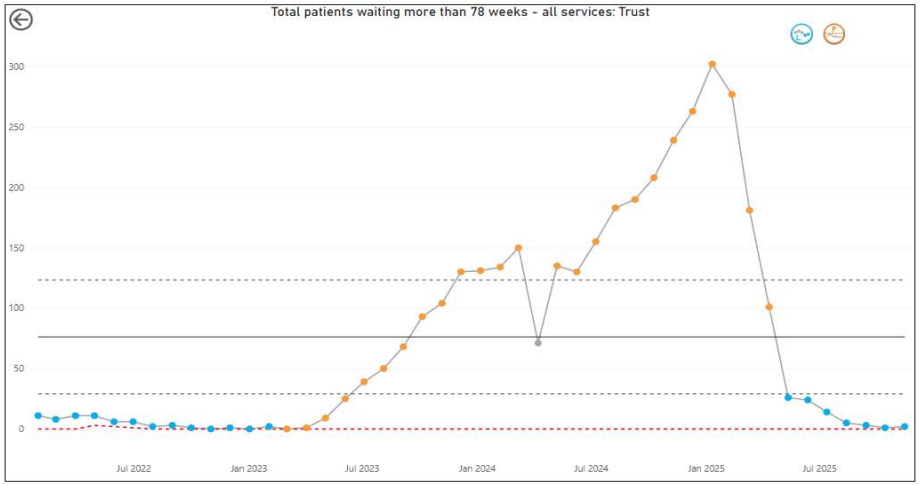
**Exception Report - Action Plan**

## Total patients waiting more than 78 Weeks – All services

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

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| 78+ Week waits - All services | Number | 24 | 14 | 5 | 3 | 1 | 2 | 2 |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trajectory | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|
| Number | 1 | 0 | 0 | 0 | 0 | 0 | 0 |

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| **Reason for performance gap:** | The 78 week position has continued to improve month on month and is slightly off trajectory (by one in Wheelchair Services). One of the above relates to a data error within MSST.<br><br>While overall numbers have reduced, there have been recent examples of data quality challenges that trigger both the 78 and 104 local waits inaccurately. | | | | |
| | **Start Date** | **End Date** | **Status** | **Outcome** | |
| | Re-Implementation of super clinics via 18 weeks | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>Action for this KPI is now complete as any new super clinics implemented would be seeing patients far lower down on the pathway.<br><br>**New Action**<br>Working with 18 weeks to re-implement previous process around super clinics. |

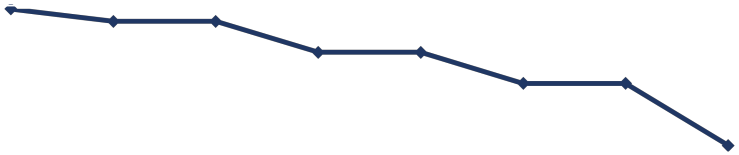
| | | | | | | |
|---|---|---|---|---|---|---|
| **Action Plan** | Review of data quality issues resulting in incorrect reporting of high waits and provide education for services with repeating occurrences | | Sep-25 | Nov-25 | On Track | **November 25 Update**<br>Report and weekly meeting provided to Deputy Director of Operations for discussion and action with teams to improve data caption.<br><br>**October 25 Update**<br>Waits report for local waits are monitored at weekly High Waits meeting. An automated report to services of any high waits on last working day of month has been created.<br><br>**New Action**<br>Information Team to compile a list of instances over the last 6 months to inform SDG leads and support services in reducing these instances. |
| | 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 | **November 25 Update**<br>QEIA has gone through quality and safety notice to be formally served to commsioners by close of November<br><br>**October 25 Update**<br>Action on track and meetings arranged following QEIA presentation.<br><br>**September 25 Update**<br>QEIA to be presented 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.<br><br>**New Action**<br>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** | 13/11/2025 | | | |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 | | | |

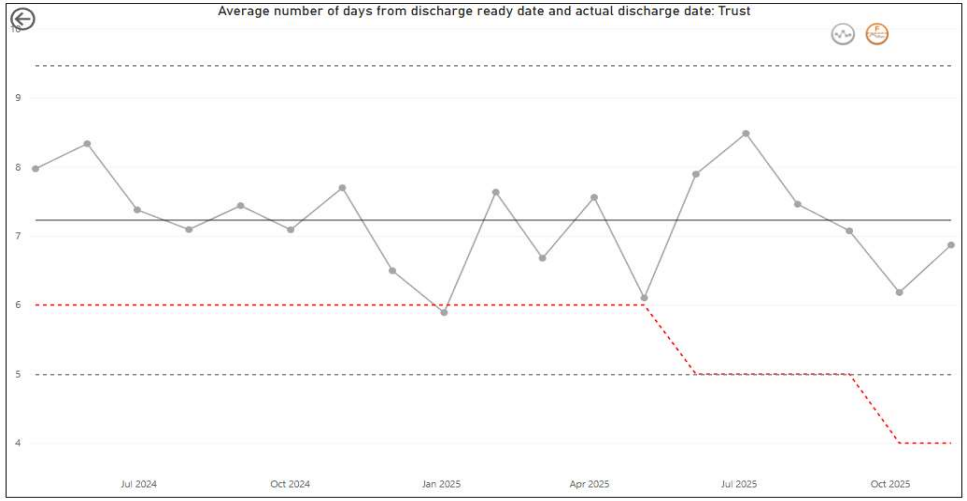
**Exception Report - Action Plan**

## Average number of days from discharge ready date and actual discharge date

| KPI Description | Latest 6 months | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | YTD |
|---|---|---|---|---|---|---|---|---|
| Average number of days from discharge ready date and actual discharge date | Number | 7.9 | 8.5 | 7.5 | 7.1 | 6.2 | 6.9 | 6.9 |
| | Target | 6.0 | 5.0 | 5.0 | 5.0 | 5.0 | 4.0 | 4.0 |

| Trajectory | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 |
|---|---|---|---|---|---|---|---|---|
| % | 6.20 | 6.00 | 6.00 | 5.50 | 5.50 | 5.00 | 5.00 | 4.00 |






| | |
|---|---|
| **Reason for performance gap:** | Currently, we are not on track with the NCTR improvement plan. This is due to a number of factors, primarily the significant dependence of this metric on the support provided by local authorities and the need to ensure that appropriate patients are admitted to community hospitals.<br><br>To address these challenges, a local complex discharge improvement workstream has been established. This workstream is overseen by the UEC Delivery Group, and the NCTR metric for community hospitals will be monitored also through this forum which will support to gain system wide engagement and focus.<br><br>As part of our ongoing efforts, a sprint improvement event was held throughout September to comprehensively review all system-wide actions intended to support NCTR in both acute and community settings. Following this review, a revised action plan has been implemented to drive progress in the coming months. The deteriroation in performance is linked to some complex patients who were discharged from the RRU prior to closure. There is a risk that this may be seen when RSH RRU closes at the end of November |

| | | Start Date | End Date | Status | Outcome |
|---|---|---|---|---|---|
| Action Plan | Process mapping to agree acurate and consistent recording of NCTR with identified roles and responsibilties to ensure there is robust decision making and accountablility for assigned actions. | Sep-25 | Oct-25 | Complete | **November 25 Update**<br>Task and finish group established to implement and monitor the new roles and responsibilities<br><br>**New Action**<br>Reduction of 1.1 days achieved throughout September. RIO recording strengthened and a revised process to manage escalations for long delays now in place |
| | Implementation of SOP for escalation of delays that replicates the SaTH Care Transfer Hub SOP to ensure partners are accountable in an equitable manner for attributable delays in the Community Hospitals. | Oct-25 | Nov-25 | Complete | **November 25 Update**<br>SOP has been implemented<br><br>**New Action**<br>TBC in November performance.SOP has been socialised with all key individuals in October with a launch to support. |
| | Implementation of Director of Operations weekly oversight performance meeings for stranded patients and those with a LoS of greater than 1 day on the NCTR list. | Oct-25 | Feb-26 | On Track | **November 25 Update**<br>Reporting requirements are being established linking with the review at high week waits meeting<br><br>**New Action**<br>TBC in November performance. |
| | Daily winter battle rhythm to be implemented to support escalations, manage NCTR in community settings and prompt senior decision makers at times of high UEC escalation pressures. | Oct-25 | Mar-25 | On Track | **November 25 Update**<br>This is in the early phases of implementation<br><br>**New Action**<br>TBC once implemented. |
| | Over the next three months, Community Hospital MADE (Multi Agency Discharge Events) sessions have been diarised regularly to underpin patient flow and effectively manage NCTR during challenging periods. These events wil also serve to enhance system-wide visibility, foster greater support, and encourage engagement from all partner organisations involved in the discharge process. | Oct-25 | Mar-25 | On Track | **November 25 Update**<br>An event took place 28th October<br><br>**New Action**<br>Fisrt MADE planned end of October |
| | Closure of RRU's has been communicated to system for support to ensure 0 delays across system to manage flow and reduction in beds | Oct-25 | Nov-25 | On Track | **November 25 Update**<br>SCC are engaged with escalating delays to ensure our RRU closure plan is delivered<br><br>**New Action**<br>Daily calls now in place for senior oversight with ICB to support system escalations and flow to reduce NCTR. |
| | Following a shift in profile from pathway 3 to pathwaty 2 an audit of pathway 2 patients is being completed to review their outcomes. This will enable a greater understanding of the types of patients who achieve the best outcomes on pathway 2. | Nov-25 | Apr-26 | On Track | **November 25 Update**<br>Data collection has commenced<br><br>**New Action**<br>TBC once implemented. |

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| **Author** | Sam Townsend/ Gemma McIver | **Date** | 11/11/2025 | |
| **Accountable Officer Approval** | Claire Horsfield | | 17/11/2025 | |

Shropshire Community Health NHS Trust

# Month 7 2025/26 Financial Performance

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Jonathan Gould Deputy CFO | **Paper date:** | 4 December 2025 |
| **Executive Sponsor:** | Sarah Lloyd, CFO | **Paper written on:** | 26 November 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 October (month 7) 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 October 2025 against both the I&E and Capital plan.

### 2.2. Summary

The Trust is reporting a £1,228k adjusted surplus as at month 7 compared to the planned surplus of £1,045k, which is favourable variance of £183k.

Key areas for consideration are:

- **Agency -** spend is £1,730k after seven months of the financial year; this is £69k favourable to plan. The reduced agency spend year to date is due to continuing controls and scrutiny and prioritising bank staff use to cover clinical shifts. However, the monthly agency spend run rate has increased over the last two months by £70k. Agency usage remains a key area of external scrutiny, and the Agency Scrutiny Group is focused on minimising agency spend without compromising patient safety. **Agency spend must remain within overall planned pay levels to deliver the financial plan.**

- **Bank pay** spend is £2,408k after seven months of the financial year; this is £784k adverse to plan. The variance is due mainly to a higher level of vacancies than planned and prioritising bank staff over agency staff 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 spend must remain within overall planned pay levels to deliver the financial plan.**

## Month 7 2025/26 Financial Performance

- **CIP** delivery at month 7 is £2,917k, which is £102k favourable to plan. Delivery of the Trust's £5,359k annual cost reduction target for 2025/26 remains a financial risk; although the Trust has now de-risked all its high-risk schemes and the £472k of medium risk schemes account for 9% of forecast delivery. **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) and the Wheelchair service. Mitigating actions have begun to reduce a number of these pressures in the past two months. **The Trust must mitigate all current and arising cost pressures during the year to deliver the financial plan**.

- **Underlying position -** planned underlying position for 2025/26 is a surplus of £932k. As at month 7 the Trust achieved an underlying/recurrent surplus of £579k, which exceeds plan by £126k. The assumptions supporting our calculation of our underlying/recurrent surplus are a key area of national scrutiny as the 2025/26 exit underlying position will be the starting point for 2026/27 plan (year 1 of the medium-term plans). **The Trust is on course to deliver the planned underlying surplus for the year.**

- **Risk and Forecast**– At month 7 the Trust is reporting all financial risks are fully mitigated on the basis that at this stage of the financial year we still have sufficient time to develop and deploy any additional mitigating actions as required. The level of financial risk has further reduced since month 6; this reflects the continued de-risking of our CIP programme and reductions in a number of cost risks. Our mostly likely forecast is a £2m surplus, however we continue to seek opportunities which could allow us to exceed our planned surplus.

### 2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 7 is a surplus of £1,228k compared to the planned surplus of £1,045k, which is a favourable variance of £183k.
- **Consider** the underlying/recurrent position year to date is a surplus of £579k, which is a favourable variance to plan of £126k and that the Trust is on course to deliver the plan underlying surplus of £932k.
- **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 plus savings from vacancies for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m with 9% 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.

# Month 7 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 7.

| Financial Performance against Plan (£k) | M07 Plan | M07 Actual | M07 Variance | YTD Plan | YTD Actual | YTD Variance | Annual Plan | Annual Forecast | Annual Variance |
|---|---|---|---|---|---|---|---|---|---|
| (Surplus)/ Deficit in Year | (203) | (293) | (90) | (1,045) | (1,228) | (183) | (2,000) | (2,000) | 0 |
| Underlying Position | (108) | (131) | (23) | (452) | (579) | (126) | (932) | (932) | 0 |
| Agency Expenditure | 228 | 308 | 80 | 1,799 | 1,730 | (69) | 2,939 | 2,939 | 0 |
| Bank Expenditure | 210 | 328 | 118 | 1,624 | 2,408 | 784 | 2,736 | 4,068 | 1,332 |
| Cost Improvement Programme | 486 | 501 | 15 | 2,917 | 3,019 | 102 | 5,359 | 5,359 | 0 |
| Capital Expenditure | 329 | 188 | (141) | 2,457 | 1,528 | (929) | 4,975 | 5,547 | 572 |

### 3.2. Adjusted Financial Performance – favourable variance to plan £183k

The adjusted financial position at month 7 is a surplus of £1,228k compared to the planned surplus of £1,045k which is a favourable variance of £183k. 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 | (75,768) | (75,864) | (97) |
| Expenditure excl. adjusting items | 74,723 | 74,636 | (87) |
| **Adjusted financial performance total** | **(1,045)** | **(1,228)** | **(183)** |
| Adjusting items | 79 | 82 | 3 |
| **Retained (surplus) / deficit** | **(966)** | **(1,146)** | **(180)** |

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

# Month 7 2025/26 Financial Performance

### 3.2.1. Income – favourable variance to plan £97k

Table 2 summarises the income position.

| | YTD Plan £k | YTD Actual £k | Variance £k |
|---|---|---|---|
| System income | (58,719) | (58,756) | (37) |
| Non-system income | (17,049) | (17,108) | (59) |
| **Total income** | **(75,768)** | **(75,864)** | **(97)** |

**Table 2: Income Summary as at 31 October 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 reporting is therefore in line with our plan. However, our activity reporting indicates that elective activity is exceeding planned levels, and we are discussing this position with the service commissioner.

### 3.2.2. Expenditure – favourable variance to plan £83k

Table 3 shows a summary of expenditure by key categories.

| | YTD Plan £k | YTD Actual £k | Variance £k |
|---|---|---|---|
| Substantive | 51,566 | 50,395 | (1,171) |
| Bank | 1,624 | 2,408 | 784 |
| Agency | 1,799 | 1,730 | (69) |
| **Total Pay** | **54,989** | **54,534** | **(456)** |
| Supplies & Services Clinical | 6,274 | 6,804 | 530 |
| Prison Escorts and Bedwatch | 153 | 272 | 119 |
| Drugs | 889 | 847 | (43) |
| Premises | 5,436 | 5,347 | (89) |
| Travel | 971 | 857 | (115) |
| Other | 6,089 | 6,058 | (31) |
| **Total Non-Pay** | **19,812** | **20,184** | **372** |
| **Total Expenditure** | **74,802** | **74,718** | **(83)** |

**Table 3: Expenditure Summary as at 31 October 2025**

### 3.2.3. Pay – favourable variance to plan £456k

The overall pay position is a favourable variance of £456k. This is due mainly to pay underspends linked to substantive vacancies. The substantive pay underspend is partially offset by the bank staff overspend; bank staff (paid at substantive rates) are utilised to cover vacant clinical shifts, wherever possible, to avoid the use of agency staff.

Bank spend was £328k in October, an increase of £4k compared to the previous month. The year to date position is now £784k adverse to plan. This represents 4.4% of total pay compared to our plan of 3.0% and is due to higher level of vacancies than planned. The 2025/26 target is £2,736k, 3.0% of the overall pay plan. It is of note that after seven months, 88% of the annual bank financial plan has been spent; consequently, the forecast outturn has been updated to reflect projected costs over the balance of the year.

# Month 7 2025/26 Financial Performance

Agency spend was £308k in October. The monthly agency spend run rate has increased over the last two months by £70k due to vacancy and sickness cover for medical staff. This is likely to continue for a number of months, which combined with potential agency usage to support onboarding of expanded Urgent Community Response (UCR) services, is likely to offset the year to date underspend of £69k. The year to date position represents 3.2% of total pay compared to our plan of 3.3%. The agency target for the Trust in 2025/26 is £2,939K, 3.2% of total pay cost.

The vacancy rate in October was 7.5% (a reduction from 10.9% in March 2025), which equates to 131 WTE vacancies, however it should be noted that 116 WTE temporary staff (82 WTE bank and 34 WTE agency) were 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.

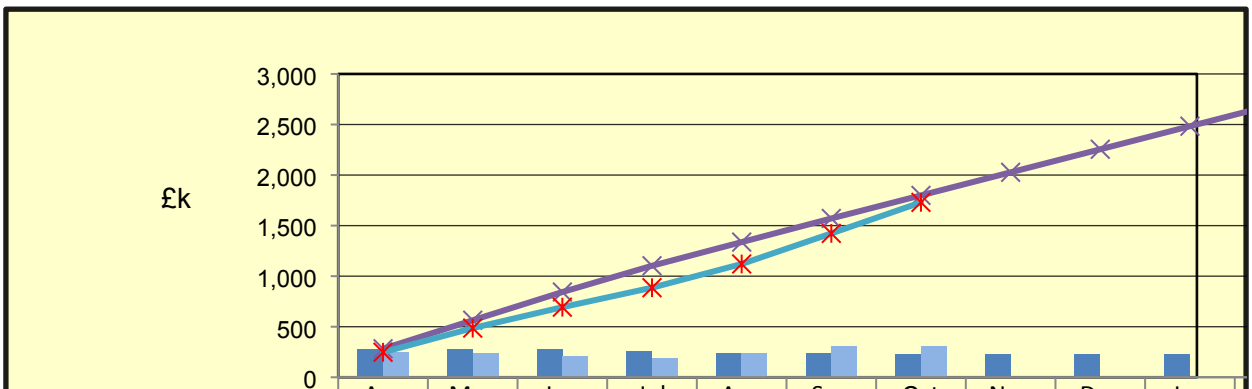
### 3.2.4. Non-Pay – adverse variance to plan £372k

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 which have begun to reduce a number of these pressures, and we are seeking additional measures to ensure the ongoing impact on the Trust's financial position is minimised.

### 3.2.5. Agency and Locum Expenditure – favourable variance to plan £69k

Table 4 shows agency spend year to date is £1,730k compared to the plan of £1,799k, which is a favourable variance of £69k. The monthly agency spend run rate has increased over the last two months by £70k. The reason for the increase is that two additional senior locum medics were engaged to cover for vacancy and sickness. There was also locum medical support for the start of the expanded UCR services in October. The underspend year to date is due mainly to the mix of staff weighted towards lower paid roles and below plan usage between months 1 to 5. Expenditure exceeded planned levels in months 6 and 7 for the reasons outline above.

The target for the Trust in 2025/26 is £2,939K, 3.2% of total pay cost. Achieving this target will now be a challenge due to the temporary medical staffing requirements, expansion of the UCR service, and the additional pressures normally experienced during Autumn and Winter months.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan |
|---|---|---|---|---|---|---|---|---|---|---|
| In Month Plan | 282 | 282 | 279 | 260 | 234 | 234 | 228 | 228 | 228 | 228 |
| In Month Actual | 247 | 239 | 207 | 193 | 235 | 302 | 307 | | | |
| Cumulative Plan 25/26 | 282 | 564 | 843 | 1,103 | 1,337 | 1,571 | 1,799 | 2,027 | 2,255 | 2,483 |
| Cumulative Actual 25/26 | 247 | 486 | 693 | 886 | 1,121 | 1,423 | 1,730 | | | |

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

# Month 7 2025/26 Financial Performance

### 3.2.6. Cost Improvement Programme 2025/26

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

Table 5 shows overall CIP delivery of £3,019k as at month 7, which is £102k favourable to plan.

| | Plan YTD £k | Actual YTD £k | Variance YTD £k |
|---|---|---|---|
| Recurrent | 1,919 | 1,975 | 56 |
| Non-recurrent | 998 | 1,044 | 46 |
| **TOTAL** | **2,917** | **3,019** | **102** |

**Table 5: 2025/25 CIP delivery as at 31 October 2025**

Recurrent delivery at Month 7 is £1,975k, which is £56k favourable to plan. Non-recurrent CIP delivery is £998k, which is £46k favourable to plan.

Positive progress is being made in relation to reducing the delivery risk of our CIP. 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 remains on de-risking medium risk schemes which now have a value of £472k (9%), a reduction of £159k on the previous month.

| Recurrent / Non Recurrent | Low £k | Medium £k | High £k | Unidentified £k | Total Forecast £k | Total Plan £k | Full Year Effect CIP £k |
|---|---|---|---|---|---|---|---|
| Recurrent | 3,102 | 472 | 0 | 0 | 3,574 | 3,574 | 3,574 |
| Non Recurrent | 1,785 | 0 | 0 | 0 | 1,785 | 1,785 | - |
| | **4,887** | **472** | **0** | **0** | **5,359** | **5,359** | **3,574** |
| Recurrent | 58% | 9% | 0% | 0% | 67% | | |
| Non Recurrent | 33% | 0% | 0% | 0% | 33% | | |
| | **91%** | **9%** | **0%** | **0%** | **100%** | | |

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

All relevant CIP schemes are reviewed through Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

### 3.2.7. Productivity

Our financial plan includes an implied productivity improvement of £1.7m to offset growth in demand without additional funding. We have a Productivity Group in place that develops and oversees delivery of schemes which are currently non-cash releasing. The Productivity Group is led by our Deputy Director of Nursing and Quality with QEIAs developed for each scheme. The current performance is as follows;

- Annual plan £1.7m, with a forecast annualised value of schemes identified of £2.8m
- Year to date delivery of £1.3m, a favourable variance to plan of £0.3m
- Schemes are valued using a cost estimate of the additional activity from each of the programmes of work.

A summary of the schemes is set out in Table 7.

# Month 7 2025/26 Financial Performance

| Productivity Schemes | Month £k | | | Year to Date £k | | | Value of Schemes Identified £k |
|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | |
| Reduction in NCTR & LOS Community Bed Based Setting | 90 | 40 | (50) | 460 | 152 | (308) | 993 |
| Community Therapy Productivity | 117 | 48 | (69) | 288 | 437 | 149 | 988 |
| Urgent Care Productivity | 20 | 105 | 85 | 39 | 329 | 290 | 295 |
| Community services productivity | 45 | 19 | (26) | 89 | 301 | 211 | 313 |
| Schedule of Growing Skills (SOGS) | 18 | 11 | (7) | 126 | 74 | (52) | 216 |
| **Total** | **289** | **223** | **(66)** | **1,003** | **1,293** | **290** | **2,805** |

**Table 7: Productivity Schemes as at 31 October 2025**

### 3.2.8. Statement of Financial Position

The summarised Statement of Financial Position (SoFP) for period ended 31 October 2025 is shown in Table 8.

| | 30 September '25 Balance £'k | 31 October '25 Balance £k | Movement in Month £k |
|---|---|---|---|
| Property, Plant & Equipment | 41,843 | 41,599 | (244) |
| Inventories | 235 | 212 | (23) |
| Non-current assets for sale | 0 | 0 | 0 |
| Receivables | 2,808 | 4,593 | 1,785 |
| Cash | 30,677 | 31,591 | 914 |
| Payables | (14,140) | (16,719) | (2,579) |
| Provisions | (3,724) | (3,717) | 7 |
| Lease Obligations on Right to Use Assets | (11,250) | (10,829) | 421 |
| **TOTAL ASSETS EMPLOYED** | **46,449** | **46,730** | **281** |
| Retained earnings | 37,082 | 37,363 | 281 |
| Other Reserves | 9,367 | 9,367 | 0 |
| **TOTAL TAXPAYERS' EQUITY** | **46,449** | **46,730** | **281** |

**Table 8: Statement of Financial Position as at 31 October 2025**

- Receivables (amounts we are owed) increased by £1,785k due mainly to outstanding quarterly contractual payments from Local Authorities for our 0-19 Services.
- Payables (amounts we owe) increased by £2,579k due mainly to deferred income movements (mainly quarterly billing for 0-19 services).
- Cash increased by £944k largely as a result of the above changes.

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

# Month 7 2025/26 Financial Performance

### 3.2.9. 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, and as a result we have prioritised our capital programme and we are now forecasting operational capital of £3,566k and IFRS16 lease capital of £1,409k, which still totals £4,975k.

In addition to our agreed capital plan, our forecast outturn includes an additional £572k linked to the freedom and flexibilities provided to high performing Trusts, which takes our overall planned spend to £5,547.

At month 7, actual capital spend was £1,528k compared to planned spend of £2,457k, an underspend of £929k, as shown in Table 9. The underspend is due mainly to the prioritisation of our capital programme with the shifting of allocation from IFRS 16 leases, included in the early months of the plan, to operational capital scheduled for later in the year. Delays in some schemes also contributed to the underspend, however all major projects have developed implementation plans and we expect to fully utilise our capital plan by the end of the financial year.

A summary position is shown in Table 9 below.

| Capital Expenditure | Annual Plan £k | YTD Plan £k | YTD Actual £k | YTD Variance £k |
|---|---|---|---|---|
| Operational capital | 2,818 | 1,316 | 990 | (326) |
| IFRS 16 leases | 2,157 | 1,141 | 538 | (603) |
| | **4,975** | **2,457** | **1,528** | **(929)** |

**Table 9: 2025/26 Capital Expenditure as at 31 October 2025**

### 3.2.10. 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 7 is £579k surplus which is £126k favourable to plan. The favourable variance is due mainly to recurrent CIP and income overperformances. The Trust is on course to deliver its planned underlying surplus for the year; to achieve this we must deliver a recurrent surplus of £353k in the remainder of the year, which we remain on track to do.

The non-recurrent year to date position is a surplus of £650k which is £57k favourable to plan with overperformance on CIP and non-recurrent pay savings more than offsetting a small number of cost pressures, which are assumed to be non-recurrent issues. The favourable non-recurrent pay position is due to vacancies in Local Authority services, and we are contracted to utilise these savings in the service or return the funds to Commissioner.

The underlying position and the assumptions are a key area of focus for NHSE and there is an expectation that this is monitored by Trust Boards and Committees. The key drivers that impact on our underlying position are: CIP delivery, management of cost pressures and Local Authority pay underspends, and this position is overseen by our Resource and Performance Committee.

# Month 7 2025/26 Financial Performance

### 3.2.11. Forecast Outturn and Financial Risk

We have reviewed current, available information relating to our financial performance for the remainder of the year and we continue to forecast that we are likely to deliver our 2025/26 financial plan, subject to continuing to mitigate our key financial risks.

The level of financial risk continues to reduce month on month reflecting reductions in both income and cost risks as the year progresses.

Our forecast outturn and financial risk assessment is considered and overseen through the Resource and Performance Committee at each of its meetings.

### 3.2.12. Monthly Monitoring Return to NHSE

The October Provider Financial Return (PFR) was submitted to NHSE on 14 November 2025 in line with the national timetable.

### 3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 7 is a surplus of £1,228k compared to the planned surplus of £1,045k, which is a favourable variance of £183k.
- **Consider** the underlying/recurrent position year to date is a surplus of £579k, which is a favourable variance to plan of £126k and that the Trust is on course to deliver the plan underlying surplus of £932k.
- **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 plus savings from vacancies for the year.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £5.4m with 9% 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.

Shropshire Community Health
NHS Trust

# Chair's Assurance Report

Charitable Funds Committee 21st November 2025

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Diane Davenport Executive Assistant | **Paper date:** | 4th December 2025 |
| **Executive Sponsor:** | Cathy Purt Charitable Funds Committee Chair | **Paper written on:** | 24th November 2025 |
| **Paper Reviewed by:** | Sarah Lloyd Director of Finance | **Paper Category:** | Governance |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

This paper presents a summary of the Charitable Funds Committee meeting held on 21st November 2025, for assurance purposes.

## 2. Executive Summary

### 2.1 Summary

- The meeting was quorate.
- The agenda items included:
  - Quarterly Report for Quarter 1 and 2 2025/26
  - NHS Charities Together – COVID 19 Appeal – Stage 3 update
  - 2024/25 Charitable Funds Accounts
  - Charitable Fund Guidelines for SCHT Manager 2025

### 2.2. Conclusion

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

## 3. Main Report

### 3.1 Introduction

This report has been prepared to provide assurance to the Board from the Charitable Funds Committee meeting which met on 21st November 2025. The meeting was quorate with two Non-Executive Directors and two Executive Director in attendance. A full list of the attendance is outlined below:

| Chair/Attendance: | |
|---|---|
| Cathy Purt | Non-Executive Director (Chair) |
| Sarah Lloyd | Chief Finance Officer |
| David Court | Head of Financial Accounting |
| Shelley Ramtuhul | Director of Governance |

# Chair's Assurance Report

Charitable Funds Committee 21st November 2025

| Apologies: | |
|---|---|
| Clair Hobbs | Director of Nursing and Clinical Workforce |

The Committee reviewed the updated actions and noted a number of actions remain open; however, progress has been made in most cases. The Terms of Reference for this Committee are due to be presented to the Board as part of the Governance pack in February 2026.

**3.3 Key Agenda**

The Committee received all required items with an outline provided below for each:

| Agenda Item / Discussion | Assured (Y/N) | Assurance Sought |
|---|---|---|
| 4. Quarterly Report for Q1 and Q2 2025/26 | | |
| The Committee was informed the total balance of Charitable Funds held by the Trust for Q1 remained stable at £170K with income and expenditure largely offsetting each other. The Committee discussed the legacy from a patient in the North Locality and the need to encourage the team to spend these generously donated funds.<br><br>In Q2 the funds reduced by £4K to £166K with income and expenditure largely offsetting each other. Income totalled £17k including various donations from Ludlow League of Friends, Shropshire Community Physio patients' welfare fund along with smaller but gratefully received donations.<br><br>The Dying Well Fund has now been fully spent including End-of-Life Folders, leaflets, guides, and other smaller items.<br><br>The Committee discussed the challenge of spending restricted funds, and it was agreed we would promote the funds with our teams.<br><br>The Committee received the Quarterly Report for Q1 and Q2 2025/26. | Y | |
| 5 NHS Charities Together -COVID 19 Appeal – Stage 3 update | | |
| The Committee considered that due to a change in one of our projects, there is some unallocated funding available, as long as we spend this on its intended purpose.<br><br>Discussions are underway with leads to assess if we can spend the remaining NHS Charities Together Funds prior to year end. It is likely that additional Health and Wellbeing days will utilise at least some of this funding. | Partial | |

# Chair's Assurance Report

Charitable Funds Committee 21st November 2025

| | | |
|---|---|---|
| The Committee suggested working with colleagues to identify further opportunities for spending the funding. | | |
| 6. 2024/25 Charitable Funds Accounts – Review and recommend presentation to the Trust Board for approval | | |
| It was discussed that our external auditor, Grant Thornton, had conducted an independent examination of the 202425 Annual Accounts and Report, and no significant issues had been found. One minor update was requested by the auditors in relation to our agreement to move to a Group model with shared leadership.<br><br>The Committee **approved** the 2024/25 Charitable Funds Annual Accounts and Report and recommended these to the Trust Board, as corporate trustee, for ratification. | Y | |
| 7. Any Other Business | | |
| Charitable Fund Guidelines for SCHT Managers 2025 | | |
| The Charitable Fund Guidelines are reviewed annually and remain unchanged from the previous year.<br><br>The Committee **approved** the 'Charitable Fund Guidelines for SCHT Managers 2025' and requested that these are circulated to teams as a reminder that the Funds are available to spend. | Y | |

**3.4 Approvals**

**The Charitable Funds Committee approved:**

- The 2024/25 Charitable Funds Annual Accounts and Report and recommended these to the Trust Board, as corporate trustee, for ratification.
- The Charitable Fund Guidelines for SCHT Managers 2025.

**3.5 Risks to be Escalated.**

There were no new risks highlighted during the course of this meeting.

**4. Conclusion**

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

Shropshire Community Health
NHS Trust

# Charitable Funds Annual Report & Accounts 2024/25

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | David Court Head of Financial Accounting | **Paper date:** | 4th December 2025 |
| **Executive Sponsor:** | Sarah Lloyd, Chief Finance Officer | **Paper written on:** | 24th November 2025 |
| **Paper Reviewed by:** | Charitable Funds Committee | **Paper Category:** | Charitable Funds Annual Report & Accounts 2024/25 |
| **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 requests the Trust Board, as the Corporate Trustee, formally approves the Charitable Funds Annual Report and Accounts for 2024/25, as recommended by the Charitable Funds Committee on 21st November 2025.

## 2. Executive Summary

The Charitable Funds Committee has considered and endorsed the 2024/25 Charitable Funds Annual Report and Accounts on behalf of the Trust Board, in line with its delegated responsibility, and recommends formal approval by the Board.

The accounts show an overall decrease in fund balances during the year of £2k, from £172k to £170k. During the year, income totalled £93k and expenditure £95k.

The income of £93k included generous donations of £83k and bank interest of £10k.

The total expenditure of £95k included:

- £79k on patient welfare and amenities, mainly for equipment to benefit patients. This included items such as specialist mattresses, touch screen tables, visitor chairs, standing aids, garden benches, bariatric shower commodes, procedure carts, physiotherapy equipment, a flow unit with accessories and a seated leg press. Of this sum, £37k was spent at Whitchurch hospital and £17k at Bridgnorth hospital and this was largely funded by very generous League of Friends donations.
- £16k spent from the staff welfare funds. This was mainly for staff wellbeing days funded from the Covid-19 NHS Charities Together Grant and for various staff events.

Given the value of the funds, they are not subject to a full external audit, however the Trust's external auditors, Grant Thornton, have conducted an independent examination, resulting in no change to the reported position.

# Charitable Funds Annual Report & Accounts 2024/25

The Annual Report and Accounts, and the draft Audit Findings Report (AFR) are attached. The draft AFR issued by Grant Thornton will be finalised following the adoption of the 2024/25 Annual Report and Accounts by the Trust Board.

The Annual Report and Accounts will be submitted to the Charity Commission as part of the annual return, prior to the deadline of 31st January 2026.

## Key Recommendations

The Board is asked to formally adopt the 2024/25 Charitable Funds Annual Report and Accounts, as approved by the Charitable Funds Committee on 21st November 2025 and in accordance with its delegated authority.

APPENDIX 1

Shropshire Community Health
NHS Trust

# Charitable Funds

# Annual Report & Accounts 2024/25

**Charity Registration Number 1056698**

## Statement of Trustees' Responsibilities in respect of the Trustees' Annual Report and Accounts

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgments and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The Annual Report and Accounts set out on pages 3 to 13 have been compiled from and are in accordance with the financial records maintained by the trustees.

Signed on behalf of the trustees:

Chair : …….  Date : …….

Trustee : ……  Date : …….

# Annual Report

## Reference & Administrative Details

In accordance with the Charities Act 2011, the charity is included in the Charity Commission's Register of Charities with the following details:

| | |
|---|---|
| Name of charity: | Shropshire Community Health NHS Trust General Charitable Fund |
| Registered charity number: | 1056698 |
| Address of charity: | Trust Headquarters,<br>Mount McKinley, Shrewsbury Business Park,<br>Anchorage Ave, Shropshire, SY2 6FG |

There are 16 separate sub-funds registered within the group registration. There are further sub-divisions for the purpose of local management of funds.

The original governing document was a deed dated June 1996, as amended by supplementary deeds due to NHS re-organisations over the years.

## Trustee Arrangements

The Trust is the sole corporate trustee of the charity. Since the Trust must act through individuals in order to express its will, trusteeship is assumed by the members of the Trust Board.

During 2024/25 they were as follows:
Patricia Davies
Sarah Lloyd
Dr Mahadeva Ganesh
Clair Hobbs
Shelley Ramtuhul
Claire Horsfield
Rhia Boyode (01/05/2024 - 31/03/2025)
Andrew Morgan (01/10/2024 - 31/03/2025)
Tina Long
Harmesh Darbhanga
Peter Featherstone (01/04/2024 - 11/11/2024)
Cathy Purt
Alison Sargent
Jill Barker

## Governance & Management

In its role as corporate trustee, the Trust Board takes into account the Charity Commission guidance on independence. A Charitable Funds Committee has therefore been set up with delegated responsibility for managing the charity, ensuring that the use of charitable funds is focussed on the needs of patients. This committee operates within the Terms of Reference and delegated powers as set by the Board.

The committee has responsibility for ensuring that:
- Spending is in line with agreed objectives and priorities.
- Devolved decision making and delegation is in accordance with the policies and procedures set out by the Board.
- All legal duties and regulations in relation to charitable funds are complied with.

The charity is accounted for and administered on a day to day basis by the Finance Department of Shropshire Community Health NHS Trust.

## Objectives & Activities

The objective of the charity is that the Trustees shall apply the income and, at their discretion, so far as may be permissible, the capital, for any charitable purposes relating to the NHS wholly or mainly for the services provided within Shropshire Community Health NHS Trust.

The charity is funded by grants received from NHS Charities Together, donations and legacies received from patients, their relatives, the general public and other organisations. The overall strategy of the charity is to provide support to the above Trust by the following means:

Patients Expenditure

- Purchase of medical equipment and provision of services not normally provided by or in addition to that normally provided by the NHS.
- Improving patient facilities and amenities to improve the environment.

Staff Expenditure

- Motivation of staff, by improving staff facilities and providing services that improve staff wellbeing.
- Education of staff by providing training over and above what would normally be provided.

## Relationships with Related Parties/External Bodies

Grants to the related NHS organisation, Shropshire Community Health NHS Trust, are made in accordance with donors' wishes and in line with Charity Commission guidance on the public benefit.

The charity works closely with the Trust. Staff within the organisation identify and advise the charity on local priorities and assist the corporate trustee in monitoring the use of the charitable funds.

The strong relationship with members of staff is particularly valued and enables the charitable funds to be directed to ensure an effective contribution is made in support of local services.

Close links are also maintained with individual hospital League of Friends organisations. The charity is pleased to work with these organisations in the provision of charitable support to the related hospitals and health services.

## Review of Finances, Activities, Achievements & Performance

The strategy of the charity is to provide support by providing funds to benefit patients and staff of Shropshire Community Health NHS Trust. It does this by purchasing supplementary and complementary equipment or services for which the Trust is unable to provide funding through exchequer sources.

The charity does not currently actively fundraise and recurrently relies upon the generosity of patients and their relatives and other donors who are familiar with, or have experienced the care of the Trust services and hospitals, or who are sympathetic and generous in their support to their local NHS services.

Finances

In the 2024/25 financial year the charity received Donations of £83k and Bank interest of £10k . Total incoming resources for the year were therefore £93k.

The charity can only continue to support the work of Shropshire Community Health NHS Trust as long as donations and legacies continue to be received. The charity is therefore indebted to the generosity of patients, their families and carers, well-wishers and friends, who have donated so generously to the work of the charity. This includes people who have left legacies in their will, and we are aware that we receive these monies at a sensitive time for the remaining family.

Patient welfare and amenities

Patients' welfare expenditure totalled £79k. The majority of this expenditure related to medical equipment with the most significant items being:

• £37k from the Whitchurch Hospital Patient Welfare Fund and this relates to the purchase of specialist mattresses £20k, digital rainbow touch screen tables £6k, visitor chairs £2k, standing aids £2k, garden benches £1k, Bariatric shower commodes £1k and £5k on other items and support costs.

• £18k from the Telford and South East Locality Patient Welfare Fund and relates to the 2023/24 Legacy for syringe drivers and lock boxes £9k and £9k on support costs.

•£17k from the Bridgnorth Hospital Patient Welfare Fund that relate to donations from the League of Friends for procedure carts £5k Physio Equipment £5k, a flow unit with accessories £4k, seated leg press £2k and £1k on other items and support costs.

Staff welfare and amenities

Expenditure from the Staff welfare funds totalled £16k.

The overall financial performance recorded a net decrease in funds of £2k.

## Future Plans

The trustees do not expect any significant changes in the objectives of the charity in the forthcoming years, and intends to continue to reduce fund balances where suitable projects and schemes can be identified.

## Reserves policy

The charity's intention is that funds are spent within a reasonable period of receipt, and therefore reserves should not be built up. Managers are encouraged to spend the funds to continue to reduce the level of funds held.

## Statement of Financial Activities for the year ended 31 March 2025

| | Note | Restricted Funds 2024/25 £'000 | Unrestricted Funds 2024/25 £'000 | Total Funds 2024/25 £'000 | Restricted Funds 2023/24 £'000 | Unrestricted Funds 2023/24 £'000 | Total Funds 2023/24 £'000 |
|---|---|---|---|---|---|---|---|
| **Income from:** | | | | | | | |
| Grants | 3 | 0 | 0 | 0 | 35 | 0 | 35 |
| Donations & Legacies | 3 | 0 | 83 | 83 | 0 | 157 | 157 |
| Investments (Bank Interest) | | 0 | 10 | 10 | 0 | 8 | 8 |
| **Total Incoming Resources** | | **0** | **93** | **93** | 35 | 165 | 200 |
| | | | | | | | |
| **Expenditure on:** | | | | | | | |
| Charitable activities: | | | | | | | |
| Patient welfare & amenities | 4 | 0 | 79 | 79 | 15 | 95 | 110 |
| Staff welfare & amenities | 4 | 3 | 13 | 16 | 0 | 10 | 10 |
| **Total Expenditure** | | **3** | **92** | **95** | 15 | 105 | 120 |
| | | | | | | | |
| **Net Movement in Funds** | | **-3** | **1** | **-2** | 20 | 60 | 80 |
| | | | | | | | |
| **Reconciliation of funds** | 10 | | | | | | |
| Total funds brought forward | | 20 | 152 | 172 | 0 | 92 | 92 |
| **Total funds carried forward** | | **17** | **153** | **170** | 20 | 152 | 172 |

## Balance Sheet as at 31 March 2025

| | Note | Restricted Funds 2024/25 £'000 | Unrestricted Funds 2024/25 £'000 | Total Funds 2024/25 £'000 | Restricted Funds 2023/24 £'000 | Unrestricted Funds 2023/24 £'000 | Total Funds 2023/24 £'000 |
|---|---|---|---|---|---|---|---|
| **Current assets** | | | | | | | |
| Debtors | 8 | 0 | 0 | 0 | 0 | 3 | 3 |
| Cash at bank & in hand | | 17 | 161 | 178 | 20 | 162 | 182 |
| **Total Current Assets** | | **17** | **161** | **178** | 20 | 165 | 185 |
| **Liabilities** | | | | | | | |
| Creditors : amounts falling due within 1 year | 9 | 0 | -8 | -8 | 0 | -13 | -13 |
| **Total Liabilities** | | **0** | **-8** | **-8** | 0 | -13 | -13 |
| **Total Net Current Assets/(Liabilities)** | | **17** | **153** | **170** | 20 | 152 | 172 |
| **Total Net Assets or Liabilities** | | **17** | **153** | **170** | 20 | 152 | 172 |
| **Funds of the charity** | 10 | | | | | | |
| Restricted funds | | 17 | 0 | 17 | 20 | 0 | 20 |
| Unrestricted funds | | 0 | 153 | 153 | 0 | 152 | 152 |
| **Total Charitable Funds** | | **17** | **153** | **170** | **20** | **152** | **172** |

The notes on pages 8 to 13 form part of these accounts.

The financial statements were approved by the trustees at the Charitable Funds Committee on the 21st November 2025 and then subsequently approved by the Trust Board for issue on behalf of the committee on the 4th December 2025

Trustee : Date :

## NOTES TO THE ACCOUNTS

### Note 1 : Accounting Policies

**a) Basis of preparation**

The financial statements have been prepared under the historic cost convention.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice : Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a "true and fair view" and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a "true and fair view". This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than Accounting and Reporting by Charities : Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

Update Bulletin 1 of the Charities SORP (FRS 102) was implemented in 2015/16.

Update Bulletin 2 of the Charities SORP (FRS 102) was implemented in 2019/20.

The trustees consider that there are no material uncertainties about the charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

**b) Funds structure**

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- An endowment fund - where the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent.
- A restricted income fund - where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

In 2024/25 the charity had no endowment funds but does have restricted income funds in the form of Grants received from NHS Charities Together in relation to COVID.

There are 16 separate sub-funds registered within the group registration with the Charity Commission, with further sub-divisions for the purpose of local management of funds.

**c) Incoming resources**

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met, then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

## NOTES TO THE ACCOUNTS

### d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when all the following conditions are met:
- Confirmation has been received from the estate representatives that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

### e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:
- There is a present legal or constructive obligation resulting from a past event.

- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement.
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

### f) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment:
- Approval and authorisation have been granted in accordance with the Scheme of Delegation operated by the Trustee.
- Receipt of goods or services have been confirmed as appropriate and payment authorised in accordance with the Trustee's Standing Financial Instructions.

### g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include costs of administration, internal and external audit costs and bank charges. Support costs have been apportioned across the categories of charitable expenditure on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 5.

### h) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 4.

## NOTES TO THE ACCOUNTS

**i) Debtors**

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

**j) Cash and cash equivalents**

All cash is held within interest bearing Government Banking Service (GBS) bank accounts.

**k) Creditors**

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

**l) Cash Flow Statement - Exemption**

Charities preparing their accounts under FRS 102 must provide a statement of cash flows, except where the disclosure exemptions permitted by SORP have been taken.

Section 7 of FRS102 provides an exemption under the small entity provisions within S1A of FRS 102; small entities that are not subsidiaries can claim exemption from preparing a cash flow statement.

The turnover of the Shropshire Community Health NHS Trust General Charitable Fund is such that it meets the definition of a small entity.

### Note 2 : Related Parties

During the year, members of the Charitable Funds Committee, which is empowered by the corporate trustee to act on its behalf in the day-to-day administration of all Funds Held on Trust, were also members of the Shropshire Community Health NHS Trust Board.

The charity has made revenue and capital grant payments to the Trust to the value of £76,000 as detailed in note 4. Other than these payments, there have been no further material transactions between the charity and the listed NHS body.

Board members of Shropshire Community Health NHS Trust, the corporate trustee, and members of the Charitable Funds Committee ensure that the business of the charity is dealt with separately from that associated with exchequer funds for which they are also responsible.

### Note 3 : Income from Grants, Donations & Legacies

| | **Restricted Funds 2024/25 £'000** | **Unrestricted Funds 2024/25 £'000** | **Total Funds 2024/25 £'000** | Total Funds 2023/24 £'000 |
|---|---|---|---|---|
| Grants | 0 | 0 | 0 | 35 |
| Donations | 0 | 83 | 83 | 74 |
| Legacies | 0 | 0 | 0 | 83 |
| **Total** | **0** | **83** | **83** | 192 |

## Note 4 : Analysis of Charitable Expenditure

The charity does not undertake any direct charitable activities on its own. All the charitable expenditure is in the form of grant funding. All grants are made to Shropshire Community Health NHS Trust, to provide for the care of patients in furtherance of the charity's aims. No grants are made to individuals.

Support costs are apportioned across the categories of charitable expenditure.

| | **Grant Funded Activity 2024/25 £'000** | **Support Costs 2024/25 £'000** | **Total 2024/25 £'000** | 2023/24 £'000 |
|---|---|---|---|---|
| Patient welfare & amenities | 62 | 17 | 79 | 110 |
| Staff welfare & amenities | 14 | 2 | 16 | 10 |
| **Total** | **76** | **19** | **95** | 120 |

## Note 5 : Allocation of Support Costs

Support costs are apportioned across the categories of charitable expenditure based on average monthly fund balances.

| | **Patient Welfare 2024/25 £'000** | **Staff Welfare 2024/25 £'000** | **Total 2024/25 £'000** | Total 2023/24 £'000 |
|---|---|---|---|---|
| Governance - internal & external audit fees | 7 | 1 | 8 | 8 |
| Financial, administration & bank charges | 10 | 1 | 11 | 12 |
| **Total** | **17** | **2** | **19** | 20 |

Governance costs of £8k are for External Audit fees and are covered further in Note 7.
The financial administration costs include £8k of staff costs for staff employed by the Trust.

## Note 6 : Trustee Remuneration & Expenses

No trustees were paid any remuneration or expenses from the charity for the work they undertake as trustees.

The Trusts Remuneration Report describing the remuneration of Very Senior Managers (VSM) namely the members of the Board and hence the Trustees of this Charitable Fund can be found on the Trusts website in the Annual Report and Accounts section. See below link:

http://www.shropscommunityhealth.nhs.uk/annual-reports-and-accounts

## Note 7 : Auditor's Remuneration

The external auditor's remuneration of £8,280 (2023/24 : £8,280) related solely to the independent examination of the annual accounts, with no other additional work being undertaken.

## Note 8 : Analysis of Current Debtors

| | **2024/25** | 2023/24 |
|---|---|---|
| | **£'000** | £'000 |
| Accrued income | 0 | 3 |
| **Total** | **0** | 3 |

## Note 9 : Analysis of Creditors Due Within 1 Year

| | **2024/25** | 2023/24 |
|---|---|---|
| | **£'000** | £'000 |
| Trade creditors | 8 | 13 |
| **Total** | **8** | 13 |

## Note 10 : Summary of Fund Movements

| | Balance B/Fwd £'000 | Income £'000 | Expenditure £'000 | Balance C/Fwd £'000 |
|---|---|---|---|---|
| Shropshire Community Health Trust General | 29 | 0 | -4 | 25 |
| Telford and South East Locality Patient Welfare | 85 | 5 | -21 | 69 |
| Whitchurch Hospital Patient Welfare | 14 | 46 | -37 | 23 |
| All other funds | 44 | 42 | -33 | 53 |
| **Net movement in funds** | **172** | **93** | **-95** | **170** |

The above table shows the movements on the significant sub-funds within the group registration, and is based on those funds which have a closing balance at 31 March 2025 in excess of £20,000. Three funds have a balance greater than £20,000 the Trusts General Fund, the Telford and South East Locality Patient Welfare fund and the Whitchurch Hospital Patient Welfare Fund. The decrease in the General Fund mainly relates to expenditure relating to the £35k COVID 19 Grant from NHS Charities Together recieved in 2023/24,the decrease in the Telford and South East Locality Patient Welfare relates to expenditure against an £83k legacy received in 2023/24, £3k relates to Staff Welfare and the increase in the Whitchurch Hospital Fund relates to League of Friends donations.

The £35k COVID 19 Grant from NHS Charities Together is a restrcted fund and is for two projects that relate to Covid Recovery. This Funding relates to 80% of the total Grant with the other 20% expected in 2025/26.

The objects of the listed funds are as follows:

**Shropshire Community Health Trust General** - is an overall fund for both patients who are, or have been treated by Shropshire Community Health NHS Trust and staff who work for the Trust.

**Telford and South East Locality Patient Welfare** - for patients who are or have been treated by Shropshire Community Health NHS Trust in Telford and South East of Shropshire.

**Whitchurch Hospital Patient Welfare** - for patients who are or have been treated by Shropshire Community Health NHS Trust in the Whitchurch Community Hospital.

The 4 community hospitals are each supported by active Hospital League of Friends who donate money to assist in the purchase of medical equipment and other patient amenities.

## Note 11 : Events After the End of the Reporting Period

Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospitals NHS Trust agreed to establish a Group between the organisations when the Trust Boards met in common on 23 September 2025. Work is progressing towards becoming a Group by April 2026, with support from NHS England. This is likely to impact the membership of the Charities trusteeship .

# Independent examiner's report to the corporate trustee of Shropshire Community Health NHS Trust General Charitable Fund

I report to the trustee on my examination of the accounts of Shropshire Community Health NHS Trust General Charitable Fund (the Charity) for the year ended 31 March 2025.

**Responsibilities and basis of report**

As the charity trustee, you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act'). The charity's corporate trustee considers that an audit is not required for this financial year under section 14 of the Charities Act 2011 and elected that an independent examination is conducted under section 149(3) of the Charities Act 2011 .

I report in respect of my examination of the Charity's accounts as carried out under section 149 of the Act. In carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 149(5)(b) of the Act.

**Independent examiner's statement**

Your examiner must be a member of a body listed in section 149(3A) of the 2011 Act. I confirm that I am qualified to undertake the examination because I am a member the Chartered Institute of Public Finance and Accountancy which is one of the listed bodies.

I have completed my examination. I confirm that no matter has come to my attention in connection with the examination which gives me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of the charity as required by section 130 of the Act; or
- the accounts do not accord with these records; or
- the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008, other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Our report is made solely to the Charity's corporate trustee, as a body, in accordance with section 154 of the Charities Act 2011. Our work has been undertaken so that we might state to the Charity's corporate trustee those matters we are required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and the Charity's corporate trustee as a body, for our work or for the independent examiner's report, or for the opinions we have formed.

**[Signature]**

Richard Anderson

CPFA

Grant Thornton UK LLP
Chartered Accountants

Birmingham
[**Date**]

Shropshire Community Health NHS Trust

# 2025/26 Operational Plan Progress Update

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | Jonathan Gould<br>Deputy CFO | **Paper date:** | 4 December 2025 |
| **Executive Sponsor:** | Sarah Lloyd, CFO | **Paper written on:** | 20 November 2025 |
| **Paper Reviewed by:** | | **Paper Category:** | Planning |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

This paper provides an update on progress for the first half of the year (H1) in delivering our 2025/26 Operational Plan and is for review and assurance.

## 2. Executive Summary

### 2.1. Context

At its meeting in April, the Trust Board approved ShropCom's 2025/26 Operational Plan. The plan is summarised within our 'Plan on a Page' and it sets out the 5 priorities upon which we are focusing during this year.

Within the Plan, we set out the improved outcomes we expect to deliver for our citizens and our people by focusing on delivery of these priority areas.

This paper is presented to summarise the good progress being made and provide assurance that delivery of our Operational Plan remains broadly on track at this stage of the year. This provides confidence that our plan will deliver the anticipated benefits by the end of the year.

Where programmes of work were delayed across earlier months of the year, Senior Responsible Officers have confirmed that progress will be recovered prior to year end and there is a high degree of confidence that this will not impact delivery of the agreed annual objectives.

A comprehensive update will be presented to the Trust Board at the end of the year, assessing the impact of the actions taken and the improvements in outcomes.

### 2.3. Conclusion

The Trust Board is asked to:

- **Consider** the progress made to date in delivering our Operational Plan
- **Recognise** that whilst a small number of actions are not currently delivering in line with the agreed timescales, there is a high degree of confidence that the anticipated outcomes will be delivered by the end of the year.

**Appendix 1**

# 2025/26 Operational Plan – Progress Update

**Trust Board**

04 December 2025

Accountable Director: Sarah Lloyd, Chief Finance Officer

# 2025/26 Operational Plan Recap

At its meeting in April, the Trust Board approved ShropCom's 2025/26 Operational Plan. The plan is summarised within our 'Plan on a Page' and it sets out the 5 priorities upon which we are focusing during this year in support of delivery of our 3 longer-term strategic objectives.

In order to deliver our Operational Plan, we set out the interventions (actions) we intend to take during the year to ensure we deliver the expected improved outcomes for our citizens and our people.

Our committees agreed the interventions and the timelines for delivery of the relevant areas of the plan. The committees have reviewed many of the outcome metrics regularly as part of their agendas. A further progress review of all outcomes will be completed by the committees by February.

This paper is presented to summarise progress and provide assurance that delivery of our Operational Plan remains broadly on track at this stage of the year.

# 2025/26 Operational Plan Progress Update (1)

The following slide presents our 'Plan on a Page' for 2025/26, including our 5 Strategic Priorities for the year.

Programme plans are in place to ensure delivery of these priorities. 9 milestones were due for delivery by this point in the year, 6 have been completed with the following 3 areas delayed :

- Plan for implementing collective leadership strategies
- Implementing culture dashboards
- Implementing a centralised bank

The SRO for each of these programme areas has confirmed that whilst delivery has been delayed across the earlier months of the year, this will be recovered prior to year end and there is a high degree of confidence that this will not impact delivery of the agreed objectives.

# Our 2025/26 Operational Plan on a Page

Shropshire Community Health NHS Trust

## Vision

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

| Strategic Objectives | Strategic Priorities 25/26 | Interventions | Progress |
|---|---|---|---|
| Looking After Our People | **CULTURE** - We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership | 1.Culture and Leadership Programme (inc. EDI and People promise int.)<br>2.Health and Wellbeing Programme (new) | 5 milestones are due for H1<br>- 2 complete<br>- 3 on track for H2 |
| | **ATTRACT & RETAIN** - We will continue to establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services | 3.NHS Long Term Workforce Plan Development<br>4.Admin Academy Benefits Realisation | |
| Care For Our Communities | **QUALITY** - We continue to support our staff to embed quality improvement methodology to improve our workforce and patient experiences in bring care closer to home | 5.Continue to deliver on Clinical Quality Strategy Ambitions<br>6.Achieve Annual Quality Performance Targets linked to PSIRF priorities (new) | 2 milestones are due for H1. Both are complete |
| | **PARTNERS** - We will work in partnership to constantly improve, recover, and redesign patient pathways and prevention | 7.Implement Integrated Neighbourhood Schemes – Phase 1 (new)<br>8.Partnership Management, Prioritisation and Approach Implemented (new) | |
| Managing Our Resources | **RESOURCES** - We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services | 9.Delivering in-year CIP and 3 year rolling CIP plan<br>10.Achieve Digital Maturity<br>11.10 Year Sustainability Plan Annual Goals | 2 milestones are due for H1. Both are complete |

## Trust Values

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

# 2025/26 Operational Plan Progress Update (2)

The following slide summarises the improved outcomes our Operational Plan sets out to deliver.

It is evident that progress is being made across many of these areas, which provides confidence that our plan will deliver the anticipated benefits by the end of the year.

The three areas which require continued focus are listed below:

- Reducing staff sickness; reducing reliance on temp staffing; and improving patient risk assessments for pressure damage

A comprehensive update will be presented to the Trust Board at the end of the year, assessing the impact of the actions taken and the improvements in the listed outcomes.

# Our 2025/26 Operational Plan on a Page

Shropshire Community Health NHS Trust

## Vision

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

| Strategic Objectives | Strategic Priorities 25/26 |
|---|---|
| Looking After Our People | **CULTURE** - We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership |
| | **ATTRACT & RETAIN** - We will continue to establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services |
| Caring For Our Communities | **QUALITY** - We continue to support our staff to embed quality improvement methodology to improve our workforce and patient experiences in bring care closer to home |
| | **PARTNERS** - We will work in partnership to constantly improve, recover, and redesign patient pathways and prevention3 |
| Managing Our Resources | **RESOURCES** - We will maximise our productivity and efficiency using digital technology to modernise how and where we deliver services |

| Outcome | FY Target | H1 (mth) |
|---|---|---|
| Reduced sickness | 4.75% | 5.5% (7) |
| Reduced turnover | 9.6% | 9.41% (5) |
| Temporary staffing efficiency | 3.4% | 3.9% (7) |
| Improved staff survey results (results published 2026) | 7.23 | 7.2 (7) |
| Improved National Quarterly Pulse Survey results | >100% | 100.02% |
| Increased apprenticeship *take up* rates | 25 | 16 (7) |
| Approved outline of the steps necessary to achieve the specific Clinical Quality Ambitions | Approved | On Track |
| QI staff survey specific questions improve *[results not due until March 2026]* | Improved | Not due |
| Reduction in falls per 1000 occupied bed days to 4 or below | 4 | 3.72 (7) |
| Reduction in medication incidents resulting in patient harm compared to 24/25 | 0 | 0 |
| Improved patient risk assessments to prevent pressure damage | 95% | 84% (6) |
| Decreased number of admissions to Community Hospitals out of hours [**Apr 2025] | 49 | 28 (7) |
| Evidence of our services "Left Shift" of work and care to community services by having at least one MDT set-up in a neighbourhood | 1 MDT | Not due |
| Strengthened relationships with system partners in by developing the INT model | 1 Model | Not due |
| Identify key partners beyond ICS / LA to support Shropcom delivering its Strategy objectives | 5 | 2 |
| Develop partnership relationship plans for Tier 1 partners with leads identified. | 5 leads | 2 leads |
| CIP Delivery | £5.4m | £0.1m fav (7) |
| Productivity improvements through RPA confirmed by the Productivity Improvement Group | 3 projects | 3 projects |
| Demonstrable improvement in patient access, quality of care and reduced risks - confirmed by user feedback | 3 projects | 1 projects |

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

**Trust Values**

# Recommendations

The Trust Board is asked to:

- **Consider** the progress made to date in delivering our Operational Plan
- **Recognise** that whilst a small number of actions are not currently delivering in line with the agreed timescales, there is a high degree of confidence that the anticipated outcomes will be delivered by the end of the year

Shropshire Community Health
NHS Trust

Board Assurance Framework

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | **Shelley Ramtuhul, Director of Governance** | **Paper date:** | **4 December 2025** |
| **Executive Sponsor:** | Shelley Ramtuhul, Director of Governance | **Paper written on:** | 28 November 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 workforce team capacity has been increased to reflect the increased likelihood whilst the management of change continues and the new workforce team structure is recruited to and embedded
- The risk in relation to the financial plan delivery has been reduced to reflect a reducing likelihood of the Trust not achieving its financial plan.

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 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | May 25 | Jun 25 | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Movement in Month | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Workforce Team Capacity | Sept 23 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 20 | ↑ | 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 | 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 | - | - | - | - | - | CLOSED | 4 |
| 3.2 | Quality Team Capacity | Oct 24 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 4 | - | - | CLOSED | 4 |
| 3.3 | Completion of actions linked to learning response | May 25 | - | - | - | - | - | - | - | 12 | 12 | 12 | 12 | 12 | 12 | ↔ | 4 |
| 3.4 | Demand exceeds capacity | Apr 22 | 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 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | ↔ | 10 |
| 4.2 | Internal governance and operational oversight arrangements for system programmes | Sep 23 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 9 | 9 | 9 | ↔ | 5 |

Board Assurance Framework

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 | Operational capacity to undertake all programmes of work | Sep 23 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | ↔ | 10 |
| 4.2 | Internal governance and operational oversight arrangements for system programmes | Sep 23 | 15 | 15 | 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 | 12 | 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 | 16 | 16 | 16 | 16 | 16 | 12 | 12 | ↓ | 6 |
| 5.4 | Insufficient capital funding | Sep 24 | 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: November 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:

- Action plans for KPIs being reviewed to ensure performance is brought back on track
- Staff survey underway with associated comms campaign
- Culture and leadership programme underway including EDI

### 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 | 5 ↑ | 2 |
| Total | 16 | 20 ↑ | 6 |

**Risk Details:**

| | |
|---|---|
| Opened: | September 2023 |
| Reviewed Date: | November 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~~ Mar 2026 | Working group established and oversight from the Shared Services Programme |
| C1 | Implementation of new workforce structure | Director HR and OD | Mar 2026 | Consultation for phase 1 completed and appointments process underway, phase 2 to commence December |

**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: November 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 developed - Completed |
| A2 | Board interview feedback to be shared with Exec Team before onward submission to the Board | Director of HR | ~~June 2025~~ ~~Sept 2025~~ Feb 2026 | Next steps agreed at Execs and plan for Culture Team to attend Board in February 2026 |

**Principal Objective: We will ensure our workforce feels valued, engaged and healthy by continuing to create a culture of civility and respect, which is supported by compassionate and inclusive leadership** **BAF 1.3**

**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: | November 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~~ March 2026 | Work to be done to management of change policy to reflect the group structure |

## 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: November 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 in place and monitored by People Committee and Board
- Temporary staffing controls remain in place and are effective
- Deep dive being undertaken in relation to staff sickness

**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: November 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 in place
- Work on new Datix system has commenced
- Internal audit of PSIRF completed with no major flags
- Patient Safety Oversight Board report put in place
- 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 3.3 | 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 3.3**

**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: November 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 | No of trained staff to be increased | Director of Governance / Director of Nursing | ~~Jan 2026~~ April 2026 | Dates have been arranged with provider and nominations for the training being sought in the meantime mitigating actions in place to ensure a trained person on the investigation teams |

**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: | November 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 |
|---|---|---|---|---|
| A1/C1/C2 | Director of Governance and Director of Nursing to review reporting and tracking | Director of Governance and Director of Nursing | ~~Sept 2025~~ Dec 25 | Harms Pro Forma added to RIO<br>Monthly reporting from RiO to assess numbers of harm proformas being completed by service area. Update will be provided in next month's quality account update. |

**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: November 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
- ✓ Electronic rostering in place for the teams that utiilse temporary staffing

**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 |
|---|---|---|---|---|
| C3 | Explore options of third party NHS bank staff provider | Director of HR | ~~Sept 2025~~ January 2026 | This is still under exploration |
| 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: November 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:**

- 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
- Extension of UCR service approved and being implemented

**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: November 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
- ✓ Programme Board Meetings in place for oversight

**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: | November 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: November 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. Director of Nursing and Quality leading programme review.
- Established CIP and productivity workstreams, exceeding planned levels at Q2 Won HSJ Digital Award for Unlocking Productivity and Efficiency, supporting delivery of this objective

**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: November 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: November 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 | 3↓ | 2 |
| Total | 20 | 12↓ | 6 |

**Risk Details:**

Opened: April 2022

Reviewed Date: November 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
- ✓ National Oversight rating for Finance and Productivity
- ✓ Integrated Performance Reports updated to reflect national requirements of recently released National Oversight Framework

**Gaps In Controls:**

- C2: Unidentified risk relating to B2/B3 review

**Gaps in Assurance:**

A1: N/A

**Action Plan to Address Gaps:**

| Ref | Action | Lead | Due | Progress |
|---|---|---|---|---|
| C2 | Timeline and scope of review to be outlined to inform risk assessment | Director of People | ~~November 2024~~ ~~June 2025~~ December 2025 | Update has been provided to Execs, offer has been made to the Unions, negotiations underway |

Shropshire Community Health
NHS Trust

# Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2025

## 0. Reference Information

| | | | |
|---|---|---|---|
| **Author:** | David Court Head of Financial Accounting | **Paper date:** | 4 December 2025 |
| **Executive Sponsor:** | Sarah Lloyd, Director of Finance | **Paper written on:** | 26 November 2025 |
| **Paper Reviewed by:** | Audit Committee | **Paper Category:** | Finance/Governance Framework Review 2025 |
| **Forum submitted to:** | Trust Board | **Paper FOIA Status:** | Full |

## 1. Purpose of Paper

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

Following an annual review of the Standing Financial Instructions, Standing Orders, Scheme of Delegation and Scheme of Reservation the Board is asked to ratify Audit Committee's decision to approve these fundamental governance documents.

## 2. Executive Summary

The Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Scheme of Reservation are based on model Department of Health documents, modified as necessary to reflect Trust specific details.

In line with best practice these documents are reviewed annually, and the latest review has resulted in a small number of proposed amendments to these documents.

Once approved the documents will replace the existing documents on the Trust's website and widespread communication will inform staff that the documents have been updated.

This governance framework will be reviewed and updated to ensure appropriate consistency in the preparation for becoming a Group with The Shrewsbury and Telford Hospitals NHS Trust in April 2026.

**The amendments are as follows:**

**Standing Orders**

- Amended Para 6.4 to ensure all relevant legislation is followed, following discussion and recommendation from the Audit Committee.

**Standing Financial Instructions**

- Amended section 10.2.8 to remove Triple Lock approval following cessation of this requirement.

# Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2025

## Scheme of Delegation

- Amended to remove Triple Lock from section 2A, following cessation of this requirement
- 6a reduced Resource Manger approval limit to £100 from £1,000 per the recommendation from Charitable Funds Committee.
- And increased the level at which a competitive procurement process is required to £50,001 from £20,000 (Section 5a), in line with a review by the system-wide Procurement Service.

## Scheme of Reservation

- No amendments required

## 3. Key Recommendations

The Board is asked to ratify the Audit Committee decision taken on the 29 October 2025 and approve the amendments to these governance documents.