BOARD MEETING

10.00am – 12.30pm
on Thursday 26 March 2020
by telephone conference
due to Covid-19 pandemic

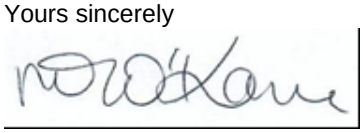
Shropshire Community Health NHS Trust
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL

Tel: 01743 277583

Dear Colleague

I enclose the agenda for the meeting of the Shropshire Community Health NHS Trust Board to be held by telephone conference due to the Covid-19 pandemic. Questions or comments from members of the public are invited by email in advance of the conference call and a recording of the meeting will be available on-line after the meeting. If you would prefer to put your question(s) in writing, please write to Ms Nuala O'Kane, Chair, Shropshire Community Health NHS Trust, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL

Yours sincerely



Nuala O'Kane
Chair

A G E N D A

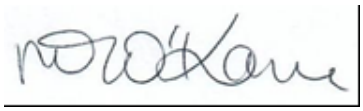
PLEASE NOTE THAT THE CHAIR AND NED MEETING WILL START AT 9.30am PRIOR TO THE BOARD MEETING

	ITEM	Purpose	Lead	Format	Time
1.	**Welcome**		N O'Kane		10.00am
2.	**Apologies**				
3.	**Minutes of the meeting held on:** • **30 January 2020**	Approval	N O'Kane	Encl 1	10.05am
4.	**Review of action log**	Assurance	N O'Kane	Encl 2	10.10am
5.	**Declarations of Interest**	Assurance	N O'Kane	Encl 3	
6.	**Chair's Communications including:** • **Brief report of Part 2 Board January 2020 & informal Board February 2020** • **Feedback from visits** • **Virtual meetings**	Information/ Consider for Action	N O'Kane	Encl 3	10.15am
7.	**Non-Executive Directors' Communications including feedback from service visits**	Information	N O'Kane/ NEDs	Verbal	10.20am
8.	**Chief Executive's Report**	Consider for Action	D Stout	Encl 4	10.25am

9.	QUALITY, SAFETY AND PRODUCTIVITY Strategic Priority 1: Good and Beyond	Purpose	Lead	Format	Time
9.1	**Quality & Safety:** **Quality Report including** • **Update from Quality and Safety Committee** • **Risks, opportunities and mitigations identified at Committee**	Consider for Action/ Assurance	S Gregory / P Featherstone	Encl 5	10.35am
9.2	**Annual Diversity and Inclusion Report including gender pay gap data**	Consider for action/ assurance	J Lowe/J Povey	Encl 6	10.45am
9.3	**Freedom to Speak up Guardian update**	Consider for action/ assurance	J Lowe	Encl 7	10.50am
9.4	**Annual Staff Survey Results**	Consider for action/ assurance	J Lowe	Encl 8	10.55am
9.5	**Performance Report**	Consider for action/ Assurance	R Preen	Encl 9	11.05am
9.6	**Improvement Plans** • **Core Services** • **Well Led**	Consider for Assurance	S Gregory C Lea	Enc 10 Enc 11	11.15am
10.	STRATEGY, INNOVATION AND SERVICE IMPROVEMENT Strategic Priorities 2: Our Transformation Plan 3: Optimising the Use of Technology				
10.1	**Strategic Developments Report**	Consider for Action/ Assurance	R Preen	Enc 12	11.20am
11.	RISK AND FINANCIAL STABILITY				
11.1	**Finance Report including:** • **Report from Resources & Performance Committee** • **Risks, opportunities and mitigations identified at Committee**	Consider for Action/ Assurance	S Lloyd/ H Darbhanga	Enc 13	11.30am
11.2	**Annual Budget Setting**	Consider for Action/ Assurance	S Lloyd	Enc 14	11.40am
11.3	**Lessons learnt from implementation of RIO**	Consider for Action/ Assurance	R Preen/A l'Anson	Enc 15	11.50am
11.4	**Governance Report Including:** • **Board Assurance Framework** • **Corporate Risk Register**	Consider for Action/ Assurance	C Lea	Enc 16	11.55am
12.	**Questions or Comments from Members of the Public**				12.05pm
13.	ITEMS FOR INFORMATION ONLY				
	Committee Minutes (most recent approved)	Information		Enc 17	12.15pm

14.	**Any Other Business**				
	• With prior agreement of the Chair		N O'Kane		
15.	**MEETING EVALUATION**				
15.1	**Reflections on the meeting: effectiveness and any new risks and assurances**	Consider for Action	N O'Kane	Verbal	12.20pm
16.	**DATE OF FUTURE MEETING**				
	Thursday 4 June 2020 – Festival Drayton Centre, Frogmore Road, Market Drayton Shropshire. TF9 3AX				

TO RESOLVE '*that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest'* (in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960



Nuala O'Kane
Chair

David Stout
Chief Executive

Shropshire Community Health NHS Trust

MINUTES OF THE BOARD MEETING

HELD AT MEETING POINT HOUSE, SOUTHWATER, TELFORD TF3 4HS AT 10.00AM ON THURSDAY 30 JANUARY 2020

PRESENT

Chair and Non-Executive Members (Voting)	
Ms. Nuala O'Kane	(Chair)
Mr. Peter Phillips	(Non-Executive Director and Vice-Chair)
Ms. Tina Long	(Non-Executive Director)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Cathy Purt	(Non-Executive Director)
Mr. Peter Featherstone	(Non-Executive Director)
Non-Executive Members (Non-Voting)	
Mr. Mike McDonald	(Associate Non-Executive Director)
Executive Members (Voting)	(Chief Executive)
Ms. Jan Ditheridge	(Director of Nursing and Operations)
Mr. Steve Gregory	(Medical Director)
Dr. Jane Povey	(Director of Finance and Strategy)
Ms. Ros Preen	(Director of People)
Ms. Jaki Lowe	(Associate Director of Finance)
Executive Members (Non-Voting)	
Ms. Sarah Lloyd	
In attendance	
Ms. Claire Lea	(Corporate Governance Consultant)
Mr. Robert Graves	(Director of Estates)
Mrs. Louise Tompson	(Minute Taker)

Members of the Public	**1**
Press	**0**
Observers	**1**
Staff	**5**
Volunteers	**0**

Ms O'Kane presented a Chair's award to the Children's Community Nursing Team for their effective and efficient team working with hospital paediatricians and Hope House Hospice, and the care and support shown to a child and their family.

Ms O'Kane presented a Chair's award to Bernadette Jones, Nurse Specialist Child Death Reviews for donating a kidney to her friend. This has transformed the lives of her friend and their family and Bernadette has had no ill effects from this donation.

ITEM

Ms O'Kane welcomed everyone to the meeting.

Minute No 2020.1.1 - Apologies

There were none.

Minute No. 2020.1.2 - Minutes of the Meeting held on 28 November 2019

The minutes were agreed as an accurate record.

Mr Phillips FORMALLY PROPOSED that the Minutes of the Board Meeting of Shropshire Community Health NHS Trust held on 28 November 2019 be received and approved as an accurate record. The proposal was SECONDED by Mr Gregory, and BOARD MEMBERS UNANIMOUSLY AGREED the proposal.

Minute No. 2020.1.3 Review of action log

Members accepted the action log, giving an update on actions from the last meeting. It was agreed that those completed would be removed from the log.

Minute No. 2020.1.4 - Declarations of Interest

No new declarations of interest.

Minute No. 2020.1.5 - Chair's Communications

Ms O'Kane presented a summary of issues discussed in private by the Trust Board in November 2019 and a summary of her engagements since the last Trust Board meeting, including the informal Board meeting in December 2019.

Before Christmas, Ms O'Kane met with the Children's Immunisation Team who had been nominated for a Chair's award as they had gone above and beyond when a delay in receipt of the flu vaccine occurred. Debbie Jones was recognised as an inspirational and motivational leader of the team.

Ms O'Kane explained that her main focus over recent weeks has been arranging the recruitment of the new Interim Chief Executive and she was delighted to announce the appointment of David Stout. This appointment means that the Trust will shortly say goodbye to Jan Ditheridge. This meeting is Ms Ditheridge's final Trust Board meeting before she takes up her new role as Chief Executive of Sheffield Health and Social Care NHS Foundation Trust.

Ms Ditheridge has been Chief Executive of this Trust for almost seven years and has overseen years of sustained improvement at the organisation – work that was recognised last year by the Care Quality Commission, which awarded the Trust a rating of Good across all of its services. Ms O'Kane took the opportunity to formally and publicly thank Ms Ditheridge for her enormous contribution to health services for the population of Shropshire, Telford and Wrekin. She will be very much missed by all at the Trust but leaves behind a strong legacy of excellence in the provision of community services which the Trust will all be determined to build upon. She has been transformational to the organisation in particular the cultural change brought about in the organisation.

Ms O'Kane welcomed comments from the Board. Mr Phillips agreed with Ms O'Kane and highlighted Ms Ditheridge's quiet determination to get things done adding that he has very much enjoyed working with her over the years. Ms Long commented that it had been a privilege to work with Ms Ditheridge over the last 12 months. Mr Featherstone said that Ms Ditheridge has been key to transforming the organisation. Mr Darbhanga said he had very much enjoyed working with Ms Ditheridge over the last 12 months. Mr Gregory commented that Ms Ditheridge has the trust of individuals and teams and she has ensured that the Trust has a stable team that delivers.

Ms O'Kane concluded by congratulating Ms Lloyd on her appointment as Associate Director of Finance, this is a well-earned and well deserved appointment.

The Board accepted the assurance provided by the Chair's report

Minute No. 2020.1.6 – Non-Executive Directors' Communications

Mr Darbhanga recently visited that Rio team which although small is dedicated and having a significant impact. Ms Long and Ms Lowe visited the finance team; they were impressed by their team work and how they were fully engaged with clinical staff. The team commented that they don't feel quite as engaged as they could be with the work of the STP and they want to understand more about this work. It was very obvious that the cultural work they have done has resulted in excellent team working.

Ms Purt and Mr McDonald have attended national Induction in London for 2 days; they commented that networking was very valuable with Non-Executive Directors from Trusts around the county.

Mr McDonald, Ms Purt and Mr Gregory met with the Shropshire Dementia Group at Whitchurch. This was a very useful visit where they learned more about the Butterfly scheme.

Mr Featherstone and Mr Gregory visited the Respiratory Team which is very committed to their patients and enthusiastic about their job. Mr Featherstone attended the NHS Providers Regional conference, the main focus was on financial pressures across the NHS.

The Board accepted the update from Non-Executive Directors.

Minute No. 2020.1.7 - Chief Executive's Report

Ms Ditheridge thanked the Board for their comments. She thanked the Executive Team for their support over the years along with other partners. She commented on a number of achievements made by the Trust over the years:

- A huge amount of transformation done
- Lead provider with the partnership of Shropdoc
- Lead provider in prison healthcare
- Urgent care has improved – more often patients are in the right place at the right time.
- Minor Injury Units are delivering much wider services than before
- Most digitally enabled provider in the system
- Staff survey score are improving every year
- The Estate generally is a better place to work than when the Trust was formed.

She confirmed that January marked the start of the International Year of the Nurse and the Midwife and that Mr Gregory will lead the Trust's response to this important initiative and will be sharing plans to celebrate nurses, midwives and health visitors with the Board in the near future. The Board discussed the possibility of have a Non-Executive champion for this initiative and the Board agreed that Ms Long would take on this role.

Urgent care remains challenging, in January a new Admissions Avoidance service commenced in Shrewsbury, in partnership with the local authority. Ms Preen commented that there will be a thematic review of urgent care at the next informal board meeting.

Action:

- **Mr Gregory to present thematic review of urgent care at the next informal board meeting.**

- The Board recognised the potential impacts and implications of the content of the Queens speech, and identified any immediate action required in relation to the new bills.

- The Board considered the proposals of the 2020/21 contract and offered considerations for the Trust's response to the consultation and any areas of focus.

- The Board recognised the International Year of the nurse and midwife

- The Board appointed Ms Long as the non - executive champion to support the Director of Nursing leading this programme locally.

-The Board considered it's contribution to the Urgent Care system and requested further assurance regarding this.

9. QUALITY, SAFETY AND PRODUCTIVITY

Minute No 2020.1.8 – Quality and Safety

Mr Gregory set out key points from the most recent Quality and Safety (Q&S) Committee meeting which were set out in the summary report and went on to highlight the items discussed at the Q&S Committee as follows:-

Mr Gregory informed the Board that just over 80% of staff have received their flu vaccination which meets the CQUIN but are still some areas which require attention. In relation to the Year of the Nurse and Midwife the Trust is working in collaboration across the system. The Trust will also consider how others i.e. AHPs are recognised. Each month the Trust will have a Director of Nursing award, one for adults and one for children's services. There will be a third which may be selected as a Board which will be linked to values and strategy.

The Trust has recently appointed a Deputy Director of AHPs (Allied Health Professionals), Claire Horsfield. This was an internal appointment but there was good competition from lots of other organisations.

Mr Gregory said that the Trust has secured the e-rostering funding which the Trust had bid for but some of the funds need to be spent quite quickly before the end of the financial year; the team will set up a meeting to discuss this before the next Resources and Performance Committee.

During a recent visit to Whitchurch Community Hospital Mr Gregory met with a range of staff who unilaterally said that morale within the hospital was good and they felt supported by each other. There were some issues raised around the availability of agency staff and the Trust is going to consider this in more detail at the Quality and Safety Committee.

In relation to the Corona Virus a communication has been released to all staff which follows guidance from Public Health England and the Trust has all appropriate plans in place.

Mr Gregory welcomed any comments or questions. Ms Lowe said that at a recent LWAB meeting the Year of the Nurse was mentioned and the need to support new international nurses in the area was discussed.

Ms Purt raised a query related to the Community Equipment Stores vehicle. Mr Gregory commented that the Trust is considering if it may be more cost effective for the service to have their own vehicle.

The Board discussed safer staffing and asked how the Q&S Committee receives assurance that there is safe staffing in all areas and in particular assurance that the fill rate is a safe rate,

considering there is a fine balance between bank, agency and substantive. Mr Featherstone commented that this has been an area that has required further information since he started as Non-Executive Director. The Committee does see a report that provides more detail on what rates mean and there is now assurance at committee level. One of the benefits of e-rostering is that it will provide further reassurance on this. Dr Povey expressed concerns that safer staffing data doesn't include medics and dentists, and that ensuring that Doctors and Dentists feel as valued as others within the Trust is important.

The Board accepted the assurance provided by the report.

Minute No 2020.1.9 – Learning from Deaths

Dr Povey presented the report which gave assurance that Shropshire Community Health NHS Trust has a robust internal Learning from Deaths review process.

The Board received the data and themes detailed in the learning from deaths report and discussed the current position in relation to the review of patient's deaths in the Trust. The Board acknowledged that there were 10 deaths in this period however they were all expected,

The Board discussed the Independent review of Serious Incidents and Deaths commissioned by Shropshire Clinical Commissioning Group which aims to identify system issues to support improvement in healthcare in Shropshire.

In relation to the Child Death Overview Panel the Board discussed the need to raise awareness of the Safer Sleeping initiative. Safe sleep training will be delivered to staff by The Lullaby Trust and this will be monitored to ensure that awareness is successful in reducing the number of Sudden Unexpected Death in infants.

The Board accepted the assurance provided by the report.

Minute No 2020.1.10 – Quarterly Guardian for Junior Doctor Safe Working Report

The report provided the Board with assurance that the 3 trainee doctors at Shropshire Community Health NHS Trust have safe working hours and conditions in order to maintain doctor and patient safety. All of the trainees are employed by Shrewsbury and Telford Hospital NHS Trust. There are no exception reports and no safety concerns for the junior doctors placed in Shropshire Community Health NHS Trust.

Ms Lowe reported that at the end of autumn 2019 the Trust received an allocation of funding for improving the lives of junior doctors. There are specific ways to use the funding and the Trust Community Paediatricians will work with junior doctors to find out what they need. This will be discussed further at the junior doctor's forum as although they are placed with the Trust they are employed by Shrewsbury and Telford Hospitals NHS Trust.

The Board accepted the assurance provided by the Quarterly Guardian for Junior Doctor safe working report

Minute No 2020.1.11 – Patient Story

Claire Turner attended the meeting to explain her role within the 6 month Wound Healing pilot currently taking place in the Wem and Preece areas. She explained that she has seen patients referred from the medical practice who have had wounds for a long period of time and that after only 5 or 6 weeks these are already showing a significant improvement. Patients are very pleased with their treatments and responses from the friends and family test is demonstrating this. Claire has a capacity of 26 patients and practice nurses can refer patients who have had chronic wounds over 4 weeks.

Claire has shown commitment to this pilot as she had been based in Telford but now commutes to Wem for this pilot. She has developed relationships with staff and patients in the local community and commented that more prevention work in the community would prevent the need for the service as wounds occur for many reasons. The Board discussed issues around upskilling of staff within medical practices and if this will be possible as currently if a wound is not healing after 4 weeks then specialist treatment is much more effective.

Ms O'Kane thanked Claire for attending the meeting today. She asked what will happen after the pilot has completed. Claire said that she would like to see the service carry on as it has shown such good results; the pilot is funded by commissioners. Dr Povey commented that the service would benefit from being more joined up to ensure that patients are received the most appropriate wound treatment quickly.

The Board understood that the patient who had been arranged to attend the meeting had not been able to. He wanted to comment that the service was outstanding and he couldn't speak more highly of his treatment following his referral which had seen his ulcers heal within 5 weeks of the start of his specialist treatment.

Ms O'Kane thanked Claire for her work and providing a strong case for this service to continue. A review of the programme is planned to take place this year and Ms Preen commented that the business case for this service will be discussed and brought back to the board through the service development report.

Minute No 2020.1.12 – Performance Report

Ms Preen reported that 19 of the Trust's performance indicators were designated as 'red' at the end of November. At the end of December the comparative performance has improved slightly to 18; where performance is 'off track' then recovery plans are in place for some of the indicators.

The Board were made aware that one measure has moved from 'red' since last month;

- Safeguarding Training Compliance (Children) Level 2 & 3

Ms Preen said there is nothing new or material that is not being monitored at committee level. A new recovery plan around Information Governance training is in place. The Board discussed the amount of unbooked leave left to the end of the holiday year. Mike Carr, Deputy Director of Operations is looking in to this and will bring a report to the Resources and Performance Committee.

The Board:
• Considered the current performance in relation to KPIs
• Reviewed the actions being taken where performance requires improvement
• Discussed the actions being taken to mitigate any risks arising to either the resources available to the Trust or the Trust's financial performance
• Discussed the content to ensure appropriate assurance is in place
• Considered the changes to the mandatory training and appraisal rate criteria
• Considered the change to safeguarding training

Minute No 2020.1.13 – Improvement Plans

Core Services

Mr Gregory presented the report which updated the Trust Board on progress and outcomes of core service improvement actions following the CQC report on 1 August 2019.

Mr Gregory reported that there are a number of areas that won't be completed by end of January but he does not consider that there will be an adverse impact on patient care. The report also contained details on what the Trust needs to do to maintain good and to improve to outstanding.

Ms Long commented that the Trust Board would need to discuss how much work would be needed to achieve outstanding and if the Trust should focus on particular areas. Ms O'Kane said that if there are some areas the Trust could reach outstanding then this should be considered but not at the cost of other areas.

The Board accepted the assurance provided by the report.

Well Led

Mrs Lea presented the report that provided the Trust Board with a final report on the progress in delivering the well-led improvements plans produced following the 2019 CQC inspection. Mrs Lea said that the Board can take assurance that everything that was due to be delivered has been delivered; and that all green areas have been incorporated into Executive Director Objectives.

In response to a query regarding the Board development programme action being marked as complete, Mrs Lea said the action presented to the CQC was to develop the programme which has been completed. At the end of the programme an assessment will take place and an ongoing evaluation of the effectiveness of the sessions will be the responsibility of Director of Governance.

The Board agreed that after the Board Development session on 13 March members would consider and sense check the programme.

Concerns were expressed that Executive Directors were not overstretching themselves and there is a lot to complete before the end of March, there is a need to not be over confident.

The Board agreed that that the action plan is not ready to be closed down yet with further work on assessing any outstanding risk from those areas not yet completed to be included in the next report.

The Board accepted the assurance provided by the report that the progress on the well led improvement action plan is on track.

10. STRATEGY, INNOVATION AND SERVICE IMPROVEMENT

Minute No 2020.1.14 – Strategic Developments Report

Ms Preen provided an update on the programmes the Trust is significantly engaged with:

- Shropshire Care Closer to Home
- Telford and Wrekin Integrated Place Partnership
- Stroke Rehabilitation in the Community

- MSK Pathway redesign

The CCGs have accepted the alliance structure approach although the timetable for key pieces of work required are challenging. Within the Alliance the Trust has been identified as the lead partner and work has commenced to establish the governance structure. Commissioners have agreed to discuss a risk sharing agreement however at the moment the gap is not known.

In relation to the Sustainability and Transformation Partnership (STP) Long Term Plan the Board discussed that there is a system emphasis on addressing the deficit and changes to financial plans have been submitted to NHSi/e and feedback is awaited.

The Board discussed latest developments on the digital agenda including the successful recruitment to the Head of Digital Services.

Members agreed that the Alliance is an effective vehicle for delivering the MSK Pathway and that it also links with the Trust's desire to work in partnership. The Board agreed that it would be useful to have more information about the effect of developments on patients in future reports.

Ms Long questioned how the Board is challenging the system and Ms O'Kane confirmed there is more Non-Executive members could do in relation to this. In her view the STP shadow board would make this more effective.

The Board accepted the assurance provided by the Strategic Developments Report

11. RISK AND FINANCIAL STABILITY

Minute No 2020.1.15 – Finance Report

Ms Lloyd presented the report which highlighted the following:

- The Trust is reporting a year to date surplus of £874k at month 9 at adjusted performance level compared to the planned position of £766k surplus, which is a £108k favourable variance
- Based on all currently available information, the team are currently forecasting delivery of the Trust's control total of £844k surplus.

The main risks to delivering this financial plan are:

- **Cost Improvement Programme** – at month 9 CIPs totalling £3,121k have been identified leaving 10% (£337k) of the in-year target of £3,458k yet to be identified (value at month 8 £537k)
- **Agency and Locum cost** – costs increased by £18k in the month, the year to date spend exceeds plan by £58k
- **Variable Healthcare Income** – based on month 8 contract monitoring variable healthcare income continues to underperform although the position has improved since month 7
- **CQUIN** – the Antimicrobial Resistance (AMR) CQUIN for quarter 2 has failed, the remaining quarters remain high risk
- **Demand-led services** – costs across a number of demand led services, including continence, wheelchair and equipment services continue to exceed planned levels, although the level of expenditure reduced compared to month 8

Members acknowledged that the Trust is on track to achieve the CIP target however it remains challenging. A particular focus next year will need to be on agency costs as this is an area of overspend for the Trust. The Trust is forecasting to spend its capital resource in full, plans are in place to spend in the last quarter of the year, and this is being closely monitored by the team. A list of capital spend will be discussed at Resources and Performance Committee.

Ms Lloyd explained that a new financial reporting standard is being introduced. She explained that this will be important for the Trust as it will affect revenue. A national assessment is currently taking place, there will be an impact on the Trust and further information on this will be brought back to the Board.

The Board agreed that further assurance around issues relating to Community Equipment Services should be considered at Resources and Performance Committee. Ms Preen, Ms Lloyd and Mr Gregory will meet to take this forward.

Action:

- Ms Preen, Ms Lloyd and Mr Gregory will meet to discuss Community Equipment Services.

The Board:

• Considered the adjusted financial position at month 9 of £874k surplus which is £108k favourable to plan
• Recognised the cash position remains strong with a balance of £17,585k as at 31 December 2019
• Accepted that the actions being taken to address the shortfall in CIP schemes compared to the identified target are sufficient to mitigate this risk.
• Considered that expenditure on agency staffing year to date remains above the value assumed within our internal plan and accepted that actions continue to be taken to safely reduce this expenditure
• Recognised that the forecast to achieve the 2019/20 control total was subject to mitigating material financial risks

Minute No. 2020.1.16 – Governance Report

Mr Phillips thanked Mr Darbhanga for chairing the last Audit Committee meeting as he was unable to attend. The Committee discussed the automatic roll forward and change in charges by auditors. There were not concerns at the meeting with regard to the fees and the term of appointment for the auditors. The Committee had accepted amendments to all of the board committees' terms of reference.

Board Assurance Framework
There were no changes to the BAF risks since the last Board meeting in November 2019. This is due to the changeover of personnel in the role of Head of Governance. A full report would be submitted for the next board meeting when the new Head of Governance will have had time to meet with the executives and discuss their BAF risks.

The Board is also considering a refresh of the strategic priorities and when this is complete the BAF will be realigned accordingly.

However, the two BAF risks in relation to Healthcare Systems and EU exit were considered at the Audit Committee.

Corporate Risk Register
The ongoing alignment of reporting software resulting from the external hosting of Datix has resulted in complications in retrieving an up to date accurate Corporate Risk Register for this month. This was explained to the Audit Committee and steps are being taken to address this such that an up to date Risk Register will be available within a month. It was confirmed that from a manual check of the register there had been no significant risks which needed to be considered by the Audit Committee.

Report from the Audit Committee
A deep dive on Healthcare Systems risk was presented and received by the committee. After a broad discussion and in particular, recognition of the financial challenges faced by system, it was agreed to maintain the risk rating for the Healthcare system. The Committee also agreed, however, that the risk narrative needed to be updated to reflect specifically that the healthcare system risk was the degree of financial challenge that the STP faces and the impact of that on the Trust's ability to deliver its clinical transformation strategy.

In respect of the EU – Exit Risk it was agreed that this could now be amended in light of the stepping down of, "No deal plans" and the Audit Committee referred this to the Board for consideration.

The Resources & Performance and Quality & Safety Committees' Terms of Reference had been approved by their respective committees, considered by Audit Committee and were recommended for approval by the Board. Audit Committee had also considered its own terms of reference and recommended them for approval by the Board. The remaining ToR (Nominations, Appointments and Remuneration Committee and Charitable Funds Committee) had not yet been signed off by their respective committees. Since the Audit Committee met, the Nominations, Appointments and Remuneration Committee had met on 23rd January and its ToR were approved. Charitable Funds is still yet to meet.

On the basis that the changes to these ToR are the same as already approved by Audit Committee it is recommended that the Board approve all of the ToR rather than wait for the next Audit Committee in April 2020. This proposal had been considered by the NAR and was agreed as an effective way of handling the matter.

The Board:

- ***Close EU Exit risk in line with NHS national guidance***
- ***Agreed the way forward in respect of the risk relating to the Healthcare System***
- ***Accepted the report of the Audit Committee***
- ***Accepted the BAF and Corporate Risk Register as presented acknowledging the discrepancies over timing.***
- ***Approved the Terms of Reference for all Board Committees as appended to the report***

Minute No. 2020.1.17 – Estates Progress Report

Mr Graves presented the report to update on key strategic estates matters and to provide assurance that actions taken to date are in line with the Trust's Estates Strategy and the Strategy remains in line with Trust's objectives.

Ms O'Kane recognised the challenges of how the estate was utilised and that it was important that the report demonstrates how the Trust is moving forward and how estates leads from the front in relation to this to help the Trust with the use of space.

Ms Ditheridge commented that the Trust needs to have the ambition of having an estate that is a great place to work. Members agreed this and further discussions will take place at Resources and Performance Committee.

Mr Feather said that the strategy needs to be clear on its objectives. Dr Povey added that this area is very complex; however there should be quick wins that could be achieved through virtual meetings.

The Board accepted the assurance provided by the Estates Progress Report

13. QUESTIONS OR COMMENTS FROM MEMBERS OF THE PUBLIC

Minute No. 2020.1.18 Questions or Comments from Members of the Public

No questions

14. ITEMS FOR INFORMATION ONLY

Minute No. 2020.1.19 – Committee Minutes

The Board accepted the minutes.

15. ANY OTHER BUSINESS – with prior agreement of the Chair

Minute No. 2020.1.20 – Any Other Business

There was no other business

16. MEETING EVALUATION

Minute No. 2020.1.21 – Reflections on the meeting: effectiveness and any new risks and assurances

Ms O'Kane reflected on an interesting patient story. The Board had had the opportunity to ask detailed questions. The Board agreed that Executive Directors need to be smarter with reports to enable us to look at points we need to look at.

Risk:

- It was agreed that the risk rating relating to Community Equipment Service should be checked as accurate, Mr Gregory and Mrs Lea to discuss.

17. DATE OF FUTURE MEETING

Minute No. 2019.10.25 – Date of Future Meeting

10am – 1pm, Thursday 26 March, Room K2, William Farr House, Mytton Oak Road, Shrewsbury SY3 8XL

Ms O'Kane thanked everyone for attending the meeting.

The following resolution was PROPOSED by Ms Preen and SECONDED by Mr Darbhanga and UNANIMOUSLY SUPPORTED by all Members: *IT WAS RESOLVED that representatives of the press, and other members of the public, be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*

Meeting Date: 30th January 2020

Part 1 – Trust Board Meeting Action Log

Action Completed | Action is not yet complete but on track | Action has slipped

Meeting Date	Minute Ref and Agenda	Issue	Action	Purpose	Update	Lead	Target Date
November 2019	Minute No 2019.10.9 – Learning from Deaths	Quality and Safety	Audit results to be presented to the February informal board meeting and formal report to the Trust Board in May 2020.	Quality and Safety	Verbal update to be provided at the meeting	J Povey	~~February~~ ~~March~~ ~~2020~~ May 2020
January 2020	Minute No. 2020.1.7 - Chief Executive's Report	Urgent Care	Mr Gregory to present thematic review of urgent care at the next informal board meeting.		Complete	S Gregory	February 2020
January 2020	Minute No 2020.1.15 – Finance Report	Community Equipment Services	Ms Preen, Ms Lloyd and Mr Gregory will meet to discuss Community Equipment Services.		This is due to be discussed at the March Resources & Performance Committee and an update will be received at the Board	R Preen, S Lloyd, S Gregory	March 2020

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	6
	Enclosure Number:	3

Meeting:	**Trust Board**		
Title:	**Chair's Update**		
Author:	**Nuala O'Kane, Chair**		
Accountable Director:	**Nuala O'Kane, Chair**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	None		

Purpose of the report		
To provide a summary of issues discussed in private by the Trust Board on January 30 To provide the Board with a summary of the Chair's engagements since the last Trust Board meeting including the informal board meeting on February 27	**Consider for Action**	
	Approval	
	Assurance	**X**
	Information	

Strategic goals this report relates to:

To deliver high quality care	To support people to live independently at home	To deliver integrated care	To develop sustainable community services
X	X	X	X

Summary of key points in report

The Chair had attended a number of meetings and engagements

In light of the Covid-19 pandemic the Chair decided that all board and board committees should move to virtual meetings to support social distancing.

Key Recommendations

To accept the assurance provided by the Chair's report and to endorse the Chair's decision to move to virtual meetings for the Board and Board Committees

To ratify the temporary amendment of the Committees' terms of reference to allow telephone conference calls until either virtual (audio & visual) meetings can be established or the Covid-19 pandemic arrangements have stepped down.

Is this report relevant to compliance with any key standards? YES OR NO		State specific standard or BAF risk
CQC	Yes	Well-Led Standard
IG Governance Toolkit		
Board Assurance Framework	Yes	Clinical Quality & Safety Organisation culture

Impacts and Implications?	YES or NO	If yes, what impact or implication
Patient safety & experience	Yes	Maintaining scrutiny and challenge through virtual meetings
Financial (revenue & capital)	Yes	Minimal additional costs to support virtual working
OD/Workforce	Yes	Actions taken to minimise infection for the Board and its administrative support
Legal	No	

CHAIR'S REPORT

1. Report on the last confidential meeting of the Board

1.1 The Board considered key areas of its work requiring confidentiality for commercial or other reasons such as individual human resources issues. Particular areas discussed included:

- An update on the GP Led Out of Hours Service
- Information regarding contracting opportunities
- An overview of the recent Staff Survey results

2. Meeting and Visits

2.1 Meetings and events I have attended and visits made since my last report include:

- I attended the Community Trust Leadership Group (CTLG) to hear the full results of our staff survey, which were very pleasing; we will hear details of this later in today's meeting.
- We said a farewell to our previous CEO Jan Ditheridge with a presentation of gifts and mementos of her time at ShropCom.
- I chaired the interviews for our Director of Governance post.
- I attended the first meeting of the Shadow Integrated Care System (ICS) Board. The initial role of the ICS in Shropshire, Telford and Wrekin is to:
    - provide health and care leadership for Shropshire, Telford and Wrekin
    - develop and oversee the implementation of an overarching health and care strategy
    - oversee and facilitate the delivery of a safe, sustainable and effective health and care system.

  This initial meeting spent some time discussing progress to date and current workstreams within the STP.
- Together with Cathy Purt and Jaki Lowe I visited the inpatient unit at Whitchurch Hospital, a very positive and informative visit.
- With fellow Board members I attended a Board Development Day, where we discussed the role of the board in ensuring we have a clear vision, setting the culture and keeping our performance on track. It was also an opportunity to get to know each other better.

2.2 Board and board committee arrangement during the Covid-19 pandemic

As a result of the increasing rise of infection and in order to support the government's guidance on social distancing I decided to move all board meetings (both public, private and informal) and all board committee meetings to virtual meetings. At present this will take the form of a conference telephone call.

Whilst I recognise this will not allow public observation of board meetings, I have asked whether the meetings can be recorded and then uploaded to the Trust website so that members of the public can still have access to the Board's debate and discussion on the board papers. Questions from staff and the public are still welcome and will be addressed during the meeting. The board's responses will be captured on the recording, in the board minutes and emailed directly the individual concerned.

The terms of reference for board committees provide for virtual meetings that allow for facilities that support both seeing and hearing. We've not been able to action that at short notice but are looking into it for future committee meetings. I am, therefore, asking board members to ratify the holding of virtual meetings for its committees by phone call only. This will validate the meetings of both the Resource & Performance and Quality & Safety Committees which have met in the last few days.

3. Conclusions and Recommendations

The Board is asked to

- accept the assurance provided by the Chair's report and to endorse the Chair's decision to move to virtual meetings for the Board and Board Committees
- ratify the temporary amendment of the Committees' terms of reference to allow telephone conference calls until either virtual (audio & visual) meetings can be established or the Covid-19 pandemic arrangements have stepped down

Nuala O'Kane
Chair

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26.03.2020
	Agenda Item:	8
	Enclosure Number:	4

Meeting:	**Formal Trust Board**		
Title:	**Chief Executive's Report**		
Author:	**David Stout, Chief Executive Officer**		
Accountable Director:	**N/A**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	N/A		

Purpose of the report		
To update the Board on key policies, issues and events and to stimulate debate regarding potential impact on strategy and levels of assurance.	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

This report sets out the national and local issues of strategic importance to the organisation, highlighting relevant policy, guidance and information that may have an impact on our strategic objectives or organisational risks, as set out in the Board Assurance Framework (BAF).
National issues covered in the report:

- Impact of coronavirus
- The March 2020 budget
- Primary Care Networks
- Developing a Tech Plan for the NHS

The local issue covered in the report is the establishment and first meeting of the Shadow Integrated Care System (ICS) Board.

Key Recommendations

The Board is asked to consider the impact of the national issues on the Trust and support the focus on the key local priorities which have endorsed at our first Shadow ICS Board.

1 Accountable Director: David Stout, Chief Executive
Board Meeting: 26th March 2020

Is this report relevant to compliance with any key standards? YES OR NO		State specific standard or BAF risk
CQC	Yes	Well-led
IG Governance Toolkit	No	
Board Assurance Framework	Yes	Healthcare system. Clinical quality & safety Organisational culture

Impacts and Implications?	YES or NO	If yes, what impact or implication
Patient safety & experience	Yes	Consequence of coronavirus will be evaluated as the pandemic develops
Financial (revenue & capital)	Yes	The Trust will monitor the financial impact of our response to the pandemic. There is a national commitment that these costs will be funded.
OD/Workforce	Yes	Our response to coronavirus will have a direct and indirect impact on staff.
Legal	N/A	

Shropshire Community Health NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT – 26th March 2020

1. Introduction

This report sets out the national and local issues of strategic importance to the organisation, highlighting relevant policy, guidance and information that may have an impact on our strategic objectives or organisational risks, as set out in the Board Assurance Framework (BAF).

The Board is asked to consider the impact of the national issues on the Trust and support the focus on the key local priorities which have been endorsed at our first Shadow Integrated Care System (ISC) Board.

2. National Issues

2.1 Coronavirus

In response to the rapidly spreading pandemic, the NHS declared a level 4 National Incident on 30 January 2020.

The Government have announced a range of measures over the last few weeks to seek to reduce the spread across the country. The latest guidance can be found at https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public

At the time of writing, the latest guidance for the NHS was set out in a letter on 17 March 2020 from Sir Simon Stevens, NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer (https://www.england.nhs.uk/coronavirus/publication/next-steps-on-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/). This letter sets out a number of important actions which every part of the NHS is asked to put in place to redirect staff and resources in order to:

- Free up the maximum possible inpatient and critical care capacity
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support
- Support staff, and maximise their availability
- Play our part in the wider population measures newly announced by Government
- Stress-test operational readiness
- Remove routine burdens, so as to facilitate the above

We have established an Incident Management Team (IMT) within Shropcom to manage our response to the pandemic, under the leadership of Steve Gregory in his role as our Emergency Planning Officer. We are also participating in the system Local Health Resilience Partnership (LHRP) to ensure that our response is co-ordinated with our local partners.

We will verbally update the Board on the latest position at the board meeting.

2.2 Budget

The Chancellor, Rishi Sunak, presented his first budget on 11th March 2020. Key points for health and care included:

- The Chancellor sought to shore up UK public confidence in the government's ability and commitment to deal with COVID-19 by announcing £5 billion of emergency funding for the NHS and other public services and stating that whether it takes 'millions or billions,' the NHS will receive the funding it needs to cope with additional strain placed on it by the coronavirus.
- In addition to funding for the NHS on coronavirus, the government presented a £30bn stimulus package to keep small firms operating, and help for people who can't work because they're ill or isolated.
- The government will change pensions tax rules to ensure that NHS staff across the UK – including senior doctors – whose income is less than £200,000, can work additional hours for the NHS without their annual allowance being reduced.
- On NHS spending, the government refreshed its commitment to £34 billion over the next five years, and in addition announced a further £6 billion in new funding over the course of this parliament.
- The Chancellor reaffirmed its intention to build 40 new hospitals, employ 50,000 more nurses and open up 50 million more GP appointments as set out in the Conservative party manifesto last year.
- No new funding was announced for social care.

The budget was followed up with a separate financial statement on 17th March 2020 in which the Chancellor announced a further package of loans and grants to help Britain to cope with the economic impact of coronavirus.

2.3 Primary Care Networks (PCNs)

The BMA's GP England Committee have voted to accept an updated GP contract package, including a much-revised model for PCN Direct Enhanced Services (DES) service specifications. Some of the key aspects relevant to PCNs are:

Workforce

- More roles have been added to the additional roles reimbursement scheme, with PCNS now able to choose to recruit from the following roles as well as those already identified by the scheme:
  - pharmacy technicians
  - care co-ordinators
  - health coaches
  - dietitians
  - podiatrists
  - occupational therapists (with mental health professionals to be added from 2021)
- Reimbursement for these roles will increase from the proposed 70% to 100%.
- Those PCNs who do not wish to employ extra staff directly are encouraged to engage community-based partners, who can employ staff on their behalf.
- Where existing practice premises are insufficient to support new staff, PCNs will be encouraged to engage with community provider partners "to agree any necessary short-term actions." They should also start developing a "fully joint vision of fit-for-purpose future estate."

Service specifications

- Significant changes have been made to the shortened structured medication review (SMR) and medicines optimisation, enhanced health in care homes (EHCH) and supporting early cancer diagnosis service specifications, which will be introduced in 2020/21.

- The specification for anticipatory care is deferred, and will now be introduced in 2021/22 following further reworking and negotiation (along with cardiovascular disease diagnosis and prevention, tacking inequalities, and personalised care).
- In place of the personalised care specification, each PCN must provide access to a social prescribing service in 2020/21, drawing on the workforce funded under the Network Contract DES.
- Delivery of SMRs is linked to available pharmacist capacity, and medical input into EHCH needs to be 'appropriate and consistent' – without a requirement for fortnightly face to face medical input.
- By 31 July 2020, PCNs are to agree the care homes for which they have responsibility with their CCG, along with a plan about how the service will operate with local partners (including community services providers)
- In recognition of the differential workload with regards to care homes, a new premium payment worth £120 per bed per year will be introduced from 30 September 2020, with every care home supported by a single PCN with a named GP or GP team.
- Where the Network Contract DES delivers services that were previously funded locally, that investment must be reinvested by the CCG into primary medical care.

We will work closely with partners to support the PCNs as they develop.

2.4 Developing a Tech Plan for the NHS

NHS Improvement/England have written to all providers announcing the launch by NHS Digital (NHSX) of a consultation on developing a technology plan for the NHS. The consultation which will be open for several months consists of the following phases from now to summer 2020:

- **Phase 1: Mission, vision and values** will set out the NHSX mission statement, vision and core values and provide context for the future phases
- **Phase 2: Objectives** drawing on the NHSX missions, we will break down what has been achieved since NHSX was established, what is planned for 2020/21 and the 3 to 5 year view on each mission
- **Phase 3: Enablers** we will cover key enablers such as 'What good looks like', clarifying our expectations of digitised health and care systems, and 'Who pays for what', aiming towards a clear and reliable source of funding
- **Phase 4: Delivery plan** will set out what will be delivered by NHSX, and across health and care in terms of tech, from 2020 to March 2024
- **Phase 5: Measuring success** will identify and measure the impact of delivery on the frontline

3. Local Issues

3.1 Integrated Care System Shadow Board

The first meeting of the Shropshire, Telford & Wrekin Integrated Care System (ICS) Shadow Board meeting took place on 26th February 2020. We are represented on the Shadow Board by our Chair and Chief Executive.

The NHS Long Term Plan set out an expectation that all Sustainability & Transformation Partnerships (STPs) will evolve in ICSs by April 2021. The establishment of the Shadow ICS Board locally is our first step towards that goal.

The first meeting considered the draft terms of reference, membership and purpose of the Shadow Board. These will be refined and confirmed at the next meeting. The shadow board endorsed the proposed priorities for the 2020/21 system operating plan.

All the priorities aim to improve quality and/or health outcomes. Those marked in red are also expected to deliver financial benefit in 2020/21.

Prevention & placed based care	Acute services	Mental health services
Out of hospital – case management (admissions avoidance)	Hospital transformation programme	All age out of hours crisis services
Out of hospital – rapid response community teams (admissions avoidance)	Urgent care – improving flow	Redesign of rehabilitation pathways to reduce out of area placements
Prevention – alcohol misuse	Maternity – roll out of LMS	Parity of esteem – improving access to services for people with autism and LDs
Prevention – weight management	Cancer – improving 62 day performance	Digital solution to support trauma informed care for people (e.g. adverse childhood experiences)
Primary care resilience/PCN development	MSK – service transformation led by provider alliance	
	Outpatient transformation – reduction in follow ups	

We have a significant part to play in delivery of a number of these priorities and would seek to take a lead role in implementation of the out of hospital priorities and MSK transformation.

David Stout
Chief Executive

Shropshire Community Health
NHS Trust

SUMMARY REPORT	Meeting Date:	26th March 2020
	Agenda Item:	9.1
	Enclosure Number:	5

Meeting:	**Trust Board meeting**		
Title:	**Quality Report**		
Authors:	**Jo Gregory - Head of Nursing & Quality (Children & Families)** **Angela Cook- Head of Nursing & Quality (Adults)** **Chris Panayi - Quality & Improvement Officer**		
Accountable Director:	**Steve Gregory, Director of Nursing and Operations**		
Other meetings presented to or previously agreed at:	**Quality & Safety Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	√	19th March 2020	A number of key actions were agreed to bring back to the April committee. Corporate governance support will provide guidance to strengthen assurance within the quality report.

Purpose of the report		
The purpose of this report is to provide the Board with an exception quality performance report as considered by the Quality & Safety Committee.	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

Part one

A quadrant report to include narrative on services that

1. have improved and are performing well and meeting CQC descriptors for Good and Trust quality KPI's
2. are falling below CQC descriptors for Good and Trust quality KPI's descriptors who are

on an improvement plan
3. where quality and performance is considered to meet or exceed CQC descriptors for outstanding and Trust performance
4. Learning from when things go well and not so well

Exception reports relating to

5. incidents subject to reporting under the Serious incident framework
6. new risks identified by the service delivery groups
7. Trust wide positon on key mandatory safety training, information governance and appraisal performance.

Part two
The report will include a maximum of three 'focus on' reports using the appreciative inquiry methodology as opportunity for more in depth discussion, assurance, recognition and celebration of the standard of care delivered by services within in this Trust.

For this month there is one appreciative inquiry on risks and risks management.

Key Recommendations

The Board is asked to

- Consider the assurance provided by the report on the Trust's approach to quality and safety
- Endorse the actions being taken to further develop clinical quality and safety within the Trust.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	Addresses all five CQC domains
IG Governance Toolkit	Yes	
Board Assurance Framework	No	Clinical quality and safety

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	This is in relation to meeting CQC quality performance domains and Trust performance.
Financial (revenue & capital)		
OD/Workforce		
Legal	Yes	This is in relation to meeting CQC regulatory requirements

1.0 Introduction to this report

Part one

The first part of this Quality and Performance exception report provides the Trust Board with key exceptions across a range of quality and performance measures for each service delivery group, to ensure the Board are informed on the following key areas:

1. Services that have improved, are consistently performing well and meeting both CQC descriptors for Good and Trust quality KPI's
2. Services falling below CQC descriptors for Good and Trust quality KPI's that are on an improvement plan
3. Services where quality and performance is considered to meet or exceed CQC descriptors for outstanding and Trust performance
4. Learning from when things go well and not so well
5. New risks identified by the service delivery groups
6. Trust overview of key mandatory safety training, information governance and appraisal performance.

Commissioners receive Trust quality performance reports as part of our monthly clinical quality review meetings and these reports also contribute to the suite of information required as part of Care Quality Commission (CQC) informal engagement visits with the Director of Nursing and Operations and Deputy Director of Nursing and Quality.

As well as our Trust quality performance KPI's, CQC as our regulatory body for quality set fundamental standard below which care must never fail, it is therefore essential quality performance relates to CQC as well as referencing other relevant national quality standards accordingly.

Part two

The second part of the report will provide the committee with a maximum of three 'focus on' reports using the appreciative inquiry methodology.

As a methodology, appreciative inquiry aims to look at systems processes from a positive, affirming perspective; to learn from excellence rather than a problem-based approach, as a means to improve.

Topics are identified by the Quality and Safety committee, Service Delivery Groups or the Nursing & Quality Directorate providing an opportunity for more in depth discussion, scrutiny and assurance. This approach enables teams to feel proud of the work they do and underpins sustained improvement

2.0 Part one exception report

Shropshire Community Health NHS Trust Children & Families SDG	
Areas that have most improved	**Areas for further improvement**
• CCN Leadership – Kate Medhurst, New Service Manager & Nikki Davies Team Leader are now in post. • Paediatric Psychology Team and MPFT (BeeU Service) are meeting quarterly to share concerns, issues and learning. This is positive progress to support better communication. • Appraisal compliance in Dentistry has increased to 91% from 73% in Oct 2019. • 3 x Dentist vacancies appointed following successful interviews.	• 0.8 WTE vacancy remains in Community Paediatrics due to not being able to recruit. Locum in post. Recruitment in progress for the 3rd time with the removal of the SaTH Named Doctor Safeguarding role in the JD • SLT 67 % within 18 weeks. SLT large backlog of initial referrals in the system: 851 children waiting - longest wait 41 weeks. Compliance expected to improve next month. • Children Physiotherapy – 78.7% seen within 18 weeks. Recovery plan states this should be 82.5%. Compliance is 90%. This will be monitored monthly to ensure upward trend. • No complaints received for either SLT or Physio re waiting times. Pro-active measures in place such as triage and well used advice line. • Staff survey – 0-19 Public Health Nursing Service is having a significant focus on this due to the need for improvement in many areas.
Celebrating outstanding practice	**Learning from when things go well and not so well**
• Community Paediatric Team have received £60K from the BMA to fund environmental changes to support trainees. Examples of funding spend: Community library for use by Community Paeds and wider SDG and subscription to professional body memberships. • Occupational Therapy Team – Successful careers event facilitated at Shrewsbury 6th form College to promote OT and OT Mental Health as a career opportunity. • Exploring opportunity to submit a Children and Young People Integration Test Site bid as part of as part of the Children and Young People's Transformation Programme. Involve collaborative working with SaTH, MPFT, CCG & RJAH.	• Special School Medicines Management Audit report presented at C&F SDG meeting. Schools compliant with the CQC standards. Learning shared across both Severndale School and The Bridge School to improve standardised safe practice. • LAC Review Health Assessment Audit report presented at C&F SDG Meeting also. Action plans have led to more detailed health assessment for C&YP.

Shropshire Community Health NHS Trust Adult SDG	
Areas that have most improved	**Areas for further improvement**
• Shrewsbury IDT shared have shared how they have improved the availability of pressure Ulcer Prevention Equipment and stock management • The recording of care needs for patients with a learning disability on Rio shows a steady increase in the numbers being reported • North West Locality Appraisal Status maintained at 98% • Adults & Children's Level 2 safeguarding compliance at 98%	• Pressure Ulcer Prevention and Management at Ludlow Ward • Record Keeping for Ludlow ward and support for non-registered staff • Root Cause Analysis Training for band 6 staff • Information Governance Compliance - service leads identified and notified out of date staff
Celebrating outstanding practice	**Learning from when things go well and not so well**
• Oswestry Minor Injury Unit has been selected as a finalist in the Student Placement of the Year: Community for the 2020 Student Nursing Times Awards, to be held at Grosvenor House, London on 24 April 2020. • HEE feedback that SCHT preceptorship programme is considered to exemplar as it meets pastoral, content, outcome, and in particular that it is multidiscipline with a 'coaching and grow ' approach which is very considered to be distinctive when benchmarking against other preceptorship programmes across East and West Midlands. • Praise & appreciation received from a family for the care of their father at the end of his life whilst at Bridgnorth Ward	• At the Serious Incident meeting in March Shrewsbury IDT shared how they had improved access and availability of pressure ulcer prevention equipment for their teams. • A Permission to Pause has been shared across clinical services in relation to the use of Silver Dressings for wound care following a patient complaint and subsequent investigation.

Shropshire Community Health NHS Trust TeMS and Outpatients SDG	
Areas that have most improved	**Areas for further improvement**
• The Community Neuro Rehabilitation Team (CNRT) have achieved an all-time performance high, 99% of their patients being seen within 18 weeks. • Clinical triage for nail surgery referrals. • More timely definitive treatment for nail surgery. Integrated working with wound healing service in Telford now in place	• The waiting times for patients to be seen within TeMS physiotherapy has deteriorated in relation to a drop in available clinical capacity. • Whilst urgent steps will be taken to remedy this position in the first place, a more resilient approach is required going forward and the service is to review the option of over recruitment. The learning from this incident will also be fed into the STP wide MSK redesign work. • A detailed review of the Podiatry service administration team has been completed by Business Support Officer Sarah Watson, as part of the SDGs move to improve and standardise administration processes. • The review highlights areas of innovation and good practice in the Podiatry administrative service, but also provides direction for improvement, to align the SDG administrative function to deliver a service of excellence. The next review to be undertaken will be the Physiotherapy service. The Did not Attend (DNA) process for high risk diabetes patients – the service has a high percentage of DNA's are reviewing methods to improve this which will include the use of Esendex and patient follow up appointments.
Celebrating outstanding practice	**Learning from when things go well and not so well**
• Podiatrist (Sam Thompson) has been working with the Telford wound healing service. This has been a real success and the service lead would like to adopt this approach as source of expertise and support for lower limb vascular problems, orthotics, footwear, diabetes foot wounds. The SDG has made 4 new key appointments commencing from the beginning of April. These include 2 new service managers; Sarah Edwards and Alastair Campbell, a Business support officer Julie Tisdale and this is a new post to lead and coordinate Consultant Outpatients administration. Finally an internal promotion for Richard Lyle as acting team lead for the Community Neuro Rehabilitation Team.	• A new & improved nail surgery triage and admin process has been implemented following a patient complaint and subsequent learning. • The introduction of individual supervision for all podiatrists to ensure assessment of patients and pathway adherence within trust values. • A recent patient incident within the Podiatry service highlighted that systems for monitoring the quality of record keeping standards have not been sufficient and the SDG will be taking urgent action to improve record keeping standards and assurance. • The SDG has commenced the roll out of the Care coordination Centre (CCC) administrative monitoring process, across the administration support services.

3.0 Part one - Serious Incidents reported in month

Serious Incidents (SI) are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified and include :

- Acts and/or omissions resulting in unexpected or avoidable death
- Unexpected or avoidable injury resulting in serious harm or requires further treatment by a healthcare professional in order to prevent the death or serious harm
- Actual or alleged abuse where appropriate action/intervention to safeguard against such abuse occurring was omitted
- A Never Event
- An incident that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services.
- Category 3 ungradeable pressure ulcers are reported in line with best practice under the serious incident framework and are subject to investigation.

The trust complies with NHSE Serious Incident (SI) framework (2015) process, and the guiding principles within this process.

This Framework endoreses the application of 7 key principles in the management of all serious incidents:

Table one provides the committee with the number of incidents reported under the SI framwork since April 2019.

Tabel one

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	YTD 2019/20	Target
Serious Incidents reported	3	6	2	2	2	2	0	1	6	3	3		30	**N/A**

Table two illustrates the number of incidents occurred in the month reported under the SI reporting framework.

Table two

Ungradeable (unstageable/ deep tissue) pressure ulcers		Where necessary any immediate actions undertaken
Number reported: 3	1 reported by the Telford Wound Healing Service 1 reported at Whitchurch Hospital 1 reported at Telford and Wrekin South Community Nursing	All ungradeable pressure ulcers continue to be reported as an SI in accordance with new guidance issues by NHSI in 2018. All are reviewed at the lessons learned group affording both individual team based learning AND at the overarching pressure ulcer improvement group led by the Head of Nursing for adults, where improvements are underpinned from themes arising from lessons learned.

4.0 New Risks Identified 12 or above

The following table provides the committee with new risks identified during the months of February/March.

It is everyone's responsibility to identify risks; it is part of speaking up about matters that are, or may affect patient safety.
It is the service leads/ managers additional responsibility to not only identify but, assess, evaluate and monitor risks with support from Risk Team.

Table three illustrates new risks identified during February/ March.

Table three

New risk description	Service	Pre mitigation Score	Key Management Actions	Post mitigation score
Following approval of a capital replacement programme to increase the number of McKinley syringe drivers and to replace existing drivers as they become unit for use and condemned by Medical Engineering, the first consignment of 50 new drivers, was received in September 2019. These cannot be used due to a MHRA safety alert published in October 2019. The risk associated with this situation is the potential to have insufficient syringe drivers available in community services to meet patient need at end of life care when indicated. Due to the possible impact of the coronavirus this risk has been escalated to 12.	End of Life	12	EOL lead has been working closely with medical engineering to establish a resolution to the safety alert however no time scale can be identified. This has been escalated via MHRA. Alternative options via procurement are being explored with MHRA.	12

5.0 Part one - Trust overall quality performance

The purpose of this table is to inform the Quality and Safety Committee of Trust level mandatory safety training and appraisals as at the end of February 2020.

This is monitored to provide assurance to the Committee on Trust level information relating to clinical staff on mandatory safety training performance in accordance with CQC domain for delivering safe care.

Assurance is provided to the Quality and Safety Committee that quality performance data within this report is in line with R&P InPhase reporting for consistent Trust level reporting.

Table four includes Trust performance on mandatory training as whole which encompasses 21 individual components. These have been further broken down into the key patient safety related training.

The key safety training requiring improvement at this time is fire safety risk training in our high risk areas (in-patients). An improvement notice has been requested to ensure training meets the performance threshold by 2020. The rosters are created to ensure there is a fire trained staff member on duty at all times. Particular attention is given to the Bishops Castle site. It is of note to the Committee that this site has three plans for three staff members on duty at night to comply with fire regulations.

Table four

Safety training compliance %	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	YTD 2019/20	Target
Basic Life Support	87	84	82	81	81	80	81	87	91	91	92		92	95%
* All mandatory Training	93.2	92.4	91.4	91.7	90.8	90.5	91.3	92.51	94.23	94.21	94.4		94.4	**94**
Safeguarding L1 (Adults)	99	97	97	97	96	97	97	97	99	98	98		98	**95**
Safeguarding L2 (Adults)	95	94	94	94	93	93	93	94	98	98	98		98	**95**
Safeguarding (Children) L2 %	89.5	88	84.4	84.5	83.3	82.8	84	85.57	90.55	91.17	91.17		91.17	**95**
Safeguarding (Children) L3	94.7	91.95	90.29	90.49	91.29	89.21	88.35	87.75	91.19	91.67	91.67		91.67	**95**
Mental Capacity Act	93	93	92	92	93	91	92	93	93	95	95.1		95.1	**95**
Fire Safety – High Risk	79.2	69.9	77.8	77.3	76	74.1	70.2	67.3	76.2	75.8	87.03		87.03	**95**
Fire Safety – All	89	86.1	87	86.2	86.7	86	85.4	86	85.6	86.5	91		91	**95**
Infection Prevention Control Level 1	97.8	97	94.4	93.4	93.7	92.4	92.5	93.3	95	94.7	94.4		94.4	**95**
Infection Prevention Control Level 2	84.5	84.2	83.4	80.8	82.2	81.4	83.3	85	88.2	88.2	89.17		89.17	**95**
Information Governance Requirements	90.5	90.7	89.5	90	89.6	88.9	88.9	90.95	90.76	90.98	92.8		92.8	**94**
Appraisal Rates	89.3	88	88	89.2	86	85	84	85.5	89.2	89.8	88.2		87.48	**95**

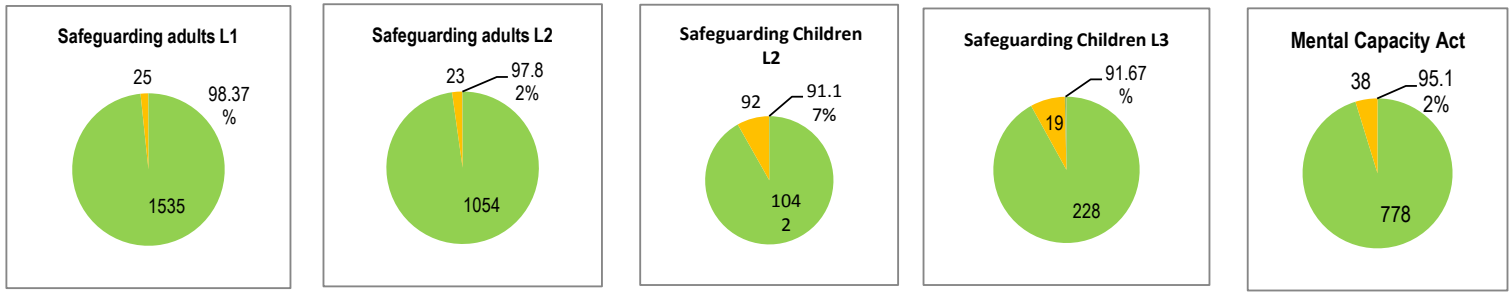
Safeguarding Training – additional information

It is a regulatory requirement to ensure systems and processes are in place to protect people from abuse and avoidable harm

Staff training is a key component of this to enable staff to be equipped with the right skills and knowledge to recognise when abuse or neglect may be occurring, and what procedures to follow.

Overall Safeguarding performance continues to meet CQC expectations. There are a very small number of teams who are currently below the quality performance threshold of 95% and within 10% tolerance. Performance target are monitored at Service Delivery Level and are receiving focused support to improve.

The following charts provide additional information on our current position related to essential mandatory safeguarding training broken doen in to actual numbers of staff who are overdue.



Mental capacity act training includes on line training for Deprivation of Living Safeguards (DoLS) . However, as DoLs allows restraint and restrictions to be used if they are in a person's best interests and only if a person will be deprived of their liberty in a hospital (or care home) additional face to face training is also provided to front line clinical staff . The nurse specialist for the adult safeguarding team monitors delivers and retains face to face training in relation to DoLS.

5.0 Focus On using Appreciative Inquiry

The principals of the following 'focus on' using the appreciative inquiry methodology are said to be transformational as they focus on supporting people to consider how they think instead of what they do .

In this context, the quality team aims to support authors to consider activities they or their services undertake, how those services relate to people who use those services, impact or outcomes of those services and also how these relate to CQC and Trust performance.

A Focus On – Appreciative Inquiry
This month's AI will be presented as a short power point presentation by Stanley Mukwenya Head Governance and Risk
Service Areas
Children and Families, Adult and TeMS
Introduction
The purpose of this appreciative inquiry is to provide the committee with an overview of how risk is being managed within Adults, Children/Families and TeMs. The Committee will hear a presentation highlighting the detailed processes currently in place, current common risk themes across the three service areas and actions in place to mitigate those risks.
What is working well and why?
It is everyone's responsibility to identify risks; it is part of speaking up about matters that are, or may affect patient safety. It is the service leads/ managers additional responsibility to not only identify but, assess, evaluate and monitor risks with support from Risk Team. Robust risk management within the three services areas has been able to inform decision making, improve quality of care leading to better service delivery. Effective communication and training from managers across the teams has embedded a positive risk culture. Risk registers are part of education and learning process informing on threats and opportunities.
What is the overall vision/best practice?
Integrating common risk themes identified across the three service areas will reduce waste and improve a coordinated approach to business strategy and service threats areas. Linking other high risk service areas e.g. complaints, Health and Safety will certainly enhance our current processes and systems. It is important to promote consistent risk scoring and embed best practices by training wider frontline staff on risk.
Plans for improvement
Risk Team is in the process of compiling training material for different levels of the three service areas. We intend to embed a risk culture in our meetings and other available forums and platforms.
What is the impact on people who use our services?
Robust risk management will improve prioritisation, decision making informing on workforce, waiting times and other related risks positively impacting on people who use our services.

CQC rating evidence
This appreciative inquiry aims to provide information to the Quality and Safety Committee that Trust risk management processes meet regulatory requirement. Through the AI process, our current risk management processes perform in accordance with regulatory requirement this means managers have an understanding of the key risks in their areas and there are processes to identify, assess report and monitor these processes mindful that there are opportunities to strengthen these processes.

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26.3.20
	Agenda Item:	9.2
	Enclosure Number:	6

Meeting:	**Trust Board**		
Title:	**Diversity & Inclusion Update along with the mandated Gender Pay Gap report**		
Author:	**Fiona MacPherson, Human Resources Manager – Workforce Diversity Lead**		
Accountable Director:	**Jaki Lowe, Director of People** **Jane Povey, Medical Director**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Quality & Safety Committee	19 March 2020	Key priorities identified for 2020/21: • Implement reverse mentoring • Training for clinical excellence panellists • Review of resources to support embedding diversity and inclusion • Developing staff networks Committee recommended the Gender Pay Gap report for approval by the Board

Purpose of the report		
To provide the Board a summary update on our progress in delivering our Diversity & Inclusion Strategy. To gain board approval for the publication of our Gender Pay Gap report to ensure SCHT is compliant with its statutory obligations.	**Consider for Action**	
	Assurance	**x**
	Information	
	Approval	**x**

Strategic Priorities this report relates to:			
To exceed expectations in the quality of care delivered	**To transform our services to offer more care closer to home more productively.**	**To deliver well-co-ordinated effective care by working in partnership with others.**	**To provide the best services for patients by becoming a more flexible and sustainable organisation**
X	**X**	**x**	**X**

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Summary of key points in report

Key points on Diversity & Inclusion Report

The Trust's Diversity & Inclusion Strategy was approved in November 2018 and covers the period 2018 – 2021. To support us in achieving the four key strategic objectives within the Strategy we have developed a delivery model, governance structure and a refreshed Strategy on a page for Diversity & Inclusion which are aligned to the NHS Long Term plan.

For the period 2019-20 we have focused on setting up the architecture for delivery of outcome based high impact actions. This has included setting up 2 staff networks, building internal capability by engaging with expert networks such as attending the women advancement and powerment event as well as continuing to work on cultural and policy environment to set the right context for an inclusive organisation.

We are pleased to see early and very positive signs that this work is making a difference, this is demonstrated by our staff survey results for 2019 where we achieved a score of 9.6 (out of 10) for equality, diversity and inclusion. This is the top score achieved by Community Trusts.

For 2020-21 our key strategic priorities for diversity and inclusion are raising awareness of diversity and inclusion and embedding diversity and inclusion within all our business processes.

The Quality & Safety Committee considered the report at its meeting on 19th March 2020 and highlighted the following strategic priorities for the D&I Strategy for 2020/21.

- Implement reverse mentoring
- Training for clinical excellence panellists
- Review of resources to support embedding diversity and inclusion
- Developing staff networks

Key points from our Gender Pay Gap Report

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

- Our gender profile has remained static for 3 years at 89% women and 11% men. In 2018 NHS Digital reported the gender profile of the workforce within the NHS was 77% women and 235 men.

- Our Mean Gender Pay Gap has reduced to 12.71% (a reduction of 1.33% since first reporting in 2017).

- Our Median Gender Pay Gap (as at 31 March 2019) has reversed and is in favour of women by 2.83% (women earn 0.41p more than men). The Office of National Statistics reports a 17.3% gender pay gap in favour of men for 2019 for all employees.

- Compared to our organisational gender profile there are proportionately more men than women in our lower pay quartile and our upper pay quartile

- Our Bonus Pay Gap which is made up of only clinical excellence awards is 74%. The Mean Bonus Pay Gap has reduced by 14.54% and the Median Bonus Pay Gap has reduced by 15.70%.

Key Priorities to address our gender pay gap 2020-21:

- Recruit more males into the lower middle and upper middle pay quartiles and more females

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into the upper pay quartile

- Ensure the Clinical Excellence Award process is robust and effective training provided

Key Recommendations

The Trust Board is asked to:

1. Authorise the publication of Gender Pay Gap Report on the Trust's website to ensure compliance with legislative requirements.
2. Authorise the publication of the gender pay data on the government online services website to ensure compliance with legislative requirements.
3. Agree the key priorities for the gender pay gap
4. Receive assurance that delivery against the Strategy is underway and that high impact actions are identified 2020-21

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	Safe, Effective, Caring, Well Led
IG Governance Toolkit	No	
Board Assurance Framework	Yes	Changing Organisational Culture

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	YES	Staff engagement, culture and values
Financial (revenue & capital)	YES	
OD/Workforce	YES	Organisational health, culture and values
Legal	YES	Diversity & Inclusion Approach to employment experience

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Gender Pay Report – For Approval and Publication on our Website

1.0 INTRODUCTION

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

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

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

1.3 As a reminder the **Mean** (average) is calculated by adding up all of the numbers in the set, and then divide that total by the number in the set. To find the **Median**, the numbers are placed in value order and the median is the middle number in the set.

1.4 This is the third year of publishing our data. The data has to be published by 30 March 2020 and is at a snapshot date of **31 March 2019**.

1.5 We are required to publish the information on the Gov.uk website – which only enables us to publish the statistical information (information within Appendix 1). We are also required to publish the information on our own website, and here we can add a narrative to describe the statistical information. We are intending to use the explanatory narrative set out in this report on our website.

2.0 GENDER PAY REPORTING IS DIFFERENT TO EQUAL PAY

2.1 The gender pay gap differs from equal pay.

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

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

3.0 ASSURANCE ON PROGRESS IN REDUCING THE GENDER PAY GAP

3.1 The information contained within this section provides a comparison between 2017, 2018 and 2019 data.

3.2 Measuring the Gender Pay - Comparison between the 3 years of data

In relation to the mean and median pay gap over the last 3 years the mean pay gap has decreased and the median has reversed in favour of women in 2019:

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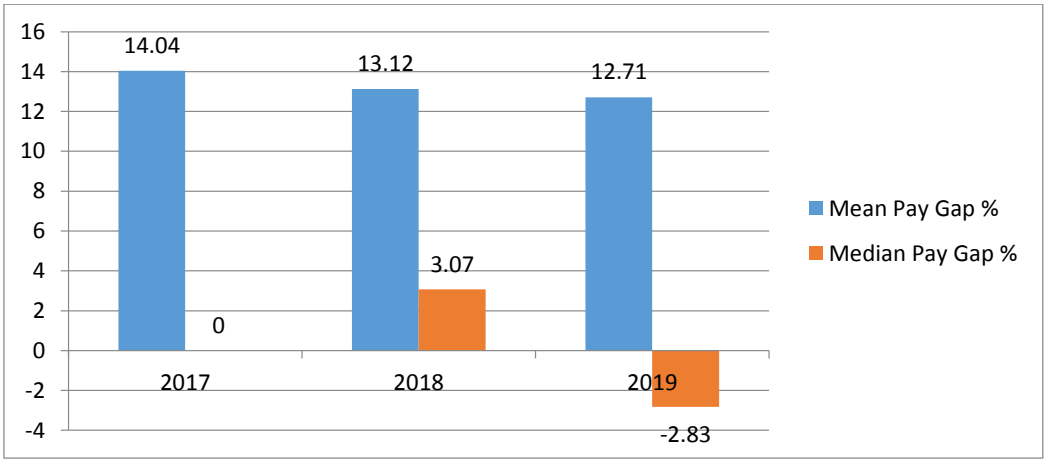


Having compared the data the mean pay gap between men and women has decreased from **14.04% in 2017 to 12.71% in 2019. A reduction of 1.33% in the mean gender pay gap over the 3 years of reporting.**

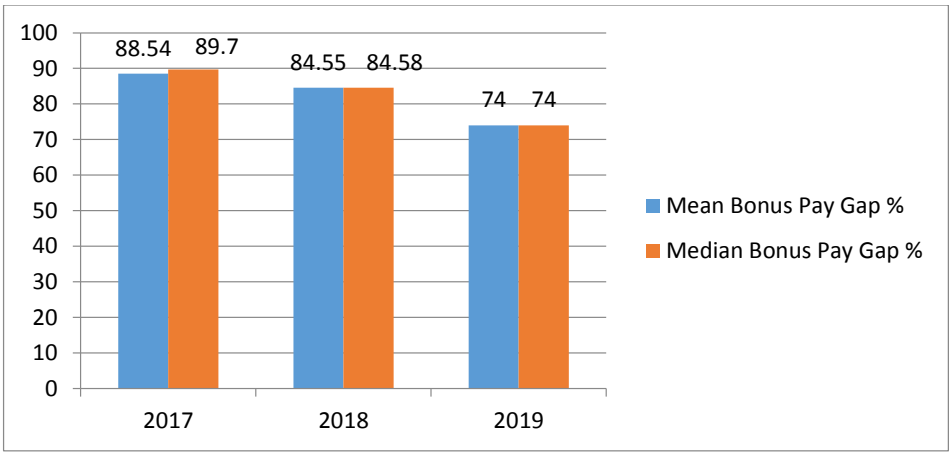
The median pay gap between men and women increased from **0% in 2017 to 3.07% in 2018 but in 2019 changed in favour of women, therefore women earn 2.83% more than men.**

3.3 Measuring the Pay Quartiles - Comparison between 3 years of data

In 2017, 2018 and 2019 there were proportionally more males in Quartile 1 and Quartile 4. When comparing the Quartiles there are only small changes in the percentage.

The main noticeable change from 2018 to 2019 is in the upper quartile where % of males has increased (from 15.28% in 2018 to 16.24% in 2019) and the % of females has decreased (from 84.72% in 2018 to 83.76% in 2019).

3.4 Measuring the Bonus Pay - Comparison between 31 March 2017 to 31 March 2018 data



When comparing the bonus pay from 2017 to 2019 the mean and median bonus pay gap has gradually decreased. The **mean** bonus pay gap has decreased by 14.54% and the **median** bonus pay gap has decreased by 15.70%.

4.0 Additional Information

4.1 The quartile figures in Appendix 1 show that there are a higher percentage of males in both the upper and the lower quartile than in the others, it is helpful to look at the

gender composition and pay gaps in each individual band. This is set out in the table below (for ease of reference we have highlighted in green where females on average (hourly rate of pay) earn more than males):

Pay Band/Category	No of Female Staff	No of Male Staff	Female Average Hourly Pay (mean)	Male Average Hourly Pay (mean)	Difference* in average hourly pay between male and females
Band 1	57	8	£10.17	£10.41	0.24
Band 2	265	34	£10.29	£10.40	0.11
Band 3	170	25	£10.08	£9.64	-0.44
Band 4	126	5	£11.48	£11.06	-0.41
Band 5	333	21	£15.28	£14.08	-1.20
Band 6	368	32	£17.67	£17.61	-0.06
Band 7	150	15	£21.08	£20.46	-0.62
Band 8 and VSM**	49	20	£30.22	£27.78	-2.44
Medical and Dental Staff ****	20	15	£34.37	£34.27	-0.11

** the negative values mean that the difference and gap are favourable to females*

*** band 8's and VSM have been categorised together due to the small numbers as individuals could be identified this excludes our Non-Executive Directors (the break down information for these categories is also available).*

***** the payments for bed fund are not included in the medical and dental element due to these not being an hourly rate of pay but for numbers of beds managed*

The above table shows that in 7 of our 9 pay categories (Band 3, 4, 5, 6 & 7, 8 and VSM and Medical and Dental) females earn more than males – there are 2 bands where males earn more than females (Band 1 & 2).

As part of the 2018 pay deal, band 1 closed to new entrants from 1 December 2018 and all current band 1's had the choice to transfer to Band 2 on 1 April 2019.

5.0 BENCHMARKING INFORMATION FOR GENDER PAY

5.1 The gender pay gap has been declining slowly in the UK in recent years. Among full-time employees it now stands at 8.9%, little changed from 2018 when it was 8.6% (not a statistically significant increase). The figure for 2019 represents a decline of 3.3 percentage points from a decade ago – 12.2% in 2009 – but only 0.6 percentage points since 2012. Among all employees the gap fell from 17.8% in 2018 to 17.3% in 2019.

The gender pay gap is higher for all employees than for each of full-time employees and part-time employees. This is because women fill more part-time jobs, which have lower hourly median pay than full-time jobs, and are more likely to be in lower-paid occupations.

Source: Office of National Statistics – 2019 data.

5.2 People Management magazine reports that for public sector organisations there is a median pay gap of 14.2% as of 31 March 2019 – a fractional increase on the first round of reporting (14%) in 2017/18.

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As a reminder our overall median pay gap was -2.83%, which is in favour of women.

6.0 What have we done to date?

- Clarified our GPwSI Local Pay Framework and Terms and Conditions.
- Provided a workshop to advise all Consultants who are eligible to apply for a Clinical Excellence Award on a high quality application.
- Delivered a management and leadership programme to a range of staff

7.0 Next steps

- Work with our communications team on our recruitment literature ensuring that our photographs are not gender bias
- Identify any gaps in training for all staff
- Evaluate the management and leadership programme to establish impact on career progression
- Deliver the CEA panellist training
- Ensure mixed gender panels for selection and remuneration purposes for Bands 8a+, VSM and Consultant appointments (including Clinical Excellence Awards)

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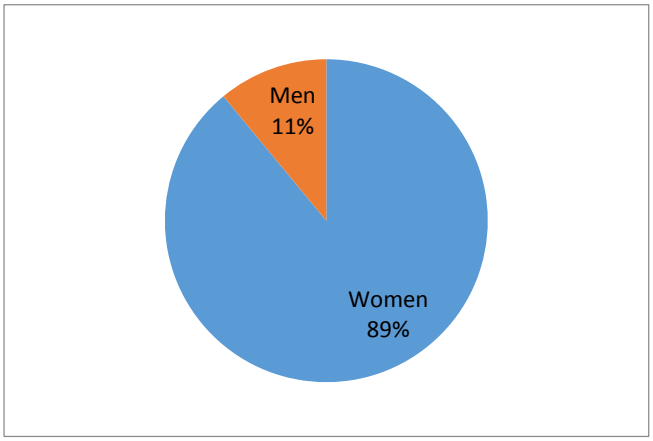
Appendix 1

1.0 GENDER PAY GAP STATISTICS FOR PUBLISHING ON GOV.UK

1.1 The data included in this section is the data that we have to publish by law on the gov.uk site.

1.2 Gender Profile

The following chart provides an overview of the number of men and women employed by Shropshire Community Health Trust as at 31 March 2019:



The workforce gender profile has remained static since 2017.

1.3 Measuring the Gender Pay

We have measured both the mean and median hourly rates of pay for males and females in our workforce. The gender pay gap is expressed as a % of male earnings.

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£17.7570	£14.5280
Female	£15.4996	£14.9398
Difference	£2.2574	£0.4119
Pay Gap %	12.7127	-2.8349

Mean Gender Pay Gap = 12.71%

Median Gender Pay Gap = - 2.83%

This demonstrates that as at 31st March 2019, the **mean** hourly pay for males is 12.71% more than females. The **median** hourly pay for females is 2.83% more than males.

These figures are based on hourly rates of pay not final salary.

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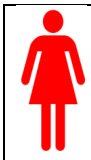
1.4 Pay Quartiles

The information below illustrates the gender profile of Pay Quartiles (blocks of 25%) for 31 March 2019:

Lower Pay Quartile

	85.92% (Headcount = 354)		14.08% (Headcount = 58)

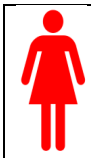
Lower Middle Pay Quartile

	92.51% (Headcount = 383)		7.49% (Headcount = 31)

Upper Middle Pay Quartile

	95.29% (Headcount = 384)		4.71% (Headcount = 19)

Upper Pay Quartile

	83.76% (Headcount = 356)		16.24% (Headcount = 69)

This is based on actual pay per hour, split into quartiles.

As a reminder, our organisational gender profile as at 31 March 2019 was female: 89% and male: 11%.

We can see that when we compare the Pay Quartile gender split to our organisational gender profile, there were proportionally more males in Quartile 1 and Quartile 4.

1.5 Bonus Pay

Only 3 people in the Trust received a bonus payment between 1 April 2018 to 31 March 2019. As this equates to less than 5 individuals in each gender category individual employees could be identifiable, therefore, the gender breakdown has not been included but is available.

Bonus pay for SCHT consists only of the Consultant Clinical Excellence Awards (CEA). CEA's are awarded as a result of recognition of excellent practice over and

above contractual requirements to Consultants – we can see that **as at 31st March 2019, there was a median and mean pay gap of 74.00% in favour of males.**

The process for awarding Clinical Excellence Awards is carried out in accordance with national guidelines and supported by a local policy.

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SUMMARY REPORT	Meeting Date:	26.3.20
	Agenda Item:	9.3
	Enclosure Number:	7

Meeting:	**Trust Board**		
Title:	**Freedom to Speak Up update**		
Author:	Alison Trumper – Deputy Director of Nursing and Quality Trust F2SU Guardian		
Accountable Director:	Jaki Lowe – Director of People		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Quality and Safety Committee	18th March 2020	Paper accepted

Purpose of the report		
The purpose of this report is to a) Provide the Trust Board with a summary of activity, themes and feedback on concerns raised to Freedom to Speak Up (F2SU) Guardians for the year 2019/20. b) Provide assurance that we have evidence that we are creating a genuinely open culture in which all safety concerns raised by staff are highly valued and meet the required regulatory requirement under SAFE domain.	**Consider for Action**	
	Approval	**x**
	Assurance	**x**
	Information	**x**

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
x	**x**	**x**	**x**

Summary of key points in report

1. The Trust Guardian continues to be the responsibility of the Deputy Director of Nursing and Quality. This was a temporary arrangement. This leadership has been crucial to establishing our strategy and ensuring that our approach fits with our values and that we have an impactful approach. We need to create further capacity to support our future work and we will update the Committee on plans in April.

2. In 2018 NHSI and National Guardian Office published a tool for Trusts to self-assess against a suite of recommendations to identify areas for development and improve the effectiveness of leadership and governance arrangements in relation to F2SU. All recommendations have been met. There are two outstanding recommendations which relate to auditing compliance with Trust F2SU policy and reporting on progress against the F2SU strategy. There is a trajectory of September 2020 for completion.

3. Our 2019 CQC inspection and our 2019 staff survey provide clear evidence of improvements in our

arrangements, systems and processes on a positive speaking up culture which contributed to our overall CQC rating of GOOD under the SAFE domain.

4. Six new referrals were made to the F2SU service during 2019/20 compared to 10 referrals in 2018/19. Referrals received have been from a variety of disciplines across pay bands ranging from band 2 to 8. The predominant theme for referral has been attitude and behaviours between people who work together, with one relating to patient safety. The issue relating to the patient safety concern was fully investigated, patients were not put at increased risk of harm and learning was undertaken with a revised system put in place.

5. Referrers have fed back they are satisfied with the outcome of actions taken in response to their referral. The key activity in reaching a satisfactory outcome for the referrer/s has been the facilitation skills of the guardians or of others to enable those involved to see each other's' perspective and the impact between one person or a group of people to another.

6. In January 2020 the Quality and Safety Committee were provided with extremely positive and energised feedback from a team where a number of improvements have been made following staff raising concern about poor team culture and low staff morale, both of which had the potential to impact on poorer patient outcomes. This was achieved through focused support provided by the organisational development team and through collective leadership.

7. The Trust F2SU Guardian continues to have regular meetings with the Director of People, the F2SU Non-Executive Lead, CEO and Trust Chair in relation to activities under F2SU. From the perspective of the F2SU Guardian, these have provided a 'safe space' and are supportive, open and transparent.

8. The guardian team will be refreshing their profile and provide a summary speaking up activities for our staff in April.

Recommendations

The Board is asked to

- Accept the assurance provided by the report that the Trust continues to create a genuinely open culture in which all safety concerns raised by staff are highly valued and meet the required regulatory requirement under SAFE domain.
- Endorse the actions being taken to further develop F2SU activity within the Trust.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	CQC ratings
IG Governance Toolkit		
Board Assurance Framework	Yes	Clinical quality and safety Organisational culture

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	F2SU supports our staff to speak safely where there are concerns around patient safety or /and poor culture
Financial (revenue & capital)		
OD/Workforce		
Legal		

1.0 Introduction

1.1 The purpose of this report is to provide the Trust Board with a summary of activity, feedback and themes of concerns raised to Freedom to Speak up Guardians (F2SU) for the year 2019/20.

1.2 The Trust F2SU Guardian continues to be the responsibility of the Deputy Director of Nursing and Quality supported by a team of advocates.

1.3 The Guardian role is under review with the aim of increasing capacity and aligning the work with other parts of our cultural work.

2.0 Background

2.1 Following the Mid Staffordshire NHS Foundation Trust failings, the Secretary of State for Health and Social Care commissioned Sir Robert Francis to carry out an independent review into the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up.

2.1a The aim of the review was to provide advice and recommendations to ensure that NHS staff (in England) feel it is safe to raise concerns, have confidence that they will be listened to, and that concerns will be acted upon without fear of reprisal for those who speak up.

2.1b The review, published in 2015, identified a number of emerging themes translated into a set of key principles as recommendations to bring about the required improvement to shift a change in culture to ensure systems and processes are in place for staff to speak out safely in the interest of delivering safe patient care and prompted the development of the National Guardian Office (NGO).

2.2 The NGO is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual.

2.2a In 2018 NHSI with the NGO published a tool for Trusts to self-assess against a suite of recommendations to identify areas for development and improve the effectiveness of leadership and governance arrangements in relation to F2SU.

2.3 Work has been undertaken as part of the Trust Culture Working Group and the F2SU Guardian with two recommendations that require improvement or attention.

These are:-

1. Audit to quality assure compliance with the Trust F2Su policy in relation to speak up processes and procedures

2. Update the Quality and Safety Committee on progress against the Trust F2Su strategy

The full self-assessment can be seen in Appendix A

3.0 Care Quality Commissioners (CQC) inspection of F2SU arrangements

3.1 Having a culture where staff know how to speak up, feel supported when they do so and where learning takes place as a result is key to a positive patient safety culture. Speaking up arrangements are therefore subject to CQC inspection under the CQC well led domain.

At inspection, CQC seek to establish if Trusts are meeting the required quality performance standard relating to speaking up around arrangements to support delivery of safe care.

As part of the inspection process CQC use judgements and data intelligence to ensure the following regulatory standards are being met in relation to speaking out safely. Compliance with these standards provides assurance to CQC that Trusts are performing well with this regard which could contribute to a CQC rating of GOOD. CQC look for evidence that:-

a) Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses
b) Staff are fully supported when they do so
c) Learning takes place from things that have gone wrong

3.2 Where CQC identify that Trusts exceed this expectation this can contribute to a CQC rating of OUTSTANDING.

CQC will look for evidence that:-

a) There is a genuinely open culture in which all safety concerns raised by staff and people who use service are highly valued as being integral to learning and improvement.

b) Where investigation is necessary, investigations are comprehensive and the service uses innovative ways of looking into concerns, including using external people and professionals to make sure there is an independent and objective approach.

3.3 In 2019 the Trust was inspected by CQC and awarded a rating of GOOD across all domains (safe, effective, caring, responsive, and well-led), all core services and Trust well-led. Under the well led domain inspectors told us our Trust culture :

- encouraged openness and honesty at all levels within the organisation.
- has a strong emphasis on the safety and well-being of staff.
- leaders at all levels are visible and approachable
- has managers across our Trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values
- is committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- has leaders who encourage staff to strive for continuous learning, improvement and innovation.
- encourages staff to work effectively with other organisations to develop and implement innovative practices.
- has a positive working culture where learning from incidents is encouraged.
- has leaders and managers across our Trust who promote a positive people first culture, focused on ensuring staff are supported and valued.
- has leadership, governance and culture promoted the delivery of high-quality, patient-centred care

3.4 Improving our safety culture has not stopped since our last CQC inspection. Key areas of further improvement include:-

- On three occasions, external experts have been invited to undertake reviews relating to clinical practice due to differing views of opinion from our internal experts. This provided an independent view that clinical practice on each occasion was identified as being safe practice.

- In February 2020, the NHSE principals of 'always events' have been piloted at one of our adult in patient core services to support improvement in patients' experience of discharge. This is as a result of a continuing trend of patient feedback on discharge as not always being a good one. A positive patient experience of a 'good discharge' has been captured in a video format, with patient involvement, placing the patient in the centre of the learning as a tool for the team to improve those aspects of discharge that should always occur.

  This approach demonstrates how staff have shown determination and creativity to improve the discharge process with whole team learning from what good looks like from the patient's perspective. Patient feedback around discharge experience will be monitored over the forthcoming months.

- In January 2020 the Quality and Safety Committee received feedback from one of our core service teams on how the focused support provided from the Trust Organisational Development Team and the positive engagement and response shown from the team, has had a positive impact on team culture with morale having greatly improved from the perspective of the staff .

  Following a number of referrals to the F2SU Guardians, staff felt safe to speak out and raise concern about poor team culture and morale, both are considered to have the potential for poor patient outcomes and safety. The Committee heard not only how their culture had improved and how this has strengthened patient safety through improved team communication.

4.0 Shropshire Community Trust staff experience survey – Safety Culture

4.1 Each year NHS staff are invited to participate in the annual staff survey. This is an anonymous survey where staff are asked to respond to a number of themes relating to, but not exhaustive, quality safety and culture. It is a useful indicator to:-

a) understand the experiences and perceptions of staff against range of themes
b) benchmark our Trust against the average, worst and best Trusts
c) provide indicators for improvement

This allows for progress, or any decline, to be identified against each theme. In 2019 58% of staff completed the annual staff survey which the highest number of staff completing the survey to date. One of the themes is safety culture.

Our staff survey helps understand from the perspective of our staff that there has been a five year on year improvement in patient safety since 2015 with the greatest improvements accelerating during 2016/17.

Theme	% Improvement since 2015	% Improvement needed to benchmark with the best
Staff being treated fairly when involved in errors or near misses	13%	8.6%
How we learn and take positive action to ensure errors don't happen again	7.3%	7.1%
Staff receiving feedback when raising concerns	13.9%	10.8%

Speaking out / raising concerns can be undertaken via a number of routes including our datix reporting system as well as the F2SU Guardian.

We will continue to improve our safety culture which has been included in our 2020 - 2023 quality strategy.

5.0 2020/21 Quality Account and F2SU

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. Reports are published annually and are available to the public.

From 2020 onwards, in its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts (and NHS foundation Trusts in England) to report annually on staff who speak up (including whistle-blowers).

Ahead of such legislation we will be required to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

This detail should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

We will be able to include this detail in our quality account going forward.

6.0 Recommendations

The Board is asked to

- Accept the assurance provided by the report that the Trust continues to create a genuinely open culture in which all safety concerns raised by staff are highly valued and meet the required regulatory requirement under SAFE domain.
- Endorse the actions being taken to further develop F2SU activity within the Trust.

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	9.4
	Enclosure Number:	8

Meeting:	Board		
Title:	Staff Survey 2019 Report – National Results, Progress and Assurance		
Author:	Juliet Morris, HR Manager		
Accountable Directors:	Jaki Lowe, Director of People		
Other meetings presented to or previously agreed at:	Committee	Date Reviewed	Key Points/Recommendation from that Committee
	Informal board	February 2020	

Purpose of the report		
The purpose of the report is to demonstrate the progress made in the Trust's performance in relation to the national staff survey results for 2019 which have been provided by Picker. It includes national benchmarks which were not previously available in February 2020 when progress against last year was provided to the informal Board. National publication of the survey was on 18 February 2020 so the embargo is now lifted.	Consider for Action	
	Approval	
	Assurance	x
	Information	X

Strategic Priorities this report relates to:			
To deliver high quality care	To support people to live independently at home	To deliver integrated care	To develop sustainable community services
x		x	x

Summary of key points in report

The staff survey was undertaken during October and November 2019.

Our results show:

- Our best response rate ever
- Significantly improved in 8 out of 11 themes
- No themes are worse than last year
- We are amongst the highest scoring Community Trusts for Equality, Diversity and Inclusion
- We are next to the best scoring Community Trusts for Staff Engagement

We have a new annual requirement to report to Board on a set of questions which are included in the Operating Framework data set. These are included with this report.

Through engagement and communication with our People we have agreed key areas of focus for the coming year.

Our leaders across Operations and Corporate Services are working on developing plans with their teams to celebrate the results and improve in areas where improvement is required.

In addition, overarching Organisational Actions are underway as follows:

- Organisation-wide Cultural Diagnostic
- Reviewing and Refining Community Trust Leadership Group
- Introducing People Plans at Team and Directorate Level
- Developing a Combined People Business Partnering Approach

Key Recommendations

The Board is asked:

a) to consider Trust's performance in the national 2019 staff survey results and accept the assurance this provides in relation to the key risks on the Board Assurance Framework
b) to consider the areas of focus for further progress and the additional actions identified for 2020/21.
c) to congratulate the staff on our very favourable national position, the considerable improvements across the staff survey and the contribution all our staff have made to this.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	YES	Safe, Well Led, Caring, Effective
IG Governance Toolkit	NO	
Board Assurance Framework	YES	Culture of our Organisation supporting our Values

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	YES	Staff experience, engagement and morale impact on patient safety and experience
Financial (revenue & capital)	NO	-
OD/Workforce	YES	Actions for OD and Workforce Team
Legal	NO	-

NHS National Staff Survey 2019

Trust Board

Shropshire Community Health NHS Trust

March 2020

Juliet Morris, HR Manager

Our Best Results Ever

- Our Highest Response Rate ever at 58%
- Achieved the Highest Score for Community Trusts - Equality, Diversity and Inclusion Theme 9.6 / 10
- Achieved Next to Highest Score for Community Trusts - Staff Engagement Theme 7.4 / 10
- Achieved Significant improvements across 8 of the 11 Themes

February Board

- Progress against Areas of Focus 2018/19
- Question level data – 25 significant improvements
- Responses that showed low staff satisfaction
- Suggested Areas of Focus for 2019/20

New information for March Board

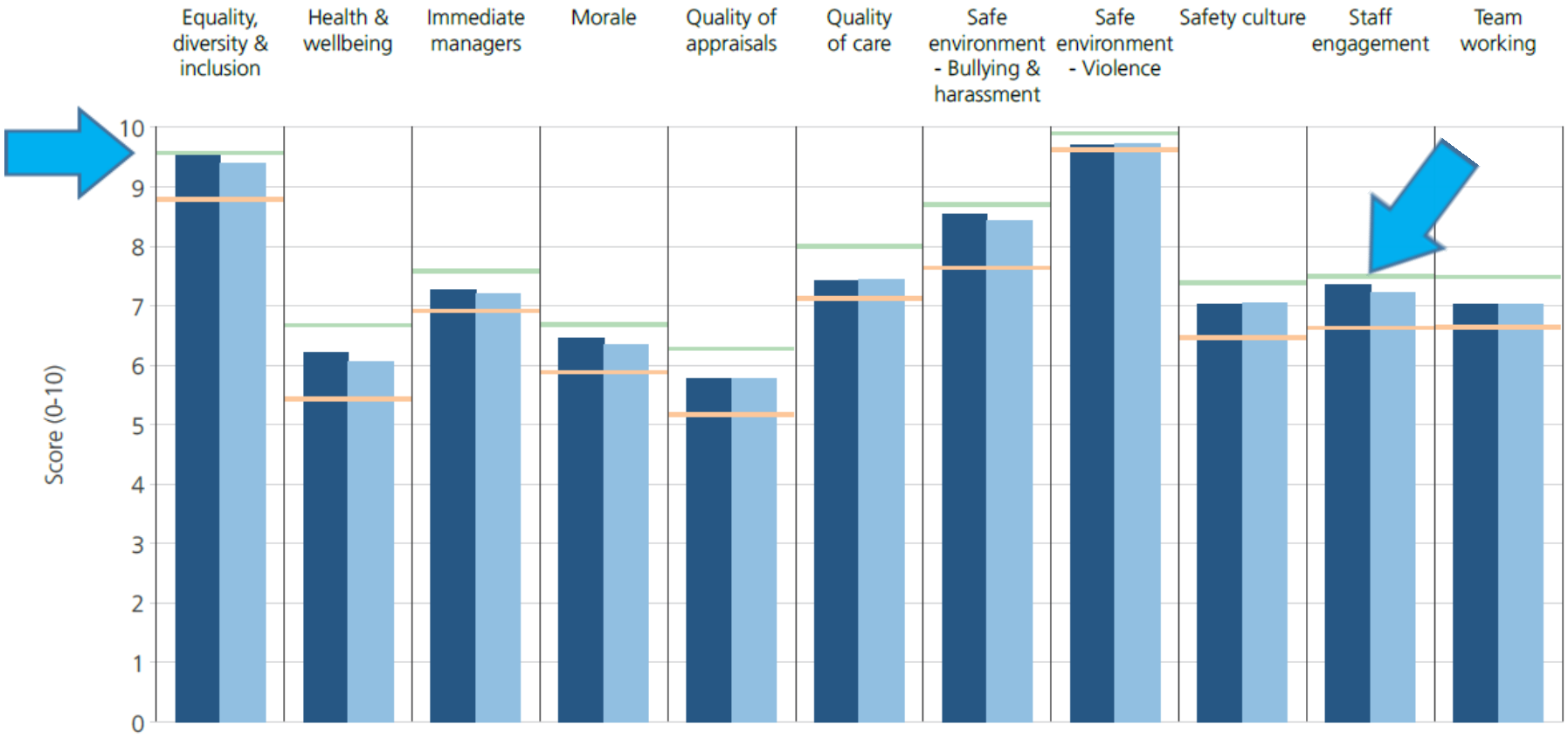
- National Benchmarks
- Staff Engagement Score
- NHS Oversight Framework
- Agreed Areas of Focus for 2019/20
- Engagement, communication, and next steps

National Benchmarks

Survey Coordination Centre

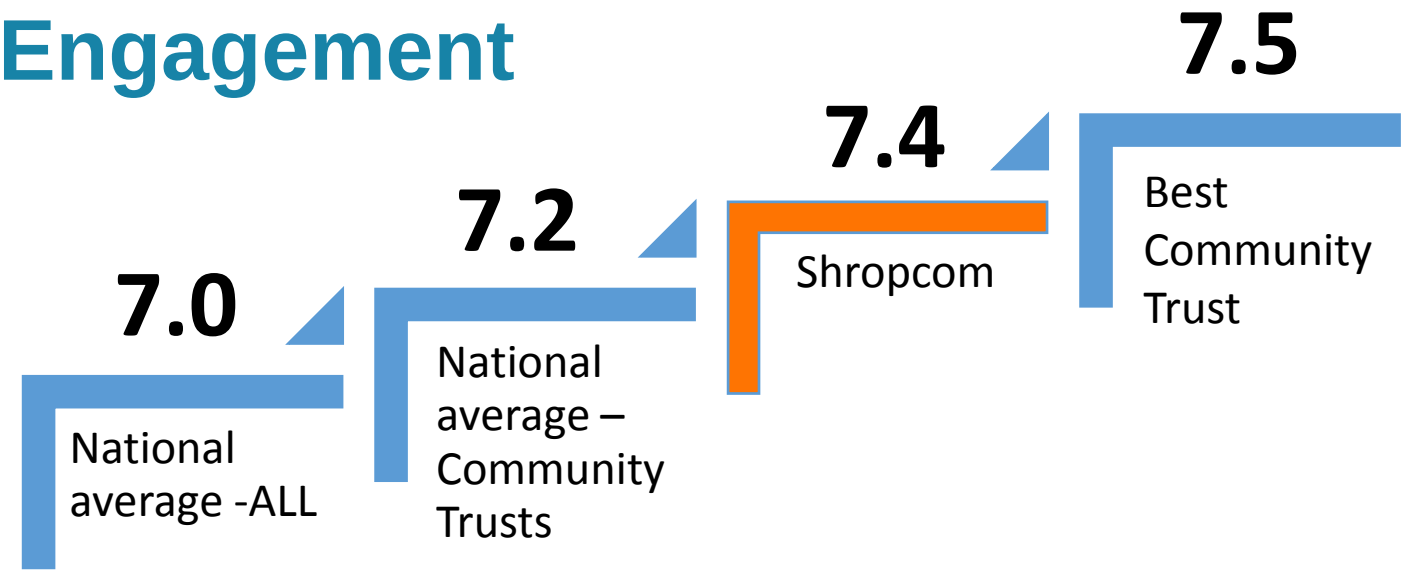
2019 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.6	6.7	6.3	8.0	8.7	9.9	7.4	7.5	7.5
Your org	9.6	6.2	7.3	6.4	5.8	7.4	8.5	9.7	7.0	7.4	7.0
Average	9.4	6.0	7.2	6.3	5.8	7.4	8.4	9.7	7.0	7.2	7.0
Worst	8.8	5.4	6.9	5.9	5.2	7.1	7.6	9.6	6.5	6.6	6.6
Responses	873	875	874	860	807	762	869	868	868	883	874

Staff Engagement



Our Staff Engagement Score last year was 7.1

The score is made up from 9 questions around Advocacy, Involvement and Motivation

- Advocacy — Significant improvements in all 3 questions
- Involvement — Significant improvements in 1/3 questions
- Motivation — Significant improvements in 1/3 questions

Picker

NHS Oversight Framework

New Annual Reporting Requirement to Board from this Year (Comparison against all Community Trusts)

Better Than Average

- I would recommend my organisation as a place to work
- In the last 12 months personally experienced harassment, bullying or abuse at work from...Patients / service users, their relatives or other members of the public?
- In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Other colleagues?
- Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?
- In the last 12 months have you personally experienced discrimination at work from…Manager / team leader or other colleagues

Average

- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.
- In the last 12 months personally experienced harassment, bullying or abuse at work from...Managers?
- The team I work in has a set of shared objectives.

Lower than Average

- The team I work in often meets to discuss the team's effectiveness.

Developing our Areas of Focus for 2020

Staff Satisfaction scores below 50%

Significant improvements since last year shown in green

Asterisks denote explicit links to areas of focus and organisational actions in the next two slides

- Being able to meet conflicting demands *
- Enough staff here to do my job properly *
- Having realistic time pressures *
- Working additional unpaid hours*
- Satisfaction with pay*
- Organisation taking positive action on Health and Wellbeing */**
- Coming to work when not well enough (and putting self under pressure) */**
- Senior Managers – communication, involving in important decisions and acting on feedback **
- Appraisal – helping to do job, agreeing objectives, discussing values, feeling valued ***

Areas of Focus for 2020

Three key areas of focus have been identified through communication and engagement with colleagues and planning is underway to look at how we address these over the next 12 months. Those areas are:

Permission to prioritise *

Around a quarter said they had been required to work additional paid hours above and beyond your contracted hours. More than half said they had come to work when not feeling well enough. Only 20% said they had realistic time pressures, while almost half said they were not satisfied with the opportunities for flexible working patterns.

Visible leadership at all levels **

We recognise the importance of good communication and would like to target these areas over the next year.

Sharing good practice on PDRs ***

Only 19% said their appraisal had helped them improve how they do their job and only 34% said clear objectives were definitely agreed.

Engagement, Communication and Next Steps

- Plans developing within Service Delivery Groups and Corporate Teams with support from the People Directorate, plus

Overarching Organisational Actions
Delivering Impact across all three Areas of Focus

- Organisation-wide Cultural Diagnostic
- Reviewing and Refining Community Trust Leadership Group
- Introducing People Plans at Team and Directorate Level
- Developing a Combined People Business Partnering Approach

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 Mar 2020
	Agenda Item:	9.5
	Enclosure Number:	9

Meeting:	**Board**		
Title:	**Performance Paper**		
Author:	Steve Price, Information Programme Manager		
Accountable Director:	Ros Preen, Director of Finance		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**

Purpose of the report		
The purpose of this report is to provide the Board with a focussed assessment of the key areas relating to risk arising across our Integrated Dashboard metrics as at 29th February 2020. This summary should enable members to consider the issues, risks and solutions in place and as such determine whether more is required to be done to reduce or avoid risk in relation to the Trust's resources or finances. The appended reports are provided to enable any member to explore more detail should this be required.	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	

Strategic goals this report relates to:

To deliver high quality care	To support people to live independently at home	To deliver integrated care	To develop sustainable community services
✓	✓	✓	✓

Summary of key points in report

There were 17 of the Trust's performance indicators which were designated as 'red' at the end of January. At the end of February the comparative performance has deteriorated slightly to 18 and the full list of these, categorised across our 10 groupings (safe, effective etc) can be found in varying levels of detail in appendix 2 and 3. The Board should note that where performance is 'off track' then recovery plans are in place for some of the indicators.

- One measure has moved to 'red' since last month;
  - Ungraded Pressure Ulcers

Several indicators are not on track to recover in line with the relevant recovery plan (see Appendix 2). Where required, recovery plan updates were reviewed at Resource and Performance Committee.

Due to the relative shift in clinical focus towards responding to Coronavirus, it has been agreed that any clinical performance reviews which are scheduled to take place in March and April will be stood down. Non clinical ones will continue as planned. This decision has been discussed between the Assistant Director of Operations and the Director of Finance.

Some measures/recovery plans have not been updated due to the requirement to respond to the Coronavirus by operational services.

Finally, Information, Operations and Quality continue to improve the reporting and performance management mechanisms. This also includes a review of the published NHS Oversight Framework. Details can be found in section 1 of the Performance Report.

Key Recommendations

The Board is asked to:

- **Consider** the current performance in relation to KPIs
- **Review** the actions being taken where performance requires improvement
- **Discuss** the actions being taken to mitigate any risks arising to either the resources available to the Trust or the Trust's financial performance
- **Discuss** the content to ensure appropriate assurance is in place

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	Regulations 9,10,11,12,13,14,15,16,17,18,20
IG Governance Toolkit	Yes	Version 9, 603
Board Assurance Framework	Yes	991 Clinical Quality and Patient Safety
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	The report and actions taken and planned developments will provide a basis for assurance on safety and experience
Financial (revenue & capital)	Yes	Costs of treatment for harmse Costs of temporary staffing
OD/Workforce	Yes	Action plans implemented through teams to ensure learning from incidents and external visits.
Legal	No	Potential impact from claims

Shropshire Community Health NHS
NHS Trust

Integrated Performance Report - Exceptions

Month 11
February 2020
Version 1.0

Accountable Director: Ros Preen
Board 26 March 2020

Table of Contents

1. Introduction

The Trust's Performance Framework is a key part of the Trust's assurance processes. This framework requires updating from time to time; either to reflect changes in the national performance framework (eg the NHS Oversight Framework now used by our regulators) or to remain focussed on key issues felt to be locally of importance to support our service delivery. NHS Improvement and NHS England have published an NHS Oversight Framework for 2019/20 which brings together the oversight for CCGs and Providers. The Information Team have conducted a review of the Oversight Framework and any discrepancies have been addressed.

Information, Operations and Quality continue to improve the reporting and performance management mechanisms. The steps below highlight the current tasks that are being undertaken to support this:-

1. Review the full set of measures and remove those that are no longer required. This step was conducted last year and it was possible to reduce the number of KPI being monitored. The latest review will inform the new financial year in terms of target setting along with ensuring focus on relevant performance measures. There are approximately 89 measures reported to committees every month, this is an excessive number of measures and removing those that are no longer required will allow for more targeted performance reporting. The review will be documented for Quality and Safety Committee and Resource and Performance Committee.

2. The development of a dashboard that focuses on the agreed key metrics continues to make progress; the measures have been specified as part of a 'Top 30' KPIs; alongside the functionality required for the ability to drill down where appropriate. The Information Team have completed the training programme. The functionality is available to use and it is expected this will help the validation process. Detail is going to be shared with the user base to stipulate data availability, inform them of how to raise validation concerns and inform them of next steps.

A further submission of the local performance framework will be required once the review has been completed. We are reporting that recovery plans are in place for some of the indicators that require them.

Of the measures that can be monitored against a recovery trajectory, several are currently achieving the recovery position in line with their authorised recovery plan. Appendix 2 shows the Recovery Status for each measure, those achieving their trajectory are listed below and the other measures are detailed in the appropriate sections of this report

- Data Quality Maturity Index
- Leavers All (FTE)

The service validation of the RTT measures continues and the current position for February is showing 18 week Referral To Treatment (RTT) for non admitted patients at 79.76% against the 95% target, 18 week Referral To Treatment (RTT) for admitted patients at 90.11% against the 90% target and 18 week Referral To Treatment (RTT) incomplete pathways at 93.79% against the 92% target.

The Integrated Performance Dashboard will aim to provide an overall assessment of the Trusts performance, and this report details exceptions in performance. For the purposes of the report an exception is defined by the status of the recovery plan for measures outside of the tolerance as follows;

1. Performance measures outside of the performance tolerance – no recovery plan in place or incomplete recovery plans
2. Performance measures outside of the performance tolerance – recovery plan in place and the actual position is not recovering in line with the plan
3. Performance measures outside of the performance tolerance – with a low or zero target will be included in a separate table

2. Key Performance Indicators Outside Performance Range – No recovery plans in place or incomplete recovery plans

The Trust's performance management framework defines a requirement that where KPIs are reported as red a recovery plan should be developed unless there is a clear reason not to. These (18) can be seen clearly in the Integrated Dashboard which is Appendix 3 to the Performance Report. The table below shows 6 measures, compared to 7 in the last report, where a recovery plan would normally be required. Several measures are still included within the table as they are either covered by other reports, there is a justifiable reason why a recovery plan is not needed or a plan has not been provided.

RAG score	Trust Measure	Recovery Plan Status
	Forecast underlying surplus/(deficit)	**Not Required – reported within the Finance paper**
	Actual efficiency recurring compared to plan Actual (YTD)	**Not Required – reported within the Finance paper**
	Sickness Absence - Nursing Workforce	**Not Required – part of trust wide sickness absence measure**
	Sickness absence – all	**Not Required – agreement to trial a plan in one area**
	Unbooked Leave	**Not required – will be replaced by a new measure for remaining annual leave**
	Proportion of temporary staff	**Not supplied**

Recovery Plan Status key

- *Not supplied – No recovery plan provided*
- *Incomplete – the recovery plan submitted will not recover the position for the Trust. An example would be a recovery plan for one operational division where the main underperformance is in another division*
- *Unauthorised – Recovery plan has not been approved*
- *Authorised – Recovery plan has been approved*

3. Key Performance Indicators Outside Performance Range – Recovery plan not on target

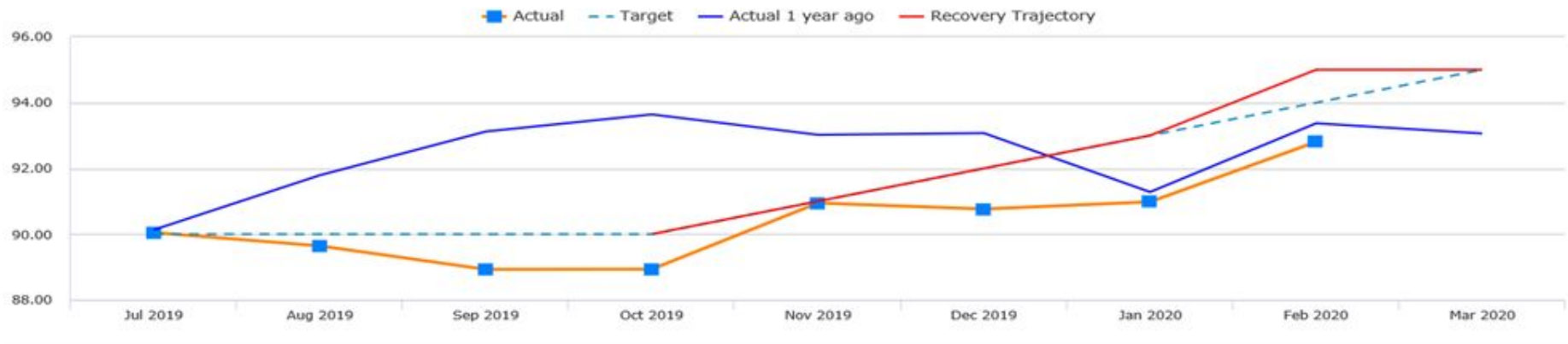
There are 5 indicators included below where an authorised recovery plan is in place and the actual position is not recovering in line with the recovery trajectory. These are reviewed in more detail below and where available a revised recovery plan has been included.

RAG score	Trust Measure
	Proportion of Delayed Transfers of Care (Days)
	Information Governance Requirements
	Appraisal Rates
	New Birth Visits % within 14 days
	Proportion of patients within 18 weeks

Proportion of Delayed Transfer of Care (Days)

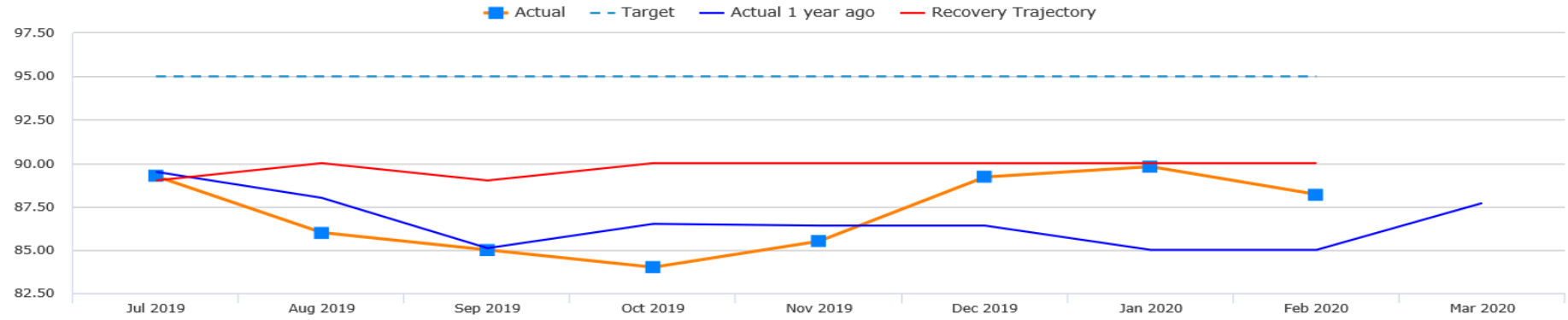
The reported position in February is a result of 37 admitted patients being delayed for 183 days collectively. While a revised recovery plan has not been provided, the most recent recovery plan has been included for information

Information Governance Requirements



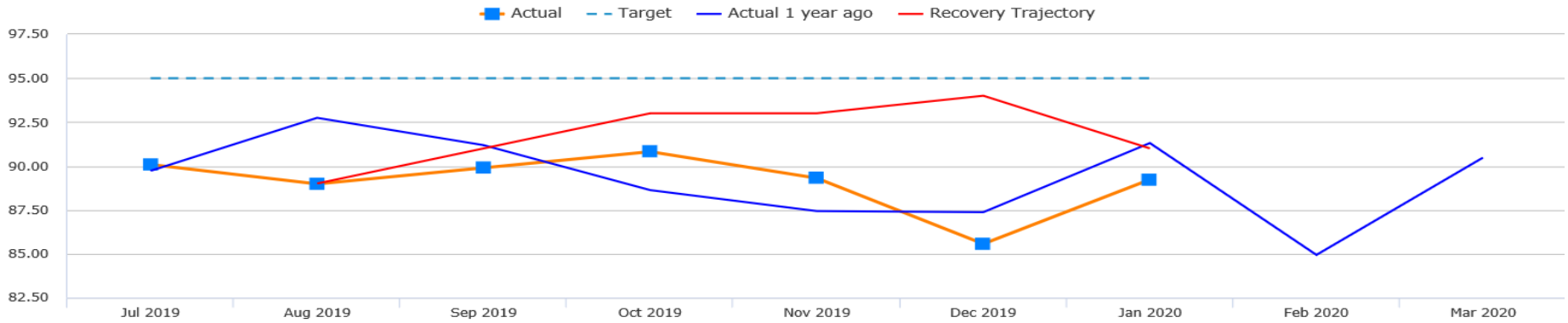
Please see recovery plan for detail

Appraisal Rates



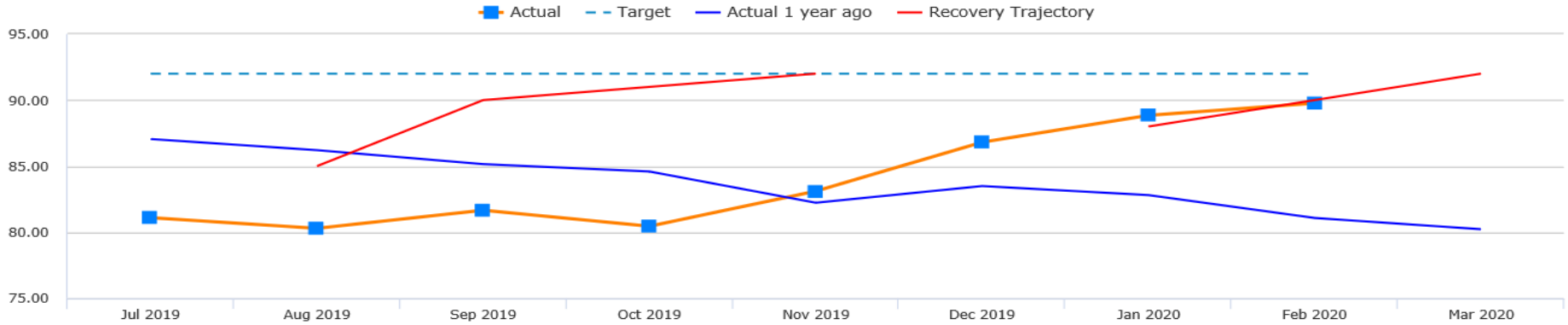
The year to date performance is amber and therefore a revised recovery plan is not required

New Birth Visits % within 14 days



The year to date performance is amber and therefore a revised recovery plan is not required

Proportion of Patients within 18 weeks



The year to date performance is amber and therefore a revised recovery plan is not required

4. Key Performance Indicators Outside Performance Range – low or zero targets

Several indicators are listed as the year to date position has already exceeded the target and tolerance while others are listed as the latest position for the indicator is exceeding the target and tolerance. As such no recovery plan will be in place for these but the Committee should be satisfied that these areas are adequately reviewed and investigated either at the Resource and Performance Committee or at the Quality and Safety Committee and that where relevant, systems and processes exist to minimise or reduce incidents in the future. Consideration as to the actual target should be reviewed and committees should be satisfied that they are relevant and meaningful.

Trust Measure	Domain	Committee responsible for review
Complaints – upheld or partly upheld	**Responsive**	**Q&S**
Clostridium Difficile – incidence rate	**Safe**	**Q&S**
Clostridium Difficile – Variance from plan	**Safe**	**Q&S**
Grade 2 Pressure Ulcers	**Safe**	**Q&S**
Ungraded Pressure Ulcers	**Safe**	**Q&S**
Percentage of new Harms	**Safe**	**Q&S**
Serious Incidents (reported)	**Safe**	**Q&S**
Total shifts exceeding NHSI capped rate	**Well Led**	**RPC**
Total shifts on a non-framework agreement	**Well Led**	**RPC**

5. Performance Icons – Key

	Achieving Target
	Not achieving target but within tolerance
	Not achieving target and outside tolerance

	Actual performance compared to target has improved
	Actual performance compared to target has no change
	Actual performance compared to target has deteriorated

Appendix 1

Indicator	Nov-19		Dec-19		Jan-20		Feb-20		Recovery Trajectory	Recovery Status	Actual YTD	YTD Target	YTD Status
Proportion of Delayed Transfers of Care (Days)	6.86%	▲	7.31%	▲	4.46%	▲	7.34%	▲	5.50%	▲	7.34%	3.50%	▲
Information Governance Requirements	90.95%	▲	90.76%	▲	90.98%	▲	92.80%	▲	95.00%	▲	92.80%	94.00%	▲
Actual efficiency recurring compared to plan - Actual (YTD)	747	▲	1,053	▲	1,474	▲	1,909	▲	?	!	1,909	2,965	▲
Forecast underlying surplus/(deficit)	-1,568	▲	-1,574	▲	-1,598	▲	-1,606	▲	?	!	-1,606	0	▲
Proportion of temporary staff	3.65%	●	4.00%	▲	4.20%	▲	3.70%	●	?	!	4.11%	3.40%	▲
Total shifts exceeding NHSI capped rate	271	▲	376	▲	378	▲	?	?	?	!	3,305	0	▲
Total shifts on a non-framework agreement	19	▲	28	▲	18	▲	?	?	?	!	254	0	▲
Unbooked Leave	26.00%	▲	20.00%	▲	14.00%	▲	9.00%	▲	?	!	9.00%	5.00%	▲

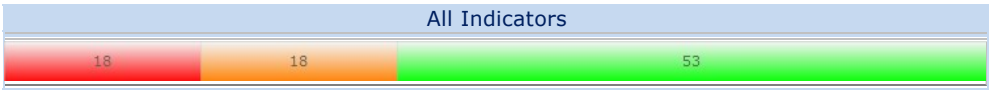
Appendix 2

Indicator	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Recov... Traject...	Recovery Status	Actual YTD	YTD Target	YTD Status
Proportion of Delayed Transfers of Care (Days)	2.23%	1.98%	1.74%	0.30%	1.25%	1.40%	5.44%	2.17%	5.52%	6.86%	7.31%	4.46%	7.34%	5.50%	▲	7.34%	3.50%	▲
Information Governance Requirements	93.3...	93.0...	90.5...	90.7...	89.5...	90.0...	89.6...	88.9...	88.9...	90.9...	90.7...	90.9...	92.8...	95.00%	▲	92.8...	94.0...	▲
Appraisal Rates	85.0...	87.7...	89.3...	88.0...	88.0...	89.2...	86.0...	85.0...	84.0...	85.5...	89.2...	89.8...	88.2...	90.00%	●	87.4...	95.0...	●
New Birth Visits % within 14 days	84.9...	90.4...	85.9...	91.0...	88.7...	90.0...	88.9...	89.8...	90.8...	89.3...	85.5...	89.2...	?	91.00%	●	88.9...	95.0...	●
Proportion of patients within 18 weeks	81.08	80.23	78.56	77.07	76.46	81.10	80.30	81.66	80.46	83.11	86.81	88.85	89.76	90.00	●	89.76	92.00	●
Data Quality Maturity Index	?	?	?	90.5%	90.3%	87.8%	94.4%	94.4%	94.5%	94.5%	?	?	?	93.0%	★	94.5%	95.0%	●
Leavers All (FTE)	0.68%	0.59%	0.73%	1.54%	0.31%	1.08%	0.82%	1.34%	0.75%	0.86%	1.04%	1.32%	0.60%	0.80%	★	0.94%	0.80%	▲
Grade 2 Pressure Ulcers	16	22	19	14	15	20	18	12	21	17	16	29	19	?	!	19	0	▲
Complaints - upheld or partly upheld	1	7	3	7	6	5	10	3	7	0	6	4	2	?	!	53	0	▲
Serious Incidents (reported)	6	5	3	6	2	2	2	2	0	2	6	3	3	?	!	31	0	▲
Ungraded Pressure Ulcers	?	?	5	5	2	4	5	1	2	4	4	3	5	?	!	5	0	▲
Percentage of New Harms	2%	2%	1%	1%	2%	2%	1%	3%	0%	3%	0%	2%	?	?	!	1%	0%	▲
Sickness Absence - Nursing Workforce	5.36%	5.16%	4.46%	5.10%	4.89%	4.66%	3.34%	5.12%	4.93%	6.53%	7.49%	6.88%	4.42%	?	!	5.26%	3.39%	▲
Total shifts on a non-framework agreement	38	39	34	31	29	38	22	21	14	19	28	18	?	?	!	254	0	▲
Forecast underlying surplus/(deficit)	-1,929	-1,933	-516	-1,041	-1,111	-1,166	-1,198	-1,249	-1,472	-1,568	-1,574	-1,598	-1,606	?	!	-1,606	0	▲
Actual efficiency recurring compared to plan - Actual (YTD)	792	904	24	58	120	209	326	446	556	747	1,053	1,474	1,909	?	!	1,909	2,965	▲
Clostridium Difficile - incidence rate	0.00	0.00	0.41	0.40	0.41	0.83	0.82	0.82	0.81	0.81	0.40	0.38	0.37	?	!	0.37	0.00	▲
Clostridium Difficile - Variance from plan	0	0	0	0	0	1	0	0	0	0	0	0	0	?	!	1	0	▲
Total shifts exceeding NHSI capped rate	367	435	344	416	315	288	312	313	292	271	376	378	?	?	!	3,305	0	▲
Sickness absence - all	5.09%	4.44%	4.66%	4.88%	4.50%	4.38%	4.34%	5.18%	5.24%	5.54%	5.67%	5.24%	4.18%	?	!	4.89%	3.39%	▲
Proportion of temporary staff	3.20%	4.06%	4.04%	5.23%	4.57%	4.00%	3.80%	4.12%	3.86%	3.65%	4.00%	4.20%	3.70%	?	!	4.11%	3.40%	▲
Unbooked Leave	?	?	68.0...	63.0...	57.0...	49.0...	43.0...	38.0...	32.0...	26.0...	20.0...	14.0...	9.00%	?	!	9.00%	5.00%	▲

Integrated Dashboard

Appendix 3

All Indicators



Caring

Indicator	RAG	Trend
New Birth Visits % within 14 days	●	↗
FFT - Inpatient Scores % Positive Response	●	↗
Staff FFT - Staff Satisfaction Score*	●	→
Staff FFT % Recommended - Care	●	↘
Access to Healthcare for people with Learning Disability	★	→
Single Sex Accommodation Breaches	★	→
FFT - Community Positive Response*	★	↗
FFT - MIU Scores % Positive Response	★	→
Staff FFT % Recommended – Work	★	↘

Responsive

Indicator	RAG	Trend
Proportion of Delayed Transfers of Care (Days)	▲	↘
Complaints - upheld or partly upheld	▲	→
Number of Claims for compensation received	●	→
Proportion of patients within 18 weeks	●	↗
CQC Conditions or Warning Notices	★	→
Number of patients not treated within 28 days of last minute cancellation	★	→
Referral to Treatment Incomplete 52+ Week Waiters	★	→
Community Equipment Store - Response within 7 days	★	↗
Diagnostics for Audio/Ultrasound	★	→
Complaints -(All) - % responded to within timescales	★	↗
Written Complaints - rate	★	↘
18 week Referral To Treatment (RTT) incomplete pathways	★	↘
MIU Total time in department - discharged within 4 hours	★	↗
MIU Unplanned Re-Attendances (within 7 days of discharge)	★	↗
MIU Percentage of people who leave MIU without being seen	★	↗
MIU Treatment Times (Arrival to Seen Time) - Median wait of 60 mins	★	↗

Effective

Indicator	RAG	Trend
Data Timeliness (2 Days)	●	↘
Data Quality Maturity Index	●	→
Deaths - unexpected	★	→
Use of NHS number	★	↘
Ethnic coding data quality	★	↘
Length of Stay (overall)	★	↘

Well Led

Indicator	RAG	Trend
Total shifts on a non-framework agreement	▲	→
Total shifts exceeding NHSI capped rate	▲	→
Unbooked Leave	▲	↘
Sickness Absence - Nursing Workforce	▲	↗
Sickness absence - all	▲	↗
Proportion of temporary staff	▲	↗
Leavers All (FTE)	▲	↗
Information Governance Requirements	▲	↗
Appraisal Rates	●	↗
Basic Life Support Training (Adult & Paediatric) (CPR)	●	↗
Safeguarding Training Compliance (Children) Level 2	●	↗
Safeguarding Training Compliance (Children) Level 3	●	↗
CQC Rating	★	→
Mental Capacity Act (MCA) Training % Compliance	★	↗
Mandatory Training Compliance	★	↘
Safeguarding Training Compliance Level 2 (Adults)	★	↘
Safeguarding Training Compliance Level 1 (Adults)	★	↗
Mandatory Core Training - Clinical Staff	★	↘
Sickness Absence - AHP Workforce	★	↘
Vacancies - all	★	↗

Safe

Indicator	RAG	Trend
Clostridium Difficile - incidence rate	▲	→
Ungraded Pressure Ulcers	▲	→
Serious Incidents (reported)	▲	→
Percentage of New Harms	▲	→
Grade 2 Pressure Ulcers	▲	→
Clostridium Difficile - Variance from plan	▲	→
Grade 3 Pressure Ulcers	●	↘
Number of patients who fell more than once	●	→
SCHT - Proportion of Clinical Staff who have completed a Hand Washing Assessment (%)	●	↗
Safety Thermometer - harm free care	●	↘
Proportion of admissions screened for MRSA	●	↗
E-coli bacteraemia BSI rate	★	→
MRSA bacteraemia rate	★	→
NHS Improvement Patient Safety Alerts outstanding	★	→
Never Events	★	→
Grade 4 Pressure Ulcers	★	→
MSSA bacteraemia rate	★	→
WHO Surgical Checklist Compliance	★	→
VTE Venous Thromboembolism Risk Assessment	★	↘
Seasonal Flu Vaccine Uptake	★	↘
Falls - Number of Falls	★	↘

Appendix 3

Designed around the Patient

2

2 Indicator	1 RAG	Trend
Early Supported Discharge	★	↗
Admission Avoidance	★	↗

Delivered in Suitable Environments

3

2 Indicator	1 RAG	Trend
Delivery of maintenance programmes	★	→
Development of estates strategy	★	→
Peat Rating	★	→

Financially Sustainable

2 | 1 | 7

Indicator	RAG	Trend
Actual efficiency recurring compared to plan - Actual (YTD)	▲	↗
Forecast underlying surplus/(deficit)	▲	→
Agency expenditure	●	↘
Bottom line I&E position - full year forecast	★	→
Forecast year end charge to capital resource limit	★	→
Is the trust forecasting a funding requirement for liquidity purposes?	★	→
Use of Resources Risk Rating	★	→
Actual efficiency recurring/non-recurring compared to plan - Actual (YTD)	★	↘
Bottom line I&E position - Actual (YTD)	★	↗
Actual efficiency non-recurring compared to plan - Actual (YTD)	★	→

Making best use of Technology

2

2 Indicator	1 RAG	Trend
EPR implementation	★	→
HSCN Implementation	★	→

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 20
	Agenda Item:	9.6
	Enclosure Number:	10

Meeting:	Trust Board		
Title:	Good and Beyond – Continuous Improvement to Deliver Outstanding Care		
Authors:	Alison Trumper – Deputy Director of Nursing and Quality		
Accountable Director:	Steve Gregory – Executive Director of Nursing and Operations		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Quality and Safety Committee	18th March 2020	Quarterly timeline for reporting agreed. Committee updated that CQC inspections have been deferred in response to the NHS escalated status.

Purpose of the report

The aim of the report is to provide the Trust Board with assurance on:-

- The process for the CQC annual well - led inspection
- Core service preparations for annual well-led inspection
- Outcome of internal core service self-assessment against CQC descriptors
- Themes to support continuous improvement to deliver outstanding care

Consider for Action	
Approval	
Assurance	**x**
Information	**x**

Strategic Priorities this report relates to:

To deliver high quality care	To support people to live independently at home	To deliver integrated care	To develop sustainable community services
x		x	x

Summary of key points in report

During 2019, the Trust underwent a comprehensive inspection by the CQC. The CQC were able to evidence core services were performing well, that the Trust was well - led, that the Trust met CQC expectations providing an overall rating of GOOD. The CQC usually repeat a comprehensive inspection of all core services within 3 years from publication of the report (August 19).

The CQC identified one regulatory breach during the 2019 inspection relating to medicines management at Severndale School. All improvements were completed and well embedded. This is evidenced through internal quality assurance reviews undertaken by the Quality lead for Children's and Young People and, through a programme of medicines management audits.

All SHOULD DO actions resulting from the inspection have been completed. To maintain GOOD at our next comprehensive core service inspection, operational and quality teams will continue to ensure all services are supported to recognise, achieve and celebrate good care to maintain GOOD.

To achieve a CQC rating of “outstanding”, core services would need to exceed CQC expectations in at least two of the five domains. We should, and want to aspire to achieve outstanding in the “Caring”. Is it possible to achieve outstanding in another domain?

A number of activities have commenced to support the Trust strategy ; Good and Beyond- Continuous Improvement to Deliver Outstanding Care-

- ✓ development of the new Trust Quality and Clinical Strategy
- ✓ aligned quality performance headlines with CQC ratings descriptors
- ✓ commencement of a review of the quality team to strengthen delivery of the Quality Strategy and Trust Good and Beyond strategy
- ✓ completion of the first internal core service self-assessments against CQC domains

As part of the CQC inspection programme, all Trusts are also subject to an ‘’approximately’’ annual inspection under the well-led question which takes place in-between comprehensive inspections. This means the Trust would have expected an inspection under the well-led domain during 2020. However, due to the NHS response to coronavirus, the schedule of CQC inspections has been delayed.

There are several components to the annual well-led inspection; provision of information request (PIR) in advance of inspection, at least one core service being inspected under all five domains and the Trust well-led inspection. There has to date been no formal notification of commencement of the annual well-led inspection. However, preparation of evidence using CQC standardised collection process will commence the collation of information on the well-led domain at Trust level, and wider information of quality at Trust and core service level.

All core services have completed an internal self-assessment against CQC ratings. All services have internally rated themselves as maintaining GOOD with two services rating themselves as OUTSTANDING in one or more domain. Two services have rated themselves REQUIRES IMPROVEMENT in two domains.

Although not exhaustive a review of themes to support our strategy have been identified and will be taken forward as we continually improve to maintain good and deliver outstanding care wherever possible.

Recommendations

The Trust Board is asked to:

1. Accept the assurance provided by the report
2. Support the activities that need to take place
3. Agree the timeline for reporting progress

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	YES	Meeting CQC Fundamental and regulatory standards.
IG Governance Toolkit	NO	
Board Assurance Framework	YES	Clinical Quality and Safety Organisational Culture

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient Safety and Experience	YES	Delivery of health care in accordance with CQC fundamental and regulatory standards.
Financial (revenue &capital)	NO	
OD/Workforce	YES	Safe, competent and available workforce.
Legal	NO	

1.0 Background and context to this paper

1.1 During January to March 2019 all core services (community adults, adult in-patients, urgent care, children's and young people, dental and end of life care) received a comprehensive inspection by Care Quality Commission(CQC) against all five key domains; are services safe, caring , effective, responsive and well led ?

1.2 Following core service inspection, the Trust was then inspected under the well-led domain.

1.3 On August 1st 2019, CQC published the outcome of the inspection resulting in the Trust receiving a rating of GOOD across all core services, all key domains and the Trust well -led domain.

1.4 This rating means CQC were able to answer the five key questions and determined the Trust is performing well, meets CQC expectations and CQC will repeat comprehensive inspection of all core services within 3 years.

1.5 However, all Trusts are also usually subject to an annual inspection under the well-led domain between comprehensive inspections.

2.0 Introduction

This paper relates to the Trust strategic priority:-

Good and Beyond - Continuous Improvement to Deliver Outstanding Care

2.1 Following the 2019 inspections, it would be a fair judgement to make that some teams have a well embedded approach to continuous improvement, posing the possibility that with further support, some teams will be in a better positon to demonstrate and evidence exceeding CQC expectations through championing outstanding care at next inspection.

2.2 Other teams were at the ''high end of GOOD '' and were able to demonstrate they are ''doing the basics '' really well', these teams will be supported to maintain GOOD, and wherever possible will be supported to identify their potential to improve to OUTSTANDING.

2.3 A very small number of services were close to REQUIRING IMPROVEMENT and will need continuous focused support to improve to GOOD and to maintain this.

2.4 CQC identified one regulatory breach during inspection relating to medicines management at Severndale School. We are confident the improvements required are well embedded, evidenced through internal quality assurance reviews undertaken by the Quality lead for Children's and Young People and, through a programme of medicines management audits.

2.5 To maintain GOOD at next core service inspection, operational and quality teams will continue to ensure all services are supported to recognise, achieve and celebrate good care to maintain performance that meets CQC expectation.

2.6 To achieve a Trust rating of OUTSTANDING, core services would need to exceed CQC expectations in at least two of the five domains.

2.7 We should, and want to aspire to achieve OUTSTANDING in caring. Could it be possible to achieve OUTSTANDING in another domain ?

2.8 Monitoring, recognising and continually improving are some of the key ingredients in achieving the Trust strategy.

Key activities we have taken to date.

- ✓ Developed our new Trust Quality and Clinical Strategy (this will be considered by the Board at the beginning of May).
- ✓ Reviewed quadrant headings in the monthly quality report to:
  - *strengthen information on quality to align with CQC rating descriptors from ''Floor to Board''*
  - *this will help services recognise how quality activities and performance at service level translate into the five CQC questions; supporting recognition, celebration and improvement.*
  - *to better enable a proactive approach at capturing key information into CQC standardised collection tool as a data repository.*
- ✓ Commenced a review of the quality team to strengthen our offer to support the quality strategy and Trust Good and Beyond strategy.
- ✓ Completed Trust wide internal self-assessment against CQC key domains.

3.0 Annual inspection under the well-led question

3.1 CQC guidance states Trusts can be expected to be inspected under the well-led key question ''approximately annually''. The Trust had expected to be inspected under the well -led domain sometime during 2020, however, due to the NHS response to coronavirus, CQC inspections have now been delayed.

3.2 There are several components to the annual well -led inspection, as follows, in order of key milestones. It is of importance to note that as part of Trust well- led, at least one core service, possibly two will also be inspected under all five domains.

In order of sequence	Activities
1	The Trust will receive an unannounced request to return the Provider information Request (PIR)
2	3 week turnaround to submit PIR to CQC
3	Within three months of PIR submission, there will be an on-site inspection of between one to three days under the five key domains in at least one core service, possibly more than one core service, to be determined by CQC.
4	Following core service inspection, the Trust will be notified of the well - led inspection to allow for planning of interviews etc.
5	Completion of on-site inspection for one to three days for the well-led inspection.

3.3 As part of the annual well-led inspection, CQC also take into account NHS Improvement's assessment of Trust's performance and leadership.

3.4 Prior to inspection, NHSI will provide information on the Trust' financial and resource governance to the CQC inspection teams, which is drawn from its regular oversight and improvement work.

3.5 The Trust can expect the onsite team for up to three days, to include:

a) specialist professional advisors with appropriate experience of organisational leadership, governance and finance, such as relevant Directors and Heads of Governance.
b) staff from NHS Improvement, to assess financial and resource governance in the Trust.

4.0 Preparing for inspection under the well led question.

4.1 It is a key priority to commence preparation for the annual well-led inspection. There are several parts to preparation.

Key activities	Status
Core service self-assessment under the four of the five questions; safe, effective, caring, responsive at core service level.	Completed for Mach 2020 – see table one
Trust level self-assessment under well - led question.	Co-ordinated through the corporate governance
Commence collection of evidence using the PIR framework.	To commence from April.
Align information on quality against CQC rating descriptors to assist information transfer from '' Floor to Board'' .	Commenced from February 2020
Develop communication strategy	Not commenced due to coronavirus situation.

5.0 Provider Information Request (PIR)

5.1 The PIR is CQC's standardised collection process for NHS inspections . It allows Trusts to provide information on the well-led key domain at Trust level, and wider information of quality in the Trust at all levels.

5.2 **Part one -** The first part of the PIR request, which is the main request for information, invites Trusts to provide CQC with information on the quality of care against the five key domains and includes changes in quality or activity since last inspection.

5.3 **Part two -** The second part of the PIR request, invites the Trust to use the key lines of enquiry for the well-led domain to tell CQC about the Trust's leadership, governance and organisational culture under the following themes.

Leadership	Board Members	Strategy	Whistleblowing
Ward to Board	Finance over view	External reviews	Data quality
Local surveys	Engagement and morale	Partners	Innovations
Accreditations	Governance		

5.4 Although there is a three week deadline for completion of the PIR from CQC request to Trust submission, it is sensible to have a proactive approach to commence collection of information in preparation particularly as other information may be requested by CQC in advance of the well -led inspection that we don't know of yet.

6.0 Internal assessment of core services against the four CQC domains; are services safe, effective, caring, and responsive?

6.1 In 2019 core services were able to provide evidence to a standard that enabled inspectors to confirm all core services were performing to required expectations and that no service was falling below this expectation with the exception of the breach in medicines management at Severndale school.

During February, core services were invited to undertake a self-assessment using CQC ratings descriptors to understand from their perspective where they can evidence they continue to meet or have exceeded CQC expectations since March 2019 .

Table one illustrates the outcome of the internal self-assessment undertaken by service leads using the CQC ratings descriptors. Evidence to support ratings will be populated over forthcoming months.

6.2 Two services rated themselves as REQUIRING IMPROVEMENT under the effective domain and the safe domain. We would expect that this position will change the end of April.

Effective - the first team is in relation to the need to improve training for non-registered care staff and volunteers and also improvements are required in relation to individual care planning.

Safe - the second team recognise improvement is required with relation to strengthening feedback following datix referrals which is in the criteria for safe domain.

Table One - Internal core services self-assessment against CQC ratings descriptors - March 2020

Core service	Safe	Effective	Caring	Responsive	Overall	Comments
Community health services for Adults	Good	Good	*Good	*Good	Good	*16 Services self-assessed as Outstanding for Caring domain *5 Services self-assessed as Outstanding for Responsive domain
Children, young people and families	Good	*Good	*Good	*Good	Good	* 1 Service self-assessed as Outstanding for Effective domain * 3 Services self-assessed as Outstanding for Caring domain * 1 Service self-assessed as Outstanding for Responsive domain
Community health inpatient services	*Good	*Good	*Good	Good	Good	* 1 Service self-assessed as Outstanding for Safe domain * 1 Service self-assessed as Outstanding for Caring domain * 1 Service self-assessed as Requires Improvement for Effective domain
Community dental services	*Good	*Good	Outstanding	*Good	Good	Dental services self-assessed as Outstanding for Caring domain
Urgent Care	*Good	*Good	Outstanding	Outstanding	Outstanding	*DAART service self-assessed as Outstanding for Caring and Responsive domain
EoLC	Good	Good	Good	Good	Good	
Overall	Good	Goo	Outstanding	Good	Good	

7.0 Additional themes for improvement and areas for celebration

7.1 Trust wide comprehensive inspection of all core services may take place at some point before August 2022, three years after publication current ratings August 2019.

7.2 Maintaining our current performance to retain our rating of GOOD is imperative as reflected in our Trust strategy. However, although not exhaustive, key areas of improvement providing opportunities to exceed CQC rating of GOOD to OUTSTANDING are summarised in Table two.

7.3 The table highlights our current position against these themes, using professional judgement in relation to themes relating to CQC descriptors of outstanding.

Key:-
Amber = requires improvement, limited or no evidence can be provided
Green = some evidence can be provided and we can improve
Blue = evidence can be provided and we will continue to improve

Domain	Description	RAG status
Safe	Consistent use of a Trust agreed quality improvement methodology	
Safe	Compliance with medicines policy and procedure is routinely monitored and action plans are always implemented promptly.	
Safe	Sustaining Trust track record of safety.	
Safe	Consistent progress towards safety goals reflected in a zero-harm culture.	
Safe	All staff are open and transparent, and fully committed to reporting incidents and near misses.	
Safe	Opportunities to learn from external safety events are identified.	
Effective	Implement quality audits to ensure patient nutrition, hydration and pain relief needs are being met	
Effective	Evidencing technologies to support the delivery of high-quality care.	
Effective	Evidencing meeting standards in the Mental Health Act Code of Practice	
Effective	Ensuring recognition of high performance from credible external bodies is reported and recorded.	
Effective	Proactive approach for clinical staff to acquire new skills to meet service need and share transferable skills accordingly.	
Effective	Using volunteers in innovative ways to support measuring improved patient outcomes people (this relates to quality of life outcomes).	
Effective	Targeted and proactive approach to health promotion and prevention of ill-health	
Effective	Practices around consent and records are actively monitored and reviewed.	
Effective	Strengthening governance arrangements around the skills of volunteers who have direct contact with patients.	
Caring	Use of innovative ways to gain feedback from people that use services to evidence staff going the extra mile and their care and support exceeds their expectations.	
Caring	Using innovative ways to evidence where people who use services and those close to them are seen as active partners in their care.	
Caring	People's privacy and dignity is consistently embedded in everything that staff do.	
Responsive	Use of innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs	
Responsive	Facilities and premises are innovative and meet the needs of a range of people who use the service.	

Responsive	Proactive approach meeting the needs of different groups including people with protected characteristics under the Equality Act , people who may be approaching the end of their life, and people who are in vulnerable circumstances or who have complex needs.	
Responsive	Technology is used innovatively to ensure people have timely access to treatment, support and care.	
Responsive	Evidence where improvements are made as a result of learning from reviews cascade of learning is demonstrated.	
Responsive	When things go wrong investigations are comprehensive and the service uses innovative ways of looking into concerns, including using external people and professionals to make sure there is an independent and objective approach.	

These, as well as other improvement initiatives, will form our quality improvement action plan underpinning our Good and Beyond improvement activities.

8.0 Recommendations

The Trust Board is asked to:

1. Accept the assurance provided by the report
2. Support the activities that need to take place
3. Agree the timeline for reporting progress

Shropshire Community Health NHS Trust

SUMMARY REPORT	Meeting Date:	26th March 2020
	Agenda Item:	9.6
	Enclosure Number:	11

Meeting:	Trust Board		
Title:	Well Led Improvement Plan		
Authors:	Julie Houlder – Corporate Governance Consultant		
Accountable Director:	David Stout CEO		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**

Purpose of the report		
As requested, this paper provides the Trust Board with a final report on the position in delivering the Well-led Improvement plans produced following the 2019 CQC inspection and the findings of the Board's well-led self-assessment. The Board can take positive assurance regarding the delivery of the plans and are asked to accept the timescales for delivery of the actions not yet fully implemented which have been incorporated into the Executive Team's 2020/21 objectives.	**Consider for Action**	
	Approval	
	Assurance	**X**
	Information	**X**

Strategic Priorities this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
X	X	X	x

Summary of key points in report

The CQC rated Shropcom as good across all domains in their Well-led assessment. Niche Health & Social Care Consulting were also appointed to support the Board's self- assessment under the NHSI Well-led framework and the outcome of this work was reported to the March 2019 Board meeting.

There were some aspects of both Well-led findings where further attention was required and a number of plans were developed to address the observations made. The Board has received regular updates on the progress made.

This is the final report to Board on the delivery of improvements and the attached plan show the position as at March 2020. Actions which are not yet fully implemented have been incorporated into 2020/21 objectives.

22 Initiatives were identified in response to the comments made as a result of the self –assessment and CQC findings. The position in March 2020 is that of these 22 initiatives, 16 are complete and 6 are on target for completion with no initiatives at risk to delivery.

The detailed plan is set out in Appendix 1 and also demonstrates the remaining risks for those actions yet to be completed which range from moderate (9) to low (6).

Table 1 –Well-Led Improvement Plan- Summary Position as at March 2020

>Dashboard Reporting
>Raising Concerns
>Board Development Programme
>NED effectiveness
>Linking of BAF to Corporate Risk Register
>Improvement in QSC assurance and reporting
>Ensuring Highly engaged staff
>Creating a healthy organisation
>Review decision making processes
>Ensuring Learning embedded
>Review Quality Improvement methodologies-
>Developing a Partnership Strategy and models of governance- On-going
>Developing robust Service Level Agreements
>Alignment of Clinical and Quality Strategies
>Diversity and Inclusion

>Increasing assurance around data
>Governance below Boards – May 2020
>Standardisation of corporate governance documentation - May 2020
>Development of Service Line Reporting - August 2020
>Business Continuity Plans - Ongoing
>Talent Management and succession - 12 month Programme
>Clinical Effectiveness Review – Ongoing

Key

Complete

On track for completion

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	YES	Meeting CQC Fundamental and regulatory standards.
IG Governance Toolkit	NO	
Board Assurance Framework	YES	Meeting CQC Fundamental and regulatory standards.

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient Safety and Experience	YES	Delivery of health care in accordance with CQC fundamental and regulatory standards.
Financial (revenue &capital)	NO	At the current stage no additional costs have been identified and activity can be contained within existing budgets.
OD/Workforce	YES	Safe, competent and available workforce.
Legal	NO	

Recommendations

The Board is asked to accept the assurance provided by this report regarding the implementation of the Well-led Improvement action plans and accept that outstanding actions have been incorporated into 2020/21 objectives.

We will need to review the timescales for addressing the outstanding actions in light of the requirements to respond to the coronavirus pandemic.

Final Well Led Plan

Ref	Action	Lead Role	Initial Risk (LxI)	Target Completion	Impact	Remaining Risk (LxI)
KLOE 6 Data Quality and security	Increasing assurance around data quality and security	Director of Finance and Strategy	3x4 = 12	Mar-20	The Information Security Policy will be clearly understood across the Organisation and information Governance issues (will be monitored and reported through the existing risk management processes, and any lessons learnt will be communicated effectively across the organisation. The Data Security and Protection Toolkit (DSPT) annual compliance submission will be subject to independent audit.	2x4 = 8
KLOE 4 Governance	Review of processes which support decision making to include Benefits Realisation and alignment toQEIA	Director of Finance and Strategy	3x3 = 9	Complete	All levels of governance and management functions interacting with each other effectively will ensure the delivery of good quality sustainable services	2x3 = 6
KLOE 4 Governance	Review of Quality improvement methodologies	Corporate Director of Finance and Strategy	3x3 = 9	Complete	The use of methods and tools to improve the quality of care and create financial savings will ensure the sustainability of services	2x3 = 6
KLOE 4 Governance	Ensuring that learning is embedded to improve decision making and service planning	Director of Nursing and Operations	3x3 = 9	Complete	A culture of learning will ensure a more consistent approach to investigations when things go wrong to support fairer treatment for staff and deliver significant benefits to patients	2x3=6
KLOE 5 Risk	Business Continuity Plans	Director of Nursing and Operations	3x4 = 12	Nov-20	Fully tested Business Continuity Plans will avoid and mitigate roisks associated with a disruption of operations. They will deal with the safety and restoration of essential patient care and other services.	2x4 = 8
KLOE 1 Leadership	Ensuring clinical engagement in the refresh and alignment of the Clinical and Quality strategies	Medical Director	4x4 = 16	May-20	Clinicians and managers actively engaged in shared leadership: strengthening quality governance of current service provision and enabling service transformation impacting on patients, eg CCtH (benefits enabling roll out of case management pilot), MSK (agreed STP clinical model), Respiratory, EOL (no unexpected deaths in CHs 2019).	2x4 = 8
KLOE 3- Culture	Diversity and Inclusion (Service Users)	Medical Director	3x4 = 12	Complete	Evolving sub-groups of patient and staff forums with focus on specific areas of inclusion.	2x4 = 8
KLOE 8- Learning	Clinical Effectiveness to include review of clinical audit and research and development opportunities	Medical Director	3x4 = 12	Complete	Patients and staff enthusiastic about involvement in R&D and will benefit from outputs of studies in which we are participating. Strengthening Clinical Effectiveness reporting to Trust Board to enable quality assurance and improvement.	2x4 = 8
KLOE 4 Governance	Standardisation - cover sheets, reports, minutes	Corporate Governance Team	3x3 = 9	May-20	Best practice governance is fundamental to ensuring decisions are made in the best interests of patients, help staff understand their responsibilities and accountabilities and for patients and the public to hold the organisation to account.	2x3 = 6
KIOE 4 Governance	Governance below Board - review of committees and their sub group structures	Corporate Governance Team	4x3 = 12	May-20	All levels of governance and management functions interacting with each other effectively will ensure the delivery of good quality sustainable services	3x3 = 9
KLOE 4 Governance	Developing robust service level agreements	Associate Director of Finance	3x3 = 9	Complete	Robust Service Level Agreements in place with partners and third parties for all significant services to ensure they are managed effectively to promote coordinated, person centred care.	2x3 = 6
KLOE 4 Governance	Development of Service line reporting on an ad hoc basis and introduction of patient level cost reporting	Associate Director of Finance	3x4 = 12	Aug-20	Accurate, timely and relevant financial information enables resources to be allocated efficiently to ensure the highest quality outcomes for patients	2x4 = 8
KLOE 1- Leadership	Develop a systematic talent and succession management framework to ensure that we have a well equipped Leadership Team	Director of People	3x4=12	Ongoing	Compassionate, inclusive and effective leadership demonstrating a high level of experience and capability. Leaders will have a deep understanding of issues challenges and priorities to ensure delivery of objectives and there will be a clear plan for succession	2x4=8

Shropshire Community Health NHS
NHS Trust

	Meeting Date:	**26 March 2020**
	Agenda Item:	**10.1**
	Enclosure Number:	**12**

Meeting:	**Trust Board**		
Title:	**Strategic Developments Update**		
Author:	**Tricia Finch, Head of Development and Transformation** **Mike Carr, Deputy Director of Operations**		
Accountable Director:	**Ros Preen, Director of Finance and Strategy** **Steve Gregory, Director of Nursing and Operations**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Resources and Performance	23rd March 2020	

Purpose of the report		
• To provide an update on activities and developments within the wider health system that we are contributing to.	**Consider for Action**	✓
	Approval	
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report : Executive Summary

- We continue to work as a strong system partner leading the development of community transformation. Our teams continue to work closely with partners adopting new ways of working across existing organisational structures. The models that are currently being tested have demonstrated benefits across the system and investment is now being secured to scale up to the rest of the communities we serve.
- The Trust is leading the MSK transformation programme. Mobilising the new service by an expected date of 1st September will require significant input from operational and corporate teams. There are also likely to be transfers of staff between partners within the Alliance. Employment models to deliver the new service are currently being explored and the Board is asked to discuss preferred options.
- Whilst we have made significant progress on developing community services, we need to be mindful of the risks associated with Coronavirus which may have an impact on the pace at which the developments are implemented and the risks already identified due to availability of staff, not only recruitment, but staff being redeployed to other parts of the health service where needed during this pandemic.
- The STP is in the process of undertaking a review which will likely reduce the number of priorities that the system focuses on for the immediate future. More information on this is provided in the Planning and System Finance paper being discussed in Part 2.

Key Recommendations
The Board is asked to: • Receive the updates on progress. • Discuss future employment models. • Consider and agree any further actions required.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	No	
Data Security Protection Toolkit	No	
Board Assurance Framework	Yes	4-2018 Healthcare Systems

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	Future service development programmes are intended to have a favourable impact.
Financial (revenue & capital)	Yes	Variable according to value of individual development schemes.
OD/Workforce	Yes	New service models will result in new ways of working and new roles for the workforce. Efficiency programmes are likely to impact on the existing workforce.
Legal	Yes	Contractual arrangements with external suppliers are subject to legal review.

Shropshire Community Health NHS
NHS Trust

Strategic Developments Update

Strategic Priority : Delivering our Transformation Plans

Trust Board – Part 1

26 March 2020

Accountable Directors: Ros Preen, Director of Finance and Strategy and Steve Gregory, Director of Nursing and Operations

Improving Lives in Our Communities

Introduction

This report provides an update to the Board on existing strategic developments that we are currently involved with and the progress to date for each of those schemes. The information is provided to the Board for information and to identify the risks associated with each of these.

Details of how these developments fit within the overall system developments is included in this report . Additional information on the future planning is included in the Planning and Systems Finance Report within the Part 2 papers.

All information contained within the report is correct at time of writing, 18 March 2020, updates and developments since that time will be provided verbally to the Board.

Contents

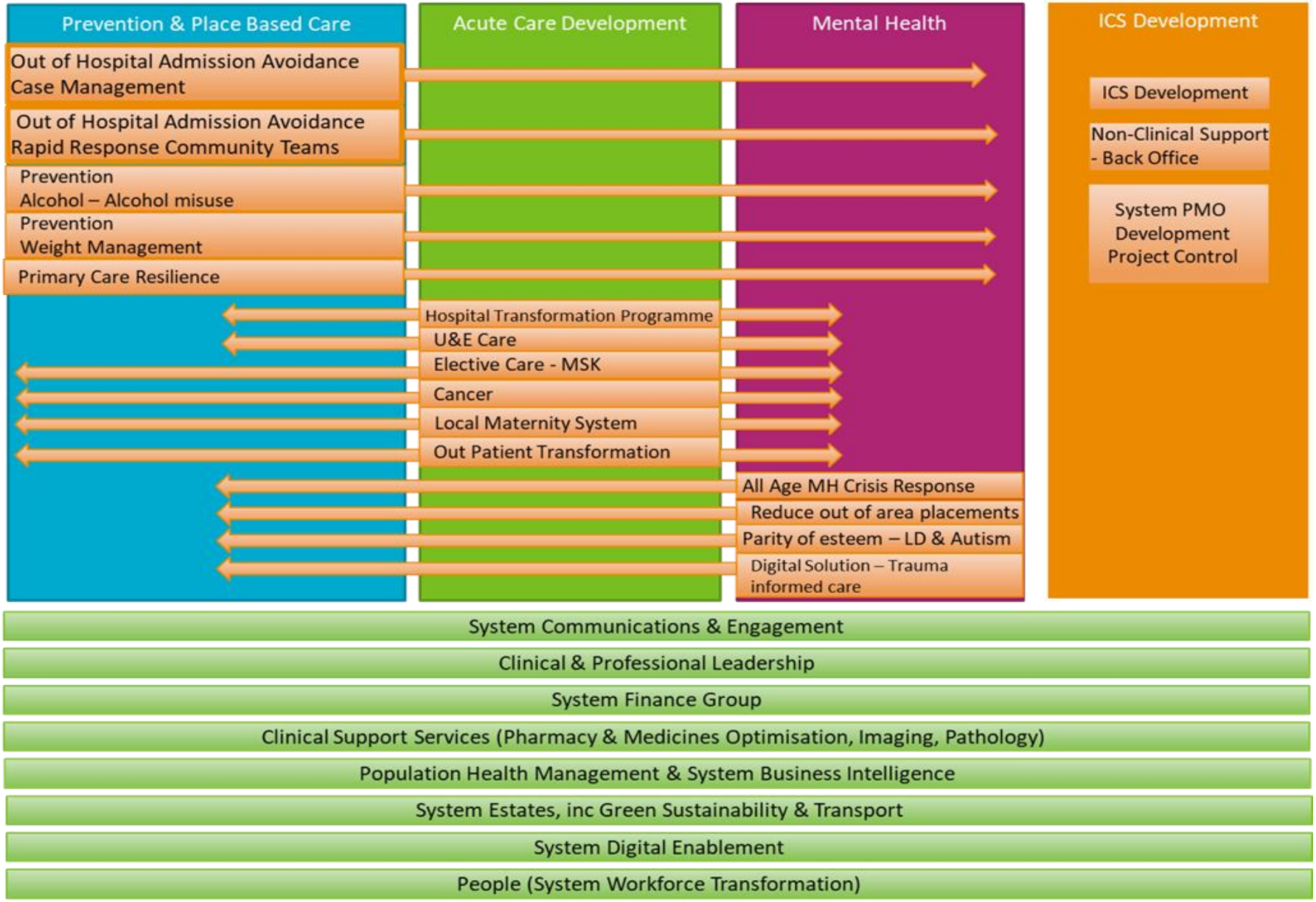
Strategic Developments

1.1 Sustainability and Transformation Partnership (STP) Long Term Plan

- Much of the transformation of our services is now driven by the wider system priorities. The development of community services is recognised as essential to meet both rising demand and also to reduce the pressures on our local acute hospitals and we are taking a lead on the implementation and pilots for these developments.
- The previous STP Plan identified a significant number of priorities. Since this was published the developments have been reviewed through a 'prioritisation process' that was reported last month. This has resulted in some of the programmes of work that we are involved in moving into a different system cluster and the renaming of some of these developments.
- A copy of the revised STP priorities is included on the following page to remind the Board of the outcome of this process and how progress will be reported going forwards.
- Throughout this report references to the programme names that we recognise are included to help orientate the Board.
- Delivery plans are being drawn up for all of the key programmes of work and details of these will be shared with the Board in future reports as the plans are developed.

This information is being provided to update the Board on work taking place outside of the Trust that we are contributing to and will shape opportunities for us in the future.

1.2 Revised System Priority Programmes and Reporting Structure



2.1 Out of Hospital Admission Avoidance - Case Management: (Shropshire Care Closer to Home)

Phase 1 Frailty Intervention Team (FIT)

- Support is continuing to be provided from our IDT, Community Matron and Rapid Response team.
- Recruitment to a fixed term post were unsuccessful. The Trust is now seeking to recruit to a permanent post which it is hoped will be more attractive to candidates.

Phase 2 Case Management Demonstrator Sites

- The CCG approved an interim business case in January to fund Case Management posts and enable roll out to a further 8 GP Practices, totaling 16 GP Practices in Shropshire ,from April 2020. The recruitment process has commenced.
- The STP Workforce Group has developed a workforce plan for phased roll out of Case Management to 41 GP Practices in Shropshire by November 2020. A second business case is being developed by the CCG to identify funding for this.

Phase 3 Hospital at Home, Rapid Response, Crisis Response and DAART

- The CCG have agreed funding for 12 months to facilitate the testing of a rapid response team for the Central Shrewsbury area. This pilot scheme will influence the development of the phase 3 model.
- The areas of impact on our existing services still relate to the additional activity associated with 'step down' from the new Phase 3 service and the required expansion / enhancement of our existing DAART services to meet the future specification.
- General impacts with regard to the availability of workforce, estate and the ability of the system to support 24/7 working still remain.

Details of the impact and risks are shown on the following page.

2.1 Out of Hospital Admission Avoidance - Case Management: (Shropshire Care Closer to Home)

Risks and Mitigating Actions

- The most significant risks associated with all phases of this programme relate to the ability to respond in terms of matching our capacity to new demand.
- The risk stratification associated with Phase 2 of the programme identified a significant number of new patients who are not known to our teams causing an in increased demand for nursing and therapy services. The Care Closer to Home Programme Board have recognised the need for a dedicated workforce to prioritise preventative interventions with patients.
- The STP Workforce Group has developed a workforce plan for phased roll out of Case Management to 41 GP Practices in Shropshire by November 2020
- The risks associated with Phase 3 have been identified and shared with the Commissioner and considered accordingly.

This update is being provided to the Board to acknowledge the continued commitment of the teams to ensure the success of the projects within the programme and the progress made to secure additional funding in recognition of the additional demands on the services.

2.2 Joint Strategic Needs Assessment – Shropshire Ageing Well Event

- The Shropshire Care Closer to Home Team held a Shropshire Ageing Well workshop on 26th February 2020. It was well attended by a wide range of stakeholders, including voluntary organisations and patient representative groups, focussing on the future health needs of Shropshire and how health and care services might best meet demands.
- The output from the workshop will now be used to guide the work of the Joint Strategic Needs Assessment (JSNA) which is developed by Shropshire Council's Public Health Department in association with local health and social care partners.
- Information shared at the workshop indicated that in the over 65 population of Shropshire (not including Telford and Wrekin) the main issues affecting their health and wellbeing were levels of obesity and depression, alcohol consumption and loneliness. Figures also predicted that the population of the over 85s is to increase by 135% by 2039 making the work of the JSNA even more relevant. This will influence our future long term planning assumptions going forward.
- Further events are planned over the coming months.

This update is being provided to the Board for information only at this stage but should be noted that the development of community services in Shropshire is now being needs assessed.

3. Out of Hospital Admission Avoidance – Rapid Response Community Teams - Telford and Wrekin Integrated Place Partnership (TWIPP)

- The Health and Social Care Rapid Response Team (HSCRRT) continues to develop and referrals into the Service are increasing. As at 6th March 97% of the referrals received have resulted in an avoided admission into hospital.
- The service continues to operate from 10am – 6pm, 5 days a week. The Team physically based in the Hub is being reviewed. Positive interactions between the team and with other teams based at Halesfield continues to thrive.
- The detailed communication plan is being continually refreshed to target areas where it is felt there are low numbers of referrals. Case studies and outcomes are being used to promote referrals where this is the case
- The operational policy is being reviewed in line with the changes required under PDSA. This should be signed off by the end of March 2020 and will form part of the midpoint review on the pilot. In addition to the operational policy a SOP is being drawn up for the referral process.

Risks and Mitigating Actions

- The current service is running as a pilot. The mid point review is underway with evidence being collated from PDSAs, case studies, patient feedback, staff surveys, stakeholder surveys, data and the service outcomes. The outputs from the review will inform the next stages and identify actions required to enable the roll out of integrated teams.
- IT access has impacted on data collection and subsequent reporting which has been a risk with regard to the evaluation of the Pilot. Data cleansing has been introduced prior to the data being transferred into the RiO system. This will ensure performance and activity reporting is robust.

This update is being provided to the Board to promote the new service and to report the progress made by the Trust working with partners to support the development of this co-located multi-agency team.

4. STP Elective Care MSK

- The MSK (Shadow) Alliance has now been established which includes all 3 providers; the Trust, SaTH and RJAH, and representatives from our 2 commissioners; Shropshire and Telford & Wrekin. As the lead Partner within the Alliance we have established a robust governance structure to take forward this programme of work.
- The new clinical model will see a single point of access for all patients across the county, known as the 'Front Door' and revised clinical pathways will provide a greater level of community based care and interventions. Work is underway to assess the impact of the pathways on existing community services and existing hospital based surgical activity.
- The full service is expected to 'Go Live' on 1st September, although the Board are advised that this is a challenging deadline. A detailed Programme Plan has been drafted with Key Milestones identified. Progress against milestones is being reported within the Alliance and to the STP Acute Cluster workstream.
- The expansion of the community interventions will result in changes in roles for staff and is likely to see staff transferred between employers including transfers through a TUPE process. The RJAH Trust has identified one group of staff that are likely to transfer to the Trust, a due diligence exercise is planned to identify the impact of this proposal. Further updates will be brought next month.
- Work has commenced on developing the future Workforce Plan which is being facilitated by the STP Workforce Workstream lead. Options for future employment models include a 'single management model' to deliver the new service.

<u>Risks and Mitigating Actions</u>

- A draft Risk Register has been produced, this is reviewed weekly by the Project Implementation Group and assessed on a monthly basis by the Alliance Board. Issues escalated on a real time basis.
- This is a complex piece of work and capacity of teams is a significant risk to the timely delivery of this programme. The increasing impact responding to emergency plans could have a significant impact on this and other transformation programmes that the Trust is involved in.

This update is being provided to the Board to report the developing partnership working. The Board is also asked to consider options associated with a single management model in order to inform alliance discussions.

1.5 Outpatient Transformation (Elective Care Outpatients)

Update

- Initially, clinical pathways for ENT, Gynaecology and Cardiology specialties were going to be the focus for the Operational Group. However, feedback from the Transformation Steering Group suggested that it was not going to deliver the scale and pace of change in outpatients that is required to achieve a long term aim of a 33% reduction in face to face outpatient appointments.
- It was suggested that this would best be achieved by doing some of the initial work, especially holding a clinical workshop open to all specialties, including ENT, Gynaecology and Cardiology which would be taken forward for more detailed transformation work through Clinical Design Groups.
- The operational group are also widening the membership of the group to add more clinical input from SCHT (GP from APCS) and RJAH and a finance link for the Acute Cluster.
- Baseline data is being identified to support the of the Clinical Delivery Groups and against which, achievement can be measured.
- At the recent Elective Care Steering Group it was agreed to proceed with the long term transformation system but for SCHT and SaTH to consider short term solutions to the most troubled specialities.

Risks and Mitigating Actions

- Other specialties within organisations are doing individual transformation projects (e.g. MSK) which could be informed by this work. This Group could be more aware of these projects, and ensure that there were no unintended consequences of changes in one project impacting on others, while overseeing and monitoring the Clinical Design Groups and any other projects included in the outpatient services redesign programme.
- SCHT is considering the feasibility and sustainability of providing outpatient services going forward, or possibly handing this over to SaTH or another provider. The current model is inefficient and not sustainable in the long term. A meeting has been arranged for 16th March between SaTH and SCHT to look at those specialties that are no longer feasible for the Trust to provide and therefore handed back to SaTH and those that could be provided in partnership

This update is being provided to the Board to report the progress made by the Trust working with partners to date to transform elective care services.

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	11.1
	Enclosure Number:	13

Meeting:	**Trust Board**		
Title:	**Finance Report for the Period Ended 29 February 2020 (Month 11 2019/20)**		
Authors:	**Anthony Simms, Head of Management Accounting**		
Accountable Directors:	**Sarah Lloyd, Associate Director of Finance**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Resource & Performance	23 March 2020	

Purpose of the report		
To update the Trust Board on the Trust's financial, agency and CIP performance and full year financial forecast as at 29 February 2020. This report has been considered at R&P Committee and a verbal update on their discussions will be given at the meeting.	**Consider for Action**	✓
	Approval	
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓			✓

Summary of key points in report

The key points of the report are:

- The Trust is reporting a year to date surplus of £950k at month 11 at adjusted performance level compared to the planned position of £824k surplus, which is £126k favourable to plan
- Based on all currently available information, we are currently forecasting delivery of our control total of £844k surplus.
- Cost Improvement Programme – the programme is fully identified and there are no schemes classed as high risk. The forecast non recurrent delivery of £1,106k remains a concern as it will be carried forward to 2020/21.
- Agency and Locum cost – exceed our internal plan by £98k but remain under the nationally set Agency Ceiling by £704k.

Key Recommendations

The Board is asked to:

- Consider the adjusted financial position at month 11 of £950k surplus which is £126k favourable to plan
- Recognise the cash position remains strong with a balance of £17,336k as at 29

February 2020

- Consider that expenditure on agency staffing year to date exceeds the value assumed within our internal plan
- Recognise that we are still forecasting to achieve the 2019/20 control total subject to mitigating any new material financial risks
- Recognise the impact of IFRS 16 as an increase in expenditure of £574k in the 20/21 final accounts of which £491k relates to the IFRS treatment of our peppercorn leases, and an additional £428k in our capital plan for 20/21.
- Consider the assurance provided in relation to capturing the necessary information for COVID-19 cost reimbursement.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	YES	Failure to achieve financial targets could place constraints on investments in improving care quality
Data Security Protection Toolkit		
Board Assurance Framework	YES	3323 – Long-term financial sustainability of the Trust
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience		
Financial (revenue & capital)	YES	Failure to achieve financial targets could put the long term financial viability of the Trust at risk.
OD/Workforce		
Legal		

Shropshire Community Health NHS
NHS Trust

Title	Finance Report for the Period Ended 29 February 2020 (Month 11 2019/20)

1. Financial Plan

1.1 The Trust is measured on its financial performance by its regulator in a number of ways, but the principle measure is total Income & Expenditure (I&E) at Adjusted Financial Performance level. Adjusted Financial Performance excludes a number of technical accounting adjustments (donated assets and government grants) and is the level at which performance is reported to and managed by NHS England/NHS Improvement (NHSE/I).

1.2 The Trust submitted a plan for the year to NHSE/I to achieve a 'control total' of £844k surplus (based on Adjusted Financial Performance), with a planned retained surplus of £775k. Provider Sustainability Funding (PSF) of £844k is available to earn for 2019/20. The Trust's internal performance control total is to breakeven. This position is demonstrated in Table 1.

	£000
Trust Performance 'Control Total'	**0**
Provider Sustainability Funding	(844)
Agreed Total 'Control Total' (surplus) / deficit	**(844)**

Table 1: 'Control Total' including PSF for 2019/20

1.3 The Cost Improvement Programme (CIP) target for the year is £3,647k with £189k being delivered from the full year effects of schemes implemented in 2018/19; the in-year recurrent target is £3,458k.

2. Income & Expenditure

2.1 Performance to Date

The Trust is reporting a year to date surplus of £950k at month 11 at adjusted performance level compared to the planned position of £824k surplus, which is a £126k favourable variance. This position is summarised in Table 2 below.

	Plan £000	YTD £000	Variance £000
Provider Sustainability Funding (PSF)	(745)	(745)	0
Income	(77,599)	(77,729)	(130)
Expenditure excl. adjusting items	77,520	77,524	4
Adjusted financial performance total	**(824)**	**(950)**	**(126)**
Adjusting items	63	17	(46)
Retained (surplus) / deficit	**(761)**	**(933)**	**(172)**

Table 2: Income and Expenditure (Surplus) / Deficit Position as at 29 February 2020

The year to date position and the plan for the financial year is illustrated in Table 3.

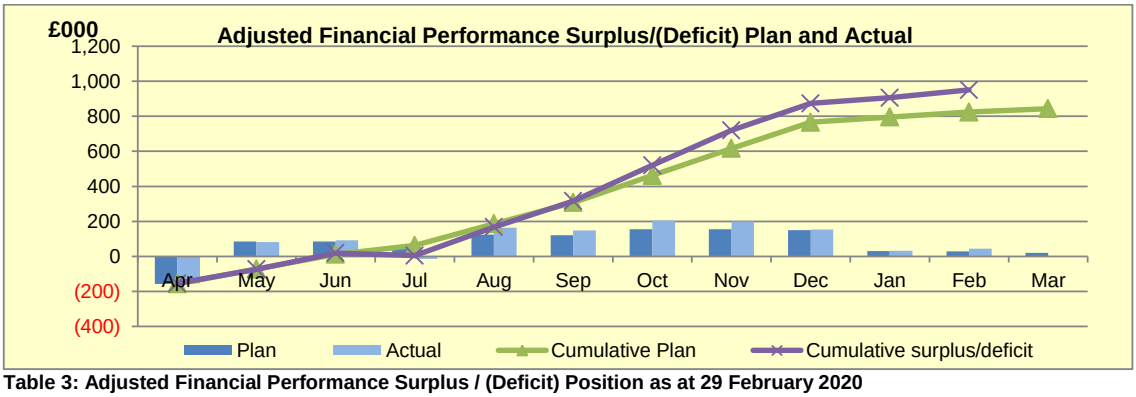


Table 3: Adjusted Financial Performance Surplus / (Deficit) Position as at 29 February 2020

2.2 Income – favourable variance to plan £130k

A summary of total income is shown in Table 4.

	Annual Plan £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Healthcare Income - Central	(80,192)	(73,477)	(73,407)	69
Healthcare Income - Divisional	(1,729)	(1,587)	(1,658)	(71)
Non-Healthcare Income	(3,600)	(3,281)	(3,409)	(128)
Total Income	**(85,522)**	**(78,344)**	**(78,474)**	**(130)**

Table 4: Income Summary as at 29 February 2020

Healthcare Income is showing a year to date favourable variance of £2k. Activity data for the period to month 10 showed an underperformance against plan for Outpatients and the Welsh contracts for Inpatients and Community Services; this is partly offset by an over performance in MIUs. The net underperformance of variable healthcare income is £36k. Additionally, TeMS income is underperforming by £21k. Non Contracted Activity (NCA) income exceeds planned levels by £67k.

The National CQUIN Team has confirmed that the AMR CQUIN for quarter 1 data is removed from the 2019/20 performance and payment calculation. We have assumed an income loss of £74k in respect of this CQUIN failure in quarter 2 and part failure in quarter 3.

Non-Healthcare Income is reporting a year to date favourable variance of £128k. The main areas of over performance are Estates income (£89k), donated assets (£44k) and training income. These were partly offset by an Occupational Health income adverse variance of £84k.

2.3 Expenditure – favourable variance to plan £42k

A summary of total expenditure is shown in Table 5.

	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Substantive	54,258	49,764	46,730	(3,034)
Bank	479	439	1,444	1,005
Agency	101	80	2,068	1,988
Total Pay	**54,838**	**50,283**	**50,242**	**(41)**
Supplies & Services Clinical	11,316	10,391	11,445	1,054
Prison Escorts and Bedwatch	188	169	166	(3)
Drugs	997	914	992	78
Premises	5,207	4,757	5,372	615
Travel	1,456	1,334	1,340	6
Other	6,915	6,287	6,037	(250)
Total Non-Pay	**26,080**	**23,852**	**25,352**	**1,500**
Cost Improvement Programme	(1,861)	(1,451)	0	1,451
Centrally Held Budgets	3,377	2,782	0	(2,782)
Non-Operational Costs	2,313	2,118	1,948	(170)
Total Central	**3,829**	**3,449**	**1,948**	**(1,501)**
Total Expenditure	**84,694**	**70,466**	**70,423**	**(42)**

Table 5: Expenditure Summary as at 29 February 2020

2.3.1 **Pay - favourable variance to plan £41k**

Bank and agency costs total £3,512k, of which £3,553k is funded by their respective budgets and the substantive pay underspend. The result is the net year to date underspend on pay of £41k (£3,553k - £3,512k).

£289k of the favourable variance relates to Corporate areas which offsets £248k of adverse variance relating to the Operations directorate. Operations is underspending by £1,739k on substantive and bank pay, this is set against £1,987k adverse variance on agency expenditure.

Further details on agency expenditure are included within Section 3 of this report.

2.3.2 **Non-Pay - adverse variance to plan £1,500k**

There is an adverse variance of £1,054k against **Supplies & Services Clinical**, the key areas of overspend are as follows:

- Continence services - £67k
- Wheelchair services - £101k
- Community equipment stores (CES) - £423k
- TeMS - £263k

As noted previously, CES has established a specialist panel to review equipment requests and set up prescriber training events to consider spend. The service has also reviewed the equipment requested by Telford & Wrekin Council alongside their SLA to ensure that the full cost is recovered; a proposal for additional funding was put forward to the Council in December. The Council activity is in line with SLA for month 11 and we will continue to assess the impact in the months ahead.

The TeMS adverse variance is due mainly to higher than planned Rheumatology (sub-contracted to RJAH) and Trauma & Orthopaedics activity which is sub-contracted to SaTH and Nuffield.

There is an adverse variance of £615k against **Premises.** This position reflects actual invoices received for the year to date from NHS Property Services (NHSPS) which is broadly in line with 2018/19 costs. As previously reported, consideration will be given to realigning the NHSPS budget for 2020/21 with baseline actual cost.

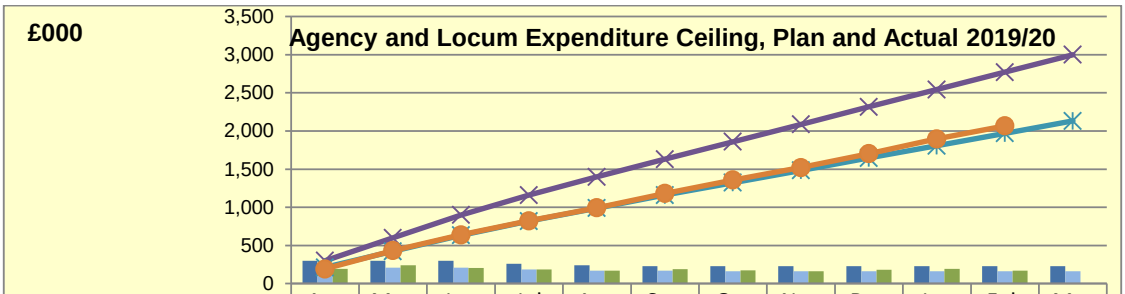
2.4 **Centrally Held Budgets**

The annual value of Centrally Held Budgets (CHB) at month 11 totals £3,377k including the contingency reserve budget of £420k which is approximately 0.5% of turnover.

The CHB represent funding that has not yet been allocated to specific budgets, most notably in relation to cost pressures, pay awards, non-pay inflation.

3. Agency and Locum Expenditure

3.1 NHSE/I issued an agency ceiling that sets the maximum annual value of agency expenditure which we may incur. Table 6 shows the NHSE/I ceiling, the planned profile for expenditure and the expenditure incurred to date.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Ceiling	300	300	300	260	240	230	230	228	228	228	228	228
In Month Plan	212	211	211	185	172	169	163	161	162	161	163	162
In Month Actual	193	240	206	184	172	188	175	164	182	193	171	
Cumulative Ceiling	300	600	900	1,160	1,400	1,630	1,860	2,088	2,316	2,544	2,772	3,000
Cumulative Plan	212	423	634	819	991	1,160	1,323	1,484	1,646	1,807	1,970	2,132
Cumulative Actual	193	433	639	823	995	1,183	1,358	1,522	1,704	1,897	2,068	

Table 6: 2019/20 Trust Wide Agency Plan and Expenditure

Year to date expenditure totals £2,068k; this represents an adverse variance of £98k compared to our plan, and a favourable variance of £704k compared to the ceiling.

The expenditure includes £15k of commissioned agency, £12k relates to Wem Wound Care clinic and £3k for Central Admission Avoidance. Therefore the adverse variance compared to planned spend is £83k (month 10 £77k) excluding commissioned spend.

Table 7 shows the expenditure by service in 2019/20

Area of Agency Expenditure	2019-20 Qtr 1 £	2019-20 Qtr 2 £	2019-20 Qtr 3 £	2019-20 Jan £	2019-20 Feb £	2019-20 YTD £
Bridgnorth Hospital (inc. MIU)	52,007	42,624	27,861	15,229	18,784	156,505
Bishops Castle Hospital	64,870	53,944	86,085	30,054	25,401	260,355
Ludlow Hospital (inc. MIU)	107,130	105,385	99,084	36,673	29,584	377,855
Whitchurch Hospital (inc. MIU)	135,713	165,383	137,667	51,463	26,557	516,782
Stoke Heath	110,422	94,771	100,396	31,055	25,479	362,123
CHOP Other (inc. Oswestry MIU)	19,886	4,343	4,238	2,338	1,755	32,560
Total for Community Hospitals & Stoke Heath	**490,028**	**466,449**	**455,331**	**166,812**	**127,560**	**1,706,180**
MSK	2,336	0	2,835	6,525	6,206	17,902
Children and Families	96,781	71,366	38,991	7,356	23,812	238,306
Community Services	17,711	1,004	15,561	12,437	11,515	58,229
ICS & Isle Court	30,981	5,276	7,749	-226	2,502	46,282
Corporate Services	1,575	0	0	0	0	1,575
Total for All Services	**639,412**	**544,095**	**520,468**	**192,903**	**171,596**	**2,068,474**

Table 7: 2019/20 Agency & Locum Expenditure by Service

The most significant changes relate to:

- Bridgnorth Hospital – increased HCAs due to enhanced supervision
- Bishops Castle Hospital – reduced HCAs agency shifts, covered by increased bank
- Ludlow MIU - reduction in registered nurse shifts covered by agency staff
- Whitchurch Hospital – reduced registered nurse shifts covered, reduced GP locum
- Children and Families – paediatric consultant locum and Speech and Language Therapist agency worker covering vacancies

Agency and locum usage continues to be closely monitored.

4. Statement of Financial Position

4.1 The Trust's summarised Statement of Financial Position (SoFP) for the period ended 29 February 2020 is shown in Table 8.

	Balance 31 Jan 20 £000	Balance 29 Feb 20 £000	Movement in Month £000
Property, Plant & Equipment	23,542	23,829	287
Inventories	408	444	36
Receivables	3,411	3,251	(160)
Cash	17,275	17,336	61
Payables	(9,595)	(9,783)	(188)
Provisions	(263)	(263)	0
TOTAL ASSETS EMPLOYED	**34,778**	**34,814**	**36**
Retained earnings	27,214	27,250	36
Other Reserves	7,564	7,564	0
TOTAL TAXPAYERS' EQUITY	**34,778**	**34,814**	**36**

Table 8: Statement of Financial Position as at 29 February 2020

Receivables decreased by £160k in month and Payables increased by £188k which is within the usual monthly movements.

The cash balance at 29 February is £17,336k and the forecast cash balance at 31 March 2020 is £13,763k, this is a positive cash balance and covers the Trust in cash terms regarding income and expenditure risks.

4.2 Aged Debt

At 29 February 2020 there are 32 invoices over £2k that have been outstanding for more than 90 days, amounting to £355k.

The most significant outstanding debts over 90 days relate to:

- 24 invoices totalling £307k raised to NHSPS. Invoices relating to Whitchurch (Claypit Street) medical practice have not been paid although the head lease has been authorised. The Trust has raised a number of queries on invoices received from NHSPS and we have therefore not paid these invoices whilst matters are agreed. As the Trust owes more to NHSPS than NHSPS owes the Trust and a payment agreement is being prepared
- 2 invoices totalling £13k to Telford and Wrekin CCG for the supply of continence products for NHS Funded Nursing Care (FNC) patients. These invoices are not in dispute, but are awaiting further validation by the CCG

4.3 Capital Expenditure

In month 11 year to date capital expenditure is £723k compared to the year to date plan of £1,805k.

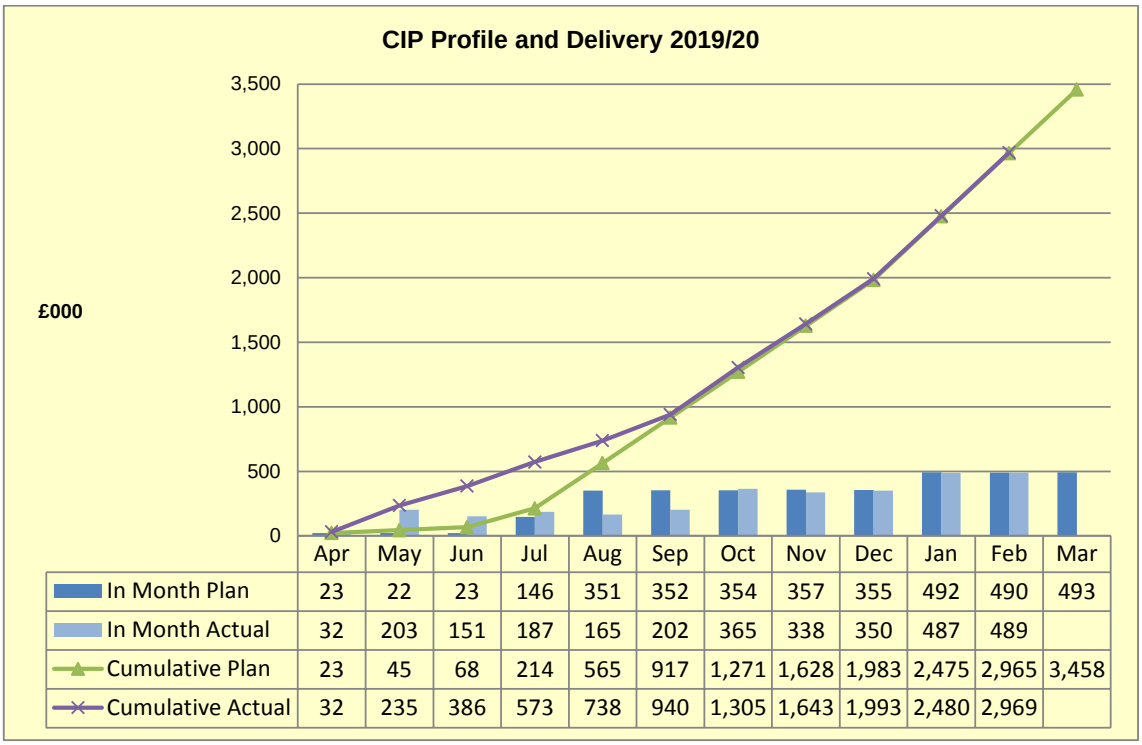
The forecast remains for all of the capital resource to be spent in year, which leaves £1,177k to be spent in March. This is supported by projects which have been approved and are underway.

Capital schemes have been requested to inform the 2020/21 plan. A draft capital plan is included within the budget setting paper also being presented to the board for approval.

5. CIP Performance

5.1 The total CIP target for the year is £3,647k; however £189k of this is delivered by schemes which commenced in 2018/19. The in-year recurrent target is £3,458k.

Table 9 demonstrates the planned delivery profile for the schemes commencing in 2019/20, as well as the actual delivery achieved.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Plan	23	22	23	146	351	352	354	357	355	492	490	493
In Month Actual	32	203	151	187	165	202	365	338	350	487	489	
Cumulative Plan	23	45	68	214	565	917	1,271	1,628	1,983	2,475	2,965	3,458
Cumulative Actual	32	235	386	573	738	940	1,305	1,643	1,993	2,480	2,969	

Table 9: 2019/20 CIP profile

5.2 On a year to date basis, £2,969k of savings have been delivered and validated against the month 11 target of £2,965k, resulting in an over performance of £4k. Of the savings delivered, £1,060k (36%) is non-recurrent.

A cost pressure review involving Deputy Directors identified areas that contributed to CIP delivery in quarters 3 and 4.

5.3 Table 10 includes the plan and actual/forecast savings by scheme.

CIP Scheme	Annual Plan £000	YTD Plan £000	YTD Actual £000	Variance £000	Total Forecast £000	Recurrent Forecast £000	Non-recurrent Forecast £000
Procurement	300	250	309	59	366	305	61
Estates Rationalisation	500	418	591	173	643	376	267
Operational Efficiencies	343	295	1,321	1,026	1,458	1,231	228
Further Opportunities	300	259	0	(259)	220	220	0
Back office savings	47	42	219	177	241	220	21
Non-recurrent mitigations	0	0	529	529	529	0	529
Total Identified	1,490	1,264	2,969	1,704	3,458	2,352	1,106
Schemes to be developed	1,968	1,700	0	(1,700)	0	0	0
2019/20 CIP delivered	**3,458**	**2,964**	**2,969**	**4**	**3,458**	**2,352**	**1,106**

Table 10: 2019/20 CIP Scheme delivery as at 29 February 2020

5.4 Financial RAG ratings are shown in Table 11. The Trust is forecasting that the full value of CIP will be delivered by the end of the financial year and all schemes are now classified as low risk. The full year delivery includes £1,106k (32%) of non-recurrent savings which will be carried forward and added to next year's target increasing the risk to the 2020/21 financial plan.

Themes	High Risk £000	Medium Risk £000	Low Risk £000	Grand Total £000
2018/19 Full Year Effects	0	0	189	189
Procurement	0	0	366	366
Estates Rationalisation	0	0	643	643
Operational Efficiencies	0	0	1,458	1,458
Further Opportunities	0	0	220	220
Back office savings	0	0	241	241
Non-recurrent mitigations	0	0	529	529
Unidentified	0	0	0	0
Grand Total	**0**	**0**	**3,647**	**3,647**
Percentage of Total CIP	*0%*	*0%*	*100%*	

Table 11: 2019/20 CIP Risk Status as at 29 February 2020

CIP meetings continue to focus on identification of recurrent schemes to offset the non-recurrent delivery. The outcome of the CIP meetings will continue to be monitored at Benefits Realisation Group (BRG).

6. Year End Forecast

6.1 The forecast outturn has been reviewed and updated and remains in line with the agreed control total of £844k surplus.

There are a number of estimates used in the forecast. The material assumptions which have a degree of risk associated with them are:

- Cost Improvement Programme – forecast assumption is that the CIP will be delivered in full. All schemes are now classed as low risk and the programme is fully identified.
- Agency and Locum cost – the forecast assumes that agency costs will be £2,280k based on the detailed work undertaken as part of the reporting cycle
- Variable Healthcare Income – the forecast assumes that performance will be at planned levels for the remainder of the year
- CQUIN – forecast assumes receipt of £700k which recognises the failure of AMR CQUIN in quarter 2 and a partial failure in quarter 3
- Demand-led services – costs across a number of services, including continence, wheelchair and equipment services continue to exceed planned levels. The forecast assumes the year to date run rate will continue for the remainder of the year
- PSF – the forecast assumes receipt of £844k for delivering the control total

All known and emerging risks and opportunities will continue to be monitored and moved to conclusion as quickly as possible.

7. External Reporting and Strategic Update

7.1 External Reporting

7.1.1 Monthly Monitoring Return to NHSE/I

Month 11 performance information, consistent with that set out in this report, was submitted to NHSE/I on 16 March 2020.

7.1.2 2020/21 Financial Planning Return

The Trust submitted its draft 2020/21 financial planning return to NHSE/I on 5 March 2020.

7.2 Strategic Update

7.2.1 International Financial Reporting Standards (IFRS) 16

- This new accounting standard is being adopted by the public sector from 1 April 2020 and forms part of the 2019/20 Accounts and the 2020/21 planning
- IFRS 16 aims to improve the comparability of companies that lease and those that purchase assets. This standard impacts both capital and revenue budgets
- All leases have been assessed in preparation for implementing IFRS 16 in 2020/21. Our assessment and reporting processes have been reviewed by our auditors, and based on our current leases, our 2020/21 accounts are likely to show an increase in expenditure of £574k in the final accounts of which £491k relates to the IFRS treatment of our peppercorn leases.
- In the 2020/21 draft financial plan the impact on our capital plan will be £428k, in addition to the planned £1,900k. The capital resource limit (CRL) is therefore £2,328k.

7.2 Coronavirus Financial Update

In a letter from NHS Chief Executive and Chief Operating office on 17 March, all NHS organisations were advised on the funding method for reimbursing costs incurred responding to the COVID-19. We have put measures in place to ensure we capture the information necessary to have our costs reimbursed.

- For 19/20, as required, we have already submitted the templates that advise of our expected costs of providing a swabbing service.
- For other costs in 19/20, and going into 202/21
    - ESR has been set up to capture the staff time relating to self-isolation, sickness and carer's leave.
    - Cost centres are in place to capture the other costs relating to our response to COVID 19.
    - Managers have been given advice on how to ensure the cost information is captured.
    - The Incident Management Team have oversight of all elements of our response, and the information for the financial returns for Revenue Cost Reimbursement.
    - We have received the Revenue Cost Reimbursement Template from NHSEI to be submitted on 23 March, to include our costs up to the 15 March and estimates to the 31 March.

8. Recommendations

8.1 The Board is asked to:

The Board is asked to:

- Consider the adjusted financial position at month 11 of £950k surplus which is £126k favourable to plan

- Recognise the cash position remains strong with a balance of £17,336k as at 29 February 2020

- Consider that expenditure on agency staffing year to date exceeds the value assumed within our internal plan

- Recognise that we are still forecasting to achieve the 2019/20 control total subject to mitigating any new material financial risks

- Recognise the impact of IFRS 16 as an increase in expenditure of £574k in the 20/21 final accounts of which £491k relates to the IFRS treatment of our peppercorn leases, and an additional £428k in our capital plan for 20/21.

- Consider the assurance provided in relation to capturing the necessary information for COVID-19 cost reimbursement.

Shropshire Community Health NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	11.2
	Enclosure Number:	14

Meeting:	**Trust Board**		
Title:	**Budget Setting 2020/21 – Opening Budgets**		
Authors:	**Anthony Simms, Head of Management Accounting**		
Accountable Directors:	**Sarah Lloyd, Associate Director of Finance**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Resource & Performance	23 March 2020	

Purpose of the report		
To present the Opening Budgets for 2020/21 and consider the recommendations of the R&P Committee in relation to these budgets.	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓			✓

Summary of key points in report

- The proposed opening budget is in line with the draft financial plan submission to NHS England/NHS Improvement (NHSE/I) on 5 March 2020.
- The national inflationary and efficiency percentages have been applied to income and expenditure where appropriate
- The contingency reserve budget has been maintained at approximately 0.5% of the Trust's turnover at £0.420m
- The CIP requirement for delivery in 2020/21 totals £3.791m including the full year effects of 2019/20 schemes
- Contract values have not yet been agreed with our main commissioners. Once agreed these income values will be reflected within budgets and will require amendments to expenditure budgets and potentially the value of the Cost Improvement Programme (CIP)
- The proposed programme included within the draft financial plan resulted in a Capital Resource Limit (CRL) requirement of £2.328m (including £0.428m IFRS 16 impact) and is entirely resourced from internally generated funds
- Further work will be undertaken to develop budgets for issues such as CIP adjustments and allocation of Centrally Held Budgets in addition to any changes as part of contract negotiations and sign-off
- Assume pay increases (totalling £0.690m including prior years) for staff working to deliver Local Authority contracts is funded recurrently

- This budget delivers a surplus of £0.077m in line with the draft plan
- These start point budgets do not reflect the updated contractual and financial regimes in place from 1 April to 31 July which have been introduced in light of Coronavirus. Any changes will be transacted in-year once fully understood.

Key Recommendations

The R&P Committee has considered the following recommendations and an update from R&P Committee will be given at the board meeting.

The Board is asked to:

- Consider that the budget presents a surplus of £0.077m in line with the draft NHSE/I plan submitted on 5 March 2020 but does not meet the financial trajectory issued to the Trust
- Recognise that further adjustments will be required to reflect agreement of healthcare contract values, identification of further CIP schemes and any agreed service developments
- Acknowledge a net Capital Programme of £2.328m is planned and is in line with the draft plan submission
- Approve the Trust's opening budget 2020/21

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	YES	Failure to achieve financial targets could place constraints on investments in improving care quality
Data Security Protection Toolkit		
Board Assurance Framework	YES	3323 – Long-term financial sustainability of the Trust
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience		
Financial (revenue & capital)	YES	Failure to achieve financial targets could put the long term financial viability of the Trust at risk.
OD/Workforce		
Legal		

Shropshire Community Health NHS
NHS Trust

Title	Budget Setting – 2020/21 Opening Budgets

1. Purpose

The purpose of this report is to formally present the output from the 2020/21 budget setting process and seek approval prior to the start of the new financial year.

The proposed opening budget is broadly in line with the draft financial plan submission to NHS England/NHS Improvement (NHSE/I) on 5 March 2020. The opening budgets will be refined as further key planning information becomes available, including contract values, any notified changes to the assumed funding for NHS pay increases for staff working to deliver Local Authority contracts and any actions required as the STP's financial plan is developed.

It is of note that contract values have not yet been agreed with our main commissioners for 2020/21. Once agreed these income values will be reflected within budgets and will require amendments to expenditure budgets and potentially the value of the Cost Improvement Programme (CIP).

Additionally, the recently received information in relation to changes to the contractual and financial changes from 1 April to 31 July in light of Coronavirus has not been reflected in opening budgets. Once these details are fully understood budgets will be amended in-year to reflect the latest position and reported through Resource and Performance Committee and Board as required.

These proposals have been considered at R&P Committee and a verbal update on their discussions will be given at the board meeting.

2. 2020/21 Plan

The Trust's draft Plan for 2020/21 was submitted to NHSE/I on 5 March 2020 with the key financial elements summarised in Table 1 below:

Detail	Draft Plan 2020/21	Comments
Adjusted Financial Performance - Surplus	£0.077m	Trajectory of £0.456m issued by NHSE/I not currently accepted. Surplus in line with the January STP financial plan.
Cost Improvement Target	£3.791m	The CIP target reflects the efficiency requirement within the tariff, estimated internal cost pressures, and the non-recurrent delivery of CIP in 2019/20
Cost Improvement as % of Patient Care Income	4.4%	Requirement via the national tariff of 1.1%.
Closing Cash Balance	£14.122m	
Net Capital Expenditure Plan	£2.328m	Includes £0.428m for IFRS16

Table 1: Key Financial Headlines from Draft 2020/21 Plan

The operational planning process has currently been suspended nationally and, at this time, it is unclear if a further financial plan will be required. Updates will be provided as further guidance is released.

3. Opening Budgets 2020/21 for Approval

The opening budgets for 2020/21 are based on the assumptions noted below but are subject to change during the financial year, for example, following agreement of contract values with commissioners or through receipt of contract variations from commissioners.

1 Accountable Director: Sarah Lloyd, Associate Director of Finance
Board Meeting: 26 March 2020

3.1 Key Assumptions

The key assumptions when formulating the budgets are as follows:

Income

- Relevant income from patient care activities has been adjusted for inflationary uplifts, see Table 2

Detail	
Total Uplift	2.50%
Less efficiency target	(1.10%)
Total	**1.40%**

Table 2: Inflationary uplift rates in 2020/21

- Agreed and anticipated outcomes from contract negotiations with commissioners (e.g. planning for outturn position for out of county contracts) have been included and matched with associated expenditure assumptions
- Pay increases (totalling £690k) for staff working to deliver Local Authority contracts is funded recurrently which remains a significant risk
- The Dudley MBC School Nursing Contract is expected to end on 30 September 2020
- Other income budgets (non-healthcare) remain consistent with 2019/20 unless specifically negotiated

Expenditure

- Pay budgets for funded establishments have been costed based on staff in post at December 2019
- Pay drift associated with historical incremental drift for funded establishment has been funded
- Vacancies have been funded at mid-point of scale
- Apart from adjustments for volume changes non pay budgets are largely unadjusted unless specific cost pressures have been identified. The non-pay inflation uplift of 1.8% has been held in a specific centrally held budget and will be allocated as required on a case by case basis, for example in relation to rates or rental inflationary uplifts.
- Impact of IFRS 16 is fully reflected – the main impact on the financial statements is that leases will be showed on the balance sheet (assets and corresponding liabilities) and lease costs previously charged to expenditure will be replaced with depreciation and interest charges. Further details are included within the Finance report.

Other

- The contingency reserve budget has been maintained at 0.5% of the Trust's turnover at £0.42m
- The CIP requirement of £3.791m (including £0.1m full year effect for 2019/20 schemes) is a result of the brought forward balance from 2019/20 due to non-recurrent delivery of schemes; the in-year requirement of 1.1% based on the national tariff; and identified cost pressures shown in Table 3

3.2 Key Movements between 2019/20 and 2020/21

Appendix 1 summarises the movements between the closing 2019/20 recurrent budgets and opening 2020/21 recurrent and non-recurrent budgets.

Material changes between the two years are as follows:

Contract Changes

This predominately includes:

- Tariff adjustments
- The assumed cessation of Dudley MBC School Nurses contract

Service Developments

Non recurrent (pilot) project for Central Admission Avoidance.

Demographic growth and any anticipated investment are excluded from the opening budgets. Budgets will be adjusted when contract values are agreed. These items were reflected within our NHSE/I plan submitted on 5 March; it was assumed all income would be matched with costs meaning there is no impact to the overall financial position of the Trust due to excluding these items from our opening budgets.

Cost Pressures

Table 3 shows the cost pressures in the draft plan:

Detail	£m
IT System - Digital agenda	0.7
IT System - Software licences	0.3
IT System - HSCN Connectivity	0.1
IT System - Telecoms wireless & fixed	0.1
Rental income reduction	0.1
Trustwide - IFRS16 Impact	0.1
Operations - general cost pressures	0.2
Trustwide - general cost pressures	0.1
Total Cost Pressures	1.7

Table 3: Cost Pressures in draft plan 2019/20

Whilst the values above have been provided for within the Trust's opening budget, it is notable that many of the values are estimated and that appropriate approval processes will be adhered to before any funding is released and committed.

Surplus

This budget delivers a surplus of £0.077m at adjusted performance level in line with the draft NHSE/I plan, compared to 2019/20 closing recurrent budget of breakeven. However, retained earnings shows a deficit of £0.5m compared to 2019/20 closing recurrent budget of £.069m deficit, the deterioration due entirely to IFRS 16 impact. The Trust is monitored on delivery of the adjusted financial performance.

The current value of CIP target for 2020/21is £3.791m including £0.1m full year effect for 2019/20 schemes.

This position will be kept under review as the position develops, for example agreeing contract values with main commissioners and any notification of pay award funding for staff working to deliver Local Authority contracts.

3.3 Opening Budget 2020/21

The proposed opening budget for 2020/21 is presented in Table 4; it shows the split between operational and corporate directorates, as well as Centrally Held Budgets. Also included are the budgeted whole time equivalents (WTE) by area.

Detail	Central Income	Operations: Adult Services		Operations: Children & Families		Operations: TeMS & Outpatients		Corporate		Centrally Held Budgets	Total Budget 2020/21	
	£000	WTE	£000	WTE	£000	WTE	£000	WTE	£000	£000	WTE	£000
Healthcare Income	(80,731)		(896)		428		(323)		(684)		-	(82,206)
Other income			(123)		(94)		(1)		(960)		-	(1,178)
Total Income	**(80,731)**	**0.00**	**(1,019)**	**0.00**	**334**	**0.00**	**(324)**	**0.00**	**(1,644)**	**0**	**0.00**	**(83,383)**
Pay		678.06	25,819	375.17	14,620	121.49	5,213	169.92	8,252		1344.64	53,904
Non-pay			5,824		4,415		2,899		11,392		-	24,530
Total Expenditure	**0**	**678.06**	**31,643**	**375.17**	**19,035**	**121.49**	**8,112**	**169.92**	**19,644**	**0**	**1344.64**	**78,434**
20-21 CIP Target			(1,435)		(683)		(365)		(1,208)		-	(3,691)
Centrally Held Budgets										4,521	-	4,521
EBITDA	**(80,731)**	**678.06**	**29,189**	**375.17**	**18,686**	**121.49**	**7,423**	**169.92**	**16,793**	**4,521**	**1344.64**	**(4,119)**
Depreciation									3,956		-	3,956
PDC									574		-	574
Interest									89		-	89
Retained (Surplus) / Deficit	**(80,731)**	**678.06**	**29,189**	**375.17**	**18,686**	**121.49**	**7,423**	**169.92**	**21,412**	**4,521**	**1344.64**	**500**
Donated Assets Adjustments									(86)		-	(86)
Peppercorn Leases Depn Adjustment									(491)		-	(491)
Adjusted Financial Performance (Surplus) / Deficit	**(80,731)**	**678.06**	**29,189**	**375.17**	**18,686**	**121.49**	**7,423**	**169.92**	**20,835**	**4,521**	**1344.64**	**(77)**

Table 4: Proposed Opening Budget 2020/21

As noted above the total value of CIP required for delivery in 2019/20 totals £3.791m including £0.1m full year effect for 2019/20 schemes. This incorporates the value of 2019/20 non-recurrent schemes. The negative CIP budget in operational and corporate directorates will be allocated to specific budget lines (i.e. reduction in budget) as and when schemes are identified.

In addition, action needs to be undertaken to address any cost pressures not addressed through budget setting, for example the premium cost associated with agency usage.

The initial value of Centrally Held Budgets (CHBs) for 2020/21 is £4,521m, all of which is recurrent. These budgets are held in two categories, specific (held for a given reason) and non-specific. Table 5 provides analysis of the CHBs in more detail.

Detail	£m
Specific	
Inflation - non pay	0.429
Inflation - pay	1.610
Total Specific	**2.039**
Non-specific	
General	0.362
Cost pressures	1.700
Contingency	0.420
Total Non-specific	**2.482**
Total Centrally Held Budgets	**4.521**

Table 5: Centrally Held Budgets 2020/21

Specific items will be devolved to the appropriate areas as and when the associated costs are incurred. We will also consider realigning NHSPS budget for 2020/21 with baseline actual cost on completion of 2019/20 assessment.

Consideration will be given to allocating non-specific items in centrally held budgets on a case by case basis following appropriate consideration and approval processes.

It should be noted that the Trust's contingency budget has been maintained at approximately 0.5% of forecast total income and totals £0.420m.

4. Capital

A 5 year capital plan was submitted to NHSE/I within the draft Plan in March 2020; the proposed schemes are shown in Table 6. 2020/21 capital plans were developed based on proposals received from budget managers and also include trust-wide schemes. The plans also include £0.428m additions resulting from implementing IFRS 16. These schemes will be managed and monitored through the Capital & Estates Group and reported to Resource and Performance Committee as appropriate.

Detail	£m
IM&T (Hardware replacement)	0.440
Backlog maintenance (Whitchurch and Bridgnorth Roofing)	0.548
Building Improvements - (Oswestry Dental and Coral House Enabling Works)	0.550
Donated equipment	0.060
Other equipment (Bridgnorth Boiler House, Ventilation System and Dental Chairs)	0.362
New building leases (IFRS 16)	0.382
New pool car leases (IFRS 16)	0.046
Gross Capital Expenditure	2.388
Donated equipment	(0.060)
Charge against CRL	2.328

Table 6: Capital Programme from the 2020/21 Draft Plan

The proposed programme included within the draft financial plan resulted in a Capital Resource Limit (CRL) requirement of £2.328m.

As in previous years, the capital programme will be entirely resourced from internally generated funds and as such there will be no borrowing requirement.

5. Further Requirements

This paper summarises the outcome of the budget setting process for 2020/21, including the proposed Capital Programme.

Further work will be undertaken to develop budgets during the first quarter of the financial year for issues such as CIP adjustments and allocation of Centrally Held Budgets in addition to any changes required as part of the contract negotiations and sign-off. All such adjustments will be made in line with the Trust's Budgetary Virement Policy.

Following approval of the opening budgets, a meeting will be held with Operational leads to share the formulation of the budgets, including clarification of assumptions and process/requirements for CIP in 2020/21, with the aim of ensuring budgets are understood and promoting ownership. To date budget managers have been updated with the budget setting requirements and they have been engaged with developing CIP plans for 2020/21. In addition, the required budget sign-off will be undertaken during May 2020.

6. Recommendation

The Committee is asked to:

- Consider that the budget presents a surplus of £0.077m in line with the draft NHSE/I plan submitted on 5 March 2020 but does not meet the financial trajectory issued to the Trust
- Recognise that further adjustments will be required to reflect agreement of healthcare contract values, identification of further CIP schemes and any agreed service developments
- Acknowledge a net Capital Programme of £2.328m is planned and is in line with the draft plan submission
- Approve the Trust's opening budget 2020/21

Appendix 1

Key Budget Movements between 2019/20 and 2020/21

Detail	2019/20 Closing Recurrent Budgets £000	Contract Changes (including tariff adjustments) £000	Cost Pressures Funded £000	Historic Incremental Drift Funded £000	Growth £000	IFRS 16 £000	Other £000	Opening Recurrent Budget £000	Opening Non-Recurrent Budget £000	Total Opening Budget 2020/21 £000
Healthcare Income	(81,302)	(408)						(81,710)	(496)	(82,206)
Other income	(1,195)	17						(1,178)		(1,177)
Total Income	**(82,496)**	**(391)**	**0**	**0**	**0**	**0**	**0**	**(82,887)**	**(496)**	**(83,383)**
Pay	53,939	(497)		35				53,477	426	53,904
Non-pay	26,195	(23)				(1,662)	0	24,510	19	24,530
Total Expenditure	**80,135**	**(520)**	**0**	**35**	**0**	**(1,662)**	**0**	**77,988**	**446**	**78,434**
CIP Reserve*	(2,869)						(822)	(3,691)		(3,691)
Centrally Held Budgets	2,986		1,700				(165)	4,521		4,521
EBITDA	**(2,244)**	**(911)**	**1,700**	**35**	**0**	**(1,662)**	**(987)**	**(4,069)**	**(50)**	**(4,119)**
Depreciation	1,675		235			2,046	0	3,956		3,956
PDC	705		(131)					574		574
Interest	(67)		(34)			190	0	89		89
Retained (Surplus) / Deficit	**69**	**(911)**	**1,770**	**35**	**0**	**574**	**(987)**	**550**	**(50)**	**500**
Donated Assets Adjustments	(69)	0	(17)			0	0	(86)		(86)
Peppercorn Leases Depreciation Adjustment						(491)	0	(491)		(491)
Adjusted Financial Performance (Surplus) / Deficit	**0**	**(911)**	**1,753**	**35**	**0**	**83**	**(987)**	**(27)**	**(50)**	**(77)**

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	11.3
	Enclosure Number:	15

Meeting:	**Trust Board**		
Title:	**Electronic Patient Record (EPR) Deployment Assurance**		
Author:	**Andrew Crookes, Head of Informatics** **Andy l'Anson, IT Programme Manager**		
Accountable Director:	**Ros Preen, Director of Finance and Strategy**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**

Purpose of the report		
To provide the Trust Board with an end of project report for the RiO EPR Project and a *'summary on a page'* document for Lessons Learned.	**Consider for Action**	✓
	Approval	
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

The report sets out the key lessons learnt from the Electronic Patient Record (EPR) project and attaches as Appendix 1 the full end of project report that was requested by the Digital Programme Group. The key lessons learnt are set out in the one page summary which follows this cover sheet.

The Appendix sets out the historical context of the Electronic Patient Record (EPR) project, describes the tender process, implementation approach and the closing stage of the project and what is being put in place to continue with the on-going support of RiO. It reviews the delivery and performance of the project against the original business cases and the Technical Specification. It also supports the dissemination of:

- Details of unfinished work, ongoing risks or potential product modifications to the Digital Programme Group charged with the future support of the project's products in their operational life.
- Issues or non-delivered objectives and benefits from the business case at the end of the programme that should become the subject of a follow-on action recommendation.
- Lessons that can be usefully applied to other projects.
- Any available useful documentation or evidence to accompany the follow-on action recommendation(s).

Key Recommendations

It is recommended that the Board;

- Accept the EPR end of project report and lesson's learned summary document.

Is this report relevant to compliance with any key standards? YES OR NO		State specific standard or BAF risk
CQC	Yes	The EPR will improve patient records in regard to responsiveness, effectiveness and safety.
DSPT	Yes	The EPR will improve data quality, data security and data accessibility, governed by legitimate access relationships/ Audit trails and alerts.
Board Assurance Framework	Yes	Risk Ref 3-2014 Optimising use of technology
Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	Progression with implementing the EPR will ensure greater security and accuracy of record keeping and safer care through the ability to share information with other parties.
Financial (revenue & capital)	Yes	Costs of resources and the impact on the contingency reserve, delay to benefits realisation
OD/Workforce	Yes	Potential increase in substantive workforce, removal of fixed term contracts. Training and development of staff.
Legal	No	N/A

RiO EPR Lesson Learned – Key Points on a Page

Leadership
- Keep a consistent Chair and Deputy
- Ensure key members attend meetings
- Create a good governance structure
- Include users and experts

Procurement
- Use the experts at Shropshire Procurement Services
- Think about Standing Financial Instructions (SFIs)
- Arrange site visits to see the product being used and talk to users
- Listen to qualified experts
- Create a formal evaluation and selection process

Requirements
- Identify what you want to achieve with the project
- Create a detailed specification with the users
- See if there is a Technical Specification on the internet to use as a starting point
- Identify the scope of the project and get it agreed to minimise ‘scope creep’

Training
- Use Face-to-face training as the main delivery
- Assess that the users have the skills to be trained in (e.g. basic IT skills)
- Create space for staff to be trained away from the workplace
- Create supporting training materials

Communications
- Communicate, Communicate, Communicate
- Make sure messages get passed down through the organisation
- Use the Communications Team to get your message across
- Use a variety of media (Email, Twitter, Newsletters)

Project Management
- Follow a structured methodology (PRINCE2)
- Create a realistic plan with stages and milestones to measure progress
- Consider starting with a ‘pilot’
- Reduce the number of meetings and documents written
- Create a cohesive team before the project starts
- Be prepared for the project to ‘shine a light’ on issues and problems unrelated to the project

Go-Live
- Create a strong support structure
- Have people on-site for the Go-Live
- Let others who are not directly involved know about the new system

Well-Being
- Projects can be stressful and demanding, look after everyone

More information? https://sharepointapp.xscpcttwpct.nhs.uk/web/EPR_Proj/eprlibrary/Forms/AllItems.aspx

Shropshire Community Health
NHS Trust

Electronic Patient Record (EPR)
End of Project Report

Version 1.0

Andy I'Anson
IT Programme Manager
2nd January 2020

Document Control

Role	Name	Date
Author / Compiler	Andy l'Anson	14/11/19
Quality Management		
Programme Director	Ros Preen	

Distribution

Role	Organisation	Location	Nr of Copies

Amendment Record

Issue Status	Version	Date	Actioned By	Description
Draft	0.1	14/11/19	Andy l'Anson	Original
Draft	0.2	09/12/19	Andy l'Anson	Amended following comments from Digital Programme Group
Draft	0.3	02/01/20	Andy l'Anson	Amended following comments from Dr K Stringer
Approved	1.0	15/01/20	Andy l'Anson	Approved by Digital Programme Board

Contents

Purpose

This report sets out the historical context of the Electronic Patient Record project, describes the tender process, implementation approach and the closing stage of the project and what is being put in place to continue with the on-going support of RiO.

It reviews the delivery and performance of the project against the original Business cases and the Technical Specification.

It also supports the dissemination of:

- Details of unfinished work, ongoing risks or potential product modifications to the Digital Programme Group charged with the future support of the project's products in their operational life.
- Issues or non-delivered objectives and benefits from the business case at the end of the programme that should become the subject of a follow-on action recommendation.
- Lessons that can be usefully applied to other projects.
- Any available useful documentation or evidence to accompany the follow-on action recommendation(s).

Historical Context

The Trust was operating 3 disparate legacy Patient Administration Systems (PAS); one for Community Services, including MIU's at the Community Hospitals; this was the iPM product from CSC supplied under the National Programme for IT (NPfIT). As well as not meeting the Trusts requirements as an EPR (it did not have the functionality e.g. cannot support mobile disconnected working) the contract was coming to an end July 2016; CSC chose not to enter into the tendering process for the replacement system.

The Trust also used a GraphNet system for the CAMHS service; this was also at the end of its lifecycle and would require a migration to the next generation product in order to deliver the Trusts requirements; GraphNet also chose not to tender for the replacement system.

The third PAS system being used is still operated by the local acute trust, Shrewsbury and Telford Hospitals; this is the SEMA Helix product, which was primarily used for inpatient management at the Community Hospitals; along with Dental services theatre management. It had the same constraints in functionality that iPM possessed in that it is clearly an Acute PAS, and did not possess the functionality required of an EPR for a Community Trust.

None of the systems integrated with each other or with other systems within the Local Health Economy and they all lacked some significant functionality that was required for the Trust to achieve both its transformational working objectives and the wider NHS objectives with regard to digital working.

To continue with the existing systems would incur additional costs in the region of £700K over 5 years; without any of the transformational benefits and with no progress on the wider NHS digital working aspirations.

Unlike the existing systems the proposed EPR would cover the majority of services that the Trust supplies with a single clinical record, which would span all of the health care professions regardless of their location.

The main drivers for implementation of the EPR within the Trust were as follows: -

- The urgent need to replace the iPM PAS system. The system would be withdrawn from use from the supplier's services in July 2016
- The requirement to integrate / interwork with other partners in the local health economy
- The need to transform the way our staff work; by providing a system that fully supported mobile disconnected working
- The opportunity to plot a clearer, phased and quicker pathway for delivering the Trust's ambition of a single service user index and electronic records system – thus providing for clinicians:

- A single, secure collection point and repository for clinical information regarding service users
- A single source of key clinical information that would be available 24/7 from all the Trust's operating bases – including mobile working
- A system that would be able to better support the clinical and risk management of service users who often have complex conditions, multiple records and engage with different parts of the service
- The basis for more consistent multi-agency and collaborative working to support service users
- More reliable and up to date clinical performance information
- Clear migration pathways for all legacy systems – including those presently in use in specialist service areas e.g. Child and Adolescent Mental Health Services (CAMHS)

Programme Manager's Report

This section of the report summarises the key points of the report as a whole. More detailed descriptions around the project can be found in the following sections.

This project was delivered, on time, to an agreed plan approved by the Resource and Performance Committee. The project has overachieved in many areas and delivered outside of the original scope of the business case in many ways, more staff have been trained on the system, more functionality has been rolled out to staff and more equipment has been issued to increase the ability of staff to work away from base to access and capture clinical information at the point of care.

93% of the original business case objectives have been fully or partially achieved. Where objectives have been identified as either 'partial' or 'not met'; these are predominantly around interfacing with third party systems or electronic messaging. A number of projects are underway to work in these objectives over the next 12 months.

The original business case identified 36 services using iPM (Lorenzo) and SEMA that needed to be moved onto RiO. As of November 2019, RiO had been rolled out to 43 Services across Shropshire and Telford and Wrekin. Some of these are extra or new services which were not identified at the beginning of the project. RiO has been put in to a number of services as 'Read-Only' to give clinicians access to the patients record. This is an overachievement of the original business case.

The project has delivered into all of the functional areas identified as part of the business case and Technical Specification. Additional functionality such as 'Riverview' and 'Summary Care Record (SCR) 1-Click Viewer' has meant that the functional areas have exceeded the original specification.

During the tender Servelec had responded with a high level of compliancy to the Technical Specifications (>99%); subsequently there have been areas that have proved to either be weak or missing. When challenged, workarounds or fixes have been provided. There have been instances where a difference of opinion of what the specification means and whether the product complies with the specification has led to either party having to accept the others definition of compliancy.

The procurement was supported by Shropshire Procurement Services and run under Open Journal of the European Union (OJEU) rules. This was the first time that the team had run a tender under OJEU; this provided to be lengthy but structured giving assurance to all parties and the Trust that the right governance and diligence, which was transparent, had been applied to the tender process.

The project was implemented under the established PRINCE2 methodology; this has been used for all IT Projects managed by the Informatics Division, it follows a structured approach

to the delivery of projects. This coupled with a strong governance structure led to the successful implementation of the project.

Review of Business Case Objectives & Benefits

The original business case and tender documents specified in detail what the Trust was expecting from a supplier and their application from a functional and technical specification perspective. The Technical Specification and associated documents are available in appendix A. The original business case objectives and benefits are given below (table 2), a summary of meeting the objectives are shown in table 1 below

Initiation Requirements	Summary	Evaluation
Fully Achieved	24	Delivery – 80% of Requirements
Partially Achieved	4	13%
Not Met	2	7%

Table 1

The main themes where requirements have either being 'partially' or 'not met' are data integration with other systems and electronic messaging of discharge summaries and notes. Both of these themes are scheduled to be implemented in the next 18 months. Integration will be a technical piece of work to connect to multiple systems across the STP/System; this is an initiative which has an established work stream working towards a system-wide Integrated Care Record for completion in 2020/21. RiO can connect to single systems directly but to connect to multiple systems additional technology needs to be deployed to manage and queue the messaging to ensure the right data gets to the right place and that the data is in a format that the receiving system can accept.

The transfer of discharge summaries requires an additional module (MESH) putting into RiO. This module has been approved and is waiting to be included in the schedule of work. It is scheduled to be implemented by end of March 2020.

Detailed action requirements are listed in the tables below.

Objective	Delivered	Actions
To replace three separate PASs with a single modern EPR, with the consequent reduction in duplication and risk reduction that can occur when records transfer across systems	Full	None
To provide a modern sustainable and well supported technical platform for a single integrated EPR, utilising current generation technologies that are provided by a well-established clinical systems supplier, that has a proven track record in systems delivery and ongoing support	Full	None
To provide opportunities to simplify, standardise and improve existing clinical processes leading to improved patient experience and patient care, through analysing current processes and deploying "LEAN" methodologies in the process mapping and design phase, the patient/client pathway can be optimised	Full	None
To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record	Partial	This needs partner organisations to be able to communicate with RiO and is part of an STP work stream. RiO can message out to individual systems but the complexity of messaging to numerous systems requires a Trust Integration Engine (TIE) to translate and manage messaging for smoother running and long-term cost benefit. This will be picked up as part of the STP work stream.
To improve bed and clinic management trust wide through using one co-ordinated bed and clinic management system, this will allow the trust to have an over-arching view of these resources and their availability, and will promote and enable effective resource planning including : • Better bed management from better predictability of bed availability • Bed Occupancy is visible across all sites • Delayed Discharges can be more effectively reported • Delayed Admissions can be more effectively reported • All services are visible and this promotes effective transfers between services	Full	None

To provide a modern user interface for users, by deploying a current generation product the end user will no longer be required to navigate around a system(s) that were designed over a decade ago, before technologies like “touch screen navigation” were the norm	Full	None
To become “paper-light”; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times	Full	None
To improve information and performance management support by ensuring that the vast majority of the Trusts patient level information is derived from the EPR as part of the day to day processes of the Trust, and not as an additional burden on staff to collect administrative data	Full	None
To improve efficiency by enabling mobile working for the clinical teams providing mobile disconnected access to the relevant caseload information that they need, when they need it, including the ability to manage “unplanned” visits	Full	None
To enable patients access to an electronic version of their records through utilising a “portal” approach; this element will be implemented in line with national requirements for patients access to their records	Not Met	This functionality is available in RiO 20.1. SCHT is scheduled for implementation of RiO 20.1 in Oct./Nov. 2020.
To reduce clinical risk by consolidating the patient index and systems from 3 separate PAS systems to one, the implementation of the single EPR will remove this existing risk, and in so doing will remove the administrative overhead that is associated with this maintenance activity	Full	None
To manage the clinical risks from incorrect record retrieval, the single EPR removes this risk as there is only one record for each patient/client	Full	It is possible for duplicate records to be created through not tracing with the national SPINE. This is not a system issue but a user action. The application reduces duplicate records.

To enable faster record retrieval and fewer incidents of duplicate records being set-up, the single EPR virtually eliminates the risk around duplicate records and being a digital record the speed of caseload retrieval is almost instantaneous	Full	None
The provide the ability to access a complete record of episodes across all sites from a single system (instead of 3 separate PAS systems) and there are no limitations as to the locations that the record can be concurrently viewed from, whether home, clinic or hospital	Full	None
To improve activity recording across services by uniformly capturing the clinical and administrative data in one record that covers the majority of the services that the Trust provides	Full	None
To enable complete and comprehensive recording of referrals for inpatient, outpatient, community and therapy services in one record, which will reduce the amount of time that is spent trying to understand the pathways that exist for our services, and will ensure that we can provide a complete picture of the services that we provide both internally and to our Commissioners	Full	None
To provide efficient Waiting Time and Waiting List Management, there will be a reduction in the time spent waiting for appointment/service provision due to the ability to streamline administrative procedures and operate internal transfers more efficiently	Full	None
To provide more efficient admission (from other Inpatient/Outpatient facilities, Other Community Services, or GPs) due to the electronic exchange of more complete and standardised data, coupled with the ability to plan across all locations. The transmission of the required information electronically from system to system will generate efficiencies by removing the existing manual processes	Not Met	Integration with partner organisations being picked up under an STP work stream. Integration into a Local Health Economy (STP/ICS wide) Integrated Care Record is planned for 2020/21. It is important to understand that some of the limitations will be partner organisation not being able to receive messages.

To deliver enhanced internal information flows and improve Delayed Discharge Management between Trust Services, as the EPR is a single record which is viewable and accessible across all the Trust services, and can link to partner organisations, this will reduce the time that is currently taken to pass information around the various systems and will result in speedier decision making	Full	None
To enable faster discharge through more effective and efficient production and transmission of discharge letters which will be transmitted electronically to the majority of recipient organisations, and all GPs, this will include current information on medication which will reduce the risks associated with this type of information being missed or being incomplete	Partial	This has been partially met; discharge documents and letters are generated through RiO. The transmission is restricted to email until a Message Exchange for Social Care and Health (MESH) service is set up in RiO to automate the process. This is scheduled to be completed by March 2020.
To improve information flows (to Commissioners, GPs, and Service Users) about discharge dates and associated information which may be required to ensure a smooth transition along the care pathway	Full	None
To deliver more efficient transfers (to other Inpatient/Outpatient facilities, to Other Community services, to Social Care or to GPs) due to the exchange of a more complete and standard data set coupled with the ability to plan across all locations. The transmission of the required information electronically from system to system will generate efficiencies by removing the existing manual processes	Partial	Documents are created through RiO and forwarded by secure email. This is tied into both the STP/ICS work stream and the MESH service. Scheduled to be completed in 2020/21
To improve NHS Number coverage as a result of the single record being utilised across the Trust, it is simpler and more efficient to operate data quality reviews across a single index, rather than across multiple ones	Full	None
To enable clinical coding in Outpatients and other areas by moving to an EPR that supports the latest clinical coding requirements, including the comprehensive recording of both inpatient and outpatient diagnosis, and procedures	Full	None

To ensure the continued accuracy of the Trusts recording of waiting lists for inpatient, outpatient and therapy services, which will be enhanced by operating a single EPR solution; where the processes and associated rules can be readily disseminated across the Trust	Full	None
To provide complete and comprehensive recording of clinical activity for inpatient, outpatient and therapy services, which will be significantly enhanced by utilising standard approaches to data capture, which will be developed and designed around the clinical service delivery rather than as an administrative add-on	Full	None
To promote the highest standards of patient care and best practice by introducing standard processes for data recording across the trust, built upon current best practice and utilising "LEAN" methodologies to ensure the maximum efficiencies are gained; whilst ensuring the greatest benefit for our patients, with no compromise on safety and caring	Partial	On-going transformation work will implement best practice to Services. This is due to the changing environment and practice and full transformative work could not be completed due to the pressure of the implementation timetable.
To ensure that the Trust maintains Clinical Negligence Scheme for Trusts (CNST) compliance	Full	None
To support the implementation of Service Line Reporting (SLR) and Patient Level Information and Costing Systems (PLICS) which will in turn enable a greater understanding of the costs vs income relationships within and between the services we provide	Partial	Waiting for a suitable finance solution to receive the data from RiO. RiO is able to output the data required.
To deliver more effective clinical assessment through the availability of a single service user record with more complete information on previous and existing episodes, allowing multi-disciplinary reviews to take place concurrently from a variety of physical locations. For instance; a patient record can be accessed and viewed from a GP Practice, Community Clinic and Social Worker base concurrently, rather than the staff having to co-locate to discuss the issue whilst reviewing the case notes	Full	None

Table 2

Review of Procurement Process

The procurement process was supported by Shropshire Procurement Services and where applicable Mills and Reeves Solicitors. The procurement process was run under the Open Journal of the European Union (OJEU) rules and opened the tender to all potential suppliers within the European Union. Through the tender process a shortlist of three suppliers was agreed. Those supplies were invited to complete the Invitation to Submit Final Tender (ITSFT).

The procurement process was run as a clear and transparent process which has stood up to audit and scrutiny. The contract was awarded to Servelec for their product RiO. A copy of the ITSFT is available in appendix B. The Pre-Qualification Questionnaire and Tender response documents contain commercially confidential information and are available through the Informatics Department. The procurement process followed a structured approach. The steps taken were:

Steps

- Issue Tender
- Pre-Qualification Questionnaire
- Notification of successful and unsuccessful Candidates following evaluation of the Responses
- Issue Invitation to participate in the Dialogue
- The Dialogue Phase
- Issue *' Invitation to Submit Final Tender'* (ITSFT) following the closure of the Dialogue Stage
- Receive final Tenders
- Supplier Presentations and Authority Q&A Session
- Project report of Authority with recommendations to board meeting
- Appointment of preferred bidder
- Standstill Period
- Contract commencement

The evaluation method is full described within the ITSFT under Annex 4 (Appendix B)

The products and suppliers were evaluated by a group selected from across the Trust. The Evaluation Panel consisted of:

Evaluation Panel

- Associate Medical Director
- Project Team Chair/Senior Clinical User
- Senior Clinical User x 2
- Senior Management Accountant
- Head of Informatics
- IT Programme Manager
- Shropshire Healthcare Procurement Service (Advisory)

  The contract was awarded on weighted criteria (Technical and Quality 60% and Cost 40%) to ensure that the tender was not won on cost alone. Following the evaluation the decision to award was presented to Project Team, Project Board and through to Resource and Performance Committee and Trust Board for approval.

  The procurement process was lengthy and unfamiliar for the project team but necessary and well supported by Shropshire Procurement Services. It gave a clear and transparent process which ensured consistency in approach and stands up to audit and scrutiny.

Review of Governance

Throughout the lifespan of the project strong governance has been put in place following the PRINCE2 methodology. The use of this methodology has been embedded in the Trust and its predecessor organisation for IT projects for over 15 years. This provides a structured approach for implementation, monitoring and delivery of products. All key members of Project Team are PRINCE2 qualified. The structure of the project is shown in fig.1. The Project Board and Team were established before the procurement process started and we involved in the procurement, selection and delivery of the Project. This has given an end-to-end view of the project.

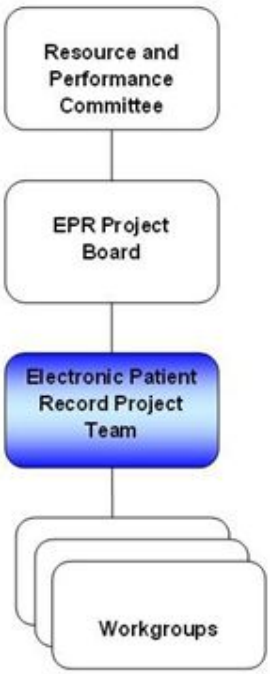


Fig 1 – Governance Structure

The structure shows the reporting to Trust Board level. This was supported by a formal risk and issue approach, and escalation through exception reporting to monitor the project keeping on track. The EPR Project Board met regularly each month. Where necessary, issues and requests for approval were passed to the Resource and Performance Committee for advice or decision.

Project Board

The Project Board consisted of:

- Director of Finance
- Director of Operations and Nursing
- Head of Informatics
- IT Programme Manager
- Associate Medical Director
- SDG Manager TeMS and Outpatients
- Business Administration Manager
- Head of Health and Social Care Systems (Midlands Partnership Foundation Trust)
- Senior Management Accountant
- Deputy Director of Nursing and Quality

The purpose of the Project Board was to:

Oversee the plans, processes and associated documents that are necessary for the Trust to:

- Provide Trust healthcare professionals with 24/7 access to “real time” electronic health records and access to clinical guidelines and knowledge bases at the point of care through the adoption of an Electronic Patient Record and associated clinical systems.
- Support processes that allow integration of services with external agencies (e.g. Social Care) and new ways of working (e.g. telehealth; telecare) as appropriate within the project.
- Ensure the technology and systems deployed support the delivery and achievement of objectives as set out in the Trust business plans, and that the benefits realisation are delivered.
- Ensure the technical infrastructure is sufficient and robust to support the project; including assurance that appropriate risk management and disaster recovery solutions are in place.
- Ensure that the Information Governance elements of the project meet the requirements of the Trust.
- Ensure that legacy issues are brought forward from previous services and that successful migration and resolution is achieved.

The structure of the Project Board was to give a ‘360 degree’ view of the project and have subject experts from all areas of the project to give challenge to the representatives from the Project Team. Monthly reports were presented to the Project Board from the Programme Manager, Finance Representative and the Head of Informatics. Progress was measured against an agreed project plan that had been accepted by the Resource and Performance Committee. Variations to the project plan were raised by a monthly exception report. This exception report was enhanced and included with a cover to the Resource and Performance Committee. During the early stages of the project there were a number of changes in the Executive Team which impacted in the delivery of the project due to changes in focus.

Where there was an unplanned variance to the project plan and schedule; the Trust’s recovery plan process and reports were used to monitor progress and bring that aspect ‘back on track’.

The Project Team managed the day-to-day implementation of the project and also delegated tasks to a number of work streams.

Project Team

The Project Team consisted of:

- Head of Informatics
- IT Programme Manager
- Principal Analyst
- Associate Medical Director & Sessional GP
- Clinical Lead MIU & DAART
- EPR Project Support Officer
- Information Technician
- Head of Management Accounting
- Head of Nursing & Quality – Adult SDG
- Records Manager and Quality Facilitator
- Business Administration Manager
- Senior Information Analyst
- HR Manager

- Head of Social Care and Health Systems - MPFT
- IG Manager
- SDG Manager for TeMS and Outpatients

Attendance at the Project Team was challenging at times with a low representation from the Operations Directorate, especially the management tier. This had to be escalated on a number of occasions. This gave to the impression that the project was an IT project as opposed to an operational and transformational project for the Trust as a whole.

The Project Team was responsible for the day-to-day delivery of the project. Engaging with services and following a structured approach to the delivery of the timeline. The Project Team had a number of work streams completing tasks and reporting back to the project team. These work streams evolved over time with some combining and some ceasing once the need for them had gone.

Training Work Stream

The project was supported by a training team whose role included business process mapping in both the 'As-Is' and 'To-Be' states and then to develop and deliver training to users. In addition to RiO specific training there was a 'Training Needs Analysis' completed which identified whether anyone needed basic IT training to bring them up to a level of competency before using RiO.

IT Work Stream - Additional Equipment and Infrastructure

Additional Equipment

From the outset of the project it was a goal to create a mobile workforce with the ability to provide an EPR at the point of care, including the patient's home. RiO was chosen, in part, for its ability to work live where a signal/connection exists or to use mobile disconnected software (Store and Forward) where staff download their caseload for the day and then upload and synchronise with the 'live' RiO system when a signal came available. To facilitate this functionality the Trust bought and rolled out 1050 laptop computers and enhanced the office based provision by deploying 650 docking stations and additional pieces of equipment such as scanners.

A robust evaluation of equipment took place, this included 'consumer panels', where the options for equipment being evaluated was shown to staff and their feedback was taken into account.

Infrastructure

It was identified that the Trust should have a sufficient and robust infrastructure to run RiO over. Connectivity was key to the success of the project at the same time the NHS N3 contract was being wound down with Trusts expected to replace the existing N3 links with their own alternatives under Health and Social Care Network (HSCN). Subject to locality and mobility, various connectivity technologies would be needed for RiO; these include wired connection, wireless, 3G and secure connection across various partner sites. Where possible hardware has had to be configured to auto-select the most appropriate connectivity medium where multiple options are available.

At times Services have resorted to using paper based systems while this links have been upgraded. A number of links were upgraded before the HSCN contract was signed to support the roll-out of RiO. At some sites there are still problems with capacity of the external link, this is being addressed through the HSCN replacement.

On the whole connectivity, especially at permanent base has been good. Problems have been encountered through:

- Some Existing links have not been big enough to cope with the increased traffic with the use of RiO.

- The order and automatic selecting of which connectivity medium was difficult in the early part of the roll-out.
- On-going problems exist through the geography and 3G mobile network signal across the county.
- The process for using a laptop and synchronising with Store and Forward can be confusing and time consuming for staff.

Data Management Work Stream (Inc. Information Governance, Configuration and Smartcard)

The roles and duties of the Data Management Work Stream were:

General

- Contribute and align to the overall project plan
- Link with services as appropriate e.g Clinical Transformation Group
- Deliver and monitor the workgroups activity aligned to the critical path
- Be the point of contact for any work stream related queries.
- Ensure appropriate sign off in accordance with the project governance arrangements
- Identify any data cleansing tasks to support the work stream
- Identify any other stakeholders that may need to be engaged with this work stream

Information Governance

- Ensure that the information governance principles are applied across the work stream;
- Provide advice and guidance;
- Understand the information governance principles within the RiO system;
- Assist with identifying data sharing requirements;
- Assist with developing data sharing agreements where required;
- Identify any confidentiality issues/risks;
- Develop a Privacy Officer process in accordance with the RiO System
- All of the above in accordance with Trust and national guidance and policies

System Access (Smartcards)

- Review existing ESR job roles, staff groups, service access requirements and relationships with other services;
- Understand the Process Mapping “to be state” for each service;
- Using the Servelec Guidance on Configuration and Menu Templates develop a set of Position Based Access Controls (PBAC) that are fit for purpose;
- Understand the principles of setting up Users in System Admin;
- Understand the relationship between the RA Team and the System Admin Team;
- In conjunction with appropriate nominated leads for the project define the access requirements;
- All of the above in accordance with the national and Trust operational guidance

Data Migration

- Review data migration specification and liaise with Servelec for any areas outside of the data migration specification scope;
- Understand the system environment and processes for loading data;
- To understand the data migration user tool;

- In conjunction with appropriate nominated leads for the project define the migration criteria and validation cycles leading up to service go-live;
- Plan the go-live validation elements;

System Admin

- Understand the principles of system administration in RiO;
- Work with the RA Team to configure and apply system admin to ensure appropriate access for Users;
- In conjunction with the appropriate nominated leads for the project define/approve information relating to clinicians, their teams and work locations. This will include data validation and must link to data migration for consistent mapping;
- To understand the boundaries between system configuration and system admin;

System Configuration

- Understand the configuration principles in RiO;
- Link with clinical leads and services from the project to define areas for configuration, including forms and letter templates;
- Contribute to development of a process control system for post go-live so that developments are approved by a panel and scheduled accordingly;

ESR Reporting

- To link with the data migration process and provide datasets covering clinicians, their job titles and work bases;
- To link with the system access process to ensure that the PBAC arrangements are maintained;
- Identify a set of ESR datasets that can be used to produce reports for the project team members.
- To agree the format of the report and provide reports to the project team as requested;
- To be aware of any changes in ESR that may impact other elements of the work stream

Relationships with other Work streams

- Approval and sign-off will be sought through the Project Team in alignment to the go-live dates.
- The configuration of forms and letters are conducted with a standardised approach.
- This work stream to link in with the appropriate clinical work streams to gain instruction on what standardised forms and letters are to be implemented for go-live;
- Seek support and advice from other experts and work streams e.g. Records Management and Servelec;

The Data Migration Work Stream consisted of a number of complimentary functions which met monthly and performed the main data and configuration tasks for the project. Closer working and regular meetings allowed the teams to react quicker to issues and challenges. The bringing together of the various functions enabled a number of potential large issues to be avoided before the issue occurred. This closer working has carried through into the new RiO Support Team and the linkages with those other functions.

Clinical Transformation Work Stream

The roles and duties of the Clinical Transformation Work Stream were:

- Maintain the clinical transformation work stream within the project plan
- Oversee the phasing of the tasks with services and clinical leads
- Standardise and rationalise the input (including all picklists) where possible to the project team for the system build
- Standardise and rationalise the documents and system configuration
- Leverage the clinical business and cultural change where necessary at a local level
- Be the point of contact for any project related clinical queries.
- To ensure successful, safe and effective implementation and realisation of associated benefits and escalate any risks or issues to the Clinical Assurance and Records Management Workgroup
- The group to provide representation, through attendance of a core member or deputy and/or through written feedback to minutes/action logs to each of the EPR team subgroups
- To ensure clinical feasibility of decisions taken and proposed actions

The Clinical Transformation Workgroup met every two weeks and looked at how RiO could be used in a transformative way. The group was also responsible for quality assuring any forms or letters produced by the RiO Delivery Team and making sure that they were clinically safe. As the project progressed and the volume of letters and forms increased, the group struggled in completing the transformative work. This coupled with the speed and complexity of the implementation plan resulted in the group being unable to deal with the transformative work. This and other factors led to the roll-out reducing in scope. Going forward the group will continue and start to work on the transformative work with the RiO Support Team.

Clinical Assurance Work Stream

The roles and duties of the Clinical Transformation Work Stream were:

- To provide assurance that clinical information and processes submitted by the Clinical Transformation Subgroup meet the Regulatory Standards required for clinical performance, Professional Practice and Clinical Records Management
- To provide assurance that standardised and rationalised documents including pick lists are appropriate, do not compromise patient safety and meet national data set requirements
- To provide assurance that the system testing, data migration and processes are not onerous on clinical staff, and are clinically feasible and to provide authorisation that the system testing results are within acceptable limits
- To ensure any legacy records are archived as stipulated by the Code of Practice for Health & Social Care (Retention Schedule)
- To be the point of contact for clinical assurance queries relating to the RiO Product
- To escalate any identified risks and issues to the Project Board, or where appropriate, to the Director of Nursing and Operations or Medical Director in their roles as Clinical Safety Officers
- To work closely with Services to review clinical performance, developing audit and monitoring mechanisms for key performance measures for clinical quality, patient safety in relation to Rio
- To highlight issues and concerns in respect of clinical services (if appropriate) to Service Delivery Group Quality & Safety Groups and Performance Groups

The Clinical Assurance Work Stream met every four weeks and ad-hoc meetings were scheduled when necessary. The main purpose of the meeting was to approve services going live onto RiO. This was a three-way conversation between the Service, the Clinical Assurance chair and the Project Team to ensure that a checklist had been completed and

the Service was ready to go live. The agreed forms were signed off by the Medical Director and the Director of Nursing.

The number of Services being put through the process and external factors meant that on occasion Services were not ready for approval in line with the schedule and ad-hoc meetings had to be convened.

Implementation

The original scope of the project was to deliver RiO into 36 Services. The project implemented RiO into 43 services. A comparison is listed in the table below.

The project was split into 4 Phases:

- Phase 1 - MIU and Podiatry
- Phase 2 - Children's Services EPR
- Phase 3 - Community Services
- Phase 4 - Community Hospitals
    - Community Hospitals Go-Live 'Limited Access - 'Read-Only'
    - Community Hospitals Go-Live – Out-Patients
    - Community Hospitals Go Live – In-Patients – PAS

The Phases were allocated an equal amount of time against the closing date for iPM/Lorenzo on a rolling programme. As the programme went forward it was found that the restriction in timescales and available resources meant that additional resource needed to be brought into the project from partner NHS organisations (MPFT) and external company. This coincided with the Programme Manager being long-term sick leave.

The quality of the work completed by the external company was, in places, poor and has had to be reworked when the quality of the work has come to notice through maintenance or enhancement.

In trying to achieve the milestones set by the project plan a number of contingencies needed to be used. These included not completing letters and some clinical forms for Phase 2 and providing e-Learning as an alternative to classroom based or face-to-face training. Subsequent feedback from the services describes the training as ‘poor’ and ‘inadequate’.

As the project progressed it was not anticipated the level of support that was needed for existing users and the training, project management and configuration support was needed to be split across both Business as Usual and implementation functions. This impact was reduced by the method of deployment and the time constraints that were present.

The acceptance of the EPR by users following the same pattern as the deployment of iPM Lorenzo, which maps to the Innovation Adoption curve where the majority of staff have now adopted the system and state that they are seeing real benefits from the system.

With IT Systems roll-out there is usually a period for the Project Implementation Team to be exposed and trained on the application with a subsequent period of getting used to the product before engaging with the services and implementing the application. Due to the time constraints due to the de-supporting of iPM Lorenzo, this period was not as long as it should have been. This, coupled with the complexity and flexibility of RiO, meant that the Services in Phases 1 and 3 did not have the same level of knowledge as subsequent Phases. This has caused some restriction in the functionality within RiO that they use and has meant a revisit to those services both ad-hoc and planned remodelling. This has caused extra work.

The tight timescales and the need to deliver PAS functionality to replace iPM made the project team deliver the product as a direct replacement to the functionality that was in iPM with limited Clinical forms. This has resulted in a lack of transformational work. The Project Team is now more knowledgeable in the use RiO and will be revisiting all services and do the transformational work.

Throughout the implementation the project team came up against parts of the application which did not work as expected; this was aggravated by the fact that some of the documentation, from Servelec, was inadequate or incorrect. In addition' the support from Servelec was inconsistent and often lacking. Servelec have since been taken over by a private equity firm and have implemented a quality enhancement programme. This has been going for 18 months and as customers we are seeing a noticeable improvement in the quality of product and the support given by Servelec.

As the project has progressed; the Trust has had changes to reporting requirements both locally and nationally, this has meant the team having to fit in new functionality into the programme such as ECDS and MESH. This has caused additional pressure on the team. In addition as the product has developed and we have realised that some functionality s enhanced or know bugs are fixed in future releases we have been pushed down the route of taking upgrades to resolve some of the quality issues of the product.

One of RiO's strengths is that it is highly configurable; the downside to this is that it needs more support and time to configure and needs user input to get the maximum benefit from it.

One of the main aims for the project was to equip community staff with equipment to enable mobile working. 1050 Number of laptops have been rolled out to Community Staff, taking into account replacement computers, this represents an overall increase of approximately 25% of devices across the Trust that need support. The nature of mobile working increases the reliance on those devices and the need for a responsive support should it be needed. This has increased the workload within the IT Department; this has been mitigated, in part, by the increased use of BOMGAR a remote access support tool, and the use of BOMGAR has been expanded into the RiO Training and Configuration teams giving RiO users direct on-screen help.

Each laptop has a mobile phone SIM to enable the connection to RiO; this has increased the mobile phone support requirement in line with the number of SIMs issued.

The increase of devices has come at the same time as the migration of the main IT links between sites from BT N3 to HSCN network. This was unavoidable but has caused issues as the older N3 links can struggle with capacity especially with changes from Microsoft in update approach technology and the requirements of NHS Digital to deliver those updates in a timely manner. The links have been managed and the bandwidth maximised for RiO users; there is a rolling programme to update the majority of links.

Project Management

Project Management was applied through the PRINCE2 methodology. Having successfully implemented a number of IT Projects, the IT Programme Manager was identified as the project management lead at the start of the process to replace iPM/Lorenzo. In addition a Programme Manager from another Trust was co-opted into the role of 'critical friend' to give an additional layer of assurance to the Trust. Following the procurement award the IT Programme Manager had a period of long term sickness absence. The Project employed a firm of IT consultants/developers to help with the development of forms and letters to keep up with the pace of delivery for the project. The director of the firm took over the role of Programme Manager and managed the project. Sometime later he became unwell due to stress and was unable to continue with the role. The 'critical friend' took up the role of Programme Manager in addition to his other commitments. Later he also had to have time away from the role and the original IT Programme Manager took up his original role after returning from sick leave.

RiO Support Team

The implementation team were recruited as a new team from the outset of the project on fixed term contracts. These posts were made substantive after the initial contract term expired and it became apparent that going forward there would be a need to have a team

that could deal with upgrades, training of new starters, new services and on-going support and reconfiguration tasks. The Team has been brought together and located in the same office offering support for RiO as part of a helpdesk function.

Outsourced work

As the project progressed it became apparent that the workload exceeded the in-house resources to keep up the pace of the project. SSSFT had used a company of consultants to do some development work and this company was recommended to the Trust. The company were employed to perform Business Process Mapping, create clinical forms and letters. As the number of letters and forms increased the quality started to drop requiring a considerable reworking to the point where at the end of a packet of work the company were 'let go'.

'Scope Creep' - Additional Services, Upgrades and Dataset Changes

During the project lifecycle a number of additional services and work was introduced; this was through:

- External factors such as changes for data requirements from Commissioners or NHS Information Standards Notices (ISN) changes
- New services being introduced often at short notice
- Operational reconfiguration
- Contract review/revision
- Need to upgrade the core RiO system for 'bug' fixing or new additional functionality.

These additional services, upgrades and data set changes were:

- Rio 7.8 Upgrade
- School Nursing – Immunisations and Vaccinations Service
- Emergency Care Data Set (ECDS)
- MESH – Electronic Discharge Summaries
- Wound Healing
- Care Home MDTs
- Independent Assessors
- DAART Intra. Antibiotics – configured, awaiting clarification on some processes. Manual reporting in place.
- MESH – Electronic Discharge Summaries (see below)
- SQL2016 Upgrade

Each of these had to be factored into the project timeline and prioritised according to clinical and operational need. This impacted on the RiO Team and its ability to deliver more transformative solutions.

Upgrade to v7.8

During the course of the project it became apparent that the Trust would also have to upgrade to a newer version. This would reduce the number of known bugs found in the original deployed software and introduce additional essential functionality for Services. Typically the upgrade process is an 8 week programme, with the exception of go-live week services were planned to go live around this. There was an intensive testing period where the application was put through various test scenarios. At the same time Store and Forward needed to be upgraded in line with the main RiO application. Testing went well and the go-live date was set. On upgrade evening serious issues were found with the Store and Forward application on a number of machines. This required fault finding with Servelec as there appeared to be no consistent pattern to the error. It was later found that in some circumstances Store and Forward did not install the new version correctly due to a legacy configuration file. This caused days of unreliability to Services and resulted in some Services stopping using Store and Forward. In addition there was an issue with how the

Internet Explorer cache saved information this caused the main application to fail to work in the clinics module for some computers. This was identified and fixed.

Review of Product and Supplier Performance

Initially the experience with the Supplier was poor with a number of issues around quality of the product and the delivery. There was a perception around the commercial focus of the company and a reluctance to be on-site during the project implementation with a 'hands-off' approach. After Phase 1, the RiO implementation team were responsible for the delivery of the project. During the roll-out of the project continuing issues with the application caused frustration and delay; any upgrades resulted in excessive disruption to the organisation and often problem resolution was protracted.

During Phase 4 the supplier was acquired by a new owner, the ethos has changed completely and there is more focus on partnership collaborative working. This can be seen rippling through the organisation with a notable increase in engagement and quality of the product.

Review of Communications

The project was aware of the need for good communication throughout the lifecycle and ensured that the Communications Team were part of the initial roll-out. As the project progressed the role of the Communications Team grew less as the Project Team took over the Communications messages unless there was a need to take advice on format and message.

RiO update documents were sent out regularly each week explaining progress and highlighting any issues that were being found during the project. These usually referred users to supporting documents via a link. Urgent messages were shared by email. Where appropriate; information was shared through Inform and the Staff noticeboard.

As the project progressed the updates and emails were not being read by users. Alternatives were used such as messages in the corner of computer screens and messages left on the IT Service Desk. These have had limited affect.

Review of Risks and Issues

The project followed an established approach under the PRINCE2 methodology; Risks and Issues were captured on a Risk and Issues register which was reviewed at Project Team and Project Board. Where there was a significant potential impact those risks were escalated onto the Trust Risk Register. The Risks and issues process has been established for all major projects and performed well.

A number of risks have been closed due the closure of the project. Remaining Risks and Issues are captured on the 'Work-Off' plan and allocated to successor groups for resolution (Appendix C).

Lessons Learned

Throughout the project lesson learned have been captured in documents and referred to in subsequent phases. These documents are available in Appendix D. The overall themes of the lessons learned are:

- Communicating to staff about changes are the key to the success of the project
- How to access support to staff is essential at go-live
- User Acceptance Testing (UAT) ids essential during the testing of the system

- Supplier relationship and account management – new skills that have had to be learnt
- Staff need more support than first thought
- The scope was identified at the beginning of the project; this helped to minimise the 'creep' and easier to manage when additional elements appeared.
- Issues/problems were uncovered that were not part of the project; they already existed and the project brought them to light.

Transition to Business as Usual

The transition to business as Usual has been different to other IT Projects; the phased approach to delivery has meant that services from previous phases were live while subsequent phases were going through the process. This had two main consequences:

1) The RiO Implementation Team quickly had to broaden their remit; supporting and implementing the system
2) Latter phases benefitted from the knowledge gained from the previous phases.
3) The know ledge gained caused the implementation team to revisit some of the previous teams to lever the benefits that had been identified in later roll-outs.

The iterative nature of the roll-out increased the support pressure on the RiO Team.

As the project has come to an end, the RiO Support Team gradually moved into business as usual. In closing down the project any 'loose ends' were looked at and a work off plan and document was approved. A copy of the document is available in appendix E.

NHS Improvement Post-Project Evaluations

In line with the actions from EPR Project Board an initial Post-Project Evaluations (PPE) is to be made 6 to 12 months after the scheme completion. The PPE should include reference to any conditions or actions required as part of the approval of the business case. The NHS TDA should be provided with these evaluations at the relevant time. This will be monitored by the Digital Programme Group with a further PPE review to be completed two years later to assess the long-term outcome.

Review of Financial Performance

Our Full Business Case included a capital sum of £1,400k for design, build and implementation of the EPR system including Electronic Prescribing & Medicines Administration (EPMA). A further £1,892k was included to cover non recurrent (£925k) and recurrent (£968k) spend over the life of the project.

Additional funding was also approved internally by the EPR Project Board and Capital & Estates Group. The capital sum approved was £1,627k for additional RiO modules and mobile devices. The additional modules were necessary to provide additional functionally to enhance the effectiveness of patient management and to meet Department of Health mandatory requirements around e-referrals. Mobile solution was essential as a key driver for delivering the anticipated benefits realisation.

Total revenue approval internally was £1,676k to cover unforeseen non recurrent (£908k) and recurrent (£768k) expenditure over the life of the project. The non recurrent sum was required for additional implementation demands due to the complexity of the RiO product. The recurrent sum was necessary to ensure the product was fully supported in business as usual state.

A summary of total capital and revenue outturn is set out in the table below.

Details	Non Recurrent £'000			Recurrent £'000			Total £'000		
	Approval	Expend.	Variance adv/(fav)	Approval	Expend.	Variance adv/(fav)	Approval	Expend.	Variance adv/(fav)
Capital									
Full Business Case	1,400	739	(661)				1,400	739	(661)
Capital & Estates Group	1,627	1,627	0				1,627	1,627	0
	3,027	**2,366**	**(661)**				**3,027**	**2,366**	**(661)**
Revenue									
Full Business Case	925	861	(64)	968	968	0	1,892	1,828	(64)
Internal Project Board	908	616	(292)	768	626	(143)	1,676	1,242	(435)
	1,833	**1,477**	**(356)**	**1,736**	**1,593**	**(143)**	**3,569**	**3,070**	**(498)**
TOTAL									
Full Business Case	2,325	1,600	(725)	968	968	0	3,292	2,567	(725)
CEG/Project Board	2,535	2,243	(292)	768	626	(143)	3,303	2,869	(435)
	4,860	**3,843**	**(1,017)**	**1,736**	**1,593**	**(143)**	**6,596**	**5,436**	**(1,159)**

The expenditure covers the whole life of the project through to the 31 March 2020 and includes an estimate for the final 5 months.

Our initial plan was to deploy a fully integrated EPMA solution with the EPR system, however the RiO offering was not suitable. Consequently EPMA implementation was delayed while we explore alternative options, this resulted in an underspend of £661k against the capital sum approved.

The complexities encountered during the early stages of implementation could not be resolved by our internal team therefore non recurrent resources were approval for the use of external specialist. However, as we progressed through the implementation stage our in-house team enhanced their skills which reduced the need for external support, this resulted in an underspend of £292k in non recurrent revenue spend. The underspend in recurrent revenue spend of £143k is due mainly to the delay in roll out of out of hours support.

Total capital and revenue expenditure to the 31 March 2020 (and closure of the project) is £1,159k lower than the overall allocation of £6,596k due to the reasons outlined above.

Appendices

Appendix A – Technical Specifications	Technical Specification T1314-4
Appendix B – ITSFT	T1314-4226-HL ITSFT V1 0 .doc
Appendix C - Risks and Issues Register example and Work-Off document.	EPR Risks and Issues - September 2019 v0
Appendix D – Lessons Learned	Lessons Learned Document EPR Projec
Appendix E – EPR Project Board Closure Checklist	EPR Project Board Closure Checklist 08-1

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 March 2020
	Agenda Item:	11.4
	Enclosure Number:	16

Meeting:	**Board Meeting**		
Title:	**Governance Report**		
Author:	**Stanley Mukwenya, Head Governance and Risk**		
Accountable Director:	**Claire Lea/Julie Houlder, Corporate Governance Support,**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	None		

Purpose of the report		
Section 1 Governance Report To present the Board with the latest versions of the Board Assurance Framework (BAF) and the Corporate Risk Register so that Board members can consider if they effectively capture our main risks, and give Board members enough assurance about how we are mitigating risks affecting our organisational objectives. To highlight other governance activities and issues including on measures against Modern Slavery and work on the Annual Governance Statement. **Section 2 Audit Committee Report** The Committee has not met since the last Board meeting in January 2020. It will next meet on 7th April 2020.	**Consider for Action**	✓
	Approval	✓
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓			✓

Summary of key points in report
Section 1 Governance Report

1 Accountable Director: Julie Houlder/Claire Lea Corporate Governance Consultants, Board Meeting: 26th March 2020

Changes to the Board Assurance Framework

Since the Board last reviewed the Board Assurance Framework (BAF) there has been ongoing work to consider the risk 'Healthcare Systems'. This work is awaiting further national guidance for the STP and a revised BAF entry will be concluded when this becomes available. The timing on this cannot be confirmed at this stage due to the impact of preparations for handling the Covid-19 pandemic.

The directors have updated their respective entries; however, these changes have not given rise to any change in the current risk rating.

Whilst the Audit Committee will not be meeting until April, the Board is asked to consider the inclusion of a new entry relating to the Covid-19 pandemic. If agreed this will be drafted for consideration by the Audit Committee with a recommendation to the next meeting of Board.

Corporate Risk Register (CRR)
Lead directors have reviewed their entries on the Corporate Risk Register. There were three changes to the Corporate Risk Register.

The Health and Safety risk score has been increased from 6 to 12 due to the delays in completing the Health & Safety review by independent consultants.

Having met in year 2019/20 Financial Targets and identifying none of the efficiency programme as high risk the risk score on *Meeting in year Financial Targets* was reduced from 12 to 9. This change also assumes that Covid-19 costs will be reimbursed in line with national guidance.

Staff Sickness risk score has been increased from 12 to 15 due to expected higher absenteeism from sickness, self-isolation or caring for family members as a result of Covid-19.

Executive directors are also working on the inclusion of a new risk relating to the impact of the Covid-19 pandemic.

Statement Regarding Modern Slavery
The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36million per annum, the NHS is obliged to comply with the Act.

The Trust is required to provide a statement about the controls it has in place to prevent modern slavery in particular aspects of its work. The draft statement is attached for Board approval. This details the measures taken by Shropshire Healthcare Procurement Service and the employment practices of the Trust and Midlands Partnership NHS Foundation Trust, who provide estates services to the Trust.

Annual Governance Statement.
Guidance has been received on the Annual Governance Statement. The statement should detail the Trust's systems and any issues relating to internal control. No fundamental changes have been made except extra requirements in relation to the publication of a register of declaration of interests within the last twelve months. The

statement will come to the May Board meeting for comment and will be approved at the Extraordinary Audit Committee on 27 May 2020.

Key Recommendations

The Board is asked to:

- **Agree** the inclusion of Covid-19 on the Trust's BAF
- **Approve** the BAF - . Are current significant risks to strategic objectives accurately captured and does it give sufficient assurance on risk mitigation. Are there specific BAF risks the Audit Committee should review in detail?
- **Accept** the CRR and the updated risk ratings
- **Accept** the process for the production of the Annual Governance Statement
- **Approve** the Modern Slavery Statement.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	Aspects of Governance are included within the standards for Safeguarding and Safety, Suitability of Staffing and Quality and Management.
IG Governance Toolkit	No	
Board Assurance Framework	Yes	Relates to all entries

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Y	Good governance processes will have a positive impact on the safety and quality of patient care.
Financial (revenue & capital)	Y	The Board Assurance Framework details major financial risk which could impact on the Trust objectives.
OD/Workforce	N	Inter-relationship between OD and workforce issues and quality.
Legal	N	Various potential legal risks if issues are not managed effectively.

Shropshire Community Health NHS
NHS Trust

SECTION ONE: GOVERNANCE REPORT INCLUDING BOARD ASSURANCE FRAMEWORK

1. Board Assurance Framework (BAF)

1.1 Changes made since the last Board meeting

Directors reviewed their entries and minor changes were made and reflected in the table below. The Audit Committee will be reviewing the BAF at its meeting in early April, from which more significant changes may come.

1.2 Changes to all BAF risks:

Ref	Name	Changes	Rating (current)	Risk level (current)
01 - 2018	Organisational culture does not support the values of the Trust	No change	6	Low risk
02 - 2018	Clinical Quality and Safety	No change	8	Moderate risk
04 - 2018	Healthcare Systems	No change	12	Moderate risk
05 - 2018	Optimising use of Technology	Following the transition of the EPR programme into business as usual the appropriate governance arrangements have been developed and enacted. This control process will be managed by the Digital Programme Group (DPG). Awaiting confirmation of the clinical and quality strategy, following this the digital strategy will be reviewed to ensure alignment.	12	Moderate risk
02 - 2019	Long-term financial sustainability of the Trust	No change	16	High risk

Since the Board last reviewed the Board Assurance Framework (BAF) there has been ongoing work to consider the risk 'Healthcare Systems'. This work is awaiting further national guidance for the STP and a revised BAF entry will be concluded when this becomes available. The timing on this cannot be confirmed at this stage due to the impact of preparations for handling the Covid-19 pandemic.

Further the Board's agreement of the new strategic priorities for 2020/21 (see below) will lead to a refreshing of the overall BAF for 2020/21 in due course.

1. Good and Beyond - Continuous Improvement to Deliver Outstanding Care
2. Transforming Services - Implement our Clinical and Quality Strategy
3. Making Best Use of Resources - People, Technology, Finances, Estates and Networks

Whilst the Audit Committee will not be meeting until April, the Board is asked to consider the inclusion of a new entry relating to the Covid-19 pandemic. If agreed this will be drafted for consideration by the Audit Committee with a recommendation to the next meeting of Board.

The BAF is attached in **Appendix 1.**

2. Corporate Risk Register

2.1 Changes to the CRR

Lead directors have reviewed their entries on the Corporate Risk Register. There were no major changes to the Corporate Risk Register except for the following three risks;

The *Health and Safety* risk score has been increased from 6 to 12 due to the delays in completing the Health & Safety review by independent consultants.

Having met in year 2019/20 Financial Targets and identifying none of the efficiency programme as high risk, the risk score for *Meeting in year Financial Targets* has been reduced from 12 to 9. This revised rating assumes that Covid-19 costs will be reimbursed in line with national guidance.

The *Staff Sickness* risk score has also been increased, from 12 to 15, due to expected higher levels of absenteeism from sickness, self-isolation or caring for family members as a result of Covid-19.

Executive directors are also working on the inclusion of a new risk relating to the impact of the Covid-19 pandemic.

2.2. Summary of Risks

The full CRR is included in **Appendix 2**. The table below shows a summary of the risks on the CRR showing the highest current risk ratings first. The table also shows which risks are currently not at their target rating.

CRR entry		Initial Rating			Current Rating			Target Rating		
	On target (OT), Above target (AT)	Cons	Like	Rating	Cons	Like	Rating	Cons	Like	Rating
Health & safety legislation	AT	4	5	20	3	4	12	2	2	4
Staff sickness	AT	3	5	15	3	5	15	3	3	9
Estates Safety and statutory compliance	AT	3	4	12	3	4	12	3	2	6
Meeting in year financial targets	AT	5	5	25	3	3	9	3	3	9

Risk Stratification Process - Phase 2 of Care Closer to Home demonstrator sites	AT	5	2	10	5	2	10	5	1	5
Training and development	OT	3	4	12	3	3	9	3	3	9
Compliance with data protection legislation	OT	3	4	12	3	3	9	3	3	9
Waiting times	AT	4	4	12	2	4	9	2	3	6
Cyber security	AT	3	4	12	3	3	9	3	2	6
Vacancies and the effect on service delivery	OT	3	5	15	3	3	9	3	3	9
End of life processes	OT	4	5	20	3	3	9	3	3	9
Diversity Requirements for Staff and Patients	AT	2	4	8	2	4	8	2	2	4
Corporate governance	OT	4	4	16	4	2	8	4	2	8
Business interruption	OT	4	3	12	2	3	6	2	3	6
Staff Engagement	OT	4	4	16	3	2	6	3	2	6
Community links and reputation	OT	3	4	12	3	2	6	3	2	6
Policies	OT	3	5	15	3	2	6	3	2	6
Risk management	OT	3	5	15	2	3	6	2	3	6
Clinical negligence or third party litigation	OT	3	3	9	3	2	6	3	2	6
Medical devices	OT	3	4	12	3	2	6	3	2	6
Safeguarding, including thresholds for referral	OT	4	4	16	3	2	6	3	2	6
Staff appraisals	OT	3	4	12	3	2	6	3	2	6
Data quality	OT	3	4	12	3	2	6	3	2	6
Lone working	OT	3	3	9	3	2	6	3	2	6
NHS Digital assessments	OT	3	3	9	3	2	6	3	2	6
SI's, other incidents	OT	4	4	16	2	2	4	2	2	4

3. Other governance issues

3.1 Statement Relating to Modern Slavery

All corporate bodies with a turnover of £36m or more are required to produce a statement which must include the steps they have taken in the previous year to ensure that slavery and human trafficking are not taking place in their supply chains or business.

In preparing our statement, the assistance of Shropshire Healthcare Procurement Service (SHPS) has been sought, as they manage supply chains on behalf of the Trust. The statement reflects the processes that are in place to manage supply risks associated with modern slavery. In addition assurance has been sought from Midlands Partnership NHS Foundation Trust that there are no risks related to modern slavery in the Estates

Services which that Trust provides to us. The statement confirms the Trust's employment practices meet required standards.

- The statement, once agreed, must be published on the Trust's website.
- The statement must be approved by the Board and signed by a Director.

The statement is attached as **Appendix 3**, and the Board is asked to approve the Statement.

3.2 Annual Governance Statement

The Annual Governance Statement is required as part of the end of year reporting process. The statement set out the systems of internal control, and any challenges faced by the organisation. Any significant control issues must be declared. Guidance on the statement was received in March and the statement is in the process of being compiled. A draft statement will be discussed at the Audit Committee meeting in April, and will be finally approved at the Extraordinary Audit Committee on 27 May 2020.

3.3 Board Development Risk Management Presentation

The focus of the presentation was on managing risk, realising and exploiting opportunities in a risk appropriate manner. The purpose of the presentation was to develop the Board's understanding of its risk appetite, begin to refresh the BAF for 2020/21, and to review current risks. Robust discussions were held on accepted appetite, capacity and tolerance levels for the Trust and a further development session will be scheduled.

3.4 Use of the Trust Seal

The seal has not been used since the last meeting.

SECTION TWO: AUDIT COMMITTEE REPORT

The committee has not met since the last Board meeting. The next meeting is on 7th April 2020.

RECOMMENDATIONS TO THE BOARD

The Board is asked to:

- **Agree** the inclusion of Covid-19 on the Trust's BAF
- **Approve** the BAF - . Are current significant risks to strategic objectives accurately captured and does it give sufficient assurance on risk mitigation. Are there specific BAF risks the Audit Committee should review in detail?
- **Accept** the CRR and the updated risk ratings
- **Accept** the process for the production of the Annual Governance Statement
- **Approve** the Modern Slavery Statement.

Board Assurance Framework

3189 1-2018 Organisational culture does not support the values of the Trust

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
1) Poor learning culture (Commitment to Quality) We don't learn from our mistakes, do not innovate change and improve. We increase chance of harm or poor experience. 2) Not person centred (Respect& Dignity, Everyone Counts, Compassionate Care) Potential to miss harm or risk to an individual because they have been excluded/not had equivalent access. To create poor patient or family experience 3) We do not encourage diversity (Everyone Counts, Commitment to Quality) Miss opportunities for innovation. Do not fully explore, represent or provide care and services to meet needs of patients, families and staff. Miss talented staff and recruitment opportunities and risk losing staff 4) Staff are not or don't feel involved/empowered in their work and decisions/changes relating to it (Respect& Dignity, Everyone Counts) Missed opportunity for innovation. Increased risk of doing the wrong thing. Resistance to change. Recruitment and retention challenges 5) Leadership and effective "followship" does not develop in all parts of the organisation - People/staff do not grow and develop. - Limited job satisfaction leading to unhealthy feelings about work. - Lack of innovation and quality improvement 6) The organisation does not have a structured approach/model to service quality improvement. This is presently a gap in assurance and is being addressed through the Well led CQC action plan – leads Ros Preen (service improvement) and Jane Povey/ Steve Gregory (for quality).	OD FRAMEWORK -implementation of framework activities -ensure full range are exercised and having an impact -tools for learning and improvement COMMUNICATION PLAN - plan is implemented and monitored for impact, Staff Survey Action Plan and Engagement Evaluations. LEADERSHIP VISIBILITY AND CLARITY - Board visibility, clarity of messaging and demonstrate values, Freedom to Speak-Up, Practice Supervision, Board Development Programme. CULTURE WORKING GROUP - Action Plan reported regularly to Board, Dignity Champion Initiative, Observe and Act.	Board clinical visits Culture working group report Delivery of agreed transformation plans Individual interactions Quality and Workforce metrics Staff and other surveys Staff and Patient feedback Staff ands other surveys Triangulation activities Triangulation of data and information	Availability of high quality information for all services/teams	Challenge of managing/leading small discreet services spread

Ratings	Cons (initial) 4	Like (initial) 4	**Initial Rating** 16	Cons (current) 3	Like (current) 2	**Current Rating** 6	Cons (Target) 3	Like (Target) 2	**Target Rating** 6

Actions Identfied

Action	Progress	When By	Responsible Person
Develop new Board Development Program Deliver Board Development programme, Quality and Safety Service, Improvement Methodologies, Inclusion Agenda, Well-being Action Plan.		30-Apr-2020	Nuala O'Kane

Non Exec Director Nuala O'Kane **Lead Director** David Stout **Monitoring Group** Quality and Safety Committee

3190 2-2018 Clinical Quality and Safety

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
•Quality monitoring and performance not sufficient to maintain standards •Failure to adhere to standards •Quality standards adversely affected by failure to recruit to clinical posts Risks to CQC compliance, patient safety and effectiveness of patient outcomes, Potential for reputational risk	Monitoring of policies, procedures and care pathways, e.g. audits. Recovery plans identified by performance management Performance monitoring (Routine/against trajectory) Self assessment of CQC standards and resulting action plans Monitoring of bank and agency use Monitoring of vacancies/recruitment initiatives Identifying and acting on event themes (e.g. complaints/incidents etc.) Acting on feedback from audits/patients/staff/students	6 monthly staffing reviews Board to site/service visits Executive director performance reviews of services Performance monitoring reports to RPC and Q&S Reviews by patient and carer panel (e.g observe and Act) Reviews by regulators/commissioners/Healt Thematic reviews Trust rated as "good" following CQC inspection in early 2019		

Ratings Cons (initial) 5 Like (initial) 4 **Initial Rating** 20 Cons (current) 4 Like (current) 2 **Current Rating** 8 Cons (Target) 4 Like (Target) 2 **Target Rating** 8

Actions Identfied

Action	Progress	When By	Responsible Person
Complete all CQC actions following 2019 inspection		31-Jan-2020	

Non Exec Director Peter Featherstone **Lead Director** Mr Steve Gregory **Monitoring Group** Quality and Safety Committee

3192 4-2018 Healthcare Systems

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
RISK The Shropshire STP system plan develops in such a way that prevents the delivery of the Trust's long term clinical transformation strategy. CONSEQUENCE The Trust is unable to: •continue to provide strong and robust clinical governance, •deliver care at a scale that can continue to deliver efficiencies, and •develop appropriate partnerships to integrate care logically for our population	In order to be present to debate, influence and highlight impact of taking plans forward we hold key seats around the key strategic planning 'tables'; - STP Strategic Leaders meetings, - Appropriate programme board representation in Shropshire and Telford and Wrekin Commissioning Programmes, and representation on work streams which add value to our transformation delivery - In partnership with LA leading the implementation of care closer to home phase 2 pilot - Membership of the new STP Senior Leaders Group (SLG)	Contracts and service developments that are realised Feedback to Board the outcomes of the various		Sufficient strategic clinical leadership in system wide

Ratings Cons (initial) 4 Like (initial) 4 **Initial Rating** 16 Cons (current) 4 Like (current) 3 **Current Rating** 12 Cons (Target) 4 Like (Target) 2 **Target Rating** 8

Actions Identfied

Action	Progress	When By	Responsible Person
Determining what the appropriate next steps with regard to clinical leadership are	Various avenues being explored within STP to enhance clinical leadership where appropriate		Dr Jane Povey
Memorandum of Understanding to be developed signed by partners	Agreement has been signed by the Trust, council and CCG	28-Feb-2019	Ms Ros Preen
Regenerating our internal planning and development group (Community Health Offer).	Action now complete	30-Nov-2018	Trish Finch
Taking the lead role in taking forward the development of work to support Alliance and ICP development. Ros P	In place	31-Jan-2019	Ms Ros Preen

Non Exec Director Mr Harmesh Darbhanga **Lead Director** Ms Ros Preen **Monitoring Group** Resource and Performance Committee

3193 5-2018 Optimising use of Technology

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
Not optimizing digital technologies effectively: - Services do not transform efficiently - Patients fail to receive optimum care. - Safety can be compromised by failure to deliver right information at the right time to the right people. - Resources are not utilized in the most efficient and effective manner - Trust is proceeding at a pace of technological development which is not being matched by partners and the wider health and social care system - Exposure to cyber security threats. - Development of Digital Strategy has insufficient engagement from the wider organisation.	Delivery of Digital Strategy. Working with Service Transformation Plan partners through the Digital Enablement Group (DEG) Engagement and compliance with NHS Digital, NHS Improvement and NHS England requirements around the digital agenda Ensuring effective Governance arrangements are in place for all Digital Transformation programmes. Where issues and risks are identified action plans are developed to address which are monitored at the appropriate group. Training programmes delivered as new technologies are deployed Utilisation of standard methodology for project management (PRINCE2) Following the transition of the EPR programme into business as usual the appropriate governance arrangements have been developed and enacted. This control process will be managed by the Digital Programme Group (DPG).	Ad hoc presentations to Board Completion of DSPT (data security and protection toolkit) External organisation penetration tests Internal Audit audits of elements of the program (e.g. Regular reports to R&P and Q&S		

Ratings Cons (initial) 4 Like (initial) 4 **Initial Rating** 16 Cons (current) 4 Like (current) 3 **Current Rating** 12 Cons (Target) 4 Like (Target) 2 **Target Rating** 8

Actions Identfied

Action	Progress	When By	Responsible Person
Refresh the digital strategy for the next 5 years.	Awaiting confirmation of the clinical and quality strategy, following this the digital strategy will be reviewed to ensure alignment.	31-May-2020	Andrew Crookes

Non Exec Director Mr Harmesh Darbhanga **Lead Director** Ms Ros Preen **Monitoring Group** Resource and Performance Committee

3323 2-2019 Long-term financial sustainability of the Trust

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
RISK Longer term future of the Trust is threatened by the size of the Trust. In particular by: - Sustained delivery of CIPs/adverse effect on service development - Financially challenged STP, restricting business development opportunities CONSEQUENCE Services do not develop to meet demands. Trust does not remain financially viable.	Benefits Realisation Group in place following review of CIP and Transformation governance arrangements. Financial monitoring by managers, reported to Resource & Performance Committee (RPC) Long Term Financial Model (LTFM)being reviewed for 2019. Renewed focus and emphasis on CIP development and implementation and monitoring. Development of CIP plans. Project Management Office function in place. Financial Forecasting - reported to RPC and Board Cash Management Processes well developed. CIP escalation process in place and meetings held. Equality and Quality Impact Assessment (EQIA) process in place including Non Executive Director membership. Financial plans submitted to NHSi, detailing required value of efficiency programme. NHS Improvement regularly updated on risks regarding financial performance. Exec involvement is regular System Senior Leadership meetings Exec involvement is regular System Senior Leadership meetings Investigation and identification of potential business opportunities in and out of county.	External audit of accounts External value for money audit Financial systems audit by internal auditors Finanical reports to Board Internal audit of CIP process		Rolling programmes of efficiencies not yet in place

Ratings Cons (initial) 5 Like (initial) 5 **Initial Rating** 25 Cons (current) 4 Like (current) 4 **Current Rating** 16 Cons (Target) 3 Like (Target) 3 **Target Rating** 9

Actions Identfied

Action	Progress	When By	Responsible Person

Non Exec Director Mr Harmesh Darbhanga **Lead Director** Ms Ros Preen **Monitoring Group** Resource and Performance Committee

Corporate Risk Register Report

Risk At Target

ID: **325** Title: **Business Interuption** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Robust business continuity plans are necessary to ensure that should either foreseen or unforeseen circumstance occur which compromise services then rehearsed and documented plans can be quickly initiated to manage the safety of these services. Some realignment is necessary of existing plans to fit in to the new organisational structures.
Example of circumstances are:
Adverse weather conditions
Fuel Shortages
Illness (e.g. flu pandemic)
Industrial Action
Heatwave
There are particular issues with snow and ice, and getting to remote community locations

Controls/Mitigation

Individual business continuity service plans
Corporate business continuity plan
Heatwave plans
DoH, NHSi and NHSE guidance
Dedicated support for emergency planning and business continuity
Regular exercise to test plans and review.
Review of plans following incidents
Annual review of Business Continuity Plans
Multi agency register of localised risks
Health Economy Planning for peaks in demand

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Develop and implement action plan resulting from Internal Audit Recommendations		31/07/2019	Mr Andrew Thomas	06/11/2019
Test locality BCMs	In progress	31/12/2019	Mr Andrew Thomas	

Rating

	Initial	Current	Target
C	4	2	2
L	3	3	3
	12	6	6

Monitoring Group

Quality and Safety Committee

Opened

04-July-2007

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3192	Healthcare Systems	12

Risk At Target

ID: **956** Title: **Staff Engagement** **Lead: Jaki Lowe** Division/Directorate: **All Directorates**

Description of Risk

Not enough, or effective enough, staff engagement processes, leading to:
- Reduced quality & productivity through staff unhappiness, sickness absence & loss of motivation.
-Missed service development opportunities through staff not being aware of business potential, based on strategies & plans.
- Engagement with staff in practice and service change.

Controls/Mitigation

- Engagement work over Trust values and wider culture.
- Work of Trust Leadership Group, and the Culture Working Group promoting engagement with teams.
- Awaydays for all staff
- Positive and engaged role with staff representatives. JNP meetings
- Inform, team brief and CEO staff briefings.
- Action plans to address issues raised by staff survey
- Executive/non Executive visits
- Health & wellbeing support
- Staff involvement in shaping staff survey actions
- Staff engagement working group established for EPR
- Culture of supervision encouraged - Supervision Policy revised and implemented
- staff satisfaction measured using the Staff FFT in Q1, 2 and 4 and Staff Survey in Q3.
- Change management processes in place

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Implement communications plan re EPR and re future of the organization.	Completed	31/03/2017	Mr Andy Rogers	18/05/2017
Refresh Communications plan re transaction	Completed	01/02/2018	Mr Chris Hudson	16/05/2018

Rating

	Initial	Current	Target
C	4	3	3
L	4	2	2
	16	6	6

Monitoring Group

Quality and Safety Committee

Opened

31-May-2011

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9

Risk At Target

ID: **966** Title: **Community links and Reputation** **Lead: Ms Ros Preen** Division/Directorate: **All Directorates**

Description of Risk

Community links not sufficiently strong or consistent across the area, leading to low awareness of Trust or poor reputation, as a result of:

- Limited capacity in-house.
- Competing interests for public/communities e.g. acute services issues
- Incorrect interpretation of our decision on sustainability or transformation issues
- Potential delay on transaction

Controls/Mitigation

- Patient and Carer Panel in place
- Meetings with wide range of stakeholders; media work; staff engagement
-Stakeholder engagement events
- Publishing of key information on Trust website
- Board members and exec team regularly meet staff and patients on informal visits.
-sustainability communication plan
- strong contact with Leagues of Friends and Health Fora
- non execs as named links with stakeholders

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Refresh comms. plan for transaction	Completed	01/02/2018	Mr Chris Hudson	28/03/2018

Rating

	Initial	Current	Target
C	3	3	3
L	4	2	2
	12	6	6

Monitoring Group

Board

Opened

31-May-2011

Links to BAF risks

ID	Risk Title	Current Rating
3192	Healthcare Systems	12

Risk At Target

ID: **1046** Title: **Policies** **Lead: Stanley Mukwenya** Division/Directorate: **All Directorates**

Description of Risk

Risk of lack of staff awareness and compliance with policies, failure of organisation to keep policies up to date
Gaps in provision of policies

Controls/Mitigation

Policies are published on the staff Internet.
Search facilities on keywords, type and subject.
Formal distribution via Datix alerting system to all senior personnel. Response required for assurance that policies have been actioned
Policy on procedural documents sets out process for development and approval of polices.
Reminders sent to authors monthly, with a summary report to Directors detailing policies overdue for review, and policies due for review in next 6 months

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
List of all approval responsibilities for policy approval to be developed.		30/06/2020	Stanley Mukwenya	
The Risk Review Meeting needs to be revitalised to ensure that any delays to policy review are escalated as appropriate.	On-going	30/06/2020	Stanley Mukwenya	

Rating

	Initial	Current	Target
C	3	4	3
L	5	3	2
	15	12	6

Monitoring Group

Quality and Safety Group

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3193	Optimising use of technology	12
3322	Meeting in year Financial Targets	16

Risk At Target

ID: **1047** Title: **Risk Management** **Lead: Stanley Mukwenya** Division/Directorate: **All Directorates**

Description of Risk

Lack of awareness of risks or lack of understanding of staff of how to report and manage risks leading to harm.
Failing to ensure that risks are identified and mitigated, and that risks are escalated appropriately
Some inconsistencies noted by CQC e.g. MIU risks, which have been resolved

Controls/Mitigation

Risk management training is part of managers mandatory training program
Awareness raising in 'Inform' and Team Brief.
Directorate registers
Reporting to Audit Committee
Risk Register Review Group reporting to Q&S Delivery Group
Risk Management Policy in place.
Individual support to managers from Risk Manager
Risks discussed at Performance Review Meetings.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Develop and support the work of the Risk Review Meeting.		30/06/2020	Stanley Mukwenya	

Rating

	Initial	Current	Target
C	3	2	2
L	5	3	3
	15	6	6

Monitoring Group

Audit Committee

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3322	Meeting in year Financial Targets	16
3323	Long-term financial sustainability of the Trust	16

Risk Above Target

ID: **1048** Title: **Health & Safety Legislation** **Lead: Stanley Mukwenya** Division/Directorate: **All Directorates**

Description of Risk

Compliance with Health and Safety, Food, Waste and Environmental Legislation

Controls/Mitigation

Staff and managers awareness of requirements through training and publicity
Support from Risk Manager
Incident reporting to highlight issues
SLA with estates for support for food, waste and environment operational activities
Policies in place or adopted
Professional support available for HS, Estates, Security and Infection Control

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Identify location leads for Trust bases, define responsibilities for Health and Safety and Security	List agreed and circulated to managers with instructions. Drop in sessions held in main locations	31/05/2018	PF	11/07/2018
Review and refresh of health and safety arrangements	Proposal agreed at Executive team.	30/06/2017	Ms Julie Thornby	01/07/2017
Engage with staff and team leaders to refresh health and safety profile and increase profile across Trust	Health and Safety risk profile established, new Health and Safety group has met and agreed TOR and reviewed risk profile. The main purpose of the group it to bring together the monitoring and assurance for the risks on the risk profile	30/09/2017	PF	15/09/2017
Appoint Health & Safety Consultants to carry out a review of the Trusts Health & Safety arrangements.		30/05/2020	Stanley Mukwenya	

Rating

	Initial	Current	Target
C	4	3	2
L	5	4	2
	20	12	4

Monitoring Group

Quality and Safety Group

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3322	Meeting in year Financial Targets	16

Risk At Target

ID: **1049** Title: **Clinical Negligence or Third Party Litigation** **Lead: Stanley Mukwenya** Division/Directorate: **All Directorates**

Description of Risk

Clinical negligence or third party claims.
Specific cases which could lead to adverse publicity or could have financial effect.

Controls/Mitigation

Legal advisors
NHS Resolution support with claims
Low number of claims
Being Open Policy
Legal updates distributed to relevant managers

Additional Controls/Actions Required:

Actions	Progress	Due By	Done date

Rating

	Initial	Current	Target
C	3	3	3
L	3	2	2
	9	6	6

Monitoring Group

Quality and Safety Group

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3323	Meeting in year Financial Targets	16

Risk At Target

ID: **1051** Title: **SIs, other incidents** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

General risk associated with clinical incidents. Specific risks raised by individual incidents. Incidents leading to avoidable patient harm and insufficient learning from them.
Risk that incidents convert into complaints and claims

Controls/Mitigation

Serious Incidents monitored on Datix.
Root Cause Analysis carried out and action plans reviewed and signed off by DoN or Deputy Directors, and Commissioners;
Reports taken to appropriate committees.
Lessons learned meetings identifies trustwide solutions and communicates lessons learned
All incidents are reviewed by line managers, actions taken are detailed, field is mandatory before incident can be approved.
All incident are centrally coded and reviewed.
Staff are supported at inquests to ensure coroner is given full picture, using legal support where appropriate
Inquest report are given to Q&S committee
Permission to Pause alerts
Freedom to speak up assessment.
Duty of Candour arrangements and reporting
SI reporting to Executive Team

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date

Rating

	Initial	Current	Target
C	4	2	2
L	4	2	2
	16	4	4

Monitoring Group

Quality and Safety Group

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8

Risk At Target

ID: **1053** Title: **Training and development** **Lead: Jaki Lowe** Division/Directorate: **All Directorates**

Description of Risk

Gaps in provision and take up. Potential system failures.
Risk of not hitting necessary levels of mandatory training.
Risk of staff not being sufficiently aware of and prepared for assessment visits by external bodies.
Full training plan not in place annually
No trust-wide monitoring of Role Specific Essential Training (RSET)

Controls/Mitigation

Core training model in place,reviewed annually
Central training database
Monthly monitoring of performance with recovery plans where necessary
Introduction of ESR Self Service
Annual review of mandatory training needs
HCA competency based training program
Data analysis and reporting
Competency criteria in place
Role specific essential training
Integrated induction program in place
Monitoring of quality reports

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Co-ordinate the production of a full Trust training plan	TNA completed	31/07/2018	PF	17/05/2018
Group to consider central recording of RSET training and other actions identified by auditors.	Scoping process has started. Gathering base information on RSET training needs for all teams across the trust.	31/12/2019	Jaki Lowe	16/03/2020

Rating

	Initial	Current	Target
C	3	3	3
L	4	3	3
	12	9	9

Monitoring Group

Quality and Safety Committee

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9
3190	Clinical Quality and Safety	8

Risk At Target

ID: **1054** Title: **Medical Devices** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Compliance with Safety Alerts
Financial and safety risk associated with possible inadequate and out of date register of devices
Adequacy of departmental arrangements for tracking, maintaining and disposing of devices
Compliance with MDSO notice requirements

Controls/Mitigation

Safety Alerts received by the Risk Manager and escalated to service heads via Datix which enables monitoring and reminders to be sent.
Responses and actions are logged onto the system automatically
Contract with SATH Medical Engineering Services for annual maintenance
Medical Device Management Policy,
Verification of assets detailed by MES
Safety promoted through divisional quality and safety groups

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Identify high risk devices for increased scrutiny	Completed	31/07/2018	PF	12/07/2018
Complete audit of high risk devices	Completed	31/03/2019	PF	14/05/2019

Rating

	Initial	Current	Target
C	3	3	3
L	4	2	2
	12	6	6

Monitoring Group

Quality and Safety Group

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating

Risk At Target

ID: **1056** Title: **Safeguarding, including thresholds for referral** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Risk of compliance with law in relation to childrens and adult safeguarding.
Specific risks relating to incidents, concern or gaps in provision

Controls/Mitigation

Safeguarding Leads identified for Children.
Deputy Director of Nursing and Quality - Operational and management lead for safeguarding.
Trust safeguarding meetings established.
Safeguarding reported to Quality and Safety Committee.
Executive Lead member on the two Local Authority Adults and Children Safeguarding Boards.
Six monthly Section 11 audits
Compliance with Safeguarding Self Assessment Tool
Mandatory training for staff
Compliance with CQC principles

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date

Rating

	Initial	Current	Target
C	4	3	3
L	4	2	2
	16	6	6

Monitoring Group

Quality and Safety Committee

Opened

04-January-2012

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8

Risk Above Target

ID: **1147** Title: **Staff Sickness** **Lead: Jaki Lowe** Division/Directorate: **All Directorates**

Description of Risk

Sickness not reaching trajectory identified in targets/recovery plans
Areas of especially high sickness at times with potential for reduced quality and increased agency use.

There is a risk that, staff absence will increase as a result of sickness, self-isolation/family members due to Covid 19 outbreak impacting service delivery and recovery plans currently in place to achieve set targets in areas of service that rely highly on agency workforce.

Controls/Mitigation

Performance management arrangements.
Attendance management policy
Monitoring of monthly statistics and identification of hot spots.
Development of appropriate actions in partnership with Ops, OH and HR leaders and expertise
Implementation of a corporate wellbeing programme including mental health (e.g. mental health first aid sessions, MH resilience), physical health (e.g. Fit in 50, My Magnificent Menopause event, Men's health event, 0-5k running groups) in line with our Health & Wellbeing strategy.
Provision of Fast Track Staff Physiotherapy for MSK problems
Adherence to the Stress & Staff Support Policy.
Manager coaching to support effective management of sickness absence
QS Committee oversight at organisational level
Annual flu vaccination programme for staff
Progression of culture shift programme to change our organisational paradigm on wellbeing and sickness absence
MH practitioner role in OH.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Continued exploration of other avenues e.g. financial health and wellbeing	Solution identified, initiative moving into implementation	31/12/2019	Jaki Lowe	16/03/2020
Refresh organisational approach (Operations, HR & OH) to health, wellbeing and flexibility at work (paradigm shift) using a culture change tool	Project Plan created and pilot team (Bridgnorth) identified Conversation threads with operational leaders on how we do flexibility at work - at retirement, in ill health situations - underway Staff Side engaged in work	31/12/2019	Sara Hayes	16/03/2020
Specific focus on mental health sickness absence	Plan agree at QS in August, to be delivers by 28/02/2020	28/02/2020	Jaki Lowe	16/03/2020
Real time information at trust and departmental level and plan redeployment and reallocation as required as well as support to staff being provided.	On-going	17/04/2020	Jaki Lowe	
Working with staff to ensure maximum flexibility of staff so can use the resource we have in different ways.	On-going	17/04/2020	Jaki Lowe	
Setting up communication with Bank workers and agency so that we work on availability and mitigate impact for people who we regularly utilise through this	On-going	17/04/2020	Jaki Lowe	
Involved in national HRD calls to understand and translate national guidance	On going	17/04/2020	Jaki Lowe	
Assessing priorities and reprioritising to areas of most need including hiring people where necessary to more front line activity	On going	17/04/2020	Jaki Lowe	

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9
3190	Clinical Quality and Safety	8

Rating

	Initial	Current	Target
C	3	3	3
L	5	5	3
	15	15	9

Monitoring Group

Quality and Safety Committee

Opened

15-May-2012

Data Date: 19/03/2020

Risk Above Target

1. Team in place working on mitigating actions overseen Director of People and Head of Human Resources.
2. An emergency reporting line for people who are not able to come to work/do their normal role/or off sick have been set up.
3. Weekly system call with HRD's in place to coordinate approach.
4. Implemented a work from home arrangement for staff.
5. Establishing an OD programme aimed at equipping people to stay well, deal with symptoms, keep connected and motivated whilst working from home.

Risk At Target

ID: **1438** Title: **Compliance with data protection legislation** **Lead: Ms Ros Preen** Division/Directorate: **All Directorates**

Description of Risk

None compliance with Data protection could lead to action by the Information Commissioner. The level of fines has increased recently with a number of NHS organisations being fined.

Controls/Mitigation

Information governance policies
Incident reporting and investigation
IG training mandatory for all staff
Provision of advice and support
Records audit.
Networking with IG leads to learn lessons across all public sector organisations.
Compliance with IG toolkit
Plan in place to be GDPR compliant

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Actions are stated within controls				

Rating

	Initial	Current	Target
C	3	3	3
L	4	3	3
	12	9	9

Monitoring Group

Quality and Safety Committee

Opened

26-October-2012

Links to BAF risks

ID	Risk Title	Current Rating
3193	Optimising use of technology	12
3322	Meeting in year Financial Targets	16

Risk Above Target

ID: **1571** Title: **Waiting Times** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Waiting times do not meet local or national targets
There are particular problems with the recording of data at an operational level
Particular problems with TEMS

Controls/Mitigation

Regular reporting of performance.
Production of recovery plans as problems arise to address where waiting time exceed acceptable parameter.
Data validation each month
Weekly validation report to service as part of monthly reporting.
Implementation of new access control policy (TEMS)
Introduction of RiO has improved control of RTT waiting times

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Implement recommendations made by internal audit	Responses on progress being collated. Operations actions updated 3rd August 2016.	30/09/2016	Mr Andy Matthews	11/11/2016
Develop and deliver recovery plan for audiology waiting times	Delivery plan agreed with SaTH. All but 4 patients seen to date, 2 patients DNA and 2 patients have appointments in July	30/06/2017	Mr Andy Matthews	29/06/2017
Deliver recovery plan for TeMS to meet requirements	In place	28/02/2020	Mrs Karen Taylor	16/03/2020

Rating

	Initial	Current	Target
C	4	2	2
L	4	4	3
	16	8	6

Monitoring Group

Resource and Performance Committee

Opened

06-September-2013

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8

Risk At Target

ID: **1609** Title: **Cyber Security** **Lead: Ms Ros Preen** Division/Directorate: **Finance and Informatics**

Description of Risk	Controls/Mitigation
Users unable to log-on the network or utilise their desktops/laptops due to infection from a virus or other malware program would cause serious disruption or inability of staff to perform their work. The virus may also mean the danger of data loss or corruption. This could affect clinical systems, leading to risks to clinical quality and safety. Limited resource to further develop security event manager system beyond primary use. Unauthorized access to Trust Clinical and Corporate systems is an ever-present danger, that could lead to denial of service to bona-fide Users or the theft, loss or corruption of Trust data	All anti-virus message alerts are sent to the IT Service Desk with details of the incident. All PC desktops and laptops are configured with an Anti-virus Programme which updates regularly through the day.. Administrator passwords are restricted to authorized staff and are only used for administrative duties. All Trust sites have a Firewall to deny access to sites from unauthorised addresses Business continuity plans for clinical services. All staff are required to undertake IG training which includes cyber-security Disaster Recovery Plan in place External assessments Use of Security Event Manager System

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date

Rating

	Initial	Current	Target
C	3	3	3
L	4	3	2
	12	9	6

Monitoring Group

IMT Strategy Group

Opened

01-December-2008

Links to BAF risks

ID	Risk Title	Current Rating
3193	Optimising use of technology	12

Risk Above Target

ID: **1717** Title: **Staff Appraisals** **Lead: Jaki Lowe** Division/Directorate: **All Directorates**

Description of Risk

Low numbers, and staff reporting low quality, of appraisals in some areas
Reduced staff motivation and contribution to Trust aims.
Lack of assurance that staff are competent to undertake their role
Staff dissatisfaction and engagement reduction
Lack of confidence from Regulators

Controls/Mitigation

Training on good appraisal conversations.
Monthly Performance Reports and actions through recovery plans and discussions at relevant meetings
QS Committee oversight
Simplification of appraisal paperwork and process, after staff engagement, New system now established across Trust
Strengthened performance management of issue in operations/Recovery plans
Appraisal is a mandatory requirement for grade step points (increments)
Appraisal forms updated and launched Dec 18 to emphasise our values and health and wellbeing of staff and staff supervision
Training package developed and is being delivered by OD

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Increase target and include bank staff		31/03/2017	Mr Steve Gregory	12/07/2017
Consider 2017 staff survey action plans	Completed	31/03/2018	Ms Julie Thornby	31/03/2018
Initiative between OD and HR to coach leaders on effective appraisal conversations	Complete: initiative has been developed and piloted. To be rolled out in Q4 of 2018/19.	30/09/2018	Ms Julie Thornby	16/11/2018

Rating

	Initial	Current	Target
C	3	3	3
L	4	2	2
	12	6	6

Monitoring Group

Quality and Safety Committee

Opened

17-December-2013

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9

Risk At Target

ID: **2000** Title: **Data Quality** **Lead: Ms Ros Preen** Division/Directorate: **All Directorates**

Description of Risk

RISK
Data relating to Trust performance is inaccurate or is not available in a timely way.
Concerns relate to clinical activity data and some HR data.
Information collected in several systems leading to collation problems.

CONSEQUENCE
Inadequate information to support decision making.
Inaccurate costings.
Not being able to demonstrate accurately compliance with performance targets.
Potential risks to income.

Controls/Mitigation

Information collation into data warehouse, although this does not cover reporting corporate systems.
Validation of operational data by informatics and operations managers.
Data quality indicators on some metrics on the performance report.
In phase software for performance reporting.
Data cleansing on waiting times to ensure accuracy for non RTT services.
Reduced target timescale for data capture (2 day target).
Performance Management Framework developed to provide greater focus on metrics.
Formation and workplan for data quality sub group, reporting to IG Operational Group, with a main focus on clinical systems, but also covering corporate systems.

Additional Controls/Actions Required:

Actions	Progress	Due By	Done date

Rating

	Initial	Current	Target
C	3	3	3
L	4	2	2
	12	6	6

Monitoring Group

Resource and Performance Committee

Opened

03-February-2014

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3192	Healthcare Systems	12
3193	Optimising use of technology	12
3322	Meeting in year Financial Targets	16

Risk Above Target

ID: **2258** Title: **Diversity Requirements for Staff and Patients** **Lead: Jaki Lowe** Division/Directorate: **All Directorates**

Description of Risk

RISK
Trust does not meet needs of people in protected characteristics group, and they have poorer access to, experience of, Trust services and employment experience.
Trust does not promote diversity and allows direct or indirect discrimination leading to patient or staff disadvantage, possible loss of Trust reputation and claims. People do not feel included and we do not make the best of the talent we have available and motivation is impacted.

Controls/Mitigation

Controls
QS Committee oversight
Everyone Counts delivery structure in place
Equality Delivery System 2
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting in place
Equalities sub group of patient panel
Information required by legislation is published
Quality and Equality Impact Assessments are carried out for service developments.
Disability Confident accreditation for HR processes
Diversity & Inclusion Strategy and Policy
Mandatory training
Diversity staff network
Refreshed E&D mandatory training
AIS arrangements publicized at team meetings
Line of responsibility defined.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Follow up on implementation of accessible information with all staff teams	On going program of team visits, added to controls	30/09/2018	PF	21/11/2018
Development of equality strategy and refresh of plan.	Completed	31/08/2018	Ms Julie Thornby	16/11/2018
Review arrangements for AIS in light of current situation and audits.		31/12/2019	Jaki Lowe	16/03/2020
Review resources for diversity and inclusion	Model agreed, joint MD and Director of people	31/12/2019	Jaki Lowe	16/03/2020

Rating

	Initial	Current	Target
C	2	2	2
L	4	4	2
	8	8	4

Monitoring Group

Quality and Safety Committee

Opened

12-December-2014

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9
3190	Clinical Quality and Safety	8

Risk At Target

ID: **2493** Title: **Lone working** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Risk associated with lone working:
Staff Safety
Road safety
Professional issues
Safety issues e.g. handling patients single handed

Controls/Mitigation

Lone working section in Violence Policy
Local assessment of particular risks with services
Local procedures, include staff whereabouts and personal details
All community staff have mobile phones
Lone worker staff survey
Audit of checking arrangements
Audit of local procedures
Safer Working Group

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Review and audit local policies and procedures, and the provision of safety devices.	Piloting lone worker devices	24/09/2018	Mrs Angela Cook	21/09/2018

Rating

	Initial	Current	Target
C	3	3	3
L	3	2	2
	9	6	6

Monitoring Group

Quality and Safety Group

Opened

19-January-2016

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9

Risk Above Target

ID: **2495** Title: **Vacancies and the effect on service delivery** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Recruitment issues regularly feature on divisional registers. These can come from national or local shortages, time taken to place staff, or where disciplines have only one post. These have included:
Prison
Community Hospitals

Controls/Mitigation

Contingency and prioritisation
Recruitment initiatives e.g. open days, work with universities, Rotational posts.
Innovation in posts, e.g. Nursing Associates Apprenticeships

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Actions are covered within the agency use entry				

Rating

	Initial	Current	Target
C	3	3	3
L	5	3	3
	15	9	9

Monitoring Group

Quality and Safety Committee

Opened

19-January-2016

Links to BAF risks

ID	Risk Title	Current Rating
3189	Organisational Culture does not support the vision	9
3190	Clinical Quality and Safety	8

Risk At Target

ID: **2773** Title: **End of Life Processes** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk

Processes are delivered by different services across muliple providers.
Consequences could include patients not being in their preferred location, inadequate medication or care and inability to access required services or equipment.
EOL plan not embedded across all services and partners

Controls/Mitigation

End of life Strategy
Incident bookmarked as EOL enabling lead to review and share learning
Liaison with other providers, particularly GP practices
End of life lead in place.
Risk register established.
EOL training in place
CQC re assessment confirms arrangements have improved since last assessment.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
With other providers develop an End of Life Strategy	Approved by Board	30/04/2017	PF	15/05/2017
Develop risk register for end of life	in place	31/12/2016	PF	21/12/2016
Develop information/training processes to implement EOL Strategy	SCHT/Hospice training is now ongoing. To be monitored in three months	30/06/2018		12/07/2018
Deliver EOL training Complete EOL care plan Audit	Completed	30/06/2019	PF	07/11/2019

Rating

	Initial	Current	Target
C	4	3	3
L	5	3	3
	20	9	9

Monitoring Group

Quality and Safety Committee

Opened

07-November-2016

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8

Risk At Target

ID: **2884** Title: **Estates Safety and statutory compliance** **Lead: Ms Sarah Lloyd** Division/Directorate: **All Directorates**

Description of Risk

Trust fails to comply with statutory inspection and testing and H&S expectations. Examples are Asbestos, Fire, Pressure Vessels, Water, Environment and Building condition.
This can be especially challenging where the building owner or operator is outside the organisation
CONSEQUENCES
HSE enforcement action, patient and staff safety compromise

Controls/Mitigation

Compliance dashboard reporting - R&P and Board
Capital and Estates group monitoring
Estates Risk Register (in preparation)
Capital program management and delivery
Legal advice where necessary

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Health & Safety review has been commissioned which will incorporate estates arrangements.	Review commenced. Report to Quality and Safety Committee due. MPFT have been requested to supply evidence.	30/05/2020		

Rating

	Initial	Current	Target
C	3	3	3
L	4	4	2
	12	12	6

Monitoring Group

Capital and Estates

Opened

13-March-2017

Links to BAF risks

ID	Risk Title	Current Rating
3190	Clinical Quality and Safety	8
3322	Meeting in year Financial Targets	16

Risk At Target

ID: **3112** Title: **NHS Digital Assessments** **Lead: Ms Ros Preen** Division/Directorate: **Finance and Informatics**

Description of Risk

On-Site Assessments: Your organisation must:
Undertake an on-site cyber and data security assessment if you are invited to do so by NHS Digital
NHSD have been informed that we are available post April 2018 for an on-site assessment.
It is likely that some areas will be challenging.

On-Site Assessments: failure to meet the required standards.

Controls/Mitigation

Assessment of high risks areas and appropriate mitigations takes place as part of our routine cyber security processes. This includes our desktop DR/GDPR exercise-event simulation and the routine monitoring of CAREcert notifications.

Additional Controls/Actions Required:

Actions	Progress	Due By	Done date

Rating

	Initial	Current	Target
C	3	3	3
L	3	2	2
	9	6	6

Monitoring Group

Resource and Performance Committee

Opened

27-April-2018

Links to BAF risks

ID	Risk Title	Current Rating

Risk Above Target

ID: **3322** Title: **Meeting in year Financial Targets** **Lead: Ms Sarah Lloyd** Division/Directorate: **Chief Executives Office/Trust Board**

Description of Risk

RISK The Trust fails to deliver its agreed in-year financial targets, namely: delivering a breakeven income and expenditure position; delivering the agreed control total; staying within the agreed Capital Resource Limit; and remaining within the planned agency spend ceiling. The key risk to delivery remains recurrent delivery of the Cost Improvement Programme (CIP) but also includes management of other arising financial risks.
CONSEQUENCE
Inability to invest in our services/service reductions
Possibility of cash shortfall

Controls/Mitigation

Benefits Realisation Group in place following review of CIP and Transformation governance arrangements.
Financial monitoring by managers, reported to Resource & Performance Committee (RPC)
Long Term Financial Model (LTFM)being reviewed for 2019.
Renewed focus and emphasis on CIP development and implementation and monitoring.
Development of CIP plans.
Project Management Office function in place.
Financial Forecasting - reported to RPC and Board
Cash Management Processes well developed.
CIP escalation process in place and meetings held.
Non recurrent measures to be identified to offset shortfalls against recurrent CIP in short term, although underlying position is still affected
Equality and Quality Impact Assessment (EQIA) process in place including Non Executive Director membership.
Financial plans submitted to NHS, detailing required value of efficiency programme. NHS Improvement regularly updated on risks regarding

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Development of 19/20 efficiency program	Initial confirm and challenge meeting held	28/06/2019	Ms Sarah Lloyd	18/09/2019
The 2019.20 efficiency programme is now fully identified and none of it is classed as high risk. No new financial risks have arisen at this time on the assumption that Covid-19 costs are reimbursed in line with national guidance.	On-going	17/04/2020	Ms Sarah Lloyd	

Rating

	Initial	Current	Target
C	5	3	3
L	5	3	3
	25	9	9

Monitoring Group

Resource and Performance Committee

Opened

23-April-2019

Links to BAF risks

ID	Risk Title	Current Rating

Risk Above Target

financial performance.
Financial recovery meetings commenced Sept 19
Confirm and Challenge meetings in place

Risk Above Target

ID: **3329** Title: **Corporate Governance** **Lead: Stanley Mukwenya** Division/Directorate: **Chief Executives Office/Trust Board**

Description of Risk

The Trust does not have good quality corporate governance systems in place to ensure a well led organisation delivering high quality, efficient and safe services.

Controls/Mitigation

- Niche Well-led review
- Well-led /CQC Improvement Plan
- Board Development
- Board Appraisals
- Board engagement staff and stakeholders
- Board and Committee evaluation
- Governance Structures
- Board and Committee Work plans
- Assurance Framework
- Internal and External Audits

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Implement actions related to the Niche report and CQC inspection report for the well led standard	Consultants appointed to project manage improvements and actions. Corporate Governance improvements are being implemented. Action plan due to be completed and reported to Board.	30/05/2020		

Rating

	Initial	Current	Target
C	4	4	4
L	4	2	2
	16	8	8

Monitoring Group

Board

Opened

21-May-2019

Links to BAF risks

ID	Risk Title	Current Rating

Risk Above Target

ID: **3357** Title: **Risk Stratification Process for Phase 2 of the Care Closer to Home Programme Demonstrator Sites** **Lead: Ms Ros Preen** Division/Directorate: **Adult Services Division**

Description of Risk

The process, as designed for this phase of the programme, may not be compliant with the NHS rules (and DPA 2018/GDPR lawful processing rules) for handling patient data for this task. The local IG advisors to the Programme are unable to come to a consensus view. As a result the potential processing risk currently sits with the Trust. This runs the risk of patient complaints to the ICO and investigation with the highest sanction being an administrative fine.

Controls/Mitigation

The Trust will seek clarification on the process in relation to the rules from NHS England's Clinical Advisory Group and will be guided by this in terms of whether the process needs to be modified.
Guidance given so far states that the services should always action in patients best interests.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Send query to NHSe CAG for advice	Being drafted	31/12/2019	Ms Ros Preen	
Notify Chair of CCtH Programme Board of action being taken and why	Being drafted	31/12/2019	Ms Ros Preen	
Improved engagement both within and between the respective Organisations involved in the Programme; to share understanding and progress, learn and adapt and resolve issues.	Completed		PF	06/11/2019
Ensure future phases (including roll-out post pilot) take account of lessons learnt, and the appropriate governance processes are refined, understood and implemented at the initial stages of each phase.	Completed		PF	06/11/2019

Rating

	Initial	Current	Target
C	5	5	5
L	2	2	1
	10	10	5

Monitoring Group

Information Governance Operational Group

Opened

13-August-2019

Links to BAF risks

ID	Risk Title	Current Rating
3323	Long-term financial sustainability of the Trust	16

Appendix 3

Shropshire Community Health NHS
NHS Trust

Modern Slavery Act 2015 – Annual Statement for 2018/19

Background

The Modern Slavery Act was passed into UK law on 26th March 2015. The Act introduces offences relating to holding another person in slavery, servitude and forced or compulsory labour and about human trafficking. It also makes provision for the protection of victims.

Organisations such as Shropshire Community Health NHS Trust, that supply goods or services, and have a total turnover of £36m or more are required under Part 6, (Transparency in supply chains), to publish an annual statement setting out the steps that they have taken to ensure that slavery and human trafficking do not exist in their business OR their supply chains.

Shropshire Community Health NHS Trust

Shropshire Community Health NHS Trust provides community health services from well over 50 bases within Shropshire and the West Midlands.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our activity and where possible, to requiring our suppliers to subscribe to a similar ethos. Any incidence will be acted upon immediately, and any required local or national reporting carried out.

All consumable goods and most contracts are purchased through Shropshire Healthcare Procurement Service (SHPS), a consortium of Shropshire healthcare providers, hosted by the Shrewsbury and Telford Hospitals NHS Trust.

Estates maintenance services are provided by Midlands Partnership NHS Foundation Trust for Trust properties, with the exception of some larger properties shared with multiple healthcare providers which are managed by NHS Property Services.

Arrangements in place

Procurement: All contracts established by SHPS use either NHS Framework Agreements for the Supply of Goods and Services, the NHS Terms and Conditions for Supply of Goods, or the NHS Terms for Supply of services. All have Anti-Slavery clauses, which require providers/contractors to comply with Law and Guidance, use Industry Good Practice and to notify the authority if they become aware of any actual or suspected incident of slavery or human trafficking.

In addition to the above SHPS will investigate any concern raised with the service. This could be by national or local media publicity, through supply chain contacts or by individuals.

Estates: Midlands Partnership NHS Foundation Trust, our provider of estates services, have produced a statement regarding slavery setting out measures they have in place to ensure that slavery and trafficking do not exist in their activity.

Employment: As an NHS Employer we are required to comply with the NHS employment check standard for all directly recruited staff.

The six checks which make up the NHS Employment Check Standards are:
1. Verification of identity checks
2. Right to work checks
3. Professional registration and qualification checks
4. Employment history and reference checks
5. Criminal record checks
6. Occupational health checks

No individual is permitted to commence employment with the Trust without these checks having been completed. The checks are carried out centrally by the recruitment team and recorded on the Trust workforce information system (ESR).

All recruiting managers are trained in safer recruitment practices. Where other staffing methods (e.g. agency) are used, contracts include a requirement to comply with the NHS employment check standard.

Training and Awareness: All SHPS staff have, or are working towards, professional purchasing qualifications.

The issues relating to Modern Slavery have been raised through articles in the Trust staff magazine Inform and by other briefing mechanisms. These will be repeated periodically. If staff have concerns about the supply chain or any other suspicions related to modern slavery they will be encouraged to raise these concerns through line management and report the issues to appropriate agencies. This will be raised particularly with clinical staff that may be in contact with vulnerable people.

Conclusion

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31

March 2020

Signed……

Position……

Date……

Shropshire Community Health
NHS Trust

Enc. 1

Minutes of a meeting of the Quality & Safety Committee held on Thursday 23rd January 2020 9.30 a.m. – 12.30 p.m.

Beechtree Community Centre, Claypit Street, Whitchurch, Shropshire SY13 1NT

Present Peter Featherstone, Non-Executive Director (Chair) (PF)
Steve Gregory, Director of Nursing & Operations (SG)
Dr Ganesh, Attended on behalf of Jane Povey, Medical Director (MG)
Mike Carr, Deputy Director of Operations (MC)
Alison Trumper, Deputy Director of Nursing & Quality (ATr)
Angela Cook, Head of Nursing & Quality Adults (AC)
Susan Watkins, Chief Pharmacist (SW)
Jo Gregory, Head of Nursing & Quality C&YP (JG)
Tina Long, Non-Executive Director (TL)
Cathy Purt, Non-Executive Director (CP)
Sarah Hayes, Head of HR & Workforce (SH)
Liz Watkins, Head of Infection Prevention Control (LW)
Jaki Lowe, Director of People (JL)
Julie Harris, Named Nurse for Safeguarding (JH)

Apologies Jane Povey, Medical Director

Minute taker: Diane Davenport, PA to Director of Nursing & Operations (DD)

Guests:

Minute number:	***Agenda Item title***	
2020/01/01	**Apologies** (Agenda Item 2) The Chair welcomed everyone to the meeting. Apologies received from Jane Povey, Medical Director and Dr Ganesh attended on her behalf.	
2020/01/02	**Declarations of Interest** (Agenda Item 3) No new declarations of interest.	
2020/01/03	**Minutes of meeting held on: 12th December 2019**(Agenda Item 4) Amendment to Minute No. 2019/11/04 Quality Report – Safeguarding Children – amendment and to read **Not on track for L3 and *some* staff are out of date.** Minutes of the meeting held on 12th December 2019 approved with the above amendment.	
2020/01/04	**Matters Arising – Action Log** (Agenda Item 5) The Committee reviewed the Action Log and updates were provided on each of the actions due. **Minute No. 2019/06/10 - Delayed Initial Health Assessments (DIHA)** – JH provided an explanation of the DIHA process. The Assessments are being undertaken within the timescale and the delay is with the recording of the assessment. A review of the process is underway and JH provided reassurance that the Health Assessments are being undertaken. PF queried if	

	CQC visited would the narrative be available to substantiate the data. JH provided assurance that the narrative is available and Dr Gregory is on track. MG provided assurance that the LAC is being undertaken on time and the initial health assessment is being done. The Committee agreed to close the Action. **Action closed**. **Minutes No. 2019/07/04 – Quality & Performance Report – Community Equipment Services** – AC provided an update on the CES pilot. It was identified via Datix that there were delays with the supply of community equipment. The Shrewsbury IDT team are piloting a different tracking system and the AHP Lead is monitoring the work. The Trust have also introduced Community Equipment Champions. The issue is checking that the equipment is correct, being used correctly and the equipment is returned. A job role is being developed for Community Equipment Services. A business case proposal is being developed and SG Commented it is important that any new roles have to be linked to savings. AC explained that in the first instance, she is attending operational meetings and the issue is getting the equipment returned. The Business Case to be written by February 2020 and will be discussed by MC, AC and SG. AC is to provide an update at the February 2020 Quality & Safety Committee and include the risks, timeframe and action. **Action to remain open.** **Minute No. 2019/08/07 – Flu Campaign** – as at 21st January 2020 the Trust is at 80.6% and JL thanked everyone for their input. SCHT are currently ranked 15 regionally and good result. SG said that still some areas where uptake is low and need to be sighted on. **Action remain open.** **Minute No. 2019/10/09 – MRSA Screening** – SG will progress this action and will raise at the next CQRM meeting. **Action to remain open**. **Minute No. 2019/11/08 – Quality Update SEND Inspection** – JG informed the Committee that the Inspection will take place week commencing 27 January 2020 and it is a joint inspection with CQC and OFSTED. The Trust are involved in various elements of the inspection and have provided data that has been requested by the CCG who are co-ordinating the inspection. Initial informal feedback will be provided at the end of the week's Inspection and a formal outcome of the Inspection will be provided to the CCG a couple of months later. JG provided assurance that the Trust have been fully involved in the preparation for the Inspection. JG will provide an informal update to the February Quality & Safety Committee. **Action remain open** **Minute No. 2019/12/06 – Improving Attendance and Wellbeing** – the data on profile of staff approaching retirement age is included in the Quarterly HR & Workforce Report. **Action closed**.	
2020/01/05	**Quality Performance Integrated Full Report** (Agenda Item 6) **Adults Dashboard** - AC provided a summary of the key points of the report. **MRSA overall screenings** - in December achieved 98%, this is the first time compliance has been achieved since July 2019. **Whitchurch Community Hospital** – received very good external feedback with regard to atmosphere and very positive.	

	Adult safeguarding level 2 is compliant with trust performance threshold. **Celebrating Success** NHS England have approached the Trust to be a Vanguard site for a national programme for Insulin administration and delegation. A visit has been arranged for January. AC is on the advisory panel for NHSE and the Trust are the only site who have rolled the programme out to Care Homes. CP asked with regard to the programme will NHSE ask the Trust to assist with the programme. AC does not have the detail and will obtain the information. CP queried if the programme has been discussed with SaTH in relation to patients admitted via ED. AC commented that the Trust have not discussed with SaTH as it is aimed at the Community and patients who cannot manage in the Community. AC explained that the Trust already share the information with SaTH. **Areas for further work** Safeguarding level 2 children training requires immediate attention and recovery plan in place. Ward based patient handovers - a draft policy has been written and is out to consultation and AC is working with the Ward Managers. It was raised at the Adults SDG meeting that quite poor attendance around Infection Prevention and Control Link Nurse Meeting attendance and challenges around releasing staff. **Shared learning** Wider distribution of monthly medicine incidents collated by Chief Pharmacist now being sent to more Trust prescribers to share learning. A Permission to Pause created and cascaded following a section 42 enquiry involving our community nurses suggesting advice was not always followed and equipment was not always used, as it should by care home staff. Anthony Archambault, Nurse Specialist – Safeguarding Adults is now attending SDG meetings and AC provided the background to the section 42 incident and shared learning. ICS Pathway coordinators presented their audit and findings on record keeping at the SDG meeting. An action plan in place and relevant learning for multiple services. In December, the number of falls reported in our community hospitals was 21. This was due to Whitchurch Community Hospital unable to correlate the data, the system was on high escalation during December, and patients were more complex. One fall at Bridgnorth Community Hospital was reported under the Serious Incident classification and an investigation is underway. A date in February has been arranged to evaluate our fall prevention equipment across in patient units. Ward stock of footwear is also being secured as an alternative to red socks to support falls prevention. Pressure Ulcers continue to be a challenge and there are a significant number of patients being referred to community teams for pressure ulcers management which have developed in the patients home or care home (not under our care). SG stated that have a duty of care to patients and are the cases being referred back to the Care Homes. AC confirmed the Care Homes are informed. SG requested data on how many referrals to a particular care provider and AC will see if the data can be obtained. Learning from recent SI's in teams has highlighted that communication between carers and IDT nurses is not always at the required level and further training required. Action to improve	

	communication by using a collaborative care plan held in the patient's home and Lead for Tissue Viability is supporting the teams. SG asked for an update on Basic Life Support compliance as the trajectory agreed was to be 95% compliant by end of November 2019. ATr shared with the committee that currently at 91.24% for substantive staff and Substantive including bank staff is 88.2%. Recovery plans in place, which includes additional training resources being obtained to facilitate staff compliance. This will be monitored via the SDG Q&S meeting PF noted that DTOC has increased and is this due to winter pressures or issues outside of the Trust's control. MC explained there are various factors affecting the delays such as patients waiting for Nursing home/EMI placement, Out of area patients waiting for therapy/enablement and there was a spike in December due to pressures in the system. Many of the delays are outside the scope of the Trust. A Capacity Manager has now been recruited and this will assist with consistency and actions to address the issues are in place. TL asked if the planned actions in relation to TeMS are on track to be completed by February 2020. MC commented that in terms of 18 week Referral To Treatment for non-admitted patients there are improvements. However, in December the RTT increased to 95% for non-admitted patients. It is the open clocks that need to be reported and currently the Trust are 23rd in the Country. The focus now is around rationalising 52 waiting lists to improve monitoring and support focused approach to challenged areas. The Committee asked for further information in relation to the award that Michelle Bramble was nominated for. JG informed the Committee that Sharon Simkin nominated Michelle for the HQIP Clinical Audit Professional of the year. Although Michelle was not successful and was a runner up and made it to hall of fame as a nominee. The Committee shared their appreciation to the Shrewsbury IDT teams on achieving 100% compliance for Mandatory Training despite staffing challenges and could this be shared with the team. **Children and Families** JG provided a summary of the key points in the report. **Areas for further work** Speech and Language Therapy Team (SALT) redesign is currently off track due to the lack of success in recruiting the approved additional therapists to enable the redesign. Quotes have been requested from external provider for additional support to aid with recovery. The Trust have been successful in recruiting to limited additional capacity, therefore some improvements can be achieved. TL asked about the speech and language on the risk register and JG advised it has been reviewed and looked at the risk score and will review. The physio department have got a big waiting list and requested a recovery plan and breaching waiting lists. Reassurance has been provided that no risk to the children. A physio has just been recruited and this will assist with reducing the waiting list.	

	Celebrating success Jane Chapman HV and Lorraine Vine SN CPT have been awarded the NSPCC Graded Care Pathway Elephant Practitioner Award in recognition for the excellent care they have provided for a family with significant needs. The nomination came from the Shropshire Council. JG will provide an update to the Committee. The Trust are contributing to the Independent Inquiry into Telford Child Sexual Exploitation (IITSCE). This is not a statutory inspection but will enable the Trust to share information to support wider learning. The Inquiry has been commissioned by Telford & Wrekin Council and led by Evershed. JG is the key link and Gill Richards, IG Manager is also involved and everyone who is involved has been informed of the inspection in case they receive requests for data and working with MPFT and RJAH. TL referred to the issue with regard to Community Equipment Stores (CES) and an increasing risk in delivering the service due to the issue with the delivery vans. MC explained to the Committee there are various factors affecting the service, and he will look into the issue and provide an update at the February Quality & Safety Committee. Whilst the future of the service is considered through current contract negotiations, the new van lease has not been agreed. Additionally the lack of storage facilities, which is pending an estates decision, is affecting the delivery of the service. Check on Risk Register Safeguarding Children – Levels 2 & 3 Training Compliance - the Committee discussed the performance compliance for Safeguarding and for future reports, the data is to be split for Levels 2 and 3.	
Reassurance		
Assurance	**SALT is included on the Risk Register**	
2020/01/06	**CQC Update** (Agenda Item 7) ATr provided a summary of the report. The aim of the report is to provide the Quality and Safety Committee with: - Progress and outcomes of core service improvement actions CQC told us the Trust 'should' and 'must' take following publication of CQC ratings of GOOD 1st August 2019. - Consideration to the strategy and vison to maintain our rating of GOOD, balanced with aspiring to progress to achieving OUTSTANDNG ratings at our next inspection. Three of the 28 SHOULD do improvements are slightly off track in January. These improvements do not increase any risk to patient safety but do require more time to fully complete. Completion date is extended to April 2020. The report provides information on the next steps and through Quality strategy engagement events, there is an appetite from staff to move to Outstanding. The Quality team with support of the Strategy team are developing a tool to help our team to understand the descriptors of where we are. TL commented it was a helpful report and asked for reminder of further work. ATr informed the Committee that the areas are:	

	- Improve all mandatory training to ensure trust target is met. - Ensure assessment forms for all specialities are incorporated into RiO. - Improve access for patients with different languages to ensure their needs met sufficiently. The Committee discussed the appetite of the staff to move to "Outstanding". Whilst it is good that staff have ambition to strive for Outstanding and do not wish to demoralise, however as a Trust maintain Good and staff deliver best care and highest quality care. CP queried if the Trusts Finances allow to aim for Outstanding, and take into account and ensure workforce and fiannces are aligned to meet the ambition. The focus of the Trust must be to maintain our rating of GOOD and support core services to achieve OUTSTANDING where services can evidence against CQC rating descriptors. ATr to provide an update at the March Quality & Safety Committee on the self assessment tool that is being developed. The CQC Report is due to go to the January Trust Board and there are a few typos and ATr to review the conclusion of the report and what the Trust are doing next.	
2020/01/07	**Safer Staffing Board Report (NQB Requirement)** (Agenda Item 8) ATr provided the background to the report and a summary of the key points. This report aims to provide the assurance to the following questions :- Safer staffing • do we have the right staff with the right skills at the right time • what impact has staffing had on patient safety There has been one occasion where Bishops Castle experienced a protracted shortfall of HCA's on the early duties across a two month period with a correlating slight increase in reported patient safety incidents. This did not trigger a concern at that time. Staffing shortfalls over greater lengths of time may result in an upward trends inpatient related incidents. TL asked in terms of the uplift, 25% seems reasonable and how does it bench mark against other Trusts. ATr advised it is broadly similar when compared to other Trusts. MC advised that there is a recruitment issue at Bishops Castle Community Hospital and a recruitment event is planned in the southwest of the County on 7th February 2020 and some good interest and have asked Ward Managers and Locality Managers to contact people who have expressed an interest. If the recruitment event is not very successful then will look at different options. PF commented that report provides detail of the Fill rate and if compared to the national average then the Trust is below and is it of concern. ATr commented that there is currently no mechanism to compare SCHT establishment with other Community Trusts and the Model Hospital is used for comparison and is it appropriate comparative. ATr to provide a paper to the Committee that looks at Model Hospital and where the Trust sit and to add to the Forward Work Programme. PF referred to the 25% uplift being applied to staffing establishment and was there an issue previously and if so increasing the people	

	or the hours. SG commented that the Trust do not recruit fully and leave a contingency to recruit to bank and people to take annual leave to recruit bank and within financial envelope available. SG commented that NQB Right skills there are 10 key things to be appraised on and could detail of the 10 be included in the report.	
2020/01/08	**Six Monthly Safeguarding report** (Agenda Item 9) JH provided a summary of the report. The report provides an overview of the wok undertaken by the Safeguarding team for the period October – December 2019. The key changes to DOLS legislation is due to become law by 1st October 2020 and to be known as 'Liberty Protection Safeguards' (LPS). Main changes will mean that the Trust will become the responsible body (previously Local Authority) for patients who will be subject to LPS. If a person does not 'wish' to receive the care/treatment or reside there then an additional review by an Approved Mental Health Care Practitioner (AMCP) will be needed. Currently there is no training for the role of an AMCP. Meetings held have discussed the possibility of combined commissioning of both AMCP's and independent Mental Capacity Professionals (IMCA) but this is still to be determined. The change was going to be introduced in October 2020 and will now be April 2021. **Safeguarding Children** – JH provided details of the challenges facing the Safeguarding team and include the geography of the area covered, an increase in the number of staff seeking safeguarding supervision and support and participation in multi-agency work. **Looked After Children** – some of the positives, the voice of the child has been captured in Meridian and regular inclusion. Audits of the review health assessments is in place and have been audited has improved the quality of the assessment. **Child death overview panel** have procured the ECDOC system which will be beneficial for the team. There were only a small number of deaths so difficulty to identify trends. JS informed the Committee that support is provided to staff who are involved in the deaths of children. TL asked in terms of MCA and DOL assessments noted that in previous audit reports that not as good as we should be. JH explained the audit was undertaken and training has been delivered and there will be a re-audit once the training has been embedded and is still on the radar and will be reported next time. TL asked if any Children Serious Case Review. MG provided detail that 3 cases could be coming through and will report back to the Committee and any lessons learnt are shared. MG advised of change in process, learning and review group who are setting up a new process for serious case review and will bring it here.	
2020/01/09	**Quarterly HR & Workforce Report** (Agenda Item 10) SH provided a summary of the key points of the report. To provide the Committee with a highlight report that covers sickness absence, transactional recruitment processes and retirement.	

	Current staff numbers and deployment – SH drew to the attention of the Committee the Headcount figure compared to last year and workforce plan and more than planned. The proportion of bank staff against agency has increased. **Sickness absence** – the Committee discussed the proposed dynamic sickness absence target of 4.7% from April 2020 to March 2021 with the aim of reducing this target further from April 20201 (or sooner if met). The report also includes work and focus on mental health and work due to finish in February 2020. At the December 2019 Quality & Safety Committee, it was agreed to represent the sickness absence information following the rolling 12-month lens. In December 2019, the rolling 12 month sickness absence rate was 4.89% and in terms of NHS target 3.39%, the rolling Trust proposal is a target of 4.7% of Trust sickness rate. JL explained the detail behind the rolling proposal of 4.7% and taking into consideration NHS target and benchmarking of other Community trusts. The Committee suggested the figure of 4.7% with the ambition to review and if reduce then revisit the target. **Flu Programme Update** – As at 23rd January 2020 the uptake figure is 80.77% The Trust target is to vaccinate 100% of our target group by the end of the programme in March 2020. The stretch target was 80% by the end of December 2019 and achieved ahead of time. The NSHI reporting continues until 29 March 2020. SG commented that the ambition for next year should be to aim to get the highest percentage possible before December. JG commented that still some Children's teams still low and still myths exist and communication and some pre work around communication campaign. JL commented it is good the Trust to be ambitious and nationally talk of the flu vaccine to be mandated, CQUIN looking at 90% for next year and good team working and peer vaccinators. PF commented lessons learned that peer vaccinators have been good and introduce earlier next time. MG asked if staff are aware that can declare if they have received the flu vaccine at alternative venue. SW commented there were some delays to receiving the vaccine due to the Trust being graded incorrectly and this has been amended and should receive the vaccine earlier. PF asked for a report back to the Quality & Safety Committee in May 2020. **Time to recruit** – against an NHSI Benchmark period of an average of 57 working days, our performance for November was an average of 52 days (exceeding the benchmark by 5 working days) and December was an average of 47 days (exceeding the benchmark by 10 working days). **DBS rechecking programme** - making good progress.	

	Apprentice Levy Allocation – at the time of reporting, the Trust are not achieving the apprentice target and will not lose levy spend and working with OD to progress. Reflection on the target and some service cannot always support an apprentice **Retirement** – following discussion at Committee in December 2019, we have looked into whether a combination of our workforce age profile and projected future retirement rates may expose us to possible future staff shortfalls. In summary, there is a low risk of significant risk short term. However, the workforce age profile indicates likely shortages of clinical staff in the longer term unless we take pre-emptive action. Details on these programmes of work are included in the report. The Committee approve the sickness target and clarify what the national average is and in relation to retirement, low risk of loss of staff in the long terms and action is to address the potential issues. Report back the next quarterly report.	
2020/01/10	**Learning from Deaths Framework Trust Report** (Agenda Item 11) MG provided summary of the report and Learning from Deaths Group is a sub-group of the Quality and Safety Delivery Group (QSDG). The group undertakes reviews of all deaths, monitors trends and reports findings, lessons learnt and recommended actions to be taken. These are reported to the Quality and Safety Committee and the Trust Board as part of the assurance around management of risk within the Trust. MG informed the Committee that Shropshire CCG have commissioned an independent review of learning from deaths by a company called NICHE. JG asked in relation to the CDOP and the themed identified from recent Sudden Unexpected Deaths (SUDI) in Infants and safer sleeping guards and has that already been actions. MG commented that it is be revised and JG has received some information from PHE and will share with MG. TL asked what is the timescale for the work to be undertaken and MG informed the Committee that it is currently under review. The Committee questioned and discussed the report and can go to the January Board meeting and to be added to the Quality and Safety Committee Forward Work Programme.	
2020/01/11	**Clinical & Quality Strategy** (Agenda Item 12) To provide the committee with a progress update on the development of the Quality and Clinical Strategy. To enable the committee to comment on the content of the quality and clinical development plan before the completion of the full strategy. The Strategy document will come back to the March Committee to recommend sign off by the Board in March 2020. The key priorities still need to be agreed and include Quality and Clinical priorities and the approach that has been taken. TL asked if there is enough focus on prevention. JG informed the Committee this is the first draft and have undertaken engagement with staff, patients,	

	children and young people and have to link with wider work of STP and LTP and need to strengthen prevention and include in the next draft.	
2020/01/12	**Infection Prevention and Control (IPC) Report for the period October-December 2019** (Agenda Item 13) LW provided a summary of the report. The main risk associated with IPC at present is the Laundry provision. In January the Trust were notified of mechanical breakdowns by the laundry provider which led to the activation of their Business Continuity Plan, this is currently being closely monitored. The laundry processing is included on the Trust's risk register. There are no issues for the Trust at present and MC, SH and SG are going to meet as Mid Cheshire Laundry have asked for a contribution to the cost of repair of the machine. SG commented it is important to ensure that the Trust have adequate provision and consider our own business continuity and have SLA and the company also provide RJAH and SaTH with laundry provision. LW informed the Committee that it is currently business as usual and if there are any developments then will provide an updte. TL asked about cleaning at Oswestry Health Centre and is this still an issue. LW commented that the cleaning is still below standard and is being monitored and LW has met with MPFT to review CP asked about the water problem. LW informed the Committee It is being managed and remedial action taking place.	
2020/01/13	**Themed Review Whitchurch Community Hospital** The Committee welcomed everyone and introduced everyone. ATr provided the context of the session. In attendance were: Kelly Evans – HCA Emily Gilmore – Bank HCA Samantha Paddock – RN Caroline Rowland – Ward sister Comments raised were: • Issue in relation to agency staff do not turn up for their shift and then have to source staff to fill the shift. MC to obtain data and feedback to the Committee. • Updating the building and the group to provide ideas • To consider a Dementia tour of the hospital • Induction training to the Hospital/Ward. Implement something for new starters and booklet to work through and competency framework and induction process. • Upskilling of staff and sharing skills of staff and utilise the skills of the staff. • Consider the environment with regard to EOL patients and a family room alongside and more homely. SG suggested could be part of capital programme. • Hospital environment does not flow on the ward and consider a central hub in the middle of the ward and centralise staff together. • To review if staffing levels are correct.	
2020/01/13	**Policies: For Endorsing/Approval** (Agenda Item 14) **Management of Norovirus and other Gastrointestinal Infections Policy**	

	Decontamination of Reusable Surgical and Dental Instruments Policy incorporating Decontaminationof Flexible Nasendoscopes, Trans-vaginal Probes, Sigmoidoscopy Light Sources and Cyro-cautery Equipment **Dental and work taking place at Craven Arms and at best practice and dental plan for the Trust as a whole.** **Water Management Policy** The Committee endorsed the Policies.	
2020/01/14	Risks (Agenda Item 15) Assurance	
2020/01/15	**Any Other Business** (Agenda Item 16) **Update on the Year of the Nurse and Midwife 2020** 2020 is Florence Nightingales' bicentennial year and designated by World Health Organisation as the Year of the Nurse and Midwife. JG provided an update on the work that the Trust are undertaking. An internal Focus group will be formed and various initiatives are being developed and there will be an article in Inform. The Executive Director of Nursing Award for excellence in nursing will be launched and will be presented at future Quality & Safety Committee. JG will provide updates to the Committee. JH informed the Committee that of the Local Authority Ofsted Inspection in Telford. LW provided an update on the recent outbreak of Norovirus. Environmental health are undertaking an inspection of our waste and how we dispose of our waste and writing an action plan and will bring back. Contacted MPFT and will wait to hear and will update next month.	
	Date of Next Meeting Thursday 20th February 2020 – 9.30 a.m. – 12.30 p.m. – K2, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL	

Shropshire Community Health NHS
NHS Trust

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Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 25th November 2019 at 10:00am
Meeting Room B, William Farr House

Present: Catherine Purt, Non-Executive Director (CP)
Sarah Lloyd, Associate Director of Finance (SL)
Peter Philips, Non-Executive Director (PP)
Mike McDonald, Associate Non-Executive Director (MMc)
Steve Gregory, Director of Nursing and Operations (SG)

In Attendance: Alice Horton, PA to the Director of Finance and Strategy (AH) – Minute Taker
Ros Preen, Director of Finance and Strategy (RP)
Nuala O'Kane, Chair (NO)
Robert Graves, Director of Facilities and Estates (RGR)
Jonathan Gould, Head of Finance (JG) – Agenda Item 7.1 only
Anthony Simms, Head of Management Accounting (AS)
Tricia Finch, Head of Development and Transformation (TF)
Mike Carr, Deputy Director of Operations (MC)
Andrew Crookes, Head of Informatics (AC)
Robert Goodrich, Procurement Lead (RGO) - Agenda Item 6.3 only
Susan Watkins, Chief Pharmacist (SW) – Agenda Item 9.1 only
Mark Mawdsley, Head of Costing and Contracting (MM) – Agenda item 7.2

Apologies: Harmesh Darbhanga, Non-Executive Director (HD) (Chair)
Julie Southcombe, Patient Representative (JS)

Minute number:	***Agenda Item title***	***Action***
2019/11/174	**Declarations of Interest** (Agenda Item 3) CP welcomed every-one to the meeting.	
2019/11/175	**Minutes of the Previous Meeting** (Agenda Item 4) Minutes from the previous meeting were approved.	
2019/11/176	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) Action 68 – *'SG to review other options for e-rostering software, work with partners in the system to ensure connectivity across the STP and bring a refreshed proposal to committee.'* This action is not due for completion until March 2020, but SG verbally updated to confirm the trust are exploring procurement options and hope to know more by next meeting. **Action ongoing.** Action 79 – *'To provide analysis on the increase in the number of purchase orders raised, in particular low cost purchase orders and under £10,000.00'* It was confirmed that this action is closed as the information is in the procurement paper. **Action closed.** Action 84 – *'AH to amend Terms of Reference and circulate to Claire Lea for her comments and bring back to October RPC and then to Board for review'.* It was confirmed that the amended Terms of Reference were included on the agenda. **Action closed.** Action 88 – *'Capital section of the Finance report to be amended to include further detail in a RAG rated table, as well as the capital value and outstanding funds.'* The section has been updated. **Action closed.** Action 89 – *'SG/MC to bring brief TeMS paper to the next committee*	

	with an update, the actions taken and the subcontract position and an update on the outcome of the Data Quality work.' It was confirmed that this paper was on the committee agenda. **Action closed.** Action 90 – *'A meeting to be held around Whitchurch Estate and any significant change/spend to come back to RPC for approval.'* SG confirmed that the meeting has been arranged and that he would provide the date to CP and MMC. SG confirmed that a lead volunteer and dementia support would also be present and that RGR would also be involved. Further update to come back to Q&S. **Action closed.** Action 91 – '*WS to confirm if there is a mandated deadline to have the Procurement Strategy in place and feedback discussion today to PD and RGo.'* It was confirmed that confirmation has been received regarding timing, and there is no firm deadline therefore the updated strategy will come back to the committee in February. **Action closed.** Action 92 – '*Amendments to be made to the Performance report, including Net Staff Position and the indicator key for the dashboard.'* It was confirmed that amendments had been made to the performance report. **Action closed.** Action 93 – *'Digital Programme Group Terms of Reference to be presented for review.'* RP confirmed that these were included on the agenda. **Action closed.** Action 94 – '*Optimising Use of Technology BAF risk to be updated and brought back to the next committee meeting.'* It was confirmed this had been amended. **Action closed**.	
2019/11/177	**Work Plan** (Agenda item 5.2) It was confirmed that there were no changes to the workplan, but the committee was asked to note that, due to a review of the IM&T strategy, the IM&T Strategy timeline may need to be revised in future.	
2019/11/178	**Future Meeting Dates** (Agenda Item 5.3) The schedule of dates was reviewed and agreed by the committee.	
2019/11/183	**Finance Report Month 7** (Agenda Item 7.1) Due to presenter availability, this item was reviewed out of agenda order and was presented before item 6.1. JG presented the report, and noted that the Trust is currently ahead of plan, which reflects the favourable performance of non-contracted activity. There were no new risks identified, but the top risk remains the level of unidentified CIP. JG noted that this is continuing to reduce and is now below £1 million, but it is not reducing fast enough. JG confirmed that mitigations are being explored and the Trust is looking at reserves for cost pressures to see if these can mitigate the gap. CP queried what else was being done around CIP to bring it down to more manageable levels of risk. JG confirmed that there is a group which works with teams to generate ideas and take them forwards. Agency also remains as a risk, but has also reduced despite still being above year to date plan. PP queried the expenditure for agency as the trust is ahead of what was budgeted for. AS explained that the Trust generally doesn't include budgets for agency, what is shown on the report is the planned levels of spending. PP queried if the target	

	should be reviewed and whether a more meaningful budget with gradation over the year should be put in place. SG agreed with PP and suggested that it would be helpful to see the plan and where we are against the plan in the same table. SG observed that fundamentally the position is better than it might have been, but here is still work to be done. NO observed that she would be very keen to see worked up plans to reduce use of agency and all the different variables; whether it was regarding e-rostering or managing within existing establishment as the current reliance on agency is more than is desirable for the safety of care of patients. **Finance report to be amended to show the budgeted position and the plan for agency in the same table.** JG gave an update on the Apprentice Levy, confirming that the Trust committed to spend the money this year and is on track to do so. JG also raised the capital expenditure, and noted that while there was a risk that the schedule might change, the Trust is still forecasting at to hit the target. SL explained the change to the capital programme due to EPR scheduling which is no longer progressing, and that replacement bids are therefore coming through later than desired this year. SL noted that there will be capital bids received at the Capital And Estates Group on 29/11/19, but noted that one of these bids is likely to exceed the value that the group can approve. Normally, the bid would then come to this committee for approval, but this would mean delaying the request until January. SL requested, under the amended terms of reference, if she could seek virtual approval from members to progress capital bids exceeding £100k, pending the agreement of the amended Terms of Reference later in the agenda. **The committee agreed to virtually approve a capital bid before the next meeting if it is approved at Capital and Estates group.** SG queried if there needed to be a meeting before the next committee meeting on the 27th January 2020 to raise the next financial year in more detail, particularly around CIP and financial sustainability. SG noted that the Trust have received the commissioning intentions, and know some possible threats and significant opportunities, so the quicker this can be discussed ahead of April the better prepared the Trust can be. SL noted that she would always encourage planning being done earlier than later, but that the estimated planning requirements won't be available until January although we do have an estimated efficiency requirement for 20/21 based on what we currently know. SG noted that there needed to be the ability to plan more proactively and JG confirmed that the CIP group is already picking up 20/21 plans, but committee oversight is useful. It was suggested that the CIP group could be asked to talk to committee and change the dialogue around spend. RP noted that she would support the suggestion of planning earlier, but queried if there needed to be an extraordinary meeting, or whether the January meeting needed to be used in a purposeful way. RP observed that having some advisory thinking from the CIP group would highlight any gaps the scale of future thinking. TF agreed that this would tie in with the planning work and raise lots of opportunities. It was also observed that the Benefits Realisation Group (BRG) does	**JG/AS**

	have oversight over the CIP development and BRG will meet before Christmas so the work will still be going on. SG raised the challenge of finding some big ticket items and doing something different in agency to really make an impact. It was queried if the right people were in the room and if not, there needed to be representatives in the room. **AH&SL to review and amend the agenda for January to ensure forward planning can be discussed thoroughly.** CP queried the non-pay adverse variance to plan and if there was a recovery plan. JG confirmed that there were controls in place to run at the current level, but there is no expectation to recover the position. JG left the meeting.	**AH/SL**
2019/11/179	**TeMS Monthly Update Report** (Agenda Item 6.1) MC presented the update and confirmed that TeMS' performance was has improved since the last update. There had been a detailed conversation last month about TeMS, and MC updated around the previously raised 'data quality issues'; confirming that a number had been resolved, that there were no cost implications. There is an impact on perceived waiting times, but this will improve in November. RP raised that there was an exploration ongoing regarding a bigger arrangement for Musculoskeletal services for the county which is likely to echo what the Trust currently have in TeMS with collaboration on the pathway for MSK patients. It was observed that any lead provider should have a good line of sight of the waiting list for sub-contractors. A question was raised in terms of how the waiting lists are being monitored for the sub-contractors; MC confirmed that it was purely a data conversation and SG observed that the Trust should hold any sub-contractors to account in the contracting meetings. TF noted that the patient's pathway will follow them and the ownership of pathway will transfer between providers as required. MC confirmed Rheumatology is an improving picture, and the issue now is in moving attention to the follow ups and using more intelligent management of follow ups to make sure patients are seen in clinical priority order. MC confirmed that the new automated process would start the middle of January.	
2019/11/180	**Monthly Performance Report** (Agenda Item 6.2) AC presented the Performance report, noting that at the last month's committee the issue around reporting of leavers had been discussed and whether it showed a net position. AC confirmed that the number of leavers forms part of national reporting, but that he has discussed with HR and future reports will also include local performance with the net position on the assumption that HR will provide the information. AC confirmed the changes to the report; the data quality maturity index is a new indicator, and there is a new oversight framework that has been reviewed. An inconsistency around VTE was observed, and this is being investigated and there are 2 new measures; the data quality score, looking at data sets for inpatients and outpatients, and the CQC rating. A number of other indicators were also coming out of the staff survey. Areas of concern are the 18 week target, information governance requirements regarding IG training and appraisal rates.	

	AC also raised the unbooked leave indicator; this is a local indicator requested by committee members earlier in the year as an attempt to identify where staff have not booked their annual leave to try to prevent a lot of leave being taken in February and March and the consequence this has on agency and bank. AC noted that this was the first year of the indicator, and that there is currently 32% of available leave not booked across the workforce. SG confirmed that some of this conversation was discussed at Q&S, and that there had been feedback around ESR being a difficult system, so while it may be booked on a calendar locally it might not be proactively booked on ESR. NO observed that leave is a managerial issue and she would like to be assured that managers are on top of the situation and are encouraging leave to be booked. RP observed that from a positive values-driven point of view it is key for staff to take leave and breaks, and also noted that audit capacity is used to do a review at an appropriate point on a new metric so this could pick up operational difficulties. SL thought this was already included in the audit program, but agreed to confirm this. **SL to confirm that the unbooked leave indicator is included in the audit programme for review.** PP raised that 22 performance indicators are red and asked if there was a way these could be presented to give better focus on areas of concern for the committee. There was a discussion around this and it was suggested that as 2 committees review the indicators, it might be best to look at the overall risk at Board and CP agreed this should be a topic for Board. It was also suggested that there could be conclusion at the end of the report to flag up real issues and areas of concern. RP suggested that there could be a piece of work pegging the performance back to the BAF risks and pulling out where board and committees need to be sighted through this. **RP to explore linking Performance to the BAF risks.** MC raised the Delayed Transfers of Care (DTOC) figure as there seems to have been a spike in October due to some patients that were delayed due to funding. MC noted that the team had looked at the reporting process and informed the committee there might be an increase in this indicator due to more appropriate recording. SG noted that there should be a measure of DTOC over the system, as transferring a patient from the acute to the community until a care package is available masks an underlying issue.	**SL** **RP**
2019/11/181	**Procurement Update** (Agenda Item 6.3) Rob Goodrich attended the meeting to present the paper. RGO noted that at the time of writing the report the CIP savings were behind the profile, but now reported that finance have signed off more savings so procurement is now back on target. RGO gave some updates around project progress; enabling works have been agreed after Christmas for the Whitchurch x-ray machine, and the managed print service is delayed due to provider issue with the cloud system. RGO also confirmed that the Wheelchair Services Database tender has finished and the database will hopefully be online for 1st April 2020 and that the contract schedule for the Health and Safety Tender was	

	issued last week. A number of other tenders are being explored or are in progress. RGO drew the committee's attention to section 5 of the report and the good news that the Procurement team's level 2 accreditation has been confirmed. CP asked RGO to congratulate the team from the committee and PP agreed it was a real achievement. RGO left the meeting.	
2019/11/182	**Terms Of Reference** (Agenda Item 6.4) SL presented the Terms of Reference, noting they had been amended by the Company Secretary to ensure continuity across all committees. Key points around virtual attendance and email approval were raised and that the Director Of Governance is now included as a member of all committees going forwards. SG confirmed that Quality and Safety Committee Meeting (Q&S) terms of reference are going to Q&S in December and there is a synergy with them and these terms of reference. PP noted that the document is well articulated. **The committee approved the Terms of Reference and they will go to Audit Committee and Board for approval.**	
2019/11/184	**Contract Monitoring Report Procurement Update** (Agenda Item 7.2) MM attended for this paper and picked out the highlights for the committee. MM noted that the contract performance has improved, due to over performance in MIU areas. After tolerances and marginal costs there is a shortfall of £50,000 which is offset by over-performance for TeMS. MM drew drawn attention to the CQUINs and noted that the antimicrobial CQUIN is a potential difficulty. It had been written off due to change in national guidance in the first quarter, but the Trust haven't haven't had any notification around further quarters. SG confirmed that most organisations are not meeting the criteria, so it is likely the decision for Q1 will continue. MM also noted the Integrated Urgent Care (IUC) contract as the Commissioners and Providers are agreeing the outcome of the review and this will drive the outcome for the service. MM also flagged up positive news around the Local Authority contracts including Dudley requesting an extension. CP raised her concern about non-signed Service Level Agreements (SLAs) and queried what is being done. MM explained that the Trust do have a number of trading relationships that are historical and the Trust are receiving payment. This issue has also gone through the Contract Management Group to ensure income is recovering and the Trust has provided training and guidance to deliver SLA's. MM left the meeting.	
2019/11/185	**Service Development Report** (Agenda Item 8.1) TF presented the report and noted that a major point that needed to be highlighted was around the partnership working with the Midlands partnerships as the team is making good progress there and it is a good platform to build on. TF also noted that the Shropshire Care Closer to Home (CCtH) have	

	managed to secure some funding for Rapid Response and thanks had been received from Shropshire CCG. TF noted that it had been a challenging time with the project, but there were some positive patient stories. RP agreed that it had been a very positive experience at Programme Board and there is now the intention to increase the pace across the commissioning footprint. Phase 3 is in the assessment phase and all providers have been asked to do an impact assessment to identify areas that need more discussion and to give a more detailed awareness around workforce, infrastructure and 24/7 cover. The Telford Health and Social Care Rapid Response Team was launched last week and the Nursing Team and Local Authority are now co-located. TF noted that they are hoping to get the assessment completed and report back this week will keep the committee updated. There will be further discussion around the County Wide Musculoskeletal service at Trust Board on 28/11/19, but this will be a significant transformation across the patch. Further information will be brought to committee as it becomes available. PP raised the IUC contract with Shropdoc and if there were concerns. RP noted that the important thing had been to get around table with commissioners to get holistic closure to the review. PP noted that it had been a professional approach over a difficult period.	
2019/11/186	**EPMA Proposal** (Agenda Item 9.1) SW attended the meeting at this point to present and CP noted that this was one of the main issues for the committee to review today. SW presented the report and explained that the Trust was keen to implement an Electronic Prescribing and Medicines Administration system (EPMA) to reduce prescribing incidents and move towards digitalisation as seen with the Electronic Patient Record (EPR). An EPMA solution has always been considered to compliment the EPR, and would allow better records and integration. Having the system would allow for partner access, particularly with Shropdoc. SW acknowledged that this would come at a cost and in light of this, the committee had approved for an application be put in for funding for year 1 national capital, which has been approved. SW noted that the lack of an EPMA causes a barrier for GP's within the hospitals as they are used to using an electronic system, and the programme would give the Trust the ability to set recommended doses, and add hard-coding to prevent doctors prescribing until they had completed relevant assessments and reduce prescribing incidents. The EPMA would also support the Nursing Associates entering the Trust, and help the hospitals' issues with recruitment as new doctors and nurses out of universities will already have experience of EPMA services and may not want to work with paper based systems. SW observed that the EPMA would help the Trust remain a system leader and it would be important to choose something fit for our trust. SW also noted that while it would be of great benefit within the hospitals, it would also be useful for MIU's, DAART, TeMS and could support District Nurses too. PP agreed that it would be very good thing to do, but the question is whether the Trust can afford it. It was discussed that we currently	

	utilise SaTH's e-script system and they would withdraw their current system if they move to an EPMA which is a risk. SL noted that the report was really well written and was a great place to start as it articulated all the quality benefits, and raised the financial aspects. This proposal needs to be considered alongside the e-community and e-rostering and the Trust's ability to invest, and SL observed that the capital funding allocated by NHSI comes with the condition that it will be released for 19/20, so the ability to spend the capital is restricted to before March 2020. SL did note that the Trust's capital position was healthy, so this is a lesser concern, but the Trust probably won't meet the conditions to draw down all the funding. SL raised her concerns about affordability as deployment is estimated to increase our costs by over £0.5m per annum, and whilst there are lots of quality benefits, not many are cash-releasing, so the only way to fund it is to increase our efficiency requirement. SL recognised that the EPMA deployment is likely to increase next year's CIP by £0.5 million at a time when the Trust is already challenged on CIP and could potentially move the Trust into a deficit position. SL suggested that the Trust need to think differently about next year's efficiency programme to allow for investments like this. SL suggested that the Trust could acknowledge the need to work on the CIP programme and that we are not yet in a position to move on this, and ask NHSI to consider availability of funding next year, acknowledging the delay in confirmation of the funding availability. PP agreed that, looking at the savings, it is the wrong timing for this as the Trust is not certain will have the funding next year. NO questioned what the Trust had available in capital, SL confirmed that the Trust currently have £1.9 million per annum to commit, but could request an increase from NHSE/I, given our cash balance, so the capital element should be achievable. CP queried what the plans are for the STP and whether the Trust would be leading on this. RP observed that ideally the organisations within the STP would be taking decisions from a system-wide view. There is the aspiration for every-one to get onto EPMA, and RP agreed that it is important to be being mindful of changes at SaTH, given our current use of e-script. NO noted that, looking at financial implications and the staffing cost, this is the kind of thing that should be looked at system-wide, and is a chance to share costs and make the system more sustainable. NO confirmed that she is persuaded that this is the right thing for patients, but that it should be taken forwards as a system. SW explained that Oswestry already have EPMA, but it is not yet implemented. SG observed that working with system partners to put a joint bid in with a new business case would be a positive way forward. NO observed this is the kind of thing the system should be doing. It was also queried how compatible it would be with GPs. AC confirmed that the systems will be able to communicate, but will not be integrated. RP summarised the discussion and noted that that a potential joint bid is a good position as the Trust have learned a lot, and can use the work already done. CP agreed and encouraged SW, as this work will all be useful preparation, and if the Trust can do a bid with partners it would be very positive. NO noted that this this seems an obvious	

	place to collaborate and echoed CP's point that SW has done a great piece of work and commended SW as her work will stand the trust in good stead. SG stated that we will need to respond to the regulator regarding the bid. RP agreed and suggested wording is agreed including positive communication with partners. **The Committee did not approve the Case for Change at this time, but approved exploring in principle a joint bid with system partners.** SW was thanked for her hard work and left the meeting. RP noted that history and experience shows that system implementation is tricky as there is not necessarily a direct correlation between implementation and savings. The committee agreed it was disappointing to not be able to progress at the moment as the benefits to patients and staff as well as the safety measures are clearly visible.	
2019/11/187	**Digital Programme Group Report** (Agenda Item 9.2) AC noted that, as discussed at previous committee, the EPR Programme Board and IM&T Strategy Group have now been combined into the Digital Programme Group. The terms of reference were reviewed at the first meeting of the group last week, and have been slightly modified. This is now the final version, asides from some final tweaks to the structure diagram at the end. **The committee approved the Terms Of Reference.**	
2019/11/189	**BAF Risks** (Agenda Item 10) The committee reviewed and approved the BAF risks.	
2019/11/190	**Benefits Realisation Meeting Minutes** (Agenda Item 11.1) The committee reviewed and approved the minutes.	
2019/11/191	**EPR Project Board Minutes** (Agenda Item 11.2) The committee reviewed and approved the minutes.	
2019/11/192	**Risks/Assurances:** **Risks Identified at the Meeting or Key Items** (Agenda Item 12.1) • While no new risks were identified, the EPMA report was noted as a key item as the financial risk has been mitigated, but there is still a reputational risk. This will be further discussed at Board. **Assurances given at the meeting of internal control/risk mitigation effectiveness** (Agenda Item 12.2) • Yes **Any Comments on the Committee's effectiveness** (Agenda Item 12.3) • It was noted that it had been a very rigorous meeting.	
2019/11/193	**Any Other Business:** (Agenda Item 13) No new business was raised. CP wished the Committee Merry Christmas and noted that the next meeting would be in January.	
Date and time of next Meeting: Monday 27th January, 10.00 am – 1.00 pm		

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Deputy Chair – Cathy Purt

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Date – 27/01/2020

Shropshire Community Health NHS
NHS Trust

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Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 27th January 2020 at 10:00am
Meeting Room B, William Farr House

Present: Harmesh Darbhanga, Non-Executive Director (HD) (Chair)
Catherine Purt, Non-Executive Director (CP)
Sarah Lloyd, Associate Director of Finance (SL)
Peter Philips, Non-Executive Director (PP)
Steve Gregory, Director of Nursing and Operations (SG)
Phil Stringer, Patient Representative (PS)

In Attendance: Alice Horton, PA to the Director of Finance and Strategy (AH) – Minute Taker
Ros Preen, Director of Finance and Strategy (RP)
Robert Graves, Director of Facilities and Estates (RGR)
Jonathan Gould, Head of Finance (JG)
Tricia Finch, Head of Development and Transformation (TF)
Mike Carr, Deputy Director of Operations (MC)
Andrew Crookes, Head of Informatics (AC)
Andy I'Anson, IT Programme Manager (attended for Agenda Item 9.2 only) (AI'A)

Apologies: Julie Southcombe, Patient Representative (JS)
Mike McDonald, Associate Non-Executive Director (MMc)

Minute number:	***Agenda Item title***	***Action***
2020/01/194	**Declarations of Interest** (Agenda Item 3) HD welcomed every-one to the meeting. There were no new declarations of interest noted.	
2020/01/195	**Minutes of the Previous Meeting** (Agenda Item 4) Minutes from the previous meeting were approved. HD thanked CP for chairing the previous meeting.	
2020/01/196	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) Action 68 – *'SG to review other options for e-rostering software, work with partners in the system to ensure connectivity across the STP and bring a refreshed proposal to committee.'* - SG updated the meeting; noting that that the Trust appeared to have been successful with their bid for central monies, but now they have to bring something back around how the e-rostering will fit with the Trust's financial position. SG also noted that the trust may also go out to procurement imminently to give a breadth of options. HD queried if Rob Goodrich is happy with the procurement and SG confirmed that Rob will be leading on this. Action ongoing. Action 91 – '*JG, RGO/PD and TF to review the Procurement Strategy, the issues raised in August and the updated Strategic Priorities from Trust Board and write a Trust Procurement Plan to accompany the Strategy. To be reviewed at February RPC and then March Trust Board.'* - Work is being undertaken on this and the result will come to the February meeting. Action ongoing Action 95 – *'Finance report to be amended to show the current agency spend position and the planned agency spend in the same table.'* The finance report has been amended. Action closed. Action 96 – *'AH&SL to review and amend the agenda for January to*	

	ensure forward planning can be discussed thoroughly.' - This has also been picked up on the agenda. Action closed. Action 97 – *'SL to confirm that the unbooked leave indicator is included in the audit programme for review.'* - SL confirmed that this had been picked up during the performance review and this was not currently on the internal audit plan schedule, so that the committee may need to make a recommendation to the audit committee to include. It was agreed this would be discussed further under the Performance Report. Action closed. Action 98 – '*RP to explore linking Performance to the BAF risks.'* - RP confirmed that she has explored this and Steve Price is looking into how this might be done/reported in future meetings. RP confirmed she is awaiting a response that will determine the timeline. It was agreed the action could be closed as the action was in progress. PP queried if this linked back to the CQC report and it was confirmed that this does have origins in feedback from the well led review. Action closed.	
2020/01/197	**Work Plan** (Agenda item 5.2) The workplan was reviewed and approved	
2020/01/198	**TeMS Brief Update** (Agenda Item 6.1) MC presented the paper, picking out main 3 elements; There is ongoing work regarding the waiting times for the rheumatology service. As previously discussed at the committee, this was due to a shortfall in capacity from consultants. MC confirmed that the new appointment waiting list is now up to the standard the Trust would expect, and the service is working on the follow-up's. HD noted his disappointment that the Service had had to cancel appointments and MC agreed, but noted that the absence had been due to sickness outside of our control. MC confirmed that the right people were in post now as well as support from a locum to catch up on the backlog. The plan is that the position should be fully recovered by the end of March. HD queried what can be done better going forwards, and MC noted that the organisation will have to work more closely in the new alliance and that more can be done to strengthen partnerships and relationships between the clinical teams. MC observed that there has been work to strengthen partnerships as well and SG and RP have been discussing possibilities around joint accountability. CP queried how the Trust are monitoring SLAs and using them to drive performance, as they are the contractual mechanism the organisation have. SG observed that these have been enacted, but if there isn't the rheumatologist the only penalty that can be applied is to not to pay them. PP noted that there had been an overspend using Nuffield and SaTH, who charge based on clinics provided, and noted that, if there may be a need for using them in future, there may need to be a renegotiation on this point. MC raised his second point which was regarding the proportion of patients waiting 18 weeks. It was noted that this was the data quality issue previously discussed here and at the Quality and Safety Committee Committee (Q&S). There has been a 10% improvement seen, and this should be maintained and improved on. The service's contribution was noted, and it was noted that this time	

	last year the service were reporting a loss, so while there has been a significant improvement from last year, there has not the improvement that was planned. It was noted that the service is making good progress, but HD noted it's late in the year and the service is a long way off their financial position. HD queried what assurance there was for the committee that this was going to be realised. **MC to circulate a more detailed recovery plan to bridge the gap between current performance and planned performance.** SL confirmed that the overall financial forecast assumed that the Service will meet its planned contribution, but there is some flexibility. MC noted that there are some schemes; including agency physio and telephone triage, that are anticipated to have an impact. HD queried the future of the service was and it was confirmed that the contract ends in August. A new countywide service is in development and will have a new financial model. RP noted that, in terms of complexity, this is something that will need to be kept on the radar as the organisation will have to manage transitional arrangements.	**MC**
2020/01/199	**Monthly Performance Report** (Agenda Item 6.2) AC presented the report and ran through the dashboard. 19 indicators are showing as red, but many of these have already been reviewed at Q&S. AC also noted that there has been a change in the way data is recorded around appraisal rates and mandatory training and SG clarified that it had been agreed the trust would report both with and without Bank Staff so the organisations were consistent with other organisations, but this would give the organisation perspective to see if there was a challenge for substantive staff compared to bank. CP agreed this was agreed at Q&S. There was a discussion around Delayed Transfers of Care (DTOC) as this was showing deterioration. It was confirmed that this may be due to a different reading of the guidance around DTOC. MC confirmed that he has looked into this and this relates to patients who are discharged from an acute setting with no rehab needs and are just waiting to get back to their normal place of care. MC confirmed that this is not a large volume of patients, and there are actions in the recovery plan. The Trust are doing the safest thing for patients while they are waiting for the implementation of care packages rather than leaving them in an acute setting. CP queried how well the trust is working with colleagues to ensure there is a seamless progress, and it was noted that within the county is a strong progress, but there is more difficult with patients from out of county. CP queried whether it would be appropriate to have conversations with commissioners regarding fining social services who are not coming in, as this has had a beneficial effect in London. It was confirmed that there were regular discussions with commissioners, but that there had been no discussion about fining and SG was cautious around the message that would send as it is relatively small numbers and it was better for patients for them to be in the community hospitals where there was certainty of a bed. CP agreed it was key to release pressure in the system and RP observed that it was important that the Trust didn't congratulate itself on a level of performance that wasn't in line with the values of the organisation.	

	It was agreed that it would be good to have a look at the DTOCs in more detail so the committee can get a better sense of scale, but it was noted this could be reviewed either here or at the Quality and Safety Committee.	
	MC to take a report to Q&S around Delayed Transfer of Care going into more detail to assure the committee that the Trust is giving patients the right experience and outcomes.	**MC**
	HD raised the Information Governance Mandatory Training requirement as the trust is not meeting target; with 162 members of staff outstanding including 2 executives. AC confirmed that the IG Manager is continually chasing managers and the staff themselves and the ESR system has an automatic renewal reminder. AC also noted that the Trust, in conjunction with NHS Digital has carried out an exercise with a targeted phishing email. AC noted that the amount of people putting credentials in was quite small, and all of these have been targeted for additional training, as well as the people who had just clicked on the link were also required to undertake the IG training again. AC observed that this was proof that most staff were aware enough not to click the link, as the trust also know how many opened the email and deleted it. SG noted that Information Governance is not on the risk register and should be. SG also noted that the predicted position would be useful for next time to predict trajectory.	
	Unbooked leave was discussed, and it was noted that this was a continuing issue. SL noted that a recovery plan was requested in November and hasn't been received and that a reminder needed to be sent for a recovery plan to come to committee for next month. CP observed that this was also discussed at Q&S.	
	AC to ensure the recovery plan is requested for inclusion with the February Performance report.	**AC**
	HD raised the New Births Visit target as the trust is not on trajectory to recovery. It was confirmed that there is a recovery plan, but that the Trust won't hit the target for the year. SG noted that this is something that will be taken back to Q&S.	
	Appraisals were also discussed and it was noted this had also been discussed at Q&S as the performance will not be recovered by year end. There was a discussion around the plan for next year and HD queried if the trust hit target last year, and what actions are required to improve. RP gave a historical perspective; the overall performance has improved significantly, but the Trust has never hit the internal target. SG reminded the committee that appraisals were not just a numbers game; it has to be a quality appraisal. It was noted that focus should be kept on areas of low compliance as this may be the same areas where mandatory training levels are low.	
	Sickness absence was discussed and it was noted that the Trust were running at more than double the year to date target. There had been a long discussion at Q&S regarding this and the Q&S Committee had agreed that it would be better to look at a rolling average. It was observed that there were issues around winter, but nothing obvious. It was noted that there had been a detailed report from HR/OD and that	

	stress appears to have gone down, so this did not appear to have been part of the problem.	
2020/01/200	**Estates Update Report** (Agenda Item 6.3) RGR presented the report, and noted that changes had been made to reduce the water management content in the report. There was a discussion regarding Bishop Castle Community Hospital's generator, but it was agreed that it would better to discuss this later as there was a number of issues that needed addressing. There was a discussion about the rationalisation overview and lease work, and RGR noted that there had been a lot of information collection via the STP. There was discussion about remodelling estate and how the Trust want to deliver services, which would be discussed in more detail in part 2. RGR raised the importance of having an approach that values the work/life balance, and flexible working There was a discussion around the William Farr house site and the capital costs of improving the meeting rooms based on feedback from staff around the condition of the rooms. JG noted that the refurbishment of the William Farr Meeting rooms is going through the capital spend process and will come to RPC outside of the meeting. Capital was discussed further, and it was confirmed that the Trust would not overspend, but are fully committed. SL raised a point around non-trust responsible properties where the Trust are seeking legal advice due to the properties not meeting the required standard. RGR confirmed that the trust are looking at potential ways could be managed, but there is a strong recommendation not to cease paying, as this will cause a breach of lease. SG noted that, as director of IPC, he would be prepared to withhold payment until they are compliant to put some pressure on, with the mitigation of being prepared to leave if necessary. The Committee was happy to for RGR take more legal advice if required and HD requested that further discussion to be held in the Estates group. RGR confirmed that in future, this will be written into the leases and licences to prevent this happening again going forwards, and there was a sense of frustration that the Government haven't done anything to enforce the guidance. **RGR to take legal advice regarding non-trust owned properties and compliance reporting.** TF observed that the STP work is starting to move at pace and that it was important to making sure estates are linked into this work.	**RGR**
2020/01/201	**Finance Report, Month 9** (Agenda Item 7.1) JG presented the report and noted that the year to date position is similar to last month; the Trust are slightly ahead of plan and are forecasting to hit control total. No more risks have been identified, and the key risks remain to be; CIP, Agency and CQUIN. JG observed that the unidentified CIP value is reducing, and further work is being done to maintain the reduction by reviewing planned cost pressures, but some of this may not be recurrent and so will need to be considered going into next year. The focus for agency is now on 20/21 as this needs to be reviewed. The Trust remains close to target.	

	CQUIN remains high risk. The assumption is that the Trust will hit the target at this point but this is under close review. It was observed that the variable health income is underperforming, but this is due to key areas; MIU is overperforming, but there is less coming in from the Welsh commissioners. CP noted at it had been discussed at Q&S that there will be a review of community equipment due to the large overspend. SG noted that the trust had met the CQUIN for the flu jabs as the Trust were over 80% uptake. This was agreed to be positive news, and HD congratulated the team.	
2020/01/202	**Budget Setting Report** (Agenda Item 7.2) JG presented the report and noted that the process is using the same principle as last year. Over next few months this will go through different stages including confirm and challenge with all the managers, then then will come to RPC and Trust Board in March. There was a discussion regarding allocating the CIP to the budgets, and it was noted that discussions are ongoing and will be picked up in part 2. There was also a discussion around funding of the 19/20 pay award costs in relation to Local Authority staff and the current assumption is that this will be recurrent, although the risk is increasing as the Trust goes into next year. PP queried the 1% contingency, as the Trust has been previously running at a contingency of 0.5%. SL and JG confirmed that this is something the trust is aiming for as 1% contingency is standard best practice, but it will mean the Trust have a larger CIP requirement. CP queried if the Trust are having to hold anything back for the STP and it was confirmed that requirements of the STP will be factored into CIP.	
2020/01/203	**Service Development Report** (Agenda Item 8.1) TF presented the report and raised the pace at which the STP programmes are starting to pick up. It was observed that the Care Closer To Home (CCTH) has had some challenges in resource and support to the Frailty team, and recruitment in the rapid response team was flagged as a risk because of this and will be raised at the next SLG. It was observed that recruitment to short term posts is never attractive, so a business case is being developed which the Trust don't currently have sight of. MC confirmed that the business case is being compiled by the CCG, but the Trust has fed in the costing, and has requested the deliverables and KPI's to get a higher level of detail. The roll out of the CCTH phase 2 is impending, but that there is still time to work on the case as this should be completed by the end of March. RP observed that the narrative from the commissioners is that they expect us to repurpose some of the existing resources that align along the new way of working which will need to be resolved. Further updates will continue to be brought here monthly and will also come to Trust Board. TF observed that the Telford Rapid Response Team is working well and demonstrating admissions avoided. There was a discussion around the MSK alliance, and it was noted that this was moving very	

	rapidly. HD queried if there was likely to be a cost to the organisation as the new model is a lot more community focused, but TF confirmed that funding for the new model was yet to be agreed, but growth of community services should be funded. TF observed that there was new business development around Occupational Heath which will come out on 14th February. It was noted that there was a 3 week turnaround on this and that Sara Hayes is leading on this. There was also discussion around co-location of teams where models change which will link in with the Estates. RP noted that this was part of the sequence the Trust needed to go through in regards to tying up enabling factors; CCTH and the Telford and Wrekin Integrated Place Partnership (TWIPP) would be significant from a point of scale as knowing the workforce requirements is important to know the size of hubs needed, so the trust have to be ready to go when the required content is received. It was noted that the digital aspect is really important as part of definition of the workforce.	
2020/01/204	**Proactive Recruitment** (Agenda Item 8.2) MC presented the report. It was noted that the front sheet needed to be amended to reflect that approval was being requested. MC focused on option 1 in the report and noted that this had been recommended by BRG in November. MC made reference to the previous report, as the trust may be leading on CCTH phase 2, the wound healing service for Shropshire and phase 3 of CCTH is also likely to have a huge impact, although the Trust is only in the early stages of understanding that. It was noted that some changes may be delivered within the next financial year so it is important to start to recruit staff. The proposal is initially to start with a nurse and a nurse associate into each IDT team, to put the Trust into a strong position so pilots can be commenced sooner and present the Trust as a positive and proactive partner. It was expected that some current staff could be promoted into senior roles, and there will be some non-recurrent savings as nurse associates will be partially filled at trainee band 3's, and then develop into band 4's. The benefits of the proposal is that it will enhance the Trust's ability to quickly mobilise, and give the Trust chance to work on recruitment over a longer period of time. The introduction of nurse associates will also diversify the workforce. It was observed that, should all the staff not be required, the Trust's workforce turnover would absorb the risk. HD queried if this was asking the committee to give a commitment/approval to spend money in addition to other costs, but it was confirmed that this proposal is not asking to go beyond overall budgeted number of employees, so this is not an increase to base budget and therefore does not require Committee approval. The Trust is currently running with 6 full time vacancies in IDTs and has been safely running with that level of vacancy although the teams are under pressure. What the committee need to be mindful of is that in terms of next year this would affect the trust's CIP requirement as it is increasing our running costs, although there has not been a deliberate choice to hold any vacancies within the trust.	

	RP noted that this paper was asking for permission to change the risk appetite by taking some risk with carefully managed application. It was observed that this puts a degree of trust in the Operational team to manage the risk, but CCTH and TWIPP are central core programmes, and the difficulty in recruiting reactively could be evidenced by the Admission Avoidance Scheme. It was agreed that there was not always time to recruit after getting funding. PP agreed that recruitment is not something that happens overnight and so this has to be done for a degree of mitigation. It was noted that if the Trust was introducing a new level of risk, there needed to be absolute intent of commissioners to invest, and also, given that there is a system push to pro-actively recruit, could this be approached as a system? SL noted that this should be prepared as system business case through the governance routes and we should request a risk sharing arrangement prior to progressing with additional recruitment. MC observed that this is going to be discussed in the STP and will be done more from a system perspective to get them to acknowledge this and agree a system mitigation. SG noted that this paper was to approve an action that alters the way the trust is currently operating and increasing the risk appetite. TF suggested that this needed to run in parallel as it can take a while for system to catch up, and there is a recognised need to invest now. The Committee approved supporting this scheme, acknowledging that the funding comes out of current funds not additional funds, but the system risk share arrangement needs discussion.	
2020/01/205	**EPR End of Project Report** (Agenda Item 9.2) AI'A attended for this item and was welcomed to the meeting. It was noted that the EPR project had had a very successful outcome. AI'A presented the highlights, and noted that the report highlights historical context from leaving IPM, the tender process and the learning from that and then the implementation of the project through to the closing stages. AI'A noted that there are still lessons being learned and this is still the beginning of the journey for EPR. It was noted that the lessons learned were summarised within the report, but the main lessons identified was that it was important to get foundations right and have a good governance structure underneath. Another key thing is impact on project team and project staff as they have been immersed in it for many years and it has been a high pressured role. HD queried how staff were kept motivated. AI'A observed that it had been important to get them to buy into the project and see the benefits engagement with the service. It was also noted that, because this was a big project it was important to break it down into phases and reward staff through good feedback. Staff upskilling was discussed, and AI'A observed that there was a large amount of training; all staff had application training as well as PRINCE2 training. There were also elements of mentoring. At the end of each phase the team would sit down and discuss feedback. AI'A also noted that the team still has the same cohort of staff, and the only turnover was 2 of the clinical project managers.	

	It was queried if the project could have been done differently, and it was noted that the initial timescale from beginning to end was very pressured initially. The time spent looking for products prior to this and discussion around budgets protracted the process by 12 months. SG also noted that Board understanding and commitment had been a tipping point, and ensuring that the trust had the right position, governance and leadership had been a big point of learning, especially if the trust were going to do something of this scale at pace. The Committee congratulated AI'A and asked that thanks were taken back to the team. RP also commented that this paper was also coming to board to reflect on this, and noted a big thank you to AI'A for his patience and to the team as they are and have been fantastic. There was a reflection on engagement but the team never experienced resistance to the degree that could have been possible. It was observed that it took time for the regulator to agree the scheme given the value was outside the trust's own discretionary limits. It was noted that it was good to have this end of project report for completion as well as to meet regulatory requirements. SG also raised that AI'A and AC have done a lot of work, and recognised that AC has received a lot of challenge over the course of this project, so well done to all of them.	
2020/01/206	**BAF Risks** (Agenda Item 10) The committee reviewed and approved the BAF risks with no recommended changes.	
2020/01/207	**Benefits Realisation Meeting Minutes** (Agenda Item 11.1) The committee reviewed and approved the minutes.	
2020/01/208	**Digital Programme Group Minutes** (Agenda Item 11.2) The committee reviewed and approved the minutes.	
2020/01/209	**Risks/Assurances:** **Risks Identified at the Meeting or Key Items** (Agenda Item 12.1) • No new risks identified. **Assurances given at the meeting of internal control/risk mitigation effectiveness** (Agenda Item 12.2) • Yes **Any Comments on the Committee's effectiveness** (Agenda Item 12.3) • Committee was considered to be effective.	
2020/01/210	**Any Other Business:** (Agenda Item 13) No further business was raised.	
Date and time of next Meeting: Monday 24th February, 10.00 am – 1.00 pm		

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Chair – Harmesh Darbhanga

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Date – 24/02/2020