BOARD MEETING

10.00am – 1.00pm
on Thursday 4 June 2020
by MS Teams virtual meeting
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 MS Teams due to the Covid-19 pandemic. Questions or comments from members of the public are invited by email in advance of the virtual meeting 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

	ITEM	Purpose	Lead	Format	Time
1.	**Welcome**		N O'Kane		10.00am
2.	**Apologies**				
3.	**Minutes of the meeting held on:** • **26 March 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 March 2020 & informal Board May 2020** • **Feedback from virtual meetings**	Information/ Consider for Action	N O'Kane	Encl 4	10.15am
7.	**Chief Executive's Report including Covid 19 dashboard**	Consider for Action/ Assurance	D Stout	Encl 5	10.25am
8.	**Staff story**	Consider for Action/ Assurance	S Gregory/ J Bettison	Verbal	10.45am

	QUALITY, SAFETY AND PRODUCTIVITY Strategic Priority 1: Good and Beyond	Purpose	Lead	Format	Time
9.1	**Report from the Quality & Safety Committee Chair including the following appendices:-**	Consider for Action/ Assurance	P Featherstone	Encl 6	11.00am
	Appendix 1 Learning from Deaths Report	Approval	J Povey	Encl 7	
	Appendix 2 Quality Report	Assurance	S Gregory	Encl 8	
	Appendix 3 Well-led assessment	Assurance	S Gregory	Encl 9	
	Appendix 4 Guardian of Safe Working Report	Approval	J Povey	Encl 10	
	REFRESHMENT BREAK				11.35am
	STRATEGY, INNOVATION AND SERVICE IMPROVEMENT **Strategic Priorities 2: Our Transformation Plan** **3: Optimising the Use of Technology**				
10.	**RISK AND FINANCIAL STABILITY**				
10.1	**Report from the Resource & Performance Committee Chair including the following appendices:-**	Consider for Action/ Assurance	H Darbhanga	Enc 11	11.45am
	Appendix 1 Performance Report	Assurance	R Preen	Enc 12	
	Appendix 2 Finance Report – Month 1	Assurance	S Lloyd	Enc 13	
10.2	**Data Security and Protection Toolkit 2019-2020 Assessment**	Approval	R Preen	Enc 14	12.00pm
	GOVERNANCE				
11	**Governance Report Including:** • **Board Assurance Framework** • **Corporate Risk Register**	Consider for Action/ Assurance	C Lea	Enc 15	12.05pm
	STRATEGIC PRIORITIES				
12.	**Strategic Developments Report**	Consider for Action/ Assurance	R Preen	Enc 16	12.15pm
13.	**Questions or Comments from Members of the Public**			Enc 17	12.40pm
14.	**ITEMS FOR INFORMATION ONLY**				
	Committee Minutes (most recent approved)	Information		Enc 16	12.45pm
15.	**Any Other Business**				
	• With prior agreement of the Chair		N O'Kane		12.50pm
16.	**MEETING EVALUATION**				

16.1	**Reflections on the meeting: effectiveness and any new risks and assurances**	Consider for Action	N O'Kane	Verbal	12.55pm
17.	**DATE OF FUTURE MEETING**				
	Thursday 6 August 2020				

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
NHS Trust

MINUTES OF THE BOARD MEETING

HELD VIRTUALLY VIA MICROSOFT TEAMS
AT 10.00AM ON THURSDAY 26 MARCH 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)	
Mr. David Stout	(Chief Executive)
Mr. Steve Gregory	(Director of Nursing and Operations)
Dr. Jane Povey	(Medical Director)
Ms. Ros Preen	(Director of Finance and Strategy)
Ms. Jaki Lowe	(Director of People)
Executive Members (Non-Voting)	
Ms. Sarah Lloyd	(Associate Director of Finance)
In attendance	
Ms. Claire Lea	(Corporate Governance Consultant)
Mr. Robert Graves	(Director of Estates)
Mrs. Louise Tompson	(Minute Taker)

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

Ms O'Kane welcomed everyone to the meeting. She acknowledged the challenging and extraordinary times that the Trust is working in and thanked all staff for their hard work and to all members for attending this virtual meeting.

Minute No 2020.2.1 - Apologies

There were none.

Minute No. 2020.2.2 - Minutes of the Meeting held on 30 January 2020

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 30 January 2020 be received and approved as an accurate record. The proposal was SECONDED by Mr Gregory, and BOARD MEMBERS UNANIMOUSLY AGREED the proposal.

Minute No. 2020.2.3 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.

In relation to the Community Equipment Services action Ms Preen commented that an initial report has been considered but a decision has not yet been made. Resources and Performance Committee recognised that this is important and it will be considered at a future meeting.

Minute No. 2020.2.4 - Declarations of Interest

No new declarations of interest.

Minute No. 2020.2.5 - Chair's Communications

Ms O'Kane presented a summary of issues discussed in private by the Trust Board in January 2020 and a summary of her engagements since the last Trust Board meeting, including the informal Board meeting in February 2020.

The Board discussed Committee and Board meetings being held virtually via video conferencing. Ms O'Kane commented that it is important Executive Directors and other staff are not overburdened during this time. Mr Stout agreed with this approach and if it is possible to record and post meetings online then this should be done.

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

Ms Long FORMALLY PROPOSED that Board and Committee meetings be held virtually via video conferencing. The proposal was SECONDED by Ms Preen, and BOARD MEMBERS UNANIMOUSLY AGREED the proposal

Minute No. 2020.2.6 – Non-Executive Directors' Communications

Ms Purt asked for an update on Whitchurch Hospital following an expectation that architects would be visiting the site to plan for some improvement works. Mr Graves said that he would take this forward but it would be difficult for architects to visit in the current circumstances.

Action: Mr Graves to follow up on architects visit to Whitchurch Hospital

The Board accepted the update from Non-Executive Directors.

Minute No. 2020.2.7 - Chief Executive's Report

Mr Stout introduced the update by explaining that the current Covid-19 situation is a very fast moving situation, with new guidance and advice being issued on a daily basis. The Executive Team have been asked to update the Board on specific issues and he explained that a dashboard of key issues would be developed for future meetings.

Staffing
Mr Gregory reported that as of Wednesday 25 March, 210 members of the workforce were not available to work due to sickness or isolation. Of these 210 people 82 people are self-isolating with no symptoms and 51 people are reported as being sick with Covid related symptoms. Today, 220 people are not available to work with 98 people self-isolating with no symptoms. Mr Phillips asked if these figures included those not available to work due to other reasons and Mr Gregory confirmed that the figure did not include those on leave (annual, maternity).

In response to a question relating to staffing and annual leave; Mr Gregory said that the Trust is broadly in line with what would be expected. Staff have been advised not to cancel leave but most staff are happy to come in if they are needed. Mr Darbhanga asked how sickness levels are impacting on the Trust's other core services. Mr Gregory reported that pressures are manageable as activity for most services has reduced.

People - National
Ms Lowe reported that the Trust is taking part in a weekly HRD call with National leads where issues can be discussed that require national/government response.. Guidance for schools and nurseries has been issued and they have been asked to provide childcare during Easter for key workers. Ms Lowe explained that the definition of Key Worker has been issued and includes all of Trust staff.

A national call for volunteers has been established through the GoodSam website. A pay circular will be sent covering all special arrangements for pay for staff and bank workers as a result of COVID. A return to service 'service' has already been established for clinical leavers/retirees. A national helpline is being set up supported by Samaritans for the public. National changes for DBS checks for recruitment have been made to speed up and simplify the process.

People - Regional/System
Regional NHSE/I and HEE colleagues are now repurposing around supporting supply and demand for COVID as well as working in the spirit of the NHS Interim People Plan. A weekly HRD COVID meeting with a task and finish group is being established. Ms Lowe reported that the system team is led by Victoria Maher. Ms Lowe was supporting regional/system priorities and ensuring the Trust's alignment. A system-wide 7 day helpline for staff will be established.

Ms Maher is working with the local authorities on guidance for schools and nurseries to ensure it is applied consistently and to deal with any issues. Ms Maher is also liaising with the local constabulary through the tactical command group to ensure the system guidance is accepted should staff be stopped whilst travelling for work. Both local authorities have offered support where the system may have staffing gaps e.g. catering.

People - Local Level
Ms Lowe reported that a 7 day absence reporting line has been established by her team and this feeds directly in to the incident management team (IMT). A local redeployment process is underway and contact with recent retirees has been made. The process for deploying volunteers and those returning to service along with students is progressing.

A daily communication is being issued to staff and guidance has also been issued to healthcare workers on showing ID when stopped whilst travelling. Within the People Team an assessment of critical functions and prioritization is underway

Training & Mandatory training: 81% of training is available on online and the Trust has seen a slight improvement to 94.69% against the target of 95%.

- All non-essential training has currently been stopped. The team will assess such training to determine in the medium term if/how it could be delivered differently
- Corporate induction has been stopped, again same action as above for medium term
- Basic Life support –the class size has been reduced to meet social distancing guidance
- Moving and handling – will review if/how the teams can deliver this in a different way

Ms Lowe reported that the next key step is to develop a comprehensive Health and Well-Being approach addressing 3 levels:

- Supporting resilience at team level
- Supporting individuals
- Supporting line managers

The strategy will be to focus on: what the Trust does now; what the Trust does in the immediate aftermath and the longer term implications

In response to a question relating to DBS Mr Gregory confirmed that patient facing staff/volunteers will be checked. A further question was asked relating to advice provided to staff. Ms Lowe reported that the Trust is providing guidance to staff and has supported working from home whilst national guidance is being worked up on this.

Business Continuity
Mr Gregory reported that an Incident Management Team (IMT) has been established. The IMT is now considering aspects of the Trust that might stop for 12 weeks or more. The IMT is a vehicle for urgent decisions and any planned cessation would be considered at the executive team meeting which takes place twice a week.

The Trust is now training people to be redeployed, currently there are 140 people to be retrained to work in the front line but there will incease. 56 people had already been trained with all training taking place allowing for social distancing.

There are 5 key areas these are:

1. Community Hospitals
2. IDTs – Therapies/District Nursing
3. CCNT – Community Children's Nursing Team
4. Discharge to Assess
5. Prisons – Mr Gregory reported that the Trust has good communication with the Governor of the prison and currently no staffing issues are reported.

Mr Gregory said that understandably some staff were worried and concerned, but that they were being supported within their teams. The Board recognised that the staff were making an incredible effort and adapting to significant changes in their work and workplaces.

Mr Darbhanga asked if there is sufficient capacity in the prison service if clinical staff go off sick due to Covid-19. Mr Gregory confirmed that there were sufficient staff in place and staff could be redeployed to the service if needed.

In response to a question from Mr McDonald relating to PPE Mr Gregory said that the supply is arriving. However, there are challenges around the testing of facemasks as the supply of facemasks that the Trust is now receiving is different to those previously supplied and therefore testing is required again. Hand sanitiser supply is also challenging and the Trust has requested a stock update on this, this has been raised locally and nationally and some local businesses are trying to supply this product.

Ms Lloyd asked a question relating to bank and agency staff. Mr Gregory said that our reliance on bank and agency staff may decrease due to redeployment.

Mr Stout asked Mr Gregory to update the Board on testing. Mr Gregory said that there has been no update when community testing would be carried out but the Trust is prepared and ready to act when needed. Mr Stout said there is a push to increase this testing and the Trust will be informed when it was expected to support staff testing. Ms O'Kane asked if the Trust has the testing kits and staff to carry this out. Mr Gregory commented that the Trust does not know what the kit will be but the staff are available when required.

Discharge to Assess
Dr Povey reported that COVID-19 Hospital Discharge Service Requirements were published 19 March 2020. She said that Community Health Services were required to:

- Identify an Executive Lead for the system - Dr Povey, Medical Director is taking on this role.
- Release staff from current roles to co-ordinate and manage discharge arrangements – Children and Young Peoples Therapies team being released to do so.

Every patient that is medically fit for discharge is discharged that day and care is arranged within the community. A system wide operational team has put the Discharge to Assess process into action this week, reporting to the Local Health Resilience Partnership, this will be overseen by A&E

Delivery Group reporting to system Chief Executives. Dr Povey commented that this system was at an advantage as relationships were already effective across organisations in this area.

Dr Povey reported that the system is not at a point where capacity is an issue, although capacity is expected to increase. It is expected that Easter will be the peak in critical care and therefore the peak for community care will be a couple of weeks after that. Ms O'Kane thanked Dr Povey for her update and commented that there will be lessons to learn for how systems work in the future. Dr Povey reported that critical care in this system is being extended significantly, by up to 6 times. This is vital so as to ensure that the rest of the acute hospitals are not overwhelmed.

Ms Purt asked a question relating to social care and planning in place to address this. Dr Povey commented that the system is on the front foot but it is difficult to predict how this situation will move forward. This doesn't seem to be an area of concern at the moment and there are processes in place to grow capacity.

Ms Lloyd asked a question relating to patients who are medically fit waiting to be discharged. Dr Povey said that there is a meeting every morning to identify is patients are medically fit and if any are blocked for discharge then this is addressed.

Mr Featherstone asked what the Trust was doing to ensure that new birth visits are being prioritised. Mr Gregory said that the Trust and SaTH have been in discussions about how support can be provided. New birth visits will be risk assessed and maintained and will continue for the time being and the Trust is not seeing a particular challenge with this. Trust Consultant Paediatricians are collaborating with SaTH to provide support.

Mr McDonald asked if there are any additional arrangements in place with GPs etc. The Board discussed opportunities to expand bed numbers at Ludlow Community Hospital. GPs in the area are keen to develop services to support the area. The Trust Medical Advisor in Ludlow, Caron Morton, is well placed to move this forward as the need arises.

Mr Darbhanga asked if the Trust would be able expand bed numbers given challenges in workforce numbers. Mr Gregory said that with the staff that the Trust is currently training the Trust would be able to do this but if the situation progresses it may need to expand community resources rather than inpatient beds. Mr Stout commented that the Trust needs to deploy resources in the right areas to have the best impact but the Trust will be flexible. Dr Povey added that each community will have different needs, for example GP 7 day cover where there are opportunities to use Community Hospital Medical Advisors to strengthen medical cover to support domiciliary care.

Finance

Ms Lloyd reported that the Trust is collecting 19/20 COVID costs and the team have put processes in place to ensure all related costs are captured and finance is represented at the IMT meetings. The finance team submitted the Trust's 19/20 forecast costs to NHSE/I on 23 March 2020 in line with national requirements. For 20/21 the Trust will continue to capture and report all COVID related financial costs. Ms Lloyd emphasised that robust financial governance remains essential.

Ms Lloyd reported that there is a new finance and contracting regime in place from 1 April to 31 July 2020 but this may be extended. Mr McDonald asked a question relating to block value costs. Ms Lloyd said that if the block value does not cover the Trust's costs then the Trust will apply for a top up. Mr Stout said that whilst the Trust needs to ensure it provides what is necessary for patients and staff and costs will be covered it also needs to maintain financial discipline. Mr Darbhanga asked if there is still a requirement to meet the control target. Ms Lloyd confirmed that there is an expectation for the Trust to deliver the financial plan.

Changes in reporting arrangements to NHSE/I or CQC

The operational focus on Covid-19 has meant that several business as usual processes have been impacted upon. Some things have been suspended; others have had their deadlines extended. Where this has been known at the time of committee meetings this week and last, changes have been indicated; however in summary the processes affected to date are;

1. Quality –
   a. Quality Accounts – audit assurance has been suspended but the deadline for production has not changed.
   b. All CQC visits have been suspended with immediate effect
2. Financial
   a. Revised time table and content for the accounts
   b. Potential for a revised time table for the external audit of our accounts
   c. Annual report - Requirements are under review.
   d. Additional monthly reporting for Covid 19 expenditure
3. DSPT
   a. The toolkit submission has been deferred until Sept 2020.
   b. New guidance regarding data sharing to support care for patients relating to Covid 19 has been issued to allow rapid access to relevant data.

Ms Preen reported an emerging picture and that all plans are subject to change. She went on to explain that the Trust has an excellent track record of maintaining statutory and regulatory requirements and Trust processes should support this to continue. The governance of Trust committees will continue to communicate exact deadlines and alterations in processes as they become clearer or are formally communicated.

System Working
In relation to the system the Trust is working with closely with partners across health and care through the Local Health Resilience Partnership. The Trust has links through the Clinical Commissioning Groups into the wider tactical command structures with the police and other agencies. The system is having increased frequency of local Chief Executive Meetings to ensure that health and local authorities are working together effectively. There are similar groups for communications leads, HR directors etc to coordinate efforts. The Trust also takes part in weekly national and regional briefings

- The Board accepted the assurance provided by update from Executive Directors

QUALITY, SAFETY AND PRODUCTIVITY

Minute No 2020.2.8 – Quality and Safety

Mr Gregory presented the summary report and welcomed any questions. The Board recognised that the report had been discussed in detail at the Quality and Safety Committee last week and therefore accepted the report without raising further questions.

The Board accepted the assurance provided by the report.

Minute No 2020.2.9 – Annual Diversity and Inclusion Report including gender pay gap data

The Board acknowledged that the report had been discussed in detail at the Quality and Safety Committee last week and approved the publication of the report. Ms Lowe added that the Trust had received confirmation that the national publication deadline for this report has been delayed. The Board agreed that the report should be published on the Trust website as soon as possible and submitted nationally when required.

The Board accepted the assurance provided by the report.

Minute No 2020.2.10 – Freedom to Speak Up Guardian Report

The Board recognised that the report had been discussed in detail at the Quality and Safety Committee last week and therefore accepted the report without raising further questions.

The Board accepted the assurance provided by the report

Minute No 2020.2.11 – Annual Staff Survey Results

The Board recognised that the report had been discussed in detail at previous Board and Committee meetings and therefore accepted the report without raising further questions.

The Board accepted the assurance provided by the report

Minute No 2020.2.12 – Performance Report

Ms Preen reported that 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. The Board acknowledged that where performance is 'off track' then recovery plans were in place for most indicators.

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

Due to the current Covid-19 crisis the rolling programme of Trust performance reviews have been suspended for 6 months, these will commence again in September 2020. The performance framework dashboard will be extended to focus on the current issues related to Covid-19.

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 2020.2.13 – Improvement Plans

Core Services and Well Led Report

Ms O'Kane thanked Mr Gregory and Mrs Lea for the reports. She commented that contained within the Core Services Good and Beyond report there is mention of what the Trust needs to do to achieve a CQC rating of outstanding. She clarified that whilst the Board continued to be ambitious, maintaining good in all areas would require significant effort by the Trust and that the Board had recognised that striving to achieve an outstanding rating was not a strategic priority. This was particularly important in the current Covid-19 situation.

The Board accepted the assurance provided by the reports

STRATEGY, INNOVATION AND SERVICE IMPROVEMENT

Minute No 2020.2.14 – Strategic Developments Report

Ms Preen presented the report for information. The confidential and commercially sensitive aspects would be discussed in more detail during the confidential part 2 Trust Board meeting.

The Board accepted the assurance provided by the Strategic Developments Report

RISK AND FINANCIAL STABILITY

Minute No 2020.2.15 – Finance Report

Ms Lloyd presented the report which highlighted the following:

- 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, the Trust is currently forecasting delivery of its 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 – exceeds the Trusts internal plan by £98k but remains under the nationally set Agency Ceiling by £704k

The Board:

• Considered the adjusted financial position at month 11 of £950k surplus which is £126k favourable to plan
• Recognised the cash position remains strong with a balance of £17,336k as at 29 February 2020
• Considered that expenditure on agency staffing year to date exceeds the value assumed within our internal plan
• Recognised that we are still forecasting to achieve the 2019/20 control total subject to mitigating any new material financial risks
• Recognised 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.
• Considered the assurance provided in relation to capturing the necessary information for COVID-19 cost reimbursement.

Minute No 2020.2.16 – Annual Budget Setting

Ms Lloyd presented the Annual Budget Setting report to the Board, summarising the key points. She said that this had been discussed in detail at the Resources and Performance Committee meeting on Monday and the Committee had recommended that Trust Board approve this. Ms Lloyd commented that the Trust recognises that the start point budgets will need to be amended but this is recommended for approval as a starting point.

The Board
• Considered 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

• Recognised that further adjustments will be required to reflect agreement of healthcare contract values, identification of further CIP schemes and any agreed service developments

• Acknowledged a net Capital Programme of £2.328m is planned and is in line with the draft plan submission

• Approved the Trust's opening budget 2020/21

Minute No 2020.2.17 – Lessons learnt from implementation of RIO

The Board acknowledged that the report completes the governance cycle and that the lessons learned summary has been adopted and will be applied for future projects. Mr Darbhanga thanked the project team for successful implementation of the project.

The Board accepted the assurance provided by the EPR end of project report and lesson's learned summary document.

Minute No. 2020.2.18 – Governance Report

Mrs Lea presented the report and highlighted the Modern Slavery Statement for approval. Members of the Board went on to approve the statement and thanked Mrs Lea for the report.

The Board:

- ***Agreed the inclusion of Covid-19 on the Trust's BAF***
- ***Approved the BAF***
- ***Accepted the CRR and the updated risk ratings***
- ***Accepted the process for the production of the Annual Governance Statement***
- ***Approved the Modern Slavery Statement.***

QUESTIONS OR COMMENTS FROM MEMBERS OF THE PUBLIC

Minute No. 2020.2.19 Questions or Comments from Members of the Public

The Trust Board is required to meet in public and whilst current government guidance makes this impossible, the Trust Board is committed to an open and transparent way of working. The Trust's website has been updated to encourage written questions from the public being submitted in advance of the meeting. Answers would be supplied at the meeting and recorded in the minutes of the meeting. No questions had been received for this meeting.

The Trust will explore options for recording and publicising its public board meetings until attendance in person is possible. Board agendas and papers will be published on the website as normal.

ITEMS FOR INFORMATION ONLY

Minute No. 2020.2.20 – Committee Minutes

The Board accepted the minutes.

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

Minute No. 2020.2.21 – Any Other Business

There was no other business

16. MEETING EVALUATION

Minute No. 2020.2.22 – Reflections on the meeting: effectiveness and any new risks and assurances

The Board acknowledged that no new risks were identified at the meeting. The Board had had the opportunity to ask detailed questions.

Ms O'Kane commented that the virtual meeting had worked well today and recognised that this method saves costs on meeting venues and reduces the carbon footprint of attendees. She thanked all of the Board for their contribution to the meeting.

Ms O'Kane formally thanked all staff within the Trust for all of their work during these challenging times.

17. DATE OF FUTURE MEETING

Minute No. 2020.2.23 – Date of Future Meeting

10am – 1pm, Thursday 4 June 2020

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: June 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	Item on the agenda	J Povey	~~February March 2020~~ May 2020
March 2020	Minute No 2020.2.6 – Non-Executive Directors' Communications	Whitchurch Community Hospital	Mr Graves to follow up on architects visit to Whitchurch Hospital			R Graves	30th July 2020 subject to any acceleration required to undertake work relating to restoration

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	4th June 2020
	Agenda Item:	6
	Enclosure Number:	4

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 the Board with a summary of the Chair's activities since the last Trust Board meeting on 26 March 2020 and the informal board meeting on 7 May 2020	**Consider for Action**	
	Approval	**X**
	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

- A summary of the issues discussed during confidential meetings of the Board
- The main activities undertaken by the Chair over the past two months

Key Recommendations

To accept the assurance provided by the Chair's report.

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	No	
Board Assurance Framework	Yes	Covid-19 BAF entry

Impacts and Implications?	YES or NO	If yes, what impact or implication
Patient safety & experience	Yes	Governance supports the safe delivery of our services
Financial (revenue & capital)	Yes	Governance supports the effective use of resources and ensures the Board is aware of the financial impact of the pandemic
OD/Workforce	Yes	Governance supports the wellbeing and safety of all staff during the pandemic
Legal	Yes	Governance supports compliance with regulatory requirements and advises on any changes in legislation

CHAIR'S REPORT

1. Report on the last confidential meeting(s) 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:

- Changes to Governance arrangements and decision making in response to Covid19
- Update on the STP Long Term Plan
- Decisions by the Nominations, Appointments and Remuneration Committee relating to a Temporary Pay Agreement for employees and bank workers during the Covid-19 pandemic in line with national and system guidance. This related to special pay arrangements for scenarios such as:
    - Covid-19 sickness absence
    - Household isolation
    - 12-week shielding
    - Being the sole carer for someone who is identified as extremely vulnerable
    - Having no care options available for dependants
- Creation of a new corporate risk in relation to RIDDOR and Covid-19 which is being reviewed by the Quality & Safety Committee.

1.2 The Board had received an online demonstration of the new live dashboard which had been created to monitor performance during Covid-19. This included key metrics related to staff availability, staff sickness and bed capacity. This would form part of the regular reporting to the Board and its committees.

2. Meeting and Visits

2.1

- As a result of Covid19 Lockdown no visits have taken place.
- Weekly briefings for all Trust Chairs have been held with NHSE/I Regional Dale Bywater, to give information on the local NHS situation re Covid19 to share challenges and good practice amongst colleagues and to plan for restoration and recovery. These briefings have proved to be extremely useful and it is likely they will continue in some form after the pandemic.
- We have also introduced a weekly briefing for all NEDs which again has proved valuable during the current situation.
- The Shadow ICS Board has held 2 virtual meetings over this period to co-ordinate local system activity and to plan for future working arrangements.
- I am grateful to Board colleagues for all their input during these extraordinary times. They are working harder than ever to maintain 'business as usual' whether that be through chairing meetings, supporting their teams and each other, communicating and disseminating vital information- all to ensure that our patients and community receive the best possible care under the circumstances.
- And I wish to pay tribute to each and every member of staff, whatever their role. Through their professionalism and dedication they have demonstrated the very best qualities of the NHS, and we will not forget the service they have given through what is undoubtedly the greatest challenge our health service has ever faced.

3. Conclusions and Recommendations

To accept the assurance provided by the Chair's report.

Nuala O'Kane
Chair

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	04.06.2020
	Agenda Item:	7
	Enclosure Number:	5

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 relate to the impact of Covid-19:

- Governance
- Restoration and recovery planning
- Testing arrangements

The longer term issue covered in the report is the preparation for flu vaccinations for Winter 2020/21.

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 for restoration and recovery.

Is this report relevant to compliance with any key standards? YES OR NO	**State specific standard or BAF risk**

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

CQC	Yes	Well-led
IG Governance Toolkit	No	
Board Assurance Framework	Yes	Healthcare system. Clinical quality & safety Organisational culture Covid-19

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	

CHIEF EXECUTIVE'S REPORT – 4th June 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 these issues on the trust.

2. Coronavirus

2.1 Governance

The primary focus for the NHS since the last Board meeting has been the management of the Coronavirus pandemic.

Our approach as a trust has been led by the national directions which have operated since the NHS declared a level 4 National Incident on 30 January.

As a trust we are playing our full part in the Local Health Resilience Partnership silver and gold command structures which provided oversight to management of the initial phase of management of the pandemic and now is focusing on Phase 2 in relation to planning restoration and recovery of services (see section 2.2).

Within Shropcom our day to day response has been managed by our Incident Management Team (IMT) which is chaired by Steve Gregory, Director of Nursing and Operations. This has recently moved from being a daily meeting to meeting three times per week. IMT reports to the Executive Team.

The main governance oversight for our response has been through our Quality & Safety and Resource & Performance Committees. Reports setting out their assurance are included on the agenda.

We have developed a Covid-19 dashboard which reports on performance on a range of key indicators on a daily basis. This is used to support both operational decision-making and to inform oversight and assurance through the board committees. The latest available data at the time of issuing board papers is attached as **Appendix 1** to this report.

2.2 Restoration and recovery

David Evans, Accountable Officer NHS Shropshire CCG and NHS Telford & Wrekin CCG sent out the following communication on the system approach to restoration and recovery at the end of May:

> *Coronavirus has had a huge impact on everyone's lives, and none more so than the NHS and care sectors and the people who work for them. The speed at which changes had to be made to local services so that we were ready for the potential*

impact of the virus was incredible, and everyone from frontline medical and clinical employees through to the behind-the-scenes teams have been truly unbelievable.

Across Shropshire, Telford and Wrekin we have now developed a clear and effective system process for managing our health and care response to current situation. This includes a series of task and finish groups with our local experts sitting on them to identify and resolve the key challenges we face. There is then a clear reporting line where decisions get made and changes happen as quickly as possible – to make sure we are always doing the right thing for our local communities. This process is led by all of the local NHS and council chief executives working together, who meet daily to review and approve any decisions.

As you will be aware we are all still working very hard across many areas of response to the virus, including:

- *testing those people who have suspected Covid-19 symptoms – including our own staff and those in care homes*
- *making sure we have enough personal protective equipment (PPE) for all local services now and in the coming days and weeks, and*
- *making sure our employees are supported during this difficult time*

But, we are also looking to how and when we can bring back other local health and care services that were in-place prior to the outbreak. This is our Restore and Recovery Plan, which is a single plan for Shropshire, Telford and Wrekin and is being developed across all health and care organisations.

As you can imagine this is a difficult process, as we need to make sure that the many inter-dependencies between services are identified and that we are in a position to safely run them again. But we are doing this at pace, and with expert clinical leadership at the heart of the work.

We have prioritised the services that we will bring back and we are working to make this happen as quickly and a safely as possible. But, the pause in their delivery and the current situation with Coronavirus has also given us the opportunity to think very carefully about how these services are delivered, and whether there are aspects that can be delivered differently so as to support the 'new normal'. The teams who are looking at this work are made up of colleagues from acute, primary care, mental health care and community services, as well as colleagues from Shropshire Council and Telford and Wrekin Council – so the approach is really a 'whole system' approach.

Our Restore and Recovery Plan includes eight key 'tests' to help us achieve success and we are working hard to make sure we achieve all of them, which will mean as a system we have:

- *responded appropriately to the Covid-19 outbreak*
- *that we have then addressed the new system priorities*
- *that we end up by developing an improved health and care system*

Naturally, there is a lot of work that needs to happen and some of this work will be immediate and some of it will take longer, but all of it is vital in making sure we have – as much as possible – a really joined-up health and care system which benefits our local communities.

We will keep you updated on the progress being made to 'restore' services, and any implications of the work.

Within Shropcom our core responsibilities in the restoration phase are to continue to provide essential community health services and to sustain our hospital discharge services. To date we have restored an element of the health visiting services which we had temporality suspended and have ensured that our school nursing services will be ready to support schools as they start to re-open.

2.3 Testing

Shropcom has played an important role over the last few weeks in providing antigen testing for NHS staff and other key workers. The service we have provided has been very positively regarded across the system.

At the time of writing, we expect antibody testing to start to be made available for NHS staff. A verbal update on the position will be given at the board meeting.

3. Flu vaccination

Work has started to plan for flu vaccination in advance of next winter. Our trust performance on rates of staff flu vaccination last year was very good and we will look to exceed that performance this year.

4. Shropshire, Telford & Wrekin (STW) Shadow ICS Board

The STW Shadow ICS Board has met twice (on 29th April and 19th May 2020) since our last Board meeting. Discussions at both meetings focused on the approach to managing the coronavirus pandemic across the system.

There were also updates given on the recent SaTH CQC inspection, the SaTH Hospital Transformation Plan and CCGs commissioning strategy.

Friday 29 May 2020

COVID-19 Employee Focused

12	COVID-19 related sickness
48	COVID-19 self isolation (no symptoms)
3	Number of employees and household members swabbed - previous day
5.35%	Percentage sickness
18.76%	Percentage staff unavailable (A/L,Maternity,Sick,Special)
87	Total off on sick leave

COVID-19 Patient Focused

124	Number of COVID-19 positive Community patients
0	Number of COVID-19 related or associated hospital deaths in last 24 hours
7	Number of Inpatients awaiting COVID-19 swab results
0	Number of inpatients diagnosed with COVID-19 in last 24 hours
1	Number of patients admitted with COVID-19 in last 24 hours
9	Total number of COVID-19 positive Inpatients

Service Focused

97	Community Hospital Bed Complement at 8am today
33	Community Hospital Unoccupied Beds at 8am today
49	MIU Attendances (exl. SaTH UTC) - previous day
2	Number of Delayed Transfers of Care (Patients)
14	Number of services closed
32	Number of services disrupted
2	SaTH UTC Attendances at MIU locations - previous day

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	4th June 2020
	Agenda Item:	9.1
	Enclosure Number:	6

Meeting:	**Trust Board**		
Title:	**Quality & Safety Committee – Chair's report to Board**		
Author:	Peter Featherstone, Committee Chair Claire Lea and Julie Houlder, Corporate Governance Consultants		
Accountable Director:	Steve Gregory – Director of Nursing and Operations		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	None		

Purpose of the report		
To assure the Trust Board that, as a result of the issues presented and discussed at the Quality & Safety Committee (Q&S), there are appropriate plans and monitoring in place to ensure that care is of high quality and provides good patient experience and outcomes. This assurance supports the five CQC domains and in particular the well-led domain and is assessed against the criteria in Appendix 1.	**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

Learning from Deaths Report
– SUBSTANTIAL ASSURANCE OVERALL

Recovery Plan update for Children's Physiotherapy & Speech and Language Therapy
- LIMITED ASSURANCE OVERALL

Safeguarding Assurance Report Covid-19 Pandemic
- SUBSTANTIAL ASSURANCE OVERALL

Quality Performance Report
(Full Integrated April 2020 and by exception May 2020)
– SUBSTANTIAL ASSURANCE OVERALL

Quality & Safety – Covid-19 update (April & May 2020)
– SUBSTANTIAL ASSURANCE OVERALL

CQC Well-led report
– SUBSTANTIAL ASSURANCE OVERALL

Health & Safety Report
– MODERATE ASSURANCE OVERALL

Quarterly safe working for junior doctors
– SUBSTANTIAL ASSURANCE OVERALL

Board Assurance Framework and Corporate Risk Register
– MODERATE ASSURANCE OVERALL

Infection Prevention Control (IPC) Update (April) & IPC assurance framework (May)
– SUBSTANTIAL ASSURANCE OVERALL

Decisions made –

1 The Committee has asked for greater assurance on the review of the impact of Covid-19 on the corporate risk register (CRR) in respect of quality and safety risks.
2 The Committee has asked for further information about the Trust's approach to recovery and restoration planning, e.g. Speech and Language Therapy Services.
3 The Committee will continue to assess the assurance provide on staffing levels, quality and safety of care and support to staff given the increase in community activity both numerically and complexity/frailty of patients.
4 The Committee will further review Health & Safety recommendations at its next meeting.

New risks –
One new risk had been agreed by the Committee, namely, 3601 – 'medical cover at community hospitals'. This was accepted by the Committee and had been approved by the Board at its informal meeting in April 2020.

Recommendations

The Board is asked to

- Accept the assurance provided by the work of the Quality and Safety Committee
- Accept the assurance provided by the Learning from Deaths report
- Accept the assurance provided by the Guardian of Safe Working Report

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	All CQC domains
IG Governance Toolkit	No	
Board Assurance Framework	Yes	ALL

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	Good governance supports the safe delivery of our services
Financial (revenue & capital)	Yes	Good governance supports the effective use of resources and ensures the Board is aware of the financial impact of the pandemic
OD/Workforce	Yes	Good governance supports the wellbeing and safety of all staff during the pandemic
Legal	Yes	Good governance supports compliance with regulatory requirements and advises on any changes in legislation

1.0 Purpose of the Committee

To provide assurance to the Trust Board that there are appropriate plans and monitoring in place to ensure that the delivery of patient care, experience and outcomes are scrutinised and challenged in order to deliver safe, effective, caring, responsive and well-led care.

In line with the assurance levels used by internal audit the Committee accepts the following levels of assurance – substantial, moderate, limited, none – as shown at the end of this report..

2.0 Reports/Items Considered by the Committee

2.1 Executive Director of Nursing Awards (April and May)

The following awards were given out -

- Tara Ashley, Locality Clinical Manager Central Shropshire
- Gail Hooper, Dudley School Nurse Team Leader
- Alice Cloak, member of the Public Health Nursing Service team
- Jane Cook, redeployed to Ludlow Community Hospital
- Denise Stone and all members of the DAART Team based at Robert Jones & Agnes Hunt Hospital
- Julie Preece – Nurse at Bridgnorth Hospital and Staff Side representative

2.2 Learning from Deaths Report – SUBSTANTIAL ASSURANCE OVERALL

The Committee accepted the assurance provided by compliance with the national framework and guidance. Further assurance would be provided by the learning from deaths clinical audit which had been suspended due to the Covid19 pandemic and was now being supported by internal audit capacity. The Committee considered and accepted the actions being taken to address the key themes. It agreed that Covid related deaths would be considered by the Committee as part of learning from deaths going forward.

The full report on Learning from Deaths is included at **Appendix 1** as the Trust is required to publish the information in the public domain.

2.2. Recovery Plan update for Children's Physiotherapy & Speech and Language Therapy - LIMITED ASSURANCE OVERALL

The report provided assurance on the recovery plans relating to the long waits for children in the physiotherapy and Speech and Language (SLT) Services. Whilst the recovery plans for both were currently off track there had been significant progress on the physiotherapy list.

The Committee acknowledged that there were system wide challenges impacting on the ability of the team to meet demand and a pathway approach in partnership with commissioners is required to have a positive impact long term. The Committee was only able to accept limited assurance on the recovery plans and requested further reports to monitor improvements.

2.3 Safeguarding Assurance Report Covid-19 Pandemic - SUBSTANTIAL ASSURANCE OVERALL

The report provides assurance on the steps being taken during the Covid 19 Pandemic to ensure the Trust is meeting its statutory responsibility with regard to safeguarding as set out in The Children Act 1989 and The Care Act 2014. There had been no changes in the

reporting processes for safeguarding concerns with risk assessments being carried out using digital technology. Additional support had been put in place with the move of Urgent Treatment Centres to Minor Injuries Unit at Bridgnorth and Whitchurch.

The Committee accepted that there were no significant risks posed during the pandemic, with the service being actively managed during the pandemic, however, the Committee recognised that referrals had reduced due to school closures. The Committee was assured by the preparations being put in place for the potential surge in referrals as schools reopen.

2.4 Quality Performance Report
(Full Integrated April 2020 and by exception May 2020)
– SUBSTANTIAL ASSURANCE OVERALL

The Committee received the full report in April and an exception report in May. The full report is included at **Appendix 2** as part of the Trust's responsibility under the NHS Constitution to be accountable to the public, communities and patients that it serves.

The purpose of the reports is to provide assurance to the Committee thereby supporting the Trust in the provision of evidence against the key lines of enquiry questions within the CQC Well Led domain. This in turn then contributes to the Trust's strategic goals and priorities. The report also provides a Trust level overview of how the three Service Delivery Groups contribute to quality and safety through their monthly quality, safety and performance governance meetings including management of their risk registers.

- The quantifiable performance information which addresses the CQC question - are services Safe, Effective, Caring, Responsive and Well-Led? The information is taken from the Trust's single data performance repository for reliability and accuracy.
- The analysis of that information and where possible, the triangulation with evidence from external benchmarking and the Trust's track record in delivery of quality and safety priorities as evidenced by the CQC's 2019 inspection report.

The Committee was able to take assurance from both reports in the following areas where improvement trajectories were observed – falls, venous thromboembolism risk assessment, safety thermometer – harm free care, SI's, pressure ulcers, new birth visits and statutory mandatory training levels incl. fire safety training (high risk patient areas),

Benchmarking against other community trusts was considered as part of this assurance for the 'safety thermometer – harm free care' and the Committee was informed that that the Trust had been approached by NHSI to share its rapid improvement work on pressure ulcers and SI's with other regional teams. The Committee also reviewed the positive assurance provided by the UNIFY return which demonstrated how well actual staffing levels compared to the planned safe levels of staffing required.

In April the Committee had asked for further assurance on improvements in increasing the levels of incident reporting (high levels are a hallmark of a positive safety culture), incident reporting for pre-existing pressure ulcers and 18 week Referral To Treatment (RTT) performance. Further reports providing greater assurance on incident reporting and pressure ulcers were considered at the May meeting.

The Committee accepted that the performance of Trust in regard to friends and family testing (FTT) responses and 18 week Referral To Treatment had been impacted by the Covid-19 pandemic and the Committee acknowledged that the regulators advice to 'reduce burden' of regulation meant that FFT had been suspended until further notice. The onset of COVID-19 had also had a significant impact on the Delayed Transfers Of Care (DTOC) process, with national reporting now suspended. The Committee agreed with the Trust's decision to continue to highlight and report any DTOC's to ensure patients are not unduly delayed.

2.5 Quality & Safety – Covid-19 update (April & May 2020) – SUBSTANTIAL ASSURANCE OVERALL

The Committee receives monthly updates which have focussed on the immediate response to the pandemic with the latest update in May considering the next phase of restoration and recovery. The purpose of the reports has to been to provide oversight of the Trust's response to the Covid-19 pandemic, including its business continuity planning, incident management, staff redeployment and wellbeing.

The Committee was able to take positive assurance from the implementation of the Board's previously approved business continuity plans which had been developed further by and aligned with national, regional and system guidance. The revised COVID-19 business continuity plan now supported the Trust through service disruptions of 12 weeks.

The Committee was assured that decisions to stop, partial stop or continue services was in line with the community service Standard Operating Procedure (SOP) issued by NHSE/I and where there needed to be any local variation e.g. MIU services, these had been resolved with the support of the system. The Committee was assured that the remaining gap against the SOP, namely, the provision of face to face appointments in a clinical setting where domiciliary visits or virtual appointments aren't deemed appropriate was under review and the appropriate action plan in place. Where significant service developments had been undertaken the Committee was assured that the appropriate QEIAs had been undertaken and decisions taken had been in line with the Trust's governance arrangements.

The development of a Covid-19 dashboard (reported earlier in the CEO's report) to monitor Trust performance on key indicators also provided positive assurance to the Committee on these developments and the wider quality and safety performance of the Trust during the pandemic. In particular the Committee was pleased to see the inclusion of employee focussed KPIs as an essential tool in monitoring the well-being and resilience of staff as well as the resilience of services during increased levels of employee sickness or varied working patterns.

NHSE had provided an education and training framework in response to the need for staff to work differently in support of the NHS response to the Covid-19 pandemic. Internally this had been described as ''preparedness training'' and the Trust's strategy had been to deliver training to underpin safe redeployment of staff and reflect the NHSE framework.

The Committee accepted the assurance provided by the work of the Culture Working Action Group which was acting as the custodian and coordinator for the support offered to staff, building resilience at team level, supporting individuals and supporting line managers/leaders. All avenues of national and international e.g. national Staff Health & Wellbeing Support package launched by NHSE/I are being made available.

In summary the Committee recognised the following significant decisions/impacts:-

- To follow the guidance from Resuscitation Council UK in relation to CPR and resuscitation in first aid and community settings
- The transfer of Shrewsbury and Telford Hospital NHS Trust (SaTH) urgent treatment centres to the Trust's Minor Injury Units
- The increasing complexity and frailty of patients now being cared for within the community and ensuring that the Trust's staff were equipped with the appropriate personal protective equipment (PPE), training and well-being support.
- Development and support for the swabbing service to include emergency services, local authority, care home and care agency colleagues.
- Support for the Discharge to Assess service supporting the national and local driver for a home first culture. Evaluation of phase 1 commenced week commencing 11th May 2020 with a system vision and recommendation to support the model to be implemented long term

- Services for shielded patients and Care Home MDT's were also being developed through the creation of neighbourhood teams and pooled system resources.

The Committee also received the workforce metrics report which gave assurance on key metrics such overall workforce numbers, sickness absence, paid special leave (Covid19 arrangements), workforce availability, appraisal completion, annual leave, and staff CV19 testing. The report also gave assurance on the Trust's approach to health and wellbeing and supporting vulnerable groups.

2.6 CQC Well-led report
– SUBSTANTIAL ASSURANCE OVERALL

The report provided assurance on a range of high level activities and associated governance arrangements undertaken by the Trust leadership team in response to Covid-19 and their alignment to the CQC well-domains. This provides evidence toward the trust-wide assessment of the well-led question at any future CQC inspection.

The full evidence list is available in **Appendix 3**

2.7 Health & Safety Report
– MODERATE ASSURANCE OVERALL

The report considered assurance regarding the Trust's Health and Safety responsibilities and obligations. The Trust had engaged external Health and Safety Consultants in December 2019 to review and refresh compliance requirements, processes and identify any gaps that exist. Although completion of the work had been impacted by Covid-19 a report with prioritised recommendations would be finalised by the end of May 2020 and reported to the Committee in June 2020.

The Committee was able to take positive assurance from the report as there had been engagement with external partners such as the Health & Safety Executive, health & safety consultants, and the Fire Service. In light of delays to the external Health &Safety Compliance Report, the Committee accepted moderate assurance from the report and will investigate further at its next meeting.

2.8 Quarterly safe working for junior doctors
– SUBSTANTIAL ASSURANCE OVERALL

This report provided assurance to the Committee that trainee doctors at Shropshire Community Health NHS Trust have safe working hours and conditions in order to maintain doctor and patient safety. This assurance is collated from Shrewsbury and Telford Hospitals NHS Trust's (SATH) Guardian of Safe Working Hours (GOSW), since our trainees are employed by SATH.

The full report is available in **Appendix 4**

2.9 Board Assurance Framework and Corporate Risk Register
– MODERATE ASSURANCE OVERALL

The Committee was assured that the risks posed by the Covid-19 pandemic were being assessed in light of the Trust's corporate risk register (CRR). One new risk had been created, namely, 3601 – 'medical cover at community hospitals'. This was accepted by the Committee and is escalated to the Board for approval.

Three current risks, i.e., 'Business interruption', 'SI's, other incidents' and 'Policies' had all had their risk scores increased to reflect the impact. New mitigations and actions would be considered with the respective executive leads. The Committee recognised that this was an ongoing piece of work and asked for further reports to demonstrate greater assurance as the situation developed.

2.10 Infection Prevention Control (IPC) Update (April) & IPC assurance framework (May)
– SUBSTANTIAL ASSURANCE OVERALL

The update report provided the Committee with assurance on the Trust's compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015) for the period January - March 2020. The assurance framework has been issued by NHSE to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks.

The update report set out that Community Trusts do not have thresholds for MRSA bacteraemia and *Clostridium difficile* infection (CDI) set by the Department of Health and Social Care (DHSC), instead local IPC objectives for 2019/20 are agreed with the Trust's commissioners.

The thresholds set are no more than three cases of Clostridium difficile infection (CDI) detected 3 or more days after admission to the Community Hospitals and a zero tolerance against MRSA bacteraemia. In addition, a compliance threshold of 97% for MRSA screening is in place.

The thresholds for CDI and MRSA have been met, however, the year to date performance MRSA screening is off target at 95.93%. Due to the current situation regarding Covid-19, the MRSA screening data for was unable to be verified in February and March. This has limited the assurance that the Committee could take on compliance with the screening threshold.

The report confirmed that positive samples of legionella spp. had been identified at Trust hospital sites. The Committee received confirmation of the remedial actions in place to and that the risk registers were up to date in relation to the ongoing risk. The Committee took positive assurance from the establishment of the Trust's own Water Safety Group and the completion of the annual Water Safety Audit for the Trust.

The impact of Covid-19 was also considered by the Committee and it was assured by the use of the NHS assurance framework which identified no major gaps in assurance and demonstrated robust mitigating actions.

3.0 Areas of Concern/New Risk

3.1 The Board accepted the new risk relating to medical cover at community hospitals (see the Governance Report later on the Board agenda)
3.2 No new risks were identified at the Committee meeting in May 2020

4.0 Action escalated to the Board

4.1 None from the meetings in April and May

5.0 Recommendations

The Board is asked to

- Accept the assurance provided by the work of the Quality and Safety Committee
- Accept the assurance provided by the Learning from Deaths report
- Accept the assurance provided by the Guardian of Safe Working Report

Assurance criteria

Level of assurance	Managing risk	Evidence of benchmarking or alignment to guidance	Performance	Governance and accountability
Substantial (Outstanding)	Appropriate procedures and controls in place to mitigate the key risks.	Clear evidence of external benchmarking or alignment with national, regional or system guidance	No, or only minor, exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led.	Clear governance and accountability structures in place.
Moderate (Good)	In the main there are appropriate procedures and controls in place to mitigate the key risks and/or minor delays in actions being taken reviewed.	Some evidence of external benchmarking or alignment with national, regional or system guidance OR minor non-compliance with such guidance	A small number of exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led.	Evidence of minor gaps in governance and accountability structures, that may put some of the assurance at risk.
Limited (Requires Improvement)	Procedures and controls are not in place to mitigate the key risks and/or major delays in actions being taken. Where practical, efforts should be made to address in-year.	Little evidence of external benchmarking or alignment with national, regional or system guidance OR major non-compliance with such guidance.	A number of reoccurring exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led, such that efforts should be made to address in-year.	Evidence of major gaps in governance and accountability structures, that may put some of the assurance at risk.
No (Inadequate)	For all associated risk areas there are significant gaps in the mitigations and/or severe delays in actions being taken. Failure to address in-year affects the quality of the organisation's overall assurance framework.	No evidence of external benchmarking or alignment with national, regional or system guidance OR complete non-compliance with such guidance.	No reliance can be placed on performance or evidence for CQC domains, safe, caring, responsive effective and well-led. Failure to address in-year affects the quality of the organisation's overall assurance framework.	Evidence of severe gaps in governance and accountability structures, that may put all of the assurance at risk.

Shropshire Community Health NHS
NHS Trust

APPENDIX 3	Meeting Date:	4 June 2020
	Agenda Item:	9.2
	Enclosure Number:	7

Meeting:	**Trust Board**
Title:	**Learning from Death Report**
Author:	**Dr Jane Povey**
Reviewing Committee:	**Quality & Safety Committee – May 2020**
Assurance level	**Substantial**
Requirement:	**NHS compliance report** The Learning from Deaths framework requires the Trust to: • **collect** quarterly information on deaths, reviews, investigations and resulting quality improvement. • publish its **policy** on how the Trust responds to and learns from the deaths of patients in its care • **publish** information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings including information on reviews of the care provided to those with severe mental health needs or learning disabilities. • **publish** an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year. This report complies with the requirement of quarterly publication deaths, reviews and investigations at a public board meeting.

1. Introduction

1.1 In line with NHS requirements the Learning from Deaths ('LfD') report for the period November 2019 to April 2020 was presented to the Quality & Safety Committee on 21 May 2020. This provided the committee with 'substantial assurance' that:

- actions were being implemented from the learning from deaths reviews; and
- the mortality data includes the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. SCHT undertakes Local Learning from Deaths reviews on every patient death within the Community Hospitals.

1.2 As a result of the national guidance issued in response to COVID-19 on reducing burden and releasing capacity, the Trust streamlined committees and groups. The

1 Accountable Director: Dr Jane Povey – Medical Director

Learning from Deaths Group had been temporarily discontinued but it is now resuming.

2. Learning from Deaths

2.1 Overall there have been 30 deaths reported during February, March and April 2020. During April of the 14 reported in that month, five were COVID related. None of these were unexpected deaths. Under the Department of Health suggested dashboard and categories all patient deaths in this period were accessed as Score 6 – "Definitely not avoidable". See Appendix 1 for the Shropshire Community Health NHS Trust (SCHT) Learning from Deaths dashboard. The main causes of death were malignancy and cardio vascular.

2.2 There have been no reported patient deaths with Learning Disabilities or with a diagnosed Mental Health condition this reporting period.

2.3 The number of Shropshire and Telford & Wrekin child death notifications for 2019-2020 year to date is 22 (as at 25/02/2020). Unsafe sleeping practices was a theme that is being focussed on with actions and planned audits to assure the safe assessment is being completed properly. The issue of a lack of paediatric bereavement services at SaTH is being followed up.

2.4 As a result of the implementation of actions derived from LCM Learning for Deaths Action Plans, the LfD groups will be obtaining evidence through key performance indicators, working with the End of Life Co-ordinators and Community hospital medical and nursing staff to support the impact on the quality of care of our patients. At present, this work is still being developed and this will continue after the COVID19 and LfD groups revert to business as usual. The type of information that will be collated and reported to demonstrate the impact is given below; these relate to the key themes identified:

Action implemented	Impact evidenced
A new Clinical model of staffing has been established on Whitchurch, as a result of a delay in issuing a death certificate due to not having a Ward GP.	No delays in issuing death certificates have been reported.
Patient unable to be discharged home for end of life care due to delay in Continuing Health Care (CHC) process. CHC assessments will continue to be monitored by End of Life Champions for reoccurring themes to determine whether any delays are impacting patients on End of Life plans.	This will be reviewed as CHC processes are restored and the level of delays reported.
Quality and existence of timely End of Life Plans: • Training of ward staff including agency nurses has been provided • Approach to forward planning determined in conjunction with the patient, relatives, carers and all staff involved in the patients care • Shropdoc responsibilities for clerking, attendance to prescribe EoL medication (controlled drugs) and review of deteriorating patients	The EoL Strategy Group will be monitoring this and an update will be provided. Discussions being held with Shropdoc and an update will be provided to the Quality & Safety Committee.

Ensuring the LfD local reviewinvolve the Community Hospital Medical Advisors and Community Hospital GPs to ensure they are aware of any LfD opportunities.	The LfD local checklist does now record the additional staff which are now involved in this review. It has been noted that GPs are now involved in this. (Specifically at Ludlow where this was recognised as issue).
Availability of the relatives' room.	A separate place for confidential discussion with / without staff present has been provided at the community hospitals. No further complaints have been received.

2.5 The Quality & Safety Committee discussed the need for them to review the mortality data each month, to ascertain reasons for any spikes and to be assured that trends were being identified and appropriate actions implemented.

2.6 Feedback was provided by BDO, the Internal Auditors, on where improvements could be made by operational staff on developing actions to measure the impact. Points raised included the following:

- Narrative in the actions needed to be specific and include a form of measurement;
- Triangulation with complaints, in order to establish whether there are themes
- Evidence the work being done with the EoL Group, which could provide assurance of a positive impact being implemented
- Ownership of the actions and allocate responsibility to provide feedback on their implementation

2.7 Further assurance that that the Learning from Deaths processes are robust will be provided by the learning from deaths report clinical audit which will review the quality of report writing at ward level to ensure that learning is identified, disseminated and the impact of this measured. In addition, an internal audit will be undertaken by BDO on how lessons arising from incidents and complaints are identified, disseminated and embedded. This will provide us assurance on the quality of our action plans, triangulation of information and identify potential areas of improvement.

3. COVID-19 REPORTING

3.1 Deaths from Covid-19 are reported daily through the national Sitrep process. The Trust is taking all possible steps to mitigate the risk of patients and staff contracting the virus within the hospitals through tight infection control procedures and adherence to national guidance, including the use of personal protective equipment.

3.2 The Quality & Safety Committee will be provided with the monthly data with respect to Covid-19 related deaths.

Appendix 1: Learning from Deaths Dashboard

Shropshire Community Health NHS Trust: Learning from Deaths Dashboard - April 2020-21

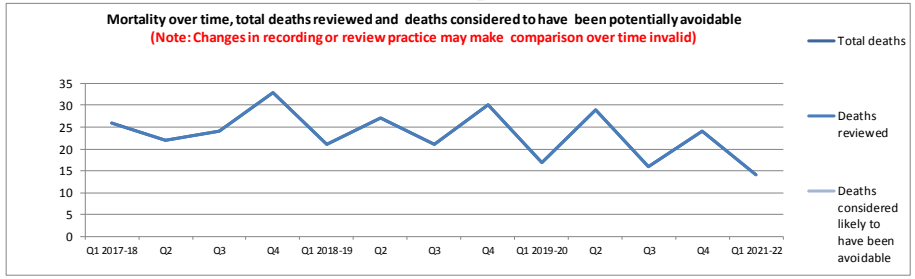
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
14	8	14	8	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
14	24	14	24	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
14	86	14	86	0	0

Time Series: Start date 2017-18 Q1 — End date 2020-21 Q1



Total Deaths Reviewed by RCP Methodology Score

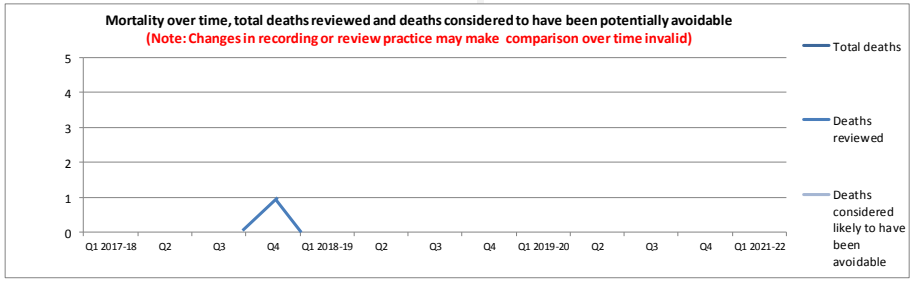
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	14	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	14	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	14	100.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2020-21 Q1



Shropshire Community Health NHS
NHS Trust

APPENDIX 2	Meeting Date:	June 2020
	Agenda Item:	9.3
	Enclosure Number:	8

Meeting:	**Trust Board**
Title:	**Quality and Safety Integrated Report**
Author:	**Ms Alison Trumper**
Reviewing Committee:	**Quality & Safety Committee – May 2020**
Assurance level	**Substantial**
Requirement:	The purpose of this report was to provide assurance to Trust Quality and Safety Committee to support the organisation in the provision of evidence against key lines of enquiry questions within the CQC Well Led domain and, to contribute to the Trust strategic goals and priorities. The report does this by :- 1. Reporting on quantifiable information from the Trust's single data performance repository for reliability and accuracy. 2. Analysing information and where possible, provide evidence through external benchmarking, Trust historical performance and triangulation of softer intelligence to strengthen both reliability and confidence in content. 3. Providing Committee with an executive summary and access to the suite of detailed data supporting this summary 4. Supporting Committee to scrutinise and challenge information provided in order to approve the report for Trust Board.

1 Accountable Director: Steve Gregory, Director of Nursing and Operations

Shropshire Community Health
NHS Trust

Quality and Safety Committee Report - April 2020

Data compiled by: Chris Panayi Quality & Improvement Officer

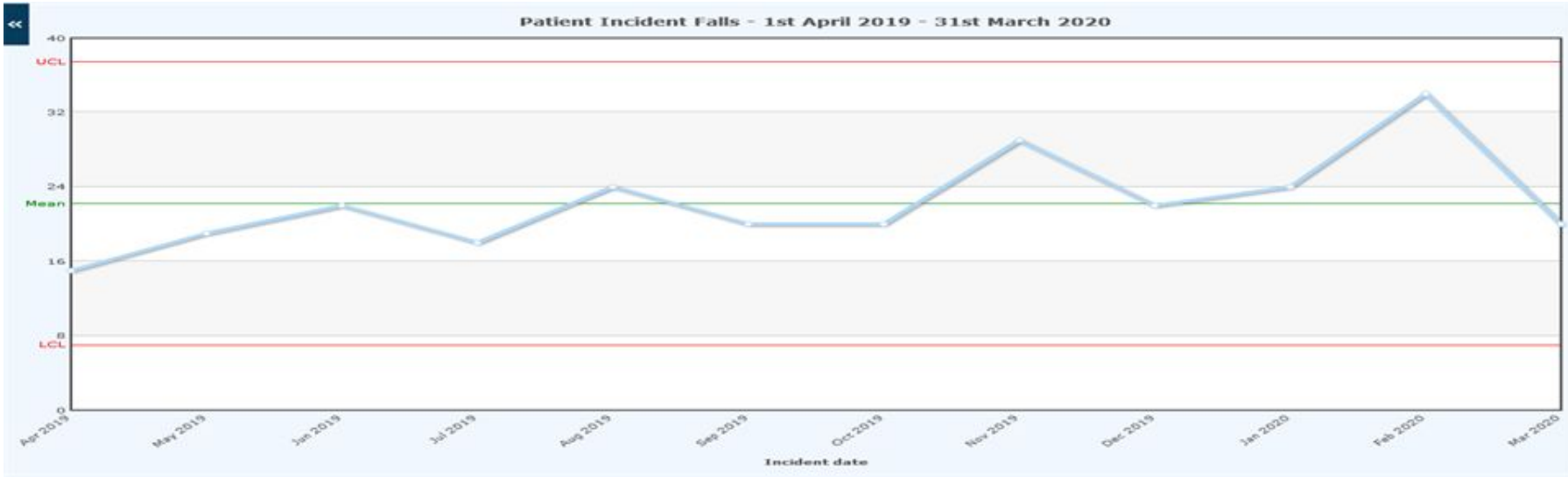
Reporting format

The report is divided into the following sections:

- Headlines and positive stories for Adults, TeMS and Children & Families Service Delivery Groups – **this has been paused for this quarters report**
- 12 monthly trend charts for each of the KPI agreed within this report. Where possible overall Trust performance has been reported alongside both SDG performance in the same line graph. However, this hasn't always been possible due to technical restrictions at this time
- Above each graph you will be made aware of the standard/outcome and performance. Commentary enables the reporting of areas requiring improvement as well as notable improved performance
- The risk registers are included for our SDG's concluding with the InPhase dashboard summarising all KPI's
- The dashboard includes the revised quality KPI's including National, local and Trust performance targets.

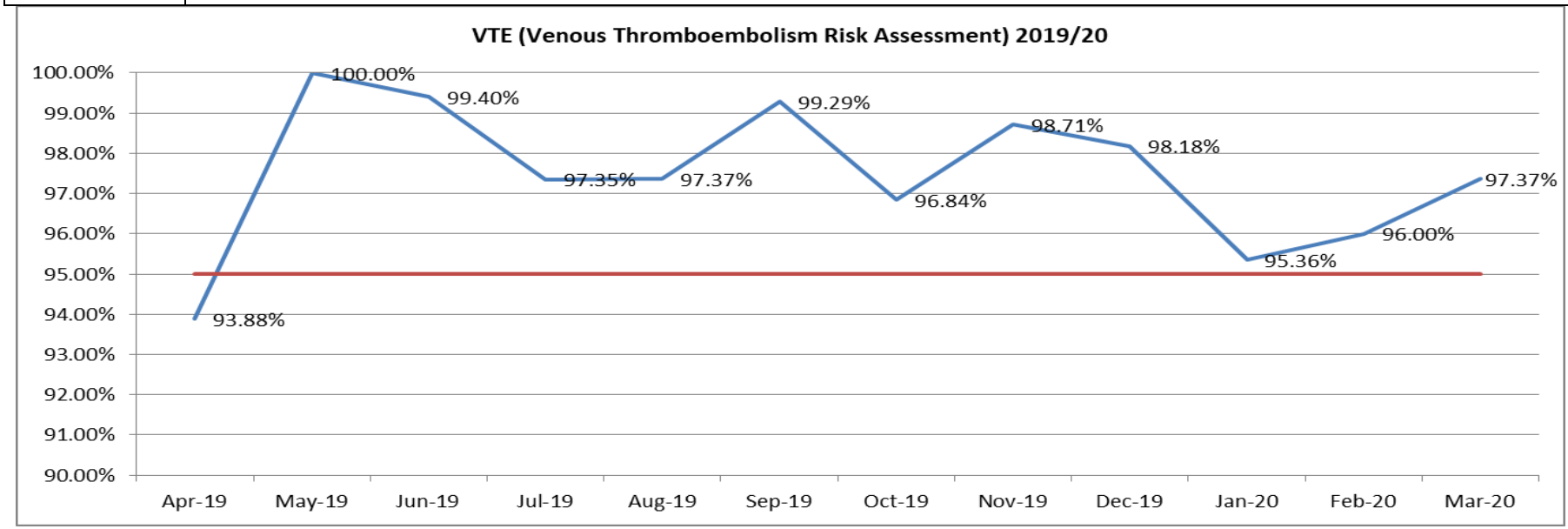
Safe

Falls – Number of Falls	
Standard and outcomes:	Any fall that occurs in an inpatient setting. The severity of the fall is defined in accordance with NRLS categories. All falls resulting in fracture, including those categorised as severe harm or death are reported and managed as serious incidents. The trust target is set at 0 for serious incident falls.
Improvement target	This Trust aims to reduce the number of people from falling year on year.
Commentary:	Overall there were 25 falls in March which is an improving position compared to 33 in February. No patients experienced a severe fall resulting in harm, reportable under the Serious Incident classification in this month. For the year 2018/19 293 patient falls were reported whilst under care of our trust. In 2019/20 a total of 272 patients experienced a fall whilst in our care, broken down as follows: Whitchurch Hospital (32 beds) had 91 patient falls, Bridgnorth Hospital (25 beds) had 75 patient falls, Ludlow Hospital (24 beds) had 65 patient falls and Bishops Castle (12 beds) had 41 falls patient falls. The data includes patients who experienced more than one fall as well as single event falls. There were 2 frequent fallers last month at Whitchurch contributed to 5 of the overall 25 falls in March. Although there has been a rise in falls since November (below), there was no record of an increase in other notable incidents which may have potentially influenced our falls rates such as staffing levels or bed occupancy. Bed occupancy was 73% at Bishops Castle, 88% Bridgnorth, 84% Ludlow and 89% at Whitchurch. Fill rates were 93.1% cover for registered nurses (RN) on day shifts and 97.8% registered nurse cover for night shifts. The unregistered nursing level was 103.2% on day shifts and 114.6% cover for night shifts. (See page 12). The Inpatient Falls Reduction Steering Group continues to focus on causes of falls and ways to reduce them. Wards are now supplying appropriate footwear for patients who are admitted without any or who are unable to obtain footwear during they stay.



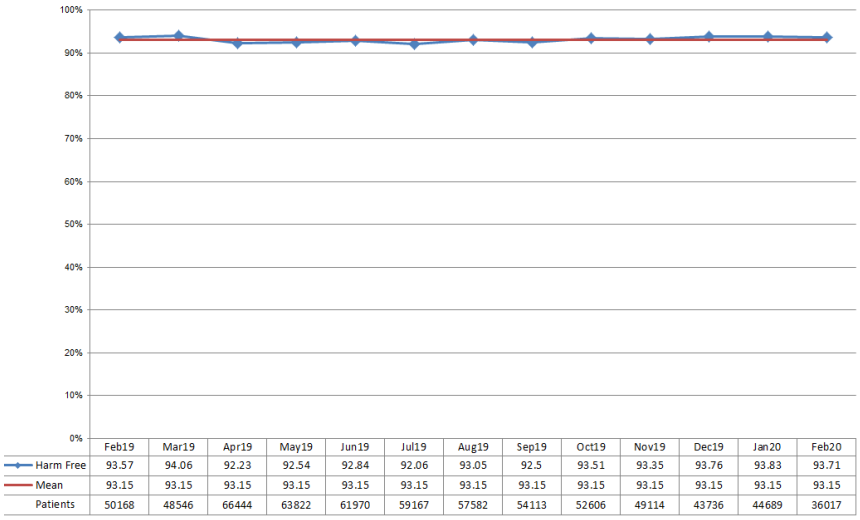
Safe

VTE (Venous Thromboembolism Risk Assessment)	
Standard and outcomes:	All inpatients should undergo a risk assessment for VTE to reduce their risk of venous thromboembolism (VTE or blood clots) and deep vein thrombosis (DVT) in people. The risk assessment aims to help healthcare professionals identify people most at risk and describes interventions that can be used to reduce the risk of VTE. 95% of patients admitted to our community hospitals must be assessed for the risk of developing a VTE.
Performance:	97.37%
Commentary:	VTE compliance has been achieved for 11 consecutive months which can be attributed to senior manager oversight, the robust training plan, revision of ward process and ownership at ward level. Compliance did reduce slightly in January and February due to Ludlow and Whitchurch not completing 100% of their assessments however still above the target of 95% and back on track in March with 97.37%



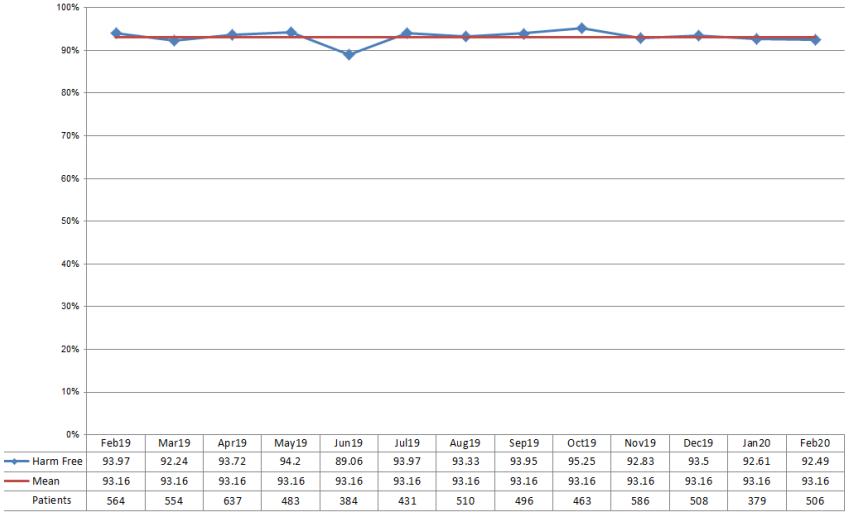
Safety Thermometer – harm free care	
Standard and outcomes:	The Classic Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. Data is a snapshot on the day collected on a single day each month and the aim is to have a snapshot picture of the 4 most commonly occurring themes in healthcare due to assisting and measuring improvement over time. The reporting system also enables trusts to benchmark nationally.
Performance:	92.49% (February 20)
Commentary:	Safety Thermometer data although is an indicator it is a snapshot date in the month. The trust performed 92.49% for February 2020 and an average of 93.16% for the previous 12 months. The Trust has performed almost exactly in line with other Community Trusts average for the year of 93.15%, although just slightly under their average in February of 93.15% with 92.49% for our trust for this month.

Graph 1 – Harm Free Care – Other Community Trust data



	Feb19	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20
Harm Free	93.57	94.06	92.23	92.54	92.84	92.06	93.05	92.5	93.51	93.35	93.76	93.83	93.71
Mean	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15	93.15
Patients	50168	48546	66444	63822	61970	59167	57582	54113	52606	49114	43736	44689	36017

Graph2 - Harm Free Care - SCHT

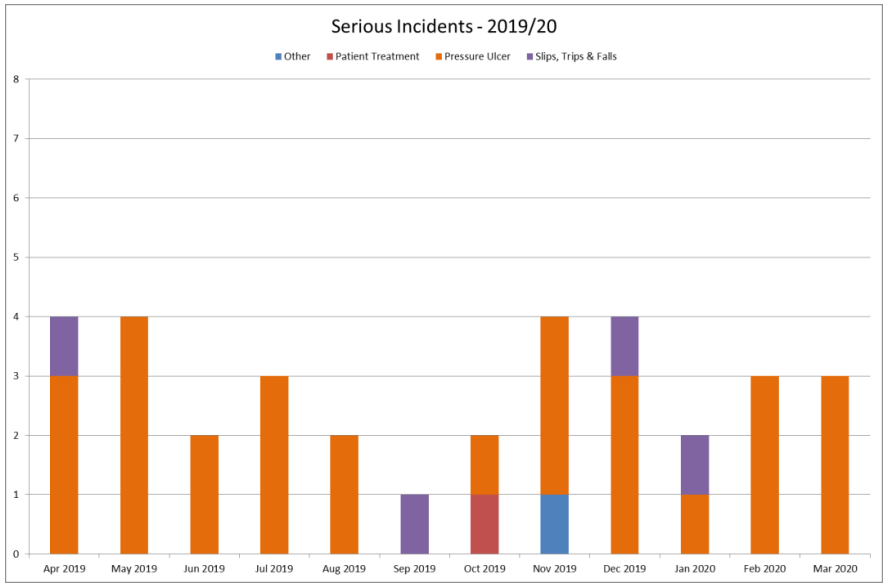


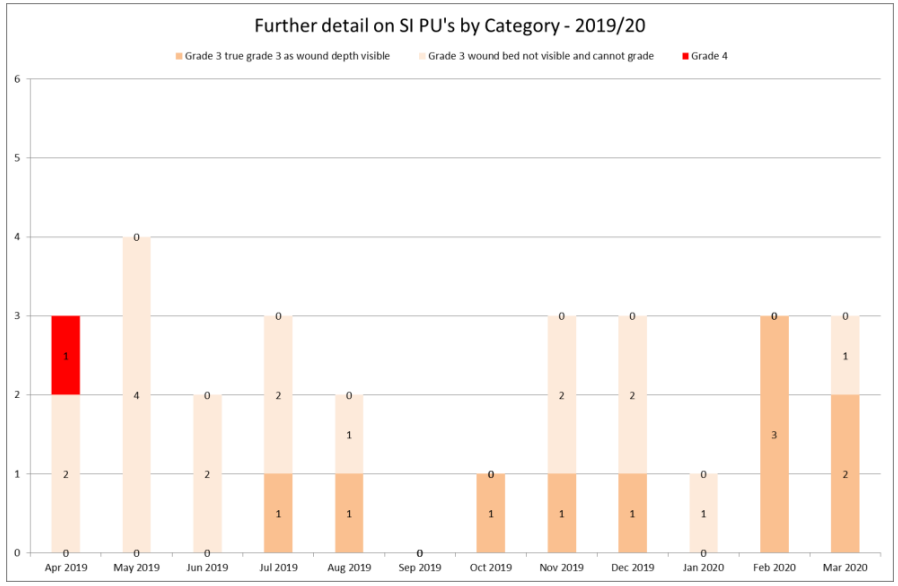
	Feb19	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20
Harm Free	93.97	92.24	93.72	94.2	89.06	93.97	93.33	93.95	95.25	92.83	93.5	92.61	92.49
Mean	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16	93.16
Patients	564	554	637	483	384	431	510	496	463	586	508	379	506

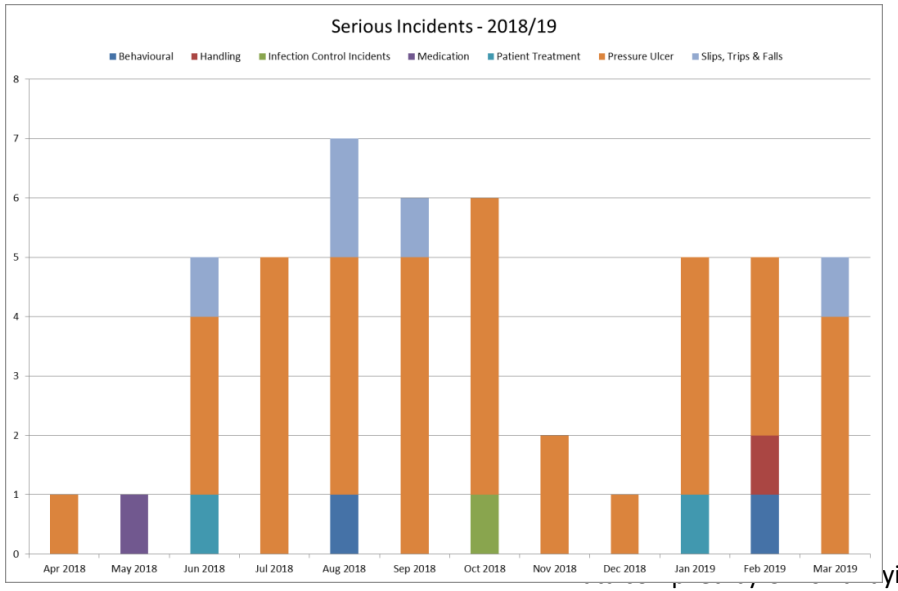
Safe

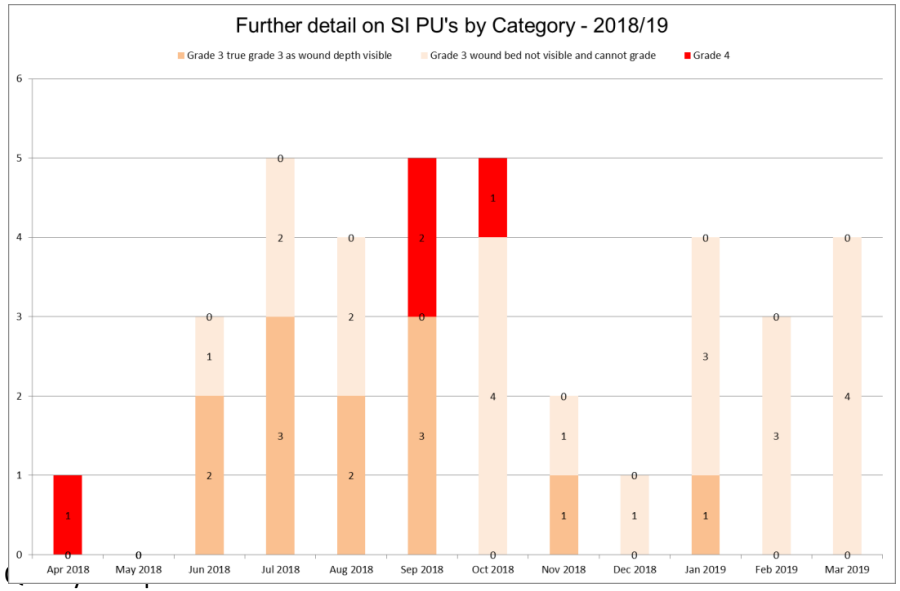
Serious Incidents (all)	
Standard and outcomes:	A Serious Incident is a serious harm caused to one or more patients. All patients, children and young people will receive safe and high quality care whilst under our care.
Total:	2
Commentary:	2 Serious incidents were reported on STEIS in March 2020. These were unstageable pressure ulcers and in line with best practice these are reported as a category 3 until a definitive category can be applied and are subject to a Root Cause Analysis Investigation. During 19/20 a total of 34 incidents were reportable under the national SI framework compared to 49 in 18/19. This is an improving picture for patient outcomes. The theme for SI reportable incidents continues to be patients developing tissue damage resulting in a pressure ulcer. Pressure ulcers are reportable under the SI framework at grade 3 unstageable, grade 3 and grade 4. Overall there has been a reduction in the number of grade 3 unstageable Pu's = 17 in 19/20 compared to 21 in 18/19 grade 3 = 10 19/20 compared to 12 18/19 grade 4 = 2 19/20 compared to 4 18/19 This would suggest the impact of the rapid improvement programme commenced Autumn 2018 is having a positive impact on patient outcomes. This has been achieved through senior oversight, development of PU sensitive KPI's and greater ownership at service level. During the improvement programme it has become clear through an analysis of the locally held data held by the IDT's , 2670 patients were referred into the service during 19/20 with an existing pressure ulcer. This does not correlate with the number of patients entering services with data held on Datix suggesting a gap in reporting onto the Trust reporting system by the IDT services. For this year this will be one of two addition focus of improvement, the second will be implementation of nurse sensitive indicators reporting positive incidents where a patients PU has headed or been downgraded (improved) as a result of service led interventions. Having shared the rapid improvement work with commissioners, the Trust was subsequently approached by NHSI to share the work competed to date with other regional teams and the Trust recommended at the March Clinical Quality Review Meeting, to consider convening a system wide group to address pressure ulcer prevention as a STP.

The 4 graphs below on the following page show a reduction in Serious Incidents overall for 2019/20 compared to 2018/19 with further breakdown of Serious Incidents by Pressure Ulcer category.



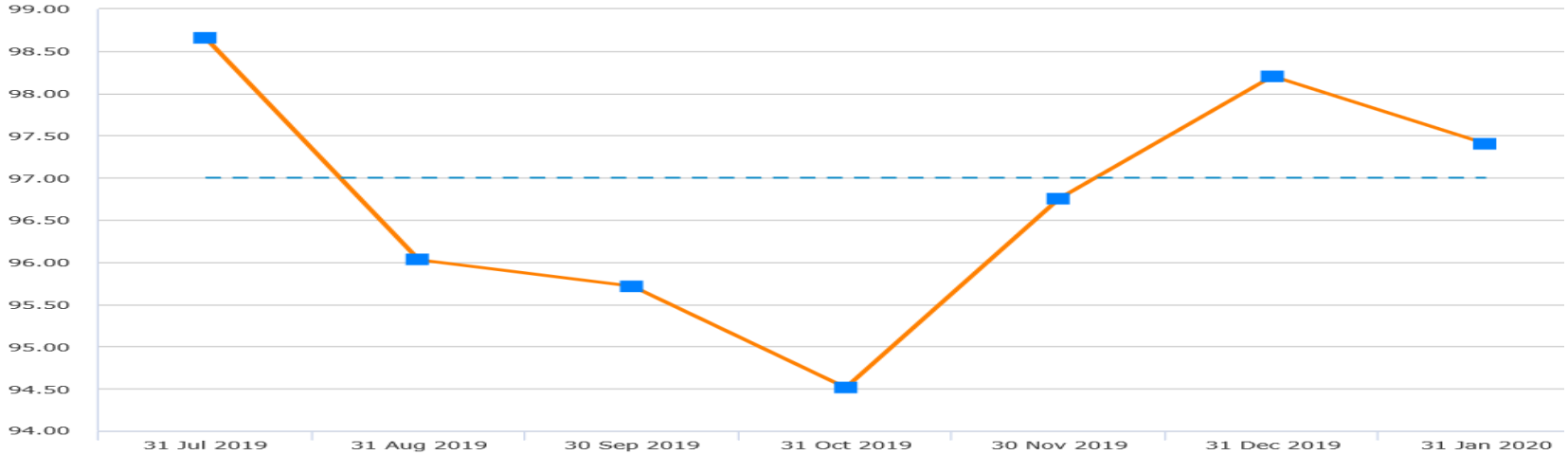






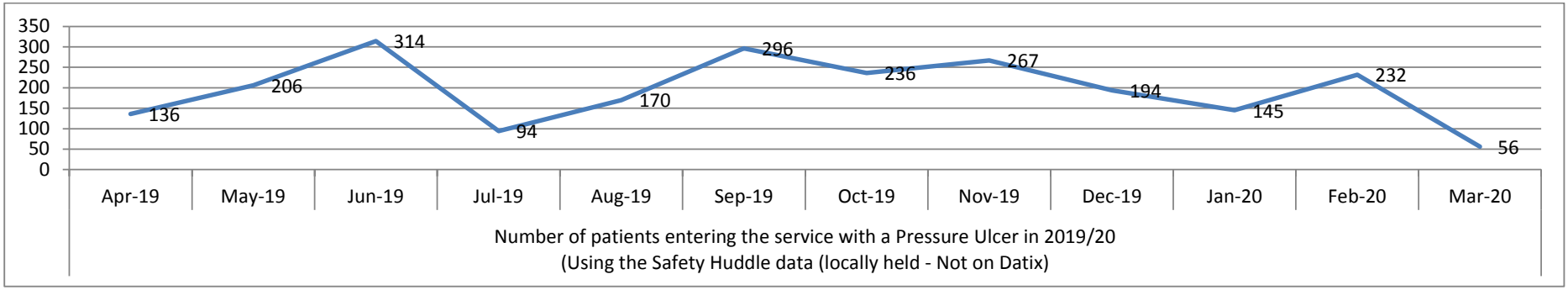
Safe

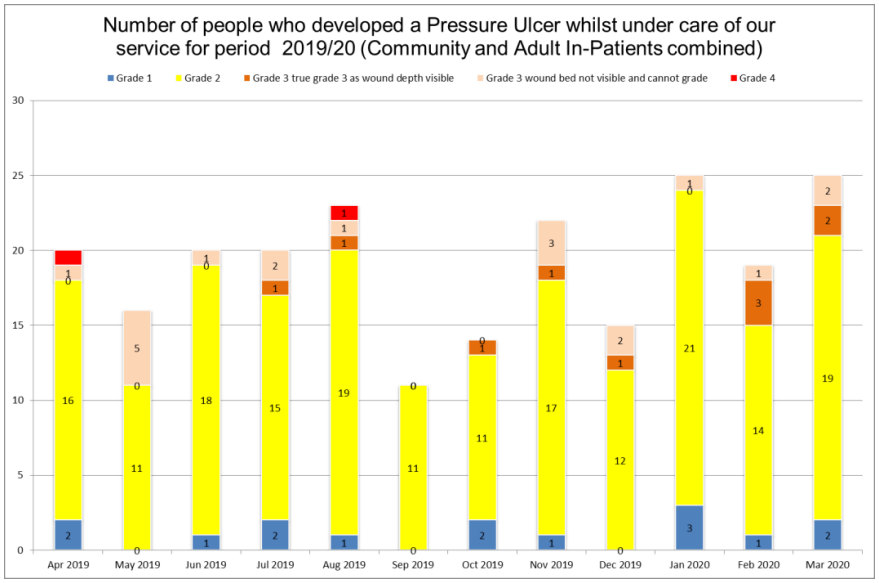
Proportion of admissions screened for MRSA	
Standard and outcomes:	Achievement of this target demonstrates our standard of practice in relation to Control of Infection, links to quality of patient care and to managing our reputation as a healthcare provider and our registration with the Care Quality Commission. In March the Trust did not experience any outbreaks of Methicillin-resistant staphylococcus aureus (MRSA) bacteraemias Proportion of admissions screened for MRSA has a target set at 97%
Performance:	97.4% (January 2020 latest validated data)
Commentary:	MRSA compliance has seen good improvement in December 19 and January 20 although admission screenings have not been received by the wards for the latest month. Safety huddles help to identify any outstanding MRSA screenings. Track and trace system available via ward specimen recording booklet and via Lab REVIEW system Information contained in the Specimen booklet informs the Weekly Screening MRSA compliance data forwarded to the IPC Team to review. This helps to identify missed screenings but also positive results for follow up and action.

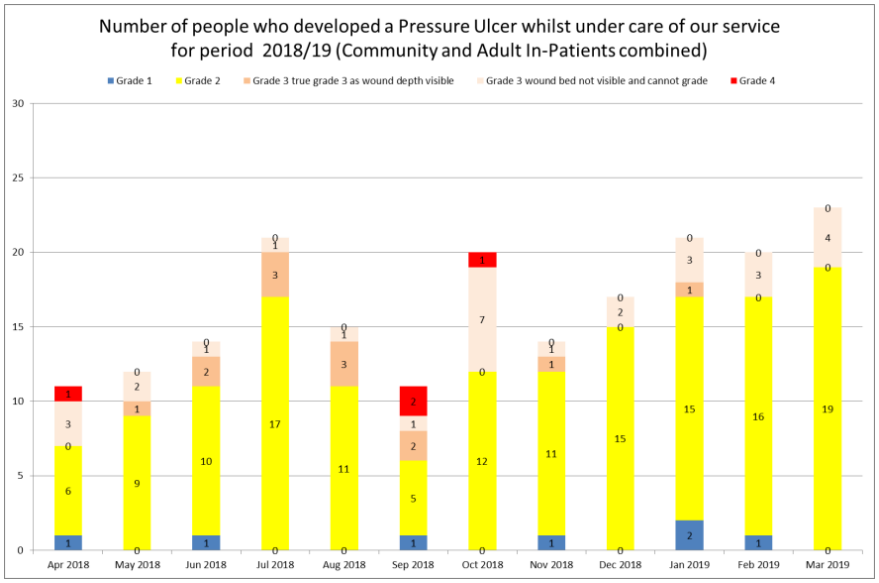


Safe

Pressure Ulcers	
Standard and outcomes:	Pressure ulcers form part of the 'harm free' care reporting suite which are reflective of 'hospital acquired harm'. Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. We aim to reduce the number of patients in our care from developing a pressure ulcer
Position :	25
Commentary:	For the year 1st April 2018 to 31st March 2019 there were a total of 199 pressure ulcers in categories 2-4 recorded on Datix as developing in our care. For this year 1st April 2019 to 31st March 2020 there were 231 pressure ulcers in categories 2-4 developed in our care Context:- there are a significant number of a patients being referred to community teams for pressure ulcers management where the patient has an existing pressure ulcer developed in the patients home (not under our care) . However, the actual number of patients reported as being referred for management does not reflect the actual number reported on our Datix reporting system (19/20 = 404 pressure ulcers , 18/19 = 500). Analysis of the locally held data by IDT's reports 2670 patients as being referred into the service with an existing pressure ulcer. Please note March has seen a reduction in Pressure Ulcers reported via the safety huddle mainly due to the ongoing national situation for COVID 19 however this has been identified and being addressed by the Head of Nursing. Head of nursing for adults has led on the pressure ulcer improvement group. Established in September 2018 to support a reduction in the number of patients who develop grade 3 and 4 PU's Through a Task and Finish group a programme of improvement work commenced. This included strengthening internal assurance processes and weekly senior nurse oversight along with additional training and skill development using a multidisciplinary approach/. It is important to utilise our incident reporting tool as the main repository for data collection , thus the IDT's will move to ensuring all patient who enter the service with an existing PU will be reported in Datix going forward AND will begin to include those patients where a PU has healed or the grade reduce as a result of the nursing intervention in partnership with the patient, carer and family. Having shared the rapid improvement work with commissioners, the Trust was subsequently approached by NHSI to share the work competed to date with other regional teams. Ongoing work continues in pressure ulcer prevention both internally and externally as our community nursing teams are reporting higher levels of pressure ulcers developing in the community. This has been discussed with our commissioning colleagues and a recommendation following March Clinical Quality Review Meeting with the CCG is to convene a system wide group to address pressure ulcer prevention as a STP.







Data compiled by Chris Panayi - Quality & Improvement Officer

Safe

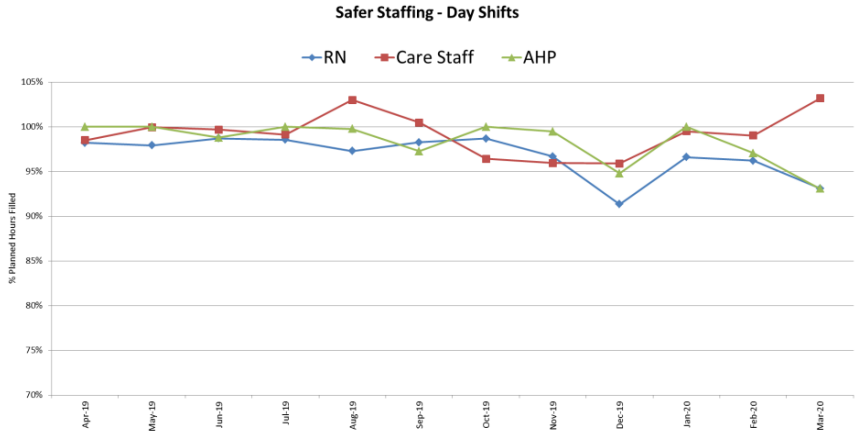
Safer Staffing

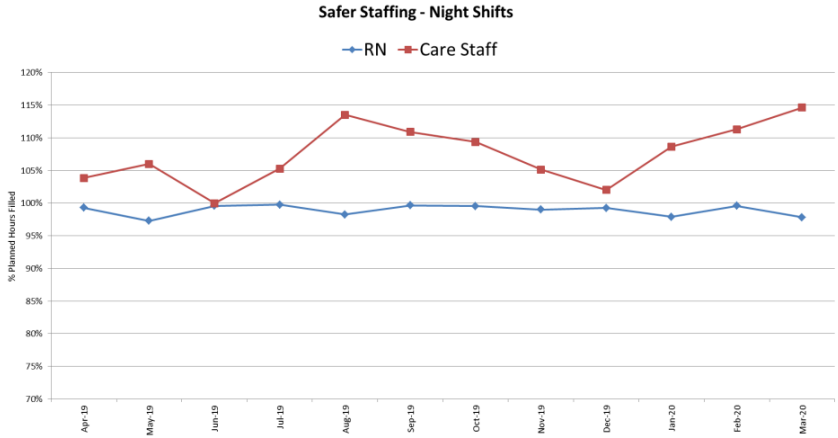
The National Quality Board (NQB) document "How to ensure the right people, with the right skills, are in the right place at the right time" (November 2013) set out expectations for providers of NHS services. The Trust reviews how staffing is reported to enable it to capture areas where additional staffing above the reed establishment has been required to ensure wards are safe, e.g. due to acuity of patients.
Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned
The graphs provide the 'fill rate' for those teams reporting less than 100% by staff group and time of day, and also 'fill rate' as recorded on UNIFY. The table provides a summary of Trust overall performance.

Overall for the month of March, the Trust had 93.1% cover for registered nurses (RN) on day shifts and 97.8% registered nurse cover for night shifts. The unregistered nursing level was 103.2% on day shifts and 114.6% cover for night shifts. Average bed occupancy continues to be below 100%: 73% at Bishops Castle, 88% Bridgnorth, 84% Ludlow and 89% at Whitchurch.

The UNIFY return provides information on how actual staffing levels compare to the planned levels (CQC KLOE S4). The March 2020 return indicates that staffing numbers overall were at a 100.2% fill rate. For March the lowest RN fill rate was at 82% on day shifts at Bridgnorth Hospital. Bed occupancy at that time was 88%. A minimum of 2 RNs were on duty for every day of that month and an average of over 4 care staff on duty for every day of the month which countered the lower than usual number of RNs on duty. Patient incidents reported via Datix were recorded as lower in March compared to February.

The registered AHP fill rate was 93.1% and 95.8% for unregistered staff at all four Community Hospitals. Those areas with a high fill rate were due to the level of additional patient supervision and covering RN shifts not filled to ensure minimum numbers.

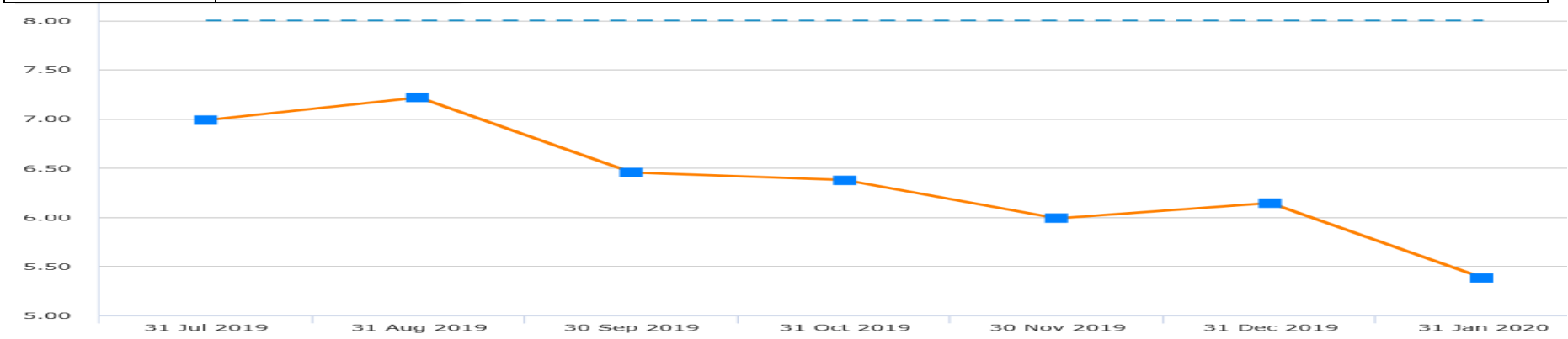




Data compiled by Chris Panayi - Quality & Improvement Officer

Safe

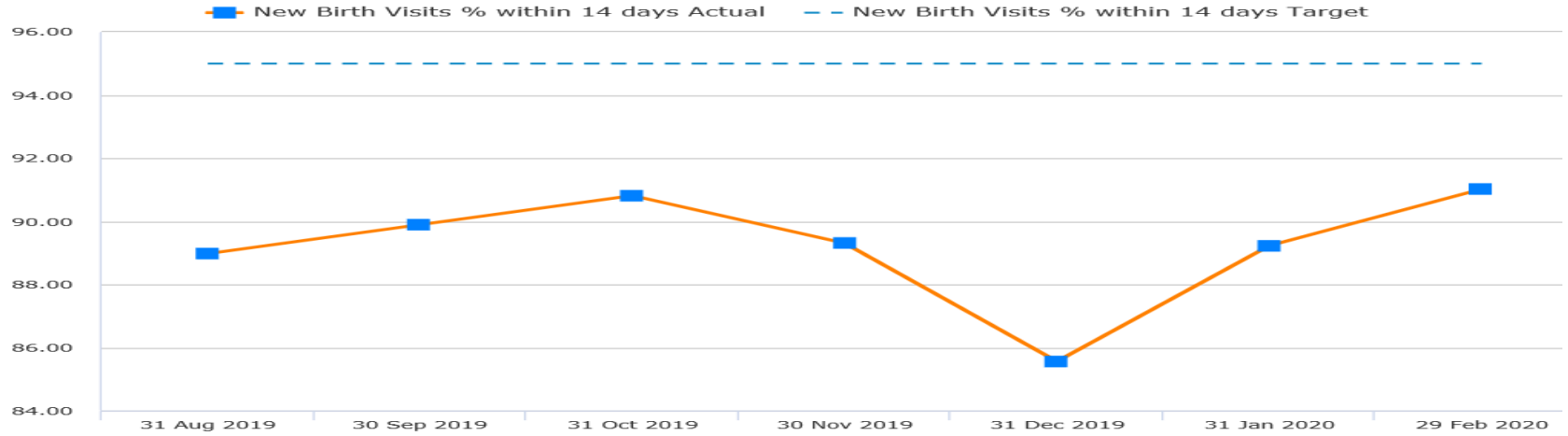
Staff Vacancy rates	
Standard and outcomes:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage.
Performance:	5.38% (January 2020 latest data)
Commentary:	For the latest available data in January 2020, funded establishment vacancy rates dropped to 5%. There has been a steady, consistent improvement in our position from August 2019 where it peaked at 7.22%.



Data compiled by Chris Panayi - Quality & Improvement Officer

Caring

New Birth Visits % within 14 days	
Standard & outcome:	95% of new birth visits to be completed within 14 days of birth
Performance:	91.02%
Commentary:	National target is face to face visit by Health Visitor for new birth visit between 10 and 14 days, visits outside of this timescale (either before or after) are not classed as adherence to the KPI. All mothers receive a HV contact by phone following a new birth notification; this is a clinical contact and relevant quality and safety information is ascertained, yet this is not captured as a new birth contact either locally or nationally. It is known nationally that this KPI may need a refresh. National concerns raised by PHE that reporting from providers is not consistent with the data expected in terms of numbers and outputs. The current % within 14 days has Increased to 91.02% from last month's 89.23% with a target of 95%. There were 5 patients owing to late visit reason being outside of the control of our service, such as where the visit was delayed through patient choice or unavailability of patient. Planned Actions: ▪ Visits which take place outside of the schedule will continue to have comments on Rio for explanation ▪ Data validation data set to be requested for team leads to facilitate security of accuracy and check against Rio records ▪ Data inputting aide memoire is being developed for staff (for 3.20) ▪ Delays caused by lack of birth notification from CHIS will be datixed and raised at the appropriate forums if pattern developing ▪ Correlation of the increasing numbers of child protection and LAC are being investigated to identify trends and whether this is impacting upon delivery of core contacts.



Data compiled by Chris Panayi - Quality & Improvement Officer

Caring

Friends and Family Test – Adult and TeMS SDG Positive Response	
Standard and outcomes:	The NHS Friends and Family Test (FFT) is a feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. The question asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their family and friends. **Please note w/e/f: March 2020 reporting has changed. IQVIA has now replaced Meridian as the data source for patient experience.**
Commentary:	Adult SDG – 98.39% of patients would recommend our services. TeMS and Outpatients – 99.12% would recommend our services. As you can see from the below graphics, the number of responses in February and March dropped significantly. This is likely to be due to the National Coronavirus situation and the impact this has had on both facilitating FFT questionnaires and the ability to collate FFT feedback during March.

Adult SDG

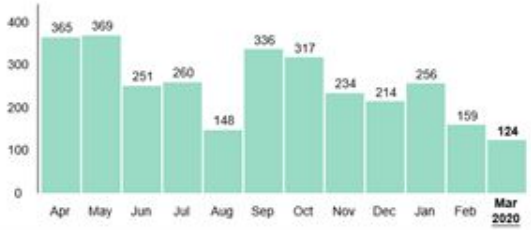
FFT Recommend and Not Recommend percentages (FFT All, Mar 2020)

FFT response breakdown (FFT All, Mar 2020)

Response	Percentage	Number of times response selected
Extremely Likely	88.71%	110
Likely	9.68%	12
Neither Likely nor Unlikely	0.00%	0
Unlikely	0.81%	1
Extremely Unlikely	0.81%	1
Don't Know	0.00%	0

Export

Number of surveys completed each month (FFT All From Apr 2019 to Mar 2020) 3033 Surveys



TeMS and Outpatients SDG

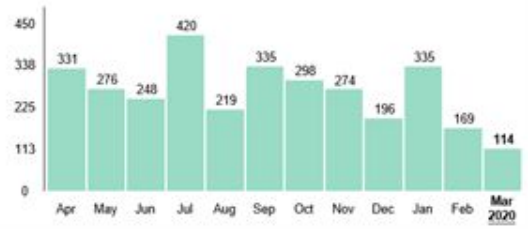
FFT Recommend and Not Recommend percentages (FFT All, Mar 2020)

FFT response breakdown (FFT All, Mar 2020)

Response	Percentage	Number of times response selected
Extremely Likely	85.96%	98
Likely	13.16%	15
Neither Likely nor Unlikely	0.00%	0
Unlikely	0.88%	1
Extremely Unlikely	0.00%	0
Don't Know	0.00%	0

Export

Number of surveys completed each month (FFT All From Apr 2019 to Mar 2020) 3215 Surveys



Caring

Friends and Family Test – Children and Families Positive Response	
Standard and outcomes:	The NHS Friends and Family Test (FFT) is a feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. The question asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their family and friends.
Performance:	98.74%
Commentary:	Children and Families SDG – 98.74% recommend. As with the other SDGs the response rate for March is significantly lower than normal most likely for the reasons.

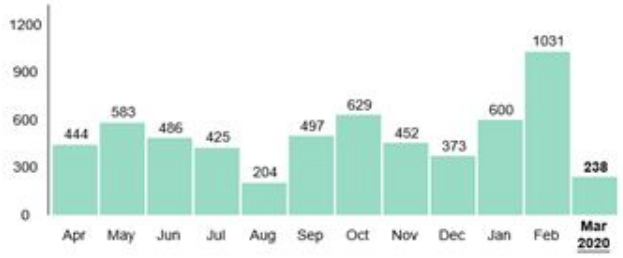
FFT Recommend and Not Recommend percentages (FFT All, Mar 2020)

FFT response breakdown (FFT All, Mar 2020)

Response	Percentage	Number of times response selected
Extremely Likely	75.21%	179
Likely	23.53%	56
Neither Likely nor Unlikely	0.00%	0
Unlikely	0.00%	0
Extremely Unlikely	0.42%	1
Don't Know	0.84%	2

Export

Number of surveys completed each month (FFT All From Apr 2019 to Mar 2020) 5962 Surveys



Data compiled by Chris Panayi - Quality & Improvement Officer

A sample of Friends and Family Test comments this month

Adult & TeMS SDG

Ludlow Inpatients
"The staff are very caring, good at listening to patients and trying to help them to help to help themselves to improve their health"

Oswestry MIU
What was good about your visit?
"was seen very quickly and everything was explained fully"

Whitchurch Hospital
"lovely lovely hospital"

Whitchurch Inpatients
Did you feel you had the opportunity to discuss your discharge from the ward with members of staff?
"Staff time is restricted"

Whitchurch Inpatients
Was your care and treatment explained in a way you could understand?
"Never know what was happening until it happens"

TeMS Rheumatology
"Only issue - male person on reception was not polite. Very unfriendly! In his position he could be more professional and helpful, he was not."

Whitchurch hospital ward has featured in previous reports with communication being a similar theme. The ward team are working hard to improve the patient experience and

Children and Families SDG

CDC
Early Links group - Monkmoor CDC."**We felt very comfortable and at ease. The staff were very supportive and helpful."**

Children's OT
"Lots of encouragement given so he was cycling by the end of the first session."

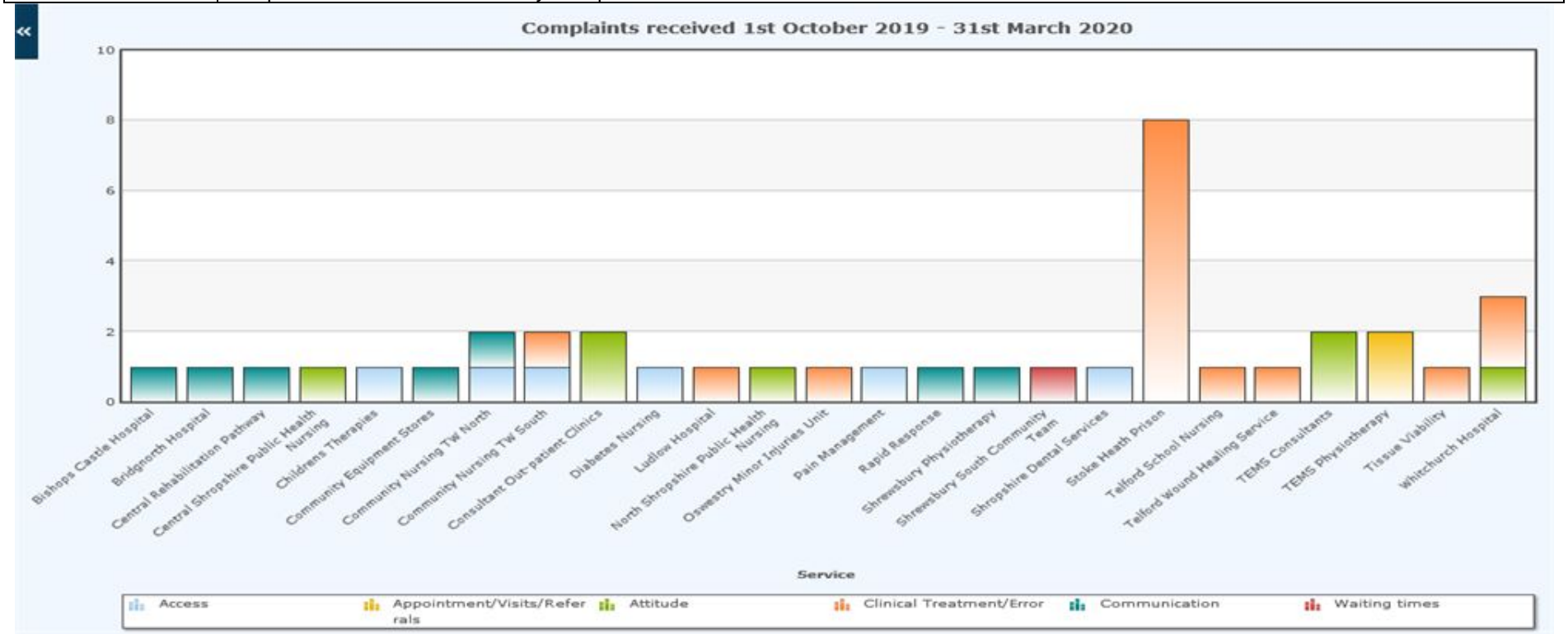
Children's Physio
"Excellent exercises set at good pace and very positive reinforcement of work"

No negative feedback received for Childrens SDG in March

Data compiled by Chris Panayi - Quality & Improvement Officer

Responsive

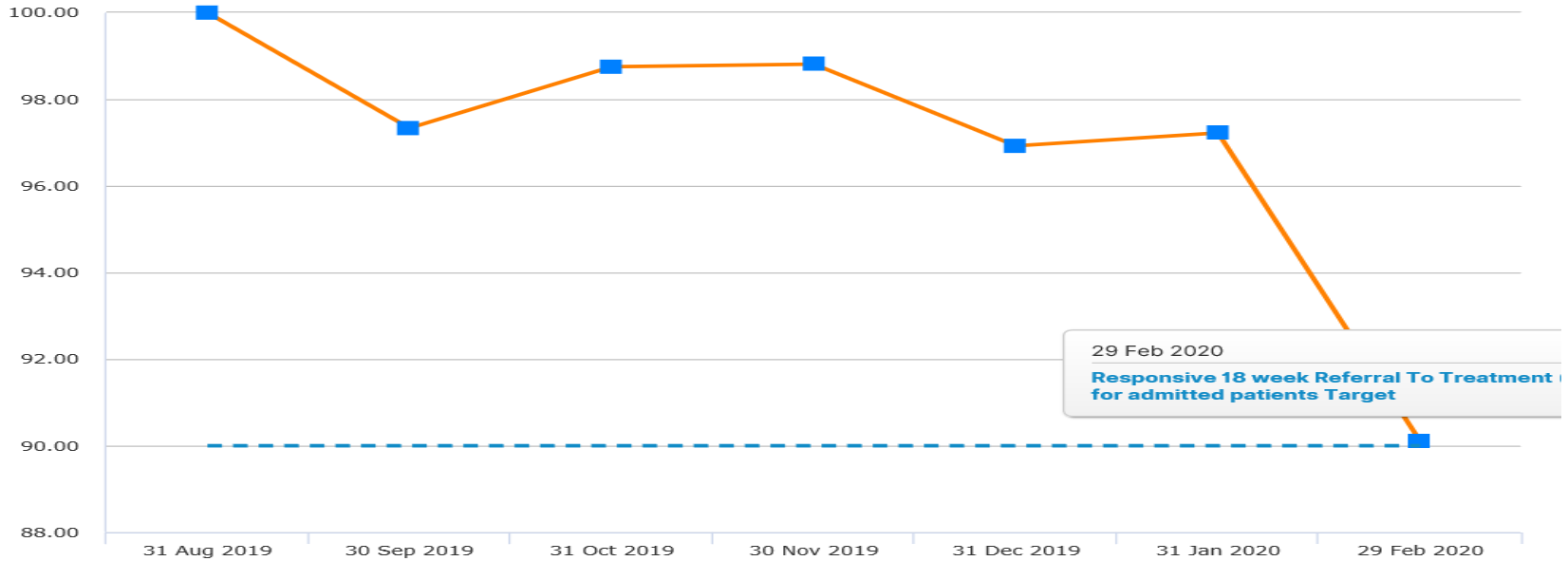
Complaints	
Standard and outcomes:	The number of written complaints. Complaints provide valuable feedback to improve care & outcomes
Performance:	6
Commentary:	During March the Trust received a total of 6 complaints. The complaints fell into the categories of 'Staff attitudes' (2), Communication (2), Quality of Care (1), Waiting Times (1). The areas where the complaints were made include Central ICS, North Shropshire Public Health Nursing, Whitchurch Hospital, Community Nursing Telford North, Stoke Heath Prison and Shrewsbury South IDT Team. There is an ongoing process in place to share learning from complaints across Service Delivery Groups.



Data compiled by Chris Panayi - Quality & Improvement Officer

Responsive

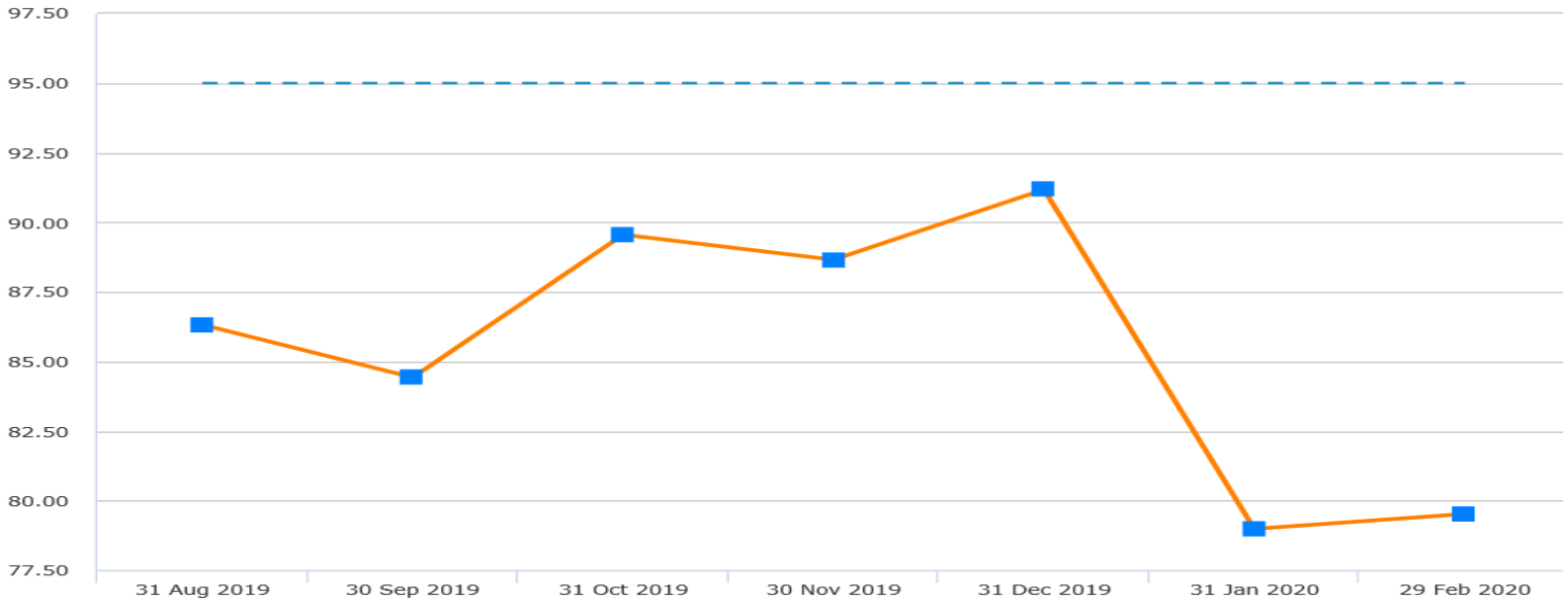
18 week Referral To Treatment for admitted patients	
Standard and outcomes:	Patients should wait no longer than 18 weeks for treatment (Admitted)
Performance:	90.1%
Commentary:	90% compliance is being achieved for February however The drop in performance is for Dental and is related to the cancellation of theatre lists by SATH related to escalation at SATH The recovery plan includes 1. Maintaining service provision as per NHS priorities during COVID-19 pandemic 2. Staying in contact with hospital providers to plan for post COVID-19 surge service delivery 3. Reviewing the waiting list to consider any alternative pathways 4. Providing support and medication for those waiting where this is appropriate



Data compiled by Chris Panayi - Quality & Improvement Officer

Responsive

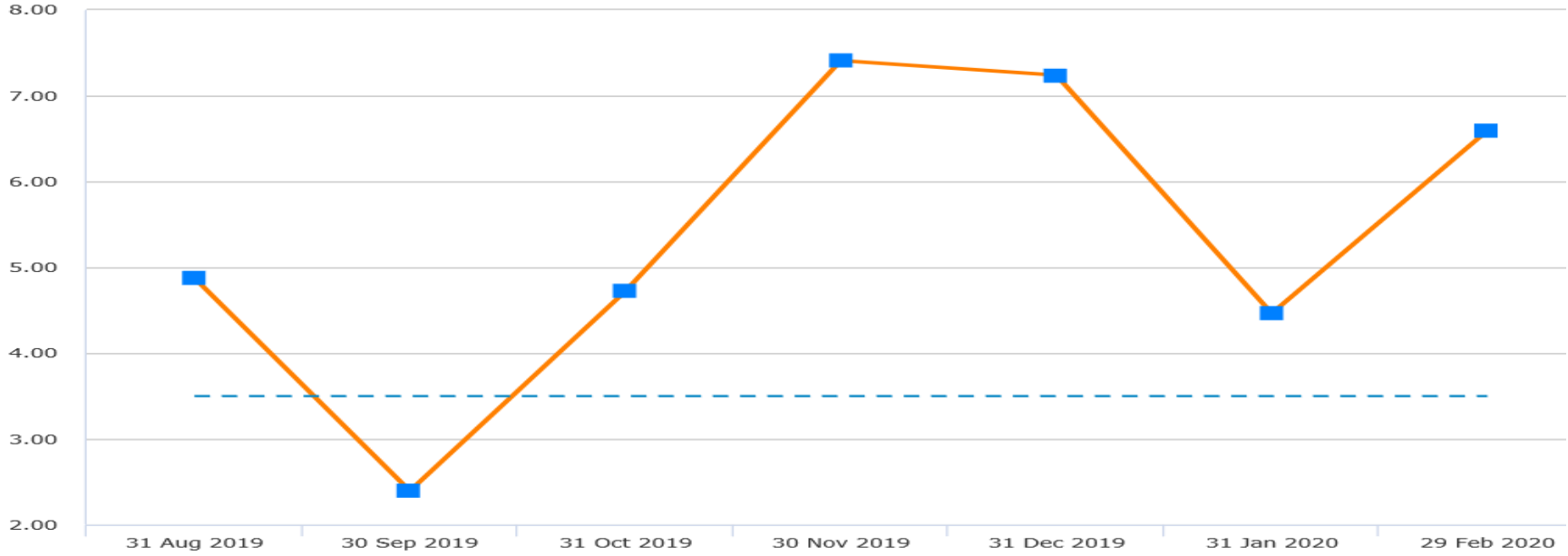
18 week Referral To Treatment for non-admitted patients	
Standard and outcomes:	At each month-end, the Trust reports the number of patients on an on-going RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. SCHT Patients should wait no longer than 18 weeks for treatment (Non-admitted)
Performance:	79.52%
Commentary:	Planned Actions: The following actions will boost the physiotherapy capacity or reduce physiotherapy demand within the service: • 1wte locum physiotherapist commenced • 0.75 maternity backfill physiotherapist start May 2020 • Additional Physiotherapy bank hours currently in negotiation commence May 2020 • Adopt Patient Initiated Follow Up process to reduce follow up demand to commence by end of quarter 1 • consideration of over recruitment of Physiotherapist to mitigate capacity challenges



Data compiled by Chris Panayi - Quality & Improvement Officer

Responsive

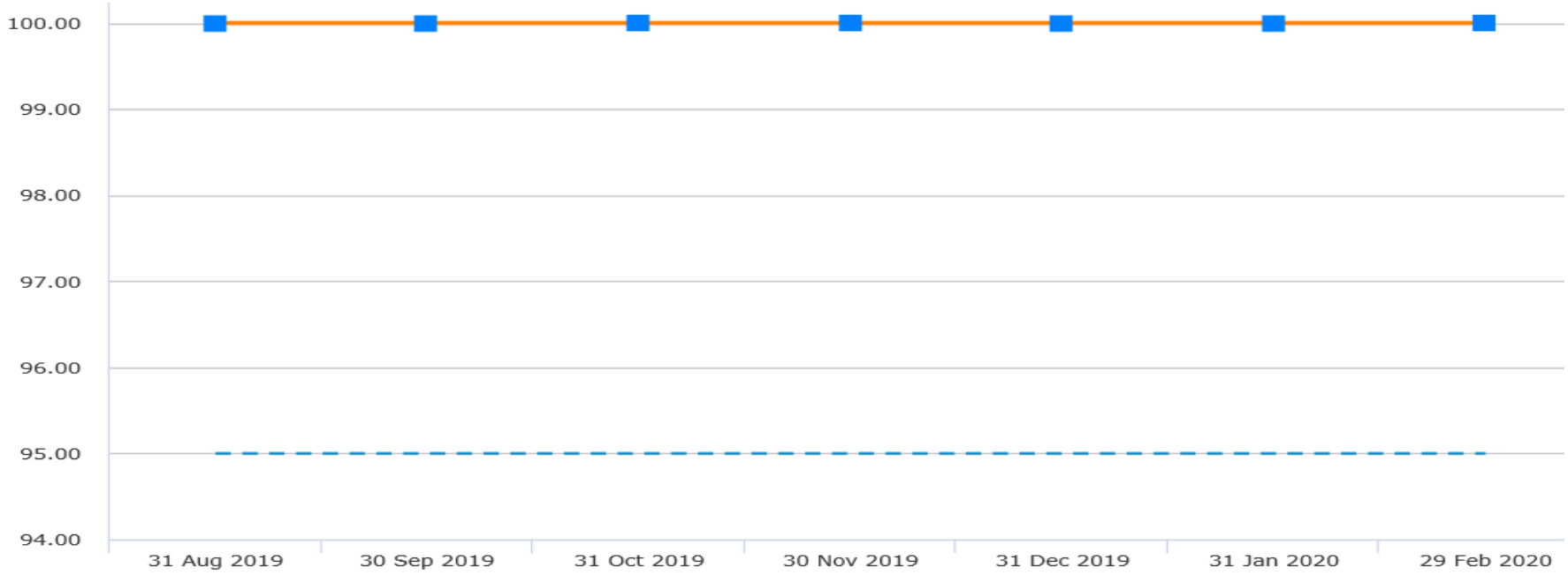
Proportion of Delayed Transfers of Care	
Standard and outcomes:	The Trust aims to discharge patients who no longer need to be in hospital in a timely manner as far as possible to prevent deterioration in their overall condition**.** The DTOC data relates to the percentage of all occupied beds that are occupied by a patient who is delayed. The National target is 3.5%
Performance:	6.59%
Commentary:	We have continued to accept a higher number of delayed patients from SaTH over winter period to support the flow of patients across the system. All patients are reviewed on a daily basis as part of the Red2 Green work stream to identify and escalate or progress any issues as a system. The onset of COVID-19 has had a significant impact on the DTOC process, with the national reporting now having stopped. Internally we continue to highlight and report any DTOC's to ensure patients are not unduly delayed.



Data compiled by Chris Panayi - Quality & Improvement Officer

Responsive

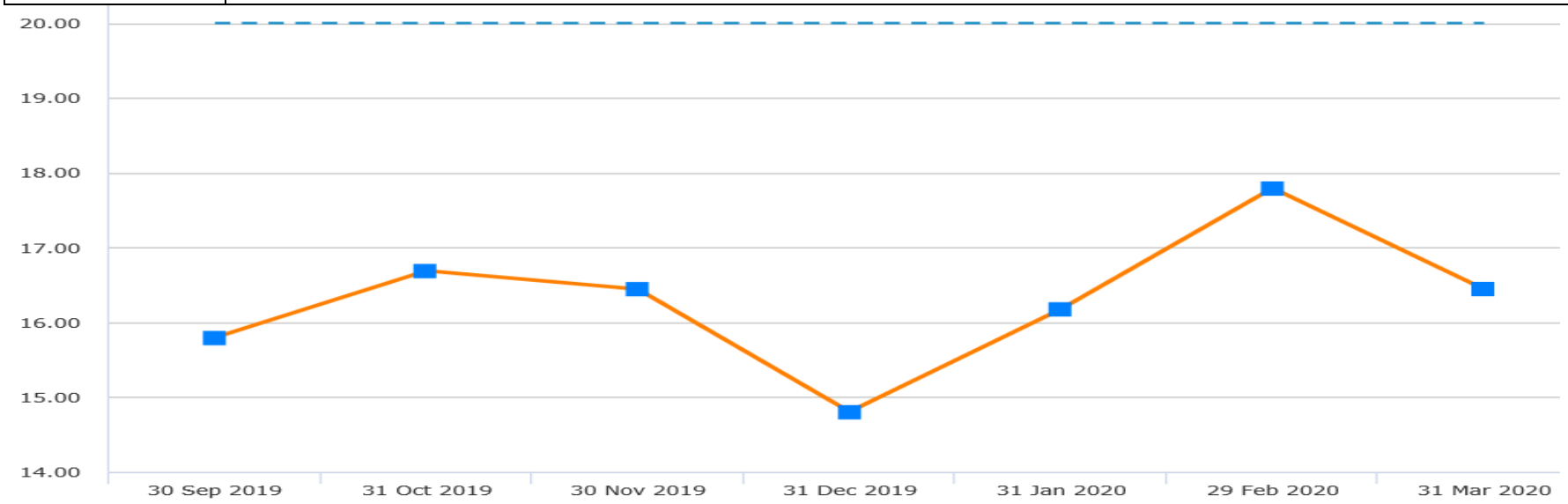
MIU Total time in department – discharged within 4 hours	
Standard and outcomes:	Patients should spend less than 4 hours before discharge. A target is that 95% of patients should be seen within 4 hours of arriving in a MIU department
Performance:	100%
Commentary:	The Trust Performance has consistently maintained 100% for the previous six months.



Data compiled by Chris Panayi - Quality & Improvement Officer

Effective

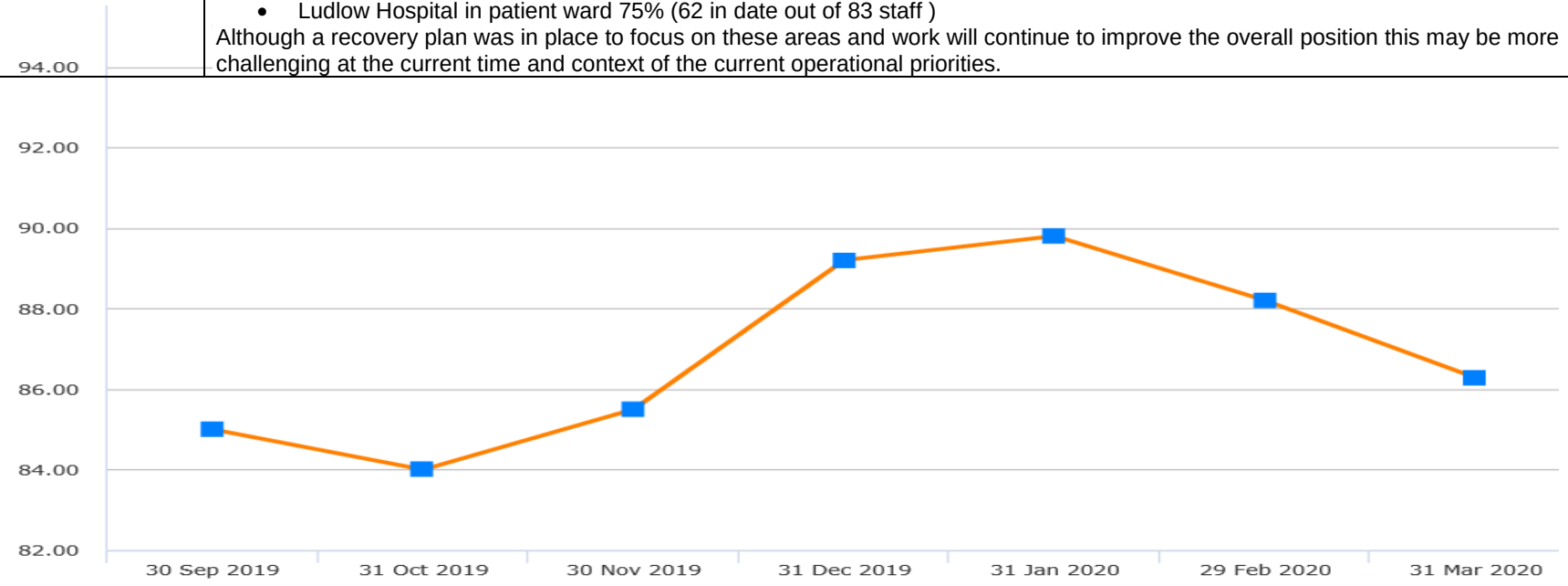
Length of Stay (overall)	
Standard and outcomes:	Bed occupancy rates are monitored to establish the utilisation of Community Hospital beds and to ensure patients do not stay longer in hospital than they need to. The average Length of Stay is the number of bed days (1 bed days = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	16 days
Commentary:	Length of stay is on target and has improved slightly to 16 days in March. The total length of staff across our 4 hospital sites ranges from 12 days at Bishops Castle to 18 days at Bridgnorth. Of note is that from September 2019 Bridgnorth community hospital became part of a system wide solution to improve the care of patients who had been diagnosed with a Cerebral Vascular Accident /Stroke. We are now supporting more patients on the ward than the 6 beds originally intended. Some of this category of patients have a longer length of stay but this often results in them going home with the family being able to support rather than needing a care package which is better for the patient.



Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

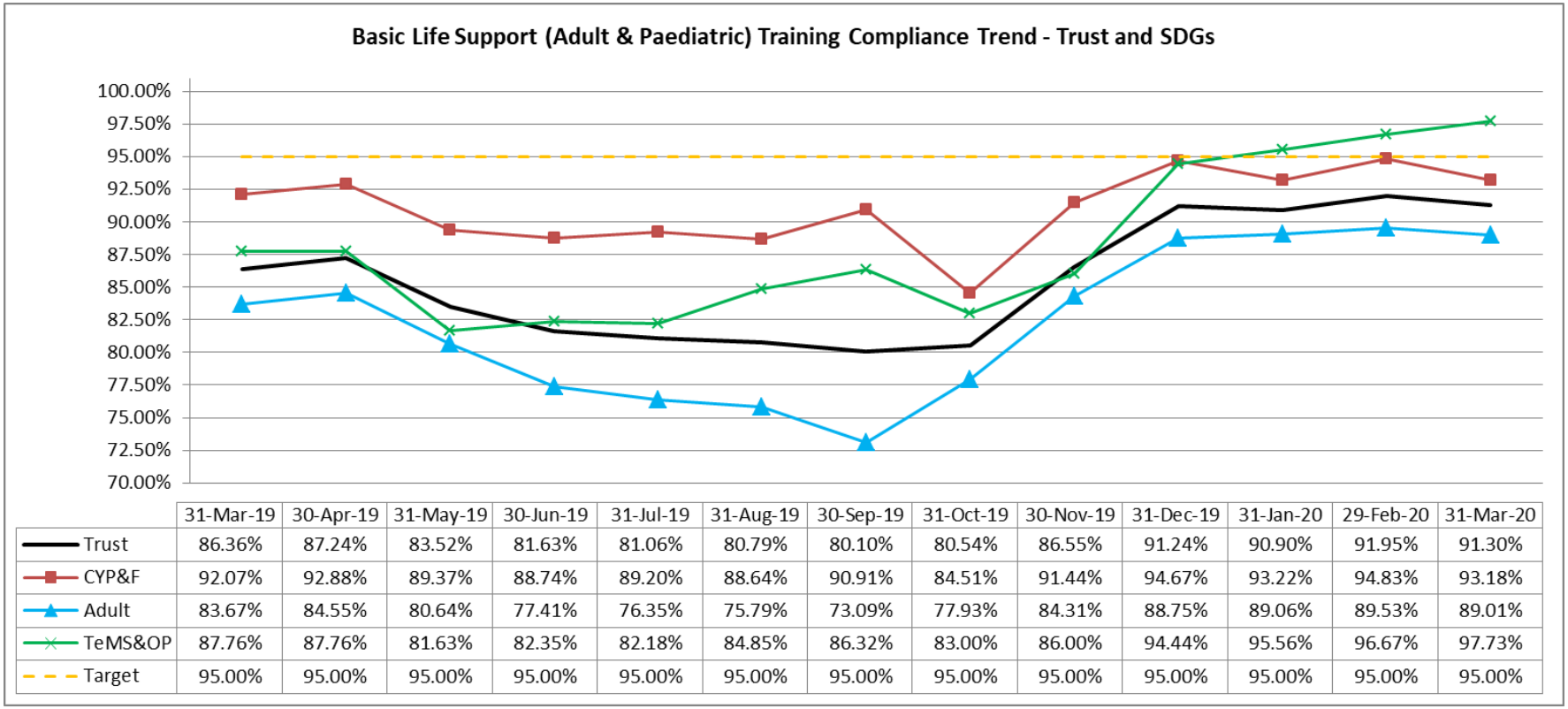
Appraisal Rates - Trust	
Standard and outcomes:	The purpose of this indicator is to provide assurance that all staff receive an appraisal within a twelve month period, that work objectives are set in alignment with the Trust objectives and that all staff have a personal development plan to support them in their current job role and future development. The Trust's internal target is set at 95%
Performance:	86.28%
Commentary:	Appraisal Rates this month have declined slightly on February's position of 88.2% It is likely appraisals will experience a worsening picture during the coronavirus period and that prior to this our performance was on an improving trajectory There were 5 teams that fell below the 10% tolerance threshold level. Those were • Ludlow Hotel Services 58% (14 in date from a possible 24 staff) • Community Equipment Stores (CES) 67% (19 in date out of 29 staff) • Bishops Castle In-Patients ward 68% (13 in date out of 19 staff) • Telford Community Neighbourhood Team - South 70% (16 from 23) • Ludlow Hospital in patient ward 75% (62 in date out of 83 staff) Although a recovery plan was in place to focus on these areas and work will continue to improve the overall position this may be more challenging at the current time and context of the current operational priorities.



Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Basic Life Support Training (Adult & Paediatric) (CPR)	
Standards:	95% of all Trust staff will have undertaken Basic Life Support Training (Adult & Paediatric) (CPR) within the last 12 months
Performance:	91.30%▼
Commentary:	There has been an actual compliance improvement in the last quarter, with a small drop this month. The small drop this month can largely be attributed to reduced class sizes in order to accommodate safe social distancing.

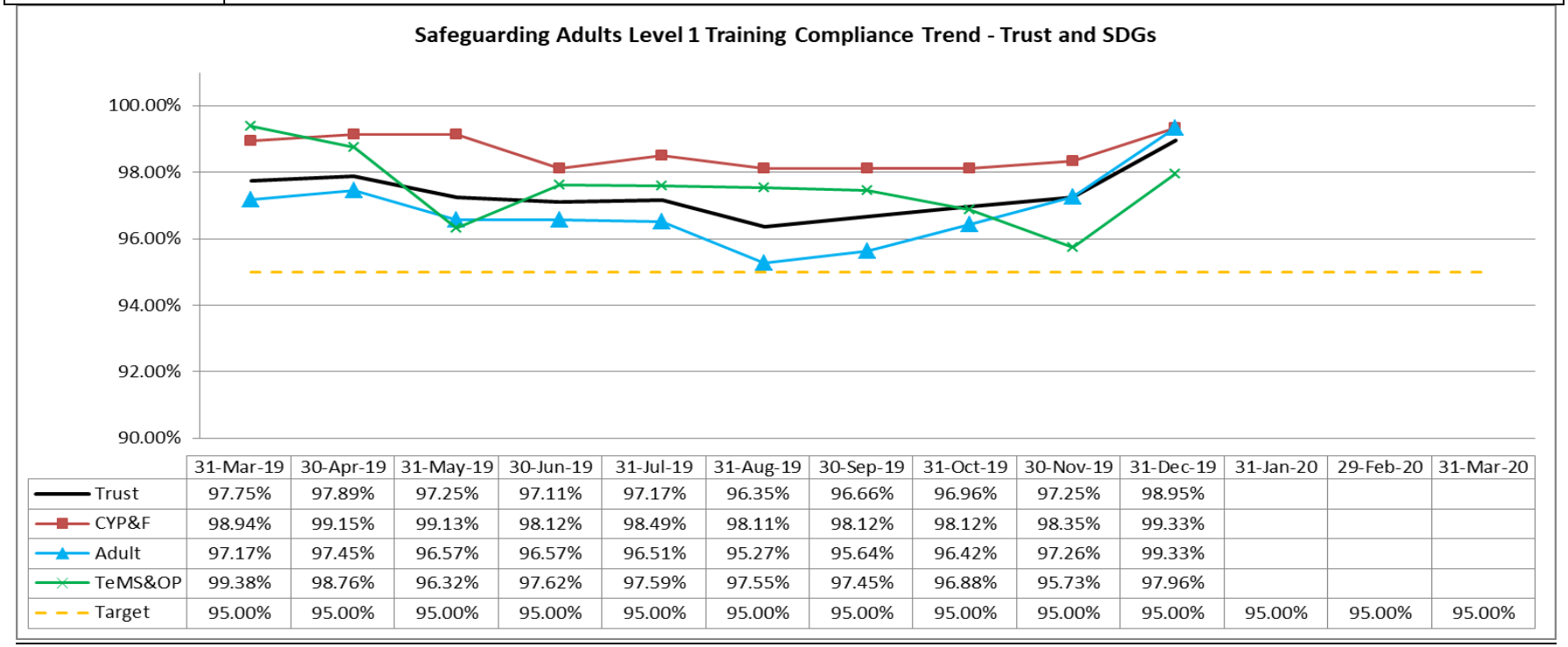


	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	86.36%	87.24%	83.52%	81.63%	81.06%	80.79%	80.10%	80.54%	86.55%	91.24%	90.90%	91.95%	91.30%
CYP&F	92.07%	92.88%	89.37%	88.74%	89.20%	88.64%	90.91%	84.51%	91.44%	94.67%	93.22%	94.83%	93.18%
Adult	83.67%	84.55%	80.64%	77.41%	76.35%	75.79%	73.09%	77.93%	84.31%	88.75%	89.06%	89.53%	89.01%
TeMS&OP	87.76%	87.76%	81.63%	82.35%	82.18%	84.85%	86.32%	83.00%	86.00%	94.44%	95.56%	96.67%	97.73%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Safeguarding Adults – Level 1 Training Compliance	
Standards:	95% of all Trust staff will achieve Safeguarding Training Compliance Level 1 (Adults)
Performance:	98.20%▼
Commentary:	A small drop this month, but still well above target.

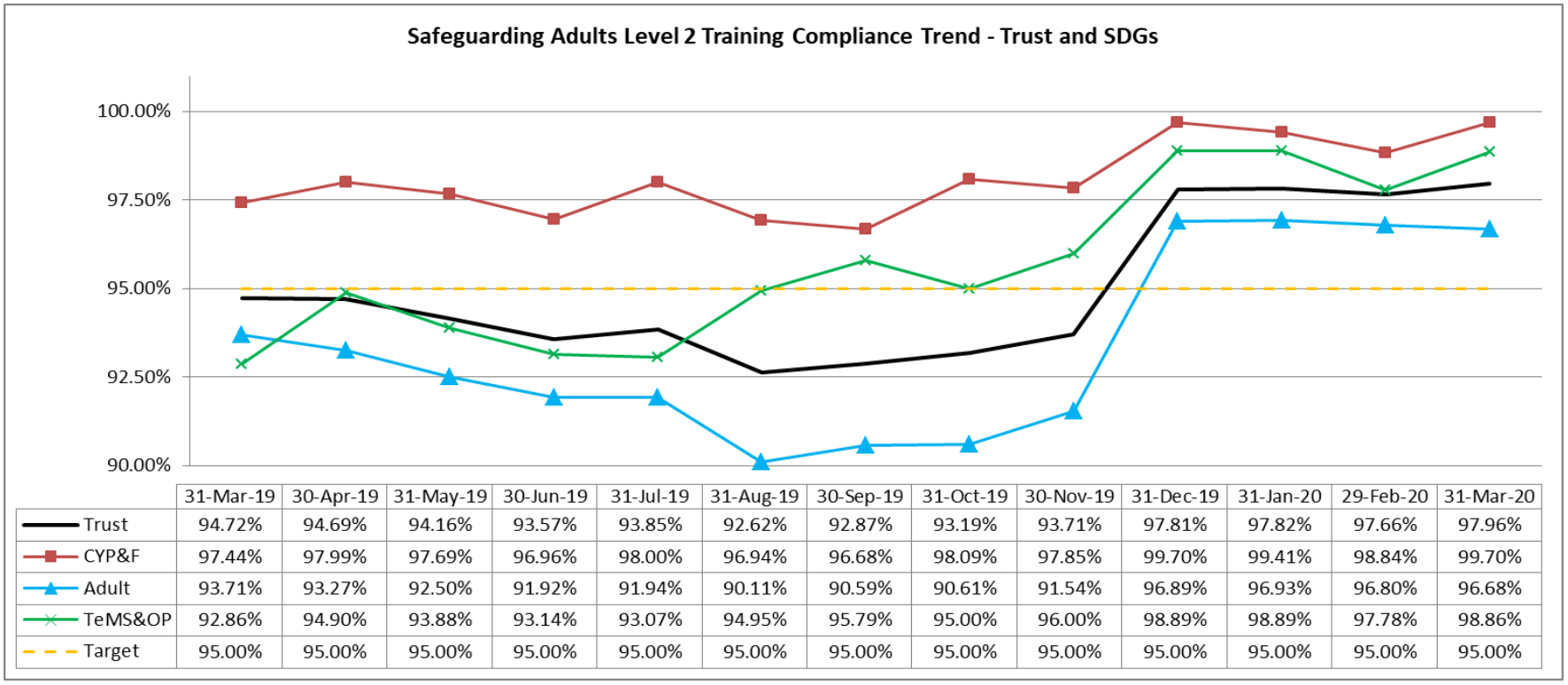


	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	97.75%	97.89%	97.25%	97.11%	97.17%	96.35%	96.66%	96.96%	97.25%	98.95%			
CYP&F	98.94%	99.15%	99.13%	98.12%	98.49%	98.11%	98.12%	98.12%	98.35%	99.33%			
Adult	97.17%	97.45%	96.57%	96.57%	96.51%	95.27%	95.64%	96.42%	97.26%	99.33%			
TeMS&OP	99.38%	98.76%	96.32%	97.62%	97.59%	97.55%	97.45%	96.88%	95.73%	97.96%			
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Safeguarding Adults – Level 2 Training Compliance	
Standards:	95% of all clinical staff will achieve Safeguarding Training Compliance Level 2 (Adults)
Performance:	97.96%▲
Commentary:	Record high compliance this month! Well above target

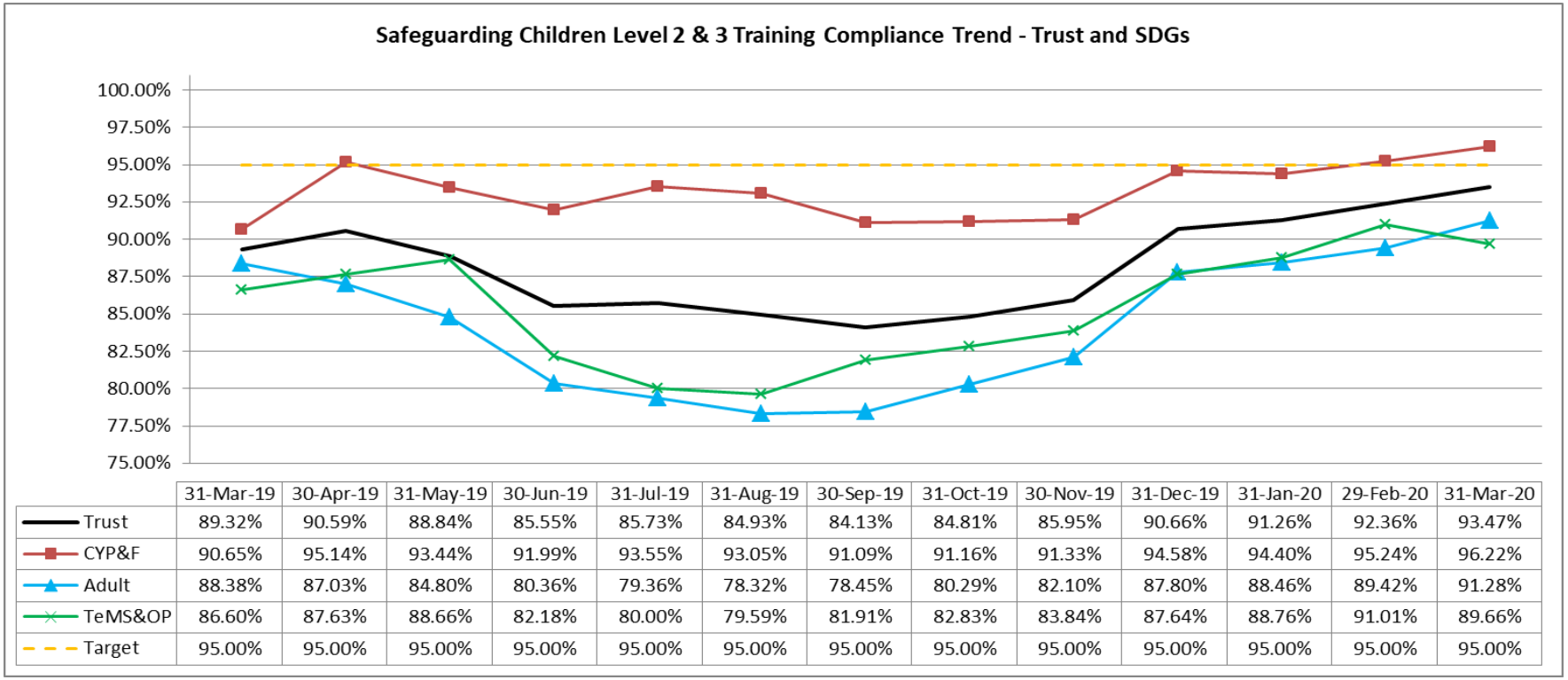


	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	94.72%	94.69%	94.16%	93.57%	93.85%	92.62%	92.87%	93.19%	93.71%	97.81%	97.82%	97.66%	97.96%
CYP&F	97.44%	97.99%	97.69%	96.96%	98.00%	96.94%	96.68%	98.09%	97.85%	99.70%	99.41%	98.84%	99.70%
Adult	93.71%	93.27%	92.50%	91.92%	91.94%	90.11%	90.59%	90.61%	91.54%	96.89%	96.93%	96.80%	96.68%
TeMS&OP	92.86%	94.90%	93.88%	93.14%	93.07%	94.95%	95.79%	95.00%	96.00%	98.89%	98.89%	97.78%	98.86%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Safeguarding Children – Levels 2 & 3 Training Compliance	
Standards:	95% of all staff requiring Safeguarding Children Level 2 & 3 Training will achieve compliance
Performance:	93.47%▲
Commentary:	A steady improvement month on month since September.



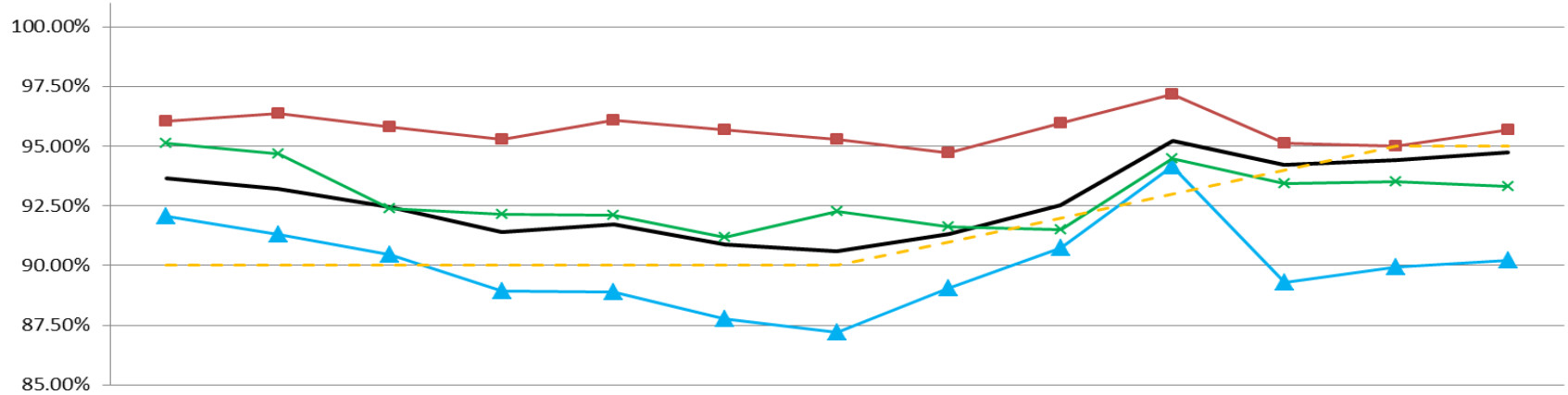
	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	89.32%	90.59%	88.84%	85.55%	85.73%	84.93%	84.13%	84.81%	85.95%	90.66%	91.26%	92.36%	93.47%
CYP&F	90.65%	95.14%	93.44%	91.99%	93.55%	93.05%	91.09%	91.16%	91.33%	94.58%	94.40%	95.24%	96.22%
Adult	88.38%	87.03%	84.80%	80.36%	79.36%	78.32%	78.45%	80.29%	82.10%	87.80%	88.46%	89.42%	91.28%
TeMS&OP	86.60%	87.63%	88.66%	82.18%	80.00%	79.59%	81.91%	82.83%	83.84%	87.64%	88.76%	91.01%	89.66%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Trust Overall Mandatory Training Compliance	
Standard and outcomes:	Mandatory Training measures the percentage of staff compliant with the requirement for core essential training. 95% of all Trust staff will have 100% compliance with their overall mandatory training
Performance:	94.73%▲
Commentary:	Overall MT compliance has improved, despite the changes associated with COVID-19. This is largely because staff can access their e-learning from home, and that is the primary method of obtaining most competences. Organisational Development have continued to be available to staff, in order to assist with ESR and e-learning/competence queries throughout the pandemic.

Mandatory Training - All Staff Training Compliance Trend - Trust and SDGs

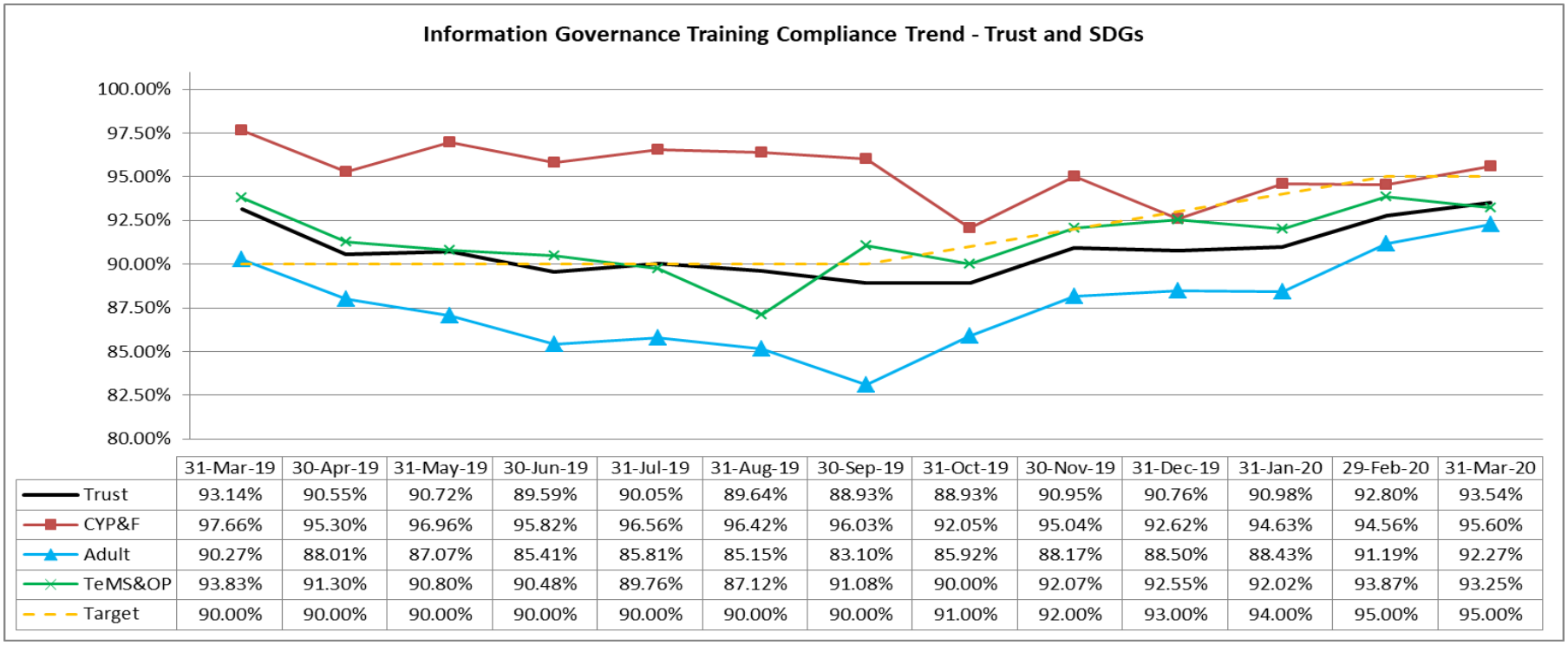


	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	93.63%	93.22%	92.44%	91.42%	91.74%	90.88%	90.58%	91.33%	92.51%	95.22%	94.21%	94.40%	94.73%
CYP&F	96.04%	96.38%	95.80%	95.30%	96.08%	95.68%	95.27%	94.72%	95.96%	97.16%	95.11%	94.99%	95.69%
Adult	92.08%	91.29%	90.46%	88.92%	88.91%	87.77%	87.19%	89.04%	90.72%	94.17%	89.29%	89.95%	90.21%
TeMS&OP	95.13%	94.68%	92.40%	92.13%	92.12%	91.19%	92.25%	91.62%	91.51%	94.50%	93.44%	93.52%	93.31%
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	91.00%	92.00%	93.00%	94.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Information Governance	
Standards:	Information Governance
Performance:	93.54%▲
Commentary:	An improvement month on month, since November; however the trust was unable to evidence 95% compliance at any point in the 2019/20 financial year.

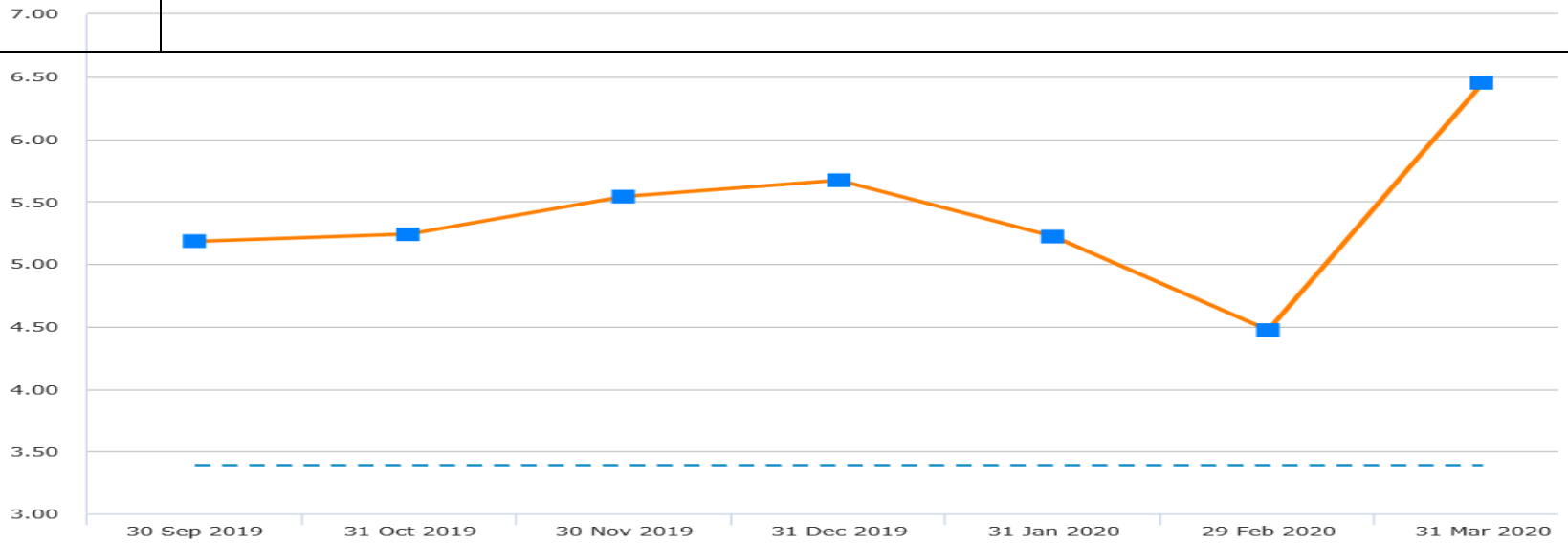


	31-Mar-19	30-Apr-19	31-May-19	30-Jun-19	31-Jul-19	31-Aug-19	30-Sep-19	31-Oct-19	30-Nov-19	31-Dec-19	31-Jan-20	29-Feb-20	31-Mar-20
Trust	93.14%	90.55%	90.72%	89.59%	90.05%	89.64%	88.93%	88.93%	90.95%	90.76%	90.98%	92.80%	93.54%
CYP&F	97.66%	95.30%	96.96%	95.82%	96.56%	96.42%	96.03%	92.05%	95.04%	92.62%	94.63%	94.56%	95.60%
Adult	90.27%	88.01%	87.07%	85.41%	85.81%	85.15%	83.10%	85.92%	88.17%	88.50%	88.43%	91.19%	92.27%
TeMS&OP	93.83%	91.30%	90.80%	90.48%	89.76%	87.12%	91.08%	90.00%	92.07%	92.55%	92.02%	93.87%	93.25%
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	91.00%	92.00%	93.00%	94.00%	95.00%	95.00%

Data compiled by Chris Panayi - Quality & Improvement Officer

Well Led

Sickness Rates - Trust	
Standard and outcomes:	Supporting staff attendance at work - aiming for less than 3.39% of our staff to be absent from work at any one time
Performance:	6.45%
Commentary:	The trust latest position for in-month absence in March 2020 saw a steep increase to 6.45% from 4.47% in February. The top 12 months average hotspot areas for March were: Bishops Castle Hospital 13.31% (28 staff) DAART team, Shrewsbury 10.79% (14 staff) Community First – Team One 10.27% (33 staff) Ludlow Inpatient Ward 9.77% (46 staff) Bridgnorth Hospital Inpatient ward 9.48% (47 staff) ICS Central 9.47% (20 staff) • A 7-day HR Advice and absence reporting line is now in operation with daily staff availability reports to Execs Team and the Major Incident Team. A process for referral to CV19 testing has been implemented. • Managers have been advised to adhere to the usual attendance management processes, however direct HR involvement in absence management meetings has been suspended. • The programme of support by the OH Wellbeing Practitioner is continuing. • Daily wellbeing tips and signposting to local and national advice



Data compiled by Chris Panayi - Quality & Improvement Officer

Risk Register with Current Rating above 12 by Directorate

Directorate	ID	Service	Title	Risk Type	Risk Subtype	Description	Handler	Risk level (initial)	Risk level (current)	Risk level (Target)	Controls in place
Adult Services Division	3249		Cancelling/ moving visits due to lack of capacity	Directorate/Divisional Risk Register	Clinical Risk	Delayed treatment or interventions leading to potential patient deterioration /infection/discomfort as a result cancelled or moved appointments due to a lack of available staffing capacity within the community nursing teams	Foord, Peter (Inactive User)	High	Moderate	Low	Risk assess individual patients and only cancel/ move those at low or reduced risk of harm, to report any harm that occurs as a result of cancellation

Risk Register with Current Rating above 12 by Directorate

Adult Services Division	2946		Reduced patient experience and continuity of care due to vacancies.	Directorate/Divisional Risk Register		Recruitment to substantive RNs remains challenging resulting in potential risk of patient incidents due reduced staffing capacity against the planned capacity.	Worrall, Ms Mandee	High	Moderate	Low	Minimum staffing establishment agreed and in place • Staffing levels reviewed daily • Weekly summary of nurse and HCA fill rates • Other safety indicators and trends – e.g.. Complaints, SIs and other harm incidents, safety thermometer reported to Q&S and the Board on a monthly basis. • Monthly reviews of vacancies and recruitment activity • Internal audit of safe staffing data/ Acuity reviews reported twice a year • 4 registered nurse rotational posts for registered recruited to • On going Recruitment rolling programme • Assistant practitioner recruitment completed • Associate nurse program commenced • Planned programme of associate nurse recruitment • Use of centralised bank, framework agencies • Monitoring of patient & staffing incidents for staffing via datix and reported via Q&S committee • Quality team and Medicines management team supporting ward teams

Risk Register with Current Rating above 12 by Directorate

TEMs and Outpatients Division	3340	TEMS RJAH	Rheumatology Capacity	Directorate/Divisional Risk Register		Due to staffing difficulties RJAH have not been able to meet the contractual capacity for Rheumatology Consultant or nurse since February 2019. this reduction in capacity has led to a backlog of both new and follow patients to be seen. both routine and urgent patients waiting longer for appointments than is ideal. Volume of Rheumatology patients on PTL over 18 weeks is growing UPDATE 26/7/19 following subcontract meeting with RJAH where required capacity was given to recover to 10 week wait by mid October it was apparent that they do not have the ability to meet this unless they can secure a locum.	Horsfield, Claire	High	Moderate	Low	1.regular discussions with RJAH 2.some consultant and nurse capacity provided from RJAH staff as short term solution 3.locum secured, however locum not suitable once started due to several issues so had to be let go 4.help line in place for exacerbations and medicine issues 5.patients clinically re prioritised so that urgent patients seen within available capacity UPDATE 26/7/19 controls 1,2,4 & 5 still in place however additional consultant sessions are inadequate to recover the current position

Risk Register with Current Rating above 12 by Directorate

Adult Services Division	96		Risk of falls resulting in harm to patients	Directorate/Divisional Risk Register	Estates/Environment	High prevalence of falls and risk for elderly pt's in all healthcare settings, especially in Community Hospitals, Some patients pose a risk of falling more than once There is a very difficult balance between ensuring their safety, and giving them choice in what they are able to do. Variation of potential harm from no injury to occasional fractures and other injuries.	Foord, Peter (Inactive User)	High	Moderate	Moderate	Accurate falls risk assessments carried out within 3 hours of admission and patient managed according to level of risk • Physical safeguards provided e.g. footwear, red socks • Implementation of Falls Policy • Post fall bundle /protocol in place • Environmental controls and environmental assessments including ROAM alerts in place in Community Hospitals, bay safe initiative, • HiLo beds provided at each hospital to support patients with dementia. • Falls reported via datix and monitored as performance and quality indicator • Review number and severity of falls each month and analyse trends • RCA investigations for all moderate harm falls & sharing lessons & action plans • Ensure monitoring of falls and post falls bundles • Analyse co-relation between falls staffing and red flag alerts added to datix forms • Implementation of new ward handover tool to ensure the risk of falling is highlighted to nursing staff at each handover • Use of Memory workers to support Diversional Therapy • Falls Champ...

Risk Register with Current Rating above 12 by Directorate

Directorate	ID	Service	Title	Risk Type	Risk Subtype	Description	Handler	Risk level (initial)	Risk level (current)	Risk level (Target)	Controls in place
Child and Family Services Division	1831	Childrens Therapies	Children's Community SLT Systems Failure - Demand and capacity	Directorate/Divisional Risk Register		Insufficient staff to meet demands of the service - high levels of sick leave, maternity leave and Staff turnover. Staff with significant personal issues impacting on their work. Case loads increasing in community clinics and special schools with continued and sustained numbers of new referrals. Increased case loads resulting in poor quality of care, ommissions and mistakes, and stressed staff who report high levels of overworking and being unable to deliver the care they aspire to. Waiting times will rise from April 2019 with large numbers of children breaching 18 weeks, impacting on the team's performance and the contract with CCGs.	Thomson, Mrs Gill	High	High	Low	Recruiting to vacancies Triage and prioritising referrals Clinical supervision Caseload management protocol Safer Staffing Survey Managing long and short term sick leave

Risk Register with Current Rating above 12 by Directorate

Child and Family Services Division	3355	Community Paediatrics - ADMINISTRATION	Community Paediatric Dictation and Transcription System	Directorate/Divisional Risk Register	Clinical Risk	Digital dictation and transcription system failing. Very old system. Various versions of hardware and software that are not compatible with each other, made worse by recent upgrade to Windows 10. Doctors sharing Dictaphones in order to dictate. Dictation and Transcription backlog building. Reports currently 5-6 weeks to be typed resulting in parents receiving late reports, delayed onward referrals. Previous capital bid for new hardware and software rejected as Trust Wide Approach to be considered.	Greaves, Nicola	High	Moderate	Very low	Bank staff assisting with typing. Urgent typing/onward referrals being typed first. Doctors sharing Dictaphones.

Risk Register with Current Rating above 12 by Directorate

Child and Family Services Division	3076	Child Development	Referral rates and waiting times Telford CDC	Directorate/Divisional Risk Register		Increased waiting times. The referrals into Telford CDC have risen significantly over the last 12 months. MDA referral exceeds capacity by 75%. Impact on assessments, risk of complaints The greatest risks from extended waiting times are: the potential for the children to have unidentified needs and appropriate referrals and investigations may be delayed. As a consequence children may make less progress than expected and parents will be less able to give their child the support they may need. EHCP process will not be triggered resulting in Education support and access to special school being delayed and the children not making as much progress as expected.	Greaves, Nicola	High	Moderate	Low	Weekly waiting list validation Monthly review of trends Risk assessment of each child's needs - agreement about type of assessment to take place at a monthly meeting. All children referred to the CDC will be under the care of the Community Paediatricians. Alternative pathways in place to trigger an EHCP. Children attending 1st steps group, if not attending reason why is known and discussion taken place with parents.
Child and Family Services Division	2452	Shropshire Dental Services	Senior/Specialist Dental Practitioner Recruitment	Directorate/Divisional Risk Register		Failure to recruit to SDO post despite advertising nationally in BDJ and redesinging the role from part time to full time Impact on 1. line management and development of staff 2. provision of specialist care 3. service development and improvement	Zubkowski, Mr Paul	High	High	Moderate	Recruiting locums and bank staff Active work with HR re recruitment Prioritisng key activity in consultation with NHSE. Clinical Support for the operators in post, more peer review Key roles shared out throughout SMT and appropriate clinicians. Additional non-clinical capacity releasing clinical capacity

Risk Register with Current Rating above 12 by Directorate

Child and Family Services Division	3510		Shropshire School Nursing Operational Delivery	Directorate/Divisional Risk Register	Staff Risk	Shropshire School Nursing team have reported that they are unable to deliver the full extent of their required service for the following reasons; - Absence due to long term sickness of school nurses within all localities - Staff reporting that they are overwhelmed with workload there is a need to support resilience - Increasing numbers of children with a child protection plan - Increasing numbers of Looked After Children - Disparity across the county of the workload; North and Central Shropshire have a more vulnerable caseload than that of the South. - Difficulty in recruiting SCPHN SN's. Recent high turn over rates of SCPHN leading to the need to review retention rates - Staff resignations; for a variety of reasons - to other school nurse services, to move to acute services or for promotions	Gough, Yvonne	High	Moderate	Moderate	Leadership team have developed a new model of service delivery with the team, for implementation from January 2020; will take 3 months to fully embed. The new model provides a corporate safeguarding team for 5-19 and locality Public Health teams. A QEIA has an options appraisal which has been prepared and shared. In the interim, staff have been supported to prioritise their workload, with child protection being the priority.

Shropshire Community Health NHS
NHS Trust

APPENDIX 3	Meeting Date:	June 2020
	Agenda Item:	9.4
	Enclosure Number:	9

Meeting:	**Trust Board**
Title:	**Trust response to Covid-19 aligned to CQC well-led domains**
Author:	**Ms Alison Trumper**
Reviewing Committee:	**Quality & Safety Committee – May 2020**
Assurance level	**Substantial**
Requirement:	**CQC well-led domains** The Trust's CQC well-led inspection is programmed at least annually and would have been due during 2020 or early 2021. However all CQC inspections have been paused nationally during NHS response to Covid-19. Opportunity has been taken to capture key trust level leadership activities in response to the national situation, align these to the eight well-led domains with the aim of presenting this as contributory evidence toward the trust-wide assessment of the well-led question at future inspection.

Coronavirus- Trust level activities aligned to CQC well –led question

1 Introduction

1.1 This paper aims to provide information on high level activities undertaken by trust leadership team during covid-19 and how these activities can be aligned to the CQC well-led question as part of contributory evidence for trust-wide assessment of the well-led question at future inspection.

2 CQC well led question

2.1 The diagram illustrates eight headings inspectors use to inform their assessment of the trust within the well-led assessment framework.

1 Accountable Director: Steve Gregory, Director of Nursing and Operations

CHARIS consultants ltd

The well-led board

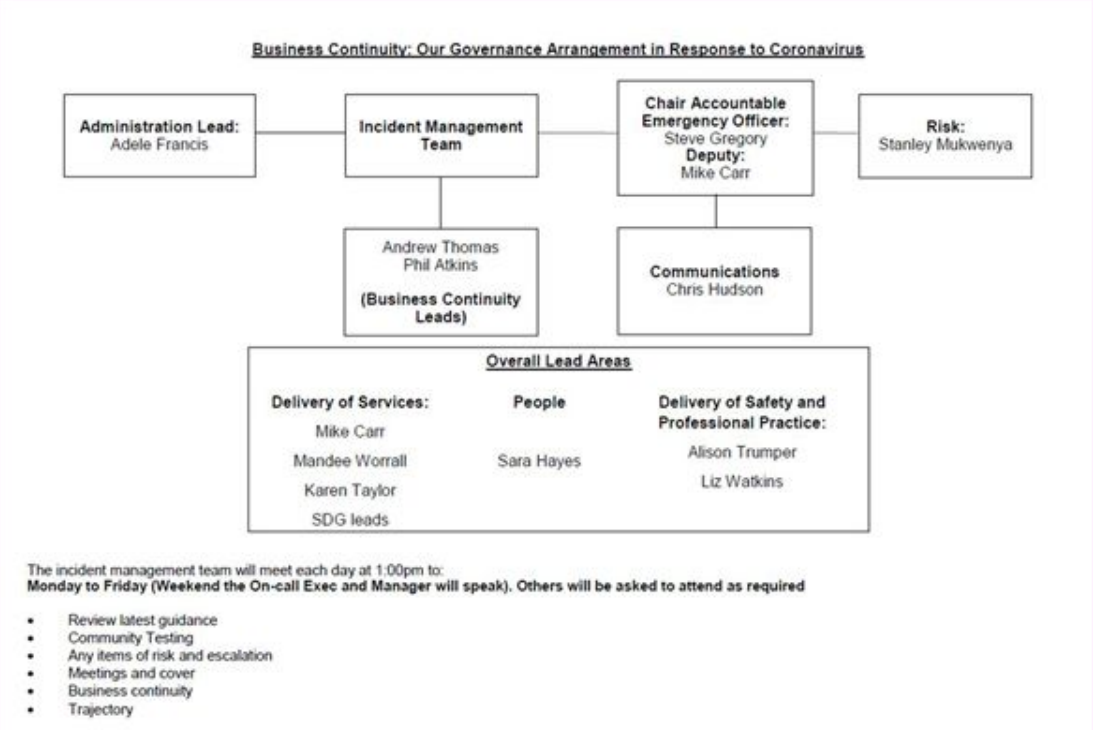
Is there leadership capacity and capability to deliver high quality, sustainable care?	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?	Is there a culture of high quality, sustainable care?
Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Are services well-led?	Are there clear and effective processes for managing risks, issues and performance?
Is appropriate and accurate information being effectively processed, challenged and acted on?	Are the people who use the services, the public, staff and external partners engaged and involved to support high quality, sustainable services?	Are there robust systems and processes for learning, continuous improvement and innovation?

Overview of evidence of activites taken during SCHT resposne to Covid-19, aligned to the CQC well-led question.

CQC Well- Led Question	
W1	Is there leadership capacity and capability to deliver high quality, sustainable care ?

1.1 Leadership arrangements have been strengthened by utilising the strengths within the senior leadership teamas illustrated in diagram one.

Diagram one



1.2 An Incident Management Team (IMT) has been established, operational 8-8 each day, including a daily meeting with a broader audience including executive directors.

1.3 Senior operational managers and clinical leads have been released from substantive roles to undertake roles within the IMT.

1.4 An Additional, COIVD specific senior manager post was implemented at weekends.

1.5 A back-up Director is available at weekends.

1.6 Each SDG has a bronze call where team leaders, supported by HR and IPC are able to discussion the current situation, esclate any concerns and senior managers can cascade information from internal and external forums.

1.7 Leaders have been supported to assist in understand the challenges and identifying necesssry actions requried though a clear visible organisational structure that cascades responsibility for delivering quality services with specified leaders actively fulfilling their business continuity responsibilities.

1.8 To increase leadership across services, senior nurses from the quality team, members of the IPC team, and all clinical educators have been allocated to various bases across services. It is important for redeployed staff, to know the leadership structures within their new work base and have all been provided with this information.

1.9 Two band 7 public health nurses have also been redeployed to support and strengthen the adjustment period for redeployed staff settling in with their new teams, this will also be replicated within therapy leadership.

1.10 The Clinical Quality Lead for C&F is working in partnership with Kate Medhurst CCN/Imms Service Manager, Priority 1 service, to strengthen resilience and support training for redeployed Registered Sick Children's Nurses into the Community Children's nurse team.

Impact – the aim of these activities is to support all staff at all levels to feel connected to each other and importantly to patients.

1.11 Individual teams and servcies are using technology for leadership – teams and conference callsLeaders are supported through a virtual CTLG (Community Trust Leadership Group) arrangements

1.12 Team held daily now twice weekly IPC Huddles virtually for all team leaders

1.13 IPC Team have relocated 2 IPC Nurses to Community Hospitals

W2	Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?

2.1 IMT has provided a systematic and integrated approach to monitoring, reviewing and providing evidence of actions taken.

2.2 Business Continuity Recovery Plans provided a coordinated approach to service continuity through response team (IMT)

2.3 The daily communication bulletin has provided key messages on a range of key items including national clinical guidance, staff terms and conditions, pay, and health and wellbeing.

2.4 The Trust revised it's business continuity plans and introduced specific Coronavirus Business Continuity Plans which focused on specific objectives with clear actions contributing to the achievement of the objectives.

2.5 IPC Information is contained within the daily Comms bulletin

W3	Is there a culture of high-quality, sustainable care?

3.1 In order to support staff feeling supported and valued there has been a strong collaborative team-working approach across all functions with a focus on sustaining the quality of care.

3.2 Training - The temporary movement of staff has been a necessary part of business continuity to enable the delivery of priority one core essential services in preparation for a predicted increase in number of patients and/or to cover for expected/unexpected staff absence

3.3 To protect our priority one services, training commenced on 25th March as a strategy to expand and redeploy workforce from paused services into priority one services. For staff, redeployment means working in unfamiliar circumstances, surroundings and in clinical areas outside of their usual practice. For patients it means aspects of care being delivered by a staff member with a different skill and competency set. To support and equip staff and to support ongoing delivery of safe care to patients, staff have completed ''preparedness training'' underpinned by fundamental principles of best clinical practice.

3.4 A large venue was secured to enable a large volume of staff to be trained in a short timeframe. The venue was risk assessed prior to commencement of the programme to ensure social distancing could be adhered to.

3.5 On 15th April NHSE provided Trusts with an education and training framework in response to the need for staff to work differently in support of the NHS Covid-19 crisis. The overall aim of the framework is to provide considerations for both NHS and independent sector organisations with regard to planning for, developing skills and delivering training to staff identified as being required to work in different care settings and roles to support priority one services. Internally we described this as our ''preparedness training'' , which commenced on 25th March, after publication of this guidance.

3.6 On review of the framework, our strategy to deliver training to underpin safe redeployment of staff was reflective of the proposed framework. There are some useful on line resources that were reviewed to assess any further opportunities for e-training and considered for their usefulness post covid-19 assuming these remain available with the required governance arrangements.

Impact – within a short timeframe, 315 clinical staff to be equipped with fundamental principles of best practice to support ongoing safe patient care resulting in initial deployment of over 200 people to support sustainability of priority one services

3.7 Mandatory training – At the time this report was developed, there is no national directive regarding pausing mandatory and statutory safety training. The Trust is advanced in its use of e-learning via the ESR system and will therefore continue to support staff to achieve and to sustain compliance in mandatory safety training. There are two elements delivered face to face; BLS and manual handling training. Manual handling has been converted to e-learning and OD are currently exploring converting BLS to e-learning.

Impact – this will enable our clinical staff to maintain key safety training at a time when people and services are working differently

3.8 Non mandatory training – all essential and non-essential clinical training has been paused except Trust wide Sepis, ReSPECT and syringe driver training and service led insulin administration, venepuncture, intravenous cannulation and wound care. A respiratory training programme will be rolled out imminently. Through partnership work with Stafford University further on –line training

resources are now available to clinical staff to support development of clinical skills for both redeployed staff and existing staff within services.

Impact –All these resources have removed the need for staff to be in close proximity during key training , enable our front line staff and where appropriate redeployed staff to maintain or develop necessary service critical skills and competencies in relation to the current crisis. Note : The Trust has continued to use one of the modules on the e-learning resource hosted by Stafford University which has since received national interest as a possible national e-learning resource .

3.9 We have provided a high level of preparedness training, communication, support from substantive and redeployment assignment line managers and teams, access to clinical supervision, practical support on timesheets, expenses, leave booking, sickness reporting etc for redeployees inside ShropCom and to the Health Economy.

3.10 We haven't systematically tested how staff feel during this crisis but there is anecdotal positive verbal feedback conveyed through bronze meetings and where staff have raised concerns, predominantly around redeployment, these have been attended to on an individual basis.

3.14 We have continued to run our monthly JNP (staff side) meetings and have added to them with a week conversation between the Staff Side Chair, Director of Operations and Head of HR & Workforce; employment relations continue to work well

3.15 We have emphasised wellbeing throughout this crisis, with daily H&WB messaging, emphasis on taking breaks, taking leave, not working overtime unless there are execptional circumstances and staying as well as people can at this time.

3.16 Our approach to terms and conditions and pay has been to demonstrate that we value our people as an organisation and as a system. We have enabled people to stay off work without impacting their pay in particular circumstances related to Covid-19. We have also provided a framework for an unpaid employment break for those who simply do not wish to be at work at this time.

3.17 We have commenced a more structured programme of workforce risk assessment and management, as well as a workforce engagement programme about what we have learned and how it can be applied to the new normal.

3.18 Staff have been reminded of individual responsibility to raise issues that trouble them in relation to but not exclusively, patient safety. Freedom to speak up messaging has been communicated with staff and our F2SU Guardian and advocates are visible in the clinical areas.

3.19 IPC Nurses have relocated to provide care and support to staff on the wards at Ludlow and Bridgnorth, we have provided weekend advice and support via an on-call system. 24 hours IPC advice and support is available via the on call consultant microbiologist at SaTH. IPC staff have provided PPE and swabbing training to staff. FFP3 Training is being undertaken throughout the Trust.

W4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?

4.1 The Board and Committees have been providing overall assurance on accountability, transparency on all processes and activities related to Covid-19.

4.2 A systematic approach has been taken in how we work with other organisations to sustain the quality of our priority services whilst responding to Covid-19.

4.3 We have worked with system People colleagues at HRD and Operational HR levels to establish a system-wide approach to people matters, including terms, conditions, pay, workforce testing, redeployment, health & wellbeing and are beginning to work on workforce risk.

4.4 Within ShropCom we have applied our usual high standard of governance to people-related

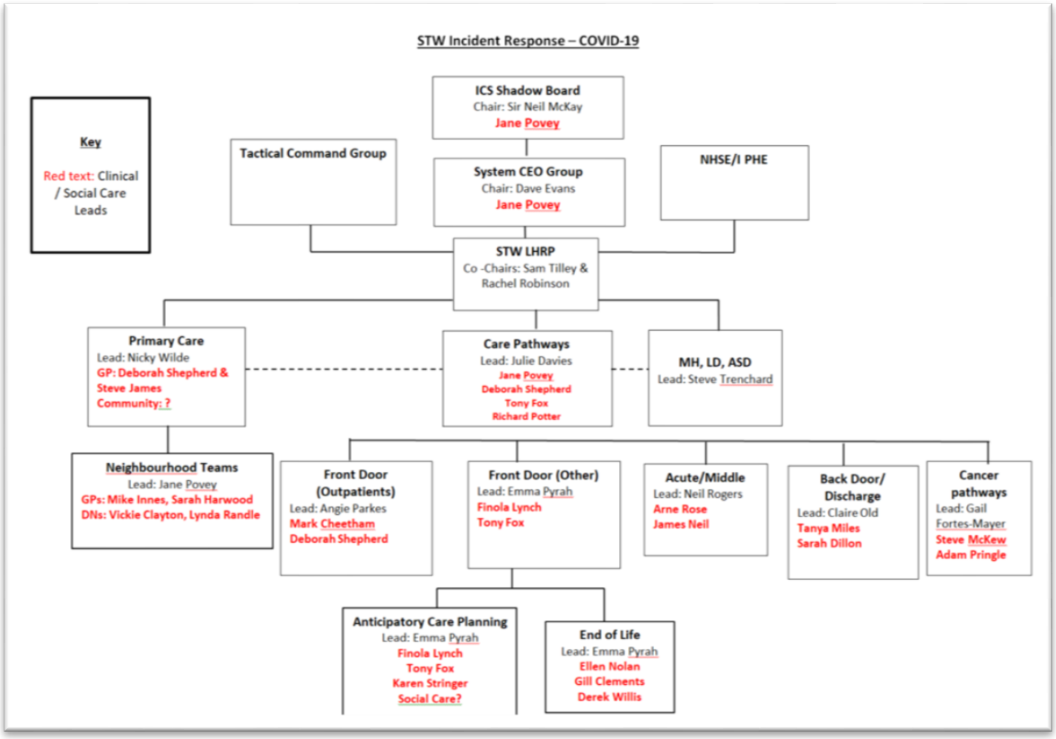
decision making – some elements have been decided and logged for review through IMT. Pay related changes have been checked and challneged by Execs and authroised by NAR (our Remuneration Committee), with a surrounding monitoring and review framework.

4.5 We have developed a set of workforce metrics that enable daily management and leadership decisions to be taken about staff deployment, teams suffering higher than normal absence etc and at the same time support daily national SitRep returns.

4.6 We have developed a governance process to support the appropriate and supportive redeployment of our workforce between teams and organisations.

4.7 We have a system-wide Honorary Practice Agreement, signed by CEOs, that enables free staff movement between employers at this time to support organisations and teams in the greatest need.

4.8 Clinical input into external governance ;



4.9 LHE IPC Teams meet weekly to discuss and concerns and issues across the whole Health Economy issues highlighted are escalated at the silver meeting

4.10 IPC Team held daily now twice weekly IPC Huddles virtually for all team leaders.

W5 Are there clear and effective processes for managing risks, issues and performance?

5.1 There is an effective comprehensive risk framework in place for identifying, monitoring and addressing current and future potential risks.

5.2 The Audit Committee continue to monitor and provide internal risk control assurance on behalf of the Board

5.3 A comprehensive Covid-19 business risk assessment impact was conducted across all services, controls and mitigation plans were developed and put in place for identified high risk areas

5.4 Risk is a standing item on Inicident Management Team's (IMT) daily meetings agenda

5.5 Due to a potential threat to wider trust objectives, a strategic risk on Covid-19 was developed and reflected on BAF

5.6 Robust up to date risk registers for all services are in place and continue to capture, monitor, evaluate and provide mitigations for identified risks.

5.7 All corporate risks on Corporate Risk Register were reviewed to reflect operational service changes as a result of Covid-19

5.8 Governance Team has continued to provide support to all Service Heads in identifying and escalating new risks for business prioritisation and decision making

5.9 Individual services have own risk registers and staff are empowered to record risks and discuss issues with their line managers

5.10 Existing processes to monitor safety incidents and incidents subject to investigation under the serious incident / lessons learned framework have continued.

5.11 Processes to ensure daily monitoring of risk, patterns or clusters of outbreak of covid -19 are in place

5.12 Internal self-assessment against compliance with PHE COVID-19 related infection prevention and control guidance have commenced using the NHSE/I infection prevention and control board assurance framework

5.13 Reporting arrangements have enabld any emerging risk to be identified and addressed quickly and openly.

5.14 Effective communication is one of several risk reduction strategies. Risks to quality and safety can increase through an absence of effective communication. An strategic communication strategy has been implemented including:

- Platform to outline core messages and actions - The Trust is adhering to Public Health England (PHE) guidance as its quality and safety strategy during covid-19.
- Consistent and frequent communication - delivery of key PHE key messages through a dedicated 4.00pm Trust communication platform
- Use of version controlled simplistic standard operation procedures and visuals to underpin guidance cascaded through a single process, hosted on a dedicated intranet site.
- Engagement and input with staff - use of Microsoft team meetings to assist with strengthening messaging and opportunity to seek staff feedback.
- Engage and respond to staff questions – use of Trust you-tube platform for CEO and Directors to respond to staff questions.

Impact – feedback from staff indicate the various communication platforms enable clear and consistent messaging across services, provide opportunity for clarification and processing of key messages through high engagement with leaders and managers across our services.

5.15 Monthly meetings are held to discuss quality of care resulting in action plans to implement changes or improvements to the service

5.16 The Trust Governance Team provides expert advice on identifying, evaluating and monitoring risks to service teams.

5.17 We have a set of workforce metrics that enable daily management and eladership decisions to be taken about staff deployment, teams suffering higher than normal absence with risk management at team level.

5.18 We are just beginning a more structured programme of workforce risk assessment and

management, as well as a workforce engagement programme about what we have learned and can apply to the new normal.

5.19 IPC Team reports are provided to QSDG on a monthly basis

5.20 QEIA assessments have been undertaken on bed spacing on cohorting of in patient areas. Risks are recorded on the IPC and Trust Risk registers.

5.21 Revised recommended minimum staffing levels have been reviewed in collaboration with Ward Managers in preparation for the possibility of an escalated situation resulting in further significant staffing shortfalls within the in-patient services. This is in response to the possibility of a significantly greater impact of Covid-19 affecting staff unavailability due to sickness or required self-isolation. The recommendation was subject to QEIA, approved by the executive team and communicated to JNP.

5.22 The Safeguarding Team continues to provide safeguarding advice and support to staff via telephone, email and more recently using Microsoft Teams. These flexible forms of communication allow staff extensive access to the team.

5.23 Safeguarding information is also being circulated to staff through the Trust Communication Team and the Heads of Nursing who disseminate through their Service Delivery Groups.

5.24 The Designated and Named Nurses from our local health economy have a virtual meeting each week for support and to discuss the current situation. It is also a platform to facilitate information flow to and from NHS England/NHS Improvement.

5.25 Due to Covid-19, face to face supervision has been replaced with virtual supervision via Microsoft Teams and occasionally by telephone. This is offered in small groups or individually. Supervision is usually offered 3 monthly and booked in advance.

W6	Is appropriate and accurate information being effectively processed, challenged and acted on?

6.1 The Trust has developed an operational dashboard to focus on COVID-19. This focuses on staff, patient and service level metrics. The reported is reviewed daily and discussed on the 1pm IMT call.

6.2 The information team work 7 days a week to ensure the timely submission of all external SitReps. To ensure these are accurate the reports are validated each monring by operational managers in each Community Hospital.

6.3 External submissions are approved by an executive director or nominated deputy each day.

6.4 The ‘Majorincident’ mailbox is constantly monitored 8am-8pm 7/7 to identify any short notice data requests.

6.5 Arrangements for situational reports and data validation reporting processes have enabled information to be validated to support reliable, timely and relevant data reporting to meet national reporting requirements.

6.6 Key meetings related to quality and safety continued using Microsoft Teams as a platform for meetings. Key information required for Baord assurance outlined within the quality and safety workplan continued to be reported in order to provide Board assurance. Specific reports related to Covid -19 were added to the quality and safety committee reports. Any deferred reports were tracked and programmed into the workplan at a later date.

6.7 When considering developments or changes to services, the impact on quality and sustainability has been assessed under the QEIA frameowrk; services that have stopped, reduced, changed or been restored have been subject to scrutiny under this process.

W7	Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

7.1 Community services have established advice lines to enable the worried-well and concerned patients and serivces users

7.2 Public has been invited to submit questions through trust website ahead of Public Board meetings which are now being held virtually through Microsoft Teams.

7.3 Complaints and PALS services have remained in place, responding and investigating arising issues despite optional government guidance to pause.

7.4 We have communicated to staff using email and our intranet to prompt management conversations, taking questions by email (eg CEO questions and answers sessions).

7.5 Patient feedback is being collated in relation to the Attend Anywhere roll-out, this is being reviewed regularly and will form part of the initial roll out review.

7.6 Staff – there is a weekly update session with JNP to discuss the pandemic response, inform decisions taken and review staff feedback.

7.7 Patients receive individual care plans related to their covid+ status, including not only PPE but also social needs and communication with familes/ loved ones etc.

W8	*Are there robust systems and processes for learning, continuous improvement and innovation?*

8.1 Covid-19 incidents are captured on Datix system and discussed at IMT and escalated to other related safety and learning groups. A review of incident reporting during the first 8 weeks of covid -19 has been revised and presented at Q&SC .

8.2 Our restoration and recovery planning includes significant engagement with colleagues to identify the positive changes made during the response which they would like to adopt.

8.3 Colleagues from the PMO are tracking the changes made to date and are beginning to identify the key metrics which will demonstrate success and how these might impact on future service delivery.

8.4 As we move to planning for Restoration, Recovery and Re-Setting we will be beginning an engagement programme for all our people on what has been learned, what they want to continue, what the new world of work will be like.

8.5 Safety training – the digital platforms that became available to us during covid-19 have enabled us to consider more innovative ways to deliver training. Clinical training = greater safety. As a Trust we are looking at how we can apporach clinical education differently as the new normal. As a system , the STP education group commenced work on a system wide approach to how clinical training resources can be enhanced for health and social care collaberatively.

8.6 Our dental servies have adapted and evolved their services to safety accommodate covid+ patients and developed a phone advice and assessment service. The phone advice line has meant identification of problems and required intervention or symptom relief through non face to face assesment and appropriate risk assesment for face to face treatments.

8.7 Our paediatricians have refreshed and developed new skills to be able to provide backup for the local acute provider to respond to any any shortfalls in paediatric on call arrangements and have increased acute care capacity in order to ensure timely child protection medicals.

8.8 Redesigned the Healthy Child Programme in Shropshire in order to continue to deliver the programme, the skills within the team have been utilised differently to deliver the programme; we now have teams for 0-5 ; 'Universal' 'Universal Plus' and 'Universal Partnership Plus'. Universal team provides new birth visits 'virtually', the 'Plus' team supports vulnerability on a needs and triaged basis either virtually or in clinics (minimal at present but will be expanded) and the 'P'ship plus' team is our safeguarding team and supports children with formal plans such as Child Protection or Child in Need

8.9 Centralised Single Point of Access in Shropshire; this was in place previously but has now been strengthened as a hub to receive all referrals into the service for 0-19 Shropshire and to respond/disseminate to our staff

8.10 Adapted assessment tools within Family Nurse Partnership to meet our needs; this will support greater understanding of need of our most vulnerable children and enabled us to work even more closely in partnership with social care for the benefit of our children.

8.11 During Covid-19 the requirement for virtual consultations has become more apparent across many of our services. This has led to an agile role out of Attend Anywhere (AA) which enables patient to clinician video consultations to take place.

Shropshire Community Health NHS
NHS Trust

APPENDIX 4	Meeting Date:	June 2020
	Agenda Item:	
	Enclosure Number:	

Meeting:	**Trust Board**
Title:	**Quarterly Guardian for Junior Doctor Safe Working Report**
Author:	**Dr Jane Povey**
Reviewing Committee:	**Quality & Safety Committee – May 2020**
Assurance level	**Substantial**
Requirement:	**NHS compliance report** The core role for the Guardian as agreed with the British Medical Association (BMA) is as follows: • To report quarterly to the trust board • To ensure there is a consolidated annual report included in the trust's quality account, and details of the disbursement of any fines included in the organisation's annual report. • To jointly with the director of medical education (DME) establish a junior doctors forum (or fora) to provide advice on and support the work of the guardian. • To oversee the imposition of any fines where doctors miss 25 per cent or more of their breaks. • To ensure their oversight of safe working hours will also include monitoring associated equality and diversity issues. This report complies with the requirement of quarterly publication to the Trust board meeting.

1. Introduction

1.1 The GoSW for Shrewsbury and Telford Hospital NHS Trust and for the Shropshire Community Health NHS Trust continues in the role since July 2016 to champion safe working hours and ensure compliance with an Exception Reporting system as mandated in the TCS Junior Doctor Contact 2016.

1.2 Junior trainees can use this process to report hours worked over, missed rest breaks, and differences in service commitments and variations in educational opportunities. The GoSW maintains an oversight of all reports and ensures that all reports are addressed in a timely manner.

2. Safe Working Report

2.1 During the reporting period 7 Jan 2020- 30 April 20:

1 Accountable Director: Dr Jane Povey – Medical Director

Number of doctors / dentists in training 227
Number of trainee doctors in the Community 4 of 227
Number of reports received by trainees in the Community 0
Number of safety concerns raised by trainees in the Community 0

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	7th May 2020
	Agenda Item:	10.1
	Enclosure Number:	11

Meeting:	**Trust Board**		
Title:	**Resource & Performance Committee – Chair's report to Board**		
Author:	Harmesh Darbhanga, Committee Chair Claire Lea and Julie Houlder, Corporate Governance Consultants		
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**
	None		

Purpose of the report		
To assure the Trust Board that, as a result of the issues presented and discussed at the Resource & Performance Committee (R&P), there are appropriate plans and monitoring in place to ensure that the use of resources is scrutinised and that performance trajectories are analysed in order to provide good patient experience and outcomes. This assurance helps the Board to consider the effective use of resources and also supports the CQC domain of well-led.	**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

Monthly Performance Report (April and May) including Covid-19 Dashboard Indicators
– MODERATE ASSURANCE OVERALL

Estates Report
– SUBSTANTIAL ASSURANCE OVERALL

Finance Report – Month 12 (2019/20) and Month 1 (2020/21)
– SUBSTANTIAL ASSURANCE OVERALL

Service Development Update – Covid-19 impact
– SUBSTANTIAL ASSURANCE OVERALL

Procurement Report
– SUBSTANTIAL ASSURANCE OVERALL

Digital Services Update/Assurance on BAF risk
– SUBSTANTIAL ASSURANCE OVERALL

Apprenticeship Levy
– LIMITED ASSURANCE OVERALL

Board Assurance Framework and Corporate Risk Register
– MODERATE ASSURANCE OVERALL

STP Long Term Plan Update
–MODERATE ASSURANCE OVERALL

Actions for the Board–

1 The Committee recommended that the Board allocate some of its board development programme to considering this work more fully and to the possibility of public sector capital investment being used to re-energise the economy.

Areas of Concern/New risks –
The financial implications of income and contracting regime for 2020/21 were of concern to the Committee and further developments would be reported at the next Board meeting.

There were no new risks identified at the meeting.

Recommendations

The Board is asked to

- Accept the assurance provided by the work of the Resource and Performance Committee

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	ALL

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	Good governance supports the safe delivery of our services
Financial (revenue & capital)	Yes	Good governance supports the effective use of resources and ensures the Board is aware of the financial impact of the pandemic
OD/Workforce	Yes	Good governance supports the wellbeing and safety of all staff during the pandemic
Legal	Yes	Good governance supports compliance with regulatory requirements and advises on any changes in legislation

1.0 Purpose of the Committee

To provide assurance to the Trust Board that there are appropriate plans and monitoring in place to ensure that the effective use of resources is scrutinised and that performance trajectories are analysed in order to provide good patient experience and outcomes.

This assurance supports the Board in considering its use of resources to provide high-quality, efficient and sustainable care for patients. Use of resources includes finances, workforce, estates and facilities, technology and procurement.

In line with the assurance levels used by internal audit, the Committee accepts the following levels of assurance – substantial, moderate, limited, none – as shown at the end of this report.

2.0 Reports/Items Considered by the Committee

2.1 Monthly Performance Report (April and May) including Covid-19 Dashboard Indicators – MODERATE ASSURANCE OVERALL

The Committee considered the assurance provided by :-

- The quantifiable performance information which addressed the Trust's use of resources and the CQC question - are services Well-Led? The information is taken from the Trust's single data performance repository for reliability and accuracy.
- The analysis of that information and where possible, the triangulation with evidence from external benchmarking and the Trust's track record in its use of resources and delivery of performance trajectories as assessed by the NHS Oversight Framework.

The Committee considered the key areas most relevant to performance during the Covid-19 pandemic. The reports also provided the Trust's Integrated Performance Dashboard up to 31 March 2020 and 30 April 2020 respectively as well as the new pilot Covid-19 Key Measures Dashboard for the same time period. The Committee also received assurance that the Covid-19 indicators were discussed at the informal weekly NED/CEO forum.

The Committee agreed that the new dashboard worked very well and gave a clear insight to the trends emerging from the pandemic in relations to the measures reported in the dashboard. Further training had been given during the informal board meeting in May to ensure that non-executive directors could access the live version which gave a great depth of trend analysis. The Covid-19 dashboard demonstrated a steady state of performance ; the only exception being the Delayed Transfers of Care indicator.

The integrated dashboard recorded 21 KPIs that were reported as not on track and of these 1 (Data Quality) had no recovery plan where one was required. The indicator is 0.3% off target and a recovery plan has not been requested. Eight of the 21 KPIs within the well-led domain were RAG rated as red and three were showing a deteriorating trend.

The Committee was assured that the structures and accountability were in place to address the KPIs that were not on track including improvements to the delivery of action plans and to support improvements within the well-led domain. Whilst there was little evidence of benchmarking performance against other community trusts the integrated dashboard was clear on the national targets required by NHSE/I in the Single Oversight Framework.

The Committee accepted that the national guidance 'Reducing the burden' would also mean that some KPIs would be suspended for the duration of the pandemic e.g. friends and family testing (FTT) responses.

The latest full performance report is available in Appendix 1

2.2. Estates Report
– SUBSTANTIAL ASSURANCE OVERALL

The report gave the Committee in April, assurance on the actions being taken to address the impact of Covid-19 on the estate and its management. No new risks had been identified but existing risks were being reviewed and further mitigation provided, e.g. the use of risk assessments given the greater use oxygen on some sites.

The Committee was able to take some assurance from the compliance report whilst recognising the challenges imposed where there were shared lease and occupancy.

There was evidence of good accountability structures in relation to water management and safety, with input from Midlands Partnership NHS Foundation Trust. The report confirmed that positive samples of legionella spp. had been identified at Trust hospital sites. The Committee received confirmation of the remedial actions in place to and that the risk registers were up to date in relation to the ongoing risk. The Committee took positive assurance from the establishment of the Trust's own Water Safety Group and the completion of the annual Water Safety Audit for the Trust.

The report provided a forward view on capital investment into the estate whilst acknowledging the limitations imposed by the Covid-19 pandemic (e.g. safe working whilst social distancing, supply chain delays). The Committee was assured from the report that the estates capital works programme for 2019/20 had been mostly completed to plan and that risk assessed backlog maintenance schedules have been put forward for the 20/21 programme.

Estates rationalisation and development work within the STP was reported as on-hold due to the Covid-19 pandemic and the resulting new ways of working would need to influence future planning of the estate usage. Internally the structure for estate optimisation was clear and the executive team would be considering a visioning paper from Mr Graves and Ms Lowe in due course.

2.3 Finance Report – Month 12 (2019/20) and Month 1 (2020/21)
– SUBSTANTIAL ASSURANCE OVERALL

The reports in April and May had provided an update on the Trust's financial, CIP and agency performance.

The Committee commended the finance team for their support and leadership to the Trust in delivering a positive year end position. This included a surplus for the year of £975k (£131k favourable variance) and a strong cash balance at £14,351k. This was a strong performance in a challenging environment. Agency spend was also within national limits although not on track for the Trust's own internal ambitions.

The position with regard to £1.1m of non-recurrent savings was less positive as this had increased the 2020/21 CIP target. The Committee was assured by the accountability structure provided by the CIP meetings and the Trust's Benefits Realisation Group in addressing the 20/21 CIP target.

In April the Committee approved a new capital bid for replacement laptop hardware (£150k) in line with the delegated limits and authority levels.

The Committee was assured as to the processes imposed to identify any additional Covid-19 costs as the costs for March had been fully refunded and that a review of these processes would be undertaken by internal audit to ensure ongoing effectiveness in order that additional Covid-19 costs would be fully refunded going forward.

The national NHS response to Covid-19 had led to significant changes in the finance regime and the full impact of these changes was still being assessed for 2020/2021. At month 1 the overall financial performance is breakeven which includes £0.5m of incremental costs for Covid-19 and £0.6m 'top-up funding' assumed from NHSEI. The latest financial report is set out in Appendix 2

2.4 Service Development Update – Covid-19 impact
– SUBSTANTIAL ASSURANCE OVERALL

The report provided the Committee with assurance on the impact assessment of Covid-19 on the Trust's services. Decisions to stop/suspend /accelerate existing projects had been taken in line national/regional/system guidance supported by the Trust's own business continuity planning. The STP have suspended the current planning process and have established a new STW Covid-19 Clinical Leadership Structure.

The Committee was assured by the report that whilst the decisions to stop or suspend projects may have a detrimental impact on the Trust's strategic priorities, the new ways of working and opportunities for new service developments outweighed this negative impact. The assurance was provided by the clear accountability structures and the alignment of decisions to support system working, e.g. MIU/UTC relocation, Attend Anywhere (Digital).

2.5 Procurement Report
– SUBSTANTIAL ASSURANCE OVERALL

The report provided assurance on the impact of Covid-19 on procurement performance. The Committee was assured by delivery of the procurement CIP savings target for 2019/20 and acknowledged the significant increase in demand of certain products to support the national response to Covid-19. The Trust was working within new working practices that had been put in place nationally to address this increase.

2.6 Digital Services Update/Assurance on BAF risk
– SUBSTANTIAL ASSURANCE OVERALL

The Committee commended the Digital Services team for their support and timely response to supporting staff with remote working and remote patient services.

The report provided the Committee with assurance on the technology and digital services activities being implemented to mitigate the associated BAF risk. The BAF risk had also been reviewed in light of Covid-19 and it was recommended that the risk score would remain at 12, further actions would be taken to build technological resilience including cyber security. The Committee took further positive assurance as many of the large scale and fast paced changes to address the impact of Covid-19 were being led by either by NHS Digital or at a STP/regional level.

2.7 Apprenticeship Levy
– LIMITED ASSURANCE OVERALL

The report described the impact of Covid-19 on the use of the Apprenticeship Levy Fund. No changes in funding requirements had been made by the Government although face to face training for apprentices had been paused and utilisation of apprentices in the workplace constrained. Contributions by the Trust had therefore continued despite the limited opportunities for expenditure as no new apprenticeships had started in 2020/21. There is a risk that funds amounting to £31,621 will expire before they can be used within the 24 month

window allowed. The Committee considered the actions being taken to mitigate this risk and recognised the limited assurance contained in the report due to the challenges to take on further apprentices during the pandemic.

2.8 Board Assurance Framework and Corporate Risk Register – MODERATE ASSURANCE OVERALL

The Committee was assured that the risks posed by the Covid-19 pandemic were being assessed in light of the Trust's corporate risk register (CRR).

Four current risks, i.e., 'Meeting in-year financial targets', 'Data Quality', 'Compliance with Data Protection' and 'Cyber security' had all been reviewed and the risk scores for the first two had been increased to reflect the impact. New mitigations and actions would be considered with the respective executive leads. The Committee recognised that this was an ongoing piece of work and asked for further reports to demonstrate greater assurance as the situation developed.

2.9 STP Long Term Plan Update –MODERATE ASSURANCE OVERALL

The Committee was assured that the Trust's financial position required no additional changes despite national changes to the financial planning for the system.

Clarity was provided on the income and contracting regime for the Trust for April to July 2020 and the resulting increased financial risk acknowledged. Further work would be required for the Committee to have substantial assurance on the financial position for 2020/21 given the possibility of further changes to the regime which are largely outside of the control of the Trust. The annual budgets for 20/21 would also need to be reworked in the light of these changes.

3.0 Areas of Concern/New Risks

3.1 The financial implications of income and contracting regime for 2020/21 were of concern and further developments would be reported at the next Board meeting.

3.2 There were no new risks identified at the meeting.

4.0 Action escalated to the Board

4.1 The Committee recommended that the Board allocate some of its board development programme to considering service developments more fully and to the possibility of public sector capital investment being used to re-energise the economy.

5.0 Recommendations

The Board is asked to

- Accept the assurance provided by the work of the Resource and Performance Committee

Assurance criteria

Level of assurance	Managing risk	Evidence of benchmarking or alignment to guidance	Performance	Governance and accountability
Substantial (Outstanding)	Appropriate procedures and controls in place to mitigate the key risks.	Clear evidence of external benchmarking or alignment with national, regional or system guidance	No, or only minor, exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led.	Clear governance and accountability structures in place.
Moderate (Good)	In the main there are appropriate procedures and controls in place to mitigate the key risks and/or minor delays in actions being taken reviewed.	Some evidence of external benchmarking or alignment with national, regional or system guidance OR minor non-compliance with such guidance	A small number of exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led.	Evidence of minor gaps in governance and accountability structures, that may put some of the assurance at risk.
Limited (Requires Improvement)	Procedures and controls are not in place to mitigate the key risks and/or major delays in actions being taken. Where practical, efforts should be made to address in-year.	Little evidence of external benchmarking or alignment with national, regional or system guidance OR major non-compliance with such guidance.	A number of reoccurring exceptions found in performance or evidence for CQC domains, safe, caring, responsive effective and well-led, such that efforts should be made to address in-year.	Evidence of major gaps in governance and accountability structures, that may put some of the assurance at risk.
No (Inadequate)	For all associated risk areas there are significant gaps in the mitigations and/or severe delays in actions being taken. Failure to address in-year affects the quality of the organisation's overall assurance framework.	No evidence of external benchmarking or alignment with national, regional or system guidance OR complete non-compliance with such guidance.	No reliance can be placed on performance or evidence for CQC domains, safe, caring, responsive effective and well-led. Failure to address in-year affects the quality of the organisation's overall assurance framework.	Evidence of severe gaps in governance and accountability structures, that may put all of the assurance at risk.

Shropshire Community Health NHS
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APPENDIX 1	Meeting Date:	4 June 2020
	Agenda Item:	10.1
	Enclosure Number:	12

Meeting:	**Trust Board**
Title:	**Performance Report**
Author:	**R Preen**
Reviewing Committee:	**Resource and Performance Committee**
Assurance level	**Substantial**
Requirement:	This report is required to meet the obligation of the NHS constitution, to be open and transparent with respect to performance.

1 Accountable Director: Ms S Lloyd,

Shropshire Community Health NHS
NHS Trust

Integrated Performance Report - Exceptions

Month 1
April 2020
Version 1.0

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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. The timescale for the review above has been extended due to the impact of the Coronavirus outbreak.

The COVID-19 dashboard continues to provide assurance to Committees and Board, as well as supporting the Incident Management Team. The performance system has a number of key measures that are updated daily so that performance can be tracked over time and a current state be understood. This is included with the appendices to this report.

The matrix of COVID-19 related submissions and returns is refreshed periodically to reflect any changes in requirements. Each iteration is shared with the Director of Finance for sign off. The Incident Management Team will receive an update as an assurance that, for the returns required, the detail is captured. The matrix includes who is submitting, the sign off process, deadlines and an indication of the quality of information amongst other items

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, there are several that are 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

- Information Governance Requirements
- Proportion of Delayed Transfers of Care (Days)
- Leavers All (FTE)

The service validation of the RTT measures continues and the current position for April is showing 18 week Referral To Treatment (RTT) for non admitted patients at 58.18% against the 95% target, there haven't been any clock stops within the 18 week Referral To Treatment (RTT) for admitted patients and 18 week Referral To Treatment (RTT) incomplete pathways at 84.02% 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 (21) can be seen clearly in the Integrated Dashboard which is Appendix 3 to the Performance Report. The table below shows 7 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.

There are a number of measures that don't yet require a recovery plan as a trend has not been established; Number of patients not treated within 28 days of last minute cancellation, Early Supported Discharge, Proportion of patients within 18 weeks, Appraisal Rates and SCHT Proportion of Clinical Staff who have completed a Hand Washing Assessment (%). These measures will be monitored in line with the performance framework

The measure Net Staff in Post Change has fluctuated from -12.72 in March to 14.93 in April. The sharp contrast between the March and April performance is due to the end of the financial year, which is a common time for all organisations to recruit new staff. Several staff leaving the trust at the end of the financial year had a last day of employment of 31st March and those joining at the start of the new year began on 1st April. Viewed as a single period, the net change for April and March was +2.2 WTE, within the expected fluctuation.

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	**Authorised – Further analysis required for formulation of a recovery trajectory**
	Sickness Absence - AHP Workforce	**Not Required – part of trust wide sickness absence measure**
	Net Staff in Post Change	**Not required – new measure, trend to be established, detail above**
	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 is 1 indicator included below where an authorised recovery plan is in place and the actual position is not recovering in line with the recovery trajectory.

RAG score	Trust Measure	Revised Recovery Plan Reference
	**Data Quality Maturity Index**	**Not required**

Data Quality Maturity Index

The actual position for this indicator is produced nationally based on patient related activity datasets submitted by the trust. The most up to date performance is January at 94.7% against a 95% target and trajectory. As the year to date position is amber, and only 0.3% off target, a revised recovery plan has not been requested

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
Number of Claims for compensation received	**Responsive**	**Q&S**
Clostridium Difficile – incidence rate	**Safe**	**Q&S**
Grade 2 Pressure Ulcers	**Safe**	**Q&S**
Grade 3 Pressure Ulcers	**Safe**	**Q&S**
Ungraded Pressure Ulcers	**Safe**	**Q&S**
Percentage of new Harms	**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

Shropshire Community Health NHS
NHS Trust

APPENDIX 2	Meeting Date:	4 June 2020
	Agenda Item:	10.1
	Enclosure Number:	13

Meeting:	**Trust Board**
Title:	**Finance Report – Month 1 (2020/21)**
Author:	**Sarah Lloyd**
Reviewing Committee:	**Resource and Performance Committee**
Assurance level	**Substantial**
Requirement:	This report is required to meet the obligation of the NHS constitution, to be open and transparent with respect the use of resources.

1 Accountable Director: Ms S Lloyd,

Shropshire Community Health NHS
NHS Trust

Title	**Finance Report for the Period Ended 30 April 2020 (Month 1 2020/21)**

1. Covid-19 Impact on Financial Performance

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 and is the level at which performance is reported to and managed by NHS England/NHS Improvement (NHSE/I).

1.2 Since we agreed our budget for 2020/21 in March, the national response to Covid-19 has led to changes that have had a significant impact on the financial management of every NHS provider. These changes have created uncertainty in the short-term as NHSE/I guidance is regularly being updated and in the medium term as we assess our likely financial performance following reinstatement of suspended services.

1.3 Key changes to date for 2020/21 include:

1. Suspending the annual planning and contracting process which usually determines the income we will receive from each commissioner for the year.
2. Replacing the income we would normally receive from each commissioner with one block payment each month from NHSE/I; this value has been determined by NHSE/I and covers our clinical income from all commissioning contracts.
3. NHSE/I has given every NHS provider a financial plan for months 1-4 only.
4. Every NHS provider is required to report a break-even position for month 1 by accruing 'top-up' income; it has been suggested by NHSE/I that this is also likely to be required for months 2-4.
5. Delivery of efficiencies not required during months 1-4.
6. We are now reporting in detail all incremental costs driven by our response to Covid-19.
7. Guidance for months 2-4 is being updated and guidance relating to months 5-12 has not yet been communicated.

1.4 These financial changes introduce a level of uncertainty for 2020/21, however we will continue to review guidance and will assess the impact as further information becomes available

1.5 In 2019/20 we delivered our agreed financial plan and as we move forwards under the new arrangements the following will support our financial performance:

1. At the end of 2019/20 our cash balance was £14m cash; this has risen to £20m at the end of April including early payments of the block income for month 2
2. We continue to maintain our existing financial controls without hindering our response to Covid-19
3. We are continuing where possible to progress some efficiency schemes without hindering our response to Covid-19
4. We are liaising with the finance teams across the Shropshire STP to discuss risks and align in our approach

2. Overall Income & Expenditure Performance

2.1 **Performance to Date**

The Trust is reporting a month 1 financial performance of breakeven compared to the NHSE/I plan of £28k surplus.

The position includes an accrual for a retrospective 'top-up' payment of £579k which largely relates to £543k Covid-19 expenses.

This position is summarised in Table 1 below.

	Plan £000	YTD £000	Variance £000
Income	(7,095)	(6,982)	113
Top Up Income	0	(579)	(579)
Expenditure excl. adjusting items	7,067	7,561	494
Adjusted financial performance total	**(28)**	**(0)**	**28**
Adjusting items	7	13	6
Retained (surplus) / deficit	**(21)**	**13**	**34**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 30 April 2020

2.2 Income – favourable variance to plan £466k

Following revised guidance, our clinical income from all main NHS Commissioners has been replaced by £6,014k block income for month 1. In addition, we have assumed an additional £579k 'top up' income value from NHSE/I to ensure we achieve a breakeven position, in line with recent guidance.

Other income shows an adverse variance to plan of £113k due to lower activity as we focus on Covid-19; additionally the guidance prevents recovery of other income from CCGs outside of the block payment. e.g. estates income, occupational health.

A summary of total income is shown in Table 2.

	YTD Plan £000	YTD Actual £000	Variance £000
Block	(6,014)	(6,014)	0
Top Up		(579)	(579)
Other Income	(1,081)	(968)	113
Total Income	**(7,095)**	**(7,561)**	**(466)**

Table 2: Income Summary as at 30 April 2020

2.3 Expenditure – adverse variance to plan £499k

Table 3 shows total expenditure in Month 1 totals £7,574k which exceeds plan by £499k; however this includes Covid-19 costs of £543k. Further details on Covid-19 are set out in section 2.4 below.

	YTD Plan £000	YTD Actual £000	YTD Variance £000
Substantive	4,648	4,481	(167)
Bank	40	149	109
Agency	15	155	140
Total Pay	**4,703**	**4,784**	**81**
Non-Pay	2,222	2,596	374
Central/ Non-Operational Costs	150	194	44
Total Non-Pay	**2,372**	**2,790**	**418**
Total Expenditure	**7,074**	**7,574**	**499**

Table 3: Expenditure Summary as at 30 April 2020

2.4 Covid-19 Costs

NHSE/I financial reporting guidance requires us to identify all costs that relate to our response to Covid-19. To ensure we capture and report Covid-19 costs, SDG Leads, Corporate Leads, managers and subcontractors have been briefed on how to identify Covid-19 costs and how to report them to the Finance Team. In addition, expenditure across the Trust is being monitored to identify changes in expenditure level which are then investigated to see whether they are Covid-19 related.

Our analysis shows that the incremental increase in cost due to our response to Covid-19 is £543k which includes £142k of additional costs incurred by sub-contractors.

3. Agency and Locum Expenditure

3.1 Agency and locum usage

Agency usage has reduced across all services although agency cover for staff sickness/isolation due to Covid-19 increased by £25k. At £154k for month 1, this is lower than our internal plan of £209k and lower than the NHSE/I ceiling of £315k.

Table 4 shows the expenditure by service compared with the last 3 months of 2019/20.

Area of Agency Expenditure	2019-20 Jan £	2019-20 Feb £	2019-20 Mar £	2020-21 Apr £	2020-21 YTD £
Bridgnorth Hospital (inc. MIU)	15,229	18,784	15,849	8,706	8,706
Bishops Castle Hospital	30,054	25,401	24,396	18,243	18,243
Ludlow Hospital (inc. MIU)	36,673	29,584	56,176	23,502	23,502
Whitchurch Hospital (inc. MIU)	51,463	26,557	33,097	14,634	14,634
Stoke Heath	31,055	25,479	24,918	17,954	17,954
CHOP Other (inc. Oswestry MIU)	2,338	1,755	5,807	2,224	2,224
Total Community Hospitals/Stoke Heath	**166,812**	**127,560**	**160,244**	**85,264**	**85,264**
MSK	6,525	6,206	5,141	0	0
Children and Families	7,356	23,812	28,093	25,066	25,066
Community Services	12,437	11,515	15,633	7,636	7,636
ICS & Isle Court	-226	2,502	-2,736	5,500	5,500
Corporate Services	0	0	0	0	0
Covid 19	0	0	6,302	31,156	31,156
Total for All Services	**192,903**	**171,596**	**212,676**	**154,622**	**154,622**

Table 4: 2020/21 Agency and Locum Expenditure by Service

4. Statement of Financial Position

4.1 The Trust's summarised Statement of Financial Position (SoFP) for the period ended 30 April 2020 is shown in Table 5.

	Balance 31 Mar 20 £000	Balance 30 Apr 20 £000	Movement in Month £000
Property, Plant & Equipment	24,626	24,496	(130)
Inventories	434	440	6
Receivables	3,896	3,544	(352)
Cash	14,351	20,929	6,578
Payables	(8,178)	(14,293)	(6,115)
Provisions	(280)	(280)	0
TOTAL ASSETS EMPLOYED	**34,849**	**34,836**	**(13)**
Retained earnings	27,246	27,233	(13)
Other Reserves	7,603	7,603	0
TOTAL TAXPAYERS' EQUITY	**34,849**	**34,836**	**(13)**

Table 5: Statement of Financial Position as at 30 April 2020

Receivables decreased by £352k in month, mainly due to a payment from NHS Property Services for £331k in relation to rent and service charges at Whitchurch Medical Practice.

Cash increased by £6,578k and Payables increased by £6,115k. Both are these changes are mainly due to the new block payment arrangements set up in relation to Covid-19. In April we received £6,014k in respect of the May block income which has been deferred into month 2.

The cash balance at 30 April is £20,929k and the forecast cash balance at 31 March 2021 is £14,710k, this is a positive cash balance and covers the Trust in cash terms regarding income and expenditure risks. The forecast will be updated during May as further guidance is provided by NHSE/I.

5. Capital Expenditure

5.1 Capital Expenditure

The year to date capital expenditure is £17k compared to the year to date plan of £0k. The full year forecast is £1,900k.

All schemes have been considered at the Capital and Estates Group in light of our response to Covid-19 to assess which schemes it is reasonable to progress at this time.

A revised capital plan for 2020/21 is due for submission to NHSE/I on the 29 May 2020. This year a capital funding envelope is being allocated to the STP with the trusts capital plans needing STP agreement prior to submission. This work is currently underway however the overall value of capital allocated to the STP appears to be sufficient to cover identified capital plan values and we expect to maintain our capital plan at £1,900k.

6. CIP Performance

6.1 Cost Improvement Programme

NHSE/I guidance confirmed that no efficiencies are required during months 1 to 4 and the efficiency target for this period has been removed from the plan. However planning and delivering efficiencies where possible remains important and we continue to review opportunities through the Benefits Realisation Group. Schemes which are currently being reviewed relate to estates optimisation and procurement.

7. Contract Management

7.1 2019/20 Full year performance

The Trust reported a total contract under-performance of £231k (0.4%) for 2019/20; £201k of the under-performance was in March, due to the impact of our response to Covid-19.

8. 2019/20 Year End

8.1 2019/20 Year End

The draft accounts and associated forms were submitted on Monday 27 April 2020.

External Audit are currently reviewing and testing the data used to compile the draft accounts, therefore the financial position for 2019/20 is provisional. This year the audit is being carried out remotely and is currently working well with no issues to report. The plan is for the final accounts and annual report to be signed off on 17 June 2020. The Accounts will be reported through the Audit Committee and Trust Board.

The Trust reported £131k favourable variance to our control total of breakeven, resulting in the Trust securing £844k of Provider Sustainability Funding, bringing our 2019/20 surplus to £975k at adjusted performance level compared to the planned position of £844k surplus.

9. 2020/21 Budget

9.1 **Budget changes for months 1 to 4**

The budget for 2020/21 was approved at the March Board meeting. The budget was in line with our draft 2020/21 annual plan submitted to NHSE/I on 5 March to deliver £77k surplus (after adjusting items), as part of the STP'S financial plan.

Subsequently NHSE/I has issued all organisations with updated financial plans for months 1 to 4 and we have therefore updated the budgets for this period non-recurrently to reflect these changes and revised arrangements. Our plan for months 1-4 was a deficit of £585k due to CIP delivery phased towards the second half of the year. The non-recurrent budget adjustments to reflect the NHSEI plan for months 1-4 (£28k surplus each month), now show a total financial performance of £112k surplus.

These changes were implemented using the budget virement policy in line with the Scheme of Delegation.

10. External Reporting and Strategic Update

10.1 External Reporting

The Month 1 monitoring return, consistent with the information set out in this report, was submitted to NHSE/I on 18 May 2020.

10.2 Strategic Update

Further guidance is expected from NHSE/I:

- to provide further clarification on how to capture and report incremental Covid-19 costs from month 2
- to confirm changes to the block income payments for months 5-7
- to confirm the timetable for completing the National Cost Collection in 2020. Dates being considered range from August through to November

11. Recommendations

11.1 The Board is asked to:

- Acknowledge that the changing financial environment introduces a level of uncertainty for 2020/21 and that we continue to assess the impact of changes as we are notified
- Consider the breakeven financial position at month 1, which is in line with NHSE/I guidance
- Acknowledge that the month 1 position includes a retrospective top-up payment of £579k which covers the incremental Covid-19 costs of £543k
- Consider that our budgets for months 1-4 have been amended to reflect the revised financial plan issued by NHSE/I
- Recognise the cash position remains strong with a balance of £20,929k as at 30 April 2020.

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT		
	Meeting Date:	May 2020
	Agenda Item:	**10.4**
	Enclosure Number:	**14**

Meeting:	**Trust Board**		
Title:	**Data Security and Protection Toolkit (DSPT) 2019-2020 Submission and General Data Protection Regulation (GDPR) Compliance**		
Author:	**Gill Richards, Information Governance Manager**		
Accountable Director:	**Ros Preen, Director of Finance and Informatics**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	none		

Purpose of the report		
To provide the Board with assurance that we are meeting our statement of compliance under the Data Security and Protection Toolkit (DSPT) and our legal obligations under the General Data Protection Regulation (GDPR). To confirm that the DSPT assessment for the year 2019-2020 was successfully completed and submitted to NHS Digital at the end of March 2020 - publishing an assessment of "Standards Met". DSPT Assurance Key: • Standards exceeded • Standards met • Standards not fully met (plan agreed) • Standards not met To inform the Board that the Information Governance Operational Group continues to make improvements in the way that we manage, document and audit the processing of personal information in accordance with the DSPT and GDPR.	**Consider for Action**	
	Approval	
	Assurance	**Yes**
	Information	**Yes**

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**
Yes			

1 Accountable Director: Ros Preen, Director of Finance
Board Meeting: June 2020

Summary of key points in report

The new DSPT was published on the 1 April 2019 and members of the Information Governance Operational Group (IG Group) have effectively managed, monitored and supported the process during 2019-2020 to ensure a positive outcome.

The DSPT is based on the 10 National Data Guardian Standards and we must provide evidence that we are meeting the requirements as set out in the DSPT together with the legal requirements of GDPR. The 10 Standards are:

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Accountable Suppliers

At the end of this financial year the IG Group has no open risks on the IG Risk Register.

The DSPT remains work in progress and with the main focus being:

- Managing and maintaining a register for Information Assets
- Information Sharing Agreements
- Information Flows
- Third Party Supplier Contracts

The Covid-19 Outbreak has had an impact on achieving the Data Security Training target of 95% with the Trust achieving 94% at the end of March. The IG Manager recommended to the SIRO that the Data Security and Protection Toolkit (DSPT) submission should still be made as the IG Training was the only outstanding evidence and under the circumstances it was a good result. The SIRO reviewed the evidence with the IG Manager and proposed submission and signed it off on behalf of the Board.

The DSPT was submitted with 116 of the 116 mandatory evidence items being met and a statement to say that the IG training compliance was at 94% and working towards compliance at the end of September.

It is important to note that due to the Covid-19 Response the period for which we can count staff as achieving compliance of the Data Security Awareness Training has been extended – it is now 1 April 2019 to 30 September 2020. Staff must continue to refresh their IG Training during the next few months to reach the 95%. The IG Manager will continue to work with the Deputy Director of Operations to improve the training compliance.

BDO internal audit provided the findings of the DSPT compliance and reported that the Trust had met 100% of the evidence assessed and therefore achieved an assurance level of “Significant”.

Key:

LEVEL OF ASSURANCE	TOOLKIT COMPLIANCE SCORE
Substantial	Compliance score is equal to 75% or more
Moderate	Compliance score is between 51% and 74% (inclusive)
Limited	Compliance score is equal to 50% or less

At the May meeting of the Digital Programme Group the IG Manager informed the members that during the Covid-19 Response requests for information under the Data Protection Act (DPA) and Freedom of Information Act (FOIA) continue to be managed in a timely manner and currently there are no risks.

Key Recommendations
The Board is asked to: 1. Ratify the DSPT and GDPR assurance outlined in this report - 2. To accept the extended compliance date for IG Training 3. To accept the extended compliance deadline of the National Opt-Out Programme 4. To accept the Covid-19 Response risk assessment for requests under DPA and FOI.

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	YES	10 National Data Guardian Standards
Board Assurance Framework	NO	

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	YES	Keeping information safe and secure.
Financial (revenue & capital)	NO	
OD/Workforce	NO	
Legal	YES	Compliance with the General Data Protection Regulation (GDPR)

Shropshire Community Health NHS
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SUMMARY REPORT	Meeting Date:	04th June 2020
	Agenda Item:	11
	Enclosure Number:	15

Meeting:	**Board Meeting**		
Title:	**Governance Report**		
Author:	**Stanley Mukwenya, Head Governance and Risk**		
Accountable Director:	**Claire Lea/Julie Houlder, Corporate Governance Support, Peter Phillips, Non-Executive Director and Chairman of the Audit Committee**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Audit Committee	7th April 2020	As set out below

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 assurance about how we are mitigating risks affecting our organisational objectives. To consider and discuss governance activities and issues. **Section 2 Audit Committee Report** The committee met virtually on the 7th April 2020 due to the Covid-19 pandemic. Report authors were requested to focus on significant updates to the Committee. The report highlights major issues received, discussed and agreed on 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**
✓			✓

Shropshire Community Health NHS
NHS Trust

Summary of key points in report

Section 1 Governance Report

Board Assurance Framework
Since the Board last reviewed the Board Assurance Framework (BAF), the Audit Committee agreed on inclusion of a *Covid-19* BAF entry with a maximum risk score of *25* as recommended by the Board ahead of the Audit Committee meeting.

Long-Term Financial Sustainability of the Trust, the BAF entry is scheduled for review and a revised BAF entry will be made available once finalised.

There are no changes to *Healthcare Systems BAF* entry as ongoing review is awaiting further STP national guidance, a revised BAF entry will be concluded when this becomes available.

Optimising the Use of Technology, the BAF entry has been reviewed and extra controls and actions have been developed to mitigate Covid-19 operational changes in regards to the use of technology. There were no changes to the risk score.

Organisational Culture does not support the values of the Trust, the BAF entry has been risk assessed and the likelihood increased from 2 to 3 with an overall risk score of 9. Despite a number of activities being undertaken to improve organisational culture and values it was agreed that prolonged business disruption due to the Covid-19 pandemic may negatively impact delivery of pre-planned activities to mitigate the risk. New control updates have been added to BAF entry relating to activities being undertaken to support staff well-being, engagement and organisational development during the pandemic.

There were no changes to *Clinical Quality and Safety* BAF entry.

Corporate Risk Register
The Corporate Risk Register review was undertaken to align individual risks with service and operational changes due to Covid-19. The review created refreshed individual risk descriptions, controls/actions and scoring ratings.

Discussions were held with all individual risk owners and changes were agreed as reflected on the current CRR attached below.

Section 2 Audit Committee

- Approved the draft Annual Governance Statement
- Accepted Internal and External Audit Progress Reports.
- Accepted a verbal update on Annual Report production.
- Approved the Going Concern report subject to the final outcome of the external audit.
- Approved Accounting Policies Report
- Agreed on Non-Consolidation policy for charity funds
- Accepted a verbal update on the Audit Committee Work Plan
- Agreed on inclusion of Covid-19 risk on BAF with a maximum scoring.

Shropshire Community Health NHS
NHS Trust

Key Recommendations
The Board is asked to: **Section 1** • **Confirm and agree** that the current BAF accurately reflect the risks to delivery of the organisational objectives • **Accept** postponement of the annual review of the BAF until the Trust's strategic objectives for 2020/21 has been finalised. • **Request** additional assurance where there are concerns • **Approve c**hanges to the Corporate Risk Register risks • **Approve** changes to scoring rating on 8 CRR risks **Section 2 Audit Committee** • **Accept** the assurances provided by the Audit Committee

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
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1 SECTION ONE: GOVERNANCE REPORT INCLUDING BOARD ASSURANCE FRAMEWORK

1.1 Board Assurance Framework (BAF)

Ref	Name	Changes	Rating (current)	Risk level (current)
01 -2018	Organisational culture does not support the values of the Trust	**Engagement related to Covid-19** – Management guidelines produced for engaging with staff during CV-19. – Information page set up on intranet to support staff with Communications. – Continuous quality of care monitoring and reporting – Communication plan refreshed – Repurpose of CTLG to create a management forum **Organisational Development** – Review of corporate induction process to be able to deliver induction remotely during CV-19 ongoing – Frontline staff CV-19 training available to wider staff – Central training database monthly monitoring of performance with recovery plans where necessary – Introduction of ESR Self Service – Role specific essential training Integrated induction program in place – Mandatory training methods have been reviewed to ensure that we still remain compliant and focus on priority areas **Well being** – Mental Health and Well-Being support disseminated to staff on daily basis through communication Team or staff intranet.	9	Moderate 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	Technology such as MS Teams and Attend Anywhere have been rolled out at pace to support the current COVID crisis, however the longer term licensing costs that will be passed down to local Trusts are yet to be formally agreed. There is no direct cost in this financial year for the Attend Anywhere system however the risk exists that costs will be passed down from NHS Digital in	12	Moderate risk

Shropshire Community Health NHS
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Ref	Name	Changes	Rating (current)	Risk level (current)
		subsequent years. NHS Digital are currently negotiating with Microsoft to reduce the costs of Office 365 which contains MS Teams, the Trust has agreed in principle to buy into this process which should represent a significant reduction in costs once negotiations complete.		
02 -2019	Long-term financial sustainability of the Trust	No change	16	High risk
03 -2020	Covid-19 impact	Business Continuity Plans in place to reduce low priority services and deploy staff to high risk areas in event of significant staff shortage and increased demand. Drive through testing for patients with suspected infection of Covid-19 virus. Gold Command telephone communications. Health protection campaigns being run by the Shropcom Infection Preventions and Control team, in line with Public Health England recommendations. Home testing of patients with suspected Covid-19 in the home environment Monitoring of staff capacity and absence Management Regular communications to provide staff awareness of current working policies eg. working from home. Staff information page set up on Trust intranet. The Trust has undertaken workforce, workplace and individual risk assessments	25	High risk

The Audit Committee was informed of pending reviews for *Long-Term Financial Sustainability of the Trust and Healthcare Systems risks*. It was further indicated that the Trust will be suspending 'deep dive' reviews of BAF risks by the Board's Committees due to the on-going Covid-19 pressures. However, the Committee was assured that a future workshop to discuss the Trust's risk appetite was planned, and would be set up as soon as services returned to normal.

1.2 Changes to all BAF risks

Since the Board last reviewed the Board Assurance Framework (BAF), the Audit Committee agreed inclusion of Covid-19 risk with a maximum score of 25. The risk score on *Organisational Culture does not support the values of the Trust* has increased due to Covid-19 service and operational pressures to delivery of planned mitigations.

Review on *Optimising the Use of Technology* risk has been completed and extra controls/actions have been added to mitigate Covid-19 operational changes on the use of technology. There were no changes to the risk score.

There were no changes to *Long-Term Financial Sustainability of the Trust* and *Healthcare Systems* risks. The risks are scheduled for reviews and revised BAF entries will be made available when completed. Review completion timing cannot be confirmed at this stage due to Covid-19 disruption. There were no changes to *clinical Quality and Safety* risk.

The BAF is attached in **Appendix - A**

1.3 Corporate Risk Register

The Corporate Risk Register was reviewed aligning all the risks with the impact of Covid-19 service and operational changes. Discussions were held with all individual risk owners on risk description to assess if it was still fit for purpose, suitability of controls/actions and of the risk score. The review resulted on increased scoring of the following 8 risks;

Business Interruption from 2 x 3 (Consequence x Impact) to 4 X 4
Polices from 3 X 2 to 3 X 3
Staff engagement from 3 X 2 to 4 X 4
Risk Management from 2 X 3 to 2 X 4
Staff sickness from 3 X 4 to 3 X 5
Data quality from 2 X 3 to 4 X 3
Vacancies and the effect on service delivery from 3 X 3 to 3 X 4
Meeting in year financial targets from 4 X 3 to 4 X 4

One new risk has been added on the CRR since the last Board meeting, **Medical cover at Community Hospitals**.
Due to COVID19, medical cover at Community Hospitals has been extended to provide a 7 day service. There is a risk that this cover cannot be maintained due to demands on the service and availability of medical cover.

1.4 Summary of Risks

The full CRR is included in **Appendix B**. 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 above their target rating.

Shropshire Community Health NHS
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CRR entry		Initial Rating			Current Rating			Target Rating		
	On target (OT), Above target (AT)	Cons	Like	Rating	Cons	Like	Rating	Cons	Like	Rating
Stoke Heath Prison Pharmacy	AT	3	4	20	4	4	16	2	3	6
Medical cover at Community Hospitals	AT	4	4	16	4	4	16	2	3	6
Staff Engagement	AT	4	4	16	4	4	16	3	2	6
Business interruption	AT	4	3	12	4	4	16	2	3	6
Staff sickness	AT	3	5	15	3	5	15	3	3	9
Meeting in year financial targets	AT	5	5	25	4	4	16	3	3	9
Estates Safety and statutory compliance	AT	3	4	12	3	4	12	3	2	6
Vacancies and the effect on service delivery	AT	3	5	15	3	4	12	3	3	9
Data quality	AT	3	4	12	3	4	12	3	2	6
Health & safety legislation	AT	4	5	20	3	4	12	2	2	4
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
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
Community links and reputation	OT	3	4	12	3	2	6	3	2	6
Policies	OT	3	5	15	3	3	9	3	2	6
Risk management	OT	3	5	15	2	4	8	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

Shropshire Community Health NHS
NHS Trust

CRR entry		Initial Rating			Current Rating			Target Rating		
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
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

2 SECTION TWO: AUDIT COMMITTEE REPORT

The Audit Committee met on the 7th April. Below are the key points from the meeting

2.1 Annual Governance Statement - AGS

The Audit Committee approved the draft AGS report subject to rectification of minor actions identified in the meeting and consideration of comments from estates, HR and Quality teams. Further discussions were held on accuracy of Trust committee membership, declarations of interest and changes to AGS Submission dates.

2.2 Going Concern Report

The Audit Committee was informed that the Going Concern report had been presented for approval. It was indicated that there were no investments that were likely to be affected, however, it was possible that the valuation of property and plant could be affected.

The Committee was further informed that draft accounts were due to be submitted on 27th April 2020 and any identified materialities would be disclosed in the audit report. The committee approved the report, subject to the final outcome of the accounts findings.

2.3 Accounting Policies

The Audit Committee was informed that there were no significant changes to accounting policies. Discussions were held on Revenue from NHS Contracts as to whether there would be debt due to Covid-19 impact on services.

The Committee was informed that the Trust had been assured that costs would be reimbursed in line with appropriate financial year. The Committee approved accounting policies report.

2.4 Charity Non-Consolidation Report

The Committee was informed that there were no significant changes to the Charity Policy made during the year. The Audit Committee agreed that charitable funds should not be consolidated in to the Trust accounts but put to good use.

2.5 Internal Audit

The Committee accepted that there would be some delays to delivery of next year's internal audit plan given the impact of Covid19. The Committee was informed that the timing of the audit would be discussed with senior management and the Audit Committee later during the year.

Discussions were held on Estates assessment's effectiveness, efficiency and value for money. RiO System, IG Toolkit and Business Continuity audits were awarded substantial assurance opinion rating. It was indicated that the Trust was compliant on its IG submissions.

The content of the report was accepted and the Audit plan was approved.

2.6 External Audit

It was indicated that Extra Ordinary Audit Committee to approve accounts would be taking place on Wednesday 17th June 2020. Discussions were held on impact of estates valuation and market value on the financial statement as a result of Covid-19. The Committee accepted the content of the report.

2.7 Work Plan

The Audit Committee accepted the content of the Audit Committee Work Plan.

2.8 Use of the Trust Seal

The seal has not been used since the last meeting.

3 RECOMMENDATIONS TO THE BOARD

Section 1: **Governance Report**

- **Confirm and agree** that the current BAF accurately reflect the risks to delivery of the organisational objectives
- **Accept** postponement of the annual review of the BAF until the Trust's strategic objectives for 2020/21 has been finalised.
- **Request** additional assurance where there are concerns
- **Approve c**hanges to the Corporate Risk Register risks
- **Approve** changes to scoring rating on 8 CRR risks

Section 2: Audit Committee

- **Accept** the assurances provided by the Audit Committee

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).	Engagement related to Covid-19 Management guidelines produced for engaging with staff during CV-19 Information page set up on intranet to support staff with communications Continuous quality of care monitoring and reporting Communication plan refreshed Repurpose of CTLG to create a management forum Organisational Development Review of corporate induction process to be able to deliver induction remotely during covid-19 ongoing Frontline staff Covid-19 training available to wider staff Central training database monthly monitoring of performance with recovery plans where necessary Introduction of ESR Self Service Role specific essential training Integrated induction program in place Mandatory training methods have been reviewed to ensure that we still remain compliant and focus on priority areas Well being Mental Health and Well-Being support disseminated to staff on daily basis through communication Team or staff intranet.	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 Board clinical visits suspended due to Covid-19 Culture group inactive due to staff reassignments Delivery of agreed transformation plans individual interactions	Challenge of managing/leading small discreet services spread

Ratings Cons (initial) 4 Like (initial) 4 **Initial Rating** 16 Cons (current) 3 Like (current) 3 **Current Rating** 9 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.		31-Jul-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-Jul-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	31-Jul-2020	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. Technology such as MS Teams and Attend Anywhere have been rolled out at pace to support the current COVID crisis, however the longer term licensing costs that will be passed down to local Trusts are yet to be formally agreed. There is no direct cost in this financial year for the Attend Anywhere system however the risk exists that costs will be passed down from NHS Digital in subsequent years. NHS Digital are currently negotiating with Microsoft to reduce the costs of Office 365 which contains MS Teams, the Trust has agreed in principle to buy into this process which should represent a significant reduction in costs once negotiations complete.	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-Jul-2020	Jon Davis

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

3560 Covid 19 (Coronavirus)

Risk Description	Mitigation/Controls in Place	Assurance	Gaps in Assurance	Gaps in Control
There is a risk that, detection of corona virus in the Trust hospitals/clinics, and within the communities that the Trust provide healthcare services, may impact our workforce capacity trying to contain a wider outbreak, make it difficult to provide services in affected areas and stretch our financial resources resulting in failure to deliver Trust priorities and wider healthcare services needs within our geography.	1. Regular guidance being provide form NHS national teams. 2. Everyday Shropcom executive monitoring meetings 3. HR providing daily updated. 4. Risk assessment undertaken.	Delivery of agreed plans Incident Management Team daily guidance to staff Quality and Safety Committee briefing and feedback Regular Board and briefing	Consistent national guidance and protocols	Challenges in managing evolving events

Ratings Cons (initial) 4 Like (initial) 4 **Initial Rating** 16 Cons (current) 5 Like (current) 5 **Current Rating** 25 Cons (Target) 3 Like (Target) 3 **Target Rating** 9

Actions Identfied

Action	Progress	When By	Responsible Person
Business Continuity Plans in place to reduce low priority services and deploy staff to high risk areas in event of significant staff shortage and increased demand.	On-going	31-Jul-2020	Ms Mandee Worrall
Drive through testing for patients with suspected infection of Covid 19 virus.	On-going	31-Jul-2020	Mr Mike Carr
Gold Command telephone communications.	On-going	31-Jul-2020	Mr Mike Carr
Health protection campaigns being run by the Shropcom Infection Preventions and Control team, in line with Public Health England recommendations.	On-going	31-Jul-2020	Elizabeth Watkins
Home testing of patients with suspected Covid 19 in the home environment.	On-going	31-Jul-2020	Mr Mike Carr
Monitoring of staff capacity and absence management	On-going	31-Jul-2020	Sara Hayes
Regular communications to provide staff awareness of current working policies eg. working from home.	On-going	31-Jul-2020	Mr Chris Hudson
Staff information page set up on Trust intranet.	On-going	31-Jul-2020	Mr Chris Hudson

Non Exec Director Peter Featherstone **Lead Director** Mr Steve Gregory **Monitoring Group** Board

Corporate Risk Register Report

Risk Above Target

ID: **325** Title: **Business Interuption** **Lead: Mr Steve Gregory** Division/Directorate: **All Directorates**

Description of Risk:

There is a risk that Business Continuity and Recovery Plans in place prior to Covid 19 pandemic did not have the recovery capacity and resilience to match length and severity of disruption resulting in ongoing challenges to business operations and a resilient recovery plan for the wider health system.

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
Business Continuity Plans have been triggered across all Trust services.
The Trust is regularly receiving national guidance on business continuity in regards to Covid 19.
The Trust has triggered the Business Continuity Incident Management Team (IMT) to lead and support on day to day operations

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
Business Continuity Plans have been refreshed to incorporate national guidance on Covid 19 risk. IMT , Bronz and Silver calls are being held daily to support service operations Risk assessments were carried out to inform business continuity decision mak	In progress	31/12/2019	Mr Andrew Thomas	

Rating

	Initial	Current	Target
C	4	4	2
L	3	4	3
	12	16	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:

There is a risk to patient care due to national and local workforce supply shortages resulting in staff capacity failing to meet demand leading to lower morale, sickness and absence impacting safe quality care.

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
- Agency staff being hired to fill staffing gaps
- Staff absence related Covid 19 being monitored and classed as sick absence
- Guidance for line Managers to support staff wellbeing and support developed.

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
- Non clinical staff working from home - Information page set up on intranet to support staff with communications - Staff redeployments to support staffing gaps - Provide MS Team training and support so that people can meet virtually	In-progress	30/06/2020	Jaki Lowe	

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:

There is a risk that, prolonged business disruption will impact negatively achieving the Trust's internal and external stakeholder engagement strategy resulting inaccurate interpretation of our decision on sustainability or transformation issues.

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
- - Coordinated Covid 19 response with local STP partners
- Participating in national and local meetings with system partners.

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
Refresh communication plan for transaction Trust Incident response team (IMT) engaging and supporting local service and corporate teams	In progress	30/06/2020	Mr Chris Hudson	

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:

There is a risk that lack of staff awareness and compliance with policies will be enhanced and prolonged negatively due to Covid19 staffing redeployments impacting on quality and safety of care. There may be delays to updating expired policies and reducing gaps in any further organisational policy requirements. Changes in national policy may not be adequately communicated to staff.

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
Owners of policies expiring in each quarter continue to receive reminders.
Need to review and align national guidance on related policies.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
List of all approval responsibilities for policy approval to be developed. National guidance is being disseminated through IMT and communication teams to staff All potential policy changes are being shared to wider staff through communication team and l		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	3
	15	12	9

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:

There is a risk that, lack of staff understanding or awareness of the Trust risk management framework, reporting and escalation process will result in failing to identify and mitigate risk threats impacting quality of service and care.

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.
Plans to reconvene Risk Steering Group being considered
Risk Team is analysing staff risk training requirements
Risk training dates being rescheduled due to Covid 19
Scheduling future Board awareness risk training.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Develop and support the work of the Risk Review Meeting. Consulting with service leads on risk training requirements Individual risk support and training being offered Risk guidance and assurance is being provided to Board Committees.		30/06/2020	Stanley Mukwenya	

Rating

	Initial	Current	Target
C	3	2	2
L	5	4	3
	15	8	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:

There is a risk that, prolonged business continuity disruption will impact compliance with Health and Safety, Food Waste and Environmental legislation reviews, plans and strategies.

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.
Identify gaps from Health and Safety Consultants final report
DDevelop plans to mitigate identified gaps.

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. Schedule H&S training dates for staff		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:

There is a risk that, continued staffing shortages due to the pandemic may affect internal investigations and response to Clinical Negligence and third party claims resulting in negative publicity or financial impact.

Controls/Mitigation:

Legal advisors
NHS Resolution support with claims
Low number of claims
Being Open Policy
Legal updates distributed to relevant managers
Regular communication with NHS Resolution and Trust Solicitors
Risk Team monitor and respond to all internal/external communication requirements.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Monthly monitoring spreadsheet for open/closed claim cases developed and put in place.	On-going		Stanley Mukwenya	
Regular updates and assurance provided to Quality and Safety Delivery Group, Committee and Service Delivery Groups. Risk Team responding and providing relevant information.	On-going		Stanley Mukwenya	

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:

Staff redeployments and operational changes due to Covid19 create a risk that non-clinical and clinical incidents data collection and recording will be disrupted leading to poor and insufficient learning outcomes and training requirements.

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
Continuous collection and reporting of data
SI review meetings to be reconvened through virtual meetings
Continuity of national reporting of incidents ongoing

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Risk Team is monitoring and responding to all external /internal communications related to SI, claims and all related areas. Reporting to Service Groups and Committees ongoing as required. All incoming alerts are being monitored and shared with responsi	On-going	30/06/2020	Mr Steve Gregory	

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:

There is a risk that, mandatory training, staff awareness and preparedness for assessment visit by external bodies may be affected due to Covid-19 staffing prioritisation impacting training plans.

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
Staff continue taking their mandatory training Courtesy reminders continue to be sent to staff to complete their expiring ma	In progress	30/06/2020	Jaki Lowe	

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:

There is a risk that, lack of compliance with Safety Alerts and having an out of date inadequate device register for tracking, maintaining and disposing of devices will result in failure to comply with MDSO requirements, and patient safety.

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.
Risk Team continue to monitor and disseminate all received alerts with responsible directors and directorates.

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
All received alerts related to Covid 19 are being shared with responsible platforms and managers.	In progress	31/08/2020	Mr Steve Gregory	

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:

There is a risk that, compliance with law in relation to children, adult safeguarding and related incidents system gaps may be impacted due to stretched management capacity resulting in poor and unsafe service.

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
Demand and capacity exercise conducted to identify needs.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Children and Young People Service Delivery Performance meetings has been reconvened through vitual meetings Arising new incidents continue to be reported through Datix and being shared with service leads Complaints related to the service continue to be	In progress	30/06/2020	Mr Steve Gregory	

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:

There is a risk that, staff absence will increase as a result of sickness, self-isolation looking after family members as a result of Covid-19 outbreak disrupting service delivery and recovery plans currently in place to achieve set targets in areas of service that rely highly on agency workforce.

Controls/Mitigation:

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.

Business Continuity response team triggered to lead on staffing shortages and service demands.
HR providing Wellbeing support to staff members
Regular communication on staffing reassignments being disseminated.

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.	Completed	17/04/2020	Jaki Lowe	26/03/2020
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	
Agency staff engaged to fill open staffing gaps Staff redeployments to areas high of service demand.	In progress	30/06/2020	Jaki Lowe	

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

Links to BAF risks

ID	Risk Title	Current Rating
3112	NHS Digital Assessments	6
3189	Organisational Culture does not support the vision	8
3190	Clinical Quality and Safety	8

Risk At Target

ID: **1438** Title: **Compliance with data protection legislation** **Lead: Ms Ros Preen** Division/Directorate: **All Directorates**

Description of Risk:

There is a risk that, the Trust may be impacted financially due to none compliance with Data protection laws by the Information Commissioner.

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.
The Trust continue to respond to FOI and SAR requests.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Actions are stated within controls				
All new FOI and SAR are being responded to within required timeframe.	In progress	23/06/2020	Ms Ros Preen	

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:

There is a risk care waiting times have increased especially in TEMS leading to failure to meet local or national targets as a result of poor data recording at operational level due to stretched staff and prolonged service disruption due to Covid 19 out break.

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.

Data continue to be reported and monitored through Datix system
Changes in national reporting and guidance being disseminated through IMT.
Restoration Plans developed
Technology is being used to examine patients, Attend from Anywhere.

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
Reported waiting time incidents continue to be shared with responsible service leads	In progress	30/06/2020	Mr Steve Gregory	

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:

There is an increased risk from a malware attack to the Trust IT Systems due to a high number of staff working remotely which may lead to data loss, disrupting business as usual and quality safety of care.

Controls/Mitigation:

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
Increased IT Desk Support presence

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Awareness spam email reminders are regularly sent to staff IT Support Desk providing support to staff remote working	In progress	30/06/2020	Jon Davis	

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:

There is a risk that, staff reassignments and high work load demands due to Covid-19 may impact negatively on quality of appraisals, assurance of staff competence, engagement and 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
Wellbeing support communication being disseminated to staff we are using daily communications to get out messages to encourage people to complete as and when it is appropriate We will monitor ongoing Supported training on MS teams so appraisals can be	In progress	30/06/2020	Jaki Lowe	

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 values of the Trust	9

Risk At Target

ID: **2000** Title: **Data Quality** **Lead: Ms Ros Preen** Division/Directorate: **All Directorates**

Description of Risk:

Due to operational and service reconfiguration as a result of Covid 19 clinical activity accuracy and reporting of Trust performance data my be impacted resulting in inaccurate costings and inadequate information to inform decision making.

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
Monthly communication reminder being disseminated to Department Heads to upload their performance numbers Departments continue to upload monthly data on Inphase.	In progress	30/06/2020	Ms Ros Preen	

Rating

	Initial	Current	Target
C	3	4	3
L	4	3	2
	12	12	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:

Due to stretched senior management requirements diversity and inclusion plans will be impacted resulting in weak and lack of protections for patient and staff falling within protected characteristics, damaging the Trust's reputation and failing to fulfilling legal and statutory diversity requirements.

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.
Continuous regular reporting to Committee and Board
National and local guidance being disseminated through IMT.

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
Follow up on implementation of accessible information with all staff teams	In progress	30/06/2020	Jaki Lowe	
BAME task force to look at best practice and emergent guidance.	In progress	30/06/2020	Jaki Lowe	
A STP BAME group has been established Re-estasblished the D&I action group and refreshed the commitments and actions during this phase		30/06/2020	Jaki Lowe	

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:

There is a risk that lone working, road safety and handling patients single handedly risks may increase due to high work demands as a result of Covid-19 outbreak.

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
Trust security team continue providing lone working advise to frontline staff
Clinical Service leads continue to provide support to front line clinical staff.
Microsoft Teams being used to communicate

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
Video calling with patients being used for consulting when there is no need for face to face clinical meetings.	In progress	30/06/2020	Mr Steve Gregory	
All lone working related incident data continue to be recorded for learning and improving service.				
Review and audit local policies and proced				

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
Recruitment agencies engaged
System restoration plans being developed

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				
Staff being reassigned from other services to provide cover Agency staff engaged to support and provide cover	in progress	30/06/2020	Mr Steve Gregory	

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:

Due to staffing pressures as result of Covid -19 end of life processes by multiple providers may be disrupted resulting in poor care, inability to access required services or equipment and patients not being treated in their preferred locations.

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.
Staffing reassignments providing cover
Agency staff filling staffing gaps.

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
New national and local guidance continue to be disseminated to staff	In progress	23/06/2020	Mr Steve Gregory	

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:

Due to operational service changes as a result of Covid-19, there is a risk that the Trust may fail to comply with Health and Safety requirements in Asbestos testing, Fire, Pressure Vessels, Water, Environment and Building condition resulting in poor patient/staff safety or enforcement action against the Trust for non-compliance

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.
Externally commissioned Trust Health and Safety review continuing
Estates Team continue monitoring H&S arising related issues

Additional Controls/Actions Required:

Actions	Progress	Due By	Done date
Health & Safety review has been commissioned which will incorporate estates arrangements.	Required H&S related risk assessments continue to be conducted.	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:

There is a risk that, prolonged business continuity disruption may impact NHS Digital data and cyber security.
On-Site Assessment plans resulting in failure to meet 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
IMT Team continue reporting on statutory requirements IMT continue to monitor quality of data and cyber security threats.	In progress	30/06/2020	Jon Davis	

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:

Due to Covid-19 there is an additional risk that the Trust may fail to maintain financial control and stewardship due to the failure to recover costs incurred in relation to Covid -19 response and the allocation of 2020/21 income and contracting planning.

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 financial performance.
Financial recovery meetings

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	4	3
L	5	4	3
	25	16	9

Monitoring Group

Resource and Performance Committee

Opened

23-April-2019

Links to BAF risks

ID	Risk Title	Current Rating

Risk Above Target

											commenced Sept 19 Confirm and Challenge meetings in place. Continue to capture and reporting COVID-19 costs to secure funding Determine how to put a case to NHSEI for a COVID-19 top-up payment, following the confirmation that our initial top-payment has been calculated as Zero. Assess the value of payments we will be expected to make to other NHS organisations. Maintain current financial controls and be prepared to propose changes to these if operational implementation or decisions are being delayed.

Risk Above Target

ID: **3329** Title: **Corporate Governance** **Lead: Stanley Mukwenya** Division/Directorate: **Chief Executives Office/Trust Board**

Description of Risk:

There is a risk that, high work load demands and multi-tasking as a result of Covid-19 by senior managers will reduce efficiency and impact on the Trust providing safe service impacting delivery of well led corporate governance systems effectiveness.

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		
Business Continuity Plan Incident response team IMT supporting and providing guidance to Managers and Service Teams Authority Matrix in place for decision-making during pandemic Corporate Risk register reviewed in light of Covid-19 impact	In progress	30/06/2020	Stanley Mukwenya	

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:

There is a risk that compliance with DPA 2018 GDPR information processing rules may be weakened due to high number of staff working remotely as a result of Covid-19 impacting security and handling of patient data and a fine to the trust in the event of a breach

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.
National guidance on Data Protection and Information processing being disseminated through Incident Management Team.

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
IG team continue to monitor Information processes All IG incidents continue to be reported	In progress	30/06/2020		

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

Risk Above Target

ID: **3503** Title: **Prison Pharmacy requires relocation** **Lead: Mr Steve Gregory** Division/Directorate: **Quality and Nursing**

Description of Risk:

There is a risk that, operational changes to the services as a result of Covid-19 may impact Stoke Heath Prison Pharmacy decision making on pharmacy workplace relocation which may result in failure to comply with a CQC recommendation .

Controls/Mitigation:

Only one prisoner is supposed to come to the gate at any one time which helps to reduce the risk, however, there are instances when distraction techniques are used which will increase the risk.

Discussions are in place with various companies with regards to the provision of new medicines cupboards. A new site has been identified for the pharmacy but a great deal of work will need to occur to enable this to happen.

21/05/2020 - Covid-19 is delaying this project. Further medicines incidents reported due to distractions within the pharmacy room. No defined date for completion of this project currently.
National guidance on prison services being disseminated through IMT
Agency staff to be engaged to cover any open gaps

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Pharmacy service continue to be provided at Stoke Heath Prison	In progress	30/06/2020	Mr Steve Gregory	

Rating

	Initial	Current	Target
C	3	4	1
L	4	4	1
	12	16	1

Monitoring Group

Opened
11-November-2019

Links to BAF risks

ID	Risk Title	Current Rating

Risk Above Target

ID: **3601** Title: **Community Hospital Medical Cover** **Lead: Dr Jane Povey** Division/Directorate: **Medical Directorate**

Description of Risk:

Due to COVID19 , medical cover at Community Hospitals has been extended to provide a 7 day service. There is a risk that this cover cannot be maintained due to demands on the service and availability of medical cover.

Controls/Mitigation:

Supply of out of hours cover from Shropdoc strengthened.
Cross cover of doctors and ANPs between community hospitals.
Discussions with SATH regarding strengthening handover arrangements during the Discharge to Assess process.

Additional Controls/Actions Required:

Actions	Progress	Due	By	Done date
Nursing staff to ensure clear care plan arrives with patients transferred from SATH to avoid unnecessary escalation to medical staff. Discussions with SATH to identify available resource for remote medical advice and support.	In progress	30/04/2020	Dr Jane Povey	
Nursing staff to ensure clear care plan arrives with patients transferred from SATH to avoid unnecessary escalation to medical staff Discussions with SATH to identify available resource for remote medical advice and support	In progress	30/06/2020	Dr Jane Povey	

Rating

	Initial	Current	Target
C	5	5	2
L	4	4	3
	20	20	6

Monitoring Group

Opened
14-April-2020

Links to BAF risks

ID	Risk Title	Current Rating

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	4 June 2020
	Agenda Item:	12
	Enclosure Number:	16

Meeting:	**Trust Board**		
Title:	**Strategic Developments Update**		
Author:	**Mark Onions, Business Development Manager** **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 (RPC)	26 May 2020	

Purpose of the report		
To update the Board on the significant progress that is being made to implement the strategic opportunities that have emerged from the response to the Covid-19 pandemic and as the System moves into the restoration phase, the Trust will build on the partnerships and new innovations we have made and introduced as we restart the programmes of work that were ongoing before this crisis.	**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

- Significant progress has been made with regards to the Trust response to the COVID-19 pandemic as we work as a strong system partner implementing new care pathways and services created to focus on responding to the needs of the patients across the whole system. New strategic opportunities have emerged, with more in the pipeline and aspects of these opportunities will continue to pave the way for strengthened partnership working, in particular with Primary Care in the future.

- As we implement the restoration phase we will eventually move to the recovery phase and we will stay engaged through these phases to ensure the best outcomes for our patients and service delivery.

- This position in relation to our engagement with System COVID response pathways have been reviewed fully by RPC

- Some suspended actions continue to delay aspects of delivery of our strategic objectives and vision. Suspended and partially suspended programmes and actions previously reported will be reviewed in June.

- The Board should note that a significant number of 'new' operational approaches born out of our response to the pandemic will move us towards our Trust vision and will have a positive impact on our delivery of our Strategic objectives of 'Transforming Services' and BAF risk assigned to Healthcare Systems when we return to the "new normal"

Key Recommendations

The Board is asked to:

- Accept the assurance provided on the progress made.
- 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	Yes	Well-led domain
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

4 June 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 the Board with an update on progress of a number of service developments which have come about as a result of the Covid-19 response that provide the building blocks for strategic opportunities.

It also provides the Board with an update on the LHRP structure which was shared with Board last month. It has been revised and developed to support the system/service restoration phase. The structure shown on the following page is accurate at the time of writing this report and may change yet again as we move through further phases to recover and reset services. It is important that the Board remains aware of this as this is guiding System decisions at the moment and the Trust remains party to and impacted on by these in certain areas.

This is with particular reference to our strategic priority of delivering our transformation plans and it's associated BAF risk which considers Health Systems risk .

All information contained within the report is correct at time of writing, 26 May 2020, updates and developments since that time will be provided verbally to the Board.

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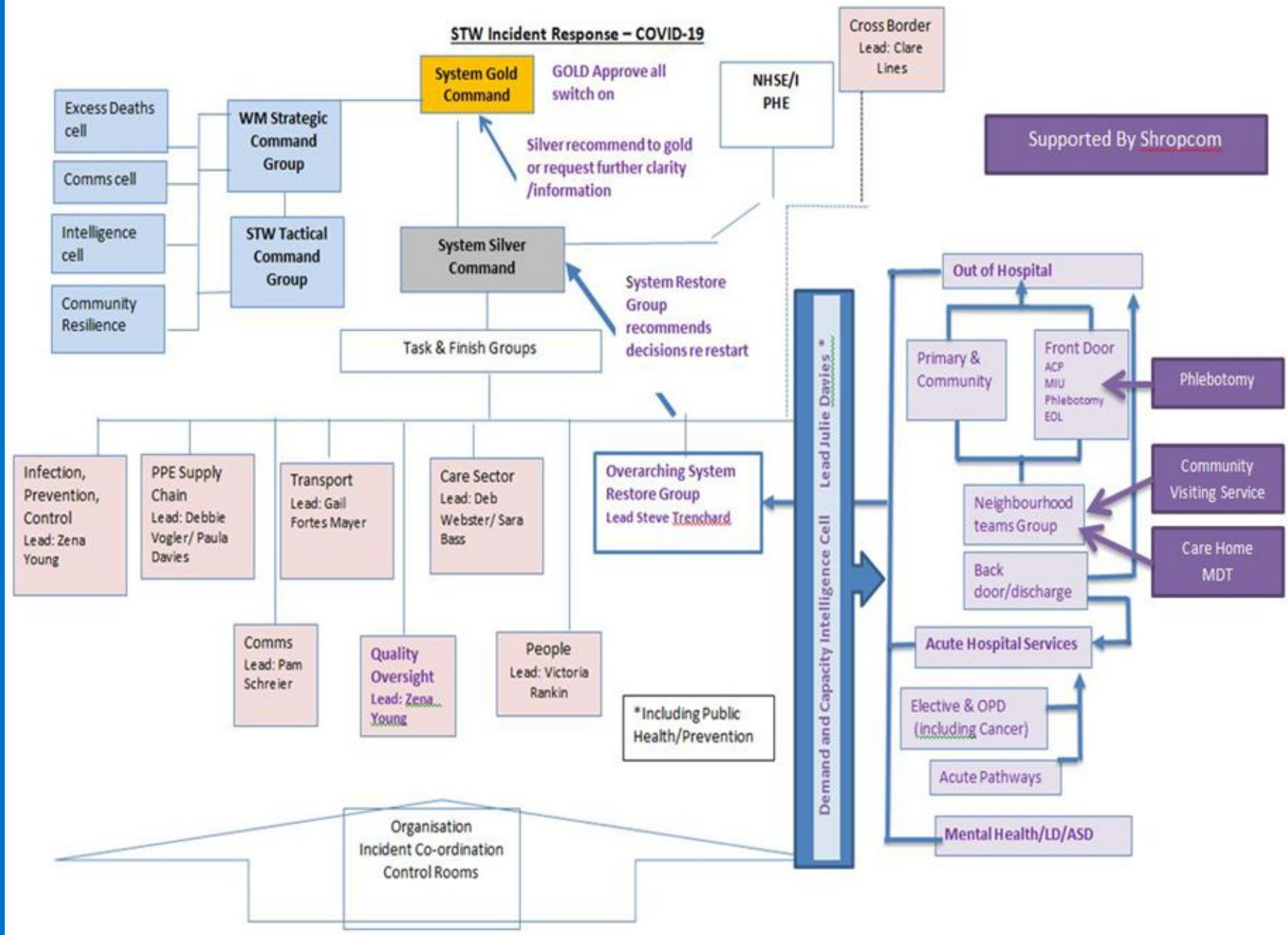
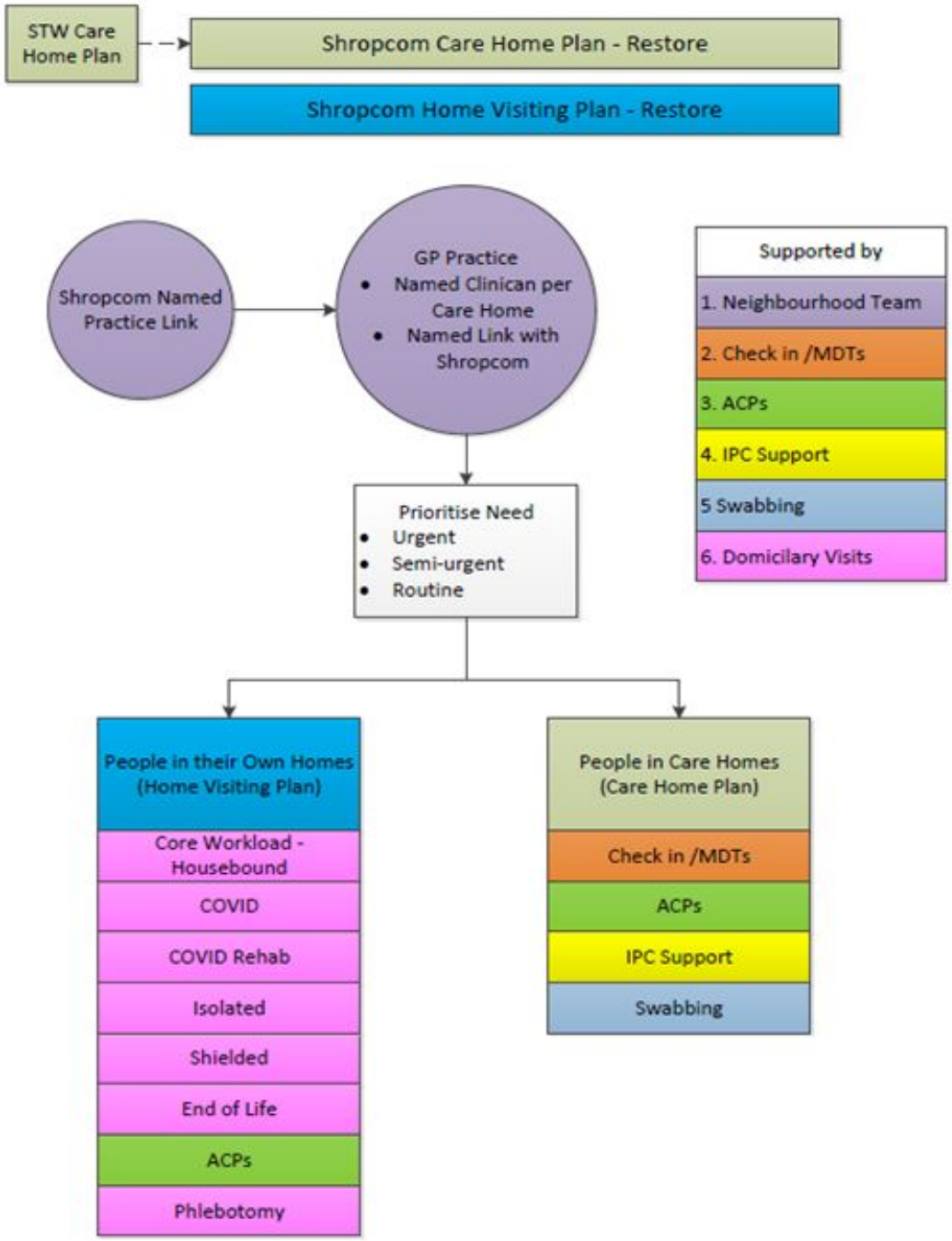

STW Incident Response – COVID-19
System Gold Command
GOLD Approve all switch on
Silver recommend to gold or request further clarity /information
Cross Border Lead: Clare Lines
NHSE/I PHE
Supported By Shropcom
Excess Deaths cell
Comms cell
Intelligence cell
Community Resilience
WM Strategic Command Group
STW Tactical Command Group
System Silver Command
System Restore Group recommends decisions re restart
Task & Finish Groups
Infection, Prevention, Control Lead: Zena Young
PPE Supply Chain Lead: Debbie Vogler/ Paula Davies
Transport Lead: Gail Fortes Mayer
Care Sector Lead: Deb Webster/ Sara Bass
Overarching System Restore Group Lead Steve Trenchard
Comms Lead: Pam Schreier
Quality Oversight Lead: Zena Young
People Lead: Victoria Rankin
*Including Public Health/Prevention
Demand and Capacity Intelligence Cell Lead Julie Davies *
Out of Hospital
Primary & Community
Front Door ACP MIU Phlebotomy EOL
Phlebotomy
Community Visiting Service
Neighbourhood teams Group
Care Home MDT
Back door/discharge
Acute Hospital Services
Elective & OPD (including Cancer)
Acute Pathways
Mental Health/LD/ASD
Organisation Incident Co-ordination Control Rooms

Shropcom's Care Home and Home Visiting Plan

- As the System moves into the Restore Phase of the Pandemic response, the Trust is supporting the "Out of Hospital" pathway groups that are part of the STW LHRP COVID-19 governance structure shown on the previous page. These include:-
  - Providing a Phlebotomy Service to vulnerable patients in our communities throughout the crisis
  - Providing support to Care Homes and their residents
  - Supporting our vulnerable patients in their own homes
- The Trust has created a plan to support the Out of Hospital Pathway (that feeds into the overarching system restore group) which focusses on Neighbourhood Teams, as a pre-cursor to re-instating the Care Closer to Home Programme in Shropshire and the Health and Social Care Rapid Response Team in Telford.
- These opportunities are in line with our strategic direction to Transform services in our Communities and we have focussed on the following:-
- Plan to Support Care Homes - In response to an NHS directive to support our Care Home residents, the Trust is working in partnership with our Primary Care colleagues and other specialists to provide a weekly check-in with each of the Care Homes in our county. This Multi-Disciplinary Team approach will enable health professionals to support Care Homes by providing advice around COVID-19 specific matters including PPE, infection prevention control and for individual patients identified as needing additional support or require an Advance Care Plan.
- Home Visiting Plan - Our domiciliary Teams are also supporting our vulnerable patients in their own homes by setting up a community visiting service that cares for our patients who are housebound and have, or recovering from, COVID-19 or they are shielding and/ or feeling isolated. We also ensuring that are End of Life patients still receive the best possible care in accordance with their wishes. As with residents in Care Homes, we are also working with GPs to prioritise those patients in their own homes that require an Advance Care Plan
- The graphic on the following page highlights the plan that the Trust has put in place to provide support to Care Homes and people in their own homes during this restore phase. Further details of these strategic opportunities are provided on 6,7 and 8


STW Care Home Plan
Shropcom Care Home Plan - Restore
Shropcom Home Visiting Plan - Restore
Shropcom Named Practice Link
GP Practice
Named Clinican per Care Home
Named Link with Shropcom
Supported by
1. Neighbourhood Team
2. Check in /MDTs
3. ACPs
4. IPC Support
5 Swabbing
6. Domicilary Visits
Prioritise Need
Urgent
Semi-urgent
Routine
People in their Own Homes (Home Visiting Plan)
Core Workload - Housebound
COVID
COVID Rehab
Isolated
Shielded
End of Life
ACPs
Phlebotomy
People in Care Homes (Care Home Plan)
Check in /MDTs
ACPs
IPC Support
Swabbing

Strategic Opportunities

1.1 Phlebotomy Service (Out of Hospital Pathway – Front Door Subgroup)

- An interim Phlebotomy service went live on Friday 1st May 2020 and continuing as part of the overall system Pandemic Response to the Covid-19 virus.
- The aim is to continue to provide vulnerable patients access to the service and protect patients from coming into contact with the virus. This is intended to provide essential blood tests only to guide diagnosis or management decisions for acute presentations or unstable ongoing conditions which cannot be postponed without causing significant harm to the patients.
- Shielded patients (highest risk of contracting Covid-19) have been identified by GP practices and are receiving either a domiciliary service provided by SCHT community nursing teams or through the 'super-cold' site at St. Michael's Clinic for Shrewsbury GP practice patients staffed by St, Michael's Clinic nurses with experience. Redeployed staff are providing additional capacity for the domiciliary service and SaTH Phlebotomy are available should further staff be required.
- Four 'Cold' sites (Bridgnorth Hospital, Whitchurch Hospital, Euston House(Telford), The Lantern (Shrewsbury)) have been set up with staffing provided by SaTH operating an appointments only service. These are for Non Shielded patients and are open to any asymptomatic/well patients usually accessing SaTH drop-in or Community Outreach clinics.
- Very few children requiring essential blood tests at the moment, but for those children seen by a Telford & Wrekin GP, the usual service is being provided by the Shropcom Community Children's Nursing Team. For all other children not requiring to shield/not on warfarin, children are referred to SATH and being seen in dedicated appointment clinics.
- In addition to this, the Community Children's Nursing Team have increased their service provision to provide home visits to those children who are shielding with the exception of those receiving warfarin. Those children on warfarin are being managed within SaTH.

1.2 Community Visiting Service (Out of Hospital Pathway – Neighbourhood Team Subgroup)

- A collaborative Community Home Visiting service is being developed to support shielded patients during the covid-19 pandemic. Primary care and community nursing are coming together to have a shared and consistent approach to supporting these patients and delivery the appropriate care through home visits.
- A prioritisation scale has been developed, trailed and agreed to ensure both primary care and community teams use the same scale, replacing the previous RAG ratings which were not aligned. This ensures accurate prioritisation of the patient to enable timely treatment and therefore negating risk. SCHT IDTs have all moved to using the new prioritisation scale.
- Video links are being trialled to enable access to a GP or GP practice staff remotely. This enables three way consultations. Initial trials are giving positive feedback in both access to care and advice and patients willing to participate; however this does mean that the GP or Community nurse attending the patient is required to facilitate the video link as well as the visit. This will continued to be monitored by the Neighbourhood Teams group.
- Outcomes based on activity are being explored in order to assess the demand and capacity going forward. Other measures are also being developed to ascertain the benefits of this project and identify risks that can be flagged up to the group overseeing this new way of working.

1.3 – Care Home Multi Disciplinary Team (Out of Hospital Pathway – Neighbourhood Teams subgroup)

- NHS guidance issued on 1st May to primary care and community health providers to support care home residents during the pandemic focussed on 3 main aspects
  - Weekly check-ins by GPs and Community Trust with Care Homes
  - Supporting the development and delivery of Advance Care Plans (ACPs) for Care Home Residents
  - Provision of pharmacy and medication support to care homes
- Of the 3 areas identified above, Shropcom is supporting:
  - Weekly check-ins - This is making good progress and Shropcom staff have been identified to join MDT meetings. Meeting have been arranged for introductions with GPs, methods of recording this activity is being explored with RiO config team. This has been delivered in the Telford and Wrekin area for some time, so the focus will be on the Shropshire Care Homes.
  - Development of ACPs – Work is underway to implement a new ACP Framework which is being introduced system wide across Health and Care Home Providers. A toolkit including guidance and documentation is being finalised to ensure a consistent approach is adopted across the whole system. Training needs are being identified for Health and Care Home staff and we working with partners to develop and deliver the training package. Metrics being developed with system partners and engaging with our RiO config team to ensure we are able to capture and report metrics relating to Trust interventions / activity.
- Shropcom are also providing Infection Prevention Control (IPC) training support within Care Homes. 2 named individuals from Shropcom will work in partnership with other System providers to support the roll out of the IPC training within the Care Homes.
- This is demonstrating good partnership working with Primary Care which will pave the way for PCN development in the future.

Other Developments of note : putting things in place to respond to Covid 19 and ensure we have appropriate arrangements to cope with the Shropshire wide restore and recover phase

1.4 - 7 Day GP Cover

- This Shropcom initiated **extension** to the support service provided by GP's into our Community Hospitals has been in place since 1 April. It was identified early on in our considerations to managing the care required during the Covid 19 pandemic that we needed to enhance the GP cover into our Community Hopsitals. This was true for the initial phases of the changes to care and also remains the case as services are starting to be put back into place across all sectors of healthcare.
- All Community Hospitals have 7 day medical cover with the exception of Whitchurch which already runs an Advanced Clinical Practitioner model and therefore have a combination of medical, Advanced Care Practitioner and nurse consultant cover. The following table shows hours that have been negotiated.

Community Hospital	Additional Hours contracted	Hours Provided by Shropdoc
Ludlow	08.00-18.00 Mon - Fri 18.00 - 22.00 Mon to Fri every week 08.00 - 22.00 Sat to Sun every week	Medical support 22.00 - 08.00 Over the phone and in person
Bishops Castle	7 day medical cover 08.00 - 22.00	Medical support 22.00 - 08.00 Over the phone and in person
Bridgnorth	4 hour session Saturday 4 hour session Sunday	Medical support 18.00 - 08.00 Over the phone and in person
Whitchurch	Full day Medical/ACP cover 08.00 - 18.00 1 vist per weekend day & telephone cover 08.00 - 18.00	Medical support 18.00 - 08.00 Over the phone and in person

- We can now report that all GP contract letters have been signed and returned by GPs/practices and all are working well together to ensure service provision. Individual letters to Trust Staff providing cover at Whitchurch hospital advising them of the arrangements has also been sent out.
- The incremental cost per month for this arrangement is approx £20k. We are finalising the processes to pay Practices as this depends upon which GPs have covered shifts etc, however currently all additional costs are being recovered through the National processes in place to recover Covid 19 related costs and do not currently expose the Trust to any financial risk or pressure.
- An initial 1 month review meeting took place where it was agreed the service would continue with a 2nd review meeting taking place on or around 17 June.

1.5 Integrated Care Record (ICR)

- The ability for our clinicians to use an ICR has been part of System discussions for a long time. It is a key digital enabler that supports a significant step towards patient record management for integrated care in any setting.
- The response to Covid-19 has served to escalate these discussions and a firmer view has recently been established to actively consider deploying the technical solution/system in place in Staffordshire here in Shropshire.
- We are a key partner of the System ICR Project Group who are developing the thinking and recommendations to support this.
- A business case, a benefits case and implementation plan are all being progressed through this group but they are not yet firm or final. Once it is we will consider them through our Committees/Board.
- We have offered to lead the technical deployment and consolidation of IG arrangements subject to further due diligence.
- Opportunities for external funding are being explored with the Regional and National NHSx teams but not outcome has been reached yet.
- Progress is being reported to Gold Command and we will update Board as appropriate.

The ICR is a key development that supports our aspirations both in terms of our Clinical and Quality Strategies but also our Digital Strategy and our overall Trust vision so this is really important to us.

This information is being provided to update the Board on how the Trust is working with partners to transform integrated care and alert the Board to an issue that will require further scrutiny and decisions that will have a financial and resource impact in the near future.

Questions to Shropshire Community Trust Board Meeting of 4th June 2020

I wish to submit the following comments/questions for consideration by the Community Trust Board Meeting of 26th May. I request that these are considered under Agenda Item 12 (Questions or Comments from Members of the Public). These questions arise following recent experiences at Ludlow Hospital.

1. My understanding is that Shropdoc is used to provide out-of-hours (OOH) medical cover for community hospitals via separate contractual arrangements, which ended a couple of years ago. A media report suggests a long-term contract ending in September 2016 and an interim contract ending in January 2018. Is this history correct?
2. Why did previous contractual arrangements for out-of-hours medical cover to community hospitals end?
3. Is it correct that out-of-hours medical input to community hospitals is now via the standard Shropdoc OOH GP service, with no additional protected resource? If not, please explain current arrangements.
4. Is it still the case that the Shropdoc GP OOH provision consists of one GP providing face-to-face patient contact across Shropshire, Telford and Wrekin with a second GP responsible for telephone triage?
5. There was, for a time, a different arrangement for medical input to Whitchurch Hospital. Is this still the case?
6. What risk assessment(s) took place prior to the reduction in out-of-hours medical cover to community hospitals? Did any risk assessment(s) include specific consideration of the impact on palliative care patients? Can I have a copy of the risk assessment(s)? Please include information relating to the ending of former contractual agreements in September 2016 and January 2018 *and* the overall Shropdoc GP OOH service reductions that took place in October 2018.
7. Are there routine audits of the adequacy of OOH medical input to community hospitals? Can I have copies of these? If these audits have not taken place, why not?
8. Anecdotally a friend has also commented that, 'Yes, I heard about the same thing happening to someone at home very recently'. I am aware of several reports of palliative care patients left in pain after Shropdoc services changed in 2018, but the Shropshire CCG view has been that that those issues had been resolved. Are there routine audits of the adequacy of current OOH GP provision, including provision for palliative care patients? Can I have copies of these? If these audits have not taken place, why not?
9. I know of previous disagreements between Shropshire CCG and Shropdoc/the Community Trust on a need for increased funding to ensure improved Shropdoc provision. What was the outcome of these discussions?
10. Finally, repeated promises were made to the public that the Shropdoc service reductions of October 2018 would be followed by a '6 month review'. Repeated requests to the CCGs for publication of the outcome have taken us nowhere. Has the review outcome now been made publicly available? If not, will it be? When?

I understand that I am asking for a level of detail here. I hope, given the circumstances, that your response will be a courteous and informative one.

Many thanks
Gill George
24th May 2020

Shropshire Community Health
NHS Trust

Enc. 1

Minutes of a meeting of the Quality & Safety Committee
Thursday 23rd April 2020 – 9.30 a.m. – 11.30 a.m.
Virtual meeting via Microsoft Teams

Present	Peter Featherstone, Non-Executive Director (Chair) (PF) Steve Gregory, Director of Nursing & Operations (SG) Tina Long, Non-Executive Director (TL) Cathy Purt, Non-Executive Director (CP) Jaki Lowe, Director of People (JL) Claire Lea, Corporate Secretary (CL) Alison Trumper, Deputy Director of Nursing & Quality (ATr) Liz Watkins, Head of Infection Prevention Control (LW) Susan Watkins, Chief Pharmacist (SW) Angela Cook, Head of Nursing & Quality Adults (AC) Jo Gregory, Head of Nursing & Quality – C&YP (JG) Mike Carr, Deputy Director of Operations (MC) Sara Hayes, Head of HR and Workforce (SH) Dr Mahadeva Ganesh, Associate Medical Director - deputising for Jane Povey (MG) Julie Harris, Head of Safeguarding (JH)
In attendance	Nuala O'Kane, Trust Chair (NOK) David Stout, Chief Executive (DS)
Apologies	Jane Povey, Medical Director – annual leave
Minute taker:	Diane Davenport, PA to Director of Nursing & Operations (DD)
Guests:	

Minute number:	***Agenda Item title***	
2020/04/01	The Chair welcomed everyone to the Quality & Safety Committee meeting via Microsoft Teams. PF explained the format of the meeting and there is a presumption that papers will have ben read, so please ask questions as directed by the Chair.	
2020/04/02	**Apologies** (Agenda Item 2) Apologies were noted from Jane Povey, Medical Director and Dr Ganesh attended on her behalf.	
2020/04/3	**Executive Director of Nursing Awards** (Agenda Item 3) Tara Ashley, Locality Clinical Manager Central Shropshire Gail Hooper, Dudley School Nurse Team Leader SG will notify the staff of the Award, forward the certificates by post to the recipients for March and April, and share via the usual communication methods. The Committee congratulated the staff on their Awards and suggested that a celebration event could be considered for a future date.	
2020/04/04	**Declarations of Interest** (Agenda Item 4) No new declarations of Interest.	

Shropshire Community Health NHS Trust

2020/04/05	**Minutes of meeting held on: 19th March 2020** (Agenda Item 5) The draft minutes of 19th March 2020 were approved as a true and accurate record of the meeting.	
2020/04/06	**Matters Arising – Action log** (Agenda Item 6) The Committee reviewed the Action Log, updates were provided on each of the actions due, and the Action log updated.	
2020/04/07	**Quality Performance Integrated Full Report** (Agenda Item 7) Friends and Family Test (FFT) comments – it was noted that some of the comments relating to Whitchurch Community Hospital are still quite negative and can the Committee be confident that progress is being made. AC commented that there have been some senior nursing issues at the hospital and these have been resolved and starting to see changes on the Wards. **Action: Provide an update and assurance that the Action Plan at Whitchurch Community Hospital is delivering the appropriate improvements. September 2020.** The Committee noted the good progress with Pressure Ulcers and good to see and well done to everyone involved. AC noted that there are only 4 Pressure Ulcers and not 12 as per the report and will amend prior to the report going to Board on 7th May 2020. TL asked if the Trust are in a position yet to understand the impact of Covid-19 on the 18 weeks Referral to Treatment (RTT) performance. MC explained there is more data available that the Committee are not sighted on with regard to RTT and as from next month, additional data will be included in the report. As yet, it is too early to determine the effect of Covid-19 on RTT and work is ongoing to review the impact and undertaking actions to mitigate against the current circumstances. Working with Informatics and looking to develop a methodology on how long to take to recover, however with no end date then difficult to determine what the effect will be. **Action: The Performance report to be altered from May 2020 to incorporate additional RTT data. Provide an update on recovery post Covid-19.** The Committee requested assurance on Safeguarding in the current climate and if there has been an increase in referrals. JH noted that there are no more referrals than this time last year. MG commented the only challenge is families are on lockdown, no school and risk factors are there. Working with Local Authority, Education Authorities and Family connect. **Action: JH to provide a report for the May Committee on Safeguarding and to include detail on response time, type of referral and to provide assurance that Safeguarding issues are being addressed.** The Chair commented that the report provides assurance to the Committee on the quality and safety of our clinical services. Further areas for learning is in relation to learning from Covid-19 and returning the services back to normal and come to the fore when start to recover from this.	**AC/ATr** **MC** **JH**
2020/04/08	**Quality & Safety Committee – Covid 19 Update** (Agenda Item 8)	

	SG provided a summary of the report, which includes an oversight of the organisations response to coronavirus, including the business continuity planning, incident management and staff redeployment and wellbeing. Prior to the lockdown in March, the Trust focus was on Covid-19 and were reviewing the Business Continuity Plan and how to deliver services differently. A range of meetings are held on a daily/weekly basis, both internal and SG Chairs the Incident Management Team daily virtual meetings. DS also attends when he can and will escalate any issues on behalf of the Trust to the Gold Health system call. The Trust have tried to maintain as many services as possible and reviewed if services could be stopped, partially stopped or continued in line with Business Continuity. NHSE/I issued Novel Coronavirus (COVID-19) Standard operating procedure: Community Health Services, providing guidance on services that could be stopped, partially stopped or continued. The emphasis is to maintain the safety of both patients and staff. There are no significant challenges for the Trust with PPE and ensure swabs are available for testing and sufficient gowns available. The Trust have received updated guidance on RESUS, there was a difference between RESUS, and PHE guidance and the Trust are following the RESUS guidance. PF asked how are the Trust in the wider Health System sharing information in relation to PPE. SG commented that a daily report is submitted on all stock at the Trust and shared across all sectors and mutual aid to other organisations. Staffing – sickness level is being maintained and self-isolation is declining. There have been Covid-19 related deaths in the Community Hospitals; however, there were attributing underlying conditions and patients were under the End of Life pathway and dealing with high level of frailty patients and providing pastoral support. NOK commented that she was assured by the comments with regard to PPE, however with regard to staff wellbeing and perception, have staff raised any anxieties with regard to PPE, are staff feeling well, and protected. SG noted that no member of staff have raised any issues with regard to PPE kit not available. SG has spoken to staff with regard to PPE and home visits and when to wear PPE. SG shared with the Committee that together with the Head of HR and Workforce, they have a weekly call with Staff side representative. DS also undertakes a weekly video call to answer staff questions. Daily Coronavirus bulletins are issued to staff, which include advice on wellbeing for staff and support available to assist with any anxieties and resilience. JL shared with the Committee that currently looking at resilience support available to teams who are working remotely and support to Line Managers. Counselling is available and engagement with clinicians and linking with Regional/National work. CP asked how staff are coping with the transfer of SaTH Urgent Care Centres (UCC) to the Community Hospitals and is appropriate cover provided. MC	

	commented that the SaTH UCC services that have transferred to Community Hospitals are still managed by SaTH. Bridgnorth Community Hospital – activity overall has increased and staff from SaTH are staffing their own areas. Data shows low levels of activity at Whitchurch Community Hospital and more activity at Bridgnorth Community Hospital and still running Minor Injury Units (MIUs). There are currently no staffing issues. From CQC perspective, SaTH are running the services under their licence. AC commented that SaTH staff have shared that they have felt welcomed at the Community Hospitals. PF referred to a recent report that NOK shared and is there an impact on complexity of patients. SG commented that the number of patients in Community Hospitals is typically less and bed capacity is 97 patients and 70% occupancy at present. Patients are more frail and seeing more people on EOL pathway and some patients Covid 19. Pressure not in physical numbers but in complexity of patients. SG commented that over 300 staff have been trained who can be redeployed if required. TL asked if patients who are being cared for in their own home have their complexities changed. AC noted that patients are detoriating quite quickly and starting syringe drivers earlier. SG commented that the Trust are looking after more patients who are shielding as GPs working differently and may be intervening and redeployed staff to assist. TL referred to the partial stopping of services and the impact and how are the risks being managed and planning for start-up when that happens. SG noted that currently reviewing data of the services and what might look like if restart service and implications to the work and some not allowed to do. It could take 12-18 months to return services to their full operational capacity. PF asked if the Trust are confident that a robust Audit trail of decisions made is being kept and there is a lot in the press about future claims being made and is this an area of concern for the Trust. SG noted that all decisions/actions are monitored and recorded and include rationale for the changes. Claims will probably not be an issue for the Trust. **Action: To provide an update on Covid-19 recovery and working differently and include detail on Attend Anywhere and details of audit trail and how decisions were made.** The Committee had a robust conversation and assurance was provided regarding actions and decision in relation to Covid-19.	
2020/04/09	**Board Assurance Framework and Corporate Risk Register – Covid-19 Update**(Agenda Item 9) This report outlines the impact of the Covid-19 pandemic on the Trust's corporate risk register (CRR). The approach taken to reviewing risks has been discussed at Board and has resulted in a new Board Assurance Framework entry relating specifically to the	

	Covid-19 pandemic and an agreement that all risks on the CRR be reviewed and refreshed to take account of the pandemic's impact. There are four risks for the Committee's consideration the remainder of the risks on the register are still under review. One of the risks is a new risk 3601 – medical cover at community hospitals. All four risks have been reviewed to acknowledge the impact of Covid-19 and their risk scores increased. New controls and mitigations have been included to support the Trust in achieving its target risk score. Board Assurance Framework – no new Risks.	
2020/04/11	**Infection Prevention Control Update** (Agenda Item 10) LW provided a summary of the key points of the report. • In the period January-March 2020 the Trust has had 0 MRSA bacteraemias • In the period January-March 2020 the Trust has had 0 *Clostridium difficile* infection (CDI) detected 3 or more days after admission to the Community Hospitals against a threshold of no more than three cases for the year. • Due to the current situation regarding Covid-19, the MRSA screening data for was unable to be verified in February and March. However, in January the Trust had achieved a score of 97.40% against the 97% MRSA screening threshold TL commented on the good performance and in the current climate how will ensure performance is maintained. LW explained that 2 members of the IPC team have been redeployed to Community Hospitals and AC at Whitchurch Community Hospital to ensure senior nursing presence available and to answer staff questions. PF asked for assurance re the Legionella work and if there is any Risk currently. LW explained that the Legionella work continues and if there is a risk then steps are in place to mitigate the risk.	
2020/04/11	**Policies: For Endorsing/Approval** None	
2020/04/12	**Risks/Assurance** No new risks identified.	
2020/04/13	**Any Other Business** None	
	Date of Next Meeting Thursday 21st May 2020 – Virtual meeting on MS Teams	

Shropshire Community Health NHS
NHS Trust

Enc 1

Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 24th February 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)

In Attendance: Alice Horton, PA to the Director of Finance and Strategy (AH) – Minute Taker
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)
Mike McDonald, Associate Non Executive Director (MMC)
Rob Goodrich, Procurement Lead (Agenda Item 6.2 only) (RGO)
Mark Mawdsley, Head of Costing and Contracting (Agenda item 7.2 only) (MM)

Apologies: Ros Preen, Director of Finance and Strategy (RP)
Julie Southcombe, Patient Representative (JS)

Minute number:	***Agenda Item title***	***Action***
2020/02/211	**Declarations of Interest** (Agenda Item 3) HD welcomed every-one to the meeting. There were no new declarations of interest noted.	
2020/02/212	**Minutes of the Previous Meeting** (Agenda Item 4) Minutes from the previous meeting were approved.	
2020/02/213	**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.'* It was noted that a paper is to be presented in part 2 of the meeting. Action closed. 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.'* HD noted that it had been agreed that the Procurement Strategy would be deferred due to a combination of factors. SL to confirm a realistic date for the paper come to Committee and board, but it was noted that this action had been open since November, and there was a need to get the strategy in place. Action ongoing. Action 99 – *'MC to circulate a more detailed TeMS recovery plan to bridge the gap between current performance and planned performance.'* The TeMS report was included on the meeting's agenda. HD observed that it would have been helpful to have the recovery plan circulated prior to the meeting. Action closed. Action 100 – *'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 confirmed that	

	the paper was going to Quality and Safety Committee (Q&S) next month. CP and SG confirmed that this had been raised at Q&S. Action 101 – *'AC to ensure the recovery plan is requested for inclusion with the February Performance report.'* This was included as appendix 4 of the performance report. Action closed. Action 102 – '*RGR to take legal advice regarding non-trust owned properties and compliance reporting.*' RGR confirmed that he has had no written response back. Action ongoing.	
2020/02/214	**Work Plan** (Agenda item 5.2) The workplan was reviewed and approved, and HD agreed that the committee would review the 2020 plan at the next meeting. SG queried if it would be beneficial to build an update around STP into the workplan TF observed that this would be included as part of the Service Development report. **SG and TF to discuss a brief STP update report to come in future.**	**SG/TF**
2020/02/215	**Monthly Performance Report** (Agenda Item 6.1) AC presented the performance report and noted the proposal from Sara Hayes (SH) detailed in appendix 4 regarding unbooked leave. AC observed that RP has noted her support of this. It was agreed that the metric recognised by AC and SH will be used in future. AC raised the IG recovery plan as IG training is most material recovery plan in regards to DPST. AC observed that the real issue is strengthening commitment with staff as the training is not onerous and it is difficult to find a viable reason why this is not done. There have been technical issues with the training not saving the pass rate, but there are workarounds for this so this is not a reason for non-compliance. MC observed that he and Gill Richards had had a detailed discussion around areas of focus and that there is a big push on this through the locality managers to help the end of February position, and going forwards there is the need to pick up training earlier to prevent it coming due in times were areas are under pressure. SG suggested asking the Director Of People to think about how the Trust could implement the pay award going forwards in regards to mandatory training non-compliance. **SG to discuss the application of pay awards and mandatory training compliance with Jaki Lowe, Director of People. JL to bring a report to Q&S SG to update to RPC.** HD observed that next year there needed to be a focus on temporary staffing, especially given challenges, and noted it would be helpful to see the cost difference in the future. **Cost difference around Temporary Staff to be included in the performance report.**	**SG** **AC**
2020/02/216	**Procurement Update/Strategy** (Agenda Items 6.2 and 6.3) RGO attended the meeting to present the report. HD observed that this paper was very helpful, and congratulated RGO and his team for their efforts. It was discussed whether a more	

	challenging CIP target could be set for the new Financial year and RGO observed that the same target had been set for 20/21, and this will be tougher to meet. RGO observed that the Trust had received a new spend comparison tool that shows spending against other providers, and through this, RGO had observed that the opportunities for the trust were not large. RGO noted the need to be smarter and to collaborate with other trusts to achieve the target. SG queried how the Trust was benefiting with collaborating with the Shropshire and Telford Hospitals Trust (SaTH). RGO observed that the ability to buy in bulk with SaTH is compromised as the Trusts buy different items, but RGO confirmed that the Trust do collaborate on basic items and benefit from combining spend. RGO observed that the Trust were looking into collaboration further afield, and discussions are ongoing with other organisations. There was a discussion around whether the Trust having a warehouse would help with costs, and it was suggested that a cost benefit analysis could be done. It was confirmed that there was no capacity to use equipment stores, but could be tied into that discussion as the Trust are looking at the current accommodation. JG observed that he had had a discussion around supplying continence products with a supplier, but they couldn't beat NHS Supplychain delivery prices, so it is unlikely that the Warehouse would reduce cost. **RGO to lead work to produce a Cost Benefit Analysis for a Trust Warehouse, to be brought back to the committee for review.** Managed Print Services were discussed and HD queried if RGO was confident that it will happen in March. RGO confirmed that the final testing is taking place this week and that he was confident technical issues have been resolved. AC noted that he was not as confident as RGO that it will be completed by end of March. This implementation had been discussed at the CIP meeting and the Trust had lost the CIP from this scheme for this year, but that the Trust will get a full year's saving if it's up and running from April. SL observed a number of learning points from this project, and confirmed that a Post Project Evaluation should be taken to BRG when the scheme is up and running, which should show what the delay has meant and what could have been done differently. The Wheelchair Service Database tender was discussed and RGO observed that this will make the service more efficient and effective through job planning and deliveries being controlled differently. MMC queried section 4 of the report regarding non contract spend and asked for the year on year comparable figure. **RGO to find and circulate the non-contract spend for 2019 for comparison.** CP queried the increase in different suppliers and whether this was a good thing. It was confirmed that this may be higher than expected for a trust this size and it was suggested that a review should be undertaken to look for detail.	**RGO** **RGO**

	RGO undertake more analysis regarding different suppliers and ensure there is no duplication and include as an appendix in future reports. RGO left the meeting.	**RGO**
2020/02/217	**TeMS Recovery Plan** (Agenda Item 6.4) MC presented the report and noted that they have challenged the service around this year's contribution. The message is that the service will not achieve the financial plan this year, but do have recovery plan. HD observed that the Committee had recognised last month it was unlikely the service would hit its target and had been given assurance that would. HD requested earlier notification around contribution the future to allow for earlier mitigation and to reduce last minute pressure on finance. MC agreed that this was reasonable and that the Service had learned from last month regarding how strong the subcontracting and reporting arrangements are, which is important learning for the new MSK service. It was noted that the performance was substantially better than last month however. MMC noted a sub-contractor's impact on the under-performance and there was a discussion around options for full cost recovery going forwards. MC confirmed that the Trust would be putting options to them to see if the Trust can recover costs from the sub-contractors. MMC suggested that the Trust need a penalty clause for non-compliance. TF acknowledged this and noted the new MSK service will have joint accountability through the alliance. HD thanked the team for their effort.	
2020/02/218	**Finance Report, Month 10** (Agenda Item 7.1) HD observed that the CIP programme is progressing well and congratulated JG and team. He observed that the Agency costs are still concerning, however. JG confirmed that the Trust is on target to hit the control total and discussions are already going on for next year. Next year the Trust has a significant CIP target, which will be a big challenge as much of the savings this year will continue to be non-recurrent, so there is a lot of pressure to bring it into line. CP raised the CIP schemes and noted her concerns around the level of recurrent to non-recurrent savings. CP requested assurance around what is being done to generate more recurrent savings and approach schemes with another level of detail. JG noted that last year, the team went through detail by line to see if any of the savings were in the same areas and therefore could be counted as recurrent, but unfortunately the savings are all in different places. JG confirmed that this work was being undertaken again for this year. SG agreed with CP that the non-recurrent delivery was concerning and the trust needed a different view and to work systematically. SG suggested reviewing and rebasing the budgets, as well as identifying big ticket items as a board. SL noted that that corporate areas had been targeted with higher CIP target to protect frontline areas, but it was agreed that there are certain areas where spend is too high/income is too low. RGR observed that this would fall into transformation and needed to involve RP. It was agreed this would be	

	discussed further in part 2. **March RPC Agenda to include have a deep dive into CIP to identify the big challenges.** PP raised the agency spend as this was £90,000 over plan and noted that the figure budgeted for Agency is always tiny, so the agency spend is always over plan. PP noted that the Trust have made strides around cutting agency, but queried if the Trust was being too ambitious. MC observed that agency was one of the things that has contributed to spend over plan so, looking forwards, there has been a different approach to high value posts, so the Trust is already better off next year, but the nursing cost will need to have a reasonable target and will be monitored outside of budgets. There was a discussion about risk of the capital expenditure and meeting the plan for the year. The Trust is still planning that this will be hit. SL agreed that there was a challenge to spend this in the last few months, and confirmed that the delay had been created by the programme change. It was noted that section 1.8 asks for a number of approvals, 2 of which had been approved virtually outside of the meeting. Another request had been made to replace a roof in 2020/21. This scheme was approved by committee. RGR observed that the spend on the William Farr Meeting Room refurbishment had been reduced following the discussion at the previous meeting. It was noted that this was something that needed doing as the meeting rooms are used constantly, and this scheme could be done in year if approved at the committee. The members approved the amended plan. MMC queried the NHSPS debtors**.** **SL and MMC to discuss NHSPS debtors outside of the meeting.**	**HD/SL** **SL/MMC**
2020/02/219	**Contract Monitoring Report** (Agenda Item 7.2) MM attended the meeting to present the paper. HD noted that this was a very useful paper. MM highlighted that in regards to contract performance there had been a very small variance against target which masks a couple of issues; the Trust is underperforming for welsh commissioners as the Trust is seeing less inpatients due to their conscious attempts to repatriate, which is being offset by over performance in Shropshire. TeMS is also showing a small underperformance compared due to some specific staffing issues. MM observed that this is likely to recover to stay in line broadly with target, but will depend on staffing. MM also raised the CQUIN risk; the antimicrobial CQUIN is high risk, and while nationally there had been a change of guidance for the first quarter, there has been not further communication from NHSE since. While the Trust is showing a loss for Q3 this is an improving position and the Trust would qualify for part payment. MM observed the main concern is the 20/21 contract and the Trust is in negotiation with commissioners. There is a meeting that SL, RP and SG will attend and MM noted it was usual at this stage to have areas	

	of disagreement. The Trust will be referring to the STP financial plan, as all of the organisations have signed up for this, which includes demographic growth and investment in community services. MM drew the committee's attention to the publication of reference costs which is generated through a national cost collection exercise and aggregated up to create efficiency index. After adjustment the Trust came out with index as 101, meaning that the Trust is just marginally more expensive than the average. It was noted that this was an improvement from last year. HD queried if any contracts are coming to an end and MM noted that one might be extended for a year. It was confirmed that the Trust had been notified that we will not get pay award funding for the Local Authority, which is a cost pressure the Trust didn't expect. These contracts will be reviewed and taken to BRG initially, and escalated if necessary. PP raised the lack of signed SLAs. It was noted that these were mostly around smaller agreements with other trusts and there are payment processes in place, so this is not seen as high risk. MM left the meeting.	
2020/02/220	**Budget Setting Report** (Agenda Item 7.3) JG presented the summary paper. It was noted that more detail is being done across teams, and this will be brought back to this committee, then to board next month for approval. JG drew attention to a couple of risks, but this process is on track for next month.	
2020/02/221	**Service Development Report** (Agenda Item 8.1) TF presented the report, and flagged the STP workstream clusters and final slide STP priorities to the committee for their information. TF noted that there was a Care Closer To Home Stakeholder workshop on the 26th February and the trust had 6 representatives from operational and clinical teams there to take part. TF confirmed that the MSK alliance has been approved by the transformation board across the system, but also noted that the Trust had not been successful for the stroke expression of interest. There is a system wide push on transforming stroke services.	
2020/02/222	**Digital Services Exception Report** (Agenda Item 9.2) AC presented this report and updated regarding the HSCN and the completed upgrade to the EPR system. It was also noted that e-dictation was being reviewed by the Childrens and TeMS services.	
2020/02/223	**BAF Risks** (Agenda Item 10) These were reviewed by the committee. HD noted that the Risk associated with EU exit needed to be updated. CP suggested that the lack of signing of SLAs should be included and SL confirmed that the risk of the lack of SLAs is recorded as part of the directorate risk register and is part of the well led action plan but is not of a high enough risk to be reviewed as a BAF risk. SL asked JG/MM to the review rating with the Head of Governance to update the risk registers as appropriate.	

	HD queried if it was still appropriate to have an IM&T/Digital Strategy that went on for 5 years given the frequency of technology changes. It was noted that this was reviewed frequently and updated, but that the 5 year horizon is useful for most big infrastructure projects, and other technologies are included as they get adopted.	
2020/02/224	**Benefits Realisation Meeting Minutes** (Agenda Item 11.1) Reviewed and approved by the committee.	
2020/02/225	**Digital Programme Group Minutes** (Agenda Item 11.2) Reviewed and approved by the committee.	
2020/02/226	**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) • No new assurances **Any Comments on the Committee's effectiveness** (Agenda Item 12.3) • No comments made.	
2020/02/227	**Any Other Business:** (Agenda Item 13) No further business was raised.	
Date and time of next Meeting: Monday 23rd March, 10.00 am – 1.00 pm		

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Chair – Harmesh Darbhanga

…….
Date – 23/03/2020

Shropshire Community Health NHS
NHS Trust

Enc 1

Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 23rd March 2020 at 10:00am
Virtual Meeting, Held Via Conference Call

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)

In Attendance: Alice Horton, PA to the Director of Finance and Strategy (AH) – Minute Taker
Robert Graves, Director of Facilities and Estates (RGR)
Ros Preen, Director of Finance and Strategy (RP)
Tricia Finch, Head of Development and Transformation (TF)
Mike Carr, Deputy Director of Operations (MC)
Julie Southcombe, Patient Representative (JS)
Phil Stringer, Patient Representative (PS)
Julie Houlder, Company Secretary (JH)
Nuala O'Kane, Chair (NO)

Apologies: Steve Gregory, Director of Nursing and Operations (SG)
Mike McDonald, Associate Non Executive Director (MMC)
Jonathan Gould, Head of Finance (JG)
Andrew Crookes, Head of Informatics (AC)

Minute number:	***Agenda Item title***	***Action***
2020/03/278	**Declarations of Interest** (Agenda Item 3) Given the virtual nature of the meeting, HD confirmed that assumption for the meeting is that everyone has read all the papers and that the group would move straight to question. It was also agreed that al the recommendations from each paper and actions would be recapped at the end of each session.	
2020/03/279	**Minutes of the Previous Meeting** (Agenda Item 4) Minutes were reviewed and approved as an accurate record of the meeting.	
2020/03/280	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) 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 of the March Trust Board.'* SL noted that the Procurement team have been pulled off their usual work to support with the preparations for Covid-19, so she recommended that the Trust recognise this as a paused piece of work for now. It was agreed that this decision would be reviewed at the June Resource and Performance Committee. NO confirmed that the Trust was prioritising the workload due to the extraordinary times the NHS is currently facing, and SL agreed to keep checking in on procurement and let them know they have the committee's support. Action to be delayed until June 2020. Action 100 – '*MC to take a report to Q&S around Delayed Transfers of Care'.* MC confirmed that this paper has been written, but that this didn't go in March due to a shortened agenda. MC confirmed the paper will go at the next possible opportunity. Action remains open.	

	Action 102 – *'RGR to take legal advice regarding non-trust owned properties and compliance reporting'.* RGR confirmed that Capsticks are drafting the wording to insert into leases as well as long list of compliance documents. Update to be brought to the next meeting, action remains open. Action 103 – *'SG and TF to discuss whether a brief STP update report should come to committee in the future.'* SG not present at the meeting so it was confirmed this would be brought to the next meeting. Action 104 – '*SG to discuss the application of pay awards and mandatory training compliance with Jaki Lowe and bring a report to Q&S'.* – AH gave an update from Sara Hayes, Head of HR and Workforce. It was confirmed that for staff who were in post before 01/04/2019 have to meet the Trust's criteria to progress to the next pay point, but their auto-increments are still switched on in ESR. For new starters to the Trust or promotions after the 1st April, progression is not automatic on ESR and they have to meet the nationally set criteria, which includes completing all statutory and mandatory training, before their approver manually triggers their pay progression. From April 2021, this will apply to all staff. Action closed. Action 105 – '*Cost difference around temporary staff to be included in the performance report'* – RP confirmed that after the last committee there had been a decision to adjust the performance report, but these updates have not yet been applied. RP confirmed that the cost difference would be included as part of these updates and would be seen next time. Action is closed. Action 106 – '*RGO to lead work to produce a Cost Benefit Analysis for a Trust Warehouse, to be brought back to committee for review'.* SL observed that a trust warehouse was not a high priority piece of work. PP noted that he considered the subject to be of some importance and it was agreed that this should be kept as an action for update in 3 months' time. RP suggested that, due to the current climate, the Trust is going to have a new experience with logistics, so it would be very important to review logistics as a whole. Action delayed for 3 months. Action 107 – '*RGO to find and circulate the non-contract spend for 2019 for comparison'.* – SL confirmed that this work had been circulated almost immediately after the last committee meeting and that the action can be closed. Action closed. Action 108 – *'RGO to undertake more analysis regarding different suppliers and ensure there is no duplication and include as an appendix in future reports'.* SL confirmed that this information was to be included in the Procurement report scheduled for the May meeting. Action remains open. Action 109 – '*March RPC to include a CIP deep dive*'. It was confirmed that this is on the agenda, so the action is closed. Action 110 – *'SL and MMC to discuss NHS debtors outside of the meeting.'* SL confirmed that she and Mike had not yet had the discussion, but she has emailed information to him. Action closed.	

2020/03/281	**Work Plan** (Agenda item 5.2) The workplan was reviewed and approved for 20/21.	
2020/03/282	**Monthly Performance Report** (Agenda Item 6.1) RP took questions on the report. HD raised the 78 members of staff who have outstanding Information Governance Training. RP updated that in regards to IG there was a recovery plan in place, but since then there has been a new understanding around relative priorities. The Information Governance Toolkit submission has now been nationally deferred to end of September, which reduces some of the pressure. RP confirmed that the only thing that would have been an issue would be the training compliance, but the Trust had been close to hitting the target before it had to mobilise for the Covid-19 outbreak. While RP confirmed that the Trust will continue to emphasise the importance of training, the guidance has nationally has alleviated some of the pressure for clinical staff during the outbreak. **Committee to review the Trust's position in regards to the Information Governance Toolkit in June ahead of the submission in September.** HD also raised un-booked leave as this had been previously discussed at RPC. RP noted that the un-booked leave is shown in more detail in appendix one, and the trust is 4% away from its target. RP noted that that this was one of various performance metrics that need to be looked at corporately in a new performance dashboard to give a better line of sight due to Covid-19, along with leave and sickness, and Delayed Transfers of Care (DTOC). RP suggested that these performance indicators could be grouped up to tell us what going on from a corporate perspective and could be escalated to board. **Coronavirus/Covid-19 Performance dashboard to be collated and escalated to Board as appropriate, with emphasis on DTOC, un-booked leave, sickness absence etc.** MC confirmed that the Operational team is looking at these indicators daily and there have been a number of incidences of people cancelling annual leave to support the operational effort. MC observed that the organisation could consider staff 'selling' untaken annual leave and this cost could be badged against the operational cost for coronavirus to prevent leave being carried into the new financial year. MC confirmed that the Trust is looking every day at the percentage of available staff, which shows where the Trust is on daily basis. DTOC and the impact on services was discussed and MC confirmed that the Trust did see a significant increase in February and early March 2020, primarily at Whitchurch. MC confirmed that this had reduced considerably, and that in relation to Covid-19 there was new guidance around discharge to free up beds. HD noted his concerns that patients should not be moved before they are fit to do so, and MC confirmed that the team has no intention at present to discharge patients if they don't have proper care packages as there are currently beds available in the hospitals.	**RP** **RP/AC**

	NO observed that she had read the new hospital discharge requirement document and noted that this would substantially speed up the process as it takes out a number of steps the Trust are normally required to follow; for example, there is no requirement for us to wait for care packages before discharge. JH noted that this document is on the executive agenda for discussion tomorrow (24/03/2020), but also observed that it is a directive, not guidance, so the trust is obliged to adhere to it. NO remarked that, the Board will want to know impact, but agreed that it is a service requirement and will fundamentally change how the Trust manages patients. **Directive regarding discharge to be discussed at the Executive Team meeting and communicated to Board on Thursday (26/03/2020**	**SG**
2020/03/283	**Finance Report, Month 11** (Agenda Item 7.1) SL observed that there has been a change in position since the paper was written, but the Trust is expecting to deliver the control total for the revenue forecast outturn, but this is reliant on ensuring that all costs relating to Covid-19 are reimbursed. SL confirmed that there are procedures in place, and that there is a return going in today. HD raised the impact of Covid-19 on the capital programme, as there had been a high amount of planned spending in March and it was queried whether Covid-19 may delay some schemes. RGR assured the committee that there was only one potential area where may have a problem, and so there was only a slight risk of underspending on capital. RGR stated that he was not expecting large impact as the Trust is nearly in the position it needs to be. PP also highlighted the capital expenditure as this has been flagged for a number of months due to the programme becoming back-ended from the move of expenditure from IM&T, but agreed it was positive to hear the programme is progressing as expected. RGR noted his concern was that if social distancing is more strictly enforced the builder's merchants may be forced to shut. RGR has flagged this risk to NHSE so they are aware. This was agreed as a risk for the Trust's capital plan. SL observed that there has been an impact on reporting arrangements; due to Covid-19 the Trust have been informed that the introduction of IFRS 16 has been delayed. SL explained that it had been expected that this new financial reporting standard would come into effect on 1 April 2020 but there are lots of changes to guidance at the moment. HD queried the implications of this and the arrangements for the future year. SL confirmed that the team will continue to monitor this as the Trust move into the new financial year. HD flagged Agency spend and queried if the Trust are still on target. SL confirmed that the trust is below the NHSI ceiling, but above internal trajectory. HD queried that, with staff self-isolating and sickness, was there an anticipated spike in cost and therefore are the Trust still likely to achieve this position. SL explained that if the Trust does see an increase in agency due to Covid-19, the Trust can reclaim costs, so this does not pose a risk to the bottom line. In information shared with the Trust there is still an expectation that the organisation will be using the agency rules, but the Trust is significantly below ceiling set by regulator and will not breach that in	

	2019/20. MC confirmed that there has been no spike in agency cost and one is not expected in March, but this may change over the next 3 months (April/May/June 2020. MC noted that as the Trust start to manage positive patients the Trust will prefer to use internal staff, as there is a better assurance. HD queried if agency staff are still available, and MC confirmed that the trust has not lost accessibility. PP drew attention to the favourable position for the centrally held budgets and clarified if these were planned to be used up in the year-end forecast and it was confirmed that this was the case. The committee accepted the recommendations and took assurance that the Trust are still on track for the year-end control total. An additional risk was noted around the Capital expenditure if the Builder's Merchants were closed due to Covid-19.	
2020/03/284	**Budget Setting Report** (Agenda Item 7.2) SL observed that this paper will also be presented to the Board at the next meeting for approval, but noted that opening budgets will need to be amended to reflect the new guidance being released. SL confirmed that the opening budget has been drafted in line with the information brought to the committee so far and shows c.£100,000 surplus in line with our element of the system plan. SL noted that she would like the Committee to recommend this to Trust Board for approval, noting that when new finance and contractual regime is understood the budgets will require amendment but it is important for us to have an opening budget in place. CP confirmed that she considered this to be a sensible way forwards as the Trust doesn't know what's going to happen with new arrangements. PP agreed, but also noted his concerns around the large CIP target being carried forwards. The Committee agreed to recommend the budget as it stands for approval at Trust Board.	
2020/03/285	**Service Development Report** (Agenda Item 8.1) TF noted that as far as the planning aspect is concerned, everything is now changing and the process has been suspended, but the Trust are still actively involved in the STP programmes. While the STP is likely to reprioritise and key programmes are likely to change, the programmes remain open, and, at this moment in time, everything is still on track. TF noted that the conversations around the MSK Alliance are fruitful; an Alliance board, with all partners involved, has been set up and the full service will go operational on the 1st September in line with existing contracts. HD clarified that the programme will be managed through programme management and TF confirmed that the Trust will go through best practice for any changes. CP observed that the Trust may become the lead provider and noted the need to capture all the costs if this is the case, as there will be probably additional costs to undertake the role. RP agreed that this will be undertaken, but the current approach is that all the providers	

	are contributing; and while our trust has been chairing and lending admin support to the Alliance Board, the Robert Jones and Agnes Hunt (RJAH) have put forwards PMO support.	
2020/03/286	**BAF Risks** (Agenda Item 9) The BAF risks were reviewed and it was noted that they captured the issues raised at the last meeting. RP reflected that the risk that might require extra consideration in context of Covid-19 is the Optimising Use Of Technology risk due to the new level of support required for staff, especially the clinical workforce and how technology could protect staff. It was confirmed that the trust is not prepared for this yet, but it is on the agenda. RP confirmed that Jon Davies, the incoming Head of Digital Services, will be looking at these risks. RP confirmed that the risk has not changed, but the descriptors need to be looked at in the current context. **Stanley Mukwenya and RP to review and amend the Optimising Use of Technology BAF risk terminology for the next committee to reflect the impact of Covid-19. JH to discuss/support Stanley with this.**	**RP**
2020/03/287	**Benefits Realisation Meeting Minutes** (Agenda Item 11.1) These were reviewed and approved at Committee.	
2020/03/288	**Digital Programme Group Minutes** (Agenda Item 11.2) These were reviewed and approved at Committee.	
2020/03/289	**Risks/Assurances:** **Risks Identified at the Meeting or Key Items** (Agenda Item 12.1) • Risk regarding the capital expenditure programme if Social Isolation requires the closure of the builder's merchants. **Assurances given at the meeting of internal control/risk mitigation effectiveness** (Agenda Item 12.2) • Assurance received regarding the year end position. **Any Comments on the Committee's effectiveness** (Agenda Item 12.3) • No comments made.	
2020/03/290	**Any Other Business:** (Agenda Item 13)	
Date and time of next Meeting: Monday 27th April, 10.00 am – 1.00 pm		

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Chair – Harmesh Darbhanga

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Date – 27/04/2020

Shropshire Community Health NHS
NHS Trust

Enc 1

Minutes of a meeting of
PART I - RESOURCE & PERFORMANCE COMMITTEE
Held on 27th April 2020 at 10:00am
Virtual Meeting, Held Via Microsoft Teams

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)

In Attendance: Alice Horton, PA to the Director of Finance and Strategy (AH) – Minute Taker
Robert Graves, Director of Facilities and Estates (RGR)
Ros Preen, Director of Finance and Strategy (RP)
Claire Lea, Company Secretary (CL)
Nuala O'Kane, Chair (NO)
Jon Davis, Head of Digital Services (JD)
Mike McDonald, Associate Non-Executive Director (MMC)
Jonathan Gould, Head of Finance (JG)
Clare Harland, PMO – observing
David Stout, Chief Executive

Apologies: Tricia Finch, Head of Development and Transformation (TF)
Julie Southcombe, Patient Representative (JS)
Phil Stringer, Patient Representative (PS)
Mike Carr, Deputy Director of Operations (MC)

Minute number:	***Agenda Item title***	***Action***
2020/04/291	**Declarations of Interest** (Agenda Item 3) PP stated that he had a new declaration of interest as he is now involved with a company that recruits volunteers, but observed that this should not bring him into conflict with the Trust.	
2020/04/292	**Minutes of the Previous Meeting** (Agenda Item 4) These were reviewed and approved with no amendments made. Signing the physical copy of the minutes was deferred to post-covid-19 to maintain social distancing.	
2020/04/293	**Monitoring of Action Log from the previous meeting** (Agenda Item 5.1) HD thanks AH for her amendments to the action log to separate the open, closed and deferred actions to increase clarity. Actions 91, 102, 100, 106, 108, 111 and 124 were all deferred to June due to the ongoing Covid-19 situation. Action 103 – *'SG and TF to discuss whether a brief STP update report should come to committee in the future'* – SG observed that the update for this meeting included a recommendation to close as this information comes in the Service Development Report. The meeting confirmed that they were happy with this approach. Action closed. Action 105 – '*Cost difference around temporary Staff to be included in the performance report.'* – RP observed that she had sent an update prior to this meeting recommending action closure as the information is available in the finance report and including the information in the Performance report would cause duplication. Action closed.	

	Action 112 – '*Coronavirus/Covid-19 Performance dashboard to be collated and escalated to Board as appropriate, with emphasis on DTOC, unbooked leave, sickness absence etc.'* RP confirmed that this report was on the agenda for today. Action closed. Action 123 – '*Service Directive regarding discharge to be discussed at the Executive Team meeting and communicated to Board on Thursday (26/03/2020).'* SG confirmed that this had been brought to board and discussion had taken place. RP confirmed that this will continue to be monitored through the Service Development Report. Action closed. Action 124 – '*Stanley Mukwenya and RP to review and amend the Optimising Use of Technology BAF risk terminology for the next committee to reflect the impact of Covid-19. JH to discuss/support Stanley with this.'* It was confirmed that the outcome of this was reflected in the Risk Report on the agenda, and that there is a separate paper on the agenda responding to the BAF risk on Optimising Technology. Action closed.	
2020/04/294	**Work Plan** (Agenda item 5.2) The committee reviewed the Work Plan and HD observed the need to streamline reporting during the covid-19 outbreak. It was discussed whether some of the reports due in May could be deferred safely. HD suggested that the Procurement Update could be deferred to reduce pressure on the Procurement team as they are facing increased challenges due to Covid-19. RGO noted that while the Procurement team are very busy, he felt it was important for the committee to see what they are working on as well as bringing committee members up to speed on stock status and the new terminology. RGO confirmed that he had started preparing paper for May to share and would be prepared to present in May to stay in line with rest of the quarterly reports. **Procurement Report to remain on the Workplan for the May committee meeting.** It was also suggested that the Digital Services Exception Report could be reduced to a quarterly basis. RP observed that she would not object to this paper being modifying to a quarterly paper as the Digital Programme Group (DPG) review the plan monthly and the DPG minutes are brought monthly to the committee for review. **Digital Services Exception Report to come next to the June 2020 committee meeting and from then to come quarterly.** CP queried if the Service Development report was required monthly if the Trust were not taking on new services. RP agreed that she was happy to consider adjusting the timing for the Service Development report, but there are things in rapid development at the moment that may need to be escalated swiftly. RP suggested the report could reduce to bi-monthly as this will also be monitored at Benefits Realisation Group (BRG) which will give monthly oversight. DS observed that if it's not clear when items need to be brought back to committee it could be kept as a standing item, but only have a paper report when something material occurs. HD and CP supported this.	

	Service Development Report to be maintained as a standing item on the RPC agenda, but as a verbal update unless there is an item of specific importance that requires a paper. SL also suggested that the Contract Monitoring Report could be presented for information and questions only as it will be a record of 2019/20. 2020/21 contracting is currently suspended so items would only be picked up by exception.	
2020/04/295	**Monthly Performance Report** (Agenda Item 6.1) Jon Davis, Head Of Digital Services, was welcomed to his first Resource and Performance Committee (RPC). The Committee considered the performance indicators for COVID and it was confirmed that everyone had seen the updated appendix. HD observed that from a Non-Executive Director (NED) perspective, this was regularly reviewed at their weekly meeting. HD stated that he found the dashboard very helpful, but suggested it could be improved by giving a comparison of the numbers from the previous week to see the Trust's progress. RP agreed it was important to get a sense of movement and trends, and observed that it might be necessary to familiarise members with the live version of the dashboard as this allows a view of the last few days/weeks. DS agreed that the PDF does not allow that level of interaction and it was agreed that there needed to be a degree of development. It was agreed that this would be discussed and developed outside of committee to find the most practical route, but noted it was good feedback, and also good to know that members were finding the report useful. CP observed that she particularly liked the dashboard and found it really helpful to give a sense of time/place. MMC commented that he too found the dashboard very useful, but would comment that all timescales for this (and other graphs) need to be consistent and appropriate for comparison and meaning, especially if they are presented in a 'static' format. **Appendix 1 – Covid-19 indictor Dashboard to be discussed outside of the meeting and the best way of showing a comparison to be considered and piloted for the next meeting.** RP queried if there was anything in regard to the Covid-19 dashboard from a risk or assurance perspective that the committee wanted to discuss and HD reiterated that this had been discussed at the NED weekly meeting. CL recommended that as the weekly meeting was not a formal session it would be important to verbalise areas where the NEDs had taken assurance so it can be recorded through committees. HD observed that the NEDs had taken assurance on the level of sickness and Covid-19 related sickness, as well as the number of hospital community beds occupied. CP observed that they had also discussed suspended services and the disruption this caused. DS agreed that the report does provide assurance, but suggested that it should include a list of things the Trust is currently not doing; for example showing patient waiting times. DS queried how this was being reported back as the dashboard mainly shows a positive	**RP**

	outlook. RP observed that the access to services needs to be standard, and that the Referral to Treatment (RTT) performance will be tracked to see the consequences. It was observed that the RTT performance was now at 67% due to elective outpatient services being suspended and it was noted that when the services are brought back on line, this needed to be tracked to ensure the Trust is returning to standard. CP observed that this had been discussed at Q&S quite deeply. **Waiting list/RTT tracking indictors to be added to the Covid-19 dashboard.** RP noted that the Trust submitted the Data Protection and Security Toolkit (DPST) information at end of March. The Trust had been allowed to defer, but took the decision to submit as a compliant submission could be put in. RP observed that this was included within performance report in the Information Governance Training appendix. RP noted that, while the indicator is red and apparently off track, the Trust training rate had been sufficient to be compliant. It was confirmed that the Trust will continue to work on IG training, but that this was a positive sign. HD agreed that this was good as this had been discussed at committee the last few months.	**RP/JD**
2020/04/296	**Estates Report** (Agenda item 6.2) 2 questions were received from PP and resolved by RGR prior to the meeting; *6.2 Estates (p.32)2.d. Whitchurch, Bridgnorth, and B.Castle Oxygen Supplies - Oxygen risk of being more flammable – please quantify risk and explain how this is being actioned?* *RGR response prior to meeting; That will be a ward environmental risk assessment based on high levels of oxygen. Effectively if a high level of oxygen therapy is being undertaken then ventilation may have to be increased (open the windows). Community hospitals are not using high levels of oxygen as this surge has been below what was possibly envisaged so oxygen therapy has been in acute settings and never been required at any level in sub-acute, so the risk is low.* *6.2 Estates (p.36)7.2 Estates Rationalisation - Hortonwood premises – timetable re lease renewal v. possible purchase?* *RGR response; This remains complex. The longer term possibilities are being considered as part of the overall estates strategy and would include discussions with commissioners.* This question was discussed further. PP agreed that it would be sensible to have a purpose built operation on a different site. RGR confirmed that this forms part of the longer term planning and would involve discussions with the CCGs. HD raised the Ludlow water and queried that, although the end result was positive, is there anything that can be done to prevent it happening again. RGR noted that options were limited as the Ludlow site is owned by NHS Property Services (NHSPS). RGR noted that there is also a report coming back regarding Oswestry, as this is also owned by NHSPS.	

	There was a discussion around the lease work for the STP and the 'new normal'. It was observed that, now the Trust is using Microsoft Teams to virtually attend meetings and there is more homeworking, a number of buildings are quite empty. RGR noted that he and Jaki Lowe, Director of People are working together to see how the Estates and the use of staff people could be different which will be brought back in 2-3 weeks' time. HD queried moving forwards and DS noted that there was a Shadow ICS Board being held this week and he expected that there will an initial conversation about how Shropshire will manage as a system and how services will carry on in the short term. DS noted that once the approach is agreed, it will also be discussed as a Trust. HD observed that under normal circumstances this could be discussed at a Board Development session and DS agreed that the Trust Board could still use meetings and development sessions for these discussions, acknowledging that this would be more difficult in a less physical environment. NO agreed the Board should take a view. NO observed that Covid-19 had given the Trust a glimpse of what future could look like, which would require proper consideration when the organisation is not responding to the crisis. NO noted that the Board should be tasking execs to start work within the STP and bring back to the Board in for final decisions. **RGR to report back on potential opportunities linked to new ways of working. This is an existing action, relating to the Agile Working Strategy, which is due back to the Committee in June.** HD noted that the Estates capital is underspent and queried how the Trust is catching up. RGR confirmed that the majority of delayed schemes are now back in progress and the decision has been made to keep progressing as long as the work does not impact on the wards. RGR confirmed that SG has been supporting with this. HD questioned how the Trust is ensuring contractors are keeping safe and RGR confirmed that full risk assessments are being done. HD queried if the contractors should be tested before they are allowed on site. RGR confirmed that this had not been discussed and SG confirmed that there is the capability to do this, but queried the rationale if risk assessments are being done. HD also raised the Euston house lease and queried if the Board members had any strong opinions about this lease. NO noted that all buildings should be considered to ensure best use of resources.	**RGR**
2020/04/297	**Finance Report, Month 12** (Agenda Item 7.1) *Question received from PP prior to the meeting;* *7.1 Finance Report(p.53) 4.1.2 Draft Annual Accounts Submission - re. Presence on site if required, is this seen as an event affecting deadlines?* *SL confirmed that external audit will have a lengthened period to review the accounts as their deadline had been extended to June as part of the national guidance. SL observed that the external auditors will be working off site.* HD thanked SL and JG for a job well done with bringing the budget in better than expected, noting that it had been a difficult year. HD	

	observed that the CIP target was very challenging, but had been achieved at year end, although this remained a big task going forwards. HD observed that the cash balance remains strong and noted that agency cost remained below the national ceiling. HD recorded the committee's thanks to the teams involved. SL observed that it had been a joint effort across the trust, but thanked HD and confirmed that she would pass the committee's thanks onto the team. CP raised the development of the CIP programme. SL noted that this will continue as far as possible but there is currently no operational input and that, under new arrangements for 20-21, efficiency requirements are suspended for April to July. SL observed that there was also learning to be gained from the current situation, for example; using technology differently, as Attend Anywhere has now been introduced at an STP level and this will need to be picked up through the recovery phase. CP reiterated the importance of considering how to move from £1.1 million non-recurrent CIP to recurrent savings. HD raised the Covid-19 costs, and observed that part of the 'new normal' will require new ways of working. HD observed that many of the Trust's offices are open plan, and queried if it would be worth planning ahead for those staff that need to come back to offices e.g. buying shields between desks etc. SL confirmed that when the time is right and staff return, adaptations can be considered but if the requirements incur financial costs, the expectation is that they would be charged to national Covid-19 budget. RGR observed that some staff won't come back for some time and it may require continued social distancing through teams. CL noted that, at the minute, the Trust has access to the basic functionality of MS teams, which has been made available to the NHS during the outbreak, and that this may not continue long term. CL observed that it was a wider issue than just making sure offices are safe, it was also important to learn from remote working, and consideration should include the Teams licence and training. **HD to raise a longer term Board discussion around Recovery And Restoration.** DS observed that the Trust had received all Covid costs claimed, so it is likely the Trust will get reimbursed for reasonable spending and that the process is working at a national level. MMC queried if the Trust suspect that there will be a deeper analysis of COVID claims at a later date. SL responded that she thought the Trust could expect additional review and that the Trust are intending to ask Internal Audit to look at this at the appropriate time. The committee reviewed the requested approval for £150,000 capital spend on replacement hardware. SL confirmed that this had been approved at Capital And Estates Group as part of a rolling programme for replacement of hardware. The committee approved this spend.	**HD**
2020/04/298	**Service Development Report** (Agenda Item 8.1) RP presented the report, and noted that the Trust had had to rapidly react to a range of decisions. The Benefits Realisation Group (BRG) has looked at the project dashboard to give the Committee and Board	

	oversight. RP observed that a number of things are suspended but that there is also more work coming through, so the dashboard gives awareness of all programmes the Trust are working on. RP also noted that this also includes decision making status, so it is clear to the Committee where decisions have been made. HD observed that the Care Closer To Home (CCTH) programme has been suspended and queried the impact as it is one of the STP's main priorities. RP observed that there is a section on new developments at the end of the report, and noted that the NEDs will be aware of the new schemes including; MIU, Attend Anywhere, Discharge To Assess, Integrated Care Record and 7 Day GP cover. RP confirmed that there would be more will added to the dashboard, but that all of those things are coming through a new governance route due to Covid so there are new areas of focus that could become replacements to the current STP programme. HD queried if there was anything that could result in the Trust ending up further away from developing CCTH and RP noted her opinion that the current work moves in same direction; pushing ahead on integrated care and the technology to support and if the STP could capitalise on this progress it may be more productive. HD queried if the Trust have the right scale of staff to take on the new programme and RP confirmed that the Trust do generally, but it will be important to keep an eye on capacity. RP observed that relationships have opened with partners and that the situation has built trust and confidence. NO observed that this has been an opportunity allowing organisations to implement things rapidly. NO observed she considered the dashboard useful. CP agreed with NO, but questioned that, if the Occupational Therapists (OT's) are now going to be mainly in the community under discharge to assess, would this delay getting patients out of hospital. RP and SG confirmed that this wouldn't delay discharges from hospital as the interventions can still be carried out. CL observed that RP had made reference to her input and flagged up why it is so important to see where decisions are being made as this will provide an audit trail for the future. DS observed that the point was well made especially if this could be kept live and accurate.	
2020/04/299	**Optimising Use of Technology BAF Risk Update** (Agenda Item 9.1) JD presented the report and noted that the IT Team have been ensuring structures are in place to support remote working, and that Microsoft Teams is being used widely across the Trust. JD also noted he was pleased to see that Attend Anywhere will go live on Friday for live patient consultations and will rolled out across the trust. HD raised the remote working and VPN technology and queried what challenges had been overcome. JD noted the difficulties around bandwidth, and that the Team are looking at how to improve use and streamline access. The IT team are managing to provide the service staff expect. JD observed that Teams has been integral for virtual meetings, and he would like to build a picture of how Teams is being used. HD also flagged up cybersecurity and queried how the Team is to minimising breaches. JD noted that this has been raised on national calls and has been raised as risk until processes can be put in place.	

	RGR observed that the Trust is using an abridged version of Teams and it was noted that using the full version is being discussed, but needs to be part of the NHS Digital discussions. It is unlikely that there will be a step back to how the teams were working before. CP thanked RP and the Digital Team for their work on behalf of the committee as they have done an incredible job. DS agreed that their efforts should be recognised as phenomenal. RP stated that she was very proud of the team with regard to keeping workforce safe and business continuity. RP raised the need to be mindful of a potential risk that the Trust may have to pick up the costs of the national arrangements later on. DS observed that the risk of the financial costs of digital hitting the trust may be counterbalanced as the Trust should be able to make savings by rationalising estates. CL queried that, given the success the Trust had had around optimising technology, was the risk still accurately scored or closer to target rating? JD noted that significant progress had been made, but there are other factors, and a holistic view needed to be taken on the Digital Strategy. **Optimising Use of Technology Risk to be considered further at DPG on 30/04/2020 and fedback to the Committee.** CL stated that the support for the Board and Committees has been much appreciated as well as the wider staff. MMC also noted that the remote approach has strengthened focus on the provision of assurance through the revised formats in papers, dashboards etc. and agreed it was a great piece of work by the team. NO agreed.	**RP**
2020/04/300	**Benefits Realisation Meeting Minutes** (Agenda Item 10.1) The minutes were reviewed and approved by the committee.	
2020/04/301	**Risk Report** (Agenda Item 11.2) CL observed that this paper set out the changes to the risks and was to provide assurance that this is the approach the Trust is taking to evaluate current risks.	
2020/04/302	**Risks/Assurances:** **Risks Identified at the Meeting or Key Items** (Agenda Item 12.1) • Nothing new but there was greater recognition of where projects were being suspended, and this was covered on corporate risk register. **Assurances given at the meeting of internal control/risk mitigation effectiveness** (Agenda Item 12.2) • **Any Comments on the Committee's effectiveness** (Agenda Item 12.3) •	
2020/04/303	**Any Other Business:** (Agenda Item 13) HD thanked every-one for their attendance and contributions.	
Date and time of next Meeting: Tuesday 26th May, 2.00 pm – 4.00 pm		

……. **…….**
Chair – Harmesh Darbhanga **Date – 26/05/2020**

Enclosure 1

Minutes of the Audit Committee meeting held on Tuesday 7th January 2020 at 13:00pm at Room K2, William Farr House

Present:	Harmesh Darbhanga (Chairman)	Non-Executive Director
	Mike McDonald	Associate Non-Executive Director
	Peter Featherstone	Non-Executive Director

In attendance:	Claire Lea	Corporate Governance Consultants
	Sarah Lloyd	Associate Director of Finance
	Grant Patterson	External Audit, Grant Thornton
	Mary Wren	External Audit, Grant Thornton
	Greg Rubins	Internal Audit, BDO
	Gurpeet Dulay	Senior Audit Manager, BDO
	Stanley Mukwenya	Head of Governance and Risk
	Alison Trumper	Deputy Director of Nursing and Quality (for item 5.3 only)
	Terry Feltus	Local Counter Fraud & Security Management Specialist (for items 6.4 & 6.5 only)
	Ian Gingell	Security Management Specialist (for items 6.4 & 6.5 only)
	Ros Preen	Director of Finance (for Item 9.2.1 only)
	Michelle Bramble	Clinical Effectiveness Lead (for item 6.3 only)
	Anita Bishop	Minute Taker

Minute Number	***Agenda Item title***	***Action***
2020/02/455	**Welcome from the Chairman** (Agenda Item 1) The Chairman welcomed everyone to the meeting.	
2020/02/456	**Apologies** (Agenda Item 2) Peter Phillips, Non-Executive Director	
2020/02/457	**Declarations of Interest** (Agenda Item 3) None were declared.	
2020/02/458	**Draft Minutes of the Audit Committee meeting held on 1st October 2019** **Enc 1** (Agenda Item 4.1) Agreed as correct by all present.	
2020/02/459	**Matters Arising** **Enc 2** (Agenda Item 5.0) **Action Log from the meeting held on 1st October 2019** (Agenda Item 5.1) The Committee accepted the actions shown as completed and agreed they could be removed from the action log. Claire Lea highlighted the need to forward any emerging issues raised by internal and external audit reports to the executive directors. This was on the agenda for consideration.	
2019/10/434	**Minute 2019/10/434 Freedom to Speak up (FTSU) Self-Assessment** (Agenda Item 5.3) Alison Trumper, the current Trust Guardian for FTSU, reported that the paper set out the self-assessment position against the guidance issued two years ago by NHSI to assist Trusts in executing their responsibility in	

	enabling people to speak up safely. Alison had performed the assessment last year against the Guidelines. It would be reviewed again in March 2020 with actions being assessed against Trust policies. All of the red and ambers categories will be addressed (turned green) with the exception of the audit of FTSU claims which would take place in April and would be reported back to the Audit Committee in due course. Sarah asked for verification of independence, and suggested that internal audit supported the work of this FTSU audit within the current year workplan. Claire and Alison confirmed that FTSU is scrutinised by Q&S Committee and then by the Board, she asked for clarity on the role of Audit Committee in regard to FTSU. Harmesh confirmed that it is part of this Committee's remit to obtain assurance on the FTSU processes and on their independence within the Trust. The FTSU self-assessment is a key part of this and would be reviewed annually by Audit Committee. The role of Q&S is to act on any issues highlighted by FTSU and ensure that any quality and safety matters identified were addressed. The Chairman and Claire discussed the strategic implications within the self-assessment and raised concerns that only 85% of staff knew who their Line Manager was. The implications were in terms of quality reporting, good practice and how performance appraisals were completed. Clarification was also sought regarding whether the FTSU process was well promoted to staff. Alison responded that the CQC rating in respect of the Trust's culture had been extremely positive and this offered assurance to the Committee that staff felt able to report matters to their Line Manager. This had also been identified in the Staff Survey. Harmesh emphasised the importance of staff knowing who their line manager was in this regard. Anita drew attention to two matters that Peter Phillips had raised prior to the meeting, namely: (i) An explanation regarding the Group 5 model. Alison clarified that there were 5 headings/boxes in the model. (ii) The Trust receives 6 monthly lessons learned; Alison confirmed that Q&S had been had omitted from the list and clarified that the report is taken to Board twice a year and that the Self-assessment Toolkit was first used in March 2019. **<u>Action</u>: Alison Trumper to investigate issues around only 85% of staff knowing who is their Line Manager**	**Alison Trumper**
2019/07/437	**Minute 2019/07/437 Internal Audit – To assist with reviewing the Governance Divisional Structure** (Agenda Item 5.4) Gurpreet Dulay asked for this to be addressed later in the meeting as part of the internal audit Report.	
	NEW ITEMS	
2020/02/462	**Review Audit Committee Terms of Reference** **Enc 4** (Agenda Item 6.1) The Chair thanked Claire Lea for her comprehensive report. Claire highlighted the changes being proposed which would improve the consistency across all committee terms of reference. The changes	

	included clear roles of the meetings along with the roles of attendees and voting rights. The ability to meet virtually had been created to support quorate meetings, however technology still needed to be addressed to support that more fully. Virtual meetings required attendees to be able to see and hear other attendees, so the equivalent of Skype would need to be available in meeting rooms going forward. Additionally the ability to pass Resolutions in writing, had also been introduced as a legitimate way to make committee decisions. The Chair drew attention to the change in membership within Audit Committee. Claire confirmed that two Non-Exec Directors (NEDs) were required to attend this committee to achieve quoracy. Additionally a NED committee member would be able to chair the meeting in the case of the Committee Chair's absence. If two of the three NEDs were unable to attend then quoracy could be attained via the Trust Chair inviting another NED to attend. Clarification was sought regarding NED oversight into other committees. The Chair asked for verification in respect of whether NEDs were obligated to attend 75% of their meetings; Claire confirmed this. Claire also highlighted the change of practice in respect of the Chairs of R&P, and Quality & Safety attending Audit Committee to ensure that Audit had line of sight into board committee. Clarity was provided to the Chair regarding (i) two NEDs providing quoracy in terms of voting and (ii) when voting members make a written resolution both members must agree. When there is disagreement a face to face meeting must be called. Claire also drew attention to Accounts sign off being required by Board and not via delegated Board authority to Audit Committee. External audit requested that special dispensation may be required regarding providing audit papers four days before Audit Committee, it was agreed this would be considered. **<u>Action</u>: Anita Bishop to circulate minutes from R&P to members.**	**Anita Bishop**
2020/02/463	**Ratification of Terms of Reference (TOR)** **(a) Resource & Performance Committee** **(b) Quality & Safety Committee** **Enc 5** (Agenda Item 6.2) The Chair thanked Claire for updating the Terms of Reference, which have been to the relevant committees and have been ratified. It was agreed that Nominations, Appointment and Remuneration Committee (NAR) was meeting on 30th January 2020 and Charitable Funds Committee (CF) later in February. The same changes to their ToR were also being proposed. The Audit Committee agreed to recommend the ToR to the Board for approval on 30th January and that the NAR and CF Committees would adopt these new ToR from this date.	
2020/01/464	**Clinical Audit (6 monthly review)** **Enc 6** (Agenda Item 6.3) Ms Bramble presented the six monthly report highlighting that subsequent to this matter being raised previously in Audit Committee, robust action plans had been undertaken resulting in a decline in the number of delayed projects.	

	The Chair noted significant progress but there were still items outstanding that were showing as 80%. He questioned how the projects could be progressed and completed. Michelle clarified that projects were approved and managed and were on SharePoint with the respective SDGs assuming management responsibilities with timescales being agreed at the approval stage. The percentage did not represent delayed projects, as they were not completed yet. The Chair also questioned target deadlines and asked for clarification regarding which were national targets. It was also noted that the embedded documents were not readable. Peter Featherstone queried the completeness of tracking and its impact on the ease of reading the report, as such an end date needed to be identified. This Report would go to Q&S as there was a need for more detail regarding late running projects. Michelle added that's SDGs were in charge of the reporting and requests for delays and projects. <u>Michelle left the room at this point.</u> Discussion ensued regarding reports being in a set format and delivering the information required. Clarity in report writing and appendices was essential because this issue had existed in the previous report. **<u>Action</u>: Michelle Bramble to provide improved clarity and appendices in future reports to Audit Committee.**	**Michelle Bramble**
2020/01/465	**Receive Local Counter Fraud Security Management Update Report Enc 7** (Agenda Item 6.4) Terry Feltus and Ian Gingell joined the meeting and Terry introduced the report. The main area this year had been increased involvement with the national body, NHS Counter Fraud with new prevention measures and Fraud Champions being introduced. Terry confirmed that all strategic governance deadlines and terms had been complied with and that there was continuing implementation of the anti-fraud culture. He also confirmed that the 'Prevent and deter' criteria was close to completion with good systems were in place. The 'Holding to Account criteria showed a slight increase in referrals (up one to 10 from last year). The Chairman asked for clarity on the Fuel Card case. Terry stated Fuel Cards were linked to a vehicle and that all referrals involved weaknesses in the system. Fuel Cards were closely monitored and a receipt issued upon receipt of the card. On the prescription case, work with the Chief Pharmacist was continuing in respect of ordering, storage and distribution and the reviewing and monitoring of missing prescriptions. The Chairman raised issues around agency staff and the potential for fraud. Terry confirmed that Finance Dept processes were stringent and many checks were completed in this area. An investigation had recently been completed and it was confirmed to be an internal agency error; the Finance Dept picked this up. All payments were stopped when a query is raised. Peter Featherstone sought clarity regarding the process and Terry confirmed the process is stringent and a system was being followed and changes were being noticed.	

	Claire sought quantification of the financial impact of the 10 referrals. Terry clarified that only the telephone system had an outstanding financial implication. There is dispute over a £3k financial limit; and payment had been frozen until resolution. A large difference had been noticed between the monthly charges and large invoices which had been signed by a manager without proper checking. The potential impact was circa £1.5k. The Chairman asked for tabulated form of financial impact in future reports. **<u>Action</u>: Terry Feltus to include tabulated figures on the financial impact and outcome in future reporting to Audit Committee.**	**Terry Feltus**
2020/01/466	**Receive Local Security Management Service Update Report** **Enc 8** (Agenda Item 6.5) Terry provided an update in the same format as in previous years. He highlighted the most recently issued standards. He reported that work with counter terrorism police colleagues was ongoing and a number of conferences had been attended. Awareness raising continues with several face-to-face training sessions completed recently. Regarding Prevent and Deter CCTV had been implemented and the feed was being shared with the police whilst also complying with data protection regulations. He also confirmed that Roam alerts were currently being implemented across hospitals and would be in place by the end of the financial year. This would operate a tag system which would lock down the premises. Access control to sites was also approaching the capital bid stage. Terry confirmed that a 'Lone Worker System' was in the process of being implemented in Oswestry, working closely with the police and county lines. Hold to Account reports were reviewed weekly and guidance offered to staff on to how to progress matters. There had been several dog attacks recently and letters had been issued to the patients involved. Peter Featherstone queried the need for staff to have aggression training e.g. MAPA which included specific training for Dementia related aggression. Terry stated there were difficulties releasing staff for the 1 and 2 day training. Questions were also raised regarding staff satisfaction with lone working support and assurance sought in respect of staff wellbeing. Peter Featherstone noted progress was restricted by location and signal issues. It was agreed that the need for training should be considered further. **<u>Action</u>: Peter Featherstone would pick up the lone-working matter and aggression training at Q&S, he would discuss the matter further with Steve Gregory regarding a forward plan.**	**Peter Featherstone**
	INTERNAL AUDIT	
2020/01/467	**Progress Report** **Enc 9** (Agenda Item 7.1) Gurpreet Dulay highlighted a report on Fitness Management and a number of reviews (IG Toolkit, Rio, Business continuity) which were currently underway with the expectation of completion in January. Estates internal	

	audit work would proceed through the Trust's review process. The internal audit work plan should be complete by the end of March 2020. The key point to raise was that there were some movements in the Plan and that the IG Toolkit was now in the Plan. There were still 15 unallocated days in this year's Plan. Sarah was discussing this internally with colleagues. Sarah replied that Ros Preen had requested that some of these days were used for a Quality and Service Improvement Methodology Audit. The unallocated days had been discussed at Execs and the Execs would return by 17th January if they were proposing their own areas to review. The question was raised whether audit committee or Ms Trumper could identify any further areas they wished to review. The Chairman stated there was a need to get good value out of the unallocated days, and have a proper plan. Gurpreet confirmed that they could be carried forward to the next year to enable a proper three year plan to be put in place. Stanley was asked to review key risks which would normally drive the internal audit and to work with Gurpreet, and contact Sarah regarding this. Claire drew attention to the fact the days requested for governance below boards had not materialised and should not be marked as completed Gurpreeet replied that the notes from the meeting he had attended had been completed and he would forward them to her. Peter Featherstone added that the Execs needed to consider mandatory and non-mandatory training as a possible area for audit. Sarah volunteered to contact Jaki Lowe to discuss this and if she supports it would be added to this year's programme, the Chairman confirmed this action. Gurpreet raised sickness management for the Trust who employ 1500 staff. The audit had looked at whether processes were being followed. He confirmed that the policies were substantial and completed and a clear process was in place. They had tested compliance in respect of actions against policies in place by checking personnel records and following the pieces of documentation. The report attached sets out the non-compliance and inconsistencies. The report suggested that there needs to be a more streamlined process because the documentation levels required for one days sickness is high and impacts on compliance. The audit was going to retrospectively look back at files for non-compliance. Procedure documents needed to be revised and reduced to encourage engagement. This would then need recommunicating with the line managers. Harmesh questioned how cumbersome processes were and Sarah confirmed that one day's absence required a lot of procedures, recording conversation, several forms, electronic recording, and interviews for one day absence. It did not compare proportionately to the process for longer term sickness. Sarah supported streamlining the process as it was currently a very time-consuming process. Gurpreeet had benchmarked with other Trusts and suggested improvements. Harmesh advised that would like to see streamlining of the process. Claire Lea raised a process question relating to what level of assurance from an internal audit report would trigger an Audit Committee intervention.	

	Claire suggested that this needed to be clear as such reports would require an Executive Director attendance in order to address the gaps in assurance. For example, this report required input from Jaki Lowe as Director of People who had not been asked to attend. Gurpreet commented that normally the trigger would be after a timeline or objective had not been met. Gurpreet stated that there was a clear line of sight between recommendation, action plan, and Exec involvement. In respect of this report on sickness management Gurpreet believed September would be an ambitious a target. The Chair asked for clarity regarding the 9 month time frame and asked Peter Featherstone to review progress within the Q&S Committee. **<u>Action 1</u>: Stanley to review key risks in respect of the Internal Audit and consult with Gurpreet and Sarah Lloyd.** **<u>Action 2</u>: Gurpreet, Sarah and Stanley to work together to establish a workplan incorporating risk factors.** **<u>Action 3</u>: Gurpreet to forward notes from the Adults meeting with Claire Lea.** **<u>Action 4</u>: Sarah Lloyd to consult Jaki regarding timing.** **<u>Action 5</u>: Audit Committee asked for the sickness absence recommendations to be fast tracked through Q&S via Peter Featherstone.**	**Stanley/ Gurpreet/ Sarah L** **Gurpreet/ Sarah L/ Stanley** **Gurpreet** **Sarah L** **Claire L /Peter F/ Stanley**
	EXTERNAL AUDIT	
2020/01/468	**Progress Report & Emerging Issues** **Enc 10** (Agenda Item 10) Grant Patterson had reviewed the external audit plan for 19/20 and the plan was consistent with prior years, the risks to focus on remained the same. Revenue risk in respect of materiality and expenditure was still important. The Auditors focus would be around variations on block contracts and management overriding controls. He also confirmed that valuation of property had specific audit procedures against it this year as a consequence of its financial impact Grant confirmed that all differences over £75k would be reported and that the Audit fee had increased by £10k (20%). The Chairman raised questions around the increase of the fee. The Chairman was assured that this increase was appropriate given the increased auditing requirements nationally now required. Peter Featherstone also confirmed that he welcomed the increased assurance and the fee increase was acceptable because more work needed to be done.	
	GOVERNANCE	
2020/01/469	**Workplan** **Enc 11**(Agenda Item 9.1) Claire stated this had been previously put before the committee and proposed that dates roll forward for 2020. Grant added that it was important to firm up the May date. With Jan Ditheridge, CEO, leaving	

	there would need to be clarity on who was signing the accounts off, they would need to be comfortable with that responsibility given their newness in the role.	
2020/01/470	**Board Assurance Framework** **Enc 12** (Agenda Item 12) Claire advised that BAF had been updated and Clinical, Quality & Safety reflecting that we have the CQC report back. The Exec team were currently re-examining The Trust's priorities, an ongoing process which will take some time because they want some staff engagement. The risks won't necessarily change. This work will come to audit committee first. This will change in the future. The meeting accepted that he Long term financial plan still remains high risk going forwards.	
2020/01/471	**Health Care Systems** **Enc 13** (Agenda Item 9.2) Ros Preen addressed the assurance provided regarding this risk and it's current level. The risk for system related items should be listed on the BAF and needed to described correctly. Ros had been considering requesting a reduction to a rating of 8, however, recent discussions in the system around the financial deficit in the system and the potential financial impact for each partner had caused her to reflect further. After further discussion, Audit Committee agreed that a risk relating to the healthcare system still existed for the Trust but the narrative describing this risk needed to be updated and the risk rating reviewed in light of the changing position. Ros was waiting for more clarity around the impact of the financial deficit on commissioners planning objectives to ascertain the impact on community services and how this might limit service transformation. This would become clearer once the planning discussions had been commenced in April 2020. The Chairman proposed that the risk should be reviewed at R&P and then referred back to Audit Committee Mike McDonald asked for an appendix to be included which set out the risk scoring criteria in order to support the Committee' work. This was agreed. **<u>Action 1</u>: R&P to review risk relating to health care systems and report back to Audit Committee.** **<u>Action 2:</u> Appendix to be added to BAF to explain further the categories of risk and why they have been applied within the difference categories.**	**Sarah Lloyd** **Ros Preen**
20/20/01/472	**Corporate Risk Register** Enc 14 (Agenda Item 9.3) Claire confirmed that this is version which had been considered by the Board in November. Peter Foord's ill health had flagged a lack of in-house expertise in Datix report production and so it had not been possible to update the register. She confirmed that a manual review of the register confirmed that there had been no significant changes to report.	

	Training was now being provided on Datix report production and a revised version would be available for the next meeting.	
2020/02/473	**Directorate Risk Register** (Agenda Item 9.4) None.	
2020/01/474	**Single Tender Approvals** (Agenda Item 9.5) None.	
2020//01/475	**Loses and Compensations** (Agenda Item 9.6) None.	
2020/01/476	**Review report from Regulatory and other External Bodies** **Enc 15** (Agenda Item 9.7) For information only. No questions were asked.	
2020/01/477	**Risks from other committees** **Enc 16** (Agenda Item 9.8) Claire confirmed that the Trust's risks were escalated by various committees and work was underway to improve this. Q&S had reviewed the risks around the roll out of the flu vaccine but there were no further reports from R&P. Harmesh confirmed that there had been nothing at R&P to escalate, discussions had focussed on the challenges and there were no new risks.	
	RISKS & ASSURANCES IDENTIFIED	
2020/01/478	**Risks and Assurances Identified at the meeting** **Enc 17** (Agenda Item 10.0) None to escalate to the Board, however, two items had been referred to the respective board committees. See actions earlier in the minutes.	
	MINUTES FROM THE QUALITY & SAFETY COMMITTEE	
2020/01/479	**Minutes from the Quality & Safety Committee** Verbal (Agenda Item 11.0) The Minutes were accepted for information. No questions were asked.	
	ANY OTHER BUSINESS	
2020/02/479	There was no further business.	
	DATES OF FUTURE MEETINGS	
2019/10/480	**Dates for future meetings** (Agenda Item 13.0) Tuesday 7th April 2020,13:00pm – 17:00, Room B, WFH Extraordinary meeting of the Audit Committee to approve the accounts TBA – 27th May 2020, 10am Room B. Tuesday 7th July 2020, 13:00pm – 17:00, Room K2, WFH Tuesday 6th October 2020, 13:00pm – 17:00pm, K2, WFH	

Approved by: …… Date: ……

Peter Phillips, Audit Committee Chairman