Shropshire Community Health NHS Trust

Trust Board - 5 February 2026

MEETING

5 February 2026 10:00 GMT

PUBLISHED

4 February 2026

Agenda

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The Haydn Smith Room, Theatre Severn, Shrewsbury, SY3 8FT	5 Feb 2026	10:00 GMT

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MINUTES OF THE PUBLIC BOARD MEETING

HELD AT SECC, ROYAL SHREWSBURY HOSPITAL, SHREWSBURY AT 10.00 AM ON THURSDAY 3 DECEMBER 2025

PRESENT

Chair and Non-Executive Members (Voting)

Mr. Andrew Morgan	(Group Chair)
Ms. Tina Long	(Non-Executive Director and Vice Chair)
Ms. Jill Barker	(Non-Executive Director)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Cathy Purt	(Non-Executive Director)

Executive Members (Voting)

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)

In attendance

Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)
Mr. Simon Balderstone	Deputy Chief People Officer

Welcome

The Group Chair opened the meeting and welcomed all those present.

Apologies and Quorum

Apologies were received from Ms Jo Williams, Group Chief Executive, and Ms Rhia Boyode, Chief People Officer. The Group Chair declared that the meeting was quorate.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 2 October 2025

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

Action Log

There were no outstanding actions.

Staff Story

The Board heard from Susan Watkins, Chief Pharmacist and Shannon Holmes, Pharmacy Technician, in relation to Pharmacy apprentices within the Trust. Following some NHSE funding, the Trust had been able to secure a number of apprentice pharmacy technicians, who were able to work across multiple sectors during their training. The Trust was now progressing with further cohorts for this training and had received excellent feedback on the quality of the training.

Public Questions

No questions were received in advance, and, in line with the Scheme for Public Questions, the Group Chair asked for questions from the floor.

Mr David Sandbach asked about funding for the closed RRUs, Ms Lloyd confirmed that this funding had reduced following their closure, however, there had been investment into core community services, the ICB would need to confirm the exact destination of any monies.

Chair's Communication

The Group Chair advised that initial feedback had been NHSE on the group assurance process, with nothing unexpected received.

Chris Witty, the Chief Medical Officer for England, had visited the county in the previous week and had expressed his interest in rurality and the way services are run in rural areas.

New Regional Chair roles had been established and were out for recruitment.

Non-Executive Director's Updates

Ms Long advised that she had visited Oswestry dental services and praised the excellent work undertaken there, particularly with phobic patients. She had also visited the new modular wards at the Royal Shrewsbury Hospital and had been very impressed.

Mr Darbhanga and Ms Long had attended the System Finance meeting.

Ms Barker had met with a colleague at Shropshire Council to discuss some of their rural winter outreach programmes. She had also undertaken visits to the Wheelchair service and Shrewsbury Dental services.

Chief Executive's Update

Ms Lloyd summarised the report of the Group Chief Executive.

Mr Darbhanga asked about the Trust's strategy of developing its pipeline of staffing and future planning for critical roles. Mr Balderstone confirmed that a unified workforce planning approach was being developed.

QUALITY AND SAFETY

Quality and Safety Committee Chair's Report

Ms Barker summarised the report. A discussion took place regarding fire safety, noting that all actions requested by the Fire Service had been completed, Ms Ramtuhul confirmed that we were awaiting a meeting with the Fire Service for them to formally review the evidence provided.

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 the Quality and Safety Committee. There had been no new cases in October of C-Difficile. There had been two unexpected, but explainable, deaths, which would be reviewed through the Learning from Deaths process.

The Terms of Reference for the Committee were presented and approved.

The Board accepted the assurance provided by the update and approved the terms of reference (appendix A of the report).

Quarterly Mortality and Learning From Deaths Report

Dr Ganesh noted that there had been 20 deaths in the quarter, noting that the reporting now included deaths of patients on the virtual ward. There were no covid related deaths and no deaths where the patient had a learning disability. There were three unexpected deaths, one of which was related to a delay in transferring the patient to an acute setting; the ambulance service was undertaking its own investigation.

The Board

- ***Accepted the assurance provided by the update***
- ***Agreed that the report provided substantial assurance that the Trust was meeting their requirements under the National Learning From Deaths Framework, including learning from deaths in relation to patients who have died within our direct care, and in addition, taking opportunities to learn from all deaths within our direct care and tin the wider community services.***

Dentist Appraisal Assurance Report

Dr Ganesh confirmed that dentists did not have to complete the same formal revalidation as doctors, however, the Trust had completed the exercise for dentists. All 15 dentists employed by the Trust had their appraisals and personal development plans completed to schedule. The report would be presented to the Board annually.

The Board noted the dentist appraisal process and acknowledged compliance with the contractual requirements for appraisals.

Bi-Annual Safer Staffing Report

The report had received full assurance at the Quality and Safety Committee. The report only considered inpatient areas, as the community tool would be available for use from January. There were no concerns to raise, there were a few recommended changes from the tool, however, Ms

Hobbs advised, using her professional judgment, to not make these changes due to the closure of the RRUs, which would lead to a demographic change in the next cohort of patients.

There were ongoing conversations regarding the removal of HCA agency workers and how this would be managed.

The Board accepted the assurance provided by the update.

Annual Report Emergency Planning and Business Continuity

The Trust had been awarded a rating of 'Substantially Compliant' for the second year running, with no areas of non-compliance. There were minor amendments proposed to both strategies.

Ms Long asked if the strategies were aligned with SaTH, Ms Hobbs confirmed that the needs of the plans were very different across the two Trusts, however, there had been joint exercises, and, although the strategies were different, they were not misaligned.

The Board
- ***Noted the contents of the report***
- ***Noted the core standards compliance award of Substantially compliant***
- ***Approved the report as assurance of the Trust's EPRR capabilities***
- ***Approved the Business Continuity and Emergency Planning Policies.***

PEOPLE

People Committee Chair's Report

Ms Purt advised that there was an action plan in place relating to sickness absences. There had been some initial learning following the staff survey; more paper copies would be available in future years. The Committee had received assurance on the flu programme, although there was still work to do.

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

Integrated People Performance Report

Mr Balderstone advised that the Trust's vacancy position had improved, which had resulted in reduced agency usage. Training compliance had improved and a plan was in place to target areas of non-compliance.

There was some ongoing work around sickness management, both long and short-term sickness.

The Board welcomed the recent audit of the Freedom to Speak Up process, which had received substantial assurance.

Ms Long asked if there had been any progress with a centralised bank, Mr Balderstone advised that this required electronic rostering, which was being rolled out, with 89 teams using the system and a further 21 planned by the end of the financial year.

The Board accepted the assurance provided by the update.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Ms Long noted that there had been partial assurance in relation to estates, primarily related to fire, with a further update planned.

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

Integrated Performance Report

Of the KPIs monitored by the Resource and Performance Committee, 12 required additional attention. 10 of those related to waiting times, one related to data quality and the final was an issue related to the financial plan, however this was a quirk of the System and the Trust was performing better than planned.

There had been consistent improvement in waiting times. The report identified 1 104 week wait, however, this was a data quality issue and the wait had not occurred. There was one 78 week wait within the wheelchair service.

There were two approvals requested within the report related to the KPIs overseen by Committees. The first was related to new home birth visits in Telford and Wrekin, to align with the contract, and the other was related to the planned surplus deficit to align with the newly released oversight framework.

The Trust had been given a rating of 2 from the National Oversight Framework, therefore was defined as an 'high performing' organisation.

The Board

- ***Considered the Trust's performance to date and the actions being taken to minimise risks and improve performance where required***
- ***Approved the changes to the measures referenced within the report***
- ***Noted the information presented in relation to the National Oversight Framework and areas which may require particular focus.***

Finance Report

At the end of month 7, the Trust had delivered a surplus of £1.2m, a favourable variance to plan of £183k. The Trust remained on track to deliver the annual plan at year end, with no new risks to flag.

Pay costs remained within overall pay funding, there had been a higher than expected level of substantive vacancies, which had increased bank costs, the forecast outturn had been updated to reflect this.

CIP was progressing better than planned, with agency usage marginally below plan. Capital spend was behind plan, due to adjustments in the programme and some delays in leases. The Trust was forecasting to fully spend the capital allocation by year end.

The Board

- ***Considered the adjusted financial position at month 7 was a surplus of £1,228k compared to a planned surplus of £1,045k, a favourable variance of £183k***
- ***Considered the underlying / recurrent position year to date was a surplus of £579k, which was a favourable variance to plan of £216k and that the Trust was on course to deliver the plan underlying surplus of £932k.***
- ***Recognised that overall pay cost must remain within planned levels to ensure that we deliver our financial plan, the key to which was containing bank and agency spend within our target plus savings from vacancies for the year***
- ***Acknowledged that schemes were 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***
- ***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.***

Charitable Funds Committee Chair's Report

Ms Purt advised that there was partial assurance in relation to NHS Charities Together. There was some money still remaining and options were being explored for how best to spend this.

The external review of the Charitable Funds had been completed by Grant Thornton, which had not found any issues.

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

2024/25 Charitable Funds Annual Report

Ms Lloyd shared the Trust's thanks to all organisations and individuals how had donated to our funds, and that we would continue to spend every pound wisely and in line with the wishes of the donor.

The Board formally adopted the 2024/25 Charitable Funds Annual Report and Accounts, as approved by the Charitable Funds Committee on 21 November 2025 and in accordance with its delegated authority.

2025/26 Operating Plan Progress Update

Ms Lloyd advised that the information was being as an update following the approval of the plan in April. The Trust was largely on track, with three areas where we were delayed, these were not concerning.

The Board
- ***Considered the progress made to date in delivering our Operational Plan***
- ***Recognised that, whilst a small number of actions were not currently delivering in line with the agreed timescales, there was a high degree of confidence that the anticipated outcomes would be delivered by the end of the year.***

Board Assurance Framework

Ms Ramtuhul advised that each element had been reviewed through the relevant committee and there had been two proposed changes to the risk ratings; the workforce team risk had increased while the management of change was taking place, and the financial plan delivery risk had reduced, as the likelihood of us not delivering our financial plan had reduced.

The Board considered and approved the Board Assurance Framework.

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

This suite of document was presented for annual review, following approval by the Audit Committee. There were minimal changes from previous years. It was acknowledged that there would be some changes that may need to be made as we move towards the Group, although there would be some warranted differences.

The Board ratified the decision of the Audit Committee, held on 29 October 2025, and approved the amendments to the governance documents.

ANY OTHER BUSINESS – with prior agreement of the Chair

Any Other Business

There was none.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 5 February 2026

Shropshire Community Health
NHS Trust

Group Chief Executive Report

Reference Information

Author:	Jo Williams Group CEO	**Paper date:**	
Executive Sponsor:	Jo Williams Group CEO	**Paper written on:**	30 January 2026
Paper Reviewed by:	Jo Williams Group CEO	**Paper Category:**	Strategic
Forum submitted to:	Public Trust Board	**Paper FOIA Status:**	5 February 2026

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 Services, especially those delivering Urgent and Emergency Care, have been facing sustained high demand. Teams continue to collaborate closely with system partners to maximise opportunities for patients to receive care closer to home. I would like to formally acknowledge and thank all teams for their commitment and persistence in meeting the key milestones outlined in the Winter plan. Several initiatives were 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 We are on track with our plans to establish our Group model alongside SaTH by 1 April 2026. Both Trusts believe that closer collaboration will lead to better patient care and an improved experience for staff.

Group Chief Executive Report

We are building on our strong existing foundations to further enhance local services, boost resilience and performance, and provide greater value for taxpayers. I also understand that this transition may feel uncertain for our colleagues, and we remain committed to supporting everyone with empathy and care.

3.3 I want to extend my thanks to the teams involved in shaping our medium-term plans. There has been a huge amount of great work happening behind the scenes as we look ahead to the ten-year plan and ShropCom's leading role in bringing care closer to home - ensuring people get the right care, at the right time and in the right place.

3.4 As we head into Quarter 4, our focus stays firmly on improving RTT and continuing to strengthen our financial position. Our RTT performance has continued to improve since December 2024, keeping us ahead of the national trajectory. Children's Speech and Language Therapy has also hit an important milestone: no child is now waiting over 52 weeks, and long waits continue to fall. We still have work to do, however, our early-intervention work with schools and early years settings is already making a real difference for families, and I'm incredibly proud of the teams involved and the progress they have made.

3.5 Another proud moment came last week, our brilliant Pharmacy Technicians, Jo Norton and Shannon Holmes, were on BBC Radio Shropshire talking about their ShropCom apprenticeship as part of the BBC's NHS Day. They did their profession and ShropCom proud.

3.6 Thursday 5 February 2026, is Time to Talk Day, which focuses on the power of everyday conversations. Working in the NHS isn't easy, especially during times of high demand and change, and it can be hard to maintain a sense of grounding or to find space for ourselves. That's why initiatives like Schwartz Rounds matter: they create safe, human spaces to pause, reflect and share how we're really feeling. This Time to Talk Day, we're encouraging colleagues to take a moment to reach out, connect and let someone in – because none of us should have to carry things alone.

Group Chief Executive Report

3.7 My thoughts are with the family and friends of Rose Roberts, who tragically lost her life in a fire in Shrewsbury Town Centre on Tuesday, 27 January 2025. Rose was well known throughout the Town, and we offer our heartfelt condolences to all affected.

3.8 Jan Stuart, Diabetes Educator at Shropshire Community Health (ShropCom), has been named X PERT Health Educator of the Year 2025. She was selected out of nine nominees, after being nominated by the Community Diabetes Specialist Nursing Service lead for going above and beyond to support those with type 2 diabetes. The national award recognises people who work on the X-PERT training courses which educate and empower people to manage their type 2 diabetes.

The ShropCom X-PERT team has also been recognised with several other awards including Highly Commended for vascular risk reduction at six months, second place nationally for reducing diabetes medication at six months, greatest improvement in body weight management at six and 12 months and second place nationally for reducing medication at 12 months.

3.9 The Trust's Flu Vaccination Programme has a target of 55.3%. As of 30 January 2026, our performance is 51%. This continues to be a real focus for the Trust to ensure that we protect our staff, our patients and citizens.

4.0. Shropshire Telford & Wrekin (STW)/ Staffordshire and Stoke on Trent (SSOT) Integrated Care System updates

4.1 The first joint public board meeting was held on Wednesday 29 January 2026 Board Meetings - NHS Shropshire, Telford and Wrekin.

5.0 RECOMMENDATION(S)

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

5.2 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

30 January 2026

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

0. Reference Information

Author:	**Jessica Donegan, Executive Assistant**	**Paper date:**	**5th February 2026**
Executive Sponsor:	Jill Barker, Non-Executive Director	**Paper written on:**	29th January 2026
Paper Reviewed by:	Jill Barker, Non-Executive Director	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality & Safety Committee meeting held on Thursday 29th January 2026 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- The Committee reviewed significant progress across patient safety, clinical effectiveness, and policy compliance, acknowledging strengthened processes and improved oversight while recognising the need for continued focus on timeliness of investigations and Risk Register consolidation.
- Fire safety and asbestos management received detailed scrutiny, with the Committee noting completion of Fire Service–related actions and commissioning of a consolidated assurance report to bring together all associated risks, mitigations, and training compliance to enable full assurance.
- The Committee endorsed emerging strategic work on health inequalities, agreeing that the forthcoming dashboard data and clarified terminology will support system-wide priorities, and requested that a full discussion of the Trust's health inequalities approach be scheduled at Board level.

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

Quality and Safety Committee Thursday 29th January 2026

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 29th January 2026. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair) Clair Hobbs, Director of Nursing, Clinical Delivery & Quality Claire Horsfield, Director of Operations & Chief AHP Dr Ganesh, Medical Director Tina Long, Non-Executive Director Sara Ellis-Anderson, Deputy Director of Nursing and Quality Shelley Ramtuhul, Director of Governance/Company Secretary Gemma McIver, Deputy Director of Operations Sharon Simkin, Quality Lead, ICB
Apologies:
Cathy Purt, Non-Executive Director Jo Williams, Chief Executive in Common

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Integrated Quality & Safety Performance report		
December activity included one C. Difficile case (total now seven against a threshold of 4), two unexpected deaths under review through Learning from Deaths Group with early learning identified, and one category 4 and three category 3	Full	

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

pressure ulcers. Three moderate-harm medication incidents occurred, and staffing levels remained safe despite reductions linked to RRU closure. Falls increased slightly, with repeated falls the main concern. Community Nursing performance continues to be strong, though pressure ulcers in inpatient areas—particularly Whitchurch—remain a key risk. Committee discussion focused on early learning from unexpected deaths; the static pressure ulcer trend despite increasing patient complexity; and the need for clearer articulation of falls improvement actions. Community Nursing teams were praised for excellent practice, with case studies to be shared. Concerns were raised regarding inpatient-acquired pressure ulcers and repeated falls at Bishop's Castle and Whitchurch. A completed thematic review on falls and ongoing SPC work will support improved oversight.		
PSII		
The report outlines all learning responses initiated in the last month and highlights ongoing PSIIs, including the Whitchurch case. Key areas for improvement include rising overdue actions—linked to service pressures—and delays in completing investigations, which risks missed learning opportunities. The Patient Safety Committee is reviewing ways to strengthen ownership, accountability, and support for investigation leads to improved timeliness. Positive developments include a comprehensive patient safety learning needs analysis that exceeds requirements and exceptionally high training compliance (99.7% for level one and 97.8% for level two), demonstrating strong staff commitment to safety. Committee discussion focused on the need for clearer articulation of learning and actions within reports, especially for the PSII linked to a Whitchurch pressure ulcer, and the importance of ensuring thematic review of actions (e.g., falls) are captured in action logs. Concerns were raised about unrealistic action and investigation deadlines, with agreement	Partial	

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

to set more practical timelines. Members commended improvements in the PSII process but emphasised the need for more timely investigation of management and stronger assurance around closing open actions. Work is underway through divisional oversight to strengthen these areas.		
Policy Tracker		
The policy tracker shows continued improvement, with 11 overdue policies reducing steadily as they progress through committees. By the end of the meeting, only one high-risk policy is expected to remain overdue. A total of 27 policies are due in the next 12 months, and the team has strengthened proactive monitoring to prevent future overdue cases. Work is also underway to track monthly policy approvals to provide clearer oversight, and each overdue policy now includes a detailed explanation and a clear completion timeline. Committee discussion highlighted confidence in the strengthened oversight, with members noting improved visibility of where policies sit within the committee structure. Positive feedback was given on the resolution of the constant observation policy. There was recognition that the organisation is in a comparatively strong position regarding policy management. Assurance was provided about current progress, with emphasis on the next step—ensuring policies are embedded effectively in practice. The committee also discussed staff awareness, with updates shared on how policies are communicated through staff zone postings, staff communications, and targeted circulation where needed.	Full	
Corporate Risk Register		
The Corporate Risk Register remains under development, with ongoing work to support divisions in reviewing and improving their risks. Training and one-to-one support are being provided, as some risks are duplicated or scored higher than appropriate for the organisation's size. Timely monthly review of high-level risks is not yet consistent, but	Partial	

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

actions are underway to streamline and close outdated or duplicate entries. The Deputies group will now provide monthly oversight, and further work is planned to refine risk scoring and remove duplications. Education remains a key focus to ensure risk assessment reflects organisational rather than service-level perspectives. Committee discussion highlighted practical challenges, including how risks are flagged for busy operational staff and the need to avoid the Governance team correcting issues on behalf of services, to support long-term cultural improvement. The importance of the register providing real assurance—rather than a long list—was emphasised. A realistic improvement timeline of around two months was agreed, supported by governance and operational leads.		
QSC BAF Risks		
No changes were made to the corporate risks this cycle. Updated reporting reflects progress against strategic objectives at the end of quarter three, along with actions to address identified control and assurance gaps. The BAF now incorporates direct reference to the Corporate Risk Register, strengthening alignment and ensuring focus on the organisation's highest risks—capacity, staffing, and patient harm associated with waiting times. Committee discussion welcomed the clearer linkage between the BAF and the Corporate Risk Register, recognising the improved visibility of strategic risk management. A further enhancement was agreed, with the addition of a KPI for harm reviews to the action log to provide stronger assurance under risk 3.5.	Full	
Fire Safety Actions Update		

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

The fire safety update confirmed strong progress against actions requested by Shropshire Fire and Rescue Service, with all items either completed or scheduled, and only the authorised engineers report and audits outstanding due to availability. Engagement with the Fire Service continues through planned meetings to formally close remaining actions. Wider fire safety gaps are being addressed. Building Managers have now been appointed for all sites, with work underway to define roles, competencies, and training. Fire door issues at Ludlow have been rectified, with snagging and a programme of work in place. Governance has strengthened through the re-established Fire Safety Group, and an external provider has been secured to act as interim Fire Safety Lead while long-term arrangements are finalised. Training compliance remains high overall at 99.67%, although high-risk fire training compliance sits at 84%, impacted by high DNA rates. This has been escalated to the Executive team and Patient Safety Committee. Work is underway to determine whether DNAs reflect non-attendance or unused capacity and to ensure appropriate release of staff for essential training. Committee discussion sought assurance regarding Ludlow fire doors, confirming they are safe and functional, and requested a composite table in the Board report to summarise actions, risks, and mitigations. Concerns were raised about repeated DNAs for high-risk fire training and the need for clearer site-level assurance. The operational teams will review training provision, attendance patterns, and compliance data over the next month to strengthen oversight and ensure staff receive the necessary training at the right time.	Partial	

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

Asbestos Update A potential asbestos exposure was identified in the Wheelchair Service area before Christmas. An external expert confirmed fiber levels were extremely low and posed no meaningful risk, with immediate cleaning and remedial work completed. The incident has been classed as a near miss, and both the Trust and MPFT are conducting investigations into how the damage occurred and why it was not escalated at the time. The Committee discussed reassurance around sampling, staff communication, and the need for stronger reporting and escalation processes. Staff have been briefed and will receive further updates once the expert report is finalised. The updated asbestos policy and the new Buildings Manager role are expected to strengthen oversight and prevent similar incidents.		
Chairs reports		
Patient Safety Committee The Committee received a substantial agenda focused on new areas of work, including thematic reviews on falls and deteriorating patients. Following a recent unexpected death at Bridgnorth, further scrutiny of deterioration—particularly at Whitchurch, where incidents and admissions back to acute care are highest—has been requested. The ETOC project continues to progress well, and Pharmacy, thanks to the Chief Pharmacist received strong commendation for providing full assurance. Work is underway on bed rails and food safety, supported by a task and finish group and external training input. CQC mock inspections are progressing, and a ward accreditation programme is being developed. Concerns were raised regarding inconsistent GP referrals and prescribing within the Wound Healing service, with the ICB working with teams on a more consistent, single-provider pathway. Risks relating to	Full	

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

radiation protection at Bridgnorth are being monitored, with specialist input expected at the next meeting. The Committee discussed deteriorating patient assurance, concluding that while systems are well designed, implementation gaps remain; the assurance level will therefore be reconsidered. Additional concerns were raised about high DNA rates for ILS training, some of which reflect walk-ins rather than true non-attendance. A separate issue regarding locked doors at Whitchurch was raised, highlighting risks to elderly patients left outside. This will be incorporated into the Whitchurch improvement plan, with monitoring to ensure sustained behavioural change. **Clinical Effectiveness Committee** A positive Clinical Effectiveness meeting took place, with a key focus on NEWS2. Gaps were identified in several audits, including delays in NEWS2 assessments, documentation, and audit completion. Sepsis has been incorporated into the audit programme given its close link with NEWS2. The introduction of the new AMAT audit tool is expected to significantly improve tracking, timeliness, and audit management going forward. The research programme continues to progress well, with a presentation scheduled for next month. **Health Inequalities** A shared terminology framework for Health & Inequalities (H&I) has now been agreed and circulated, resolving previous inconsistencies. Work on the H&I dashboard is progressing well, with the next phase focusing on how data will be used to prioritise support for patients, including those from ethnic minority groups. One emerging priority is the "patient not brought" project, identified as a key area for improvement. Collaborative working with SaTH's H&I lead is	Full Partial	

Chair's Assurance Report

Quality and Safety Committee Thursday 29th January 2026

also being strengthened to ensure a unified approach to supporting shared patient groups. A self-assessment for H&I is due to be rolled out to all Board members shortly, with an action plan to follow. The Committee also noted the value of a future Board discussion to agree clearer health inequalities priorities for the organisation.		
Approvals		
TES (Corridor care) SOP and gap analysis Approved **Asbestos Policy** Approved **Claims Management Policy** Approved **Lone Working Policy** Approved **Constant Watch Policy (for oversight)**		

4. Conclusion

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

0. Quality and Safety Report – January 2026

Author:	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	5th February 2026
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	19th January 2026
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Quality and Safety
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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

7 of the 16 Quality and Safety dashboard KPIs are showing **special cause variation of a concerning nature** in Month 9 (December)

- *Clostridium Difficile* – There has been one case of C-Difficile in Whitchurch in December. The organisation has had 7 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, decontamination of equipment and recruitment to Housekeeper roles.
- E-Coli – No cases in month but remains above trajectory on the 12-month rolling metric due to the case in March 2025.
- There were 2 unexpected deaths in December, one on Bridgnorth ward and one on Virtual Ward. Both cases will be discussed in Learning from Deaths forum.
- There was 1 patient that developed a Category 4 Pressure Ulcer in service. This case was presented to PSIP on 31/12/25 with no further actions, it was identified that the community team had made all the appropriate referrals required for this patient, the patient was high risk of developing pressure damage and had all appropriate equipment in place.

- There were 3 medication incidents resulting in moderate harm (1 physical harm and 2 psychological harm). The psychological harms relate to waits for pain relief due to not receiving the drug chart on transfer from another hospital and distress caused by requiring readmission to hospital.

- All four safer staffing metrics fell below the target of 95% in November 2025. Ward 18 was open with reduced beds meaning staffing templates were adjusted accordingly. All areas were safely staffed with a minimum of 2 RNs on duty at all times.

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

- In December 2025 there were 22 inpatient falls reported within our care. The falls per 1000 occupied bed days has subsequently increased for the second month in a row to 7.69 above the 4.0 target. Three out of the four Community Hospitals saw increases (Ludlow, Bishops Castle and Bridgnorth) and there were several patients that fell more than once. 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 3 Category 3 pressure ulcers reported in-service in December 2025, all which are due to be discussed at PSIP throughout January.
- There were zero PSIIs declared in December

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 **November 2025**
- Average fill rates for RNs were at 88% for day and 80% for night shift, 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.
- Average fill rates for non-registered workers were also below target at 92% for day and 86% for night shift, the aggregated % scores include the RRU where bed numbers were reduced to facilitate closure at the end of November 2025.

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 for 26/27. Moderate harm incidents are reviewed as part of the Trust's weekly Patient Safety Incident Panel. Harms review policy has been updated and due for approval at Patient Safety Committee and harms proforma is now on RiO with mandated fields for all services to use.

It is proposed that a new Deaths in Custody metric is added for 26/27 where number of Deaths in Custody per 1000 is added to enable benchmarking.

2.3. Conclusion

The Board is asked to:

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

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Patient Safety	Category 3 Pressure Ulcers	2025-12-31		3	0	3	3	0	3	
Quality & Safety Committee	Patient Safety	Category 4 Pressure Ulcers	2025-12-31		1	0	1	1	0	1	
Quality & Safety Committee	Effectiveness and experience of care	Complaints - (Open) % within response timescales	2025-12-31		100.00%	95.00%	5.00%	90.76%	95.00%	-4.24%	
Quality & Safety Committee	Effectiveness and experience of care	CQC Conditions or Warning Notices	2025-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Deaths - unexpected	2025-12-31		2	0	2	2	0	2	
Quality & Safety Committee	Patient Safety	Falls per 1000 Occupied Bed Days	2025-12-31		7.69	4.00	3.69	7.69	4.00	3.69	
Quality & Safety Committee	Patient Safety	Medication Incidents with Moderate Harm	2025-12-31		3	0	3	11	0	11	
Quality & Safety Committee	Patient Safety	NHS Staff Survey - raising concerns sub-score	2025-12-31		6.83	7.08	-0.25	6.83	7.08	-0.25	
Quality & Safety Committee	Patient Safety	Patient Safety Incident Investigations	2025-12-31		0	0	0	7	0	7	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2025-12-31		250.00%	100.00%	150.00%	250.00%	100.00%	150.00%	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2025-12-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2025-12-31		0	0	0	0	0	0	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-11-30		92%	95%	-3%	92%	95%	-3%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-11-30		86%	95%	-9%	86%	95%	-9%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-11-30		88%	95%	-7%	88%	95%	-7%	
Quality & Safety Committee	Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-11-30		80%	95%	-15%	80%	95%	-15%	

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Exception Report - Action Plan

Complaints - (Open) % within response timescales

Proportion of open complaints still within timescale. Timescales are 25 working days for single service complaints, 60 working days for complex cases

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Complaints - (Open) % within response timescales	%	100.0%	83.3%	86.4%	72.7%	77.8%	100.0%	90.8%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:	6 complaints were submitted during December relating to the following divisions; Adults & Community - 1 Children, Families & Planned Care -4 Urgent and Emergency – 1 1 of the 6 complaints has been closed within the deadline. The remaining 5 open complaints are on target and are within deadline.					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	Systems and processes are under review. Communications between the govenance team and investigating officers will be strengthenend through improved training and understanding of the process.	Dec-24	Ongoing	Active and ongoing	Ongoing, to be monitored for effectiveness.	
	As part of the Learning Needs Analysis plans are in place to offer an opportunity for staff to complete the PHSO online training and expressions of interest will be invited by the Governance team. Communication plan in place. The training will be rolled out in Q4.	Jan-26	Sep-26	In progress	Improved knowedge, skills and understanding of the PHSO standards.	
	An assessment against the PHSO standards will be conducted during Q4. The Patient Experience Delivery Group will monitor the progress and assurance will be presented to the Patient Experience Committee.	Jan-26	Mar-26	In progress	Improvement in compliance. Risks and Issues to be identified. Progress to be monitored.	
Author	Emma Bayliss - Senior Governance Manager	**Date**	1/8/2025			
Accountable Officer Approval	Shelly Ramtuhul Director of Governance	**Date**				

Exception Report - Action Plan

Clostidium difficile infection rate

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD (Rolling 12 months)
Clostidium difficile infection rate	Number	13	14	13	13	11	10	10
	Target	4	4	4	4	4	4	4

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number	0	0	0	0	0	0	0

Narrative/Description:

There has been one new case of C-Diff reported in December across inpatient wards. This was in Whitchurch and a Post Infection Review has commenced.

The rolling 12 months total now stands at 10 and there have been 7 cases YTD against an annual threshold of 4. A Post Infection Review/After Action Review is completed for each case with many patients having been on multiple courses of anti-biotics for other infections identified as the most probable cause. Quarterly thematic reviews will continue for 25/26 to identify improvements in systems and processes required with actions monitored below and via the IPC Improvement plan. Ribotyping is requested in all cases. A rolling deep clean programme is in place across all Community Hospital sites.

The seven cases YTD for 2025/26 are:
April: Ward 36 x 2 and Ludlow x 1
May: Ludlow x 1
July: Whitchurch x 1
August: Ludlow x 1
December: Whitchurch x 1

Action Plan

	Start Date	End Date	Status	Outcome
Create visual aids (videos or posters) on how to clean key pieces of equipment (i.e. beds)	Jun-25	~~01/08/2025~~ March-26	In progress	On recent audit over 10 types of bed in use across all 4 sites. Locality Clinical Managers working to standardise to one type of bed so video on how to clean can be produced.
Introduce disinfectant decontamination processes following identification of patients with diarrhoea as undiagnosed patients and carriers may excrete the organism into the environment.	Aug-25	Sep-25	Complete	What Cleaning Product' Posters produced
SIGHT or alternative posters capturing need for timely stool sample collection displayed in all inpatient community hospital sluices	Sep-25	~~01/10/2025~~ November 2025	Complete	Poster has been shared across all 4 inpatient Community Hospitals
Use of AAR template/poster to disseminate and embed learning across Community Hospitals	Sep-25	~~01/12/2025~~ February 2026	In progress	Draft on IPCOG January agenda for sign off
Extend HCAI/Outbreak meeting to Medical staff to ensure timely feedback of antibiotic stewardship and to ensure regular clinical reviews/assessments of patients with CDiff carrier status	Sep-25	Oct-25	Complete	
Fidaxomycin for CDI relapse cases to be added to Trust Antibiotic guidelines	Aug-25	Sep-25	Complete	
E-learning module to raise awareness of identification, assessment and treatment of CDI	Sep-25	Mar-26	In progress	E-learning modeule identified by IPEAT. Link circulated to all Ward Managers, Deputy Ward Managers and Medical staff for Community Hospitals by DDIPC
Review implementation of bedspace cleaning checklist	Sep-25	Dec-25	Complete	Via IPC QAA
Ensure Housekeeper roles and responsibilities are mapped to daily/weekly/monthly and are consistent across all sites to support with environmental decontamination	Sep-25	Mar-26	In progress	

Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	19.01.2026
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery and DIPC	**Date**	21.01.2026

Exception Report - Action Plan

Deaths - Unexpected

Deaths - Unexpected

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month
Deaths - unexpected	Number	1	2	2	2	0	2	2
	Target	0	0	0	0	0	0	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number	0	0	0	0	0	0	0

Narrative/Description:	In accordance with the Trust's Learning from Deaths Policy, all deaths that are unexpected are required to be added to the Trust's Incident Reporting System and a Learning from Death Review Completed. There were 2 unexpected deaths recorded in December under the direct care of the Trust. One inpatient at Bridgnorth Hospital who was waiting transfer to the Acute and one patient on Virtual Ward. The Governance Team monitor all deaths recorded at point of triage so that appropriate consideration through PSIP where indicated in accordance with Trust Policy and Procedure.					
		Start Date	**End Date**	**Status**	**Outcome**	
Action Plan	Request Benchmarking data for similar Community Trusts	Oct-25	Feb-26	In Progress	Will be in Q3 Learning from Deaths report	
	Virtual Ward deep dive for QSC to include review of deteriorating patient/escalation and safety netting	Oct-25	Dec-26	In Progress		
Author	Lindsey Regan - Senior Governance Manager - Patient Safety and Risk Management	**Date**	1/7/2026			
Accountable Officer Approval	Dr Mahadeva Ganesh	**Date**				

Exception Report - Action Plan

Category 4 Pressure Ulcers

The number of Category 4 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest month
Category 4 Pressure Ulcers	Number	1	2	1	1	1	1	1
	Target	0	0	0	0	0	0	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number	1	1	1	1	1	1	1

Narrative/Description:	In December 2025, one Category 4 pressure ulcer was reported in-service. This case was presented to PSIP on 31/12/25 with no further actions, it was identified that the community team had made all the appropriate referrals required for this patient, the patient was high risk of developing pressure damage and had all appropriate equipment in place. There were also difficulties with repositioning the patient due to 2 previous hip surgeries so unable to lay side to side which impacted the development of pressure damage further, alternative equipment and repositioning aids were soughy. The Tissue Viability Team continues to support the IDT through monthly caseload review meetings and a consistent presence on community hospital wards to assist staff with classification.					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	Further PURPOSE T sessions planned for 2026 to support clinical teams	Jan-26	Dec-26	In Progress		
	Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	May-25	Dec-25	Complete	This is ongoing throughout the year	
	Documentation update for community nurses re-introducing aSSKINg into notes (this comes as an action from PSII)	Oct-25	Feb-26	In Progress		
	TV sessions added to Core Clinical Skills week throughout 2026 - am - Pressure ulcer prevention and management, PM - Wound assessment/recognising the deteriorating wound	Jan-26	Dec-26	In Progress		
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	1/19/2026			
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026			

Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month
Category 3 Pressure Ulcers	Number	0	0	0	0	3	3	3
	Target	0	0	0	0	0	0	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number	1	1	1	1	1	1	1

Narrative/Description:	There were 3 Category 3 pressure ulcers reported in-service in December 2025, all which are due to be discussed at PSIP throughout January - Incident 1 - Patient was being managed by virtual ward and developed pressure damage to sacrum which deteriorated . Incident 2 - Frail patient that developed pressure damage to the heel which deteriorated due to co-morbidities. Incident 3 - Deterioration of exisiting pressure ulcer to the heel, Podiatry advice was sought and continues to provide advice					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	PURPOSE T sessions for clinical staff to attend in 2026	Jan-26	Dec-26	In Progress		
	Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	May-25	Dec-25	Complete	This is ongoing throughout the year	
	TV sessions added to Core Clinical Skills Week for 2026 - AM - PU classification and PM - wound assessment and recognising the deteriorating wound	Feb-26	Dec-26	In Progress		
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	1/19/2026			
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026			

Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month
Falls per 1000 OBDs	Number	3.95	5.14	4.67	3.60	6.10	7.69	7.69
	Target	4	4	4	4	4	4	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jun-26
Number	4.50	4.50	4.00	4.00	4.00	4.00	4.00

Narrative Description:

In December 2025 there were 22 inpatient falls reported within our Inpatient Community Hospital wards this is a increase of 3 from our last monthly report (November 2025 = 17 reported falls in December monthly report for November data however, please note upon review for the Q3 falls thematic review there were an additional 2 falls in November not recorded at time of monthly report so updated total for November 2025 = 19 falls). This equates to a Trust rate of 7.69 falls per 1000 Occupied Bed Days (OBDs) which, has increased from 6.10 last month and is above our Trust target of 4.0 falls per 1000 OBD's. The range of falls per 1000 OBD's is LCH 11.8 (previous month 0); BCCH 9.6 (previous month 7.4); WCH 7.3 (previous month 9.9); BNCH 6.5 (previous month 5.4). It is is to be noted that 3 sites have increased their falls per 1000 OBD's and only WCH have seen a reduction in their falls per 1000 OBD's for this month.

For the number of falls per 1000 OBD's per individual Community Hospital site for December 2025 it is to be noted that Ludlow have had 7 falls in one month compared with 4 consistent months of 0 falls. Ludlow Dinham Ward Manager highlighted a possible reason for their upward trend of 7 falls in December 2025 was due to the number of Enhanced Therapeutic Observations of Care (ETOC) patients they had on the ward. A deep dive has found that LCH completed 14 ETOC RIO digital assessments in December however, only 1 score classified the patient as a cohort/amber patient and that was completed for 1 of their patient that fell in December 2025 however, not until weeks after they had fallen. We have bi-weekly ETOC meetings and we are supporting Ward Managers at their face-to-face meeting on 14/1/2026 with the full implementation of the new ETOC digital RIO assessment forms that were launched 1/12/2025.
It is to be noted that a theme contributing to the increase in falls per 1000 OBD's are the number of patients that fall multiple times: with BCCH having 1 patient with confusion and hearing issues who fell 3 times in December accounting for 75% of their falls; BNCH having 1 patient who fell once in December 2025 however, had fallen twice in the previous month; LCH had 1 patient who fell twice accounting for 29% of their falls; WCH had 1 patient who fell twice within December and they had 1 patient who fell once in December 2025 however, they had fallen on ward in the previous month.

The majority of falls are classified as Fall from bed / chair / trolley, 45% (10). The majority of falls in December were classified as no or low physical harm, 82% (18) however, 3 were recorded as moderate harm. In November the majority of falls were recorded as no to low psychological harm, 95% (21) and 1 was recorded as moderate psychological harm. This month 68% of falls (15/22) were unwitnessed which as reduced from 88% in November. Of the 22 falls 9 ambulances were called to our inpatient wards, resulting in 2 being sent to an acute hospital, this has increased compared with last month.

Action Plan

	Start Date	End Date	Status	Outcome
Digital falls equipment - ramblegard pilot at Bridgnorth and Whitchurch community hospital	Jan-25	Jan-26	Completed	**January Update**: Ramblegard business case was submitted to Deputy Director of Nursing and Quality and Deputy DIPC and the digital sensors for bed and chair, 16 sets (to be shared per ward) and 3 year service maintenance has been approved for funding as per 01/2026. We await purchase order and delivery within Q4 for roll out across all 4 wards. Measures of the impact of the sensors will be reviewed by the QI team.
Dementia friendly environment standardisation QI project - Phase 1) Ludlow Phase 2) Bishop's Castle Phase 3) Bridgnorth Phase 4) Whitchurch	Jun-25	Phase 1 28/2/2026; Phase 2 Easter 2026	In Progress	**December Update:** We met with South West Locality Service Manager and she is seeking quotes from the company that have already reviewed Ludlow for all 4 sites to see if there is the potential for a discount if bulk ordering and she is also seeking alternative funding to LOF through capital funding. Recommendations for BNCH dementia upgrade have been identified through their PLACE audit.
Moderate falls learning - Improve pro-active learning from moderate falls within inpatient wards Phase 1) Bishop's Castle Ward	Sep-25	Mar-26	In progress	**December Update:** Clinical Quality Lead has established capacity to do a weekly datix review of falls rather than monthly process to support more timely connection with the wards. Governance team to alert Clinical Quality Lead to any falls with moderate harm and are exploring a Quality Dashboard. Clinical Lead for quality attends weekly governance triage of Datix meetings. Clinical Lead for Quality has booked a visit to WCH ward specifically, following the patient case study that will be presented within the quarterly thematic review this month for Q3 that flagged one patient fell 5 times during their in-patient admission to the ward. Clinical Lead for Quality now invited to PSIP for falls and reports are provided in advance of these meetings.
Falls under-reporting audit - as per RCP Guidance within NAIF	Oct-25	Jan-26	Completed	**December Update:** As recommended within PSC we have conducted a falls under-reporting audit for our 4 inpatient wards (excluding RRUs). This was completed by the QI team in October and November 2025 and verbal update to PSC in November, with a full report submitted for the January 2026 PSC meeting and findings shared with Ward Managers at their face to face meeting 14/1/2026.
NICE guidance - SCHT endorse the most recent NICE falls guidance (April 2025) that all inpatients are classed as high risk of falls due to their inpatient needs therefore, there is an expectation to improve implementation of a multifactorial falls assessments for all inpatients which, will require an MDT approach.	Sep-25	Mar-26	In progress	**December Update:** Clinical Lead for Quality has shared the current falls pathway digital process maps for all inpatient wards as part of National Falls Awareness week in September 2025. The falls task and finish group meet monthly to promote nursing and therapy staff engagement with implementing changes to our falls pathway and assessment processes. As part of the group model and Better Together we have now been added to the attendees for SaTH falls prevention steering group meetings and a SaTH representative attends our meeting so we can align approaches across the pathway. On RIO we now have the 4AT acute delirium/confusion outcome measure that falls task and finish group reps will pilot using and feedback impact. The falls task and finish group has a seperate action log to capture improvement initiatives, currently for December 2025 we are scoping clinical staff (Nursing and AHP) confidence and competence with a comprehensive multifactorial falls assessment. We have scoped with SaTH the Bedside Mobility Assesment tool (BMAT) after they attended our falls meeting and we will explore this.
Hydration QI project - Now launched as of 3/11/25 across all wards. First audit due first week of December 2025 with initial results to be presented	Nov-25	Feb-26	Completed	**December Update:** Commenced across all wards, audit of all 4 wards completed in December 2025 and report to be presented to Clinical Effectiveness Group (CEG) in January 2026. Audit results to be shared with Ward Manager meeting face to face in February 2026.
Anti-slip Hospital Socks - There was recent evidence presented at Regional Falls Group that provided research and evidence against anti-slip hospital socks and in the SCHT Q2 July-September 2025 quarterly falls thematic review it was noted that 59% of reported falls for that quarter (29 patients) were wearing socks at time of fall. It was suggested as a topic of discussion for PSC that we update datix to define between "anti-slip hospital" and "patient's own" socks within the categories so we can obtain more specific data to inform any future decision making. Regional peer organisations were scoped in the regional falls group on 13/11/2025 and literature searches will be shared to support SCHT decision making.	Nov-25	Mar-26	In progress	**December Update:** Presented socks category data in PSC Q2 quarterly falls thematic review. Met with Senior Governance Manager 25/11/2025 and datix category changes for Q4 to clearly define patient own socks and hospital non-slip socks. Literature search and briefing paper re: evidence for and against hospital anti-slip socks shared with Head of Nursing, Deputy Director of Nursing and Head of Quality on 10/12/2025 who are supportive of a QI project to cease use of hospital anti-slip socks. We are now seeking a Locality Clinical Manager to Project Lead this and the QI team will facilitate and support this project with a phased approach with an aim of a hard stop from 1.4.25.
New confusion datix category and alignment to NEWS2 scores- Within the Q2 PSC Falls Quarterly thematic review it was highlighted that 41% of falls (21 patients) had new confusion category selected within the datix submission. NEWS2 audit QI work has not identified such high levels of new confusion thus, the QI team are interested to correlate NEWS 2 charts to falls datix for specific patients regarding documentation of new confusion to deep dive this finding and share any learning.	Dec-25	Mar-26	In progress	**December Update:** PSC Q2 quarterly falls thematic review presented in November new confusion category data. Clinical Lead for Quality and QI team are supporting wards currently with their COUN audits inc. NEWS audit so we will seek to align falls datix reports to NEWS2 documentation audits to review if any link between NEWS2 score recording and risk of falls and/or deteriorating patient. Clinical Lead for Quality now attends Governance triage meeting and as capacity allows will review falls weekly and work closely with colleagues to triangulate. For PSC Q3 quarterly falls thematic review 20 falls were recorded as falls associated with patients with new confusion, 40% which is slightly lower than Q2, 43%. Note: Clinical Lead for Quality has deep dived 20 records in Q3 where confusion yes answered and checked NEWS2 score prior to fall and has noticed 3/20 were a low systolic BP was recorded leading to a new NEWS2 score of 1 from a pattern of 0 and then a fall within 24 hours, 15% of records reviewed; 2/20 records where a low SATS of 94% was recorded leading to a NEWS score of 1 and the a subsequent fall and 1/20 where a low temperature resulted in a NEWS2 score of 1 and then subsequent fall in next 24 hours. Promotion of lying, sitting and standing BP assessments and also actions to change in NEWS2 score if a new pattern of a score of 1 to be flagged and acted upon for early warning signs would be encouraged.
Falls Community service(s) and falls assessment scoping - both Clinical Lead for Quality, Hayley Grice and Sarah Venn met 5/12/2025 to process map our current community services offer for falls across multiple services and identified the need for a full service review within SCHT as highlighted by the NICE guidance benchmarking that has flagged gaps in our current offer.	Dec-25	Dec-26	To be launched	**December update:** The community service process map produced on 5/12/2025 has been shared with Head of Quality. We have been scoping data as it appears a large proportion of patients with falls accesa our Urgent Community Response teams- Rapid Response and Virtual Ward. It is clear we do not have internally a clear falls pathway once someone is identified as at risk of falls or post-fall. In alignment set out in the latest NICE guidance for falls it is recommended that we consider a pro-active and prevention approach to falls that encompasses all services and we would recommend it is timely to commence a full service review to internally outline our falls pathway. This will require a Phased QI approach with stakeholder engagement and we have identified UCR as the first services to be reviewed with our support and we have commenced engagement with them and have a follo wup meeting on 26/1/2026. We have a meeting specifically with ICB Strategy Development Manager on 20/1/2026 and continue to engage with the ICB Falls Steering group that will meet monthly.

Author	Hayley Grice - Clinical Lead for Quality	**Date**	1/12/2026
Accountable Officer	Clair Hobbs - Director of Nursing Quality and Clinical Delivery	**Date**	21.01.2026

Exception Report - Action Plan

Medication Incidents with Moderate Harm

Number of internal medication incidents per month resulting in moderate harm

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Medication Incidents with Moderate Harm	Number	0	1	0	0	0	3	11
	Target	0	0	0	0	0	0	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number	2	1	1	1	1	1	1

Narrative/Description:	All of these incidents are included in the Patient Safety Incident Response Framework (PSIRF) 6 monthly thematic review. There was 1 moderate physical harm relating to a reduced dose of Digoxin not initiated on discharge and readmission due to toxicity and 2 moderate psychological harms (low physical harm) reported in December 2025. The psychological harms relate to waits for pain relief due to not receiving the drug chart on transfer from another hospital and distress caused by requiring readmisison to hospital due to insulin not being prescribed and subsequently not given.					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**	
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Jan-26	In Progress	Meeting held with Diabetes Specialist Nursing team on 09/10/25. Agreed that best course of action was to set up a Diabetes intranet page with links to all relevant resources and guidance that would have been in insulin booklet. JMW / SH to contact GP to set this up. Update expected 26.01.26 from JMW	
	Review and update of inpatient medicines administration chart	Apr-25	Jul-26	In Progress	SW leading on review of document, multiple changes being made and different professionals involved in review, therefore, deadline extended to July 2026 for approval at Patient Safety Committee	
Author	Clare Walgrove - Head of Quality	**Date**	15.01.26			
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026			

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	YTD
Safer Staffing	%	100.0%	99.0%	96.0%	94.0%	85.0%	88.0%	88.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:

Bishops Castle - 106% 6% due to new staff on supervisory shifts
Bridgnorth - 99.3%
Ludlow - 103% 3% due to RN shift being used for HCA shift
Whitchurch - 134.5% 34.5% over due to TES beds being opened

Aggregate score < target due to closure of Ward 18 and reduced number of beds

Action Plan

	Start Date	End Date	Status	Outcome
Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submitted to the national team on progress being made
Further education with the ward managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and Challenge monthly meeting continue to ensure complaince is maintain
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
For the 6 shifts at Whitchurch review whether there were any safer staffing red flags and triangulate with patient safety data	Sep-25	Sep-25	Completed	
Review RN to HCSW ratios for 26/27 as cost pressures	Dec-25	Mar-26	In Progress	Paper with Executives for review and discussion

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	1/8/2026
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Safer Staffing	%	108.0%	103.0%	104.0%	99.0%	88.0%	87.5%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95%%

Trajectory	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:	Bishops Castle - 103% 3% due to new staff on supervisory shifts Bridgnorth - 100% Ludlow - 117% 17% due to new staff on supervisory shift Whitchurch - 99% Aggregate score < target due to closure of Ward 18 and reduced number of beds			
Action Plan		**Start Date**	**Status**	**Outcome**
	Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Complete	
	National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Complete	Jan 26 2nd set data sent to the national team on progress made thus far.
	Further education with the Ward Managers around the health roster and adding additional shifts	Feb-25	Completed and ongoing	Check and challenge meeting to address this action. weekly data now being received to monitor additional shift code so any discreptencies can be discussed with relevant teams
	ICB Peer review of staffing fill rates	Apr-25	Complete	
	Review RN to HCSW ratios for 26/27 as cost pressures	Dec-25	In Progress	Paper with exceutives for review and discussion
Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	1/9/2026	
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026	

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	YTD
Safer Staffing	%	123.0%	117.0%	121.0%	110.0%	104.0%	92.0%	92.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	May-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description

Bishops Castle - 97%
Bridgnorth - 103% 3% due to Cohorting/1:1 shifts required
Ludlow - 112% 12% due to Cohorting/1:1 shifts required
Whitchurch - 111% 11% due to cohorting/1:1 shifts required

Aggregate score < target due to closure of Ward 18 and reduced number of beds

Action Plan

	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
Review of Enhanced Supervison policy and behaviour charts to allow for more timely step down	Mar-25	~~01/09/2025~~ 30/11/2025	Complete	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Submitted 2nd set of data to the national team to update on progress
Quality Improvement Project following peer review	Apr-25	Jul-25	Complete and ongoing	Regular meetings held to discuss improvement plans
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
Review of Memory and Health and Wellbeing worker role to be completed	Apr-25	~~01/08/2025~~ ~~30.10.2025~~ 30.12.2025	Complete	
Review of shift patterns for inpatient areas	Apr-25	Jul-25	Complete	
Paper to JNP regarding changing shift patterns from 3 per day to 2 per day	Aug-25	Jan-26	In Progress	Staff now in consulation
Use of NHSP as national bank to increase number of HCSW available to reduce reliance on agency	Jan-26	Mar-26	In Progress	

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	1/9/2026
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026

Exception Report - Action Plan

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

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

KPI Description	Latest 6 months	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	YTD
Safer Staffing	%	138.0%	119.0%	104.0%	109.0%	94.0%	86.0%	86.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Narrative/Description:

Bishops Castle - 106% 6% due to 1:1/cohorting patients
Bridgnorth - 106% 6% due to Cohorting/1:1 shifts required
Ludlow - 93%
Whitchurch - 100%

Aggregate score < target due to closure of Ward 18 and reduced number of beds

Action Plan

	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submission 28th March 2025 (regional request received wc 17/3/25). succesful on cohort 2, national visit to Trust
Review of Enhanced Supervison policy and behaviour charts to allow for more timely step down	Mar-25	~~01/09/2025~~ 30/11/2025	Complete	Policy has been approved by PSC
Quality Improvement Project/ETOC following peer review	Apr-25	Sep-25	Complete	ETOC Improvement plan submitted to NHSE as per deadlines and will be an agenda item at QSC in September 2025 and a paper will go bi-monthly to demonstrate progress
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
Review of Memory and Health and Wellbeing worker role to be completed	Apr-25	~~01/08/2025~~ ~~30.10.2025~~ 30.12.2025	Complete	Meeting with the Memory and Wellbeing worker on the 15/10/25. JD reviewed and updated.
Review of shift patterns for inpatient areas	Apr-25	Jul-25	Complete	Shift patterns reviewed and QEIA completed
Paper to JNP regarding changing shift patterns from 3 per day to 2 per day	Aug-25	Jan-26	In Progress	Staff now in consultation
Use of NHSP as national bank to increase number of HCSW available to reduce reliance on agency	Jan-26	Mar-26	In Progress	

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	1/9/2026
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	21.01.2026

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. 1509 harm proformas have been completed to date; with 86.88% indicating no harm and 11.67% indicating low harm and can be treated and resolved.

There have been 22 cases (1.45%) 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 151.

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	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Harm proformas completed	844	968	1064	1111	1132	1212	1293	1348	1428	1464	1500	1509
Number of low harm	143	151	155	157	162	168	168	169	175	176	176	176
Number of moderate harm	15	15	15	15	19	20	20	21	21	22	22	22
Percentage of no harm	81.27%	82.85%	84.00%	84.52%	84.02%	84.50%	85.46%	85.97%	86.35%	86.48%	86.80%	86.88%
Percentage of low harm	16.94%	15.60%	14.60%	14.13%	14.31%	13.85%	13.00%	12.54%	12.25%	12.02%	11.73%	11.67%

Percentage of moderate harm	1.80%	1.55%	1.40%	1.35%	1.67%	1.65%	1.54%	1.50%	1.40%	1.50%	1.47%	1.45%

The current harms policy has been reviewed and updated, going to Patient Safety Committee in January. 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.

FTSU Report – Quarter 2 25/26

Shropshire Community Health NHS Trust

0. Reference Information

Author:	David Ballard, Freedom to Speak Up Guardian	**Paper date:**	24 Nov 25
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	14 Nov 25
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Governance
Forum submitted to:	People Committee & Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an outline of the ongoing work of the Freedom To Speak Up (FTSU) service and provides a review of the Freedom To Speak Up (FTSU) activity for Quarter 2 of 2025 - 26.

2. Executive Summary

2.1. Context

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

2.2 Summary

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

Reporting Period	Compliant	Partially Compliant	Not Compliant
Q3 23-24	21	16	3
Q4 23-24	28	8	4
Q1 24-25	29	9	2
Q2 24-25	30	8	2
Q3 24 – 25	30	8	2
Q4 24 - 25	29	11	0
Q1 25 – 26	29	11	0
Q2 26 - 26	34	6	0

The paper also presents the quarterly FTSU activity both in terms of updates from previous cases and any new cases reported.

2.3 Conclusion

The People Committee and Trust Board is asked to **note** the updated position and the position regarding the self-assessment. Trust continues to invest in FTSU with further work planned in 2026/27 to raise the profile of the service. Progress continues to be made, however there is still further work to be done.

The assessment remains at partial assurance overall.

3.0 QUARTER 2 25 / 26 FTSU ACTIVITY

FTSU Reports

There were 8 new cases raised during Q2 25 / 26, five of which remains open.

Case #	Staff Type	Issue Raised	Category	Action Taken	Outcome
35	Nursing and Midwifery	**14 Jul 25** Leadership Behaviours	Leadership / Line Manager	Investigation ongoing	Case open
36	Nursing and Midwifery	**24 Jul 25** Innappropriate staff behaviours	Bullying and Harassment	Manager supporting	Case open
37	Nursing and Midwifery	**7 Aug 25** Leadership Behaviours	Bullying and Harassment	Support ongoing	Case open
38	Nursing and Midwifery	**19 Aug 25** Mal practice	Patient Safety	HR Investigating	Case open
39	Nursing and Midwifery	**19 Aug 25** Mal practice	Patient Safety	Support provided by Exec Lead	Case open
40	Admin and Clerical	**3 Sep 25** Cultural Review	Resources to do job	Investigation concluded	Case closed
41	External GP	**19 Sep 25** Doctors not being paid	General	Investigated	Case closed
42	Admin and Clerical	**15 Sep 25** preventing access to resources	Resources to do job	Support provided by Exec Lead	Case closed

FTSU Headlines, Network Meetings, and actions

The network continues to work on the Project Plan and associated actions at Appendix 2.

Annual National Summary from the National Guardians' Office

The National Guardian's Office provide an annual summary of national concerns raised, with key points highlighted below.

Concerns related to worker safety or wellbeing rose by a significant 36 per cent to 14,171 cases, representing 39 per cent of all cases raised.

Inappropriate behaviours and attitudes were the most commonly reported issue for the second consecutive year, featuring in 40 per cent of all cases.

Bullying or harassment was a factor in 18 per cent of cases.

Concerns related to patient safety or quality comprised 18 per cent of cases in 2024/25, a decrease from 19 per cent in 2022/23 and sustaining a downward trajectory.

Only 3 per cent of cases in 2024/25 indicated detriment for speaking up, a 1 per cent decrease from four per cent in 2022/23.

The proportion of cases raised anonymously rose to 12 per cent, a 45 per cent increase in volume from 2023/24, the largest percentage change across all themes.

Of the 9,369 pieces of feedback received in total, 80 per cent of the workers who spoke up would speak up again.

Audit of the FTSU Service

A routine audit of SCHT's FTSU service was undertaken during Q2 by the Mersey Internal Audit Agency (MIAA). Overall, the FTSU service for SCHT was found to have a Substantial level of assurance, with 'a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently' (MIAA).

The Audit will be presented to Audit Committee on 23 February 2026.

FTSU visits

The FTSU Guardian continues to visit services to raise the profile of the service. One of the most recent visits, following a follow-up visit, resulted in 3 concerns being raised. The Exec Lead for FTSU has taken positive action to address and support staff and further visits to the service are planned for Q3.

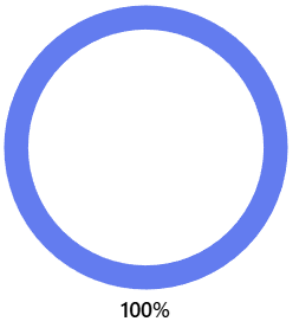
Staff Feedback

In keeping with the Self Reflection actions at Appendix 1, feedback has been sought from those staff who have raised concern through the FTSU service.

Results from the respondents (N=13) revealed the following key points:

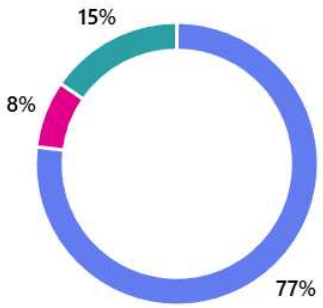
1. Were you thanked for raising your concern?

Yes	13
No	0

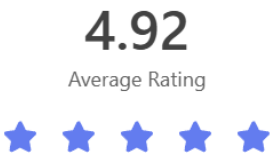


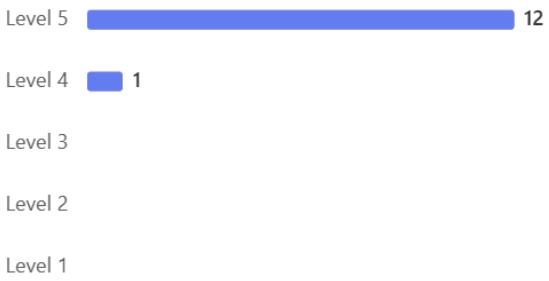
2. Was your concern responded to in a timely manner?

Yes	10
No	1
Partially	2

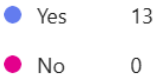


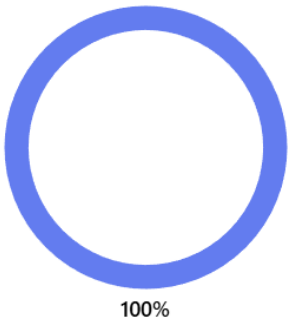
3. How supportive was the FTSU Guardian?



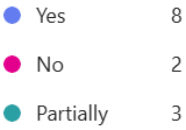


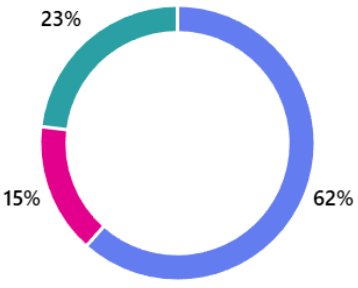
4. Would you recommend the FTSU service to another member of staff?





6. Was your concern resolved in a timely manner?





Sample comments from Qs 5 and 7:

'I found the experience really useful and was so nice to be able to freely speak up and not judged but as well as this it was also really nice to feel supported and agreed that my concern was justified and I really felt listened to'.

'It is a very safe space to share your concerns without fear or prejudice. I felt totally listened to and it is better to speak up about a concern that you have rather than hope it will go away or not get any worse'.

'I felt [FTSUG] listened to me and allowed me to raise my concerns in a safe space. He then provided the appropriate route to try and address them'.

'The FTSU service was easy to access, it was prompt, and I felt fully supported with advice and options given in taking matters forward'.

'I felt heard and that my concerns were taken seriously'.

'I never received any feedback from my concern. I felt listened to and understood, but some more feedback would have been helpful for the team'.

'Whilst I absolutely endorse freedom to speak up, I do believe that when used vexatiously there should be a right to respond if not evidenced otherwise there is potential for it to be misused when trying to manage someone'.

'Although I decided to withdraw from proceeding further, I felt that matters were being taken seriously and that appropriate support was in place should I have chosen to proceed'.

'Very professional support with good listening skills'.

APPENDIX 1: SELF ASSESSMENT JUNE 2025

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

Reflect on the feedback and make changes as necessary	26 Jan 26	"You said we did" bulletins, Board session held on staff survey results and with wider SLT, manager toolkit issued and staff survey conversations commenced	2025 staff survey results will inform future actions and a discussion to take place between OD BP & Head of HR Services to implement actions.
Constructively and compassionately challenge each other when appropriate behaviour is not displayed	26 Jan 26		This is being explored through the work of the Culture and Leadership Programme. June 25 – The Board has indicated that it wishes to do this jointly with SaTH, an indicative quote is being taken to SaTH Board. Nov 25- Board conversations are now completed with a flash report due to be presented Q4 2025
Demonstrate commitment to FTSU			
The board can evidence their commitment to creating an open and honest culture by demonstrating:			
There are a named Executive and non-executive leads responsible for speaking up	15 Oct 24	Director of Nursing, Quality & Clinical Delivery is Executive Lead for FTSU, Harmesh Darbhanga is the Non-	
Speaking up and other cultural issues are included in the Board Development Programme	15 Oct 24	Culture session held in March 24 with a further session planned for July 24	Three levels of National Guardian training (dependant on role) has been recommended for inclusion in mandatory training programme for the Trust. Board have been invited to undertake their level of training.
They welcome workers to speak about their experiences in person at Board meetings	15 Oct 24	Staff stories are shared at Board on a regular basis.	

		With the new Guardian in post, they report to the People Committee on a quarterly basis.	
The Trust has a sustained an ongoing focus on the reduction of bullying, harassment, and incivility	15 Oct 24	The introduction of the FTSU online platform will provide data collection and analysis. The Trust launched its Civility and Respect Programme delivered by OD in Q1 of 24/25 which is available to all staff. The output of this training gets reported to JNP and the assurance report of People Committee.	.
There is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made	30 Sep 25		The FTSU Guardian as part of the feedback loop to individuals who use the service, will determine whether detriment has been suffered. The data for this is also captured as part of the data submitted to the NGO on a quarterly basis. The evidence of this has not been captured previously. A feedback form has been created in Q1 25/26 which will be used to assess detriment. This will continue to be monitored.

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

The strategy is linked to or embedded within other relevant strategies	15 Oct 24	New strategy links with the Culture and Engagement Strategy	
The Board is regularly updated by the Executive Lead on the progress against the strategy as a whole	30 Sep 25		Board are regularly updated on the strategy by the Exec Lead.
The Executive Lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	30 Sep 25	FTSU Group is in place and meets monthly.	Quantitative measures now included at Appendix 3 of FTSU reports.
Support your FTSU Guardian			
The Executive Team can evidence they actively support their FTSU Guardian. Evidence should demonstrate:			
They have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively	15 Oct 24	The FTSUG is the OD BP and has 0.2 of his WTE allocated to FTSU work. This time allocation will continue to be monitored.	
The Guardian has been given time and resource to complete training and development	15 Oct 24	FTSUG has completed the NGO Training and attends regional and national guardianship meetings and is part of the FTSU network	
There is support available to enable the Guardian to reflect on the emotional aspects of their role	15 Oct 24	The FTSU Guardian seeks supervision from the NGO and of FTSU colleagues, most notable his counterpart at SaTH.	
There are regular meetings between the Guardian and key executives as well as the non-Executive lead.	15 Oct 24	Attendance at the monthly FTSU Network meetings includes the Exec Lead and NED sponsor.	

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

Be assured your FTSU culture is healthy and effective

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

Assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience.	15 Oct 24	Data is available to FTSU Guardian as required.	
You map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
You have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection	15 Oct 24	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
You evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	30 Sep 25	Former FTSU Guardian is the Trust's lead on Board Assurance and regular reporting has been established to Board and People Committee and will remain a champion	
The Board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	15 Oct 24	Going forward the new Guardian will attend Board to present each quarterly report.	
The Board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	31 Dec 25		The Trust will need to review the JD of the new FTSU Guardian and due to the size of the organisation this has been added to an existing role.

The Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	15 Oct 24	Gap analysis has been completed and presented to both Audit Committee and People Committee which are attended by members of the Board	
Be open and transparent			
The Trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:			
Discussion with relevant oversight organisation	31 Dec 25	The Board is briefed on issues reported, none have yet required discussion with oversight organisation	A healthy speaking up culture is created by Boards that are open and transparent and see speaking up as an opportunity to learn. The Board should routinely discuss challenges and opportunities presented by matters raised through speaking up.
Discussion within relevant peer networks	15 Oct 24	Access to the national FTSU network which has email forums for problem solving. FTSU System meeting attended	
Content in the trust's annual report	15 Oct 24		Overview of the Trust's FTSU has been included in 24/25's QA report that was approved at Board in June 25.
Content on the trust's website	15 Oct 24	Content on Trust's website has been refreshed and provides in-depth detail of the Trust's FTSU provision	
Discussion at the public Board	15 Oct 24	Quarterly reports to the Board	
Welcoming engagement with the National Guardian and her staff	15 Oct 24	FTSU is in communication with the NG and receives all the network	

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

APPENDIX 2: FTSU PROJECT PLAN

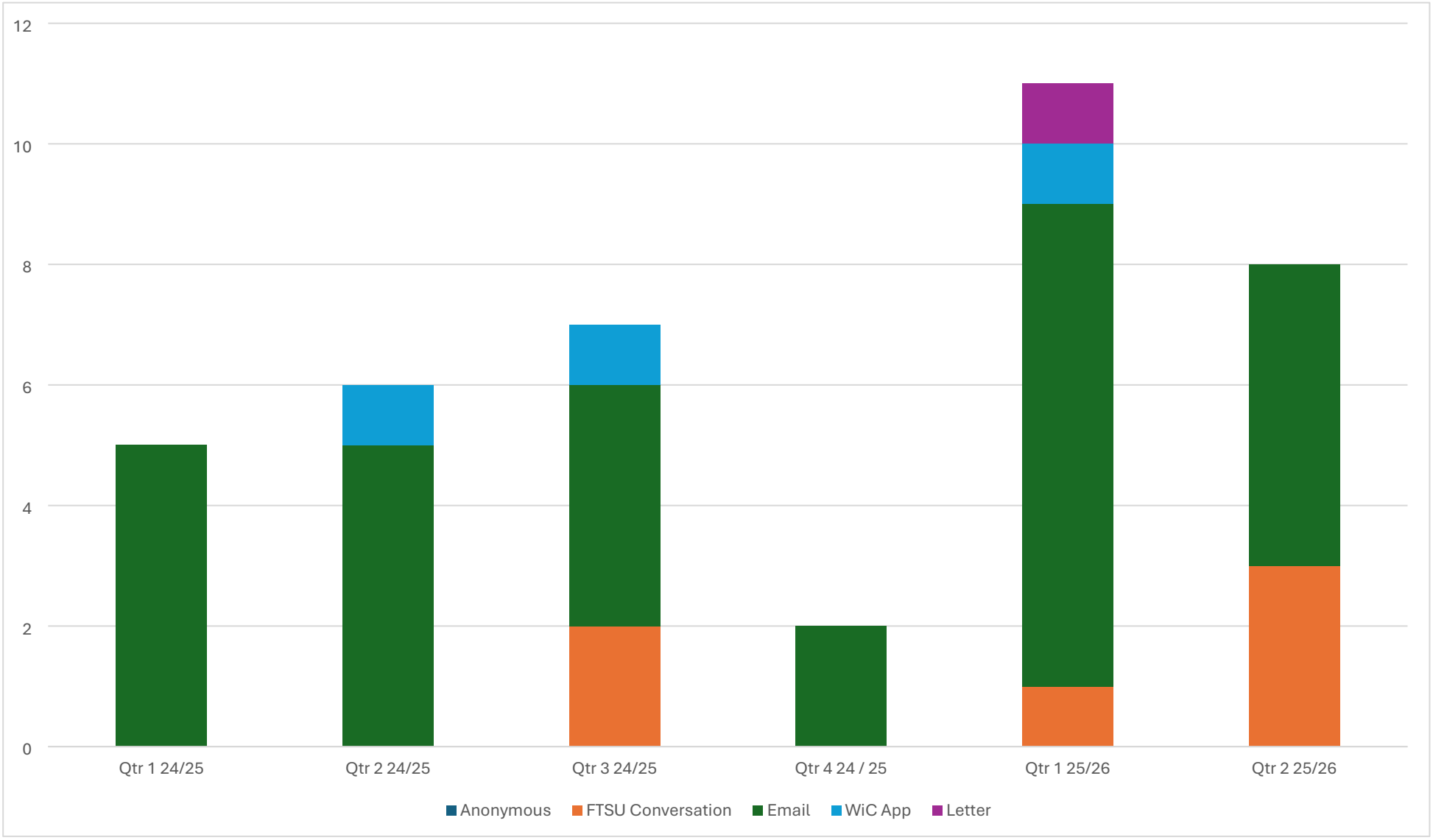
	Project Plan Deliverables	Project Lead	Start Date	Deadline	Status	Notes
1	**Set Up**					
1.1	Project plan to be drafted and approved	Project Officer	15/04/2024	25/04/2024	Completed	
1.2	FTSU Guardian to complete training & be onboarded	FTSU Guardian	15/04/2024	31/05/2024	Completed	
1.3	Comms & engagement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

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

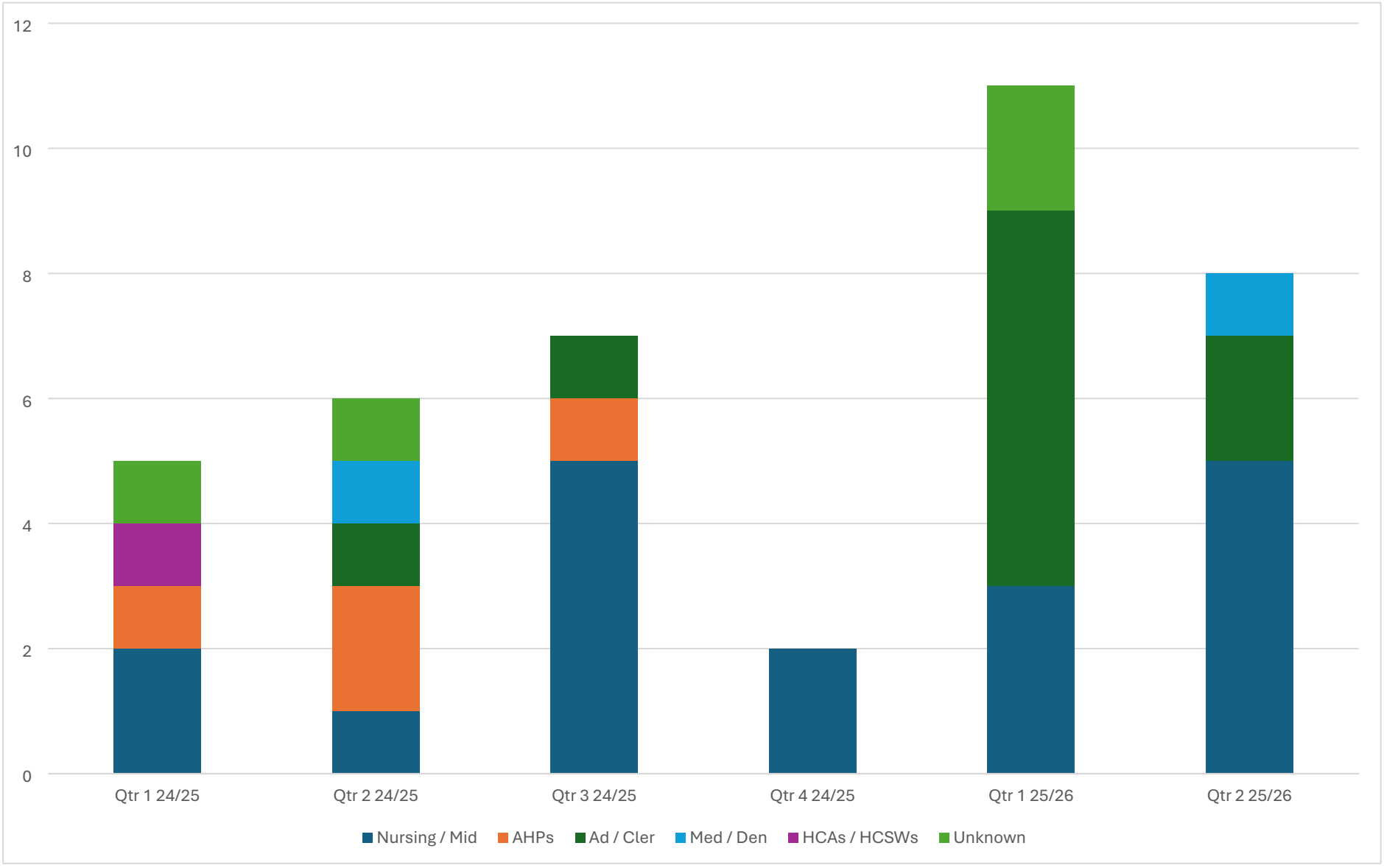
3.2	Complete admin training	Project Officer	15/04/2024	22/04/2024	Completed	
3.3	Confirm who will respond to messages (master admins)	FTSU Guardian	15/04/2024	29/04/2024	Completed	
3.4	Link with IG for considerations to be made; GDPR & Data Protection	Project Officer	01/06/2024	08/06/2024	Completed	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

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

APPENDIX 3: CONCERNS RAISED BY CHANNEL



APPENDIX 4: CONCERNS RAISED BY STAFF GROUP



APPENDIX 5: FTSU CHAMPIONS

NHS
Shropshire Community Health
NHS Trust

Your Freedom to Speak Up Champions

Clair Hobbs

Shropshire Community Health NHS Trust

Chair's Assurance Report

Health Inequalities Steering Group

0. Reference Information

Author:	**Diane Davenport**	**Paper date:**	**29th January 2026**
Executive Sponsor:	Dr Ganesh, Medical Director	**Paper written on:**	26th January 2026
Paper Reviewed by:		**Paper Category:**	Quality
Forum submitted to:	Quality & Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Health Inequalities Steering Group meeting held on 22nd January 2026 for assurance purposes. The Committee is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Steering Group is an Executive led Group established as a sub-group of the Quality & Safety Committee. The purpose of the Steering Group is to support the Quality & Safety Committee to review data and intelligence to support continuous services improvement and the delivery of high-quality care.

- Oversee and monitor delivery of key statutory requirements in relation to Health Inequalities.
- Review data and intelligence relating to the health inequalities of services provided and to initiate service improvements where required.
- Develop and govern a responsive health inequalities audit plan, that links to the Trust priorities and key risks.
- Review adherence to best practice in the delivery of the Trust's Health Inequalities strategy.
- Develop and implement a process of local guideline sign off and assurance.
- To develop a suite of performance indicators which promote and strengthen health inequalities such as ethnicity coding and others agreed by the group.
- Ensure continuous improvement and learning culture environment.
- Oversee new health inequalities pathways and models of care to ensure an evidence-based approach; and to measure the outcomes.
- To assess the health inequalities impact of any significant service change decisions, through feedback from the Internal Planning Group.
- Receive reports on new policies and procedural documents, highlighting any impact on Health Inequalities, both for staff and service users.

Chair's Assurance Report

Health Inequalities Steering Group

- Provide reports, with a focus on improvement, a culture of continuous learning and health inequalities effectiveness, to the Quality & Safety Committee as required.
- Review and monitor those risks on the board assurance framework and corporate risk register which relate to health inequalities and high-risk operational risks which could impact on care.
- Provide a regular Health Inequalities report to the bi-monthly ICS Health Inequalities and Prevention Group.
- Provide support and oversight to the projects undertaken by the CORE20PLUS Ambassadors

2.2 Summary

The Steering Group met on 22nd January 2026 and was quorate with 2 Executive members attending, along with other attendees. The Steering Group 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 Quality & Safety Committee is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report

Health Inequalities Steering Group

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Quality & Safety Committee from the Health Inequalities Steering Group which met on 22nd January 2025. The meeting was quorate with 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:

Members:		
Dr Ganesh	Medical Director (Chair)	MG
Steve Ellis	Deputy Director of Operational Service Development	SE
Lisa Gibbons		LG
Olivia Siegal	Head of Communications	OS
Clair Hobbs	Director of Nursing & Clinical Delivery	CH
Claire Horsfield	Director of Operations & Chief AHP	
Steve Price	Head of Information and Performance Assurance	SP
Diane Davenport	Note taker	DD

Apologies:

Helen Jones Business Intelligence Lead CORE20PLUS5 Champion, Mark Mawdsley Head of Costing and Contracting, Jon Davis Associate Director of Digital Services, Tom Seager Clinical Director, Jennie Fullard Chief Communications Officer, Sara Ellis Anderson Deputy Director of Nursing and Deputy IPC

Shropshire Community Health NHS Trust

Chair's Assurance Report

Health Inequalities Steering Group

3.2 Key Agenda

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
1.	**Review of minutes and actions from last meeting**		
	The minutes from the meeting held on 20th November 2025 were approved as a true and accurate record of the meeting. The Action log was discussed and updated.	Y	
2.	**Health Inequalities Terminology update**		
	The Group discussed the proposed health inequalities terminology guidance provided by the Chief Communications Officer. The Group will review the document and discuss at the next meeting on 18th February 2026.	Partial	Proposed terminology to be reviewed to ensure a consistent use of HI terminology.
3.	**Self-Assessment update**		
	The Self-Assessment tool to be shared with the Board for their view. This will then help to provide a gap analysis between the Organisation's and Board to identify areas for improvement. The results from the self-assessment could help with the Strategy and a 'Plan on a page'. The Health Inequalities dashboard is in development.	Partial	The Self-assessment tool to be shared with the Board to obtain their view of Health Inequalities.
4.	**Any Other Business**		
	The Group discussed attendance at the ICB Health Inequalities meetings, and the Chair will pick up with the Deputy Chair.		

3.4 Approvals

Approval Sought	Outcome

4. Conclusion

The Quality & Safety Committee 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, Head of Resourcing, Fiona MacPherson, Head of People Services Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper date:**	5th February 2026
Executive Sponsor:	Rhia Boyode, Chief People Officer SCHT & SaTH	**Paper written on:**	15th January 2026
Paper Reviewed by:	Simon Balderstone, Director of Workforce and People Services Sarah Allan, Deputy Workforce Operations Director (Interim)	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

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

2. Executive Summary

2.1 Context

This report focuses on the key areas of performance relevant to People Committee, including a review of performance against the month 9 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	7	0	1	**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 9 the total workforce is under plan by 18.5 WTE and we are expecting to deliver against our planned levels for total workforce.

Temporary staffing usage has increased slightly in Month 9 with both Agency and Bank usage increasing. Our agency usage is 0.8 WTE over plan in month 9. Vacancy levels have decreased, and we are now under target (7.12% vs 8.0%). This is a continuing trend since April 25 and is the lowest it has been in this financial year to date.

Admissions avoidance are the highest users of agency in Month 9: 9.22 WTE which is above plan (5.60 WTE) a variance of 3.62 WTE. This is an increase in the position from month 1 when the variance was 0.62 WTE under plan. This is due to the new UEC services opening.

Following the cessation of B2 and B3 agency workers following the NHSE directive, agency bookings made before 1st November can continue up until 31 January 26. We have a breakglass process in place to ensure patient safety and the UEC service has used this process whilst substantive recruitment progresses.

December roster period workforce unavailability (33.2%) increased compared to November's at 23.1%, with the highest reason being annual leave (including bank holidays), followed by sickness absence.

Integrated Performance Report
Month 9 Position

Plan (WTE)	June-25	July-25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Substantive	1689.80	1694.7	1702.2	1700.73	1671.14	1670.8	1634.4
Bank	62.9	61.4	59.6	57.8	55.70	55.7	62.4
Agency	36.2	31.7	28.7	28.7	27.28	27.3	27.3
Total	1788.90	1787.7	1790.5	1787.2	1754.12	1753.8	1724.10
Actual (WTE)	**June-25**	**July-25**	**Aug 25**	**Sep 25**	**Oct 25**	**Nov 25**	**Dec 25**
Substantive	1626.70	1631.4	1,31.6	1635.14	1,624.84	1621.8	1599.72
Bank	81.6	73.4	78.6	76.8	81.54	86.4	77.8
Agency	33.7	30.2	37.4	37.8	34.28	30.3	28.10
Total	1742.10	1735.0	1747.6	1749.7	1,740.66	1729.4	1705.62
Variance (WTE)	**June-25**	**July-25**	**Aug 25**	**Sep 25**	**Oct 25**	**Nov 25**	**Dec 25**
Substantive	(63.1)	(63.3)	(70.6)	(65.6)	(46.30)	(58.1)	(34.70)
Bank	18.8	12.0	19.0	19.0	25.84	30.7	15.40
Agency	(2.5)	(1.4)	8.7	9.1	7.00	3.0	0.82
Total	(46.8)	(52.7)	(42.9)	(37.5)	(13.46)	(24.4)	(18.48)

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

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

Metric	Target	June-25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Appraisal	90%	88.89%	91.32%	91.05%	87.81%	87.28%	86.61%	88.56%

Integrated Performance Report

Temporary Staff	3.4%	2.7%	2.4%	3%	3.9%	3.9%	3.5%	3.7%
Sickness	4.75%	5.32%	5.35%	5.41%	5.48%	5.52%	5.60%	5.68%
Total Shifts exceeding NHSI capped rate	No Target	56	47	64	64	108	279	303

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, seven 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 1 is a common cause variation with no significant change.

1. Appraisal Rates - improving
2. Mandatory Training Compliance – improving, now above 97%, the highest level of compliance recorded to date
3. National Education and Training Survey overall satisfaction score - below target, concerning
4. Net Staff in Post Change – no significant change
5. Proportion of temporary staff – above target
6. Sickness Rate - concerning
7. Staff survey engagement theme score - improving
8. Total shifts exceeding NHSI capped rate – above target due to medical staffing requirements
9. Total shifts on a non-framework agreement – no significant concern
10. Vacancy rate - improving, below target

Appraisal Rates

The December compliance rate has decreased from 86.61% in November to 88.55% in December. Due to the reporting parameters changing in 2025 work continues to ensure that all appraisals are recorded correctly. 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.
- Associate Director of Professional Standards and Clinical Education to review those appraisals that have been recorded incorrectly on ESR to ensure that they are recorded as performance appraisals

Mandatory Training

The compliance rate for December increased by 0.73% to reach 97.01%, marking the highest level of compliance recorded for Mandatory Training to date. Recognition is due to operational staff, who constitute the majority of our workforce, for completing their training requirements amidst significant demands. In December, all topics except four demonstrated improved compliance rates, with increases ranging from 0.01% (Patient Safety Level 1) to 5.11% (High Risk Fire). However, Resus Level 3 experienced a further decrease, resulting in performance falling below the targeted benchmark.

DNA – High Risk Fire – 56. Spaces not used 69 (11 in Oswestry, 34 in Ludlow and 24 in Whitchurch)
DNA – Resus Level 2 – 29
DNA – Resus Level 3 – 5
DNA – Moving and Handling Level 2 – 29. Spaces not used 56. There was 1 session cancelled due to lack of bookings
DNA - Corporate Induction – 3. Spaces not used 29

High Risk Fire has been set to reach 95% compliance by April 2026. High Risk Fire Trajectory - Oct 2025 - Target 75%. Actual 77%. (+2%). Nov 2025 Target 77%. Actual 78% (+1%), Dec 2025 - Target 82%. Actual 84% (+2%).
Jan 2026 - 89%, Feb 2026 - 91% and Mar 2026 - 95%.

We had a total of 8 sessions running on December 3 in Whitchurch, 3 in Ludlow and 2 in Oswestry. We had a very high number of DNA and spaces not used. A total of 56 people Did Not Attend their booking. We had 11 spaces not used in Oswestry, 34 spaces not used in Ludlow and 24 not used in Whitchurch.

We are still above target, so are on track to reach 95% by April 2026.

Integrated Performance Report
Resus Level 2 Adult - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%)
Trajectory - Jan 2026 90%. Feb 2026 92%. Mar 2026 95%
Resus Level 2 Paediatric - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%)
Trajectory - Jan 2026 90%. Feb 2026 92%. Mar 2026 95%
Resus Level 3 Adult - Nov 2025 - Target 73%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%)
Trajectory - Jan 2026 80%. Feb 2026 90%. Mar 2026 95%
Resus Level 3 Paediatric - Nov 2025 - Target 84%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%)
Trajectory - Jan 2026 80%. Feb 2026 90%. Mar 2026 95%
During December there was 29 DNAs for Resus Level 2 and 5 DNAs for Resus Level 3. We cannot monitor the attendance for the Resus Level 2 and Level 3 training, as there is not the need to book their place through ESR and can turn up to the training.

It should be noted that it is anticipated the deadline for achieving 95% compliance with Resus Level 3 training will need to be extended, from April 2026 to June 2026. The Resus Level 3 training requires four hours, and current operational pressures make it challenging to release staff for training sessions. Operational leads have been instructed to prioritise Resus Level 3, and, if necessary, utilise bank staff to ensure adequate area coverage.

Absence

Since March 2025 the rate continues to remain above target with marginal increases each month. The rolling absence for month 9 is 5.68%. 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 9 and an increase in short Term, with overall levels consistent with previous months.

Review of Short-Term absence

It is recognised that short term absence is seeing an increasing trend, on this basis, a process has been implemented for short term absence reports to be sent to Line Managers to flag individuals who have reached the short-term absences triggers.
This will be overseen by the People Team.

Opportunities for Improvement in terms of long-term absence management

Work is continuing on the following to improve management of long-term absence:

- 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.

Integrated Performance Report
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
- Sending short term absence trigger reports to Line Managers with People Team oversight
- Continue to deliver our Winter ready campaign which includes flu action plan for our flu campaign (at week 7 current flu vaccination uptake is 40%)
- Continue to implement the opportunities for improvement identified above

Vacancies

Month 9 vacancy position is 7.12% (122.9 WTE) a reduction on month 8 position (8.13%, 143 WTE). Month 9 top hotspots are: UEC, Community Hospitals: (Bishops Castle, Ludlow), Community Nursing and Stoke Heath Prison. The Prison vacancy rate remains high at 17.0% (4.55 WTE). They currently have 2.6 WTE in the recruitment process, some of which are from the previous month due to the time taken to complete the recruitment process.

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 which is awaiting approval to use
- The recruitment team have held 5 targeted recruitment events, 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 64 progressing through to appointment. A further recruitment event will take place at the end of January.
- Rolling bank recruitment events are being scoped with ops and the recruitment team.

Agency Spend

Month 9 agency use is 28.1 WTE with an expenditure of £118K against a plan of 27.3 WTE and £100k, a variance of (0.8) WTE and (£17k) respectively.

A number of medical agency/locums are in place – these are on the West Midlands agency rate as NHSE have not yet advised of a new price cap for this staff group - any use will continue to be recorded as above price cap. Currently there are medical agency in:

- Long Covid (service dependent on funding),
- UEC (Virtual Ward and Integrated Frontdoor, expansion of services so new medical posts),
- Paediatrics (LTS and wait list)
- Stoke Heath. Stoke Heath have recruited so it is expected this will cease by March 26.

Integrated Performance Report

Admissions Avoidance are the highest users of agency in Month 9: 9.22 WTE which is above plan (5.60 WTE) a variance of 3.62 WTE. Integrated Discharge team is the second highest usage with 5.46 WTE followed by Hospital Inpatient Wards at 5.11 WTE. Compared to month 8 Hospital Inpatient Wards were using 11.07 WTE agency workers, this 50% reduction is in part due to the NHSE directive on the cessation of B2 and B3 workers (HCAs)

Our work towards mitigation of this change of agency rules has been in previous months with 5 targeted recruitment events resulting in 64 new Band 2 HCAs joining the bank.

The temporary staffing team booked a total of 85 agency shifts in month 9 a decrease on month 8 figures (145 shifts)

In Month 9 the Temporary staffing team booked 356 bank shifts of which 110 Bank HCA were for both B2 and B3 for all teams on the e-roster system:

- The highest reason for booking was vacancies followed by High Demand
- The third highest reason for bookings was sickness absence

Actions to Deliver Improvements - Current Focus:

- New medical posts in UEC – working with Ops managers on jds and Royal College approval.
- 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.
- Fast tracking any HCA's going through recruitment for bank and permanent roles
- Review fill rates and any mitigations to move HCAs to fill gaps where we are using agency at moment
- Communication with agency workers to transition to SCHT bank and/or NHSP National Bank
- 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 are following the West Midlands Regional Rate card until NHSE advise of the new Price Cap. Further action to monitor compliance of 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.

3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

Integrated Performance Report

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.

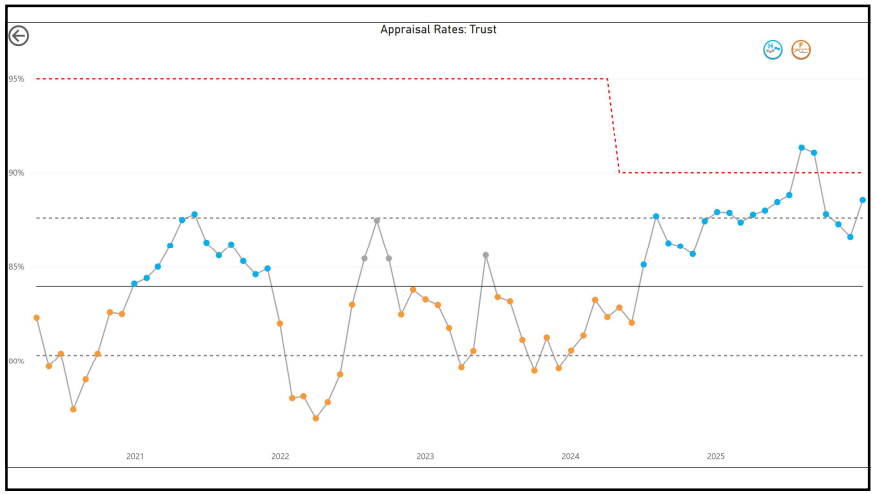
Appendix 1
People Committee – SPC Summary
Month 9 (December) 2025/2026 Performance

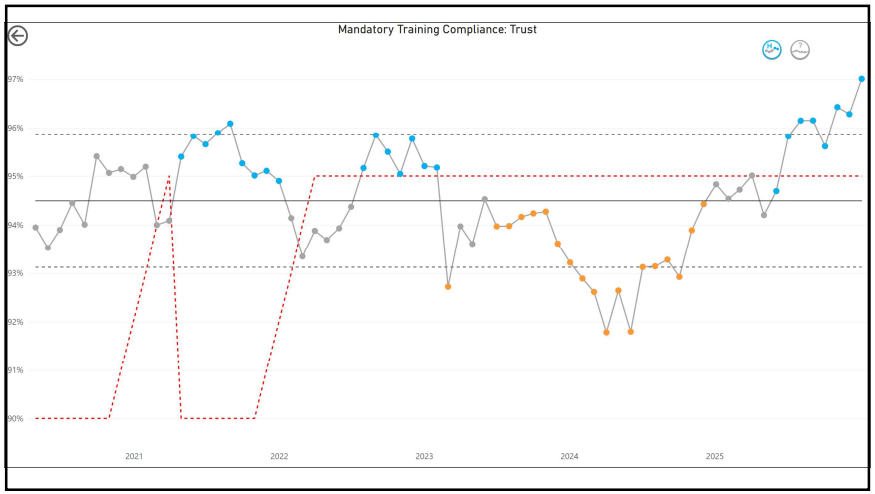
Shropshire Community Health NHS
NHS Trust

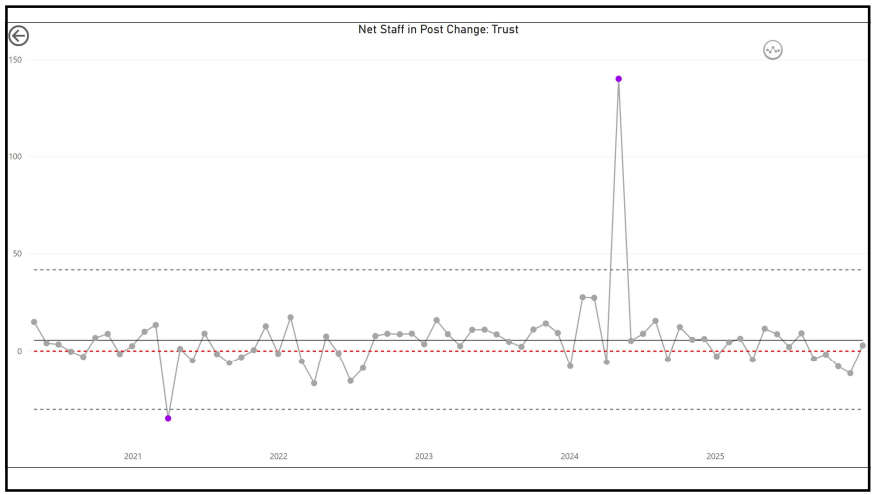
Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	People and Workforce	Appraisal Rates	2025-12-31	H	88.56%	90.00%	-1.44%	88.66%	90.00%	-1.34%	F
People Committee	People and Workforce	Mandatory Training Compliance	2025-12-31	H	97.01%	95.00%	2.01%	97.01%	95.00%	2.01%	?
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	2025-12-31		2.92	0.00	2.92	0.95	0.00	0.95	
People Committee	People and Workforce	NHS staff survey engagement theme score	2025-12-31	H	7.2	7.2	0.0	7.2	7.2	0.0	F
People Committee	People and Workforce	Proportion of temporary staff	2025-12-31	L	3.7%	3.4%	0.3%	3.3%	3.4%	-0.1%	F
People Committee	People and Workforce	Sickness Absence Rate	2025-12-31	H	5.68%	4.75%	0.93%	5.68%	4.75%	0.93%	F
People Committee	People and Workforce	Total shifts exceeding NHSI capped rate	2025-12-31	L	303	0	303	113	0	113	F
People Committee	People and Workforce	Total shifts on a non-framework agreement	2025-12-31	L	0	0	0	1	0	1	?
People Committee	People and Workforce	Vacancies - all	2025-12-31	L	7.12%	8.00%	-0.88%	8.61%	8.00%	0.61%	?

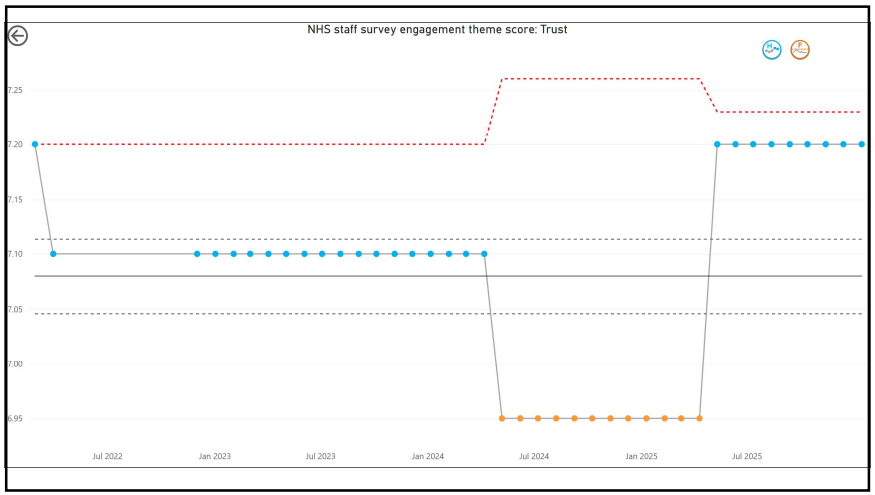
Appendix 2
People Committee
Month 9 (December) 2025/2026 Performance

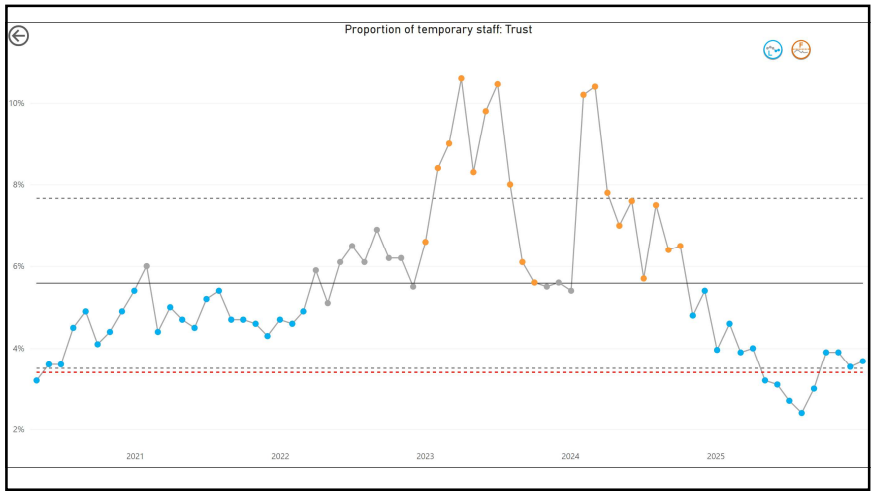
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where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

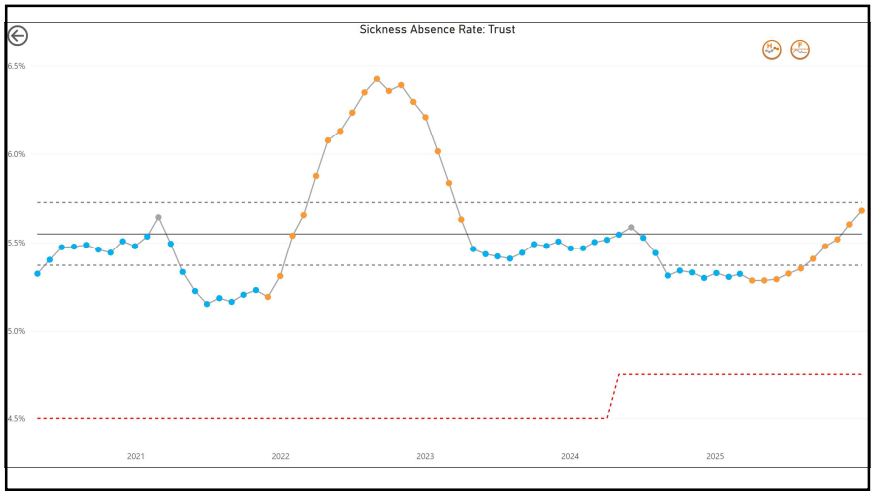

Appraisal Rates: Trust
95%
90%
85%
80%
2021
2022
2023
2024
2025

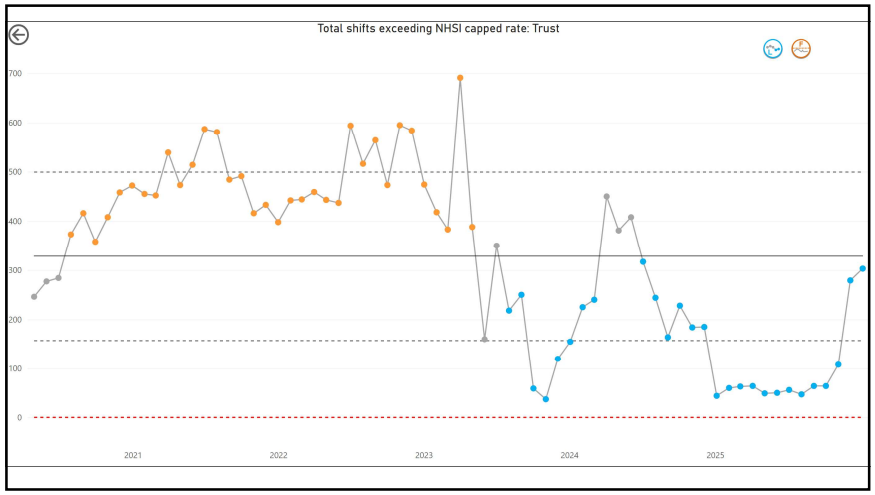

Mandatory Training Compliance: Trust
97%
96%
95%
94%
93%
92%
91%
90%
2021
2022
2023
2024
2025

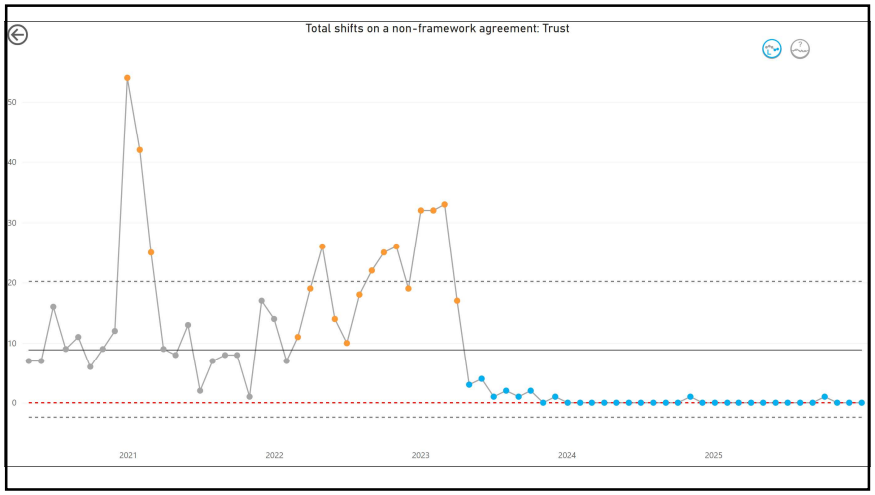

Net Staff in Post Change: Trust
150
100
50
0
2021
2022
2023
2024
2025

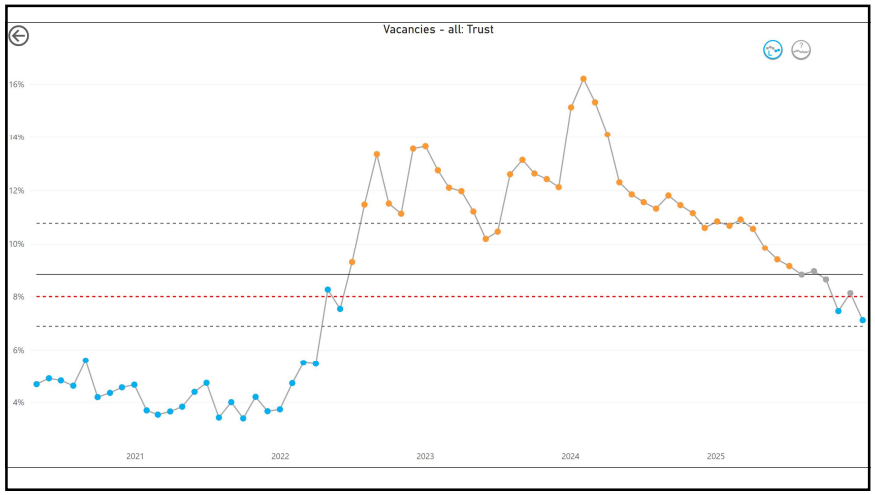

NHS staff survey engagement theme score: Trust
7.25
7.20
7.15
7.10
7.05
7.00
6.95
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025
Jul 2025


Proportion of temporary staff: Trust
10%
8%
6%
4%
2%
2021
2022
2023
2024
2025


Sickness Absence Rate: Trust
6.5%
6.0%
5.5%
5.0%
4.5%
2021
2022
2023
2024
2025


Total shifts exceeding NHSI capped rate: Trust
700
600
500
400
300
200
100
0
2021
2022
2023
2024
2025


Total shifts on a non-framework agreement: Trust
50
40
30
20
10
0
2021
2022
2023
2024
2025


Vacancies - all: Trust
16%
14%
12%
10%
8%
6%
4%
2021
2022
2023
2024
2025

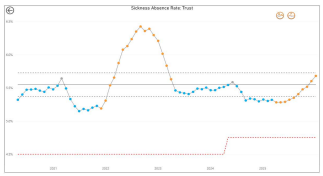
Exception Report - Action Plan

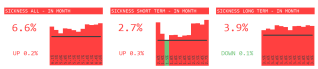
Sickness Rate

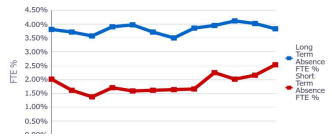
Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Sickness Rate	%	5.35%	5.41%	5.48%	5.52%	5.60%	5.68%	5.68%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	5.60%	5.50%	5.40%	5.30%	5.30%	5.20%	6.00%







Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	292	363	11,520.47	34.3
S13 Cold, Cough, Flu - Influenza	666	840	3,067.83	9.1
S25 Gastrointestinal problems	523	662	2,909.74	8.7
S12 Other musculoskeletal problems	123	146	2,864.23	8.5
S98 Other known causes - not elsewhere classified	174	193	2,385.66	7.1

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	233.20	664.27	35.11%
825 Ludlow Outpatient Service	169.29	569.40	29.73%
825 Children's Continence Service	97.47	481.87	20.23%
825 Telford & Wrekin Paediatric Physiotherapy Team (DO NOT USE)	125.60	659.60	19.04%
825 Workforce Systems Service	161.00	1,047.00	15.38%
825 Ludlow Hospital Admin Service	143.51	1,017.75	14.10%
825 Whitchurch Hospital Inpatients Service	1,854.85	13,293.74	13.95%
825 Research and Development Service	219.20	1,667.80	13.14%
825 Stoke Heath YOI Service	945.17	7,724.00	12.24%
825 Bishops Castle Hospital Service	878.29	7,375.33	11.91%

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 small 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 are well underway with their Winter Ready campaign which includes promoting the importance of the flu vaccination, know your numbers and HWB days. In week 15, our flu vaccination uptake stands at 51% which is the same as this time last year (the rate is 0.68% over this). . As per our operational plan submission we had planned for a reduction during summer months and an increase to 5% by end of the year. In month absence has remained relatively static in September, October, November and December. At present there is no assurance that short term absence (which has increased) is being managed in line with the Managing Attendance Policy. This is a key action area for our teams to monitor compliance and provide support to managers in maintaining compliance with our policy

Action Plan

Action	Start Date	End Date	Status	Outcome
Adult Community Services sickness absence is 7.06% (3.34% short term 3.73% long term) 23 individuals on long term absence, 141 episodes of short term sickness in November, CSM's to overview and ensure short term absence is being monitored and actioned in line with Managing Attendance Policy. Whitchurch Hospital Inpatients is flagging as a hot spot for current absences for MSK. Service Delivery Group Manager discussing with Clinical Services Manager to ensure support (4 indiividuals)	Dec-25	Feb-26	On track	To ensure all absences are receiving the required support and being managed in line with the Managing Attendance Policy
The People Team to commence sending short term absence trigger reports to line managers to support the management of short term absence in line with teh Managing Attendance triggers. The CSM's/relevant Senior Leaders will have oversight of the reports to ensure actions are in place.	Jan-26	Feb-26	On track	To support Line Managers identify individuals who have met the triggers within the Managing Attendance Policy
Adult Community Services (December) 7.52% in month (short term 3.69% Long term 3.83%). Whitchurch Hospital has been identified as a hot spot. Review the current action plan in place for Whitchurch Hospital and ensure all absences are being actioned and supported appropriately. 16.61% absence at Whitchurch Hospital inpatient with other not known causes making up 15% of absences. Action for the CSM to explore the reasons that are being recorded on ESR for absence to ensure they are being recorded appropriately	Jan-26	Mar-26	On track	Absences are recorded appropriately to support taregtted approaches to prevention and supporting return to work
Planned care- Total absence is 8.5% Clinical Services Managers to review the absence hot spots provide appropriate bespoke support to hot spot teams.	Dec-25	Feb-26	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	Feb-26	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	Feb-26	On Track	To prevent absences around MSK
Identify hot spot teams for stress anxiety and depression and develop action plans to establish preventative and ongoing support for those teams.	Mar-25	Feb-26	On Track	Develop action plans for teams identified as hot spots for stress anxiety and depression.
Implement the opportunities for improvement identified in the long term absence review of absence cases that was shared with teh Executive Team	Nov-25	Feb-26	On track	Ensure opportunities for improvement are implmented to support teh management of long term absence
UEC Division - Operational Lead will check to ensure those absences categorised as unknown is most appropriate category. Operational lead will communicate the current workshops (Meditation and stress management and ensure where appropriate stress risk assessments are undertaken). 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 in line with the Managing Attendance Policy	Oct-25	Feb-26	On Track	Provide staff with appropriate support
Long Term Absence Workshop to be scheduled in January 2026 (by Operations) 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. Please note this was cancelled due to Operational Pressures	Nov-25	Jan-26	Overdue	To provide an overview of long term absence cases raising awareness of redeployment opportunities and assurance the appropriate support is in place
CYP Shropshire 5.89% in month, long term absence is 3.73% and short term is 2.25%. Highest reason is stress anxiety and depression. Long term absence has reduced. Continue to oversee management of short term absence to gain assurance this is being managed appropriately and in line with the Managing Attendance Policy. Flu action in Dudley to encourage uptake due to local data identifying Dudley as a low uptake area	Jan-26	Mar-26	On track	Increase the uptake of flu vaccinations to protect staff and ensure absence is managed appropriately ensuring staff have teh appropriate support in place
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	Mar-26	On track	To ensure all staff take time away from work to rest and recuperate
Undertake a deep dive of all absences to establish any themes looking at age profiles, gender, job role etc	Jan-26	Mar-26	On track	To understand if there are any underlying themes etc for absences
Develop and implement a robust flu plan for the 2025-26 flu campaign using the data gathered from the flu survey	Aug-25	Mar-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	Feb-26	On Track	Provide staff with appropriate support
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

Author	Fiona MacPherson	**Date**	1/19/2026
Accountable Officer Approval	Rhia Boyode	**Date**	1/19/2026
		Date	

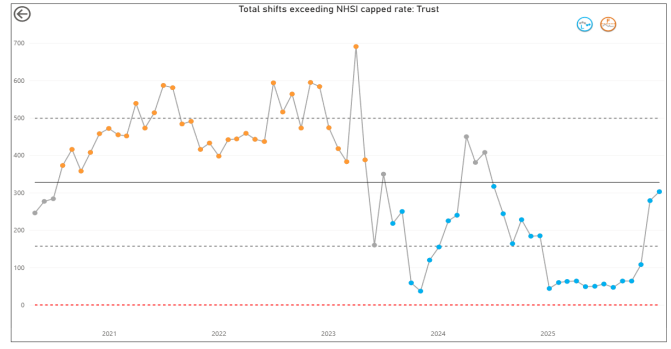
Exception Report - Action Plan

Total shifts exceeding NHSI capped rate

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Shifts	Number	47	64	64	108	279	303	113
	Target	0	0	0	0	0	0	0

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	300	300	300	250	250	200	200



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. 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 agency Medical staff to: Long Covid, Virtual Ward, Integrated Front Door, Paeds, Stoke Heath Prison.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	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 **Event 2/1/2026** scheduled to take place at Mount McKinley **13/1/26** Event Cancelled due to adverse weather. Rearranging for 23 or 30/1/26 (Subject to ops availability for interview
	Expansion of UEC: medical staffing reviewed requirement for Consultant, Speciality Dr and GP.	Oct-25	May-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. **23/12/25** Consultant jd comments from RC requires jd to be updated and resubmitting. Spec Dr JD drafted and awaiting form completion by ops to go to Royal College for approval. Both jds with ops and Medical Director for further work **13/1/26** Consultant job approval from RC received 14/1/26 - kitemark application in process (approx 1 day for return expected latest 16/1/26). Scoping out dates for March and panel members for the AAC process. Speciality Dr jd to be completed by Ops by 16 Jan 2026 for submission to Royal College w/b 19/1/26. Revised date set due to length of time for
	Reduction in the use of medical agency staff	Dec-25	Mar-26	On Track	Where vacancies are the casue work with managers on reveiwing jads and adverts as appropriate to the post. Long Coved: review the requirement and if a fixed term contract is appropriate as funding dependent. Virtual Ward & IFD - part of the UEC expansion - priortise vacancies in these areas (on going work with jds als0 taking pklace). Paeds - this is to cover LTS (HR involved) and waiting lists. Stoke Heath - GPwER has been offered a post - recruitment to priortise the onboarding.

Author	Gina Billington	**Date**	1/14/2026
Accountable Officer Approval	Rhia Boyode	**Date**	1/19/2026

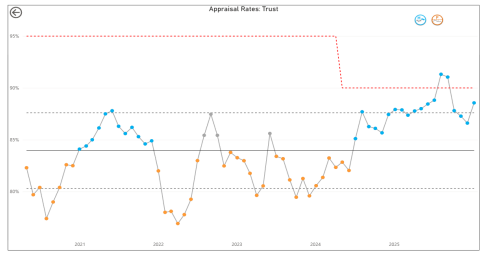
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Appraisals	%	91.32%	91.05%	87.81%	87.28%	86.61%	88.56%	88.66%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	89.00%	89.00%	90.00%	90.00%	91.00%	91.00%	91.00%



Reason for performance gap:

In November the compliance rate slightly dropped, however, in December we have seen the highest compliance rate since August 2025. We continue to send detailed appraisal reports to Managers to ensure they have sight of those appraisals out of date on ESR. 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 February at the latest 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. Work continues to ensure that all appriasals are inputted correctly on the system as at 13.01.26 there were 11 appraisals recorded incorrectly on the system, therefore not included in the overall %.

Action Plan

Action	Start Date	End Date	Status	Outcome
The Line Managers of the 11 people reorcrded incorrectly on ESR will be contacted by the Associate Director of Professional Standards to ensure this is rectified by the end of January	Jan-26	Feb-26	On track	To ensure that all appraisals that have taken place are recorded and counted within teh appraisal compliance rate
Adults Community Services Division - 40 appraisals expiring in January. There are 15 people non compliant across Whitchurch Inpatients (10 people) and Domestics (5 people), however there is a overall improvement plan overseen by Director of Nursing and Clinical Delivery. Adults have 70 staff non compliant with appraisals. Meeting with CSM's to discuss compliance and action for compliance. Bridgnorth Inpatients 8 people non compliant, Community Nursing NW 8 people non compliant by end of January. 5 people not recorded cotrrectly across the division. Contact all CSM's to ensure that the monitor and gain assurance that appraisals are completed by the end of February	Jan-26	Mar-26	On track	To ensure that all appraisals that are non compliant are undertaken
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 care 83.25% Virtual Ward, UCR and MIU Hot spot teams. Across the Division there are 10 expiring 3 incorrectly recorded and 3 new starters that require an appraisal. One hot spot team will be followed up by the Operational Lead. Appraisals will be discussed with Clinical Services Managers to ensure they are completed asap	Jan-26	Mar-26	On track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place
Planned Care Dividion recovery plan for podiatry 7 outstanding 4 outsanidng for Stoke Heath will be completed by early February. 14 expiring in January 1 logged incorrectly. Operational Lead is following up all outstanding appraisals to ensure completion	Jan-26	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	Feb-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 complaince	Nov-25	Dec-25	On track	Ensure compliance is achieved and CSM's support Line Manager to foster a culture of accountability
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
Shropshire CYP & Dudley CYP both over 90% compliance. Dudley CYP have 2 appraisals recorded incorrectly to be followed up by Operational Lead. Dudley School Nursing Dudley 22 oustanding (19 completed but not logged, therefore Operational Lead to provide support to get logged) 23 oustanding in total for Dudley. Shropshire 31 outstanding School Nurses are hot spot. Dudley 8 due. Operational Lead to review all non compliant appraisals and have discussions with Line Managers to provide support to complete	Jan-26	Feb-26	On track	To ensure all appraisals are recorded correctly and non compliance appraisals completed

Author	Fiona MacPherson	**Date**	1/19/2026
Accountable Officer Approval	Rhia Boyode	**Date**	1/19/2026

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	6	60.0
825 Finance Service	11	8	72.7
825 Whitchurch Hospital Inpatients Service	41	31	75.6
825 5-19 School Nursing Dudley Service	37	26	70.2
825 5-19 School Nursing Shropshire Service	27	20	74.0
825 Shropshire PHNS Admin Service	11	8	72.7
825 Podiatry Service	28	21	75.0
825 Stoke Heath YOI Service	21	17	80.9
			80.7
			73.6
			76.7

SDGs and Divisions of 10+ staff	Assignment Count	Reviews Completed	Reviews Completed %	
825 Digital Division	44	39	88.64	↑
825 Finance, Strategy and Estates Division	31	27	87.10	↓
825 Governance Division	17	10	58.82	↑
825 Medicines Management Division	14	13	92.86	↔
825 Operations Directorate Management Division	11	10	90.91	↑
825 People and OD Division	28	25	89.29	↔
825 Safeguarding Children Division	12	12	100.00	↑
825 Service Delivery Group - Adult Community Services Division	595	525	88.24	↑
825 Service Delivery Group - CYP&F Dudley Services Division	136	124	91.18	↑
825 Service Delivery Group - CYP&F Shropshire Services Division	334	310	92.81	↑
825 Service Delivery Group - Planned Care Division	208	182	87.50	↑
825 Service Delivery Group - Urgent Care Division	209	174	83.25	↑

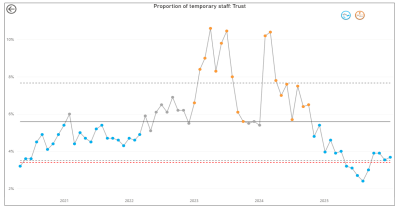
Exception Report - Action Plan

Proportion of temporary staff

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Prop Temporary staff	%	2.4%	3.0%	3.9%	3.9%	3.5%	3.7%	3.3%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	3.50%	3.50%	3.40%	3.40%	3.40%	3.40%	3.40%



Reason for performance gap:	UEC consultant recruitment : Consultant JD with the Royal College for approval who have returned with comments. Community Peads have Locum consultant covering LTS and waiting lists work. HMP Stoke are using a GP to cover a vacancy.. The Long Covid team are using a locum GP to support the service. In BCCH and LCH there is some sickness absence which is impacting on their agency and bank use. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. The NHSE price cap programme and the work already undertaken across our system will improve price cap compliance through a targeted strategy working collaboratively to set rate reductions over the coming months. Price Cap for agency: we are compliant with 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. **23/12/25** Consultant jd comments from RC requires jd to be updated and resubmitted. Spec Dr JD drafted and awaiting form completion by ops to go to Royal College for approval. Both jds with ops and Medical Director for further work. GPwER jd drafted.**13/01/2026** Consultant job approval from RC received 14/1/26 - kitemark application in process (approx 1 day for return expected latest 16/1/26). Scoping out dates for March and panel members for the AAC process. Speciality Dr jd to be completed by Ops by 16 Jan 2026 for submission to Royal College w/b 19/1/26.
Prison: GP Vacancy - using a locum. Resourcing support to jd writing.	Nov-25	Feb-26	On track	JD advertised. Recruitment underway - interviews 14/1/26. Offer made individual - in checks stage.
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%. **23/12/25** Currently 91 teams are live on e-roster with a further 22 teams now scheduled up to 31/3/26. Roster approval lead time - full approval = 53 days, Partial approval 61 days. % contract hours unused 2.06%, % hours additional duties 7%. **13/1/26** Currently 103 teams are live on e-roster with a further 19 teams now scheduled up to 31/3/26. Roster approval lead time - Full approval = 61 days, Partial approval 56 days. % contract hours unused 3.90%, (Adjusted to account for 8 records where individual is not actively rostered) % hours additional duties 6.22%
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	**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 **Event 2/1/2026** scheduled to take place at Mount McKinley. **13/01/26** Event cancelled due to adverse weather. Rearranging for 30/1/26 (Subject to ops availability for interview panels)
Roll out e-roster to all clinical staff and non-clinical bank workers. New revised end date.	Sep-25	Jun-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. **23.12.25** Implementation plan in place: 91 teams on e-roster with 22 teams planned for implementation until March 2026 - 3 teams planned for April implementation with further scoping and planning to utilise licences in progress for Q1and Q2 2026/27 **13/1/26** Implementation plan in place: 103 teams on e-roster with 19 teams planned for implementation until March 2026 - 1 teams planned for April 2026 implementation with further scoping and planning to utilise licences in progress for Q1and Q2 2026/27
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	Closed	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 worked up by the operational teams. Working to a Go live Date of 9/12/25 **23/12/25** Lead in times input to the rostering system for sending shifts to NHSP bank. Training for TST taking place and for managers in the New Year. Comms drafted for current agency workers with opportunity to join NHSP bank. **13/1/26** System now live.
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**	1/14/2026
Accountable Officer Approval	Rhia Boyode	**Date**	1/19/2026

Local Action Plans

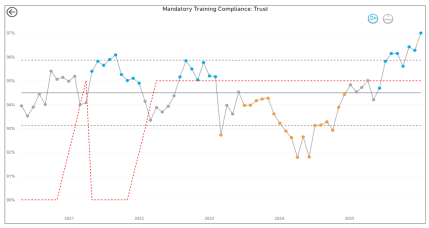
Exception Report - Action Plan

Mandatory Training Compliance

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

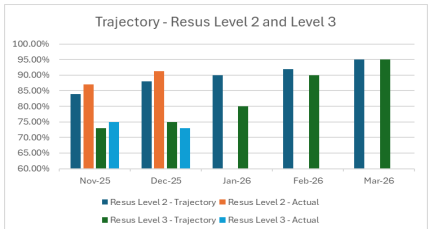
KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Mandatory Training	%	96.15%	96.15%	95.71%	96.42%	96.28%	97.01%	97.01%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	97.10%	97.10%	97.60%	97.60%	98.10%	98.10%	98.60%



TOPIC	November	Oct-25	December	Variance
Conflict Resolution (England)	98.8%	▼	98.7%	-0.05%
Corporate Induction	98.1%	▲	98.5%	0.33%
Equality, Diversity and Human Rights	98.8%	▲	99.4%	0.61%
Fire Safety - 2 Years	99.7%	▼	99.7%	-0.05%
Fire Safety - High Risk	78.8%	▲	84.0%	5.11%
Fraud Awareness	98.0%	▲	98.1%	0.11%
Health, Safety and Welfare	98.6%	▲	98.9%	0.23%
Infection Prevention and Control - Level 1	97.6%	▲	98.5%	0.83%
Infection Prevention and Control - Level 2	96.4%	▲	97.3%	0.97%
Information Governance and Data Security	97.7%	▲	98.7%	0.94%
Moving and Handling - Level 1	97.6%	▲	97.9%	0.29%
Moving and Handling - Level 2	83.9%	▲	86.6%	2.74%
Oliver McGowan Mandatory Elearning	98.2%	-	98.2%	0.00%
Patient Safety - Level 1	99.7%	▲	99.7%	0.01%
Patient Safety - Level 2	97.7%	▲	97.8%	0.13%
Preventing Radicalisation - Prevent Awareness	97.9%	▲	98.7%	0.77%
Resuscitation - Level 2 - Adult Basic Life Support	87.3%	▲	91.4%	4.06%
Resuscitation - Level 2 - Paediatric Basic Life Support	87.2%	▲	91.3%	4.11%
Resuscitation - Level 3 - Adult Immediate Life Support	75.1%	▼	73.0%	-2.09%
Resuscitation - Level 3 - Paediatric Immediate Life Support	75.2%	▼	73.0%	-2.19%
Safeguarding Adults - Level 1	98.1%	▲	98.4%	0.28%
Safeguarding Adults - Level 2	98.0%	▲	98.8%	0.83%
Safeguarding Adults Level 3	94.2%	▲	95.6%	1.41%
Safeguarding Children - Level 1	96.5%	▲	97.1%	0.56%
Safeguarding Children - Level 2	94.0%	▲	94.9%	0.87%
Safeguarding Children Level 3	94.2%	▲	95.0%	0.82%
Safeguarding Children Level 4	100.0%	-	100.0%	0.00%

Competency	Mandatory Competencies	Number of staff who require competency	Number of staff who have obtained competency	Number of staff who have not obtained competency	Current Compliance
NHS [MANDE Corporate Induction]	1	1823	1795	28	98.46%
NHS [CITP Information Governance and Data Security - 1 Year]	1	1823	1799	24	98.68%
NHS [CITP Fire Safety - 2 Years]	1	1823	1817	6	99.67%
NHS [OPA] Fire Safety - High Risk - 1 Year]	1	413	347	66	84.02%
NHS [CITP Equality, Diversity and Human Rights - 3 Years]	1	1825	1812	11	99.40%
NHS [CITP Health, Safety and Welfare - 3 Years]	1	1823	1802	21	98.85%
NHS [MANDC Fraud Awareness - 3 Years]	1	1823	1789	34	98.13%
NHS [CITP Moving and Handling - Level 1 - 3 Years]	1	1823	1785	38	97.92%
NHS [CITP Moving and Handling - Level 2 - 2 Years]	1	911	789	122	86.61%
NHS [CITP] NHS Conflict Resolution (England) - 3 Years]	1	1823	1800	23	98.74%
NHS [CITP Preventing Radicalisation - Prevent Awareness - 3 Years]	1	1823	1796	24	98.68%
NHS [CITP Infection Prevention and Control - Level 2 - 3 Years]	1	1823	1795	28	98.46%
NHS [CITP Infection Prevention and Control - Level 2 - 1 Year]	1	1391	1354	37	97.34%
NHS [CITP Resuscitation - Level 2 - Adult Basic Life Support - 1 Year]	1	1123	1026	97	91.36%
NHS [CITP Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year]	1	1134	1035	99	91.27%
NHS [CITP Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year]	1	252	184	68	73.02%
NHS [CITP Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year]	1	241	176	65	73.03%
NHS [CITP Safeguarding Adults - Level 1 - 3 Years]	1	1823	1794	29	98.41%
NHS [CITP Safeguarding Adults - Level 2 - 3 Years]	1	754	745	9	98.81%
NHS [MANDC Safeguarding Adults Level 3 - 3 Years]	1	639	611	28	95.62%
NHS [CITP Safeguarding Children - Level 1 - 3 Years]	1	1823	1770	53	97.09%
NHS [CITP Safeguarding Children - Level 2 - 3 Years]	1	877	832	45	94.87%
NHS [MANDC Safeguarding Children Level 3 - 3 Years]	1	517	491	26	94.97%
NHS [MANDC Safeguarding Children Level 4 - 3 Years]	1	7	7	0	100.00%
NHS [MANDC The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 (Learning)]					
NHS [MANDC Patient Safety - Level 1 - 3 Years]	1	1823	1791	32	98.24%
NHS [MANDC Patient Safety - Level 2 - 3 Years]	1	1823	1818	5	99.73%
	1	793	768	17	97.83%



Reason for performance gap:

Corporate Updates – The compliance rate for December increased by 0.73% to reach 97.01%, marking the highest level of compliance recorded for Mandatory Training to date. Recognition is due to operational staff, who constitute the majority of our workforce, for completing their training requirements amidst significant demands. In December, all topics except four demonstrated improved compliance rates, with increases ranging from 0.01% (Patient Safety Level 1) to 5.11% (High Risk Fire). However, Resus Level 3 experienced a further decrease, resulting in performance falling below the targeted benchmark.
DNA – High Risk Fire – 56. Spaces not used 69 (11 in Oswestry, 34 in Ludlow and 24 in Whitchurch)
DNA – Resus Level 2 – 29
DNA – Resus Level 3 – 5
DNA – Moving and Handling Level 2 – 29. Spaces not used 56. There was 1 session cancelled due to lack of bookings
DNA - Corporate Induction – 3. Spaces not used 29

We are anticipating a decline in compliance levels across the organisation, primarily as a result of the challenges posed by Winter Pressures. These seasonal strains are affecting various areas, making it increasingly difficult to maintain compliance. In addition to the operational pressures, there has been a noticeable rise in staff sickness. This trend is having a direct effect on our workforce availability, further compounding the strain experienced during this period. The increase in staff absences means that employees are not able to be released for training at full capacity. As a consequence, training programmes are facing disruptions, and the organisation is unable to deliver training to the intended extent. This situation is likely to have a continued impact on staff development and overall compliance moving forward.

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	Mar-26	On Track	Resus Level 2 Adult - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%) Trajectory - Jan 2026 90%. Feb 2026 92%. Mar 2026 95% Resus Level 2 Paediatric - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%) Trajectory - Jan 2026 90%. Feb 2026 92%. Mar 2026 95% Resus Level 3 Adult - Nov 2025 - Target 73%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%) Trajectory - Jan 2026 80%. Feb 2026 90%. Mar 2026 95% Resus Level 3 Paediatric - Nov 2025 - Target 84%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%) Trajectory - Jan 2026 80%. Feb 2026 90%. Mar 2026 95% During December there was 29 DNA's for Resus Level 2 and 5 DNA's for Resus Level 3. We cannot monitor the attendance for the Resus Level 2 and Level 3 training, as there is not the need to book their place through ESR and can turn up to the training. 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. Areas have been asked to give Resus Level 3 a priority on releasing staff to attend this training. If Bank is required to cover, Tracie Black has agreed this can be done. Staff and managers are being encourage to action the 3 month
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	Mar-26	On Track	High Risk Fire Trajectory - Oct 2025 - Target 75%. Actual 77%. (+2%). Nov 2025 Target 77%. Actual 78% (+1%), Dec 2025 - Target 82%. Actual 84% (+2%) Jan 2026 - 89%, Feb 2026 - 91% and Mar 2026 - 95%. We had a total of 8 sessions running in December, 3 in Whitchurch, 3 in Ludlow and 2 in Oswestry. We had a very high number of DNA and spaces not used. A total of 56 people Did Not Attend their booking. We had 11 spaces not used in Oswestry, 34 spaces not used in Ludlow and 24 not used in Whitchurch. We are still above target, so are on track to reach 95% by April 2026. The 2026 dates have now all been organised. Staff and managers have
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)) 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. A bespoke training session for Resus has been arranged for June 2025.	Apr-25	Mar-26	On track	Improved mandatory training compliance. Stoke Heath - Admin Team have reached the 95% Compliance Target. There have been leadership gaps there has been lack of drive on manadotory training. Divisional Clinical Lead and Operational Lead will be leading on the recovery.
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	Jan-26	On track	Managers are emailed where they have staff who are non-compliant with Safeguarding Children Level 2 and Safeguarding Children Level 3. The Safeguarding Team have also been liaising with managers with regards to the Safeguarding compliance

Author	Catherine Morris	**Date**	
Accountable Officer Approval	Rhia Boyode	**Date**	

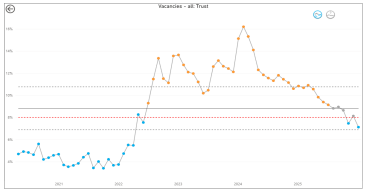
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Vacancies	%	8.82%	8.95%	8.65%	7.46%	8.13%	7.12%	8.61%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	8.0%	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 - UEC are expanding their services 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 and a review of fixed term contracts vs. permanent with HR. Dental service is holding vacancies due to contract reviews.

Month 9 hotspots: UEC, CH (BCCH, Ludlow) Community Nursing (North and North West teams) 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. **13/1/26:** 1 Nurse starting Feb 26, 4 WTE Nurse posts and 1 WTE HCA in offer; 9.80 WTE HCA in shortlisting; 1 WTE Nurse in Interview
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. 23/12/25 Consultant jd comments from RC requires jd to to be updated and resubmitting. Spec Dr JD drafted and awaiting form completion by ops to go to Royal College for approval. Both jds with ops and Medical Director for further work. **13/1/26** Consultant job approval from RC received 14/1/26 - kitemark application in process (approx 1 day for return expected latest 16/1/26). Scoping out dates for March and panel members for the AAC process. Speciality Dr jd to be completed by Ops by 16 Jan 2026 for submission to Royal College w/b 19/1/26
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	**15/01/2025** **Community Nursing**: Longlisting: 1 WTE Band 4 Nurse Associate Interview: 0.73 WTE Band 2 HCSW, 0.6 Band 3 HCA Offer: 2.8 WTE Band 3 HCA's, 7.44 WTE Band 5 Community Nurses **Community Hospitals**: Longlisting: 0.68 WTE Band 2 Cook Interview: 1 WTE Band 2 Porter, 0.85 WTE Band 2 Domestic Assistant, 1 WTE Band 2 Housekeeper, 0.53 WTE Band 2 HCA Offer: 3.36 WTE Band 2 HCA's, 1.35 WTE Domestic Assistants, 2.6 WTE Band 5 Staff Nurses, 3 WTE Deputy Ward Managers Starting: 1.5 WTE Band 2 Porter's, 2 WTE Band 5 Staff Nurses, 1.01 Band 7 Emergency Practitioner (MIU) **Stoke Heath**: Longlisting: 1 WTE Band 6 Prison Mental Health Nurse Shortlisting: 1 WTE Band 2 HCA Interview: 0.6 WTE CD (interviewed and offered 16/1/26)
Recruitment policy in draft to commence the consultation stage. Includes new flowcharts and toolkit for managers. Revised target date set due to consultation and committee dates..	Jun-25	Mar-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. **13/1/26** policy out for consultation - revised date set.
Recruitment continue to review their processes to ensure timely recruitment.	Apr-25	Dec-25	Closed	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 **13/1/26** Time to hire 34.5 days
Look at internal moves due to vacancies and identify hotspots for this movement.	Apr-25	Mar-26	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. **13/1/26** Due to further increased capacity issues we have been unable to complete this work. Revised target date set.
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 Event 2/1/2026 scheduled to take place at Mount McKinley **13/1/26** Event cancelled due to adverse weather conditions. Rearranging to 30/1/26 (Subject to ops availability for interview panels)

Author	Gina Billington	**Date**	1/14/2026
Accountable Officer Approval	Rhia Boyode	**Date**	

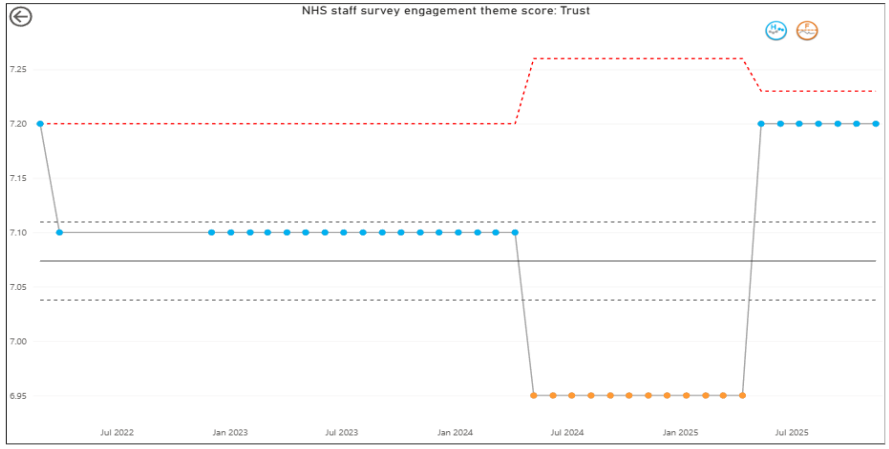
Yearly Reported KPIs

Exception Report - Action Plan

NHS Staff survey engagement theme score

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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



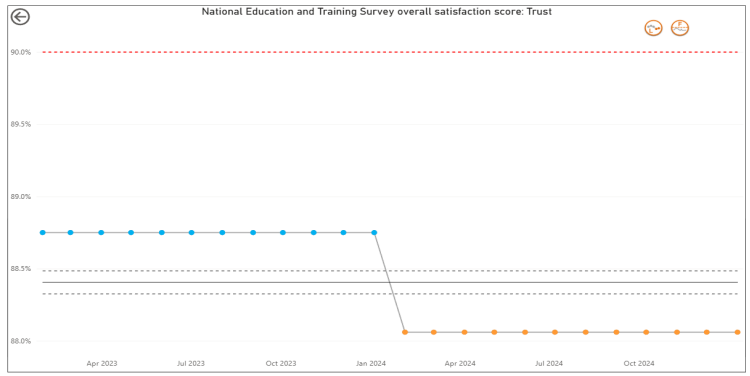
Reason for performance gap:	SCHT's score is close to the national average, however work continues around engagement.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Implement a reward and recognition programme to include a recognition calendar and events	Dec-24	Jul-25	Completed	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**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

National Education and Training Survey overall satisfaction score

KPI Description	Latest 6 months	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
National Education and Training Survey	Number	88.06%	88.06%	88.06%	88.06%	88.06%	88.06%	88.06%
	Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Trajectory				Jan-26	Feb-26	Mar-26	Apr-26
%							



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

Shropshire Community Health NHS Trust

Gender Pay Gap Report
0. Reference Information

Author:	**Fiona MacPherson, Head of People Services**	**Paper date:**	26 January 2026
Executive Sponsor:	Rhia Boyode, Chief People Officer	**Paper written on:**	2 January 2026
Paper Reviewed by:	Lisa Gibbons, Associate Director of People, OH and OD	**Paper Category:**	Workforce
Forum submitted to:	People Committee	**Paper FOIA Status:**	Full/Partial

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

Our gender pay gap report has to be published on our website by 30 March 2026, the publication of this data must be approved by our Trust Board.

2.2 Summary

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 set out a public authority's gender pay gap reporting duties, which form part of its public sector equality duty under the Equality Act. Our gender pay data is at a snapshot date of 31 March 2025.

Key points from our gender pay gap data:

- Our gender workforce profile has shown minimal change over the past nine years. As of the snapshot date, 31 March 2025, women comprised 89% of our workforce, while men represented 11%. For comparison, the gender composition of the NHS workforce in 2025 is reported to be 76% women and 24% men.
- Our mean gender pay gap has dropped to 3.63%, which is a reduction of **1.29% compared to 2024**. This marks the lowest level since gender pay gap reporting began in 2017.

Gender Pay Gap Report

- Our Median Gender Pay Gap is -4.09% in favour of women (women earn 0.75p more than men). The Office of National Statistics reports a 12.8% gender pay gap for 2025 for all employees.
- The mean pay gap equates to 0.75p in favour of men and the median pay gap equates to 0.75p in favour of women.
- Compared to our organisational gender workforce profile there are proportionately more men than women in our upper and lower middle pay quartile
- There is no bonus pay gap as only females are in receipt of bonus pay which is made up of only clinical excellence awards. In 2022 there was a bonus pay gap of 72.87%.

Key Priorities for gender pay gap 2026-27 (refer to appendix a for full list of priorities):

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

2.3. Conclusion

The People Committee are asked to:

1. Receive assurance and agree to the gender pay gap report being presented at Trust Board for approval to be publicised on the SCHT website and government online services to ensure we are compliant with legislative requirements.

Gender Pay Gap Report
3.0 Main Report

3.1 INTRODUCTION

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

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

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

The data must be published by 30 March 2026 and is at a snapshot date of **31 March 2025**.

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

3.2 GENDER PAY REPORTING IS DIFFERENT TO EQUAL PAY

The gender pay gap differs from equal pay.

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

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

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

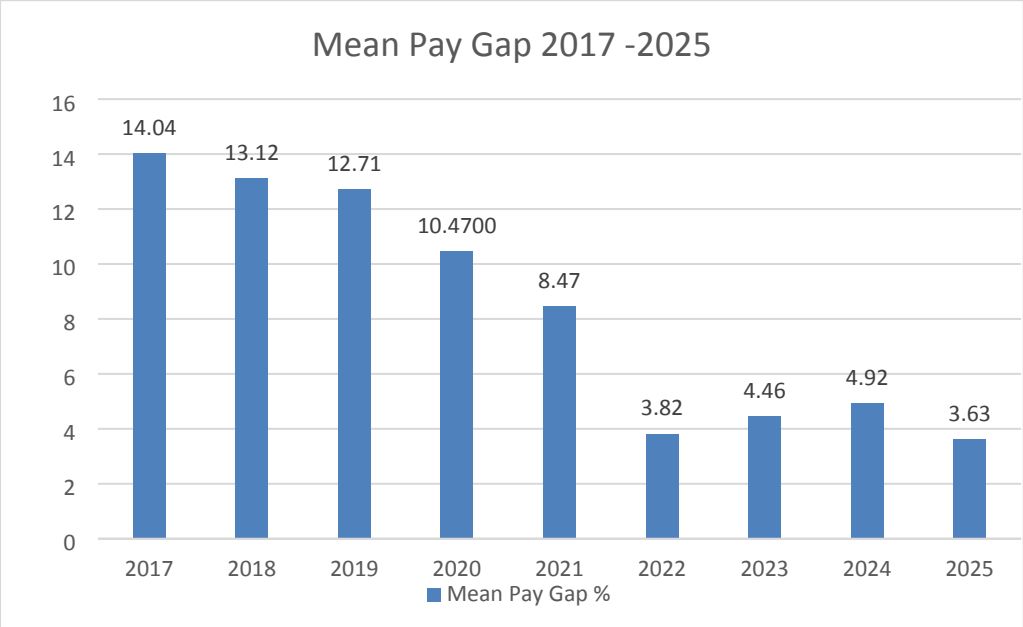
3.3 COMPARISON BETWEEN OUR GENDER PAY DATA (2017-2025)

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

Gender Pay Gap Report

Measuring the Gender Pay Gap - Comparison between 2017-2025 data

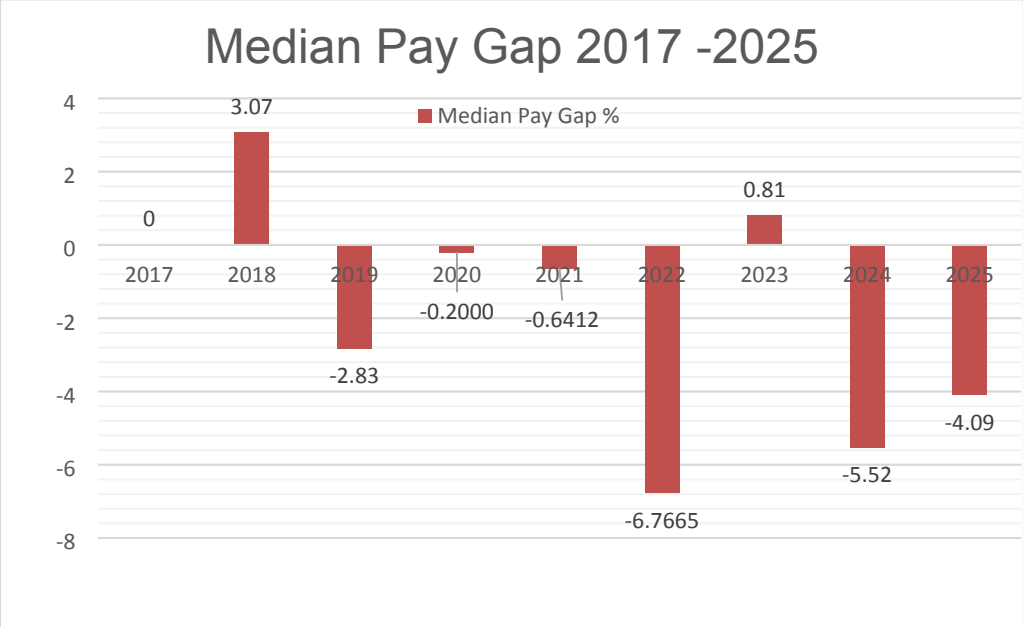
Mean Pay Gap



The chart above illustrates the changes in the mean gender pay gap within the organisation over time. In 2017, the mean pay gap stood at 14.04%, indicating that, on average, men earned significantly more than women. Over the following years, this gap steadily decreased, reaching 3.82% in 2022. This demonstrates considerable progress in the reduction of pay disparities between men and women.

In 2023, there was a slight increase in the mean pay gap in favour of males. Despite this minor rise, the gap remained much lower than the figures reported between 2017 and 2022. In 2025 we have seen the lowest mean pay gap since reporting commenced in 2017.

Gender Pay Gap Report



The **median pay gap** rose from 0% in 2017 to 3.07% in 2018 but shifted in favour of women in 2019. This trend continued until 2023, when the gap moved to favour men by 0.81% (equivalent to £0.14), before reversing again to favour women in 2024—a pattern that has continued into 2025.

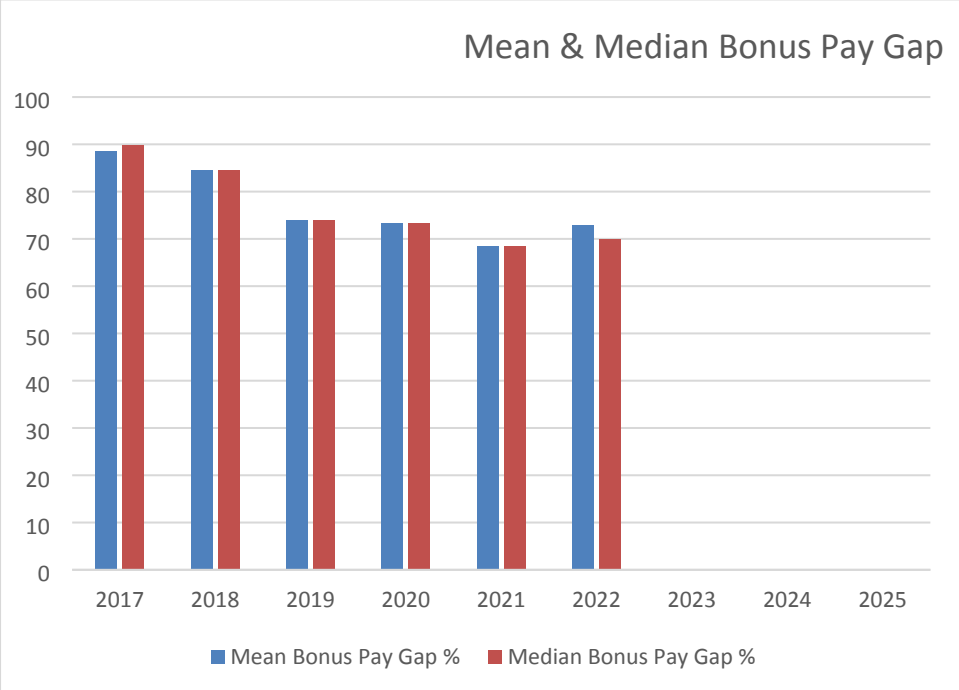
Measuring the Pay Quartiles - Comparison between 9 years of data

Between 2017 to 2022 there were proportionately more males in Quartile 1 and Quartile 4 compared to our workforce gender profile. In 2023 this changed to their being proportionately more males in upper pay quartile only. In 2024 there were proportionately more males in Quartile 1 and Quartile 4 and in 2025 there were more men in the lower middle and upper quartile. When comparing the Quartiles there are only small changes in the percentage.

Measuring the Bonus Pay - Comparison between 31 March 2017 to 31 March 2025 data

When comparing the bonus pay from 2017 to 2025 the mean and median bonus pay gap has been gradually decreasing. In 2023, 2024 and 2025 only women received bonus pay (clinical excellence awards).

Gender Pay Gap Report



Gender mix at Pay Band

	No of Female Staff	No of Male Staff	Total Staff	Female Avg Hourly Rate	Male Avg Hourly Rate	Difference F M
Band 2	296	51	347	£13.69	£14.09	£0.40
Band 3	235	23	258	£13.38	£12.92	-£0.46
Band 4	173	18	191	£14.60	£14.67	£0.07
Band 5	366	37	403	£18.96	£17.56	-£1.40
Band 6	479	41	520	£22.07	£22.01	-£0.06
Band 7	211	28	239	£25.59	£25.38	-£0.21
Band 8 and VSM	84	29	113	£33.35	£35.16	£1.81
Medical and Dental	28	5	33	£53.85	£37.70	-£16.15
Total	**1872**	**232**	**2,104**	**£19.73**	**£20.48**	**-£0.75**

The above information shows that p**ay differences vary by band:**

- **Bands where men earn more on average:**
-
  - **Band 2:** men earn £0.40 more
  - **Band 4:** men earn £0.07 more
  - **Band 8/VSM:** men earn £1.81 more

Gender Pay Gap Report

- **Bands where women earn more on average:**
-
    - **Band 3:** women earn £0.46 more
    - **Band 5:** women earn £1.40 more
    - **Band 6:** women earn £0.06 more
    - **Band 7:** women earn £0.21 more
    - Medical & Dental: women earn £16.15 more

3.4 BENCHMARKING

Nationally the gender pay gap has been declining slowly over time. Over the last decade it has fallen by approximately a quarter among both full-time employees and all employees. Among all employees, the gender pay gap decreased to 12.8% in 2025 and is still below the levels seen in 2019 (17.4%). *(Source: Office of National Statistics 2025).*

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

3.5 Next steps

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

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

4.0 Conclusion

The People Committee are asked to:

1. Receive assurance and agree to the gender pay gap report being presented at Trust Board for approval to be publicised on the SCHT website and government online services to ensure we are compliant with legislative requirements

Shropshire Community Health
NHS Trust

Gender Pay Gap Report 2025

Reported January 2026

Introduction

The data analysis snapshot for this report is as at 31 March 2025 and is taken from the Electronic Staff Record System (ESR). The total number of employees was 2104, of which 89% were female, and 11% male, and includes all employees holding an employment contract with the Trust.

Background

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

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

Reporting Requirements

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

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

What do we do with the information?

We use our gender pay reporting to assess:

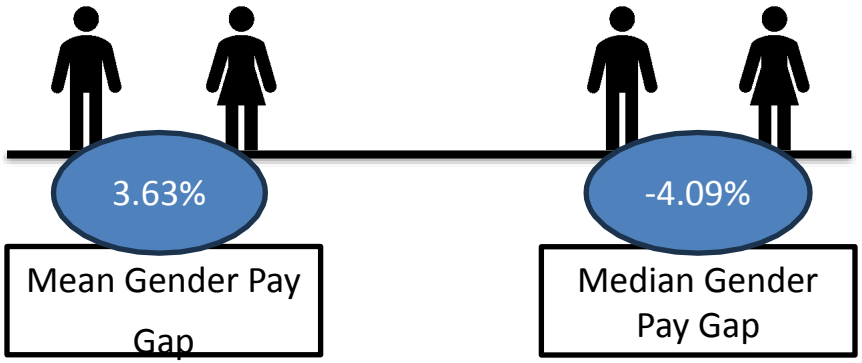
- Gender equality across our workforce
- Representation of men and women at different pay levels
- Our effectiveness in recognising and rewarding talent

Important points to note

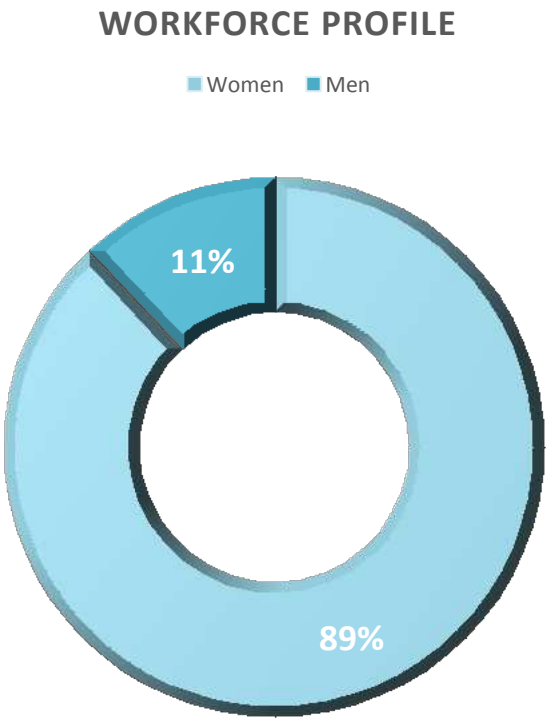
- **Gender pay gap is not the same as unequal pay.** Equal pay for equal work is a separate legal requirement.
- **Our current records do not include non-binary gender identities**. We fully acknowledge and respect the diversity of gender identities, including non-binary and transgender individuals.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

Our Headline Gender Pay Gap Data

Our mean gender pay gap is 3.63%. The median gender pay gap is -4.09%. This is inclusive of our Medical and Dental colleagues.



Our Gender Profile



Snapshot date – 31 March 2025

This chart shows our gender profile which shows an increase of 1% in the number of female employees within our workforce (88% on 31 March 2024 compared to 89% on 31 March 2025).

Mean average Rates of Pay by Gender

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

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

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

Continued

Mean average Rates of Pay by Gender

This indicates that, on average, men earn £0.75 more per hour than women.

While our overall mean pay gap has varied over the past five years, it has decreased since the 2021 report and is currently at its lowest level.

	2021	2022	2023	2024	2025
Male	£17.78	£17.50	£18.58	£19.30	£20.48
Female	£16.27	£16.83	£17.75	£18.35	£19.73
£ Difference	£1.51	£0.67	£0.83	£0.95	£0.75
% Variance/Pay Gap	8.47%	3.82%	4.46%	4.92%	3.63%

Median average Rates of Pay by Gender

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

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

Continued

Median average Rates of Pay by Gender

When comparing median hourly pay women earn £0.75p more than men earn.

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

	2021	2022	2023	2024	2025
Male	£15.56	£15.10	£17.14	£16.76	£18.34
Female	£15.66	£16.13	£17.00	£17.69	£19.09
£ Difference	-£0.10	-£1.03	£0.14	-£0.93	-£0.75
% Variance/Pay Gap	-0.64%	-6.77%	0.81%	-5.52%	-4.09%

Our Gender Pay Gap Data 2025

Ordinary Pay	
Mean gender pay gap	3.63%
Median gender pay gap	-4.09%

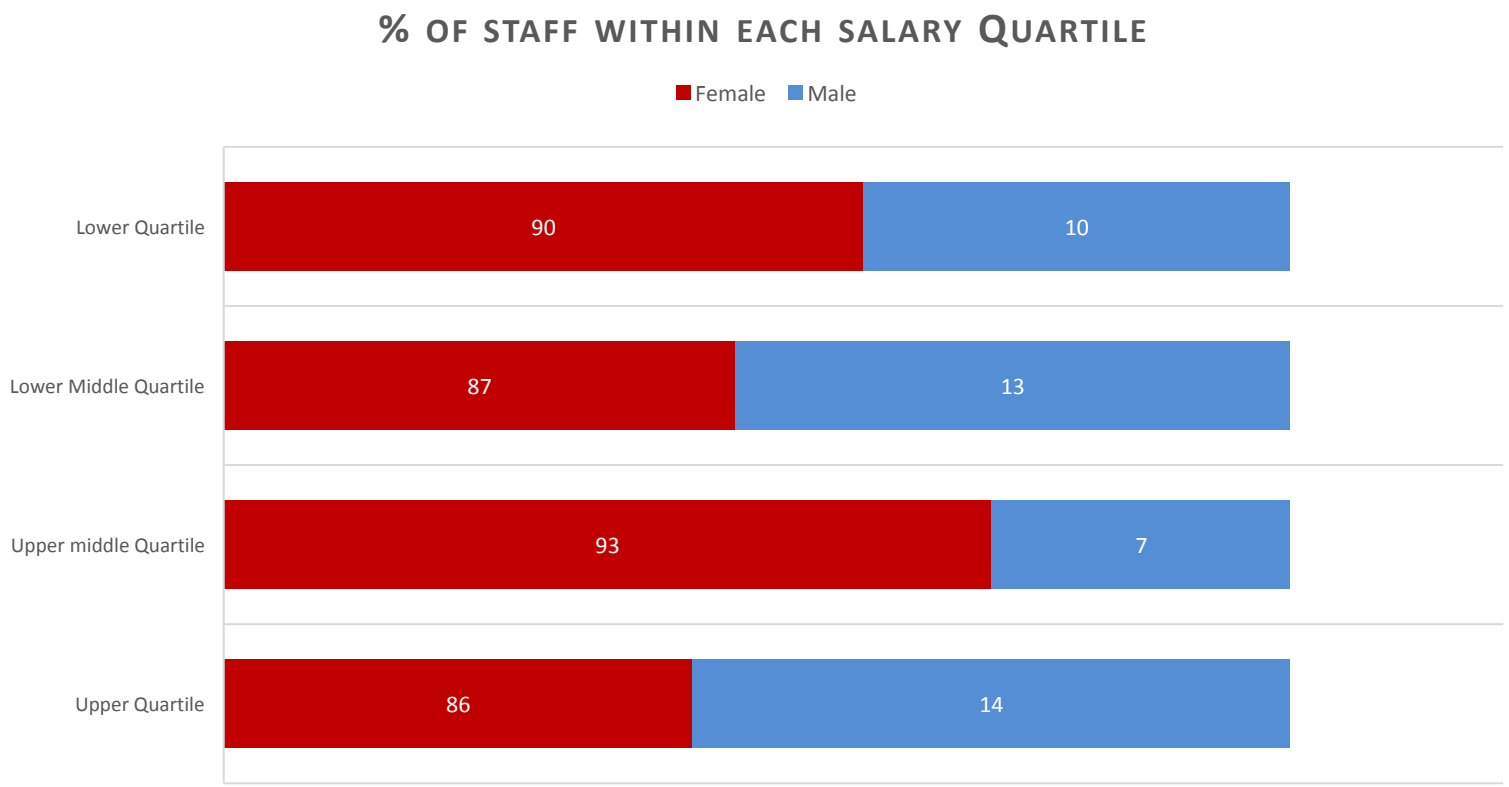
Shropcom's mean gender pay gap has decreased from 4.92% in 2024 to 3.63% in 2025. The median pay gap remains in favour of females -5.52% in 2024 to -4.09% in 2025.

The mean pay gap equates to men earning 0.75p (a reduction of 0.20p from 2024) more than women and the median equates to women earning 0.75p per hour more than men.

Bonus Pay Gap

In relation to the bonus pay gap, only female employees received bonus pay in 2025 which means there is no pay gap to report. Our last reported mean bonus pay gap was in 2022 where it was 72.87% and the median pay gap was 70% in favour of males.

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



Our gender pay gap data

The information below details the % of staff within each salary quartile for 2024 and 2025:

	2024		2025	
	Male	Female	Male	Female
Lower Quartile	14	86	10	90
Lower Middle Quartile	12	88	13	87
Upper Middle Quartile	8	92	7	93
Upper Quartile	15	85	14	86

Our gender mix pay band data

The information below details the breakdown of the gender of staff within each salary band and the average hourly rates of pay for 2025:

	No of Female Staff	No of Male Staff	Total Staff	Female Avg Hourly Rate	Male Avg Hourly Rate	Difference F-M
Band 2	296	51	347	£13.69	£14.09	£0.40
Band 3	235	23	258	£13.38	£12.92	-£0.46
Band 4	173	18	191	£14.60	£14.67	£0.07
Band 5	366	37	403	£18.96	£17.56	-£1.40
Band 6	479	41	520	£22.07	£22.01	-£0.06
Band 7	211	28	239	£25.59	£25.38	-£0.21
Band 8 and VSM	84	29	113	£33.35	£35.16	£1.81
Medical and Dental	28	5	33	£53.85	£37.70	-£16.15
Total	**1872**	**232**	**2,104**	**£19.73**	**£20.48**	**£0.75**

Our gender pay gap band data: Key Findings

Pay Differences Vary by Band

- **Bands where men earn more on average:**

  - **Band 2:** men earn £0.41 more
  - **Band 4:** men earn £0.06 more
  - **Band 8/VSM:** men earn £1.81 more

- **Bands where women earn more on average:**

  - **Band 3:** women earn £0.46 more
  - **Band 5:** women earn £1.40 more
  - **Band 6:** women earn £0.06 more
  - **Band 7:** women earn £0.21 more
  - Medical & Dental; women earn £16.15 more

Key Priorities for 2026/27

- Continue to work with our system partners (SaTH) in offering our staff the opportunity to undertake leadership development by attending SaTH's leadership courses.

- We are committed to an inclusive workplace and promoting equitable opportunities for all employees, to support this we are developing an inclusive recruitment toolkit and offering Safer Recruitment training.

- We have recently become a Disability Confident Leader. As part of this work we will continue to raise awareness around our Health Passport, reasonable adjustment guidelines, access to work etc

Key Priorities for 2026/27

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

Key Priorities for 2026/27

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

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

Conclusion

Our 2025 gender pay gap analysis shows continued improvement, with a reduced mean gap and a median gap that remains in favour of women. While female representation is strong across all pay quartiles, our focus is to understanding underlying patterns, supporting equitable career progression, and ensuring that all staff—regardless of gender - experience fairness, inclusion, and opportunity. By investing in leadership development, inclusive recruitment, and staff engagement, we remain committed to creating a workforce culture where everyone can thrive

The End

www.shropscommunityhealth.nhs.uk

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 28th January 2026

0. Reference Information

Author:	Diane Davenport Executive Assistant	**Paper date:**	5th February 2026
Executive Sponsor:	Tina Long, RPC Chair	**Paper written on:**	28th January 2026
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 28th January 2026 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Procurement Strategy Refresh/Progress
    - Service Transformation Update
    - Finance and Capital
    - Annual Budget Setting
    - CIP (Delivery plans and actions)
    - Procurement Update
    - Digital Services Update
    - Fire Risk Management Update
    - Review of external support
    - Review of BAF Risks
    - System Integrated Improvement Plan
    - Work Plan Review
    - Minutes from Sub-groups

2.3. Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 28th January 2026

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Resource and Performance Committee which met on 28th January 2026. The meeting was quorate with three Non-Executive Director and four Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Tina Long	Non-Executive Director (RPC Chair)
Sarah Lloyd	Chief Finance Officer
Claire Horsfield	Director of Operations and Chief AHP
Harmesh Darbhanga	Non-Executive Director
Jonathan Gould	Deputy Chief Finance Officer
Jill Barker	Non-Executive Director
Jon Davis	Associate Director of Digital Services and Performance
Shelley Ramtuhul	Director of Governance
Paula Davies	System Director of Procurement - STW (agenda item 7 only)
Kate Leach	Senior Procurement Manager – Group
Steve Ellis	Deputy Director of Operational Service Development
Steve Price	Head of Information & Performance Assurance (agenda item 11)
Rosi Edwards	Non-Executive Director, SaTH (Observing)
Richard Miner	Non-Executive Director, SaTH (Observing- Part meeting).
Apologies:	
Cathy Purt	Non-Executive Director
Clair Hobbs	Director of Nursing & Clinical Delivery

3.2 Actions from the Previous Meeting

The action log was reviewed, and all open actions were completed and closed.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
7. Procurement Strategy Refresh/Progress		
An updated Procurement Strategy was presented for approval, which is consistent across all four NHS organisations in Shropshire, Telford and Wrekin. The strategy aligns to the national focus of shifting towards mandatory frameworks, the use of digital tools, benchmarking spend, and supply chain consolidation.	Full	

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The Committee considered how to ensure local suppliers can easily engage with the NHS to minimise the environmental impact. Additionally, consideration was given to the impact of geopolitics on the supply chain, and alignment of policies across partners. **The Committee approved the update Procurement Strategy.**		
8. Service Transformation Update		
The Committee received an update on the Trust's key transformation programmes, with a focus on Neighbourhood Health workstreams, aligned to the NHS 10 year plan. The Committee considered that the Neighbourhood Health workstreams are aligned to the relevant national pillars of this programme and that we continue to work with all partners to collectively progress at pace. Both Adult and Children's services were considered to ensure each has appropriate focus. The Prison Healthcare transformation programme and work streams were considered, noting the good engagement with the commissioner of the service and that projects remain largely on plan.	N/A – for information	
9. Finance and Capital Report		
The Committee reviewed December (Month 9) financial performance, forecast and risks. The Trust shows a favourable variance to plan of £283k. Whilst both agency and bank staffing costs exceed planned levels, our overall pay spend remains below planned levels. CIP delivery at month 9 is £4,018k; this is a £129k favourable to plan and the forecast is to fully meet this financial target, both in-year and recurrently. Additionally, the Committee considered that all CIP schemes are now rated as low risk in terms of delivery. Identified financial risks are currently mitigated, and the level of risk is reducing. The revenue forecast remains £2m surplus, in line with the agreed plan, however it was noted that it is likely we will exceed this target. The Committee discussed the financial challenges in a number of service areas and that financial plans for next year have considered this.	Full	

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10. Annual Budget Setting		
The Committee received an update on the budget setting process. A budget setting timetable was presented in November which planned for draft 2026/27 budgets to be presented to the January Committee meeting for approval. However, there remain a number of areas within our local plans which are yet to be finalised. For this reason, it was proposed that the final changes would be included within start point budgets which will be presented to the March RPC meeting for review and recommendation to the Trust Board for approval at the start of April.	Update only	
11. Integrated Performance Report		
The Committee considered the latest performance information, in line with the Performance Framework. There are no KPIs within this committee's remit which are reported as both an assurance concern and special cause variation concern this month. It was noted that there are continued improvements in waiting times, particularly in Children's services and MSST. The 'proportion of patients within 18 weeks – Children's Service' is no longer flagged as a variation concern, which is an improving picture. The Committee noted the significant reduction in waiting times for Children's Speech & Language therapy with no patients waiting longer than 52 weeks. The SLT team has been asked to share their approach at a national community of practice event.	Full	
12. CIP Delivery Plans and Actions		
The 2025/26 CIP delivery is on track to meet or exceed the annual target. Additionally, the Committee was updated on the significant progress in capturing the impact of productivity improvements; again, these programmes are on track to meet or exceed target levels. Planning for future years is in train and leads confirmed that the majority of both CIP and Productivity targets have been identified although there remains further work to do in this area. The Committee proposed that, given the level of assurance in this area, CIP and Productivity updates should be incorporated into the main Finance Report in the future.	Full	

Shropshire Community Health NHS Trust

Chair's Assurance Report

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13. Procurement Update		
The report provided an update on procurement activities over the last quarter, for information and assurance. Due to organisational changes, there is now a new Group Procurement lead who will support the Trust. The CIP target forecast for 2025/26 delivery is on track to fully deliver against the target with forward planning for the 2026/27 CIP analysis and planning underway The Committee was advised that key areas of focus remain: data quality; supplier rationalisation; and standardisation across partners.	Full	
14. Digital Services Exception Report		
The Committee received an update on Digital Services and delivery against the Digital Strategy. The Committee noted the introduction and enhancement of numerous digital initiatives including Power BI development, the use of robotics to successfully support a complex data migration and trialling technology in support of sharing digital clinical records. The opportunities for Digital Services to be a key enabler to our Group was discussed. Initial digital priority areas for work across the Group are: device portability; telephony integration; and real-time record sharing. The Committee discussed the on the use of robotics, the impact on productivity through the use of digital tools such as Co-pilot and the return on investment where a charge is levied. The Committee agreed to formally close the Trust's 2020-2025 Digital Strategy and requested a report to detail the impact of this work. Additionally, whilst a Group Digital Strategy is developed and agreed, it was requested that a 'transition year' set of objectives should be agreed across both SaTH and ShropCom and presented within the report, for agreement.	N/A	Assurance to be considered when closedown report on 2020-2025 Digital Strategy is presented, considering the impact of the work.
15. Fire Risk Management Update		
The Committee received an update in relation to fire compliance. All actions agreed with Shropshire Fire and Rescue Service have been completed with the exception of the Authorised Engineers Audit which will commence on 2nd February 2026. This marginal delay was due to the contractors capacity.	Partial	The Committee requested a report is presented to the Trust Board, covering all obligations, current status, risks and mitigations.

Chair's Assurance Report

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The Fire Service had been provided with updates regarding the present status of the actions and had raised no concerns. The Trust is due to meet with the Fire Service Representative shortly with a view to closing the action plan. Additional areas for improvement were identified through internal Fire Safety Group meetings, a progress update was provided and there was discussion regarding the mitigations currently in place.		
16. Review of External Support		
The Committee received an update regarding the utilisation of an external supplier to support with reduction of MSST waiting lists. The Committee was advised that the company was engaged via an existing framework and had provided support to other NHS organisations and was recommended. The intervention materially reduced the waiting list from and our RTT for this area saw a marked improvement over a five month period. Quality metrics remained stable. It was noted that future monitoring will assess improvement in patient experience and complaints.	Full	
17: Board Assurance Framework		
The Committee received an update on the BAF and considered the proposed changes. The Committee supported closing the risk in relation to 'costs exceeding plan' due to improved financial confidence and the consequential reduction in risk scoring. No other BAF score changes.	Full	
18. System Integrated Improvement Plan		
The System Integrated Improvement Plan was not available at the time of this meeting and will be circulated to Committee members in due course.	N/A	
19. Work Plan Review		
The Committee reviewed the work plan, agreeing to remove the separate CIP update which will now be incorporated within the Financial Update.	N/A	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 28th January 2026

20. System Transformation Group minutes		
Noted		
21. Digital Assurance Group minutes		
Noted		
Meeting Evaluation		
The Committee agreed it was a positive meeting, with strong assurance provided, further improved papers and the progress in relation to Group work was well received.		

3.4 Approvals

The Committee approved the updated Procurement Strategy.

3.5 Risks to be Escalated

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

4. Conclusion

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

Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**5th February 2026**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**28th January 2026**
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. 26 indicators are highlighted as a concern (49.1%), 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	6	1	1	**16**	**8 (50%)**
Resource & Performance	1	11	0	**27**	**12 (44%)**

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**
  Now flagged as a variation concern:-

  - Deaths – unexpected
  - Medication Incidents with Moderate Harm
  - Rates of Healthcare Associated Infection (E-Coli)
  - Safer Staffing - Average Fill Rate Non-Registered Nurses – Night

  Safer Staffing - Average Fill Rate Registered Nurses – Day is no longer flagged as a variation concern

- **Resource and Performance Committee**
  -New Birth Visits % within 14 days - Telford is no longer 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' which is achieving target but is flagged as special cause variation due to historical performance and SPC calculations.

Please note that the RTT measures for December 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.
- **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

Eleven 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. Proportion of patients within 18 weeks - Children's Services
5. Percentage of patients waiting over 52-weeks for community services
6. Data Quality Maturity Index
7. Total patients waiting more than 52 Weeks – All services
8. Total patients waiting more than 65 Weeks – All services
9. Total patients waiting more than 78 Weeks – All services
10. Total patients waiting more than 52 Weeks to start consultant-led treatment
11. Average number of days from discharge ready date and actual discharge date

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

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

1. *New Birth Visits % within 14 days – Telford* is no longer flagged as having a variation concern

Performance Update

December 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	1	24	27	24	28
65+ weeks	0	0	0	5	0	5
78+ weeks	0	0	0	1*	0	1*
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 in January, there has been improvements in many of the high waits in the table above with the exception of 'Total patients waiting more than 52 Weeks to start consultant-led treatment' and 'Total patients waiting more than 65 Weeks – All services' in Adult Services.

The appended plans describe the actions being taken and the trajectories for improvement. **The local 78+ and 104+ week wait has been confirmed as a data quality issue, and this will affect the other local wait KPI also.**

'18 week Referral to Treatment (RTT) incomplete pathways' has shown a recent levelling with 80.90% in November and 80.75% in December, although the December position was still being validated at the time of preparing the paper/dashboards. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature. Further detail is included in the action plan.

The indicator for 'Proportion of patients within 18 weeks' has also levelled, with performance of 80.87% in December compared with 81.85% in November. While the target is not being achieved, the indicator is still flagged as special cause variation of an improving nature.

Additional validation for the Community Services SITREP was conducted for December's position. As part of this process we have included additional services, removed the Wheelchair Restrictive Interventions waits which are being transferred back to the Commissioner (from all local wait KPI) and validated high waits in Wheelchair services against the SITREP definition. The KPI has had to be refreshed which will result in slight discrepancies between our KPI and what has been historically submitted within the SITREP but these will align for December data onwards.

The Resource and Performance Committee was informed at its January meeting that NHSE is reviewing the community SITREP with an aim of ultimately replacing it and utilising data from the datasets we submit. This SITREP informs the KPI 'Percentage of patients waiting over 52 weeks for community services' which is an indicator within the National Oversight Framework. NHSE has developed dashboards and we have requested additional information in relation to definition and validation of data to ensure this represents an accurate reflection for SCHT.

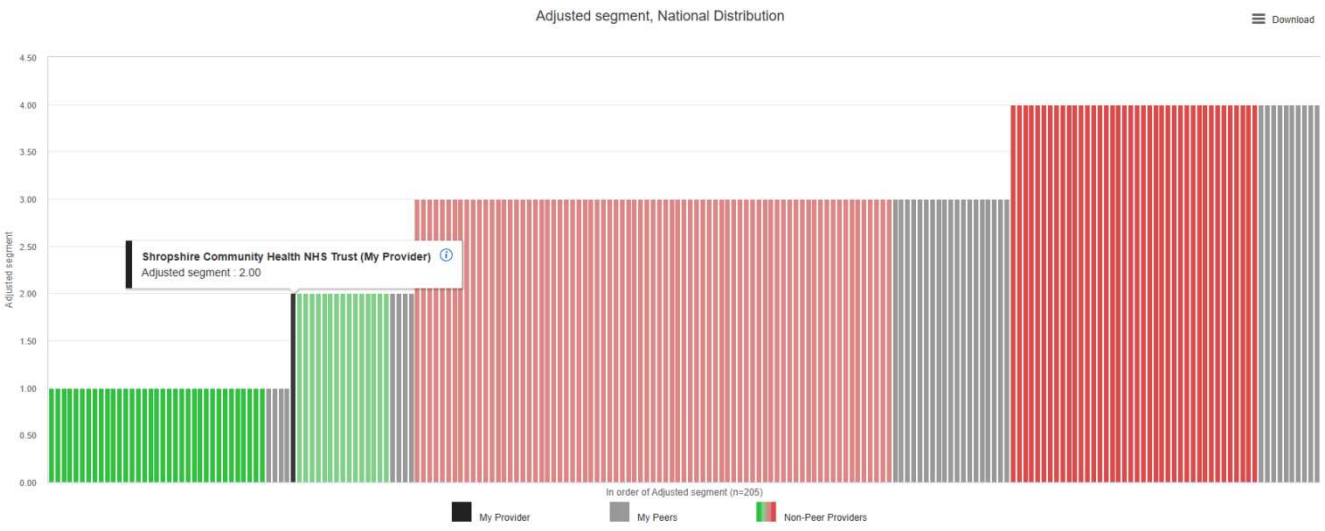
Performance Update

The data issue previously reported in relation to Continence products was resolved at the time of preparing the dashboards. The KPI 'total activity undertaken against current year plan' is therefore up to date.

3.3 National Oversight Framework

Following the national release of the Quarter 2 2025/26 Oversight Framework scores, we continue to review our performance in relation to peers and assess if further efforts can be applied to particular KPIs in order to improve individual domain scores.

The National Oversight Framework dashboards have been refreshed, and recent scores have been released. SCHT performs well with 4 out of 5 domains scoring above average or higher within the Oversight Framework, which contributes to maintaining the positive overall NOF score of 2, as per chart below. Organisations rated as 1 are reported as the best performing and organisations rated as 4 requiring the most support.



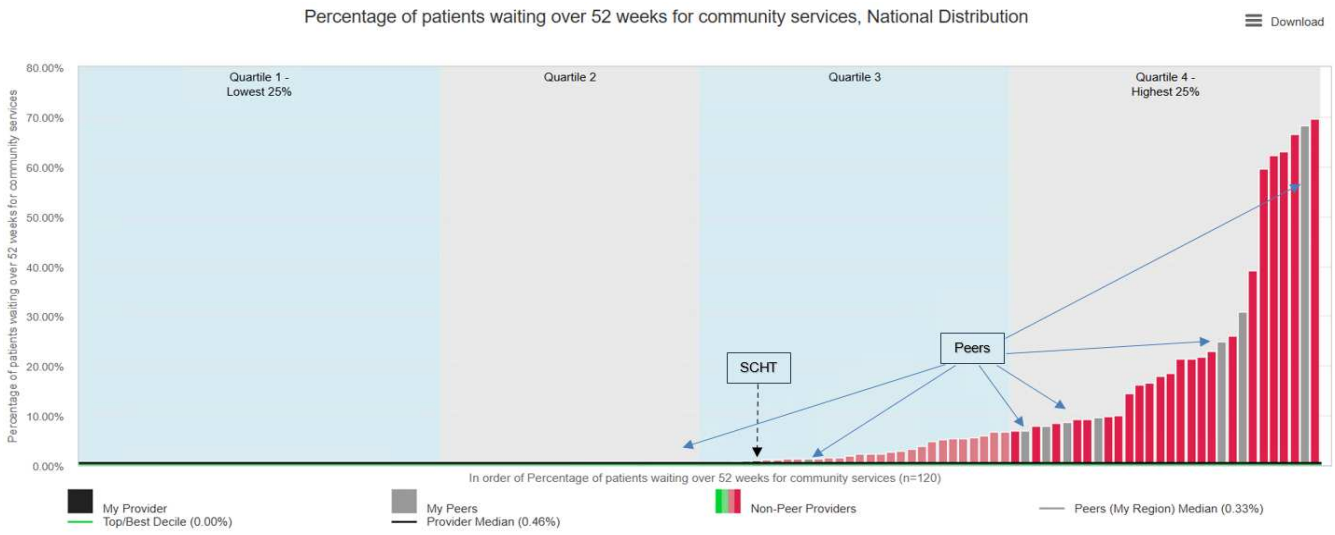
There are individual KPI within the NOF where SCHT is shown as below average in the recent position:

- Percentage of patients waiting over 52 weeks for community services (Resource and Performance Committee remit), although this position has improved during the published quarter.
- Sickness absence rate (People Committee remit). This position has deteriorated during the published quarter.

These KPI are already flagged as a concern within our performance reporting, and details in relation to the actions being taken to improve the performance are shown within the relevant action plans, and assurance is gained through the relevant committees.

Performance Update

Percentage of Patients Waiting over 52 weeks for Community Services



Reducing waits for healthcare remains a key area of focus. Good progress has been made although we recognise that there is more to do and our action plans set out our determination to continue to reduce waiting times at pace.

3.4 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.5 Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board.
- **Note** the information presented in relation to the National Oversight Framework and areas which may require particular focus.

PERFORMANCE REPORT APPENDICES - REFERENCE INFORMATION

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	2025-12-31		6.6	4.0	2.6	6.6	4.0	2.6	F
Finance and Productivity	Data Quality Maturity Index	2025-09-30	H	94.9%	95.0%	-0.1%	94.9%	95.0%	-0.1%	F
Access	Difference between actual and planned 18 week elective performance	2025-12-31		16.75	0.00	16.75	16.75	0.00	16.75	
Finance and Productivity	Financial efficiency - variance from efficiency plan	2025-12-31	H	1.82%	0.00%	1.82%	1.82%	0.00%	1.82%	?
Finance and Productivity	Implied productivity level	2025-12-31		101.38%	100.00%	1.38%	101.38%	100.00%	1.38%	?
Access	New Birth Visits % within 14 days - Dudley	2025-11-30	H	90.61%	90.00%	0.61%	90.93%	90.00%	0.93%	?
Access	New Birth Visits % within 14 days - Shropshire	2025-11-30	H	84.76%	90.00%	-5.24%	86.07%	90.00%	-3.93%	?
Access	New Birth Visits % within 14 days - Telford	2025-11-30		90.06%	90.00%	0.06%	90.49%	90.00%	0.49%	?
Access	Number of patients not treated within 28 days of last minute cancellation	2025-12-31		0	0	0	0	0	0	?
Access	Percentage of patients waiting less than 18 weeks - RTT	2025-12-31	H	80.75%	92.00%	-11.25%	80.75%	92.00%	-11.25%	F
Access	Percentage of patients waiting over 52-weeks for community services	2025-12-31	L	0.05%	0.00%	0.05%	0.05%	0.00%	0.05%	F
Access	Percentage of patients waiting over 52-weeks RTT	2025-12-31	L	0.31%	0.00%	0.31%	0.31%	0.00%	0.31%	F
Improving health and reducing inequality	Percentage of people waiting over 6 weeks for a diagnostic procedure or test	2025-11-30		95.89%	99.00%	-3.11%	95.89%	99.00%	-3.11%	?
Finance and Productivity	Planned surplus/deficit	2025-12-31	H	1.57%	0.00%	1.57%	1.57%	0.00%	1.57%	P
Access	Proportion of patients within 18 weeks	2025-12-31	H	80.87%	92.00%	-11.13%	80.87%	92.00%	-11.13%	F
Access	Proportion of patients within 18 weeks - Childrens Services	2025-12-31		73.95%	92.00%	-18.05%	73.95%	92.00%	-18.05%	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	2025-12-31		107.72%	100.00%	7.72%	101.18%	100.00%	1.18%	
Access	Total patients waiting more than 104 weeks - all services	2025-12-31		1	0	1	1	0	1	
Access	Total patients waiting more than 52 weeks - all services	2025-12-31		28	0	28	28	0	28	
Access	Total patients waiting more than 52 weeks to start consultant-led treatment	2025-12-31		24	0	24	24	0	24	
Access	Total patients waiting more than 65 weeks - all services	2025-12-31		5	0	5	5	0	5	
Access	Total patients waiting more than 65 weeks to start consultant-led treatment	2025-12-31		0	0	0	0	0	0	
Access	Total patients waiting more than 78 weeks - all services	2025-12-31		1	0	1	1	0	1	
Effectiveness and experience of care	Urgent Community Response 2-hour performance	2025-09-30		87.76%	70.00%	17.76%	87.76%	70.00%	17.76%	
Finance and Productivity	Variance year-to-date to financial plan	2025-12-31		119.78%	100.00%	19.78%	119.78%	100.00%	19.78%	
Finance and Productivity	Virtual ward bed occupancy	2025-12-31		88.12%	80.24%	7.88%	88.12%	80.24%	7.88%	

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	2025-12-31		3	0	3	3	0	3	
Patient Safety	Category 4 Pressure Ulcers	2025-12-31	H	1	0	1	1	0	1	
Effectiveness and experience of care	Complaints - (Open) % within response timescales	2025-12-31	H	100.00%	95.00%	5.00%	90.76%	95.00%	-4.24%	
Effectiveness and experience of care	CQC Conditions or Warning Notices	2025-12-31		0	0	0	0	0	0	P
Patient Safety	Deaths - unexpected	2025-12-31	H	2	0	2	2	0	2	
Patient Safety	Falls per 1000 Occupied Bed Days	2025-12-31		7.69	4.00	3.69	7.69	4.00	3.69	
Patient Safety	Medication Incidents with Moderate Harm	2025-12-31	H	3	0	3	11	0	11	
Patient Safety	NHS Staff Survey - raising concerns sub-score	2025-12-31	H	6.83	7.08	-0.25	6.83	7.08	-0.25	F
Patient Safety	Patient Safety Incident Investigations	2025-12-31		0	0	0	7	0	7	
Patient Safety	Rates of Healthcare Associated Infection (C-Difficile)	2025-12-31	H	250.00%	100.00%	150.00%	250.00%	100.00%	150.00%	F
Patient Safety	Rates of Healthcare Associated Infection (E-Coli)	2025-12-31	H	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Patient Safety	Rates of Healthcare Associated Infection (MRSA)	2025-12-31		0	0	0	0	0	0	P
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Day	2025-11-30		92%	95%	-3%	92%	95%	-3%	
Patient Safety	Safer Staffing - Average Fill Rate Non-Registered Nurses - Night	2025-11-30	L	86%	95%	-9%	86%	95%	-9%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Day	2025-11-30		88%	95%	-7%	88%	95%	-7%	
Patient Safety	Safer Staffing - Average Fill Rate Registered Nurses - Night	2025-11-30	L	80%	95%	-15%	80%	95%	-15%	

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	2025-12-31	H	88.56%	90.00%	-1.44%	88.66%	90.00%	-1.34%	F
People and Workforce	Mandatory Training Compliance	2025-12-31	H	97.01%	95.00%	2.01%	97.01%	95.00%	2.01%	?
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	2025-12-31	~	2.92	0.00	2.92	0.95	0.00	0.95	
People and Workforce	NHS staff survey engagement theme score	2025-12-31	H	7.2	7.2	0.0	7.2	7.2	0.0	F
People and Workforce	Proportion of temporary staff	2025-12-31	L	3.7%	3.4%	0.3%	3.3%	3.4%	-0.1%	F
People and Workforce	Sickness Absence Rate	2025-12-31	H	5.68%	4.75%	0.93%	5.68%	4.75%	0.93%	F
People and Workforce	Total shifts exceeding NHSI capped rate	2025-12-31	L	303	0	303	113	0	113	F
People and Workforce	Total shifts on a non-framework agreement	2025-12-31	L	0	0	0	1	0	1	?
People and Workforce	Vacancies - all	2025-12-31	L	7.12%	8.00%	-0.88%	8.61%	8.00%	0.61%	?

Icon Descriptions

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

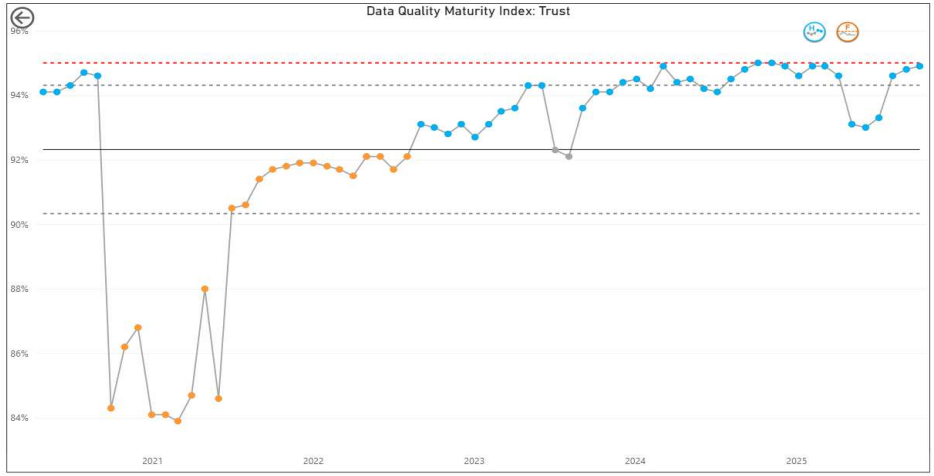
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
DQMI	%	93.1%	93.0%	93.3%	94.6%	94.8%	94.9%	94.9%
	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 September 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 had been fully validated. 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 . 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
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	Off Track	**January 26 Update** The plan is still to achieve improvements by the end of quarter four, with significant progress expected through enhancements in coding. Ongoing oversight at performance meetings across all divisions will continue to support and understand improvements and areas of target at service level. A plan is also in place to work with BI lead to continue to roadshow importance of ethnicity reporting at team meetings and admin academy. **December 25 Update** Ongoing drive for improvement across all areas and continued drill down at service level. Improved representation at Data Quality Sub Group. Approach has driven key improvements in MIU acuity and chief complaint. **November 25 Update** 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. **October 25 Update** 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.
Area 1 - Clinical Coding: Stabilisation of clinical coding workforce	Nov-25	Jan-26	On Track	**January 26 Update** Secured additional support from a 3rd party company, which will start in January 26. They will prioritise the most recent uncoded episodes and this will have the biggest impact upon DQMI performance. It is likley to take 6 months to recover the uncoded position so impact will be fully realesed by July 2026. **December 25 Update** Recruitment plans continue to progress and bank utilisation continues. Those who have applied for courses remain prepared to commence in January **November 25 Update** Recruitment plans continue to progress and bank utilisation continues. If able to recruit, plan will be to have individuals in post by Jan -26. Those who have applied for courses remained prepared to commence in January **October 25 Update** 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. 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.

	Targeted approach to clinical coding to provide change in KPI performance	Oct-25	Jan-26	On Track	**January 26 Update** The 3rd party company will be prioritising the most recent uncoded episodes and the internal coders will concentrate on the backlog, to gain the biggest immediate impact to the DQMI performanceIt is likley to take 6 months to recover the uncoded position so impact will be fully realesed by July 2026. **December 25 Update** Staffing shortages within the admin resource has led to prioritisation of tasks diverting capacity away from coding. We have now recruited to the admin support role and await recruitment processes before they can start and allow our coder to fully focus on the coding element. They are aware that they need to start with the most recent admissions for maximum impact on DQMI position **November 25 Update** Implemented - ongoing monitoring to understand how this impacts performance commenced **October 25 Update** 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	Complete	**January 26 Update** Secured additional support from a 3rd party company, which will start in January. They will prioritise the most recent uncoded episodes. It is likley to take 6 months to recover the uncoded position so impact will be fully realesed by July 2026. **December 25 Update** Awaiting availability of a suitable coder in the external company. Aim to have in place in next 2 months **November 25 Update** 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. **October 25 Update** Complete a procurement exercise in month
	Area 2 - Ethnicity: 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	Off Track	**January 26 Update** Performance in Ethnicity is not improving in Community Hospital Outpatients, despite the changes to the letter. This is being taken forwards by CSM in regard to embedding the process of reviewing letter data and ensuring the transfer into Rio **December 25 Update** Letter has been added to Synertec as a template and included Spoken Language, alongside Ethnicity, to work towards improved capture. **November 25 Update** The letter has been written and will be Rio configured following ratification with a plan to go live first week in December. **October 25 Update** Current performance = Bridgnorth (39%), Ludlow (53%), Whitchurch (67%). Trajectory to improve to 90% by February 2026

Action Plan	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	Off Track	**January 26 Update** Performance at 60%. Service to request another drill down to organisation/clinic level to look at targeted improvement in relevant areas. Then needs to be embedded in processes on a daily basis. **December 25 Update** Improvement is 10% on 12 months ago position, but has now stabilised at approx. 61%. Return to improvement plans and review areas of concern and re-enforce with staff on the need to ensure Ethnicity recording is on their radar **November 25 Update** 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. **October 25 Update** 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	**January 26 Update** Recruited to vacant admin post. Review of admin processes being undertaken and use of Rio front end report by new admin appointment to target records for updating **December 25 Update** Admin post in process of recruitment, plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** 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. **October 25 Update** 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	**January 26 Update** Going back out to advert for admin post. Staff sickness has also impacted on drop in performance in December to 49%. Mutual aid from Respiratory is being sought in the interim period. Triage process to be looked at and Ethinicity recording to be embedded. **December 25 Update** Admin post in process of recruitment plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** Performance has deteriorated in November to 66%, 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. **October 25 Update** 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	**January 26 Update** Continuation of implementing improvement plan with aim to recover position, currently at 82% in comparison to 79% in November **December 25 Update** Telford team now have improvement plan in place to recover position. **November 25 Update** 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. It is key that the self check in talks to Rio and updates records in real time	Jan-26	Apr-26	On Track	**January 26 Update** No update available. To be escalated to Digital lead and need to be a priority on roadmap. **December 25 Update** Digital team continuing to scope options and progress of self check in will now be overseen in Digital Assurance Group. **November 25 Update** 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. **October 25 Update** 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.
	Urgent Care Division - CSM to ensure cascading of reports through team leads and team members, to drive home the importance of ensuring Ethnicity recording is improved and staff are sighted on the level of monitoring that is happening and the improvements required to get to 90% by April 2026	Dec-25	Apr-26	On Track	**January 26 Update** Overall performance has remained static, with particular issue in DAART. CSM meeting with team lead and admin staff in DAART to agree an improvement plan to meet trajectory for April 2026. Areas like Virtual Ward to be targeted

	School Nursing Shropshire & Telford - Ethnicity Improvement has failed to continue and so target work required to embed the plan	Jan-26	Apr-26	On Track	**January 26 Update** Previous improvement in School Nursing in SC and TW has failed to continue since initial action completed around an improvement plan. Work to be revisited in order to embed improvement plan as part of daily processes within the schools and look at shared learning from better performing Dudley 0-19 teams
	Area 3 - MIU: MIU DQ Issues - Weekly Task and finish group for MIU dedicated to improving DQMI performance	Oct-25	Apr-26	On Track	**January 26 Update** Performance overall in Acuity and Chief Complaint has dropped to 66% in November, from 74%, however looking at early December position, this has started to improve again 69%, particular improvements in seen in Bridgnorth, Oswestry and Whitchurch as a result of this action, however a separate issue in Ludlow MIU that has begun in the last 2 months is dragging the overall performance trajectory down to a lower level. A separate action has been added below for the Ludlow issue **December 25 Update** Performance in acuity and chief complaint has dropped to 67% from 74%, in November. Review of data at site level shows that Ludlow and Bridgnorth are the particular areas of challenge that require targeted focus. T&F group established and DQ is high on the agenda, to lead to an improvement trajectory to reach 90% by April 26. Additional admin roles and triage process at Ludlow and Bridgnorth due to commence in January will also be key to improving this metric. **November 25 Update** 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 **October 25 Update** 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	**January 26 Upddate** Receptionsit will commence in post end of January **December 25 Update** Recruited to the receptionist post at Ludlow, start date pending. **November 25 Update** 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 **October 25 Update** Post presented to VRF agreed and commenced recruitment process
	Ludlow MIU - Triage Issue to be urgently solved Staff misunderstanding that using the triage field in Rio to add Acuity and Chief Complaint is populating the Triage timestamp that feeds the 15 minute Triage assessment KPI.	Jan-26	Feb-26	On Track	**New Action** Rio Config been asked to confirm that populating these fields do not impact upon the triage assessment time measure and they will be providing supportive information, which will be supplied to staff by ops for their assurance that this is the correct process to follow. CSM to meet Ludlow team lead on 14/1/26 to provide information, assurance and agree process and implement with immediate effect. CSM will ensure staff understand the impact of not populating this information, which feeds to NHSE. To be added to risk register if further issues should be determined

	Area 4 - Unoutcomed Appointments Requirement to proactively improve outcoming of appointments in a timely manner. Unoutcomed Appointments in Community Hospitals have increased by a large amount in recent months, due to staffing issues. This will impact upon DQMI performance un upcoming months.		Jan-26	Feb-26	On Track	**New Action** Community Hospital Admin Staff returning from sick leave which will increase the admin capacity available to support this position. Mutual aid has been provided by other services to support typing backlog and this will support improvement in outcoming appointments 0-19 lead is proactively picking up unoutcomed appointments across Health Visiting and School Nursing services. Initial improvement has been seen in December, further progress needed and will be monitored in DQ Subgroup standing item
Author	Alastair Campbell/Helen Cooper/Wendy Hallows/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas	**Date**	13/01/2026			
Accountable Officer Approval	Claire Horsfield	**Date**	19/01/2026			

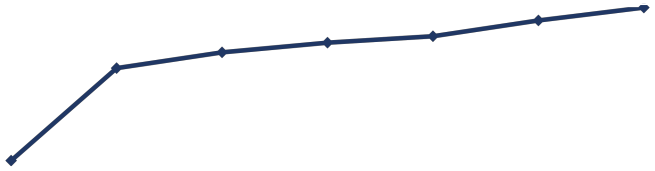
Exception Report - Action Plan

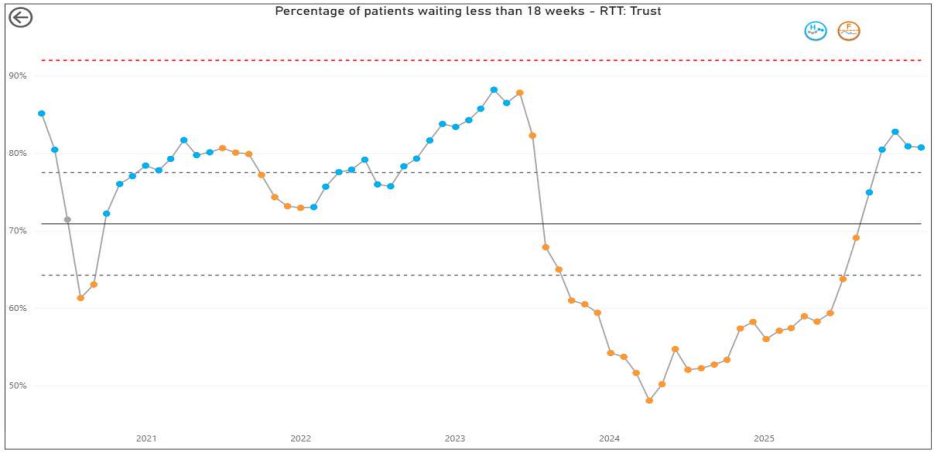
Percentage of Patients waiting less than 18 weeks - RTT

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
RTT Incomplete Pathways	%	69.09%	74.95%	80.47%	82.77%	80.90%	80.75*%	80.75*%
	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%





Reason for performance gap:	Since December 2024, overall recovery has improved and stabilised, though a 2% decline last month leaves performance behind the internal trajectory. Nevertheless, results remain substantially ahead of the national pathway for achieving 65% RTT compliance by March 2026 and 92% by March 2029. The internal goal is to achieve 18-week RTT by March 2026, with MSST (the largest activity area) on track, currently at 85.57% (unvalidated) for December. Targeted improvements at level 3 have continued, but the recovery profile is evolving; a renewed focus on level 2 demand and activity is underway to secure planned delivery. The primary risk to the March 2026 target is within Community Hospital Outpatients, where performance has declined across ENT, Respiratory, and Gynaecology specialties: •Bridgnorth: 49.72% in December (unvalidated), down from 61.03% in November and 66.74% in October •Ludlow: 67.74% in December (unvalidated), down from 74.8% in November and 78.07% in October •Whitchurch: 60.33% in December (unvalidated), up from 56.51% in November Declines at Bridgnorth and Ludlow are linked to consultant leave during the festive period and limited capacity for SaTH to provide alternative cover/ Locums. Whitchurch's improvement reflects the impact of the ENT improvement plan and enhanced outsourcing. Key actions in partnership with SaTH to recover Community outpatients include: •Joint Patient Tracking Lists (PTLs) •Job planning and standardisation of clinic templates •Targeted additional interventions for ENT, respiratory, and gynaecology over all wait lists Service transformation in APCS and Dental is ongoing; APCS saw a modest improvement to 49.71% in December (unvalidated), with a further 2–3% rise forecast post-validation predicted. Dental remains on trajectory despite seasonal fluctuation (72.88% in December - unvalidated). Ongoing recovery across all RTT pathways is supported by monthly data validation, real-time performance dashboards, and regular review meetings. There remains overall confidence in meeting March 2026 targets if risks are actively managed and current interventions progress as outlined.

		Start Date	End Date	Status	Comments
	Implementation of super clinic within existing capacity	Aug-25	Mar-26	On track	**January 25 Upadate** Ongoing with dual model through18 weeks outsourcing capacity and planning continues into 26/27 for this to roll over as business as usual. Blitz days for level 2 also planned in month **December 25 Update** 18 weeks super clinics extended, learning from the model captured for future with an in house model ready to go if required, currently continuing with a blended model with current teams working alongside 18 weeks this will be reviewed for ongoing progress by end of March when 18 weeks intervention ends. End date now reviewed and extended to reflect ongoing utilisation of 18 weeks. **November 25 Update** The future plan for MSST is to have consistent super clinic models as part of business as usual and this is being incorporated into job planning.
	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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA.
on Plan	Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients.	Nov-25	Dec-25	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks.

Acti	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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.
	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On track	**January 26 Update** Continues on track, out to advert and working with local PCNS and ICB to scope attracting primary care. Promoting sessions through local GP Board. **New Action** Going through VRF process.
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	On track	**January 26 Update** This was accelerated to support recovery as part of the improvement event and all areas are now on TPRO. Operationalising continuing and this will provide productivity opportunity and improved timely reporting. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants
	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, inovation, Group and left shift..	Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026
Accountable Officer Approval	Claire Horsfield	**Date**	19/01/2026

**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*

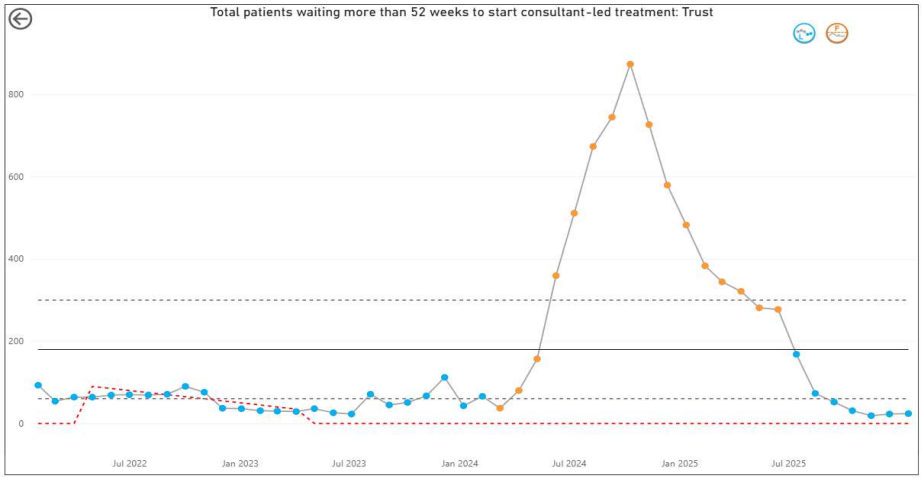
Exception Report - Action Plan

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
RTT 52+ week waits	Number	73	52	31	19	23	24*	24*
	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



Reason for performance gap:	This marks the second consecutive month in which performance has not progressed towards either the projected trajectory or the established target. There has however been considerable improvement across the 52-week cohort over the last 12 months, with progress ahead of the national profile. For reportable RTT (Referral to Treatment) services, there are currently no 52-week waits in MSST, Dental, or APCS. Risk associated with 52 week waits to move forward for these services is very low. The 24 (unvalidated) 52 week waits in December aligned to Community Outpatients services. All of these had dates and appointments and have been seen throughout January. Declines in community outpatients are linked to consultant leave during the festive period and limited capacity for SaTH to provide alternative cover/ Locums. The current objective is to now achieve 0 52 week waits across all services by March 2026. Contingent on the advancement of the following actions and intentions in partnership with SaTH: •Joint Patient Tracking Lists (PTLs) •Job planning and standardisation of clinic templates •Targeted additional interventions for ENT, respiratory, and gynaecology over all wait lists Close collaboration with SaTH to bolster ENT capacity has resulted in a substantial increase in the number of patients seen for their initial appointments in November 2025. While this has not translated into immediate performance improvement, it has enabled the majority of patients on the ENT waiting list to begin their treatment pathways and will consequently support to reduce the overall long waits . As the largest service within community outpatients, this development means many patients are now progressing to diagnostics or follow-up appointments, which will underpin longer-term service performance in conjunction with the plans outlined above, including continued partnership with SaTH. Nationally, the prioritisation of long waits remains a central focus and is reported during the weekly Tier 1 NHSE call.

	Start Date	End Date	Status	Outcome
Implementation of super clinic within existing capacity	Aug-25	Mar-26	On track	**January 25 Upadate** Ongoing with dual model through18 weeks outsourcing capacity and planning continues into 26/27 for this to roll over as business as usual. Blitz days for level 2 also planned in month **December 25 Update** 18 weeks super clinics extended, learning from the model captured for future with an in house model ready to go if required, currently continuing with a blended model with current teams working alongside 18 weeks this will be reviewed for ongoing progress by end of March when 18 weeks intervention ends. End date now reviewed and extended to reflect ongoing utilisation of 18 weeks. **November 25 Update** The future plan for MSST is to have consistent super clinic models as part of business as usual and this is being incorporated into job planning.
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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA.

Action Plan	Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients.	Nov-25	Dec-25	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** 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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.
	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	On track	**January 26 Update** This was accelerated to support recovery as part of the improvement event and all areas are now on TPRO. Operationalising continuing and this will provide productivity opportunity and improved timely reporting. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants
	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, inovation, Group and left shift..	Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026
Accountable Officer Approval	Claire Horsfield	**Date**	19/01/2026

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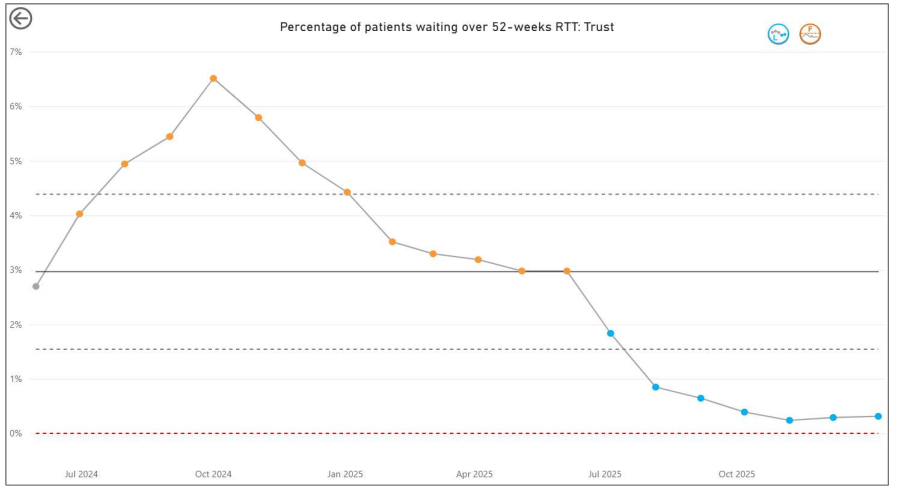
Exception Report - Action Plan

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Percentage of Patients waiting over 52 weeks - RTT	%	0.85%	0.65%	0.39%	0.24%	0.29%	0.31%*	0.31%*
	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%



Reason for performance gap:	This marks the second consecutive month in which performance has not progressed towards either the projected trajectory or the established target. There has however been considerable improvement across the 52-week cohort over the last 12 months, with progress ahead of the national profile. For reportable RTT (Referral to Treatment) services, there are currently no 52-week waits in MSST, Dental, or APCS. Risk associated with 52 week waits to move forward for these services is very low. The 24 (unvalidated) 52 week waits in December aligned to Community Outpatients services. All of these had dates and appointments and have been seen through out January. Declines in community outpatients are linked to consultant leave during the festive period and limited capacity for SaTH to provide alternative cover/ Locums. The current objective is to now achieve 0 52 week waits across all services by March 2026. Contingent on the advancement of the following actions and intentions in partnership with SaTH: •Joint Patient Tracking Lists (PTLs) •Job planning and standardisation of clinic templates •Targeted additional interventions for ENT, respiratory, and gynaecology over all wait lists Close collaboration with SaTH to bolster ENT capacity has resulted in a substantial increase in the number of patients seen for their initial appointments in November 2025. While this has not translated into immediate performance improvement, it has enabled the majority of patients on the ENT waiting list to begin their treatment pathways and will consequently support to reduce the overall long waits . As the largest service within community outpatients, this development means many patients are now progressing to diagnostics or follow-up appointments, which will underpin longer-term service performance in conjunction with the plans outlined above, including continued partnership with SaTH. Nationally, the prioritisation of long waits remains a central focus and is reported during the weekly Tier 1 NHSE call.

Action Plan		Start Date	End Date	Status	Comments
	Implementation of super clinic within existing capacity	Aug-25	Mar-26	On track	**January 25 Upadate** Ongoing with dual model through18 weeks outsourcing capacity and planning continues into 26/27 for this to roll over as business as usual. Blitz days for level 2 also planned in month **December 25 Update** 18 weeks super clinics extended, learning from the model captured for future with an in house model ready to go if required, currently continuing with a blended model with current teams working alongside 18 weeks this will be reviewed for ongoing progress by end of March when 18 weeks intervention ends. End date now reviewed and extended to reflect ongoing utilisation of 18 weeks. **November 25 Update** The future plan for MSST is to have consistent super clinic models as part of business as usual and this is being incorporated into job planning.
	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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** 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	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** 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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.
	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	On track	**January 26 Update** This was accelerated to support recovery as part of the improvement event and all areas are now on TPRO. Operationalising continuing and this will provide productivity opportunity and improved timely reporting. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants
	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, inovation, Group and left shift..	Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026
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**Please note that the actual performance for the month is subject to change as the validation for the national submission continued at the time of updating the action plan*

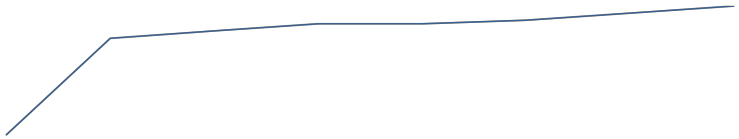
Exception Report - Action Plan

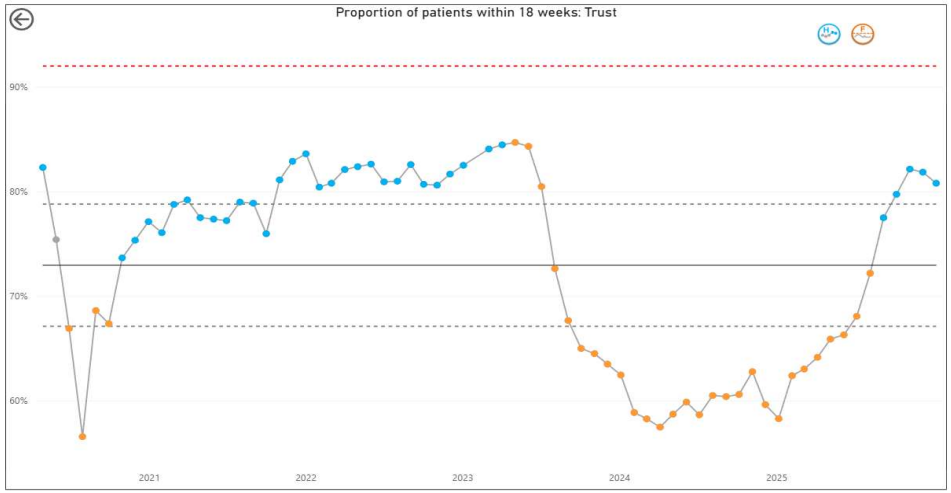
Proportion of patients within 18 weeks

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Proportion of patients within 18 weeks	%	72.19%	77.50%	79.73%	82.14%	81.85%	80.87%	80.87%
	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 experienced a marginal decline of 1% since November. While there has been a slight reduction in performance, the overall trend is however positive with reduced waiting lists and improved access across several key services. The total waiting list decreased by 262 patients. This suggests that, overall, service throughput and patient access are improving despite the minor dip in performance metrics. Key Services Impacting Performance •Bridgnorth Outpatients •CNRT (Community Neuro Rehab Team) •CDC (Childrens Develemont Centre) •Community Paediatrics •Diabetes •Dental •MSST (Musculoskeletal Services Shropshire and Telford) •Pulmonary Rehabilitation These areas have had the most significant influence on recent performance changes. Revised recovery trajectories have been established for each, and progress is being closely monitored through action plan workshops and local performance meetings. Every service, including both RTT (Referral to Treatment) and non-RTT reportable areas, has a robust, aligned recovery plan to ensure equitable provision. While restoring the 18-week referral to treatment target remains a key objective, priority is consistently given to clinically urgent and long-waiting patients, in line with national guidelines, with particular emphasis on MSST due to the large patient cohort. The stability of the service has improved following the transfer of Tems, supported by targeted waiting list initiatives and comprehensive demand and capacity modelling. Progress has been particularly achieved, through targeted improvements at level 3 within MSST, resulting in more patients being seen within the 18-week timeframe. The recovery strategy to realign with the trajectory, will now broaden to include level 2, with the introduction of super clinics and the adoption of best practices from level 3 to further reduce waiting lists and enhance overall service delivery, driving further improvements in the coming months. Speech and Language Therapy: Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of December. There's also been progress in reducing those waiting over 40 weeks. Wheelchair Services: Waits also improved from 70.23% in November to 79.92% in December. Enhanced validation procedures have been implemented, and restrictive intervention cases are being transitioned back to commissioners. Areas: Some services continue to contribute to unmet performance indicators, including Community Hospital Outpatients, APCS, Adult Physiotherapy, Childrens Physiotherapy, Continence, Bridgnorth Hospital Day Case, CIC, and Telford Care Homes MDT. Ongoing recovery plans, targeted interventions, and robust monitoring are all aligned to support recovery across all services.

	Start Date	End Date	Status	Outcome
Due to additional external Local Authority 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	**January 26 Update** This continues and the impact has been a result of zero 52 weeks within the CDC waiting list. **December 25 Update** This is now live with a total of 50 children seen by w/c 8/12/2025 **New action** 20 further appointments to be procured via private providers during December 25 and January 26.
Implementation of super clinic within existing capacity	Aug-25	Mar-26	On track	**January 25 Update** Ongoing with 18 weeks and planning continues into 26/27 for this to roll over as business as usual. **December 25 Update** 18 weeks super clinics extended, learning from the model captured for future with an in house model ready to go if required, currently continuing with a blended model with current teams working alongside 18 weeks this will be reviewed for ongoing progress by end of March when 18 weeks intervention ends. End date now reviewed and extended to reflect ongoing utilisation of 18 weeks. **November 25 Update** The future plan for MSST is to have consistent super clinic models as part of business as usual and this is being incorporated into job planning.
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	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.

	Recruitment of additional speech and language therapist within CNRT to support improvement in SLT waiting times.	Oct-25	Feb-25	On Track	**January 26 Update** No applicants however re-advertised Jan 2026. One additional day of SLT support has been sourced to mitigate. **December 25 Update** No applicants so re-advertised WB 8th Dec. **November 25 Update** Post was approved and has been out to advert with no suitable candidates. Team will readvertise.
	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	Complete	**January 26 Update** Embedded as business as usual. **December 25 Update** Super Penguin continuing to embed and recruitment to vacancies has commenced to ensure ongoing service resilience. **November 25 Update** In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway **New Action** 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	Complete	**January 26 Update** Improved by 2.24%. **December 25 Update** This piece of work has been delayed slightly due to workforce capacity. This will therefore continue into Jan 26. **November 25 Update** Liaised with Head of AHPs and D&C analysis has commenced. Clinical utilisation analysis being undertaken by the single point of access manager. **New Action** 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	Complete	**January 26 Update** Phase Two complete with additional clinical space available. **December 25 Update** The work at Coral House re increasing clinical space remains on track and will support therapy clinic utilisation. **New action** Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025

Action Plan	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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** 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	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** 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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.

	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On track	**January 26 Update** Continues on track, out to advert and working with local PCNS and ICB to scope attracting primary care. Promoting sessions through local GP Board. **New Action** Going through VRF process.
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**January 26 Update** This was excelerated to support recovery as part of the improvement event and all areas are now on TPRO. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants
	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	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	**January 26 Update** Recruited to vacant admin post. Review of admin processes being undertaken and use of Rio front end report by new admin appointment to target records for updating **December 25 Update** Admin post in process of recruitment, plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** 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. **October 25 Update** Alignment of admin process with SPR to strengthen reliance and vacancy offered to redeployment in the RRU's to support to manage the gap.
	Diabetes Nursing - recruitment of clinical vacancies	Nov-25	Mar-26	On Track	**New Action** Successfully recruited to post subject to recruitment checks and starters process
	Pulmonary rehab. workforce review underway and recruit to admin vacancy to support clinic utilisation.	Dec-25	Feb-26	On Track	**New Action** Event planning commenced, plan is date to be agreed early January.
	Community Paediatrics Job planning - Group session planned for January to support continued improvement.	Jan-26	Feb-26	On Track	**New Action** 2nd round of job planning to start in January.

	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, innovation, Group and left shift..		Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026			
Accountable Officer Approval	Claire Horsfield	**Date**	19/01/2026			

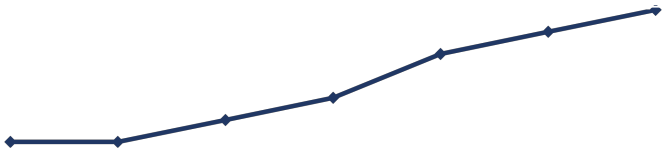
Exception Report - Action Plan

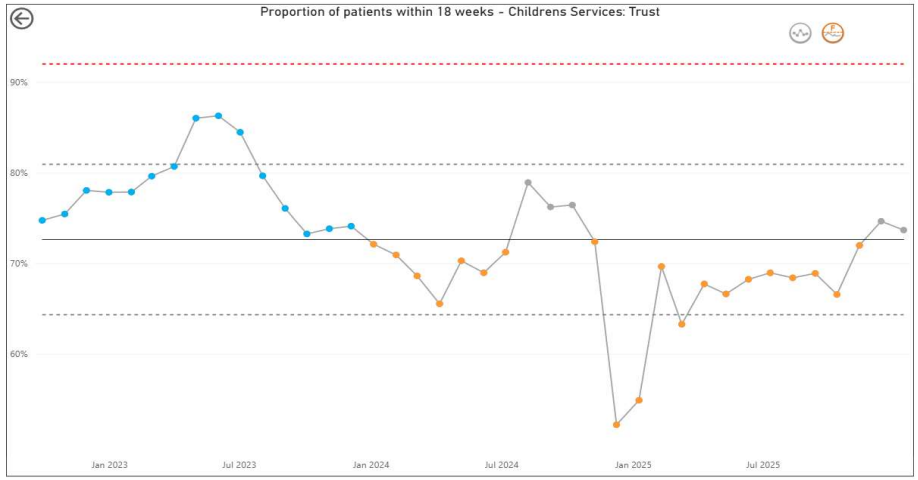
Proportion of patients within 18 weeks - Children's Services

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Proportion of patients within 18 weeks - Children's Services	%	68.40%	68.88%	66.56%	71.98%	74.64%	73.95%	73.95%
	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%





Reason for performance gap:	Service performance across Children's Community Services has seen a slight decline, with a 0.69% drop since November 2025. The primary areas influencing this change are the Children's Development Centre (CDC), Community Paediatrics, and Dental services. In December, revised trajectories for all these services were put in place. Progress is closely monitored through action plan workshops and local performance meetings. Each service has a strong recovery plan to address current challenges. For services that are both RTT (Referral to Treatment Time) and non-RTT reportable, careful alignment has ensured equitable provision and prioritisation of non-RTT services. For CDC and Comm Paeds core focus over the next month to recover is through the Coral House Estates reconfiguration we are maximising clinic space to increase clinics as part of recovery. Dental there is an impact on seasonal variation and the increase in respiratory related illnesses which has seen a spike in DNA's and cancelled appointments. In line with national predictions respiratory related illness impacting is likely to stabilise by mid - end of January. Service-Specific Improvements: •Children's Speech and Language Services SLT have demonstrated a steady improvement in waiting list management. Implementing early intervention programmes, running holiday clinics, and revalidating waiting lists have resulted in a notable outcome: no children or young people (CYP) were waiting over 52 weeks as of December. There has also been an improvement for those waiting over 40 weeks, indicating ongoing positive momentum. •Wheelchair Services Waiting times for wheelchair services improved significantly, rising from 70.23% in November to 79.92% in December. Additional validation for the Community Services SITREP was carried out for December's data. This included the removal of Wheelchair Restrictive Interventions that are being transferred back to Commissioners, and further validation of high waits in accordance with the SITREP definition. •Children's Physiotherapy Over the past 12 months, Children's Physiotherapy has faced challenges due to long-term staff absences and attrition. However, December saw a 2.24% improvement in performance. Recruitment efforts are ongoing, though filling specialised posts remains difficult. Mutual aid options, both internally and with SaTH, have been exhausted. The MSST team has supported by accommodating some CYP aged 16–18 years. To address demand and capacity, clinic utilisation exercises have been undertaken, and additional clinic space is being sought through estate changes at Coral House. A comprehensive workforce review and recruitment drive are currently underway to recover waiting list positions and stabilise the service.

		Start Date	End Date	Status	Outcome
Action Plan	Due to additional external local authority 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	**January 26 Update** This conitnues and the impact has been a result of zero 52 weeks within the CDC waiting list. **December 25 Update** This is now live with a total of 50 children seen by w/c 8/12/2025 **New action** 20 further appointments to be procured via private providers during December 25 and January 26.
	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	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
	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	Complete	**January 26 Update** Embedded as business as usual. **December 25 Update** Super Penguin continuing to embed and recruitment to vacancies has commenced to ensure ongoing service resilience. **November 25 Update** In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway **New Action** 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	Complete	**January 26 Update** Improved by 2.24%. **December 25 Update** This piece of work has been delayed slightly due to workforce capacity. This will therefore continue into Jan 26. **November 25 Update** Liaised with Head of AHPs and D&C analysis has commenced. Clinical utilisation analysis being undertaken by the single point of access manager. **New Action** 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	Complete	**January 26 Update** Phase Two complete with additional clinical space available and being booked into. **December 25 Update** The work at Coral House re increasing clinical space remains on track and will support therapy clinic utilisation. **New action** Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025
	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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** To be raised at CRM Oct 25. Finance/ Contracting team to explore recompense and future SLA.
	Community Paediatrics Job planning - Group session planned for January to support continued improvement.	Jan-26	Feb-26	On Track	**New Action** 2nd round of job planning to start in January to further enanhce productivity.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026	
Accountable Officer Approval	Claire Horsfield		19/01/2026	

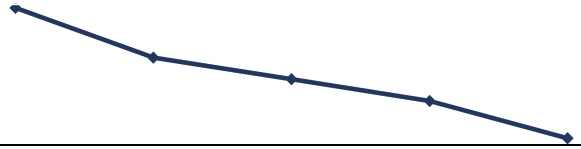
Exception Report - Action Plan

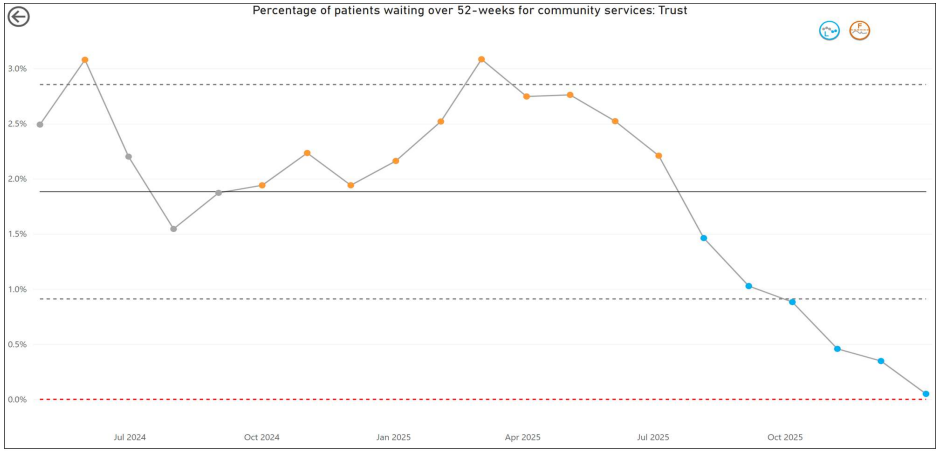
Percentage of patients waiting over 52-weeks for community services

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Percentage of patients waiting over 52-weeks for community services	%	1.46%	1.03%	0.88%	0.46%	0.35%	0.05%	0.05%
	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%





Reason for performance gap:	There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery has significantly improved and is in line with the trajectory. Wheelchair services waits have been improving from 70.23% for November to 79.92% in December. Additional validation for the Community Services SITREP was conducted for December's position. As part of this process we have removed the Wheelchair Restrictive Interventions that are being transferred back to Commissioners (from all local wait KPI) and validated high waits in Wheelchair services against the SITREP definition There are other services which contribute to not meeting this performance target such as Diabetic Nursing and Childrens Physiotherapy.

		Start Date	End Date	Status	Outcome
	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	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
	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	Complete	**January 26 Update** Phase Two complete with additional clinical space available and being booked into. **December 25 Update** The work at Coral House re increasing clinical space remains on track and will support therapy clinic utilisation. **New action** Operational lead initiating an estates realisation project for CYP therapy services. To report requirements by Dec 2025

Plan

Action	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	Complete	**January 26 Update** Embedded as business as usual. **December 25 Update** Super Penguin continuing to embed and recruitment to vacancies has commenced to ensure ongoing service resilience. **November 25 Update** In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway **New Action** 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.
	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	**January 26 Update** Recruited to vacant admin post. Review of admin processes being undertaken and use of Rio front end report by new admin appointment to target records for updating **December 25 Update** Admin post in process of recruitment, plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** 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. **October 25 Update** Alignment of admin process with SPR to strengthen reliance and vacancy offered to redeployment in the RRU's to support to manage the gap.
	Diabetes Nursing - recruitment of clinical vacancies	Nov-25	Mar-26	On Track	**New Action** Successfully recruited to post subject to recruitment checks and starters process

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026	
Accountable Officer Approval	Claire Horsfield		19/01/2026	

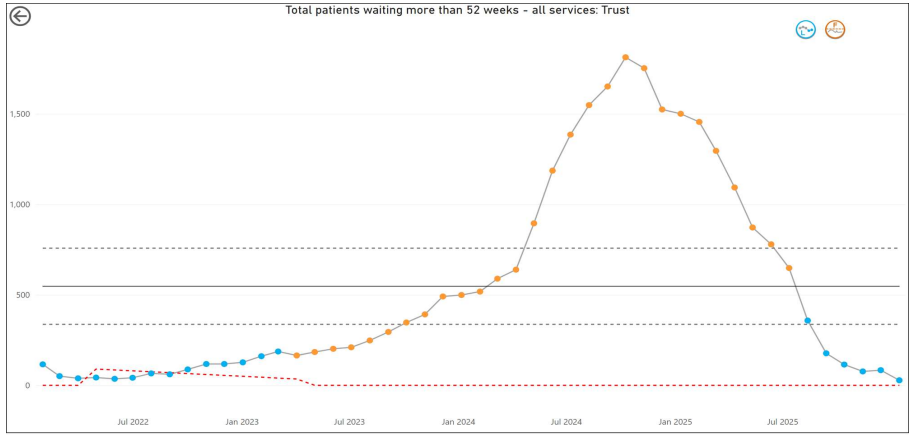
Exception Report - Action Plan

Total patients waiting more than 52 Weeks – All services

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
52+ Week waits - All services	Number	358	177	115	77	84	28	28
	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



Reason for performance gap:	There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery has significantly improved and is in line with the trajectory. Operationally targeting the community hospital outpatient's (21) performance will have an impact on recovery over the next month. The challenges with this position are attributable mainly to ENT, respiratory and Gynae. Additionality has been aligned for ENT from accessing through SaTH an outsourcing company, this has generated an admin typing backlog for patients to be outcomed and clocks closed (clinically urgent have been prioritised). This will be influencing overall performance and there is a robust plan in place to recover this with admin mutual aid from across the organisation aligned . Respiratory and Gynae service provision via consultants has been ad hoc due to consultant availability, leave and sickness. Weekly meetings with SaTH at all levels are now well established to recover and align community outpatients' provision and performance to SaTH's overall improvement plan, to ensure equity of service provision across STW. There are other services which contribute to not meeting this performance target such as MSST, Diabetic Nursing, Bridgnorth Hospital Daycase, Childrens Physiotherapy and DAART. Wheelchair services waits have been improving from 70.23% for November to 79.92% in December. Additional validation for the Community Services SITREP was conducted for December's position. As part of this process we have removed the Wheelchair Restrictive Interventions that are being transferred back to Commissioners (from all local wait KPI) and validated high waits in Wheelchair services against the SITREP definition

	Start Date	End Date	Status	Outcome
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	**January 26 Update** This conitnues and the impact has been a result of zero 52 weeks within the CDC waiting list. **December 25 Update** This is now live with a total of 50 children seen by w/c 8/12/2025 **New action** 20 further appointments to be procured via private providers during December 25 and January 26.
Implementation of super clinic within existing capacity	Aug-25	Mar-26	On track	**January 25 Upadate** Ongoing with dual model through18 weeks outsourcing capacity and planning continues into 26/27 for this to roll over as business as usual. Blitz days for level 2 also planned in month **December 25 Update** 18 weeks super clinics extended, learning from the model captured for future with an in house model ready to go if required, currently continuing with a blended model with current teams working alongside 18 weeks this will be reviewed for ongoing progress by end of March when 18 weeks intervention ends. End date now reviewed and extended to reflect ongoing utilisation of 18 weeks. **November 25 Update** The future plan for MSST is to have consistent super clinic models as part of business as usual and this is being incorporated into job planning.
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	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.

Action Plan	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	Complete	**January 26 Update** Phase Two complete with additional clinical space available. **December 25 Update** The work at Coral House re increasing clinical space remains on track and will support therapy clinic utilisation. **New action** 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	Complete	**January 26 Update** Embedded as business as usual. **December 25 Update** Super Penguin continuing to embed and recruitment to vacancies has commenced to ensure ongoing service resilience. **November 25 Update** In school initiatives commenced end of September and will continue through the autumn term. Development of super penguin continues and piloting is underway **New Action** 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.
	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	Complete	**December 25 Update** Peformance continuing to improve, provision improved, no further action. This is now monitored through Tier 1 calls to maintain consistency in provision and performance **November 25 Update** Discussions ongoing directly with SaTH to support with plans for future. Notification of theatre provision improving and SaTH scoping plan to reach full SLA if this cannot be delivered then mitigation will be formalising current arrangements with RJAH. **New Action** 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	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** 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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.
	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**January 26 Update** This was excelerated to support recovery as part of the improvement event and all areas are now on TPRO. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants

	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, inovation, Group and left shift..	Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.
	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	**January 26 Update** Recruited to vacant admin post. Review of admin processes being undertaken and use of Rio front end report by new admin appointment to target records for updating **December 25 Update** Admin post in process of recruitment, plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** 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. **October 25 Update** Alignment of admin process with SPR to strengthen reliance and vacancy offered to redeployment in the RRU's to support to manage the gap.
	Diabetes Nursing - recruitment of clinical vacancies	Nov-25	Mar-26	On Track	**New Action** Successfully recruited to post subject to recruitment checks and starters process

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026	
Accountable Officer Approval	Claire Horsfield		19/01/2026	

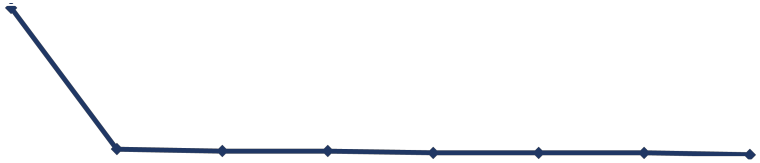
Exception Report - Action Plan

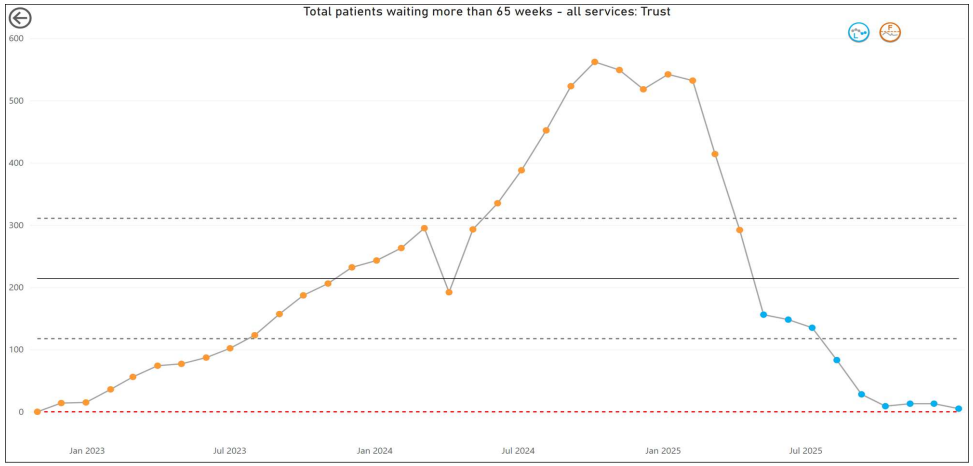
Total patients waiting more than 65 Weeks – All services

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
65+ Week waits - All services	Number	83	28	9	13	13	5	5
	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 improved with 5 over 65 week waits. The services which contribute to not meeting this performance target are MSST, Community Hospital Outpatients, Diabetes Nursing and DAART Wheelchair services waits have been improving from 70.23% for November to 79.92% in December. Additional validation for the Community Services SITREP was conducted for December's position. As part of this process we have removed the Wheelchair Restrictive Interventions that are being transferred back to Commissioners (from all local wait KPI) and validated high waits in Wheelchair services against the SITREP definition

	Start Date	End Date	Status	Outcome
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	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
Discussions are taking place with 18 weeks to provide additional Respiratory and Gynaecology capacity to support community Outpatients.	Nov-25	Dec-25	Off Track	**January 26 Update** As an alternative to expanding 18-weeks outsourcing provision across community Outpatients, partnership with SaTH, we are scoping feasibility of using their existing outsourcing companies for ENT and other specialties to promote equity and consistency of service provision. Additionally, combined PTL and job planning, along with unified clinic templates, have been introduced to ensure service provision is aligned across both SaTH clinics and SCHT Outpatients ensuring consistent improvement to both organisations. **December 25 Update** Pending start dates from 18 weeks but also working with SaTH re combined long waits PTL meeting to ensure provision aligned equitably across STW to ensure future sustainability. **New Action** The plan is going through the governance process to receive ratification and plans are being worked through with 18 weeks.

Action Plan	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	Complete	**January 26 Update** Standardisation and mutual aid across the Trust with roll out of Tpro across all of outpatients has supported completion of this action with oversight now coming into the weekly senior PTL meeting to sustain progress. **December 25 Update** MSST typing back log has improved within KPI, for APCS and Community Outpatients mutual aid across admin services trust wide scoped. SaTH approached for mutual aid, unable to support at this time but conversations remain live. Further sickness across services has prevented full recovery. Working with workforce and Occupational Health re individuals who are sick and could return to non-clinical admin duties to help work through back log. Working with MedAX the provider for ENT additional capacity to also align admin support. Interviews planned for W/C 15th December for admin vacancies. Bank authorisation aligned for individuals to work additionally. **New Action** 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.
	Additional administrative recruitment (APCS, Community Outpatients and MSST).	Dec-25	Feb-26	Complete	**January 26 Update** Recruited to typist position in community outpatients and APCS. All admin posts now recruited. With start dates by end of January. **New Action** Interviews planned in Dec
	Further roll out of T-PRO across community outpatients	Dec-25	Mar-26	Complete	**January 26 Update** This was excelerated to support recovery as part of the improvement event and all areas are now on TPRO. **New Action** System ordered awaiting delivery and implementation date, a total of 28 Consultants
	To support typing recovery further, we will unite all Medical Secretaries and Admin staff across the planned care / children's division in a Quality Improvement Day focused on using lean methodology to clear administrative backlogs, prepare for the Tpro system launch, and standardise processes Trust-wide.	Dec-25	Jan-26	Complete	**January 26 Update** Mutual aid aligned from across Trust and TPRO rolled out ahead of plan **New Action** Event planning commenced plan is date to be agreed early January.
	Joint Community Outpatients improvement and growth group to be established between SCHT and SaTH to maximise recovery, inovation, Group and left shift..	Jan-26	Feb-26	On track	**New Action** TOR drafted and attendance planned with rotating chair of Deputy COO for SaTH and Deputy Director of Ops for SCHT.

	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	**January 26 Update** Recruited to vacant admin post. Review of admin processes being undertaken and use of Rio front end report by new admin appointment to target records for updating **December 25 Update** Admin post in process of recruitment, plan to have someone in post January. Ongoing improvement plan progressing. **November 25 Update** 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. **October 25 Update** Alignment of admin process with SPR to strengthen reliance and vacancy offered to redeployment in the RRU's to support to manage the gap.
	Diabetes Nursing - recruitment of clinical vacancies		Nov-25	Mar-26	On Track	**New Action** Successfully recruited to post subject to recruitment checks and starters process
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026			
Accountable Officer Approval	Claire Horsfield		19/01/2026			

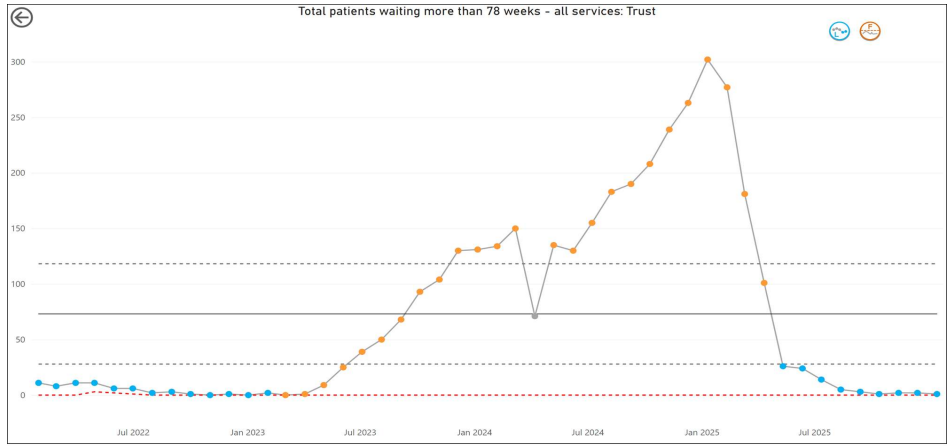
Exception Report - Action Plan

Total patients waiting more than 78 Weeks – All services

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
78+ Week waits - All services	Number	5	3	1	2	2	1	1
	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



Reason for performance gap:	The 78 week position has improved and the remaining wait was a data error within DAART. Wheelchair services waits have been improving from 70.23% for November to 79.92% in December. Additional validation for the Community Services SITREP was conducted for December's position. As part of this process we have removed the Wheelchair Restrictive Interventions that are being transferred back to Commissioners (from all local wait KPI) and validated high waits in Wheelchair services against the SITREP definition 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**	
	Review of data quality issues resulting in incorrect reporting of high waits and provide education for services with repeating occurrences	Sep-25	Nov-25	Complete	**December 25 Update** Continue to meet weekly to report on improvements. Raising awareness in different arenas e.g. weekly huddle, divisional performance meeting and Divisional Clinical Drop in meetings. **November 25 Update** Report and weekly meeting provided to Deputy Director of Operations for discussion and action with teams to improve data caption. **October 25 Update** 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. **New Action** Information Team to compile a list of instances over the last 6 months to inform SDG leads and support services in reducing these instances.

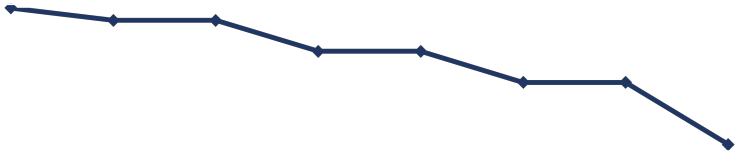
Action Plan	QEIA to be completed re restrictive intervention for Wheelchairs and discussion with commissioners re activity on waiting list not commissioned to deliver		Aug-25	Nov-25	Complete	**December 25 Update** Completed and notice served with agreement for patients already in progress to be completed and all other diverted back to ICB for signposting to most appropriate service. Letters drafted for referrers and patients to ensure clear communication of revised pathway. **November 25 Update** QEIA has gone through quality and safety notice to be formally served to commissioners by close of November **October 25 Update** Action on track and meetings arranged following QEIA presentation. **September 25 Update** 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. **New Action** QEIA re impact to be presented internally September, meeting to talk through with commissioners end of August arranged and bench marking commenced re other areas pathways and provision to support mitigation at system level.
Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	13/01/2026			
Accountable Officer Approval	Claire Horsfield		19/01/2026			

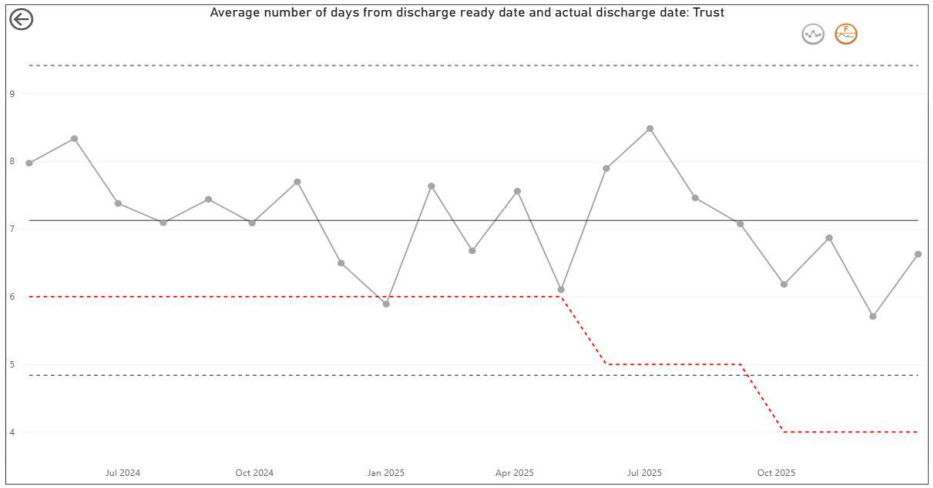
Exception Report - Action Plan

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

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Average number of days from discharge ready date and actual discharge date	Number	7.5	7.1	6.2	6.9	5.7	6.6	6.6
	Target	5.0	5.0	4.0	4.0	4.0	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:	NCTR performance is currently below target and not in line with the expected improvement trajectory. The situation worsened in December, largely owing to reduced care package capacity over the festive period and a Covid and Flu A outbreak at Whitchurch, both of which negatively affected results. The improvement plan is however making progress and is being managed by a dedicated task and finish group, with support from the wider system. Oversight of this workstream is provided by the UEC Delivery Group as part of the complex discharge improvement plan. Continued progress depends significantly on engagement from local authorities and ensuring that suitable patients are admitted to community hospitals. A major risk to sustaining improvement, especially during winter, is the national rise in Flu and Covid cases. This could increase the risk of patient deconditioning and require more intensive care following discharge, leading to additional delays and longer length of stay. To address this, enhanced infection prevention and control (IPC) measures have been introduced, including daily IPC support, mandatory red mask use, and consolidating 'red to green' and 'no criteria to reside' meetings into a single daily meeting. This change is designed to free up clinical therapy time and provide more focused rehabilitation support on wards, fostering a stronger rehabilitation culture and minimising unnecessary internal delays. Additionally, a system-wide 'Home for Turkey' initiative was organised prior to Christmas to improve flow throughout the system. Unlike previous events that focused mainly on acute capacity and pathway 2 beds. Insights gained from this event have been integrated into the broader improvement programme, ensuring that successful strategies are maintained and applied throughout the year.

		Start Date	End Date	Status	Outcome
Action Plan	Implementation of Director of Operations weekly oversight performance meetings for stranded patients and those with a LoS of greater than 1 day on the NCTR list.	Oct-25	Feb-26	Complete	**December 25 Update** In place and established this has supported improvement through a clearly established escalation and assurance route. Plan is for this to now remain as part of business as usual. **November 25 Update** Reporting requirements are being established linking with the review at high week waits meeting **New Action** 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-26	Complete	**January 26 Update** This is now buisness as usual **December 25 Update** Complete and in place this will be reviewed in January for effectiveness. Briefing to all of Ops established and across SLT to ensure all sighted on plans for Winter. **November 25 Update** This is in the early phases of implementation
	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 will 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-26	On Track	**January 26 Update** Really productive leading up to Christmas and then impacted over festive period as described above. New dates are being developed for Feb/Mar **December 25 Update** Home for Turkey planning established at system level with senior ops and clinicians aligned across the period. **November 25 Update** An event took place 28th October **New Action** First 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	Complete	**December 25 Update** Both RRU's closed by 24th November in line with system agreed plan **November 25 Update** SCC are engaged with escalating delays to ensure our RRU closure plan is delivered **New Action** 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 pathway 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	**January 26 Update** Due to escalation levels, the data is being reviewed 19th January **December 25 Update** Data collection continuing and monthly finding being fed into task and finish group. **November 25 Update** Data collection has commenced **New Action** TBC once implemented.
	Condense the NCTR daily oversight calls at ward level to once a day to reduce duplication, align RIO oversight and release time bac to care for therapy staff		Dec-25	Apr-26	On Track	**January 26 Update** Task and Finish Group is well established with reviews of reporting and use of Rio Forms currently being undertaken **New Action** TBC once implemented.
	System wide planning event to review 12 months of UEC Improvement programmes is arranged for January 26th. Within this NCR system wide progress will be reviewed and agheed oversight and next steps to secure whole system flow and progress will be agreed with clear governance structures in place to drive improevment.		Dec-25	Jan-26	On Track	**New action** SCHT senior attendance confirmed and plans for newley appointed CTH manager to become system lead for system NCTR recovery.
	Appointment of a Care Transfer Senior Lead		Jan-25	Apr-26	On Track	**January 26 Update** Recruitment process in place with interviews being held in January **New Action** Recruitment process commenced
Author	Sam Townsend / Sally Stubbs / Gemma McIver	**Date**	13/01/2026			
Accountable Officer Approval	Claire Horsfield		19/01/2026			

Shropshire Community Health NHS Trust

Month 9 2025/26 Financial Performance

Author:	Jonathan Gould, Deputy CFO	**Paper date:**	5 February 2026
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	27 January 2026
Paper Reviewed by:		**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance in December (month 9) 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 December 2025 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £1,714k adjusted surplus as at month 9 compared to the planned surplus of £1,431k, which is favourable variance of £283k.

Key areas for consideration are:

- **Agency -** spend is £2,278k after nine months of the financial year; this is £23k adverse to plan. The overspend is due to the commencement of Enhanced UCR services where agency staff are being utilised pending substantive recruitment. Locum medics are also covering unplanned vacancy and sickness absence which has contributed to the overspend. The forecast outturn is an adverse variance to plan of £200k at the year-end. **Agency spend must continue to remain within overall planned pay levels to deliver the financial plan.**

- **Bank pay** spend is £3,094k after nine months of the financial year; this is £1,029k 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. The forecast outturn is an adverse variance to plan of £1,332k at the year-end. **Bank spend must continue to remain within overall planned pay levels to deliver the financial plan.**

- **CIP** delivery at month 9 is £4,018k; this is £129k favourable to plan. The Trust has now de-risked the programme in full, with all schemes now reported as low risk in relation to forecast delivery. **The Trust must deliver the CIP target in full to deliver the financial plan.**

Month 9 2025/26 Financial Performance

- **Cost pressures –** the year to date financial performance is impacted by cost pressures in Prison Healthcare, Rehab and Recovery Units (RRUs) and the Wheelchair service. Mitigating actions have reduced a number of these pressures in the past few months and we are seeking additional measures to ensure the ongoing impact on the Trust's financial position is minimised. **The Trust must continue to mitigate any cost pressures in order to deliver the financial plan**.

- **Underlying position –** the planned underlying position for 2025/26 is a surplus of £932k. As at month 9 the Trust achieved an underlying/recurrent surplus of £786k, which is a favourable variance to plan of £138k. **The Trust is on course to deliver £1,100k underlying surplus for the year which is favourable to the plan by £168k.**

- **Risk and Forecast**– At month 9 the Trust is reporting all financial risks are fully mitigated and the level of financial risk has further reduced since month 8. We are forecasting to deliver our planned surplus of £2m, however we are looking at opportunities which will allow us to exceed this level of surplus given our year to date favourable variance to plan.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 9 is a surplus of £1,714k compared to the planned surplus of £1,431k, which is a favourable variance of £283k.
- **Consider** the underlying/recurrent position year to date is a surplus of £786k, which is a favourable variance to plan of £138k and that the Trust is on course to deliver £1,100k underlying surplus for the year which is favourable to plan by £168k.
- **Acknowledge** that our forecast outturn is to deliver our planned surplus of £2m and that we are looking at opportunities which could allow us to exceed this level of surplus.

Month 9 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 9.

Financial Performance against Plan (£k)	M09 Plan	M09 Actual	M09 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast	Annual Variance
(Surplus)/ Deficit in Year	(182)	(191)	(9)	(1,431)	(1,714)	(283)	(2,000)	(2,000)	0
Underlying Position	(87)	(90)	(3)	(648)	(786)	(138)	(932)	(1,100)	(168)
Agency Expenditure	228	276	48	2,255	2,278	23	2,939	3,139	200
Bank Expenditure	231	342	111	2,065	3,094	1,029	2,736	4,068	1,332
Cost Improvement Programme	486	502	16	3,889	4,018	129	5,359	5,359	0
Capital Expenditure	855	978	123	3,592	2,805	(787)	4,975	4,975	0

3.2. Adjusted Financial Performance – favourable variance to plan £283k

The adjusted financial position at month 9 is a surplus of £1,714k compared to the planned surplus of £1,431k which is a favourable variance of £283k. Further details on the underlying position are set out in section 3.2.9.

Table 1 summarises the position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(96,795)	(97,065)	(270)
Expenditure excl. adjusting items	95,364	95,351	(13)
Adjusted financial performance total	**(1,431)**	**(1,714)**	**(283)**
Adjusting items	103	110	7
Retained (surplus) / deficit	**(1,328)**	**(1,605)**	**(277)**

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

Month 9 2025/26 Financial Performance

3.2.1. Income – favourable variance to plan £270k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System income	(74,910)	(74,971)	(61)
Non-system income	(21,885)	(22,094)	(209)
Total income	**(96,795)**	**(97,065)**	**(270)**

Table 2: Income Summary as at 31 December 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. Although our activity reporting indicates that elective activity is exceeding planned levels, it is unlikely we will receive any additional funding given national funding flows. SCHT elective income reporting is therefore in line with our plan.

3.2.2. Expenditure – favourable variance to plan £7k

Table 3 shows a summary of expenditure by key categories.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	65,993	64,321	(1,672)
Bank	2,065	3,094	1,029
Agency	2,255	2,278	23
Total Pay	**70,313**	**69,693**	**(620)**
Supplies & Services Clinical	8,292	8,763	470
Prison Escorts and Bedwatch	197	321	124
Drugs	1,135	1,112	(22)
Premises	6,857	6,758	(99)
Travel	1,252	1,136	(117)
Other	7,421	7,678	257
Total Non-Pay	**25,154**	**25,768**	**613**
Total Expenditure	**95,467**	**95,460**	**(7)**

Table 3: Expenditure Summary as at 31 December 2025

3.2.3. Pay – favourable variance to plan £620k

The overall pay position is a favourable variance of £620k. 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 at month 9 is £3,094k; this is £1,029k adverse to plan. This is 4.4% of total pay compared to planned spend of 2.9% and is due to higher level of vacancies than planned. The forecast outturn has been updated to reflect a likely adverse position of £1,332k by the year-end.

Month 9 2025/26 Financial Performance

Agency spend in month 9 was £276k, consistent with the previous month. Year-to-date expenditure is £23k above plan. The monthly run rate has risen in recent months due to vacancies, medical staff sickness, and additional agency use to support the expansion of Urgent Community Response (UCR) services pending recruitment of substantive staff. The annual agency target is £2,939k (3.2% of total pay costs), but achieving this will be challenging for these reasons. The forecast outturn was therefore updated in month 8 to reflect a projected adverse variance of £200k by year-end.

Total pay costs are forecast to remain within overall planned levels.

The vacancy rate in month 9 was 7.1% (a reduction from 10.9% in March 2025), which equates to 123 WTE vacancies, however it should be noted that 106 WTE temporary staff (78 WTE bank and 28 WTE agency) were used in the month with the majority covering clinical vacancies.

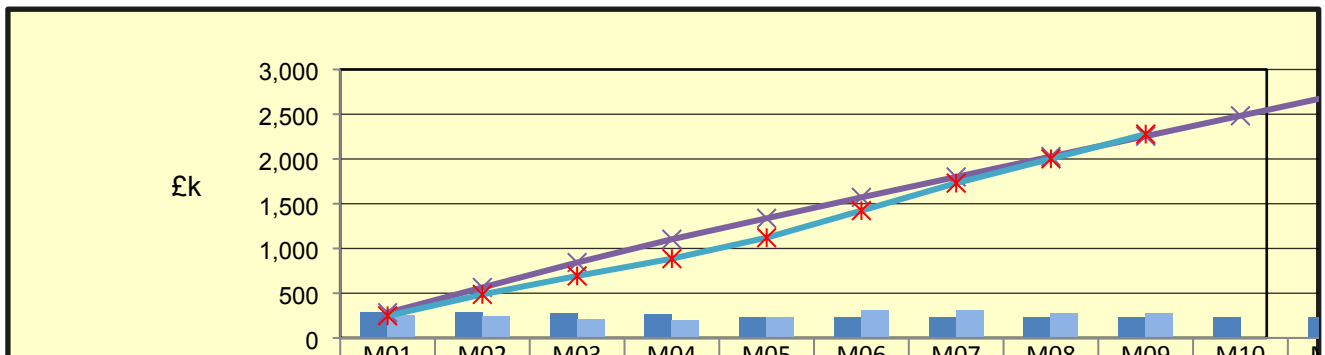
The vacancy position is kept under close review through the weekly Vacancy Control Panel and the People Committee. Improved recruitment and retention remain crucial to reduce the Trust's reliance on temporary staff.

3.2.4. Non-Pay – adverse variance to plan £613k

There are continuing cost pressures in Stoke Heath Prison and the Wheelchair service 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 – adverse variance to plan £23k

Table 4 shows that year-to-date agency expenditure stands at £2,278k, which is £23k above the planned figure of £2,255k. Since September 2025, agency usage has increased due to additional temporary medical locum requirements and the expansion of the UCR service. Consequently, the Trust is now forecasting an adverse variance of £200k for 2025/26, exceeding the annual target of £2,939k (representing 3.2% of total pay costs).



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	
In Month Plan	282	282	279	260	234	234	228	228	228	228	
In Month Actual	247	239	207	193	235	302	308	271	276		
Cumulative Plan 25/26	282	564	843	1,103	1,337	1,571	1,799	2,027	2,255	2,483	2
Cumulative Actual 25/26	247	486	693	886	1,121	1,423	1,730	2,002	2,278		

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

3.2.6. Cost Improvement Programme 2025/26

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

Month 9 2025/26 Financial Performance

Table 5 shows overall CIP delivery of £4,018k as at month 9, which is £129k favourable to plan.

	Plan YTD £k	Actual YTD £k	Variance YTD £k
Recurrent	2,575	2,640	65
Non-recurrent	1,314	1,378	64
TOTAL	**3,889**	**4,018**	**129**

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

Recurrent delivery at Month 9 is £2,640k, which is £65k favourable to plan. Non-recurrent CIP delivery is £1,378k, which is £64k favourable to plan.

Positive progress has been 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 all schemes are now categorised as low risk.

Recurrent / Non Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total Forecast £k	Total Plan £k	Full Year Effect CIP £k
Recurrent	3,574	0	0	0	3,574	3,574	3,574
Non Recurrent	1,785	0	0	0	1,785	1,785	-
	4,962	**0**	**0**	**0**	**5,359**	**5,359**	**3,574**
Recurrent	67%	0%	0%	0%	67%		
Non Recurrent	33%	0%	0%	0%	33%		
	100%	**0%**	**0%**	**0%**	**100%**		

Table 6: CIP 2025/26 full year breakdown as at 31 December 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. Statement of Financial Position

The summarised Statement of Financial Position (SoFP) for period ended 31 December 2025 is shown in Table 7.

	30 November 25 Balance £k	31 December 25 Balance £k	Movement in Month £k
Property, Plant & Equipment	41,661	42,149	488
Inventories	212	212	0
Non-current assets for sale	0	0	0
Receivables	4,443	3,298	(1,145)
Cash	30,650	31,613	963
Payables	(15,490)	(14,896)	594
Provisions	(3,713)	(3,713)	0
Lease Obligations on Right to Use Assets	(10,751)	(11,474)	(723)
TOTAL ASSETS EMPLOYED	**47,012**	**47,189**	**177**
Retained earnings	37,645	37,822	177
Other Reserves	9,367	9,367	0
TOTAL TAXPAYERS' EQUITY	**47,012**	**47,189**	**177**

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

Month 9 2025/26 Financial Performance

- Receivables (amounts we are owed) decreased by £1,145k due mainly to receipt of outstanding quarterly contractual payments from Local Authorities for our 0-19 Services.
- Payables (amounts we owe) decreased by £594k due mainly to deferred income movements for patient services activity.
- Cash increased by £963k largely because of the above changes.

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

3.2.8. Capital Expenditure

The 2025/26 plan is £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 are now forecasting operational capital spend of £3,527k and IFRS16 lease capital spend of £1,448k, which totals £4,975k.

The additional capital of £3,572k which is available to ShropCom in relation to freedom and flexibilities provided to high performing trusts, is now forecast to be spent in 2026/27. This assumes we continue to achieve a NOF 2 rating. If our NOF rating deteriorates, our flexibility to spend surpluses as capital is unlikely to be available.

At month 9, actual capital spend was £2,805k compared to planned spend of £3,592k, an underspend of £787k. The underspend is due mainly to moving the allocation from IFRS 16 leases anticipated 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 8 below.

Capital Expenditure	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Annual Forecast £k	Annual Variance £k
Operational Capital	1,701	1,561	(140)	2,818	3,527	(709)
IFRS 16 Leases	1,891	1,244	(647)	2,157	1,448	709
	3,592	**2,805**	**(787)**	**4,975**	**4,975**	**0**

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

3.2.9. Underlying financial position

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

The underlying year to date position at month 9 is £786k surplus which is £138k favourable to plan. The favourable variance is due mainly to recurrent CIP and income overperformances. The Trust is on course to deliver £1,100k underlying surplus for the year which is £168k favourable to plan, based on our forecast recurrent CIP delivery.

Month 9 2025/26 Financial Performance

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, cost pressures and Local Authority pay underspends.

3.2.10. Forecast Outturn and Financial Risk

Following review of all available information relating to our financial performance for the remainder of the year, the Trust is reporting all financial risks are fully mitigated with further reduction in the level of financial risks since month 8. This provides confidence that we will deliver our forecast outturn of £2m surplus, which is in line with plan. The Trust is also looking at opportunities which could allow us to exceed this level of surplus.

In line with usual practice, our forecast outturn and financial risk assessment was considered through the January Resource and Performance Committee meeting.

3.2.11. Medium Term Financial Planning – 2026/27 to 2027/28

Following review and approval at the Trust Board meeting on 4 December 2025, the first draft plans were submitted to NHSE on 17 December 2025. The plans included two-year plans for workforce and finance and a capital expenditure plan covering four years.

Final plan submissions are due on 12 February 2026 and will include three-year plans for activity, performance, workforce and finance together with supporting narrative for years 4 and 5. Capital expenditure plans will also be submitted covering four years.

The final version of our plan will be approved by the Trust Board prior to submission.

3.2.12. Monthly Monitoring Return to NHSE

The Month 9 Provider Finance Return (PFR) return to NHSE was submitted on Friday 23 January 2026 and is consistent with the information contained in this report.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 9 is a surplus of £1,714k compared to the planned surplus of £1,431k, which is a favourable variance of £283k.
- **Consider** the underlying/recurrent position year to date is a surplus of £786k, which is a favourable variance to plan of £138k and that the Trust is on course to deliver £1,100k underlying surplus for the year which is favourable to plan by £168k.
- **Acknowledge** that our forecast outturn is to deliver our planned surplus of £2m and that we are looking at opportunities which could allow us to exceed this level of surplus.

Shropshire Community Health NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**5 February 2026**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	29 January 2026
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:

- Delivery of the objectives as at Q3
- 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
- The risk in relation to the financial plan delivery has been reduced to reflect a reducing likelihood and consequence of the Trust not achieving its financial plan. This is now recommended for closure as it has met the target risk rating

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	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Movement in Month	Target
1.1	Workforce Team Capacity	Sept 23	16	16	16	16	16	16	16	16	16	16	20	20	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	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	-	-	-	-	-	-	-	CLOSED	4
3.2	Quality Team Capacity	Oct 24	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	12	12	↔	4
3.4	Demand exceeds capacity	Apr 22	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	9	9	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	16	16	16	16	16	12	12	12	6	↓	6
5.4	Insufficient capital funding	Sep 24	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: January 2026

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:

- Culture paper being presented to the Executive Team for consideration of enhanced culture programme
- Long term sickness cases have been reviewed and assurance gained regarding the long term conditions
- Review of occupational health underway as a system

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:	January 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	2495

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	Phase 1 is completed with one vacancy remaining for the education role, comms going out to the organisation and phase 2 has commenced and will conclude by the end of March 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 1.2**

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:	January 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	5834, 7101

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	Cultural programme being informed by the board interview feedback and developed in the context of group

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:	January 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	5834, 7101

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, agreed with staffside to do this jointly

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: January 2026

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 has been completed in relation to staff sickness
- Vacancies have reduced
- Workforce planning to be undertaken

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: January 2026

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
- Deep dives undertaken in hotspot areas with learning and improvement opportunities identified

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:	January 2026
Source of Risk:	Internal Audit
Corporate Risk Register	7101

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
- C4: Overdue PSII reports
- C5: Operational capacity to complete the actions

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
C4	Ownership of the reports to be reinforced	Director of Governance / Director of Nursing	April 2026	Discussed at Patient Safety Committee agreed that deadlines will be set with authors to attend patient safety panel
C5	Oversight at Divisional Governance Meetings of action plans	Director of Governance / Director of Ops	March 2026	Emphasis on overdue actions to be increased in reports to Divisional Governance meetings and escalation to Director of Nursing and Director of Ops if actions not brought back on track by next meeting

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:	January 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	3249, 3620, 3167, 3947, 4590

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
- ✓ Incident data

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 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. Completed
C2	Review all services with waiting times	Director of Nursing / Director of Operations	June 2026	
A1	KPI to be established	Director of Nursing	June 2026	Work is underway to develop a KPI, working with the information team

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:	January 2026
Source of Risk:	Internal Risk Assessment / External Guidance and Controls
Corporate Risk Register	3167, 3947, 4595, 4806, 7162

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 utilise 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	Ongoing

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: January 2026

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:	January 2026
Source of Risk:	Internal risk assessment
Corporate Risk Register	3167, 3249, 3947, 4590, 4595, 5834, 6286

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~~
- Uncertainty regarding commissioning intentions which have potential to impact on operational capacity

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
C2	Engagement with the commissioners	Director of Ops	June 2026	Ongoing discussions between senior operational staff and commissioner to understand the implications of the intentions

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

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:	January 2026
Source of Risk:	Internal Risk Assessment / Integrated System Improvement Plan
Corporate Risk Register	N/A

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~~ February 2026	Draft statement has been reviewed by Governance Leads and feedback provided, awaiting final draft for approval

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: January 2026

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:

- Exceeding delivery against financial plan and productivity target
- HSJ Award won for unlocking productivity through automation for the E-consent project which is now being rolled out more widely
- Sustained improvements in patient access as demonstrated through our improved oversight framework score
- ERIC returns demonstrate improved estate management
- Digital investment supporting improved efficiency and more directly the cost improvement plans

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:	January 2026
Source of Risk:	Internal Risk Assessment
Corporate Risk Register	N/A

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. On track with submission due in Q2

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:	January 2026
Source of Risk:	Internal Risk Assessment / Vacancy Rate
Corporate Risk Register	N/A

Controls:

- ✓ Digital strategy and programme of work in place with clinical prioritisation of projects through the digital assurance group
- ✓ 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 **RECOMMENDED FOR CLOSURE**

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	3↓	3
Likelihood	5	2↓	2
Total	20	6↓	6

Risk Details:

Opened: April 2022

Reviewed Date: January 2026

Source of Risk:

Corporate Risk Register N/A

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	Completed