Shropshire Community Health NHS Trust

Trust Board - 5 December 2024

MEETING

5 December 2024 10:00 GMT

PUBLISHED

29 November 2024

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MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE RAMADA HOTEL, TELFORD AT 10.00 AM ON THURSDAY 3 OCTOBER 2024

PRESENT

Chair and Non-Executive Members (Voting)

Mr. Andrew Morgan	(Chair)
Ms. Tina Long	(Non-Executive Director and Vice Chair)
Mr. Peter Featherstone	(Non-Executive Director)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Alison Sargent	(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)
Ms. Claire Horsfield	(Director of Operations and Chief AHP)

Executive Members (Non-Voting)

Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)

In attendance

Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)
Ms. Sam Townsend	Divisional Clinical Manager, Adult Community Services (Observing)
Mr. Simon Balderstone	Assistant Director of Workforce (SaTH) Integrated People Performance Paper Only
Ms. Mary Aubrey	Observing

Welcome

Mr Morgan welcomed attendees to the meeting, he stated this was his first meeting as Chair in Common of Shropshire Community Health Trust and Shrewsbury And Telford Hospitals Trust. By way of background, Mr Morgan stated that he had retired in June as Group Chief Executive of Lincolnshire Community and Hospitals NHS Group. Mr Morgan stated that he had already met people who had shown a real determination to develop our services. He paid tribute to Ms Long who had been acting Chair for the last 18 months.

Apologies and Quorum

Apologies were received from Ms Cathy Purt and Ms Jill Barker, Non-Executive Directors.

Declarations of Interest

Mr Morgan stated that he was the Chair of Shrewsbury and Telford Hospitals Trust and was a Board Member of the ICB in his position as Chair in Common.

Minutes of the Meeting held on 1 August 2024

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

Action Log

Dr Ganesh confirmed the Research Team would provide a presentation at the December Board Meeting.

Public Questions

None received.

Notification of Any Other Items of Business

There was none.

Chair's Award

Ms Long presented the following Chair's Awards:

Brian McMillan
Who had been nominated by the Quality Improvement Team for:
We'd like to nominate Brian McMillan for a chairs award for his consistent dedication and hard work towards his role within the Trust which does not go unnoticed.
He is extremely supportive to all services and has had a noticeable impact. Brian is a highly respected and valued member of staff who is exceptional at his role and regularly goes above and beyond (including out of hours cover / availability to support the trust).
His resilience exercises have received nothing but positive feedback and have been a great learning opportunity for all that have been able to access them.
Business continuity is now being established throughout the Trust, thanks to his guidance, knowledge and expertise.

Gareth Biggs
Who had been nominated by Gemma McIver for:
Gareth is truly one of our future shining stars and incredibly passionate about community nursing and delivering incredible patient care. I am so proud to have watched Gareth and the entire team flourish over the last 12 months.

Chair's Communication

Ms Long summarised her report, highlighting the clinical visits she had attended. Ms Long praised the staff she had met during her visits. Ms Long had visited Ludlow Community Hospital and had seen the team working together as one, a real multi-disciplinary team.

Ms Long welcomed the publication of the Darzi review and said that the Trust would use this as a platform to build on.

The Board notes the report.

Non-Executive Director's Communication

Mr Featherstone stated that he continued to provide NED input into the ICB Finance Committee. He had attended two events, including the Midlands NHS Leadership Meeting.

The Board notes the update provided.

Chief Executive's Update

Ms Davies summarised her report and noted the Leadership changes that had taken place across the System, including Mr Morgan's appointment and the new Interim Chief Executive at SaTH, Jo Williams. Ms William had a wealth of experience and Ms Davies looked forward to working with her. Ms Davies thanked Ms Long and Louise Barnett, previous Chief Executive at SaTH, for the hard work and dedication.

Ms Davies echoed her sentiments of the previous meeting in relation to the tragic events that had taken place in Southport. Both the event and the riots after were distressing and difficult to comprehend. The Trust would not tolerate racism or hate of any description.

The NHS Staff Survey had recently been launched and she encouraged all members of staff to complete the survey. Ms Lloyd had recently been appointed as Deputy Chief Executive, in addition to her role as Director of Finance.

Ms Long asked about the provider collaborative and if the Committee In Common needed to be set down, Ms Davies noted that the Committee only met in shadow form. The governance would be contained within the existing committees and each workstream would be a collaborative in its' own right.

The Board notes the report.

QUALITY, SAFETY AND PEOPLE

Quality & Safety Committee Chair's Report

Ms Hobbs summarised the report on behalf of Ms Barker. The Committee approved the Clinical Quality Strategy to be presented to Board for final approval. The Committee had received its first thematic review, looking at medicines.

Mr Darbhanga queried the electronic prescribing system, Ms Hobbs noted this was a long project and further work was needed. The Board recalled previous presentations in relation to electronic prescribing and noted the significant revenue costs involved. Ms Lloyd stated that the digital team had developed a system, linked to Rio.

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

Integrated Quality and Safety Performance Report

Ms Hobbs highlighted the two special causes for variation contained within the report; there had been one C-Diff casein June, so the rolling 12-month figure was now 3, it was noted that there had been a national increase in cases and the regional team were leading work to understand the

causes of this. The other variation was in relation to patient safety incidents; the Trust had moved to LFPSE and there had been a national pause on reporting so the Trust could not measure against it.

Ms Davies asked about the pause in reporting of data in relation to patient safety incidents, Ms Hobbs confirmed this was still taking place and that manual work-arounds had been developed. Ms Long asked about the harm proformas and if there was clinical oversight of these, Ms Hobbs confirmed this was the cause, all moderate harms came to the incident panel. Ms Ramtuhul noted that there had been no serious incidents. Ms Hobbs said that further work was taking place to ensure psychological harm was appropriately captured.

Mr Featherstone asked about safer staffing, Ms Hobbs said that she personally approved each case of above fill rate. Ms Hobbs said she would like to increase the number of bank shifts over agency, as they would be our own staff so aware of Trust policies as well as having financial implications.

In relation to Bridgnorth and falls, there were no particular hotspots, the Trust was a rehabilitation and recovery specialist and part of this was supporting and encouraging mobilisation, so an increase in falls was not unexpected.

The Board accepted the assurance provided by the update.

Revalidation Policy

Dr Ganesh stated that there were national NHSE requirements in relation to revalidation. The Trust had a small number of doctors; all had appraisals which had been independently audited to be of good quality.

The Board approved the submission.

Clinical Quality Strategy

Ms Hobbs presented the Strategy for approval. The Strategy had been produced in collaboration with the teams, following surveys and drop in sessions. The Strategy contained clear measurables.

Ms Long welcomed the report and asked if the admin staff had been included in the collaboration, as they were a key part of the teams, Ms Hobbs stated that the drop-in sessions were open to the admin team.

The Board approved the Strategy.

PEOPLE

People Committee Chair's Report

Ms Sargent summarised her report. She noted that there were a number of KPIs that needed attention, some of which were annual metrics, but it was vital that action plans were in place around this.

The Committee had discussed some staff not having access to laptops to complete the staff survey so there had been a number of initiatives put in place to support them to complete the survey.

A discussion took place around Schwartz Rounds and the value of them, the Board Members who had attended a Round found them very positive. The Board encouraged story tellers to come forward to share their stories and that support was provided. Mr Darbhanga suggested that international colleagues would provide a different perspective.

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

Equality, Diversity & Inclusion Update Report

Ms Boyode summarised her report. It was vital that people had a voice and a sense of belonging. The actions within the report would be monitored by the People Committee.

Ms Davies noted that, although it was pleasing to see improvements in the number of incidents of harassment, these numbers were still to high and reiterated that there was no place for hate within the organisation.

A discussion took place regarding disability discrimination and that some staff did not feel comfortable in disclosing their disability.

Ms Lloyd asked if the right actions were in place to progress the improvements as quickly as possible, Ms Boyode advised she was confident the right actions were in place. The work needed to be led and owned by staff and the Trust needed to ensure that it listened to voices.

The Board
- ***Authorises the publication of WRES metrics and improvement plan (Appendix A of the report) on the SCHT website to ensure compliance with legislative requirements.***
- ***Authorises the publication of WDES metrics and improvement plan (Appendix B of the report) on the SCHT website to ensure compliance with legislative requirements.***
- ***Notes the assurance provided on the delivery of high impact actions for 2024-2025.***

Integrated People Performance Report

Mr Balderstone presented the report, highlighting areas of focus for the Board. He highlighted that that there had been improvement in leaders rates and sickness absence in the past few months and this needed to be monitored closely.

There was still some way to go in relation to agency reduction; the price cap compliance would support with this. The price cap was progressing well at SaTH and the learning from this would be shared with ShropCom.

In response to a question, Mr Balderstone confirmed that the team were working closely with regional colleagues, sharing good practice. Mr Morgan said that benchmarking was important and recommended that non-NHS organisations be looked at too, to see if they had any applicable learning.

Ms Hobbs asked if there were plans for a System wide bank, Ms Boyode confirmed there were plans for this, with certain areas being used as a trial.

The Board notes the performance across relevant indicators to date.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Mr Featherstone stated that the committee had continued its close focus on RTT and non-RTT waiting times. There had been assurance gained in relation to 104 and 74 week waits, but only partial assurance for 52 week waits, however, the Trust remained ahead of the national target.

In relation to CIP action plans and delivery, these had been fully identified and were slightly ahead of plan.

Mr Morgan welcomed the report. He noted that 52 weeks was still a year of waiting and the unacceptable had become normalised across the NHS.

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

Performance Report

Ms Lloyd summarised the Trust's overall performance. For RPC, there were 23 KPIs, of which 12 required attention. 11 of these related to access to services and waiting times and the interdependencies relating to these were discussed.

In relation to harm reviews, RTT and non-RTT waits were treated the same and there were no reportable breaches above 64 weeks.

Ms Horsfield advised that the internal target for 52 week waits had been ambitious and, although the Trust would not meet its own target, there was a clear month on month improvement. There was a high level of risk related to system dependencies and patient choice.

A discussion took place regarding TeMS and the larger discussion around elective orthopaedics was noted.

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

Finance Report

Ms Lloyd stated that the Trust continued to deliver to its financial plan, which was very challenging. The Trust was forecast to deliver its annual financial plan and was forecasting delivering a surplus of £1.8m, subject to careful management and the mitigation of a number of key risks.

A high percentage of CIP scheme were still rated as high risk of delivery. The Financial Recovery Group continued fortnightly to review.

There was one financial risk that was not able to be quantified, which was a potential staff banding issue which may materially impact the financial plan. RPC had reviewed a range of scenarios and the impact this may have.

Mr Morgan congratulated staff on the report for their hard work. Ms Davies said that it was not easy and that staff know that quality care was the priority.

The Board

- ***Considered 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.***
- ***Recognised that agency and overall pay costs must remain within planned levels to ensure we deliver our financial plan.***
- ***Acknowledged that schemes are now full 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.***
- ***Recognised we have reprofiled our capital expenditure plans and are working with System partners to assess potential further changes to our capital allocation.***
- ***Acknowledged the forecast outturn was to deliver our planned surplus of £1,768k but there are key risks which must be managed to achieve this position.***

AUDIT

Board Assurance Framework

Ms Ramtuhul advised the report had been presented to committees and updated accordingly. Risks that had not changed would be monitored closely.

The Board approves the Board Assurance Framework.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 5 December 2024

Trust Board

Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
03-Oct-2024	**2024/10/13 - QSC Chair's Report**	Update on the electronic prescribing system to be bought to Board	CHor			ONGOING
03-Oct-2024	**2024/10/16 - People Committee Chair's Report**	Update on Schwartz Rounds to be bought to Board, including wider System collaboration and engagement	MG		*Completed - Development session completed*	COMPLETED

CHIEF EXECUTIVE'S REPORT – Dec 2024

Introduction

This report sets out issues of importance to the organisation (for information) not picked up in other Board reports. These are presented under the headings of our three strategic objectives:

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

In addition the paper sets out any national and local issues of note.

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

National and Local Issues

1. Local issues - Changes in leadership across the system

Following the retirement of Sir Neil McKay at the end of October, I would like to welcome Mr Roger Dunshea as the interim Chair of the Integrated Care Board (ICB). Roger is a Non-Executive Director and the Audit Chair of the ICB. Roger commenced in post on 1st November and will be supporting the ICB in this role whilst NHSE completes the recruitment process for a substantive Chair. As stated in my last report, I want to acknowledge again Sir Neil's formidable contribution to this STW system and the wider NHS over the course of his career and I wish him well in his retirement.

I would also like to welcome to the STW system, Mr Ned Hobbs, who has taken up the position as Chief Operating Officer (COO) at the Shrewsbury and Telford NHS Trust (SaTH). Ned commenced in post at the end of October and is already working closely with our teams for the benefit of patients and residents. Ned brings with him a wealth of operational experience and I look forward to working with Ned and the wider SaTH team in this new chapter and ShropCom will continue to strengthen our commitment as a supporting partner.

Colleagues will be aware that Hayley Flavell, Director of Nursing at SaTH, left the Trust at the end of November to take up a post with the Florence Nightingale Foundation. Paula Gardner has taken on the role as Interim Director of Nursing with the Trust having retired from being the Director of Nursing at Oxfordshire University Hospitals Trust. I would like to formally welcome Paula and wish Hayley all the very best for the future.

2. National issues

2.1 National Change Campaign - In my last report the Darzi diagnostic review of the NHS been published, and the Secretary of State for Health and Social Care was about to commence the engagement process to support the development of the 10-year plan for health. This engagement with the public and staff commenced in October and is due to close on 2nd December. Locally, ShropCom has been working alongside system partners to raise awareness of the National Change Campaign and ensure that we all have an opportunity, as NHS staff, patients, and residents, to play a part in building a health service fit for the future. This included a focus group with JNP and senior clinical and operational leaders to formulate the Trust organisational response. It is anticipated that the 10-year plan will be published in Spring 2025.

2.2 System Integrated Plan – As part of the new National Operating Framework, all Trusts are assessed not only in terms of their statutory responsibilities and performance as an NHS Trust, but we are also assessed in terms of our ability to operate as a system. The benefit of this is to focus the mind not only on transactional delivery, which requires us to work together more effectively in terms of use of resources, but also focuses the system on population health and where resources need to be targeted in the longer term to best meet the needs of the population. As a leader, resident, and patient, I welcome an approach that 'joins the dots' and shines a light on more longer-term approaches to delivering care in an integrated way. This is the first system plan and I think as we move through the development and delivery of this plan, yet to be signed off by Boards, we will become more effective as a system in supporting the 'left shift' central to the SoS mission and NHSE policy direction.

2.3 National Meeting with Local Leaders - Chief Executives across the system and Andrew Morgan attended an assurance meeting in London on 20th November with the national team relating to the system position. This was a positive meeting with progress noted in terms of operational performance, system improvement and delivery against plan. There is still much to do to manage winter as well to collectively work through planning for 2025/26 and beyond. This is the immediate focus for the Trust and system partners.

Taking Care of Our People

3. Staff Recognition

The Trust has launched an award scheme to celebrate the hard work and dedication of our staff and innovation across the Trust. We launched the ACE awards at our AGM in October in line with our ACE cultural characteristics:

Agility	be responsive at pace to the needs our community, continuously learning and improving as we go.
Cohesion	we work together to deliver services for our community, acting with integrity, inclusivity, and transparency.
Empowerment	decisions are made by those with the best information. People have permission to act, safely, quickly, and accurately.

Nominations can come from any one in or outside the Trust and relate not only to individuals but teams also. These are bimonthly awards, and I am pleased to announce the first winners of these awards for December which are as follows:

Award Category	Individual Award	Team Award
Agile	Alun Gordon, Lead Counter Fraud specialist	Nursery Nurses 0-19 Telford
Cohesive	Sammy McMullen, Community Nurse	Long COVID service
Empowerment	Kerry Davani, Admiral Nursing Team	The Children's Physio Team
Overarching ACE	Jas Sahota, Lead Pharmacist	Healthy Smile Team

4. The Staff Survey

The survey launched at the end of September and closed on the 29 November 2024. We look forward to seeing the results in January as one lens to understand the thoughts and views of our staff. At the time of reporting, before the close of the survey we had a response rate of 60.42% which means 1168 staff out of 1933 WTE responded to the survey, up from 845 last year. I would like to thank staff for responding to this survey which serves as an important barometer in terms of how we are doing as a Trust. The staff survey is one lens that we are using as a Trust alongside the People Promise programme of work and wider work that we are doing to constantly engage with our staff. For example, we have launched our Culture Group, undertaken a flexible working campaign and flexible working survey, undertaken a financial wellbeing survey and much more.

5. Wellbeing offer & Flu vaccination.

In line with the People Promise and engagement work, the Trust has been building on the already established wellbeing offer we have including, access to financial advice and training workshops, wellbeing days, keeping healthy, well woman and man workshops to name but a few. As we are now well into the winter season, our vaccination offer to staff has been a key theme. Our overall uptake as of 18 November is 44% this includes individuals who have received their vaccination through alternative routes such as there GP and Pharmacist. In terms of internal delivery of the vaccination a total of 705 vaccinations have been administered compared to our final figure of 715 last year. We are now analysing our data to target areas of low uptake with additional communications and discussions with our Occupational Health team.

6. Culture and Leadership Programme

During November, the Trust commenced the Discovery phase of the programme with the gathering of our Culture Change Team and Champions. This was well attended with a fantastic number of employees coming together, all from different roles, bandings, backgrounds, and services to share why they wanted to be part of this vital culture change initiative and get started with this important work.

7. Celebratory Awards Event

The Trust recently held an afternoon tea celebratory event where we were joined by colleagues from across the Trust to celebrate long service and welcome our Internationally Educated Nurses.

Caring for Our Communities

7. COVID Autumn Campaign

As system lead for the COVID vaccinations programme, the Trust has again been supporting the coordination and delivery of the COVID vaccine.

Vaccination against COVID 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).

Across STW, the total number of individuals eligible for the COVID vaccine during the autumn campaign is 212,509. Our target level of uptake for this campaign is 60.8%, the same as Autumn 2023, which equates to 129,205 individuals. As at 10 November 2024, the Vaccination Programme delivered 80,927 vaccinations which is 38% of the total eligible population and 63% of our target. At approximately the same point last year the Vaccination Programme delivered 86,223 vaccinations which was 40% of the total eligible population (213,800) and 60% of our Autumn 2023 target.

At 4 November 2024, STW are within the median range for all cohorts when benchmarked against Midland's region Systems.

During the current campaign we are seeing an increased level of vaccine fatigue and resistance in relation to Covid-19 vaccinations which is a risk to achieving our overall target uptake of 60.8%, and we continue to promote the benefits of taking up the offer.

8. Family Nurse Practitioner (FNP)

The FNP service across Shropshire, Telford, and Wrekin has just celebrated 10 years of operation. Commissioned by Councils, ShropCom provide FNP services as part of our Children and Young People offer.

This is a targeted home-visiting programme for first-time young mothers and families. The programme aims to improve children's life chances. It is a licensed programme developed by the University of Colorado Denver, USA. The programme has been established in 8 countries and delivered in England since 2007 and has been in place across STW since 2014.

FNP works primarily through the mother. However, family nurses also engage with the mother's partner, whether they are the child's biological father or otherwise. This helps support improved programme delivery and outcomes for the child, as shown in the Fatherhood Institute's 2022 report Bringing Baby Home: UK fathers in the first year after birth.

First-time mothers are recruited aged up to 24, in line with local area eligibility criteria. The programme is structured and personalised to reflect the strengths and needs of each individual.

Each mother is partnered with a specially trained family nurse who provides consistency and continuity, visiting the mother regularly from early pregnancy until their child is aged 2. Family nurses provide a safe, reflective space for mothers to process information and guidance on key areas relating to their pregnancy and parenthood. They work relationally, supporting the young parent in making positive changes for themselves and their baby by focusing on their strengths.

Wider determinants of health play a complex role in influencing future health and wellbeing outcomes of young mothers. FNP has been shown to improve vulnerable children's development, school readiness and early educational attainment. These improvements can in turn help influence better long-term health and wellbeing and economic outcomes and this is something that we have seen across out FNP services in Shropshire, Telford, and Wrekin and more recently this year Dudley too. Clair Hobbs, Dr Ganesh, and I had the pleasure of attending the Shropshire 10-year celebrations. Listening to staff giving their presentations and hearing from the mums and little ones how this service has transformed their lives was humbling and emotional and filled me with a huge sense of pride. Data and performance reports clearly demonstrate the great outcomes relating to the commissioned service, but the real impact is in the stories from the young mums, their partners and families themselves.

Huge congratulations to the team for their 10th anniversary and the very deepest of appreciation and thanks from the Board for the compassion and skill the team have demonstrated and continue to demonstrate across all of your CYP services.

This is one key area that the quality improvement and operational teams have been focused on and I will report further in future Chief Executive reports the outputs from other areas of our Quality Impact work.

Managing Our Resources

9. 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.

In my last report, I specifically mentioned the work to reduce duplication and more effectively manage resources through co location a system wide dynamic multi-disciplinary team (MDT). This team includes staff across the acute, local authority and community, building on the effective integrated discharge team model that SCHT has been the lead agency for. The aim of this next piece of focused work is to strengthen the pathway for patients, ensuring 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. Both having gone live on 7th October and the early results have been impressive and the aim will be to ramp this up through winter as a major plank in the management of non elective care.

And Finally – Good News Stories

Remembrance

We marked Remembrance Day with several activities across the Trust. In Shrewsbury the main reception area at the Children's and Families Centre, Monkmoor Campus, was decorated with poppies as a mark of respect to our Armed Forces comrades who have served for our country, in both World Wars and all conflicts. We were also represented at the Remembrance Match which saw Shrewsbury play Barnsley. Bridgnorth Hospital saw a local Knit & Natter group hand out handmade poppies to both staff and patients on the Agnes Campbell ward and at Whitchurch Hospital poppies were displayed on windows with flags & pictures hung in patient areas.

Parkinson's UK – Charity Boxing Event

Alastair Campbell, Operational Lead for Planned Care services, literally stepped into the ring at a white collar boxing event in Shrewsbury back in July, to raise funds for Parkinson's UK. Alastair was Inspired by his late grandfather, Dick Campbell, who lived with Parkinson's as well as the work that the Trust does in terms of supporting individuals with a range of neurological needs including Parkinson's. Huge achievement, Alastair and well done.

Cyber Award

Paul Stokes was announced as the winner of the Emerging Threats award in the inaugural Immersive Labs Customer Awards. Paul was commended for exceptional performance across 2024 and for being amongst the top points earners for the year within the entire platform.

The Emerging Threats award recognizes the individuals at the forefront of threat detection and threat hunting. Taking into consideration the total number of Cyber Threat Intelligence labs completed, as well as the average time to complete and respond to every new CTI lab, Immersive Labs are rewarding the best and brightest for their diligence and dedication in responding to the latest threats quickly and effectively.

King's award for Voluntary Service

Shrewsbury & Oswestry Crucial Crew have received the prestigious Kings Award for Voluntary Service. The volunteers of Shrewsbury and Oswestry Crucial Crew are due to receive the King's Award for Voluntary Service 2024 and this included the support provided to the Crucial Crew from Shropshire's School Nursing team.

Nursing Times Award Finalists

ShropCom were finalists for the Nursing Times Award in 'Public Health Nursing', and Karen Pountney for 'Nurse Leader of the Year.' Ten staff members from various services such as School Nursing, Family Nursing Partnership, Admin and Health Visiting were invited to attend the event, which left them inspired and ambitious to receive more nominations next year.

The Rainbow Baby pilot was also recognized as "highly commended" at the CPHVA awards, a testament to Amanda Hall's outstanding work. Additionally, Jo Bettison was invited as a keynote speaker at the CPHVA conference.

Care Transfer Hub – William Farr Award

The Care Transfer Hub is our Integrated Health and Social Care Complex Discharge team based within Shrewsbury and Telford NHS Trust. The team Pathway 0 coordinators work in partnership with the local authority homelessness and housing teams, charity and voluntary organisations to support patients with their housing, homeless needs and health & wellbeing and care requirements for discharge. They have been awarded the William Farr Award from Dr Kevin Eardley and the celebration will be communicated with the SaTH communications. This is a celebration of collaboration and partnership to support our patients from the hospital to the community.

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality & Safety Committee 27th November 2024

0. Reference Information

Author:	**Jessica Donegan, Executive Assistant**	**Paper date:**	**5th December 2024**
Executive Sponsor:	Clair Hobbs, Director of Nursing, Clinical Delivery & Quality	**Paper written on:**	27th November 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Clinical Delivery & Quality	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality & Safety Committee meeting held on 27th November 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 Quality and Safety Committee is a sub-Committee of the Board of Shropshire Community Health NHS Trust (the Trust) and has delegated authority from the Board to oversee, co-ordinate, review and assess the quality and clinical safety arrangements within the Trust.

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

2.2 Summary

To note that due to system pressures, Quality & Safety Committee on 27th November was shortened to 30 minutes to discuss the following items:

- Integrated Quality & Safety Performance report
- SCHT Business Continuity Strategy V9.3
- SCHT EPRR Strategy V6.1

An additional Committee is to be organise to review the rest of the papers.

2.3. Conclusion

The 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 & Safety Committee 27th November 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Quality & Safety Committee which met on 27th November 2024. The meeting was quorate with a list of the attendance is outlined below:

Chair/ Attendance:
Jill Barker, Non-Executive Director (Chair)
Clair Hobbs, Director of Nursing, Clinical Delivery & Quality
Cathy Purt, Non-Executive Director
Sara Ellis-Anderson, Deputy Director of Nursing & Quality
Shelley Ramtuhul, Director of Governance/Company Secretary
Jessica Donegan, Executive Assistant/Minute Taker

3.2 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Integrated Quality & Safety Performance report		
Highlights from the report: - In October 2024 there were 17 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Wards. This equates to a rate of 5.04 falls per 1000 Occupied Bed Days (OBDs), which represents a lower incidence rate in comparison to Month 6. - Medication incidents with harm were 5 in September reducing to 3 in October. PSIRF thematic reviews have identified medication administration, missed doses and documentation as key emerging themes. - There was two category 4 and three category 3 pressure ulcers developed in service in October and with Stop the Pressure Day planned for November. The first thematic review on pressure ulcers has been completed and will be reviewed at the next Committee. - There were no Patient Safety Incident Investigations (PSII) reported in October. - There have been no unexpected deaths reported in October.	Y	

Chair's Assurance Report

Quality & Safety Committee 27th November 2024

2. SCHT Business Continuity Strategy V9.3		
This document has been developed to support SCHT with the management of its Business Continuity Management System. Maintaining an effective business continuity management system is a statutory requirement of the Trust. This has been taken through Patient Safety Committee who commented and amendments were made. It was taken to Quality & Safety to approve for approval at Board following a Confirm & Challenge for core standards compliance with NHSE.	Y	
3. SCHT EPRR Strategy V6.1		
1 Introduction / Purpose This Strategy outlines the Trust's commitment to EPRR and provides the framework for maintaining and assuring readiness. It aligns to the Core Standards framework EPRR Strategy and will be reviewed annually against the standards, ensuring it aligns to any changes. In providing this assurance, the Trust also complies with its requirements under the Civil Contingencies Act 2004, Health and Social Care Act 2022 and the NHS Standard Contract (SC30). As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must evidence they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. The NHS England Board has a statutory requirement to formally assure itself of its own, and the NHS in England's, EPRR readiness. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care, and the Secretary of State for Health and Social Care. The NHS England EPRR Core Standards framework sets the minimum standards in emergency preparedness. They provide a common reference point for all organisations and are reviewed annually, including an annual 'deep dive' on a particular area of response. Providers of NHS funded services complete an assurance self-assessment based on these core standards.	Y	Minor amendment was requested so that Patient Safety Committee, Audit Committee & Quality & Safety Committee were all included within the document for reference.

3.4 Approvals

Approval Sought	Outcome
SCHT EPRR Strategy V6.1	Approved
SCHT Business Continuity Strategy V9.3	Approved

4. Conclusion

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

0. Quality and Safety Report – November 2024

Author:	Chris Panayi – Governance Data Manager Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	5th December 2024
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	20th November 2024
Paper Reviewed by:	Sara Ellis-Anderson – Deputy Director of Nursing and Quality	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.
This paper aims to provide assurance to the Board to support the organisation in the provision of evidence against key lines of enquiry and to contribute to the Trust strategic goals and priorities.

2. Executive Summary

2.1 Context

The report aims to:
- Provide the Committee 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

3 of the 16 Quality and Safety dashboard KPIs are showing **special cause variation** in Month 7:

- *Clostridium Difficile* – 1 case reported in September in Ludlow Community Hospital bringing the 12-month rolling count to 4 for October. IPC thresholds have been published for 2024/25 and the organisation has had 2 hospital acquired *C-difficile* case against a threshold of 4. The October QSC Dashboard shows 5 – this is an error for October with the 3rd case of Hospital Acquired C-difficile being reported in November. A deep clean has been requested for Ludlow as an additional mitigation.
- E-Coli bacteraemia remains at 1 for the rolling 12 months with a case being reported in September. No lapses in care were identified.
- 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 October 2024 there were 17 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Wards. This equates to a rate of 5.04 falls per 1000 Occupied Bed Days (OBDs), which represents a lower incidence rate in comparison to Month 6.
- Medication incidents with harm were 5 in September reducing to 3 in October. PSIRF thematic reviews have identified medication administration, missed doses and documentation as key emerging themes.

- There was two category 4 and three category 3 pressure ulcers developed in service in October and with Stop the Pressure Day planned for November. The first thematic review on pressure ulcers has been completed.
- There were no Patient Safety Incident Investigations (PSII) reported in October.
- There have been no unexpected deaths reported in October.

Safer staffing data and harm review data remains in the report in previous format and awaiting addition to the QSC dashboard.

The Information department have changed how they are reporting the 'National Patient Safety Alerts not completed by deadline' KPI, so this will show as 1, from March 24 to date. An initial breach of deadline was reported 1st March 2024.

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 – 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 ...	2024-10-31		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-10-31		3	0	3	3	0	3	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-10-31		2	0	2	2	0	2	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-10-31		5.00	0.00	5.00	5.00	0.00	5.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-10-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-10-31		97.83%	95.00%	2.83%	98.51%	95.00%	3.51%	
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	2024-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-10-31		1.00	0.00	1.00	1.00	0.00	1.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-10-31		5.04	4.00	1.04	5.04	4.00	1.04	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-10-31		4	0	4	35	0	35	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia...	2024-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-10-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Never Events	2024-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-10-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-10-31		0	0	0	2	0	2	

ICON DESCRIPTIONS

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

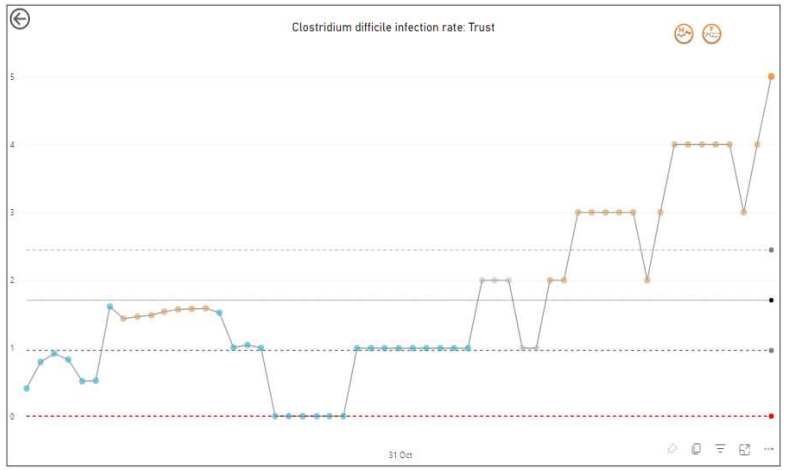
Exception Report - Action Plan

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

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number	0	1	0	0	1	1	0



Narrative/Description:	Rolling 12 months total now stands at 4 for October following a case in September on Dinham Ward Ludlow. Patient had a history of C-difficile infection and a Post Infection Review has been completed. SCHT have had 2 cases against a threshold of 4 for 2024/25.			
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Post Infection Review to be completed for recent hospital acquired case at Ludlow	Sep-24	Oct-24	Complete	PIR completed and will be discussed at next monthly outbreak/infection meeting
	Contribute to STW Quality Performace Committee C *difficile* Report to ensure shared learning and improvement actions	Sep-24	Oct-24	Complete	Paper tabled at STW QPC but deferred for discussion in November
	Deep clean of Dinham Ward Ludlow requested	Oct-24	Nov-24	In progress	
Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	20/11/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	20/11/2024		

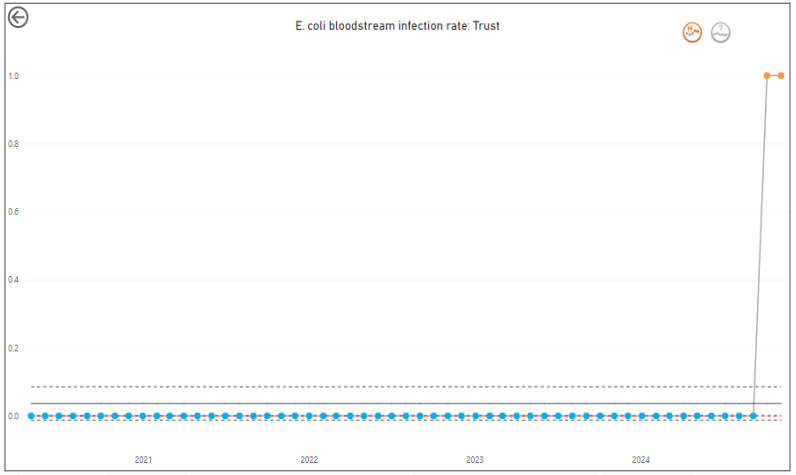
Exception Report - Action Plan

E.coli bloodstream infection rate

12-month rolling counts of E.coli bloodstream infection rate reported by the trust

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
E.coli bloodstream infection rate	Number	0	0	0	0	1	1	1
	Target	0	0	0	0	0	0	0

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number	0	0	0	0	0	0	0



Narrative/Description:	There was 1 reported incident of E.coli in September. Investigation from IPCN established that the patient was admitted onto Ward 18 with a history of bowel cancer. The patient had no invasive devices and no breaks in skin identified. He was reported unwell on the 25 September 2024 and a fever was noted. Reviewed by the medical team, blood cultures were taken and Tazocin prescribed, and an IV device inserted. The patient also had a history of gram-negative bacteraemia. There have been no further cases in October so the Turst remains at 1 for the rolling 12 monht count year to date.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Ensure Trust has SOP for taking blood cultures on RRUs and Community Hospitals	Oct-24	Dec-24	In Progress	
	Ensure Trust training needs analysis incorporates taking Blood Cultures	Oct-24	Dec-24	In Progress	
Author	Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Date**	20/11/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	20/11/2024		

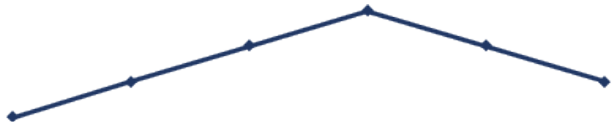
Exception Report - Action Plan

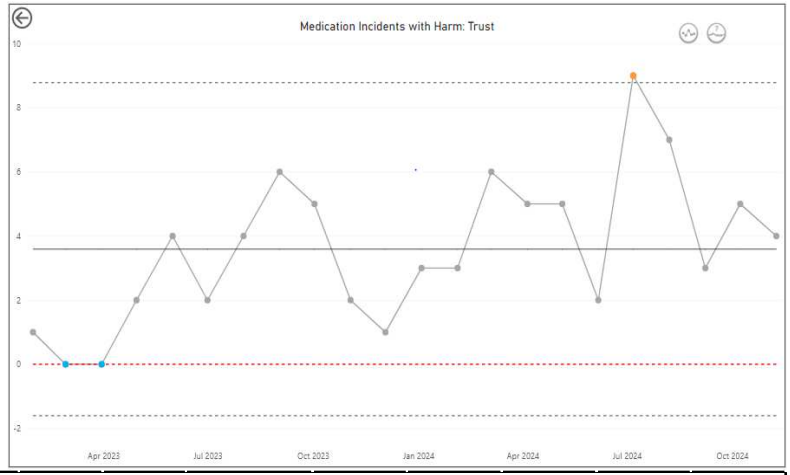
Medication Incidents with Harm

Number of medication incidents per month resulting in harm

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Medication Incidents with Harm	Number	2	9	7	3	5	3	35
	Target	0	0	0	0	0	0	0

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number	3	4	5	6	5	4	4





Narrative/Description:	All of these incidents are included in the Patient Safety Incident Rresponse Framework (PSIRF) quarterly thematic review. **Low** *1 x Internal -* 1. Patient prescribe Nitrofurantoin whist on Virtual Ward. Patient has a recorded allergy to the medication and patient suffered an adverse reaction due to taking the prescribed medication whist on Virtual Ward (Discussed at PSIP - local action to be taken only, contributory factor identified as locum consultant.) *1 x External –* 1. Patient should have been given Metformin by carer - however, only 2 tablets from the blister pack had been given over a week period. **Moderate** *1 x External* 1. DN unable to gain access to property which led to patient being admitted to hospital in DKA (Incident discussed at PSIP as patient had not been referred to DN team)				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Deep dive into missed doses Insulin by MSO	Aug-24	Nov-24	In Progress	
	Escalated at PSIP the number of medication incidents due to patients not being referred for continuation of insulin / other regular medicines by acute trust. SE advised would also escalate.	Nov-24	Nov-24	In Progress	
	Amendments being made to RiO RR/ VW Medication module to reduce number of RR/VW related medication incidents	Nov-24	Nov-24	In Progress	
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Nov-24	In Progress	
Author	Lucy Manning - Medicines Safety Officer and Non-Medical Prescribing Lead	**Date**	18/11/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Quality and Clinical Delivery	**Date**	19/11/2024		

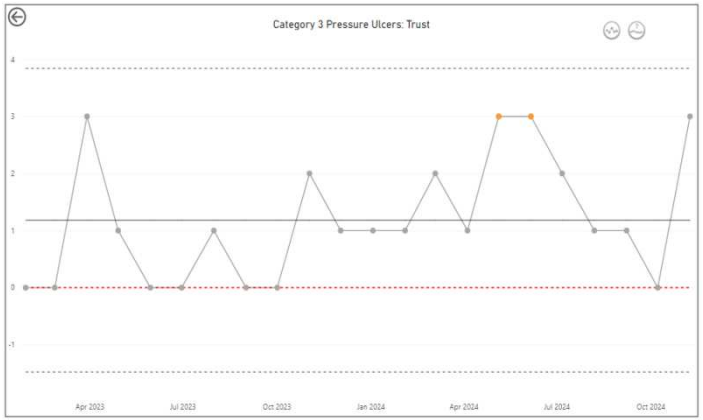
Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

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

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number	1	1	1	1	1	1	1



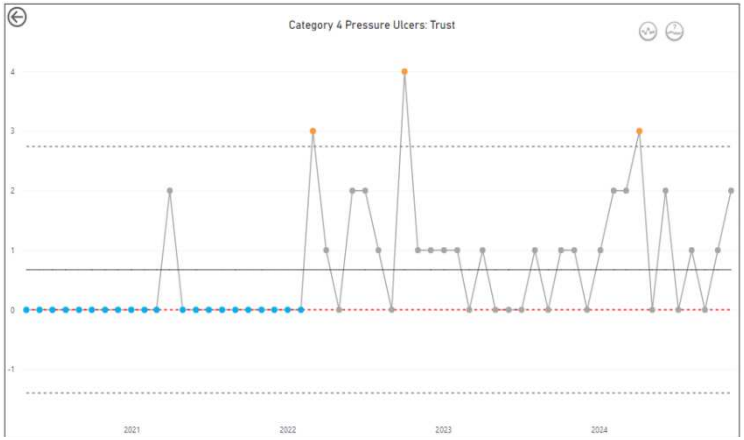
Exception Report - Action Plan

Category 4 Pressure Ulcers

The number of Category 4 Pressure Ulcers developed in service

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

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number	1	1	1	1	1	1	1



Category 3 Pressure Ulcers

Narrative/Description:	There were three Category 3 pressure ulcers developed under the care of the Trust in October 2024. 1 in South East IDT which was located on the sacrum due to frailty and end of life status, 1 in North West IDT located on the sacrum which was as a result of dying phase, 1 in South Telford located to sacrum as a result of frailty and end of life status				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Stop the Pressure Day conference taking place on Thursday 21st November 2024	Nov-24	Nov-24	Complete	
	Pressure ulcer policy update now fully approved and live which incorporates PURPOSE T changes and pathway which is approved by NHSE	Aug-24	Oct-24	Complete	
	Associated documents to be launched in November to support PURPOSE T and preventation and management of pressure ulcers	Sep-24	Nov-24	Complete	
	Bitesize face to face sessions and virtual sessions to arranged for October/November to support launch of PURPOSE T and policy update.	Sep-24	Dec-24	In progress	Community nursing teams education is complete
	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	In progress	Complete for community nursing teams
	PURPOSE T Phone to be live for 2 weeks following 'Go-Live' date to support staff with transition from Waterlow to PURPOSE T	Nov-24	Dec-24	In progress	

Category 4 Pressure Ulcers

Narrative/Description:	2 Category 4 pressure ulcers have developed in service in October - 1 in South East IDT which was located on the coccyxc, a contributing factor for this incident being non-concordance with equipment. 1 in North Telford IDT - which was located on the heel and Diabetes being a contributory factor for deterioration.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Stop the Pressure Day conference taking place on Thursday 21st November 2024	Nov-24	Nov-24	Complete	
	Pressure ulcer policy update now fully approved and live which incorporates PURPOSE T changes and pathway which is approved by NHSE	Aug-24	Oct-24	Complete	
	Associated documents to be launched in November to support PURPOSE T and preventation and management of pressure ulcers	Sep-24	Nov-24	Complete	
	Bitesize face to face sessions and virtual sessions to arranged for October/November to support launch of PURPOSE T and policy update.	Sep-24	Dec-24	In progress	Complete for community nursing teams
	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	In progress	Complete for community nursing teams
	PURPOSE T Phone to be live for 2 weeks following 'Go-Live' date to support staff with transition from Waterlow to PURPOSE T	Nov-24	Dec-24	In progress	
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	15/11/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	19/11/2024		

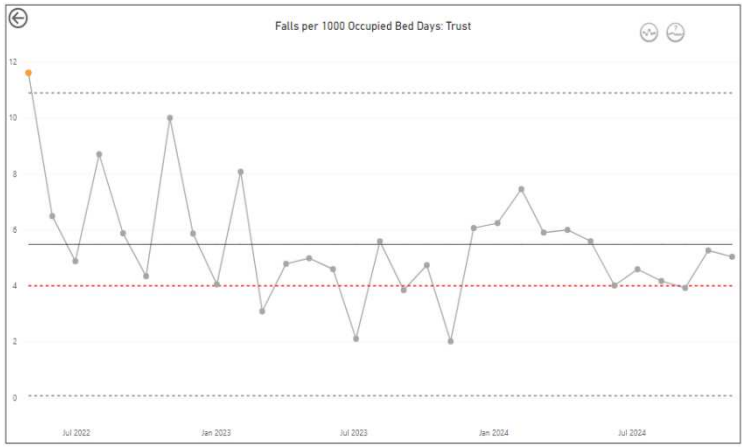
Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Falls per 1000 OBDs	Number	4.00	4.59	4.19	3.92	5.26	5.04	5.04
	Target	0	0	4	4	5	5	0

Trajectory	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Apr-25
Number	4.00	4.50	4.50	3.00	4.00	4.00	



Narrative/Description:	In October 2024 there were 17 inpatient falls reported within our care at the Community Hospitals, Rehabilitation and Recovery Wards. This equates to a rate of 5.04 falls per 1000 Occupied Bed Days (OBDs), which represents a lower incidence rate in comparison to M6. (The number of falls and OBD reflects the removal of duplicated falls recorded in Datix). The number of falls per individual community hospital site is as follows: Whitchurch Community Hospital (2), Bridgnorth (3), Ludlow (1) , RSH RRU (4), PRH RRU (4) , Bishops Castle (3). The indicated level of harm recorded is (9) falls recorded as no harm/injury and,(8) falls recorded as low harm resulting in minor bruising/marking to the skin .One patient was transferred to ED for review of a bang to the head and treatment of a skin laceration . The identified themes this month align to, (10) falls happened in the day between the hours of 8am and 8pm, (7) falls occured at night between the hours 8pm - 8am , the night time falls have reduced in comparrison to M6. The rate of unwitnessed falls identified was (15) which remains high a new PHUDD assessment is being considered ,which will be on handover to identify ward areas in which continous tag nursing / baywatch is incoprated into each shift . This will be discussed and considered for a trial with the CSMs and the Ward Managers.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	SWITCH to Decaff approved at QEIA - Following staff Education delivery the pilot with go live in Bridgnorth Community Hospital.	Sep-24	Dec-24	In Progress	QI project aiming to reduce number of falls . Staff awareness and education to be completed as per QEIA guidance before trial can commence ,time is allocated to staff to complete the online
	Falls prevention assessment and management plan updated - Trailed on ward 36	Sep-24	Nov-24	In Progress	Pilot extended to ensure each patient is fully assessed . Evaluaution planned with ward 36 week commencing 11th November . Next
	End PJ Paralysis Break the Cycle week Whitchurch Community hospital planned 23rd October .	Oct-24	Nov-24	Completed	Bed boards now being ultised for self directed activty , staff encourage patients to particapate in activity twice daily. Group activity provided 3/7 days, staff identifying how this can be expanded to daily planned group activity .
	Improving Hydration, reducing UTIs project piloting at Whitchurch	Sep-24	Nov-24	On Track	Trial fluid intake form updated to reflect the jug lid colours and ensure acurate recording of fluid balance.
	Gemba walk to be planned with Bishops castle - increase in falls	Nov-24	Dec-24	On Track	End PJ Paralysis Information / education videos have been shared with staff at Bishops castle. Planned End PJ Paralysis event December with the support of the education team .
	PHUDD assessment at shift handover being discussed with ward managers to support review of staff in each area of the ward and encourage tag nursing / baysafe during shifts .	Nov-24	Dec-24	In progress	
Author	Sarah Venn - Clinical Lead for Quality	**Date**	07/11/2024		
Accountable Officer Approval	Clair Hobbs - Director of Nursing, Clinical Delivery and Workforce	**Date**	19/11/2024		

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. BCCH will be included in the data collection in January 2024. The National Team has paused with the CNSST tool for review and plan to relaunch in January 2025. 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

October 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	109.5%	118.4%	102.4%	174.8%
Bridgnorth	98.3%	98%	100%	105.4%
Ludlow	94.3%	149.4%	102%	165.2%
Whitchurch	105.6%	120.6%	110.8%	156.4%
Ward 18 RSH	99.9%	118%	100.1%	135%
Ward 36 PRH	95.6%	147.5%	100.1%	141.9%

September 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	108.8%	109.4%	102.3%	127.9%
Bridgnorth	100.6%	95.5%	100.1%	100.4%
Ludlow	98.7%	113.0%	100.1%	108.9%
Whitchurch	90.6%	107.9%	104.0%	145.8%
Ward 18 RSH	99.8%	130.0%	100.0%	149.7%
Ward 36 PRH	95.8%	142.8%	99.8%	138.2%

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day and night shifts during October 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 October 2024
Bishops Castle	**81.2%**
Bridgnorth	**94.3%**
Ludlow	**95.4%**
Whitchurch	**95.4%**
Ward 18 RSH	**98.4%**
Ward 36 PRH	**96%**
Overall Target 91%	**94.2% ↑ by 1.2% on previous month**

Registered Nurse shifts covered in Community Wards- September and October 2024

	September 2024	**October 2024**
Total number of RN shifts covered	1268	966
Substantive staff	**1010**	**732**
Percentage	79.6%	75.8%
Percentage change from previous month	**3.3%**	**3.8% ↓**
Bank	111	140
Percentage	8.7%	14.5%
Percentage change from previous month	1.0%	**5.8% ↑**
Agency	**147**	**85**
Percentage	11.5%	8.8%
Percentage change from previous month	**2.2%**	**2.7% ↓**

There was a total of 2-night shifts that were 100% RN agency for the month of October 2024 in Ludlow Community Hospital due to vacancies.

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. 586 harm proformas have been completed to date; with 76.10% indicating no harm and 21.68% indicating low harm and can be treated and resolved.

There have been 13 cases (2.22%) of moderate harm identified up to September 2024; 9 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 service is routinely conducting a review of 10% of the harm proformas completed which equates to 55.

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

18-week RTT	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Harm proformas completed	428	474	481	495	506	513	517	528	537	544	550	586
Number of low harm	102	102	104	105	107	109	111	114	114	116	118	127
Number of moderate harm	0	4	5	6	6	7	7	8	8	9	10	13
Percentage of no harm	77.50%	77.65%	77.34%	77.58%	77.66%	77.39%	77.18%	76.90%	77.28%	77.03%	76.73%	76.10%
Percentage of low harm	22.50%	21.51%	21.62%	21.21%	21.15%	21.25%	21.47%	21.59%	21.22%	21.32%	21.46%	21.68%
Percentage of moderate harm	0.00%	0.84%	1.04%	1.21%	1.19%	1.36%	1.35%	1.51%	1.50%	1.65%	1.81%	2.22%

The current harms policy has been reviewed and is out to consultation 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.

Meeting	Shropshire Community Health NHS Trust -Quality and Safety meeting
Meeting Date	November 2024
Paper Title	Guardian of Safe Working Hours Quarterly Report For the Shropshire Community Health NHS Trust 1 July – 30 September 2024
Paper Written	November 2024
Author	Dr Bridget Barrowclough Guardian of Safe Working Hours (GoSW)

Executive Summary

The GoSW hours for Shrewsbury and Telford Hospital NHS Trust and for the Shropshire Community Health NHS Trust (SCHCT) continues in the role since July 2016 to champion safe working hours and ensure compliance with an Exception Reporting system as mandated in the TCS Junior Doctor Contact 2016. Resident doctors (previously referred to as Post graduate doctors in training) and Locally Employed Doctors (LEDs)can use this process to report hours worked over, missed rest breaks, and differences in service commitments and variations in educational opportunities. The GoSW maintains an oversight of all reports and ensures that all reports are addressed in a timely manner.

High level data
Number of RDs/LEDs in the SCHCT :3

Exception reporting
In this quarter there were no exception reports filed by the doctors working in the Shropshire Community Health NHS Trust.

Shropshire Community Health
NHS Trust

EPRR plan approvals
0. Reference Information

Author:	Brian McMillan, EPRR Senior Lead	**Paper date:**	5th December 2024
Executive Sponsor:	Clair Hobbs, Director of Nursing & Clinical Delivery & AEO	**Paper written on:**	27th November 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing & Clinical Delivery & AEO	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents an update on the requirements to approve strategic EPRR documents at Board level, following this years EPRR Core Standards process.

2. Executive Summary

2.1 Context

The Trust maintains 2 strategic EPRR documents – the EPRR Policy and the Business Continuity Policy. Both documents have historically been approved by the Patient Safety Committee and reported through to Quality and Safety and Audit Committees and Board via Committee delegation and chairs reports. For clarity, EPRR now reports to the Patient Safety and Audit Committee and this is the escalation route for routing plans, however for the two Strategic documents the approval route includes Quality and Safety Committee prior to submission to the Board.

Following this years EPRR Core Standards process, the Trust was challenged by NHS England on the approval mechanism for both documents. NHS England state it is a requirement for both documents to be signed off by the Trust Board, rather than a group or individual through delegated authority schemes.

The standards and background guidance is not explicitly clear on governance and approval routes, however to prevent future challenges and risk, the Trust's Accountable Emergency Officer has agreed to amend the approval route for both documents at the earliest opportunity.

2.2 Summary

The EPRR Strategy (V6.1) is the overarching strategic document that structures our EPRR arrangements. It addresses all aspects of EPRR delivery and references the response plans and arrangements required for compliance.

The document itself is considered compliant and is reviewed and approved annually. It was previously approved by Patient Safety Committee on 31st July 2024 and 23rd August 2023. The Strategy is within the bundle for review.

EPRR plan approvals

The Business Continuity Strategy (V9.3) is the overarching strategic document that structures the Trust's business continuity management system. It details our plan phases, roles and responsibilities and aligns to ISO 22313 and the NHS England Business Continuity Toolkit.

The document itself is considered compliant. It was included in the 2023/2024 audit by BDO auditors that went to Audit Committee. It was previously approved on 20th May 2024 and in May 2023.

The strategy is contained within the bundle for review.

2.3 Conclusion

The Trust Board are asked to:

- **note** and **approve** the contents of the report and amended approval routes for both documents, and
- **approve** both documents for the current annual cycle.

Shropshire Community Health NHS
NHS Trust

Document Details	
Title	Emergency Preparedness, Resilience and Response (EPRR) Strategy v6.1
Trust Ref No	2271-84159
Main points the document covers	This strategy provides a framework within which the Trust can comply with EPRR and business continuity requirements. The purpose of the guidance is to make the Trust ready and able to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained.
Who is the document aimed at?	All staff
Owner	Brian McMillan, EPRR Senior Lead
Approval process	
Who has been consulted in the development of this policy?	EPRR Working Group, STW ICB, NHS England Regional EPRR Team
Approved by (Committee/Director)	Trust Board & Trust Accountable Emergency Officer
Approval Date	
Initial Equality Impact Screening	Yes
Full Equality Impact Assessment	No
Lead Director	Clair Hobbs, Director of Nursing & Clinical Delivery - and Accountable Emergency Officer
Category	Operations
Subcategory	EPRR
Review date	October 2025
Distribution	
Who the policy will be distributed to	ALL STAFF
Method	Email, staff zone, EPRR Teams Channel, Resilience Direct

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

Contents

1 Introduction / Purpose

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

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

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

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

2 Process

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

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

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

The Trust's Patient Safety Committee and the Trust Audit Committee shall be the governance and approval route for EPRR documents, with the EPRR Strategy being approved by Board. The EPRR Core Standards state within the 'suggested evidence' that the EPRR Policy, or Strategy, must be approved by the Board with Board reports and minutes as required evidence. This requirement has triggered this amendment to Version 6.1.

2.1 Trust EPRR undertakings

The organisation works under a single EPRR structure.

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

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

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

EPRR Senior Lead

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

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

(In incidents of sickness or absence, the EPRR Senior Lead shall be deputised by the Clinical Site Manager for Bridgnorth – Kate Stevens)

Deputy Director of Ops

The EPRR Lead is managed by the Deputy Director of Operations and has day to day oversight of the Emergency Planning function and chairs the EPRR Working Group.

Command Support Team

The Command Support Team are individuals within the organisation who provide ad hoc resilience to the EPRR Lead function, particularly during incident response. The Support role comprises an individual who has knowledge and experience of EPRR processes and structures – Kate Stevens. Additionally, there are three individuals who have knowledge and understanding of EPRR systems that support an Incident Management Team – Laura Bradshaw, Layla Charnell-Jones and Holly Grainger. This team works together when required, to support the Trusts Incident response arrangements.

CBRN Teams

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

On Call Staff

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

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

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

Loggists

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

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

EPRR Working Group

The Trust has an EPRR Working Group comprising of multi-disciplinary leads from the Trust, who are responsible for reviewing, engaging and consulting on Emergency Planning documents and the EPRR workplan. They have authority to approve EPRR action cards and lessons register, however approval of formal response plans sits with the Patient Safety Committee. Strategic EPRR document are approved at Trust Board.

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

Patient Safety Committee

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

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

Audit Committee

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

EPRR Workplan

The organisation shall have an approved annual work plan that identifies EPRR workstreams, priorities and gaps. As the Core Standards assessment provides a reference point for, and underpins the essential competencies of EPRR, it shall

inform and form the basis of the annual work plan, ensuring that annual priorities align to a fully compliant state of preparedness.

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

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

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

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

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

2.2 Response Arrangements

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

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

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

With alternative sites being located at:-

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

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

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

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

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

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

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

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

Plans

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

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

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

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

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

2.3 Debriefs

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

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

• **Structured debrief** – Conducted within 2 weeks of the incident by an independent party. Commissioned within a scope agreed by the Accountable Emergency Officer and shall include all other agencies involved. This debrief will usually be conducted by the EPRR Lead, partner agencies EPRR Lead or NHS England / Local Resilience Forum trained debriefers. (Where external colleagues facilitate the debrief on behalf of the Trust, it is the Trust's responsibility to provide a scribe and to draft the debrief report for the Accountable Emergency Officer. The report shall be complete within 1 week of the debrief)

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

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

2.4 Business Continuity Management

The Trust is committed to Business Continuity Management and shall have a Business Continuity Management System (BCMS) in place. Plans shall be written for service level, locality level and organisation level processes and be focused on identification of prioritised activities, identifying how the organisation will respond to ensure continuity of service delivery for the duration of a disruption.

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

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

The plans shall be written in line with the appropriate guidance (ISO 22301) and be reviewed by the relevant team Business Continuity Leads. The Business Continuity Plans will support the Business Continuity Strategy which is written in line with guidance (ISO 22313). The Trust's Business Continuity Strategy shall be approved by the Trust Board.

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

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

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

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

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

An annual report on the status of the Business Continuity Plans, including any feedback and lessons identified from any business continuity plans will be written for the AEO.

Risk

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

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

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

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

2.5 Training and Exercising

The organisation will have a training and exercise programme and this is identified In the Trust's EPRR Training and Exercising Policy. The Training pathway for on call staff will be captured by the Trust Training Needs Analysis (TNA). The TNA will

provide the necessary assurance that training has been delivered across the Strategic, Tactical and EPRR supportive roles.

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

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

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

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

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

3 Associated Documents

- The Civil Contingencies Act 2004
- NHSEI EPRR Core Standards
- The Health and Social Care Act 2008
- NHS Standard Contract SC30
- ISO 22301:2019 Security and Resilience

4 Duties

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

5 Document retention periods

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

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

6 Implementation

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

Shropshire Community Health NHS Trust

SCHT Business Continuity Strategy v9.3

Document Details	
Title	**Business Continuity Strategy v9.3**
Trust Ref No	2034-84110
Main points the document	Set out how the Trust manages its Business Continuity Management Systems
Who is the document aimed at?	All managers and employees of Shropshire Community Health NHS Trust
Owner	EPRR Senior Lead
Approval Process	
Who has been consulted in the development of this plan?	Locality Clinical Managers, Communications, Divisional Clinical Managers, Business Continuity Leads, EPRR Working Group, Patient Safety Committee, STW ICB, NHS England
Approved by	Trust Board
Approval Date	
Initial Equality Impact	Yes
Full Equality Impact	No
Lead Director	Accountable Emergency Officer
Category	Operations
Sub-category	Business Continuity
Review date	October 2025
Distribution	
Who the policy will be distributed to	All staff, held electronically on Microsoft Teams and Staff Zone with a resilient copy on Resilience Direct. Paper copy in the Incident Control Room at Halesfield office.
Method	Teams and email alert to all affected groups. Highlight item in Trust communications and BC Training
Keywords	Business Continuity, Business Impact Assessment, ISO 22301, ISO 22313
Document Links	
Required by CQC	Yes
Other	NHS National contract NHS E EPRR Core Standards, ISO 22313, Business Continuity Institute Good Practice Guidelines, NHSE BC toolkit 2023

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

1. Contents

2. Scope

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

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

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

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

2.1.3 ISO 22313 is the best practice standard for business continuity strategies. ISO 22301 is the best practice standard for business continuity plans. The NHS England Business Continuity Toolkit 2023 aligns to the standards and is designed to help NHS organisations, and providers of NHS funded care, to prepare for, respond

to and recover from unexpected and disruptive incidents. It also provides a structure for the Trust to align with and as a result, highlights key areas that must be adopted as part of the Plan, Do, Check, Act (PDCA) cycle.

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

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

3. Objectives

3.1 List the objectives and obligations for the organisations business continuity management system.

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

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

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

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

3.1.4 Each plan will identify prioritised functions within the Team / Division or Organisation and shall focus on the following key areas –

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

- Requirements for ongoing patient care

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

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

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

4. Purpose

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

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

4.2. Individual Roles within the strategy

- **Accountable Emergency Officer** – Board Level Executive Director responsible for the Trust EPRR programme including BCMS. Must be trained in the Principles of Health Command Strategic level training.
- **Emergency Planning Senior Lead** – Lead individual for supporting the review, maintenance, training, exercising and guidance on BCMS planning. Must be CBCI qualified and hold a level 3 teaching certification.
- **Business Continuity Lead** – Local service leads responsible for maintenance, review and exercising of local operational level (service or team) BC plans. Must have undertaken BC awareness training to develop knowledge of the NHS England BC toolkit.
- **Locality business continuity lead** – Locality Clinical Managers responsible for collation of information that feeds into the business continuity plans, such as utilities and alarms, etc. Must have undertaken BC awareness training to develop knowledge of the NHS England BC toolkit.

5. Risk Assessment

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

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

6. Business Impact Analysis

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

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

6.1.2 The Trust's current strategic organisational BIA is attached at **Appendix A**. This is being reviewed as part of the 2024 plan re-build programme.

7. Business Continuity Plans

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

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

- Loss or disruption to:-
- People
- Premises
- Utilities including IT
- Information and Data
- Supply chain
- Service, resulting in compromised patient care

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

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

8. Training

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

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

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

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

9. Exercising

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

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

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

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

10. External Suppliers and Contractor

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

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

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

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

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

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

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

11. Governance & Audit

10.1 Governance

The approval mechanism for BCMS plans is as follows:-

For team/service level plans – these will be reviewed by the service structure and approved by their internal governance route. The plan must be shared with the EPRR Senior Lead as part of the consultation as this role is the Trusts subject matter expert in business continuity.
For Locality level plans – these will be reviewed by the EPRR Senior Lead with the relevant Clinical Site Lead.
For Organisational level plans – These shall be reviewed by the EPRR Senior Lead and approved via the Audit Committee following consultation with the EPRR Working Group.

10.2 Audit

10.2.1 The Emergency Planning Senior Lead shall direct where audits should take place, having regard to

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

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

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

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

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

10.2.4 External audits can be commissioned by the Audit Committee who regularly engage with external audit partners to provide oversight of key areas of the business. The EPRR Senior Lead shall coordinate with any external appointed auditor to provide evidence for external audit purposes.

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

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

10.3 Documentation Control

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

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

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

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

11. Communication

11.1 Business Continuity works best when it is an embedded culture within the Teams and they have a good understanding of their plans as they are locally maintained, reviewed, and tested.
Trust strategic documents – the Business Continuity Strategy, the Organisational and Locality Level Plans, will be centrally stored and reviewed. These documents will be communicated via the Trusts Manager and Director on Call network and Divisional Operations Groups and Huddles to ensure all response roles know the plans and their locations.

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

12. Review of BCMS

12.1 The Trust BCMS shall have 2 levels of review:

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

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

APPENDIX A – Organisational BIA (Levels 1 and 2 only –being reviewed as part of the 2024 Business Continuity Improvement Plan)

Priority	Service1	Service	Activity	SDG
			(Immediate/within 1- 4 hours)	
1	Childrens Community Nursing	CCN service	Provide nursing care to children with acute, long term, complex/long term conditions and palliative care, e.g. Administration of routine medication via injection/ CVL End of life care Wound care Supplies Enteral feeding Oxygen dependent patient assessment	CYP+F
1	Bridgnorth Hospital and OP services	Community Hospital In-Patient Service	24/7 inpatient rehabilitation nursing and medical care	ADULTS
1	Whitchurch Hospital and OP services	Community Hospital In-Patient Service	27/7 inpatient rehabilitation nursing and medical care	ADULTS
1	Whitchurch Hospital and OP services	Community Hospital Hotel Services Support	7 days a week support to inpatient services, catering and cleaning	ADULTS
1	Ludlow Hospital	Inpatients	24/7 Nursing, medical and therapy for rehabilitation, care of acute and sub-acute patients identified to be supported in the community hospital, end of life care	ADULTS
1	PRH Rehabilitation and Recovery Unit	Inpatients	24/7 Nursing, medical and therapy for rehabilitation, care of acute and sub-acute patients identified to be supported in the community hospital, end of life care	ADULTS
1	RSH Rehabilitation and Recovery Unit	Inpatients	24/7 Nursing, medical and therapy for rehabilitation, care of acute and sub-acute patients identified to be supported in the community hospital, end of life care	ADULTS
1	Bishops Castle	Inpatients	24/7 nursing, medical and therapy for rehabilitation, care of acute and sub-acute patients identified to be supported in the community hospital, end of life care	ADULTS
1	Ludlow Hospital	Hotel services support	Provision of meals and a clean environment	ADULTS
1	Shrewsbury and North	District nursing	Nursing care & treatment of patients in their own homes requiring daily visits, admission avoidance & early supported discharge	ADULTS
1	Community Substance Misuse Team	CSMT	Community detoxification	ADULTS

Priority	Service1	Service	Activity	SDG
1	HMP Stoke Heath	Primary care nursing	Administration of essential medication	ADULTS
1	HMP Stoke Heath	Primary nursing care	Maintaining a safe environment to those prisoners with high suicide/self harm risk	ADULTS
1	HMP Stoke Heath	Primary care nursing	First response for medical and discipline (where medical presence is required) emergencies within the establishment.	ADULTS
1	HMP Stoke Heath	Primary care nursing	Substance misuse (IDTS) basic service is delivered	ADULTS
1	HMP Stoke Heath	Primary care nursing	Daily visits to SCCU	ADULTS
1	Clinical Services Telford and Wrekin, SE & SW Shropshire	Community Nursing	Providing nursing care to patients in their own homes according to a care plan. Some patients are medically vulnerable and require daily care/medication and early supported discharge from Hospital	ADULTS
PRIORITY 2 SERVICES (within 24 hours)				
2	Childrens Community Nursing	Special school team	To support pupils in special schools for essential nursing care.	CYP+F
2	HV North	Health Visiting	Advice line	CYP+F
2	HV Shrews	Health Visiting	Advice line	CYP+F
2	Bridgnorth Hospital and OP services	Community Hospitals Reception	Main reception open Monday – Friday 08.30 – 17.00	ADULTS
2	Bridgnorth Hospital and OP services	Community Hospital In-Patient Physiotherapy and Occupational Therapy	Monday – Friday service 08.30 – 16.30. rehabilitation and assessment on admission and discharge	ADULTS
2	Bridgnorth Hospital and OP services	Community Hospitals Portering Service	Part time porter only Monday - Friday	ADULTS
2	Bridgnorth Hospital and OP services	Community Hospital Hotel Services Support	7 days per week service both catering and Domestic	ADULTS
2	Whitchurch Hospital and OP services	Community Hospitals Reception	5 days a week service, meeting and greeting, appointments, switchboard	ADULTS
2	Whitchurch Hospital and OP services	Community Hospital In-Patient Physiotherapy and Occupational Therapy	Inpatient rehabilitation therapy support	ADULTS

Priority	Service1	Service	Activity	SDG
2	Whitchurch Hospital and OP services	Community Hospitals Portering Service	7 days a week ancillary support, patient internal transport, supplies, gas cylinder exchange	ADULTS
2	Ludlow Hospital	Inpatients physiotherapy and occupational therapy	Monday – Friday 8.30-16.30 Treatment of chests and mobility assessments, rehabilitation, facilitation of discharge and provision of equipment	ADULTS
2	Ludlow Hospital	Community hospital reception	Monday to Friday 8.30- 17.00hrs. provides reception for out-patients clinics, MIU, x-ray and Physiotherapy	ADULTS
2	Ludlow Hospital	Community hospitals portering service and maintenance	Porters available 7.00- 15.00 Monday to Friday. Maintenance support on-site 8.30-16.30 Monday to Friday	ADULTS
2	Bishops Castle Hospital	Hotel services support	Provision of meals and a clean environment	ADULTS
2	Bishops Castle Hospital	Community hospital reception	Bishops Castle Hospital switchboard , booking appts, ordering on oracle, finance, bed status reporting, filing , staff issues , agency staffing, coding, filing, switchboard	ADULTS
2	HMP Stoke Heath	Primary nursing care	Prisoner receptions – drug review	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	GP Surgery	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	Wound care management	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	Administration of non-urgent medication	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	Nurse triage clinics	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	Hospital escorts for emergency care assessments	ADULTS
2	HMP Stoke Heath	Primary care nursing/GP	Delivery of pharmacy supplies	ADULTS
2	Family Nurse Partnership	FNP	Child Protection	CYP+F
2	Podiatry	Clinic Administration	Support in clinics and clinicians. Booking of appointments	TeMs
2	Podiatry	Consultant led Diabetic Foot Clinic	Outpatient activity (block contract). New and Follow Up Appointments 1 day a week (4 sessions)	ADULTS
2	Clinical Services Telford and Wrekin, SE & SW Shropshire	Single Point of Referral	Receive new referrals to community nursing team and other therapists, manage direct patient referrals for care and care related products.	TeMs

Priority	Service1	Service	Activity	SDG
2	Dental Services	Dental Services	Out of Hours Emergency Dental Services (OOH EDS) for both Shropshire County and Telford & Wrekin PCTs (weekends, bank holidays and evenings).	CYP+F
2	Chldrens Safeguarding	Safeguarding	Urgent referrals, support and assessments	CYP&F

Shropshire Community Health
NHS Trust

Performance Update
0. Reference Information

Author:	Jen Deakin, Fiona MacPherson Gina Billington Heads of Service	**Paper date:**	28 November 2024
Executive Sponsor:	Rhia Boyode, Group Chief People Officer SCHT & SATH	**Paper written on:**	20 November 2024
Paper Reviewed by:	Simon Balderstone Interim Workforce Operations Director	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

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

2. Executive Summary

2.1 Context

This report focuses on the key areas of performance relevant to Board, including a review of performance against the month 7 workforce plan position. The KPI's throughout the report are key drivers of performance, which underpin the delivery of the 24/25 workforce plan.

2.2 Summary

The key points for the Trust Board 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.

Performance Update

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. SPC charts and icon descriptions are included in the appendices should members wish to review further.

2.3. Conclusion

The Board is asked to:

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

Performance Update

3. Main Report

3.1 Introduction

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

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

3.2 Summary of key points in report

The workforce plan for 2024/25 set a 33 WTE increase from the start of the year which incorporated an 81 WTE increase in substantive workforce. This included the transfer of the 0-19 Dudley Children's Services. The target set to reduce agency usage was a 42% reduction, to be off-set with increases in the permanent workforce. At month 7 the total workforce is under plan by 15.3 WTE.

Our agency usage is 10.55 WTE over plan driven by additional usage in Community Nursing and Community Hospital Inpatient Wards. Based on our forecast position at the end of the year we are expecting to deliver against our planned position. Bank usage has been above planned levels since June; however, this has been offset by the substantive workforce under plan by an average of 45 WTE over this period.

Our bank usage is expected to remain above plan to the end of year, however given the costs are comparative to substantive workforce this is not expected to create a cost pressure and overall, we are expecting to deliver against our planned levels for total workforce.

Overall, our pay spend is under plan by £89k.

Month 7 Position

Plan (WTE)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Substantive	1607.9	1618.9	1635.5	1641.2	1647.5	1648.5	1654.1
Bank	58.0	58.0	58.0	58.0	58.0	58.0	58.0
Agency	89.4	71.3	54.6	51.1	44.7	43.7	38.1
Total	1755.3	1748.2	1748.1	1750.3	1750.3	1750.3	1750.3
Actual (WTE)	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**
Substantive	1573.9	1586.2	1589.7	1598.0	1594.3	1603.3	1615
Bank	79.7	67.1	77.0	66.0	67.7	70.0	71
Agency	64.0	49.1	41.7	43.6	46.7	44.3	48.68
Total	1717.6	1702.3	1708.5	1707.6	1708.7	1717.6	1735
Variance (WTE)	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**

Performance Update

Substantive	(34)	(33)	(46)	(43)	(53)	(45)	(39.1)
Bank	22	9	19	8	10	12	13
Agency	(25)	(22)	(13)	(8)	2	1	10.58
Total	(38)	(46)	(40)	(43)	(42)	(33)	(15.3)

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

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

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

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

Performance Update

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	September	October
Appraisal	90%	87.7%	86.27%	86.10%	85.67%
Leavers	9.6%	11.59%	11.48%	10.89%	10.95%
Mandatory Training	95%	93.14%	93.28%	92.9%	93.89%
Temporary Staff	3.4%	7.5%	6.4%	6.5%	4.8%
Vacancies	8%	11.32%	11.81%	11.45%	11.15%
Sickness	4.75%	5.44%	5.31%	5.34%	5.33%
Total Shifts exceeding NHSI capped rate	No Target	244	164	228	184

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

Training

Mandatory training will continue to fluctuate as work 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. Comms have been sent out to inform managers and staff.

Weekly reminders are sent to the teams who are responsible for updating training statuses in ESR for attendance at face-to-face training, this reminder is to ensure attendance is captured in the monthly compliance reports.

All mandatory training topics have increased in compliance this month except for Trust Induction and there are only 8 out of the 19 mandatory topics that are below the target of 95%, this is evident in mandatory training action plan.

Appraisals

Appraisal compliance has remained relatively static since August (4.9% under target). Appraisal training sessions are continuing for staff and managers to attend, and support is being provided to areas with lower compliance rates.

Performance Update

Turnover

The Leaver rate has seen a gradual improvement since April but still below target by 1.05% (1.29% last month). Our leavers rate has slightly increased in October. A deep dive is being undertaken in relation to hot spots for leavers in terms of reasons, leavers with less than 12 months service etc to establish any bespoke support required for teams. The main driver of the turnover is retirement. Initiatives to support more flexible retirement may support people to work longer before full retirement and encourage more flexible options. Our leavers policy has also been updated to provide various methods for completion of exit interviews.

Absence

Our absence rate has remained relatively static. We regularly review the application of our new Policy and provide support where required to ensure it is being applied consistently. We have a suite of offers from a HWB perspective in particular the roll out of our HWB days. The People Team supported by the Occupational Health team are rolling out workshops on how to complete a stress risk assessment. Work is being undertaken on ensuring timely Occupational Health referrals by Line Managers. Seasonal conditions such as cold and flu are also a significant reason for sickness, getting winter prepared by promoting the vaccination campaign will provide a level of mitigation going into the colder months.

Vacancies

Vacancies are above target although have reduced by 0.30% from the previous month, the focus is on the ensuring we are filling our critical roles particularly those roles that impact on where we are using temporary staffing. Roles requiring NMC PINS last month for newly qualified staff have now been received and individuals commenced. The vacancy control process is allowing greater scrutiny but also to enable discussions on options to reform roles to provider improved efficiency and in some case reduced cost.

Collaborative support from SaTH recruitment team to cover vacancy and absence continues to support maintaining timely recruitment to vacancies. This will be reviewed in January 2025. The number of pre-employment check appointments continues to rise, and this will be reviewed in November to assess uptake. Training for recruiting managers (delivered collaboratively with SaTH), and drop-in sessions for Trust recruiting managers are all in place to support managers to manage their vacancies and reduce the number of queries to the recruitment team.

Agency Spend

Agency Price Cap compliance has continued to improve with a week on week fall in the number of shifts booked above price cap. October shifts booked above price cap were 184 compared to May 24 shifts booked which were 408. This is due to the temporary staffing lead and team in building relationships with the agencies.

We will continue this work by focusing on both volume reductions and price of agency. NHSE have launched a new programme aiming to improve price cap compliance for agencies across the Midlands. We have issued letters to all our agencies with regard to price cap compliance and future bookings with the aim of 100% compliance by 31 March 2025.

Performance Update

The focus will be on filling vacancies where we are using agency, so we can reduce demand and on reducing the price of agency by improving price cap compliance and maximising bank efficiency. This will be supported by moving to central bank function and potentially utilising the National bank scheme where it makes sense to use.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Board is asked to:

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

Appendix 1
People Committee – SPC Summary
Month 07 (October) 2024/2025 Performance

Shropshire Community Health NHS
NHS Trust

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership ...	2024-10-31	H	7.4	7.5	-0.1	7.4	7.5	-0.1	F
People Committee	Well Led	Appraisal Rates	2024-10-31	H	85.67%	90.00%	-4.33%	85.10%	90.00%	-4.90%	F
People Committee	Well Led	CQC well-led rating	2024-10-31		Good	Good		Good	Good		P
People Committee	Well Led	Leaver rate	2024-10-31	L	10.95%	9.60%	1.35%	10.95%	9.60%	1.35%	F
People Committee	Well Led	Mandatory Training Compliance	2024-10-31	L	93.89%	95.00%	-1.11%	93.89%	95.00%	-1.11%	?
People Committee	Well Led	Net Staff in Post Change	2024-10-31		5.80	0.00	5.80	26.22	0.00	26.22	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-10-31	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	2024-10-31		75.00%	66.00%	9.00%	75.00%	66.00%	9.00%	P
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-10-31	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...	2024-10-31	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...	2024-10-31	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...	2024-10-31	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...	2024-10-31	H	22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	F
People Committee	Well Led	Proportion of temporary staff	2024-10-31		4.8%	3.4%	1.4%	6.5%	3.4%	3.1%	F
People Committee	Well Led	Sickness Rate	2024-10-31	L	5.33%	4.75%	0.58%	5.33%	4.75%	0.58%	F
People Committee	Well Led	Staff survey engagement theme score	2024-10-31	L	7.0	7.3	-0.3	7.0	7.3	-0.3	F
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-10-31	L	184	0	184	275	0	275	F
People Committee	Well Led	Total shifts on a non-framework agreement	2024-10-31	L	1	0	1	1	0	1	?
People Committee	Well Led	Vacancies - all	2024-10-31	H	11.15%	8.00%	3.15%	11.63%	8.00%	3.63%	?

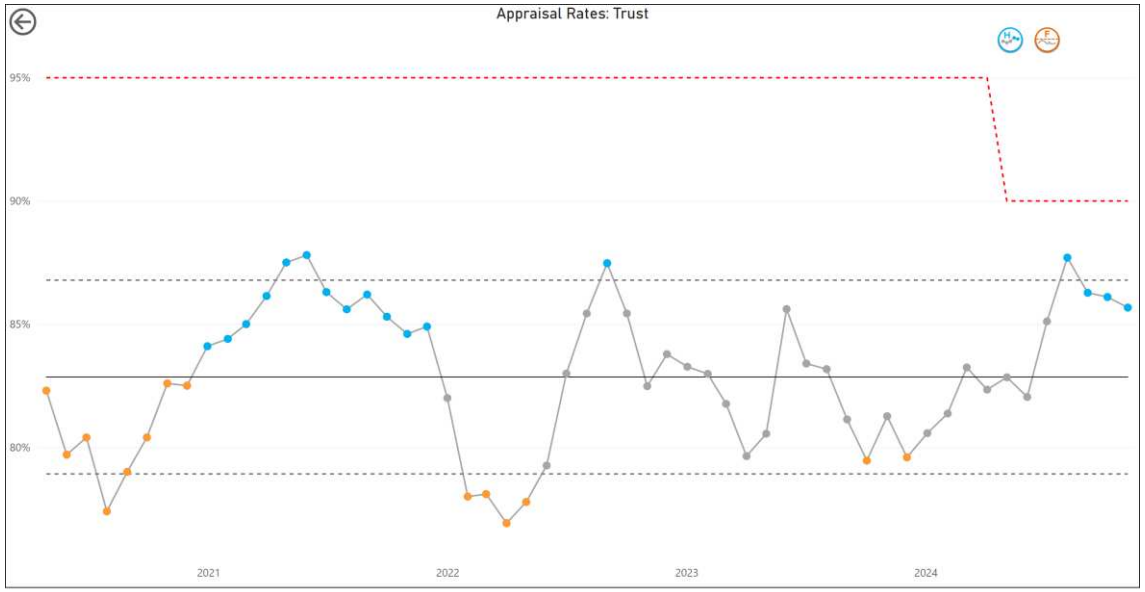
Appendix 2
Trust Board
Month 07 (October) 2024/2025 Performance

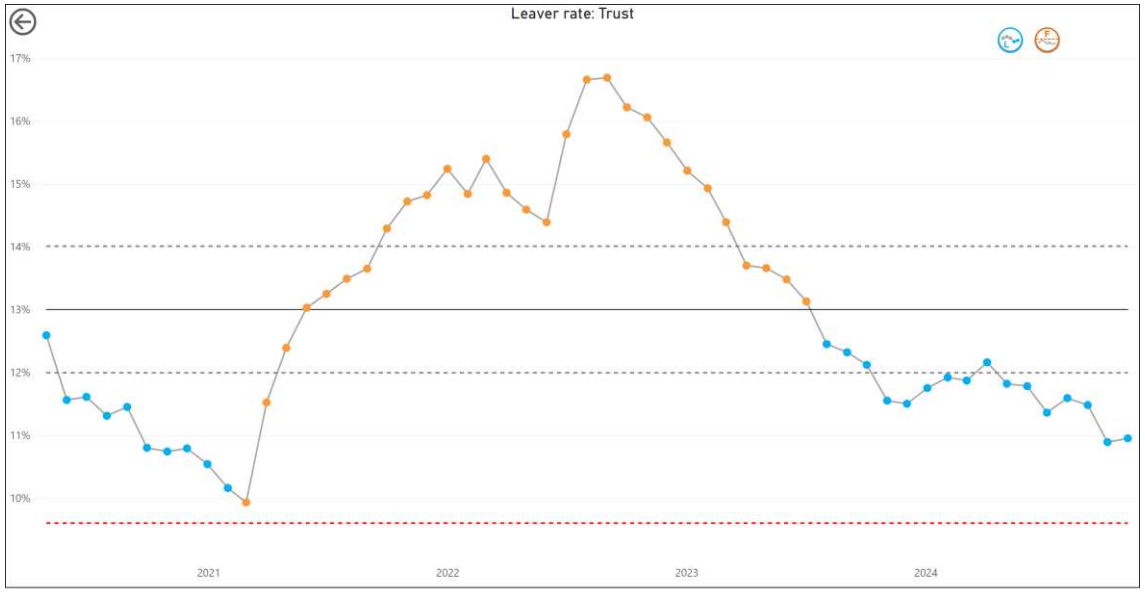
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where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

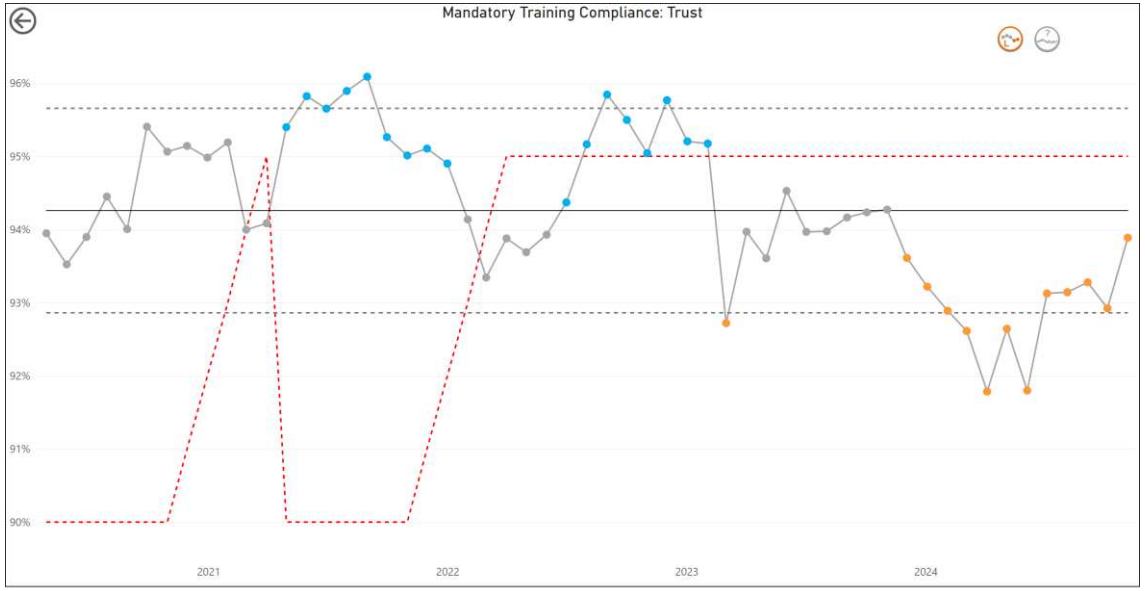
Appendix 3

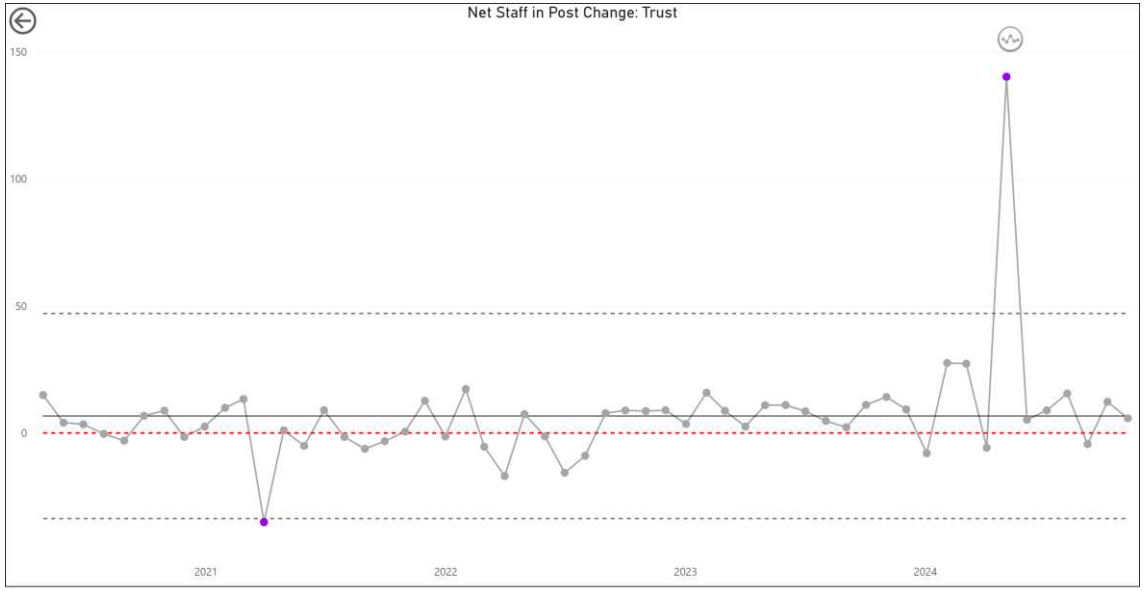
Trust Board

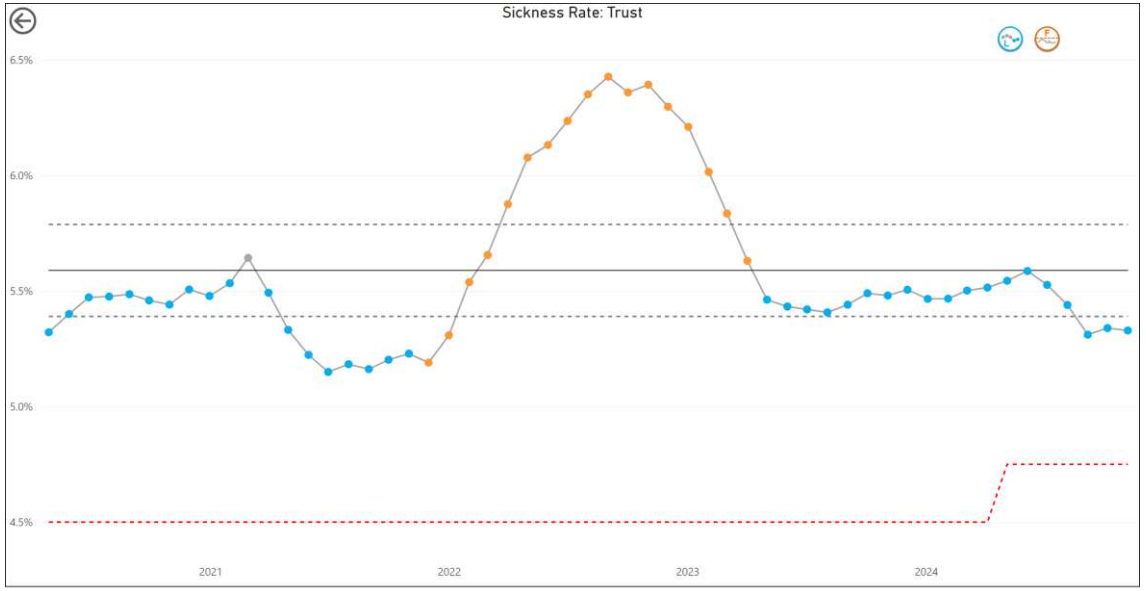
Month 07 (October) 2024/2025 Performance

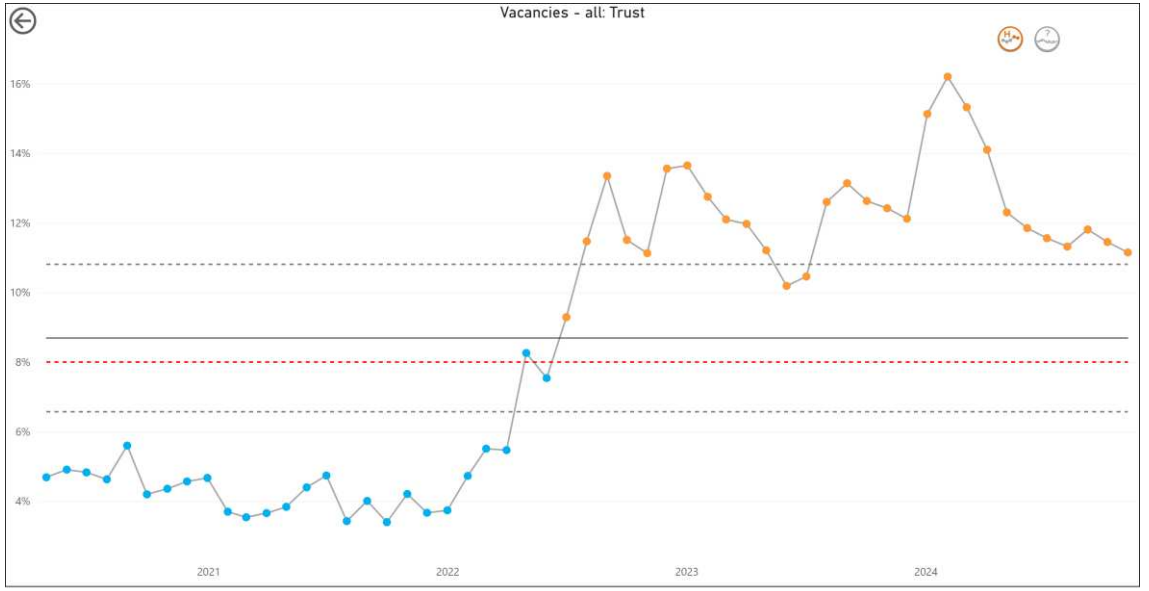


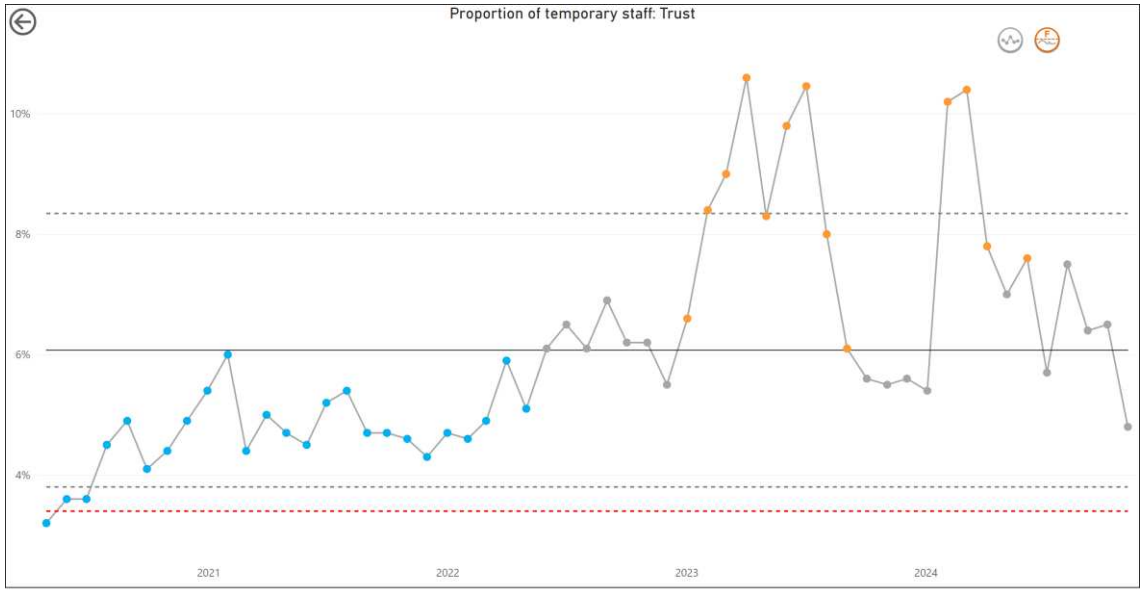


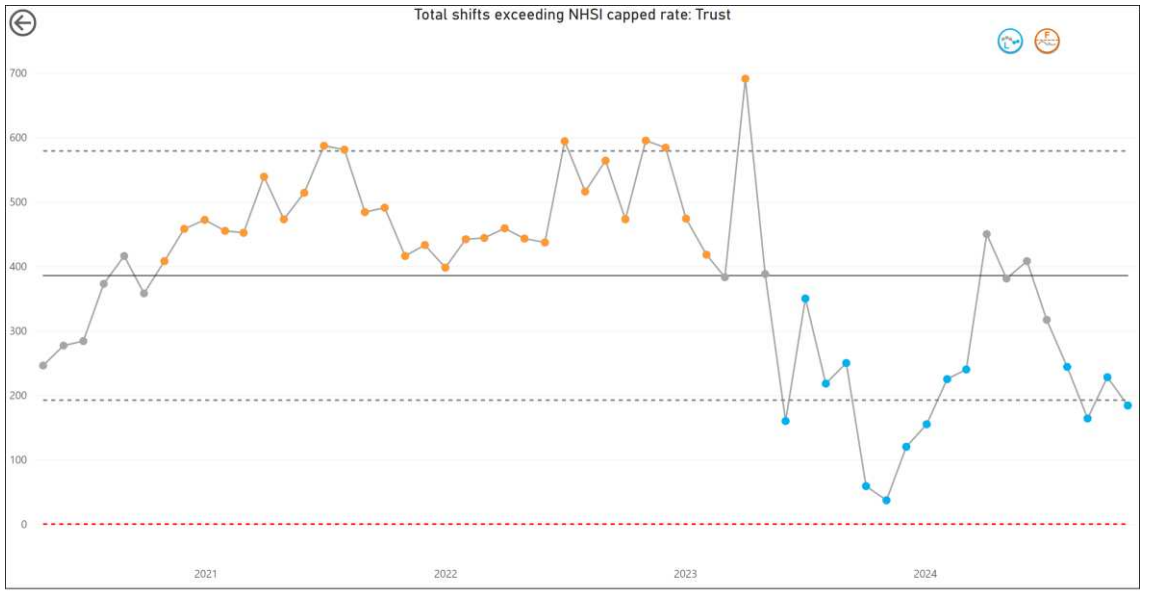


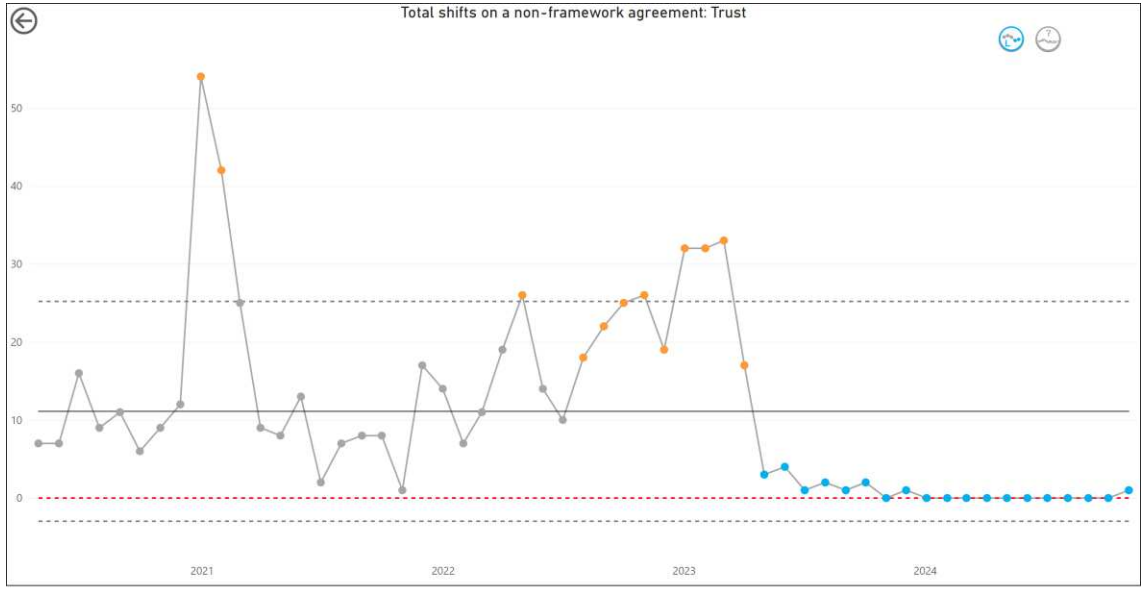



Sickness Rate: Trust
6.5%
6.0%
5.5%
5.0%
4.5%
2021
2022
2023
2024


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


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


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


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

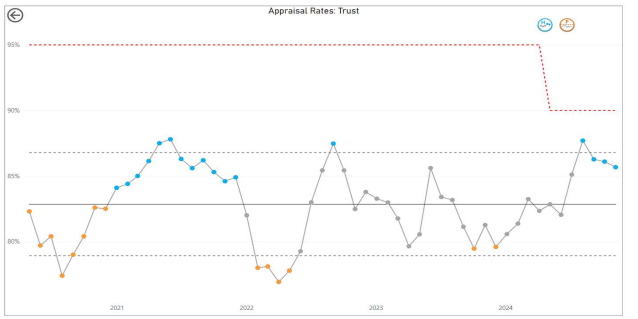
Exception Report - Action Plan

Appraisal Rates

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Appraisals	%	82.04%	85.11%	87.70%	86.27%	86.10%	85.67%%	85.10%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	88%	88%	88%	88%	89%	89%	90%



Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 75%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Recovery and Rehabilitation Unit Service	10	4	40.00
825 Advanced Care Planning Service	15	11	73.33
825 Community Therapies South East Service	12	7	58.33
825 Bishops Castle Hospital Service	12	8	66.67
825 Paediatric Occupational Therapy Service	14	8	57.14
825 Dentistry Service	47	32	68.09
825 Stoke Heath YOI Service	17	10	58.82
825 Rapid Response Service	34	25	73.53
825 Virtual Wards Service	35	25	71.43

SDGs and Divisions of 10+ staff	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	39	29	74.36
825 Finance Division	26	24	92.31
825 Governance Division	18	15	83.33
825 Medicines Management Division	21	20	95.24
825 Nursing and Quality Division	12	9	75.00
825 Operations Directorate Management Division	13	11	84.62
825 People and OD Division	22	22	100.00
825 Safeguarding Children Division	12	12	100.00
825 Service Delivery Group - Adult Community Services Division	611	528	86.42
825 Service Delivery Group - CYP&F Shropshire Services Division	336	302	89.88
825 Service Delivery Group - Planned Care Division	185	147	79.46
825 Service Delivery Group - Urgent Care Division	134	104	77.61
825 Trust Board Division	12	12	100.00

Reason for performance gap:

There has been a gradual improvement in the appraisal rate from the beginning of the year, with a slight reduction from August into October. The overall rate is 4.9% below target with 8 out of 13 divisional teams below 90% completed. There is a level of corelation between departments with higher vacancies, higher levels of sickness and low appraisal completion rates. Support and intervention is required in these areas. The focus is on setting a plan for the services with the lowest completion rates and to set dates for completion before December. A process for monitoring progress in place, with target support for managers and alerts and reminders to ensure completion.

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 and look at interventions to improve appraisals, including service specific appraisal plans, identifying who conducts the appraisal and when it will be completed.	May-24	Ongoing	Complete	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 to support improved approach to appraisal process enhancing the experience for employees and setting clear expectations of the importance of the appraisal and completing when due.	Jan-24	Ongoing	Complete	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
Target Corporate areas with low compliance to ensure areas that have less clinical impact are running at 100% compliance which will support overall numbers	Nov-24	Ongoing	On Track	Introduce Corporate discussions to ensure compliance (and recovery) against key workforce metrics
Stoke Health increased staffing to support greater capacity to complete appraisals	Oct-24	Dec-24	On Track	Plans in place to recover appraisal position due to increased substantive staff position
Review reports available for appraisal compliance to enable teams to monitor appraisal compliance	Oct-24	Dec-24	Complete	Ensure Managers have the information easily available to support compliand
People team to support areas of low compliance to develop recovery plans for their appraisal compliance	Oct-24	Ongoing	On Track	To ensure teams with low compliance are supported to increase their compli

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

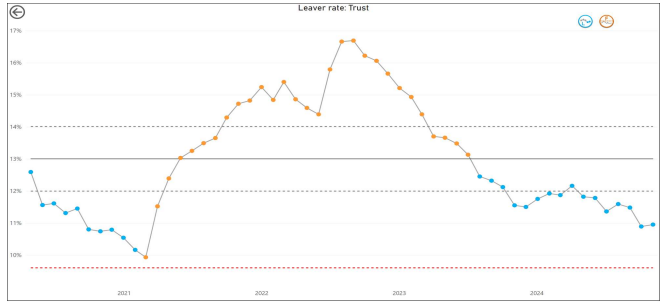
Exception Report - Action Plan

Leaver rate

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Leaver rate	%	11.78%	11.36%	11.59%	11.48%	10.89%	10.95%	10.95%
	Target	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	11.3%	11.3%	11.4%	11.5%	11.3%	11.0%	10.7%



Reason for performance gap:	The Leaver rate has seen a gradual improvement since April but still below target by 1.05% (1.29% below target last month). The main drivers of the turnover is retirement which based on the age profile is likely to remain over coming years. Initiatives to support more flexible retirement may support people to work longer before full retirement and encourage more retire and return. The second highest reason for leaving is related to work life balance. Health and wellbeing support and initiatives to support more flexibility in how people work are underway to support retention. Two of the teams with the highest leaver rate (Community Equipment Delivery Team and Warehouse) TUPE'd to an alternative provider on 1 April 2024.

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	Nov-24	Complete	The updated Policy is currently going through the policy approval process with the aim to be completed in November 2024
Roll out Stay Conversation and 30, 60, 90 day conversations workshops in particular targeting areas with high leaver rates	Sep-24	On-going	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	Complete	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	Complete	Flexible working survey has been published and currently analysing the results to inform next steps
Review the leavers information in relation to incompatible working relationships to establish next steps	Nov-24	Dec-24	Not Started	To evaluate any further support required for teams
Review the leavers information in relation to work life balance to establish next steps alongside flexible working requests recorded on ESR	Oct-24	Dec-24	In progress	To evaluate the reasons for work life balance as a reason for leaving and develop further support as required
Review and monitor leavers with less than 12 months service	Nov-24	On-going	Not started	Ensure new starters are receiving appropriate onboarding processes, 30, 60, 90 day conversations
Review staff survey information for areas with high leaver rate to establish any patterns	Nov-24	Jan-24	Not started	Establish if there are any areas of correlation with staff survey in the areas of higher leaver rate
Appointment of People Promise Manager	Jul-24	Jul-25	Complete	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.
Raise awareness of Pension awareness sessions which cover flexible retirement options	Jul-24	On going	Complete	Ensure staff are fully informed about their options in relation to flexible retirement including retire and return
Monthly Professional Standards and Absence team meetings with Clinical Services Manager & Divisional Service Managers to discuss leavers and other workforce metrics compliance to provide support where possible	May-24	On-going	Complete	Hot spot area are discussed along with required support

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

Leaving Reason (top 10)	Leavers
Retirement Age	54
Voluntary Resignation - Work Life Balance	29
Employee Transfer	21
Voluntary Resignation - Promotion	16
Voluntary Resignation - Relocation	14
Voluntary Resignation - Health	13
End of Fixed Term Contract	8
Voluntary Resignation - Incompatible Working Relationships	8
Voluntary Resignation - To undertake further education or training	7
Voluntary Resignation - Child Dependants	5
Voluntary Resignation - Lack of Opportunities	5

Org L7	Leavers
825 Ludlow Hospital Ward	8
825 Community Equipment Delivery Team	7
825 Community Equipment Warehouse Team	7
825 Virtual Wards Team	7
825 Community Nursing Team - South East	6

Staff Group	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Add Prof Scientific and Technic	2	1.20	4.40%	3.18%
Additional Clinical Services	37	28.57	9.93%	9.40%
Administrative and Clerical	63	53.10	15.52%	15.41%
Allied Health Professionals	17	12.75	7.67%	7.13%
Estates and Ancillary	7	6.60	8.92%	13.41%
Medical and Dental	3	1.43	9.09%	6.42%
Nursing and Midwifery Registered	76	61.87	11.24%	11.07%
Students	0	0.00	0.00%	0.00%

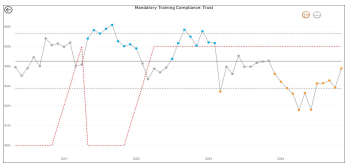
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Mandatory Training	%	91.80%	93.13%	93.14%	93.28%	92.92%	93.89%	93.89%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	93.9%	94.0%	94.0%	94.1%	94.2%	94.3%	94.5%



Sector	Substantive staff count	% Compliance
825 Stoke Heath YOI Sector	22	80.34%
825 Operations Directorate Management Sector	13	85.57%
825 Governance Sector	20	86.55%
825 South West Sector	128	87.88%
825 Central Sector	111	88.96%
825 Dudley PHNS 0-19 Sector	149	91.13%
825 Clinical Services - CYP&F Sector	20	93.13%
825 Service Delivery Group - Adult Community Services Management Sector	5	93.15%
825 Shropshire PHNS 0-19 Sector	104	93.60%
825 North West Sector	192	93.94%
825 Wheelchairs Sector	11	94.48%
825 Vaccination Sector	14	94.63%
825 South East Sector	135	94.68%
825 Trust Board Sector	12	94.74%
825 MIU & DAART Sector	45	94.77%

TOPIC	September Compliance		October Compliance	Variance against previous month
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	97.1%	▲	97.6%	0.46%
NHS|CSTF|Fire Safety - 1 Year|	95.1%	▲	95.2%	0.10%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	97.0%	▲	97.6%	0.61%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	97.3%	▲	97.6%	0.34%
NHS|CSTF|Information Governance and Data Security - 1 Year|	92.0%	▲	92.0%	0.06%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	96.6%	▲	97.0%	0.45%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	96.7%	▲	97.1%	0.39%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years|	97.1%	▲	97.7%	0.60%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	89.8%	▲	90.3%	0.50%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	94.7%	▲	95.7%	1.00%
NHS|MAND|Patient Safety - Level 1 - 3 Years|	97.3%	▲	97.5%	0.23%
NHS|MAND|Corporate Induction|	94.9%	▼	94.8%	-0.06%
NHS|MAND|Fraud Awareness - 3 Years|	95.1%	▲	95.5%	0.34%
NHS|MAND|The Oliver McGowan Mandatory Training		94.0%	▲	94.9%	0.94%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	92.9%	▲	96.2%	2.28%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	71.4%	▲	72.1%	4.70%
NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	69.4%	▲	74.9%	5.53%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	88.4%	▲	94.4%	0.98%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	89.0%	▲	90.2%	1.14%

Reason for performance gap:	Due to ESR downtime (national ESR issue -ESR not being able to be accessed), the end of month checks and daily audit reports were not completed before compliance reports were produced. This work has now been completed and will show in the November reports. There is some confusion with regards to BLS Level 2. For the requirement to be updated both the face to face training and the eLearning need to be completed. There are staff only completing the face to face training and therefore not gaining the competency. The ESRLM Team have requested the poster advertising the face to face sessions to be updated with this information and requested the trainers remind staff during the face to face training the eLearning module also needs to be completed. Mandatory training will continue 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. Comms have been sent out to inform managers and staff.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Monthly Professional Standards & Absence People team meetings with Clinical Services Manager & Divisional Service Managers to discuss mandatory training and other workforce metrics to support compliance	May-24	On-going	Complete	In place and ongoing. These meetings discuss hot spots and what support us required from a the People team to increase compliance .
	Stoke Health increased staffing to support greater capacity to complete mandatory training	Oct-24	Dec-24	In Progress	Oct 2024 - Plans in place to recover mandatory training position due to increased substantive staff position
	To implement a process to remind core ESR learner users to update training attendance status in ESR.	Sep-24	On-going	Complete	The ESRLM Team now send weekly emails to teams responsible for updating training statuses in ESR for attendance at face to face training, this reminder is to ensure attendance is captured in the monthly compliance reports.
	Appraisal and Mandatory Training Compliance Targets Briefing paper update	Jun-24	Dec-24	In Progress Task 1 Complete Task 2 Complete Task 3 Complete Task 4 Complete Task 5 In Progress	Oct 2024 - Task 3 complete • The ESR course catalogue and classes have been audited and updated following national best practice. The introduction of the ESR Learning Admin Working Group ensures all ESRLM admin users are given best practice guides and any new updates on ESR. All new staff who have ESRLM access are given training to ensure best practice is followed. Sept 2024 - 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 respect of its service delivery and risks.
	High Risk Fire	Jul-24	Dec-24	In Progress	Oct 2024 - SCHT have arranged a meeting with RWT in November to discuss RWT providing a fire service for SCHT. Sept 2024 -SCHT currently do not have a fire safety manager, RWT provide a fire service for SaTH. SCHT's estate's manager is contacting MPFT 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 standard 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.
	Safeguarding Training - Position Review	Jul-24	Dec-24	In Progress	Sept 2024 - The mapping review has commenced and is currently with the Safeguarding Team to review.
	Review Mandatory Training Topics	Jul-24	Dec-24	In Progress	Sept 2024 - A 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	Dec-24	In Progress	Sept 2024 - 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	Complete	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	Complete	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	Complete	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	Complete	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	Complete	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	Complete	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	Complete	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**	11/18/2024
Accountable Officer Approval	Rhia Boyode	**Date**	

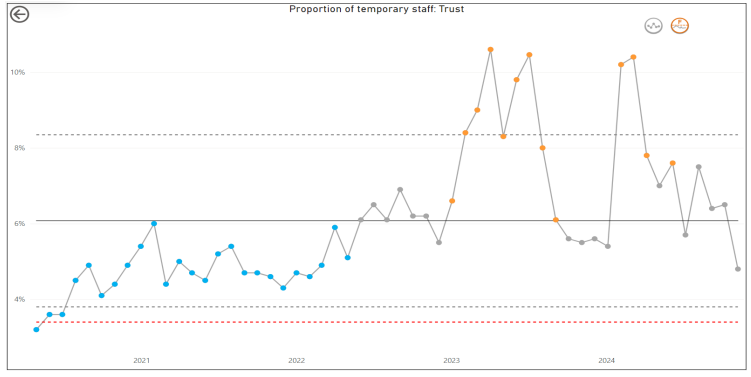
Exception Report - Action Plan

Proportion of temporary staff

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Prop Temporary staff	%	7.6%	5.7%	7.5%	6.4%	6.5%	4.8%	6.5%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	6.0%	5.0%	4.0%	4.0%	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 workforce solution is planned for this service. Paediatrics is the other area currently using locum whilst recruitment to a Speciality Doctors - this post commences 31/10/24 and agency ends on this date. Community Nursing is currently using agency above plan to cover staff absences (maternity, long term sickness and recruitment to vacancies).To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. NHSE have launched a new programme aiming to improve price cap compliance for agencies across the Midlands which will support improvement in price by setting target dates for reduction over the coming months. The aim is to ensure price cap compliance for nursing by end of March 25.				
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	Vacancy filled and agency stopped.
	R & R Ward 36 local Consultant - plans for this cover are not yet finalised by the operational team: an alternative model is being scoped via an SLA due to be finalised by November	Unknown	Nov-24	In-progress	Locum cover ceased
	Paediatrics - recruitment complete Speciality Doctor start date 31/10/24	Feb-24	Nov-24	Complete	Reduction in locum use from November 2024
	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 recruitment team remain in contact with these individuals. There are currently only 3 Nursing Associate PINs now outstanding.	Sep-24	Oct-24	Complete	NQ's receive PINS and commence employment.
	Operational agency scrutiny meetings take place weekly	Unknown	Unknown	On-going	Challenge on timescales for the use of agency in ops teams and their strategies to manage
	Check and Challenge meetings commenced October 24 - run by clinical lead (Assos. Director of Workforce and Professional standards) to ensure efficient and effective use of e-roster to show transparency in shift management by roster creators and maintainers.	Oct-24	Unknown	On-going	Monthly meetings identify any issues and the processes required to rectify to reduce agency
	New temporary staffing policy in draft for consultation process including flowcharts on bank and agency approval process for clarity	Oct-24	Nov-24	In progress	Policy published on staff zone
	Implement price reductions for agency in line with NHSE price cap compliance programme	Oct-24	Mar-25	In progress	Reduced price of agency shafts and consistency across system and region
Author	Gina Billington	**Date**	11/18/2024		
Accountable Officer Approval	Rhia Boyode	**Date**			

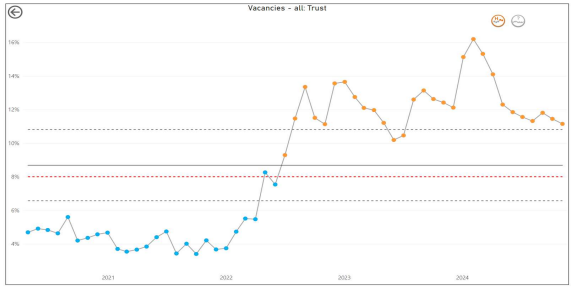
Exception Report - Action Plan

Vacancies - all

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Vacancies	%	11.85%	11.56%	11.32%	11.81%	11.45%	11.15%	0.00%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	10.0%	9 %%	10.0%	9.5%%	8.0%	8.0%	8.0%



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. Focus on the areas with vacancies that are creating demand for temporary staffing which will be across in patient areas. Focus on the areas with vacancies that are creating demand for temporary staffing which will be across in patient areas. RRU Shrewsbury have some B2 HCA posts held whilst not operating at 32 beds.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	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 recruitment team remain in contact with these individuals.	Sep-24	Oct-24	Complete	NQ's receive PINS and commence employment.
	Recruitment continue to review their processes to ensure timely recruitment. Time to hire is currently 35.5 working days.	Apr-24	On-going	On-going	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 within a 2 week window. Write to all successful applicants reminding them to book in and the documents they need to bring.	Jul-24	Sep-24	In progress	31 checks took place in August, 27 in September and 34 in October (47 were available to book).
	Gain approval to recruit to resignation of the team. Collaborative support to cover the vacancy sought from SaTH.	Jul-24	Sep-24	Complete	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	
	Recruitment policy in draft to commence the consultation stage. Includes new flowcharts and toolkit for managers.	Oct-24	Nov-24	In progress	To ensure managers are up to date with recruitment processes and provides the tolls for them to recruit.
	Recruitment managers training - collaborative delivery with SaTH	Sep-24	On-going	On-going	Recruiting managers trained and aware of the processes involved in recruitment to aid in the appropriate recruitment processes and time lines. To reduce the number of queries received by the recruitment team.
	Drop-in sessions taking place with the ESR team for managers to attend covering ESR queries, recruitment and trac queries. Annual plan in progress	Sep-24	On-going	On-going	To support managers in the processes involved in addressing vacancies.
Author	Gina Billington	**Date**	11/18/2024		
Accountable Officer Approval	Rhia Boyode	**Date**			

Division	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer	33.32	0.13	0.4
Urgent Care (Adults)	189.3	33.62	17.8
Community Services (Adults)	742.17	81.16	10.9
Planned Care SDG	214.64	33.34	15.5
Children and Families Division	455.87	33.59	7.4
Chief Executive	12.64	0.80	6.3
Director of Finance and IM&T	82.57	10.59	12.8
Director of Governance	22.7	2.32	10.2
Director of People	33.86	4.13	12.2
Director of Nursing and AHPs	33.71	3.40	10.1
Medical Directorate	3.18	0.30	9.4
Total	1823.96	203.38	11.2

Inpatient Wards	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward	21.63	4.14	19.1
Ludlow Hospital Ward	35.72	6.31	17.7
Whitchurch Hospital Ward	41.13	4.30	10.5
Bridgnorth Hospital Ward	41.35	4.26	10.3
Rehab & Recovery Unit - Shrewsbury	53.84	17.51	32.5
Rehab & Recovery Unit - Telford (War	45.52	9.20	20.2
Total	239.19	45.72	19.1

Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Sickness Rate	%	5.59%	5.53%	5.44%	5.31%	5.34%	5.33%	5.33%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	5.2%	5.3%	5.3%	5.3%	5.2%	5.1%	5.0%

Reason for performance gap:	Overall sickness has reduced since April but continues to remain above target (0.58% above target). The main drivers are stress, anxiety and depression conditions. Support around health and wellbeing, resilience and flexibility are critical to support reduction in absence levels and are being implemented by the People Team. Seasonal conditions such as cold and flu are also a significant reason for sickness, getting winter prepared by promoting the vaccination campaign will provide a level of mitigation going into the winter months.				
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	On-going	In place	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	On-going	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	On-going	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	Complete	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	Sep-24	On-going	Complete	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	Dec-24	Dec-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	Nov-24	Dec-24	In progress	MSK is the second highest reason for absence and we are looking at preventative actions as well as curative
	Work with hot spot teams to understand reasons for absence and tailor support e.g. stress risk assesssment, MSK support	Oct-24	On-going	In progress	To ensure appropriate support is in place
Author	Fiona MacPherson	Date			
Accountable Officer Approval	Rhia Boyode	Date			

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	252	322	11,205.92	37.9
S13 Cold, Cough, Flu - Influenza	624	795	3,026.93	10.2
S12 Other musculoskeletal problems	125	132	2,272.77	7.7
S25 Gastrointestinal problems	436	546	1,917.33	6.5
S28 Injury, fracture	58	59	1,563.99	5.3
S15 Chest & respiratory problems	154	176	1,200.97	4.1
S26 Genitourinary & gynaecological disorders	86	103	1,136.76	3.8
S98 Other known causes - not elsewhere classified	64	70	1,067.01	3.6
S11 Back Problems	77	84	999.08	3.4
S17 Benign and malignant tumours, cancers	18	27	960.44	3.2

Org L7	Absence FTE	Available FTE	Absence FTE %
825 Shrewsbury ICS Nursing Team - South	30.00	68.99	43.49%
825 MSK Rheumatology Team	202.60	543.60	37.27%
825 Compass Health Team	45.60	146.40	31.15%
825 CYP Nurse Management Team	46.00	214.00	21.50%
825 Community Children's Nursing Admin Team	105.60	500.75	21.09%
825 Single Point of Referral Team	496.61	2,600.68	19.10%
825 Isle Court Team	63.00	335.00	18.81%
825 Bishops Castle Hospital Domestics Team	141.49	779.81	18.14%
825 Telford Wound Healing Service Clinical Team	679.80	3,997.40	17.01%
825 Whitchurch Physiotherapy Clinical Team	155.92	956.81	16.30%

Staff Group	Absence FTE	Available FTE	Absence FTE %
Add Prof Scientific and Technic	400.56	14,240.80	2.81%
Additional Clinical Services	8,115.67	115,708.22	7.01%
Administrative and Clerical	5,215.43	125,715.42	4.15%
Allied Health Professionals	2,089.56	64,505.83	3.24%
Estates and Ancillary	775.57	17,746.97	4.37%
Medical and Dental	496.25	7,801.08	6.36%
Nursing and Midwifery Registered	12,446.48	206,350.72	6.03%
Students	45.00	3,954.00	1.14%

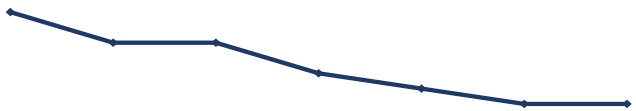
Exception Report - Action Plan

Total shifts exceeding NHSI capped rate

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Shifts	Number	408	317	244	164	228	184	0
	Target	0	0	0	0	0	0	0

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	60	40	40	20	10	0	0



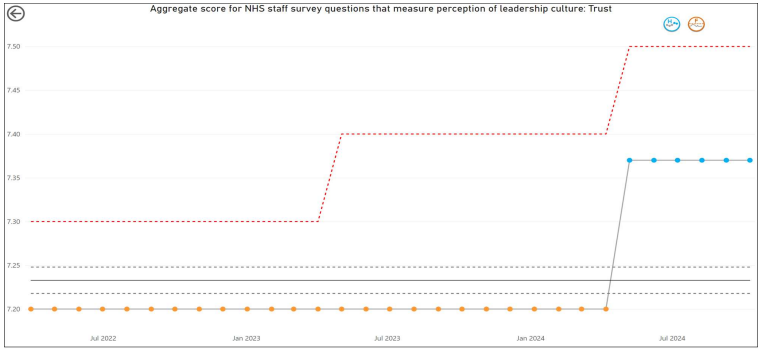
Reason for performance gap:	Demand for agency workers and market rates is contributing to high price of agency shifts above price cap. The NHSE price cap programme and the work already undertaken across our system will improve price cap compliance through a targeted strategy working collaboratively to set rate reductions over the coming months. We are aiming to get to a position of 100% price cap compliance by 31 March 25.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Determine phased approach and reductions in rate and work collaboratively on the development of a rate reduction schedule to bring down rates gradually over coming months.	Jul-24	Mar-25	On-going	Approach agreed
	Phase 2 of price cap compliance negotiations: system and regional groups established and agreed letters sent to agencies regarding price cap compliance. Letters sent Oct 24.	Oct-24	Dec-24	On-going	Reduction in price cap provision by agency
	Agency scrutiny meetings held weekly with Ops and temp staffing and recruitment	Oct-24	Dec-24	On-going	Challenge on timescales for the use of agency in ops teams and their strategies to manage
	Check and Challenge meetings commenced October 24 - run by clinical lead (Assos. Director of Workforce and Professional standards) to ensure efficient and effective use of e-roster to show transparency in shift management by roster creators and maintainers.	Oct-24	Unknown	On-going	Monthly meetings identify any issues and the processes required to rectify to reduce agency
	New temporary staffing policy in draft for consultation process including flowcharts on bank and agency approval process for clarity	Oct-24	Nov-24	In progress	Policy published on staff zone
Author	Gina Billington	**Date**	11/18/2024		
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Aggregate score for NHS staff survey questions	Number	7.4	7.4	7.4	7.4	7.4	7.4	7.4
	Target	7.5	7.5	7.5	7.5	7.5	7.5	7.5

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	7.4	7.4	7.4	7.4	7.4	7.4	7.4



Reason for performance gap:	The national average is 7.5 and we are close to this with a score of 7.4. There have been changes over the last 24 months which have included change management across leadership roles which will take time to embed and change culture. The culture change team has been launched and will support changing this score over time.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Undertake Cultural Maturity Audit	Oct-24	Dec-24	In progress	To understand further the culture of the Trust
	Implement Culture Change Team	Oct-24	Ongoing	In place	Make a difference: drive meaningful change across ShropCom to enhance employee experience, review our culture and leadership behaviours, bring 'The People Promise' alive, and improve the care we provide to our patients and communities.
	Commence discovery phase of the culture and leadership change programme	Nov-24	Ongoing	In progress	Make a difference: drive meaningful change across ShropCom to enhance employee experience, review our culture and leadership behaviours, bring 'The People Promise' alive, and improve the care we provide to our patients and communities.
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of staff in senior leadership roles	Number	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52
	Target	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%	9.52%

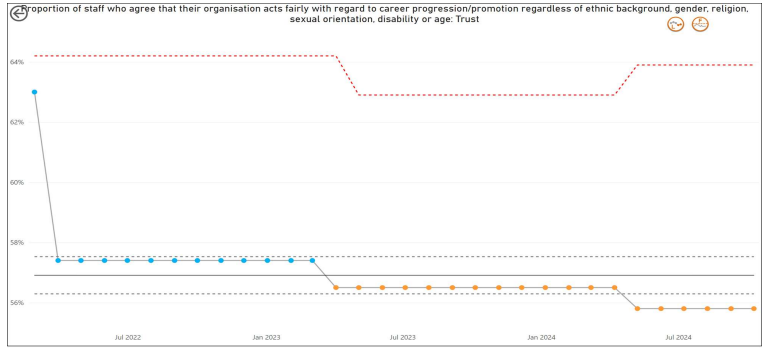
Reason for performance gap:	The WRES 2023/24 report shows our colleague representation for Asian, Mixed, Black and other minority people has increased year on year since 2020 and makes up 7.82% of our workforce. The 2021 census showed population by ethnicity in Shropshire as White people 96.7% and Asian, Mixed, Black, and other minority people as 3.3%. The population by ethnicity for Telford and Wrekin in the 2021 census was White people 88.2% and Asian, Black, Mixed and other minority people 11.8%. While this indicates our senior leadership workforce is over representative when compared to our local Shropshire community, we do recognise that our senior leadership workforce is not representative compared to our local Telford & Wrekin community.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Nov-24	Ongoing	In progress	Ensure recruitment processes are fair, inclusive and transparent
	Work in collaboration with SaTH to offer places on the Galvanise Leadership Course for Ethnic Minority Staff	Aug-24	Ongoing	In place	Ensure staff have the opportunity to access leadership courses
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of staff who agree that their organisation	Number	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%
	Target	63.90%	63.90%	63.90%	63.90%	63.90%	63.90%	63.90%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%	55.80%



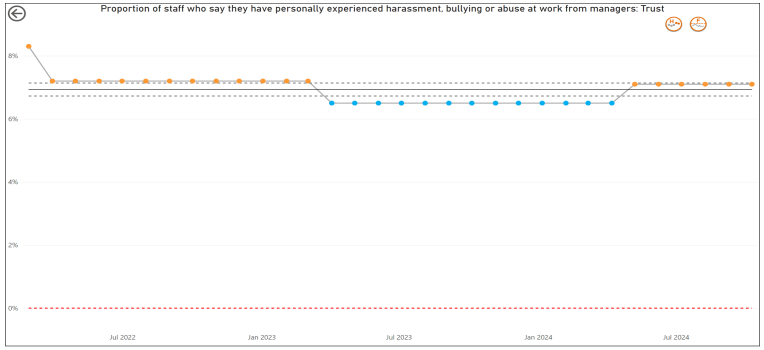
Reason for performance gap:	There is a gap of 8.1% between the national average and SCHT's score. For a period of time leadership courses have not been available internally for our staff to attend however, more recently we have been working in collaboration with SaTH and places have been offered to our staff on their leadership courses.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Nov-24	Ongoing	In progress	Ensure recruitment processes are fair, inclusive and transparent
	Work in collaboration with SaTH to offer places on the Galvanise Leadership Course for Ethnic Minority Staff and other leadership courses	Aug-24	Ongoing	In place	Ensure staff have the opportunity to access leadership courses
	Work with the Workforce Race Equality Network to understand development needs and how their careers can be supported	Nov-24	Mar-25	Not Started	Ensure support is appropriate and meets individual's needs
	Publicise positive staff stories around career and development opportunities	Dec-24	Mar-25	Not started	Raise awareness of career development
	Explore implementing 'scope for growth' conversations	Nov-24	Feb-25	Not started	Ensure all staff have the opportunity to discuss careers aspirations
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of staff who say they have personally	Number	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%



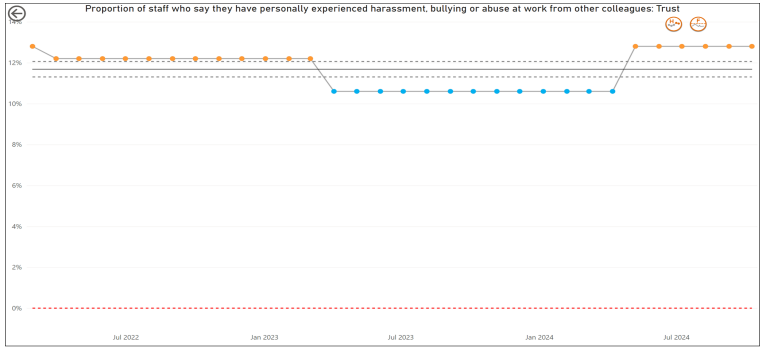
Reason for performance gap:	When reviewing the information retained by the People team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review our Dignity at Work Policy	Oct-24	Nov-24	In progress	To ensure the Dignity at Work policy is fit for purpose
	Develop a launch campaign to increase awareness and promote use of the Dignity At Policy	Oct-24	Dec-24	In progress	To ensure people are aware of how to access and raise concerns
	Raise awareness of FTSU Guardian and their role	Jul-24	Ongoing	In progress	To ensure people are aware of how to access and raise concerns
	Continue to roll out the civility & respect training programme	Jul-24	Ongoing	In progress	Create an environment free of bullying and harassment and raise awareness
	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	Nov-24	Dec-25	In progress	Targeted support for areas where bullying and harassment is reported
	Develop a Civility & Respect booklet to support the Civility and Respect programme	Nov-24	Jan-25	Not started	Create an environment free of bullying and harassment and raise awareness
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of staff who say they have personally	Number	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%



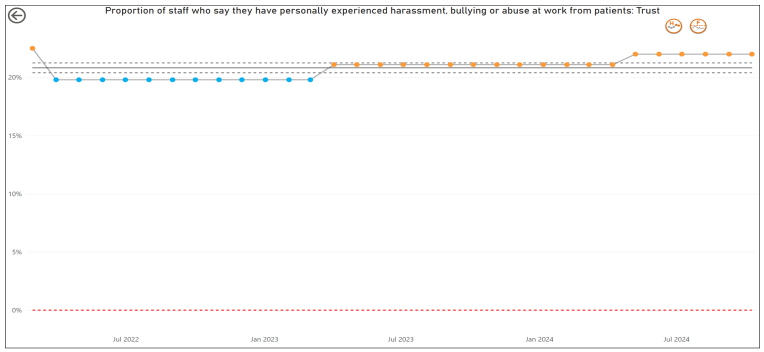
Reason for performance gap:	When reviewing the information retained by the People Team not all cases of individuals feeling bullied are reported. The aim is to reduce cases by implementing the action plan and encourage people to speak up about their experiences.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review our Dignity at Work Policy	Oct-24	Nov-24	In progress	To ensure the Dignity at Work policy is fit for purpose
	Develop a launch campaign to increase awareness and promote use of the Dignity At Policy	Oct-24	Dec-24	In progress	To ensure people are aware of how to access and raise concerns
	Raise awareness of FTSU Guardian and their role	Jul-24	Ongoing	On Going	To ensure people are aware of how to access and raise concerns
	Continue to roll out the civility & respect training programme	Jul-24	Ongoing	In progress	Create an environment free of bullying and harassment and raise awareness
	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	Nov-24	Dec-25	In progress	Targeted support for areas where bullying and harassment is reported
	Develop a Civility & Respect booklet to support the Civility and Respect programme	Nov-24	Jan-25	Not started	Create an environment free of bullying and harassment and raise awareness
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

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

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of staff who say they have personally	Number	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%



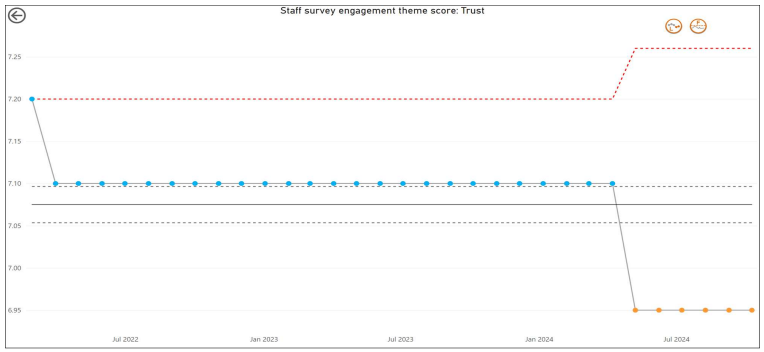
Reason for performance gap:	Staff experience bullying by patients, the aim is to raise awareness of the impact of this behaviour and support staff as required.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Launch work without fear campaign	Dec-24	Feb-25	Not started	Raise awareness to our patients, relatives and members of the public
	Develop nudge posters around zero tolerance	Dec-24	Mar-25	Not started	Raise awareness to our patients, relatives and members of the public
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

Exception Report - Action Plan

Staff survey engagement theme score

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Staff survey engagement theme score	Number	7.0	7.0	7.0	7.0	7.0	7.0	7.0
	Target	7.3	7.3	7.3	7.3	7.3	7.3	7.3

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	7.0	7.0	7.0	7.0	7.0	7.0	7.0



Reason for performance gap:	SCHT's score is close to the national average, however work continues around engagement with the appointment of the People Promise Manager and the work they are undertaking.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Appointment of a People Promise Manager	May-24	Jul-24	In place	Increase awareness of the People Promise
	Develop a local listening promise	Jul-24	Dec-24	In progress	visible commitment to listening
Author	Fiona MacPherson	**Date**			
Accountable Officer Approval	Rhia Boyode	**Date**			

0. Reference Information

Author:	**Tracie Black Associate Director for Workforce Education and Professional standards**	**Paper date:**	**October 2024**
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	August 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper Category:**	Workforce, Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

2.2 Summary

- This report went to October's Quality and Safety Committee and was approved for submission to Trust Board.
- The Community Safer Staffing tool was introduced to the Trust in January 2023, however at the beginning of 2024 the National Team paused the tool due to issues with the efficacy of the tool. The latest information is that this will be re-launched sometime in early 2025 with some changes to the tool. All staff will need further update training prior to using the tool in the Trust.
- The Community District Nursing Teams have completed a service review in 2024 to understand the full impact of the demand on the service. This work continues.
- Currently a service specification review is underway in the Community District Nursing Team with Commissioners to ensure work undertaken is appropriately financed.
- The Safer Nursing Care Tool (SNCT) was introduced to the Community Hospitals in June 2023 and they undertook their first data collection in June/July 2023. The SNCT tool was refreshed in late 2023 but was not available for the January 2024 data collection but was introduced for the June 2024 data collection.
- The Trust has seen an increase in the need for enhanced care for our patients across the Trust and this has impacted on agency usage as the staffing establishment does not include any uplift for enhanced care.
- Safecare has now been launched to all inpatient areas. Safecare provides staff with live visibility of staffing levels matching with patient demand, it can highlight areas with short workload-based care hours. It allows for the acuity and dependency of patients to be

visible daily so wards can demonstrate how dependant their ward is at all times. There is ongoing work with all teams to embed safecare.

- As the tool has been updated and June was the first time we collected data from it, we will need to collect at least another set of clean data before we would make any recommendations for change.
- As the Rehabilitation and Recovery Wards (RRUs) were only opened in January 2024, we need to monitor the impact this has on the community-based beds.
- Recruitment to the RRUs has been successful with now only minimal vacancies. Agency usage has dropped to only requesting agency for enhanced care patients and to cover short term absences.
- Vacancy rates in our Community Hospitals have seen a marginal increase from January 2024 of 13.04 WTE to 13.08 WTE, however it is to be noted that in January 2024 we only included the 3 community hospitals in the June 2024 data collection we have included the community hospitals and the RRUs.
- The Trust has seen continued reduction in agency usage however much of the agency within the Community Hospitals can be attributed to the enhanced care needs of the patients.
- Bishops Castle Community Hospital reopened the inpatient facility in July 2024 to 16 beds. They will be part of the data collection for January 2025.
- The Workforce Safeguard Gap analysis action plan now has 11 of the 14 action fully completed with the remaining 3 actions partially completed with completion dates to allow the Trust to be fully complaint.
- It is the professional judgement of the Director of Nursing who is also a CNO for England Safer Staffing Fellow that no changes are made to Nursing establishments at this time. Continued oversight of metrics for staffing, quality and safety are maintained on a daily and then monthly basis to Quality and Safety Committee.

2.3. Conclusion

The Trust Board is asked to **review** the information and **accept** the recommendation that there is **assurance for safer staffing within the Community Hospitals and RRUs and moderate assurance on Workforce Safeguard compliance**. The Trust is partially compliant with the national policy (Developing Workforce Safeguards), the progress of this will be monitored at the Quality & Safety Committee quarterly to monitor compliance against the policy.

3. Main Report

3.1 Introduction

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

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

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

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

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

Of which this paper confirms that we have adopted this triangulated approach. The Trust has a Workforce Safeguards Gap analysis action plan which has 14 recommendations of which 11 are fully compliant and 3 that are partially compliant with completion dates before the end of 2024 at which point we will be fully complaint. (see attachment 1).

The Trust commenced using the validated inpatient tool (SNCT) in June 2023 once the required licence had been received, this tool is used widely in other Community Hospitals across the country. The inpatient tool was updated in 2023 and released for use in 2024.The June 2024 data is the first set of data using this updated tool. The National Community Safer Staffing tool was introduced nationally in September 2022 but has been paused in May 2023 by the National Team whilst further checks were undertaken, and this is expected to be relaunched in early 2025. This report outlines the first set of data using the refreshed tool for the community inpatient wards and the RRUs captured via this validated, evidence-based method.

4.0 Nurse to Patient ratio – Inpatient wards

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

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

4.3 Table 1 shows the average RN: Patient ratio at Shropcom during June 2024 for our community and RRU inpatient areas (Bishops Castle not included). It demonstrates that during June 2024 all community and RRU inpatient wards met the national requirement of an overall 1:8 for day shifts at the time of the data collection although it should be noted this national guidance is based on acute inpatient facilities.

Table 1: Actual Average RN: Patient ratio during June 2024

Hospital	RN: Patient Ratio- Day Shift
Ludlow	1:8
Bridgnorth	1:8.4
Whitchurch	1:8.2
Ward 36	1:8.4
Ward 18	1:8.6

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

4.5 Actual versus planned staffing numbers for June 2024 showed that for 3 inpatient wards and the 2 RRUs 86.7% of all shifts (both RN and HCSW) were covered by substantive staff; this is an increase from 71.8% on January 2024 data. 11.4% were filled by Agency RN staff and 9.6% were shifts filled by Bank staff. This demonstrates that the fill rate was over 100%.

5.0 Safer Nursing Care Tool (SNCT)

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

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

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

5.4 The Trust gained its licence in early 2023 and 3 sets of data have now been collected and will continue to collect 2 sets per year, as this allows us to understand our adherence to the national standards and offer the Board greater assurance.

5.5 Training is in place and continues for staff undertaking the SNCT data collection. Safecare has now been launched in the inpatient wards and so we are able to see the acuity and dependency of our patients on a daily basis. This is a new tool and is taking time to embed with all the teams and further support has been put in place.

5.6 Bridgnorth has 25 beds with the daily average at 19.05 patients at the time of the data collection 8.3 patients scored level 0, 0.26 scored level 1a, 10.38 scored level 1b and 0.16 scored level 1c (this is the new score for patient requiring one to one

care) (See appendix 1 for the SNCT score). This scoring is appropriate and expected for the patients profile we see for the type of patients in our Community Hospitals. The scoring suggests we should have 20.75 RN and 13.83.HCA, suggesting a split of 60:40 RN to HCA. The actual establishment for the ward at present is RN 15.53 and HCA 20.29 a total of 35.62, which is a split of 43:57 RN to HCA. When we look at the results of the data collection it suggests the ward needs 34.58 to run the ward and suggests that the ratio of RN to HCA needs to change. It also suggests that and additional 0.51 WTE is required for the 1c & 1d patients. The agency/bank usage for June 2024 was 8.37 WTE which covered enhanced supervision and vacancy gaps. With the actual establishment at 35.62 WTE **no change is required**.

5.7 Ludlow has 24 beds with the daily average at 23.93 patients at the time of the data collection. 3.87 patients scored level 0, 1.87 scored level 1a, 12.29 scored level 1b and 5.90 scored level 1c. The data suggest we should have 21.28 RN and 14.19 HCA totalling 35.47 WTE suggesting a split of 60:40. The actual establishment for the ward is RN 15.21 and HCA 14.99 a total of 30.22 WTE which is a split of 50:49 RN to HCA. . When we look at the results of the data collection it suggests the ward needs 35.47 WTE to run the ward and suggests the ratio of RN to HCA needs to change. it also suggest that an additional 18.95 WTE is required for the 1c and 1d patients. With the actual Establishment at 30.22 there is a **deficit of 5.00 WTE** without the consideration of enhanced care. The agency/bank usage for June 2024 was 47.60 this was a mixture of RN and HCA to cover the high number of enhanced care patients and vacancy.

5.8 At the time of the review, Whitchurch had 32 beds with the daily average at 31.22 patients at the time of the data collection. 19.23 patients scored level 0 and 11.99 patients scored 1b. This scoring is appropriate and expected for the patients profile we see for the type of patients in our Community Hospitals. The scoring suggests we should have 25.61 RN and 17.07 HCA which is a split of 60:40. The actual establishment for the ward is RN 14.67 and HCA 19.79 a total of 34.64. which is a split of 42:57 RN to HCA When we look at the results of the data collection it suggests the ward needs 42.9 WTE to run the ward **which would be an increase of 8.26 WTE and suggests that the ratio of RN to HCA needs to change**. There was no recommendation for 1b/1c patients as there were none for June 2024 however it is to be noted that the ward does have patients requiring enhanced care as part of the standard admission criteria.

5.9 Ward 36 has 20 beds with a daily average of 19.2 patients at the time of the data collection. 10.36 patients scored Level 0,8.46 scored level 1b and 1.10 scored level 1c. This scoring is appropriate for the patient profile in the RRUs. The scoring suggests that the ward should have 16.49 RN and 10.99 HCA totalling 27.48 WTE which is a split of 60:40 The establishment for the ward is RN 16.78 and 14.67 HCA totalling 31.45 WTE which is a split of 54:46 RN to HCA . When we look at the data collection it suggests the ward needs 31.02 and so the **establishment covers the suggested staffing level**. It further suggests a further 3.53 WTE for the 1c/1d patients. The agency/bank usage for June 2024 was 9.83 WTE which was cover for the enhanced care patients and vacancy.

5.10 Ward 18 has 26 beds with a daily average was 25.18 patients at the time of the data collection. 10.2 patients scored Level 0, 14.5 scored level 1b and 0.45 scored level 1c. This scoring is appropriate for the patient profile in the Rehabilitation and Recovery Units. The scoring suggests the ward should have 24.26 RNs and 16.17 HCA which is a split of 60:40 The establishment for the ward is RN 21.17 and 16.50 HCA totalling 37.67 WTE which is a split of 56:44 WTE . **The data would suggest an increase of 2.76 WTE**. It further suggests 1.45 WTE for the1c/1d patients.

5.11 For the community inpatient wards and the RRUs this is the first set of data using the refreshed data collection tool. You can see from the results of the 1c and 1d there are variations in need across the wards, this will need to be monitored as there will be variation each month dependant of the patient needs. **In January 2024 the Director of Nursing had instructed to maintain monitoring with no changes to establishments for a further 6 to 12 months within the Community Hospital bed bases. This is to allow time for the impact of the RRUs to take effect and for 2 clean data sets of the new SNCT to take place. Staffing is monitored on a daily basis with risk constantly being assessed.**

5.12 The gold standard for skill mix of staff would be 70% RN to 30% HCA (Royal College of Nursing 2012), linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021). Within the Community Wards the skill mix is often circa 50:50. It is to be noted that when benchmarking, most Trusts including acute Trusts, do not reach the standard of 70:30, the aim is to work towards increasing the Nurse-to-patient ratio on a trajectory to eventually get to 65% and that the 65% would include NAs. This is the professional judgement of the Director of Nursing. The data collection recommendations are based on a 60:40 skill mix.

6.0 Community Safer Care Tool (CNSST)

6.1 The data for the CNSST has not been included following national instruction to pause it's use whilst further testing is undertaken. The latest update is that the refreshed tool will be available in late 2024/early 2025 but the changes in the tool will mean that it will need to be relaunched with training for staff prior to the tool being used.

6.2 Training will be needed for all staff due to the changes to the tool and once the national team put the training dates out then there will be a cascade approach for the team.

6.3 The caseloads for the District Nursing Teams are split into 3 categories, patient contacts, continence contacts and phlebotomy contacts. There are 8 District Nursing Teams within Shropshire Community Health Trust (SCHT) and in June 2024 there were 3011 face to face visits, 1253 phlebotomy visits and 1355 continence visits. 1646 visits were cancelled with 2910 rescheduled.

6.4 Benchmarking data identifies that the teams are working efficiently against their peers and are more productive. It also shows that the Trust has a larger number of cancellations and rescheduled contacts against its peers, which demonstrates demand is outstripping capacity on a daily basis.

6.5 In addition to the service review, a revised service specification is currently underway with Commissioners.

6.6 One of the current pressures is the number of non-housebound patients the teams are seeing; this is impacting on the work load. Rio has been configured to capture this data so that we have an accurate picture of the issue to share with Commissioners.

6.7 The introduction of Dexcom monitors for Diabetic patients has also increased the workload for the District Nursing Teams, as patients have 24-hour monitoring it has been found that their requirement for Insulin has increased thus increasing the amount of visits each patient needs. Within the community patients we see a high rate of non-compliance again resulting in increased need and visits.

6.8 Capacity pressures vary across the teams due to the demographic of patients and examples are: High levels of daily contacts for Insulin, High number of housebound patient unable to attend clinics as well as staffing issues including: High levels of sickness, vacancies/maternity leave.

6.9 It is to be noted that the teams are mostly covering urgent work and so creating delays in holistic, lower limb and continence assessments.

6.10 As we do not have CNSST data to demonstrate the need for increase workforce, we **cannot make recommendations on staffing increases**, however we can see that in the benchmarking data, that it is important for the service specification work to be completed to see if any of the case work can and or should be re-distributed back to alternative providers thus supporting the community teams in managing their caseloads.

7.0 Fill rates for inpatient wards

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

7.2 The RRUs opened in January 2024, and have now been included in the reporting for fill rate data.

7.3 The position for June 2024 Source (June 1st – 30st June 2024) is shown in table 2.

Table 2 – Fill rates (June 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%	105%	105%	104%
Ludlow	110.%	131%	101%	183%
Whitchurch	96%	100%	100%	160%
Ward 36	100%	135%	100%	115%
Ward 18	102%	95%	101%	100%

7.4 HCA day and night shifts were higher than planned to maintain ongoing management and safety for patients requiring enhanced supervision. This is particularly noticeable at both Whitchurch and Ludlow where they have seen high numbers of patients needing enhanced supervision. This is a recurrent theme as this is a similar picture to the January 2024 data.

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

7.6 Bed occupancy rates reported for January 2024 were 97.5%. This breakdown for bed occupancy at each site as 96.1% Bridgnorth, 99.9% Ludlow, and 95.6%, Whitchurch, Ward 36 PRH, 98.1% and Ward 18 RSH 98.8%.

7.7 For the 3 community inpatient areas, two shifts were reported in June 2024 as 100% RN agency staff. These were in relation to two shifts at Whitchurch both night duty and staff on shift were regular agency to Whitchurch. The RRUs did not have any 100% agency for June 2024.

7.8 All 5 ward areas were above the 90% fill rate for both days and nights in June 2024.

8.0 Care Hours per Patient Day (CHPPD)

8.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Insight-Model Hospital website. SCHT data is now available on the Model Hospital site and on performing benchmark analysis, for the last quarter (June 2024) the average overall for our Trust is 6.9 care hours per patient day (CHPPD), compared to with average of other similar community NHS trusts of 8.7 (as shown in table 3). This data cannot be viewed in isolation and when triangulating with other data and professional judgement and quality and safety indicators there is not a cause for concern. CHPPD will continue to be monitored monthly.

Table 3 - Model Hospital Benchmarking table

Organisation Name	CHPPD - overall
Derbyshire Community Health Service Foundation Trust	4.8
Birmingham Community Healthcare	3.9
Overall Average	8.7
Central London Community Healthcare	8.6
Hertfordshire Community	7.7
Kent Community Health NHS Foundation Trust	7.7
Leeds Community Healthcare NHS Trust	7.3
Lincolnshire Community Health Services	7.1
Shropshire Community Health	6.9
Norfolk Community Health and Care	6.8
Sussex Community	6.3
Hounslow and Richmond Community Healthcare	5.8
Bridgwater Community Healthcare	5.6

8.2 Table 4 shows the rolling care hours per day for the last year. Care hours per patient day are calculated by dividing the total number of nursing hours on a ward by the

number of patients in beds at midnight. The calculation proved the average number of care hours available each patient on the ward.

8.3 CHPPD data for the RRUs is now being collected, however due to the RRU's being only opening in January 2024 there is no comparable data from 2023. To note, CHPPD does not take into account the skill mix and should not be viewed in isolation from other safer staffing metrics.

8.4 Following introduction of eroster we have had a reduction in CHPPD, this likely due to the previous process being manual and there was options for errors. We have now introduced safecare where the staffing levels are inputted daily along with the acuity of patients and so the data which should allow for accurate data, however we have noted an issue when agency staff are requested out of hours there are occasion when they are not being inputted to the roster and only noted a month or so later when the invoice is sent in and so this will give us a lower CHPPD data than we should have had. There is work being undertaken to eliminate this issue.

Table 4 – Care hours per patient day – total staffing

	Jun23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24
Bridgnorth	7.7	6.7	8.0	8.0	7.7	7.9	7.5	6.7	6.7	6.7	6.4	6.9	6.7
Ludlow	7.2	6.2	7.0	7.1	7.4	7.7	8.7	8.3	8.3	7.0	7.3	7.5	6.85
Whitchurch	8.9	6.9	7.5	7.5	6.7	6.9	7.0	6.4	6.4	6.2	6.3	6.1	6.41
RRU Ward 36													6.0
RRU Ward 18													5.9.

9.0 Substantive Unavailability

9.1 Vacancy levels are measured as the difference between the Whole Time Equivalent (WTE) budgeted establishment and the WTE substantively employed, represented as a percentage.

9.2 **Table 5** Shows the vacancy position for the Community Hospitals for June 2024. Bishops Castle had not opened in June 2024 however the date for reopening was July 2024.

Table 5 - Vacancy percentages for Community Hospitals (June 2024)

Community Hospital	Registered Nurse Vacancy Position Includes Bands 4,5,6 &7	Unregistered Nurse Vacancy Position Includes Band 2&3
	WTE	WTE
Bishops Castle	4.70	0.31
Ludlow	1.95	2.49
Bridgnorth	0.35	0.99
Whitchurch	1.79	2.76
RRU – Ward 18	6.64	4.5
RRU – Ward 36	1.04	1.55

9.3 To date the Trust has employed 32 Internationally Educated Nurses from December 2022 to February 2024. These Nurses have predominantly filled vacant gaps in our Community and RRU wards. We have no plans for further international recruitment programmes at present, but we are exploring an opportunity to train any Internationally Educated Nurses that are working within the Trust that are Healthcare Support Workers (HCSW), as this would be a great opportunity for the Trust to gain further Registered Nurses and appropriately utilising the Nurses skills.

10.0 Incidents

10.1 During June 2024 there were 8 reported staffing issues at Ludlow, on review although patient needs were high, 7 of the shifts had extra staff on duty and the remaining shift had gone to Agency for extra cover, but agency could not be sourced. No harm was recorded.

10.2 During June 2024 there were 2 occasions that the Community inpatient wards had 100% RN agency on night duty, they were both in Whitchurch on the 7th and 9th June 2024. There were no 100% agency for RRU wards. There were no falls or incidents of any significance.

10.3 During June 2024 there were 17 inpatient falls reported which occurred across 5 of our inpatient areas (Bishops Castle reopened in July 2024), which equates to a rate of 4.65 falls per 1000 Occupied Bed Days (OBDs). This is a higher number and incidence rate than in M02 but does demonstrate a 3-month reduction compared to months 10/11/12.

Table 6 – Falls Data

Year		M1 April	M2 May	M3 June	M4 July	M5 Aug	M6 Sept	M7 Oct	M8 Nov	M9 Dec	M10 Jan	M11 Feb	M12 Mar
2022/23	Falls	26	15	11	21	12	10	24	14	10	18	7	11
	Falls/ 1000 OBDs	11.46	6.69	5.18	9.01	5.35	4.29	9.87	5.79	4	7.29	3.08	4.38
2023/24	Falls	11	11	5	14	9	13	5	15	17	25	18	22
	Falls/ 1000 OBDs	4.56	4.5	2.15	5.84	3.79	5.43	1.97	6.09	6.67	7.11	5.29	5.88
2024/25	Falls	16	14	17									
	Falls/ 1000 OBDs	4.31	3.58	4.65									

11.0 Recommendations available to review and accept

11.1 To continue to embed the twice-yearly data collection tool for both the Community Hospitals and restart the use of the tool in Community District Nursing Teams once instructed by the National Team (aim is for early 2025 with the first round of data collection being January 2025). Ensuring training is available for staff to allow for high quality data to be collected.

11.2 To include Bishops Castle in the January 2025 data collection now they have reopened.

11.3 Although we have launched E-roster Safecare into all Community Hospital Wards, there is ongoing work to embed this system to our teams. We are putting extra workshops in to support staff.

11.4 Training will be continuous to ensure staff are able to undertake data collection accurately.

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

11.6 For the inpatient data collection, the June 2024 was the first set of data with the refreshed tool, and so we need at least 2 sets of data before making any recommendations. We also need to allow for the RRU's to settle as they only opened in January 2024, and we need to see what change in demographic this has for all the community wards. Mitigations are in place and risk remains well controlled with daily staffing checks to maintain safety.

11.7 Introduce the CNST and safecare to Bishops Castle inpatient facility staff now they are open and the first set of data in January 2025 before data is collected.

12.0 Revalidation of Registered Nurses

12.1 The Nursing & Midwifery Council (NMC) have changed the requirements which Nurses and Midwives must meet in order to renew their registration every three years. This is a process of revalidation, which whilst it has similarities to medical revalidation is a different process commenced from April 2016. All registrants from April 2016 are required to meet a number of minimum standards in the years preceding the date of their application for renewal.

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

12.3 Whilst the Trust put reminders in place for staff it is the responsibility of the registrant to ensure that their PIN number is valid at all times.

12.4 The Trust has 642.02 WTE which equates to 900 Registered Nurses that need to renew their PIN by paying their annual fee and revalidate 3 yearly. In the last 12 months August 2023 to August 2024 there has been 3 occasions where staff have failed to revalidate, immediate action was taken, and all 3 staff did not work without a current pin number.

13.0 Conclusion

The Trust Board is asked to **review** the information and **accept** the recommendation that there is **assurance for safer staffing within the Community Hospitals and RRUs and moderate assurance on Workforce Safeguard compliance**. The Trust is partially compliant with the national policy (Developing Workforce Safeguards), the progress of this will be monitored at the Quality & Safety Committee quarterly to monitor compliance against the policy.

Supporting Literature

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Appendices

Appendix 1 – Inpatient Decision matrix

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

Attachment 1

		Developing Workforce Safeguards Gap analysis action plan			
	Executive Sponsors	Clair Hobbs - Director of Nursing & Clinical Delivery			
	Responsible Officers	Tracie Black - Associate Director for Workforce, Education and Professional Standards			
	Corporate Nursing Review	02.09.2024			
	Report signed by (Executive Lead)	Clair Hobbs Director of Nursing & Clinical Delivery			

Developing Workforce Safeguards Action Plan

Recommendation	Site	Complinace	Actions required	Deadline	Status
Recommendations 1 & 2 1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safer staffing governance. 2. Trusts must ensure the 3 components are used in their sfaer staffing processes (evidence based tools, professional judgement and patient outcomes).	Trust	Partial complaince	SOP in progress for annual calendar for training, data collection and inter-rater reliability checks being organised for completeness in regards to the bi-annual staffing process.	30.11.2024	In progress
			Training on acuity and dependency ratings delivered by National Team. All community staff to be trained and band 7 and 6 to be trained in the inpatient areas.	30.06.2023	Delivered ongoing monitoring
			Ensure yearly renewal of safer Nursing Care Tool licence	30.05.2023	Delivered
Recommendations 3, 4 & 5 Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement.	Trust	**Fully Compliant ↔**	Director of Governance to add statement to future annual governance statement.	31.03.2024	Delivered ongoing monitoring
			Biannual staffing reviews will have been reviewed and statement from the Director of Nursing regarding assurances in relation to safer staffing.	30.05.2023	Delivered ongoing monitoring

Recommendation	Site	Complinace	Actions required	Deadline	Status
Recommendation 6 As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Trust	**Partially compliant. ↔**	Additional training with senior staff on acuity and dependency.	30.05.2023	Delivered ongoing monitoring
			A further full biannual staffing review to take place in June 2023.	20.05.2023	Delivered
			Organisational wide process for vacancy oversight from department/ward upwards	31.01.2024	Delivered ongoing monitoring
			Development of a local Safer Staffing Policy which includes establishment setting and will note the requirement to have QEIAs for all changes to staffing establishments – signed off by the Director of Nursing.	31.11.2024	In progress
			Commence an inaugural Safer Nursing Care Tool assessment in the Community Hospitals	31.06.2023	Delivered ongoing monitoring
			Commence an inaugural Safer Nursing Care Tool assessment in the Community District Nursing Teams	31.01.2023	Delivered ongoing monitoring
Recommendation 7 Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The Board should discuss the workforce plan in a public meeting.	Trust	**Fully Compliant ↔**	Workforce Plan for the next 5 years is in place and been seen and signed off by executive team. The plan the future domestic and international pipelines annually for the next 12 months.	31.04.2023	Delivered ongoing monitoring
			Workforce plan will be presented at a Public Board.	31//06/2022	Delivered ongoing monitoring
Recommendation 8 The Trust must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	Trust	**Fully Compliant ↔**	Triangulation and CHPPD in monthly quality report that goes to the Qualtiy and Safety Committee then to board	22.05.2023	Delivered

Recommendation	Site	Complinace	Actions required	Deadline	Status
Recommendation 9 An assessment of re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgement and outcome.	Trust	**Partially Compliant ↔**	Completion of SOP as stipulated in actions from recommendations 1 & 2.	31.11.2024	In progress
			Biannual staffing to continue.	31/01/2023	Delivered ongoing monitoring
Recommendation 10 There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Trust	**Fully Compliant ↔**	Associate Director for Workforce Education and Professional Standards is the Safer staffing lead for the Trust and oversees the full use of the Safer Nursing Care Tool ensuring no manipulation of the multipliers.	31/06/2023	Delivered
Recommendation 11 & 12 As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill mix changes, must have a full quality impact assessment (QIA) review.	Trust	**Partially compliant ↔**	Development of a safer staffing policy which will include the agreed QEIA process as previously mention in actions form recommendation number 6.	31.11.2024	In progress
Recommendation 13 Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Trust	**Fully compliant ↑**	Monthly Quality report records risks linked to staffing.	20.05.2023	Delivered and ongoing monitoring
			Review of Agency approval process.	25.05.2023	Delivered ongoing monitoring
			Training and utilisation of the Safecare module for all inpatient ward areas to support professional judgement, risk assessments and escalation.	31.06.2024	Delivered ongoing monitoring
Recommendation 14 Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Trust	**Fully compliant ↑**	Staffing monitored and action taken when departments/wards become unsafe.	20.05.2023	Delivered
			Need set escalation plan for raising staffing concerns which should be added to the safer Staffing policy.	31.11.2024	In progress

Shropshire Community Health NHS Trust

Safeguarding Annual Report 2023-2024

Reference Information

Author:	Sarah Rock and Julie Harris Head of Safeguarding	**Paper date:**	5th of November 2024
Executive Sponsor:	Clair Hobbs, Director of Nursing Quality and Clinical Delivery	**Paper written on:**	July 2024
Paper Reviewed by:	Sara Ellis, Deputy Director of Nursing and Quality and Deputy DIPC Members of Safeguarding Committee and Quality and Safety Committee	**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA (Freedom of Information Act) Status:**	Full

Purpose of Paper

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

This paper presents an annual update for the Safeguarding Committee on key safeguarding activities for the period 01 April 2023 to 31 March 2024 to provide assurance that Shropshire Community Health NHS Trust (SCHT) is meeting its statutory responsibility to safeguarding and promoting the welfare of children, adults and families that come into contact with our services as set out in the Children Act 1989 and 2004 and The Care Act 2014.

Executive Summary

Context

The Shropshire Community Health Trust Safeguarding Annual Report 2023-2024 highlights the organisations efforts and achievements in safeguarding children and adults. It details increased activity, multi-agency collaboration, training compliance, key challenges, risks and key areas of focus for future improvements.

Summary

- The Mental Capacity e-learning training was withdrawn without notice earlier in the year. This was addressed by replacing it with two bespoke online training packages. The end of year compliance figure (March 2024) was 82.9%.
- There have been challenges achieving the Level 2 and Level 3 Safeguarding Children Training Compliance target of 95%.
- There has been a change of Nurse Specialists within the Safeguarding Team, these were replacement posts and not additional staff.

- Health representation within Family Connect (Telford & Wrekin's First Point of Contact) and Compass Health (Shropshire First Point of Contact) is now well established and stable in sharing health information at the front door to support decision making.

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

- Monthly quality visits continue to each Community Hospital and additional settings by the Nurse Specialist for Safeguarding Adults and Nurse Specialists for Safeguarding Children, with a focus around Mental Capacity and Deprivation of Liberty Safeguards, domestic abuse, and child protection.

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

- The Child Death Overview Process started its transition to the ICB late in 2023 following a Peer Review commissioned by the ICB. The Nurse Specialist, Child Death Overview Process left the Trust to take up a promotion outside of the organisation.

Conclusion

The Quality and Safety Committee is asked:

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

MAIN REPORT

1. Introduction

1.1 This Annual Report provides an update on the key safeguarding activities for the period 1st April 2023 to 31st March 2024 and incorporates the work of the Safeguarding team within Shropshire Community Health NHS Trust (SCHT).

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

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

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

2. Background

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

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

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

2.1.3 The Mental Capacity Act (2005)

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

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

3. Update on 2023-2024 Safeguarding Priorities

3.1 <u>Continuation of the Quality Engagement visits beyond the Community Hospitals and to encompass safeguarding children supporting integrated working</u>

3.1.1 Monthly quality visits by the Nurse Specialist for Safeguarding Adults and Nurse Specialists for Safeguarding Children to the Community Hospitals continue. There is a focus around Mental Capacity and Deprivation of Liberty Safeguards, Domestic Abuse and Child Protection. The Nurse Specialists provide advice and support thereby supporting an integrated approach to promoting safeguarding across the Trust.

Community Hospital/Service Area	Number of Quality Visits
Whitchurch	9
Bridgnorth	8
Ludlow	8
North Telford IDT	1
South + Central Telford IDT	2
Newport IDT	1
Market Drayton IDT	2
Dental Services	1
Occupational Health	1
Sub-Acute Ward (RSH – Ward 18)	2
Sub-Acute Ward (PRH – Ward 36)	2
Oswestry Minor Injuries Unit (MIU) + IDT	1
Total	**38**

3.2 A focused review and transfer of Child Death in light of the Peer Review that was commissioned by the Inegrated Care Board (ICB) in 2023

3.2.1 Discussions with ICB following a commissioned Peer Review in 2023 resulted in the transition and transfer of the CDOPs (Child Death Overview Panel) responsibility to the ICB which was expedited following the resignation of our Nurse Specialist, Child Death Reviews who was successful in securing a promotion in another organisation.

3.3 Progress and sustainability of e-Learning level 3 Adult's training package

3.3.1 The Safeguarding Adult's Level 3 e-learning package which went live for staff to access in November 2022, has sustained an amazing upward trend in compliance throughout much of this financial year 2023/24 above 95%.

3.4 Safeguarding involvement within the Dudley 0-19 tender process

3.4.1 The Safeguarding Team has been actively involved with the Dudley 0–19 tender to ensure safeguarding practice is aligned to ensure there was a smooth transition on the 1st of April 2024.

3.5 Development of skills within the workforce

3.5.1 There has been a change of personnel within the team, two Nurse Specialists were recruited, these were replacement roles. One Nurse Specialist had secured a promotional post following experience and development gained within the Safeguarding Team and the second post was the result of a team member taking advantage of the retire and return process.

3.5.2 There has been continued professional development of the Team members to ensure they have the specialist knowledge required for their roles.

3.5.3 Three members of staff have completed the Bond Solon Leadership in Safeguarding in January 2024.

3.5.4 Two Nurse Specialists have engaged in NSPCC (National Society for the Prevention of Cruelty to Children) Safeguarding Supervision in June and September 2023 to ensure supervision has a strong evidence base to support SCHT staff in their practice.

3.5.5 One member of staff attended the NSPCC Named Nurse Level 4 Training to support continued learning in January 2024.

3.5.6 Two members of staff attended the 6th Safeguarding Children: Delivering a More Effective and Robust System in September 2023.

3.6 Work as part of a collaborative with the Integrated Care Board (ICB) to support joined up working

3.6.1 Collaborative working continues with ICB and partner agencies. The development of a training platform to support wider availability of safeguarding training to the health economy has not progressed. Assurance is given that this has not detracted staff from accessing any safeguarding training.

3.7 Provide learning opportunities to the Trust and disseminate any learning generated through Safeguarding Partnership working

3.7.1 The Team have been innovative in developing a variety of learning materials across all areas which include videos, voice over briefings and 7-minute briefings to suit different learning styles which are available on the staff-zone.

3.7.2 Newsletters are disseminated on a regular basis across the Trust through the Communications Team.

4. Post Covid-19 pandemic challenges and benefits

4.1 Challenges of using virtual platforms and potential connectivity issues, can play a part in the quality of the experience and its effectiveness. However, post COVID-19, hybrid working has maximised time management for the Team and the Safeguarding Partnership fostering effectiveness and efficiency.

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

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

5. Safeguarding Arrangements

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

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

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

5.4 Safeguarding representation is in place at the front door systems of both local authorities; Compass Health in Shropshire and Family Connect in Telford & Wrekin. The Nurse Advisors collate and share health information from the wider health economy.

6. Quality and Safety

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

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

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

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

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

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

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

6.8 A shortened Datix has been developed and is available to all staff around safeguarding referrals which will allow us to identify trends and themes to focus safeguarding work. Currently themes and trends related to adult safeguarding form part of the adult Safeguarding Dashboard which is tabled at the quarterly Safeguarding Committee.

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

7. Training Compliance

7.1 It is mandatory that **all** SCHT staff are compliant at Level 1 and that **all** clinical staff are compliant at Level 2 for both Safeguarding Adults and Safeguarding Children's training. Role specific training at levels 3 and 4 are based on the Intercollegiate

Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Fourth edition (2019) and Adult Safeguarding Roles and Competencies for Health Staff First edition: August (2018).

7.2 The following tables demonstrate the Trust's compliance rates by month for 2023/2024

7.2.1 It should be noted that the Trust target is 95% and the target set by STW ICB is 90%

Safeguarding Children Training

Safeguarding Children Training 1st April 2023 – 31st March 2024	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
Safeguarding Children Level 1 Training	95%	95.22	95.64	95.62	94.63	95.68	95.99	95.30	95.29	94.39	94.39	94.04	92.48
Safeguarding Children Level 2 Training	95%	94.12	93.88	94.65	93.88	92.77	93.27	92.53	93.51	94.84	92.25	91.36	91.82
Safeguarding Children Level 3 Training	95%	92.34	91.58	93.15	96.23	95.56	92.89	93.78	94.84	92.79	92.79	90.52	91.08
Safeguarding Children Level 4 Training	95%	100	100	100	100	100	100	100	100	100	100	100	100

Safeguarding Adults Training (includes MCA/DoLS and Prevent)

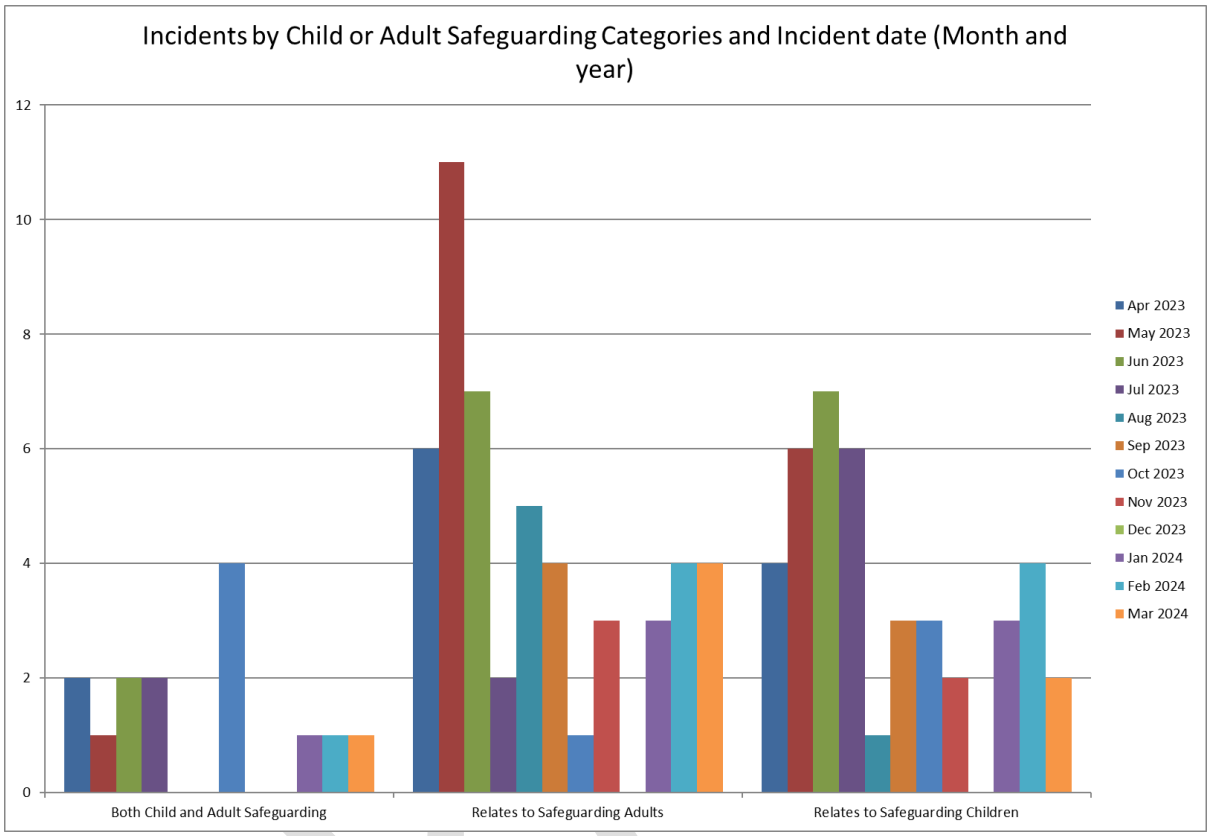
Safeguarding Adult's Training 1st April 2023 – 31st March 2024	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
Level 1 Training for Safeguarding Adults	95%	96	96.7	96.2	95.2	95.6	95.9	95.5	95.6	95.6	95.6	95.1	94.3
Level 2 Training for Safeguarding Adults	95%	95.5	96.9	96.5	95.7	95.1	95.3	95.3	95.3	95.3	95.6	95.8	95.9
Level 3 Training for Safeguarding Adults	95%	88.3	91.1	94.3	93.6	94	96	96	96	96.4	96.2	96.6	97.5
Mental Capacity Act /Dols training	95%	95.5	96.5	94.6	95.7	95.9	95.6	93.6	91.1	86.8	83.3	80.5	82.9
Basic Prevent Awareness Training (Levels 1 & 2)	85%	95.7	96.5	96.6	96.3	96.7	97	96.9	97.1	97.1	97.2	96.4	95.7

7.3 Additional Training Delivered

7.3.1 Tailored Safeguarding training was delivered to the Executive Board by the Nurse Specialist, Safeguarding Adults, and the Nurse Specialist, Safeguarding Children in July 2023.

7.3.2 Discussions have now been successful in ensuring safeguarding training is delivered as part of the Trust's induction programme.

8. Adults and Childrens Safeguarding incidents reported



8.1 A total of 105 safeguarding incidents were recorded in 2023-2024, this shows good awareness and reporting across the divisions.

9. Safeguarding Adults

9.1 Section 42 Enquiries

9.1.1 There have been no Section 42 enquiries undertaken within the period 1st April 2023 – 31st March 2024.

9.2 Safeguarding Adult Reviews

9.2.1 There have been 9 Safeguarding Adult Reviews in the period covered by this report (5 for Shropshire, and 4 for Telford & Wrekin), and 12 Domestic Homicide Reviews (8 for Shropshire, 3 for Telford & Wrekin and 1 from Powys Local Authority where no information was held).

9.2.2 This is a noticeable increase by 75% in the request for reviews from the last period where there were 6 Safeguarding Adult Reviews, and 6 Domestic Homicide Reviews.

9.2.3 In all the above reviews, SCHT staff had varying contact with the persons in question. A member of the Safeguarding Team completed the scoping documents and

attended the review meetings when invited. Initial learning identified by the Team member during the process and any subsequent learning identified by the Safeguarding Partnerships is shared across the Trust.

9.3 Shared Learning

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

9.3.2 Mental Capacity Act Assessment Audit conducted in July 2023 and noted overall improvement in quality with 86% rated fully compliant (green), 10% partially compliant (amber), and 4% red (not compliant), compared to previous year's audit (79% green, 16% amber, and 5% red).

9.3.3 A self-neglect awareness session was delivered to the South & Central Telford Community Nursing Team in Quarter 4.

9.3.4 Three Safeguarding Adult's newsletters were produced over the year focusing on '*Prevent,*' '*Forced and Predatory Marriage*,' and '*Hoarding*,' these are available to all Trust staff via the staff intranet and shared across all adult services.

10. Safeguarding Children

10.1 The number of children who are subjects of a Child Protection (CP) plan has steadily decreased during 2023/2024 within Telford & Wrekin and Shropshire. This year in Telford & Wrekin there has been a significant decrease of children between 5 to 18 years of age who are subjects of a child protection plan. This has been recognised in the Partnership and in part accredited to threshold training around Early Help has been delivered.

10.2 Telford & Wrekin Local Authority Open CP Plans

Telford & Wrekin Local Authority	Open CP Plans as at end of month 2022/23			Open CP Plans as at end of month 2023/24		
Month	**Under 5**	**5 to 18**	**TOTAL**	**Under 5**	**5 to 18**	**TOTAL**
April	71	143	214	78	157	235
May	66	158	224	70	139	209
June	77	164	241	69	132	201
July	82	167	249	69	130	199
August	92	185	277	72	131	203

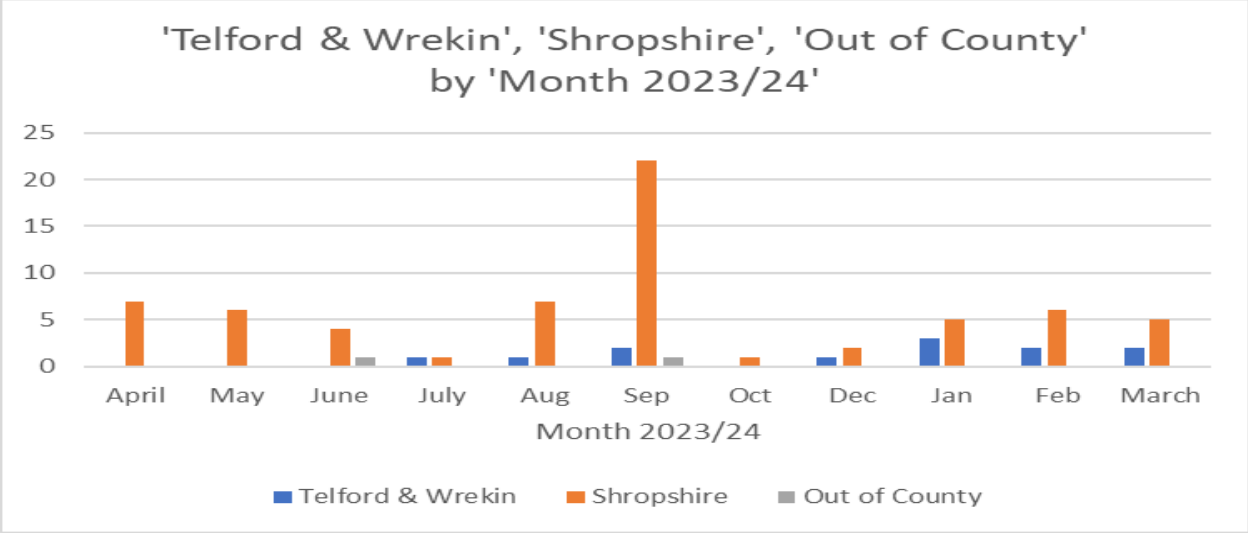
September	96	183	279	74	129	203
October	94	188	282	72	121	193
November	93	175	268	69	110	179
December	95	172	267	61	99	160
January	90	151	241	67	96	163
February	86	171	257	64	92	156
March	78	160	238	64	87	151

10.3 Shropshire Local Authority Open CP Plans

Shropshire Local Authority	**Open CP Plans as at end of month 2022/23**			**Open CP Plans as at end of month 2023/24**		
Month	**Under 5**	**5 to 18**	**TOTAL**	**Under 5**	**5 to 18**	**TOTAL**
April	70	142	212	78	162	240
May	70	144	214	84	172	256
June	74	146	220	84	173	257
July	82	150	232	72	173	245
August	81	165	246	72	164	236
September	78	158	236	76	160	236
October	70	160	230	65	155	220
November	75	163	238	66	146	212
December	75	169	244	73	137	210
January	73	168	241	72	119	191
February	75	163	238	71	117	188
March	82	155	237	71	119	190

10.4 There have been 80 requests for Court Statements. 12 from Telford & Wrekin, 66 from Shropshire and 2 from out of area. Conversations in September with a Shropshire Senior Social Worker resolved the challenge of social workers requesting Court Statements for

health information that they had already received through the child protection process. This is evidenced by the significant decrease in numbers after September. (See graph below).



10.5 Child Safeguarding Practice Reviews

10.5.1 Learning from all Rapid Reviews, Local Child Safeguarding Practice Reviews and Child Safeguarding Practice Reviews are shared with colleagues through Datix, Safeguarding Newsletters and Permission to Pause briefing papers. Themes include professional curiosity and voice of the child.

10.6 Shropshire Safeguarding Partnership

10.6.1 There have been 12 children reviewed in 8 Child Safeguarding Practice Reviews within this time-period (April 2023 - March 2024).

10.7 Telford & Wrekin Safeguarding Partnership

10.7.1 There have been 2 cases considered for Child Safeguarding Practice Reviews in the time-period (April 2023 - March 2024)

- A teenager was involved in a road traffic incident and sadly died from their injuries
- An overseas student, who was enrolled at an independent school, attended a residential placement over the school holidays and died due to an overdose

10.8 Shared Learning

10.8.1 Four sessions of Level 3 Safeguarding and Protecting Children training have been delivered. It is in-house training which is available to all new staff or those who have been off work for a prolonged period.

10.8.2 Five sessions focused on learning from CSPRs have been delivered to the majority of Public Health Nurses within Telford & Wrekin. This is bespoke in-house level 3 safeguarding children training.

10.8.3 Safeguarding training was delivered to Trust Board members on the 6th of July 2023.

10.8.4 Safeguarding presentations were provided at the Shropshire Public Health Nurse Conference, Dental Services Development Day, and Adult Services Core skills training sessions.

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

10.8.6 Quarterly Group Safeguarding Supervision sessions were available for all practitioners who have face to face contact with children and young people.

10.8.7 Support has been provided to all staff that have been required to provide a Statement of Evidence for Court.

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

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

10.8.10 Safeguarding information is available on Staff Zone. It is reviewed, and amended to reflect changes in legislation, policies, and processes.

11. CHILD DEATH OVERVIEW PROCESS

11.1 The Nurse Specialist, Child Death Reviews, produces a stand-alone Annual Report which is shared across the Safeguarding Partnerships.

12. KEY RISKS

12.1 Limited resilience of the Family Connect and Compass Health Teams, due to team size and working patterns. This has been mitigated by adopting a cross Team approach.

12.2 Non-compliance with Mental Capacity Act training target due to the training module being removed from ESR. Replacement modules are now in place and compliance is being monitored through safeguarding dashboards.

12.3 Level 2 and 3 Safeguarding Children compliance is below target. Practitioners are being reminded and encouraged to access training through the service leads and operational groups.

12.4 Two new members of staff within the team require development. This has been mitigated by a robust induction period, regular one to one meeting with the line manager, attendance at face-to-face team meetings and support to attend appropriate training.

12.5 Challenges within the Child Death Overview Process particularly around the resilience of service and the planned transition to ICB. Regular meetings between senior managers with SCHT and ICB took place to enable transition.

12.6 All risks are on the risk register and there are mitigations in place.

13. Safeguarding Priorities for 2024/2025

- Support the integration of Black Country and Dudley 0-19 staff.

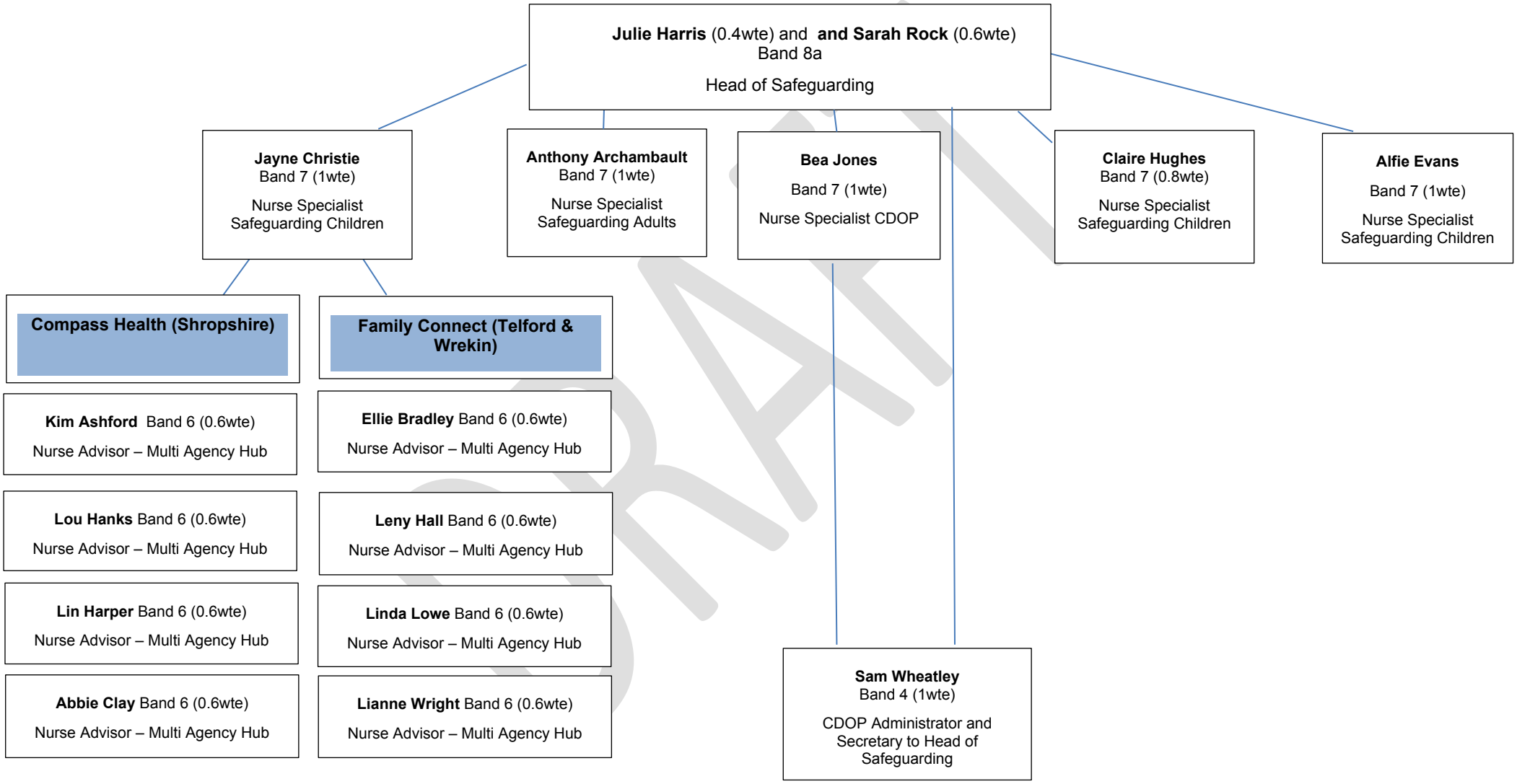
- Initiate and enable the integration of Family Connect staff and Compass Health staff to strengthen the resilience of the service provision.
- Encourage and support the professional development of Team members through training and academic pursuits. This will support succession planning and ensure evidenced based practice.
- Develop an annual Safeguarding audit plan
- Work with 0-19 teams to review the recording and oversight of safeguarding supervision

14.0 Conclusion

The Quality and Safety Committee is asked to:

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

12. HIERARCHY - SAFEGUARDING TEAM STRUCTURE



Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**5th December 2024**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**25th November 2024**
Paper Reviewed by:		**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. 31 indicators are highlighted as a concern (48.4%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	2	7	5	**19**	**14 (73.7%)**
Quality & Safety	1	2	3	**16**	**6 (37.5%)**
Resource & Performance	3	2	6	**29**	**11 (37.9%)**

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 by Operational colleagues and included at Appendix 3 for the measures flagged as a concern in this report, with the exception of Proportion of patients spending more than 12 hours in an emergency department as detailed within the report.

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

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

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required, as set out within the action plans.
- **Consider** the current action plan reporting and if any amendments are required in order to strengthen the assurance provided to the Board in relation to the actions being taken to improve performance.
- **Approve** the retrospective update of the target for New Birth Visits % within 14 days – Dudley.

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, 11 require focused attention with 10 of the 11 relating to access to services and waiting times.

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

Performance Update

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

1. Outpatient follow-up activity levels compared with 2019/20 baseline
2. Diagnostics for Audiology and Ultrasound – DM01
3. Proportion of patients spending more than 12 hours in an emergency department

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

1. Data Quality Maturity Index
2. Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

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 relatively unchanged from the last report to Board but there are some changes to note;

- Proportion of patients spending more than 12 hours in an emergency department has been flagged with a variation concern. This relates to a delay with an ambulance request and although this is a rare exception, the Service is reviewing this. If this continues or a trend emerges an action plan will be developed but at this stage the assurance position is showing as 'will consistently pass the target if nothing changes'.

- Total patients waiting more than 65 Weeks to start consultant-led treatment (National target) is no longer showing an assurance concern.

- New Birth Visits % within 14 days – Dudley is no longer showing an assurance concern. The target was changed from 90% to 95% and was agreed through RPC/Board in Summer. There have been subsequent conversations with the Commissioner and confirmation has been provided that the target should be 90%. This target has been updated retrospectively and **the request to amend the target from 95% to 90% of New Birth Visits within 14 days for the Dudley 0-19 service is brought to the Board for final approval following the recent approval at Resource and Performance Committee on 25th November 2024.**

As of October 2024:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	750	1745
Patients waiting over 65 weeks	0	549
Patients waiting over 78 weeks	0	239
Patients waiting over 104 weeks	0	2

Performance Update

When reviewing the SPC charts it is clear that there has been improvement between the September to October positions in many of the high wait areas above with the exception of the local 78 week and 104 week measures.

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 an improvement from 53.34% in September to 57.03% in October, although the October position was still being validated at the time of preparing the paper/dashboards. Proportion of patients within 18 weeks has shown an improvement, with performance of 60.6% in September to 63.01% in October.

Data for Continence products has not been available for October and this impacts total activity undertaken against current year plan. Once the issue has been resolved the measure will be refreshed.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

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.
- **Approve** the retrospective update of the target for New Birth Visits % within 14 days – Dudley.

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	2024-10-31	L	57.03%	92.00%	-34.97%	57.03%	92.00%	-34.97%	F
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2024-10-31	L	103.86%	100.00%	3.86%	103.86%	100.00%	3.86%	?
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2024-10-31	L	45.82%	100.00%	-54.18%	45.82%	100.00%	-54.18%	P
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2024-10-31	H	38.76	38.76	0.00	38.76	38.76	0.00	?
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2024-10-31	~	0	0	0	0	0	0	P
Resource & Performance...	Effective	Data Quality Maturity Index	2024-07-31	H	94.5%	95.0%	-0.5%	94.5%	95.0%	-0.5%	F
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2024-09-30	L	77.59%	99.00%	-21.41%	77.59%	99.00%	-21.41%	?
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2024-10-31	~	6.78%	0.00%	6.78%	6.78%	0.00%	6.78%	?
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2024-10-31	~	3.30%	0.00%	3.30%	3.30%	0.00%	3.30%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2024-09-30	H	92.54%	90.00%	2.54%	89.54%	90.00%	-0.46%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2024-09-30	~	85.78%	90.00%	-4.22%	87.54%	90.00%	-2.46%	?
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2024-09-30	~	89.27%	95.00%	-5.73%	91.91%	95.00%	-3.09%	?
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2024-10-31	L	0	0	0	0	0	0	?
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2024-10-31	H	87.93%	75.00%	12.93%	96.28%	75.00%	21.28%	?
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2024-10-31	H	0.03%	1.99%	-1.96%	0.00%	1.99%	-1.99%	P
Resource & Performance...	Responsive	Proportion of patients who have a first consultation in a post-covid ser...	2024-10-31	H	75.00%	92.00%	-17.00%	37.18%	92.00%	-54.82%	F
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2024-10-31	L	63.01%	92.00%	-28.99%	63.01%	92.00%	-28.99%	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	2024-10-31		81.99%	100.00%	-18.01%	91.47%	100.00%	-8.53%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2024-10-31		218.67%	120.00%	98.67%	163.30%	120.00%	43.30%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2024-10-31	H	113.06%	103.00%	10.06%	116.41%	103.00%	13.41%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2024-10-31		2	0	2	2	0	2	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2024-10-31		0	0	0	0	0	0	P
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2024-10-31	H	1,745	0	1,745	1,745	0	1,745	F
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2024-10-31	H	750	0	750	750	0	750	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2024-10-31	H	549	0	549	549	0	549	F
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2024-10-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2024-10-31	L	0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2024-10-31	H	239	0	239	239	0	239	F
Resource & Performance ...	Effective	Virtual ward bed occupancy	2024-10-31		81.63%	71.86%	9.77%	81.63%	71.86%	9.77%	

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	2024-10-31	H	6.13	6.42	-0.29	6.13	6.42	-0.29	F
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-10-31		3	0	3	3	0	3	?
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-10-31		2	0	2	2	0	2	?
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-10-31	H	5.00	0.00	5.00	5.00	0.00	5.00	F
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-10-31	H	100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	F
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-10-31	H	97.83%	95.00%	2.83%	98.51%	95.00%	3.51%	?
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30	L	83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	F
Quality & Safety Committee	Effective	Deaths - unexpected	2024-10-31		0	0	0	0	0	0	?
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-10-31	H	1.00	0.00	1.00	1.00	0.00	1.00	?
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-10-31		5.04	4.00	1.04	5.04	4.00	1.04	?
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-10-31		4	0	4	35	0	35	?
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-10-31		0	0	0	0	0	0	P
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-10-31	H	1	0	1	1	0	1	F
Quality & Safety Committee	Safe	Never Events	2024-10-31		0	0	0	0	0	0	P
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-10-31		Good	Good		Good	Good		P
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-10-31		0	0	0	2	0	2	?

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 ...	2024-10-31		7.4	7.5	-0.1	7.4	7.5	-0.1	
People Committee	Well Led	Appraisal Rates	2024-10-31		85.67%	90.00%	-4.33%	85.10%	90.00%	-4.90%	
People Committee	Well Led	CQC well-led rating	2024-10-31		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2024-10-31		10.95%	9.60%	1.35%	10.95%	9.60%	1.35%	
People Committee	Well Led	Mandatory Training Compliance	2024-10-31		93.89%	95.00%	-1.11%	93.89%	95.00%	-1.11%	
People Committee	Well Led	Net Staff in Post Change	2024-10-31		5.80	0.00	5.80	26.22	0.00	26.22	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-10-31		9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-10-31		75.00%	66.00%	9.00%	75.00%	66.00%	9.00%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-10-31		4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2024-10-31		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 or a...	2024-10-31		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 or a...	2024-10-31		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 or a...	2024-10-31		22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	
People Committee	Well Led	Proportion of temporary staff	2024-10-31		4.8%	3.4%	1.4%	6.5%	3.4%	3.1%	
People Committee	Well Led	Sickness Rate	2024-10-31		5.33%	4.75%	0.58%	5.33%	4.75%	0.58%	
People Committee	Well Led	Staff survey engagement theme score	2024-10-31		7.0	7.3	-0.3	7.0	7.3	-0.3	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-10-31		184	0	184	275	0	275	
People Committee	Well Led	Total shifts on a non-framework agreement	2024-10-31		1	0	1	1	0	1	
People Committee	Well Led	Vacancies - all	2024-10-31		11.15%	8.00%	3.15%	11.63%	8.00%	3.63%	

Icon Descriptions

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

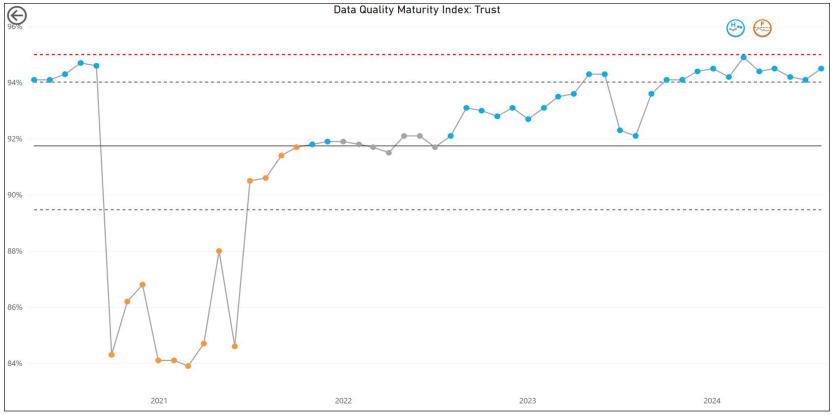
Exception Report - Action Plan

Data Quality Maturity Index

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

KPI Description	Latest 6 months	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	YTD
DQMI	%	94.9%	94.4%	94.5%	94.2%	94.1%	94.5%	94.5%
	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
%	95.0%	95.0%	94.0%	94.0%	94.0%	94.5%	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 gradually improved since but there are still a number of areas requiring improvement. Data quality challenges do still exist in several data items particually with Chief Complaint and Acuity for MIU, Clinical Coding for Admitted Patient Care, Ethnicity and Spoken Language. Clinical coding is now a risk also for Rehab and Recovery Units following SATH serving notice. Alternative arrangements are being sought 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	Jan-25	Ongoing	Attendance logs are kept and escalations to Operational Leads will be made if there are any patterns of non attendance. Action remains open until attendance is consistent and review of diary clashes has commenced to support Operational attendance. End date was initially Sep-24 but due to importance this will be monitored until Jan-25
	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	Dec-24	Ongoing	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 and ensure accessible and accurate dashboards are in place for each division. This action is outstanding from April with a revised time frame to be resolved now by December which ops , BI and quality are re exploring to accelerate this time line. Information Analyst booked for all divisional meetings with allocated agenda item.
	Work with RiO teams re mandatory fields that must be completed before further data can be input	Jan-24	Jan-25	Closed	Ethnicity is already a mandatory field in RiO. Field review taking place and elements link in to DQ Audit. Assessment and decision required as to which data items need to be mandated without having an adverse impact on data quality. Assessment made at DQ Sub Group and it will not have the desired improvement outcome, alternative actions required.

	Ethnicity data capture element need aligning with the Health Inequalities programme	Nov-24	Nov-25	On Track	Standard agenda item at the Health Inequalities Steering Group. Connected to the topic areas under the Population Health Management Core Ambassador role.
	CSDS Workshop to be held with leads from each SDG to explore areas of improvement	Jun-24	Oct-24	Complete	Each SDG has nominated DQ leads, workshop took place 2nd October 2024
	Clinical Audit Tool feedback to be strengthened through SDG meetings	Jun-24	Nov-24	On Track	Results from quarterly discussions at DQ Subgroup are being communicated back through SDG meetings. This was discussed at the workshop above and a dedicated meeting to go through an understand priority for audit actions has been completed.
	Appointment of MIU service lead to provide senior oversight to MIU data quality is it is 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.
	Stablisation of clinical coding workforce task	Nov-24	Jan-25	On Track	Meet with the leads involved and scope an options appraisal. Explore through admin academy any options for internal training.

Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson	**Date**	14/11/2024	
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024	

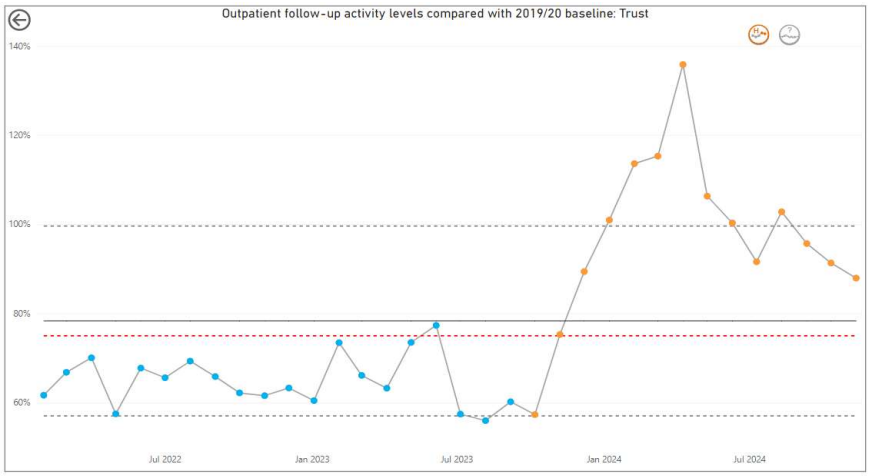
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Outpatient follow-up	%	100.15%	90.35%	96.23%	90.83%	89.55%	87.77%	96.25%
	Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Trajectory	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
%	86.0%	84.0%	82.0%	80.0%	78.0%	75.0%	75.0%



Reason for performance gap:

There continues to be a focus on ensuring clinically appropriate follow-up activity and the positive adherence to utilising PIFU (Patient Initiated Follow Up) across MSST. PIFU performance is currently 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	Oct-24 (Rounded to 0 dp)
APCS	97%
Bridgnorth Outpatients	57%
DAART	72%
Ludlow Outpatients	65%
MSST	12765%
TEMS	3%
Whitchurch Outpatients	111%

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.
Review of APCS templates and new/FU ratio alongwith skill mix (medic and nurse)	Oct-24	Dec-24	On track	Review service templates and compare data to understand impact of implementation of CNS into the model has commenced.
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. Revised date of Dec-24 has now been offered by SaTH

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

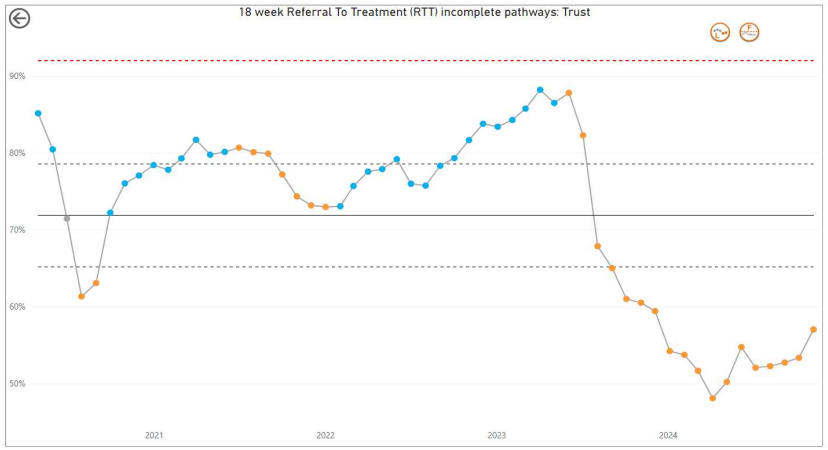
Exception Report - Action Plan

18 week Referral To Treatment (RTT) Incomplete Pathways

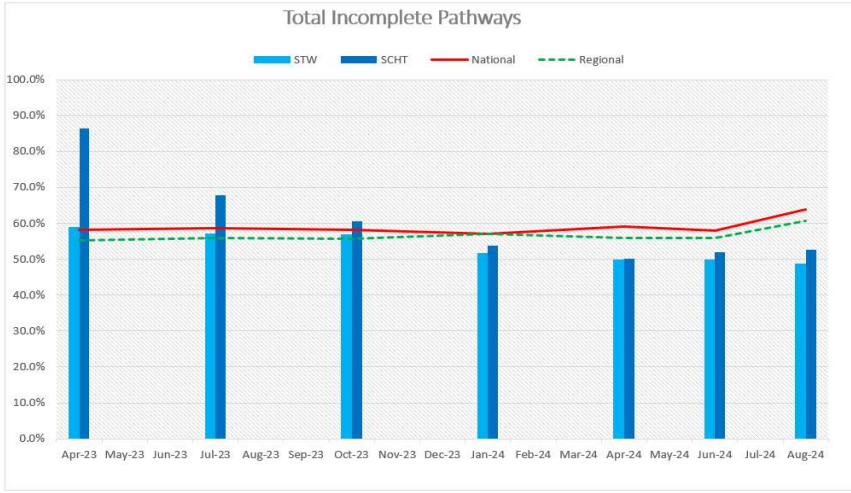
As at the end of the month, the percentage of patients that are still waiting for treatment and are within 18 weeks

KPI Description	Latest 6 months	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
RTT Incomplete Pathways	%	54.74%	52.06%	52.26%	52.73%	53.34%	57.03%*	57.03%*
	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
%	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	Aug-24
STW	58.8%	57.0%	56.8%	51.6%	49.7%	49.8%	48.7%
SCHT	86.4%	67.9%	60.5%	53.7%	50.2%	52.0%	52.7%
National	58.3%	58.6%	58.2%	57.0%	59.1%	58.0%	63.8%
Regional	55.3%	55.9%	55.7%	57.0%	56.0%	55.9%	60.7%



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). However, there has been a 3.69% improvement between Sep-24 and Oct-24. 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. New referrals are triaged to support clinical need and ongoing demand and capacity modelling and recovery planning continues to progress to support the 18-week recovery in line with the planned trajectory. Performance has stabilised and now not meeting the trajectory this is largely attributable to delay in access to diagnostics and the balance and national drive to concentrate more heavily on the prevention of long waits.

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. Revised date of Dec-24 has now been offered by SaTH. 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 is making progress in reducing it's longest waiters with the service now having zero 52 week breaches at present.

Community Hospital Outpatients has a number of backlog patient pathways. This is due to ongoing challenges with consistent capacity being provided across all SLA with the acute Trust, particularly seen within ENT and Respiratory again this is being overseen at system level and escalated through Tier 1 national calls to maintain ongoing focus and flow through the service. This is also an avenue utilised for mutual aid across the region if required.

Access to external diagnostics is an ongoing challenge across all RTT services with waiting times increasing across many of the modalities with current routine waiting times shown below.

MRI (non-contrast)	32 - 33 Weeks
CT	20 - 21 Weeks
Ultrasound	28 - 30 Weeks
Ultrasound Injection	38 - 40 Weeks
X-ray	5 - 6 Weeks

From a benchmarking perspective NHSE most recent data relates to August 24, for total reportable incomplete pathways demonstrates that:
•SCHT are performing favourably against local peers by 4%(SCHT 52.7% and STW 48.7%)
•Performance at regional level is 8% lower (Regional position 60.7%)
•National level underperforming in terms of alignment by 11.1% (national position 63.8%).
•This pattern of performance is further mirrored when bench marking more specifically at MSK services. (National 47.0%, Regional 49.9%, STW 41.7% 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. It's also worth noting that national and regional MSK performance is declining within MSK which accounts for the majority of our RTT pathways.

There are other services which contribute to not meeting this performance target such as Dental.

n Plan

	Start Date	End Date	Status	Comments
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. Revised date of Dec-24 has now been offered by SaTH
Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways
MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
SATH Radiology Escalation route for long wait patients	Aug-24	Sep-24	Complete	Support provided by SATH radiology to expedite patients appoitmnets and reports to mitigate long waiting times.

Actio	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Nov-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory but awaiting date to discuss ENT with SATH. Original end date was Sept-24, now extended in line with the above. With no additional capacity the risk of 52 and 65 week breaches remains.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
	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	Complete	Options appraisal completed this will be shared at system level

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

**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*

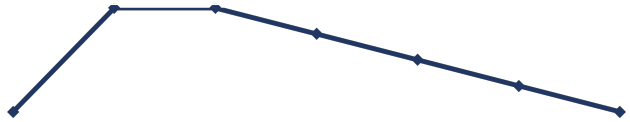
Exception Report - Action Plan

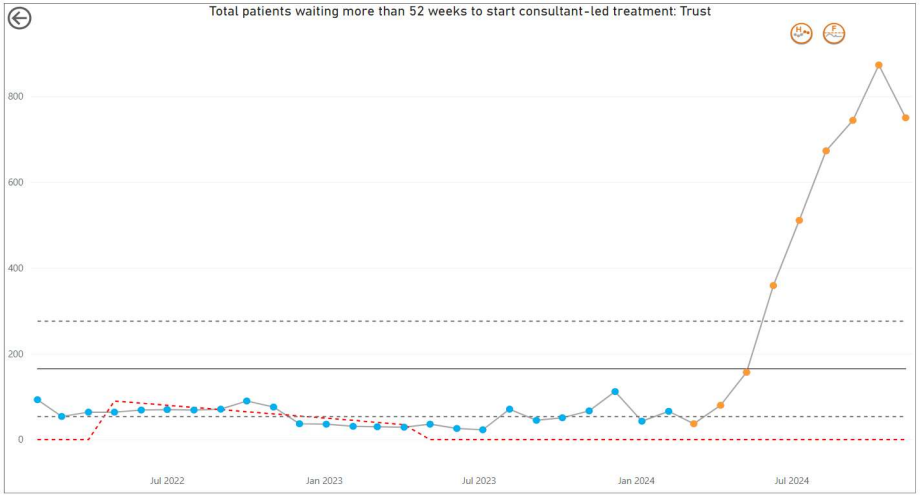
Total patients waiting more than 52 weeks to start consultant-led treatment

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
RTT 52+ week waits	Number	359	511	673	744	873	750*	750*
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Number	700	900	900	850	800	750	700





Reason for performance gap:

For the first time in a few months there has been a change in the number of 52 week breaches reducing significantly. A 52 week trajectory is now in place for MSST, aiming for a reduction in 52 week breaches to zero by the end of March 25.

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. Revised date of Dec 24 has now been offered by SaTH. 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.

Significant imporvement in the volume of Dental patients waititng over and above 40 weeks. Currently no 52 weeks but challenegs remain matching demand to capacity.

There are other services which contribute to not meeting this performance target such as Community Hospital Outpatients and APCS.

	Start Date	End Date	Status	Outcome
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. Revised date of Dec-24 has now been offered by SaTH
Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways

Action Plan	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.		Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
	SATH Radiology Escalation route for long wait patients		Aug-24	Sep-24	Complete	Support provided by SATH radiology to expedite patients appoitmnets and reports to mitigate long waiting times.
	Additional capacity being sought to support Community Hospital Outpatient backlog		Mar-24	Nov-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory but awaiting date to discuss ENT with SATH. Original end date was Sept-24, now extended in line with the above.
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
	Dental team linking with SATH colleagues to consider further options to increase theatre capacity.		Oct-24	Nov-24	On track	Tom Seager liasing with SATH colleagues to review option of utilising lofthouse for Dental theatre lists.
	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	Complete	Options appraisal completed this will be shared at system level
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024			

**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*

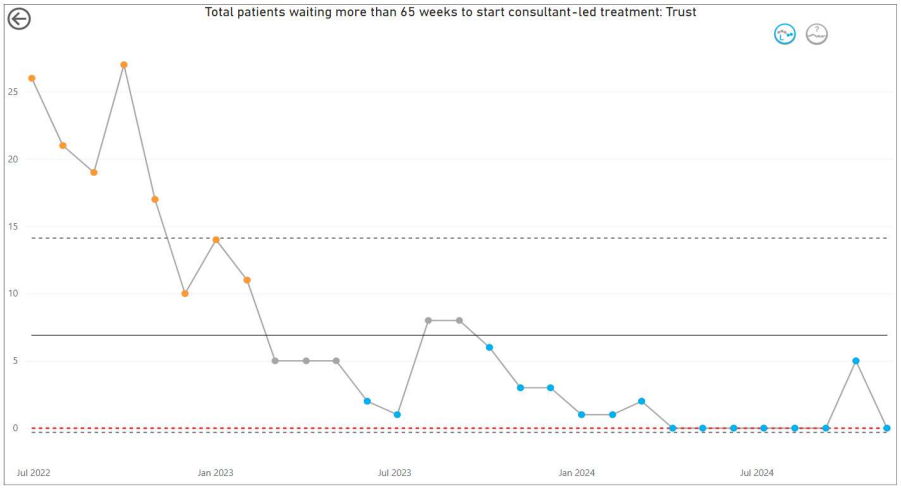
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
RTT 65+ week waits	Number	0	0	0	0	4	0*	4
	Target	0	0	0	0	0	0	0

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



Reason for performance gap:

September census position is the first month since February 2024 to have breaches reported. September there were 4 reportable breaches, all clocks have been closed for these breaches reaching 66, 67, 68 and 69 weeks in total. Breaches were caused by delays in diagnostic results, patient choice which did adhere to access policy. National guidance was sought, and escalations made through Tier 1 to support however this did not result in us being able to avoid these 4 breaches. October has reverted to 0 breaches

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 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. Revised date of Dec-24 has now been offered by SaTH

Action Plan	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
	SATH Radiology Escalation route for long wait patients	Aug-24	Sep-24	Complete	Support provided by SATH radiology to expedite patients appoitmnets and reports to mitigate long waiting times.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Nov-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory but awaiting date to discuss ENT with SATH. Original end date was Sept-24, now extended in line with the above.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
	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%
	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	Complete	Options appraisal completed this will be shared at system level

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

**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*

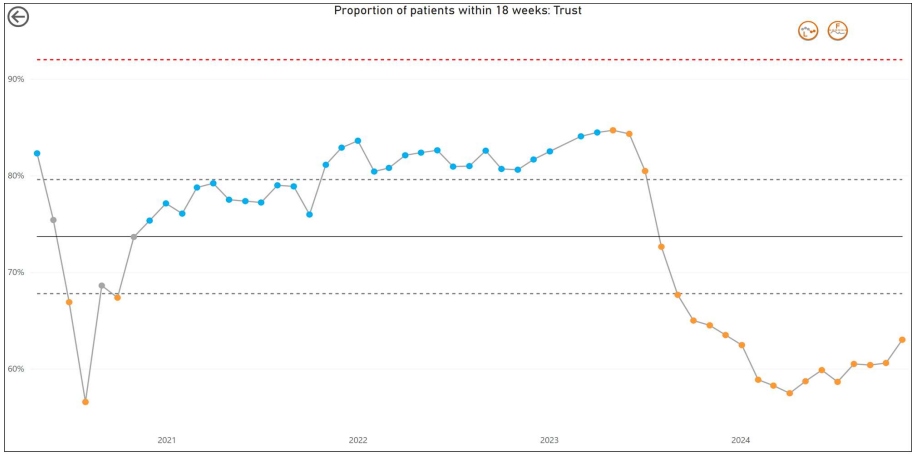
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of patients within 18 weeks	%	59.87%	58.65%	60.50%	60.39%	60.60%	63.01%	63.01%
	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
%	60.0%	61.0%	62.0%	63.0%	64.0%	65.0%	66.0%



Reason for performance gap:	Improvement trajectory for October has been achieved with 63.01% against the plan of 63.0%. 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. Revised date of Dec-24 has now been offered by SaTH. 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. Dental continues to have patients waiting above 18 weeks but improvememnt has been since with a reduction in the longest waiting patients. 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. Community outpatients waiting list continues to be challeneged due to a disparity between the demand and capacity and the reliance on external providers with the teams focusing on reducing and mitigiting the longest waiting patients on the pathways. There are other services which contribute to not meeting this performance target such as CNRT, Diabetic Nursing, Pulmonary Rehab, Bridgnorth Hospital Day case, Wheelchair Services, Adult Physio.

		Start Date	End Date	Status	Outcome
	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. Revised date of Dec-24 has now been offered by SaTH

Action Plan	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
	Increase in level 3 capacity at Euston House	Oct-24	Dec-24	Complete	Increase in level 3 capacity at EH should start to support recovery of APP waiting list.
	Substantive recruitment to Consultant Psychology position.	Oct-24	Jan-25	On track	Psychology SLA in place and recruitment process is at interview stage for the substantive Consultant Psychology position.
	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.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	Nov-24	Off Track	Additional Gynaecology sessions provided which has significantly reduced the wait position with current longest wait 16 weeks. To help reduce backlog and risk of 65 week breaches additional support required within ENT and Respiratory. Discussions started with SATH re Respiratory but awaiting date to discuss ENT with SATH. Original end date was Sept-24, now extended in line with the above.
	Dental team linking with SATH colleagues to consider further options to increase theatre capacity.	Oct-24	Nov-24	On track	Tom Seager liasing with SATH colleagues to review option of utilising lofthouse for Dental theatre lists.
	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	Complete	Options appraisal completed this will be shared at system level
	Conducting a Demand and Capacity exercise for Community Paediatrics and aligning mitigations to manage current and future workforce gaps	Nov-24	Nov-25	On track	New Paediatrician commence in post, service review is planned and are sourcing a locum at reduced rates from previous

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

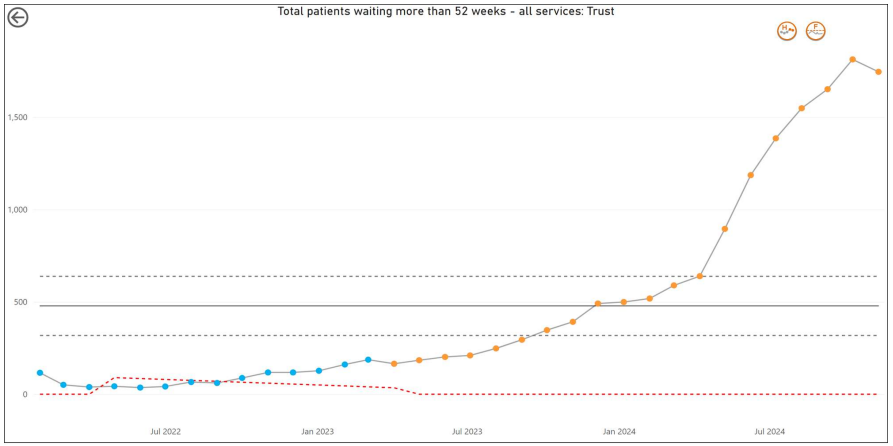
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
52+ Week waits - All services	Number	1186	1385	1548	1651	1812	1745	1745
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
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 months 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. 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. Revised date of Dec-24 has now been offered by SaTH. 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. 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 58 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. The trajectory above highlights an ongoing growth of 52, 65 and 78 week 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. Revised date of Dec-24 has now been offered by SaTH. There are other services which contribute to not meeting this performance target such as CDC, Childrens Speech and Language Therapy, Community Hospital Outpatients and Wheelchair Service

	Start Date	End Date	Status	Outcome
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. Revised date of Dec-24 has now been offered by SaTH
MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways

Action Plan	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.		Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
	Increase in level 3 capacity at Euston House		Oct-24	Dec-24	Complete	Increase in level 3 capacity at EH should start to support recovery of APP waiting list.
	Substantive recruitment to CNRT Consultant Psychology position.		Oct-24	Jan-25	On track	Psychology SLA in place and recruitment process is at interview stage for the substantive Consultant Psychology position.
	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.
	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	Complete	Options appraisal completed this will be shared at system level
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
Author	Alastair Campbell/ Helen Cooper / Mark Onions	**Date**	11/11/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024			

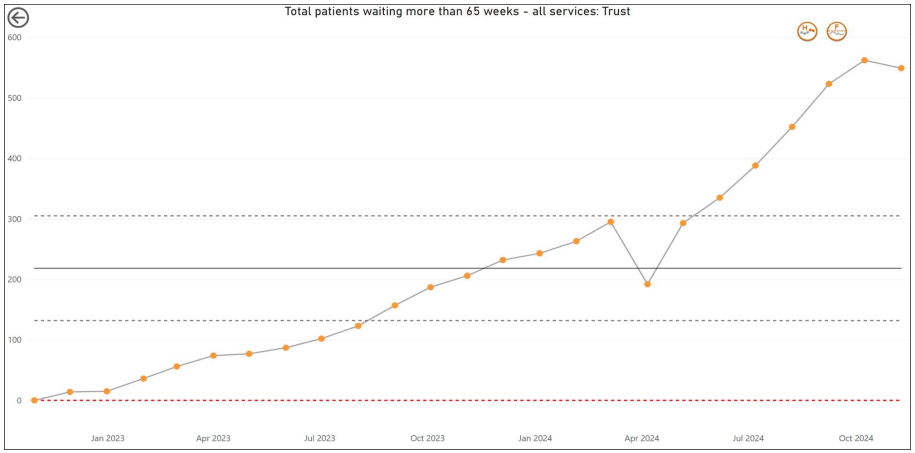
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
65+ Week waits - All services	Number	335	388	452	523	562	549	549
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Number	450	500	550	600	650	700	750



Reason for performance gap:	There has been a slight improvement in October. 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 weeks bracket due to the previous 12 months challenges with access to Psychology provision. An SLA is now live but this is only providing minimal capacity therefore recovery is slow. 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. There has been a slight deterioation in the 65 week wait position for Community Paediatrics from 6 to 10 children waiting. These are all in relaiton to children waiting Schedule of Growth Skills (SOGS) appointments. The trajectory above highlights an ongoing growth of 52, 65 and 78 week waits at a rapid pace. This is primarily attributable to MSST Activity and those patients who have been internally referred post initial treatment for Orthopaedic intervention. Orthopaedic transfer was initially due to transfer in April 2024 and extended to September 2024. Revised date of Dec-24 has now been offered by SaTH. 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 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. Revised date of Dec-24 has now been offered by SaTH
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways
	MSST Clinical Triage audit completed early October with results to be shared and an action plan to be produced to implement learning.	Oct-24	Dec-24	On track	Potential for a proportion of Level 3 pathways to be converted to level 2 pathways which will support with reduction in level 3 backlog and demand.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position

Action Plan	Increase in level 3 capacity at Euston House	Oct-24	Dec-24	Complete	Increase in level 3 capacity at EH should start to support recovery of APP waiting list.
	Substantive recruitment to CNRT Consultant Psychology position.	Oct-24	Jan-25	On track	Psychology SLA in place and recruitment process is at interview stage for the substantive Consultant Psychology position.
	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.
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways
	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	Complete	Options appraisal completed this will be shared at system level
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	14/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

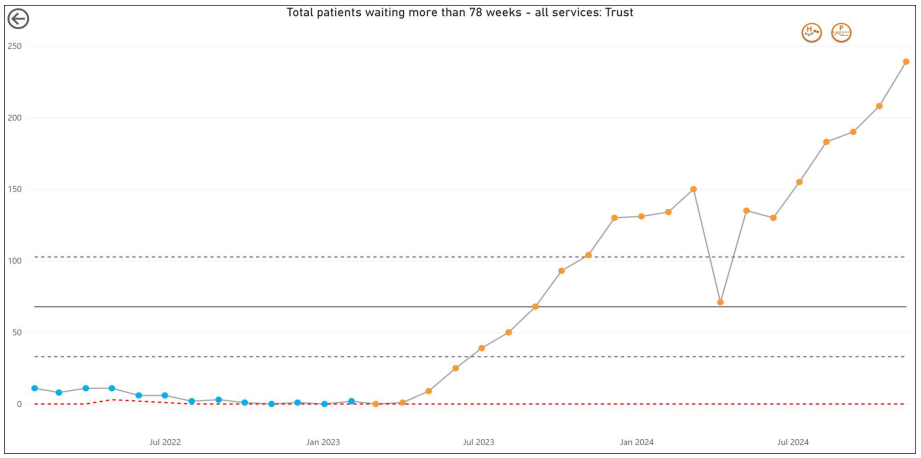
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
78+ Week waits - All services	Number	130	155	183	190	208	239	239
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
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. Revised date of Dec-24 has now been offered by SaTH. 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.

		Start Date	End Date	Status	Outcome
on 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. Revised date of Dec-24 has now been offered by SaTH
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Oct-24	Complete	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. We have aligned leadership in SCHT and with RJAH to sustain position
	MSST Clinically led improvement and innovation group set up to support new ways of working to help support recovery, utilisation and outcomes. Led by Ops lead with APP and Physio members.	Oct-24	Dec-24	On track	Feedback from Physio meetings regarding different ideas to help support efficency in patients pathways to help support reduction in watiing times and improve patient pathways

Acti	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Nov-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. Original end date was Aug-24, now extended in line with the above.
	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	Complete	Options appraisal completed this will be shared at system level
	Substantive recruitment to CNRT Consultant Psychology position.		Oct-24	Jan-25	On track	Psychology SLA in place and recruitment process is at interview stage for the substantive Consultant Psychology position.
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	11/11/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024			

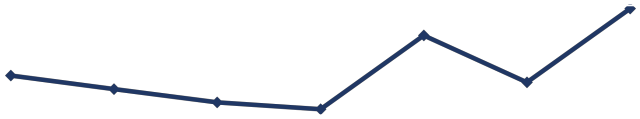
Exception Report - Action Plan

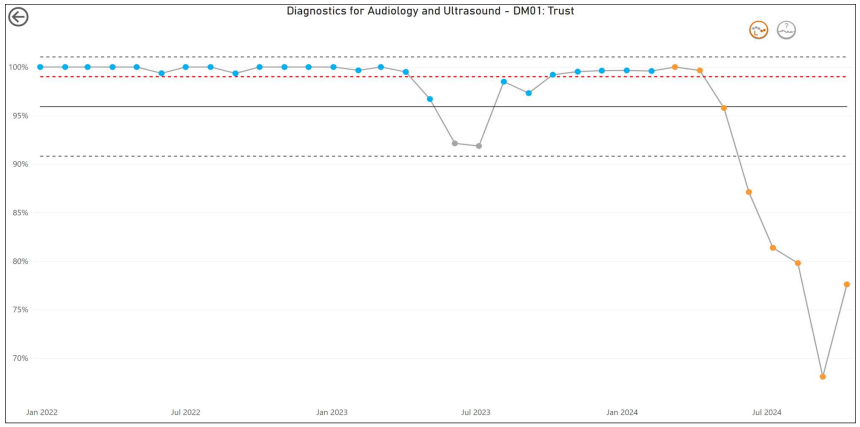
Diagnostics for Audiology and Ultrasound - DM01

DM01 statutory return - Percentage of patients waiting within 6 week standard

KPI Description	Latest 6 months	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	YTD
DM01	%	95.78%	87.11%	81.36%	79.79%	68.08%	77.59%	77.59%
	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 difficult 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	Dec-24	Planned	Service Review Planned to support an new SLA
	Understanding of the national change in reporting and impact on performance - review of data quality	Oct-24	Nov-24	On track	Deep dive arranged with national support to understand and bench mark position locally
	Demand and capacity model with SaTH to understand clinic capacity to support improvement trajectory	Oct-24	Dec-24	On track	Analysis commenced, linking with Contracts to formalise the ask
	Contract review meeting with SaTH to review recovery of performance	Dec-24	Jan-25	On track	Arranging meeting dates and attendance
Author	Mark Onions	**Date**	11/11/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024		

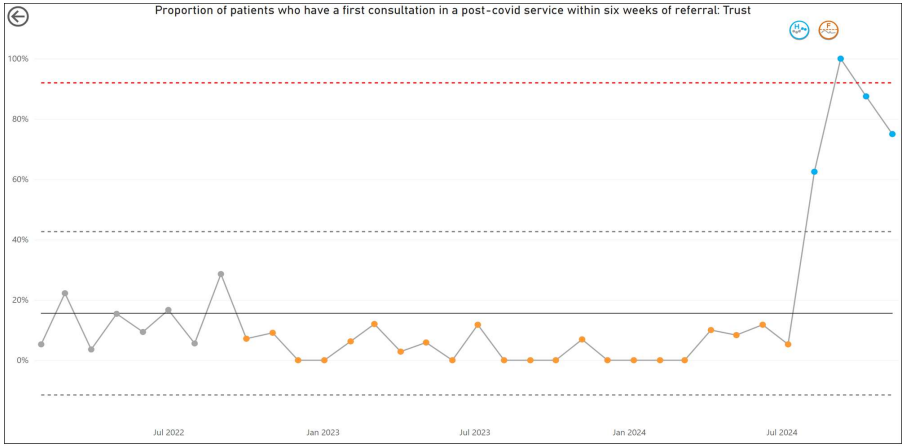
Exception Report - Action Plan

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Proportion of patients within 6 weeks	%	11.76%	5.26%	62.50%	100.00%	87.50%	75.00%	75.00%
	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:	Improvement seen over the past few months with plans to continue this. The sustained position has not been reached from August however this is on track to recover and the size of the waiting list has now decreased so activity is still lower than previously reflected within the percentage. The reduction in % is actually aligned to two patients and patient choice in relation to an appointment date. 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. Improvement 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. There are no major concerns with the servcie and it's waiting times going forward but due to the small number of patients on the waiting list there may be a little fluctuation.

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 referral model	Sep-24	Dec-24	On track	PDSA planning has commenced
	Include waiting list acutal numbers and activity in update for RPC to provide context over	Nov-24	Jan-25	On track	Activity numbers included within the report
	Working with Commissioners towards planning cycle	Nov-24	Apr-25		

Author	Alastair Campbell	**Date**	11/11/2024
Accountable Officer Approval	Claire Horsfield	**Date**	18/11/2024

Shropshire Community Health NHS Trust

Month 7 2024/25 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	5 December 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	25 November 2024
Paper Reviewed by:		**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance as at month 7 and is for action and assurance.

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 October 2024 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £1,112k adjusted surplus for the year to date compared to the planned surplus of £663k, which is a favourable variance of £449k.

Key areas for consideration are:

- **Pay award.** Our Position has improved in M07 compared to M6 year to date. This favourable movement largely reflects this year's national pay award being distributed in M07, at a level for Shropcom that exceeds the actual pay cost increase due to this pay award. The pay award is based on the planned workforce numbers and not the actual workforce numbers, and we currently have 11.2% vacancies. This is a £200k non-recurrent benefit.
- **Agency** spend to month 7 is £3,324k. This is favourable to plan by £105k. Our expectation is for agency costs to be in line with plan for the year as some slippage in the agency reduction programme is anticipated 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 by £349k, with actual delivery of £1,631k efficiencies. Delivery of the Trust's CIP target of £3,588k remains a risk to our financial plan. £383k of CIP schemes are currently rated as high risk in terms of delivery which is an improvement of £157k compared to the position reported at month 6. **We must deliver the CIP target in full to deliver the financial plan.**

Month 7 2024/25 Financial Performance

- **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 £0.6m at month 7 which is based on NHSE ERF reported values for the Trust covering months 1 to 4 actual activity, pending agreement of the overall system position.

- **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. There are a number of identified risks that could impact on delivery and these are regularly reviewed together with mitigations and potential opportunities. **The risks, mitigations and opportunities are being regularly assessed to inform our forecast.**

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 7 is a surplus of £1,112k compared to the planned surplus of £663k, which is a favourable variance of £449k.
- **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 £0.4m 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 remain a number of risks, mitigations and opportunities which may impact upon delivery.

Month 7 2024/25 Financial Performance

3. Main Report

3.1. Introduction

The Trust is measured on its financial performance in several ways, but the principal measure is total Income & 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	M07 Plan	M07 Actual	M07 Var	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast Outturn	Annual Variance
(Surplus)/ Deficit in Year	(99)	(398)	(299)	(663)	(1,112)	(449)	(1,768)	(1,768)	0
Agency Expenditure	311	422	111	3,429	3,324	(105)	4,898	4,898	0
Cost Improvement	339	562	223	1,282	1,631	349	3,588	3,588	0
Capital Expenditure	277	37	240	1,132	301	831	2,250	2,250	0

3.2. Adjusted Financial Performance – favourable variance to plan £449k

The adjusted financial position is a surplus of £1,112k compared to the planned surplus of £663k, which is a favourable variance of £449k. Our position has improved in month 7 largely due to receipt of national pay award funding in excess of our actual pay cost increase. The pay award is based on the planned workforce numbers and not the actual workforce numbers, and the benefit is therefore driven by the current level of vacancies. This is a non-recurrent benefit of £200k.

Table 1 summarises the position and a detailed revenue analysis may be found at Appendix 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(72,361)	(73,370)	(1,010)
Expenditure excl. adjusting items	71,698	72,259	561
Adjusted financial performance total	**(663)**	**(1,112)**	**(449)**
Adjusting items	90	86	(4)
Retained (surplus) / deficit	**(573)**	**(1,026)**	**(453)**

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

Month 7 2024/25 Financial Performance

3.2.1. Income – favourable variance to plan £1,010k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	YTD Variance £k
System Income	(54,119)	(54,747)	(628)
Non system Income	(18,242)	(18,623)	(381)
Total Income	**(72,361)**	**(73,370)**	**(1,010)**

Table 2: Income Summary as at 31 October 2024

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

Work is ongoing regarding the realignment of activity and corresponding elective income across all three providers of the Musculoskeletal Service, Shropshire and Telford (MSST). Our internal monitoring is indicating an elective overperformance against planned levels and this is consistent with NHSE Elective Recovery Fund (ERF) reported values. As a result we have assumed a favourable variance to the income plan of £600k based on month 1 to 4 activity and the current ERF reimbursement rules. This position may improve pending agreement of the system position.

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

3.2.2. Expenditure – adverse variance to plan £557k

Table 3 shows a summary of expenditure, by key categories, for the year to date at month 7.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	47,354	46,588	(766)
Bank	1,403	1,719	316
Agency	3,429	3,324	(105)
Total Pay	**52,186**	**51,631**	**(555)**
Clinical Supplies & Services	6,282	7,401	1,119
Prison Escorts and Bedwatch	153	256	103
Drugs	1,003	955	(48)
Premises	5,843	5,748	(95)
Travel	898	818	(80)
Other	2,373	3,220	847
Non-Pay	**16,552**	**18,399**	**1,847**
Trust wide Central Charges	3,049	2,315	(734)
Total Non-Pay	**19,602**	**20,714**	**1,112**
Total Expenditure	**71,788**	**72,345**	**557**

Table 3: Expenditure Summary as at 31 October 2024

3.2.3. Pay – favourable variance to plan £555k

The overall pay position is a favourable variance of £555k for the year to date. This is largely due to substantive vacancies which total £766k at this point in the year. The substantive pay underspend is partially offset by bank usage which is an adverse position of £316k overspent; bank staff are utilised to cover vacant shifts, wherever possible, to avoid the use of agency staff.

Month 7 2024/25 Financial Performance

Agency costs are £105k favourable to plan, mainly due to favourable variances in some key services (Admission Avoidance, MSK and Stoke Heath Prison) and the continued enhanced scrutiny and controls in place.

The vacancy rate in month 7 is 11.2% which equated to 203 WTE vacancies compared to the month 6 position of 11.4% and 207 WTEs, respectively. 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 £1,112k

Clinical supplies and services are overspent by £1,119k for the year to date and this is largely due to:

- Out of hours medical cover costs for the Rehabilitation and Recovery Units (RRUs) is exceeding planned levels, and therefore alternative approaches to providing this medical cover are 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 the final outcome expected in the near future.
- Costs associated with income over-performance including the funding received from Local Authority contracts and the ERF income over-performance. The income received fully offsets these increased costs.

The adverse variance within 'Other' non-pay is due to some CIP budgets which have not yet been allocated to relevant budget lines and some additional charges relating to the RRUs. We made some progress in allocating CIP budgets in month and work continues with individual budget managers to identify budget adjustments which will reduce this adverse variance once completed. The additional RRU charges are under review.

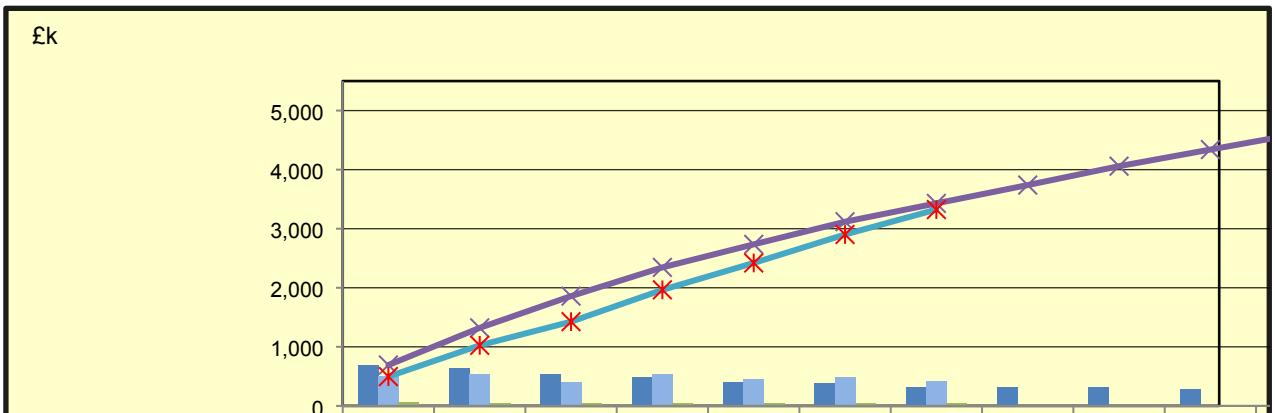
The favourable variance for central charges relates largely to interest received on our bank balance.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £105k

Table 4 shows agency spend is £3,324k at month 7 which is £105k favourable to the plan of £3,429k. The annual agency plan for 2024/25 is £4,898k.

It is of note that our agency costs again exceed planned levels during the month with spend of £422k compared to a plan of £311k. The adverse variance in month is due mainly to RRU medical agency costs; alternative provision was planned to commence in month 5 however this change was delayed until mid-November.

Month 7 2024/25 Financial Performance



	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	482	422			
In month WTE	63.98	49.05	41.72	43.58	46.69	44.29	48.68			
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	2,902	3,324			

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

The key drivers of the favourable year to date agency variance of £105k are: successful recruitment across some key services (Admission Avoidance, RRU non-medical, MSK and Stoke Heath); increased bank staff usage to cover vacant clinical shifts; and the enhanced scrutiny and controls in place. However, there is continuing pressure in Community Nursing teams arising from increased demand for timed medication visits, expansion of supported living establishments where demand for services tends to be greater, plus high levels of maternity leave. This is resulting in agency usage in these teams exceeding planned levels. Agency spend for medical cover on the RRU Wards is due to reduce from December, when an alternative to agency provision is in place.

In October, 49 WTE agency staff were used, an increase of 5 WTEs compared to September. The national agency ceiling target for the NHS in 2024/25 is 3.2% whilst STW has a cap of 6.5%. The Trust is currently at 6.4% at this stage of the year which is within the STW target.

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 and pressures in Community Nursing teams outlined above.

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.

Month 7 2024/25 Financial Performance

Table 5 shows actual CIP recurrent delivery for the year to date position at month 7 is £1,237k, this is £45k adverse compared to the recurrent plan of £1,282k at this stage of the year. However, this is mitigated by the Trust delivering £394k of non-recurrent CIP ahead of the non-recurrent CIP target. This results in an overall CIP delivery of £1,631k, which is £349k favourable to plan.

It should be noted that our CIP is profiled more heavily towards the latter months of the year, which increases the level of risk within our plan.

Category £k	Annual Plan £k	Year to Date £k		
	Recurrent	Plan YTD	Actual YTD	Variance (adv)/fav
Recurrent	3,088	1,282	1,237	(45)
Non-Recurrent	500	0	394	394
GRAND TOTAL	**3,588**	**1,282**	**1,631**	**349**

Table 5: CIP 2024/25 YTD Performance as at 31 October 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 mitigations. Progress is being made at each meeting with the value of high risk schemes reducing by £157k compared to month 6. All relevant CIP schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

Table 6 shows that we have fully identified schemes to deliver the 2024/25 CIP target of £3,588k. To date, £383k (11%) of schemes are rated 'high risk' in terms of delivery, an improvement compared to month 6 when high risk schemes made up £540k (15%) of our target.

Recurrent/Non Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total £k	Full Year Effect of 24/25 CIP £k
Recurrent	1,865	840	383	-	3,088	3,304
Non Recurrent	500	-	-	-	500	-
	2,365	**840**	**383**	**-**	**3,588**	**3,304**
Risk Percentages						
Recurrent	52%	23%	11%	0%	86%	
Non Recurrent	14%	0%	0%	0%	14%	
	66%	**23%**	**11%**	**0%**	**100%**	

Table 6: CIP 2024/25 full year breakdown

As noted above, the risk of fully delivering our CIP in-year continues to reduce. **We must deliver the CIP target in full to deliver the financial plan.**

Month 7 2024/25 Financial Performance

3.2.7. Statement of Financial Position

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

	30 Sept '24 Balance £k	31 Oct '24 Balance £k	Movement in Month £k
Property, Plant & Equipment	42,327	42,166	(161)
Inventories	210	210	0
Non-current assets for sale	0	0	0
Receivables	2,924	5,333	2,409
Cash	24,742	25,078	336
Payables	(11,887)	(14,291)	(2,404)
Provisions	(3,343)	(3,493)	(150)
Lease Obligations on Right to Use Assets	(12,584)	(12,230)	354
TOTAL ASSETS EMPLOYED	**42,389**	**42,773**	**384**
Retained earnings	33,464	33,848	384
Other Reserves	8,925	8,925	0
TOTAL TAXPAYERS' EQUITY	**42,389**	**42,773**	**384**

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

- Receivables (amounts we are owed) increased by £2,406k largely due to the quarterly invoice for the Dudley 0-19 service. Payables (amounts we owe) increased by £2,404k which reflects the deferral of 2 months of Dudley 0-19 income and payroll deductions relating to pay award back pay.
- Cash increased by £336k, 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.

3.2.8. National Cost Collection

The most recent National Cost Collection results show that overall Shropcom's costs are 1% less than the national average costs for 2022/23. Preliminary benchmarking information has been reviewed but further analysis is being completed and we will develop actions for any areas which warrant further exploration.

3.2.9. Capital Expenditure

Our 2024/25 capital expenditure allocation has two elements:

(1) Business as Usual (BAU) capital expenditure for maintenance, building projects, equipment replacement.

(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.

Month 7 2024/25 Financial Performance

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	855	264	591
IFRS 16 Leases	5,135	3,528	3,591	(63)
	7,385	**4,383**	**3,855**	**528**

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

BAU capital spend 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 spend is now rescheduled for later in the year. The completion of ventilation works has also been moved to later in the year.

3.2.10. NHSE Expenditure controls

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. We are continuing to focus on expenditure without a PO, by building in further controls.

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. The increase in both income and pay run rates in October reflects months 1 to 6 back pay for the 2024/25 pay award and the associated funding.

Actual income and expenditure £k	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24
Income	**(9,996)**	**(10,045)**	**(10,058)**	**(10,129)**	**(10,424)**	**(10,272)**	**(12,448)**
Substantive	6,407	6,230	6,414	6,347	6,406	6,714	8,070
Bank	195	238	201	274	230	256	326
Agency	496	529	401	539	455	482	422
Net impact on FOT (favourable)/adverse	**7,098**	**6,997**	**7,016**	**7,160**	**7,091**	**7,451**	**8,817**
Non-Pay	2,790	3,063	2,951	2,898	3,229	2,678	3,277
Non-Operating	(27)	(30)	(35)	(48)	(36)	(36)	(45)
Net impact on FOT (favourable)/adverse	**2,763**	**3,033**	**2,916**	**2,850**	**3,193**	**2,642**	**3,232**
(Surplus) / Deficit	**(135)**	**(15)**	**(126)**	**(119)**	**(140)**	**(179)**	**(398)**
No PO No Pay percentage	**33%**	**33%**	**46%**	**61%**	**58%**	**58%**	**54%**

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

Month 7 2024/25 Financial Performance

3.2.11. Forecast Outturn and Financial Risk

Our current forecast outturn is to deliver our planned surplus of £1,768k subject to mitigation of a number of identified key risks. We continue to review our current, relevant information relating to our financial performance for the remainder of the year, in particular the financial risks, mitigations and opportunities including: some potential back-dated pay costs; efficiency delivery; and the possible benefits of elective income overperformance.

The financial risks, together with reviews of potential mitigations and opportunities, are being regularly assessed with updates reported to the Resource and Performance Committee.

3.2.12. 2025/26 Financial Planning

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

3.2.13. 2024/25 NHSE Provider Finance Return

The Month 7 Provider Finance Return (PFR) return to NHSE was submitted on Friday 15 November 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 7 is a surplus of £1,112k compared to the planned surplus of £663k, which is a favourable variance of £449k.
- **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 £0.4m 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 remain a number of risks, mitigations and opportunities which may impact upon delivery.

Shropshire Community Health
NHS Trust

Estates Strategy Update

0. Reference Information

Author:	Richard Best, Associate Director of Estates	**Paper date:**	05 December 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	26 November 2024
Paper Reviewed by:		**Paper Category:**	Governance/Quality and Safety/Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper provides a progress update on delivery of our Estates Strategy. This paper is to provide information and assurance that good progress is being made to date and there are no key risks to escalate in relation to delivery of this strategy.

2. Executive summary

2.1 Context

Shropcom's Estates Strategy was approved by the Trust Board in December 2022 and covers the period of 2022 to 2027.

The strategy, and our current delivery, considers national NHS estates policy, updates to statutory requirements and development of the Shropshire, Telford and Wrekin ICS Estates Strategy. Our Estates Strategy and forward planning also informs elements of our Medium Term Financial Plan.

2.2 Summary

Both our Estates planning and our investment priorities support delivery of our Estates Strategy. This paper summarises how Shropcom's estate is being managed to deliver the 7 key objectives agreed within our Estates Strategy.

2.3. Recommendations

The Board is asked to:

- **Acknowledge** how our estate is being actively managed to support delivery of our Estates Strategy
- **Recognise** that there are no material risks to bring to the Board's attention in relation to delivery of this Strategy.

Estates Strategy Update

3. Estates Strategy 2022-27

Our Estates Strategy sets out 7 key objectives and Table 1 summarises how our planning and investment priorities are actively supporting delivery of this strategy. This summary demonstrates that good progress is being made in relation to progressing this strategy, whilst it is acknowledged that we have further work to do over the next three years.

One area of particular focus is collaboration with partner organisations within the Integrated Care System and beyond, to maximise the use of our estate, resulting in fewer, higher quality properties which better meet the needs of our local communities and staff.

At this time, there are no material risks to bring to the Board's attention in relation to delivery of this strategy.

Objective	Description	Progress
1. Estates as an enabler	Clinical need will determine our estate	**Headline: An increase in direct leases has reduced rental costs and enabled more flexible use of our estate** • Finalised direct lease to enable the development of Coral House to increase capacity for patient care • Finalised direct lease for Halesfield to support the development of a Community Hub in Telford. • Preparing for direct lease of a central Telford property to allow for delivery of increased activity of key clinical services and co-location of teams. • Preparing for relocation of our Digital team and reviewing options to co-locate with a partner organisation.
2. Functional Suitability	Properties are maintained effectively to provide safe and fit for purpose environment.	**Headline: Estates management KPIs are consistently achieving over 90%** • Planned investment of £1.1m in estates improvements during 2024/25 • Shropcom estates team continually review and update maintenance schedule with our estate management providers, both of which achieve over 93% of Estates Management KPIs. • Management of the Shropcom Estate is informed by the national NHS Premises Assurance Model and data collection. • Shropcom Estates team advise operational teams and quality assurance groups across the trust, to ensure estates developments meet national guidance.

Estates Strategy Update

Objective	Description	Progress
3. Sustainability	Ensuring our estate reduces its impact on the environment	**Headline: We self-generated 178 megawatt hours of electricity last year from our investment in solar panels** • Solar panels have been installed at Whitchurch, Bridgnorth Community Hospital and Hadley Health Centre to generate green electricity. • Boiler and controls upgrade at Bridgnorth Community Hospital and Wellington Medical Practice to increase the efficient use of fuel. Similar upgrades of controls planned for Bishops Castle and Whitchurch • Installing LED lighting in Whitchurch Community Hospital, Bishop Castle, Monkmoor and Halesfield to reduce the electricity demand. • Reducing the age of the estate through consolidation. • Increasing the proportion of buildings with more modern insulation and greater options to invest in more equipment to support ShropCom's Green plan.
4. Location	Review locations based on service needs	**Headline: Clinical and operational teams have influenced investment schemes of £1.1m in 2024/25** • Specific building reviews are clinically and operationally led to ensure a focus on service need • Proposals to change or update locations are managed via the Estates Optimisation Group which include Clinical and Quality representatives (e.g. Coral House upgrade) • Locations are reviewed at Estates Optimisation Group to consolidate where necessary to increase capacity and access for patients across fewer locations. • All proposed changes are subject to the outcome of a Quality & Equality Impact Assessment. • The STW ICS Estates Strategy is expected to provide further direction on planning the development of the Shropcom estate to meet service needs.
5. Flexibility	Work with clinical services to provide an estate that meets their service needs	**Headline: Three sights have been remodelled to respond to service user needs** • Our Estates Capital Investment Programme opportunities are reviewed with clinical leads to understand needs and rationale (e.g. Assessing the options to improve Dental services). • Our Procurement route reflects SFIs and standardised processes to incorporating staff and service user views. For example, improvements to layout of clinic and office space to accommodate co-location of teams in Bridgnorth.

Estates Strategy Update

Objective	Description	Progress
6. Value for Money	Balancing clinical need, productivity and cost	**Headline: External benchmarking shows the cost of our estate per square metre remains below the average cost of other community providers for the fourth year.** • Quarterly Contract Management Meeting with our estates management providers are used to review and amend planned maintenance programmes to focus on statutory and mandatory requirements at each site. • Capital investment approval process includes a Value For Money assessment for each proposal. • Digital solutions are providing options to improve the productivity of the estates • All capital schemes are evaluated at the Capital and Estates Group where we have broad representation including Clinical, Operational, Procurement, Finance and Estates to ensure all aspects of development are considered.
7. Partnerships	Collaboration with internal and external stakeholders	**Headline: We are gaining value from working in partnership with other organisations.** • The Shropcom estates team continues to work with ST&W ICB estates leaders to develop the STW Infrastructure Strategy and prioritise investment. • Shopcom continues to implement the One Public estate as demonstrated in our leases of local authority locations (e.g. Mount Mckinley, Shirehall, Dudley 0-19, Euston house) • Our Estates Management Providers (MPUFT and NHSPS) are NHS providers and provide insight for Shropcom estates planning from their experience across the NHS. • Shropcom Associate Director of Estates chairs the Healthcare Estates and Facilities Management Association for the West Midlands and promotes closer working and integration to improve the estates provision in improve patient outcomes, experience and productivity.

Table 1: Summary of progress to deliver the 7 Estates Strategy objectives.

Shropshire, Telford and Wrekin Estates Strategy

The Shropshire, Telford and Wrekin (STW) Estates and Physical Infrastructure Strategy was reviewed by the STW Strategic Commissioning Committee in July 2024 and we expect to receive the STW Estates Strategy once it is finalised.

The Shropcom Estates Management team has actively provided information and insight to support the review of the STW Estates Strategy, and we expect the STW Estates Strategy to continue to reflect many of the elements in Shropcom's own Estates Strategy. In addition, this will reflect the findings of the Lord Darzi NHS review and the NHS 10 year plan in due course. We expect there to be a continued focus on developing the estate across Shropshire, Telford and Wrekin and beyond to improve patient outcomes, experiences and deliver value for money.

4. Recommendations

The Board is asked to:

- **Acknowledge** how our estate is being actively managed to support delivery of our Estates Strategy
- **Recognise** that there are no material risks to bring to the Board's attention in relation to delivery of this Strategy.

Shropshire Community Health NHS Trust

Planning update

0. Reference Information

Author:	Jonathan Gould, Deputy CFO	**Paper date:**	05 December 2024
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	25 November 2024
Paper Reviewed by:		**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

Purpose of Paper

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

This paper provides a summary on progress of delivery of our 2024/25 operational plan and an update on the development of both our own 2025/26 operational plan and the NHSE/System plan.

2. Executive Summary

The planning update includes:

- an update on delivery against the agreed interventions and milestones to deliver our 2024/25 operational plan. These are currently on track.
- the key dates for developing our interventions and milestones for our 2025/26 operational plan. Subject to any changes in the timetable, these will be presented to the February Trust Board meeting for approval.
- an update on 2025/26 NHSE/System plan development. This will be submitted to NHSE in March following approval by the Trust Board/ICS Board. We are currently submitting our activity baseline analysis to support this process.

It is of note that the national/local 2025/26 timetable may change following release of the NHSE planning guidance.

3. Conclusion

The Board is asked to:

- **Acknowledge** that our 2024/25 interventions and milestones are currently on track to support delivery of our operational plan.
- **Recognise** the key milestones and deadlines for developing our 2025/26 operational plan.
- **Consider** that we are submitting a baseline activity analysis to the ICB in line with the 2025/26 planning timetable.

Planning Update

Trust Board

05 December 2024

Accountable Director: Sarah Lloyd, Chief Finance Officer

1. Introduction

This planning update includes:

- an update on delivery against the agreed interventions and milestones to deliver our 2024/25 operational plan. These are currently on track
- the key dates for developing our interventions and milestones for our 2025/26 operational plan. Subject to any changes to the timetable, these will be presented to the February Trust Board meeting for approval.
- an update on 2025/26 NHSE/System plan development. This will be submitted to NHSE in March following approval by the Trust Board/ICS Board. We are currently submitting our activity baseline analysis to support this process.

It is of note that the 2025/26 timetable may change following release of NHSE planning guidance.

The Board is asked to:

- **Acknowledge** that our 2024/25 interventions and milestones are currently on track to support delivery of our operational plan
- **Recognise** the key milestones and deadlines for developing our 2025/26 operational plan
- **Consider** that we are submitting a baseline activity analysis to the ICB in line with the 2025/26 planning timetable.

Contents

2. Developing the 2024/25 interventions - Recap

May 2023

The Board confirmed Shropcom's **vision and values**

Jan 2024

The Board confirmed Shropcom's **strategic objectives**

May 2024

The Board approved Shropcom's **strategic priorities** (see next slide) to be included in the 2024/25 published operational plan

June 2024

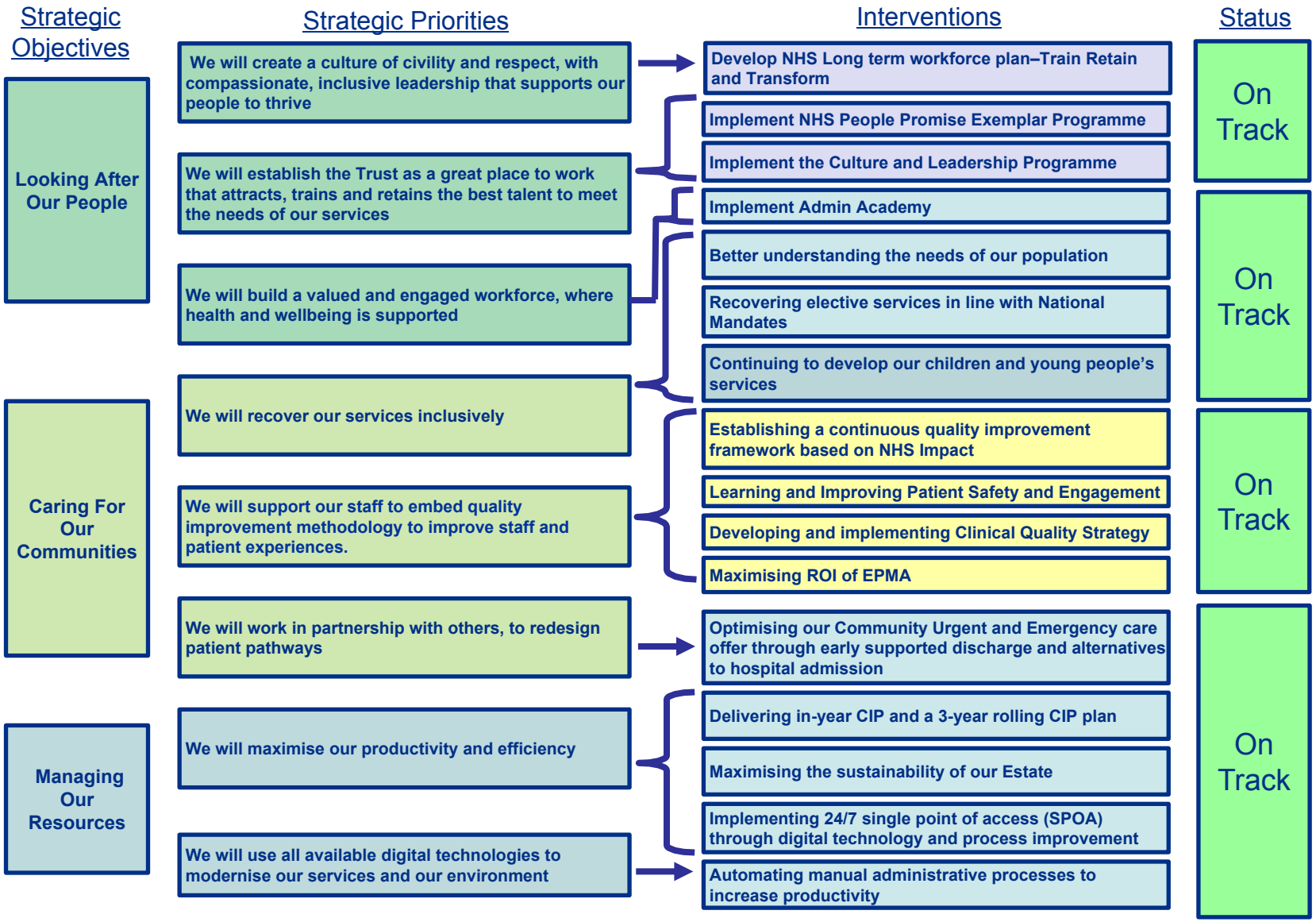
The Board approved the 2024/25 **interventions** to deliver Shropcom's strategic priorities (see next slide). To be managed through our committees; Resource and Performance, Quality and Safety, People.

'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.'

Trust Values

- Improving Lives
- Everyone Counts
- Commitment to Quality
- Working Together for Patients
- Compassionate Care
- Respect and Dignity

2. The 2024/25 interventions are on track



- The appendix provides a recap of the interventions, milestones and expected outcomes previously agreed at RPC, Q&S, People Committee and Trust Board
- Each intervention lead has provided an update to show that delivery is on track. A summary of the progress is on the next slide.

2a. The 2024/25 milestones and outcomes for the interventions are progressing as expected

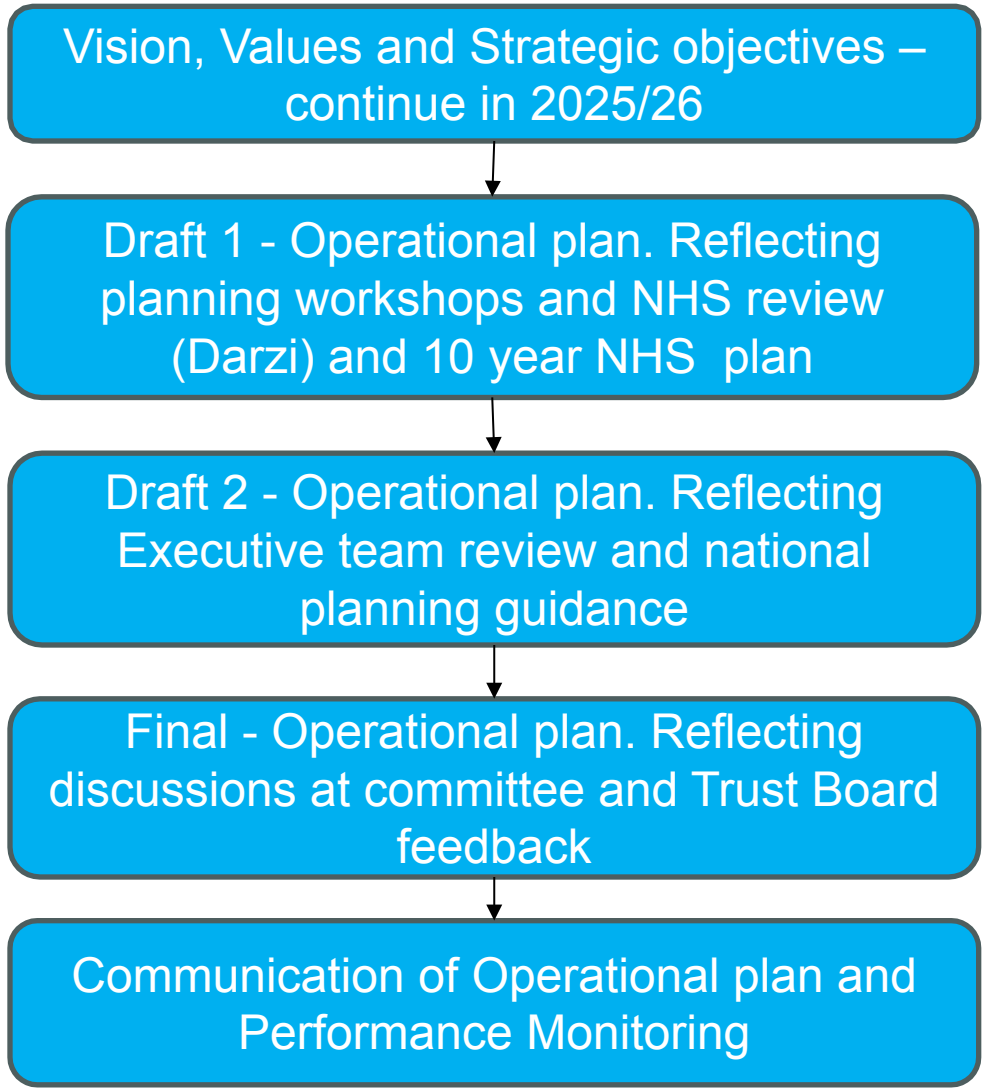
Interventions	Status	Progress update*
Develop NHS Long term workforce plan–Train Retain and Transform Implement NHS People Promise Exemplar Programme Implement the Culture and Leadership Programme	On Track	• Communication, broad and targeted continues across the Trust. • Health roster manager support implemented, and apprenticeship requests process improvements started. • Culture and Leadership change team recruited. H&WB programme communicated and running. • No concerns.
Implement Admin Academy Better understanding the needs of our population Recovering elective services in line with National Mandates Continuing to develop our children and young people's services	On Track	• Admin Academy sessions held, T&F groups commenced, and reduction in bank/agency already realised. • Slightly behind due to gap in PM support to drive at pace. • PHM & HI agenda progressing, and related projects commenced. SMS texting has reduced DNAs. • Over 65 weeks met by May 24 although challenging with some breaches in September. • Dental service on track to eradicate > 18 week waits by Dec 24. • Huge amount of tender work underway (0-19 bids: Liverpool and 2 in Cumbria), plus SaLT in Cheshire East.
Establishing a continuous quality improvement framework based on NHS Impact Learning and Improving Patient Safety and Engagement Developing and implementing Clinical Quality Strategy Maximising ROI of EPMA	On Track	• QI Framework shared across Trust. • Both use of patient feedback and embedding PSIRF across Trust progressing well. • Three-year Clinical Quality Strategy presented at Q&S committee and SLT. • EPMA project being rebased due to competing priorities – currently reviewing new PID with timelines.
Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission 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 Automating manual administrative processes to increase productivity	On Track	• UEC 2-hour response (target 70%) consistently delivered • VW 80% occupancy on track to be met as planned • SPR referrals increased Q1 to Q2. • CIP 24-25 forecast on track and 3-year CIP schemes completions expected by March 25. • E-Consent reducing printing • Virtual assistant and hybrid email being deployed across Trust to improve productivity • Microsoft Power Automate starting to be utilised to digitally automate previously manual (people) processes to further drive productivity. • Integrated with ERS and STRATA to support digital triage. • Slightly behind with digital pace of transformation as we continue to develop capacity within the Digital team. • On track to reduce our carbon footprint.

KEY
- People Committee
- R&P Committee
- Q&S Committee

*See appendix for further detail of progress

3. Developing 2025/26 Strategic Priorities and Operational Plan of interventions

- Our strategic priorities for 2025/26 are expected to be similar to 2024/25, to continue the momentum of delivery from 2024/25.
- Following on from 2024/25, the 2025/26 priorities are expected to include:
  - A focus on prevention
  - Increasing care closer to home
  - Growth in digital solutions
  - Productivity improvement
- Our 2025/26 Strategic Priorities and Operational Plan will be presented to the Trust Board for approval in February 2025



3. 2025/26 Strategic Priorities and Operational Plan of interventions

Tasks	Outputs	Date 2024/25	Review / Approval
Planning Workshops	Operational Priorities	31 October	Internal Planning Group
Confirm internal plan timetable	Key dates / deliverable for the internal plan	25 November	RPC – planning update
Operational Plan draft 1	Plan reflecting Darzi Report, Operational priorities, Joint forward plan,	20 December	Executive Team
Operational Plan draft 2	Confirm strategic objectives and priorities	27 January	• Executive Team • RPC – planning update • Q&S committee • People Committee
Operational Plan Final	Proposed interventions, milestones and outcomes	6 February	Trust Board
Communication of operational plan and performance monitoring	Corporate and service leads to confirm targets and performance reporting timetable	From 25 March	Internal Planning Group and Committees

- The table provides the milestone dates for developing the strategic priorities and the interventions to deliver these
- The table also provides details of the reviews and approvals through to Trust Board in February 2025

4.a 2025/26 NHSE Planning Update - Overview

- System/NHSE planning launched 6 September with a focus on:
  - Moving from one to five-year planning, refreshing annually
  - Strengthening focus on addressing health inequalities
  - Local first approach, i.e. not waiting for national guidance/priorities
  - All providers shared an initial short list of potential developments. SLT and Execs will continue to prioritise a list of developments. Shropcom's initial list includes the following:
    - People Development, Population Health Management and Service Mapping, Paediatric Virtual Ward, Care Pathway Optimisation, Technology Optimisation

- Internal planning workshops for our three Operational Divisions took place in October.

4.b 2025/26 NHSE Plan - Timeline

Planning stage	Dates	Key tasks	Approval
Stage 1: Pre-launch – Complete,		Stage 2: Set-up - Complete	
Stage 3: First Cut	4/10 – 20/12 (11 wks)	• Draft ICS MPFT. • Review commissioning intentions. • Draft activity baselines and interventions • Draft planning narrative • National Planning Guidance released (20/12/24) • Submit first cut of activity, KPIs, workforce and finances with narrative	Extr. RPC 18/12/24
Stage 4: Review	03/01 – 07/03 (9 wks)	• Update MPFT • Confirm and challenge meetings • Update activity, KPIs, workforce and finances with narrative	RPC 27/01/25 TB 06/02/25
Stage 5: Approval and submission	14/04 – 21/03 (2 wks)	• **Submit Final plan to NHSE 20/03/25**	Extr. RPC 17/03/25
Stage 6: Post submission	04/04 – 16/05 (7 wks)	• Publish local Plan • Respond to NHSE feedback • Lesson learned report	TB 08/05/25

- A first cut of the plan showing activity, KPIs, workforce and finances with narrative is required before Christmas.
- The 'Confirm and Challenge' sessions lead by the ICB are planned for January and February.
- The planning timetable shows that we will require extraordinary RPC meetings in December and March.

4.c 2025/26 NHSE Planning Update – Baseline Submission

- Stage 3 of NHSE plan timetable requires an activity baseline, based on month 6 information
- The analysis shows we are forecasting an overall 2% underperformance across our services.
- The full baseline submission provides further detail on our mitigations and actions plans to address the variance to plan. This is to inform the negotiations for the 2025/26 activity plan.

5. Recommendations

The Board is asked to:

- **Acknowledge** that our 2024/25 interventions and milestones are currently on track to support delivery of our operational plan
- **Recognise** the key milestones and deadlines for developing our 2025/26 operational plan
- **Consider** that we are submitting a baseline activity analysis to the ICB in line with the 2025/26 planning timetable.

6. Appendix

Appendix 6a: Our 2024/25 'Plan on a Page'

Vision

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

Strategic Objectives	Strategic Priorities
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive
	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
	We will build a valued and engaged workforce, where health and wellbeing is supported
Caring For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways
Managing Our Resources	We will maximise our productivity and efficiency
	We will use all available digital technologies to modernise our services and our environment

Trust Values

- Improving Lives
- Everyone Counts
- Commitment to Quality
- Working Together for Patients
- Compassionate Care
- Respect and Dignity

Appendix 6a. *Our Operational Plan Interventions and Outcomes*

KEY: People Committee | R&P Committee | Q&S Committee

Vision

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

Strategic Objectives	Strategic Priorities	Interventions	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	Develop NHS Long term workforce plan–Train Retain and Transform	Improve sickness absence Improve Staff turnover Improve Staff survey results Reduce the use of Agency Staff	31/03/25 – Asso. Director of Wrkfrce & Resourcing, Asso. Director for People, Employee Relations and Occupational Health
	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	Implement NHS People Promise Exemplar Programme		
		Implement the Culture and Leadership Programme		31/03/25 – Associate Director for People, Employee Relations and Occupational Health
		Implement Admin Academy	Improve staff Turnover, Staff survey results	31/03/25 – CYP & Planned care Division Manager
	We will build a valued and engaged workforce, where health and wellbeing is supported	Better understanding the needs of our population	Target services to make improvements across CORE20PLUS metrics	31/12/24 – Adult & Community service Division Manager
Caring For Our Communities	We will recover our services inclusively	Recovering elective services in line with National Mandates	Improve DNA, PFIU and virtual consultations	31/12/24 – CYP & Planned care Division Manager
		Continuing to develop our children and young people's services	Improve patient access to Shropcom services	31/12/24 – CYP & Planned care Division Manager
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	Establishing a continuous quality improvement framework based on NHS Impact	Increasing training and awareness Set a base for avoidable errors	30/9/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Learning and Improving Patient Safety and Engagement	Improve patient engagement. LFPSE - compliance	31/10/24 – Director of Governance
		Developing and implementing Clinical Quality Strategy	Set a base for avoidable errors	30/11/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Maximising ROI of EPMA	Continuously improve medicine management, Financial improvement	30/11/24 – Chief Pharmacist
	We will work in partnership with others, to redesign patient pathways	Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	Improve pathways through collaboration with system partners	31/03/25 – Urgent Care Division Manager
Managing Our Resources	We will maximise our productivity and efficiency	Delivering in-year CIP and a 3-year rolling CIP plan	Deliver £3.5m efficiencies in 2024/25, add 3 yr CIP plan to the Med. Term financial Plan	31/03/25 – Deputy Ops Director
		Maximising the sustainability of our Estate	Reduce carbon footprint and OC12. improve occupancy	31/03/25 – Associate Director of Estates
	We will use all available digital technologies to modernise our services and our environment	Implementing 24/7 single point of access (SPOA) through digital technology and process improvement	Improve patient access to Shropcom services	31/03/25 – Associate Director of Digital
		Automating manual administrative processes to increase productivity	Demonstrate productivity improvement	31/03/25 – Associate Director of Digital

Appendix 6.b *RPC*: Interventions and Outcomes 2024/25

Vision

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

Strategic Objectives	Strategic Priorities	Interventions for **RPC**	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	Implement Admin Academy	Improve staff Turnover and staff survey results	31/03/25 – CYP & Planned care Division Manager
	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	Better understanding the needs of our population	Target services to make improvements across CORE20PLUS metrics	31/12/24 – Adult & Community service Division Manager
	We will build a valued and engaged workforce, where health and wellbeing is supported	Recovering elective services in line with National Mandates	Improve DNA, PFIU and virtual consultations	31/12/24 – CYP & Planned care Division Manager
Caring For Our Communities	We will recover our services inclusively	Continuing to develop our children and young people's services	Increase patient access to our successful services	31/12/24 – CYP & Planned care Division Manager
	We will work in partnership with others, to redesign patient pathways	Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	Improve pathways through collaboration with system partners	31/03/25 – Urgent Care Division Manager
Managing Our Resources	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	Delivering in-year CIP and a 3-year rolling CIP plan delivery	Deliver £3.5m efficiencies in 2024/25, add 3 yr CIP plan to the Med. Term financial Plan	31/03/25 – Deputy Ops Director
	We will maximise our productivity and efficiency	Maximising the sustainability of our Estate	Reduce carbon footprint and improve occupancy	31/03/25 – Associate Director of Estates
		Implementing 24/7 single point of access (SPOA) through digital technology and process improvement	Improve patient access to Shropcom services	31/03/25 – Associate Director of Digital
	We will use all available digital technologies to modernise our services and our environment	Automating manual administrative processes to increase productivity	Demonstrate productivity improvement	31/03/25 – Associate Director of Digital

Appendix 6.c *Q&S Committee:* Interventions and Outcomes 2024/25

Vision

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

Strategic Objectives	Strategic Priorities	Interventions for **Q&S Committee**	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive			
	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			
	We will build a valued and engaged workforce, where health and wellbeing is supported			
Caring For Our Communities	We will recover our services inclusively			
	We will work in partnership with others, to redesign patient pathways			
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	Establishing a continuous quality improvement framework based on NHS Impact	Increasing staff training and awareness Set a base for avoidable errors to improve on.	30/9/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Learning and Improving Patient Safety and Engagement	Improve patient engagement. Learning From Patient Safety Events - compliance	31/10/24 – Director of Governance
		Developing and implementing Clinical Quality Strategy	Set a base for avoidable errors to improve on	30/11/24 – Deputy Director of Nursing and Quality and Deputy DIPC
Managing Our Resources	We will maximise our productivity and efficiency	Maximising Return On Investment (ROI) of Electronic Prescribing Management (EPMA)	Continuously improve medicine management. Financial improvement	30/11/24 – Chief Pharmacist
	We will use all available digital technologies to modernise our services and our environment			

Appendix 6.d *People Committee:* Intervention and Outcomes 2024/25

Vision

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

Strategic Objectives	Strategic Priorities	Interventions for **People Committee**	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	Develop NHS Long term workforce plan – Retain and Transform	Improve sickness absence Improve Staff turnover Improve Staff survey results	31/03/25 – Associate Director of Workforce & Resourcing
	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	Implement NHS People Promise Exemplar Programme	Improve staff turnover Reduce the use of Agency staff	30/09/24 – Associate Director for People, Employee Relations and Occupational Health
		Implement the Culture and Engagement Programme	Improve staff survey results Improve Staff turnover Improve sickness absence	30/9/24 – Associate Director for People, Employee Relations and Occupational Health
	We will build a valued and engaged workforce, where health and wellbeing is supported	*Implement Admin Academy (OVERSEEN BY RPC DUE TO CIP LINK)*	*Improve staff Turnover and staff survey results*	*31/03/25 – CYP & Planned care Division Manager (OVERSEEN BY RPC)*
Caring For Our Communities	We will recover our services inclusively			
	We will work in partnership with others, to redesign patient pathways			
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.			
Managing Our Resources	We will maximise our productivity and efficiency			
	We will use all available digital technologies to modernise our services and our environment			

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Audit Committee – October 2024

0. Reference Information

Author:	Stacey Worthington	**Paper date:**	5 December 2024
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	24 October 2024
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit Committee meeting held on 23 October 2024 for assurance purposes. The Audit Committee is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Committee provides an overarching governance role with a specific focus on integrated governance, risk management and internal control. It also reviews the work of other governance committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. It also receives input from the Trust's internal and external auditors.

2.2 Summary

The Committee met on 23 October 2024 and was quorate with 2 Non-Executive Directors 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 within the main report.

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

Audit Committee – October 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Audit Committee which met on 23 October 2024. The meeting was quorate with 2 non-Executive and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Peter Featherstone	Chair – Non-Executive Director
Cathy Purt	Non-Executive Director
Sarah Lloyd	Director of Finance
Shelley Ramtuhul	Director of Governance
Stacey Worthington	Executive Assistant / Corporate Office Manager (Minute Taker)
Apologies:	
Harmesh Darbhanga (Chair, Non-Executive Director) and Jill Barker (Non-Executive Director)	

3.2 Actions from the Previous Meeting

The Committee received all items on the work plan with a summary of each provided below:

AGENDA ITEM / DISCUSSION		ASSURED (Y/N)	ASSURANCE SOUGHT
3.	**DECLARATIONS OF INTEREST** None declared.	N/A	
4.	**REVIEW OF THE ACTION LOG** The Committee reviewed the action log and noted the actions that could be removed. Business Continuity Audit – regular update reports to continue to be provided to the Committee	FULL	
6.	**RISK MANAGEMENT UPDATE** Committee noted the improved position and that the datix upgrade was due shortly. Committee noted that risks would be tracked moving forward and changes highlighted monthly.	PARTIAL	**CONTINUED UPDATES ON THE PROGRESS**
7.	**BAF ASSURANCE** The Committee accepted the report and noted that the Trust was making good progress but that there was still further work to do.	FULL	

Chair's Assurance Report

Audit Committee – October 2024

9.	**STANDING REPORT ON POLICIES OVERDUE FOR APPROVAL BY AUDIT COMMITTEE** The Committee heard of the progress made to date. Ongoing rationalisation of policies to combine where appropriate was taking place. The Committee discussed System policies and that further work was needed in this area.	PARTIAL	**APPETITE FOR SYSTEM POLICIES TO BE ESTABLISHED**
12.	**INTERNAL AUDIT REPORTS** The Committee reviewed and discussed the internal audit reports. The Committee noted there were no overdue recommendations.	FULL	
14.	**EXTERNAL AUDIT PROGRESS REPORT** The Committee noted that planning for next year was underway and that work was progressing well on completion of last years audit.	FULL	
15.	**REVIEW OF STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS, SCHEME OF DELEGATION AND SCHEME OF RESERVATION** The Committee recommended the policies be presented to Board for ratification.		

4. Risks to Escalate

There were no risks to escalate.

5. Conclusion

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

Shropshire Community Health NHS Trust

Board Assurance Framework

0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**5 December 2024**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	28 November 2024
Paper Reviewed by:		**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 and what input is required?

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

2. Executive Summary

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

The BAF has been reviewed with each Executive Lead and is presented to the Committee 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 Q2 2024/25
- Updates on actions being taken to address identified control / assurance gaps
- Risk 4.1 in relation to ability to transition to LFPSE has been reduced as Senior Governance Manager now in post and undertaking the required reconfigurations of Datix with initial testing positive and a go live date of 29 November
- Risk 5.3 in relation to operational capacity was reduced in October to take into account the strengthened operational structure and the system operational collaboration.
- Two new risks have been added
    - Risk 4.3 in relation to the capacity of the quality improvement team. This has potential to impact on the pace and breadth of quality improvement projects and is being mitigated by taking a risk based approach to prioritisation
    - Risk 8.2 in relation to insufficient capital funding as there is potential for the Trust to breach the funding limit if patient safety concerns require capital spend

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

Board Assurance Framework

BAF Risk Tracker

Ref	Risk Title	Opened	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov24	Movement in Month	Target
1.1	Workforce Team Capacity Carried forward from 23/24	Sept 23	16	16	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	16	16	↔	6
4.1	Ability to transition to LFPSE	Sept 23	16	16	16	20	20	20	12	12	↔	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	12	12	↔	4
4.3	Quality Improvement Team Capacity	Oct 24	-	-	-	-	-	-	12	12	↔	
5.1	Demand exceeds capacity Carried forward from 23/24	Apr 22	20	20	20	16	16	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	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	15	15	↔	10
5.4	Recruitment challenges	Apr 22	16	16	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	15	15	↔	5
7.1	Cyber attack	Sep 23	12	12	12	12	12	12	12	12	↔	6
7.2	Digital Capacity	Sep 23	20	20	20	20	20	20	12	12	↔	8
8.1	Costs exceed plan	Apr 22	20	20	20	20	20	12	12	12	↔	6
8.2	Insufficient capital funding	Sep 24	-	-	-	-	-	-	9	9	↔	6

Risk Increasing		New Risk	
Risk Decreasing		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: October 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 has launched
- New sickness management policy has been launched
- Leadership Programme launched to support managers
- Agency usage is reducing
- Improving price cap compliance position
- STW Temporary Staffing Task and Finish Group has been established and a regional agency reduction group 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

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: October 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
- C2: Capacity to progress with centralised bank

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 - completed
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 - completed
C2	Scoping of collaborative working options	Director HR and OD	January 2025	

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

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: October 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
- ✓ Civility and Respect training

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

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ System People Board Oversight
- ✓ Staff Survey
- ✓ Incidents
- ✓ Quality & Safety Committee
- ✓ Reduced leaver rate

Gaps In Controls:

- C3: Age profile of the organisation means high level of retirees

Gaps in Assurance:

- A1: Staff Survey Results a year out of date

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C3	Promotion of flexible work and retire and return	Director of HR	Ongoing	Comms has been issued about flexible working and retire and return
A1	Staff survey comms campaign	Director of HR / Director of Governance	October-November 2024	Comms campaign has commenced with weekly update on uptake to Execs and wider organisation, currently have the highest uptake for a community Trust

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: October 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. Leadership and culture programme ready to be rolled out along with flexible working programme.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above
Further risk to be worked up in relation to poor retention leading to gaps in workforce

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: October 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 has commenced with good uptake

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:

Opened: June 2024
Reviewed Date: October 2024

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 and celebration events continuing
- 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 commenced 1 October 2024 and is reviewing patient engagement mechanisms, observe and act schedule in place
- Clinical Quality Strategy signed off by the Board

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
BAF 4.3	Quality Improvement Team capacity

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

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	3	1
Total	16	12↓	4

Risk Details:

Opened: September 2023

Reviewed Date: November 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:

- ~~C1: Datix reconfiguration to be completed and resource constraints~~
- ~~C2: Datix software compatibility~~
- ~~C3: Lack of Datix expertise within the organisation (no trained lead)~~
- C4: Datix does not capture the right quality of data

Gaps in Assurance:

- ~~A1: 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	Reconfiguration timetable completed and system expected to be ready 1 November 2024 - completed
C2	Ongoing support from Datix	Director of Governance	~~November 2023~~ ~~March 2024~~ October 204	Current version of Datix updated to enable transition, initial testing indicates the system is ready to go live - completed
C3	Appointment of Datix lead	Director of Governance	October 2024	Senior Governance Manager / Datix lead now in post - completed
C4	Reconfiguration of Datix to capture required data	Director of Governance	December 2024	Reconfiguration work has been completed to enable transition to LFPSE, wider reconfiguration to improve quality of data is ongoing. Go live date 29th November

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

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: November 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

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~~ December 2024	Patient Experience Lead retired, new lead appointed and started in post on 1 October and will be taking this plan forward
A1	Recruitment and retention tracking to be put in place once plan devised	Director of Governance	~~January 2024~~ December 2024	Volunteers management software in the process of being scoped to support the recruitment and management of the volunteers

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.3**

Principal Risk: Quality Improvement Team Capacity NEW

Operational pressures impacting on staff engagement with QI training, ability to measure clinical quality strategy implementation

Risk Rating:

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

Risk Details:

Opened: October 2024

Reviewed Date: October 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Regular team meetings
- ✓ Risk based approach to prioritising quality improvement projects
- ✓ QI Training being rolled out

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

- ✓ Quality reporting
- ✓ Oversight from Quality and Safety Committee
- ✓ Executive and Non-Executive Walkabouts

Gaps In Controls:

- C1: Uptake on training / time needed to train staff

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Continued roll out of training with support from operational team to increase uptake	Director of Nursing / Director of Operations	January 2025	

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: October 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%
- 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.
- Health Inequality steering group to be established in Q3 to improve reporting

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

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: October 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	Majority of services now have drill down data available which is presented to Performance Board for the KPIs - completed
A1	KPIs to be reviewed and updated when national oversight framework published	Director of Operations / Director of Finance	TBC	This is outside of the Trust's control and the oversight framework is awaited

We will recover our services inclusively **BAF 5.2**

Principal Risk: Potential for patient harm due to waiting times

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: November 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~~ November 2024	Policy has progressed through Patient Safety Committee and due to go to Quality and Safety Committee
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~~ December 2024	Not yet started, awaiting ratification of policy

We will recover our services inclusively **BAF 5.3**

Principal Risk: Operational capacity to undertake all programmes of work

Potential for operational pressures to affect prioritisation of system programmes both internally and across the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	2
Total	20	15 ↓	10

Risk Details:

Opened: September 2023

Reviewed Date: October 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
- ✓ Review of OPEL level action cards to ensure capacity is prioritised during periods of high escalation

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 work through the system governance arrangements to ensure they link and align with provider governance frameworks	Director of Governance	October 2024	Governance leads have agreed the changes and the ToRs are being revised to then be taken through each organisation for approval and changes to governance frameworks - completed
C1/A1	Streamlined governance for system operational programmes	Director of Governance	December 2024	Plan for changes to governance framework to be approved and implemented in December 2024

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: October 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: Electronic rostering solution to support staffing

C2: Sustainable solution for medical cover across all sites

Gaps in Assurance:

- -N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing Director of HR	March 2025	Collaboration with the system on e-rostering in its infancy with project plan developed ongoing but on track
C2	Options appraisal to be completed and progressed	Director of Operations / Medical Director	September 2024	Options appraisal completed and approved to go out to for bids - completed

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: October 2024

Key Measures:

✓ Improved pathways through collaboration with system partners

Progress Update:

- Care Transfer Hub launched 1/10/24
- Co-location of single point of access and SCHT UCR test if change completed and to continue due to success
- Re-sequencing of Directory of Services enacted to re-direct flow away from EDs

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services
- Development of Integrated Care Coordination in system
- Development of Integrated neighbourhood Teams
- Development of Frailty pathway
- Further embedding of VW & RR pathways
-

Key Assumptions

- N/A

Risks:

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: October 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Establishment of system transformation group to improve collaborative working
- ✓ Weekly vacancy panel established at system level

Assurance: **Source of Assurance** **3**

- ✓ Quality and Safety Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework
- C2: Alignment of risk management across the system

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework
- A2: Alignment of risk management across the system

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	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 work through the system governance arrangements to ensure they link and align with provider governance frameworks	Director of Governance	October 2024	Governance leads have agreed the changes and the ToRs are being revised to then be taken through each organisation for approval and changes to governance frameworks - completed
C1/A1	Streamlined governance for system operational programmes	Director of Governance	December 2024	Plan for changes to governance framework to be approved and implemented in December 2024
C2/A2	Risk management to be aligned across the system	Director of Governance	December 2024	Trust's risk management strategy has been updated, alignment work with other partners underway

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: October 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 although progress does continue to be made

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	4	2
Total	20	16↑	6

Risk Details:

Opened: September 2023

Reviewed Date: October 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:

- ~~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
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. Particular challenge with MFA compliance, IG and Digital Team working through solution, on the agenda for SLT for operational support and additional support being provided to IG team

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: October 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 system level and going through internal process for recruitment
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: October 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 circa £500k 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

Following discussion at RPC it was agreed there would be a review of the risk of under / over performance against the contract

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: October 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~~
- C2: Unidentified risk relating to B2/B3 review

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 - completed
C2	Timeline and scope of review to be outlined to inform risk assessment	Director of People	November 2024	

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

Potential for there to be insufficient funding for all required projects, where there are safety concerns there is potential for the Trust to breach statutory duty by exceeding capital resource limit

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	3
Likelihood	3	3	2
Total	12	9	6

Risk Details:

Opened: October 2024

Reviewed Date: October 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 - meetings held with system and NHSE

Shropshire Community Health
NHS Trust

Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2024

0. Reference Information

Author:	David Court Head of Financial Accounting	**Paper date:**	5 December 2024
Executive Sponsor:	Sarah Lloyd, Director of Finance	**Paper written on:**	24 October 2024
Paper Reviewed by:	Audit Committee	**Paper Category:**	Finance/Governance Framework Review 2024
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

Following an annual review of the Standing Financial Instructions, Standing Orders, Scheme of Delegation and Scheme of Reservation the Board is asked to ratify Audit Committee's decision to approve these fundamental governance documents.

2. Executive Summary

The Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Scheme of Reservation are based on model Department of Health documents, modified as necessary to reflect Trust specific details.

In line with best practice these documents are reviewed annually and the latest review has resulted in a small number of proposed amendments to these documents.

In particular, the Trust Board's attention is drawn to the introduction of two new sections within the Scheme of Delegation (Sections 35 and 36) in relation to delegated limits for the approval of tenders for new business and the approval of business cases. The Board may wish to consider if the proposed limits are set at a reasonable level.

Once approved the documents will replace the existing documents on the Trust's website and widespread communication will inform staff that the documents have been updated.

The amendments are as follows:

All Documents have been updated to change the title of the 'Director of Nursing, Clinical Delivery and Workforce' to 'Director of Nursing and Clinical Delivery'.

Standing Orders

- Amended NHS Improvement/ England to NHS England.

Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2024

Standing Financial Instructions

- Amended NHS Improvement/ England to NHS England.
- A new section on business cases has been added (Section 3.4)
- Section 10.2.1 has been amended to reference the Trust's No Po No Pay policy.
- A new section has been added to reference the Triple Lock requirements (Section 10.2.8).

Scheme of Delegation

- Amended 'Director of Nursing, Clinical Delivery and Workforce' to 'Chief People Officer'.

Section 2A) Non-Pay Revenue Expenditure Requisitioning/Payment/Contract Signing:
- Clarified contract signatures are included within these limits
- Included the 'Triple Lock' approval requirement in line with NHSE regulations
- Increased the upper limit in (g) to £600,000 to align with Section 5(e).

Section 8) Engagement of Staff not on the Establishment:
- Clarified external (NHSE) approval requirements
- Chief Finance Officer can engage the Trust's Solicitors.

Section 9) Workforce and Pay
- Added the Trust's Vacancy Control Panel
- Clarified approval requirements for Special Severance Payments through HM Treasury
- Chief People Officer added in 9(c) as an authorised approver of additional increments.

Section 27) Reviewing the Trust's compliance with the Data Protection Act for computerised financial data
- Added clarity as relates to computerised financial data.

Section 35) Approval of Tenders for New Business and Section 36) Approval of Business Cases
- These sections have been added to ensure clarity regarding approval limits in relation to the above.

Scheme of Reservation

- Amended the limit in Section D.11 'Strategy, Plans and Budgets' to £600,000 to match Scheme of Delegation.

3. Key Recommendations

The Board is asked to ratify the Audit Committee decision taken on the 23 October 2024 and approve the amendments to these governance documents.

Shropshire Community Health
NHS Trust

Charitable Funds Annual Report & Accounts 2023/24

0. Reference Information

Author:	David Court Head of Financial Accounting	**Paper date:**	5th December 2024
Executive Sponsor:	Sarah Lloyd, Director of Finance	**Paper written on:**	19th November 2024
Paper Reviewed by:	Charitable Funds Committee	**Paper Category:**	Charitable Funds Annual Report & Accounts 2023/24
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper requests the Trust Board, as the Corporate Trustee, formally approve the Charitable Funds Annual Report and Accounts for 2023/24, as recommended by the Charitable Funds Committee on 18th November 2024.

2. Executive Summary

The Charitable Funds Committee has considered and endorsed the 2023/24 Charitable Funds Annual Report and Accounts in line with its delegated responsibility and recommends formal approval by the Trust Board.

The Accounts show an overall increase in fund balances during the year of £80k, from £92k to £172k, as a result of income totalling £200k and expenditure of £120k.

The income of £200k included a grant from NHS Charities Together in relation to Covid-19 recovery (£35k), a very generous legacy (£83k) and donations (£74k), plus bank interest of £8k.

The total expenditure of £120k included: £110k on patient welfare and amenities, mainly for equipment to benefit patients, such as rise and recline chairs, bedside lockers, vital sign monitors with stands and an ECG machine. This was spent at Bridgnorth hospital (£40k), Whitchurch hospital (£28k) and Ludlow hospital (£17k) and was largely funded by very generous League of Friends donations. In addition, £18k was spent on computer tablets to aid with Revive Care Home project funded from the Covid-19 grant from NHS Charities Together. Expenditure from the Staff Welfare Funds totalled £10k and was mainly for pin badges to commemorate the NHS being awarded the George Cross and for the NHS 75th birthday and for staff events.

Given the value of the funds they are not subject to a full external audit, however the Trust's external auditors, Grant Thornton, have carried out an independent examination, resulting in no change to the reported position.

Shropshire Community Health
NHS Trust

Charitable Funds Annual Report & Accounts 2023/24

The Annual Report and Accounts, and the draft Audit Findings Report (AFR) are attached. The draft AFR, issued by Grant Thornton, will be finalised following the adoption of the 2023/24 Annual Report and Accounts by the Trust Board.

The Annual Report and Accounts will be submitted to the Charity Commission as part of the annual return prior to the deadline of 31st January 2025.

Key Recommendations

The Board is asked to formally adopt the 2023/24 Charitable Funds Annual Report and Accounts, as approved by the Charitable Funds Committee on 18th November 2024 and in accordance with its delegated authority.

Shropshire Community Health
NHS Trust

Charitable Funds

Annual Report & Accounts 2023/24

Charity Registration Number 1056698

Statement of Trustees' Responsibilities in respect of the Trustees' Annual Report and Accounts

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgments and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The Annual Report and Accounts set out on pages 3 to 13 have been compiled from and are in accordance with the financial records maintained by the trustees.

Signed on behalf of the trustees:

Chair : …….. Date : ……

Trustee : …… Date : ……

Annual Report

Reference & Administrative Details

In accordance with the Charities Act 2011, the charity is included in the Charity Commission's Register of Charities with the following details:

Name of charity:	Shropshire Community Health NHS Trust General Charitable Fund
Registered charity number:	1056698
Address of charity:	Trust Headquarters, Mount McKinley, Shrewsbury Business Park, Anchorage Ave, Shropshire, SY2 6FG

There are 16 separate sub-funds registered within the group registration. There are further sub-divisions for the purpose of local management of funds.

The original governing document was a deed dated June 1996, as amended by supplementary deeds due to NHS re-organisations over the years.

Trustee Arrangements

The Trust is the sole corporate trustee of the charity. Since the Trust must act through individuals in order to express its will, trusteeship is assumed by the members of the Trust Board.

During 2023/24 they were as follows:
Patricia Davies
Sarah Lloyd
Dr Mahadeva Ganesh
Angie Wallace (1st April 2023 to 4th June 2023)
Clair Hobbs
Shelley Ramtuhul
Claire Horsfield (1st June 2023 to 31st March 2024)
Tina Long
Harmesh Darbhanga
Peter Featherstone
Cathy Purt
Alison Sargent
Jill Barker

Governance & Management

In its role as corporate trustee, the Trust Board takes into account the Charity Commission guidance on independence. A Charitable Funds Committee has therefore been set up with delegated responsibility for managing the charity, ensuring that the use of charitable funds is focussed on the needs of patients. This committee operates within the Terms of Reference and delegated powers as set by the Board.

The committee has responsibility for ensuring that:
• Spending is in line with agreed objectives and priorities.
• Devolved decision making and delegation is in accordance with the policies and procedures set out by the Board.
• All legal duties and regulations in relation to charitable funds are complied with.

The charity is accounted for and administered on a day to day basis by the Finance Department of Shropshire Community Health NHS Trust.

Objectives & Activities

The objective of the charity is that the Trustees shall apply the income and, at their discretion, so far as may be permissible, the capital, for any charitable purposes relating to the NHS wholly or mainly for the services provided within Shropshire Community Health NHS Trust.

The charity is funded by grants received from NHS Charities Together, donations and legacies received from patients, their relatives, the general public and other organisations. The overall strategy of the charity is to provide support to the above Trust by the following means:

Patients Expenditure

- Purchase of medical equipment and provision of services not normally provided by or in addition to that normally provided by the NHS.
- Improving patient facilities and amenities to improve the environment.

Staff Expenditure

- Motivation of staff, by improving staff facilities and providing services that improve staff wellbeing.
- Education of staff by providing training over and above what would normally be provided.

Relationships with Related Parties/External Bodies

Grants to the related NHS organisation, Shropshire Community Health NHS Trust, are made in accordance with donors' wishes and in line with Charity Commission guidance on the public benefit.

The charity works closely with the Trust. Staff within the organisation identify and advise the charity on local priorities and assist the corporate trustee in monitoring the use of the charitable funds.

The strong relationship with members of staff is particularly valued and enables the charitable funds to be directed to ensure an effective contribution is made in support of local services.

Close links are also maintained with individual hospital League of Friends organisations. The charity is pleased to work with these organisations in the provision of charitable support to the related hospitals and health services.

Review of Finances, Activities, Achievements & Performance

The strategy of the charity is to provide support by providing funds to benefit patients and staff of Shropshire Community Health NHS Trust. It does this by purchasing supplementary and complementary equipment or services for which the Trust is unable to provide funding through exchequer sources.

The charity does not currently actively fundraise and recurrently relies upon the generosity of patients and their relatives and other donors who are familiar with, or have experienced the care of the Trust services and hospitals, or who are sympathetic and generous in their support to their local NHS services.

Finances

In the 2023/24 financial year the charity received a Grant of £35k, Donations of £74k, a Legacy of £83k and Bank interest of £8k . Total incoming resources for the year were therefore £200k.

The charity can only continue to support the work of Shropshire Community Health NHS Trust as long as donations and legacies continue to be received. The charity is therefore indebted to the generosity of patients, their families and carers, well-wishers and friends, who have donated so generously to the work of the charity. This includes people who have left legacies in their will, and we are aware that we receive these monies at a sensitive time for the remaining family.

Patient welfare and amenities

Patients' welfare expenditure totalled £110k. The majority of this expenditure related to medical equipment with the most significant items being:

- £40k from the Bridgnorth Hospital Patient Welfare Fund that relate to donations from the League of Friends for rise and recline chairs £16k, bedside lockers £10k, vital sign monitors and stands £7k, Portering chairs £2k and £5k on other items and support costs.

- £17k from the Ludlow Hospital Patient Welfare Fund and relates to donations from the League of Friends for Vital Signs Monitors £7k, Rehab Steps £2k, Coagucheck Meter £2k, recliner chairs £2k, Transfer Aid £1k, Leg Rest £1k, Sit to Stand £1k and £1k on other items and support costs.

- £18k from the Trusts General Fund in relation to a COVID 19 Grant from NHS Charities together for Tablets £15k and the remaining is on other small items and support costs

- £28k from the Whitchurch Hospital Patient Welfare Fund and this relates to the purchase of a LED Headlight and charging unit £3k and Linen and cleaning trollies £2k that were funded by the League of Friends, and an ECG machine £4k, Electrocardiograph £3k, chairs £3k, dispensing trolleys £2k, Mattress covers £1k, Tympanic thermometers £1k, chair repairs £1k and £8k on other items and support costs.

Staff welfare and amenities

Expenditure from the Staff welfare funds totalled £10k.

The overall financial performance recorded a net increase in funds of £80k.

Future Plans

The trustees do not expect any significant changes in the objectives of the charity in the forthcoming years, and intends to continue to reduce fund balances where suitable projects and schemes can be identified.

Reserves policy

The charity's intention is that funds are spent within a reasonable period of receipt, and therefore reserves should not be built up. Managers are encouraged to spend the funds to continue to reduce the level of funds held.

Statement of Financial Activities for the year ended 31 March 2024

	Note	Restricted Funds 2023/24 £'000	Unrestricted Funds 2023/24 £'000	Total Funds 2023/24 £'000	Restricted Funds 2022/23 £'000	Unrestricted Funds 2022/23 £'000	Total Funds 2022/23 £'000
Income from:							
Grants	3	35	0	35	0	0	0
Donations & Legacies	3	0	157	157	0	175	175
Investments (Bank Interest)		0	8	8	0	4	4
Total Incoming Resources		**35**	**165**	**200**	0	179	179
Expenditure on:							
Charitable activities:							
Patient welfare & amenities	4	15	95	110	0	200	200
Staff welfare & amenities	4	0	10	10	0	5	5
Total Expenditure		**15**	**105**	**120**	0	205	205
Net Movement in Funds		**20**	**60**	**80**	0	-26	-26
Reconciliation of funds	10						
Total funds brought forward		0	92	92	0	118	118
Total funds carried forward		**20**	**152**	**172**	0	92	92

Balance Sheet as at 31 March 2024

	Note	Restricted Funds 2023/24 £'000	Unrestricted Funds 2023/24 £'000	Total Funds 2023/24 £'000	Restricted Funds 2022/23 £'000	Unrestricted Funds 2022/23 £'000	Total Funds 2022/23 £'000
Current assets							
Debtors	8	0	3	3	0	4	4
Cash at bank & in hand		20	162	182	0	102	102
Total Current Assets		**20**	**165**	**185**	0	106	106
Liabilities							
Creditors : amounts falling due within 1 year	9	0	-13	-13	0	-14	-14
Total Liabilities		**0**	**-13**	**-13**	0	-14	-14
Total Net Current Assets/(Liabilities)		**20**	**152**	**172**	0	92	92
Total Net Assets or Liabilities		**20**	**152**	**172**	0	92	92
Funds of the charity	10						
Restricted funds		20	0	20	0	0	0
Unrestricted funds		0	152	152	0	92	92
Total Charitable Funds		**20**	**152**	**172**	**0**	**92**	**92**

The notes on pages 8 to 13 form part of these accounts.

The financial statements were approved by the trustees at the Charitable Funds Committee on 18th November 2024 and then subsequently approved by the Trust Board for issue on behalf of the committee on the 5th December 2024

Trustee : Date :

NOTES TO THE ACCOUNTS

Note 1 : Accounting Policies

a) Basis of preparation

The financial statements have been prepared under the historic cost convention.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice : Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a "true and fair view" and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a "true and fair view". This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than Accounting and Reporting by Charities : Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

Update Bulletin 1 of the Charities SORP (FRS 102) was implemented in 2015/16.

Update Bulletin 2 of the Charities SORP (FRS 102) was implemented in 2019/20.

The trustees consider that there are no material uncertainties about the charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- An endowment fund - where the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent.
- A restricted income fund - where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

In 2023/24 the charity had no endowment funds but does have restricted income funds in the form of Grants received from NHS Charities Together in relation to COVID.

There are 16 separate sub-funds registered within the group registration with the Charity Commission, with further sub-divisions for the purpose of local management of funds.

c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met, then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

NOTES TO THE ACCOUNTS

d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when all the following conditions are met:
- Confirmation has been received from the estate representatives that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:
- There is a present legal or constructive obligation resulting from a past event.

- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement.
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

f) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment:
- Approval and authorisation have been granted in accordance with the Scheme of Delegation operated by the Trustee.
- Receipt of goods or services have been confirmed as appropriate and payment authorised in accordance with the Trustee's Standing Financial Instructions.

g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include costs of administration, internal and external audit costs and bank charges. Support costs have been apportioned across the categories of charitable expenditure on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 5.

h) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 4.

NOTES TO THE ACCOUNTS

i) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

j) Cash and cash equivalents

All cash is held within interest bearing Government Banking Service (GBS) bank accounts.

k) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

l) Cash Flow Statement - Exemption

Charities preparing their accounts under FRS 102 must provide a statement of cash flows, except where the disclosure exemptions permitted by SORP have been taken.

Section 7 of FRS102 provides an exemption under the small entity provisions within S1A of FRS 102; small entities that are not subsidiaries can claim exemption from preparing a cash flow statement.

The turnover of the Shropshire Community Health NHS Trust General Charitable Fund is such that it meets the definition of a small entity.

Note 2 : Related Parties

During the year, members of the Charitable Funds Committee, which is empowered by the corporate trustee to act on its behalf in the day-to-day administration of all Funds Held on Trust, were also members of the Shropshire Community Health NHS Trust Board.

The charity has made revenue and capital grant payments to the Trust to the value of £100,000 as detailed in note 4. Other than these payments, there have been no further material transactions between the charity and the listed NHS body.

Board members of Shropshire Community Health NHS Trust, the corporate trustee, and members of the Charitable Funds Committee ensure that the business of the charity is dealt with separately from that associated with exchequer funds for which they are also responsible.

Note 3 : Income from Grants, Donations & Legacies

	Restricted Funds 2023/24 £'000	**Unrestricted Funds 2023/24 £'000**	**Total Funds 2023/24 £'000**	Total Funds 2022/23 £'000
Grants	35	0	35	0
Donations	0	74	74	171
Legacies	0	83	83	4
Total	**35**	**157**	**192**	175

Note 4 : Analysis of Charitable Expenditure

The charity does not undertake any direct charitable activities on its own. All the charitable expenditure is in the form of grant funding. All grants are made to Shropshire Community Health NHS Trust, to provide for the care of patients in furtherance of the charity's aims. No grants are made to individuals.

Support costs are apportioned across the categories of charitable expenditure.

	Grant Funded Activity 2023/24 £'000	**Support Costs 2023/24 £'000**	**Total 2023/24 £'000**	2022/23 £'000
Patient welfare & amenities	93	17	110	200
Staff welfare & amenities	7	3	10	5
Total	**100**	**20**	**120**	205

Note 5 : Allocation of Support Costs

Support costs are apportioned across the categories of charitable expenditure based on average monthly fund balances.

	Patient Welfare 2023/24 £'000	**Staff Welfare 2023/24 £'000**	**Total 2023/24 £'000**	Total 2022/23 £'000
Governance - internal & external audit fees	7	1	8	6
Financial, administration & bank charges	10	2	12	11
Total	**17**	**3**	**20**	17

Governance costs of £8k are for External Audit fees and are covered further in Note 7.
The financial administration costs include £8k of staff costs for staff employed by the Trust.

Note 6 : Trustee Remuneration & Expenses

No trustees were paid any remuneration or expenses from the charity for the work they undertake as trustees.

The Trusts Remuneration Report describing the remuneration of Very Senior Managers (VSM) namely the members of the Board and hence the Trustees of this Charitable Fund can be found on the Trusts website in the Annual Report and Accounts section. See below link:

http://www.shropscommunityhealth.nhs.uk/annual-reports-and-accounts

Note 7 : Auditor's Remuneration

The external auditor's remuneration of £8,280 (2022/23 : £5,527) related solely to the independent examination of the annual accounts, with no other additional work being undertaken.

Note 8 : Analysis of Current Debtors

	2023/24	2022/23
	£'000	£'000
Accrued income	3	4
Total	**3**	4

Note 9 : Analysis of Creditors Due Within 1 Year

	2023/24	2022/23
	£'000	£'000
Trade creditors	13	14
Total	**13**	14

Note 10 : Summary of Fund Movements

	Balance B/Fwd £'000	Income £'000	Expenditure £'000	Balance C/Fwd £'000
Shropshire Community Health Trust General	12	40	-23	29
Telford and South East Locality Patient Welfare	6	83	-4	85
All other funds	74	77	-93	58
Net movement in funds	**92**	**200**	**-120**	**172**

The above table shows the movements on the significant sub-funds within the group registration, and is based on those funds which have a closing balance at 31 March 2024 in excess of £20,000. Two funds have a balance greater than £20,000 the Trusts General Fund and the Telford and South East Locality Patient Welfare. The increase in the General Fund mainly relates to the COVID 19 Grant from NHS Charities Together of £35k and the increase in Telford and South East Locality Patient Welfare relates to a £83k legacy received in year.

The £35k COVID 19 Grant from NHS Charities Together is a restrcted fund and is for two projects that relate to Covid Recovery. This Funding relates to 80% of the total Grant with the other 20% expected in 2024/25. The Trust has 24 months to spend this Grant.

The objects of the listed funds are as follows:

Shropshire Community Health Trust General - is an overall fund for both patients who are, or have been treated by Shropshire Community Health NHS Trust and staff who work for the Trust.

Telford and South East Locality Patient Welfare - for patients who are or have been treated by Shropshire Community Health NHS Trust in Telford and South East of Shropshire.

The 4 community hospitals are each supported by active Hospital League of Friends who donate money to assist in the purchase of medical equipment and other patient amenities.

Note 11 : Events After the End of the Reporting Period

There were no events after the end of the reporting period.

Independent examiner's report to the corporate trustee of Shropshire Community Health NHS Trust General Charitable Fund

I report on the accounts of Shropshire Community Health NHS Trust General Charitable Fund (the "charity") for the year ended 31 March 2024, which are set out on pages x to x.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011;
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met.

Basis of independent examiner's statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as the trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement above.

Respective responsibilities of corporate trustee and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees considers that an audit is not required for this year under section 149(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 149 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 149(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Your attention is drawn to the fact that the charity's trustees has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

This report is in respect of an examination carried out under section 149(3) of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustee those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or

assume responsibility to anyone other than the charity and the charity's trustee as a body, for my work, for this report or for the opinions I have formed.

Richard J J Anderson; CPFA

Grant Thornton UK LLP
Chartered Accountants

Birmingham

XX Nov 2024