NHS
Shropshire Community Health
NHS Trust

Public Trust Board - 3 October 2024

MEETING
3 October 2024 10:00 BST

PUBLISHED
30 September 2024

Agenda

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Shropshire Community Health NHS Trust

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE MEMORIAL HALL, OSWESTRY AT 10AM ON THURSDAY 1 AUGUST 2024

PRESENT

Chair and Non-Executive Members (Voting)	
Ms. Tina Long	(Chair)
Mr. Peter Featherstone	(Non-Executive Director and Vice Chair)
Mr Harmesh Darbhanga	(Non-Executive Director)
Non-Executive Members (Voting)	
Ms. Jill Barker	(Associate Non-Executive Director)
Executive Members (Voting)	
Ms. Patricia Davies	(Chief Executive)
Ms. Sarah Lloyd	(Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Clair Hobbs	(Director of Nursing & Clinical Delivery)
Executive Members (Non-Voting)	
Ms. Claire Horsfield	(Director of Operations and Chief AHP)
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Ms. Rhia Boyode	(Director of Human Resources) ***Culture Item only***
In attendance	
Ms. Diane Davenport	Executive Personal Assistant (to take the minutes of the meeting)

Welcome

Ms Long welcomed all to the meeting and noted that this was a meeting of the Board held in public. Ms Long thanked the members of the public and press for attending. The Chair welcomed Holly Grainger, Community Sister, who had attended the meeting as part of her training to qualify as a District Nurse.

The Chair paid respects to the people in Southport following the tragic events on Monday and said that the thoughts of the Trust were with them.

The Chair acknowledged that the Trust Board papers were published late on the Trust's website due to extenuating circumstances and an error on the part of the Trust and provided apologies for this. The Chair acknowledged that questions from the public had been omitted from the agenda in error and this would be reinstated. The Board had agreed that going forward public questions would be one of the first items on the agenda.

Apologies and Quorum

Apologies were received from Cathy Purt (Non-Executive Director) and Alison Sargent (Non-Executive Director). Rhia Boyode (Director of People and OD) attended for the Culture item only.

Declarations of Interest

Mr Featherstone advised that he had taken up an agency position in London, there was no conflict with the Trust.

Chair's Award

Ms Long presented the following Award:

Sally Stubbs
Who had been nominated by Clair Hobbs Director of Nursing & Clinical Delivery.
Sally is always a positive and compassionate leader and remains hard working and patient focussed. Nothing is too much trouble, and she always conducts herself with enthusiasm, passion and upmost professionalism. She is a wonderful example of how clinical leaders should conduct themselves bringing positivity and compassion to everything she does even in difficult situations. Whilst on call over the weekend we received a complaint about a patient in our care which concerned me greatly. Sally once again went above and beyond and immediately attended the ward to conduct a thorough assessment of the patient and their clinical records, feeding back to me so we could devise a plan and so that I could offer comfort and reassurance to the patient's relatives. Her clinical judgement and conduct with the patient and the team and the responsiveness and care she showed once again demonstrated to me what a wonderful asset she is to our team, and I am very grateful.

Ms Stubbs thanked the Chair for the Award, she said it was good to receive feedback from the Chief Nurse, and commented she was just doing her job.

Patient Story

The Chair welcomed Sarah Venn (Clinical Lead for Quality) and Lucy Hawkins (Admiral Nurse) to the meeting. Ms Venn explained that the story was from both staff and relative perspectives relating to the End-of-Life Care for a patient who had dementia and cancer.

The Chair thanked Ms Venn and Ms Hawkins for the video and sharing the story. Ms Venn explained the importance of services working together to provide end of life care, but that someone needed to take the lead.

Ms Hobbs thanked Ms Venn and Ms Hawkins for sharing the story and demonstrating compassion and tenacity for supporting the patient and their family. As Director of Nursing, Ms Hobbs offered to spend some clinical time with Ms Hawkins to understand the journey of the patient, any learning and share with System colleagues as there is nothing more powerful than a patient story. Ms Hobbs

mentioned that this is a good example of where a true Community Matron role would have helped in pulling a wider multi-disciplinary and senior oversight approach to this patient's care.

Ms Horsfield acknowledged it was important to hear patient stories, both good and bad; it was time to reflect on practice for both the patient and family. The key was integration, teams from different services working together and seeing the patient as a person. The Community Matron role would support MDT working and see the patient as a person.

Mr Darbhanga thanked Ms Hawkins for sharing the story. He suggested that Ms Venn and Ms Hawkins return Board to provide an update in the future.

Public Questions

The Chair apologised that the Board papers were not available on the Trust website in a timely manner due to technical issues. The questions would be published as an addendum to the minutes and individual responses would be sent to the relevant individual.

Dates and venues of Board meetings would be published on the Trust's website going forward.

Ms Long handed over to Ms Ramtuhul to summarise the questions received.

Ms Ramtuhul explained that there had been a lot of duplication in the questions so she would summarise the themes of the questions, noting what Ms Long had said about the full questions and answers being made available to the public via an addendum to the minutes of the meeting:

Questions about the publication of papers

Ms Ramtuhul re-iterated that the papers had been completed on Friday but that there had been a technical issue loading the papers onto the website. Those who had contacted the Trust regarding this were provided with a copy without any delay. Ms Ramtuhul clarified that the Trust's usual practice was to publish the papers on the Friday before the Board Meeting.

Questions about the response to public questions

Ms Ramtuhul confirmed that public questions are always published in full in the minutes along with the Trust's response. In the instance of the Trust receiving too many questions to address in the meeting these would be summarised and then included as an addendum. Anyone raising a question could expect an individual answer in addition.

Question about the video recording of the June meeting being available.

Ms Ramtuhul explained that the Board previously took a decision to hold the Board meetings face to face rather than virtually, as per the practice pre-Covid, the meetings were therefore no longer being recorded.

Questions about a contract that has been awarded to a third-party organisation for the provision of medical services, due diligence and suggested privatisation of the NHS.

Ms Horsfield provided an overview; the contract referenced was put to tender, as required under NHS procurement rules. There were no bids from NHS organisations and there were no bids from local organisations. A rigorous procurement process was undertaken by the system procurement team on the Trust's behalf, and Ms Horsfield stated she was content that the company awarded the contract was able to meet the service specification and provide the required quality services to patients.

A question was received about how the Non-Executive Directors are assured regarding the procurement of a third part contract.

Mr Darbhanga commented that there was a discussion at Audit Committee relating to procurement exercises. Internal audit provided good assurance that the internal system procurement team followed due diligence and procurement rules when awarding contracts. It was also noted that no other bids were received from local organisations to provide the service.

Mr Featherstone noted that the Non-Executive Directors relied on the information provided to the Board and were assured at Audit Committee that the procurement process had been followed correctly. There was a discussion at RPC and assurance provided that the provider awarded the contract covered the quality metrics.

The Board agreed:
The request for the service spec for the contract will be dealt with as a FOI request.
The full questions and responses will be published as an addendum to the minutes and individual response will be provided.
The Chair and the Chief Executive offered to meet with members of the public outside the meeting to follow up.
Agenda item relating to "Public questions" to be reinstated.

Minutes of the Meeting held on Thursday 6th June 2024

Ms Lloyd requested clarification under the section **Performance Framework – Integrated Performance Reporting Update 2024/25**. The minutes reflect that there was a detailed discussion relating to sickness absence reporting in KPIs and possibly increasing the target from 4.5% to 5%. Ms Lloyd's understanding was that it was agreed that the target would be set at 4.75% and sought clarification on this. The minutes recorded that the target is set to 5% and KPIs have been set to 4.75%. The Board agreed that the target was set to 4.75%.

With the above amendment, the minutes were accepted as accurate record of the meeting.

Notification of Any Other Item of Business

There was none.

Chair's Report

Ms Long provided an update on key activities and noted that she had attended a Board Development session on Equality, Diversity and Inclusion which reconfirmed the Trust's commitment to being an inclusive organisation. The Board were in the process of agreeing objectives for this year and encouraged the Board to send their suggestions to Ms Boyode.

Ms Long and Ms Horsfield had attended the ICB Board Development Session with colleagues, where there had been a good discussion and ideas on how we can work better together and picked up as part of the ICB work.

The Board noted the report.

Non-Executive Director's Communication

Mr Darbhanga advised that he attended a mock CQC interview last week which was conducted by a representative from the Solihull Mental Health Trust, it was challenging, and focused was on how Non-Executive Directors sought assurance.

Mr Darbhanga was the NED lead for Freedom to Speak Up and was pleased to report there was now a web-based app that staff could use to raise any concerns. There had been very few FOI issues raised and the app may encourage staff to raise concerns and already seen an increase in the number received. The Board requested that the Freedom to Speak Up Guardian present to the Board at a future meeting.

Mr Featherstone had provided Non-Executive Director input to the ICB Strategic Commissioning meeting which had a role in reviewing the System finance as a whole. In his role as Vice Chair, he had attended the regional meeting to discuss finances and attended a CQC mock interview.

Chief Executive Update

Ms Davies paid tribute to the colleagues in the emergency services following the incident in Southport on Monday. Ms Davies summarised her report and noted the key updates since the last meeting of the Board.

Mr Featherstone stated that he had revisited the prison in the last 12 months and noted a profound change in the culture since his first visit.

Mr Darbhanga acknowledged the positive report. It was good to hear that Bishops Castle Community Hospital inpatients had re-opened and suggested that a press release be issued. He welcomed the news that Elective Care were meeting the national targets and thanked Ms Horsfield and team for their work relating to the 52 weeks wait target.

Ms Barker commented was heartening to have a way forward for dental services and thanked colleagues.

The Board noted the report.

QUALITY, SAFETY AND PEOPLE

Quality and Safety Committee Chair's Report

Ms Barker summarised the report and noted it was a good meeting with assurance provided in most areas. The Committee received a report on the current DATIX system issues, the transition to LFPSE and the mitigations in place.

The Board accepted the assurance provided by the update.

Integrated Quality and Safety Performance Report

Ms Hobbs summarised the report and key headlines. Falls work continued as part of the Quality Improvement programme, a deep dive and thematic review of pressure ulcers was in progress, and it was noted that staff fill rates in June were above the 90% threshold. There had been a case of C.Diff at Ludlow Community Hospital in June and rolling total in year of 4 which was above the annual metric of 1, it was noted that the Trust was waiting for this year's metrics. Ms Hobbs had been working with colleagues on C.Diff as SaTH had seen an increase in cases and were conducting a deep dive. Of the 4 reviewed within ShropComm, there were no lessons for the Trust to learn and everything was in line with the policy, apart from 1 case where a sample was sent off late.

The Board noted the report.

Quarterly Mortality Learning from Deaths Review

Dr Ganesh summarised the report; there had been 9 deaths in the last quarter, 2 were unexpected but explainable deaths and there had been no deaths relating to Covid in this quarter, none of the deaths were a patient with autism or a learning difficulty. The Medical Examiner service for Independent Review of the Cause of Death had been rolled out and started with a pilot at Ludlow Community Hospital. Dr Ganesh had CQC Interview with the Medical Examiner and was advised that there were good robust processes in place.

Ms Hobbs noted that Whitchurch Community Hospital had a higher number of deaths than other areas and there had been triangulation work by linking with a subject matter expert, who had provided assurance through the Patient Safety Committee, there were no themes or trends relating to the deaths. Ms Hobbs, Dr Ganesh and Ms Horsfield would meet to review if anything else needed to be done.

Dr Ganesh informed the Board that since January 2024, the Child Death Overview Process was managed by the ICB rather than the Trust. Dr Ganesh chaired the meeting in his role as ICB Interim

Medical Director and there were no issues to raise; he would provide a further update to the next Quality & Safety Committee.

The Board
- ***Noted the report and the themes detailed***
- ***Agreed the full assurance provided by the report.***

Annual report – Infection Prevention and Control

Ms Hobbs provided a summary of the Annual Report which has been to the IPC Committee and Quality & Safety Committee for sign off and was presented to the Trust Board for final approval before publishing on the Trust's Website. The report provided a summary of the infection prevention and control work that had been undertaken for the year 2023/24.

Ms Hobbs thanked the IPC Team, Richard Best, Hotel Services and Pharmacy Team for their input into the Annual Report.

Ms Long asked about cleaning at Oswestry following the Regional IPC visit last year. Ms Hobbs informed the Board that following the visit concerns were raised about the cleaning at Oswestry Health Centre and the bed spaces at Whitchurch Community Hospital. A follow up Regional IPC visit was carried out in June 2024 and the Trust received a letter advising that due to work done and improvements, that the Trust had moved back to routine monitoring from enhanced monitoring and the Regional Team were impressed with what had been achieved in 12 months. There were a few recommendations in the letter that would continue as actions through the IPC Committee and it was noted that the Trust would continue to review the bed spaces at Whitchurch.

Mr Darbhanga asked what the plan was for next year and innovative ideas, Ms Hobbs noted that as part of the Quality Improvement Programme there was a full work plan for the next 12 months and that a quality improvement project for catheters and 12-month cycle of Audits/visit for IPC.

The Board approved the report and recommended that take forward the actions and recommendations and hear progress in QSC.

Maintaining focus and oversight on quality of care and experience in pressurised services

Ms Horsfield provided a summary of the letter which had been received by all Trusts from NHSE following the Dispatches programme the Board to gain assurance on how the Trust are sighted on any potential pressures.

The letter set out 6 areas for Boards to assure themselves against and evidence was presented to provide assurance against all six areas. Evidence was provided for assurance regarding care in unconventional care areas. There were recommendations to take forward which were to provide further oversight, triangulation and assurance and it was noted that the paper went to Quality & Safety Committee.

Ms Davies advised that the Executive team had spent time reviewing at the programme to understand where some of the weak points were and must recognise that staff work in challenging situations. District Nurses must also be taken into consideration as they are out in the community, very often on their own. Ms Davies welcomed the recommendations and they had been discussed with staff and she was confident they are the right recommendations.

Ms Lloyd acknowledged it is a good report in providing assurance on the Trusts oversight of pressurised services to ensure quality and safety. She asked if there were consequences for the Trust regarding the escalation beds being open in relation to delivering care in unconventional areas and noted the a reduction in falls following the removal of the escalation beds. Ms Hobbs commented that the removal of the 4 escalation beds had indeed seemed to improve the level of falls being seen on this ward. When the escalation beds were open, the Trust were having to use temporary staff to maintain safety within the area which had continued to be a challenge so closing the beds now that Bishops castle was open and winter pressures had ceased was the right thing to do. The opening of Bishops Castle beds has allowed further quality work to be conducted by closing further beds at Whitchurch temporarily to complete a deep clean programme.

Ms Long commented that MIUs were more pressurised than other areas and were a potential pinch point. Ms Hobbs commented that from quality and operational perspective the Trust was well sighted on where the pressures where. There was the option for MIUs to activate "Permission to pause".

Mr Featherstone asked about Virtual Ward occupancy levels and said that it was important care was not compromised and were the Trust working with SaTH to utilise the service. Dr Ganesh advised that there was an in-reach team who work with SaTH to identify patients for VW and RRU. Ms Davies advised that Virtual Ward occupancy levels were in line with national figures.

The Board:
Approved the recommendations with inclusion of staff can raise concerns about services and MIUs use of permission to pause.
A visit by SaTH Board and Shropcom Board to be arranged to RRUs to understand the pressures and capability in our system and partners.
An update to provided on a regular basis to Board.

PEOPLE

Culture Report

Ms Boyode provided an update on the Culture and Leadership Programme. Following the Board development day in June, the Board were supportive of the proposals, and Ms Boyode was asked to return with a summary of the work, and evidence of how the culture programme would measure improvements. The Board was asked to formally approve the implementation of the Culture Leadership Programme and seek assurance on the progress to date. The Culture and Leadership Programme was discussed at JNP where it was well received, and the staff side would like to contribute and be part of the culture journey.

Ms Ramtuhul suggested that on the annual calendar of events be produced which would include Occupational celebration days.

Ms Hobbs commented that there needs to be an acknowledgement of Corporate Services also as part of the programme.

The Board discussed the programme and commented that would like to see key measures for improved culture, how the Board would receive assurance that the culture of the organisation was improving and not wait 12 months for the staff survey and making incremental improvements.

Ms Boyode provided details of some of the culture work that was already happening. Regular updates would be provided to the Board, which would include progress on metrics through team and Pulse survey results and update on any risks or changes to the programme.

The Board discussed the issue around race and how to work together on Equality Diversity & Inclusion as there were pockets of EDI and racism was present in wider society. The Trust were reviewing EDI and working with leads, the community and networks to raise awareness of EDI.

The Board:
Supported the recommendations in the report.
A short Culture update to be provided at every Board meeting.

RESOURCE & PERFORMANCE

Resource & Performance Committee Chair's Report

Mr Featherstone summarised the report. The meeting was pleased with assurance relating to RTT waiting times and that good progress was made with 52 week waits. The Committee reviewed the non-RTT challenges and noted that work with the MSST service was progressing and he expected to see an improvement. In relation to the Elective Activity Plan and Delivery, the Committee gained

assurance from the recovery plan and agreed this element of reporting could be stood down. The reduction in the use of agency continued and summary of bank data was presented for the first time and the Committee requested further information on bank worker usage and policy. CIP schemes were progressing, and 100% CIP schemes had been identified with a percentage high risk in terms of delivery.

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

Integrated Performance Report

Ms Lloyd advised that the report summarised the Trust wide position. There were 64 performance indicators reported in this period across all committees. There were 33 indicators highlighted as a concern and said that each Committee was responsible for reviewing its own KPIs. From an RPC perspective, the Committee reviewed 29 indicators, 14 required particular focus with 13 of the 14 relating to access to services and waiting times. A review of Data Quality and internal audit report found substantial assurance that processes worked well and effective and more processes in place.

Ms Horsfield provided an update regarding 52 week waits. A separate report was presented to RPC and national target as 65 week, which the Trust was ahead of but noted this was not without risk. There was an element of patient choice and the need to achieve 52 week waits by end of September 2024. The RPC paper demonstrated an achievement of 7 weeks of improvement against the ambition. The right actions were in place, with the ability to enact in the timeframe and the risk was dependent upon partners and still working towards the September 2024 target.

The Board approved the alteration to the KPI details for New Birth Visits % within 14 days – Dudley and addition of Virtual Ward Occupancy and content to sign off the 2 KPIs.

Performance Framework

Ms Lloyd provided an update on the Trust's updated Performance Framework, which had been reviewed and amended, largely to reflect the Trust's updated governance structure and Executive team responsibilities. In Section 11 there was a diagram that set out the structure for accountability and assurance in relation to performance monitoring and reporting. The Action plan template is appended to the report and the recommendation is that each committee uses the Action plan template to provide assurance to Committee and Board.

The Board approved the Trust's updated Performance Framework.

The Accountability section Never Events to be allocated to the Director of Nursing & Clinical Delivery.

Finance Report

Ms Lloyd presented the Month 3 Financial report. The Trust was reporting a £276k adjusted surplus this year to date compared to the planned surplus of £284k. This was a challenging financial plan. Elective activity was in line with the plan, agency and pay costs were doing well and Ms Lloyd thanked the teams and recruitment for their work in recruiting to substantive posts. The largest risk was in relation to delivery of the efficiency plan which is reviewed in FRG, and the risk was reducing. Significant capital constraints and it was noted there may be further risk that there may be further pressures in relation to the system wide capital allocated to cover lease obligations.

Mr Darbhanga expressed concern around the system deficit and the impact on the Trust if the deficit was higher than planned. A pay award of 5.5% has been agreed for Agenda for Change staff and the Doctors pay award had been agreed and asked if this would have an impact on budgets in the system or was it fully funded.

Ms Lloyd agreed that this was a particularly challenging financial system, which had been the case for a long time. The focus was to safety deliver the plan and any risks would be discussed at the Finance Committee. The System would work together to drive efficiency work across Shropshire Telford & Wrekin. The National pay award had been agreed, and Ms Lloyd said that the assumption was that pay awards would be fully funded.

The Board noted the report.

2024/25 Planning Process

Ms Lloyd provided an update on the agreed 2024/25 Operational Plan to deliver the eight Strategic Priorities and the longer-term objectives. Senior responsible Officers (SROs) were developing detailed delivery plans with milestones for each intervention and would propose how achievement of the outcomes would be measured and evidenced. Each Committee had approved the proposed interventions and outcomes.

Mr Featherstone endorsed the proposal and asked how it would link together from Executive perspective. Ms Davies explained that delivery of agreed outcomes would be monitored at the monthly Performance Board meetings which Executive Team attend and would include oversight through Board Committees.

The Board approved the proposed interventions, outcomes and delivery dates.

AUDIT

Audit Committee Chair's Report

Ms Ramtuhul stated Risk Management report was presented at the Audit Committee and the risks had reduced, however there were a couple of items overdue; the Oswestry DAART and Children's service, so only partial assurance was agreed by the Audit Committee.

The Risk Management strategy had been approved and provided a verbal update on BAF Risks. The review by Internal Audit on procurement provided moderate assurance and recommendation relating to the ATOM system to be maximised. Data quality Audit received substantial assurance. RTT progress was good news and good work being undertaken.

Internal audit recommendations for review are Violence, Aggression & Bullying and Business Continuity. The Audit Plan for 2024/24 had been agreed.

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

Board Assurance Framework (BAF)

Ms Ramtuhul advised that the BAF was presented and approved by Committees last week. A report on Board Performance Quarter. 1 and any risks would be provided to the Board.

Board Development 24-25

MS Ramtuhul provided an update on the Board Development programme for 2024-25.

Ms Long suggested a Development Session on “How effective we are as a Board” in October and to have a Schwartz round at private Board.

Ms Hobbs suggested including Quality Improvement.

ANY OTHER BUSINESS

Ms Ramtuhul informed the Committee that Mark Donovan the Patient Experience Lead was leaving the Trust at the end of August 2024 due to retirement. Ms Ramtuhul on behalf of the Trust thanked him for his hard work and the Patient Stories would be his legacy. A new appointment had been made to the role and would be responsible for patient stories.

DATE OF FUTURE MEETING

Date of Future Meeting

Thursday 3 October 2024.

Shropshire Community Health
NHS Trust

TRUST BOARD
1 AUGUST 2024

ACTIONS FROM THE MEETING

Actions from Last meeting	Lead Responsibility	Progress
A presentation to be provided to the Board on Research and Development within the Trust	**Dr Ganesh**	**Update 01.08.2024 –** Dr Ganesh to consider when the R&D presentation will come to the Board.
Outstanding Actions from Previous Meetings	**Lead Responsibility**	**Progress**

Shropshire Community Health NHS Trust

Chair's Update

0. Reference Information

Author:	Tina Long	**Paper date:**	3 October 2024
Executive Sponsor:	Shelley Ramtuhul	**Paper written on:**	17 September 2024
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an update from the Chair on activities in the last two months for information purposes.

2. Executive Summary

2.1 Context

The Chair provides a regular update to the Public Board on any key activities and highlights of the preceding two months which are felt to be of interest to the Board and the general public.

2.2 Summary

This report provides an overview of the following:

- Meetings and visits that have taken place
- Summary of the Private Board Meeting held in September
- Outline of recent Board Development Session

2.3. Conclusion

The Board of Directors is asked to note the update for information purposes.

Chair's Update

3. Main Report

3.1 Main Report

Since our last Public Board in July I have again been busy with the Non-Executives visiting some of our services to talk to staff and to see for ourselves the care being delivered to patients. We have undertaken visits to the Recovery and Rehabilitation wards at both Shrewsbury and Telford hospitals. As we have heard at the Board from the executive team these services enable patients to recover and rehabilitate in preparation for their discharge following a stay on Acute hospital wards. We heard from Nursing staff, Allied Health Professionals, Medical staff and Administrative staff about the excellent care they provide to patients and also some of the challenges they face. This service has been developed through true collaborative working with our colleagues across the system.

We also visited Ludlow Hospital and again saw the pride and passion staff have for their hospital and how volunteers and bank staff are contributing in innovative ways as well as talking with portering and catering staff who are key members of the multi-disciplinary team.

We have more visits planned over the next couple of months which include Bishops Castle Hospital and Telford South Community Nurses.

Lord Darzi of Denham has now published the findings of his investigation of NHS Performance in England which has drawn on evidence from a wide range of stakeholders. It focuses on diagnosing the problems facing the NHS in relation to access to care, quality of care and performance of the health system. Some major themes have emerged which include:

- Moving care closer to home
- Driving productivity
- Investing in technology
- Focusing on prevention
- Re-engaging staff and empowering patients

As a Board we welcome Lord Darzi's report which will enable us to further develop as a community provider in partnership with others and continue to transform services for patients through integration and collaboration.

3.2 Summary of the Private Board Held in September and received and considered the following items:

Chief Executive's Update

Performance Reports

Service Reviews

Finance Report

System Update

Lease Approvals

Chair's Update

The afternoon of the Board Meeting was dedicated to development time with the Board receiving presentations on Culture and Engagement and Health Inequalities.

The Board also considering elements of its performance against the well led framework and committed to undertaking a review of it's effectiveness over the coming months. This would be supported by the work undertaken earlier in the year regarding the skills and make up of the Board and would inform the Board's ongoing development programme.

3.2 Conclusion

The Board of Directors is asked to note the update for information purposes.

CHIEF EXECUTIVE'S REPORT – October 2024

Introduction

This month and going forward, the Chief Executive report will be presented using a new format reporting on strategic activity undertaken in line with our three key objectives, our progress against delivering our vision and continuing to outline any key announcements:

- Looking after our People
- Caring for our Communities
- Managing our Resources
- Delivering our Vision

Key Announcements

1. Changes in leadership across the system

Colleagues will know that Jo Williams has taken over as the Interim Chief Executive (CEX) for the Shrewsbury and Telford (SaTH) Hospitals NHS Trust. Jo commenced in post on the 9th September and joins from the Royal Orthopaedic NHS Foundation Trust in Birmingham where she is the CEX. I am delighted to be working with such a talented and experienced colleague and look forward to working with her in this role. I would also like to recognise my colleague, Louise Barnett, who left the Trust in September and who made a phenomenal shift and improvement in care delivery.

Sir Neil McKay, Chair of the Integrated Care Board (ICB), also announced his retirement in the summer and whilst he is with us and just before he retires at the end of October, I want to acknowledge his formidable contribution to this STW system and the wider NHS over the course of his career.

2. Chair in Common

We announced earlier this year our intention to appoint a Chair in common with SaTH, given the collaborative working that has been taking place across the system over the last 2-3 years and in particular the last 18 months with the development of the Virtual Ward and Rehab and Recovery Wards. This joined up approach will mean that whilst each Trust will retain a Chair as separate statutory bodies, we have sought to appoint the same person for each of the roles. The appointments process has now concluded and Andrew Morgan has been appointed as the Chair in Common and commences in post on 1st October.

Tina Long has been our acting Chair for the last 20 months and I would like to thank her for the stability and strong leadership she has provided. I am very pleased to say she will be returning to her position as Non-Executive Director (NED), thus staying with the Trust and providing very clear continuity and support to Andrew as the incoming Chair in Common.

3. Shropshire, Telford & Wrekin ICS Programmes of Work

There are several key areas/programmes of work that the Chief Executive Group and wider System Transformation group are focused on, each with a Chief Executive leading the area of work/programme on behalf of the system, as per the table below, which reports into the ICB governance processes as well as the appropriate organisational processes:

No	Programme of work	Chief Exec Lead
1	Urgent and Emergency Care	Jo Williams
2	Hospital Transformation Programme (HTP)	Jo Williams
3	Workforce	Stacey Keegan
4	Musculo-skeletal (MSK) Alliance	Stacey Keegan
5	Mental Health	Neil Carr
6	Local Care Transformation Programme	Patricia Davies
7	Provider Collaboration	Patricia Davies

Taking Care of Our People

4. Standing Up Against Racism

Our last public Board on the 1st August, was a few days after the tragic events in Southport and we noted our condolence, shock and prayers for all of those affected and admiration and support for colleagues in their care and response to the tragedy. We all continue to try and process this as a nation. Equally difficult to understand are the riots and behaviour that followed.

With almost 200 nationalities represented in the NHS workforce today, the NHS is built on migration and celebrates the diversity, difference and skills this brings to many communities including ours in Shropshire. For many NHS workers, seeing this flare-up of racism will leave them feeling afraid and unwelcome and I support the message of Amanda Pritchard that this 'is fundamentally wrong, fundamentally un-British and a source of deep shame'.

I stand shoulder to shoulder with Amanda and my colleagues across the NHS and wider public and voluntary sector. I am proud that as a group STW Chief Executives we have made our thoughts and intentions clear, made the thoughts of our staff and communities clear - we will not tolerate racism and hate in any form. As a Trust we have been working to strengthen that

message with a review of our violence and aggression policies and processes and the support available to staff.

5. Staff Recognition

The Trust is gearing up to celebrate our staff and their hard work and dedication through a series of events and campaigns and there is more on this in our AGM so I won't steal the thunder other than to say that our staff deserve every accolade and recognition for the work they do day in and day out.

6. The Staff Survey

The survey launches at the end of September. This is such an important time of the year for us, I would encourage everyone to take the time to fill in the survey, which is anonymous, to ensure that your voice is heard. We have strengthened the staff experience processes recently and are ready to receive your thoughts and views as we remain committed to making ShropComm a great place to work.

Caring for Our Communities

7. Darzi Report

The new Secretary of State for Health, Wes Streeting, appointed Professor Ara Darzi to lead an independent investigation into the state of the NHS, to uncover the extent of the issues facing the nation's health service and this report has now been published. Importantly, Lord Darzi's audit provides a starting point for the development of a 10-year plan for health – which will be led by Sally Warren, lately Director of Policy at the King's Fund, with support from teams at the Department of Health and Social Care and NHSE. Plans for how NHS staff and leaders will be able to contribute to both phases of this work are being developed now, but with a clear expectation that they both reflect current experience, and draw on solutions and best practice from staff, patients, the public and other experts.

8. Doctor Strike Action and Impact on Care

In terms of the junior doctor strike action, it is welcome news that the Department for Health and Social Care (DHSC) has undertaken formal negotiations with the British Medical Association (BMA) to resolve the long-running junior doctors pay dispute. The BMA have balloted members on the latest offer and at the time of writing the report the result of this ballot had not been concluded. Colleagues will also be aware that the BMA ballot of General Practitioners (GPs) on the 29th July was supported in terms of Collective Action in response to concerns over workload pressures, funding, and staffing shortages. We are working with the ICB and wider system partners to mitigate any impact to patients and the system including community services. The

Trust has seen an increase in activity flow from Primary Care, albeit this is a growing trend. This has not translated into other areas of the system at the time of writing this report.

9. COVID Autumn Campaign

Vaccination continues to help protect against severe illness, hospitalisations and deaths arising from COVID-19. Just to put this into context last year across the UK, between November, December and January over 38,000 people were admitted to hospital with the virus. As such vaccinations remains as a real plank in our armoury for winter. As per previous years, the eligible groups are, with some minor changes:

- adults aged 65 years and over
- residents in a care home for older adults
- individuals aged 6 months to 64 years in a clinical risk group (as defined in tables 3 or 4 in the COVID-19 chapter of the Green Book)
- frontline NHS and social care workers, and those working in care homes for older people.

The eligibility is the same across the 4 nations of the UK (England, Scotland, Wales and Northern Ireland).

Managing Our Resources

10. Managing Our Resources

Managing resource effectively is not only vital to ensure financial efficiencies but also to improve our patient pathways and streamline care across all our services at a system level. Repeatedly patients feedback wanting to tell one version of their story and particually when they are unwell having to repeat their wishes and concerns to several professionals can be frustrating and a strain. In September working with our acute and local authorities the STW Care Transfer Hub will launch. This is an expansion to our Integrated Discharge Team (IDT) and supports with a trusted assessor model. Through co location a system wide dynamic multi-disciplinary team (MDT) will exist including acute therapy, local authority social workers and community practitioners. This will strengthen the pathway for patients but also ensures that we are maximising all our available workforce across the system to support patient discharge and reduce unnecessary duplication for patients and across the MDT.

As well as supporting hospital discharge as part of the ongoing system level improvement plan for urgent and emergency care (UE), SCHT are leading on a system programme to provide a Care coordination offer to support all alternative pathways to ED. This again looks at opportunities to integrate care across our system and best collectively utilise our resources to ensure an efficient and effective model of care that is sustainable for the future. On the 7th October a co location 2 week trial will take place working with the ShropDoc care coordination centre, WMAS (West Midlands Ambulance Trust) and our RAPID Response, Virtual Ward and

MIU teams to support with ensuring more patients access appropriate and safe pathways outside of an acute hospital setting.

Manging resources within our core services is also vital to ensure our accountability in relation to our day to day spend. Many of our clinical leads have therefore come together to support our procurement colleagues to review and explore all of our clinical and non clinical consumables. A quality focus is still paramount to ensure no changes to consumables impacts patient care, but as ever in the true spirit of ShropCom some really dynamic solutions to high spend products have been identified. As well as opportunity to look across our estates to collectively manage and share stock to utilise space more effectively and share learning across teams. This has delivered both financial savings but also been a great exercise to strengthen our team work in all areas.

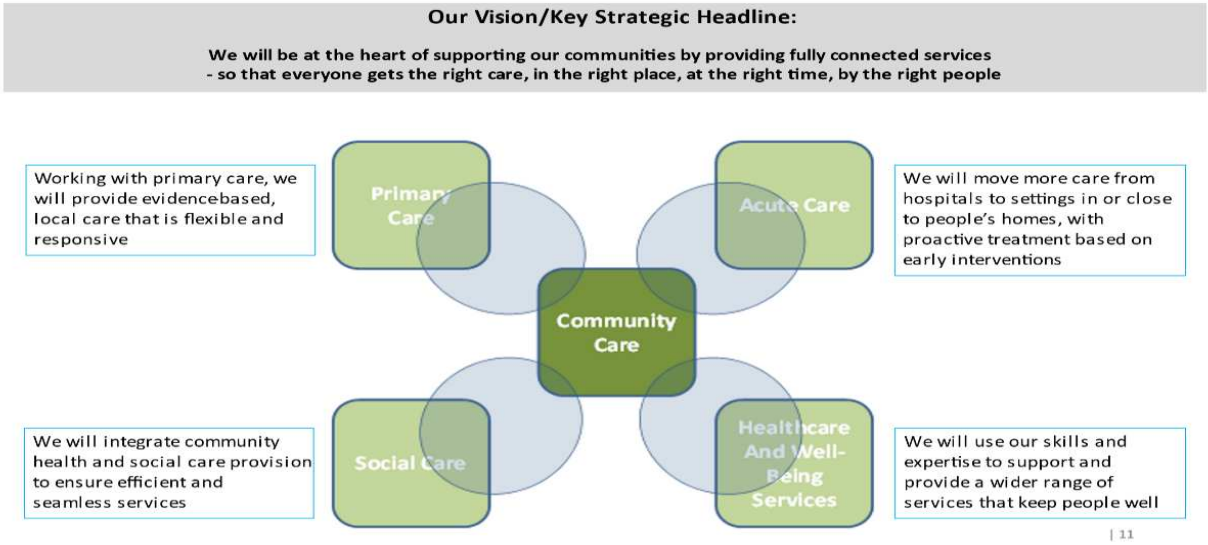
Delivering Our Vision

11. Our Strategy

As stated in my last report, we understand to achieve the priorities and objectives within our strategy we need to continue to work hard towards creating a culture where every one of us feels empowered to use our skills and expertise to make a difference - Not only in providing the best possible care for our patients but to make ShropCom a great place to work.

As an Executive Team we have worked together with senior leaders across the Trust to develop a strategy that reflects our ambitions **to keep care as close to home as possible** for our service users. I have a real sense of optimism in delivering this strategy given the commitment to the 'shift left' of care outlined by the new government and ambition as set out by Amanda Pritchard.

As a reminder, our Strategy has been developed to focus on 4 key priorities to enable us to connect the dots and deliver our overall vision as follows:



Our 4 key priorities:

1. To keep care as close to home as possible for our patients, providing proactive treatment based on early interventions.
2. To empower our staff to use their wealth of expertise to support and provide a wider range of services that answer the specific health needs of our community.
3. To work cohesively with our primary care partners to provide evidence-based, local care that is agile and responsive.
4. To integrate community health and social care provision to ensure our services are efficient and seamless.

These are being delivered through the Local Care Programme and align nicely with the three key ambitions for the NHS recently announced by Amanda Pritchard, the Chief Executive Officer (CEO) of the NHS, in her three key ambitions for the NHS:

i). Moving more care out of hospital into primary and community – not just better for individuals in terms of clinical outcomes and independence but offering the potential to release hospital beds for those who need them and deliver more for taxpayers' money.

ii). Better use of technology and data – offering the opportunity to deliver more effective use of money and staff time, give patients more convenience and control, and make the NHS a better place to work for our staff.

iii). Boosting prevention – maximising the opportunity of local partnership working to support people to stay well, reduce health inequalities and help people stay in work.

Our Trust Strategy and system ambition, through the Local Care Transformation Programme (LCTP), are already based on these principles. This heralds a real opportunity for us to

influence with our staff, our partners, and our communities this positive move and shift in emphasis to the promotion of wellness rather than being reactive to sickness.

12. Shaping Our Future – We all have a role to play

Culture plays an integral part in helping an organisation to deliver its ambitions and is key to creating an environment where staff are both empowered and enabled in its delivery. At ShropComm we want our culture to provide strong foundations for our future, our staff, and our service users.

It is, therefore, important that our culture is one that encourages and enables staff to pull together and work cohesively. One that ensures staff feel empowered to use their expertise to provide and develop services. And is one that is agile enough to provide flexibility and speedy responsiveness for staff and service users alike.

With this in mind, we have developed a set of ACE cultural characteristics that we are committed to promoting and embodying in our day-to-day working lives and we are working with our fabulous staff across the organisation to embody them as a Trust. In addition, Rhia Boyode, our Director of People, and the workforce team are implementing exciting opportunities to ensure staff have a voice when it comes to our Trust culture including #WeAreShropcom Shaping our Future programme because we all have a role to play in shaping the future of the Trust's services and culture.

Excitingly, we will be launching the ACE cultural characteristics at our AGM later today.

And Finally – Good News Stories

Quality Improvement

The Trust Quality Improvement Framework was launched earlier this year, there has been some great collaborative working with the Improvement hub at SaTH helping us at Shropshire Community Trust to increase our quality improvement capability. The team have enabled to date this year over 60 of our staff to sign up to the QI fundamentals day and a further 6 staff signed up for the Improvement Practitioners course and the engagement of staff continues. Every member that has attended has returned enthused and engaged in our QI journey going forward.

Freedom to Speak Up

The Trust's speaking up offer was refreshed in March 24 with the appointment of a new Freedom to Speak Up Guardian, David Ballard, OD Business Partner, and a Project Officer, Rachael Watts. The refresh also saw the launch of the new Work In Confidence (WIC) web

based service which enables staff to raise their concerns confidentially and with anonymity if they prefer, along with providing the Guardian and Champions with a means to effectively manage cases.

A recent recruitment drive has seen the appointment of 10 new FTSU Champions from a variety of settings across the Trust. Aided by a communications campaign to raise awareness, since the relaunch we have responded to 12 new cases, 2 of which are still open. This represents a significant increase in staff feeling able to raise their concerns, where previously we were typically seeing only 1 or 2 cases per quarter.

Awards

I am pleased to announce our Education Lead, Jill Bell has been nominated and shortlisted for Nursing Times Award Non-Clinical Leader of the Year, the award ceremony is in October, and we look forward to hearing the outcome.

The Education Team were also recently nominated and shortlisted for their innovative work on delivering moving and handling training in the National Back Exchange.

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality and Safety Committee – 25 September 2024

0. Reference Information

Author:	Stacey Worthington, Corporate Office Manager and Executive Assistant	**Paper date:**	25/09/2024
Executive Sponsor:	Jill Barker, Non-Executive Director	**Paper written on:**	25/09/2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing & Clinical Delivery	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality and Safety Committee meeting held on 25 September 2024 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 (QSC) 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 members approved the Clinical Quality Strategy to progress to the Trust Board for final approval.
- The Committee received a comprehensive thematic review of medicines safety.
- BAF Risks related to Quality and Safety Committee were reviewed and discussed.

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 – 25 September 2024

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 Thursday 25th September 2024. The meeting was quorate with a full list of the attendance is outlined below:

Chair/ Attendance:	
Jill Barker	Non-executive Director (Chair)
Claire Horsfield	Director of Operations and Chief AHP
Clair Hobbs	Director of Nursing & Clinical Delivery
Cathy Purt	Non-executive Director
Alison Sargent	Non-executive Director
Sara Ellis-Anderson	Deputy Director of Nursing and Quality
Martin Howard	Patient Experience Representative
Tina Long	Chair (part)
Gill Richards	Associate Director of Governance
Dr Ganesh	Medical Director
Lucy Manning	Medicines Safety Officer and Non-Medical Prescribing Lead
Stacey Worthington	Executive Assistant/Minute Taker
Apologies:	
Shelley Ramtuhul, Director of Governance	

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:

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality and Safety Committee – 25 September 2024

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Terms of Reference		
The Clinical Effectiveness Committee to be added and the Incident Review Group be amended to Patient Safety Incident Panel		Once amendments have been made TOR can be approved
2. Patient Experience, Annual Complaints & PALS Report		
Committee discussed the report and welcomed the data and information contained within. Committee requested that the report return with: • An action regarding training, following up learning and how this has been implemented • Inclusion of compliments so areas of good practice can be shared • Triangulation against other metrics • Adult Service Division data to be broken down • Lessons learnt from complaints to the Ombudsman	Partial	The report, including action tracker, to return to Committee for a further review
3. PSII Report		
Committee noted the new process was in place and in use by the Trust. A discussion took place regarding the impact of the new processes on staff, who were doing these investigations alongside their jobs. Committee discussed deaths in custody and requested further information to a future Committee. Committee requested that in future, the reports be submitted for assurance.	N/A	
4. Integrated Quality and Safety Performance Report		
Committee discussed the report. Questions were asked about the narrative around falls, it was confirmed that there were no exceptions to report. The Committee received additional information in regards to the 2 KPIs showing special cause variation (Clostridium Difficile and reporting of patient safety incidents). Pressure Ulcer Deep Dive / Thematic Review would be presented at an upcoming meeting. Committee noted that the format of the report had recently been updated in line with the Trust Performance Framework.	Full	
5. NHS Resolutions Report (Claims, Inquests and Litigations)		
Committee reviewed the report and requested further information in relation to: • Clarification on time to resolve claims	Partial	Further evidence that learning has been embedded

Chair's Assurance Report

Quality and Safety Committee – 25 September 2024

• Embedding of learning from incidents • Mitigations in relation to delays in diagnosis or treatment		
6. Inspections Flash Report		
Formal report from NHSE visit to the Prison Service awaited. The Committee noted the importance of also highlighting good practice and celebration as well as areas for action.	Full	
7. Quarterly Guardian for Junior Doctor Safe Working Report and Annual Revalidation Report		
There were no exceptions to report. Request to bring information on Dentist revalidation to a future meeting. Audits on Doctors revalidation had been very positive and the Trust was fulfilling all requirements. The Committee approved for the paper to go to Trust Board.	Full	
8. Thematic Review - Medicines		
Lack of electronic prescribing system within the Trust had been raised throughout the report, it was the long term plan for this to be implemented. Paper documentation would need to remain for business continuity purposes once an electronic solution was in place so recent efforts had been made to ensure this was robust and safe as it would be used in the interim period as well as for business continuity in the future. Fully supportive of all recommendations to become actions which would be tracked.	Full	
9. QSC Related BAF Risks		
There were no closed risks, new risks or risks with changed scores. Risk in relation to LFPSE had improved in recent months due a plan to implement the new DATIX system by the end of December 2024	Full	

3.4 Approvals

Approval Sought	Outcome
Clinical Quality Strategy	Approved to be presented to Board for final approval

Chair's Assurance Report

Quality and Safety Committee – 25 September 2024

Clinical Effectiveness Committee Terms of Reference	Approved, subject to the inclusion of Claire Horsfield as Chief AHP as a member

4. Conclusion

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

0. Quality and Safety Report – September 2024

Author:	Chris Panayi – Governance Data Manager Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	25th of September 2024
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	17th of September 2024
Paper Reviewed by:	Sara Ellis-Anderson – Deputy Director of Nursing and Quality and Deputy DIPC	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.

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

2. Executive Summary

2.1 Context

The report aims to:

- Provide the 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

2 of the 16 Quality and Safety dashboard KPIs are showing **special cause variation** in Month 5:

- *Clostridium Difficile* – 1 case reported in June and no further cases in July and August bringing the 12-month rolling count to 3. IPC thresholds have been published for 2024/25 and the organisation has had 1 hospital acquired *C-difficile* case against a threshold of 4.
- Consistency of reporting patient safety incidents - Rolling data updated monthly, to show the number of patient safety incidents reported to the National Reporting and Learning System (NRLS) in the last 12 months. **NHSE have currently paused the publishing of this data while we consider future publications in line with the introduction of LFPSE. The data was last published June 2023**.

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

- In August 2024 there were 15 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Wards noting some slight improvement in the number of falls per occupied bed days. Most falls occurred at nighttime this month. There is on-going improvement work including the trial of switching to decaffeinated drinks taking place.
- Medication incidents with harm saw a reduction from 5 in July to 3 in August, PSIRF thematic reviews have identified medication administration and documentation as key emerging themes.
- There was one category 3 pressure ulcer developed in service in August with Stop the Pressure Day planned for November.
- 0 Patient Safety Incident Investigations (PSII) were reported in August same as for July.

- There have been no unexpected deaths reported in August.

Safer staffing data and harm review data remains in the report in previous format until KPIs have been approved for addition to the QSC dashboard.

2.3. Conclusion

The Board is asked to:

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

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2024-08-31		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-08-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-08-31		3.00	0.00	3.00	3.00	0.00	3.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-08-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-08-31		98.32%	95.00%	3.32%	98.57%	95.00%	3.57%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30		83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-08-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-08-31		3.92	4.00	-0.08	3.92	4.00	-0.08	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-08-31		3	0	3	26	0	26	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-08-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-08-31		0	0	0	0	0	0	

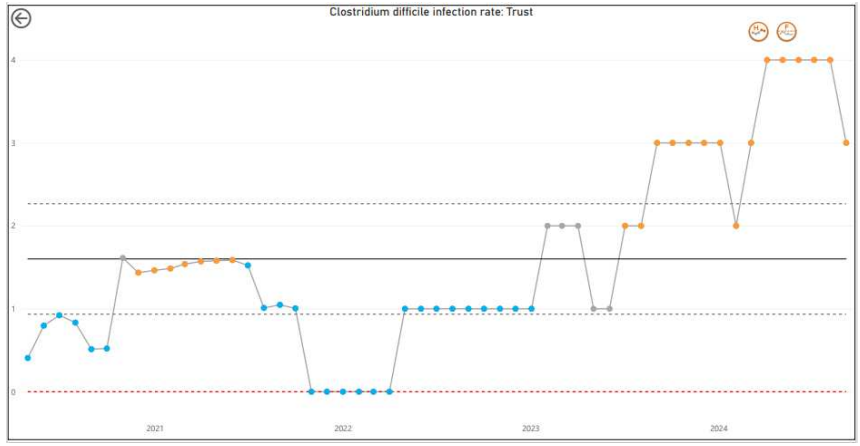
Exception Report - Action Plan

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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Clostidium difficile infection rate	Number	4	4	4	3	4	3	3
	Target	0	0	0	0	0	0	0

Trajectory	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number	1	0	0	1	0	0	1



Narrative/Description	No further cases of hospital acquired *C-difficile* since the last case in June. Rolling 12 months total now stands at 3. New thresholds for 2024/25 have now been published and SCHT have had 1 case against a threshold of 4.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Post Infection Review summary from Ludlow *C-difficile case* to be shared in IPCC	Aug-24	Sep-24	Complete	Shared learning across in-patient areas.
	IPC team to review and update STW collaborative C-Difficile Improvment Plan	Aug-24	Oct-24	In Progress	STW Collaborative C-Difficile Improvment plan to October IPCC
	IPC team to review IPC Quality Assurance audits to incorporate review of stool charts in inpatient areas	Aug-24	Oct-24	In Progress	Aim to revise IPC QAA audit question sets to start from November 24

Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	17/09/2024
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	17/09/2024

Exception Report - Action Plan

Medication Incidents with Harm

Number of medication incidents per month resulting in harm

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Medication Incidents with Harm	Number	5	5	2	9	7	3	26
	Target	0	0	0	0	0	0	0

Trajectory	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number	5	4	3	4	5	6	5

Narrative/Description:	All of these incidents are included in the Patient Safety Incident Rresponse Framework (PSIRF) quarterly thematic review. Low harm: 1 x internal incident - patient administered wrong insulin (long-acting instead of short-acting) – patient refused to attend hospital but visited next day and blood glucose within normal range with no concerns raised overnight Moderate harm: 1 x external incident – Patient took overdose of in-possession medication – awaiting discussion at PSIP to confirm harm level 1 x external incident – Patient instructed to discontinue Acitretin whilst taking Doxycycline but continued with both medication following discharge from acute hospital despite being given clear instruction – discussed at PSIP on 4/9/24 awaiting more information from acute trust.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	AAR for Zoladex Injection incident	Aug-24	Aug-24	Completed	Training and competency document to be rolled out to Community Nursing
	Deep dive into missed doses Insulin by MSO	Aug-24	Sep-24	In Progress	
	Risk Assessment for administration of Zoladex Injection to include actions being taken to reduce risk of incident re-occuring	Aug-24	Sep-24	In Progress	
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Oct-24	In Progress	
Author	Lucy Manning - Medicines Safety Officer and Non-Medical Prescribing Lead	**Date**	16/09/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	17/09/2024		

Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Category 3 Pressure Ulcers	Number	1	2	0	2	1	1	6
	Target	0	0	0	0	0	0	0

Trajectory	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number	1	1	1	1	1	1	1

Exception Report - Action Plan

Category 4 Pressure Ulcers

The number of Category 4 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Category 4 Pressure Ulcers	Number	3	0	2	0	1	0	3
	Target	0	0	0	0	0	0	0

Trajectory	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number	1	1	1	1	1	1	1

Narrative/Description:	Category 3 Pressure Ulcer was developed in the North West Community Team. Complex patient issues with concordance, delay with ordering of TOTO system and completion of holistic assessment.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Stop the Pressure planning has commenced - conference on 21/11/2024. The TVN Team also will plan a week's worth of events around the county with the actual launch date of PURPOSE T on 21/11/24	Nov-24	Dec-24	In progress	
	Pressure ulcer policy update in process which will incorporate PURPOSE T changes and pathway which is approved by NHSE.	Aug-24	Oct-24	In progress	
	E-Learning package for PURPOSE T to be added to ESR for staff to complete	Sep-24	Nov-24	In progress	
	Bitesize face to face sessions and virtual sessions to be planned for October/November to support launch of PURPOSE T and policy update.	Sep-24	Dec-24	In progress	
	Purpose T to be launched in November 2024. Community teams to launch first in November and then community hospitals/RRU in December	Oct-24	Dec-24	Not started	
	Tissue Viability team to increase hotline days to 3 times per week to support community nursing teams to discuss issues with pressure ulcers on caseload following safety huddles	Sep-24	Oct-24	In progress	
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	10/09/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	17/09/2024		

Safer Staffing

The National Quality Board (NQB, 2016) recommend a 'triangulated' approach to staffing decisions. The Trust has a validated tool for acuity and dependency for both the Community CNSST (Community Nursing Safer Staffing Tool) and Inpatient Wards SNCT (Safer Nursing Care Tool) this will enable a robust triangulated approach. Data collection is collected twice a year and this data forms part of planned biannual staffing reviews to allow SCHT to comply with National safer staffing guidelines. The National Team has paused with the CNSST tool as there some issues with the data collection and so data will not be collected in June 2024. The National Team plan to relaunch in September 2024. We continue to utilise Fill Rates. A description of both is below. Fill Rate is calculated by comparing planned hours to that of actual hours worked. A figure over 100% indicates more hours worked than planned.

Community Hospital Inpatient ward fill rates

August 2024

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bishops Castle	92.3%	94.8%	100%	100.6%
Bridgnorth	103.5%	107.8%	100.1%	114.0%
Ludlow	103.3%	116.6%	100.0%	124.7%
Whitchurch	106.9%	108.4%	102.4%	168.1%
Ward 18 RSH	100.1%	111.0%	101.1%	121.7%
Ward 36 PRH	100.8%	144.1%	100.0%	141.9%

July 2024

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	97.4%	101.3%	100.1%	108%
Ludlow	100.6%	116.0%	100.4%	124.2%
Whitchurch	103.7%	98.3%	107.0%	120.3%
Ward 18 RSH	102.1%	113.1%	100.1%	128.8%
Ward 36 PRH	97.6%	154.1%	97.9%	112.9%

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day and night shifts during August 2024 for all six open inpatient wards.

The overall trend shows staffing levels on day and night shifts for both RN and HCAs were above 90% for all areas day and night. The HCA cover on night duty is over 100% on all of the wards and this is due to the amount of enhanced care required in order to maintain safety.

Bed Occupancy Rate

Hospital Site	Bed Occupancy Rate for August 2024
Bishops Castle	**90.5%**
Bridgnorth	**90.6%**
Ludlow	**86.7%**
Whitchurch	**71.3%**
Ward 18 RSH	**93.3%**
Ward 36 PRH	**95.8%**
Overall **Target 91%**	**86.8% ↓ by 4.7% on previous month**

Registered Nurse shifts covered in Community Wards- July and August 2024

	July 2024	**August 2024**
Total number of RN shifts covered	1197	895
Substantive staff	**882**	**683**
Percentage	74%	76.3%
Percentage change from previous month	**No Change**	**2.3% ↑**
Bank	97	69
Percentage	8.1%	7.7%
Percentage change from previous month	1.1% ↓	0.4% ↓
Agency	**218**	**143**
Percentage	18.2%	16%
Percentage change from previous month	**1.4% ↑**	**2.2% ↓**

There was a total of 9 night shifts that were 100% RN agency for the month of August. 7 of these shifts were at Bishops Castle Community Hospital, reduction of reliance on RN agency is expected with 2 WTE RNs starting September and 1 in October. There was also one night shift that was 100% RN agency on Whitchurch Community Hospital and one night shift at Ludlow Community Hospital.

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. 544 harm proformas have been completed to date; with 77.03% indicating no harm and 21.32% indicating low harm and can be treated and resolved. Looking into the cases where harm was identified the vast majority were Rheumatology patients.

There have been 9 cases (1.65%) of moderate harm identified in July 2024; 5 following delays to first appointment, 2 due to delayed follow up appointments in Rheumatology, 1 due to patient choice delay to commence medication and 1 due to delay of referral onward. All 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 Patient Safety Incident Panel have reviewed 3 of the 8 cases; further work is required to understand the rationale for the level of harm for 2 cases and further investigation involving system partners is required for the 3rd.

The service is routinely conducting a review of 10% of the harm proformas completed which equates to 54. Of the most recent review, 1 was revalidated as having no further harm occurring.

The below table and charts display the number of harm proformas completed and percentages of low and no harm - over an 11-month period.

18 week RTT	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Harm proformas completed	406	428	474	481	495	506	513	517	528	537	544
Number of low harm	102	102	102	104	105	107	109	111	114	114	116
Number of moderate harm	0	0	4	5	6	6	7	7	8	8	9
Percentage of no harm	74.90%	77.50%	77.65%	77.34%	77.58%	77.66%	77.39%	77.18%	76.90%	77.28%	77.03%
Percentage of low harm	25.10%	22.50%	21.51%	21.62%	21.21%	21.15%	21.25%	21.47%	21.59%	21.22%	21.32%
Percentage of moderate harm	0.00%	0.00%	0.84%	1.04%	1.21%	1.19%	1.36%	1.35%	1.51%	1.50%	1.65%

The current harms policy will be reviewed by end of October 2024 to ensure all services that have patients waiting over 52 weeks have harm reviews completed. Outcomes of harms reviews will be reviewed at Divisional Governance meetings with escalation to Patient Safety Incident Panel.

1	2	3	4	5	6	7	8	9	10	11	12	13	... 11

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Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

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

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

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

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

Action from last year:	Dr M Ganesh is appointed as Medical Director and RO
Comments:	
Action for next year:	None

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

Yes / No:	Yes
Action from last year:	Funds provided to support implementation of new appraisal portfolio
Comments:	Appropriately supported
Action for next year:	Maintain support

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

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

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

Action from last year:	Medical Appraisal and Revalidation Policy was awaiting HR review following recent clarification of national position on appraisal and decision on local appraisal tool provision
Comments:	Review including updated GMC professional standards and appraisal guidance underway by HR
Action for next year:	Completion of the policy review and approval process imminent

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

Action from last year:	Peer review had been planned
Comments:	Decision was made to implement the new appraisal portfolio and an external audit team has been commissioned to report on medical revalidation
Action for next year:	An external audit team has been commissioned to report on medical revalidation arrangements at the trust

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

Action from last year:	None
Comments:	Process in place to support all staff needs, including locum and short-term placement staff
Action for next year	Continued support of all staff needs

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

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

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

Action from last year	NA
Comments:	
Action for next year:	

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

Action from last year:	Review of the policy will be undertaken against the national guidance on Medical Appraisal and referring to the trusts chosen appraisal tool
Comments:	In progress
Action for next year:	Review of the Appraisal and Revalidation Policy completed, including more emphasis on provision of supporting evidence at appraisal for whole scope work, with approval process completion imminent

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

Action from last year:	To facilitate appraiser training where needed
Comments:	We have 4 trained appraisers for 9 attached doctors which is currently sufficient. One doctors underwent appraisal training this year and has commenced appraising with good feedback.
Action for next year:	Continue to facilitate appraiser training where needed.

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

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

Action from last year:	Complete all update training, embed new tool use and reaudit self-assessment.
Comments:	We provide biannual appraiser updates and training with ad hoc updates where needed. Appraisal feedback audit is completed annually with action plan agreed. External appraisal update training offered to all appraisers.
Action for next year:	An external audit team has been commissioned to report on medical appraisal and revalidation arrangements at the trust. Reaudit of self-assessment of appraiser skills planned.

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

Action from last year:	Peer review and audit quality of appraisals.
Comments:	Annual appraisal feedback audit completed, and action plan developed, reporting to Board via Quality and Safety Committee. Peer review has been unfeasible, and an external audit team has been commissioned to report on medical revalidation and appraisal as an alternative process to provide assurance and feedback.
Action for next year:	An external audit team has been commissioned to report on medical revalidation arrangements at the trust

1C – Recommendations to the GMC

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

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

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

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

1D – Medical governance

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

Action from last year:	Work with operational leaders working with medical/dental leaders to support doctors and dentists in their CPD (including towards revalidation) and address medical/dental performance concerns.
Comments:	Doctors with a prescribed connection to our organisation are supported by clear clinical governance arrangements for doctors. Some new and existing services are supported by doctors with a prescribed connection to another designated body, requiring clinical governance arrangements for doctors to encompass this model of provision.
Action for next year:	Improve clarity over clinical governance for doctors working in all services, including those with a prescribed connection to another designated body, through annual role review, providing supporting evidence for them at their appraisal and strengthened assurance processes for the trust.

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

Action from last year:	Use refreshed Medical Appraisal policy as opportunity to improve operational managers understanding of service appraisal/ annual role review
Comments:	The Appraisal and Revalidation policy review has strengthened the trust systems for monitoring conduct and performance of doctors by including clearer reference to requirement to provide supporting evidence for all

	roles at appraisal, including annual role reviews for doctors employed in our services.
Action for next year:	Use the roll out of the refreshed Appraisal and Revalidation Policy as an opportunity to build awareness of annual role appraisal in all services employing doctors with a prescribed connection to another designated body.

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

Action from last year:	None
Comments:	Roll out of the Fourteen fish appraisal tool has enabled appraisees to easily gather appropriate supporting information and we have received positive feedback at audit
Action for next year:	Continue to support

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

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

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

Action from last year:	Remain alert to recommendations regarding how to report to the board effectively, considering protected characteristics, whilst maintaining appropriate confidentiality

Comments:	No concerns have been raised this year. However when these occur the small numbers of doctors raise challenges for reporting confidentiality.
Action for next year:	Maintain awareness of issue

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

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

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

Action from last year:	RO and HR medical governance lead to access regional / national training to remain updated and explore opportunities to improve processes to ensure processes are fair, free from bias and discrimination.
Comments:	No regional or national training was available to attend. Mandatory training covering discrimination is provided and the Maintaining high standards of performance policy has been updated to ensure processes are fair, free from bias and discrimination.
Action for next year:	Maintain

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

Action from last year:	NA
Comments:	There are regular meetings with other ROS and CMOs from the ICB.
Action for next year:	Maintain

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

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

1E – Employment Checks

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

Action from last year:	Maintain focus on timely and thorough check for medical and dental roles as often high cost and safety critical.
Comments:	New HR process around recruitment now embedded and improved timescales to recruitment with no identified issues. All pre-employment checks are undertaken in line with NHS Employers standards and national legislation. No prospective employee commences employment without satisfactory checks are in place.
Action for next year:	Continue

1F – Organisational Culture

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

Action from last year:	NA
Comments:	The Senior leadership team, executive team and board have received external training on providing a supporting environment and culture, with further cascade to management teams. There has been a wholesale review of the trust values and strategy. Establishment of multi-professional leadership forum.
Action for next year:	Build on and implement the trust strategy

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

Action from last year:	NA
Comments:	Policies and procedures and training are in place to support compassion, fairness, respect, diversity and inclusivity and these behaviours are proactively promoted. We introduced the Oliver McGowan training as a mandatory requirement in the last 12 months and Tier1 and 2 modules are now available. We have a workforce race equality staff network, a disability staff network and a LGBTQ+ staff network. We are an accredited Disability Confident Employer at level 2. We have a Veterans Group.
Action for next year:	Monitored monthly with regard to who has undertaken the mandatory training. We report annually and publish the WDES & WRES reports.

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

Action from last year:	NA

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

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

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

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

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

1G – Calibration and networking

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

Action from last year:	NA
Comments:	There are regular RO meetings with partner system trusts and meetings with higher level RO
Action for next year:	An external audit team has been commissioned to report on medical revalidation arrangements at the trust.

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

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

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	**9**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**7**
Total number of appraisals approved missed	**2**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	1

Total number of late recommendations	0
Total number of positive recommendations	1
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	8
Total number of trained case managers	10
Total number of new concerns registered	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March	0
Median duration of concerns processes closed	0
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	1
Number of new employment checks completed before commencement of employment	1

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

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

General review of actions since last Board report
All actions outlined in the previous report have been actioned or where delayed have a plan in place to address. No new or significant risks have been identified.
Actions still outstanding
Formal Approval of the reviewed Appraisals and Revalidation policy. Addition of training origin
Current issues
Challenge of supporting a small number of employed doctors across services in a consistent way.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
External audit of revalidation process scheduled- 3 months. Reaudit of self-assessment of appraiser skills planned-9 months. Formal Approval of the reviewed Appraisals and Revalidation policy- 4 months. Improve clarity over clinical governance for doctors working in all services, including those with a prescribed connection to another designated body, through annual role review, providing supporting evidence for them at their appraisal and strengthened assurance processes for the trust. Commence collecting data on country of primary medical qualification, (or healthcare qualification for other health professionals) when concerns and complaints are brought to attention – Imminent.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Changes to the professional standards and appraisal and revalidation processes required by recent national recommendations have been actioned and staff and appraisers have been supported.

A new appraisal portfolio has been implemented with training and is well received by appraisers and appraisees. The leadership forum and Clinical Effectiveness committees support our values and help develop leadership skills and behaviours for our senior clinicians. Building on the culture training and values review aspiring for this to be reflected in improvement in future staff survey results

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body.

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

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

Name:	Patricia Davies
Role:	Chief Executive
Signed:	
Date:	

Shropshire Community Health
NHS Trust

Clinical Quality Strategy 2024 - 2027

Contents

Foreword by Clair Hobbs Director of Nursing, Quality and Clinical Delivery

I am very proud to be sharing our 3-year Clinical Quality Strategy for 2024-2027. This strategy has been developed with full collaboration from our clinical staff across a breadth of professions including Nursing, Allied Health Professionals, Medics, and Pharmacy colleagues.

This strategy aligns to national and local priorities and highlights a road map for the next 3 years with measurables to ensure we remain on track to deliver against our identified objectives.

Our collaborative quality ambitions which align with our overall Trust Vision and Strategy are well embedded within this strategy.

Huge thanks to all who have contributed and helped make the feedback useable to ensure the voice of our staff and the priority of our patients and service users is clear.

I very much hope you take the time to read and enjoy the document and I look forward to working with Shropshire Community staff and our wider partners to make these objectives a reality.

Clair

Introduction:

Shropshire Community Health NHS Trust's aim is to be at the heart of supporting our communities enabling people to get the right care, in the right place, at the right time delivered by the right people.

We provide community-based health services for adults, children and young people in Shropshire, Telford and Wrekin, and Dudley. Our services work from a range of locations including in people's homes, children's development centres, community hospitals, prisons and in local clinics and GP surgeries.

We currently serve a population of over half a million people which is continuously growing. We know there are significant health inequalities in our local communities, this coupled with an ageing population with an increased prevalence of frailty, long term conditions and dementia will continue to be our focus as we adapt our local services in the years to come.

Our 1,600 dedicated and committed staff deliver a wide range of high quality medical, nursing, and therapeutic care to people from their earliest moments to their last.

Our Vision:

We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people.

Our Culture:

Our Values:

Our strategy is underpinned by our commitment to providing excellent care at the heart of the community. We are guided by our values which are at the heart of everything we do.

Commitment to Quality

We all strive for excellence and getting it right for patients, carers, and staff every time.

Respect & Dignity

We see the person every time – respecting their values, aspirations, and commitments in life – for patients, carers & staff.

Working Together for Patients

Patients come first. We work and communicate closely with other teams, services, and organisations to make that a reality.

Compassionate Care

We put compassionate care at the heart of everything we do.

Everyone Counts

We make sure no one feels excluded or left behind – patients, carers, staff, and the whole community.

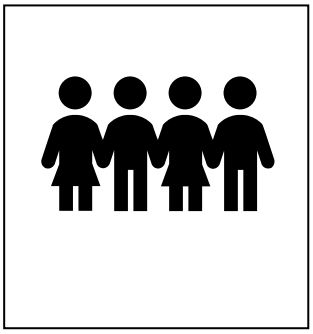
Our Story in numbers

We serve a population of over **500,000** people in Shropshire Telford & Wrekin.

3962 responses to Friends and Family Test in **2023/24**

97.15% of our patients reported Good or Very Good in their feedback.

We provide community based 0-19 integrated health in Dudley to over **75,000** children and their families.



We have over **1600** members of staff at SCHT.

According to the 2021 Census, there are **60,100** people living in the **20%** most deprived areas nationally in Shropshire, Telford & Wrekin, of which 45,400 live in Telford & Wrekin and 14,700 live in Shropshire.

National Context

The NHS Long Term Plan articulates the need for continuous improvement. There is a clear focus on long term conditions like diabetes, heart failure and respiratory conditions. The Shared Commitment to Quality is an associated document to the Long-Term Plan and clearly states that high quality must be the organising principle of our health and care service. It is what matters most to people who use services and what motivates and unites everyone working in health and care.

The National Patient Safety Strategy describes how we will continuously improve patient safety. It aims to maximise the things that go right and minimise the things that go wrong setting out what the NHS will do to achieve its vision to continuously improve patient safety by building on two foundations of a patient safety culture and a patient safety system that will underpin three strategic aims of improvement, insight, and involvement.

The recently published NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients, and give better outcomes for communities.

Shropshire Telford & Wrekin Integrated Care System (STW ICS)

Shropshire Telford and Wrekin ICS want to transform the health and care of the population we serve by:

- Providing a greater emphasis on prevention and self-care
- Helping people to stay at home with the right support with fewer people needing to go into hospital
- Giving people better health information and making sure everyone gets the same high-quality care
- Utilising developing technologies to fuel innovation, supporting people to stay independent and manage their conditions
- Attracting, developing, and retaining world class staff
- Involving and engaging our staff, local partners, carers, the voluntary sector, and residents in the planning and shaping of future services
- Developing an environmentally friendly health and care system

How we developed our strategy

In order to understand what was important to our communities in the development of this strategy we engaged and listened to our staff and service users through surveys, drop-in sessions and a series of focus groups.

The survey alone generated over 348 comments and several themes emerged:

The clinicians drive and passion to ensure that our patients get the support and care they need.

Local teams and good working relationships to try to achieve best care and outcomes for patients.

Staff go the extra mile every day in providing high quality, compassionate, individualised care with the children and families we work with.

Our staff are the cornerstone of everything we do, and we are proud of the quality patient care delivered every day. This short document can't convey every complexity of the challenges that we know we will face. But by working together we can deliver care that truly puts our community first.

Our Clinical Quality Ambitions

Clinical Quality Ambition 1: Delivering Safe Integrated Care

Aligned to our strategic vision we will work with our key partners in Primary Care, Social Care, Acute and Specialist services, using our skills and expertise to deliver safe integrated community care across all age groups.

Starting Well: Our Children and Young People services will work together with partners to support both the child and their families and carers to ensure we give every child the best possible start in life.
To achieve this, we will:
• Continue to develop the targeted care to children and young people with long term conditions such as asthma and diabetes who are at high risk of admission to hospital.
• Continue to ensure all children and families receive universal and timely support as outlined in the Healthy Child Programme, with a focus on the nationally identified high impact areas.
• We will work to ensure our families only need to tell their story once aiming for excellent holistic care with our partners, and embedding multidisciplinary working across physical, mental health, education, social care, and the voluntary sector.
We will measure success by:
• Reduction of A&E attendances for Children and Young People in relation to their long-term condition
• Improved patient outcome measures
• Increased number of compliments recorded

Staying Well: Focussing on the Community we serve we will take a pro-active and preventative approach to minimising harm by supporting people to keep active and independent and well in their own home.
To achieve this, we will:
• Roll out the REVIVE programme to local care homes and care providers to improve patient outcomes and reduce the risk of falling.
• Embed Rehabilitation and Recovery pathways for patients who need it to reduce their length of stay and get them back to a place they call home as soon as possible.
• Expanded rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter to the individual

- Expand and grow patient education programmes to enable patients to manage their long-term conditions.
- Be leaders and experts in Wound Care and Continence care, working with partners and patients to enhance experience and redesign pathways
- Expand and grow our Community Nursing and Therapy teams to meet increasing demand
- Expand our Urgent Care and Virtual Ward pathways enabling more patients to be cared for in their own home avoiding a hospital admission.

We will measure success by:

- Increase the number of patients that have access to the REVIVE programme by 10%
- No more than 90 patients a day are waiting in an acute bed for care when they are fit and well enough to come home, during winter 2024/2025
- Length of Stay in the Rehabilitation and Recovery Units is reduced to 17 days
- Increase the number of patients accessing patient education programmes across Shropshire Telford and Wrekin
- Improved patient outcomes following rehabilitation
- Improved patient outcomes and experience in wound care
- Improved patient outcomes and experience in continence care
- Increase the number of patients accessing Virtual Ward pathways by 10% to consistently deliver an 80% occupancy rate

Dying Well: People nearing the end of their life deserve to receive high quality and compassionate care and are supported to live well and to die with dignity in a place of their choosing.

To achieve this, we will:

- Ensure all people on an End of Life Care register will be offered an assessment and advance care plan
- We will enable more people to die in their preferred place, with dignity and with the care that they need
- Ensure our staff will have the knowledge skills and confidence to care for people at the end of their life and their families and loved ones

We will measure success by:

- Increased number of people on the End-of-Life Care Register will have an Advanced Care Plan in place
- Improved patient and family experience

Clinical Quality Ambition 2: Listening to and supporting the patient voice.

Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.

We will develop innovative ways for the voice of the child to be heard.
To achieve this, we will:
• Implementation of 'Take Over Days' within Children and Young People Services
• Development of local Youth Forum or Networks
• Work in collaboration with Local Authority, Social Care and Education partners across our communities to develop co-ordinated pathways to ensure a safe transition for young people
We will measure success by:
• Increased voice of the child influencing service improvements
• Outcomes and feedback from 'Take Over Days' shared
• Improved patient experience measures for children and young people transitioning into adult services

We will ensure that all voices, including under-represented groups can be heard and encouraged to influence change.
To achieve this, we will:
• Renew and refresh our Equality Diversity System (EDS2) plan.
• Co-design our Observe and Act visits with patients with Learning Disabilities and Autism
• Enhance Dementia Care and support for families and carers.
We will measure success by:
• Our EDS2 Plan updated and published on public facing website
• Increased feedback through Observe and Act visits completed by service users with Learning Disabilities and Autism
• Increased number of referrals to the Admiral Nursing Team
• Increased number of focus groups to include under-represented groups

Clinical Quality Ambition 3: Learning and Improving together.

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients, and give better outcomes for communities.

We will enhance opportunities to learn together across care pathways and involve people in delivering improvement ideas.
To achieve this, we will:
• Build improvement capacity and capability by training our staff in using Quality Improvement (QI) methodology.
• Quality Improvement (QI) methodology and approaches will be embedded throughout the organisation enabled by access to learning, guidance and coaching to improve care for the people who use our services.
• Strengthen the links between audit and quality improvement, ensuring that audit data inform new and existing QI programmes
We will measure success by:
• 50 staff across all directorates will have received training in QI methodology.
• SCHT Quality Improvement Framework will be embedded across the organisation.
• Increased number of local audits completed

We will share our improvements, celebrating, and recognising achievements and using this as a springboard for further improvement and innovation.
To achieve this, we will:
• Implement a quarterly meeting for celebrating success and sharing QI project outcomes.
• Establish Learn at lunch sessions for development opportunities and sharing of ideas.
We will measure success by:
• 10 QI projects delivered by March 25 with year-on-year increase
• 10 QI Advocates within the organisation that have completed QI practitioner training by March 2025 with year-on-year increase
• Response to specific staff survey questions improving by 5%

We will increase visibility and accessibility of innovation and research across all disciplines.
To achieve this, we will:
• Increase Research activity as we continue to promote, undertake and use research as part of how we improve
We will measure success by:
• Increase the number of Research Champions across the organisations in multiple disciplines

Clinical Quality Ambition 4: Delivering Equitable and Sustainable Services

Everyone should have the same opportunity to lead a healthy life, no matter who they are or where they live.

We will take a population health approach, striving to create equality of outcomes across the populations we serve and ensure we recover our services inclusively.
To achieve this, we will:
• Reducing the time people wait for our services and encouraging our patients to 'wait well'
• Contribute to initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.
• Focus on Rural Health opportunities with the development of Rural Wellbeing Hubs
We will measure success by:
• Improving the length of time that people wait to access our services
• Publication of an annual report at Trust Board demonstrating progress against the strategic objectives and National Core20PLUS5 Approach to Reducing Healthcare Inequalities
• Implementation of Rural Wellbeing Hub in Bishops Castle Community Hospital

We will aim to deliver outstanding care, in the right buildings, supported by technology, whilst reducing our carbon footprint.
To achieve this, we will:
• Reduce our carbon footprint by progressing SCHT Green Plan, optimising our estate and reducing unnecessary journeys.
• Strive to make the best use of new technology and deliver innovative ways in how we share patient information and deliver patient care using technology.
We will measure success by:
• The implementation of Virtual Assistant, for referrals and triaging in Single Point of Access, Virtual Wards and 0-19 services.
• Reduce the number of buildings SCHT operate out of bringing teams together
• Development of the admin academy

Linked Strategies and Frameworks

- SCHT Digital Strategy
- SCHT Research and Innovation Strategy
- NHS People Plan
- Quality Improvement Framework
- NHS IMPACT
- National Patient Safety Strategy
- SCHT PSIRF Policy and Plan
- National Palliative and End of Life Care Framework
- STW Palliative Care Strategy

Monitoring and Review

This strategy covers 2024 – 2027 but will be subject to review and evaluation on a yearly basis. The Clinical Quality Ambitions and priorities set out in this strategy will be prioritised in accordance with Shropshire Community Health Trust Strategic Objectives. The Quality and Safety Committee has ownership of and responsibility for the implementation of this strategy and the subsequent action plan will be monitored by the members of the committee on a 6 monthly basis.

Shropshire Community Health
NHS Trust

Chair's Assurance Report

People Committee

0. Reference Information

Author:	**Diane Davenport**	**Paper date:**	**3rd October 2024**
Executive Sponsor:	Alison Sargent Chair of Committee	**Paper written on:**	26th September 2024
Paper Reviewed by:	Sarah Allan Deputy Director of People	**Paper Category:**	People
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 26th September 2024 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

- The purpose of the People Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:
  - Promote excellence in staff health and wellbeing.
  - Identify, prioritise and manage risks relating to staff.
  - Ensure efficient and effective use of resources.
- To ensure the Trust is meeting its statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans.
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues.
- To ensure that the Committee has adequate information on which to advise and assure the Board.

Chair's Assurance Report

People Committee

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

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

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

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

2.2 Summary

The Committee met on 26th September 2024 and was quorate with 1 Non-Executive and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen in the grid below.

2.3. Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

People Committee

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the People Committee which met on 26th September 2024. The meeting was quorate with 1 non-Executive members and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Alison Sargent	Chair – Non-Executive Director
Jill Barker	Associate Non-Executive Director
Sarah Allan	Deputy Director of People
Claire Horsfield	Deputy Director for Quality & Chief AHP
Tracie Black	Associate Director of Workforce, Education & Professional Standards
In attendance	
Tina Long	Chair of the Trust
Patricia Davies	Chief Executive

Apologies:
Lisa Gibbons Associate Director of People, Employee Relations & OH, Shelley Ramtuhul Corporate Secretary/Corporate Secretary, Rhia Boyode Director of People and OD and Fiona MacPherson Head of Human Resources Services

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.

Chair's Assurance Report

People Committee

3.3 Key Agenda

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

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
1.	**Review of Minutes and actions from the last meeting: 27th July 2024** The minutes from the People Committee on 27th July 2024 were approved as a true and accurate record of the meeting. The Action log was discussed and updated.		
2.	**People Metrics and KPI Dashboards** **Appraisal rates** – August position is 86.27& against a target of 90%. Actions in place to increase compliance. **Leavers** rate – August compliance 11.48% which is a reduction and still more work to do to meet the target of 9.6%. **Mandatory training** – 92% compliance against target of 95%. Action plans in place to increase the compliance target. Areas of low compliance are being targeted. **Temporary staffing** – no off framework shifts. **Vacancies** – on a downward trend **Sickness** – on a downward trend and lots of support being provided to Managers and Staff. The Committee discussed the report and asked for clarity on the following areas: - Definition of time to hire data of 35.7 working days and is this from time to advertise to person in post. - If data is available on how quickly the Manager advertises the post once a vacancy is apparent. - The trajectory to increase the bank staff to reduce the use of agency staff in line with partners in the system. The Committee discussed the number of KPIs that are off track and there should be an action plan to support the recovery. Some of the KPIs do not have action plans and this could be because they link to annual measures such as the staff survey.	Partial	Therefore, in order to provide assurance to People Committee and the Board a review to be carried out to determine if the correct actions are in place to meet the KPI.

Chair's Assurance Report

People Committee

3.	**Staff Survey Hotspots**		
	The Staff survey will go live on Monday. The Comms plan has been launched to encourage staff to complete the survey.		
4.	**EDI Report and WRES/WDES Annual Report**		
	The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standards (WRES) metrics, achievements, areas of focus for 2023/24 and Information on the NHS England's EDI Improvement Plan were provided for authorisation to publish the WRES and WDES metrics and improvement plan on the Trust's website to ensure compliance with our legal obligations. The Committee authorised the standards to go to Trust Board for final approval for publication next week with the following amendments: - The timelines in the action plan to be reviewed. - The statement referring to the decline in ethnic minority of staff having experienced harassment, bullying or abuse from patients, relatives and the public to be clarified for accuracy.	Partial	Amendments to be made to the WRES and WDES prior to submission to the Trust Board for final approval.
5.	**Schwartz Rounds**		
	The Committee received the Schwartz Round Annual report for 2023-24. Some of the celebrations over the last year include: - Seen a steady risk in the number of staff who attend Schwartz rounds. - Looking to collaborate with system partners on Schwartz rounds. - Have held two Schwartz rounds in the prison which were challenging but a good experience. - Membership of the steering group is small and needs to be more diverse and looking to extend group membership. - Trainee Psychologist undertook an evaluation project on Schwartz rounds to look at benefits and barriers. The report is to be reviewed and will inform the work of the steering group. - Need to encourage more story tellers to come forward. - Sara Ellis Deputy Director of Nursing & Quality has agreed to be the SLT connection.	Yes	

Chair's Assurance Report

People Committee

	The Committee acknowledged the good work that is being undertaken from both the Schwartz rounds and the psychology team.		
6.	**Board Assurance Framework – People Risks**		
	There are no changes to the People Risks. However, the Committee did not that it is quite unusual for no change to the risks during the year. Therefore, does the BAF require a review as the level of risk might have changed due to work undertaken.	Partial	The People Risks to be reviewed.
7.	**Updated Terms of Reference for discussion/approval**		
	The Committee discussed the updated terms of reference. Job titles to be amended. Frequency of meetings to remain as monthly. Tracie Black to be included as an attendee and Clair Hobbs to be included in membership. SA shared with the Committee that as part of the interim People Structure there is a new Deputy Director of Workforce who is providing support to Shropcom and SaTH and will present the Integrated Performance Report as part of their portfolio.		
8.	**Any Other Business**		
	Discussion took place about the People Committee on 31st October which will not be quorate and to look to rearrange if possible.		

3.4 Approvals

Approval Sought	Outcome
The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standards (WRES) metrics, achievements, areas of focus for 2023/24 and Information on the NHS England's EDI Improvement Plan	Approved

4. Conclusion

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

Shropshire Community Health NHS Trust

Equality, Diversity & Inclusion Update Report

(including the mandated Workforce Race and Disability Equality Standards)

0. Reference Information

Author:	**Fiona MacPherson, Head of HR Services**	**Paper date:**	**3 October 2024**
Executive Sponsor:	**Rhia Boyode, Chief People Officer**	**Paper written on:**	19 September 2024
Paper Reviewed by:	**Sarah Allan, Deputy People Director**	**Paper Category:**	Workforce
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 the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) metrics, key achievements, areas of focus for 2024/25 and information on the NHS England's EDI Improvement plan.

This paper is for approval to be published on our web site to ensure compliance with our legal obligations.

2. Executive Summary

2.1 Context

On an annual basis we have to publicise our WRES and WDES data as they are mandated by the NHS Standard Contract and apply to all NHS Trusts. Our data and action plans have to be published on our website by 31 October 2024.

2.2 Summary

Key highlights from our WRES data are:

- We have improved in 6 out of the 9 indicators
- The data indicates that 9.19% of ethnic minority staff have experienced harassment, bullying or abuse from staff in the last 12 months, this is a significant decrease from 2022 where 22.22% of ethnic minority staff reported experiencing harassment, bullying or abuse.
- The data indicates that 65.71% of ethnic minority staff believe the Trust provides equal opportunities for career progression or promotion, this is 9.76% higher than white staff. This score has significantly increased from 2022 when it was 37.04% for ethnic minority staff
- The data indicates that 27.32% of ethnic minority staff have experienced harassment, bullying or abuse from patients, relatives and the public compared to 21.62% of white staff. In 2022, 19.23% of ethnic minority staff experienced harassment, bullying or abuse.

Equality, Diversity & Inclusion Update Report

(including the mandated Workforce Race and Disability Equality Standards)

Our WDES data shows:

- We have seen an improvement in 3 areas compared to last year
- The data shows that non-disabled applicants are 1.788 times more likely to be appointed from shortlisting compared to disabled applicants. This has improved from 2.34 times more likely in 2022/23.
- The data shows that disabled staff are 19.40 times more likely to enter into a formal capability process compared to non-disabled staff. It is worth noting that with such small numbers of capability cases and a disabled workforce of 4.33% it is likely that a small number of cases can result in a negatively ranked score on this indicator.
- The % of staff with a long lasting health condition or illness saying that we have made reasonable adjustment (s) to enable them to carry out their work has decreased from 77.66% to 72.34%.

Areas for action: It is clear there are some key areas of action which are the same for both the WRES and the WDES. These actions are around the experience staff in terms of bullying and harassments, raising the profiles of EDI and reviewing People policies.

For both the WRES and WDES data we will continue to work closely with our networks and staff to look at what we can do to improve the experiences of our staff.

2.3. Conclusion

Trust Board is asked to:

1. Authorise the publication of WRES metrics and improvement plan (appendix A) on the SCHT website to ensure we are compliant with legislative requirements.

2. Authorise the publication of the WDES metrics and improvement plan (appendix B) on SCHT website to ensure we are compliant with legislative requirements.

3. Receive assurance on the delivery of high impact actions for 2024-25

Shropshire Community Health NHS
NHS Trust

NHS Workforce Disability Equality Standard Annual Report 2023-24

Context – Background to WDES and Disability

The Workforce Disability Equality Standard (WDES) was introduced into the NHS in 2019. The report is based on a snapshot of data from 31 March each year. The purpose of its implementation is to improve the experiences of disabled people working in, or seeking employment within the NHS. The mandated evidence based metrics help an organisation understand more about the experiences of it's staff.

The WDES report compares data between disabled and non-disabled staff in order to identify inequalities within the workplace. The inequalities are then reviewed to inform our WDES action plan which aims to address these inequalities.

What is disability?

The Equality Act 2010 defines a disabled person as:

> *"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities"*

WDES metrics report

Detailed below is Shropshire Community Health Trusts WDES data which was submitted in August 2024 covering the period 1 April 2023 - 31 March 2024. The information below is provided in the template from NHS Employers.

Metric 1 **Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.**

(Data source: ESR).

	Clinical staff						Non-clinical staff					
Pay band	**No of not-disabled colleagues**	**%**	**No of disabled colleagues**	**%**	**Disability unknown/not stated**		**No of not-disabled colleagues**	**%**	**No of disabled colleagues**	**%**	**Disability *unknown/not stated**	
Band 2	113	88.28%	1	0.78%	14	10.94%	138	79.3%	13	7.5%	23	13.2
Band 3	136	90.67%	2	1.33%	12	8%	84	84.8%	5	5.1%	10	10.1
Band 4	98	78.40%	6	4.80%	21	16.80%	33	71.7%	3	6.5%	10	21.7
Band 5	227	87.64%	13	5.02%	19	7.34%	37	77.1%	1	2.1%	10	20.8
Band 6	322	84.96%	22	5.80%	35	9.23%	27	77.1%	0	0%	8	22.9
Band 7	149	80.11%	8	4.30%	29	15.59%	19	86.4%	1	4.5%	2	9.1
Band 8A	29	93.55%	0	0%	2	6.45%	18	81.8%	1	4.5	3	13.6
Band 8B	4	100%	0	0%	0	0%	14	100%	0	0%	0	0
Band 8C	5	83.33%	0	0%	1	16.67%	4	80%	0	0%	1	20
Band 8D	0	0%	1	100%	0	0%	3	100%	0	0%	0	0
Band 9	0	0%	0	0%	0	0%	3	100%	0	0%	0	0
VSM	2	100%	0	0%	0	0%	3	100%	0	0%	0	0
Other	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Consultant	6	100%	0	0%	0	0%	0	0%	0	0%	0	0
Non-consultant career grade	19	73.08%	0	0	7	26.92%	0	0%	0	0%	0	0
M&D Trainee grade	1	100%	0	0	0	0%	0	0%	0	0%	0	0
TOTAL	**1111**	**85.20%**	**53**	**4.06%**	**140**	**10.74%**	**383**	**80.80%**	**24**	**5.06%**	**67**	**14.14%**

**Disability unknown refers to staff who have indicated that they prefer not to say and staff who have not responded to the whether they are disabled in ESR*

Summary by Pay Band grouping

	Non-Clinical Staff						Clinical Staff					
	No. of Disabled staff	%	No. of non disabled	%	Unknown	%	No. of Disabled staff	%	No. of non disabled	%	Unknown	%
Cluster 1 Bands 1-4	21	6.6%	255	79.9%	43	13.5%	9	2.2%	347	86.1%	47	11.7%
Cluster 2 Band 5-7	2	1.9%	83	79%	20	19%	43	5.2%	698	84.7%	83	10.1%
Cluster 3 band 8a and 8b	1	2.8%	32	88.9%	3	8.3%	0	0%	33	94.3%	2	5.7%
Cluster 4 Band 8c & VSM	0	0%	13	92.9%	1	7.1%	1	11.2%	7	77.8%	1	11.1%

Workforce demographics

The total number of substantive staff employed within Shropshire Community Health Trust:

	2024		**2023**		
	Headcount	**%**	**Headcount**	**%**	**Difference**
Disabled	77	4.33	71	4.22	+0.11%
Not Disabled	1494	84.03	1368	81.33	+2.7%
Unknown	207	11.64	243	14.45	-2.81
	1778		1682		

Metric 2 – Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

WDES Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts. 1st April 2023 – 31st March 2024 (Disabled compared to Non-disabled)		
	Non-disabled	Disabled
Number of shortlisted applicants	1019	112
Number appointed from shortlisting	179	11
Relative likelihood of appointment from shortlisting	0.098	0.176
Relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff		1.788

The above data shows that non-disabled applicants are 1.788 times more likely to be appointed from shortlisting compared to disabled applicants. This has decreased from 2.34 times more likely in 2022/23. Work will continue in 2024/25 to further improve this likelihood which can be seen in the improvement plan.

Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

WDES Indicator 3 Relative likelihood of Disabled staff compared to Non – Disabled staff entering the formal capability process, as measured by entry into the capability procedure. This metric is based on data from a two-year rolling average.		
	Disabled	**Non-Disabled**
Relative Likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff (*These are auto calculations undertaken within the Excel Spreadsheet provided to us by the National WDES team)*	19.40	

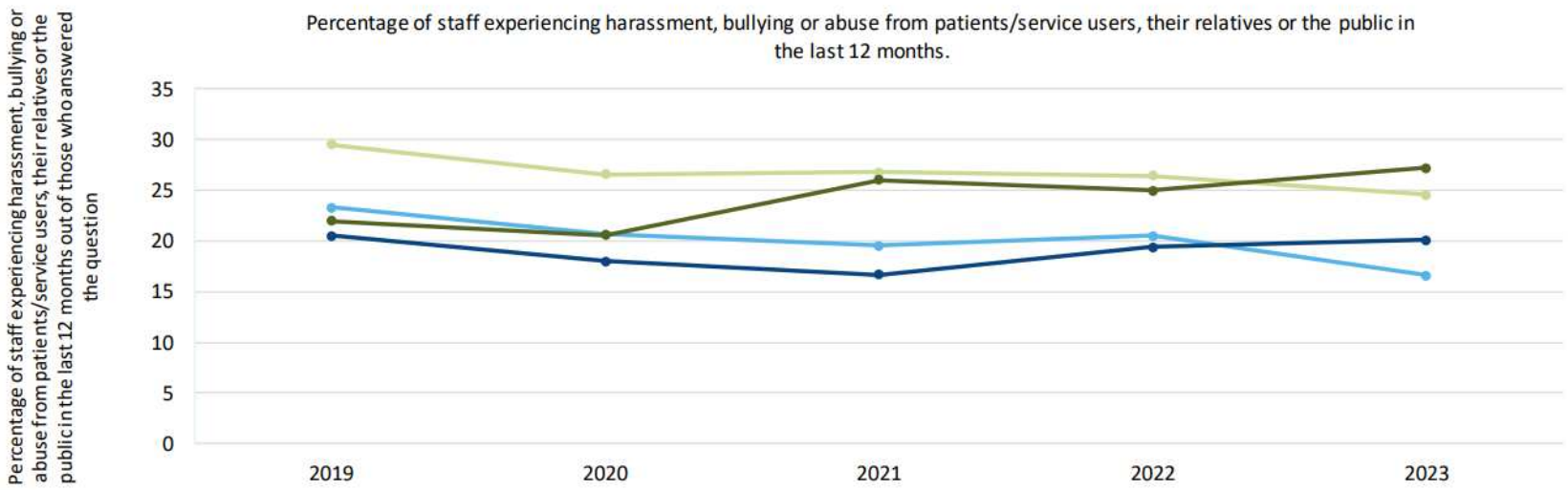
This data shows that disabled staff are 19.40 times more likely to enter into a formal capability process compared to non-disabled staff. The likelihood score has increased from 2023 when it was 0. It is worth noting that with such small numbers of capability cases and a disabled workforce of 4.33% it is likely that a small number of cases can result in a negatively ranked score on this indicator. However, we are continuing to monitor this and will be refreshing our Maintaining High Standards of Performance Policy (Capability).

Metric 4 – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

(Data source: Question 13, NHS Staff Survey)

Workforce Disability Equality Standards

Survey Coordination Centre NHS

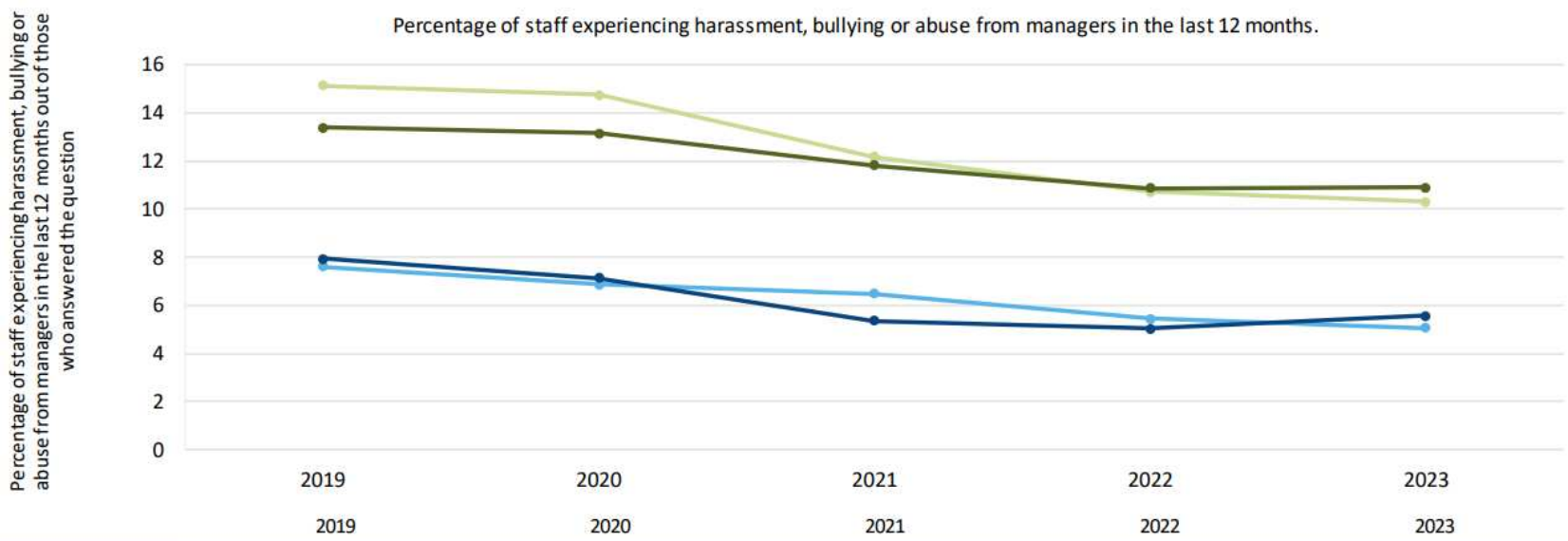


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	22.01%	20.57%	26.02%	25.00%	27.21%
Staff without a LTC or illness: Your org	20.55%	18.03%	16.67%	19.42%	20.08%
Staff with a LTC or illness: Average	29.52%	26.60%	26.81%	26.46%	24.59%
Staff without a LTC or illness: Average	23.32%	20.67%	19.53%	20.51%	16.64%
Staff with a LTC or illness: Responses	159	175	196	184	229
Staff without a LTC or illness: Responses	696	649	672	582	585

The % of staff with a Long Term Condition (LTC) or illness experiencing harassment, bullying or abuse from patients/service users, their relatives or the public has increased in the last 12 months from 25% to 27.21%. This has also increased for staff without a LTC or illness from 19.42% to 20.08%. We will launch the work without fear campaign and ensure staff are encouraged to raise incidents.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

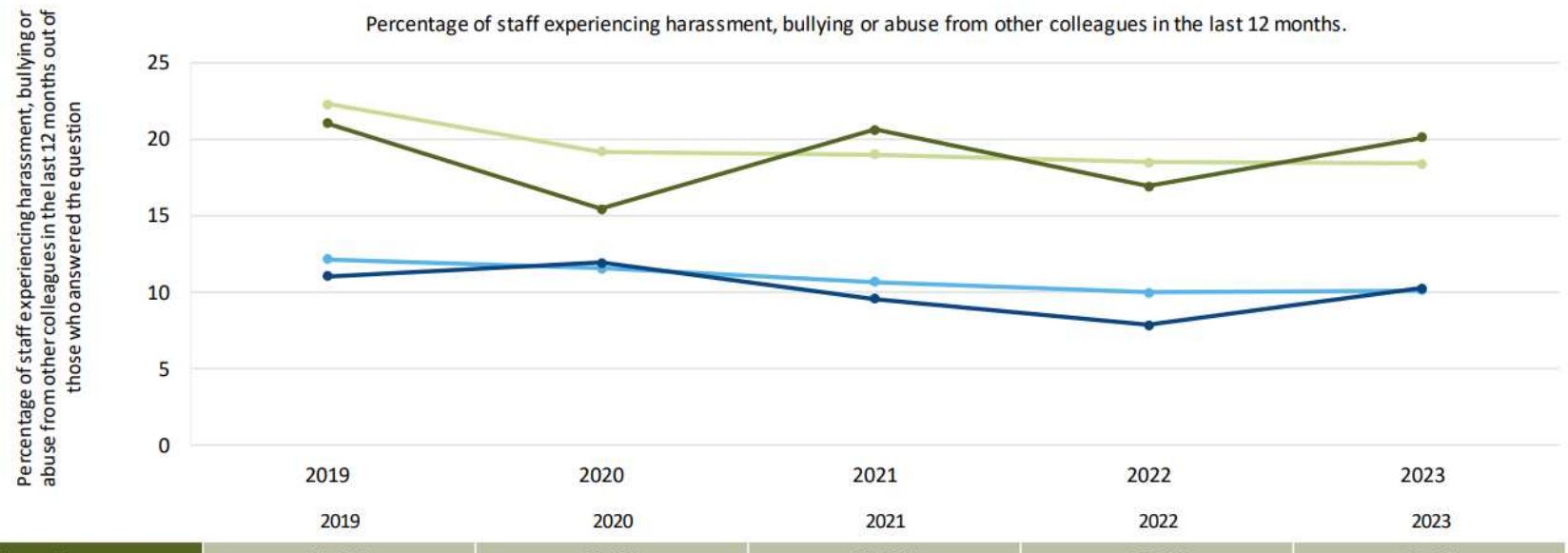


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	13.38%	13.14%	11.79%	10.87%	10.90%
Staff without a LTC or illness: Your org	7.93%	7.12%	5.37%	5.02%	5.57%
Staff with a LTC or illness: Average	15.12%	14.75%	12.17%	10.71%	10.28%
Staff without a LTC or illness: Average	7.59%	6.85%	6.49%	5.45%	5.05%
Staff with a LTC or illness: Responses	157	175	195	184	229
Staff without a LTC or illness: Responses	694	646	671	578	574

The % of staff with a Long Term Condition (LTC) or illness experiencing harassment, bullying or abuse from managers has remained relatively static in the last 12 months; in 2022 this was 10.87% and in 2023 this is 10.90%. This is the same as staff without a LTC or illness which was 5.02% in 2022 and 5.57% in 2023. We will continue to deliver our Dignity at Work workshops, raise awareness of our Dignity at Work Policy and our Freedom to Speak up Guardians.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

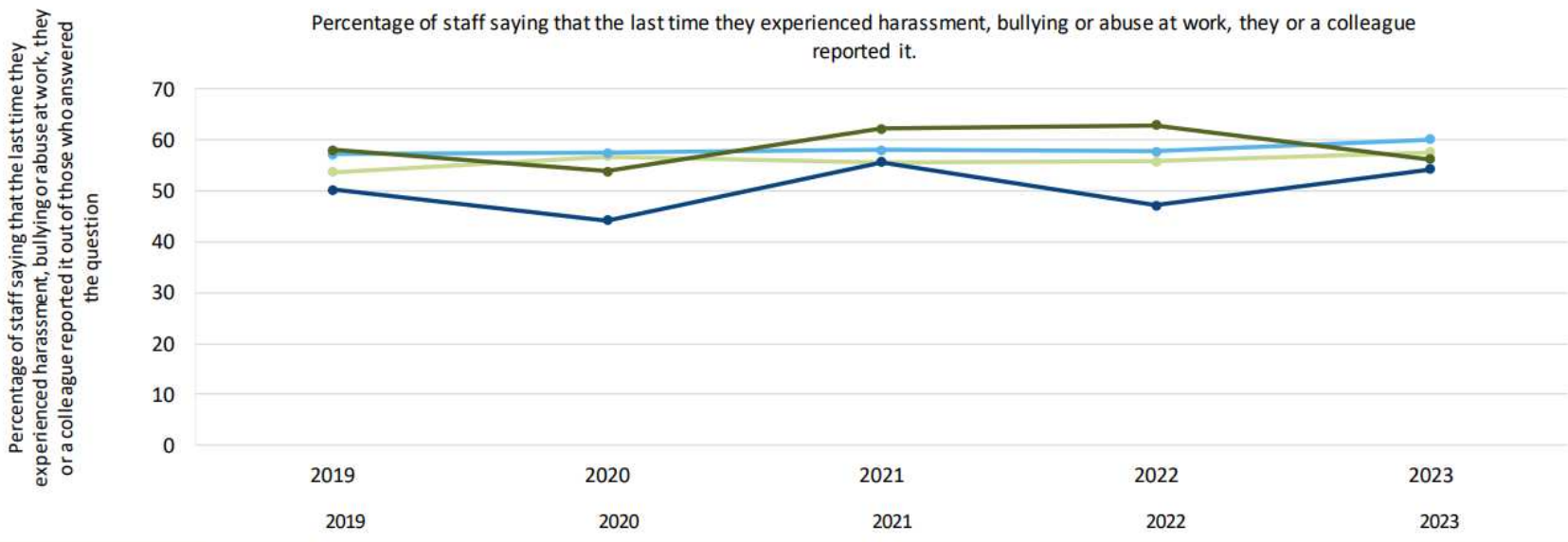


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	21.02%	15.43%	20.62%	16.94%	20.10%
Staff without a LTC or illness: Your org	11.06%	11.92%	9.58%	7.84%	10.26%
Staff with a LTC or illness: Average	22.31%	19.19%	19.00%	18.49%	18.43%
Staff without a LTC or illness: Average	12.15%	11.56%	10.69%	10.01%	10.10%
Staff with a LTC or illness: Responses	157	175	194	183	225
Staff without a LTC or illness: Responses	696	646	668	574	575

The % of staff with a Long Term Condition (LTC) or illness experiencing harassment, bullying or abuse from colleagues in the last 12 months has increased from 16.94% to 20.10%. This has also increased for staff without a LTC or illness from 7.84% to 10.26%. We will continue to roll out our Civility & Respect programme and we will be developing a booklet to support the programme.

Workforce Disability Equality Standards

Survey Coordination Centre NHS



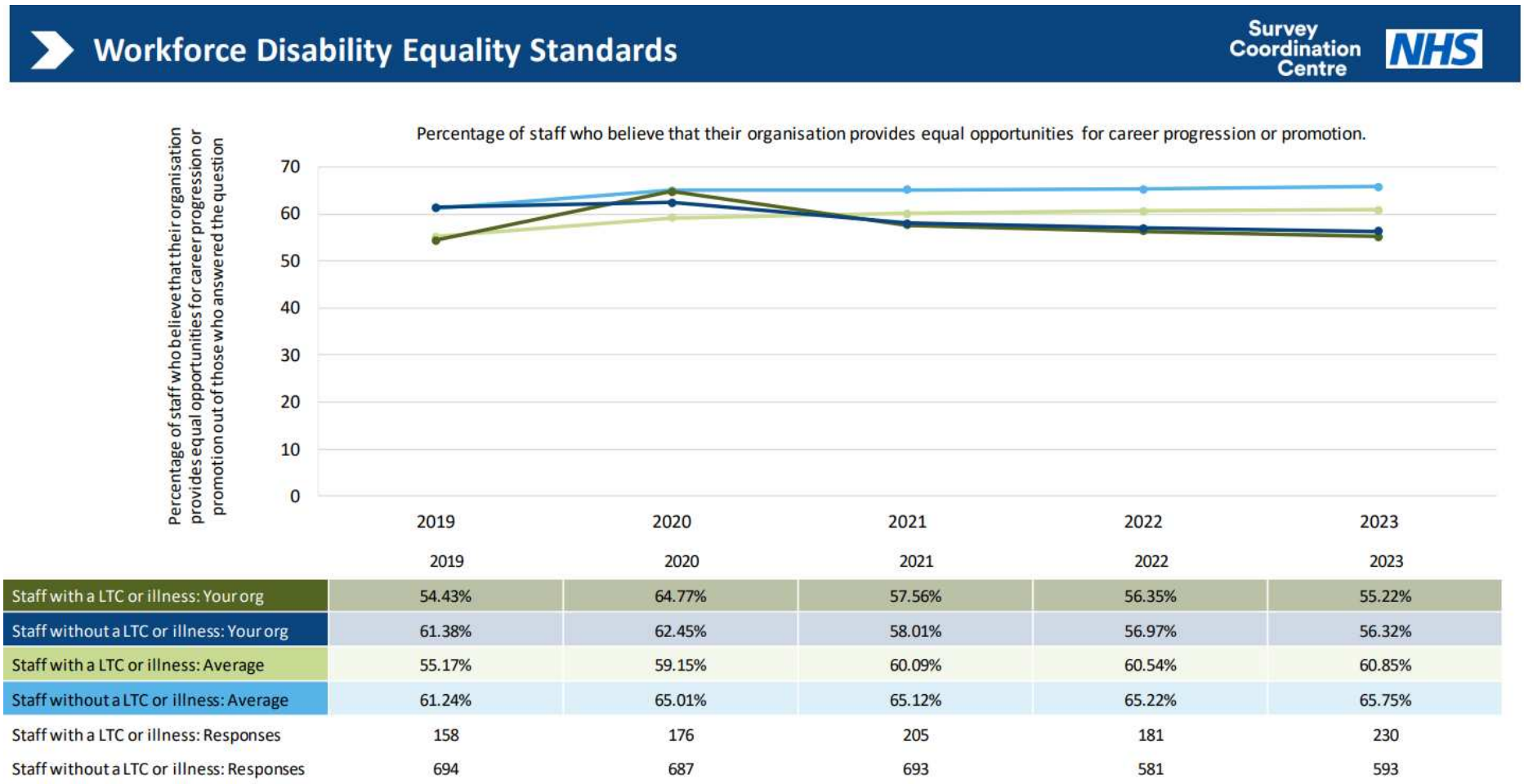
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	58.06%	53.85%	62.32%	62.90%	56.27%
Staff without a LTC or illness: Your org	50.29%	44.17%	55.63%	47.20%	54.23%
Staff with a LTC or illness: Average	53.69%	56.81%	55.68%	55.80%	57.63%
Staff without a LTC or illness: Average	57.19%	57.46%	58.08%	57.82%	60.10%
Staff with a LTC or illness: Responses	62	52	69	62	89
Staff without a LTC or illness: Responses	175	163	160	125	133

The % of staff with a LTC or illness saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it has decreased from 62.90% to 56.27%. This has increased for staff without a LTC; 47.20% to 54.23%. we will continue to raise awareness of our Freedom to Speak Up Guardian and our staff networks to ensure staff are aware of how concerns can be raised.

Metrics 5 – 8

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

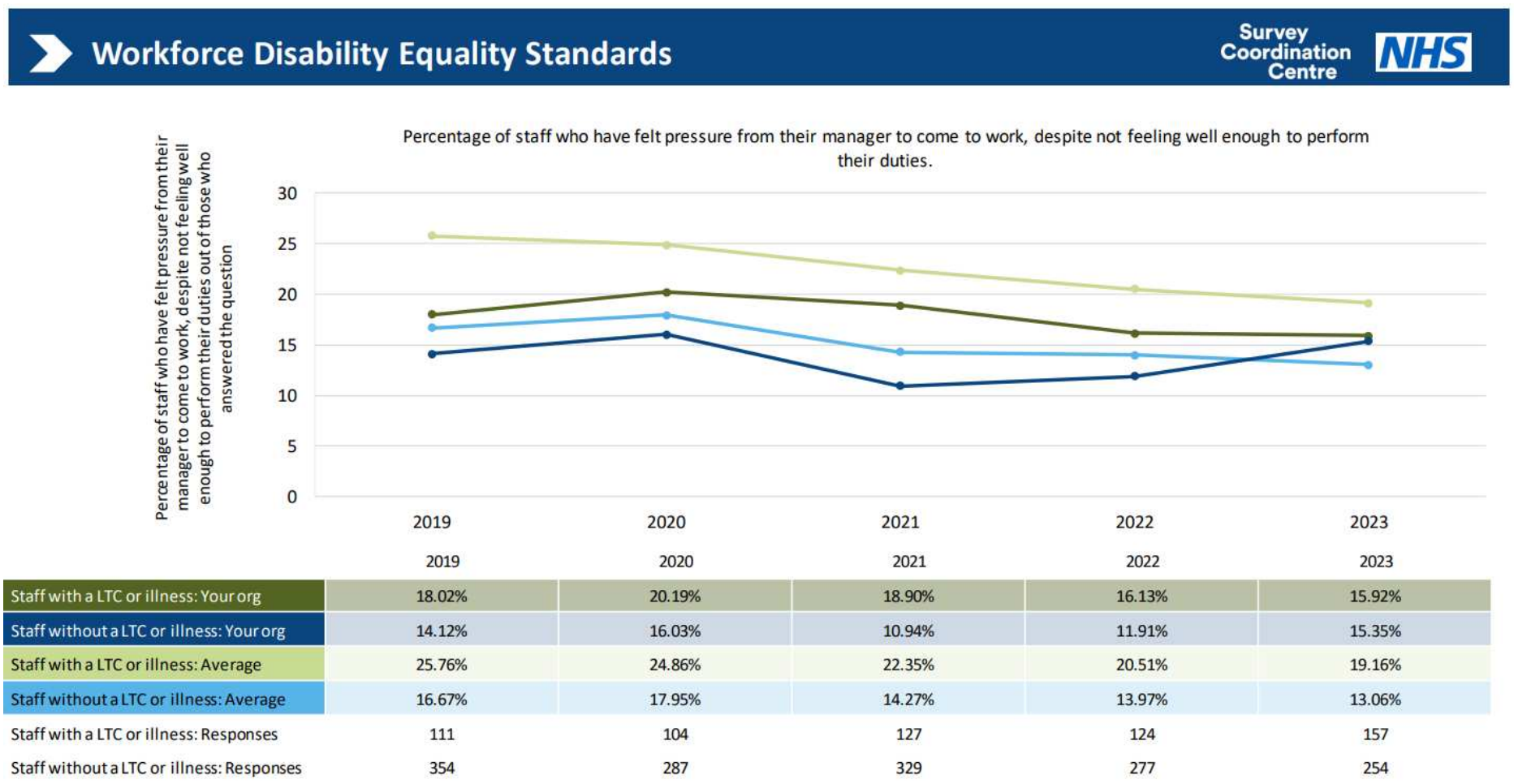
Metric 5 – Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	54.43%	64.77%	57.56%	56.35%	55.22%
Staff without a LTC or illness: Your org	61.38%	62.45%	58.01%	56.97%	56.32%
Staff with a LTC or illness: Average	55.17%	59.15%	60.09%	60.54%	60.85%
Staff without a LTC or illness: Average	61.24%	65.01%	65.12%	65.22%	65.75%
Staff with a LTC or illness: Responses	158	176	205	181	230
Staff without a LTC or illness: Responses	694	687	693	581	593

The % of staff with a LTC or illness who believe that we provide equal opportunities for career progression or promotion has slightly decreased from 56.35% to 55.22%. We are currently working in collaboration with Shrewsbury and Telford Hospitals and they are offering their leadership courses to our staff and we are currently exploring launching scope for growth conversations.

Metric 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



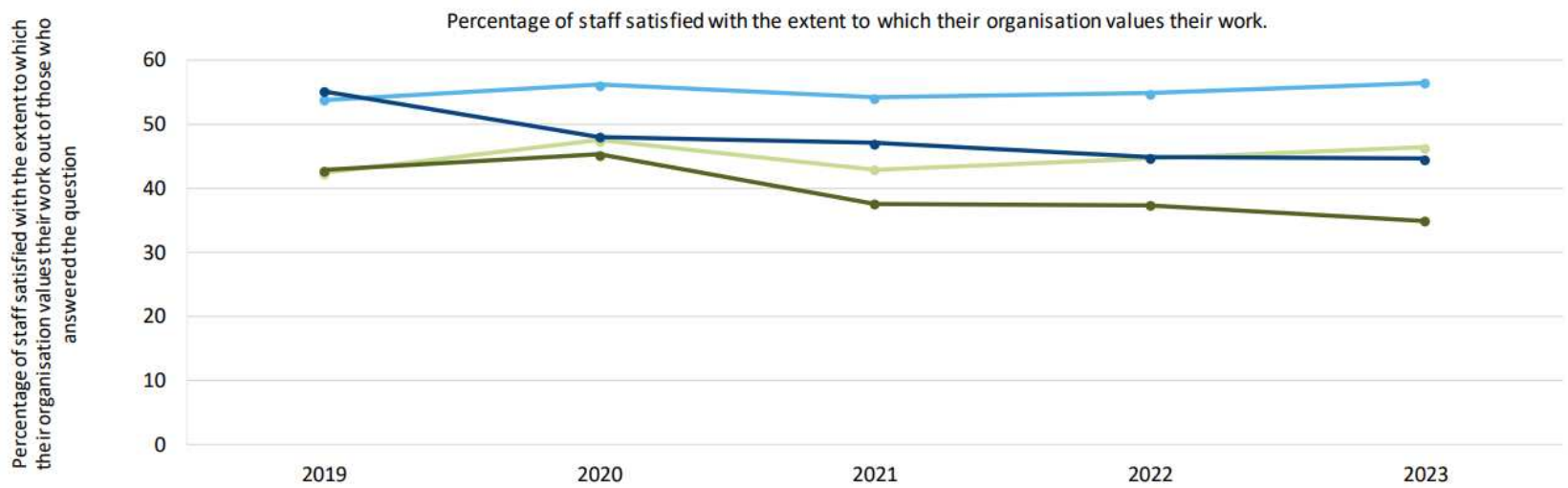
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	18.02%	20.19%	18.90%	16.13%	15.92%
Staff without a LTC or illness: Your org	14.12%	16.03%	10.94%	11.91%	15.35%
Staff with a LTC or illness: Average	25.76%	24.86%	22.35%	20.51%	19.16%
Staff without a LTC or illness: Average	16.67%	17.95%	14.27%	13.97%	13.06%
Staff with a LTC or illness: Responses	111	104	127	124	157
Staff without a LTC or illness: Responses	354	287	329	277	254

The % of staff with a LTC or illness who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has slightly decreased from 16.13% to 15.92%. We will continue to work on our Health and Wellbeing offer for staff which includes rolling out Wellbeing conversations training.

Metric 7 – Percentage of staff satisfied with the extent to which their organisation values their work

Workforce Disability Equality Standards

Survey Coordination Centre NHS



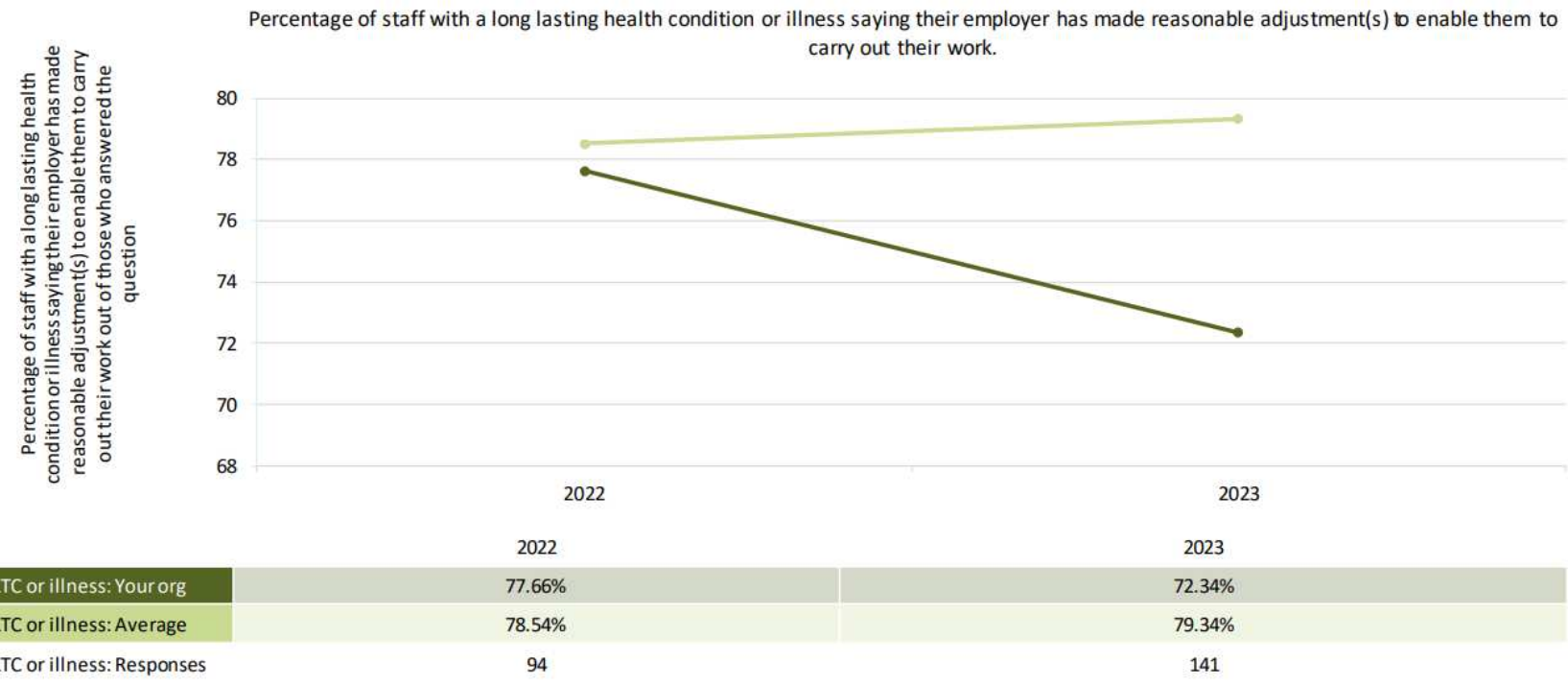
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	42.77%	45.25%	37.56%	37.36%	34.93%
Staff without a LTC or illness: Your org	55.11%	48.05%	47.00%	44.85%	44.56%
Staff with a LTC or illness: Average	42.35%	47.49%	42.95%	44.69%	46.35%
Staff without a LTC or illness: Average	53.76%	56.14%	54.16%	54.77%	56.49%
Staff with a LTC or illness: Responses	159	179	205	182	229
Staff without a LTC or illness: Responses	695	693	700	582	597

The % of staff with a LTC or illness satisfied with the extent to which their organisation values their work has decreased from 37.36% to 34.93%. This has remained relatively static for staff without a LTC or illness from 44.85% to 44.56%. we have launched our appreciation station with thank you cards and other cards to acknowledge events and we are reviewing our reward and recognition offer with the plan to launch additional events in 2024/25.

Metric 8 – Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment (s) to enable them to carry out their work

Workforce Disability Equality Standards

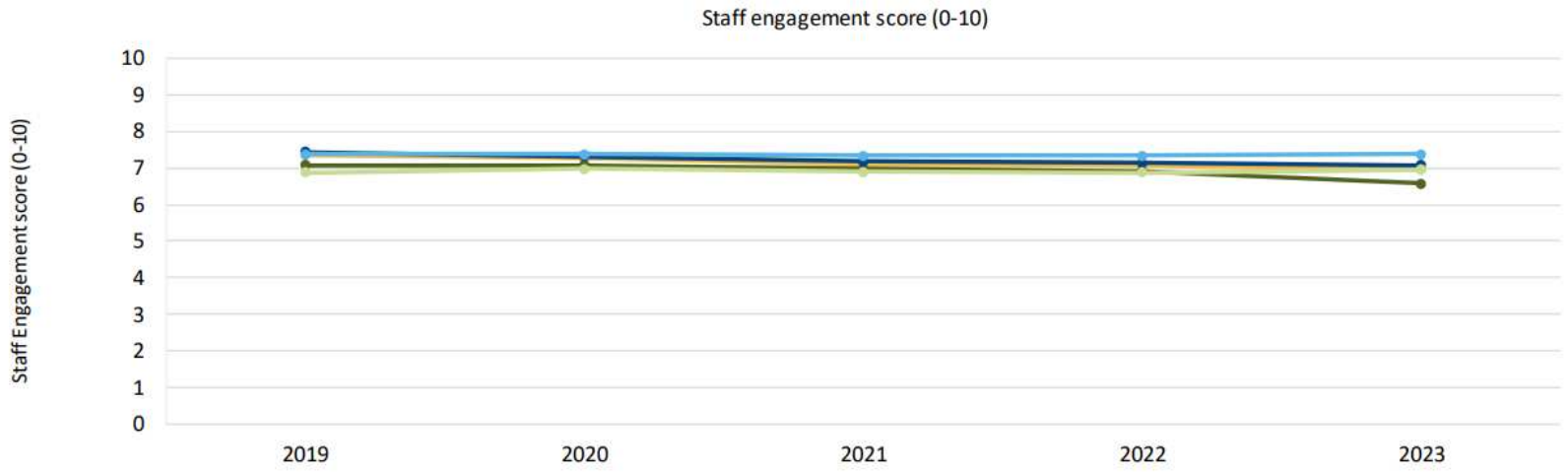
Survey Coordination Centre NHS



	2022	2023
Staff with a LTC or illness: Your org	77.66%	72.34%
Staff with a LTC or illness: Average	78.54%	79.34%
Staff with a LTC or illness: Responses	94	141

The % of staff with a long lasting health condition or illness saying that we have made reasonable adjustment (s) to enable them to carry out their work has decreased from 77.66% to 72.34%. We have launched reasonable adjustment guidelines and we are currently looking at how we ensure awareness is raised around access to work and the process of ordering equipment etc is made as simple as possible for staff and managers.

Metric 9 – Staff Engagement Score



	2019	2020	2021	2022	2023
Organisation average	7.36	7.25	7.10	7.07	6.95
Staff with a LTC or illness: Your org	7.08	7.08	6.98	6.92	6.58
Staff without a LTC or illness: Your org	7.44	7.32	7.17	7.13	7.08
Staff with a LTC or illness: Average	6.88	6.97	6.89	6.88	6.95
Staff without a LTC or illness: Average	7.37	7.37	7.34	7.34	7.39
Staff with a LTC or illness: Responses	159	179	206	183	230
Staff without a LTC or illness: Responses	697	693	700	585	599

Overall our staff engagement score has been slowly declining since 2019. We will continue to work with staff and our networks focusing on how we create opportunities for our networks to connect together.

Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)

Metric 10 **Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:** • **by voting and non-voting membership of the board** • **by executive and non-exec membership of the board.**			
	Non-disabled	**Disabled**	**Unknown**
Executive Directors	100%	0%	0%
Non-Executive Director	83.33%	0%	16.67%
Voting membership	90%	0%	10%
Difference (Voting membership – Overall Workforce)	6%	-4%	-2%
Difference – Executive Directors compared to overall workforce	**16%**	-4%	-12%

This data shows that our board profile is not representative of our disabled workforce. We are continually reviewing our recruitment processes with actions identified in our improvement plan.

WDES improvement plan 2024/25

Workforce Disability Equality Standard (WDES): Improvement Plan 2024 – 2025

Having considered our 2023/24 data, it is acknowledged that further work is required to all of our indicators to improve the experience for our disabled staff.

This improvement plan has been developed with the aim of bringing about positive change across the Trust.

WDES Indicator	Objective	Action	Lead	Timescale	Status
WDES Indicators 1, 2, 5 & 10	Ensure our recruitment and selection processes are inclusive and fair and target under representation and lack of diversity	Review and update the Safer Recruitment Policy, training and associated documentation with a focus on reducing bias in recruitment and selection, ensuring our processes are inclusive and fair Ensure recruitment campaigns target under-represented groups and improve representation in recruitment campaign materials	Head of Resourcing	March 2025	
WDES Indicators 1, 2 & 5	Support staff with a LTC or illness to have pathways that support and encourage staff to develop and enhance their careers	Continue to work in collaboration with Shrewsbury and Telford Hospital to offer places on their Leadership Programme targeting disability network members Work with the Disability Network to understand development needs and how their careers can be supported Publicise positive staff stories around career and development opportunities Explore implementing ‘scope for growth’ conversations	Head of People Services Head of People Services Head of People Services OD Business Partner	Ongoing and in place March 2025 March 2025 February 2025	

WDES Indicator	Objective	Action	Lead	Timescale	Status
WDES Indicator 3, 6, 8	Ensure resources and support are in place to create an environment where disabled staff can thrive	Revamp our Maintaining High Standards of Performance Policy with the support of our Disability Staff Network	People Business Partner	March 2025	
		Develop guidance to support the Access to Work process to ensure there are clear processes for approval	People Business Partner	December 2024	
		Continue to roll out Wellbeing Conversations training	Head of People Services	In place and ongoing July 2025	
		Explore implementing a HWB/Health Passport	People Business Partner	March 2025	
WDES Indicators 4	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work	Continue to roll out the civility & respect training programme	OD Business Partner	In place and ongoing	
		Review our Dignity at Work Policy and Grievance Policy to ensure they are supportive of individuals raising concerns involving individuals who have been through the process	People Business Partner	March 2025	
		Review our staff survey results in relation to bullying and harassment raising awareness of Freedom to Speak up, Dignity at Work and Civility and Respect programme	Head of People Services	December 2024	
		Develop a Civility & Respect booklet to support the Civility and Respect programme	Head of People Services	January 2025	
		Launch the ‘Work without fear campaign’	Head of People Services	February 2025	

WDES Indicator	Objective	Action	Lead	Timescale	Status
WDES Indicator 7	Create an environment where disabled staff feel valued, rewarded and recognised for the work that they do	Refresh our reward and recognition offer	People Promise Manager / Head of People Services	January 2025	
		Continue to raise awareness of the Trust's Appreciation Station	People Business Partner	Ongoing	
		Undertake a Health and Wellbeing survey. Review the results and create a health and wellbeing plan on a page	HWB Lead	December 2024	
WDES Indicators ALL	Raise awareness of equality, diversity and inclusion and embed in everything we do	Refresh a Trust Wide EDI strategy with a refreshed set of objectives	Head of People Services	June 2025	
		Develop a programme of events to mark dates in the equality, diversity and inclusion calendar e.g. Disability History month	Head of People Services	December 2024	
		Develop a robust communications and marketing plan for the networks	Head of People Services	December 2024	
		Create channels for networks to connect together	Head of People Services	March 2025	

Shropshire Community Health NHS
NHS Trust

NHS Workforce Race Equality Standard Annual Report 2023-24

Introduction

The WRES is a requirement for all NHS organisations to publish data and action plans against 9 indicators of workforce race equality.

Research and evidence strongly suggest that ethnic minority staff have a poorer experience or opportunities than white staff and this has a significant impact on the efficient and effective running of the NHS and impacts on quality of care received by patients.

WRES aims to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace and support NHS organisations make the necessary structural and cultural changes needed to advance workforce race equality.

The data for indicators 1-4 and 9 are taken from the Trusts workforce data as at 31 March 2023 and data for indicators 5 – 9 are taken from the Trusts National Staff Survey 2022 results.

Indicator 1: Headcount of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

- **Non-clinical staff**
- **Clinical staff of which:**
  - **Non-Medical staff**
  - **Medical and Dental Staff**

	2023				2024			
Non-Clinical	White	Ethnic Minority Staff	Unknown	Total	White	Ethnic Minority Staff	Unknown	Total
Under Band 1	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0
2	168	5	6	179	161	7	6	174
3	91	1	2	94	95	1	3	98
4	50	1	2	53	44	1	1	46
5	41	1	1	43	46	1	1	48
6	30	1	1	32	32	1	2	35
7	21	0	0	21	20	2	0	22
8a	30	0	0	30	21	1	0	22
8b	10	2	1	13	11	2	1	14
8c	7	0	0	7	4	1	0	5
8d	3	1	1	5	3	0	0	3
9	1	0	0	1	2	0	1	3
VSM	4	0	0	4	0	0	0	0
Total	**456**	**12**	**14**	**482**	**442**	**17**	**15**	**474**

	2023				2024			
Clinical	White	Ethnic Minority Staff	Unknown	Total	White	Ethnic Minority Staff	Unknown	Total
Under Band 1	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0
2	81	4	8	93	98	22	8	128
3	114	8	7	129	130	18	2	150
4	91	6	7	104	111	7	7	125
5	213	16	5	234	217	35	7	259
6	365	14	9	388	351	22	6	379
7	164	7	2	173	174	9	3	186
8a	26	2	2	30	28	1	2	31
8b	4	0	0	4	3	1	0	4
8c	3	1	0	4	5	1	0	6
8d	0	0	0	0	1	0	0	1
9	0	0	0	0	0	0	0	0
VSM	1	0	0	1	2	0	0	2
Consultant	3	2	0	5	3	3	0	6
Non Consultant Career Grade	25	5	4	34	20	2	0	22
Trainee Grades	0	1	0	1	0	1	4	5
Other	0	0	0	0	0	0	0	0
Total	**1090**	**66**	**44**	**1200**	**1143**	**122**	**39**	**1304**

Workforce Demographics

Year	White - number of staff in overall workforce	Ethnic Minority - number of staff in overall workforce	Unknown – number of staff in overall workforce	Overall % of ethnic minority staff
2023	1546	78	58	4.65%
2024	1585	139	54	7.82%

The 2024 data shows that 7.82% of Shropcom's workforce is from an ethnic minority, which is a 3.17% increase from 2023.

For information, the 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, Mixed, Black, and Other people as 3.3%. The population by ethnicity for Telford and Wrekin in the 2021 census was White people 88.2% and Asian, Black, Mixed and Other people 11.8%.

We are continually striving to have a diverse workforce and our figures show that we are making steps towards this. We will continue with our work to ensure our workforce is as diverse as possible. Please refer to our improvement plan for the actions we will be focussing on.

Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

Table 2

WRES Indicator	Metric Description	*2023 Score*	*2024 Score*
2	Relative likelihood of white staff being appointed from shortlisting compared to ethnic minority staff being appointed from shortlisting across all posts	***2.77***	***0.54***

This figure has changed from 2.77 in 2023 to 0.54 in 2024. A figure below "1" indicates that white candidates are less likely than BME candidates to be appointed from shortlisting

Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary procedure

Table 3

WRES Indicator	Metric Description	*2023 Score*	*2024 Score*
3	Relative likelihood of ethnic minority staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process	***0***	***1.63***

The data above shows that ethnic minority staff are 1.63 more likely to enter into a formal disciplinary process than White staff. The likelihood score has increased from 2023. It is worth noting that with such small numbers of disciplinary cases and a ethnic minority workforce of 7.82% it is likely that a small number of ethnic minority cases (one in this reporting year) can result in a negatively ranked score on this indicator. However, we are continuing to embed a Just and Learning Culture.

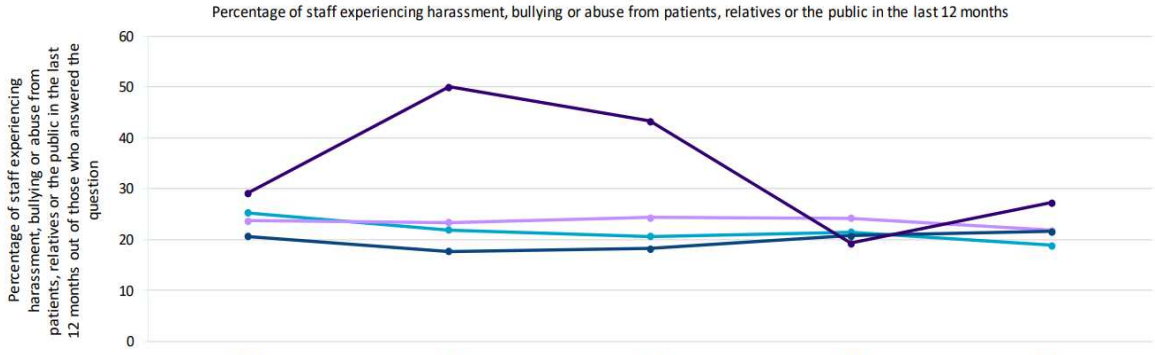
Indicator 4: Relative likelihood of staff accessing non mandatory training and CPD

Table 4

WRES Indicator	Metric Description	*2023 Score*	*2024 Score*
4	Relative likelihood of White staff accessing non mandatory training and CPD compared to ethnic minority staff	***0.98***	***0.83***

A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than ethnic minority staff. This position has continued for the last 2 years of reporting.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

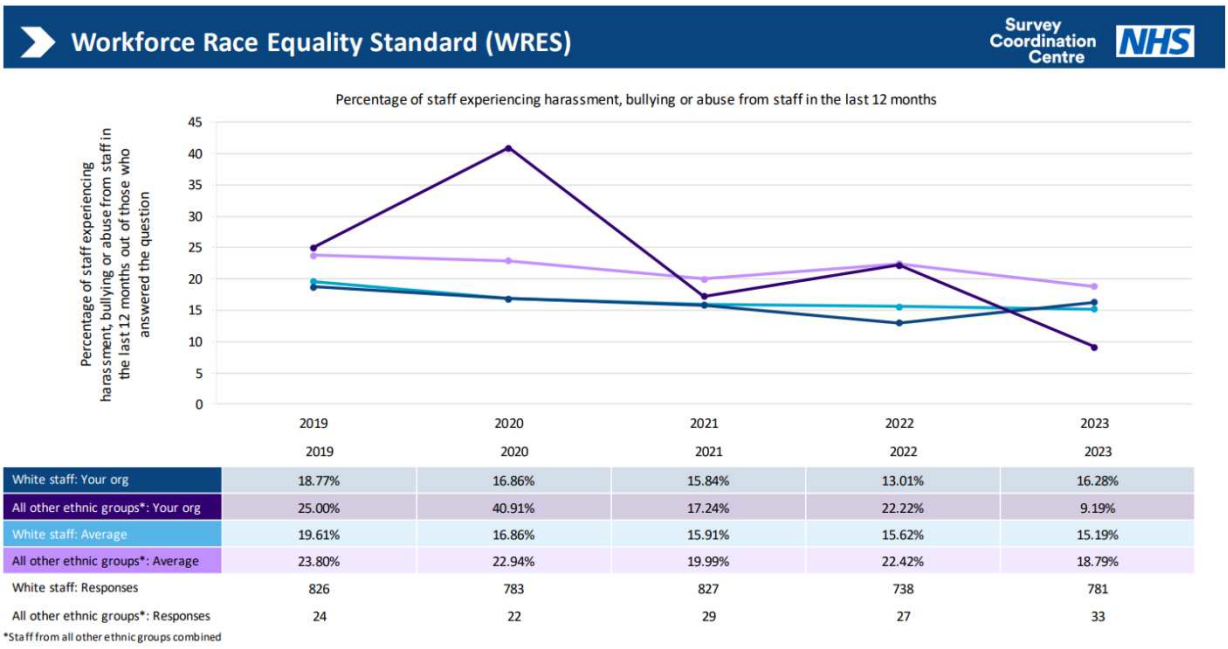


	2019	2020	2021	2022	2023
White staff: Your org	20.58%	17.71%	18.16%	20.70%	21.62%
All other ethnic groups*: Your org	29.17%	50.00%	43.33%	19.23%	27.32%
White staff: Average	25.23%	21.93%	20.65%	21.52%	18.86%
All other ethnic groups*: Average	23.66%	23.41%	24.30%	24.24%	21.80%
White staff: Responses	826	785	826	739	785
All other ethnic groups*: Responses	24	22	30	26	33

*Staff from all other ethnic groups combined

The data above indicates that 27.32% of ethnic minority staff have experienced harassment, bullying or abuse from patients, relatives and the public compared to 21.62% of white staff. In 2022, 19.23% of ethnic minority staff experienced harassment, bullying or abuse. Although there has been an increase in 2023 the % remains lower than reported in 2019, 2020 and 2021.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



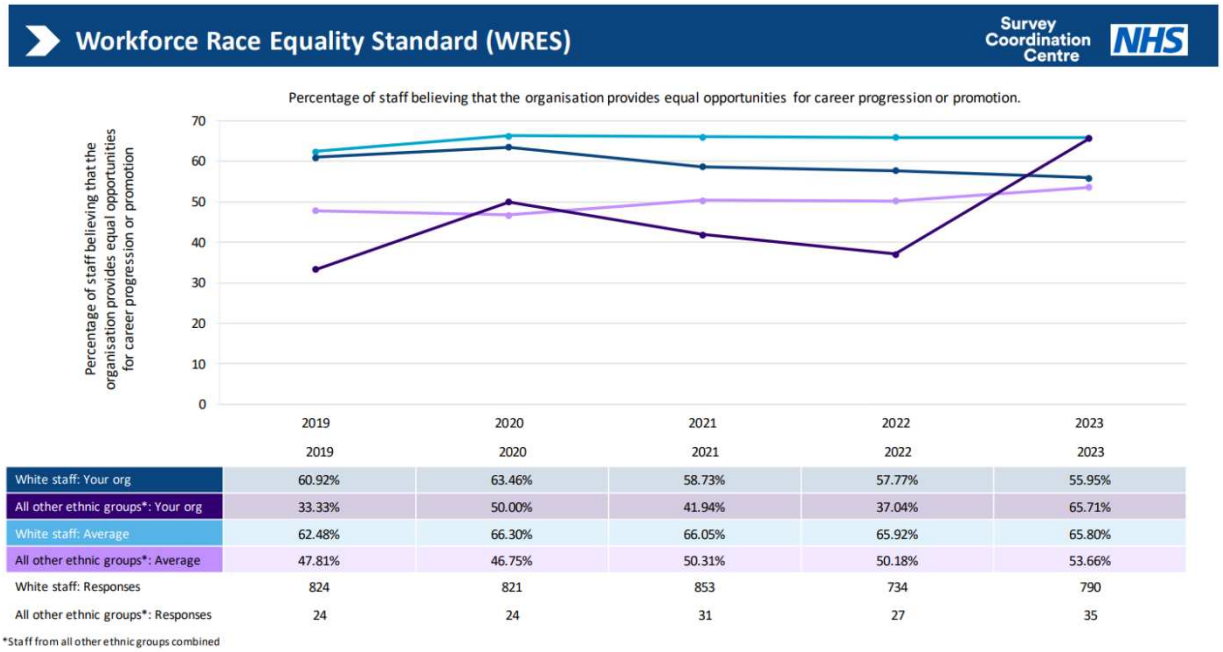
	2019	2020	2021	2022	2023
White staff: Your org	18.77%	16.86%	15.84%	13.01%	16.28%
All other ethnic groups*: Your org	25.00%	40.91%	17.24%	22.22%	9.19%
White staff: Average	19.61%	16.86%	15.91%	15.62%	15.19%
All other ethnic groups*: Average	23.80%	22.94%	19.99%	22.42%	18.79%
White staff: Responses	826	783	827	738	781
All other ethnic groups*: Responses	24	22	29	27	33

*Staff from all other ethnic groups combined

The data above indicates that 9.19% of ethnic minority staff have experienced harassment, bullying or abuse from staff in the last 12 months, this is a significant decrease from 2022 where 22.22% of ethnic minority staff reported experiencing harassment, bullying or abuse. 16.28% of white staff reported experiencing harassment, bullying or abuse from staff.

We have refreshed our Dignity At Work Policy and we continue to promote our Freedom to Speak Up Guardian for raising concerns.

Indicator 7: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

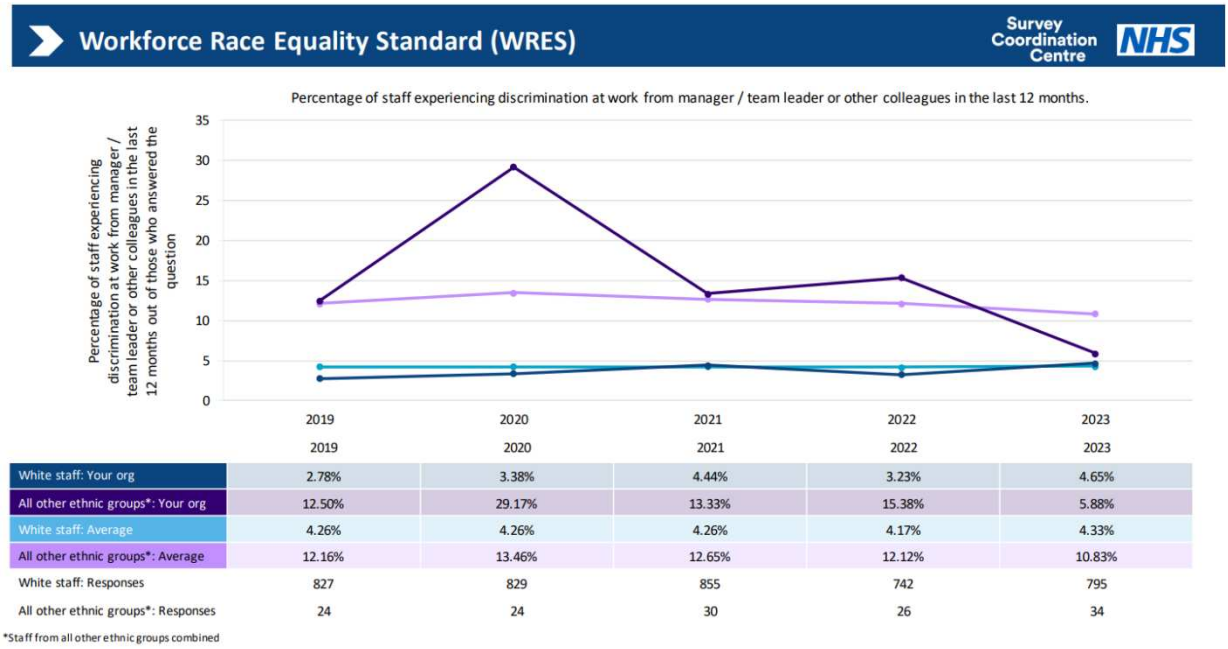


	2019	2020	2021	2022	2023
White staff: Your org	60.92%	63.46%	58.73%	57.77%	55.95%
All other ethnic groups*: Your org	33.33%	50.00%	41.94%	37.04%	65.71%
White staff: Average	62.48%	66.30%	66.05%	65.92%	65.80%
All other ethnic groups*: Average	47.81%	46.75%	50.31%	50.18%	53.66%
White staff: Responses	824	821	853	734	790
All other ethnic groups*: Responses	24	24	31	27	35

*Staff from all other ethnic groups combined

The data above indicates that 65.71% of ethnic minority staff believe the Trust provides equal opportunities for career progression or promotion, this is 9.76% higher than white staff. This score has significantly increased from 2022 when it was 37.04% for ethnic minority staff. We have collaborated with Shrewsbury and Telford Hospital Trust which has enabled us to offer our BME staff places of their Galvanise BME Leadership Programme.

Indicator 8: Percentage of staff personally experiencing discrimination at work from their manager/team leader or colleague in the last 12 months



	2019	2020	2021	2022	2023
White staff: Your org	2.78%	3.38%	4.44%	3.23%	4.65%
All other ethnic groups*: Your org	12.50%	29.17%	13.33%	15.38%	5.88%
White staff: Average	4.26%	4.26%	4.26%	4.17%	4.33%
All other ethnic groups*: Average	12.16%	13.46%	12.65%	12.12%	10.83%
White staff: Responses	827	829	855	742	795
All other ethnic groups*: Responses	24	24	30	26	34

*Staff from all other ethnic groups combined

The data above indicates that 5.88% of ethnic minority staff have personally experienced discrimination at work from their manager/team leader or colleague in the last 12 months, this is 1.23% higher than white staff. This score has improved for ethnic minority staff since 2022 (by 9.5%).

Indicator 9: Percentage difference between Board membership and its overall workforce disaggregated by:

- **Voting membership of the Board**
- **Executive membership of the Board**

Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated: • **by voting and non-voting membership of the board** • **by executive and non-exec membership of the board.**			
	Etnic Minority	**White**	**Unknown**
Total Board members	18.18%	72.73%	9.09%
Of which: voting Board members	20%	70%	10%
:Non voting Board members	0%	100%	0%
Of which: Exec Board members	20%	80%	0%
:Non Executive Board members	16.67%	66.67%	16.67%
Difference (Voting membership – Overall Workforce)	12%	-19%	7%
Difference – Executive Directors compared to overall workforce)	12%	-9%	-3%

Figures are automatically calculated on the WRES template.

Workforce Race Equality Standard: Action Plan 2024 - 2025

Having considered our 2023/24 data, there has been some improvements for our ethnic minority staff which are overall representation of the workforce a reduction in ethnic minority staff experiencing harassment, bullying or abuse from staff in the last 12 months and ethnic minority staff believing the Trust provides equal opportunities for career progression or promotion. However, it is acknowledged that further work is required to all of our indicators to improve the experience for our ethnic minority staff.

This action plan has been developed with the aim of bringing about positive change across the Trust in terms of Race Equality. In developing this action plan, consideration has also been made to the NHS People Promise.

WRES Indicator	Objective	Action	Lead	Timescale	Status
WRES Indicators 1, 2 & 9	Ensure our recruitment and selection processes are inclusive and fair and target under representation and lack of diversity	Review and update the Safer Recruitment Policy, training and associated documentation with a focus on reducing bias in recruitment and selection, ensuring our processes are inclusive and fair Ensure recruitment campaigns target under-represented groups and improve representation in recruitment campaign materials	Head of Resourcing	March 2025	

WRES Indicator	Objective	Action	Lead	Timescale	Status
WRES Indicator 3	Fully embed a Just and Learning Culture	Continue to embed a Just and Learning Culture. • Review the decision making process paperwork and update as required • Deliver workshops to managers on the Just and Learning culture in relation to People processes • Refresh our Disciplinary process and provide education to managers on the policy and its principles	People Business Partner	March 2025	
WRES Indicators 1, 2, 7	Support ethnic minority staff to have pathways that support and encourage ethnic minority staff to develop and enhance their careers	Continue to work in collaboration with Shrewsbury and Telford Hospital to offer ethnic minority staff places of their Galvanise BME Leadership Programme Work with the Workforce Race Equality Network to understand development needs and how their careers can be supported Publicise positive staff stories around career and development opportunities	Head of People Services	In place and ongoing March 2025 March 2025	

WRES Indicator	Objective	Action	Lead	Timescale	Status
		Explore implementing 'scope for growth' conversations	OD Business Partner	February 2025	
WRES Indicators 6, 7 & 8	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work	Continue to roll out the civility & respect training programme	OD Business Partner	Ongoing and in place	
		Review our Dignity at Work Policy and Grievance Policy to ensure they are supportive of individuals raising concerns involving individuals who have been through the process	People Business Partner	March 2025	
		Review our staff survey results in relation to bullying and harassment raising awareness of Freedom to Speak up, Dignity at Work and Civility and Respect programme	Head of People Services	December 2025	
		Develop a Civility & Respect booklet to support the Civility and Respect programme	Head of People Services	January 2025	

WRES Indicator	Objective	Action	Lead	Timescale	Status
		Launch the 'Work without fear campaign'	Head of People Services	February 2025	
WRES Indicators ALL	Raise awareness of equality, diversity and inclusion and embed in everything we do	Refresh a Trust Wide EDI strategy with a refreshed set of objectives	Head of People Services	June 2025	
		Develop a programme of events to mark dates in the equality, diversity and inclusion calendar e.g. Holocaust Memorial Day, South Asian History Month, Black History Month	Head of People Services	December 2024	
		Develop a robust communications and marketing plan for the networks	Head of People Services	December 2024	
		Create channels for networks to connect together	Head of People Services	March 2025	

Shropshire Community Health
NHS Trust

Performance Update
0. Reference Information

Author:	Jen Deakin, Fiona MacPherson Gina Billington Heads of Service	**Paper date:**	26th September 2024
Executive Sponsor:	Rhia Boyode, Group Chief People Officer SCHT & SATH	**Paper written on:**	18th September 2024
Paper Reviewed by:	Sarah Allan, Interim Deputy People Director	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

The paper is intended to provide information on key metrics and where relevant the actions being undertaken to support improvement in performance.

Following the introduction of the new interim People structure across SCHT and SaTH the contents and style of reporting may change for future papers. From October a review of data and reporting will be undertaken by Simon Balderstone, Interim Workforce Operations Director which will set out recommendations to improve the content of the paper. Initial feedback has been provided via People Committee including a requirement to strengthen the actions that support KPI improvements. This will be included as part of the review and will be addressed in future papers.

2. Executive Summary

2.1 Context

This report focuses on the key areas of performance relevant to People Committee.

2.2 Summary

The key points to consider are:

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

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	2	7	5	**19**	**14 (73.7%)**

Action Plans have been developed by the Heads of People, Resourcing and Workforce and included as Appendix 4 for many of the measures flagged as a concern in this report.

Performance Update

*Actions plans will be developed for the areas where the actual performance is updated on a less frequent basis and presented to People Committee for review.

2.3. Conclusion

The Board is asked to:

- **Note** the performance across relevant indicators to date

3. Main Report

3.1 Introduction

The full list of KPIs 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

There are 19 performance indicators reported in this period as described in Appendix 1, and 14 of these require focused attention.

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

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

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

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

1. Mandatory training compliance
2. Vacancy rate

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

1. Aggregate score for NHS staff survey questions that measure perception of leadership culture*
2. Appraisal Rates
3. Leaver rate
4. Proportion of staff in senior leadership roles who are from a) a BME background*
5. Proportion of temporary staff
6. Sickness Rate
7. Total shifts exceeding NHSI capped rate

Performance Update

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

1. Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age*
2. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers*
3. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues*
4. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public*
5. Staff survey engagement theme score*

Metric	Target %	July %	August %
Appraisal	90	87.7	86.27
Leavers	9.6	11.59	11.48
Mandatory Training	95	93.14	92.28
Temporary Staff	3.4	7.5	6.4
Vacancies	8	11.32	11.81
Sickness	4.75	5.44	5.31
Total Shifts	No Target	244	164

There has been slight improvement with leavers, temporary staff, sickness, and total shifts but appraisals and mandatory training have dropped, and vacancies have increased. This is evident in the chart above and the charts within the appendices.

Mandatory training is likely to fluctuate as works continues assigning mandatory training requirements to ESR positions. These updates will impact the overall Trust's compliance figures, this is due to more staff being reported on via the compliance reports that were not previously included, therefore reducing compliance figures.

Appraisal compliance has slightly reduced in August; however, we are seeing the compliance increase over time. A number of appraisal training sessions are in place for staff and managers to attend and when requested bespoke sessions are delivered.

Our leavers rate has slightly declined in August, we hope to see this reduce further over coming months with the appointment of our People Promise Manager and the work they are supporting around Culture change alongside the work being undertaken by the People team around 30, 60, 90 days and stay conversations.

Our absence rate has slightly decreased, we have implemented a new Absence Management Policy and over time we hope to see the rate reduce further as the policy is embedded. We have a suite of offers from a HWB perspective in particular the roll out of our HWB days in the Autumn.

Performance Update
Vacancies have increased with some outstanding recruitment partly due to a delay in the issue of NMC PINs for successful nursing applicants across different areas of the Trust. The recruitment team are continually reviewing their processes to support timely recruitment with the current time to hire date at 35.7 working days and increasing the number of pre-employment checks available to successful applicants.

Agency spend across the trust has fluctuated in the last period and remains above target. This is in part due to the number of clinical locums in place whilst recruitment take place. Agency Price Cap compliance has continued to improve with a week on week fall in the number of shifts booked above price cap.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Board is asked to:

- Note the performance across relevant indicators to date

Appendix 1

People Committee – SPC Summary

Month 05 (August) 2024/2025 Performance

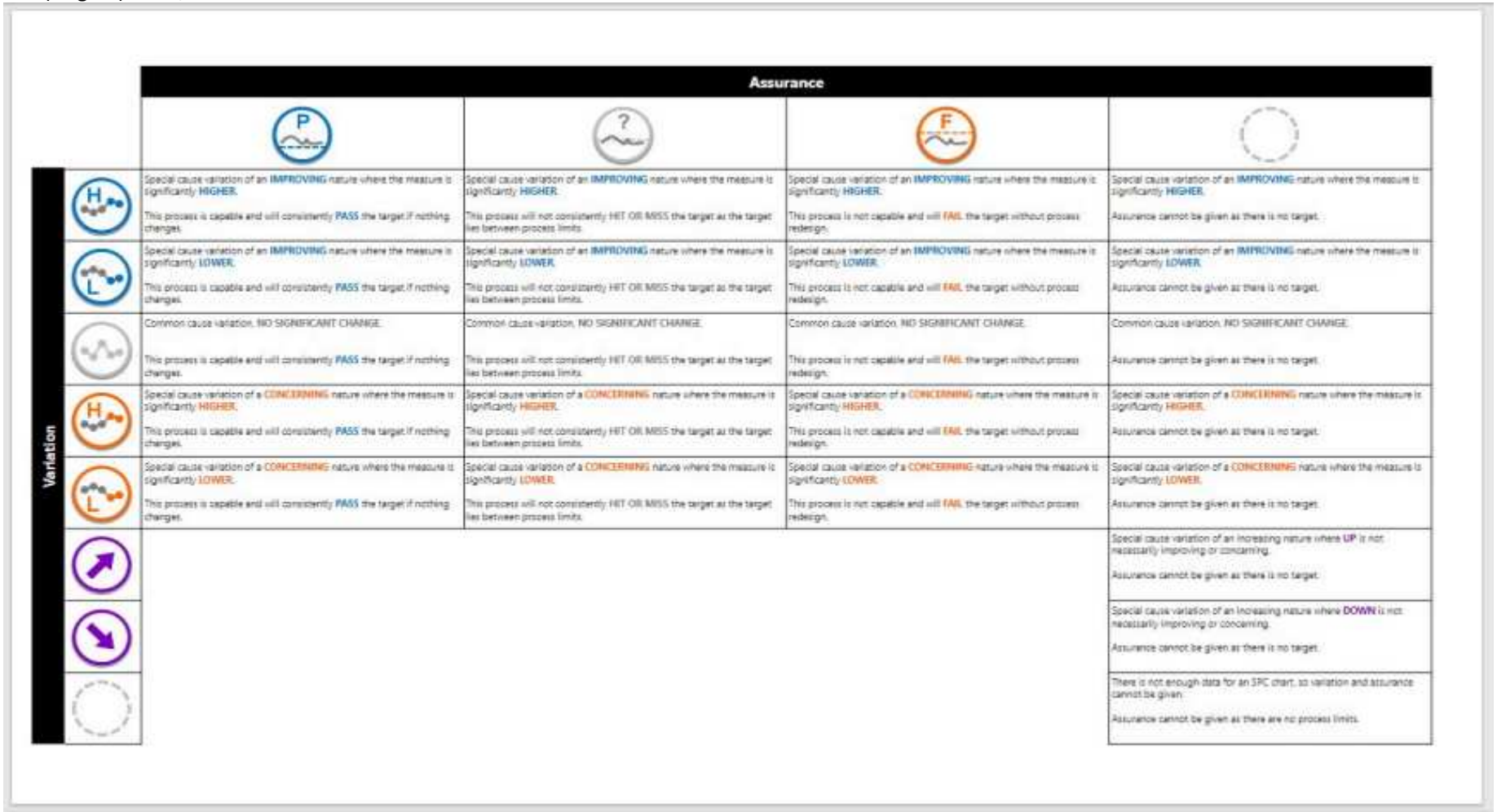
NHS

Shropshire Community Health

NHS Trust

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	CQC well-led rating	2024-08-31		Good	Good		Good	Good		
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-08-31		4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	
People Committee	Well Led	Mandatory Training Compliance	2024-08-31		93.28%	95.00%	-1.72%	93.28%	95.00%	-1.72%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-08-31		71.43%	66.00%	5.43%	71.43%	66.00%	5.43%	
People Committee	Well Led	Total shifts on a non-framework agreement	2024-08-31		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2024-08-31		11.81%	8.00%	3.81%	11.77%	8.00%	3.77%	
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leaders...	2024-08-31		7.4	7.5	-0.1	7.4	7.5	-0.1	
People Committee	Well Led	Appraisal Rates	2024-08-31		86.27%	90.00%	-3.73%	84.79%	90.00%	-5.21%	
People Committee	Well Led	Leaver rate	2024-08-31		11.48%	9.60%	1.88%	11.48%	9.60%	1.88%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-08-31		9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career...	2024-08-31		55.80%	63.90%	-8.10%	55.80%	63.90%	-8.10%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying ...	2024-08-31		7.1%	0.0%	7.1%	7.1%	0.0%	7.1%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying ...	2024-08-31		12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying ...	2024-08-31		22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	
People Committee	Well Led	Proportion of temporary staff	2024-08-31		6.4%	3.4%	3.0%	6.8%	3.4%	3.4%	
People Committee	Well Led	Sickness Rate	2024-08-31		5.31%	4.75%	0.56%	5.31%	4.75%	0.56%	
People Committee	Well Led	Staff survey engagement theme score	2024-08-31		7.0	7.3	-0.3	7.0	7.3	-0.3	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-08-31		164	0	164	303	0	303	
People Committee	Well Led	Net Staff in Post Change	2024-08-31		-4.38	0.00	-4.38	33.08	0.00	33.08	

Appendix 2
People Committee
Month 05 (August) 2024/2025 Performance

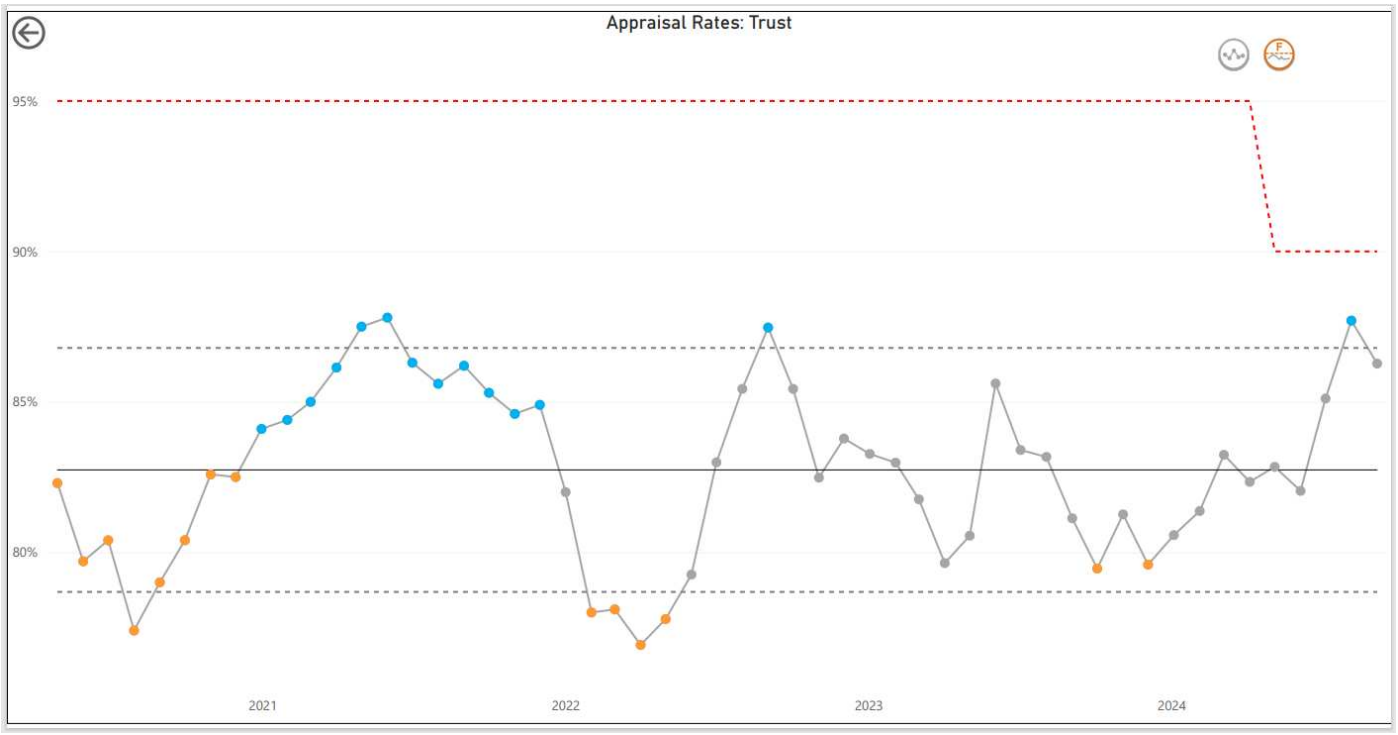


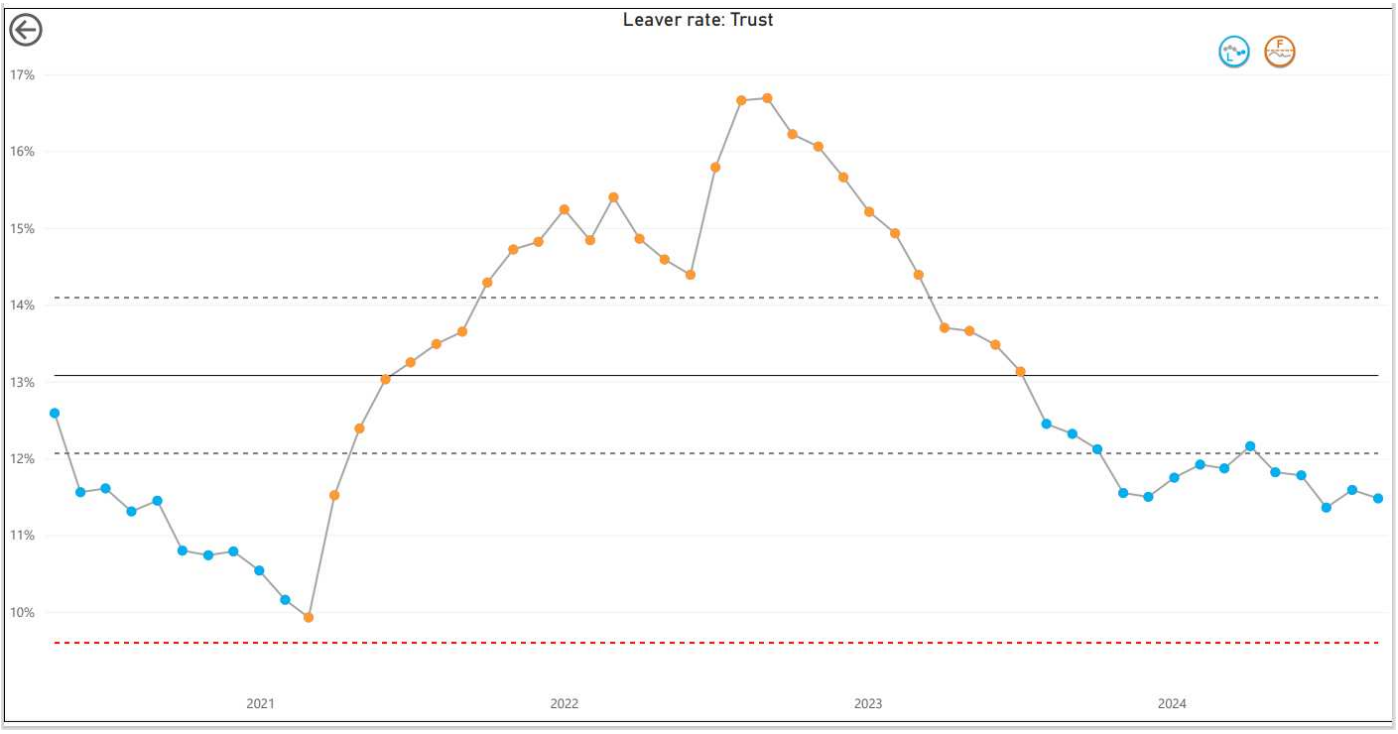
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure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

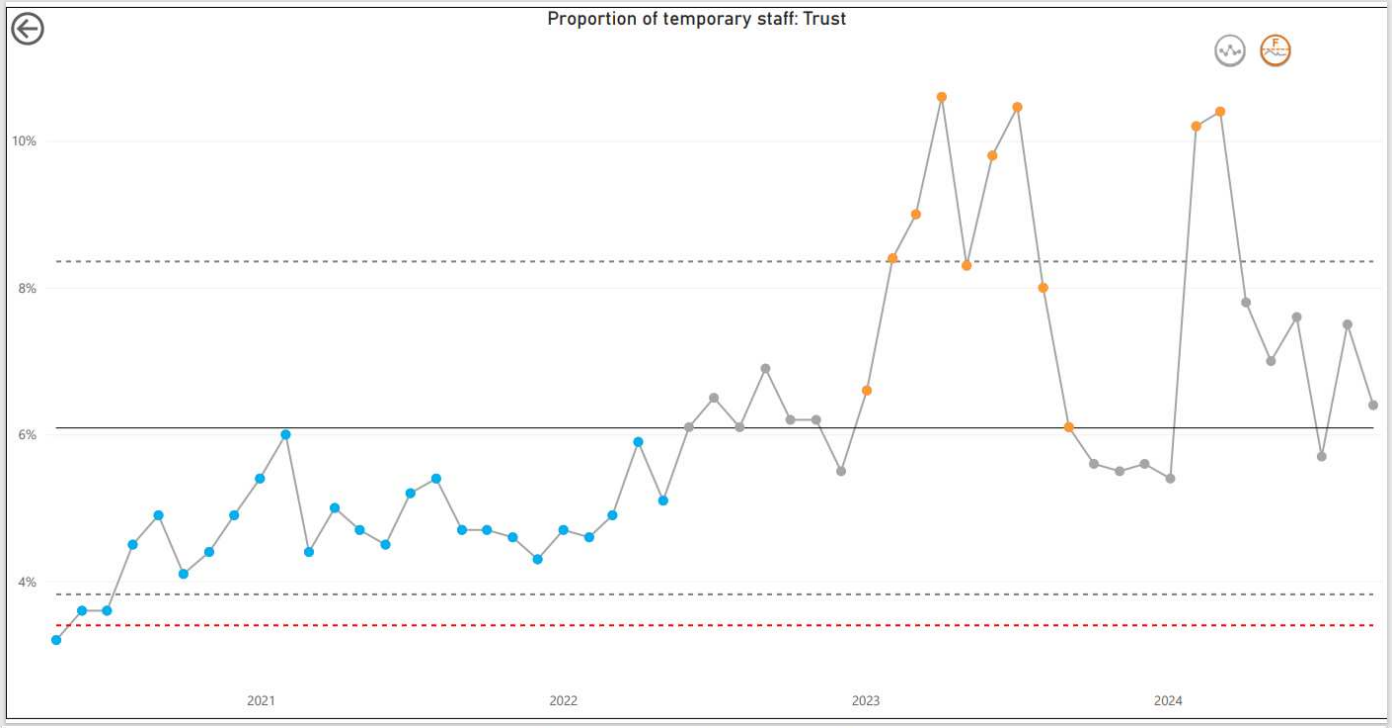
Appendix 3

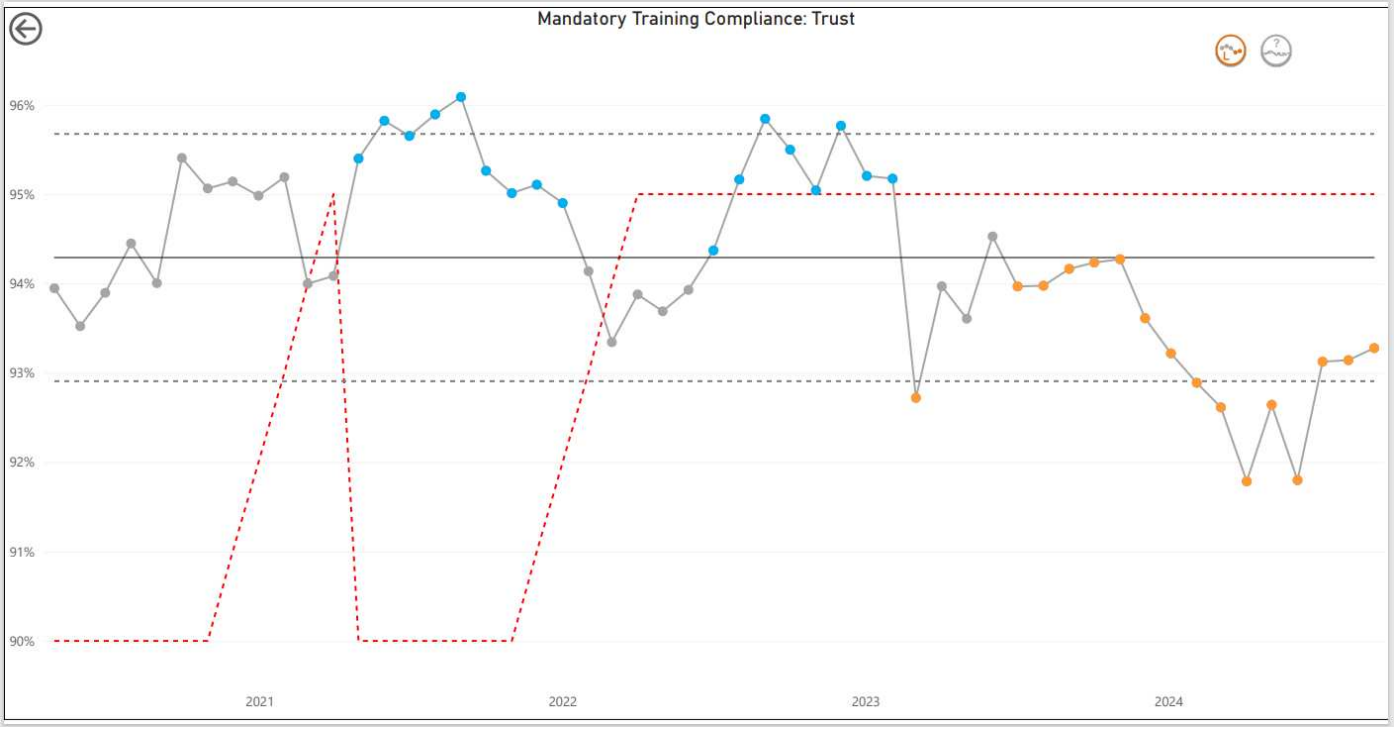
People Committee

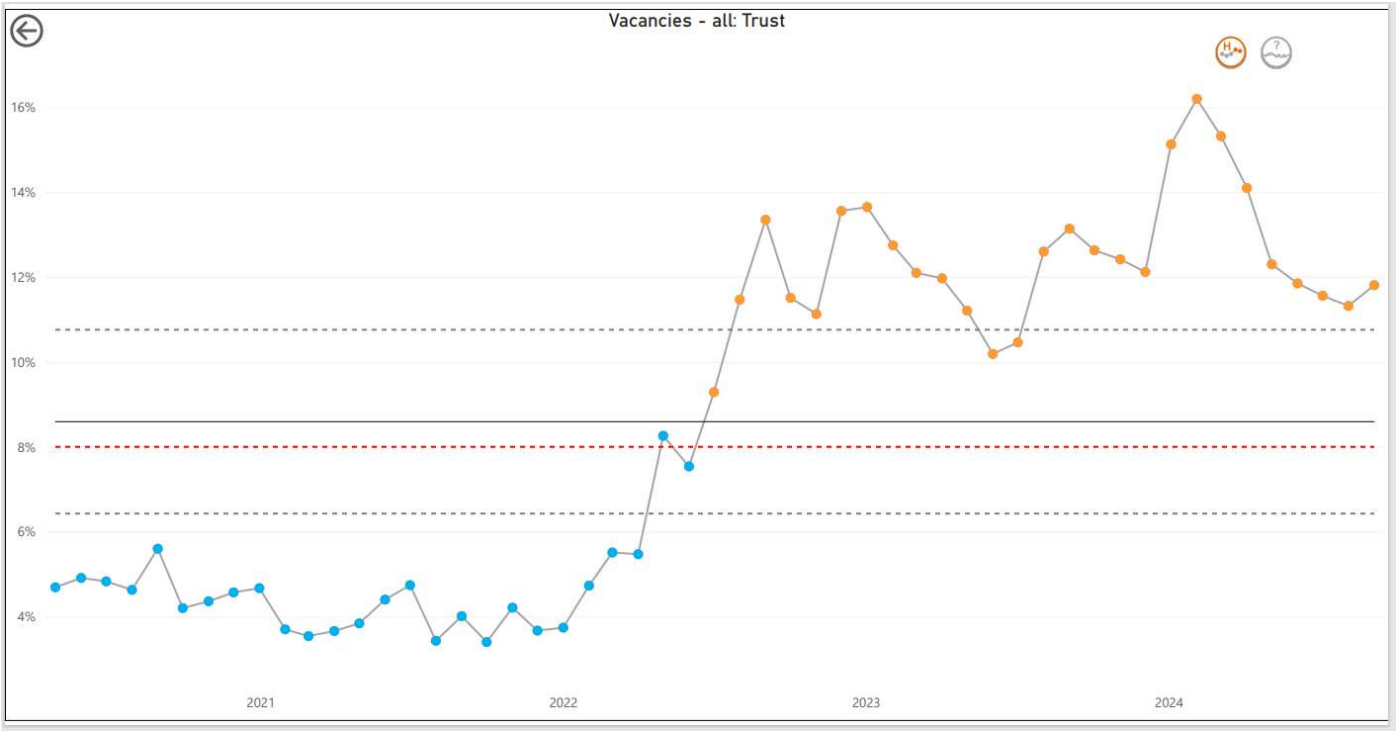
Month 05 (August) 2024/2025 Performance

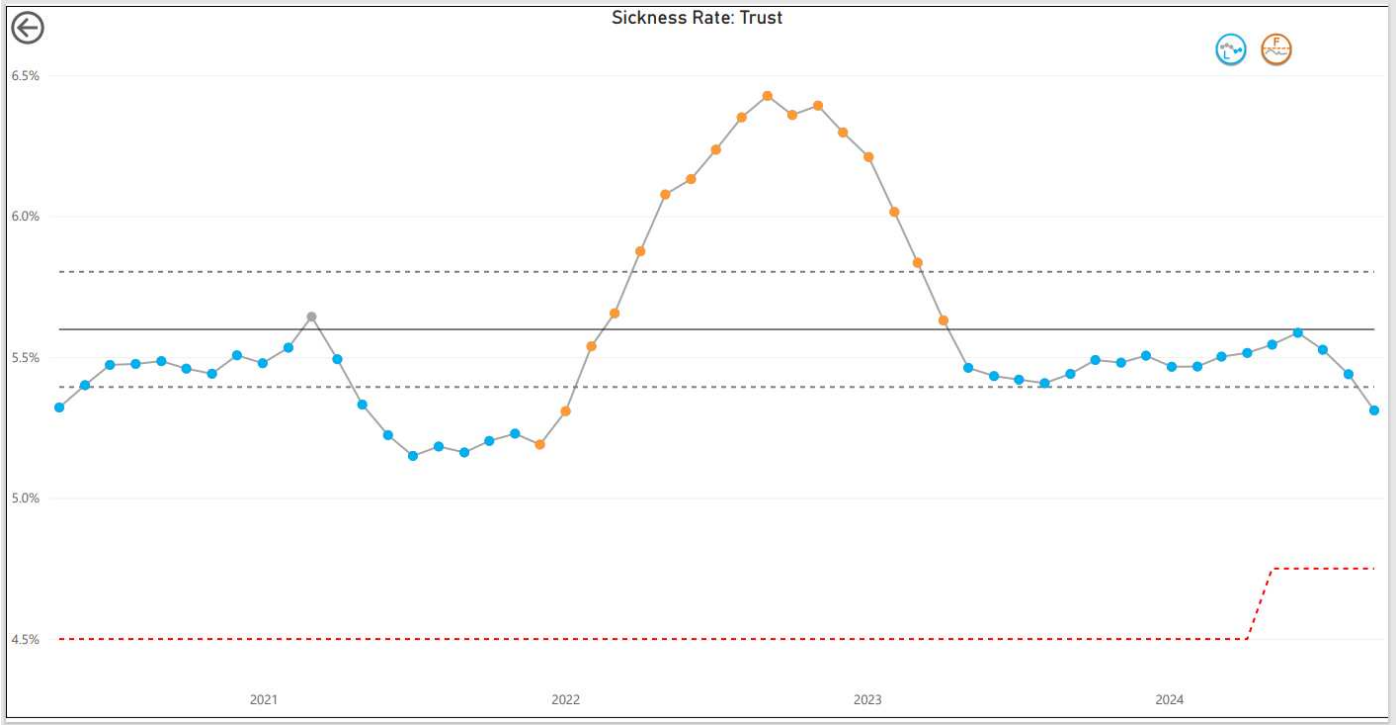


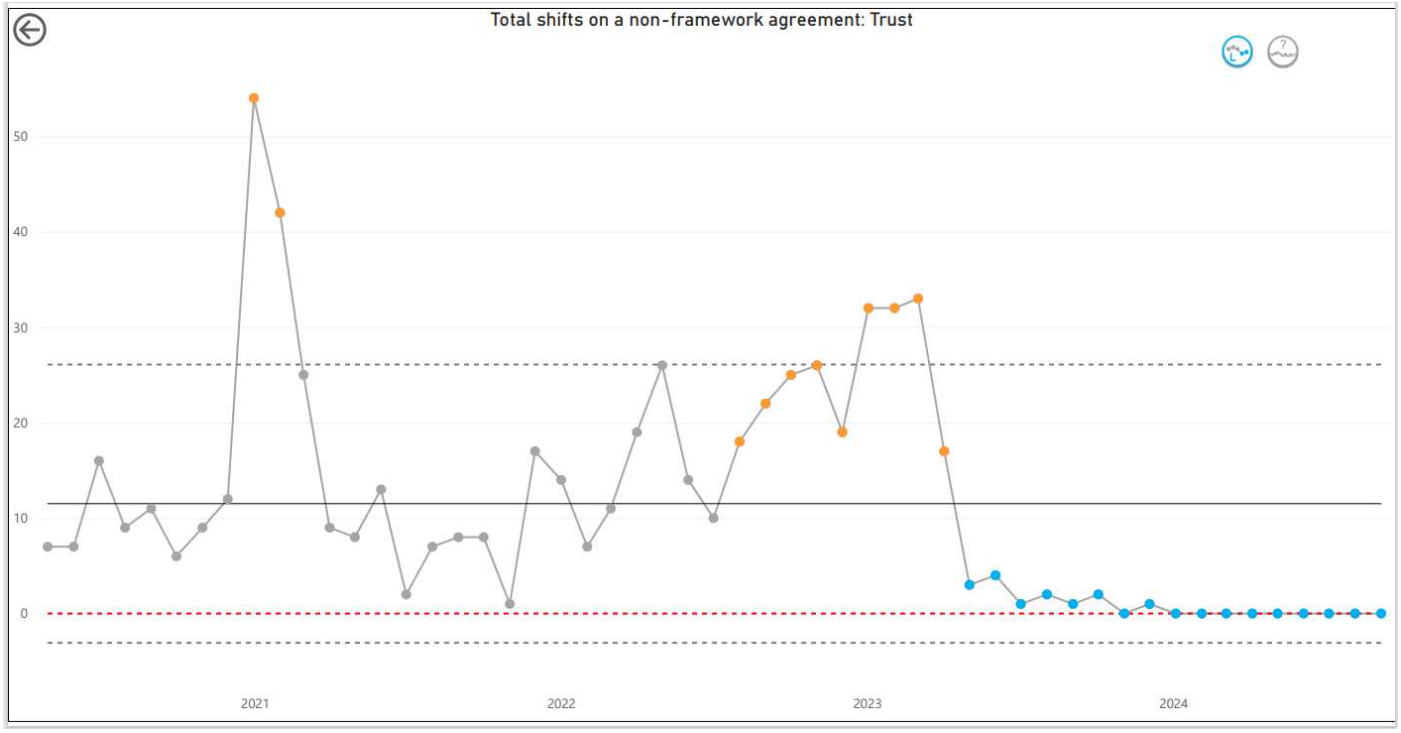


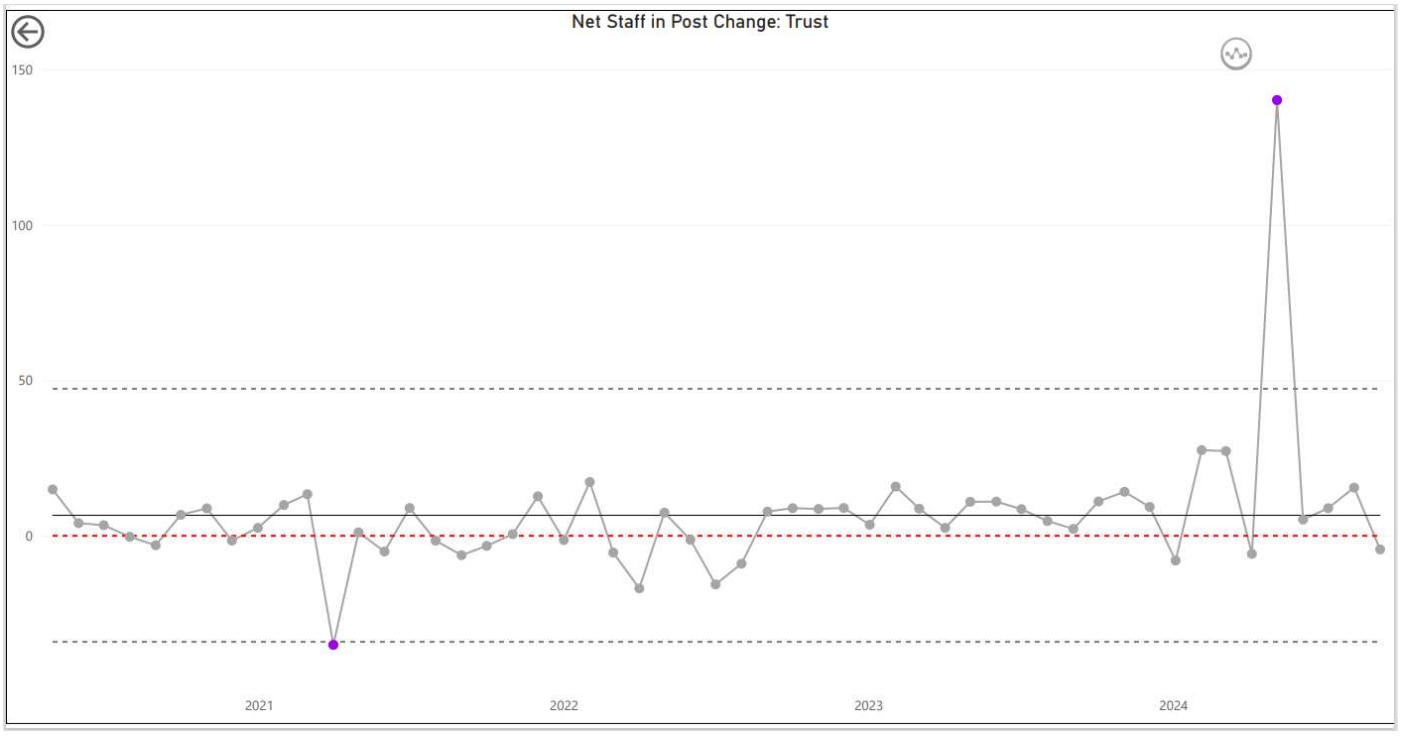

Proportion of temporary staff: Trust
10%
8%
6%
4%
2021
2022
2023
2024

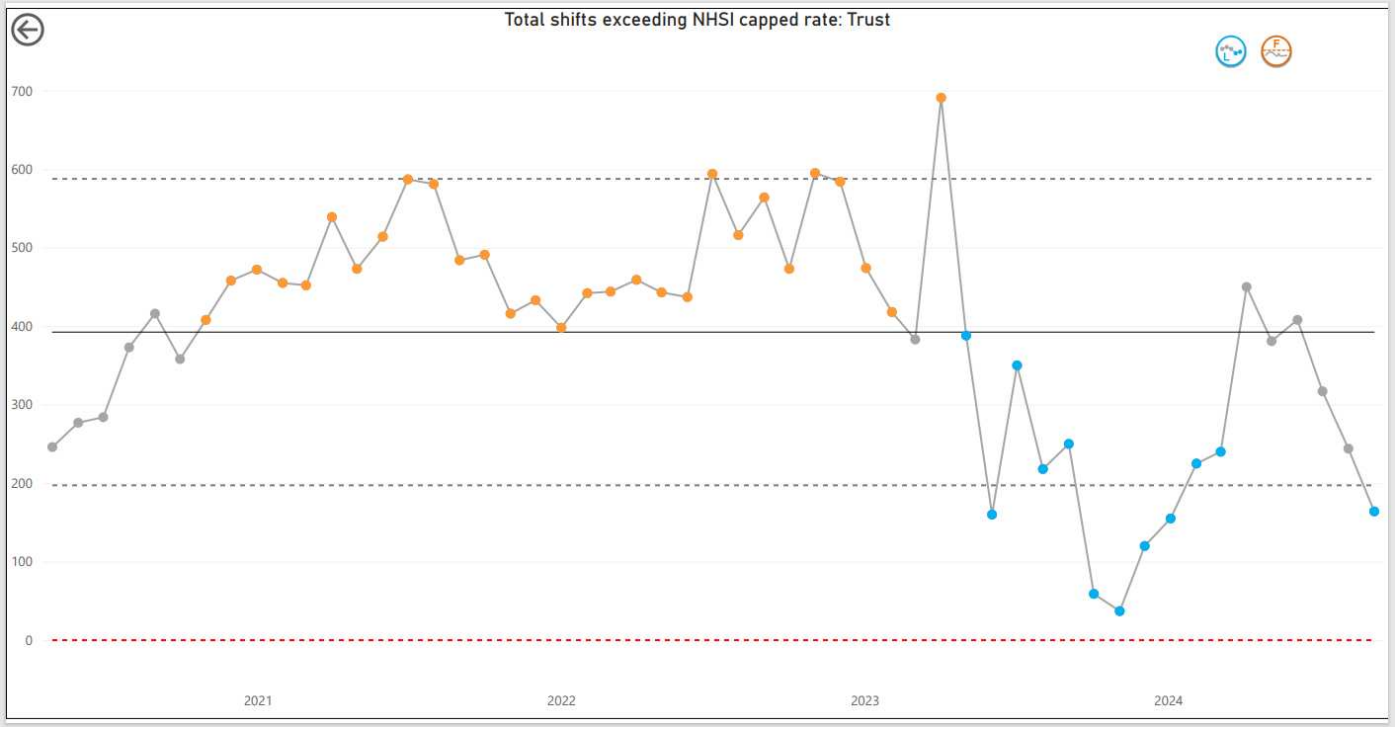

Mandatory Training Compliance: Trust
96%
95%
94%
93%
92%
91%
90%
2021
2022
2023
2024


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


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


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


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


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

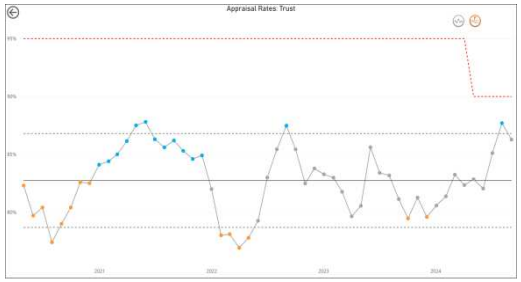
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Appraisals	%	82.34%	82.84%	82.04%	85.11%	87.70%	86.27%	84.79%
	Target	95.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	86%	87%	88%	88%	88%	88%	89%



Reason for performance gap:					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Monthly Professional Standards & Absence People team meetings with Clinical Services Manager & Divisional Service Managers to discuss appraisal and other workforce metrics to support compliance	May-24	Ongoing	In place	In place and ongoing. These meetings discuss hot spots and what support us required from a the People team to increase compliance .
	Provide regular appraisal training for staff and managers	Jan-24	Ongoing	In place	In place and ongoing. These sessions are reviewed and if fully booked additional dates are added as required. Bespoke sessions are also arranged e.g. Dudley 0-19 service
Author	Fiona MacPherson	**Date**	18.09.24		
Accountable Officer Approval	Rhia Boyode	**Date**			

Team (hotspot areas are teams with 10 or more staff members and with compliance of less than 75%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Shrewsbury Community Nursing Service	51	38	74.51
825 Bridgnorth Hospital Hotel Service	13	8	61.54
825 Community Therapies South East Service	12	8	66.67
825 Dentistry Service	46	27	58.7
825 MSK Shropshire & Telford (MSST) Service	23	17	73.91
825 Stoke Heath YOI Service	18	13	72.22

SDGs and Divisions of 10+ staff	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	36	31	86.11
825 Finance Division	26	24	92.31
825 Governance Division	17	13	76.47
825 Medicines Management Division	21	20	95.24
825 Nursing and Quality Division	10	9	90
825 Operations Directorate Management Division	10	7	70
825 People and OD Division	24	22	91.67
825 Safeguarding Children Division	12	12	100
825 Service Delivery Group - Adult Community Services Division	593	507	85.5
825 Service Delivery Group - CYP&F Shropshire Services Division	329	301	91.49
825 Service Delivery Group - Planned Care Division	185	146	78.92
825 Service Delivery Group - Urgent Care Division	132	112	84.85
825 Trust Board Division	12	12	100

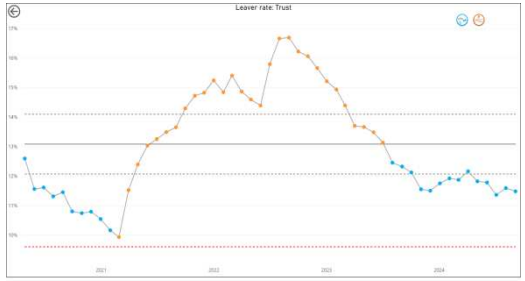
Exception Report - Action Plan

Leaver rate

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Jul-24	YTD
Leaver rate	%	12.16%	11.82%	11.78%	11.36%	11.59%	11.48%	11.48%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	11.4%	11.4%	11.3%	11.3%	11.4%	11.5%	11.3%



Reason for performance gap:					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Refresh and update our Leavers Policy to include various methods for completing exit questionnaires which includers, paper copy, MS Forms, ESR & electronic version	Jul-24	Sep-24	In progress	The updated Policy is currently going through the policy approval process
	Roll out Stay Conversation and 30, 60, 90 day conversations workshops in particular targeting areas with high leaver rates	Sep-24	Ongoing	In progress	Workshops for stay and 30, 60,90 day conversations have been developed to include supporting compassionate conversations. These were advertised in October 2024.
	Develop and launch a flexible working campaign to raise awareness around work life balance	Apr-24	Jul-24	Completed	Ongoing campaign in place with updated flexible working policy
	Develop and launch flexible working survey along with recording flexible working on ESR and flexible working workshops	Apr-24	Jul-24	Completed	Flexible working survey has been published and currently analysing th
	Review the leavers information in relation to incompatible working relationships to establish next steps	Sep-24	Oct-24	Not Started	To evaluate any further support required for teams
	Appointment of People Promise Manager	Jul-24	Jul-25	In progress	The People Promise Manager is working on different projects aligned to our staff survey results. In particular they are working on a change programme and awards week.
	Monthly Professional Standards and Absence team meetings with Clinical Services Manager & Divisional Service Managers to discuss appraisal and other workforce metrics compliance to provide support where possible	May-24	Ongoing	Complete	Hot spot area are discussed along with required support
Author	Fiona MacPherson	**Date**	18.09.24		
Accountable Officer Approval	Rhia Boyode	**Date**			

Leaving Reason	Leavers
Retirement Age	53
Voluntary Resignation - Work Life Balance	31
Employee Transfer	20
Voluntary Resignation - Promotion	17
Voluntary Resignation - Relocation	16
Voluntary Resignation - Health	11
Voluntary Resignation - Incompatible Working Relationships	10
End of Fixed Term Contract	9
Voluntary Resignation - Lack of Opportunities	7
Voluntary Resignation - Child Dependants	6

Team	Leavers
825 Bridgnorth Hospital Ward	9
825 Community Equipment Delivery Team	7
825 Community Equipment Warehouse Team	7
825 Ludlow Hospital Ward	7
825 Virtual Wards Team	7

Staff Group	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Add Prof Scientific and Technic	1	0.4	2.25%	1.09%
Additional Clinical Services	41	31.9717	11.16%	10.67%
Administrative and Clerical	73	62.4165	18.14%	18.40%
Allied Health Professionals	14	10.8296	6.56%	6.32%
Estates and Ancillary	9	7.8933	11.47%	15.95%
Medical and Dental	3	1.428	9.38%	6.59%
Nursing and Midwifery Registered	68	55.5722	10.28%	10.15%

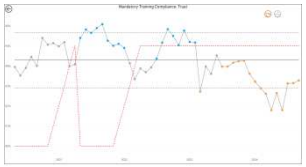
Exception Report - Action Plan

Mandatory Training Compliance

Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only (with the exception of Information Governance which includes bank staff)

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Mandatory Training	%	91.79%	92.64%	91.80%	93.13%	93.14%	92.28%	92.28%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	92.4%	92.8%	93.0%	93.2%	93.0%	93.0%	93.2%



Reason for performance gap:	With the ongoing work within the Learning Management Team, mandatory training is likely to fluctuate as works continues assigning mandatory training requirements to ESR positions and the review of the Trust's training needs analysis.

Action Plan

	Start Date	End Date	Status	Outcome
Appraisal and Mandatory Training Compliance Targets Briefing paper update	Jun-24	Dec-24	In Progress	Task 1 Training Completions • All existing training completions have been received and recorded in ESR. Task 2 ESR Access • Core user ESR access has been audited and updated where required and training has been given to the relevant staff who manage training in ESR. Task 3 Existing ESR Course Catalogue • The ESR course catalogue has been audited and updated following national best practice. Task 4 Competency Requirements • Best practice is being followed by using national competencies, this allows us to accurately record training completions and supports the Enabling Staff Movement Strategy by reducing the duplication of mandatory training when staff move between roles in the NHS. Task 5 Review of Statutory and Mandatory Training Needs Analysis • A formal review of the statutory and mandatory training needs analysis (TNA) is currently being conducted, the TNA process will be used to determine the range of risk related training required and the groups of staff that are required to undertake the training. In conducting the TNA, the Trust will consider: •Statutory training requirements •Mandatory training government requirements •Mandatory role essential training that the Trust has identified in
High Risk Fire	Jul-24	Dec-24	In Progress	SCHT currently do not have a fire safety manager, RWT provide a fire service for SaTH. SCHT's estate's manager is contacting NPFT to enquire about their fire service (as they are similar org). High risk fire (HRF) completions are recorded on ESR. If the HRF objectives meet the CSTF objectives, staff who are required to complete the HRF training will not need to complete the fire safety training. There are also discussions over fire warden training and who should complete this, who would provide the training and how it is recorded in ESR.
Mandatory Training Policy	Jul-24	Dec-24	In Progress	The policy is currently under review and will be sent out in October for consultation.
Safeguarding Training - Position Review	Jul-24	Oct-24	In Progress	The mapping review has starter and is currently with the Safeguarding Team to review.
Review Mandatory Training Topics	Jul-24	Dec-24	In Progress	Meeting took place with the Director of Nursing and Clinical Delivery to discuss the mandatory training priorities (including role essential topics), and it was agreed a report will be provided listing all mandatory and role essential topics that are currently set up in ESR. The report will list the delivery mode, frequency and the named SME. Within this report information will be provided on what actions have already taken place for each topic and what still needs to be actioned. A decision will then be taken to decide on which topic(s) will be prioritised to ensure ESRLM is set up correctly.
An Inter Authority Transfer (IAT) working group has been set up to investigate the process for core skill training framework (CSTF) training to be transferred to the learning record for new starters who have completed this training in their previous NHS organisation.	Jul-24	Oct-24	In Progress	To ensure where staff are moving from one NHS organisation to SCHT their CSTF training is transferred so they only need to complete any new or expired topics and removes the need to duplicate training.
Resuscitation Training Level 3	Jun-24	Sep-24	In Progress	The resuscitation training requirements have been reviewed, with the introduction of Level 3 for certain areas, positions will be updated with these changes.
Manual Handling for People Handlers training.	Jun-24	Sep-24	In Progress	Clinical Education have identified the ESR positions that are required to complete the training. With support from IBM, these positions will be updated in ESR over the next 2 months, so staff will have the correct training requirements.
All positions have current training requirements attached	Mar-24	Sep-24	In Progress	These updates will impact the overall Trust's compliance figures, this is due to more staff being reported on via the compliance reports that were not previously included, therefore reducing compliance figures. Comms have been sent out to inform managers and staff. The ESRLM Lead will also be linking in with departments to ensure ESR is maintained correctly, and training is being awarded in the correct manner.
Review completions in ESR	Mar-24	Jun-24	Completed	Confirms have been updated to attended or did not attend. If updated to attended this will have made a positive impact on compliance. If did not attend, this will not have made any impact on compliance.
Backlog of training completions to be updated in ESR	Mar-24	Mar-24	Completed	The backlog of training completions for Local Fire training and Basic Life Support has been completed, this has made a positive impact on training compliance.
400+ Oliver McGowan (OM) training completions errors have been identified.	Mar-24	Mar-24	Completed	All OM training completions have been corrected, this has made a positive impact on training compliance.
New ESR Learning Management (ESRLM) Lead appointed	Dec-23	Mar-24	Completed	ESRLM started 18 March and will be working with HR, Divisional managers and the Subject Matter Experts to ensure ESR is set up correctly and maintained to ensure accurate compliance data.

Author	Jen Deakin	**Date**	11.09.24
Accountable Officer Approval	Rhia Boyode	**Date**	

Sector	Substantive staff count	% Compliance
825 Service Delivery Group - Adult Community Services Management Sector	6	**74.70%**
825 Central Sector	110	**81.08%**
825 Operations Directorate Management Sector	12	**83.43%**
825 Stoke Heath YOI Sector	24	**86.65%**
825 Governance Sector	20	**88.08%**
825 South West Sector	131	**89.64%**
825 Wheelchairs Sector	11	**90.85%**
825 People Management Sector	1	**92.31%**
825 Urgent and Emergency Care Sector	119	**92.46%**
825 Dudley PHNS 0-19 Sector	154	**92.76%**
825 Quality and Clinical Excellence Sector	13	**93.15%**
825 North East Sector	121	**93.54%**
825 South East Sector	133	**93.57%**
825 MIU & DAART Sector	46	**93.87%**
825 North West Sector	181	**94.05%**
825 Service Delivery Group - CYP&F Management Sector	6	**94.17%**
825 Childrens Psychology Sector	7	**94.31%**
825 Planned/Elective Care Sector	139	**94.33%**
825 Shropshire PHNS 0-19 Sector	103	**94.43%**
825 Trust Board Sector	12	**94.74%**
825 Planned Care Management Sector	3	**94.87%**

August 2024 Compliance Overview

TOPIC	July Compliance		August Compliance	Variance against compliance
NHS|MAND|Corporate Induction|	91.23%	▲	91.89%	0.66%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	97.28%	▲	97.40%	0.14%
NHS|CSTF|Fire Safety - 1 Year|	99.71%	▲	99.83%	0.12%
825|LOCAL|Fire Safety - High Risk - 1 Year|	79.11%	▲	79.49%	0.39%
NHS|MAND|Fraud Awareness - 3 Years|	95.49%	▲	95.48%	-0.00%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	96.84%	▲	97.20%	0.36%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	95.84%	▲	97.09%	1.24%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	89.65%	▲	95.79%	5.15%
NHS|CSTF|Information Governance and Data Security - 1 Year|	90.27%	▼	90.03%	-0.24%
NHS|CSTF|Moving and Handling - Level 1 - 1 Years|	96.05%	▲	96.53%	0.48%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	96.69%	▲	97.04%	0.35%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years|	96.49%	▲	96.74%	0.25%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	97.29%	▼	92.91%	-4.38%
NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	75.49%	▼	70.89%	-4.61%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	96.22%	▲	97.22%	0.93%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	89.95%	▲	90.13%	0.19%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	93.79%	▲	94.35%	0.57%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	92.8%	▼	92.8%	-0.03%
NHS|MAND|The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 (Learning)|	95.07%	▲	96.15%	1.08%

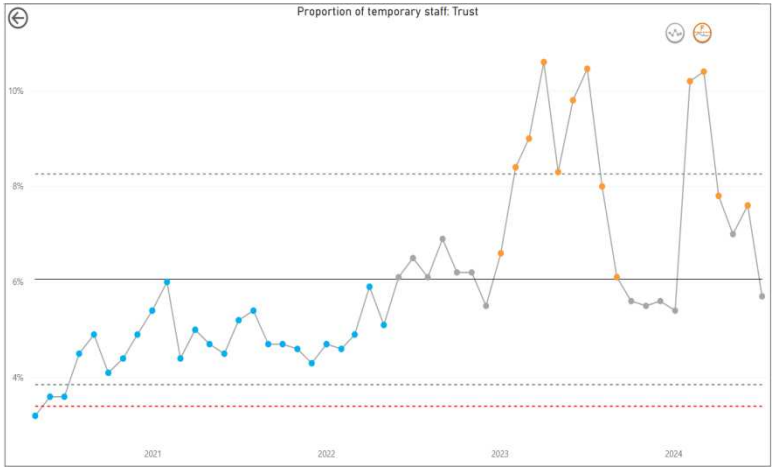
Exception Report - Action Plan

Proportion of temporary staff

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Prop Temporary staff	%	7.8%	7.0%	7.6%	5.7%	7.5%	6.4%	7.0%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	8.0%	7.0%	6.0%	5.0%	4.0%	4.0%	4.0%



Reason for performance gap:	Use of Locum GP in Post Covid-19 Syndrome Clinics whilst recruitment takes place. Locum consultant in R & R (Ward 36) whilst recruitment is planned for this service. Paediatrics is the other area currently using locum whilst recruitment to a Speciality Doctors takes place. Community Nursing is currently using agency above plan to cover staff absences.

Action Plan	**Start Date**	**End Date**	**Status**	**Outcome**
Recruitment to vacancy is underway in the Covid-19 Syndrome clinics - resourcing team supporting this.	Feb-24	Nov-24	In progress	
R & R Ward 36 local Consultant - plans for this cover are not yet finalised			Not yet started	
Paediatrics - recruitment underway to Speciality Doctor	Feb-24	Nov-24	In progress	Reduction in locum use from November 2024 once recruitment is complete
Community nursing - some recruitment outstanding due to the issue of PINs by the NMC. Anticipated issue is end of October however this is subject to the NMC. The		Oct-24	in progress	NQ's receive PINS and commence employment.

Author	Gina Billington	**Date**	18.09.24
Accountable Officer Approval	Rhia Boyode	**Date**	

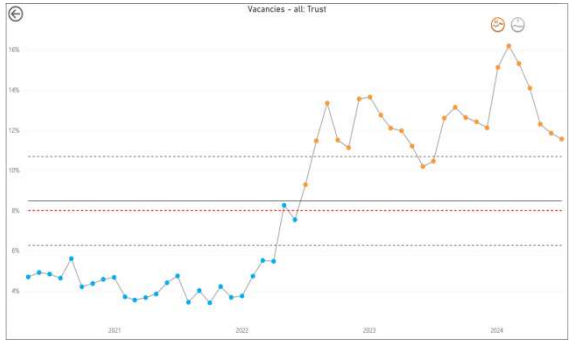
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Vacancies	%	14.10%	12.30%	11.85%	11.56%	11.32%	11.81%	11.76%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	12.0%	11.0%	10.0%	9 %%	10.0%	9.5%%	8.0%



Inpatient Wards and RRUs	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward	21.63	6.91	31.95
Ludlow Hospital Ward	35.72	5.38	15.06
Whitchurch Hospital Ward	42.43	6.54	15.41
Bridgnorth Hospital Ward	41.34	3.38	8.18
Recovery & Rehabilitation Unit (RSH)	53.84	18.12	33.66
Recovery & Rehabilitation Unit (PRH)	45.52	8.2	18.01
Total	**240.48**	**48.53**	**20.18**

Division	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer	44.32	6.14	13.85
Urgent Care (Adults)	188.57	35	18.56
Community Services (Adults)	745.98	98.8	13.24
Planned Care SDG	179.77	29.64	16.49
Children and Families Division	473.03	25.49	5.39
Chief Executive	12.64	1	7.91
Director of Finance and IM&T	78.82	10.64	13.5
Director of Governance	22.7	2.92	12.86
Director of People	31.86	0.99	3.11
Director of Nursing and AHPs	33.71	3.4	10.09
Medical Directorate	3.18	0.3	9.43
Total	**1814.58**	**214.32**	**11.81**

Reason for performance gap: There are a number of nurse applicants awaiting their PIN from the NMC before being able to commence in their role in the Trust. The recruitment team are currently experiencing staff shortages due to resignation, sickness absence and annual leave.

Action Plan

	Start Date	End Date	Status	Outcome
Some recruitment outstanding due to the issue of PINs by the NMC. Anticipated issue is end of October however this is subject to the NMC. The recruitment team remain in contact with these individuals.	Jul-24	Oct-24	In progress	Reduction in vacancies due to commencement in post following issue of PINs
Recruitment continue to review their processes to ensure timely recruitment. Time to hire is currently 35.5 working days.			In progress	There are currently 30 applicants with start dates in September and October with 1 of these having a start date of 1 Nov.
Increase the number of pre-employment check slots available for successful applicants to book	Jul-24	Sep-24	In progress	31 checks took place in August, to date in Sept (16th) 27 checks have taken place.
Gain approval to recruit to resignation in the team. Collaborative support to cover the vacancy sought from SaTH.	Jul-24	Sep-24	completed	Approval gain from VRF panel. Support from SaTH commences 30/9/24 to be reviewed in January 25.
Review provision of collaborative support to team	Jan-25	Jan-25	Not started	

Author	Gina Billington	**Date**	18.09.24
Accountable Officer Approval	Rhia Boyode	**Date**	

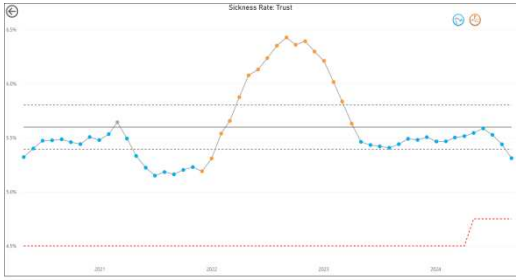
Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Sickness Rate	%	5.51%	5.54%	5.59%	5.53%	5.44%	5.31%	5.31%
	Target	4.50%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	5.3%	5.2%	5.2%	5.3%	5.3%	5.3%	5.2%



Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	59	60	947.76	41
S12 Other musculoskeletal problems	22	23	229.29	9.8
S25 Gastrointestinal problems	55	56	224.95	9.7
S13 Cold, Cough, Flu - Influenza	35	35	133.72	5.7
S26 Genitourinary & gynaecological disorders	10	10	93.14	4
S19 Heart, cardiac & circulatory problems	5	5	91.53	3.9
S28 Injury, fracture	9	9	82.52	3.5
S17 Benign and malignant tumours, cancers	5	6	81.45	3.5
S98 Other known causes - not elsewhere classified	8	8	78.33	3.4
S11 Back Problems	9	9	77.96	3.3

Org L7	Absence FTE	Available FTE	Absence FTE %
Telford Wound Healing Service Clinical Team	112.8	353.4	31.92%
Bridgnorth Hospital Domestics Team	58.4	184.03	31.73%
MSK Rheumatology Team	12.6	44.2	28.51%
Single Point of Referral Team	44.31	164.51	26.93%
Family Connect Team	40.2	167.4	24.01%
Bridgnorth Hospital Radiology Team	13.2	68.2	19.35%
Family Nurse Partnership Telford Team	12.4	68.2	18.18%
Rapid Response Team - Central	48	266.6	18.00%
Adult Community Therapy Central Team	92	516.25	17.82%
DAART Team - Oswestry	12.4	74.4	16.67%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Add Prof Scientific and Technic	36.83	1,179.73	3.12%
Additional Clinical Services	770.55	10,163.95	7.58%
Administrative and Clerical	297.31	10,456.81	2.84%
Allied Health Professionals	174.71	5,654.63	3.09%
Estates and Ancillary	89.77	1,495.97	6.00%
Medical and Dental	22.8	640.56	3.56%
Nursing and Midwifery Registered	935.95	19,349.01	4.84%

Reason for performance gap:

Action Plan

	Start Date	End Date	Status	Outcome
Monthly People team meetings with Clinical Services Manager & Divisional Service Managers to discuss appraisal compliance and support where possible	May-24	Ongoing	In place	Hot spot areas, timely referrals are discussed and explored as required
Develop workshops to support managers to complete the stress risk assessment	Jul-24	Ongoing	In progress	To provide managers with the support to undertake risk assessments appropriately
Launch personal resilience sessions for staff and managers	Sep-24	Dec-24	In progress	To provide staff and managers with the tools to ensure they look after their staff and own wellbeing
Cross check all stress, anxiety & depression absences to ensure appropriate referrals have been completed. If not educate relevant Line Managers	Sep-24	ongoing	In progress	Ensure appropriate referrals are being undertaken. Areas where these are not being completed the People team will support with education
Roll out HWB days to include flu vaccination and other services	Oct-24	Dec-24	In progress	The HWB days include flu vaccinations, health checks, physio and signposting to key HWB support
Roll out Wellbeing Conversations training	Jul-24	Ongoing	In progress	To provide managers and staff with a framework to have wellbeing conversations. These sessions are scheduled until December 2024 with further dates to follow for 2025
Refresh and update Stress and Staff Support Policy	Jul-24	Oct-24	In progress	Ensure the policy is fit for purpose and provides managers with the tools and guidance to support staff
Implement HWB working group with attendees committing to being HWB Champions	Jul-24	On going	Completed	The HWB working group members act as champions and gather views of their teams, colleagues to feed into the work around HWB
Conduct HWB survey to support the ongoing implementation of the HWB action plan	Sep-24	Nov-24	In progress	This survey will gather views/ideas/feedback on the HWB offer and what staff would like to see
Targeted support for areas with high MSK absence	Sep-24	Dec-24	Not Started	MSK is the second highest reason for absence and we are looking at preventative actions as well as curative

Author	Fiona MacPherson	**Date**	18.09.24
Accountable Officer Approval	Rhia Boyode	**Date**	

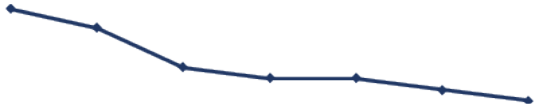
Exception Report - Action Plan

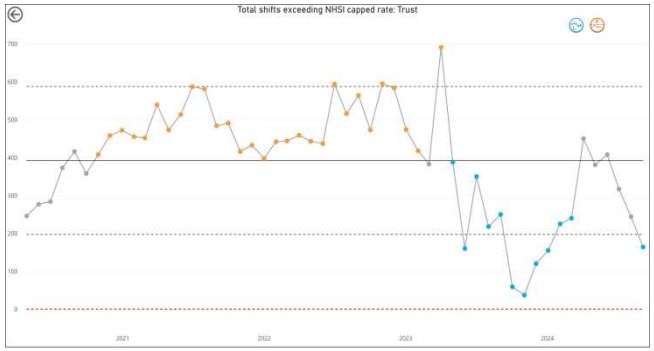
Total shifts exceeding NHSI capped rate

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Shifts	Number	450	381	408	317	244	164	303
	Target	0	0	0	0	0	0	0

Trajectory	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
%	164	130	60	40	40	20	0





Reason for performance gap:					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Liaise with system partners on their approach	Jun-24	Jul-24	Complete	Approach and phased approach shared with SCHT
	Discuss with procurement framework requirements	Jul-24	Jul-24	Complete	Meetings held and support provided by Procurement Lead
	Determine phased approach and reductions in rate	Jul-24		On-going	Approach agreed
	System meeting held and system approach shared	Aug-24	Aug-24	Complete	Approach shared and ongoing phases determined
	Phase 1 of price cap compliance negotiations	Jun-24	Sep-24	In progress	Reduction in price cap provision by agency
	Phase 2 of price cap compliance negotiations	TBC	TBC	Not started	Reduction in price cap provision by agency
Author	Gina Billington	**Date**	18.09.24		
Accountable Officer Approval	Rhia Boyode	**Date**			

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 23rd September 2024

0. Reference Information

Author:	Poppy Owens, Executive Assistant	**Paper date:**	3rd October 2024
Executive Sponsor:	Peter Featherstone, RPC Chair	**Paper written on:**	23rd September 2024
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Resource and Performance Committee meeting held on 23rd September 2024 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Waiting times – RTT and Non RTT
    - Integrated Performance Report
    - Deep Dive Agency, Bank, Workforce
    - CIP Actions and Delivery
    - Benchmarking paper – Virtual Ward
    - Finance & Capital Reporting Month 5
    - 2024/2025 Planning Progress Update
    - Procurement Strategy Update
    - Estates and Environment Quarterly Update / Strategy Progress
    - Green Plan 6 monthly update
    - Digital Services Exemption report and Strategy Refresh/Progress
    - Review of BAF risks
    - Annual Meeting Evaluation
    - Workplan Review
    - System Transformation Group update
    - Digital Assurance Group Minutes

2.3. Conclusion

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

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 23rd September 2024

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 23rd September 2024. The meeting was quorate with one Non-Executive Director, one Associate Non-Executive Director and four Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Peter Featherstone	Non-Executive Director (RPC Chair)
Sarah Lloyd	Chief Finance Officer
Shelley Ramtuhul	Trust Secretary/Director of Governance
Claire Horsfield	Director of Operations
Patricia Davies	Chief Executive Officer
Clair Hobbs	Director of Nursing, Clinical Services and Workforce
Jill Barker	Associate Non-Executive Director
Jonathan Gould	Deputy Chief Finance Officer
Gemma McIver	Deputy Director of Operations
Jon Davis	Associate Director of Digital Services
Richard Best	Associate Director of Estates (part meeting)
Michael Hill	Financial Accountant (shadowing)
Mary Aubrey	Programme Director, Getting To Good (observing)
Poppy Owens	Executive Assistant [Minutes]

Apologies:	
Harmesh Darbhanga	Non-Executive Director

3.2 Actions from the Previous Meeting

The Committee reviewed all open actions from previous meetings, and all received an update with the exception of one.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
7. Waiting times – RTT and Non RTT		
The Committee heard the overall position has stabilised in line with trajectory and the zero reportable 65-week position has been maintained.	Partial	Work with system partners in relation to MSST.

Chair's Assurance Report

Resource and Performance Committee Part 1 – 23rd September 2024

It was discussed that the orthopaedic pathway discussion remains ongoing with system partners but this is impacting our RTT waiting time performance . The 47% admin MSST vacancy rate has vastly improved, and the Rheumatology service change has been successful. The Committee discussed that in all reportable services (including non-RTT) the 78, 65 and 52 week position has continued to deteriorate which is not in line with planned trajectory and is heavily dependent on reviewing the orthopaedic pathway.		Continued close scrutiny given the risk of breaches.
8. Integrated Performance Report		
The Committee were advised there are 6 KPIs that are both assurance concern and special cause variation concern and 4 with assurance concerns which relate to data quality, birth visits and post covid consultations. It was noted that with one exception, areas which require attention relate to access, waiting times and activity. The Committee discussed the effectiveness of this report which was praised with some minor tweaks only suggested.	Y	
9. Deep Dive Agency, Bank, Workforce		
Neither this paper nor a representative was unavailable at Committee and an update has been requested.	Not Available	To be circulated following the meeting.
10. CIP Actions and Delivery		
The Committee heard month 4 CIP position shows an overperformance of £3k with month 5 showing a continued overperformance of £12k. There are currently 34% of schemes which are rated red/high risk which is a reduction from 43% from when the report was first written. The team are currently on track to have zero PIDs outstanding by Thursday 26th September. The Committee noted the good progress and discussed the main risk regarding CIP schemes are that some are interdependent with other elements on the system, which are known. Continued efforts to derisk the programme are vital in relation to in-year and recurrent delivery of the CIP programme.	Partial	Continued focus on de-risking the identified schemes.

Chair's Assurance Report

Resource and Performance Committee Part 1 – 23rd September 2024

11. Benchmarking paper – Virtual Ward		
The team introduced a combined virtual ward paper and benchmarking paper that had been requested at a prior Committee. The members heard that virtual ward is currently performing at a 72.92% average against a national target of 80% and a national average of 68.4%. The Committee noted good performance against available benchmarking data and noted the additional actions which are underway to make further improvements.	N/A	
12. Finance & Capital Report Month 5		
The Committee discussed the key elements of the finance report including; Agency spend, CIP performance, Elective income, Capital funding, and Forecast outturn. The Committees attention was drawn to (i) capital funding relating to leases which is being addressed as a system as all partners are forecasting to spend over the allowance and (ii) the level of risk which remains in relation to delivery of the financial plan and the mitigations which are currently in place to partially offset this. Key actions are identified and require continued close attention and pace.	Y	
13. 2024/25 Planning progress update		
The Committee were presented with a planning progress update which helped demonstrate some of the milestones needed to deliver interventions and ultimately our strategic priorities. Regular progress updates will be shared and an end of year review will ensure items have been completed as expected.	N/A	
14. Procurement Strategy Update		
September's update will be circulated post Committee.	Not Available	
15. Estates and Environmental Quarterly Update / Strategy Progress		
The Committee heard that all KPIs included within the approved strategy are all on track and are meeting the actions that have been set. The Committee's attention was drawn to the two leases which have recently been signed which are significant on capital expenditure moving forwards and vital in relation to delivering patient care.	Y	Good assurance but could be strengthened by further reporting on system wide estate matters.

Chair's Assurance Report

Resource and Performance Committee Part 1 – 23rd September 2024

16. Green Plan 6 monthly update		
The Committee was updated that the Green plan is currently on track to achieve targets as set by NHSE net zero and our carbon footprint is decreasing due to the impact of the solar PV systems. Further description of the non-estates areas of work will be included within the Board update.	Y	More extensive reporting of the non-estates elements of this work to be included in future.
17. Digital Services Exemption Report & Strategy Refresh/Progress		
The Committee commended team on the positive news of the Power BI reports which are currently ranked 213 out of 39,000 reports putting the reports in the top 1% of those assessed. A number of independent elements of assurance are provided in the report and demonstrate the good service provision by our Digital team. Capacity to delivery key programmes of work remains a challenge. .	Y	
18. Review of BAF risks for R&P		
The Committee discussed the two risk changes which includes (i) Cost exceed plan and (ii) Potential for insufficient capital funding.	Y	Target risk ratings to be included in future.

3.4 Approvals

None

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:**	**3rd October 2024**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**24th September 2024**
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 updated Performance Framework.

This report focuses on the measures relevant to the Resource & Performance Committee as actions being taken in relation to performance indicators considered by the Quality and Safety Committee and People Committee are reported separately to the Trust Board.

2.2 Summary

The key points for the Trust Board to consider are:

- There are 64 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. 30 indicators are highlighted as a concern (46.9%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	2	7	5	**19**	**14 (73.7%)**
Quality & Safety	0	2	2	**16**	**4 (25.0%)**
Resource & Performance	2	4	6	**29**	**12 (41.4%)**

Each Committee is responsible for reviewing its KPIs, seeking assurance and agreeing actions to improve performance where required, and subsequent reporting to the Board.

Performance Update

Action Plans have been developed for the measures flagged as a concern that are reviewed by the Resource and Performance Committee and these are included at Appendix 3.

Please note that the RTT measures for August are subject to change as the validation for the national submission continues at the time of preparing this paper/dashboards.

The Board should note that whilst other performance indicators are not flagged as an area of concern there are instances where the dashboards/SPC charts are showing that an indicator/process will not consistently hit or miss the target. Further details are included in the appendices should members wish to review this position.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.

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 all three of our 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 29 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 12 require focused attention with 11 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 **amber a concerning one.**

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

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

1. Outpatient follow-up activity levels compared with 2019/20 baseline
2. Diagnostics for Audiology and Ultrasound – DM01

Performance Update

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

1. Total patients waiting more than 65 Weeks to start consultant-led treatment (National target).
2. Data Quality Maturity Index
3. New Birth Visits % within 14 days – Dudley
4. Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

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

1. 18 week Referral to Treatment (RTT) incomplete pathways (National target)
2. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)
3. Proportion of patients within 18 weeks (Local target)
4. Total patients waiting more than 78 Weeks – All services (Local target)
5. Total patients waiting more than 65 Weeks – All services (Local target)
6. Total patients waiting more than 52 Weeks – All services (Local target)

The list of KPIs which are of concern is largely unchanged from the last report to the Board but the following changes are to note;

- Total patients waiting more than 104 Weeks – All services (Local target) is no longer showing a variation concern.

As of August 2024:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	757	1651
Patients waiting over 65 weeks	0	523
Patients waiting over 78 weeks	0	190
Patients waiting over 104 weeks	0	1

There has been significant deterioration across the high wait KPI with the exception of Total patients waiting more than 104 Weeks – All services (Local target) which has 1 patient waiting as of August 2024. The trends are evident in the charts within the appendices and detail regarding actions being taken is included in the action plans.

The measures relating to waiting times and RTT are likely to fluctuate as the implementation and transition of the system wide MSK transformation programme continues to embed.

18 week Referral to Treatment (RTT) incomplete pathways has shown a slight improvement from 52.26% in July to 52.61% in August, although August position was still being validated at the time of preparing this paper. The Proportion of patients within 18 weeks has shown a slight deterioration, with performance of 60.5% in July to 60.39% in August.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

Performance Update

3.4 Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.

Resource and Performance Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance...	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2024-08-31	L	52.73%	92.00%	-39.27%	52.73%	92.00%	-39.27%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2024-08-31		116.79%	100.00%	16.79%	116.79%	100.00%	16.79%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2024-08-31	L	53.32%	100.00%	-46.68%	53.32%	100.00%	-46.68%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2024-08-31	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2024-08-31		0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2024-05-31	H	94.2%	95.0%	-0.8%	94.2%	95.0%	-0.8%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2024-08-31	L	68.08%	99.00%	-30.92%	68.08%	99.00%	-30.92%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2024-08-31		0.83%	0.00%	0.83%	0.83%	0.00%	0.83%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2024-08-31		3.70%	0.00%	3.70%	3.70%	0.00%	3.70%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2024-07-31	H	92.93%	95.00%	-2.07%	88.72%	95.00%	-6.28%	F
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2024-07-31		87.83%	90.00%	-2.17%	88.10%	90.00%	-1.90%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2024-07-31		92.31%	95.00%	-2.69%	93.21%	95.00%	-1.79%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2024-08-31		0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2024-08-31	H	90.83%	75.00%	15.83%	98.07%	75.00%	23.07%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2024-08-31		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	P
Resource & Performance...	Responsive	Proportion of patients who have a first consultation in a post-covid ser...	2024-08-31	H	100.00%	92.00%	8.00%	28.79%	92.00%	-63.21%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2024-08-31	L	60.39%	92.00%	-31.61%	60.39%	92.00%	-31.61%	F

Resource and Performance Committee - SPC Summary (continued)

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance ...	Effective	Total activity undertaken against current year plan	2024-08-31		87.43%	100.00%	-12.57%	93.94%	100.00%	-6.06%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2024-08-31		119.01%	120.00%	-0.99%	155.70%	120.00%	35.70%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2024-08-31	H	111.65%	103.00%	8.65%	115.07%	103.00%	12.07%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2024-08-31		1	0	1	1	0	1	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2024-08-31		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2024-08-31	H	1,651	0	1,651	1,651	0	1,651	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2024-08-31	H	757	0	757	757	0	757	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2024-08-31	H	523	0	523	523	0	523	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2024-08-31	L	0	0	0	0	0	0	F
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2024-08-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2024-08-31	H	190	0	190	190	0	190	F
Resource & Performance ...	Effective	Virtual ward bed occupancy	2024-08-31		73.32%	56.89%	16.43%	73.32%	56.89%	16.43%	

Quality and Safety Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2024-08-31		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-08-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-08-31		3.00	0.00	3.00	3.00	0.00	3.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-08-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-08-31		98.32%	95.00%	3.32%	98.57%	95.00%	3.57%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30		83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-08-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-08-31		3.92	4.00	-0.08	3.92	4.00	-0.08	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-08-31		3	0	3	26	0	26	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-08-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-08-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-08-31		0	0	0	0	0	0	

People Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2024-08-31	H	7.4	7.5	-0.1	7.4	7.5	-0.1	F
People Committee	Well Led	Appraisal Rates	2024-08-31		86.27%	90.00%	-3.73%	84.79%	90.00%	-5.21%	F
People Committee	Well Led	CQC well-led rating	2024-08-31		Good	Good		Good	Good		P
People Committee	Well Led	Leaver rate	2024-08-31	L	11.48%	9.60%	1.88%	11.48%	9.60%	1.88%	F
People Committee	Well Led	Mandatory Training Compliance	2024-08-31	L	93.28%	95.00%	-1.72%	93.28%	95.00%	-1.72%	?
People Committee	Well Led	Net Staff in Post Change	2024-08-31		-4.38	0.00	-4.38	33.08	0.00	33.08	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-08-31	H	9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	F
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-08-31		71.43%	66.00%	5.43%	71.43%	66.00%	5.43%	?
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-08-31	H	4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	P
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2024-08-31	L	55.80%	63.90%	-8.10%	55.80%	63.90%	-8.10%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-08-31	H	7.1%	0.0%	7.1%	7.1%	0.0%	7.1%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-08-31	H	12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	F
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment, bullying or a...	2024-08-31	H	22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	F
People Committee	Well Led	Proportion of temporary staff	2024-08-31		6.4%	3.4%	3.0%	6.8%	3.4%	3.4%	F
People Committee	Well Led	Sickness Rate	2024-08-31	L	5.31%	4.75%	0.56%	5.31%	4.75%	0.56%	F
People Committee	Well Led	Staff survey engagement theme score	2024-08-31	L	7.0	7.3	-0.3	7.0	7.3	-0.3	F
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-08-31	L	164	0	164	303	0	303	F
People Committee	Well Led	Total shifts on a non-framework agreement	2024-08-31	L	0	0	0	0	0	0	?
People Committee	Well Led	Vacancies - all	2024-08-31	H	11.81%	8.00%	3.81%	11.77%	8.00%	3.77%	?

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.
(common cause)	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.

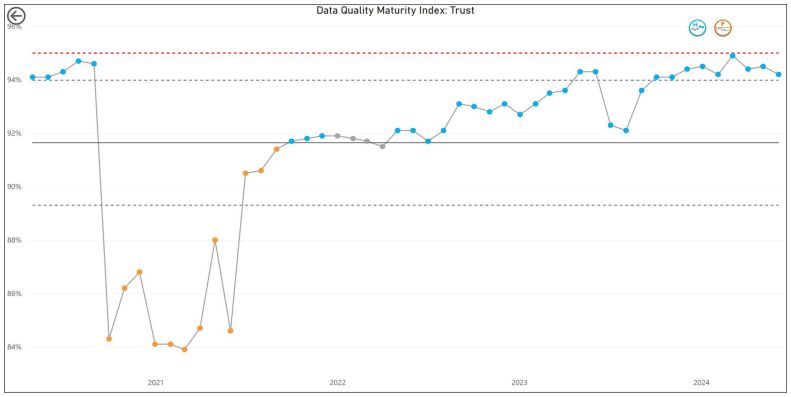
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
DQMI	%	94.50%	94.20%	94.90%	94.40%	94.50%	94.20%	94.2%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	94.2%	94.4%	94.6%	94.8%	95.0%	95.0%	95.0%



Reason for performance gap:	Performance reduced in June/July 2023 following a number of errors highlighted in the dataset submissions as the Trust implemented the new version of a dataset submission standard. The datasets have been corrected and resubmitted. Performance has therefore recovered from this and continued in line with the planned improvement trajectory. Data quality challenges do still exist in several data items particually within MIU e.g. Chief Complaint, Clinical Coding for Admitted Patient Care, Ethnicity and Spoken Language. The main area of challenge impacting this metric is in relation to compliance re-recording of ethnicity. Education to teams re importance and relevance of capturing this metric is ongoing. Challenges with admin capacity (aligned to NHSE controls) to ensure this action is completed has had an impact however working with informatics to see how certain fields that support improving data quality become mandatory for completion.

Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Data Quality Sub-Group to have representation from all divisions	Jan-24	Sep-24	Off track	Attendance logs are kept and escalations to Operational Leads will be made if there are any patterns of non attendance. No operational attendance at the September meeting and this has been escalated. Action remains open until attendance is consistent.
	Implementation of new Divisional performance and Quality meetings in line with new divisional structure to ensure reporting is embedded into governance structures not just reflected in the improvement group	Mar-24	Apr-24	Complete	Plans in place to include data quality as standard agenda item. Meetings are up and running with further action to include other corporate services. Separate items for Quality and Governance with further discussions required with the Governance Team. Information Analyst has attended CYP/Planned Care meetings to discuss data quality
	Work with RiO teams re mandatory fields that must be completed before further data can be input	Jan-24	Jan-25	Ongoing	Ethnicity is now a mandatory field in RiO
	CSDS Workshop to be held with leads from each SDG to explore areas of improvement	Jun-24	Oct-24	On Track	Each SDG has nominated DQ leads, workshop has been arranged for 2nd October 2024
	Clinical Audit Tool feedback to be strengthened through SDG meetings	Jun-24	Sep-24	Ongoing	Results from quarterly discussions at DQ Subgroup are being communicated back through SDG meetings. This will also form part of the workshop above
	Appointment of MIU service lead to provide senior oversight to MIU data quality is it s an outlier and a priority	Sep-24	Nov-24	Complete	Appointment made and Individual in post data quality is part of their work plan to understand and improve. Progress will be monitored through the data quality sub group.

Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson	**Date**	13/09/2024
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024

Exception Report - Action Plan

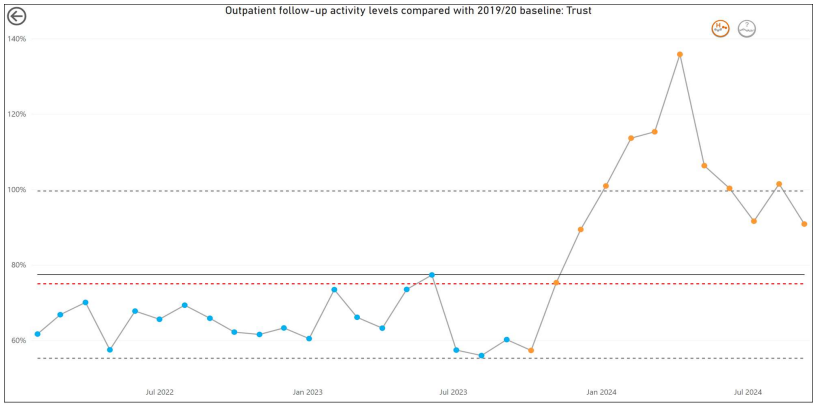
Outpatient follow-up activity levels compared with 2019/20 baseline

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Outpatient follow-up	%	135.83%	106.31%	100.15%	90.35%	96.23%	90.83%	98.1%
	Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	120.0%	120.0%	120.0%	120.0%	120.0%	120.0%	100.0%

To be reviewed



Reason for performance gap:

There continues to be a focus on ensuring clinically appropriate follow-up activity and the positive adherence to utilising PIFU (Patient Initiated Follow Up) across MSST. PIFU performance is currently over performing at 13.1% against the target of 5.5% demonstrating an effective use of the pathway and best practice approach. From a local persepective SCHT are modelling a best practice approach peforming consitently above the national target and also above local peers (SaTH are at 4.7% and RJAH at 4.9%)

The difficulty with this KPI is that MSST was not in existence in 19/20 so there is no baseline to compare to hence the continued demonstration of overperformance seen above. This would be similar for the TeMS service as the TeMS model is significantly different now than it was compared to 19/20.

Service	Aug-24 (Rounded to 0 dp)
APCS	72%
Bridgnorth Outpatients	49%
DAART	88%
Ludlow Outpatients	42%
MSST	11033%
TEMS	4%
Whitchurch Outpatients	122%

Action Plan

	Start Date	End Date	Status	Outcome
Continue to embed PIFU across all clinically appropriate services and maintain performance	Jun-23	Mar-24	Complete	Currently overperforming with processes and standards embedded in all areas. For ERF (Elective Recovery Fund) services from Apr 24 - July 24 the trust saw an average performance of 15.6%.
Work with informatics to look at approach in reporting this KPI due to the challenges with comparison for TeMS/MSST	Feb-24	Jun-24	Complete	Agenda item in performance cycle meeting discussed initially in Feb pending feedback for March. Initial conversations taking place at a system level in reviewing 2019/20 elective baseline.
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Transition agreed for follow ups too but all new/FU activity is now being recorded via RJAH.
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk.

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024

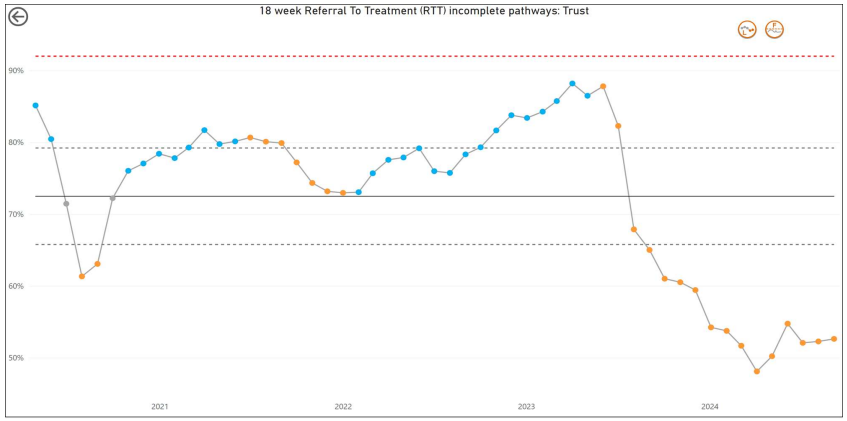
Exception Report - Action Plan

18 week Referral To Treatment (RTT) Incomplete Pathways

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
RTT Incomplete Pathways	%	48.08%	50.20%	54.74%	52.06%	52.26%	52.61%*	52.61%*
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
%	51.0%	52.0%	55.0%	57.5%	60.0%	62.5%	65.0%



Total Incomplete Position						
	Apr-23	Jul-23	Oct-23	Jan-24	Apr-24	Jun-24
STW	58.8%	57.0%	56.8%	51.6%	49.7%	49.8%
SCHT	86.4%	67.3%	60.5%	53.7%	50.2%	52.0%
National	58.3%	58.6%	58.2%	57.0%	59.1%	58.0%
Regional	55.3%	55.9%	55.7%	57.0%	56.0%	55.9%

Benchmarking:- The information provided follows on from the Operations benchmarking report provided to RPC in March. The data is taken from NHS England's official statistics for referral to treatment waiting times. Further work is underway to source data that can provide more in depth benchmarking against 52, 65 and 78 weeks with support being provided by the ICB.

Reason for performance gap:	The current position continues to be a challenge (in line with national trends following Covid recovery). For SCHT the challenges in performance are mainly attributable to the implementation of the MSST service (80% of total activity). It is also important to note that although there is a trajectory to recover the 18 weeks position locally the national priority and target has been to focus on the reduction of long waits which SCHT have delivered ahead of planned scheduled dates. New referrals are triaged to support clinical need and ongoing demand and capacity modelling and recovery planning continue to progress to support the 18-week recovery in line with the planned trajectory, which is currently on track in terms of planned delivery. MSST - The service has now been live for 12 months, with phase 1 of the system transformation complete and SCHT are now the gateway for MSK referrals system wide. Recovery of performance was dependent on the implementation of Phase 2. Phase 2 detailed 3 key actions that needed to be implemented at system level. Action 1 was to close the 47% admin vacancy gap and this has been completed. Action 2 was for Rheumatology to transfer to RJAH and this completed in April 2024. The final action due initially in April 2024 and extended to September 2024 was for SCHT to transfer all Orthopaedic activity to SaTH. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance and scoping of alternative plan at a system level has commenced. This is currently reporting into MSK delivery board and Planned Care delivery board for oversight, escalation, and ownership at a system level. Progress is also reported on weekly through the Tier 1 system calls. APCS recruitment is underway to source additional clinicians to support and this has been signed off this month for the service to progress. Community Hospital Outpatients has a number of backlog patient pathways. This is due to ongoing challenges with consistent capacity being provided across all SLA, particularly seen within ENT and Respiratory again this is being overseen at system level and escalated through Tier 1 calls to maintain ongoing focus and flow through the service. From a benchmarking perspective June position for total reportable incomplete pathways demonstrates that: •SCHT are performing favourably against local peers by 2.2%(SCHT 52% and STW 49.8%) •Performance at regional level is 3% lower (Regional position 55.9%) •National level underperforming in terms of alignment by 6% (national position 58%). •This pattern of performance is further mirrored when bench marking more specifically at MSK services. (National 54.6%, Regional 53.6%, STW 41.2% and SCHT 51.9%) The underperformance from a benchmarking position can be explained due to the system wide interdependencies and this is reflected within STW's overall position. Challenges impacting recovery are around delays with orthopaedic transfer and long waits aligned to access to diagnostics. There are other services which contribute to not meeting this performance target such as Dental.

Action Plan

	Start Date	End Date	Status	Comments
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Transition agreed for follow ups but all Open RTT pathways have been transferred.
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.
Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
Plan with RJAH to mitigate the system wide APP workforce gap	Aug-24	Sep-24	Complete	Agency APP available, SCHT/RJAH working through finances before confirming next steps also RJAH support to pause an internal triage audit
Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
MSST focusing on improving clinical utilisation and implementing waiting list initiatives within level 2 including additional clinics, blitz clinics etc.	Apr-24	Jun-24	Complete	Significant improvement seen within the level 3 and 2 clinic utilisation. Podiatry blitz clinic underway. Triage event taken place to support with correct allocation to levels to support with clinic utilisation. Current clinic utilisation across L2 & 3 following a series of improvements is 91% (85.7% for L2 and 100% for L3). This is a 14.1% improvement in 12 months compared to July 23 where clinic utilisation was 76.9% - admin leadership from SCHT has hugely contributed to this improved performance.
Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Sep-24	Complete	Additional Gynaecology sessions are now being provided this has significantly reduced the wait position with current longest wait 19 weeks. Further discussions taking place with SaTH regarding a more robust approach to the ENT and Respiratory SLA.
Implementation of digital systems to support with validation and waiting list management.	Jul-24	Aug-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST.

	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
	Review the 52 week cohort trajectory		Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

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

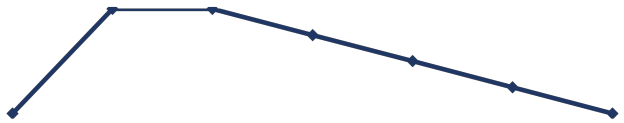
Exception Report - Action Plan

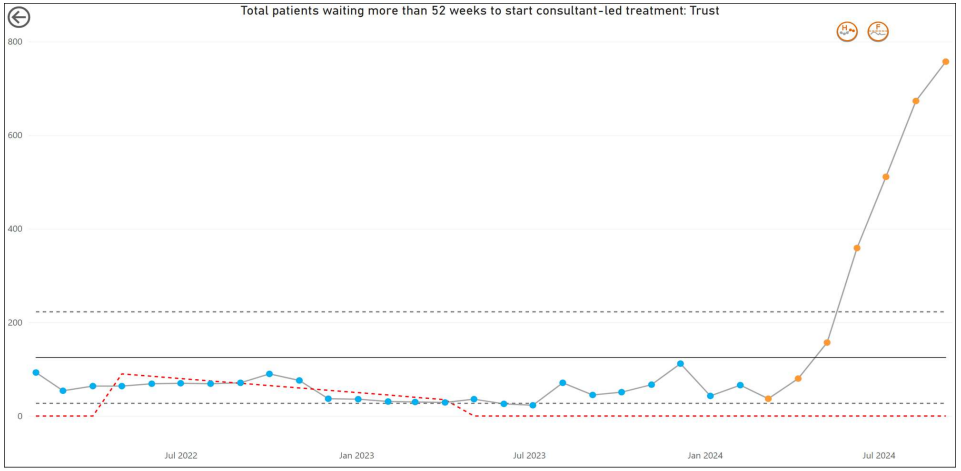
Total patients waiting more than 52 weeks to start consultant-led treatment

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

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
RTT 52+ week waits	Number	80	157	359	511	673	757*	757*
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
Number	700	900	900	850	800	750	700





Reason for performance gap:	Currently delivering ahead of the planned trajectory for improvement. Following full launch of phase 1 12 months ago the system transformation for MSK services is now complete and SCHT are now the gateway for MSK referrals system wide. Recovery of long waits and delivery of the 52 week trajectory was interdependent Phase 2. Phase 2 detailed 3 key actions that needed to be implemented at system level. Action 1 was to close the 47% admin vacancy gap and this has been completed. Action 2 was for Rheumatology to transfer to RJAH and this completed in April 2024. The final action due initially in April 2024 and extended to September 2024 was for SCHT to transfer all Orthopaedic activity to SaTH. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance and scoping of alternative plan at a system level has commenced. Access to system wide diagnostics to also prevent long delays is also strained at system level and presents a further interdependency that could impact delivery of the 52 week planned trajectory. This presents a risk to ongoing delivery of the 52-week trajectory. This is currently reporting into MSK delivery board and Planned Care delivery board for oversight, escalation, and ownership at a system level. Progress is also reported on weekly through the Tier 1 system calls. Current mitigation is in place to manage individual cases on a daily basis. Dental continues to improve following regular access to theatre provision and are on track with 0 52 week waits and a forecast to have longest wait of 40 weeks by mid September. There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients.

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.
Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Complete	Contract discussions continuing for additional capacity however increased clinics are now in place and consistent
Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.

Action Plan	Plan with RJAH to mitigate the system wide APP workforce gap		Aug-24	Sep-24	Complete	Agency APP available, SCHT/RJAH working through finances before confirming next steps also RJAH support to pause an internal triage audit and align APP capacity
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Aug-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST.
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
	Review the 52 week cohort trajectory		Aug-24	Oct-24	On track	Review trajectory in line with changes to demand and capacity and following SaTH's notification they cannot support Orthopaedic transfer in line with the system wide trajectory
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

**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*

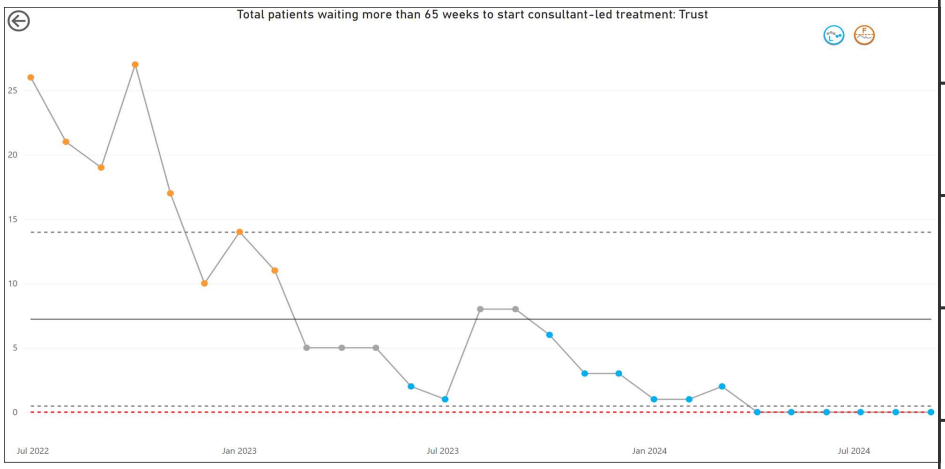
Exception Report - Action Plan

Total patients waiting more than 65 weeks to start consultant-led treatment

As at the end of the month, the number of patients that are still waiting for treatment and have been waiting 65 weeks and over

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
RTT 65+ week waits	Number	0	0	0	0	0	0*	0*
	Target	0	0	0	0	0	0	0

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



Reason for performance gap:

The trajectory has remained on track to achieve and maintain 0 reportable 65 week waits in month.

In terms of ongoing risk for 78-week delays SCHT also continue to report 0. When benchmarking locally reportable 78-week data, SCHT and SaTH are the only current provider to continue with maintaining a 0 78 week delays. RJAH reported for June 10 78-week delays and SaTH are now forecasting 56 x 78 weeks for Aug and 83 for September. Nationally 4,668 78-week breaches were reported in June demonstrating at a national level recovery in this area is significantly off track.

SCHT achieved a 0 65-week position in March ahead of the nationally prescribed target for September demonstrating significant over performance in managing high week waits. There is however a risk to maintaining this position. Maintaining performance in this area is currently being achieved through 'man marking' every patient and escalating delays to partners at every stage of the pathway to mitigate a 65-week reportable delay. Much of the patient pathway is interdependent with SaTH and RJAH in particular:

•Access to diagnostics current system wait times and access to reports are MRI 21 - 23 Weeks, CT 17 - 18 Weeks, Ultrasound 22 - 24 Weeks, Ultrasound Injection 42 - 44 Weeks, X-ray 7 - 9 Weeks

•Access to Advance Practice Physiotherapists (APP) (RJAH have vacancy and sickness and have delayed mitigating agency due to system wide agency reduction plan)

•Transfer or orthopaedics has now been delayed for a third time and the system wide agreed trajectory to supporting reducing wait times is heavily dependent on the transfer of orthopaedic activity to SaTH who have now paused this arrangement with no indicative date of this now happening.

The recovery actions below detail areas where SCHT are mitigating and influencing impact of above and are the correct agreed actions to manage the long wait position in the system. The priority and influence over this is a risk given the 78 week position we are prioritised against. With local peers still targeting managing a 78-week cohort this places managing SCHT's 65 week cohort at significant risk.

Currently RJAH are demonstrating for June 297 reportable 65-week delays and SaTH 2,370. National trajectories are falling behind the plan to achieve 0 65 weeks by September with discussions at the national Tier 1 planned care call that this trajectory is currently under review.

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.

Action Plan	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH		Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.
	Continue to seek and formalise support from RJAH for Dental sessions.		Jan-24	Mar-24	Complete	Contract discussions continuing for additional capacity however increased clinics are now in place and consistent
	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.		Nov-23	Ongoing	On track	SaTH have offered 2 regular consistent slots at RSH for adults and have agreed to support with the children's lists. Scoping to confirm regular days and times continues. Continue to monitor and escalate if provision reduces in winter
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity		Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
	Plan with RJAH to mitigate the system wide APP workforce gap		Aug-24	Sep-24	On track	Has been escalated with RJAH Exec's and MSK SRO agreed interim agency hosted by RJAH and utilisation of upper limb consultants capacity
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
	Additional Podiatry capacity being provided to MSST. Blitz style clinics being planned.		Jul-24	Aug-24	Complete	SCHT Podiatry service has started planning to provide additional sessions to support MSST recovery both at Level 2 and Level 3 with future plans to implement blitz style clinics. The additional Podiatry sessions has reduced podiatry waits within the 52 week cohort by 40%
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Aug-24	Off Track	Implementation of my recovery and Strata to support MSST waiting list management. Revised implementation date of October now which may have an impact on RTT/65/52 week recovery. Delay is attributable to capacity within digital team to deliver. Band 7 digital lead has been approved at internal VRF panel and will now progress through ICB triple lock process to support with dedicated digital capacity to MSST.
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

**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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Proportion of patients within 18 weeks	%	57.47%	58.71%	59.87%	58.65%	60.50%	60.39%	60.39%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
%	60.0%	61.0%	62.0%	63.0%	64.0%	65.0%	66.0%

Reason for performance gap:

Currently 1% behind the planned trajectory for improvment.

Majority of activity aligns to MSST - The service has now been live for 12 months, with phase 1 of the system transformation complete and SCHT are now the gateway for MSK referrals system wide. Recovery of performance was dependent on the implementation of Phase 2. Phase 2 primarily detailed 3 key actions that needed to be implemented at system level. Action 1 was to close the 47% admin vacancy gap and this has been completed. Action 2 was for Rheumatology to transfer to RJAH and this completed in April 2024. The final action due initially in April 2024 and extended to September 2024 was for SCHT to transfer all Orthopaedic activity to SaTH. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance. As the transformation programme continues to progress, ongoing Demand and Capacity work is also a priority to align workforce to each priority level, to manage activity long term and ensure effective triage is in place and workforce is aligned appropriately to all elements of the model moving forwards.

Community Paediatrician vacancies and sickness continue to have an adverse impact on the waiting list for Community Paediatrics in addition to the increased number of referrals for complex cases. This in turn also adversely affects the Child Development Centre waiting lists.

Speech and Language Therapy have also seen an increase within this cohort due to maternity leave, sickness, increased referrals from schools and a national shortage of qualified Speech & Language Therapists. The new triage model in place has however significantly reduced long waits over the last 6 weeks. This is due to further accelerate and will significatly support SLT with future waiting list management and recovery.

APCS also has a number of backlog patients following sickness within this area, particularly seen within the ENT element of the service. Recruitment to APCS will support recovery and ongoing discussions with SaTH continue to stregthen delivery of the agreed SLA.

There are other services which contribute to not meeting this performance target such as CNRT, Bridgnorth Hospital Day case, Community Hospital Outpatients, Dental, Wheelchair Services, Post COVID

	Start Date	End Date	Status	Outcome
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	Complete	Specialist Doctor post appointed to.
APCS to recruit to outsanding clinical post	Feb-24	Nov-24	On track	Agreed by tripple lock and progressing to recruitment
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.

Action Plan	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity		Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
	Plan with RJAH to mitigate the system wide APP workforce gap		Aug-24	Sep-24	Complete	Agency APP available, SCHT/RJAH working through finances before confirming next steps also RJAH support to pause an internal triage audit and align APP capacity
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
	MSST focusing on improving clinical utilisation and implementing waiting list initiatives within level 2 including additional clinics, blitz clinics etc.		Apr-24	Jun-24	Off track	Utilisation has remained at 80%. Work underway to review the clinic templates to convert FU slots to new to improve. Increase in admin capacity will help to improve utilisation.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list		Mar-24	Jul-24	Complete	Psychology SLA provision agreed and implemented as of July 2024. Top 20 longest waits have either now been seen or have appointments by the end of August 2024
	SLT to launch an improvement programme relating to waiting list initiatives.		Jul-24	Sep-24	Complete	Targeted 65+ and 52+ week cohorts initially, with a plan to have 0 52+ week waits by end of August 2024. There is only one child now waiting over 52 weeks.
	Review the 52 week cohort trajectory		Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

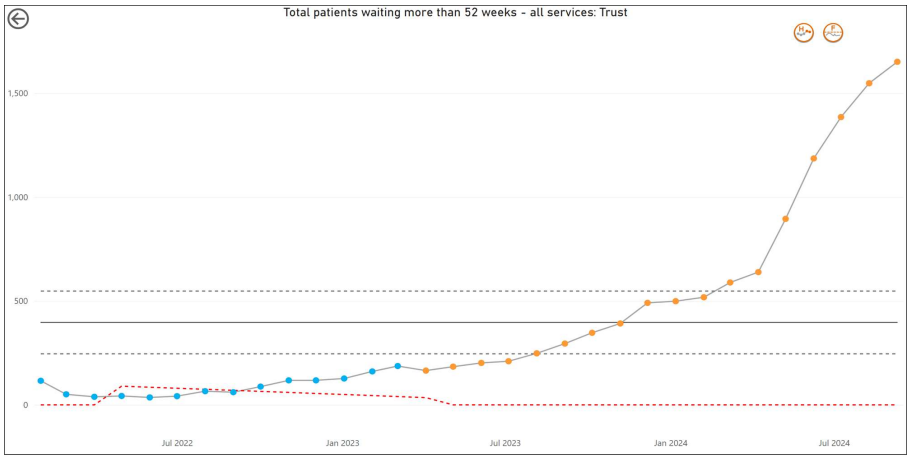
Exception Report - Action Plan

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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
52+ Week waits - All services	Number	639	895	1186	1385	1548	1651	1651
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
Number	1550	1700	1850	2000	2150	2300	2450



Reason for performance gap:

On track in line with planned trajectory currently. It is predicted that mainiting this position will not be achievable. For assurance recovery can be achieved but is reliant on orthopaedic transfer. Until this is fully supported and implemented at system level a date to recover can not be forecast.

CNRT has a number of patients within 52 weeks due to the last 12 mnths challenges with access to Psychology provision. An SLA is now live with a focus on tackling th backlog of patients in Chronological order and clinical priority. A full service review has commenced to re explore the clinical model in its entirety of the CNRT model to scope areas to increase productivity and more effectively manage wait times across the MDT moving forward.

Community Paediatrician vacancies and an increase in the number of complex case referrals continue to have an adverse impact on the waiting list for Community Paediatrics. There are 49 children waiting to be seen at 52 weeks or above. All children waiting longer than 52 weeks in Community Paediatrics are attributable to Children waiting for Schedule of Growth Skills (SOGS) appointments. This has been due to the decreased capacity of our Specialist Nursery Nurse Team and reduced admin capacity to support with managing clinics and validation. There are regular meetings with the team to review the waiting list and prioritise as well as planned start dates for peadatrian and nursery nurses which will ensure capacity moving forward to continue to reduce the 52 week cohort.

Significant progress has been achieved in Speech and Language therapy over the last month who have reduced their high week wait position from 112 children over 52 weeks in May 24 to zero at the end of August. This waiting list initiative has demonstrated enormous improvements in the service and will continue to be utilised to mitigate long waits moving forward.

The trajectory above highlights an ongoing growth of 52, 65 and 78 week non reportable waits at a rapid pace. This is primarily attributable to MSST activity and those patients who have been internally refereed post initial treatment for Orthopaedic intervention. Orthopaedic transfer was initially due to transfer in April 2024 and extended to September 2024. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance and alternative options.

There are other services which contribute to not meeting this performance target such as CDC, APCS, Community Hospital Outpatients and Wheelchair Service

	Start Date	End Date	Status	Outcome
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	Complete	Specialist Doctor post appointed to.
APCS to recruit to outsanding clinical post	Feb-24	Nov-24	On track	Agreed by tripple lock and progressing to recruitment
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.

Action Plan	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity		Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
	Plan with RJAH to mitigate the system wide APP workforce gap		Aug-24	Sep-24	Complete	Agency APP available, SCHT/RJAH working through finances before confirming next steps also RJAH support to pause an internal triage audit and align APP capacity
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further
	MSST focusing on improving clinical utilisation and implementing waiting list initiatives within level 2 including additional clinics, blitz clinics etc.		Apr-24	Jun-24	Off track	Utilisation has remained at 80%. Work underway to review the clinic templates to convert FU slots to new to improve. Increase in admin capacity will help to improve utilisation.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list		Mar-24	Jul-24	Complete	Psychology SLA provision agreed and implemented as of July 2024. Top 20 longest waits have either now been seen or have appointments by the end of August 2024
	SLT to launch an improvement programme relating to waiting list initiatives.		Jul-24	Sep-24	Complete	Targeted 65+ and 52+ week cohorts initially, with a plan to have 0 52+ week waits by end of August 2024. There is only one child now waiting over 52 weeks.
	Review the 52 week cohort trajectory		Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
Author	Alastair Campbell/ Helen Cooper / Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

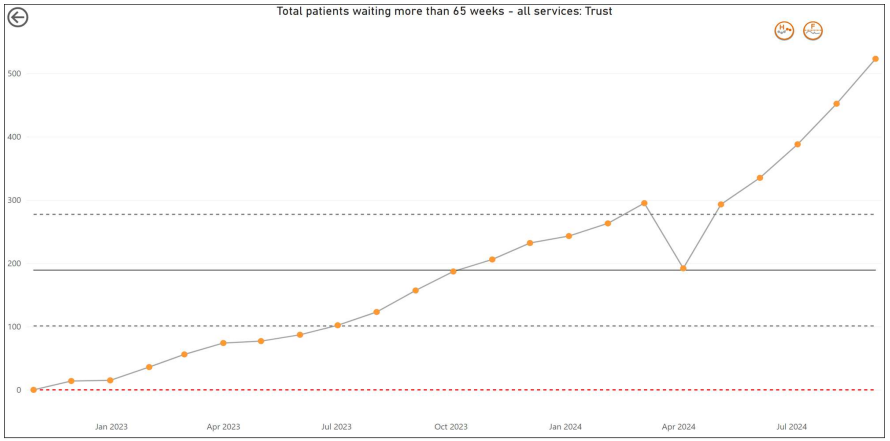
Exception Report - Action Plan

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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
65+ Week waits - All services	Number	192	293	335	388	452	523	523
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
Number	450	500	550	600	650	700	750



Reason for performance gap:	Currently off track from trajectory by 23 patients a decline in performance was predicted and is reflected in the trajectory. This decline has occurred slightly ahead of forecast. For assurance recovery can be achieved but is reliant on orthopaedic transfer. Until this is fully supported and implemented at system level a date to recover can not be forecast. CNRT has a number of patients within 65 week bracket due to the previous 12 months challenges with access to Psychology provision. An SLA is now live with a plan for all waits over 52 weeks to be seen by end of September. A full service review has commenced to re explore the clinical model in its entirety of the CNRT model to scope areas to increase productivity and more effectively manage wait times across the MDT moving forward. Improvement in the 65 week wait position has been demonstrated for Community paediatrics with 6 children now waiting over 65 weeks. Community Paediatrician vacancies and an increase in the number of complex case referrals continue to have an adverse impact on managing the waiting list for Community Paediatrics. All children waiting longer than 65 weeks in Community Paediatrics are attributable to Children waiting for Schedule of Growth Skills (SOGS) appointments. Significant progress has been achieved in Speech and Language therapy over the last couple of months and we continue to have no children waiting over 65 weeks The trajectory above highlights an ongoing growth of 52, 65 and 78 week non reportable waits at a rapid pace. This is primarily attributable to MSST activity and those patients who have been internally refereed post initial treatment for Orthopaedic intervention. Orthopaedic transfer was initially due to transfer in April 2024 and extended to September 2024. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance and alternative options. There are other services which contribute to not meeting this performance target such as CDC, Community Hospital Outpatients

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps and also reduce locum costs.	Nov-23	May-24	Complete	Specialist Doctor appointed that starts in September. Job plans for the new starter taking place to manage gaps
Waiting list initiative being rolled out in CDC. Looking at different ways of working using specialist nursery nurses and speech and language therapists.	Jun-24	Jul-24	Complete	Number of children waiting longer than 65 weeks has increased by 7 to 18 now waiting more that 65 weeks. We are commencing new format MDAs in September. New MDA Schedule to focus on longest waiting children.

Action Plan	5 week Speech and Language waiting list initiative commenced June 24 focusing on the early years complex care pathway where we have the highest waits	Jun-24	Jul-24	Complete	We now have no children waiting above 65 weeks
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
	Plan with RJAH to mitigate the system wide APP workforce gap	Aug-24	Sep-24	On track	Has been escalated with RJAH Exec's and MSK SRO agreed interim agency hosted by RJAH and utilisation of upper limb consultants capacity
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience	Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
	Review the 52 week cohort trajectory	Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	Jul-24	Complete	Psychology SLA provision agreed and implemented as of July 2024. Top 20 longest waits have either now been seen or have appointments by the end of August 2024

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024

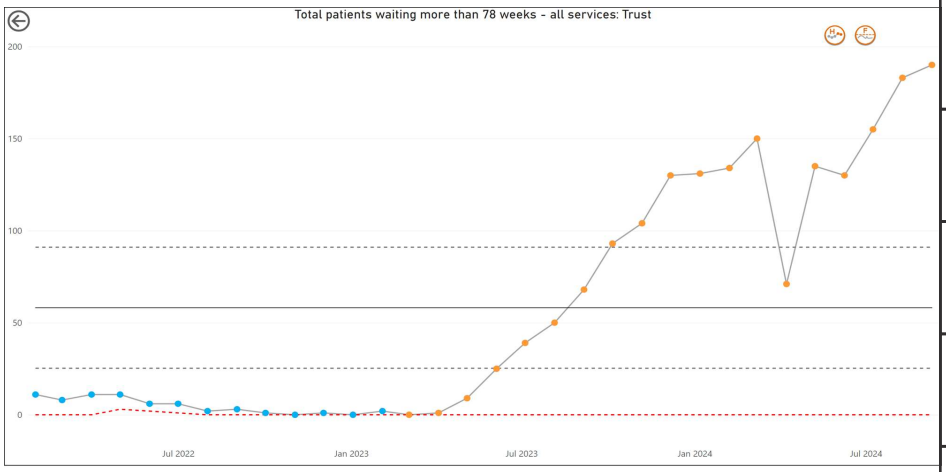
Exception Report - Action Plan

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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
78+ Week waits - All services	Number	71	135	130	155	183	190	190
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
Number	180	205	230	255	280	305	330



Reason for performance gap:	On track in line with planned trajectory currently. It is predicted that mainiting this position will not be achievable. For assurance recovery can be achieved but is reliant on orthopaedic transfer. Until this is fully supported and implemented at system level a date to recover can not be forecast. MSST - The service has now been live for 12 months, with phase 1 of the system transformation complete and SCHT are now the gateway for MSK referrals system wide. Recovery of performance was dependent on the implementation of Phase 2. Phase 2 primarily detailed 3 key actions that needed to be implemented at system level. Action 1 was to close the 47% admin vacancy gap and this has been completed. Action 2 was for Rheumatology to transfer to RJAH and this completed in April 2024. The final action due initially in April 2024 and extended to September 2024 was for SCHT to transfer all Orthopaedic activity to SaTH. SaTH have notified SCHT they are unable to meet this deadline and alternative mitigation and action is now taking place to understand impact on performance. As the transformation programme continues to progress, ongoing Demand and Capacity work is also a priority to align workforce to each priority level, to manage activity long term and ensure effective trigae is in place and workforce is aligned appropriately to all elements of the model moving forwards. CNRT has also seen some long waits within their waiting list due to significant challenges with Psychology provision. There are other services which contribute to not meeting this performance target such as CDC

		Start Date	End Date	Status	Outcome
ction Plan	Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	Off track	SATH have confirmed they are unable to continue with agreed implementation date of Sept 24. Discussions ongoing but puts SCHT recovery for RTT/65/52 weeks at risk. Plan to pursue RJAH as alternative.
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	New full time APP started in MSST at Euston House WB 9th September.
	Plan with RJAH to mitigate the system wide APP workforce gap	Aug-24	Sep-24	Complete	Has been escalated with RJAH Exec's and MSK SRO agreed interim agency hosted by RJAH and utilisation of upper limb consultants capacity

A	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	On track	We have recruited to the 47% admin gap and we continue to lead the admin function for the system and we are aligning with digital systems to further improve productivity and efficiencies
	System wide view of MSST clinical and operational leadership to be completed with recommendations to support long term leadership model and service resilience		Aug-24	Oct-24	On track	Currently in discovery phase to map at system level
	Review the 52 week cohort trajectory		Aug-24	Sep-24	Complete	Updated trajectory completed with revised recovery plan.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list		Mar-24	Jul-24	Complete	Psychology SLA provision agreed and implemented as of July 2024. Top 20 longest waits have either now been seen or have appointments by the end of August 2024
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

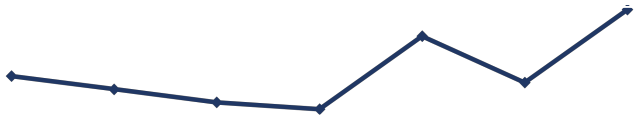
Exception Report - Action Plan

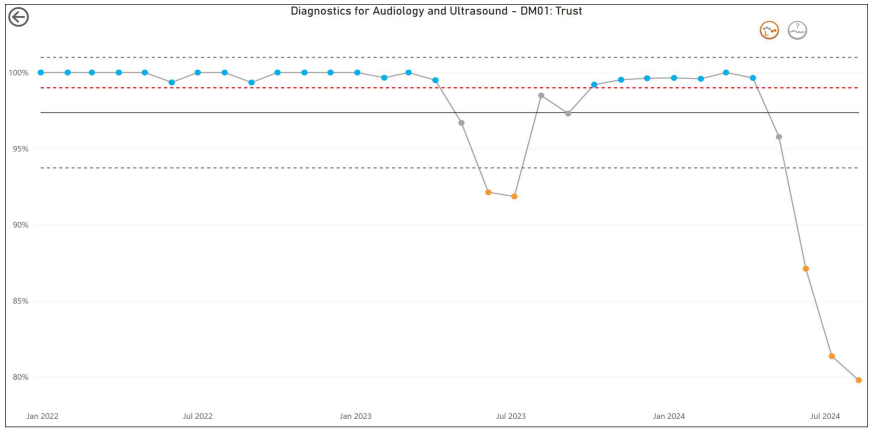
Diagnostics for Audiology and Ultrasound - DM01

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

KPI Description	Latest 6 months	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	YTD
DM01	%	100.00%	99.65%	95.78%	87.11%	81.36%	79.79%	79.79%
	Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Trajectory	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
%	93.0%	92.8%	92.6%	92.5%	93.6%	92.9%	94.0%





Reason for performance gap:	For Audiology we are now reporting any planned patients that are overdue for their appointment as active waits, as per National DM01 requirements. Figures are higher and there are more breaches due to this. Due to the changes in DM01 rules additional capacity is needed. This is alongside an increase in demand There is significant building work that is ongoing at Royal Shrewsbury Hospital which is impacting on service delivery. The patient facing part of the service is entirely provided by SaTH and therefore dificult to manage the capacity. This service is undertaking a review starting in September, where there will be a recommendation as to where to take the service in the future.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review of SLA with SaTH	Jun-24	Nov-24	Planned	Service Review Planned to support an new SLA
	Service review	Sep-24	Nov-24	Planned	Service Review Planned to support an new SLA
Author	Mark Onions	**Date**	13/09/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024		

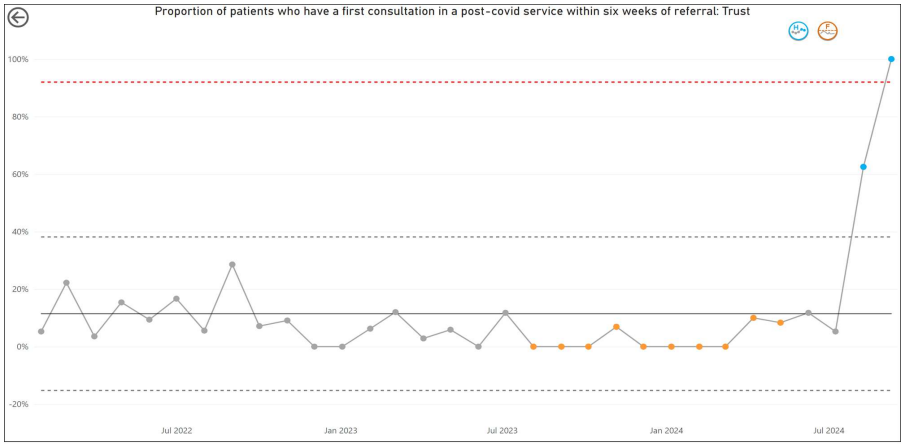
Exception Report - Action Plan

Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

The percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral

KPI Description	Latest 6 months	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Proportion of patients within 6 weeks	%	10.00%	8.33%	11.76%	5.26%	62.50%	100.00%	100.00%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	40.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%



Reason for performance gap:	Delivering against target and over delivering against planned improvement trajectory Waiting times within the Long Covid Service have been a challenge since the service commenced in November 2020. NHS England had high expectations from the beginning and this was evidenced by the main reportable national key performance indicator (KPI) focusing on waiting times. The aim was for all patients to receive an initial assessment within 6 weeks of referral.Due to high demand and back log this has been a challenged KPI in Shropshire Community Health NHS trust (SCHT) due to multifactorial reasons including finance, workforce availability and high referral rates. Improemnet has been demonstarted through July with a further significant step change in August following the team clearing historical backlog aligned to large demand when the service initially launched. Targeting the back log waiting list with additional clinics, a revised approach to triage and MDT approach has enabled the demand profile to now meet aligned capacity, it is anticipated long covid will now continue to improve its performance in line with the planned trajectory.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Model has been revised to enable quicker access to a first assessment.	Jan-24	Apr-24	Complete	Revised Model
	Booking of patients into appointments within 6 weeks.	May-24	Aug-24	Complete	Appointments booked with 6 weeks for all patients
	Work with NHSE and primary care to scope a self refferal model	Sep-24	Dec-24	On track	PDSA planning has commenced
Author	Alastair Campbell	**Date**	13/09/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024		

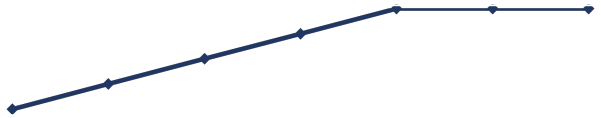
Exception Report - Action Plan

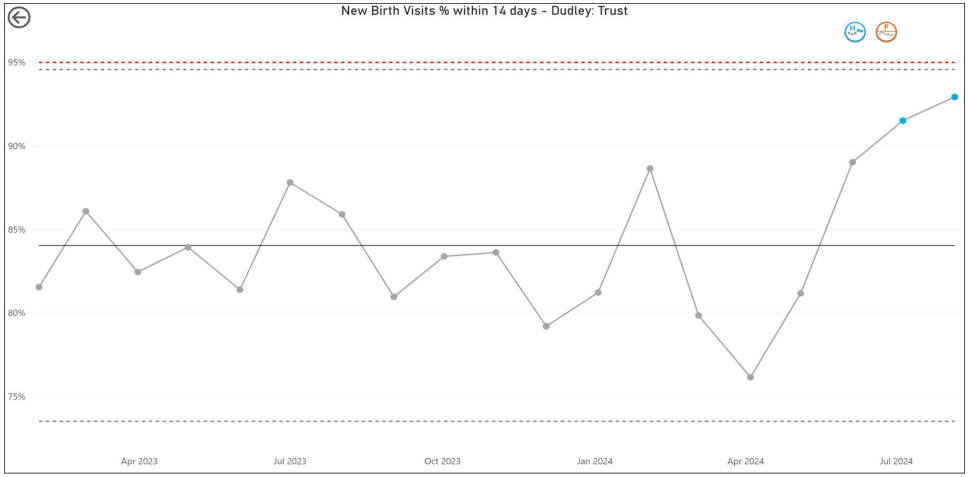
New Birth Visits % within 14 days - Dudley

Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Dudley)

KPI Description	Latest 6 months	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	YTD
New Birth Visits % within 14 days	%	79.85%	76.16%	81.18%	89.03%	91.51%	92.93%	88.72%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%





Benchmarking:- Figures are released from the Office of Health Inequalities and Disparities for benchmarking. Our commissioners submit these after the quarterly meetings for national analysis. This is why we have the local figures shown monthly and the regional and national quarterly.

Area	April	May	June	July	Q1
Telford	93.79%	91.94%	94.41%	92.30%	93.88%
Shropshire	89.80%	85.45%	90.06%	87.80%	88.40%
Dudley	81.18%	89.03%	91.51%	92.90%	87.24%
Midlands					71.60%
National					80.90%

Reason for performance gap:	The 0-19 service in Dudley transferred on 1st April 2024. Initial mobilisation plan was based around the safe landing of staff and establishing the infrastructure around the teams to be able to deliver the services effectively. Some initial challenges, including staff feeling concerned about the transfer, effected the delivery of the Healthy Child Programme within the specified timeframes. This is demonstrated in both March's and Aprils data for the new birth visit. However since SCHT have been working within Dudley we have seen continued improvement of service delivery. Commissioners are reducing the new birth visit target, to 90% from July 24, as are many areas across the country to reflect the increase in populations and public health needs across communities. Since becoming provider of the service we have demonstrated an improvement in new birth visits each month. From a bench marking perspective Dudley performance is now higher than the national and regional averages and coming into line with performance across Shropshire and Telford.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Exception reporting to be included in the monthly divisional Quality & Safety meeting for monitoring and benchmarking.	Aug-24	Oct-24	On track	Utilise forum to share best practice and improve all areas delviery of the HCP
	Team leaders to run allocation meetings to identify NBV that are at risk of breaching 14 days	Aug-24	Oct-24	On track	Focus on NBV allocation will increase NBV delivery
	Discussions with commissioners regarding funding for extra hours and weekend working	Aug-24	Oct-24	On track	Opportunity to utilise bank workforce and offer extra hours.
	Introduce weekend working for families that prefer weekend visits to facilitate choice.	Aug-24	Oct-24	On track	Increase opportunities to deliver NBV over 7 days a week opposed to current 5 working days.

	Explore mutual aid from South Shropshire teams to build resilience in the workforce		Aug-24	Oct-24	On track	Increased workforce to deliver more NBV within timescales
	Service Lead to analyse exception reports from last six months to identify any trends to ensure that NBV are booked and offered effectively.		Aug-24	Oct-24	On track	Audit of late NBV may provide ideas of changing delivery model for NBV
Author	Helen Cooper	**Date**	13/09/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	16/09/2024			

Shropshire Community Health NHS Trust

Month 5 2024/25 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	3 October 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	23 September 2024
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance at month 5 and is for assurance and to consider for action.

2. Executive Summary

2.1. Context

The Trust's 2024/25 Income and Expenditure (I&E) plan is to achieve a surplus of £1,768k; this reflects the financial plan submission to NHS England (NHSE) on 12 June 2024. The Trust's 2024/25 capital expenditure plan (excluding capitalised leases) is £2,250k.

This paper summarises the Trust's financial performance for the period ended 31 August 2024 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £535k adjusted surplus for the year to date compared to the planned surplus of £487k, which is a favourable variance of £48k.

Key areas for consideration are:

- **Agency** spend to month 5 is £2,420k. This is favourable to plan by £315k. Our expectation is for agency costs to be in line with plan for the year as some slippage in the agency reduction programme is possible later in the year. **Agency usage and overall pay costs must remain within planned levels to deliver the financial plan.**
- **CIP** performance to date is a favourable variance to plan of £12k, with actual delivery of £668k efficiencies for the year to date. Delivery of the Trust's CIP target of £3,588k remains a significant risk to our financial plan. £810k of CIP schemes are currently rated as high risk in terms of delivery which is an improvement of £918k compared to the position reported at month 4. **We must deliver the CIP target in full to deliver the financial plan.**
- **Elective Income**. The Musculoskeletal Services, Shropshire and Telford (MSST) was introduced in 2023/24 and is expected to be fully implemented in 2024/25. Whilst realignment of MSST activity and corresponding income across all three providers of the service is being finalised we have assumed an overperformance against plan of £300k at month 5 which is an estimate based on internal reporting. We anticipate NHSE will release quarter 1 values shortly and any variance to our estimate will be reflected in next month's reporting.

Month 5 2024/25 Financial Performance

- **Capital funding** has been reduced by 10% during this year, in line with new NHSE business rules, and we have been unsuccessful in gaining national digital funding. The Capital and Estates Group (CEG) has reprofiled expenditure plans to accommodate this reduction. There is also a risk of further pressures in relation to the system-wide capital allocation to cover lease obligations (IFRS 16). This position is being reviewed by NHSE however there remains a risk that an overspend in IFRS 16 capital across the system could result in further pressure to reduce other capital spend across the system. **Maintaining our capital expenditure within available resources is being managed closely.**

- **Our forecast outturn** is to deliver our planned surplus of £1,768k. However, there are a number of identified risks that could impact on delivery in particular the potential re-banding of a staff group and efficiency delivery. **These risks are being regularly assessed, together with reviews of potential mitigations.**

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 5 is a surplus of £535k compared to the planned surplus of £487k, which is a favourable variance of £48k.
- **Recognise** that agency and overall pay costs must remain within planned levels to ensure we deliver our financial plan.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3.6m although £0.8m of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that we have reprofiled our capital expenditure plans and are working with system partners to assess potential further changes to our capital allocation.
- **Consider** forecast outturn is to deliver our planned surplus of £1,768k but there are key risks which must be managed to achieve this position.

3. Main Report

3.1. Introduction

The Trust is measured on its financial performance in several ways, but the principal measure is total Income & 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.

Financial Performance against Plan £k	M05 Plan	M05 Actual	M05 Var	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast Outturn	Annual Variance
(Surplus)/ Deficit In Year	(97)	(141)	(44)	(487)	(535)	(48)	(1,768)	(1,768)	0
Agency Expenditure	390	455	65	2,735	2,420	(315)	4,898	4,898	0
Cost Improvement	242	249	7	656	668	12	3,588	3,588	0
Capital Expenditure	195	172	(23)	578	232	(346)	2,250	2,250	0

Month 5 2024/25 Financial Performance

3.2. Adjusted Financial Performance – favourable variance to plan £48k

The adjusted financial position is a surplus of £535k compared to the planned surplus of £487k, which is a favourable variance of £48k as summarised in Table 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(50,015)	(50,652)	(636)
Expenditure excl. adjusting items	49,528	50,116	588
Adjusted financial performance total	**(487)**	**(535)**	**(48)**
Adjusting items	61	61	(0)
Retained (surplus) / deficit	**(426)**	**(475)**	**(49)**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 31 August 2024

3.2.1. Income – favourable variance to plan £636k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	YTD Variance £k
System Income	(37,435)	(37,733)	(298)
Non system Income	(12,580)	(12,918)	(338)
Total Income	**(50,015)**	**(50,652)**	**(636)**

Table 2: Income Summary as at 31 August 2024

System income comprises of agreed block income and an element of variable income linked to the delivery of elective activity.

Work is ongoing on the realignment of activity and corresponding elective income across all three providers of the Musculoskeletal Service, Shropshire and Telford (MSST). To date, our internal monitoring is indicating an elective overperformance against planned levels. As a result we have estimated a favourable variance to the income plan of £300k based on current Elective Recovery Fund (ERF) reimbursement rules. We are expecting NHSE to release quarter 1 values in month 6 and any adjustment to our estimate will be reflected in next month's reporting.

Non system income overperformance is due mainly to additions to Local Authority contracts and training income that are offset with expenditure.

3.2.2. Expenditure – adverse variance to plan £588k

Table 3 shows a summary of expenditure, by key categories, for the year to date at month 5.

Month 5 2024/25 Financial Performance

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	32,257	31,805	(452)
Bank	920	1,137	218
Agency	2,735	2,420	(315)
Total Pay	**35,911**	**35,362**	**(549)**
Clinical Supplies & Services	4,433	5,256	823
Prison Escorts and Bedwatch	109	177	67
Drugs	800	763	(38)
Premises	4,187	4,197	10
Travel	606	584	(22)
Other	1,440	2,199	760
Non-Pay	**11,576**	**13,176**	**1,600**
Trust wide Central Charges	2,102	1,639	(463)
Total Non-Pay	**13,678**	**14,815**	**1,137**
Total Expenditure	**49,589**	**50,177**	**588**

Table 3: Expenditure Summary as at 31 August 2024

3.2.3. Pay – favourable variance to plan £549k

The overall pay position is a favourable variance of £549k for the year to date and is largely due to substantive vacancies which total £452k at this point in the year.

The pay underspend also reflects that the cost of medical provision at some of our community hospitals is reported within our non-pay costs, as these are provided as a service by an external provider, whereas our plan assumed that the costs would be within the pay category. This results in a favourable year to date pay variance and an adverse non-pay variance.

The substantive pay underspend is partially offset by Bank usage which is now showing an adverse position of £218k overspent; Bank staff are utilised to cover vacant shifts wherever possible to avoid the use of agency staff.

Agency costs are £315k favourable to plan, mainly due to underspends in some key services (Rehabilitation and Recovery Units (RRUs), MSK and Prison), and the continued enhanced scrutiny and controls in place.

The vacancy rate in month 5 is 11.8% which equated to 214 WTE vacancies; this is an increase from the month 4 position of 11.3% vacancy rate, 205 vacancies. The financial plan assumed a relatively high vacancy rate from the start of the financial year which reduces as recruitment into key roles continues.

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 agency usage.

NHSE financial controls require all recruitment to be subject to review and approval by system partners.

3.2.4. Non-Pay and Central Charges – adverse variance to plan £1,137k

The adverse variance on clinical supplies and services is largely driven by the following;

Month 5 2024/25 Financial Performance

- **Medical cover** – The planned cost for the in-hours provision at two of our Community Hospitals is within our pay plan but the cost is recorded within our non-pay, creating an adverse variance. The out of hours support cost for the RRUs exceeds planned levels, so an alternative approach to providing this medical cover is being explored.

- **Secondary mental health** services at Stoke Heath Prison were sourced from an alternative provider at short notice resulting in some cost pressures. Discussions are ongoing with the new provider and commissioner to identify potential mitigations with a final outcome expected by end of October.

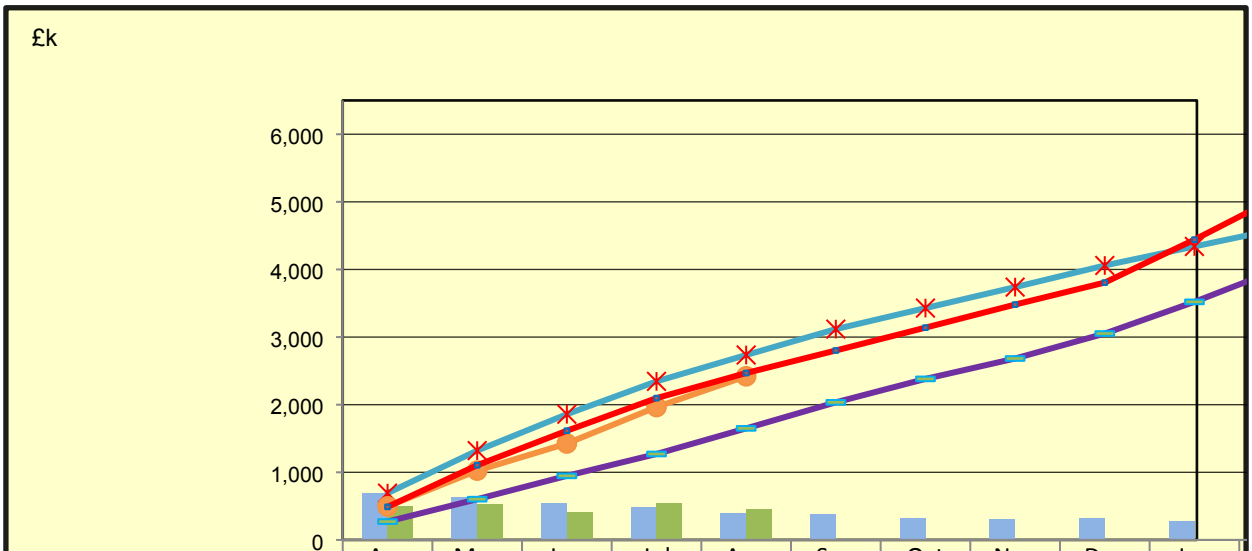
- **Costs associated with the income overperformance** including the funding received from Local Authority contracts and elective income overperformance. The income received fully offsets these increased costs.

The adverse variance within 'Other' non-pay is due to CIP budgets which have not yet been allocated to relevant budget lines and some additional recharges relating to the RRUs. The adverse variance will be reduced once adjustments for CIP are agreed with individual budget managers. The additional RRU charges are under review and are expected to be finalised in month 6 and reflected in next month's reporting.

The favourable variance for central charges relates largely to interest received on our bank balance.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £315k

Table 4 shows agency spend is £2,420k at month 5 which is £315k favourable to the plan of £2,735k. The annual agency plan for 2024/25 is £4,898k.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
In Month Plan	692	629	538	486	390	383	311	310	320	281
In Month Actual	496	529	401	539	455					
Cumulative Plan 24/25	692	1,321	1,859	2,345	2,735	3,118	3,429	3,739	4,059	4,340
Cumulative Actual 24/25	496	1,025	1,426	1,965	2,420					
Cumulative Actual 23/24	489	1,105	1,615	2,097	2,468	2,802	3,140	3,481	3,806	4,441
Cumulative Actual 22/23	271	603	948	1,271	1,650	2,035	2,382	2,683	3,052	3,521

Table 4: 2024/25 Agency and Locum Expenditure as at 31 August 2024

Month 5 2024/25 Financial Performance

The key drivers for the favourable agency underspend of £315k are: successful recruitment across some key services (RRU, MSK and Prison); increased Bank staff usage to cover vacant shifts; the use of service providers for medical cover in some Community Hospitals; and the enhanced scrutiny and controls in place.

In month 5, 47 WTE agency staff were used, an increase in use since month 4 reflecting cover for HCA and registered nursing vacancies at Bishops Castle.

Although our agency spend is favourable to plan for the year to date, we forecast agency costs will be in line with our plan at year end due to some anticipated slippage in our agency reduction programme.

STW ICB has established a System Workforce Agency Reduction Group which includes the three providers and the ICB. We also have an internal Agency Scrutiny Group which meets weekly to scrutinise all requests for agency usage; if the request is accepted by the group, it is then submitted to the Director of Nursing for final approval. The above measures are designed to safely reduce agency spend; however, the agency reduction programme is closely monitored to take account of any patient safety risk. Quality, Equality Impact Assessments are undertaken for any changes as appropriate.

3.2.6. Cost Improvement Programme

The Trust's CIP target for 2024/25 is £3,588k which is 3.5% of the Trust's overall planned expenditure for this year. The recurrent CIP element totals £3,088k and the non-recurrent element is £500k.

Table 5 shows actual CIP recurrent delivery for the year to date position at month 5 is £574k, this is £82k adverse compared to the recurrent plan of £656k at this stage of the year. However, this is mitigated by the Trust delivering £94k of non-recurrent CIP ahead of the non-recurrent CIP target. This results in an overall CIP delivery of £668k, which is £12k favourable to plan.

Category £k	Annual Plan £k	Year to Date £k		
	Recurrent	Plan YTD	Actual YTD	Variance (adv)/fav
Recurrent	3,088	656	574	(82)
Non-Recurrent	500	0	94	94
GRAND TOTAL	**3,588**	**656**	**668**	**12**

Table 5: CIP 2024/25 YTD Performance as at 31 August 2024

Our CIP Working Group meets weekly and is overseen by the Financial Recovery Group. The Groups are focussed on de-risking our CIP programme at pace and developing alternative schemes as potential mitigation. Progress is being made at each meeting with the value of high risk schemes reducing by £918k compared to month 4.

All relevant CIP schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered. In addition, we have a plan to further improve our Grip & Control, CIP planning process and governance by the end of October. This is the result of the recommendations from an external review across system.

Table 6 shows that we have fully identified schemes to deliver the 2024/25 CIP target of £3,588k. To date, £810k (23%) of schemes are rated 'high risk' in terms of delivery, a significant improvement compared to month 4 when high risk schemes made up 48% (£1,728k) of our target.

Month 5 2024/25 Financial Performance

Recurrent / Non-Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total £k
Recurrent	1,510	768	810	-	3,088
Non-Recurrent	94	406	-	-	500
	1,604	**1,174**	**810**	**-**	**3,588**
Risk Percentages					
Recurrent	42%	21%	23%	0%	86%
Non-Recurrent	3%	11%	0%	0%	14%
	45%	**33%**	**23%**	**0%**	**100%**

Table 6: CIP 2024/25 full year breakdown

CIP delivery remains a significant risk to delivery our financial plan. **We must deliver the CIP target in full to deliver the financial plan.**

3.2.7. Statement of Financial Position

The summarised Statement of Financial Position as at 31 August 2024 is shown in Table 7.

Receivables (amounts we are owed) decreased by £1,298k and Payables (amounts we owe) decreased by £1,235k. Cash increased by £386k, reflecting movements in Receivables, Payables and our surplus. All movements are within the expected monthly range and there are no exceptions to bring to the Board's attention at this time.

	31 July 24 Balance £k	31 Aug 24 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,536	42,661	125
Inventories	185	185	0
Non-current assets for sale	0	0	0
Receivables	4,899	3,601	(1,298)
Cash	23,793	24,179	386
Payables	(14,024)	(12,789)	1,235
Provisions	(3,044)	(3,044)	0
Lease Obligations on Right to Use Assets	(12,251)	(12,570)	(319)
TOTAL ASSETS EMPLOYED	**42,094**	**42,223**	**129**
Retained earnings	33,169	33,298	129
Other Reserves	8,925	8,925	0
TOTAL TAXPAYERS' EQUITY	**42,094**	**42,223**	**129**

Table 7: Statement of Financial Position (SoFP) as at 31 August 2024

3.2.8. Capital Expenditure

Our 2024/25 capital expenditure allocation has two elements:

(1) Business as Usual (BAU) capital expenditure for maintenance, building projects, equipment replacement. BAU capital has been reduced by £0.25m to £2.25m due to a 10% reduction as per NHSE business rules. In addition, ShropComm has been unsuccessful in securing central funding for digital investment. The Capital and Estates Group (CEG) has reprofiled the capital expenditure plans to ensure high priority capital investment projects can still be delivered in 2024/25.

Month 5 2024/25 Financial Performance

(2) Capital expenditure to cover additional lease obligations required by IFRS 16. The STW system capital allocation for IFRS 16 is less than the value required and we are working with NHSE Midlands to review this position. It is important to secure additional IFRS 16 allocation for 2024/25 because any shortfall is expected to be covered by reductions in BAU capital expenditure. If unresolved, this will pose a significant challenge to the Trust's IFRS 16 lease position and the system capital position as a whole.

Table 8 sets out capital expenditure for year to date compared to the plan. Whilst capital spend is below planned levels for the year to date, we expect both BAU and IFRS 16 Lease capital expenditure to achieve the planned levels within the year.

Capital Expenditure	Plan £000	YTD Plan £000	YTD Actual £000	YTD Variance £000
BAU Capex	2,250	578	232	346
IFRS 16 Leases	5,135	3,518	3,591	(73)
	7,385	**4,096**	**3,823**	**273**

Table 8: 2024/25 Capital Expenditure as at 31 August 2024

BAU capex is behind plan due to a delay in extending a lease for a building where we had planned to invest in further re-design. The lease has now been signed and this BAU capital spend has been rescheduled for later in the year. The completion of ventilation works has been moved to later in the year along with other investments in equipment.

3.2.9. NHSE Expenditure controls

Members may recall that the triple lock process implemented as an additional control measure by NHSE continues this financial year. Non pay expenditure (excluding clinical supplies, drugs, utilities, rent and rates) above £10k is subject to the triple lock process which requires prior approval of expenditure from the relevant provider, the ICB and NHSE. There could be exceptions for emergency cases where retrospective approval will be sought.

Other controls include improving the 'No PO No Pay' percentage, tracking the expenditure run rate and monitoring variance to the financial plan.

Table 9 shows the No PO No Pay percentage and monthly run rates which are relatively consistent for the year to date, which reflects the effectiveness of the above controls.

Actual income and expenditure £k	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Income	**(9,996)**	**(10,045)**	**(10,058)**	**(10,129)**	**(10,424)**
Substantive	6,407	6,230	6,414	6,347	6,406
Bank	195	238	201	274	230
Agency	496	529	401	539	455
Net impact on FOT (favourable)/adverse	**7,098**	**6,997**	**7,016**	**7,160**	**7,091**
Non-Pay	2,790	3,063	2,951	2,898	3,229
Non-Operating	(27)	(30)	(35)	(48)	(36)
Net impact on FOT (favourable)/adverse	**2,763**	**3,033**	**2,916**	**2,850**	**3,193**
(Surplus) / Deficit	**(135)**	**(15)**	**(126)**	**(119)**	**(140)**
No PO No Pay percentage	**33%**	**33%**	**46%**	**61%**	**70% (TBC)**

Table 9: 2024/25 I&E Run Rates as at 31 August 2024

Month 5 2024/25 Financial Performance

3.2.10. Forecast Outturn and Financial Risk

Our forecast outturn is to deliver our planned surplus of £1,768k subject to mitigation of a number of identified key risks.

We have reviewed current, relevant information relating to our financial performance for the remainder of the year, in particular the financial risks relating to: some potential back-dated pay costs; efficiency delivery; and the possible benefits of elective income overperformance.

The detailed forecast outturn position showing the impact of potential risks and mitigations was considered thoroughly by the Resource and Performance Committee (RPC) on 23 September 2024. At this time, based on the identified risks and mitigations, we continue to forecast delivery of our financial plan at year end. The financial risks, together with reviews of potential mitigations, are being regularly assessed with updates reported to the RPC.

3.2.11. 2025/26 Financial Planning

Our financial planning for 2025/26 will be informed by the system wide Medium-Term Financial Plan which will have a 5-year planning horizon and will be supported by the ICBs demand and capacity review alongside the ICB financial strategy. The National Planning guidance will also be reflected once it is available later in the year.

Future updates will include the 2025/26 planning timetable and draft planning assumptions as they become available.

3.2.12. 2024/25 NHSE Financial Planning Return

The month 5 Financial Planning Return (FPR) return to NHSE was submitted on Monday 16 September 2024 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 5 is a surplus of £535k compared to the planned surplus of £487k, which is a favourable variance of £48k.
- **Recognise** that agency and overall pay costs must remain within planned levels to ensure we deliver our financial plan.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3.6m although £0.8m of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that we have reprofiled our capital expenditure plans and are working with system partners to assess potential further changes to our capital allocation.
- **Consider** forecast outturn is to deliver our planned surplus of £1,768k but there are key risks which must be managed to achieve this position.

Shropshire Community Health NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**3 October 2024**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	26 September 2024
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Board	**Paper FOIA Status:**	

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 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 and presented to each Committee meeting in September for consideration and approval.

The Board is asked to note the following changes to the BAF since it's last presentation:

- Updates provided regarding progress against delivery of the objectives for Q1 2024/25
- Updates provided on actions being taken to address identified gaps in controls and assurance
- Risk 8.1 in relation to costs exceeding plan has been reduced to reflect the Trust's financial forecast and the fact that the required level of cost efficiencies have been identified, albeit some remain at risk with work to identify further efficiencies ongoing.
- A new risk has been added (Risk 8.2) in relation to the potential for there to be insufficient capital funding. The system has submitted an appeal to NHS England but there remains a risk that if the cap remains that the Trust will need to consider any safety implications and weight this against breaching the set limit.
- The inclusion of a tracker to show the movement over the lifetime of each risk

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

Shropshire Community Health NHS Trust

Board Assurance Framework

BAF Risk Tracker

Ref	Risk Title	Opened	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Movement in Month	Target
1.1	Workforce Team Capacity Carried forward from 23/24	Sept 23	16	16	16	16	16	16	↔	6
1.2	Principal Risk: Recruitment restrictions impact on staff morale Carried forward from 23/24	Sept 23	16	16	16	16	16	16	↔	6
4.1	Ability to transition to LFPSE	Sept 23	16	16	16	20	20	20	↔	4
4.2	Reliance on volunteer input for key patient experience workstreams such as observe and act	Sept 23	12	12	12	12	12	12	↔	4
5.1	Demand exceeds capacity Carried forward from 23/24	Apr 22	20	20	20	16	16	16	↔	6
5.2	Potential for patient harm due to waiting times Carried forward from 23/24	Apr 23	16	16	16	16	16	16	↔	6
5.3	Operational capacity to undertake all programmes of work Carried forward from 23/24	Sep 23	20	20	20	20	20	20	↔	10
5.4	Recruitment challenges	Apr 22	16	16	16	16	16	16	↔	6
6.1	Internal governance and operational oversight arrangements for system programmes	Sep 23	15	15	15	15	15	15	↔	5
7.1	Cyber attack	Sep 23	12	12	12	12	12	12	↔	6
7.2	Digital Capacity	Sep 23	20	20	20	20	20	20	↔	8
8.1	Costs exceed plan	Apr 22	20	20	20	20	20	12	↓	6
8.2	Insufficient capital funding	Sep 24	-	-	-	-	-	9	NEW	6

Risk Increasing	
Risk Decreasing	
New Risk	
Closed Risk	

Looking after our People — OBJ 1

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive

This objective will focus on the development of the NHS long term plan – retain and transform

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 24

Reviewed Date: September 24

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage
- ✓ Improvement in staff survey results

Progress Update:

- Staff survey launching 30th September and comms plan in place to promote staff completion.
- Sickness absence improving, new policy on sickness management being launched
- Leadership Programme launched to support managers
- Agency usage is reducing and no off framework use from November 2023 -date
- Improving price cap compliance position
- STW Temporary Staffing Task and Finish Group has been established

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- N/A

Risks:

1.1 Workforce team capacity
1.2 Recruitment restrictions impacting on staff morale

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **BAF 1.1**

Principal Risk: Workforce Team Capacity Carried forward from 23/24

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of team capacity and prioritisation
- ✓ Revised workforce team structure
- ✓ Streamlined workforce processes
- ✓ Recruitment of a designated HRD

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 in the process of being put in place – will need to embed

Gaps in Assurance:

- People Performance Report should be presented to Board on a regular basis

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
A1	People Performance Report to be presented to the Board each month	Director HR and OD	October 2024	Going to People Committee on 26th September and then to Board in October
C1	New structure to be communicated to the organisation	Director HR and OD and Director of Governance	September 2024	Structure information has been provided and is being collated into Trustwide organisation structure

We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **BAF 1.2**

Principal Risk: Recruitment restrictions impact on staff morale Carried forward from 23/24

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ QEIA process to ensure robust consideration of impact
- ✓ Scrutiny of vacancy panel decisions at Finance Recovery Group
- ✓ Case of Need proforma to assess options
- ✓ VRF panel chaired by Director of Ops and DoN
- ✓ VRF panel agreements – agreed and prioritised weekly by executive team
- ✓ System panel for vacancy approvals
- ✓ Collaborative working promoted

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:

- ~~C1: Triple lock process not defined to allow for recruitment to progress~~
- ~~C2: No system process for agreeing recruitment~~
- C3: Age profile of the organisation means high level of retirees

Gaps in Assurance:

- Staff Survey Results a year out of date

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Triple lock process to be agreed	Director of Finance	January 2024	Process has been agreed for local approval of recruitment with ICB / NHS E challenge as appropriate - completed
C2	System vacancy panel to be agreed	Director of Nursing, Workforce and Clinical Delivery	April 2024	Completed
C3	Promotion of flexible work and retire and return	Director of HR	Ongoing	Comms has been issued about flexible working and retire and return

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 implementation of the NHS People Promise Exemplar Programme and the Trust's Culture and Engagement Programme

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

People Promise Exemplar Programme underway with a number of initiatives underway with regular reporting to People Committee.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Looking after our People — OBJ 3

Principle Objective: We will build a valued and engaged workforce, where health and wellbeing is supported

This objective will focus on the implementation of the admin academy.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

Regular reports to Finance Recovery Group on agency usage with good progress noted with reduction. Further controls being looked at for bank usage too. Campaign for staff survey due to start shortly, with briefing to the Board and plans to brief managers. Hotspots being reviewed with update to People Committee.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above

Lead Director:

Director of HR and OD

Lead Committee:

People Committee, Resource and Performance Committee

Caring for Our Communities — OBJ 4

Principle Objective: We will support our staff to embed quality improvement methodology to improve staff and patient experiences

This objective can be broken down into the following key components; establishing a continuous quality improvement framework based on NHS impact, learning and improving patient safety and engagement, developing and implementing a clinical quality strategy, maximising return on investment of electronic prescribing management

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Key Measures:

- ✓ A baseline and improvement for avoidable errors
- ✓ Increased staff training and awareness of quality improvement
- ✓ Improved patient engagement
- ✓ Improved medicines management
- ✓ Financial improvement
- ✓ Evidence of learning from patient safety events

Progress Update:

- Quality improvement framework in place and staff training commenced, celebration events have started
- Staff training in PSIRF compliant safety investigations completed
- Thematic review on medicines safety completed and taken to quality and safety committee
- New Patient Experience Lead commencing 1 October and to review patient engagement mechanisms
- Clinical Quality Strategy going to October Board for sign off

The deliverables and measurables were agreed at the Quality and Safety Committee on 25 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF4.1	Ability to transition to LFPSE
BAF 4.2	Reliance on volunteer input for key patient experience workstreams such as observe and act

In addition risks in relation to the following are being worked up – quality improvement team capacity, operational pressures impacting on staff engagement with QI training, ability to measure clinical quality strategy implementation

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.1**

Principal Risk: Ability to transition to LFPSE Carried forward from 23/24

Non-compliance with patient safety standards, requirement to dual run with STEIS and ongoing resource implications, limitations to reporting

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	5	1
Total	16	20↑	4

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ PSIRF Working group overseeing transition
- ✓ LFPSE testing completed with ongoing support from Datix
- ✓ System Working group
- ✓ System partner support (those also using Datix)
- ✓ National toolkit being followed
- ✓ Extension of NRLS and STEIS due to national issues with LFPSE

Assurance: **Source of Assurance** **2**

- ✓ Patient Safety Committee and Quality and Safety Committee Oversight
- ✓ NHS E and system oversight of implementation

Gaps In Controls:

- Datix reconfiguration to be completed and resource constraints
- Datix software compatibility
- Lack of Datix expertise within the organisation (no trained lead)
- Datix does not capture the right quality of data

Gaps in Assurance:

- Timeline for datix reconfiguration dependent on onboarding of datix expertise

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1, A1	Reconfiguration timetable to be compiled and implemented	Director of Governance	~~November 2023~~ ~~March 2024~~ October 2024	New Datix system has been purchased and will be implemented when Datix lead in post. In the interim CSU are providing support with LFPSE compliance and are scoping the work required
C2	Ongoing support from Datix	Director of Governance	~~November~~ 2023 March 2024 October 204	Ticket logged with Datix to update the current version to enable transition to LFPSE
C3	Appointment of Datix lead	Director of Governance	October 2024	Appointment made and indicative start date of 1 October
C4	Reconfiguration of Datix to capture required data	Director of Governance	December 2024	This is dependent on the onboarding of the Datix Lead, with minor improvements possible through the interim bank / CSU arrangements. In the meantime to mitigate any risk, manual review of the data is being undertaken to enable reporting

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.2**

Principal Risk: Reliance on volunteer input for key patient experience workstreams such as observe and act Carried forward from 23/24

Loss of volunteers would impact on ability to delivery key workstreams

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Restructure of Governance Team to improve resilience including for patient experience work
- ✓ Administrative support for volunteers identified in new structure
- ✓ Board recognition for volunteers work to improve morale and retention
- ✓ Identified Patient Experience Lead overseeing volunteers with good and longstanding relationships
- ✓ Director of Governance attendance at volunteer meetings on request

Assurance: **Source of Assurance** **1**

- ✓ Patient Experience Committee

Gaps In Controls:

- C1: Lack of recruitment and retention plan for volunteers
- ~~C2: Lack of admin support until new Governance Structure in place~~

Gaps in Assurance:

- A1: No tracking of recruitment and retention of volunteers

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Recruitment and retention plan to be devised	Director of Governance	~~December 2023~~ ~~April 2024~~ October 2024	Current patient experience lead is retiring, recruitment of new lead underway and plan to commence from their start date.
C2	Administrative support to be put in place	Director of Governance	December 2023	Support now in place as a temporary fix with plans to recruit permanently -completed
A1	Recruitment and retention tracking to be put in place once plan devised	Director of Governance	~~January 2024~~ October 2024	Not yet commenced – recruitment and retention plan to be devised in the first instance

Caring for Our Communities — OBJ 5

Principle Objective: We will recover our services inclusively

This objective can be broken down into three key components; better understanding the needs of our population, recovering services in line with the national mandate, continuing to develop our children and young people services

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

- ✓ Improvements across CORE20PLUS metrics
- ✓ Improvement in DNA, PIFU and virtual consultations
- ✓ Increased patient access to our successful services

Progress Update:

- PIFU is being utilised effectively, with levels above the target of 5.5%, currently at 13.1%
- The Trust now has a Health Inequalities Ambassador and is encouraging more staff to express an interest to become an ambassador Health Inequalities presentation to the Board with a focus on Core20Plus.

Supporting Programmes of Work:

- OP Transformation programme
- MSK Programme

Key Assumptions

-

Risks:.3

5.1 Demand exceeds capacity
5.2 Potential for patient harm due to waiting times
5.3 Operational capacity to delivery the programmes of work
5.4 Recruitment challenges

Lack of MSST demand and capacity profiling is being worked up as a risk, also a risk in relation to data quality to support health inequalities

In addition see Risk 7.2 in relation to RTT

Lead Director:

Director for Operations / Director of Nursing

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will recover our services inclusively **BAF 5.1**

Principal Risk: Demand exceeds capacity Carried forward from 23/24

Inability to restore activity levels resulting in increasing waiting times and poor patient experience. Non-compliance with national oversight framework, regulatory and system scrutiny and loss of reputation, potential for loss of income if activity levels not achieved.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	3	3
Likelihood	4	4	2
Total	20	12	6

Risk Details:

Opened: April 2022

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of performance against plan for early identification of actions
- ✓ Realtime review and monitoring of waiting lists
- ✓ Internal Planning Group in place for monitoring
- ✓ Performance Board in place for oversight of delivery

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

- ✓ Resource and Performance Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee

Gaps In Controls:

- C1: Gaps in service level data

Gaps in Assurance:

- A1: Waiting for national oversight framework to enable assessment against requirements

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Service level data programme of work for improvement	Director of Operations / Director of Finance	Ongoing for 24/25	Continued progress with improvements to the service level data, focussing on the operational drill downs first with information presented to the Performance Board.
A1	Operational teams to work with corporate services to improve the data drill down	Director of Operations / Director of Finance	Ongoing for 24/25	This is an ongoing piece of improvement work with the teams working through the data requirements in order of priority. Each month there is demonstrable improvement in the drill down data available.

We will recover our services inclusively **BAF 5.2**

Principal Risk: Potential for patient harm due to waiting times **Carried forward from 23/24**

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: April 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Programme of work to eliminate waits of in line with nationally mandated requirements
- ✓ Patient Safety Incident Panel reviewing any harms assessments with moderate harm or above
- ~~✓ Harms assessment process~~
- ~~✓ Harms Assessment Group established to deliver process~~

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

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

Gaps In Controls:

- C1: Harms assessment process has only embedded in some areas

Gaps in Assurance:

- A1: Lack of formal tracking or reporting of harms process

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Harms review policy to be reviewed	Director of Nursing	September 2024	Review of policy underway
A2	Training on harms review process to be rolled out following revised policy being put in place	Director of Operations / Director of Governance	October 2024	

We will recover our services inclusively **BAF 5.3**

Principal Risk: Operational capacity to undertake all programmes of work Carried forward from 23/24

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	4	2
Total	20	20 ↑	10

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Revised operational structure
- ✓ Transformation Board and Programme Board in place for senior operational oversight

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

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Review of governance and operational frameworks to ensure system programmes are captured	Director of Operations / Director of Governance	December 2023	Transformation oversight group established which reports to Performance Board. Completed
C1/A1	Governance leads in system to meet to worth through the system governance arrangements to ensure they link and align with provider governance frameworks	Director of Governance	October 2024	Meetings have taken place with way forward agreed in principle, ToRs for the relevant meetings have been drafted and reviewed, next meeting taking place last week of September.

We will recover our services inclusively **BAF 5.4**

Principal Risk: Recruitment challenges

Inability to meet safe staffing requirements, reliance on agency staff, impact on service delivery, reduction in standards of care and patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: April 2022

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment programme
- ✓ International recruitment as a system
- ✓ Availability of system mutual aid
- ✓ Planned early start to recruitment with potential 'recruit as risk' for key posts approach to minimise service delays and financial consequences

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

- ✓ People Committee oversight
- ✓ Safe Staffing reporting to Board biannually
- ✓ Quality metrics
- ✓ System People Board oversight

Gaps In Controls:

~~C1: Line of sight on vacancies and agency usage~~

C2: Sustainable solution for medical cover across all sites

Gaps in Assurance:

- ~~A2: System People Board has not met with any frequency~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing Director of HR	March 2024	Collaboration with the system on e-rostering in its infancy with project plan developed ongoing
~~A2~~	~~Engagement with System People Board~~	~~Director of Nursing / Director of Governance~~	~~September 2023~~	~~New People Committee established for ICB, Shrop Comm NED representative agreed. - completed~~
C2	Options appraisal to be completed and progressed	Director of Operations / Medical Director	September 2024	Options appraisal completed and presented to the Executive Team and is now progressing for the community hospitals. RRU cover to be discussed. Two out of four community hospitals have sustainable covr in place and RRU contract awarded. Scoping for the two remaining sites.

Caring for Our Communities — OBJ 6

Principle Objective: We will work with others to redesign patient pathways

This objective will focus on optimising our community, urgent and care through early support discharge and alternatives to hospital admission

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

✓ Improved pathways through collaboration with system partners

Progress Update:

- System transformation group in place
- Progress being made with a new collaborative structure in the system to support the operational collaboration required.

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services

Key Assumptions

- N/A

Risks:

6.1 Internal governance and operational oversight arrangements for system programmes

Risk of transfer of orthopaedics being transferred to SaTH is being worked up

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will work with others to redesign patient pathways

Principal Risk: Internal governance and operational oversight arrangements for system programmes Carried forward from 23/24

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

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Establishment of CiC to improve collaborative working
- ✓ Weekly vacancy panel being established at system level

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

- ✓ Quality and Safety Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Review of governance and operational frameworks to ensure system programmes are captured	Director of Operations / Director of Governance	December 2023	Transformation oversight group established which reports to Performance Board. Completed
C1/A1	Governance leads in system to meet to worth through the system governance arrangements to ensure they link and align with provider governance frameworks	Director of Governance	October 2024	Meetings have taken place with way forward agreed in principle, ToRs for the relevant meetings have been drafted and reviewed, next meeting taking place last week of September.

Managing Our Resources

Principle Objective: We will use all available digital technologies to modernise our services and our environment

This objective will focus on automating manual administrative processes to increase productivity

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

✓ Demonstrable productivity improvement

Progress Update:

Productivity Improvement Group established and reporting into the Finance Recovery Group. Opportunities have been identified and will inform the 25-26 efficiency programme. Progress constrained by capacity in the digital team

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

7.1 Risk of cyber attack
7.2 Digital team capacity

Lead Executive

Director of Finance

Lead Committee:

Resource and Performance Committee

We will use all available digital technologies to modernise our services and our environment

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	3	2
Total	20	12	6

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ DSPT Toolkit compliance oversight
- ✓ External expertise input into cyber risk management
- ✓ SIRO and Deputy SIRO oversight
- ✓ Cyber security programme
- ✓ Information asset owners and register
- ✓ Business continuity plans in place

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

- ✓ Audit Committee Oversight
- ✓ Data Security Group

Gaps In Controls:

- ~~C1: Information asset owner processes still embedding~~
- C2: Information asset owner compliance
- C3: DSPT compliance only at working to standards

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Information Asset Owner Network meetings to be established	Director of Governance	December 2023	Schedule in place with holds in the diary - completed
C2	Additional training and support to be put in place for information asset owners	Director of Governance	September 2024	IG Manager appointed and additional support procured via CSU to address gaps in IG team and provide support with information asset owner records and training. Forms part of DSPT Toolkit Improvement Plan. -completed
C3	Full DSPT compliance to be achieved	Director of Governance	December 2024	Improvement plan in place which is being reviewed by NHS Digital with a view to approval, this will be monitored via Audit Committee.

Maximise the potential of digital technologies ensuring a core level of digitisation in every service across systems to transform the delivery of care and patient outcomes **BAF 7.2**

Principal Risk: Digital Team capacity

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital strategy and programme of work in place
- ✓ Regular team meetings with oversight from Director of Finance

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

- ✓ Digital Assurance Group

Gaps In Controls:

- C1: Recruitment controls preventing appointments to vacancies
- C2: Line of sight on programmes of work requiring digital input impacting on prioritisation and workload

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Digital B7 Case of Need to be presented to Execs	Director of Finance	November 2023	Approved at Execs and remains subject to system governance controls.
C2	Transformation Oversight Group to include digital input	Director of Operations	September 2024	Approved ToR in place and meetings established and reporting to Performance Board - Completed

Managing Our Resources — OBJ 8

Principle Objective: Maximise our productivity and efficiency

This objective can be broken down into three key components; delivering in year CIP and a 3-year rolling CIP plan, maximising the sustainability of our estate, implementing 24/7 single point of access (SPOA) through digital technology and process improvement

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: September 2024

Key Measures:

- ✓ Deliver £3.5m efficiencies for 2024/25, add 3 year CIP plan to the medium term financial plan
- ✓ Reduce carbon footprint and improve estate occupancy
- ✓ Improve patient access to shropcom services

Progress Update:

Fully identified programme, level of risk materially reducing with £800k still high risk

Supporting Programmes of Work:

- CIP Programme
- Net Zero Group
- Capital Programme

Key Assumptions:

- Operational delivery of CIP identified
- Elective activity delivery

Risks:

BAF8.1	Costs exceed plan
BAF 8.2	Capital funding insufficient

Lead Director:

Director of Finance

Lead Committee:

Resource and Performance Committee

Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners **BAF 8.1**

Principal Risk: Costs exceed plan

Escalation within system oversight framework and increased regulatory scrutiny, inability to invest, loss of opportunity to transform services

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	3	2
Total	20	12↓	6

Risk Details:

Opened: April 2022

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Use of non-recurrent schemes to allow more time to implement recurrent cost saving schemes
- ✓ CIP Delivery Group working on identifying CIP schemes
- ✓ Robust QEIA process in place
- ✓ Financial Recovery Group in place for operational oversight

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

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee oversight
- ✓ KPI Metrics
- ✓ Value for Money audit

Gaps In Controls:

- ~~C1: Shortfall in CIP schemes currently identified~~

Gaps in Assurance:

- A1: Performance and Programme Board to be embedded

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Ongoing work through CIP Delivery Group feeding into Financial Recovery Group	Director of Finance	March 2024	Weekly meeting continue to take place with Executive oversight
A1	Performance and Programme Board to continue to be embedded	Director of Finance / Director of Operations	September 2024	Four meetings have now taken place and continue to embed the performance framework

Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners **BAF 8.2**

Principal Risk: Insufficient Capital Funding **NEW**

Potential for there to be insufficient funding for all required projects, where there are safety concerns there is potential for the Trust to breach statutory duty by exceeding capital resource limit

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	3
Likelihood	3	3	2
Total	12	9	6

Risk Details:

Opened: April 2022

Reviewed Date: September 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Capital and Estates Group in place and have reprofiled the plan with input from clinical and operational colleagues to reduce in year capital spend where possible
- ✓ System appeal to NHS England regarding the gap

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

- RPC Oversight
- Included in finance report to Board for oversight

Gaps In Controls:

- C1: Outcome of appeal to NHS awaited

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Await outcome of appeal to NHSE	Director of Finance	Dec 2024	Ongoing reporting of the issue until the outcome of the appeal is known