Shropshire Community Health NHS Trust

Public Trust Board - 7 December 2023

MEETING
7 December 2023 10:00 GMT

PUBLISHED
1 December 2023

Agenda

Location	Date	Time
Hencote, Crosshill, Shrewsbury	7 Dec 2023	10:00

	Item	Owner	Time	Page
1	Welcome and Chair's Award	Chair	10:00	-
2	Apologies and Quorum	Chair		-
3	Declarations of Interest	Chair		-
4	Staff Story	CHobbs	10:10	-
5	Minutes of the Meeting held on 5 October 2023	Chair	10:35	6
6	Matters Arising and Action Log	Chair		-
7	Chair's Communication	Chair	10:40	17
8	Non-Executive Director Communication	NEDs	10:45	-
9	Chief Executive's Report	CEO	10:50	21
	Quality & Safety			-
10	Quality and Safety Committee Chair's Update	J Barker	11:00	30
11	Integrated Quality and Safety Performance Update	Director of Nursing	11:05	35
12	Quarterly Mortality and Learning from Death Update	Medical Director	11:15	59
13	Guardian of Safe Working Report	Medical Director	11:20	60
14	Rural Health Update		11:25	-
14.1	PCN Collaboration	Chief Executive		-
14.2	Bishop's Castle Update	Director of Nursing, Workforce and Clinical Delivery		61
	Break		11:40	-
	Governance & Audit			-
15	Audit Committee Chair's Report	Harmesh Darbhanga	11:50	71
16	SFIs/SOs/SoD/SoR - for approval	Director of Governance	11:55	76
17	EPRR Annual Report	Director of Operations	12:05	78

	Item	Owner	Time	Page
18	Board Assurance Framework			94
	Resource & Performance			-
19	RPC Chair's Report	P Featherstone	12:15	-
20	Performance Report	S Lloyd	12:20	122
21	Finance Report	S Lloyd	12:30	138
22	Charitable Funds Accounts	S Lloyd	12:40	146
23	Charitable Funds Committee Chair's Report	A Sargent	12:45	162
24	Patient Safety Incident Response Framework - For Information			166
25	Questions or Comments from Members of the Public	Chair	12:50	-
26	Any Other Business	Chair		-
27	Meeting Evaluation	Chair		-

Contents

	Item	Page
1	Welcome and Chair's Award	-
2	Apologies and Quorum	-
3	Declarations of Interest	-
4	Staff Story	-
5	Minutes of the Meeting held on 5 October 2023	6
6	Matters Arising and Action Log	-
7	Chair's Communication	17
8	Non-Executive Director Communication	-
9	Chief Executive's Report	21
10	Quality and Safety Committee Chair's Update	30
11	Integrated Quality and Safety Performance Update	35
12	Quarterly Mortality and Learning from Death Update	59
13	Guardian of Safe Working Report	60
14	Rural Health Update	-
14.1	PCN Collaboration	-
14.2	Bishop's Castle Update	61
15	Audit Committee Chair's Report	71
16	SFIs/SOs/SoD/SoR - for approval	76
17	EPRR Annual Report	78
18	Board Assurance Framework	94
19	RPC Chair's Report	-
20	Performance Report	122
21	Finance Report	138
22	Charitable Funds Accounts	146

	Item	Page
23	Charitable Funds Committee Chair's Report	162
24	Patient Safety Incident Response Framework - For Information	166
25	Questions or Comments from Members of the Public	-
26	Any Other Business	-
27	Meeting Evaluation	-

Shropshire Community Health NHS Trust

MINUTES OF THE BOARD MEETING

HELD AT THE SHREWSBURY TOWN FOOTBALL CLUB, SHREWSBURY
AT 10.00 AM ON THURSDAY 5 OCTOBER 2023

PRESENT

Chair and Non-Executive Members (Voting)	
Ms. Tina Long	(Chair)
Mr. Peter Featherstone	(Non-Executive Director and Vice Chair)
Mr. Harmesh Darbhanga	(Non-Executive Director)
Ms. Alison Sargent	(Non-Executive Director)
Ms. Cathy Purt	(Non-Executive Director)
Non-Executive Members (Non-Voting)	Ms. Jill Barker, Associate Non-Executive Director
Executive Members (Voting)	
Ms. Patricia Davies	(Chief Executive)
Ms. Sarah Lloyd	(Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Clair Hobbs	(Director of Nursing & Workforce)
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Executive Members (Non-Voting)	(Director of Operations and Chief AHP)
Claire Horsfield	
In attendance	Executive Personal Assistant (to take the minutes of the meeting)
Mrs. Louise Tompson	

Welcome and Chair's Award

Ms Long welcomed all to the meeting, reminding those present that the meeting would be recorded and uploaded on to the Trust's website. Ms Long presented the Chair's Award to:

Advanced Care Planning in Care Homes Team joint award with the executive team.
The team nominated some of the executive directors who visited the team, the team felt the visit was constructive and supportive. This is a joint award for the team as they do lots of great work. Ms Davies said that the feedback received following the visit was lovely, adding that the openness and honesty the team expressed around the help and support they need to do more was welcomed.

Staff from Oswestry Minor Injuries Unit, nominated by Gemma McIver who wrote: the team in the MIU had an incredibly difficult shift resulting in an air ambulance being required for a patient. Their fast response and incredible support to the gentleman who presented, has undoubtedly saved his life. The team thanked Ms Long for the recognition; it was a challenging day but the whole team pulled together.

Apologies and Quorum

Apologies were received from.

Declarations of Interest

None to declare.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Staff Story

Paulson Arancheril, Jancy Wilfred, Anitha Kavunkal Sasidharan and Trace Black attended the meeting to talk about how we are supporting new international recruits and feedback from them about what it is like to work at Shropcom.

Jancy and Anitha said that they arrived in the country in January 2023, and they are both currently working at Whitchurch Community Hospital. They said they are very happy to be working with the Trust and colleagues are very supportive. The Trust initially provided 3 months accommodation, they said it was challenging to secure further accommodation as agencies often require tenants to provide a credit score which they did not have, however the Trust were able to assist them with securing the accommodation. Both Jancy and Anitha said they were pleased as their families were also able to be with them.

Ms Davies thanked them both for choosing our Trust, it is a joy to have their skill and level of competence at the Trust and we are learning hugely from their vast experience.
Ms Davies and Ms Hobbs expressed their thanks to Paulson who has provided a huge amount of support to the international recruits. Teams within the trust have welcomed the level of skill the international nurses have brought to the Trust. Tracie echoed this adding that the different cohorts of international nurses really support new arrivals, and they really look after each other.

Mr Featherstone welcomed Jancy and Anitha to the Trust, he asked if they were able to get transport, Tracie said that there is a package of transport in place and some of the international recruits have driving licences. However, a lot of the international nurses have sourced accommodation very near the hospital so don't require transport for work. Ms Ramtuhul welcomed the well thought out package for international nurses but are there little things that might be able to be implemented for future cohorts. Tracie said that Paulson is working on this, and these will be implemented going forward..

Ms Long thanked the nurses and their colleagues, she is pleased how well they have settled and acknowledged the huge contribution they are making, she said that if there is anything they feel could be improved then they are welcome to make contact.

Mr Darbhanga asked a question around how the international nurses are welcomed adding that the system has a diverse range of skills. Ms Hobbs said that we work closely with Shrewsbury and Telford Hospital NHS Trust and Robert Jones and Agnes Hunt NHS Foundation Trust with joint training taking place over 12 weeks. Dr Ganesh would welcome the opportunity to meet with the international nurses in the near future.

Minutes of the Meeting held on 3rd August and 7 September 2023

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

7 September
Page 3 – add inpatient beds and change acronyms to full names throughout minutes.
Page 13 – Ms Barker will discuss with other rural providers.

Following the changes being made the minutes were agreed as an accurate record.

Matters Arising and Review of action log.

All other action items were noted to be on track or completed.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

Chair's Communication

Ms Long reported that she has recently held positive discussions with public health colleagues in local authorities with a view to having discussions at a future board meeting around population health, this is currently scheduled to take place in February 2024. She explained that at the last public board meeting in Bishops Castle an important decision was made to have another attempt to recruit staff for the inpatient beds, this will be discussed later in this meeting. Ms Long has recently had an enjoyable visit to Robert Jones and Agnes Hunt NHS Foundation Trust, she met with the Chair and also attended their annual general meeting, adding that she will try and do more visits like this as it is so important to build relationships.

Mr Featherstone said the meeting held recently with Primary Care Networks was very encouraging, Ms Davies said that there is an important role for us to play in terms of development and transformation, we can help build the joint working and support the ICB. There are challenges around allowing the time for senior clinical leaders to come together, but there are good positive conversations going on as we move forward.

Non – Executive Directors' Communication

There were no updates from Non-Executive Directors

Chief Executive's Report

Ms Davies highlighted some of the key areas from her report.

She said that it has been a busy time and the system has been under a lot of pressure around the volume of activity and ambulance conveyances to the acute Trust and non-elective activity is increasing.

In relation to Bishops Castle Community Hospital Ms Davies explained the decision that was made at the last Board meeting to work through another round of recruitment jointly with partners and the community. She thanked local councillor's, politicians and particularly the Mayor Josh Dickin for his support. Ms Davies went on to explain that we were clear at the Board meeting however that if we cannot recruit after a distinct period of time, we would need to have a discussion with commissioners around the ongoing plan for the inpatient facility. At the moment the very positive work with the community and other partners is ongoing.

Ms Davies went on to explain that one of the biggest demands at the moment is managing vaccination. There are two elements we focus on, vaccinating our patients and our staff. She noted that some Board members had received their vaccination prior to the meeting. Flu vaccinations have started with huge energy across the Trust, our target is 75-80% of patient facing staff taking the vaccine and she encouraged all staff to take this opportunity. In relation to Covid vaccinations, we are working closely with community pharmacies and others to progress this. There is a big focus on over 75-year-olds and those in care homes, and there is an aim to get all care home residents vaccinated by 24th October. Ms Davies emphasised that other vulnerable adults and children are also being invited to be vaccinated.

There has been a huge amount of work within the People team in relation to staff engagement which is an important part of our recruitment and retention plan and Ms Davies was please to report another improvement for the 2nd quarter of the national pulse survey across all domains. This is testimony of the listening and leadership events and the Your Voice campaign. This is showing what we are doing in response of feedback is showing results although staff are still telling us they are under pressure, and we are looking at what more we can do.

Elective referral to treatment and non-elective referral to treatment is under pressure, particularly in musculoskeletal. But alongside Shrewsbury and Telford Hospital NHS Trust (SaTH) and Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH) have implemented a musculoskeletal alliance from 1st August. Shropcom are leading the front end of the care and RJAH and SaTH are providing the more acute side of intervention.

We are using the same process with our non-referral to treatment services, in relation to children and young people services, in particular speech and language services. Ms Davies went on to explain that we need greater investment in children and young people services. Discussions are ongoing jointly with commissioners and local authorities around how we can do things differently and she was pleased to report that the recent SEND inspection at the local authorities was really positive.

In relation to the Prison Ms Davies explained the pressures that the service has recently had. Unfortunately, we had to go into business continuity, but this demonstrated that our plans in place were robust. This demonstrates the focus we have on safety first across the organisation.

Ms Davies informed the Board that teams across the organisation have been nominated for a range of Nursing Time and other national awards, this demonstrates the skills we have across Shropcom.

Ms Sargent commented that it is good news the business continuity plan was successful and good feedback was received, she asked if there were any learning points. Ms Horsfield said that Brian McMillan, the Trust's EPRR Lead, is an asset to the trust, Brian has huge experience in leadership around implementing this. She said there is learning, we know where we don't have business continuity processes in place and Brian is working on this.

Mr Darbhanga asked if there is a way of sharing innovation amongst others at Shropcom. Ms Davies said this is something that has been discusses with executives. Jonathan Davies, the Trusts digital lead will be considering how programme support can be put in place so improvements can be tracked. There is lots of innovation in the Trust, we need to support this and disseminate appropriately.

Mr Featherstone remarked that it would be helpful to the Board to receive a report from Allied Health Professionals, as there is a huge amount of wonderful work going on. There was a suggestion that the People Committee could receive and update on the AHP strategy that is being finalised and then this could also come to a future Board meeting, the paper could also include pharmacy.

Ms Purt expressed concerns around the recovery of the musculoskeletal elective referral to treatment target, she asked if there is anything further, we could do get the patients through in the required time frame. Ms Horsfield said that she is confident, the team have been fantastic over the last couple of weeks in terms of redeploying staff where needed and we have regular fortnightly meetings to discuss detail.

Ms Long thanked Ms Davies for her comprehensive report. She said that although it is early days there are positive green shoots around the impact of the listening events and engaging with staff. The staff survey is out, and we need a good response, and we need to hear what staff are telling us to make sure we continue the report, she encouraged all staff to take part.

Ms Long asked if there is more, we need to do around Freedom to Speak Up (FTSU) and raising concerns. Ms Davies said that the executive team have had discussions around how we improve our FTSU and there is more we can do across organisations including the Integrated Care Board (ICB). Ms Ramtuhul said that we have done a gap analysis, so we know where the areas of work that need strengthening. This has been discussed at People Committee and they have approved a new policy based on a national template. She went on to explain that a new app has been purchased so that staff can raise any issues anonymously, this will be rolled out now that Ms Ramtuhul has had the training. There is some board development work needed on this and we have added this to the programme, so all are sighted on this.

The Board accepted the assurance provided by the report.

QUALITY, SAFETY AND PEOPLE

Quality and Safety Committee Chair's Verbal Update

Ms Purt thanked everyone from the committee for all of their hard work. There had been 0 MRSA cases and 1 serious incident, which is being investigated. She noted that the numbers completing mandatory training has increased and People Committee also noted this, but Board should be focussed on 100%. She raised concerns around the number of appraisals as this appears to be declining, and this could raise quality issues. She welcomed a decrease in sickness absence rates. There will also be a process for benchmarking falls, moving forward.

The Board accepted the assurance provided by the update.

Integrated Quality & Safety Performance Report

Ms Hobbs provided a summary of the key points from the report noting that some areas have been discussed including referral to treatment and MRSA. She noted that there was a case of C Dificile in August which is a shame because we didn't take samples in 72 hours so therefore it was attributed to our organisation. New birth visits have seen an improvement, complaint responses are a concern. Mandatory training and appraisals are still an issue and there have been detailed discussions at People Committee around what more we can do. She noted the new paperwork for appraisals is much easier to complete. In relation to mandatory training, we are looking at group training, but we then need to find a way to put on individuals ESR record so there is a lot going on to address this. She reported there was one unexpected death at Whitchurch Community Hospital which is under investigation by the coroner.

Questions and comments were welcomed. Ms Barker thanked Ms Hobbs for the full and comprehensive report, commented that we benchmarked positively against the care hours per patient days, do we know if this links to dependency. Ms Hobbs said that it did not, it is difficult to compare this, but work will be done to look at this in the staffing report.
In relation to complaints, Ms Hobbs said that this would come back to Quality and Safety Committee for further discussion. Ms Purt raised the issue of complaints and response times, and she asked what the plan is to get us back on track. Ms Ramtuhul said that we had significant sickness in the team, so capacity had been reduced. The team are working through the backlog, and she is supporting the team to do that. We should see this improve as there is a time lag. Ms Purt asked if there is any other system, we could do to support his, electronic methods. Ms Ramtuhul said that we have a very small team of 2 so it is quite a manual process, and we are not making full use of Datix. We are getting more support in the Governance team to enable more senior support with Datix, so this will hopefully build in some resilience. Ms Hobbs said that we need to be more proactive, there will be a toolkit, so managers are able to deal with issues as they arise hopefully reducing the complaints. Ms Ramtuhul said the complaints received at this Trust are quite in-depth and complex, there are not that many complaints but those that are received are detailed.

Mr Featherstone commented that Shropshire are still struggling with new birth visits and more work needs to be done to address this. What assurances can the Board provide as our contribution to child health. Ms Davies said that across the west midlands there seems to be a higher-than-average child mortality. She said there is a wide-ranging look at the influencing factors and health inequalities. This issue was raised at the recent Integrated Care Board meeting and there is a need to understand the data to consider what we as a trust can do around prevention and support.
Dr Ganesh said that the Child Death Overview Panel is looking at this and trying the establish links with deprivation and poverty. Nick White wants to publicise all information and data, there will be a number of working groups to consider what interventions will be the right interventions to that will improve outcomes for patients.

Mr Darbhanga asked a question relating to patient experience data. Ms Ramtuhul confirmed that because the numbers are small the data is considered quarterly at the Quality and Safety Committee.

The Board noted the report and accepted the assurance provided by the report.

WRES/WDES

Ms Hobbs provided a summary of the report which has been discussed in detail and approved at People Committee.

The Board discussed possible events to celebrate diversity, they noted that he ICB had held an event in September, but Ms Davies said that it is important to celebrate this as a Trust. Mr Darbhanga commented that the report was balanced but said that the diversity and inclusion group had not met for some time and more work on this within the system would be welcomed.

Board went on to authorise the publication of the plan on the Trust website.

PEOPLE

People Committee Chairs Report

Ms Purt provided a verbal update from the most recent People Committee. She reported that the committee discussed the Bishops Castle Community Hospital plan. The Committee also discussed other metrics around people and staff.

Bishops Castle Community Hospital Workforce and Recruitment Plan

The Board noted the report for information and acknowledged that this has been discussed in detail at People Committee. Ms Hobbs presented a summary of the main themes and informed the Board that there are already a lot of actions in place to address the issues raised.

Ms Hobbs reported that the workforce action plan is for sign off today following agreement at the People Committee. She emphasised that it is important that actions put in place are not just a repeat of what has happened before. She went on to thank the local Mayor who has been very helpful. The group includes the mayor and residents, the local Primary Care Network and staff from the hospital have been invited. Ms Hobbs said she is excited about the innovative ways we are trying to recruit, and the progress of this plan will be monitored weekly.

Ms Long thanked Ms Hobbs for the update adding that the action plan has been co-produced and has been very open and transparent an. She went on to thank Ms Hobbs and the HR Team for all of their work on this. Ms Long emphasised that there had a been lengthy discussion at the recent People Committee but welcomed any comments today. Mr Darbhanga commented that it is a strong and robust plan, and he is very proud of the team and the work that has gone into this.

Ms Long commented that this should be able to come back to the Board meeting in March 2024 and by December this year or January 2024 we will have a good idea of the success of the plan. Ms Davies confirmed that the trust will not be remaking the decision, but we will be able to see if we have met the agreed metrics. Non-Executive Directors were invited to the open recruitment events being held. Board members when on to agree the action plan as discussed at the recent People Committee.

The Board noted the report and accepted the assurance provided by the report.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Mr Featherstone reported that the meeting was enjoyable and there was good discussion on the key themes. The committee discussed collective activity, CIP where partial assurance was received on work undertaken. Committee did not express concerns around year end although this is being monitored. Committee is paying increased attention on elective RTT, we have asked for more information on that, and we are mindful the need for more pace on this.
The committee discussed agency and focussed on areas with the top 10 spend and top 10 in terms of length of appointment. Committee discussed Virtual Ward KPIs and we need to review these in respect of the increasing importance of Virtual Ward going forward. Mr Featherstone commented that Steve Price has done great work on analysis, but he would like more operational input to consider what is working well and what we are concerned about and what is the planned going forward.

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

Performance Report

Ms Lloyd presented the headline performance information to the board for review and highlighted the key risks and issues, following discussion at the Resource and Performance.

There are 58 performance indicators reported in this period across all committees, 29 indicators are highlighted as a concern (50%), although there are interdependencies across many of these. Of the 23 measures that Resource and Performance Committee reviews 8 require attention, 6 relate to waiting times and access to services. The planned care working group looks at this issue regularly, and the monthly Resource and Performance Committee will also consider this. There is lots of work going on to address this but still more to do, Ms Lloyd commented that our trust is not alone and there is a similar position nationally. The remaining 2 areas flagged relate to agency usage and this position has improved since August.

Ms Long expressed concerns around waiting times, she acknowledged that there is a lot of work going on but as of now can we be confident that this will be addressed. Ms Horsfield agreed that yes, we can be confident, but we will also need assurance on benchmarking. Ms Purt asked if we could validate patients on the list, and also carry out harm reviews. Ms Horsfield said that in relation to elective patients, these have not yet been validated however Quality and Safety Committee have seen that harms assessment are being done. Discussion ensued around waiting list initiatives, Ms Horsfield said that teams are working hard, and we have had investment with new staff joining, new Physiotherapists joining the trust will see large amount of patients, and we expect numbers waiting to reduce.

The Board considered the current performance indicators and actions being taken to minimise risks and improve performance where required.

Finance Report

Ms Lloyd presented the Finance report, detailing key financial information in relation to Month 5

The Trust is reporting a £290k adjusted surplus for month 5 year to date compared to the planned surplus of £284k, which is a small favourable variance of £6k. The Trust is broadly on track to deliver the financial plan of a breakeven position and there are no new risks to bring to the Boards attention.

Ms Lloyd highlighted 3 areas:
- Agency spend at month 5 is £2,468k. This exceeds planned levels by £1,138k (86%), although there was a reduction of £112k in August compared to the spend in July. A weekly Agency Scrutiny Group, which reports to the newly created Financial Recovery Group (FRG), is in place and its role is to safely manage this reduction in agency spend.
- CIP - our performance to date is an adverse variance to plan of £201k – with actual delivery of £996k year to date. Delivery of the Trust's £4,108k CIP target for 2023/24 remains a financial risk,

particularly the £1,072k non-recurrent 'stretch target' agreed with STW ICS partners for the May plan submission. A CIP Working Group, which reports to the FRG, is in place to oversee the delivery of the Trust CIP programme. Ms Lloyd said that the forecast position has improved but there is still a significant amount of work to be done on this. There is a significant amount of work with NHS England and system colleagues to look at the forecast for the whole system and individual organisations.

- Elective Income - at month 5 elective income is reported as £200k adverse to plan. The forecast outturn assumes that the current adverse position will be recovered in future months and that full delivery of elective income of £3.8m will be achieved (notwithstanding the fact the £3.8m target may be adjusted to take the impact of the ongoing Industrial Action). Based on performance year to date, this is the most significant risk to deliver of our financial plan for 2023/24. It is noted that Dental activity is unlikely to deliver to plan due to theatre access at SaTH although options are still being explored.

Mr Darbhanga thanked Ms Lloyd adding that the Board can be assured around the work going on to address this. It is reassuring going to have a break-even plan, he asked about how confident we can be that we will hit the breakeven plan. Ms Lloyd said that we are saying to the system that we can achieve a breakeven position if we can mitigate the risks. We have a lot of work to do to get to position so we can't do more for the system at the moment. We are pulling out all the stops currently, we are doing everything we can around agency spend and CIP.
In relation to confidence, Ms Lloyd said that we can get there and deliver the financial plan, it will take more of the same and a continued effort, there is much more to do, but with the teams we have in place we can do it. She added that the team are preparing a best, worst and most likely position.

In relation to digital transformation, forecasting delivery of scheme is slower than expected. We are unable to recruit to some posts because of the financial position. In terms of working with system partners, there is more that can be done at system level. We are a leader in terms of using digital technology and the introduction of Electronic Patient Records (EPR) at SaTH and RJAH will help.

Ms Long noted the good news on agency spend but there is still a long way to go, she thanked Ms Lloyd for the report. The Board acknowledged the letter from Julian Kelly, Chief Finance Office NHS England that is in the pack relating to Better Payment Practice Code (BPPC) performance of the trust. Ms Darbhanga commended this phenomenal achievement.

The Board

- Considered the adjusted financial position for the year to date is a surplus of £290k compared to the planned surplus of £284k, which is a favourable variance of £6k.
- Recognised that agency costs continue to exceed our plan despite the controls in place and continued increases in substantive staff.
- Acknowledged the Trust's challenging CIP target for 2023/24 and that recurrent plans are not yet fully identified to deliver this level of efficiency.
- Recognised that the delivery of the elective income is the most significant risk to our financial plan.

GOVERNANCE AND AUDIT

Fit and Proper Person Test Framework for Board Members

Ms Ramtuhul provided an overview of the new Fit and Proper Persons Test (FPPT) Framework that has come into effect from 30th September 2023. It provides an outline of the changes that this means in practice and makes recommendations for approval to ensure compliance.

Highlighting three sections Ms Ramtuhul explained.

- Reference checks have been strengthened.
- Strengthening of annual checks, this needs to be reported annually.
- There is a need to complete the standard reference check and hold on personal files.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

The Board accepted the recommendations contained in the report and Ms Ramtuhul will work with Information Governance to implement the privacy notice.

The Board noted the assurance contained in the report.

QUESTIONS OR COMMENTS FROM MEMBERS OF THE PUBLIC

Questions or Comments from Members of the Public

Questions from a member of the public were submitted in advance of the meeting. Full responses were provided following the meeting. The full response is attached as an Appendix to the Minutes.

ANY OTHER BUSINESS – with prior agreement of the Chair

Any Other Business

There was none.

MEETING EVALUATION

Reflections on the meeting: effectiveness and any new risks and assurances

Ms Long thanked the Board for their contributions and M Darbhanga thanked Ms Ramtuhul and the Executive team for producing the reports.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 7 December 2023

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)

Appendix: Response to Public Questions

1. What consideration has the Trust given to including a 'Golden Hello' in its recruitment package (as used e.g., by Wye Valley?)

As part of our Workforce and Recruitment action plan, scoping of financial initiatives is being reviewed.

2. The 2022 Staff Survey confirms that Shropcom is a poorly performing organisation where opportunities for flexible working are concerned. This appears to have been the case for very many years. This can obviously be 'make or break' around retention of experienced staff whose personal situations may change. Can the Trust Executive take urgent steps to turn this around? Does the Trust actively encourage staff to request flexible working opportunities? Does the Trust audit the number of requests made, the percentage of requests approved, and the validity of reasons for non-approval? Are there opportunities for more supportive consideration of requests, or for independent appeals process where requests are turned down?

In support of the NHS, We Work Flexibly campaign, the Trust is currently developing resources for raising awareness and promotion of flexible working. This will include training and support for line managers to encourage both informal and formal flexible working arrangements for our staff. There are plans in place for the Trust to centrally gather formal flexible working requests to ensure oversight, support, and audit. The Trust policy does have appeals process in place should a flexible working request be declined.

3. Did the Trust pay the one-off non-consolidated lump sum payment to its bank staff? I am aware this was not funded centrally, and payment was therefore at the discretion of individual Trusts. If not, what would the cost have been of making this payment to Shropcom bank staff? What evaluation took place around the cost of payment versus the loss of goodwill and the potential consequences of this?

The Trust adhered to NHS Employers national guidance around the pay deal and the Trust did not pay the one-off non-consolidated lump sum payment to its bank staff. Through our Regional and Systems networks it was confirmed non-payment of the lump sum to bank staff was consistent with other providers.

4. Quite rightly, the Trust has – and publicises – an approach of low tolerance to risk around patient safety. How does this square with the current squeeze on the use of agency staff to cover for staff sickness or annual leave? Is the Trust confident that no patients are being put at risk through this?

For our clinical services an additional staffing FTE is included within budgets to ensure our substantively appointed staffing has contingency built in to cover annual leave, sickness, study leave etc. Safer staffing levels are monitored robustly through multiple scrutiny meetings each week. Where staffing levels fall below safter staffing limits, agency and bank are utilised. Daily – any additional shifts requested have to have an accompanying QEIA that is thoroughly scrutinised alongside the acuity and dependency of patients for that shift. Final sign off for additional staff to maintain safety is then agreed by the Director of Nursing. All quality and safety metrics are reviewed monthly and triangulated against safe staffing data and shared at the Quality and Safety Committee. Therefore, the Trust is assured through its robust patient safety governance arrangements that patients are not being put at risk, and Board have oversight by way of a Quality and Safety monthly report.

5. Wye Valley and MPFT attend 'Meet Your Future' events at Ludlow Sixth Form College. Has Shropcom considered this? Could attendance at this and similar careers events across STW be a valuable component of an ongoing recruitment strategy?

Our Education Team do link with multiple education agencies, and we continue to build upon this as part of our ongoing recruitment initiatives. We will absolutely make contact with Ludlow Sixth Form College.

Shropshire Community Health
NHS Trust

Chair's Update

0. Reference Information

Author:	Tina Long	**Paper date:**	7 December 2023
Executive Sponsor:	Shelley Ramtuhul	**Paper written on:**	29 November 2023
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

2.2 Summary

This report provides an overview of the following:

- Meetings and visits that have taken place
- Summary of the Private Board Meeting held in November
- Staff Long Service Recognition Awards and International Nurses Welcome

2.3. Conclusion

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

Shropshire Community Health NHS Trust

Chair's Update

3. Main Report

3.1 Meetings and Visits

One of the Non-Executive Directors and I attended a Schwartz Round held at the Health Centre in Oswestry to hear some staff share stories of how they have shown leadership in turbulent times. The stories were very powerful and staff present contributed to the reflective discussion. I include some information (Appendix One) on the purpose of Schwartz Rounds and their impact from Dr Camilla Johns who is a Consultant Clinical Psychologist and Professional Lead. I would like to thank Camilla and other colleagues for their continued leadership in this area and all those staff who attend the Rounds thank you.

I also did a clinical visit with a Non-Executive Colleague to the North Telford Community Nursing Team. We spent time talking with the Team Leader and some of the staff in the team. They told us about their improvement journey, and some of the positive changes to the quality of care for patients that the team have made over the past few months. They have offered to make a video on their journey and lessons learnt that can then be shared with the Board. Thank you to the team for spending time with us and for your absolute commitment to high quality patient care.

I have also attended a number of meetings with Primary Care Colleagues to further discuss how we can work collaboratively and Cathy Purt has agreed to be the Non-Executive Director lead in this area.

I have also attended a number of meeting with colleagues from partner organisations to further our collaborative working and partnership arrangements. In particular the inaugural meeting of the Provider Committee in Common which met in shadow form and marks an exciting step forward in formalising the collaborative working with our NHS partners in the system.

3.2 Private Meetings of the Board

In November the Trust Board met in private in Shewsbury where we discussed several important issues, including:

- Board appointments
- Sub-Acute Modular Ward Programme
- Bishop's Castle Community Hospital – Progress
- Quality and Safety Report
- Performance Report
- Financial Report

In addition to the above, the Board held an extraordinary meeting in November to consider new guidance on the financial challenges faced by the NHS, largely due to industrial action. Like all NHS organisations, we are experiencing financial pressures and we discussed what the guidance means for Shropcom and the Shropshire, Telford and Wrekin ICS. As a result, we confirmed our commitment to delivering our challenging financial plan but reinforced that our priority must always be patient and staff safety.

Chair's Update

3.3 Staff Long Service Awards and International Nurses Recognition

This month the organization held an awards ceremony to recognize those staff who have provided 25+ and 40+ years of service to the NHS. This was also an opportunity to recognize and welcome international nurses into the NHS.

This was the first such ceremony held since the pandemic and was a very rewarding afternoon which provided an opportunity to recognize the collective contribution of our amazing staff.

3.4 Conclusion

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

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Appendix One: Schwartz Rounds

Schwartz Rounds are a facilitated, confidential forum open to all staff, both clinical and non-clinical.
The aims of Schwartz Rounds are to give staff a space to talk and reflect on their own personal experiences of working in healthcare, while adopting a 'no problem-solving' approach. They provide a safe, confidential space to get together with other Trust colleagues and reflect on the stresses and dilemmas that we face while caring for patients and working in the NHS. Led by two trained Schwartz Facilitators, Rounds follow a set structure – 2 or 3 staff members share their own story on a predetermined topic relevant to all staff; these stories act as a springboard for discussion with the audience who are then invited to reflect on what they have heard and what struck them, exploring together the non-clinical aspects of our work and the personal impact that our job has on our thoughts, feelings and emotions. The purpose of the Round is to share experiences and support one another. Each Round lasts an hour, with a free lunch beforehand. Currently in Shropcom, Rounds are held face to face, approximately every six weeks, at different venues across the county. They are licenced by the Point of Care Foundation and are now running in over 300 NHS Trusts across the UK. They are recommended by the CQC because of the clear evidence base about their impact.

Impact/benefits

The underlying premise is that the compassion we draw on and show to each other makes all the difference, in turn, to how we deliver patient care, in whatever role we hold. To deliver compassionate care we all need to feel understood and supported in our work. Schwartz Rounds are an opportunity for this to happen. Talking together in Rounds helps us feel more supported, understood by our colleagues and allows us time and space for reflection together. Through talking in Rounds we make connections with each other and it helps to recognise that we are rarely alone in feeling the way we do. Research shows that staff who regularly attend Schwartz Rounds feel less stressed and isolated at work. Listening to colleagues describe the challenges of their work helps to normalise emotions which are often part of working in health care but which are often not talked about. This shared understanding improves communication between us and gives us a sense of better team-working. Discussing the personal impact of working in health also reduces the sense of hierarchy that exists between us. Seeing beyond the professional identity of our colleagues allows us to feel more connected to one another. Being part of a Schwartz Round provides us with a greater insight into how our colleagues, regardless of their role, play a vital part in our patients' journey.

NHS
Shropshire Community Health
NHS Trust

Chief Executive's Report

0. Reference Information

Author:	Patricia Davies	**Paper date:**	7 December 2023
Executive Sponsor:	Patricia Davies	**Paper written on:**	29 November 2023
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

3. Main Report

It is with immense sadness that we have learned of the four local young men who lost their lives in North Wales in November in such tragic circumstances. On behalf of the Board and all staff who work at Shropshire Community Health Trust, we would like to offer our deepest condolences to the family, friends and wider community affected by this devastating loss.

3.1 <u>Introduction</u>

This report sets out the national and local issues of strategic importance to the organisation (for information) not picked up through other Board reports.

The Board is asked to consider the impact of these issues on the Trust.

3.2 <u>Key Issues</u>

3.2.1 Bishops Castle Community Hospital

Following on from the decision taken on 7th September regarding Bishops Castle Inpatient beds, the Trust immediately recommenced recruitment and thereafter

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

revised the recruitment process in line with the recommended workforce and recruitment plan. This plan has been designed in collaboration with the public, staff and stakeholders through the Bishops Castle Steering Group and has been signed off by the October Trust People Committee and Trust Board.

Two recruitment events have already taken place on 13th October and 25th November and will continue into the new year (Friday 12th January 2024 and Saturday 24th February 2024, between 10am and 2pm at Bishop's Castle Community Hospital) alongside the advertisement and broad communication of adverts that have been supported in terms of production and advertisement by our local councillors and public. There have been several radio interviews and social media advertisements for the events and jobs available in addition to publications via local press. I would like to thank our staff and public for their commitment and support, which has brought the wider community, the trust, health, and local authority partners together. A further update on the recruitment plan can be found in the Director of Nursing and Workforce report. All the vacancies at Bishop's Castle Community Hospital can be found on our website.

In addition to the workforce and recruitment plan and efforts, the Trust has been working with the Southwest Primary Care Network and steering group on the wider model of care for Bishops Castle. There is a focus on expansion of outpatient facilities and the introduction of ambulatory and care coordination functions. Initial meetings have taken place with primary care and local authority partners. This work is closely related to the Shropshire Integrated Partnership Board (ShIPP Chaired by Shropshire Local Authority) and the work they are doing related to the development of 'Integrated Neighbourhood Team working'. There is a commitment from all partners to ensure that services which provide holistic care across the whole life span are part of this work. There is a plan to start testing service delivery in December. Further phases will then be developed with system partners in the new year.

I will report further on the recruitment plan and model of care in the New Year

3.2.2 Vaccination – Flu Vaccinations

The annual Flu programme saves thousands of lives every year and reduces GP consultations, hospital admissions and pressures on A&E. Vaccinating our staff is essential in protecting both our workforce (and their families), our patients and all visitors to our hospitals and services. The Commissioning for Quality and Innovation (CQUIN) target for the 2023/24 flu immunisation programme is for 75%-80% of patient-facing staff to take up the vaccination.

The Occupational Health and Wellbeing (OHWB) Team has developed an action plan which will be supported by the Communications Team for this year's campaign. The programme began on 12 October and several roving clinics have taken place and continue with peer vaccinators supporting the campaign, along with local 'Flu Champions'. Progress updates are provided to the Executive weekly and to the Board

via the People Committee. I will provide progress updates to these committees and Board throughout the programme and a final position in March 2024.

3.2.3 Vaccinations – Covid Vaccinations

The Trust remains the lead provider for the Shropshire, Telford and Wrekin (STW) Covid-19 Vaccination Programme.

Following the emergence of a new Covid-19 variant (BA.2.86), the NHS was asked to bring forward this year's Autumn/Winter Covid vaccination programme from the planned October date to 11th September for Care Home and housebound residents, with other eligible cohorts able to book into clinics from 18 September. I am pleased and proud to announce that STW have again delivered the COVID vaccine to our most vulnerable residents in full and on time, with all care home vaccinations being delivered by 22nd October putting STW as 4th in the Country in terms of performance in this vital area.

As of 12th November, the Trust, in collaboration with colleagues in Primary Care Networks (PCNs) and Community Pharmacies have delivered over 110,000 vaccinations to residents in the STW area, with percentage uptake at or above national and regional averages. However, in a similar pattern to the spring programme, our week-on-week uptake at the mid-point of the core programme remains stronger than most of our regional peers and well above regional and national averages. Our current uptake amongst the key over 75s cohorts is around 75%, with a forecasted uptake of 80% by the end of the programme.

Staff uptake within the Trust is currently 36.9% which, although not as high as during the Autumn 2022 campaign, does place the Trust as 3rd best performing trust in the Midlands region. The comms team are continuing to stress the importance of staff winter vaccinations (both Flu and Covid) to help protect staff and their loved ones during the key winter period.

The eligible cohort across the STW area amounts to almost 240,000 people, which includes everyone aged 65 and over, residents in a care home for older adults, frontline health, and social care workers, those aged 6 months to 64 years in a clinical risk group, carers aged over 16, and household contacts aged over 16 of immunosuppressed patients. The core programme runs until 15 December with activities to address vaccine health inequalities continuing until 31 January 2024.

During this current campaign, there are a blend of providers including SCHT, PCNs and Community Pharmacies located across the county. Pop-up clinics and roving teams are being utilised by the programme to ensure that we maximise potential to reach all our eligible cohorts. Based on previous performance, the programme is forecasting to deliver a total of over 140,000 vaccinations, approximately 60% uptake overall, but with a much higher uptake rate in our Care Home residents and over 75s.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

The Board will continue to receive regular updates on the performance of both the Trust and the System against these plans over the coming months.

3.3 Our People

3.3.1 Staff Survey

The 2023 National Staff Survey opened at the beginning of October and closed on the 24 November. During this time, we ran a supportive 'Take Twenty to ensure your voice is heard' campaign to increase the uptake and completion of the survey. We are encouraged by the quarterly pulse survey uptake and results from the previous 2 quarters and will await the results of the staff survey in early 2024 to build on the programme of work previously reported regarding Listening Events and staff engagement and inclusion.

3.3.2 Recognition and Reward

In mid-October we introduced the Tusker Salary Sacrifice scheme for cars scheme and 8 individuals have signed up during the first month. The George Cross and NHS 75th Anniversary pin badges have started to be distributed throughout the Trust. Late November the Trust held an afternoon tea celebratory event to recognise Long Service and welcome our International Nurses.

We continue to deliver actions against our recruitment and retention improvement plan, recent achievements include: -

- Arranging the final Race Code Onboarding session for 6 December 2023

- Implementation of E-rostering system commenced with a phased approach to rolling out across the Trust.

- Recruitment events for HMP Stoke Heath, Bishops Castle Community Hospital and Sub-acute wards (in collaboration with SaTH)

- Digital Marketing Platform commissioned to enhance advertising

- Developed recruitment branding for a consistent look across all adverts

3.4 Other Areas of Performance

3.4.1 Elective RTT and non RTT

Trust overall performance from September 2023 was 61% which was impacted significantly in August following the launch of the MSST service (Musculoskeletal services, Shropshire, and Telford), phase 2 of the system (Musculoskeletal) MSK

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

transformation programme of work (more on this programme of work later in the report). As with all big changes to processes involving several organisations, there have been some challenges that the system has needed to work through, whilst moving to a more effective and joined up approach. SCHT and system teams have responded to this by putting in place clear operational plans to oversee wait times at both organisational and system levels. The Trust and system partners have plans in place to reduce waits further in line with the NHSE trajectory of zero 65 week waits by the end of March 2024.

Given c80% of RTT performance aligns directly with MSST, which is part of a provider MSK Alliance with our Robert Jones and Agnes Hunt (RJAH) and SaTH partners, this is a key area of focus for the Trust and system. All actions need to be aligned with system partners given the interdependency of service delivery and this is being overseen by the ICB through the system MSK Transformation programme, which RJAH are the programme lead. Enhanced governance at both Trust and System level has been aligned to ensure the delivery of elective recovery.

The other key RTT area of challenge has been within our specialist dental service which I have previously reported on. I am pleased to report that these long waits have been considerably reduced with a robust plan for recovery in place and following additional theatre sessions being made available from Shrewsbury and Telford Hospital NHS Trust (SaTH).

More detail on RTT and non-RTT performance can be found within the integrated performance report.

3.4.2 Non-RTT Services

Areas of good practice and improvement are particularly visible across pulmonary rehab and long covid from a non RTT perspective.

Significant improvement has been seen within the Pulmonary rehab service which had previously had a large backlog of patients over 18 weeks with some waiting over 65 weeks. The longest wait in this service is now 35 weeks with a plan to reduce further. The service is currently performing at 87% in terms of an 18-week pathway which is an improvement of 37% since January 2023. This is a continuing improving forecast and has been achieved by enhanced senior oversight, increased clinic capacity, and digital implementation of some pathways.

The waiting list for other non-RTT services is currently in the best position it has been since pre-pandemic. With currently only 4 patients waiting above 4 weeks for initial assessment and performance is currently at 93%. In January 2023 there were 179 patients waiting over 18 weeks with performance at 32%. This recovery has been successfully achieved again with enhanced operational and clinical oversight,

Chief Executive's Report

streamlined pathways, and following a best practice approach for self-help advice and guidance.

Childrens services such as Child Development Centre (CDC), Children's Physiotherapy and Speech and Language therapy continue to experience challenges in reducing the number of patients waiting above 18weeks. All these services have seen a consistent increase in demand (this is also reflected at a national level). Gaps in workforce particularly for paediatricians and Speech and Language therapists have further compounded the challenges over the summer. The immediate actions to support recovery are:

• Tender process for General Practitioner with Paediatric specialist interests to support with community paediatric activity.

• Enhanced recruitment campaign and exploration of international recruitment for Paediatrician consultants.

• Ongoing acceleration of the SLT pathways working closely with education

• Speech and language therapist due to start end of December and service are utilising agency to safely manage the gap and cope with demand as an interim measure.

The Community Neurorehabilitation Team (CNRT) is the only other non-RTT service that is currently underperforming in relation to the number. This service is currently delivering 66% RTT with 82 patients over 18 weeks. The key challenge being vacancies in Psychology which has required a 6-month lead time to fill. A series of locums have been used to mitigate and support urgent cases however this has not always proven to be consistent and reliable. I am pleased to report that we have now successfully secured a contract arrangement with a consultant psychology service from December which will enable us to focus on a clear recovery plan to reduce waits further in line with the Trust recovery plan.

3.5 <u>Programmes of Work</u>

3.5.1 Local Care Transformation

Local Care Transformation covers a range of programmes and transformation initiatives across the STW Integrated Care System to deliver more care in local communities and where possible in people's homes. The ICS wide programme focuses on delivering more proactive and joined-up care, aiming to help people keep healthy and independent in their community. In doing so, we will reduce and avoid unnecessary admissions to acute hospital settings and achieve improved outcomes by supporting people in the community.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

Shropshire Community Health NHS Trust has played a significant role in the implementation of Local Care to date, including the delivery of rapid response services, the continued expansion of the virtual ward, and the establishment of an Integrated Discharge Team (IDT). Virtual wards provide sub-acute medical care in the place a person calls home - enabling appropriate patients to return home from hospital sooner or avoid an admission in the first place. The Integrated Discharge Team (IDT) focuses on proactively planning for discharge from the point of admission to safely discharge from hospital with the right support in place. The IDT team is a multidisciplinary staff mix with a range of professional experience across acute, community, mental health and social care, who are empowered to make autonomous and accountable decisions that are respected across all partner organisations. The team also work closely with Pharmacy, Mental Health Liaison Services and Hospital Clinical and Management Leadership teams. These initiatives have played a critical role in supporting people in their communities and reducing/avoiding the need for care within an acute hospital setting.

The next phase of Local Care Transformation is planned to focus on supporting the further development of Integrated Neighbourhood Teams (INTs) across STW, with an initial system wide focus on the expansion of multi-disciplinary teams providing targeted and co-ordinated support to people who are frail and have multiple long-term conditions. The aim is to support independence and wellbeing and to prevent avoidable exacerbation. This is a system wide programme which will involve staff working across primary care, community health, social care and voluntary sector to work even more closely together to support this particular cohort of people.

3.5.2 MSK Transformation and MSST

Musculoskeletal services (MSK) was one of the original big six ticket items for Shropshire, Telford & Wrekin in terms of efficiency and clinical outcome gains for patients and residents. The aim of the ICS system programme of work is to integrate MSK services across the county to ensure equitable access to evidenced based pathways of care, ensuring the right care, in the right place at the right time by the most appropriate clinician. This is turn will reduce the volume of patients needing to see a consultant and potentially converting to surgical procedures. The strategic programme lead is RJAH.

The first element of transformation in the programme is the elective pathway. Through engagement and co-design clinical and service models have been developed - MSST (Musculoskeletal Service Shropshire & Telford). A phased approach is being taken to the implementation of MSST. Both Phase 1 and Phase 2 are now live which sees the single point of access, centralised standardised triage, outpatient physio, OT & Podiatry and Advanced Practitioner & GP with Specialist Interest clinics operational. Delivery of the service is across all 3 providers; SaTH, RJAH & SCHT, so requires close partnership working.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

There have been unintended consequences, and as with any programme of work the system is focused on ensuring that the model of care which has been agreed and is right for patients, is operationally delivered in the right way. Issues with wait times are continuing to be worked though to ensure recovery and then quick and timely access to therapy as per the original model. County wide joined up clinical triage has been a real success with all referrals triages against standardised criteria within 48 hours of receipt.

As we continue to improve performance within the current phases, work on phase 3, which sees the addition of consultant level clinics, is ongoing and we are working with partners to expedite this to ensure equitable access and a joined-up approach to prevent long waiting patients.

3.6 Good News Stories

3.6.1 Dudley Tender

The Trust is very pleased to have been informed that they have been successful in their bid to provide a 0-19 (25) service to deliver all elements of the Healthy Child Programme in the Dudley Metropolitan Borough Council area. This service includes:

· Health visiting

· Family Nurse Partnership

· School Nursing

· A universal emotional health and wellbeing service.

The contract is due to begin in April 2024 and the team are busy planning the successful mobilisation of the service. This is significant new business for the Trust and represents an expansion of the similar service that is provided in Shropshire, Telford & Wrekin.

3.6.2 Graduate from Developing Aspirant Leaders Programme

Paulson Baby Arancheril, Pathway Co-Ordinator on Virtual Ward graduated the Developing Aspirant Leaders Programme (DAL) this month. The programme is designed to assist ethnic minority nurses and midwives who aspire to attain senior leadership positions. Developed by and for ethnic minority nurses and midwives, DAL offers academic learning, sponsorship, and a stable platform for professional growth, therefore establishing an initiative for career advancement.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chief Executive's Report

Paulson came to ShropCom as an International Nurse, and he continues to work with our International Recruits to provide support and learning opportunities.

NHS
Shropshire Community Health
NHS Trust

"The DAL leadership training journey was really motivating and I explored lots of skills and it also motivated my own leadership skills.

I look forward to bringing these skills into my everyday work"

Paulson Baby Arancheril
Pathway Co-Ordinator
Virtual Ward
Shropshire Community Health Trust

3.6.3 Remembrance Day

As a Trust with staff who are serving and ex serving members of the military Remembrance is an incredibly important time of year. Colleagues across the Trust marked the day to pay our gratitude and respect to all our serving and veteran military and their families, across the Trust and in our community in a number of ways.

Maggie Durrant, RRC, Lt Col (Ret'd), who is the Armed Forces Lead for the Trust said:

"To pause, reflect and remember, with deep gratitude, appreciation and respect, the brave men and women who have served and continue to serve our country during times of war, conflict and peace, is the least I can do. I wore my beret, medals and poppy with pride and bowed my head in thanks, lest we forget."

3.6.4 Long Service Awards

On 28th of November we celebrated many of our staff who have worked for the NHS in Shropshire for a few years. We are blessed with having many experienced staff who have worked for us and the local community for many years delivering fabulous care and supporting wider staff and new starters at the beginning of their careers. Hearing their story was a real inspiration and makes me feel even more privileged to serve this community trust and the staff within it as the Chief Executive. Thank you for your service and commitment to Shropshire, Telford, and Wrekin.

During the same event, we also celebrated and welcomed our international recruits some of whom have been working with us for nearly a year and some are new cohorts of clinicians who have just joined us in the last few weeks. All bring an absolute wealth of skill and experience and thank you so much for your service and commitment and making Shrop Comm and even better place to work.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

NHS
Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality and Safety Committee 23rd November 2023

0. Reference Information

Author:	Jessica Donegan Executive Assistant	**Paper date:**	23rd November 2023
Executive Sponsor:	Clair Hobbs, Director of Nursing, Clinical Delivery, and workforce and DIPC	**Paper written on:**	29th November 2023
Paper Reviewed by:	Sara Ellis-Anderson, Deputy Director of Nursing and Quality and Deputy DIPC	**Paper Category:**	Quality and Safety
Forum submitted to:	Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality and Safety Committee meeting held on the 23rd of November 2023 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

This paper presents a summary of the Quality and Safety Committee meeting held on the 23rd of November 2023 for assurance purposes. The role and purpose of the Committee is to oversee all aspects of Quality and Safety to provide onward assurance to the Board.

2.2 Summary

- Historic Serious Incidents being looked at by Hill Dickenson for NHSE were delayed to allow for the inquest to take place.

- Action plans for SEND, HMIP, Prison Inspections have been created with progress being made in all areas. There was also an update on CQC preparedness given.

- Patient Transfers were discussed due to a review of an unexpected death at a community hospital. it was agreed that we were to look into the handover process in detail to mitigate potential patient safety risk.

- The winter planning report indicated the key areas for focus this winter

- The research our Trust is carrying out and doing for the wider system was commended

- The Prison Service update provided assurance that progress was being made on recruitment and governance processes had been established.

- An update on Sub Acute Wards which is scheduled to open January 2nd 2024 was given to the committee

2.3. Conclusion

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

Shropshire Community Health NHS Trust

Chair's Assurance Report

Quality and Safety Committee 23rd November 2023

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Quality and Safety Committee from the Patient Safety Committee Meeting which met on the 12th of October 2023. The meeting was quorate. A full list of the attendance is outlined below:

Chair/ Attendance:
Chair: Jill Barker, Non-Executive Director Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce and DIPC Alison Sargent, Non-Executive Director Cathy Purt, Non-Executive Director Dr Ganesh, Medical Director Shelley Ramtuhul, Director of Governance/Company Secretary Claire Horsfield, Director of Operations Patricia Davies, Chief Executive Sara Ellis-Anderson, Deputy Director of Nursing and Quality Gemma McIver, Deputy Chief Operating Officer Helen Cooper, Clinical Divisional Manager for CYP and planned care Martin Howard, Patient Safety Representative Jessica Donegan, Executive Assistant
Apologies:
Tina Long, Chair Susan Watkins, Chief Pharmacist Tracie Black, Associate Director for Workforce, Education & Professional Standards

3.2 Actions from the Previous Meeting

The chair noted the actions of the previous meeting and received an update on the progress of each open action.

3.3 Key Agenda

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

NHS
Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality and Safety Committee 23rd November 2023

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Minutes and actions from previous meeting		
Minutes reviewed and approved. Update on actions received and action log updated.	Y	
2. Workplan		
Limited agenda to be created for an extraordinary December meeting for the Medical Cover and Staffing Model Update for Sub-Acute Wards	Y	14th December 2023
3. Patient Experience Report (Including Complaints and PALS report)		
Discussion was held around the FFT, service level FFT data and the complaints received. Total of 133 compliments within Q2, twelve observe and acts visits with environment and signage being the common theme.	FULL	
4. NHS Resolution Report (Claims, Inquests and Litigation) Annual		
Update provided, Claims, we do not receive many annually, this report will look more meaningful once the new Associate Director is in place. Inquests needs to have the reporting addressed with the potential to create a separate report. The two inquests we have received we have yet to be informed of outcome and will report on that once received.	Partial	Further assurance required on progress.
5. SI report- Process & Compliance and Learning/Outputs		
The historic incidents requested to be reviewed by NHSE, this is the first report we will have presented using the new process implemented in December 2022. The report is looking to be altered as the Trust transitions to PSIRF. The data will also be double running for 12months following the implementation of PSIRF to allow for learning, responses, details and information to be held while systems are moving. In regard to overdue actions the team are working through and clearing them with the operational teams.	PARTIAL	Awaiting for the team to be established, linking with operations and updating and closing the actions.
6. Inspections flash report- CQC, SEND and Prison		
SEND 6 month review took place November 6th and verbal feedback received indicated it went well. The Prison service remedial action plan was closed formally August 1st and the Trust met with NHSE on the 9th November to implement some further actions which includes having a central repository and central inbox for all NHSE Prison communications. CQC engagement meeting held in November.	FULL	
7. Quarterly Mortality and Learning from Deaths review Q2		
Eight deaths total, three were unexpected, two of those within the Community Hospital and one within the Prison. There		

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

Chair's Assurance Report

Quality and Safety Committee 23rd November 2023

were no covid deaths. One death of an adult with learning disability. The discussion around the post-surgical transfer from SaTH death led to a deep discussion around the transfer of patients as well as the Medical Examiner role, this has been filled and hoping to see a start of April 2024.	FULL	
8. Integrated Quality and Safety Performance		
Key highlights included a drop In Falls and a rise in Pressure ulcers in October, the team in Telford North is dropping in a positive perspective, this has been put down to a change in leadership. CDIF had three, January, June and August. Mandatory training didn't reach overall target but was close	Partial	Awaiting work regarding level of harm to long covid patients
9. Winter Planning Report		
Main areas noted within the paper are keeping staff and patients well with the use of Covid and Flu vaccinations. Progress is ongoing with the 52 sub-acute beds which is opening 2nd January 2024 at RSH & PRH.	PARTIAL	
10. Chairs Reports		
Patient Safety Committee PSIRF Policy and plan was approved and a DRG was agreed. There are still concerns around Discharge letters, we have sought for further assurance to ensure no further impact on patient safety or readmissions.	FULL	
11. Clinical Effectiveness Report		
Twenty-two audits in six months, there is one delay in prison, likely due to capacity. We continue to submit the four national audits we are a part of. Discussion held on work of the Research team and their initiative of Research champions within the organisation.	FULL	
12. Quarterly Guardian for Junior Doctors for Safe Working Reports		
Three trainees currently on placement with us, no complaints received or special exemption reports from them. The training program has changed from September 2023 so we may not have six month positing of trainees going forward it is competency based. It was agreed that the level fours and other aspiring leaders could be invited into committees to experience them.	FULL	
13. Prison Update		
There have been national pressures on prisons over the last 12 months and inmates have been increasing, so we have been working to manage that capacity and the requirements.	FULL	

Chair's Assurance Report

Quality and Safety Committee 23rd November 2023

Equally that has put pressure on all healthcare services and the transfer between prisons has also increased, all inmates receive an initial screening upon entering. August 2023 saw a vacancy crisis with 15 WTE vacancies and we have seen additional pressures from these. It was decided that moving forward Helen Cooper would chair the Prison governance meeting so it would sit with us. Research within the prison was considered with numerous different suggestions offered and potentially escalating so that full funding could be received. Some Prisoners have been trained to give aspects of care to others to help bridge the gaps.		
14. QSC related BAF risks		
Live document that is submitted so is consistently changing, we will be having these checked when Execs meet to ensure line of sight of these elements is happening and we can challenge ourselves going forward	PARTIAL	
15. Medical Cover Paper for Sub-Acute Wards		
Current position is 52 beds opening 2nd January split between PRH & RSH, there will be three pathways, Orthopedics, Stroke Rehab and Frailty. Buy in from sub-acute settlements has been good but has lacked from Specialist Consultants. The ultimate Medical Model for out sub-acute is a combination of GP and ACP, to get that in a substantive position will take some time. The step down of sub-acute ideally will be home, Virtual Ward or rapid response, the underlying principle all have agreed to is home first. Further information will be presented at extraordinary QSC December 14th.	PARTIAL	
16. CQUIN Updates		
The biggest risk to the delivery is CQUIN 12, assessments are being completed just not within the six-hour timeframe. Bridgnorth appear to have good process, so it is about learning from their process and sharing that.	PARTIAL	

3.4 Risks to be Escalated

No risks identified.

4. Conclusion

The Board is asked to note the meeting that took place, the progress being made and the assurances obtained.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

0. Quality and Safety Report – November 2023

Author:	Chris Panayi – Quality Facilitator Sara Ellis-Anderson - Deputy Director of Nursing and Quality and Deputy DIPC	**Paper date:**	7 December 2023
Executive Sponsor:	Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce	**Paper written on:**	13th November 2023
Paper Reviewed by:	Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce	**Paper Category:**	Quality and Safety
Forum submitted to:	Public Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

2. Executive Summary

2.1 Context

The report aims to:
- Provide the Board with an executive summary focusing on areas for and areas of improvement.
- Provide access to the suite of detailed quantifiable information from the Trust's single data performance repository for reliability and accuracy.
- Analysis to provide evidence through external benchmarking, Trust historical performance and triangulation of softer intelligence to strengthen both reliability and confidence in content.
- Report improvement headlines from the Service Delivery Groups (SDGs).

2.2 Summary

Safe
- The 12-month rolling count of MRSA Bacteraemia infection rates were reported as zero for October.
- The number of inpatient falls (5) in our care fell significantly in October compared with 13 in September. The rate of falls per 1000 occupied bed days (1.97) has also dropped significantly and compares favourably with the average for 2022/23 (6.41). We also saw an overall decrease in harm relating to falls this month with 3 falls resulting in low harm only.
- 2 Serious Incidents (SI's) were reported in October, one more than the previous month.
- The development of pressure ulcers in our care was reported as 67 in October, an increase of 23 compared to 44 reported in September.
- The count of Never Events reported by the Trust for October was 0.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 1...

- The count of National Patient Safety Alerts not completed by deadline reported by the Trust for October was 0.
- The 12-month rolling count of E. coli Bacteraemia reported in October 2023 was 0.
- The 12-month rolling counts of Clostridioides Difficile (C. Diff) infections in October 2023 is 3 with cases in January, June and August 2023. There were no new cases reported in October.

Caring

- New Birth Visits (NBV) reported a reduction in performance for the latest month with 81.95% of NBV undertaken within 14 days across the County in September. There were no incidents of harm linked to late visits and all visits did take place.

Responsive

- Complaint response has improved slightly to 25% - 18 complaints have exceeded their reply deadline.
- The 18-week RTT data improved for the 13th consecutive month with percentage of no harm reported at 74.9% for September compared to 74.2% in August. Percentage of low harm also improved to 25.1% from 25.8% in August. 406 harm proformas have been completed to date.

Well Led

- Mandatory Training overall target of 95% was not achieved in October with 94.27% reported, with a slight increase from 94.23% reported in the previous month.
- Appraisal position in October was reported as 81.26% a 1.7% improvement from 79.46% in September. Robust monitoring meetings are in place to ensure recovery occurs along with the launch of the new appraisal paperwork.
- Sickness rates in October were 5.9%, which is a 0.7% increase from 5.2%, reported in September.

Effective

- There were no deaths categorised as unexpected for October.

2.3. Conclusion

The Committee is asked to:

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

Safe - Inpatient Falls

Community Hospitals form part of the Integrated Care System (ICS) transitional care pathways. This can lead to challenges on our Hospital Wards as the Trust cares for people who require rehabilitation often relating to falls and are therefore at higher risk of further falls when on the ward. The Trust aims to reduce the risk of patients sustaining any harm because of a fall whilst in our care. When patients do fall, a level of harm are assigned to the incident as follows:

- No harm – no harm caused to patient.
- Low harm – patient required extra observations or minor treatment.
- Moderate harm – patient required a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area.
- Severe harm – death or permanent harm are caused to the patient.

These descriptors are used during this report and are recorded on DATIX.

Total number of Falls in month 5 ↓
Falls per 1000 Occupied Bed days 1.97 ↓

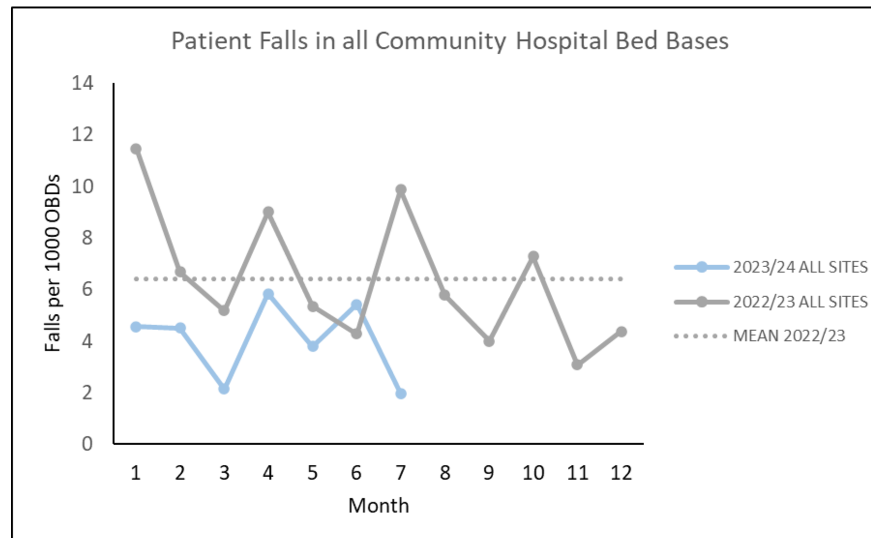
During October there were 5 inpatient falls reported which occurred in our care across the Community Hospital Wards, which equates to a rate of 1.97 falls per 1000 Occupied Bed Days (OBDs). This is a lower number and incidence rate than in M6, represents a significant improvement in performance, and is significantly below the average incidence for 2022/23 (6.41). Our falls incidence in month compares favourably with other regional community providers. Please see the table below detailing the rate of falls per 1000 OBDs for 2022/23 and 2023/24.

		M1 April	M2 May	M3 June	M4 July	M5 Aug	M6 Sept	M7 Oct	M8 Nov	M9 Dec	M10 Jan	M11 Feb	M12 Mar
2022/23 ALL SITES	Falls	26	15	12	21	12	10	24	14	10	18	7	11
	Falls per 1000 OBDs	11.46	6.69	5.66	9.01	5.35	4.29	9.87	5.79	4	7.29	3.08	4.38
2023/24 ALL SITES	Falls	11	11	5	14	9	13	5					
	Falls per 1000 OBDs	4.56	4.5	2.15	5.84	3.79	5.43	1.97					

Graph 1 below shows the occurrence of falls per 1000 OBDs across 2022/23 and 23/24, with mean falls occurrence for 22/23 also shown.

Falls Graph 1

Falls per 1000 occupied bed days 22/23 & 23/24



In total 5 individual patients fell in October, with no repeated falls seen. Only one of the falls was witnessed and occurred during supervised mobilisation of a patient by nursing staff at Bridgnorth. Investigation of this event revealed that the staff involved were not following the advice of therapy staff, and the need for an agreed MDT plan for mobility has been highlighted with the staff involved and learning shared at subsequent safety huddles.

In October, only 1 fall occurred between the hours of 22:00 and 07:00, a continuation of a lower rate in night-time falls after an increase in M5. All the patients were mobilising or transferring at the time of their fall, and staffing was not identified as contributing factor in any of the incidents. Confusion has been identified as a contributory factor in 3 of the incidents and in all cases, supervision levels were reviewed and either increased, or the patient moved to a bedspace with greater visibility. All falls occurred in patient bays.

The distribution of inpatient falls across the hospital sites in October was as follows:

Community Hospital Site	**Total number of falls**	**No Harm**	**Low Harm**	**Moderate Harm**	**Severe Harm**	**Falls per 1000 OBD's**
Whitchurch	1	0	1	0	0	0.95
Bridgnorth	4	2	2	0	0	5.34
Ludlow	0	0	0	0	0	0

In M7 there was an overall decrease in harm. Three patients suffered low harm (skin tear and bruising) only and two of these individuals were conveyed to secondary care for review but returned with no other harm identified and with no change to their management plans.

Review of DATIX relating to Falls in M7 revealed a persistent reduction in the quality and completeness of reporting with all DATIX missing key information including details specific to the individual patient and the circumstances of the incident. Locality Clinical Managers have been asked to continue to work with their teams to support them to address this.

Quality Improvement in M7 included:

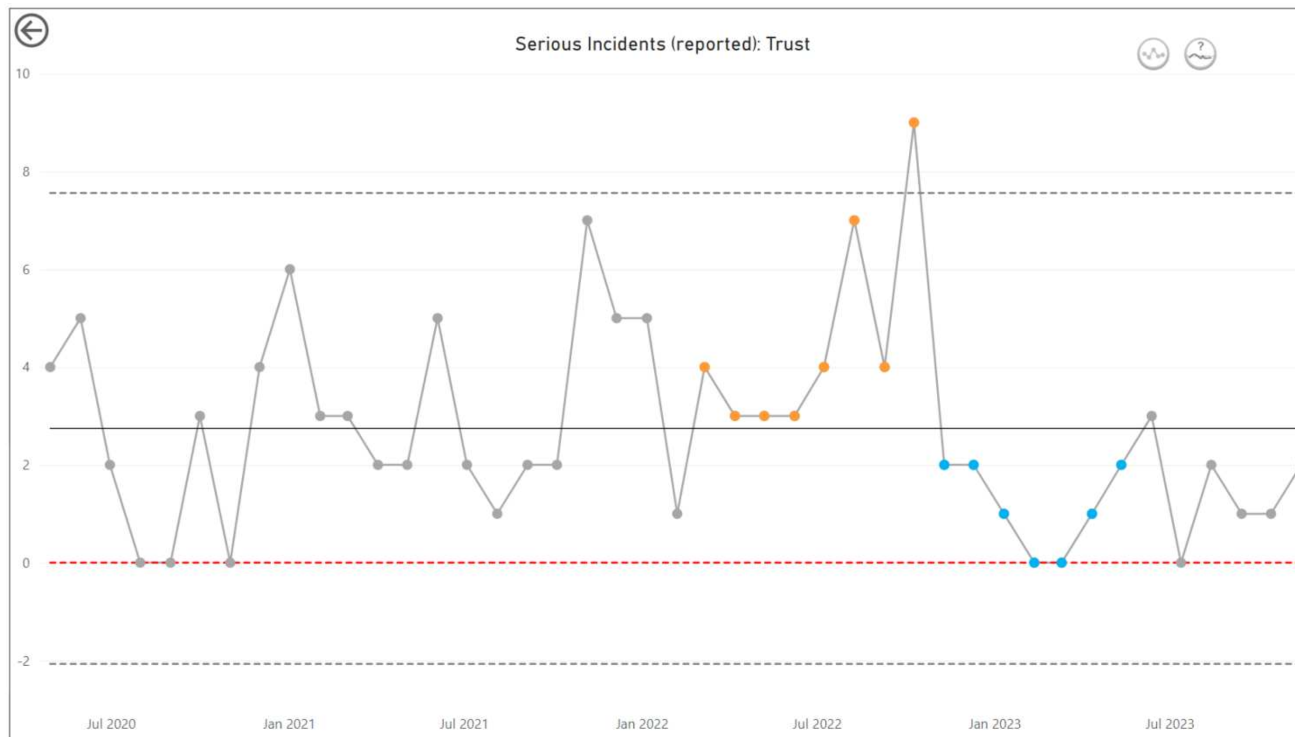
- Continuation of data deep dive to understand correlation between time of transfer to our bed bases and incidence of falls in confused patients.
- Prevention strategies to be reinforced at safety huddles including prioritisation of patient supervision.
- Reiteration of importance of comprehensive reporting of patient incidents with ward-based staff.

Safe - Serious Incidents

Serious Incidents (SI) are events in healthcare where the potential for learning is so great, or the consequences to patients, families or carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
All patients will receive safe and high-quality care whilst under our care.

Total reported = 2 ↑

There were 2 Serious Incident's reported in October, one more than the previous month. One incident involved an inpatient fall (incident occurred in September) resulting in moderate harm due to the patient sustaining a bleed and skull fracture and the other relates to the death of a patient shortly upon discharge from Stoke Heath Prison. Regular ongoing monitoring remains in place to ensure oversight of all potential Serious Incidents, through Panel meetings chaired by Directors and with representation from the ICB.



Safe – Pressure Ulcers

We aim to reduce the number of patients in our care from developing a pressure ulcer attributable to our acts or omissions.

Total = 67 developed in service ↑

67 pressure ulcers were reported as developing in the care of the Trust in October. This is twenty three more than reported in September (44). None were reported as Serious Incidents. There was 1 category four pressure ulcer reported, 3 category three, 8 unstageable pressure ulcers, 33 category two, 19 suspected deep tissue injuries, and 3 category one.

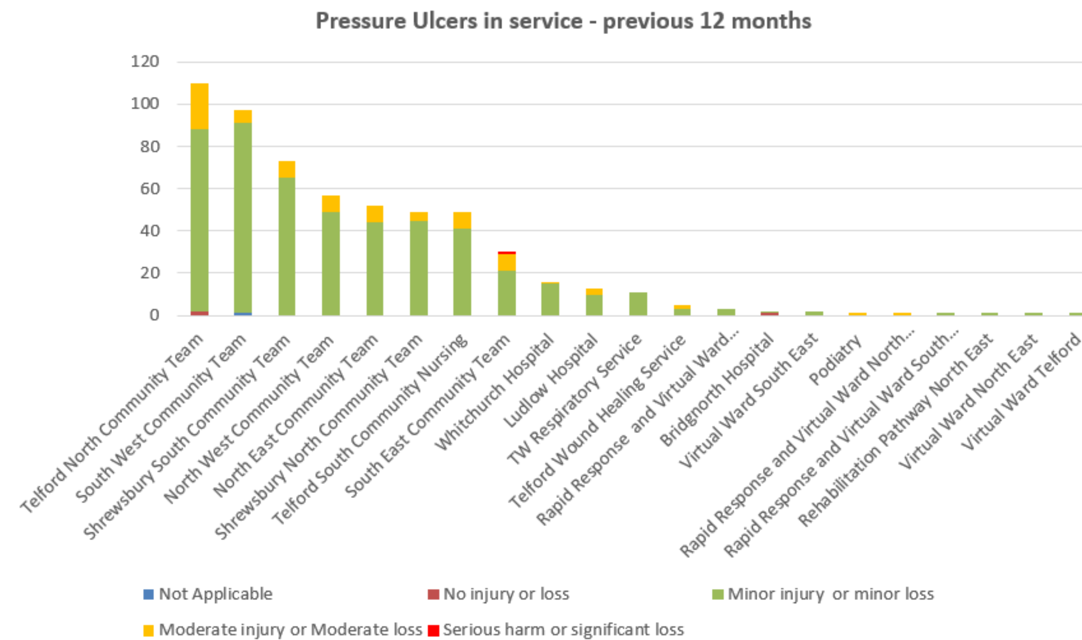
The level of moderate harm reported overall has increased in October to 11, slightly above the average reported of 10.

There has been an drop to 9 (from 14) category 3 pressure ulcers reported, and 6 (from 18) category 4 pressure ulcers at this stage in 2023 compared to the same period last year. This demonstrates a reduction in harm and a positive reporting culture.

The distribution of pressure ulcers across the Community Nursing Teams in October was as follows including the level of harm associated:

Service/Team	1	2	3	4	Unstageable	Suspected Deep Tissue Injury	Total	Low Harm	Moderate Harm
South West Community Team	0	7	0	0	2	3	12	11	1
Telford South Community Nursing	2	4	0	0	1	3	10	9	1
North East Community Team	0	4	2	0	0	3	9	9	0
Telford North Community Team	0	4	0	0	2	2	8	6	2
Shrewsbury South Community Team	0	4	0	0	0	2	6	5	1
Shrewsbury North Community Team	1	3	0	0	0	1	5	5	0
North West Community Team	0	2	0	0	0	2	4	3	1
South East Community Team	0	0	0	1	0	3	4	2	2
Ludlow Hospital	0	1	0	0	0	0	1	0	1
Podiatry	0	0	0	0	1	0	1	0	1
Rehabilitation Pathway North East	0	0	0	0	1	0	1	1	0
Telford Wound Healing Service	0	0	1	0	0	0	1	0	1
TW Respiratory Service	0	1	0	0	0	0	1	1	0
Virtual Ward North East	0	1	0	0	0	0	1	1	0
Virtual Ward South East	0	1	0	0	0	0	1	1	0
Virtual Ward Telford	0	1	0	0	0	0	1	1	0
Whitchurch Hospital	0	0	0	0	1	0	1	1	0
Total	3	33	3	1	8	19	67	56	11

The graph on the following page illustrates the distribution of pressure ulcers across each service with the associated levels of harm.



South West Community Team account for the majority of pressure ulcers reported in October (12), and Telford North Team account for the majority over the previous 12 months, however Telford North have represented a continued decreasing trend for this team over the last 7 months. Reasons for higher pressure ulcer reporting for Telford North could be attributed to the population they serve with an older age profile and a higher than average income deprivation.

Actions in place to improve:

- Planning for Stop the Pressure week has been communicated out with a weeks' worth programme including education on all community wards and virtual education sessions covering aSSKINg the theme being 'Every Contact Counts'.
- New NHSE (NHS England) classification guidance has been released at end of October 2023 which will impact the way in which pressure ulcers are classified which will result in changes to reporting.
- Four pressure ulcer categories will remain: Unstageable will no longer remain but will be reported as Category 3 with new guidance.
- Deep Tissue Injuries (DTIs) are not to be reported until skin is broken, and category of damage is revealed.
- New recommendations are being presented at Patient Safety Committee on 13/11/23 for discussion and approval.
- PURPOSE-T form has been finalised and just awaiting NHSE pathways to be added. There is no additional risk as a result in the delay in roll out.
- Monthly caseload reviews continue to discuss complex wounds with caseload holders and pressure ulcers to ensure appropriate actions have been taken to prevent deterioration in wounds/pressure ulcers.
- Tissue Viability Hotline is in place which occurs weekly for teams to discuss any issues and gain support from the Tissue Viability Service.

Safe – Compliance with CQC Medicines Management

Proportion of actual compliances with standards against potential compliances

Performance = 98.18 ↑

CQC standards concerning Medicines Management are monitored for a number of services on a monthly basis. These standards help to evidence that the fundamentals of medicines management at ward or clinic level are maintained. Each standard monitored is defined by the CQC. These standards include monitoring of room and fridge temperatures, daily monitoring of resuscitation trolleys, daily checks of controlled drugs, appropriate management of sharps bins, spill kits and fully documented allocation of FP10 prescriptions.

A Standing Operating Procedure (SOP) supports staff and defines expected actions. The minimum target for compliance is set as 95% which was agreed by the Quality and Safety Committee in 2019. The results from the last quarter can be seen below:

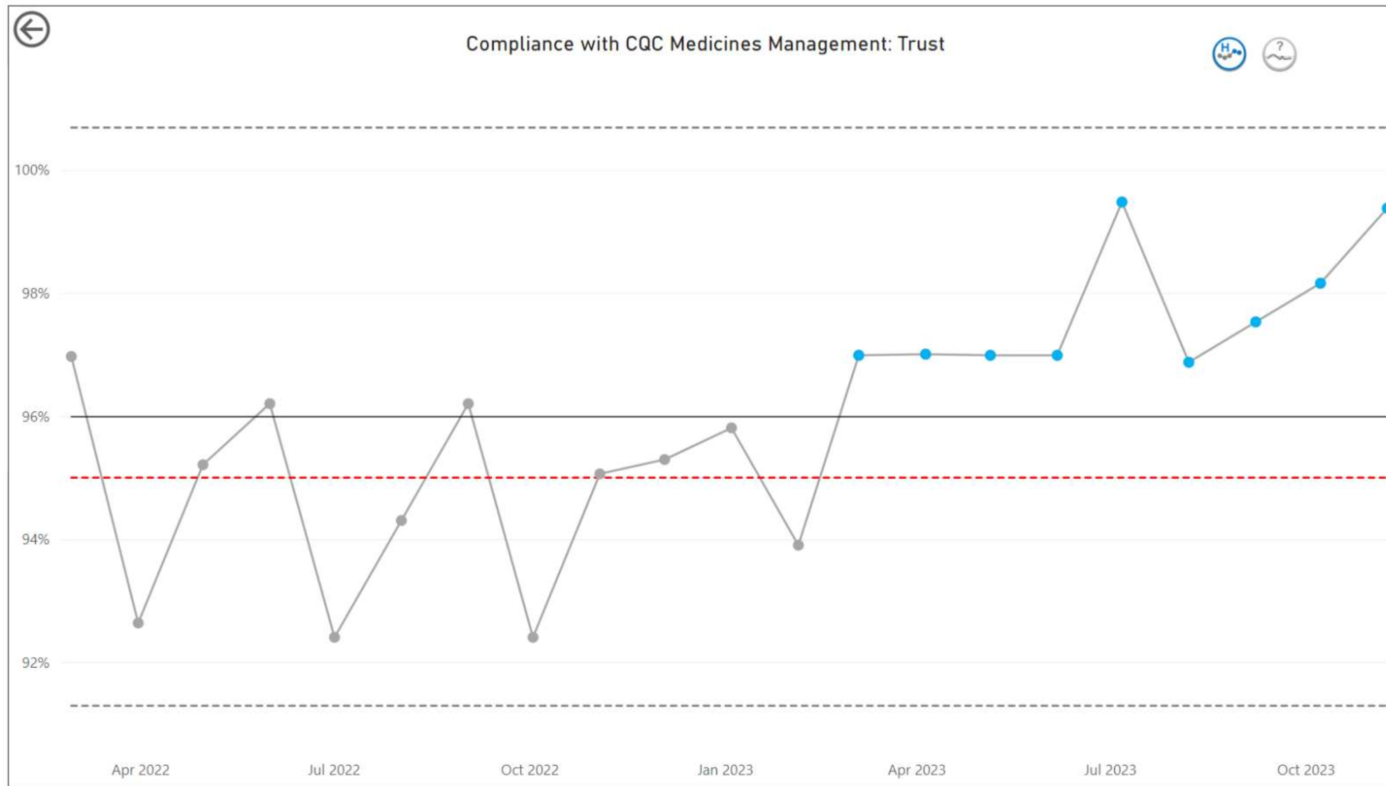
	Service	
Month	**Adults (%)**	**CYP&F (%)**
July	95.24	100
August	96.19	100
September	98.11	98.25

The breakdown of non-compliance in adult services was seen at only Ludlow in-patient setting, with their non-compliance due to not completing CD register checks on a daily basis and not completing the accounting log on a shift basis for medicine keys.

Children's services had one non-compliance following a single FP10 prescription not being logged as used and therefore unaccounted for within the paediatrics service. A prescription recall will take place once data is available so the prescription can be accounted for before the incident is closed. All procedures were followed, and the team are satisfied that this was human error.

The Pharmacy Team will continue to monitor and support.

The graph below shows the Trust's overall trust position at 98.18% for September, which was an improvement on August.



Safe – Safer Staffing

The National Quality Board (NQB, 2016) recommend a 'triangulated' approach to staffing decisions. The Trust has a validated tool for acuity and dependency for both the Community CNSST (Community Nursing Safer Staffing Tool) and Inpatient Wards SNCT (Safer Nursing Care Tool) this will enable a robust triangulated approach. We have now collected 2 sets of data for the Community teams and our first set of data for the inpatient wards. These tools forms part of planned biannual staffing reviews to allow SCHT to comply with National safer staffing guidelines.

We continue to utilise Fill Rates and Care Hours Per Patient Day (CHPPD). A description of both is below:

Fill Rate: is calculated by comparing planned hours to that of actual hours worked. A figure over 100% indicates more hours worked than planned.

CHPPD: It is calculated by dividing the total numbers of nursing hours on a ward by the number of patients in beds at midnight. The calculation provides the average number of care hours available for each patient on the ward.

October 2023

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	93.89%	88.53%	100%	85.04%
Ludlow	85.9%	97.21%	100%	124.35%
Whitchurch	90.51%	91.48%	100%	100.81%

Community Hospital Inpatient ward fill rates

September 2023

	Day		Night	
Hospital Site	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered Nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	91.2%	102.4%	100%	97.7%
Ludlow	93.2%	89%	100%	100.3%
Whitchurch	92.2%	94.7%	100%	107.7%

1 2 3 4 5 6 7 8 9 10 11 12 13 1…

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day shifts during October for Bridgnorth and Whitchurch, with Ludlow reporting 85.9% due to increased sickness and inability to backfill with bank/agency at short notice.

The overall trend shows staffing levels on night shifts for both RN and HCAs were just on or just below 100% to meet increased patient care needs with Bridgnorth being the exception with 85% reported. It is important that nights and weekends staffing levels are at their optimum as out of hours there are no other staff around to support the nursing teams. The increase in HCAs on day and night shifts is to maintain ongoing management and safety for patients requiring enhanced supervision. This is noticeable at Ludlow for night shifts where the fill rate is 124.35%, due to enhanced patient needs.

Bed occupancy rates reported for the month of October were 96.5% overall, fractionally lower than 96.6% reported in September. The breakdown for bed occupancy at each site was 96.6% Bridgnorth, 100.1% Ludlow, and 94% at Whitchurch. The overall target is 91%.

Overall, for all inpatient wards there were 654 RN shifts requiring cover with 470 being covered by substantive staff (71.8%, a 3% decrease from (74.7%) last month. 138 were filled by agency RN staff (21.1%), a 3.9% increase from last month (17.2%)
There were 34 shifts filled by bank staff (5.2%), a decrease of 2.3% from last month (7.5%). There were 12 shifts that were not filled at all (1.83%), compared to 5 last month (0.7%).

No Serious Incidents or incidents with harm were reported due to agency use or staffing shortfalls.

For all inpatient wards, there were no shifts reported throughout October where 100% RN agency staff were used, no change from the previous month.

Care Hours Per Patient Day (CHPPD) data

The below is a rolling data table updated monthly to show staffing levels in relation to patient numbers on an inpatient ward. Shropshire Community Health NHS data from the NHS England model hospital tool. On performing benchmark analysis, for the latest quarter (up to July 2023), the average overall for our trust is 6.6 care hours per patient day (CHPPD), which is 1.1% below the average of other similar community health NHS trusts at 7.7. See table below. However since August the average has increased, with the latest internal data reported for October averaging 7.2 across the 3 inpatient wards.

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Bridgnorth	7.8	7.8	7.9	8.2	8.1	7.9	7.5	7.2	6.7	7.7	8	7.7
Ludlow	7.3	6.7	8.1	13.7	7.6	7.9	8	7.2	6.2	7.6	7.1	7.4
Whitchurch	6.9	6.7	7.2	8.4	8.4	8.7	7.6	8.9	6.9	7.3	7.5	6.7

Care Hours Per Patient Day (CHPPD) data

The below is a benchmarking table against other Community Health NHS Trusts reported at July 2023, sourced from the most recent data on the Model Hospital tool, NHS England. We currenty sit below the average of 7.7 with 6.6 Care Hours per Patient Day.

Organisation Name	CHPPD - Overall
Hertfordshire Community	9.0
Kent Community Health NHS Foundation	8.9
Birmingham Community Healthcare	8.8
Hounslow And Richmond Community Healthcare	8.3
Lincolnshire Community Health Services	7.7
Sussex Community	7.2
Norfolk Community Health and Care	7.1
Shropshire Community Health	6.6
Leeds Community Healthcare NHS Trust	6.4
Bridgewater Community Healthcare	5.9
Overall average	7.7

Safe – Staff Vacancy Rates

The tables below illustrate the October 2023 vacancy position for the 4 Community Hospital sites for RNs and HCAs (Table 1). The second table shows vacancies within Community Nursing Teams over the last 6 months.

Community Hospitals Vacancies – Table 1

Community Hospital	Registered Nurse Vacancy Position		Unregistered Nurse Vacancy Position	
	WTE	%	WTE	%
Bishops Castle	6.97	68.1 →	7.69	70.6 →
Ludlow	1.95	14.8 ↑	6.35	29.1 →
Bridgnorth	-0.55	3.9 ↑	2.67	10.8 ↑
Whitchurch	1.49	16.4 ↓	1.49	6.4 ↑

Community Nursing Vacancies – Table 2

Community Nursing Team	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
North Telford	22.6%	18.2%	19.1%	18.4%	17.2%	17.4%
South Telford	-3.5%	-8%	-8%	-8%	-2.1%	-2.1%
Central	21.1%	19.2%	21.1%	21.3%	16.2%	12.2%
North East	10.3%	19.6%	16.7%	12%	10.5%	15.7%
North West	3%	3%	5.8%	1.8%	6%	-2.1%
South East	-2.9%	1.9%	8.8%	8.8%	12.5%	3.3%
South West	0.2%	4.6%	4.6%	4.6%	-0.9%	3.5%

1 2 3 4 5 6 7 8 9 10 11 12 13 14...

Responsive – Complaints (open) % within response timescales

Complaint's response performance is measured by the percentage of complaints answered within the timescale that has been agreed with the complainant; the target is set at 95%. Complaints provide valuable feedback to improve care & outcomes.

Performance = 25%

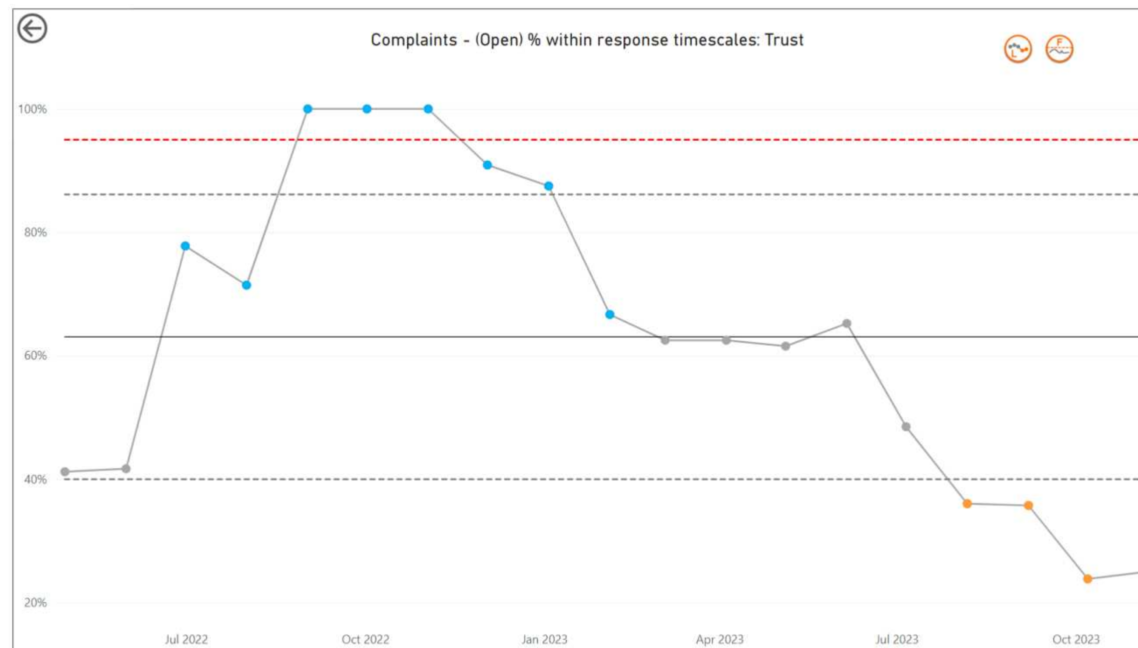
As at 8 November 2023, 24 complaints are being investigated, 6 (25%) of which are currently within their deadlines for reply. 18 complaints have exceeded their reply deadline mainly due to capacity issues within the Complaints Team which have since been resolved.

A total of 6 complaints were received in October 2023 as follows;

- 5 in Adults Services – Bridgnorth Hospital (3), and Oswestry MIU (2)
- 1 in Covid 19 Vaccination Mobile Units (BUS)

4 (44.4%) out of the 9 complaints closed in October 2023 were replied to within their deadlines. Of the 9 complaints closed in October 2023, 1 was partly upheld. Lessons learnt / action taken included the following;

- Explanation of waiting times was given together with an apology – recruitment of staff is being undertaken to increase capacity. A date for the patient's treatment was arranged.



1
2
3
4
5
6
7
8
9
10
11
12
13
15...

Responsive – 18 Week Referral to Treatment (RTT) Pathways – Harm Proformas

Harm Proformas have been completed for all new patients seen over 52 weeks as an essential, but also for follow up patients if the clinician deems necessary. 406 harm proformas have been completed to date; with 74.9% indicating no harm and 25.1% indicating low harm and can be treated and resolved. Looking into the cases where harm was identified the vast majority were rheumatology patients. By March 2022, all 52-week RTT breaches in Rheumatology had been seen, therefore Rheumatology harm proformas were undertaken as the clinician deemed necessary as opposed to routinely for longest waits. With the increase in Consultant Orthopaedic capacity via Nuffield in September/October 2022, most harm proformas have come from this cohort of patients, where the Orthopaedic Consultants have identified less cases of harm.

The service has conducted a review of 10% of the harm proformas completed which equates to 40. Of these, 39 were revalidated as having no further harm occurring. The remaining one, where it was deemed further harm had come to the patient, has since started the appropriate treatment. The patient continues to be under review of the clinical team who will continue to assess any harm to the patient.

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

18 week RTT	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Harm proformas completed	269	278	289	302	315	322	332	352	370	396	406
Number of low harm	100	100	101	101	101	101	101	102	102	102	102
Percentage of no harm	62.80%	64.00%	65.10%	66.60%	67.90%	68.60%	69.60%	71.10%	72.40%	74.20%	74.90%
Percentage of low harm	37.20%	36.00%	34.90%	33.40%	32.10%	31.40%	30.40%	28.90%	27.60%	25.80%	25.10%

Update on Dental waiting list:

Top longest waiting CYP has received treatment. Second longest wait (63 weeks) CYP did not attend for their theatre provision on 3.11.23 and new CYP theatre list identified 24.11.23. Harm proformas completed with no harm identified.

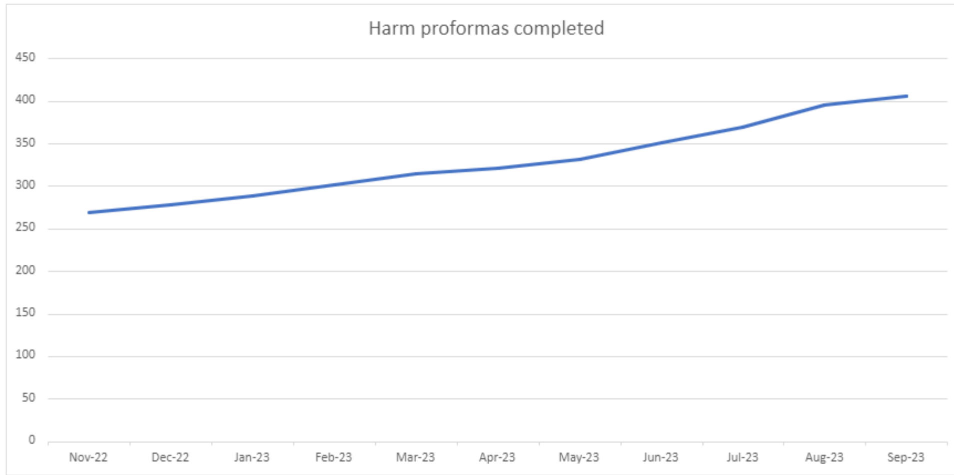
Actions being taken include:

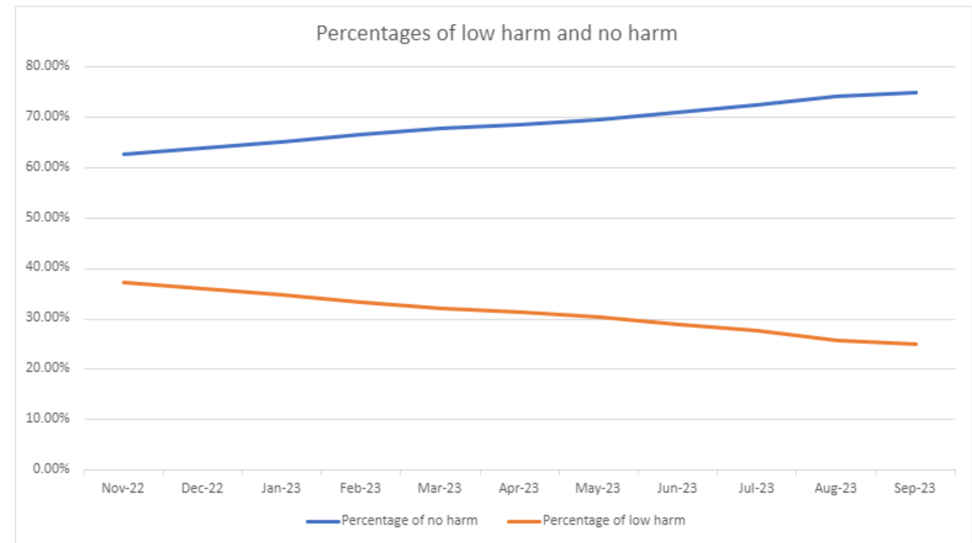
Continue to explore options for extra capacity with SaTH for Dental and regular provision

Clear robust escalation process in place with service level and senior level patient tracking meetings.

Weekly meetings with NHSE, ICB and system providers to review longest waiters and ensure robust plans in place to prevent 78 week breaches.

Continue to work with RJAH to provide noncomplex CYP theatre lists on a monthly rota.


Harm proformas completed
450
400
350
300
250
200
150
100
50
0
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23


Percentages of low harm and no harm
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Percentage of no harm
Percentage of low harm

Responsive – Proportion of patients who have a first consultation in a post-covid service within six weeks of referral (92% target)

This indicator is the percentage of patients who have an initial assessment in a Post Covid service within 6 weeks of referral.

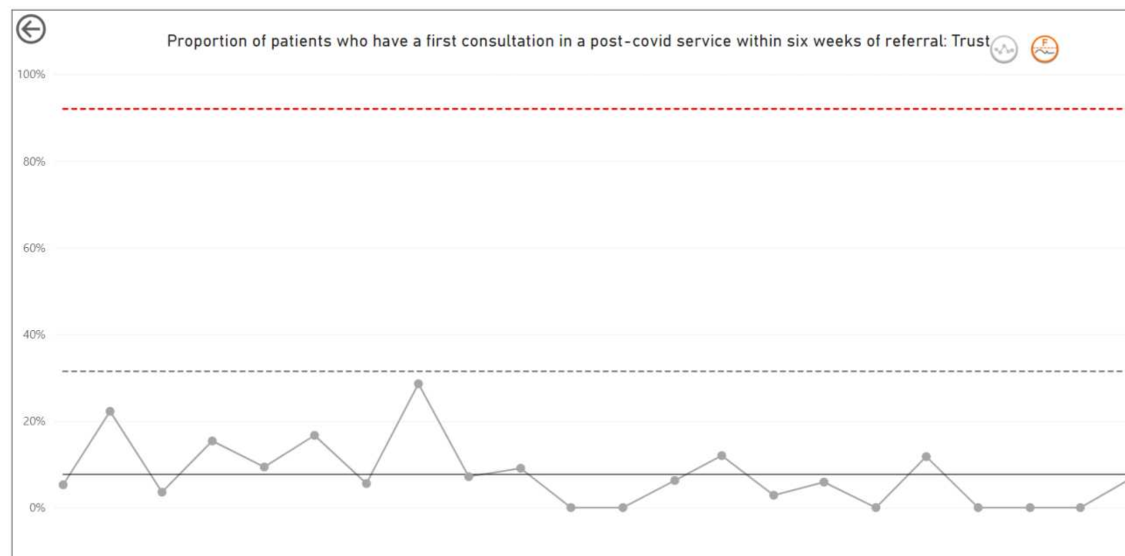
Performance = 0% →

The below is the current position for Long Covid patients being seen for their initial assessment within 6 weeks. The service has struggled with capacity to manage the demand of initial assessments and has carried a backlog due to staffing issues when the service was first launched. Whilst the funding allocation has now been confirmed it is significantly less than the service had planned its workforce for. Therefore, the service will continue to struggle to achieve the 6-week target with the capacity available with the new funding.

A revised workforce plan and service delivery approach to create the capacity required to work towards achieving the target of referral to assessment within 6 weeks has been implemented. We have changed our intervention delivery approach in the hope that it will improve the capacity of the current workforce to carry out more initial assessments. This is now reflected in the overall number of patients waiting for the initial assessment, currently standing at 59 (the lowest number in over 12 months), with the longest waiting patient without an appointment or opt in letter standing at 15 weeks.

As this change has been implemented, the prevention of harm to patients has continued to be addressed by ensuring that they are fully triaged by the long covid GP to ensure that no patient is entering the service with an unknown or unaddressed clinical risk / concern. Patients are sent booklets and contact information following the triage process so should their condition deteriorate whilst waiting for the assessment, they can contact the service to report this, with view to expediting the referral.

Harm proformas will be completed for patients waiting longer than 52 weeks for their initial assessment as well as for those patients it is deemed necessary as in alignment to other services.



1
2
3
4
5
6
7
8
9
10
11
12
13
18...

Caring - New Birth Visits (NBV) % within 14 days

National target remains at 95% however commissioners in Shropshire have changed the local target to 90%

Combined Performance across county = 81.95% ↓ September

The overall percentage of New Birth Visits (NBVs) completed within targeted timescales for Shropshire, Telford & Wrekin decreased from 88.11% in August to 81.95% in September

Shropshire NBV

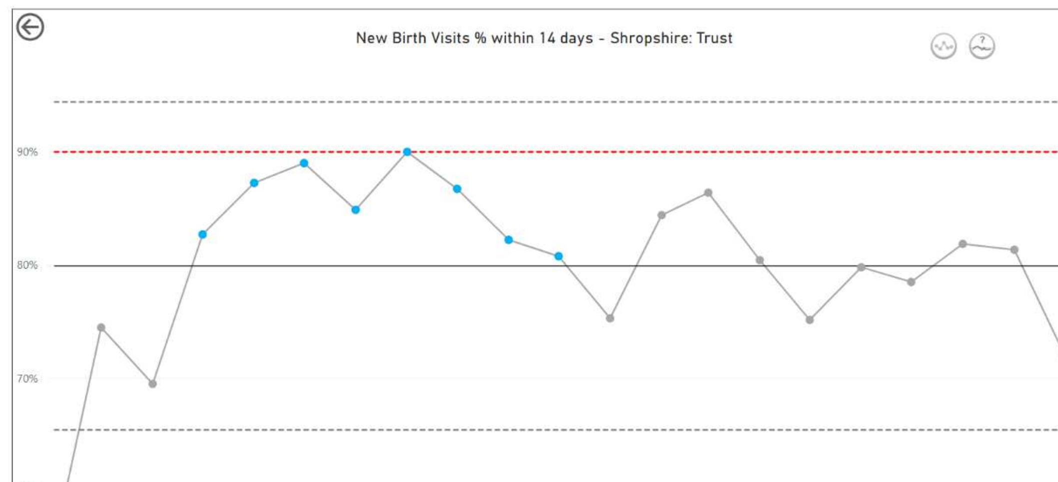
90% of New Birth Visits to be completed within 14 days of birth (Shropshire)

Shropshire Performance = 72.11% September ↓

There were a total of 190 births in September, out of which, 52 visits were delivered out of timescales within Shropshire.

- 21 were due to parental choice of appointment date
- 4 due to babies being in the Neonatal Unit (NNU)
- 26 due to workforce capacity
- 1 due to staff sickness

Parental choice and availability has affected the performance this month, including not being available for the HV contact offered, requesting to rearrange visit, family illness impacting on original appointment and declining appointments offered at the weekend (Bank). This has meant that it pushes the appointment that the parent finally agrees to outside of the timeframe. There continues to be a complexity within the workload (increased vulnerabilities, safeguarding concerns, development needs) and health visitors in the Central team particularly are carrying an increasingly time and labour-intensive caseload, due to the volume of CP, CIN, LAC and targeted work required. Out of the 53 NBV out of timeframe, 23 of these were completed on day 15 & 16.



1
2
3
4
5
6
7
8
9
10
11
12
13
19...

Telford NBV

95% of New Birth Visits to be completed within 14 days of birth

Performance = 94.59% September ↓

The Telford Team achieved 94.59% in September which is a decrease from the 97.78% achievement during August.

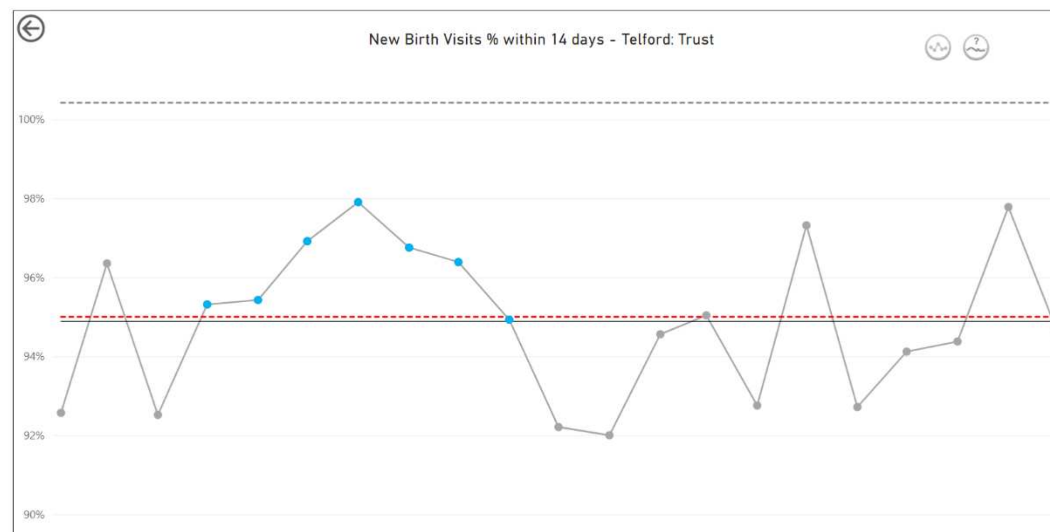
Of the 8 visits that were recorded out of timescale, all were due to situations out of the control of the Health Visiting Team;

- 2 Babies were still in the Neonatal Unit (NNU)
- 1 due to staff sickness
- 4 Parental Choice
- 1 Unable to contact parent

Across both Teams 100% of all birth visits were undertaken and no harm detected due to any delays in visit. No complaints (formal or informal) were reported when a visit was completed out of timescales.

Actions being undertaken:

- Workforce plan in place, the first student HV's have now qualified and have commenced in post. A further health visitor in training will complete their training in February 2024 and three further student HV's have now commenced their training
- Staff returning from long term sickness leave and maternity leave
- Support to be accessed from other HV Teams and Bank workforce including the offer of extra hours.
- Recruitment continues for any vacant posts. Further interviews taking place on 6th November



The table below illustrates that families are now seen within 21 days with the overall seen within 21 days as 97.5%.

6 Month Summary

Row Labels	Within 14 Days	15-21 Days	22-28 Days	Above 28 Days	Grand Total
Shropshire	845	197	24	11	1077
Telford	786	28	6	6	826
Grand Total	**1631**	**225**	**30**	**17**	**1903**

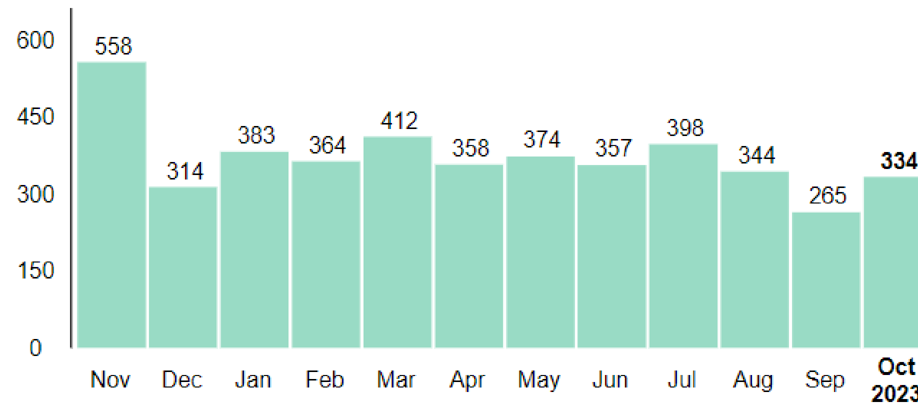
Shropshire Locality - Summary by Month

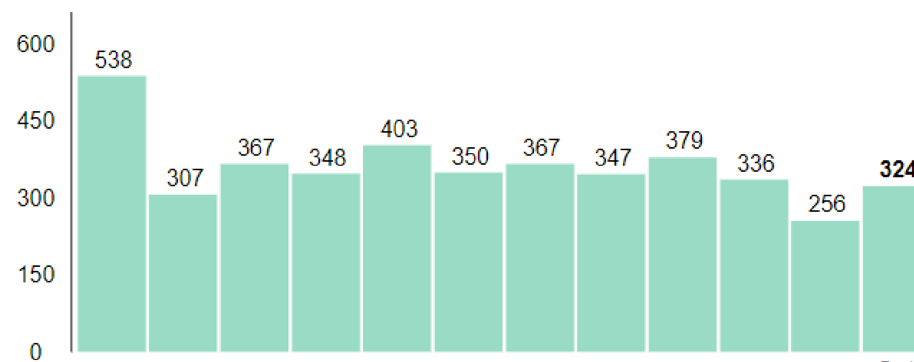
Month	Within 14 Days	15-21 Days	22-28 Days	Above 28 Days	Grand Total
Apr-23	75.14%	21.55%	3.31%	0.00%	100.00%
May-23	82.89%	11.76%	3.21%	2.14%	100.00%
Jun-23	78.68%	17.77%	2.03%	1.52%	100.00%
Jul-23	81.86%	14.71%	1.96%	1.47%	100.00%
Aug-23	80.51%	17.80%	1.69%	0.00%	100.00%
Sept-23	72.11%	26.32%	1.05%	0.53%	100.00%
Grand Total	**78.46%**	**18.29%**	**2.23%**	**1.02%**	**100.00%**

Caring - Friends & Family Test

The table below is an extract taken from the patient experience web system (IQVIA) which indicates responses across all Friends and Family Test (FFT) responses for the previous 12 months. For the latest position in October, 97.01% positive feedback was reported, a very slight decrease from 96.9% reported in September. In October, there was an increase in responses received (334), compared to 265 in September. Responses for October are slightly below averages for this time of year, however, are fairly comparable to the same period last year, with 401 responses received in October 2022.

Work continues within services to improve the FFT uptake and response rates and the use of digital solutions, including the use of QR codes. For all negative feedback received, all service leads are contacted for their response and actions. These are also discussed at the Patient Experience Committee, and directly with service leads for appropriate action. Negative feedback for the latest month centered around communication, where often environment is the common theme.





Well Led - Mandatory Training Compliance

To ensure staff have the right skills to do their roles safely and effectively a minimum of 95% compliance against mandatory training will be achieved.

Performance = 94.27% ↑

Overall performance against the target improved slightly in October from 94.23% reported last month.

The main reason for overall non-compliance with the target over the last quarter is due to the introduction of the Oliver McGowan Learning Disability and Autism training. Overall compliance without this is 94.93%. As of the end of October, 84.01% compliance with the new training had been achieved, showing continuing increase for quarters 1 and 2 in 2023/24, however a slight decrease from 84.22% in September.

Mandatory Training areas not achieving compliance targets in October are described below.

- High Risk Fire Training - compliance reduced slightly in October to 87.7% from 87.9% in September. There continues to be a focus on improving this level of compliance and working with the ESR team to reduce the time it takes for the training to be recorded onto ESR.
- Basic Life Support (BLS) training has declined slightly to 86.12% for Adults, from last month (86.45%), and % for Paediatric BLS, 84.39% a slight decline from last month (85.14%).
- Information Governance overall performance for October was reported at 92.6%, a slight improvement from 91.9% reported last month.

Monthly meetings are in place to monitor mandatory training with operational teams led by the Associated Director for Workforce, Clinical Education & Professional Standards and HR colleagues. Action plans are developed and progress against them monitored. A combination of workload pressures, new staff and absence of Team Leaders is continuing to contribute to the current position. Access to laptops and computers have also been reviewed to ensure that all staff members are able have ease of access.

Well Led – Appraisal Rates

Supporting staff to achieve their potential through supported career conversations, our target is 95% of our staff to be compliant.

Performance = 81.26% ↑

Appraisal position in October was reported as 81.26% a 1.7% improvement from 79.46% in September.

The focussed work at a team level is starting to show some small improvements. Teams are being encouraged to plan in appraisals when there is an overlap of staffing during shift handovers, especially in the community hospitals. The new operational structure is in the process of being recruited to and will then become embedded. This will strengthen the oversight and capacity to ensure that appraisals are completed consistently and in a timely manner.

Monthly meetings are in place to monitor appraisal recovery with operational teams led by the Associated Director for Workforce, Clinical Education & Professional Standards and HR colleagues. Action plans are developed and progress against them monitored. A combination of workload pressures, new staff, late entries on to ESR and absence of Team Leaders is contributing to the current position.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Meeting	Shropshire Community Health NHS Trust Board Meeting
Meeting Date	September 2023
Paper Title	Guardian of Safe Working Hours Quarterly Report For the Shropshire Community Health NHS Trust 1 July – 30 September 2023
Paper Written	November 2023
Author	Dr Bridget Barrowclough Guardian of Safe Working Hours (GoSW)

Executive Summary

The GoSW hours for Shrewsbury and Telford Hospital NHS Trust and for the Shropshire Community Health NHS Trust 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. Post graduate doctors and dentists in training and Locally Employed Doctors can use this process to report hours worked over, missed rest breaks, and differences in service commitments and variations in educational opportunities. The GoSW maintains an oversight of all reports and ensures that all reports are addressed in a timely manner.

High level data
Number of trainee doctors in the SCHCT :3

Exception reporting
In this quarter there were no exception reports filed by the doctors from the Shrewsbury and Telford NHS Trusts Paediatric and Neonatal Unit or the Shropshire Community Health NHS Trust.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Shropshire Community Health NHS Trust

Bishop's Castle Inpatient Service

0. Reference Information

Authors:	Tracie Black- Associate Director of Workforce, Education and Professional Standards Sarah Allan – Associate Director of Workforce and Resourcing	**Paper date:**	07.12.2023
Executive Sponsor:	Clair Hobbs	**Paper written on:**	29.11.2023
Paper Reviewed by:	Clair Hobbs – Director of Nursing, clinical Delivery & Workforce & Claire Horsfield – Director of Operations and Chief AHP	**Paper Category:**	Quality and Safety / Governance / Operations
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents the position to date to update the Board with regard to the recruitment campaign for Bishop's Castle.

2. Executive Summary

2.1 Context

The inpatient beds at Bishop's Castle Community Hospital (BCCH) was temporarily closed in October 2021 due to staffing shortages which were impacting on safety and the quality of care. Following engagement with staff, patients, and the wider public and stakeholders it was agreed that a targeted recruitment campaign would be undertaken until the end of March 2024.

2.2 Summary

2.2.1 High level actions

- Developed detailed recruitment and retention action plan.
- Weekly Workforce and recruitment working group that includes external stakeholders.
- Weekly internal delivery group.
- Weekly Flash report for the Executive Team
- Regular updates to People Committee and JNP

Bishop's Castle Inpatient Service

- Scheduled four recruitment events at Bishop Castle Community Hospital
- Created a video that includes staff.
- Digital marketing campaign with external company and refresh of Trust recruitment branding.
- Contact made with bank staff, ex-employees and existing BCCH staff regarding returning to BCCH.
- Scoped the ability to use Nursing Associates, International Nurses and newly qualified Nurses at BCCH.
- Recruitment of legacy mentors
- Approval of financial recruitment and retention incentive for Registered Nurses (RN) new to Shropshire Community Health Trust.

2.2.2 Current Recruitment Position

- The Registered Nurse funded establishment is 12.24 Whole Time Equivalents (WTE). With 3.47WTE BCCH existing staff and 5.33WTE posts offered, the current vacancy is 3.44WTE.
- The Healthcare Care Support Worker (HCSW) establishment is 8.69WTE. 3.80WTE posts offered, the current vacancy is WTE 4.89. The HCSW vacancies have not yet been advertised as these are easy to recruit to, the appointments to date have resulted from walk in candidates at the recruitment events. The remaining vacancies will be advertised during December 2023.
- Vacancies for Housekeeping, Ward Clerk, Physiotherapists and Occupational Therapists will be advertised in December 2023. These posts have not been advertised to date as the initial focus has been to recruit to the RN vacancies as the inpatient service will be unable to be safely staffed without these roles.

2.2.3 Risks

- Suitable applicants for the RN roles have slowed and there remains a risk that recruitment to the total RN establishment will not be achieved.
- If the establishment required is achieved there is a risk to Ludlow Community Hospital as they will lose 3.47 WTE RNs including 2 WTE senior posts, as this is where remaining BCCH staff are currently working.
- There is a risk that candidates that have been appointed to may withdraw due to not having an indicative start date. This is due to the need to get the required RN establishment prior to agreement to reopen BCCH inpatient facility. To mitigate this risk, there is an action built into the plan to keep the candidates warm which is being led by the BCCH Ward Manager.
- A decision will need to be made in January 2024 regarding timescales for advertising the Ludlow posts. At this stage the Trust may not have reached the target for RN for BCCH. This presents a risk that the Trust over recruit to posts at Ludlow which are then not vacant if the decision is then made end March 2024 not to re-open due to insufficient RNs at that time.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Bishop's Castle Inpatient Service

2.3. Conclusion

The Board of Directors is asked to:

- Note the current position and actions being taken to recruit to Bishop's Castle beds, and the associated risks.
- Take particular note to the RN position as the RN shortages impacted the quality and safety of care which resulted in the temporary closure of Bishops Castle inpatient facility. Note the work in progress to expand and develop services at BCCH in partnership with key stakeholders

Shropshire Community Health NHS Trust

Bishop's Castle Inpatient Service

3. Main Report

3.1 Background

The Shropshire Community Health NHS Trust (SCHT) Board concluded in March 2023 that the Trust remained unable to provide an inpatient bed facility at Bishop's Castle Community Hospital and could see no realistic prospect of reopening the (temporarily closed) beds.

The Board agreed to formally advise NHS Shropshire, Telford and Wrekin (NHS STW) that the Trust continued to have no reasonable prospect of being able to safely staff and re-open the beds and that therefore wished to make a decision regarding whether it could continue to provide the inpatient service.

The Board agreed to commence a process of engagement with patients, carers, members of the public, stakeholders, and staff so that the outcome of that engagement could feed into a final decision for the Trust and further inform any next steps or considerations required by NHS STW.

The conclusion of the Shropshire Community NHS Trust Board that met in September 2023 was that it understood the strength of feeling from local people about the desire to make sure all avenues to recruit staff to the service have been explored. The Board agreed to develop a workforce and recruitment plan for Bishop's Castle with clear targets as to the numbers and type of staff to be recruited, would review progress in December 2023 and make a final decision in March 2024 following a 6-month recruitment campaign.

3.2 Actions to Date

3.2.1 The Campaign commenced in September 2023 with the introduction of two delivery groups, one external facing to include stakeholders, from local counsellors, Bishops Castle Mayor and elected members of the local campaign group and one for internal staff. These were initially twice weekly to gain traction and to socialise the plan and gain any feedback.

3.2.2 The delivery groups quickly changed to weekly once the action plan was approved at Trust board in October 2023. This allowed time for the internal group to work on the actions from the plan.

3.2.3 Four recruitment dates were agreed with the stakeholders. These were to be held between October 2023 and February 2024. It was decided that two would be Fridays and two would be Saturdays. This was to offer flexibility for potential applicants and considered preference from the external stakeholders.

3.2.4 An action log has been produced and maintained, to demonstrate progress against the plan. The action log and a flash report is shared weekly with the Executive Team to provide assurance on progress.

3.2.5 Existing BCCH staff who had been redeployed to other areas of the Trust were met with individually to understand their position regarding a move back to BCCH. There are 3.47WTE RNs wishing to return and no HCSW wanting to return. They were also given the action plan and an opportunity to give their feedback and make suggestions to the plan.

Bishop's Castle Inpatient Service

3.2.6 A digital marketing campaign was launched to promote the BCCH vacancies, as part of the campaign an online enquiry form was developed for the November recruitment event that allowed all candidates looking at the advert to send a message to the Trust to gain further information. To date 45 enquiries have been received. Of these 45 enquiries no one attended the recruitment events, however two candidates submitted applications for posts, one non-BCCH and one for BCCH (HCSW).

3.2.7 The focus for the first two recruitment events has been for RN posts in order to understand the potential uptake prior to advertising any other posts. For the January and February 2024 recruitment events, the focus will be recruiting to all vacant positions. Any potential interested candidates who are not RNs have also been engaged with as part of the recruitment process.

3.2.8 All bank staff have been contacted, to explore those who may be interested in a permanent position. To date no interest has been received.

3.2.9 Ex-employees of Bishop Castle have been written to explore the potential interest for recruitment. To date no interest has been received.

3.2.10 Recruitment branding for the Trust has been refreshed to support the BCCH recruitment campaign via social media.

3.2.11 Through regular communication and inclusion through the weekly stakeholder meeting, positive working relationships with external stakeholders have been established.

3.2.12 For the two recruitment events already held, an external stakeholder was included as part of the interview panel, and this will continue for future events. This has been well received by the external stakeholders.

3.2.13 The ability to use Nursing Associates, International Nurses and newly qualified Nurses has been carefully considered and to mitigate risk, the plan is to employ one Nursing Associate and one newly qualified Nurse in order to maintain safe staffing and to allow appropriate support to these staff. The potential to incorporate International Nurses to BCCH has been factored into the medium to long term staffing plan.

3.2.14 A pop-up recruitment event in Newtown has been explored. After reviewing the market day footfall this was not suitable, however we do have posters in the job centres in Newtown and the local Council have shared our posters on their social media platform.

3.2.15 Vacancies for the RNs have been circulated to all our local Universities including Glyndwr.

3.2.16 Return to practice staff opportunities have been promoted at the Universities the Trust has links with. The Trust are promoting this via a poster campaign via social media.

3.2.17 Creation by the external stakeholders of a community pack and marketing of the local area, that have been available for potential candidates on the recruitment events. The

Bishop's Castle Inpatient Service

engagement at the recruitment event by the external stakeholder group has been supportive and demonstrates the cohesive approach taken around this campaign.

3.2.18 The opportunity to recruit legacy mentors to support retention has been scoped and funding sourced to be able to advertise for 1.00 WTE band 6 fixed term for 12 months as a proof-of-concept role. If the role proves successful a business case will be required to secure permanent funding.

3.2.19 Approval to offer a financial recruitment and retention incentive of £3,000 for band 5 RNs newly appointed to BCCH and SCHT, this is to support recruitment and retention.

3.3 Recruitment Position

3.3.1 The tables below show the establishment for Bishops Castle and of the staff that are working in other parts of the Trust but wishing to return to BCCH if the Hospital reopens and the offers made to date at the recruitment events.

Table 1- Establishment

Establishment	In Budget		Staff in post at present		Staff needed
	Band	WTE	Band	WTE	WTE
Trained	7	1	7	1	0
	6	2	6	1	1
	5	7.24	5	1.47	5.77
	4	2	0	0	2
Total trained		12.24		3.47	8.77
Untrained	3	1.2	3	0	1.2
	2	7.49	2	0.0	7.49
Total untrained		8.69		0.0	8.69
Total		20.93		3.47	17.46

Table 2- Recruitment to date

Establishment	In Budget		Staff in post at present	Staff offered position 13.10.2023	Staff offered on 25.11.2023	Staff needed
	Band	WTE	Band	WTE	WTE	WTE
Trained	7	1	1	0	0	0
	6	2	1	0.80	0	0.20
	5	7.24	1.47	2.00	1.53	2.24
	4	2	0	1.00		1.00
Total trained		12.24	3.47	3.80	1.53	3.44
Untrained	3	1.2	0	0	0	1.2
	2	7.49	0	0.4	3.40	3.69
Total untrained		8.69	0.0	0.40	3.40	4.89
Total		20.93	3.47	4.20	4.93	8.33

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Bishop's Castle Inpatient Service

3.3.2 To reopen Bishops Castle inpatient beds, we need 3.97 WTE RNs. Having reviewed the band 4 establishment, it would not be a safe option to have 2 band 4's in the staffing numbers and will convert the 1.00 WTE band 4 to band 5 to ensure safety on the ward.

3.3.3 At BCCH there are some other staff roles to recruit to and these will be advertised ready for the January 2024 recruitment event. These are Ward Clerk 0.8 WTE, Domestic 0.53 WTE, Occupational Therapist 1.00 WTE and 0.6 WTE Physiotherapist.

3.4 Next Steps

3.4.1 To advertise for legacy mentors at band 6 to support staff and promote retention within our teams.
3.4.2 To advertise for the HCSW and other vacant roles for the January 2024 recruitment event.
3.4.3 Continue to actively advertise our vacancies and to look at the potential of holding a recruitment event in Wales to ensure our campaign reaches a broader geographical area.
3.4.4 Radio advertising campaign to be undertaken to attract a different audience. Local radio and press interest has commenced thanks to the local campaign group which has been positive.
3.4.5 To commence the 'Keep the Candidate's Warm Campaign' as a number of posts have been offered.
3.4.6 Develop a recruitment pack as part of a refresh for the Trust branding and the recruitment materials to ensure the campaign remains fresh and current.
3.4.7 Produce a stakeholder newsletter, this is to summarise and provide a full picture of all the activities and progress made since the campaign commenced. It will also include frequently asked questions to confirm rationale of initiatives that are not being taken forward. This newsletter can be shared externally with any interested parties.
3.4.8 To develop an action plan of timescales for opening Bishops Castle beds that will include the advertising of roles at Ludlow, so that reopening BCCH does not destabilise Ludlow.

3.5 Risks

3.5.1 There remains a risk that recruitment to the total RN establishment will not be achieved. Work continues to vary the approach to the recruitment campaign, in an attempt to attract to job seeking candidates.
3.5.2 There is a risk to Ludlow hospital as 3.47 WTE RNs will transfer back to BCCH. Posts for Ludlow will be advertised in December to reduce any potential gaps in staffing.
3.5.3 There is a risk that candidates that have been appointed to may withdraw due to not having an indicative start date. To mitigate this risk, there is an action built into the plan to keep the candidates warm which is being led by the BCCH Ward Manager.
3.5.4 To ensure the vacancy gap at Ludlow is minimise posts will be advertised in December. At this stage the Trust may not have reached the target for RNs for BCCH, this may

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

create an over recruitment position . To minimise the candidates will be offered vacant position elsewhere in the Trust.

3.6 Estates Position

3.6.1 A condition survey was carried out in 2022 and an update took place on 21st November 2023. Whilst current costs and risks have not been issued the consensus was that the main themes identified previously remain. It is expected that the Backlog Maintenance costs (BLM) will increase due to the age and recent increases in material costs.

3.6.2 The main elements are that investment through BLM remain and include the roof, ventilation systems, floor covering the service ducting in the main corridor in the inpatient areas and some electrical infrastructure such as lighting and distribution services.

3.6.3 Investment should be planned, and the property is in reasonable condition noting that works will be required to re-enable it as an impatient facility such as recommissioning the medical gas and water systems across the locality. These enabling works will require a 3 – 4 week recommissioning programme prior to occupancy.

3.6.4 Maintenance has been on-going and there are defects currently being addressed.

3.6.5 For noting the condition survey does not include addressing functional IPC concerns around cleaning standards, such as the pipe boxing, which is in reasonable condition but painted wood, nor does it extend to equipment. Equipment has been maintained from a functional perspective but not from a service perspective as it has remained out of functional use for some time. It is worth noting that investment from a lifecycle replacement perspective will be required to both equipment and infrastructure as some of the systems are 14 years old having been installed in 2009.

3.7 Quality

3.7.1 The inpatient service at BCCH was temporarily closed and remains closed as a result of quality and safety concerns as a result of staffing shortages and reliance on agency staffing workforce.

3.7.2 At the time of temporary closure, a Quality and Equality Impact Assessment (QEIA) was completed, and the Trust Board decided to temporarily close inpatient beds at BCCH on safety grounds, due to the consistent very high reliance on agency staffing and the lack of adequate numbers of staff to provide the services in a safe manner, acknowledging that the continued operation of the inpatient service would carry the following unacceptable risk:

- Lack of continuity of care leading to potential harm to patients
- Shortage of staff on a shift leading to poor patient experience and potentially more errors
- Regulatory and statutory non-compliance

Bishop's Castle Inpatient Service

3.8 Service Development

3.8.1 In November the Trust Chief Executive met with the Southwest Shropshire Primary Care Network (PCN). In this meeting it was agreed that SCHT would work with the PCN and other system partners to collaborate on projects that would enhance the provision of services for the community of Southwest Shropshire. An initial meeting was held and led by the Trust with representation from a range of system partners, these included, Primary Care, the Local Authority, Public Health, representatives from the voluntary and community sector were also invited but were unable to attend. The group discussed two elements of the project which it was agreed would be called 'Enhancing services for the Southwest Shropshire Community' it was felt that this was title was inclusive of the whole of the Southwest community and would focus on best utilising the available space at the Bishops Castle Community Hospital site.

3.8.2 The first element seeks to increase the utilisation of the out-patient clinic space. This will initially be through improved usage of Trust Teams. The Physiotherapy service has doubled their provision of out-patient appointments and will be recruiting a First Contact Practitioner Physiotherapist in partnership with the PCN. This will enable the provision of a full musculoskeletal physiotherapy service to be delivered from the Bishops Castle site. Adult Specialist Nursing Services are also scoping providing continence, tissue viability and diabetes clinics. The Children's services will start to deliver a variety of clinic-based services from Bishops Castle in January 2024. These will include the full range of school aged children's immunisations, 0-19 Health Visitor clinics and drop-in sessions. The Admiral Nursing service is based at Bishops Castle Hospital and Age UK who run the Dementia Support Group have requested to use the training area to deliver the group which has been agreed. This builds on the vision that Bishops Castle Community Hospital can evolve to become a vibrant community hub for all ages and provide services that are clinical and non-clinical. The offer for utilising the space has also been made to the South Shropshire Local Authority Team to deliver Let's Talk Local sessions and the Midlands Partnership University Foundation Trust to scope whether space would be useful for them to deliver their services from. It will be important to capture the patient and community experience from people who attend Bishops Castle Community Hospital for these new services so that impact can be monitored.

3.8.3 The second element agreed by the group is to test a model of ambulatory, multi-disciplinary assessment for people. The concept being of a 'one stop shop' where different professionals could come together and assess a person to devise a comprehensive support plan with the person that focusses on what is important to them. These tests will follow the Quality Improvement methodology of 'Plan Do Study Act' and will be presented back to the group to inform further tests, capture the learning, and agree next steps. These tests will commence in December and January and be evaluated on a weekly basis. The first session will be a 'walk through' of the clinical model of delivery, which will be undertaken with a patient who can co-produce the model with the team to ensure that their perspective is at the centre of the design.

3.8.4 In addition to the clinical and community focussed services increased use of the training room is being scoped to deliver a broader range of training and educational

Bishop's Castle Inpatient Service

packages from BCCH. This will further increase the awareness of the site and its availability for usage which may lead to more innovative schemes that could be delivered from the site. In summary, delivery of all of the above once tested and evaluated through the project group will provide a good template for the delivery of vibrant, proactive community hubs throughout Shropshire, Telford, and Wrekin.

3.9 **Recommendations**

3.9.1 At the end of March 2024 if the staffing position is appropriate then the BCCH inpatient facility should be re-opened following any Estates and IPC checks and actions that need to be taken.

3.9.2 If the staffing position is not quite at an optimum at the end of March 2024, the Trust could consider;

a) continuing the recruitment campaign for a further defined period.
b) continuing the recruitment campaign until such time that the staffing position is safe to reopen.

3.9.4 At the end of March 2024 the Trust may consider not reopening BCCH facility as staff recruitment remains an issue as the target for RN's has not been met and recruitment progress indicates this will be on-going issue for BCCH inpatient ward.

4.0 Conclusion

The Board of Directors is asked to:

- note the current position and actions being taken to recruit to Bishop's Castle beds, and the associated risks.
- take particular note to the RN position as the RN shortages impacted the quality and safety of care which resulted in the temporary closure of Bishops Castle.
- note the work in progress to expand and develop services at BCCH in partnership with key stakeholders

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Shropshire Community Health NHS Trust

Chair's Assurance Report

Audit Committee

0. Reference Information

Author:	Antigone Bracken	Paper date:	December 2023
Executive Sponsor:	Harmesh Darbhanga	Paper written on:	20th October 2023
Paper Reviewed by:	Shelley Ramtuhul	Paper Category:	Audit
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit Committee meeting held on 18th October 2023 for assurance purposes. The Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1. Context

The Committee provides an overarching governance role with a specific focus on integrated governance, risk management and internal control. It also reviews the work of other governance committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. It also receives input from the Trust's internal and external auditors.

2.2. Summary

The Committee met on 18th October 2023 and was quorate with 2 Non-Executive Directors and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen within the main report.

2.3. Conclusion

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

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

Chair's Assurance Report

Audit Committee

3. Main Report

3.1. Introduction

This report has been prepared to provide assurance to the Trust Board from the Audit Committee which met on 18th October 2023. The meeting was quorate with 2 non-Executive and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Harmesh Darbhanga	Non-Executive Director (Chair)
Shelley Ramtuhul	Company Secretary/Director of Governance
Sarah Lloyd	Chief Finance Officer
Cathy Purt	Non- Executive Director
Keith Chaiswa	External Audit
Stacey Worthington	Executive Assistant/Corporate Manager
Antigone Bracken	Executive Assistant (Minute Taker)
Apologies:	
Peter Featherstone, Alison Sargent, Gurpreet Dulay	

3.2. Key Agenda

The Committee received all items on the work plan with a summary of each provided below:

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
3.	**Declarations of Interest** None declared.	N/A	
5.	**REVIEW OF THE ACTION LOG** The Committee reviewed the action log and noted the actions that could be removed. Review System for ensuring compliance with CQC key lines of enquiry – Board development sessions being provided in November Board Declarations of interest: SR to suggest centralised coordination of declarations	FULL	
7.	**RISK MANAGEMENT**		
7.1	Board Assurance Framework (BAF) The Committee accepted verbal updates and reviewed and reflected on the BAF. BAF will come to Board when reviewing the CQC preparation.	PARTIAL	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chair's Assurance Report

Audit Committee

7.2	**Risk Management Performance** SR presented the report. The Committee noted the progress made and actions undertaken to improve the current level of assurance whilst acknowledging the next area of focus is identifying mitigations for all high risks.	PARTIAL	
7.3	**Review Directorate Risk Registers – Medicines Management** SR introduced noting it is regularly reviewed by QSC and PSC. Identified risks have mitigating actions	PARTIAL	
8	**GOVERNANCE**		
8.1	**Freedom to Speak Up Update** SR confirmed FTSU has progress through Patient Safety Committee (PSC) and Audit Committee (AC). The Committee decided PSC provides audit and governance with AC providing oversight. Further work is required.	PARTIAL	
8.2	**Information Risk Management** GR introduced a comprehensive risk management framework report. The Committee acknowledged the value of this detailed piece of work and the high levels of mandatory training compliance within the Trust.	FULL	
8.3	**Committee Effectiveness – RPC** The Committee acknowledged that RPC satisfies its Terms of Reference and is an effective Committee. Two areas of improvement were highlighted.	FULL	
8.4	**Audit Committee Terms of Reference** The Committee accepted the Terms of Reference which contained no changes.	FULL	
8.5	**Work Plan Review** The Committee reviewed the workplan, making amendments where necessary.	FULL	
9	**POLICIES**		
9.1	**Policies Register – Programme Update** GR presented a summary of the new Infreemation policy system which is being	FULL	

Chair's Assurance Report

Audit Committee

	implemented within the Trust. It will provide robust, standarised, customised framework for the Trust's policies, SOPS and clinical assessment forms.		
9.2	**Policies Approval and Ratification Framework** GR introduced the new policy framework. The Committee decided to distribute and approve the policy online to allow members sufficient time to fully review and comment on the document prior to circulating approval via email. Any material changes raised will trigger an extraordinary meeting.		
9.3	**Policies for Approval** The annual review of policies recommended their approval; there were no material changes. The Committee recommended key constitutional documents be presented to Board.	FULL	
10	**Compliance with SFIs**		
10.1	**Single Source Arrangements for Goods and Services** SL recommended the Committee approve the four Single Source on the basis that full discussion and debate has occurred elsewhere. The Committee approved the single source documents.	FULL	
11.	**Internal Audit Reports**		
	The Committee reviewed and discussed the internal audit report noting the moderate assurance provided in respect of the violence and aggression audit. It was acknowledged work is taking place on Datix as the Trust transfers to LFPSE. Discussion of the internal audit follow up report highlighted the need to focus attention on resolving older risks. It was agreed that RPC, PC and Q&S will support these efforts.	PARTIAL	
12.	**External Audit**		
12.1	The Committee reviewed external audit progress noting that the Charitable Funds Committee audit has been completed without issue. It will progress through the approvals process.	FULL	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chair's Assurance Report

Audit Committee

4. Risks to Escalate

There were no risks to escalate.

5. Conclusion

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

Shropshire Community Health
NHS Trust

Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2023

0. Reference information

Author:	David Court Head of Financial Accounting	**Paper date:**	7 December 2023
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	22 November 2023
Paper Reviewed by:	Audit Committee	**Paper Category:**	Finance – Governance Framework Review 2023
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

Following an annual review of the: Standing Financial Instructions; Standing Orders; Scheme of Delegation; and Scheme of Reservation the Board is asked to ratify the Audit Committee's decision to approve these fundamental governance documents.

2. Executive Summary

The Trust's Standing Orders (SO's), Standing Financial Instructions (SFIs), Scheme of Delegation and Scheme of Reservation are based on model Department of Health documents, modified as necessary to reflect Trust specific details.

In line with best practice these documents are reviewed annually and the latest review has resulted in a small number of proposed amendments to these documents.

Once approved the documents will replace the existing documents on the Trust's website and widespread communication will inform staff that the documents have been updated.

The amendments are as follows:

All Documents have been updated to change the title of the Director of Nursing and Workforce to Director of Nursing, Clinical Delivery and Workforce

Standing Orders

Paragraph 4.8.6 has been added to reflect the establishment of the People Committee plus minor formatting and grammatical amendments.

Standing Financial Instructions

No changes required.

Review of Standing Orders, Standing Financial Instructions, Scheme of Delegation & Scheme of Reservation 2023

Scheme of Delegation

The People Committee has been added in relation to Delegation of Committees.

Scheme of Reservation

No changes required.

3. Recommendations

The Board is asked to ratify the Audit Committee decision taken on the 18th October 2023 and approve the minor amendments to these governance documents.

NHS
Shropshire Community Health
NHS Trust

EPRR Annual report

0. Reference Information

Author:	Brian McMillan, EPRR Senior Lead	Paper date:	7th December 2023
Executive Sponsor:	Clair Hobbs, Director of Nursing, Workforce & Clinical Delivery	Paper written on:	23rd November 2023
Paper Reviewed by:	Claire Horsfield, Director of Operations & Chief AHP	Paper Category:	Governance
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an update on the Trusts Emergency Preparedness, Resilience and Response (EPRR) function for Board scrutiny and assurance.

2. Executive Summary

2.1 Context

The NHS England EPRR Framework, requires the Trusts EPRR service to report to Board annually on the state of its preparedness, detailing provision in several key areas. This paper covers the 2023 calendar year and includes an update on our most recent NHS England EPRR Core Standards assurance process.

2.2 Summary

There have been many positive changes over the calendar year with new plans and processes introduced.

- In house training and exercising capability
- New Trust decontamination capability
- New EPRR Risk strategy
- New business continuity programme
- Several new plans and action cards
- New Incident Control Rooms
- Greater partnership working and collaboration

The EPRR Core Standards self-assurance rated the Trust as partially compliant.

2.3. Conclusion

The Trust Board is asked to note the contents of the report.

EPRR Annual report

3. Main Report

3.1 Introduction

The Trust has an annual assurance process for Emergency Planning, Resilience and Response (EPRR). The NHS England EPRR Core Standards assurance framework is the yardstick for assurance of the Trusts resilience.
The Standards set out the requirements for EPRR teams to report annually to the Board on themes across the EPRR workplan to provide assurance of the Trusts' capability and preparedness.
During 2023, the Trust employed a dedicated EPRR Senior Lead to facilitate the workplan within a new team structure. The developments within the EPRR service include a more operationally focused EPRR provision, with more support mechanisms. Collaboration with health and multi-agency partners have been strengthened through joint planning and exercising.
Although new and of the required standard, many of the new processes are still in their infancy which did not always translate into compliant Core Standards assessments. However, the EPRR function is in a healthy state and improvements will continue into the next calendar year.

3.2 Resources and Structure

The Trust has an Accountable Emergency Officer (AEO), which is a statutory role providing overall responsibility and accountability for the service. The AEO role changed during 2023 and is changing again to ensure compliance with the new expectations of NHS England.

The new AEO moving forward will be the Director of Nursing, Workforce & Clinical Delivery.

The Trust EPRR Senior Lead will work within the Operations structure which aligns well to EPRR. Reporting generally to the Director and Deputy Director of Operations, this structure has worked well throughout the calendar year.

Governance structures have been altered, with EPRR reports going to the Patient Safety Committee and escalating to Quality and Safety Committee.

The Trust has a 24/7 On Call mechanism at both Strategic and Tactical levels. These have recently been bolstered with additional staff members. The EPRR lead is managing in ours EPRR delivery, with the On Call staff providing out of hours cover.

The EPRR Core Standards require that the Board has assurance that the resources in place are sufficient to deliver the EPRR programme effectively. The team feel the resources are sufficient.

3.3 Summary of Incidents and Business Continuity disruptions

Within NHS organisations, incidents and disruptions can be frequent. The Civil Contingencies Act 2004 requires NHS organisations to cooperate and collaborate with statutory partners during incidents to support any response. Collaborative working is vital to the success of incident response and recovery.

The Trust had 3 significant disruptions during 2023;

EPRR Annual report

1. **7th August 2023 – Oswestry Beam Collapse – Loss of building**
   On 7th August 2023, a roofbeam within the roofing structure of a courtyard at Oswestry Health Centre collapsed. It was a Sunday morning, and the Minor Injuries Unit and District Nurses were the only services running. Plans were followed to close the Minor Injuries Unit whilst NHS Property Services contracted a building surveyor to deem the building safe. An internal Incident Management Team (IMT) dealt with the incident and although there was no formal declaration of an incident, the matter was notified to the ICB as the building remaining closed on the Monday morning would have resulted in severe disruption across several services. However the building reopened later on the Sunday afternoon with no disruption to other Trust or Partner organisations.
2. **1st September 2023 – Prison Service Team – Staffing disruption**
   Due to a combination of short notice sickness, vacancies and rota difficulties, the Prison Service team had staffing difficulties for 1st September 2023 which would have severely hampered the ability to maintain safe service levels. This was picked up on 31st August 2023 with minimal time to resolve the issue. An incident team was convened and additional staffing was provided to the service. This identified difficulties in dropping in staff to the prison environment at short notice. The debrief provided some learning and additional measures have been put in place to ensure staffing support is easier to achieve in future disruptions.
   This disruption was not formally declared as an incident by the Trust as the mitigation measures put in place were effective in restoring safe staffing levels in time to avoid significant disruption.
3. **20th – 22nd October 2023 – Storm Babet – flooding and service disruption**
   The impacts of Storm Babet in October 2023 caused some service disruption across parts of the Trust footprint. Leading up to the storm, the Trust received weather alerts and linked with partner agencies. However, the amount of rainfall and the speed of flooding was unexpected. The South West locality was impacted more than others with Ludlow effectively cut off by floods and all public transport cancelled during 20th October 2023.
   An Incident Management Team was convened and managed the Community Nursing workload across the weekend. Ludlow Minor Injuries Unit was closed for 2 x days, due to staff not being able to get to site. The Inpatients service was maintained fully and all staff and patients were safe and accounted for.
   The post incident debrief highlighted some good practice and minor amendments have been introduced to make whole site communications easier.
   The Trust worked well with multi-agency partners throughout the 3 days of disruption, utilising the on-call mechanisms who were supported by the EPRR Senior Lead.
   The Trust formally declared a business continuity incident and escalated within the Health Structure. No external support was required, the declaration followed standard response activation guidance.

3.4 Training and Exercising

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Historically the Trust has relied on partner agencies to deliver EPRR training. The Trust now has this capability in house, via the EPRR Senior Lead. Training is available to all staff across Strategic, Tactical and Operational roles.

The Training follows a pathway which is aligned to the National Occupational Standards and the Minimum Occupational Standards for EPRR. Training attendance is captured on a Training Needs Analysis and the Trust has a new Training and Exercising Policy which has been identified as effective for gathering compliance data. Training delivery is in its infancy therefore compliance figures are not where they need to be. There is a delivery plan and a 1:1 has been scheduled for all role holders with the EPRR lead to ensure training and exercising is addressed for each individual over each calendar year.

In addition to the local training offer, On Call role holders must undertake a mandated Principles of Health Command course with NHS England. However, booking of spaces was paused in early 2023 whilst NHS England moved to a new booking system. It has not been restarted yet.

For Strategic role holders

- 8 of 15 have attended the mandated NHS England training.
- There are 6 internal courses (90 delivery slots) of which, 1 has been delivered.

For Tactical role holders

- 10 of 23 have attended the mandated NHS England training.
- There are 6 internal courses (138 delivery slots) of which, 20 have been delivered.

For Operational role holders

- 57 courses across the EPRR spectrum have been delivered with none of these mandated.

Training compliance will need to improve for the Trust to be compliant and for staff to be as prepared as possible, however training is continuing and will be reported quarterly to the Patient Safety Committee for oversight and support.

Exercising

The Trust must deliver a set number and type of exercise within its programme. The minimum required is

- 2 x communication tests per year. One in hours and one out of hours.
- 1 x business continuity exercise per year
- 1 x desktop exercise per year
- 1 x CBRN (Chemical, Biological, Radiological & Nuclear) exercise on reviewing the CBRN plan
- 1 x command post exercise every 3 years
- 1 x live exercise every 3 years

The Trust has not historically run its own exercises, however this capability was introduced in April 2023 with the new EPRR Senior Lead role. Since April, the Trust has undertaken a series of internal and external exercises, however due to the programme being in its infancy the Trust were partially compliant on 2 of the exercise standards.

- 30th March 23 – Exercise Mighty Oak – external multi-agency national power outage exercise
- 11th May 23 – Internal IT business continuity exercise
- 4th July 23 – Exercise Waste Side - External (SaTH) CBRN exercise in desktop and live format
- 25th July 23 – Exercise Jefferson – Internal communications exercise
- 12th October 23 – Exercise Icy Blast – Internal Command Post exercise of a severe weather incident
- 10th November 23 – External ICB cyber exercise
- 16th November 23 – External (SATH) Hospital evacuation exercise
- 17th November 23 – Exercise Alport – Internal community hospital evacuation exercise
- 20th November 23 – External (RJAH) – CBRN exercise
- Exercise Activate – External communication test on 3rd, 5th, 13th, 17th, 23rd, 25th October and 22nd November 23 – all passed.

In addition to these, a further exercise is planned for the week of 18th December 23. This will be a live CBRN exercise and a command post exercise within the new HQ Incident Control Room.
The Trust must also consider supporting the Local Resilience Forum's live exercise every 3 years. There is a national government led exercise within the same cycle. The next national exercise is imminent and will test Pandemic response. The Trust EPRR Senior Lead is part of the Local Resilience Forums training and exercising workgroup.

3.5 Business Continuity Planning

The Trust is required to have business continuity plans and an overarching strategy or policy framework that sets out how this will be maintained, trained and governed. This has been a weakness within NHS organisations as there was a lack of a national template and local variations in training, understanding and uptake.
Plans need to be written and owned by each service lead, therefore effective training and support is required for them to understand how to write and maintain a plan. This training and support has been lacking historically due to lack of qualified staff. Existing Trust plans are in a variety of templates and lack some of the basic elements required in an effective plan.
The Trust now has an approved business continuity strategy. This establishes the business continuity framework. Additionally, NHS England released the Business Continuity Toolkit in 2023, which provides a national template and guidance for training. Combining this with the International Standard (ISO 22301), the Trust provision aligns to best practice moving forward.

The EPPR Senior Lead has commenced a wholesale review and reworking of all Trust plans. They are being worked into the national template and training is being provided to all service leads in how to write plans and how they are used. This is a significant piece of work and will require a large number of new plans – circa 300. A project of this scale will take longer than 12 months as the training and facilitation is lengthy and engagement can be slow.

The new programme is being tracked within a business continuity audit tool and will be reported quarterly to the Patient Safety Committee. The Trust is also currently undergoing an external audit on our business continuity management.

The sheer number of new plans means this is a longer term project and requires extensive engagement. Of 275 identified teams, initial contact has been made with 35% of teams, with 14% having a draft document that is compliant with the new standard. Work is ongoing to support further progress on this.
Until such time as we have effective business continuity plans across the Trust, it remains our most challenging area during incident response.

3.6 Lessons Identified

NHS England Core Standards requires the Trust to report to the Board on lessons identified during incidents and exercises within the previous year. A summary list of lessons identified and good practice captured is detailed below. The full list is attached as Appendix 1.

The Trust process of capturing and recording these within a lessons register has been identified in Core Standards as good practice.

Summary of lessons identified

Incident Response

1. Internal incident structures and relevant contacts to be shared between NHS Property Services and ShropDoc.
2. On call processes to ensure that where there is dialogue with external contractors such as superior landlords, this is shared with other on call staff and full situational awareness is shared between all parties.
3. Full list of services and contacts for the site to be created and drafted into response and business continuity plans. To be replicated across other weekend/out of hours sites.
4. All parties to ensure that any formal incident declaration is cascaded to partners with an accompanying SBAR or METHANE message, to ensure that relevant response structures are aware of impacts and actions being taken.
5. The use of Resilience Direct mapping was not embedded across the Incident Control Room staff.
6. There was no embedded process to easily identify vulnerable patients.
7. The use of Voluntary 4x4 response needs investigating. It has been raised with the system and LRF, but organisations continue to use them. It puts staff at risk but those not using them have a much harder task to mitigate issues.

Staffing

8. It was difficult to drop temporary staffing into the prison environment as they are not key trained and approved, requiring escorts from within the prison service staff or the short-handed prison service team.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

9. To support temporary staffing, the prison BC plan should include an action card with maps and instructions on dress code and unauthorised items that cannot be taken into the prison environment.

Communications

10. Communications at Trust and system level could be improved. Dissemination of weather and travel updates if coordinated, could be easier and reduce burden across the system.

Evacuation

11. Localised off site evacuation plan to be drafted and annexed to the main Trust Plan.
12. Ward based evacuation packs do not contain sufficient radios to affect a large incident/evacuation.
13. Due to access issues, any localised plan must include early arrangements for road closures to prevent hampering a blue light response and endangering patients by moving amongst vehicles.
14. In the event of an incident or fire impacting the main entrance, exit with a bed may be difficult due to the surface and lack of lighting.
15. Lack of pharmacy detail for an offsite evacuation. Particularly access to information and an off-site critical medication grab bag/box.

Training

16. Ward staff need further training in the operational and multi-agency support that is available during a large incident. Particularly in their responsibilities during an evacuation.

Summary of good practice identified

Incident Response

1. Business Continuity measures used on the day were effective in managing patients outside of the setting and reducing patient impacts.
2. The (incident) support from the ICB was good.
3. The Trust enabling an early Incident Management Team Call for the following morning to consider impacts and a formal declaration if required would have put service users and partners on a proactive footing.
4. Feedback from the ICB was that the Trust response was calm and effective with good situational reports and updates.
5. Trust linked with TWC and Env Agency to review an area of heightened flood risk and identified potential (health) vulnerabilities within that area. Better suited to an ICB response as they have better links to primary care records but facilitated within the hour by the Trust with the use of Resilience Direct and UCR teams.

Communications

6. There was a good communication channel with between SCHT on call and the ICB on call teams. Communications were “slick”.

Staffing response

7. Local operational huddle to report on staff and patient safety was excellent and improved the IMT situational awareness and assurance.
8. The willingness of staff to come in when not on duty, and to work outside of the setting, minimised the impact to patients and on partner agencies, through effective triage and signposting.

3.7 EPRR Core Standards

As highlighted previously, the EPRR Core Standards is the Trusts annual self-assessment against the minimum standards.

Standards are set out in 10 different domains. A standard is rated compliant, partially compliant or non-compliant. Only compliant standards are counted towards the overall award.

Awards are given as follows:

- Fully compliant – 100% compliant standards
- Substantially compliant – 88 – 99% compliant standards
- Partially compliant – 77 – 88% compliant standards
- Non-Compliant – less than 77% compliant standards

Post COVID and MEN Arena enquiry, the 2023 Core Standards were far tougher than previous years. To be compliant, every piece of evidence must be demonstrated and have been reviewed within the current 12-month cycle.

The Trust achieved a partially compliant rating of 77%. In real terms, there has been a significant improvement in the Trusts resilience and the direction of travel is towards a substantial rating in the future. Our award was favourable to other regional partner organisations and the Trust was the only Shropshire, Telford and Wrekin organisation to pass and improve on last year's submission. The Trust had no non-compliant standards this year.

In addition to the overall award, there is an annual 'deep dive'. This year's deep dive was in Training – Content, delivery, standards and recording. The Trust achieved 100% on the deep dive, although this does not count towards the award.

Core Standards Summary

Although partially compliant is not where we want to be on our journey, the services and planning arrangements were too new to have the body of evidence required for a better rating against such a robust test. Some of the standards require system level plans and arrangements that are not yet in place. An action plan has been produced against this year's submission to address the identified gaps and work has commenced on improvements to better this year's award.

EPRR Annual report

The new plans and processes are working and the feedback from Operational teams is positive. The Trust is now taking a leading role in multi-agency planning, particularly training and exercising.

3.8 Conclusion

The Trust Board is asked to note the contents of the report, particularly the Core Standards award and commentary.

Trust EPRR Annual Report APPENDIX 1

Lessons identified and good practice

Lessons identified:

SCHT 21	OHC Beam Incident	Internal incident structures and relevant contacts to be shared between NHS PS and ShropDoc	Response arrangements	Structures in the process of being drafted and shared with NHS PS. SCHT losing the notification contract as it moves to SATH but will be shared	31.09.23	
SCHT 22	OHC Beam Incident	On call processes to ensure that where there is dialogue with external contractors such as superior landlords, this is shared with other on call staff and full situational awareness is shared between all parties	Communications channels	Will be included within the On Call handbook, was more relevant to NHSPS who have picked this up	31.09.23	
OCHT 23	OHC Beam Incident	NHS Property Services are liaising with the structural engineers, who have surveyed the beams to see what reparations are required. When available, this assurance to be shared with SCHT.	Assurance processes	Will be shared with Oswestry staff and on call staff when received in case of a further beam incident.	31.09.23	
OCHT 24	OHC Beam Incident	Full list of services and contacts for the site to be created and drafted into response and business continuity plans. To be replicated across other weekend/out of hours sites.	Business Continuity	Contact list received for Oswestry, geographically very useful and will ensure this is replicated across all CH sites	31.09.23	Complete

OCHT 25	OHC Beam Incident	All parties to ensure that any formal incident declaration is cascaded to partners with an accompanying SBAR or METHANE message, to ensure that relevant response structures are aware of impacts and actions being taken.	Response arrangements	Part of the training and will be reiterated in the new on call handbook with timescales included. Was more of an NHS PS lesson as they declared internally and did not communicate this to other parties.		Complete
SCHT 26	Prison Service staffing disruption Aug 23	It was difficult to drop temporary staffing into the prison environment as they are not key trained and approved, requiring escorts from within the prison service staff or the short handed prison service team	Staffing mitigation	EPRR Lead has now undergone key training and can support as a designated escort for mitigating staff, whilst providing a senior presence to support staff throughout the disruption	Nov-23	Complete
SCHT 27	Prison Service staffing disruption Aug 23	To support temporary staffing, the prison BC plan should include an action card with maps and instructions on dress code and unauthorised items that cannot be taken into the prison environment.	Staffing mitigation	Action card complete, no feedback from the Prison Service	Nov-23	Complete
SCHT 28	Ex ICY BLAST Oct 23	The use of RD mapping was not embedded across the room.	Command and Control	New Trust loggists are being trained and recruited and will be trained in Resilience Direct. Further exercising involving the loggists will help to utilise and embed RD mapping skills and familiarity, whilst testing community vulnerability identification	Nov-23	Complete - loggist numbers increased from 3 to 7 and ongoing training and exercising is within the TNA and workplan

SCHT 29	Ex ICY BLAST Oct 23	There was no geographical list of services	Business Continuity	A list of services to be created and plotted against the Trust estate list. This can then be mapped and listed in the On Call folder	Dec-23	Ongoing - map and list created but need this checked with relevant leads
SCHT 30	Ex ICY BLAST Oct 23	No embedded process to easily identify vulnerable patients	Command and Control	See SCHT 28. Process was tested in Ex ICY BLAST and used again in the flooding of Oct 23. Highlighted in feedback through the LRF and ICB debrief processes.	Nov-23	Complete
SCHT 31	Storm BABET Oct 23	Communications at Trust and system level could be improved. Dissemination of weather and travel updates if coordinated, could be easier and reduce burden across the system	Command and Control - Communications	New Trust 'EPRR Live' page created on main intranet page so that centrally coordinated weather/traffic and bc intelligence can be shared across the organisation. Opportunities for local staff to update via a forum facility so that best intelligence is captured	Nov-23	Complete. Page is now live and due to be tested in Command Post exercise in Dec 23
SCHT 32	Storm BABET Oct 23	Voluntary 4x4 response needs investigating. It has been raised with the system and LRF, but organisations continue to use them. It puts staff at risk but those not using them have a much harder task to mitigate issues	Business Continuity	Raised with the LRF and Hepog. External verification being sought and clarity on organisational risk being explored. Explained that it is much harder to mitigate without the 4x4 response but using them poses a risk	Nov-23	Complete. Awaiting LRF and LHRP feedback but not used within the Trust until clarity is obtained
SCHT 33	Ex ALPORT Nov 23	Localised off site evacuation plan to be drafted and annexed to the main Trust Plan	Response Plans	Drafting underway, awaiting final feedback on the PXR	Dec-23	Onoing

SCHT 34	Ex ALPORT Nov 23	Ward based evacuation packs do not contain sufficient radios to effect a large incident/evacuation	Business Continuity	Ward are procuring more handheld radios	Jan-24	Ongoing
SCHT 35	Ex ALPORT Nov 23	Due to access issues, any localised plan must include early arrangements for road closures to prevent hampering a blue light response and endangering patients by moving amongst vehicles	Response Plans	Drafting underway, awaiting final feedback on the PXR	Dec-23	Ongoing
SCHT 36	Ex ALPORT Nov 23	Ward staff need further training in the operational and multi-agency support that is available during a large incident. Particularly in their responsibilities during an evacuation	Response Plans	New operational training drafted. Ward asked to identify training delegates for delivery asap	Jan-24	Ongoing
SCHT 37	Ex ALPORT Nov 23	In the event of an incident or fire impacting the main entrance, exit with a bed may be difficult due to the surface and lack of lighting	Response Plans	Bed push scheduled for local training date and with H&S leads input, will develop any improvement plan	Dec-23	Ongoing
SCHT 38	Ex ICY BLAST Oct 23	Lack of pharmacy detail for an offsite evacuation. Particularly access to information and an off-site critical medication grab bag/box	Response Plans	Pharmacy developing plans with two focuses. One is the access to information in an evac, the second is a grab bag of life saving/preserving medicines	Dec-23	Ongoing

SCHT 39	Ex ALPORT Nov 23	Other inpatient sites may have off site shelter sites but have not tested the operational and logistical issues around an evacuation.	Response Plans	Other locality leads asked to prioritise a review of their local evac and shelter arrangements with a similar exercise. Dates to be forwarded to the EPRR lead	Dec-23	Ongoing

Good practice identified:

SCHT01	OHC Beam collapse July 23	Business Continuity measures used on the day were effective in managing patients outside of the setting and reducing patient impacts	Business Continuity	Noted, plans being redrafted but good to hear the measures are seen as effective
SCHT02	OHC Beam collapse July 23	There was a good communication channel with between SCHT on call and the ICB on call teams. Communications were slick	Communications	Noted, good to hear the on call teams were communicating effectively
SCHT03	OHC Beam collapse July 23	The support from the ICB was good	External partners	Noted, good to hear
SCHT04	OHC Beam collapse July 23	The willingness of staff to come in when not on duty, and to work outside of the setting, minimised the impact to patients and on partner agencies, through effective triage and signposting	Business Continuity	Noted, good to hear and escalated to QSC

SCHT05	OHC Beam collapse July 23	The willingness of staff to come in when not on duty, and to work outside of the setting, minimised the impact to patients and on partner agencies, through effective triage and signposting	Log taking	Effective notes were key to the timeline and debrief. Good to see and included in training discussions
SCHT06	OHC Beam collapse July 23	The Trust enabling an early Incident Management Team Call for the following morning to consider impacts and a formal declaration if required would have put service users and partners on a proactive footing.	Response arrangements	Noted, forward planning was key to informing partners and planning mitigation for the following day
SCHT07	Storm Babet Oct 23	Feedback from the ICB was that the Trust response was calm and effective with good situational reports and updates	Command and Control - sitrep reporting	Noted, good to have good feedback
SCHT08	Storm Babet Oct 23	Local operational huddle to report on staff and patient safety was excellent and improved the IMT situational awareness and assurance	Command and Control - sitrep reporting	Local arrangements reflected in the Trust plan for future improved responses.

SCHT09	Storm Babet Oct 23	Trust linked with TWC and Env Agency to review an area of heightened flood risk and identified potential (health) vulnerabilities within that area. Better suited to an ICB response as they have better links to primary care records, but facilitated within the hour by the Trust with the use of Resilience Direct and UCR teams	Multi-agency collaboration	Noted. Escalated to LRF and ICB debriefs and the LRF commented that this is an example of excellent collaborate partnership working.

Shropshire Community Health
NHS Trust

Board Assurance Framework
0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	Paper date:	**30 November 2023**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	7 December 2023
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Quality & Safety Committee	**Paper FOIA Status:**	

1. Purpose of Paper

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

The Board is asked to ***note*** the current performance position against the Trust's objectives and ***consider and approve*** the proposed risks to delivery cited on the Board Assurance Framework.

2. Executive Summary

The Board of Directors uses the BAF as tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy.

This report presents the BAF which has been reviewed by the Executive Team and presented to each Lead Committee with the exception of the People Committee which has not met this month.

The Board is asked to consider the following:

- Are the risks identified correct and in line with the Committee's knowledge? Are there any other risks that should be included?
- Are there adequate controls and assurances identified or are there gaps that should be cited?
- Are appropriate actions identified to address known gaps in controls and assurances? Where actions have been identified are they on track?

Conclusion

The Board is asked, having given due to consideration to the above outlined questions, approve the BAF.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Looking after our People — OBJ 1

Principle Objective: Invest in our workforce addressing existing gaps ensuring a compassionate and inclusive culture for all staff

This objective can be broken down into three key components; develop and implement a 5 year workforce plan and development programme that builds strong leadership and increases training and apprenticeship opportunities, identify and implement actions to improve staff experience and engagement, recognise and celebrate success and learning from success across all services

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: October 2023

Key Measures:

- ✓ Digital innovation for people processes, improved ESR data quality, expanding our recording of role specific essential training and workforce reporting (Q4)
- ✓ Recruitment and retention improvement plan will be delivered, our time to hire will improve and reliance on agency staffing will reduce (Q4)
- ✓ Implementation of Healthroster (Q4)
- ✓ CPD funding and opportunities for educational development, talent management and apprenticeship approaches, including new roles and flexible employment models (Q4)
- ✓ Growing the bank to provide an increased and agile flexible workforce (Q4)
- ✓ Staff engagement listening events to inform action plan (Q1)
- ✓ Staff satisfaction improvement plan will be finalised (Q1)
- ✓ National Self Assessment Toolkits for all available workstreams to inform actions (Q2)
- ✓ Just and learning culture principles and civility and respect programme delivered (Q3)
- ✓ Reduced sickness absence (Q4)
- ✓ Retention improvement plan will be delivered (Q4)
- ✓ Implementation of 6 EDI high impact actions / RACE code / national EDI improvement plan. Our WDES and WRES metrics will have improved (Q4)
- ✓ Implementation of actions from staff improvement plan (Q4)
- ✓ Improvement in staff survey results (Q4)
- ✓ Raised awareness of Trust's work through regular comms (Q1-4)
- ✓ Raise the profile of the Trust through creative comms (Q1-4)
- ✓ Highlight our services / achievements at a series of events / awards (Q1-4)
- ✓ Engage regularly with staff to ensure Trust communications are effective (Q1-4)
- ✓ Celebrate and promote successes through national awareness days (Q1-4)

Progress Update:

- Long service awards being organised to recognise staff contribution
- Listening events have been held with initial feedback compiled into an action plan and further dates planned for remainder of financial year 2 editions of Your Voice shared with staff and regular oversight of action plan and Your Voice comms oversight through Executive Team meeting monthly
- PIN badges being distributed in October/November to staff for St Georges Cross and 75 year NHS of the NHS
- ESR project plan continues at pace
- Health Roster implementation project on track and due for first services to come on line in April 2024 as planned
- R&R improvement plan – regular updates going to People Committee
- This years' staff satisfaction underway. Pulse survey results showing improvements in a number of key areas.
- TRAC implementation complete and fully operational
- Sickness absence continues to show sustained improvement
- Health & Well Being days – 1st one has taken place and well received with good attendance
- Health & Well being improvement plan I place and monitored through people Committee
- EDI Improvement plan in place – not commenced but will go through people Committee

Supporting Programmes of Work:

- Cultural programme
- Aspiring Leaders Programme

Key Assumptions:

- Improvement in staff survey results
- Substantive recruitment to 2 Assoc. Dir posts in the People Team for oversight and direction

Risks:

1.1 Workforce team capacity
1.2 Recruitment restrictions impacting on staff morale

Lead Director:

Director of Nursing, Workforce and Clinical Delivery

Lead Committee:

People Committee

Principle Objective: Invest in our workforce addressing existing gaps ensuring a compassionate and inclusive culture for all staff **BAF 1.1**

Principal Risk: Workforce Team Capacity

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of team capacity and prioritisation
- ✓ Revised workforce team structure
- ✓ Streamlined workforce processes

Assurance: **Source of Assurance** **3**

- ✓ People Committee oversight on key programme metrics
- ✓ Pulse checks
- ✓ System People Board

Gaps In Controls:

- C1: Ability to recruit substantively to Associate Director posts in workforce team

Gaps in Assurance:

- TBC

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Case of need to be presented to Executive Team for approval	Director of Nursing, Workforce and Clinical Delivery	November 2023	Case of Need presented and approved

Principle Objective: Invest in our workforce addressing existing gaps ensuring a compassionate and inclusive culture for all staff **BAF 1.2**

Principal Risk: Recruitment restrictions impact on staff morale

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ QEIA process to ensure robust consideration of impact
- ✓ Scrutiny of vacancy panel decisions at Finance Recovery Group
- ✓ Case of Need proforma to assess options

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

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ System People Board Oversight
- ✓ Staff Survey

Gaps In Controls:

- N/A

Gaps in Assurance:

- Staff Survey Results a year out of date

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress

Caring for Our Communities **OBJ 2**

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

This objective can be broken down into four components; implement and embed the new Patient Safety Incident Response Framework across the Trust, continue to deliver quality improvement, identifying learning needs and supporting staff to enhance pressure ulcer management and reduce inpatient falls, strengthen our use of patient experience information supported by robust governance processes to ensure that we are listening and improving our services and develop and embed robust processes to undertake research and identify areas for clinical development

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: October 2023

Key Measures:

- ✓ Compliance with Patient Safety Standards and a ratified Patient Safety Plan and Patient Safety Incident Response Policy in place (Q3)
- ✓ Role out of Purpose T pressure ulcer risk assessment (Q3)
- ✓ Achieve CQUIN for assessment and documentation of pressure ulcer risk (Q4)
- ✓ Bespoke training programmes for high risk teams to look at themes from RCAs and improvement measures (Q3)
- ✓ Pressure ulcer champions to be developed in all areas (Q1)
- ✓ Roll out of simple assistive technology for falls prevention (Q2)
- ✓ Complete evaluation of complex visual assistive technology for falls prevention and proceed to complete capital bid proposal if evaluation supportive (Q2)
- ✓ Achieve and sustain >95% compliance with the use and interpretation of lying and standing BP recording and interpretation (Q2)
- ✓ Revision of SCHT falls guidelines with national best practice and PSIRF (Q2)
- ✓ Full implementation of revised falls guidelines (Q2)
- ✓ Full implementation of SCHT Enhanced Supervision Policy (Q2)
- ✓ Achieve and sustain >95% compliance with falls prevention training (Q2)
- ✓ Reduce mean incidence of falls across Q1 and Q2 to <6 per 1000 bed days (Q2)
- ✓ Reduce incidence of repeated falls in same patient to <1 per patient per month (Q3)
- ✓ Reduce annualised mean incidence of falls to <6 per 1000 bed days (Q4)
- ✓ Reduce harm from falls, number of serious incidents relating to falls <2 for 23/24 (Q4)
- ✓ Review patient feedback methods across the Trust (Q1)
- ✓ Robust programme of observe and act (Q1)
- ✓ Strengthen relationship with Healthwatch (Q1)
- ✓ Expand digital methods of patient feedback (Q2)
- ✓ Patient Experience Delivery Group to report into Patient Experience Committee (Q2)
- ✓ Develop robust processes and structures to provide assurance that actions from patient feedback are implemented and shared (Q2)
- ✓ Publicise patient and service user feedback more regularly and robustly for staff, patients and public (Q3)
- ✓ Continue to deliver high quality research, reaching all WM Clinical Research Network High Level Objectives and gaining Research Capacity Funding (Q3)

Progress Update:

- PSIRF Working Group in place with draft policy and plan being worked on and plan for it to go to Patient Safety Committee and Quality and Safety Committee in October
- Purpose T implementation on hold at National level – therefore unable to progress in Q2 as planned
- CQUIN meetings and oversight occurring monthly and a delivery meeting bi-monthly
- Falls quality improvement work continues including assistive technology
- Enhanced supervision policy currently under review with further discussions following rapid learning following a recent SI
- Currently developing a Quality Improvement oversight Group that will align to Patient safety Committee and up to QSC for assurance and oversight
- Patient Experience delivery Group has now been established and is reporting to the committee
- Baseline assessment against NHSEI assessment tool – due to come to Patient safety Committee – awaiting feedback and benchmarking data from the national team

Key Measures Continued

- ✓ Grow the commercially partnered research activity in line with the DoH and NIHR Research programme promoting commercial research (Q2)
- ✓ Continue to grow the research champions scheme within the Trust increasing the number of colleagues engaging with the programme (Q4)
- ✓ Achieving Innovation and Improvement funding from the WM Clinical Research Network's Annual Funding round to grow research buy in within the Trust (Q4)

Supporting Programmes of Work:	Key Assumptions
○ PSIRF Programme ○ Urgent completion of Governance restructure	○ Governance restructure approved and implemented

Risks:	
BAF2.1	Ability to transition to LFPSE
BAF 2.2	Reliance on volunteer input for key patient experience workstreams such as observe and act
BAF 2.3	Completion of Governance restructure overdue and impacting on ability to have increased oversight of local governance that feeds higher level assurance within the organisation

Lead Director:	Lead Committee:
Director of Nursing, Workforce and Clinical Delivery	Quality and Safety Committee

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 2.1**

Principal Risk: Ability to transition to LFPSE

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ PSIRF Working group overseeing transition
- ✓ LFPSE testing completed with ongoing support from Datix
- ✓ System Working group
- ✓ System partner support (those also using Datix)
- ✓ National toolkit being followed

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

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

Gaps In Controls:

- o Datix reconfiguration to be completed and resource constraints
- o Datix software compatibility

Gaps in Assurance:

- o None identified

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Reconfiguration timetable to be compiled and implemented	Director of Governance	November 2023	Reconfiguration work has commenced with initial testing completed
C2	Ongoing support from Datix	Director of Governance	November 2023	Tickets logged with Datix for ongoing support – additional resource has been procured and is now progressing

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas — BAF 2.2

Principal Risk: Reliance on volunteer input for key patient experience workstreams such as observe and act

Loss of volunteers would impact on ability to delivery key workstreams

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Restructure of Governance Team to improve resilience including for patient experience work
- ✓ Administrative support for volunteers identified in new structure
- ✓ Board recognition for volunteers work to improve morale and retention
- ✓ Identified Patient Experience Lead overseeing volunteers with good and longstanding relationships
- ✓ Director of Governance attendance at volunteer meetings on request

Assurance: Source of Assurance 1

- ✓ Patient Experience Committee

Gaps In Controls:

- C1: Lack of recruitment and retention plan for volunteers
- C2: Lack of admin support until new Governance Structure in place

Gaps in Assurance:

- A1: No tracking of recruitment and retention of volunteers

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Recruitment and retention plan to be devised	Director of Governance	December 2023	Director of Governance and Patient Experience Lead in discussion to formulate plan
C2	Administrative support to be put in place	Director of Governance	December 2023	Interim support in place with transition to new post holder underway
A1	Recruitment and retention tracking to be put in place once plan devised	Director of Governance	January 2024	Not yet commenced – recruitment and retention plan to be devised in the first instance

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

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 2.3**

Principal Risk: Completion of governance structure delaying increased governance oversight

Lack of governance resource and capacity impacting on ability to improve oversight and assurance at a higher level

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ New governance framework implemented in 2022
- ✓ Expertise within the existing team
- ✓ Datix monitoring in place with key metrics

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

- ✓ Reporting to Audit Committee on Risk Management performance
- ✓ Robust governance framework and reporting
- ✓ Chair's reports for clarity around assurance being achieved through committees

Gaps In Controls:

- o Governance capacity due to lack of structure

Gaps in Assurance:

- o Improvements in reports and monitoring needed

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Governance restructure	Director of Governance	November 2023	Restructure has been articulated, consultation has been opened and closed with staff, executive approval to proceed with recruitment has been obtained, JDs have been completed and interview of AD for Governance taking place on 27 November.
C2	Ongoing support from Datix	Director of Governance	November 2023	Tickets logged with Datix for ongoing support and additional support has been procured and is progressing

Caring for Our Communities — OBJ 3

Principle Objective: Tackle the problems of ill health, health inequalities and access to health care using data and analytics to redesign care pathways and measure outcomes

This objective can be broken down into two key components: promote uptake of vaccinations to improve health and reduce emergency admissions, further develop health inequalities measures and embed 'making every contact count' for all services

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: September 2023

Key Measures:

- ✓ Delivery a spring 2023 covid 19 vaccination campaign to the cohorts recommended by the JCVI. To achieve locally agreed uptake targets (Q2)
- ✓ Deliver an autumn/winter 20234/24 covid 19 vaccination campaign to the cohorts recommended by JCVI to achieve locally agreed uptake targets (Q4)
- ✓ Implement Brilliant Brushers programme across increased volume of targeted settings (Q1-4)
- ✓ Increase accessibility to high strength fluoride toothpaste for vulnerable elderly in care home settings (Q2)
- ✓ Increased offer of specialist dental care to children in STW (Q3)
- ✓ Implement Brilliant Brushers programme across increased volume of targeted settings (Q1-4)
- ✓ Increase accessibility to high strength fluoride toothpaste for vulnerable elderly in care home settings (Q2)
- ✓ Increased offer of specialist dental care to children in STW (Q3)

Progress Update:

- The Covid Vaccination Service delivered a spring campaign between April 2023 – June 2023 as per JCVI guidance. They achieved overall uptake of 71% against a local target of 61%. This was made up of 82.1% of Care Home residents, 75.5% of eligible over 75s and 45.6% of Under-75 Immunosuppressed.
- The Covid Vaccination Service has begun an Autumn campaign in September 2023. Data will be reported following its completion on 31/01/2024.
- The Brilliant Brushers supervised toothbrushing programme for 3-5 year olds has now been up taken by 79 settings with 141 settings offered the programme (cumulatively up to the end of Q2)
- PGD has been developed, and further governance working with NHSE for provision of high strength fluoride toothpaste to vulnerable elderly in care (nursing home environments). Training of the care homes will be provide by the healthy smiles team and community pharmacy (PGD training) once the pharmacy provider has endorsed the process (Q3)
- PGD developed with NHSE partners for provision of HSF toothpaste to vulnerable homeless population via The Ark. Healthy Smiles team to deliver training to The Ark and pharmacy provider. Stalled at request of Ark and pharmacy pressure due to operational pressures. Operational delivery of community dental care to vulnerable homeless- screening process completed within the Ark. Delivery of services to commence at Shrewsbury Dental when the Ark reopens and can support service users to appointments
- ST4 in paediatric dentistry in post (1 day per week) widening offer of specialist paediatric care in STW (Q3)
- Acceptance of governance model by pharmacy provider for HSF toothpaste programme
- Capacity of primary care pharmacy and within the Ark to adopt the vulnerable homeless HSF and community dental care model

Supporting Programmes of Work:	Key Assumptions
○ N/A	○ N/A

Risks:	
3.1	Reduced 'Item of Service' payments to vaccination providers for the second half of the Autumn Covid Vaccination programme may result in some providers reducing their clinics during November and December unless delivered in conjunction with flu vaccination clinics. (Risk being worked up)

Lead Director:	Lead Committee:
Director for Operations	Quality and Safety Committee

Caring for Our Communities **OBJ 4**

Principle Objective: Restore and recover our services tackling the backlog and reduce long waits.

This objective can be broken down into two key components; aligned to commissioning intentions increase capacity through improved efficiency and models of care developing robust capacity plans to deliver predicted demand and reduce waiting lists and implement system wide outpatient transformation pathways including increasing patient initiated follow ups, advice and guidance

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: September 2023

Key Measures:

- ✓ Full implementation of Phase 1 of the system wide MSK transformation project (MSST) (Q1-2)
- ✓ Reduction to zero 52 week patients (Q4) national target 65 weeks
- ✓ Continue to explore further system wider transformation projects (diabetes) (Q2-3)
- ✓ Reduction of referral to treatment waiting list backlogs to ensure compliance with the 92% incomplete target (Q4)
- ✓ Overall implementation of all aspects of the system wider MSK Transformation Project (Q4)
- ✓ Implementation of PIFU across appropriate outpatient services (Q1)
- ✓ Continue to provide patients with options of virtual consultations (Q1)
- ✓ Work together with the system OP transformation group to look at standardising patient communications (Q2-3)
- ✓ Continue to develop plans to help reduce DNA alongside the system OP Transformation Group

Progress Update:

- Phase 1 and becoming business as usual
- Active partner in System Diabetes forum
- MSK Board and Transformation project ongoing
- PIFU in pace I appropriate services
- Virtual consultations are offered as appropriate with constant review on further opportunity
- Actively involved in System Out Patients transformation group
- Phase 2 of the project has now been implemented (Aug23). This now means that MSST has a single front door with a standardised referral proforma across the county. Level 2 and Level 3 therapy are now live with MSST clinics and seeing MSST patients with work being undertaken to look at recovering the current waiting list backlogs. Plans continue to implement Phase 3 of the project with Rheumatology due to go live now in march. At present no timescale has been agreed for Orthopaedics, Pain services and Orthotics.
- PIFU is now fully implemented in the appropriate services and is consistently above the national target for SCHT overall, currently at 10%.
- Services continue to utilise virtual consultations across multiple services. Whilst services are not routinely hitting the national aim of 25% further work is being undertaken to understand the appropriateness of 25% in specific services to understand how appropriate and achievable 25% is.
- This hasn't progressed any further as a system due to the OP transformation group having a refresh in priorities in Q2. Internally within SCHT we are looking to implement My NHSAPP which will provide patients the opportunity to receive appointment and clinical letters digitally which will increase efficiency and reduce costs.
- Further work is underway to support missed appointments via the use of text message reminders and to scope other digital solutions. However at present SCHT is consistently achieving the target set nationally of having a 5% DNA rate by March 24 but this may be impacted as we move forward by the system wide MSK service, MSST. This will be monitored closely within the project and via the OP Transformation group.

Supporting Programmes of Work:	Key Assumptions
○ OP Transformation programme ○ MSK Programme	○ MSK transformation phases will continue as planned

Risks:

BAF4.1	Demand exceeds capacity
BAF 4.2	Potential for patient harm due to waiting times
BAF 4.3	Internal governance and operational oversight of system programmes
BAF 4.4	Operational capacity to deliver the programmes of work?
BAF 4.5	Developing risk of inequity in regards to RTT – to be raised to system Quality Committee (Risk being worked up)

Lead Director:

Director for Operations

Lead Committee:

Resource and Performance Committee / Quality and Safety Committee

Restore and recover our services tackling the backlog and reduce long waits — BAF 4.1

Principal Risk: Demand exceeds capacity

Inability to restore activity levels resulting in increasing waiting times and poor patient experience. Non-compliance with national oversight framework, regulatory and system scrutiny and loss of reputation, potential for loss of income if activity levels not achieved.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	3	3
Likelihood	4	4	2
Total	20	12	6

Risk Details:

Opened: April 2022

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of performance against plan for early identification of actions
- ✓ Realtime review and monitoring of waiting lists
- ✓ Internal Planning Group in place for monitoring

Assurance: Source of Assurance 3

- ✓ Resource and Performance Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee

Gaps In Controls:

- C1: Internal operational performance framework in infancy with Performance Board needing to be re-established
- C2: Operational Forecasting gaps

Gaps in Assurance:

- A1: Waiting for national oversight framework to enable assessment against requirements

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Performance board to be re-established	Director of Finance / Director of Governance	November 2023	First meeting Scheduled for 6th December
A1	Complete assessment against national oversight framework once published	Director of Finance	December 2023	

Restore and recover our services tackling the backlog and reduce long waits — BAF 4.2

Principal Risk: Potential for patient harm due to waiting times

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: April 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Programme of work to eliminate waits of over 104 weeks as a priority and reduce waits of over 78 weeks.
- ✓ Harms assessment process
- ✓ Harms Assessment Group established to deliver process

Assurance: **Source of Assurance** **3**

- ✓ Quality and Safety Committee oversight
- ✓ National reporting on waiting times
- ✓ System Delivery Committee
- ✓ Patient Safety Committee established

Gaps In Controls:

- C1: Completion of harms reviews and embedding in patient pathway

Gaps in Assurance:

- A1: Lack of formal tracking or reporting of harms process

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Harms reviews to be completed for all patients waiting over 52 weeks	Director of Operations	December 2023	
A2	Tracking and reporting of harms process to be put in place	Director of Operations / Director of Governance	December 2023	

Restore and recover our services tackling the backlog and reduce long waits — BAF 4.3

Principal Risk: Internal governance and operational oversight arrangements for system programmes

System programmes are taken through system governance and don't have links into the Trust's governance and operational oversight arrangements, potential for risks to not be identified and mitigated from a Trust perspective when SROs sit outside of the organisation

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings

Assurance: **Source of Assurance** 3

- ✓ Quality and Safety Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- ○ C1: System programme meetings not aligned to Trust's operational meeting framework

Gaps in Assurance:

- ○ A1: System programme meetings not aligned to the trust's governance framework

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Review of governance and operational frameworks to ensure system programmes are captured	Director of Operations / Director of Governance	December 2023	Transformation Oversight Group established which will sit alongside Performance Board.

Restore and recover our services tackling the backlog and reduce long waits — BAF 4.4

Principal Risk: Operational capacity to undertake all programmes of work

Potential for operational pressures to affect prioritisation of system programmes both internally and across the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	?	?
Likelihood	4	?	?
Total	20	?	?

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Revised operational structure

Assurance: Source of Assurance 3

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee with Trust representatives in attendance

Gaps In Controls:

- C1: System programme meetings not aligned to Trust's operational meeting framework

Gaps in Assurance:

- A1: System programme meetings not aligned to the trust's governance framework

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1/A1	Review of governance and operational frameworks to ensure system programmes are captured	Director of Operations / Director of Governance	December 2023	Transformation oversight group established which will sit alongside Performance Board

Caring for Our Communities — OBJ 5

Principal Objective: Build community care capacity supporting people to stay well and out of hospital

This objective can be broken down into four key components, improve on the integrated discharge team improvements across STW, further reducing LoS for patients with no criteria to reside and thereby supporting patient flow across STW, develop care models for sub-acute and post-acute care based on the needs of our population, making best use of our community bed base capacity and community assets and expand community-based services to provide more care and treatments and prevent hospital attendances, continue the planned expansion of Virtual Ward to enable patients to receive medical care in their home or usual place of residence, supporting improved outcomes ad experience for patients and reducing demand on acute hospital beds, play an active role in working with system partners to develop person centred and proactive models of care for the most vulnerable patients in our community and ensure that these models are embedded in our community services and working with system partners to develop neighbour hood models of care, with a clear focus on the alignment of community staff to geographical localities.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ P1 pathways decreased use / reduced waiting list (Q1)
- ✓ P2 pathways increased use / reduced waiting list (Q1)
- ✓ Reduced ward LoS for complex discharges (Q1)
- ✓ Reduction in MFFD numbers (Q1)
- ✓ Milestones and outcomes will be developed as part of the phase 2 of the Local Care Transformation Programme (Q1-4)
- ✓ Increased referrals (step up and step down) and bed occupancy in VW according to the agreed system trajectory (Q1)
- ✓ Reduction of acute beds as a direct results of virtual wards. This can be translated into the number of wards related to this reduction bed days. Monetised by applying the cost of a ward (Q1)
- ✓ Outcome or milestones set as part of Phase 2 of LCTP (Q1-4)

Objective Details:

Opened: April 2023

Reviewed Date: October 2023

Progress Update:

- Increasing numbers on Virtual Ward since the inception of 1 point of referral phone line
- Acuity and dependency of patients being reviewed on VW
- Original target bed numbers to be reviewed and discussed with regional colleagues
- Recruitment and pathways underway for sub-acute wards
- P1 pathways increased use / reduced waiting list (Q1) The Integrated Discharge Team based within the acute provider has a focused work stream to drive the home first philosophy for discharge , with home being the default discharge pathway. The ambition to increase the number of pathway 1 referrals inline with the national discharge pathway profiles. Working with the local authority adult social care hospital / reablement teams and acute hospital staff the IDT continues to focus on this service improvement work, pathway 1 discharge were 47% of the total complex discharge April-June 2023, the work is to further increase the number of pathway 1 discharges when safe and appropriate to do so and decrease the dependant on pathway 2/3 provision continues.
- P2 pathways decreased use / reduced waiting list (Q1) Pathway 2 referrals remain higher than predicted and account for 30-35% of all complex discharges from the acute hospitals with high rates of community hospital occupancy. The reduction of pathway 2 referrals is linked to the IDT home first approach and the interdependencies of professional decision making, safety netting and risk management, availability of domiciliary care including night services and critical incidents where community hospital criteria is flexed to

support the demand and has an impact on the referral rates. The workstreams and review of metric is ongoing as part of the IDT project delivery group.

- Reduced ward LoS for complex discharges (Q1) Average LOS reduction by 2 days for complex discharge from baseline March 2023 16.4 days to 14,2 days September 2023, this remains variable and rises in line with escalation and availability of pathway 1-3 provisions
- Reduction in MFFD numbers (Q1) Q1 achieved an increase of the average complex discharges 25 to 27 weekday. Weekend discharges fluctuated but slight improvement on an average from 20 to 21.Q2 – continue to deliver weekday average of 27 and average weekend of 20 complex discharges. The reduction in the number of No criteria to reside numbers is also correlated to the reduction in average LoS of complex patients seen in Q1, which will reduce the required number of bed days. The overall bed day reduction trajectory is monitoring via the ICB demand and capacity modelling group.
- Sub acute wards is in Phase 1 with Service Delivery Groups focussing on the operational delivery of the varied workstreams including Workforce, Finance, Estates, Clinical Pathways with a weekly oversight Group chaired by the designated SRO (COO at SaTH)

Supporting Programmes of Work:

- Local Care Programme
- Virtual Ward programme

Key Assumptions

- Recruitment of key staff

Risks:

BAF 5.1	Recruitment challenges
BAF 5.2	Community capacity fails to have impact
BAF 5.3	Continued movement of timescales for opening of sub-acute beds – out of SCHT control

Lead Director:

Director of Nursing, Workforce and Clinical Delivery

Lead Committee:

Resource and Performance Committee / Quality and Safety Committee

Build community care capacity supporting people to stay well and out of hospital — BAF 5.1

Principal Risk: Recruitment challenges

Inability to meet safe staffing requirements, reliance on agency staff, impact on service delivery, reduction in standards of care and patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: April 2022

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment programme
- ✓ International recruitment as a system
- ✓ Availability of system mutual aid
- ✓ Planned early start to recruitment with potential ‘recruit as risk’ for key posts approach to minimise service delays and financial consequences

Assurance: Source of Assurance 3

- ✓ People Committee oversight
- ✓ Safe staffing reporting to Board
- ✓ Quality metrics
- ✓ System People Board oversight

Gaps In Controls:

- C1: Line of sight on vacancies and agency usage

Gaps in Assurance:

- ~~A1: People Committee in its infancy~~
- A2: System People Board has not met with any frequency

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing	March 2023	Collaboration with the system on e-rostering in its infancy with project plan to be developed
A2	Engagement with System People Board	Director of Nursing / Director of Governance	September 2023	New People Committee established for ICB, Shrop Comm NED representative agreed.

Build community care capacity supporting people to stay well and out of hospital — BAF 5.2

Principal Risk: Community capacity fails to have impact

Inability to progress with programme and commence recruitment campaign in full resulting in delays with opening of modular ward

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ VW metrics reported to Executive Team for oversight
- ✓ Provider Transformation Committee meeting regularly
- ✓ IDT in place

Assurance: Source of Assurance 3

- ✓ System Integrated Delivery Committee
- ✓ Resource and Performance Committee
- ✓ NHS E Reporting
- ✓ Joint committee with SaTH on transformation work

Gaps In Controls:

- C1: Reliance on system partner working and collaboration

Gaps in Assurance:

- A1: Committee in common to be established

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Improved system working	Chief Executive	December 2023	Committee in common being established

Build community care capacity supporting people to stay well and out of hospital — BAF 5.3

Principal Risk: Continued movement of timescales for opening of sub-acute beds – out of SCHT control

Inability to progress with programme and commence recruitment campaign in full resulting in delays with opening of modular ward

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Planned early start to recruitment with potential 'recruit as risk' for key posts approach to minimise service delays and financial consequences
- ✓ Programme plan in place

Assurance: Source of Assurance 3

- ✓ Steering group in place attended by SCHT Executives
- ✓ SaTH / Shrop Comm Transformation Committee
- ✓ Project flash reports

Gaps In Controls:

- C1: Programme plan not on track due to changing timeframes

Gaps in Assurance:

- A1: Oversight of system programmes (addressed above through implementation of Transformation Oversight Group)

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
	Weekly reporting to Executive Team for oversight	Director of Nursing and Director of Ops	Ongoing	Weekly updates in place

1 2 3 4 5 6 7 8 9 10 11 12 13 ⋮

Caring for Our Communities — OBJ 6

Principle Objective: Develop strong partnerships expanding the range of services provided out of hospital settings

This objective can be broken down into two key component; seek opportunities to strengthen links with mental health services including CYP LD&A and SEND and building on the success of the Oswestry Test and Learn Project and the Brighter Futures Multi-Agency Programme, continue to strengthen partnerships and expand services for Children, Young People and their Families

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: October 2023

Key Measures:

- ✓ Joint peer supervision forum launched (Q1)
- ✓ 'Voice of the Child' outcome tool developed (Q2)
- ✓ Partners will have come together to analyse the successes and outputs of these events to enable the next stage of development (Q1)
- ✓ Multiagency offer to support working together for 2023/24 including expansion to include Telford and Wrekin (Q2)

Progress Update:

- Supervision steering group re-established. Sara Ellis introduced as new chair to progress this workstream
- A second peer supervision meeting with BeeU took place in October 2023. These events continue to strengthen the partnerships between MPFT and SCHT.
- North Shropshire role out of the integration pilot has commenced. Evaluation will follow in the new year.
- Multi-agency workstream commenced to develop a local Voice of the Child outcome tool. Participants from Local Authority, Health, Education, SEND and parent groups engaged. Takeover day planned to hear the views of school aged children at the end of November.
- Brighter Futures events paused whilst Safeguarding Summit and panel analyse recent safeguarding cases. Themes and interagency learning will underpin the agenda for the next event scheduled for February/ March 2024 for the whole of Shropshire.

Supporting Programmes of Work:

- N/A

Key Assumptions

- N/A

Risks:

BAF 6.1 BeeU are experiencing workforce and capacity challenges which means engagement is not guaranteed at peer supervision sessions. Leaders across both organisations are attempting to make this a priority to release staff whilst managing the risk to waiting lists and demand. (Risk being worked up)

Lead Director:

Director of Nursing, Workforce and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Managing Our Resources — OBJ 7

Principle Objective: Maximise the potential of digital technologies ensuring a core level of digitisation in every service across systems to transform the delivery of care and patient outcomes

This objective can be broken down into four key components; building on the benefits released through virtual assistants, digital consent and improved agile working technologies, further extend digital channels to give patients better options to access health and social care services and support patients to manage their own health and care, maintain strong systems and processes and strengthen the Trust's cyber security capabilities working with the ICS to optimise our capabilities in this area, develop robust digital training plans to upskill our workforce to maximise the potential associated with digital development made to date and connect with the ICS to enable our staff to drive through a digital first approach to delivering care and offer a greater digital choice for how citizens can access and manage health and care services and supporting implementation of ICS wide EPMA for hospitals and community services to reduce medicines related errors waste and to optimise the use of the system medicines formulary

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: October 2023

Key Measures:

- ✓ Appointment management online so that patients can see and change upcoming appointments (Q3)
- ✓ Expand digital consent and introduce more opportunity through online forms that will add patient related information directly into the clinical record (Q3)
- ✓ Strengthening of defences in depth and resilience against potential cyber threats (Q2)
- ✓ Embed digital first culture and optimise digital channels available (Q4)
- ✓ EPMA Business case (Q1)
- ✓ Medicines management team included in SCHT digital meetings (Q1)
- ✓ Review all medicine stock lists (Q1)
- ✓ Support finalising full EPMA business case (Q4)

Progress Update:

- EPMA Business – looking at solution within RIO and full engagement with the medicines management team. Agile development in train.
- Internal audit review plus NHS E review of cyber resilience, both showing improvement and that arrangements are robust.

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

7.1 Risk of cyber attack
7.2 Digital team capacity

Lead Executive

Director of Finance

Lead Committee:

Resource and Performance Committee

Maximise the potential of digital technologies ensuring a core level of digitisation in every service across systems to transform the delivery of care and patient outcomes **BAF 7.1**

Principal Risk: Cyber attack

Loss of data or operationality of systems, reputational damage, impact on service delivery

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	3	2
Total	20	12	6

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ DSPT Toolkit compliance
- ✓ External expertise input into cyber risk management
- ✓ SIRO and Deputy SIRO oversight
- ✓ Cyber security programme
- ✓ Information asset owners and register
- ✓ Business continuity plans in place

Assurance: **Source of Assurance** **3**

- ✓ Audit Committee Oversight
- ✓ Data Security Group

Gaps In Controls:

- C1: Information asset owner processes still embedding

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Information Asset Owner Network meetings to be established	Director of Governance	December 2023	Schedule in place with holds in the diary

Maximise the potential of digital technologies ensuring a core level of digitisation in every service across systems to transform the delivery of care and patient outcomes **BAF 7.2**

Principal Risk: Digital Team capacity

Lack of capacity results in programmes of work being paused or delayed, loss of momentum with digital agenda, staff unsupported with digital service needs

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	5	5	2
Total	20	20	8

Risk Details:

Opened: September 2023

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital strategy and programme of work in place
- ✓ Regular team meetings with oversight from Director of Finance

Assurance: **Source of Assurance** **3**

- ✓ Digital Assurance Group

Gaps In Controls:

- C1: Recruitment controls preventing appointments to vacancies
- C2: Line of sight on programmes of work requiring digital input impacting on prioritisation and workload

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Digital B7 Case of Need to be presented to Execs	Director of Finance	November 2023	Submitted to Execs and approved to proceed
C2	Transformation Oversight Group to include digital input	Director of Operations	November 2023	ToR in development

Managing Our Resources — OBJ 8

Principle Objective: Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners

This objective can be broken down into three key components; develop 3 year cost improvement programmes informed by benchmarking intelligence, develop an Estates Plan which ensures buildings are safe and fit for purpose and all associated backlog maintenance requirements are priorities and addressed accordingly, support the development of a broader approach to carbon reduction towards Net Zero extending beyond the built environment

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2023

Reviewed Date: October 2023

Key Measures:

- ✓ Review and analyse the benchmarking reports shared with RPC during 22/23 for CIP opportunities to ensure a focussed trust wider approach is proposed to avoid duplication of effort (Q1)
- ✓ Agree CIP priority areas informed by the Q1 benchmarking intelligence exercise (Q2-3)
- ✓ Agree 3 year CIP targets with Board, STW and NHS England from 24/25 onwards
- ✓ CIP priority PIDs and Business cases are developed based on benchmarking intelligence to contribute towards 3 year CIP targets from 24/25 onwards (Q4)
- ✓ Review current estates backlog to provide an update to the annual ERIC returns (Q1)
- ✓ Review capital programme to identify links to backlog requirement and identify where schemes mitigate against growth of in year backlog (Q1)
- ✓ Updates through working groups (Q1)
- ✓ Space Utilisation and Hybrid working policy in place defining principles of property usage (Q1)
- ✓ Identification of site specific differences (Q1)
- ✓ Processes of design, sign off and handover in place for significant works (Q1)
- ✓ Review of PPM regimes as areas are refurbished (Q1)
- ✓ Ongoing review of BLM (Q1)
- ✓ Review revenue implications of BLM with service providers and any potential new works that fall below the capital allowance (Q2)
- ✓ Review priorities to identify any changes to spend activity (Q2)
- ✓ Review mitigation strategy where capital funding is constrained and link to the PAM update for September 2023 (Q2)

Progress Update:

- Estates plan has been approved via RPC with benchmarking showing good compliance
- Substantial progress with Net Zero agenda in relation to the estate, focus needed on the other areas of the programme
- Space Utilisation surveys complete for areas of the estate and action plans being developed
- CIP Plan in place for 23/24 with some gaps remaining. Weekly meetings with the Executive Team to address gaps.

Supporting Programmes of Work:

- CIP Programme
- Net Zero Group
- Capital Programme

Key Assumptions:

- Operational delivery of CIP identified
- Elective activity delivery

Risks:

BAF1.1 Costs exceed plan

BAF 1.2 Capital funding insufficient (risk being worked up)

Lead Director:

Director of Finance

Lead Committee:

Resource and Performance Committee

Make the most effective use of our resources moving back to and beyond pre- pandemic levels of productivity reviewing internal processes and reviewing pathways with our partners — BAF 8.1

Principal Risk: Costs exceed plan

Escalation within system oversight framework and increased regulatory scrutiny, inability to invest, loss of opportunity to transform services

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	4	2
Total	20	16	6

Risk Details:

Opened: April 2022

Reviewed Date: October 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Use of non-recurrent schemes to allow more time to implement recurrent cost saving schemes
- ✓ CIP Delivery Group working on identifying CIP schemes
- ✓ Robust QEIA process in place
- ✓ Financial Recovery Group in place for operational oversight

Assurance:

Source of Assurance: 3

- ✓ Resource and Performance Committee oversight
- ✓ System Delivery Committee oversight
- ✓ KPI Metrics
- ✓ Value for Money audit

Gaps In Controls:

- C1: Shortfall in CIP schemes currently identified
- C2: Elective activity performance

Gaps in Assurance:

- A1: Performance and Programme Board to be re-established
-

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Ongoing work through CIP Delivery Group feeding into Financial Recovery Group	Director of Finance	March 2024	Weekly meeting continue to take place with Executive oversight
A1	Performance and Programme Board to be embedded	Director of Finance	February 2023	First meeting of new Performance Board scheduled for 5 December
C2	Establish assurance committee for elective activity and patient waits	Director of Finance / Director of Governance	December 2023	ToR in development and date being held in diary for first meeting

NHS
Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Information Programme Manager Gemma McIver, Deputy COO	**Paper date:**	**7th December 2023**
Executive Sponsor:	Sarah Lloyd, Director of Finance	**Paper written on:**	**27th November 2023**
Paper Reviewed by:		**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The purpose of this report is to provide oversight of the key performance indicators included within the Trust's Performance Framework.

The paper is intended to provide information and assurance and consider for action.

2. Executive Summary

2.1 Context

The purpose of this report is to provide oversight and an assessment of the key areas of performance relevant to the Trust's updated Performance Framework.

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

2.2 Summary

The key points for the Trust Board to consider are:

- There are 60 performance indicators reported in this period across all committees.
- The table below summarises the number of KPIs highlighted as a concern against each responsible committee. 29 indicators are highlighted as a concern (48.3%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	3	9	3	**19**	**15 (79%)**
Quality & Safety	0	2	3	**16**	**5 (31%)**
Resource & Performance	0	5	4	**25**	**9 (36%)**

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

NHS
Shropshire Community Health
NHS Trust

Performance Update

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

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

1. Available Virtual Ward capacity per 100k head of population
2. Data Quality Maturity Index
3. Total elective activity undertaken compared with 2019/20 baseline.
4. Total patients waiting more than 65 Weeks to start consultant-led treatment (National target).
5. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target).

4 KPIs are both an assurance concern *and* special cause variation concern.

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

The list of KPIs which are of concern is largely unchanged from the last report. 'Agency spend – compared to the agency ceiling' is no longer a variation concern and 'Available Virtual Ward Capacity per 100k head of population' is now flagged has having an assurance concern.

As of October 2023:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	82	399
Patients waiting over 65 weeks	3	206
Patients waiting over 78 weeks	0	104
Patients waiting over 104 weeks	0	0

Of the 3 patients waiting over 65 Weeks to start consultant-led treatment there was: 1 patient at 75 weeks in Dental (subsequently closed at 75 weeks), 1 patient at 67 in TeMS and 1 patient at 67 in MSST.

Overall, this is a deterioration from the last position reported to the Board.

The measures relating to waiting times and RTT are likely to fluctuate as the implementation and transition of the system-wide MSK transformation programme continues to embed. The increase in reported pathways for the Trust is significant which will require additional validation efforts, with limited capacity, and this could affect our performance. This is under close review by Operational teams within the programme.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Performance Update

18 week Referral to Treatment (RTT) incomplete pathways has deteriorated again from 61% in September to 59.31% in October, which largely relates to the revised MSK pathway. **Please note that the RTT measures for October are subject to change as the validation for the national submission continued at the time of preparing the paper/dashboards.**

The Resource and Performance Committee reviewed this information and were advised of an issue with 'Total elective activity undertaken compared with 2019/20 Baseline', and that the value should be 101.25% in October and 'Outpatient follow up activity levels compared with 2019/20 Baseline' should be 74.38% in October. These will be refreshed for the next reporting cycle.

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

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required.

3. Main Report

3.1 Introduction

Following approval by the Board of the updated Performance Framework, a revised set of KPIs was agreed for monitoring the Trust's performance. The full list of KPIs monitored across all three of our committees is shown in Appendix 1 of this document.

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

3.2 Summary of key points in report

There are a total of 60 performance indicators reviewed by our committees. Actions being taken in relation to performance indicators considered by the Quality and Safety Committee and People Committee are reported separately to the Trust Board.

This report focuses on the 25 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 9 are felt to be worthy of particular focus and discussion with 8 of the 9 relating to access to services and waiting times with most showing a deterioration in performance over the last couple of months and some of this is a consequence of the introduction of the system-wide MSK service.

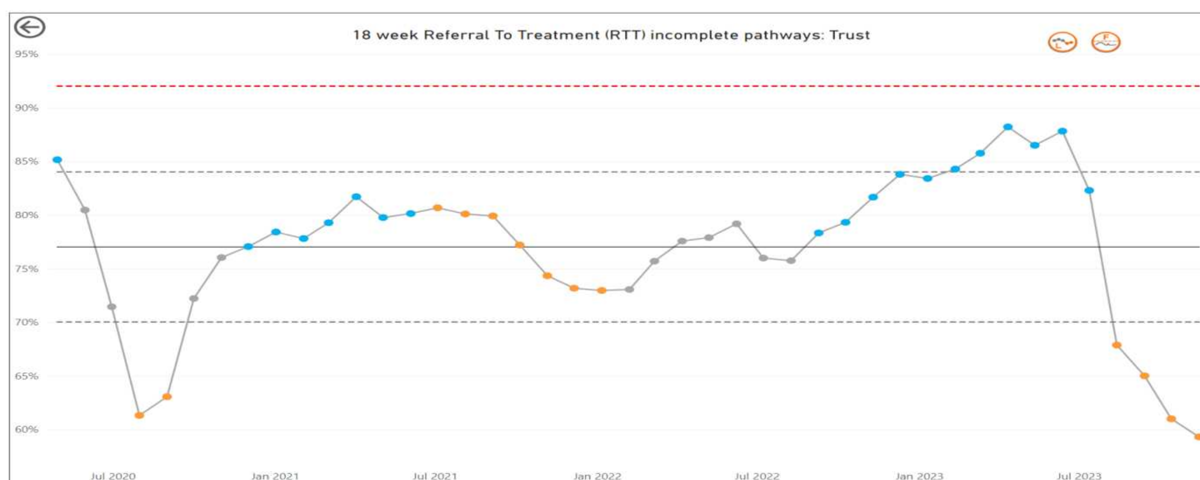
Performance Update

The Committee received an update paper from Deputy Chief Operating Officer on RTT and waiting times and it was agreed a separate time-limited committee meeting will be established to review recovery actions in relation to access to services and waiting times.

SPC charts are presented within this report for the 9 KPIs which require additional consideration from a resource or performance perspective. The actions being taken to improve this position are included below.

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

18 week Referral to Treatment (RTT) incomplete pathways:-



There has been a significant decline in performance recently and special cause variation of a concerning nature exists, as the variation icon and amber shading depicts, with actual performance outside of the control limits. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign.

As noted above, and applicable throughout this report, please note that the RTT measures for October are subject to change as the validation for the national submission continued at the time of preparing the paper/dashboards.

Operational Narrative:- The current position continues to be a challenge to SCHT mainly due to the implementation of the MSST MSK service. Phase 1 was February 2023 with referrals starting to come through and Phase 2 in August was the start of patients being seen across the MSST service. This has led to SCHT taking all the responsibility for reporting the system-wide service. The main concerns focus around clinical utilisation (mainly seen within RJAH) and capacity to validate the RTT position. Discussions are ongoing with providers and the ICB about the next steps to enable a robust recovery plan to be implemented. TeMS legacy services are also challenged particularly within the Lower Limb element of the service with the likely solution being the next Phase of MSST.

Shropshire Community Health NHS Trust

Performance Update

Community Paediatrician vacancies and sickness have had an adverse impact on this waiting list. Numerous attempts at recruiting to a Community Paediatrician post have been unsuccessful prompting a review of the skill mix within the team. A meeting is arranged for 20th November to discuss and plan the next steps.

There are other services which contribute to not meeting this performance target, such as APCS, Dental, and Community Hospital activity and operational narrative will again be requested for future reports.

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

Although this measure has been flagged as having special cause variation of an improving nature, as the blue variation icon depicts, this KPI is flagged as not capable and will fail the target without process redesign.

Operational Narrative:- The main area of concern is with the TeMS service and particularly seen within the Lower Limb Orthopaedic element of the service. This is in part due to the delay in full implementation of the MSST system which would have enabled a system wide equitable approach to tackling backlogs and a reduction in capacity that should be provided via the sub-contract with SATH. Due to the phased approach of MSST this has led to TeMS maintaining these elements of MSK separate to MSST. Positively, there are now weekly meetings with NHSE/ICB./RJAH/SATH to look at a more system-wide approach to managing the demand. The overall plan is to move towards the next phase of MSST to enable these elements to be managed by the appropriate trusts i.e. RJAH/SATH.

Dental surgery is likely to see some patients tip into the 65+ due the challenges with theatre capacity.

NHS
Shropshire Community Health
NHS Trust

Performance Update

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

Common cause variation is evident as per the grey variation icon, although there has been a rapid increase in breaches of the standard recently. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign as shown by the amber assurance icon.

At the end of October there were 82 patients reported waiting over 52 weeks (under the consultant led RTT incomplete pathways definition) across Trust services, 3 patients waiting over 65 weeks and 0 patients waiting over 78 weeks. This is a slight improvement in the 65 weeks and over categories but the 52 weeks and over is growing.

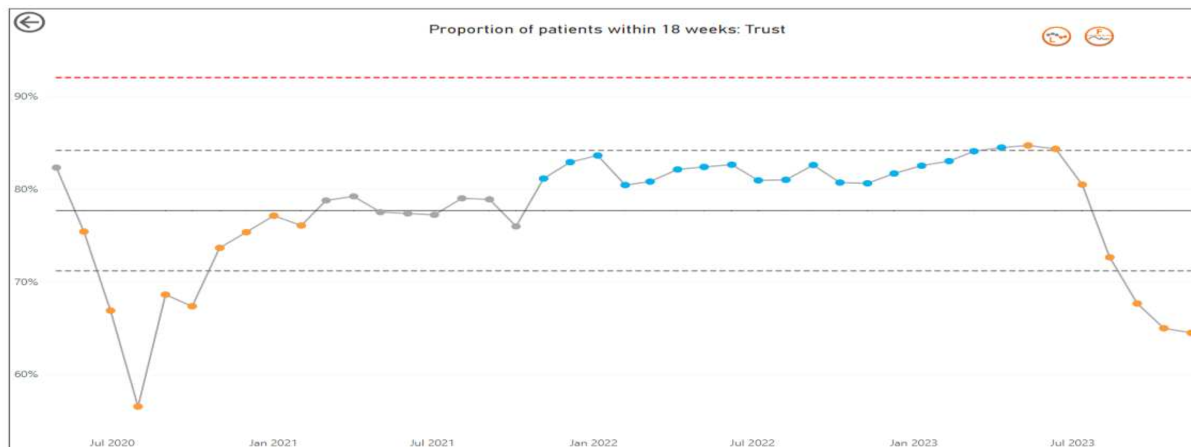
Operational Narrative:- The main concern sits within the TeMS service and particularly seen within the Lower Limb Orthopaedic and Rheumatology elements of the service. This is in part due to the delay in full implementation of the MSST system which would have enabled a system wide equitable approach to tackling backlogs and a reduction in capacity that should be provided via the sub-contract with SATH. Due to the phased approach of MSST this has led to TeMS maintaining these elements of MSK separate to MSST. Positively, there are now weekly meetings with NHSE/ICB./RJAH/SATH to look at a more system wide approach to managing the demand. The overall plan is to move towards the next phase of MSST to enable these elements to be managed by the appropriate trusts RJAH/SATH.

There are a number of 52 week waits within the Community Outpatients service but this should dramatically reduce/cease imminently with the Gastro service being returned to SATH to manage.

Dental surgery continues to experience challenges with securing appropriate theatre capacity to manage the complex paediatric elements but there has been some additional support recently and the hope is through direct Chief Executive escalation that a more robust future plan is close.

Performance Update

Proportion of patients within 18 weeks:-



As with 18 week Referral to Treatment (RTT) incomplete pathways measure, there has been a significant decline in performance and special cause variation of a concerning nature exists, as the variation icon and amber shading depicts, with actual performance outside of the control limits. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign.

Operational Narrative:- The current position continues to be a challenge to SCHT mainly due to the implementation of the MSST MSK service. Phase 1 was February 2023 with referrals starting to come through and Phase 2 in August was the start of patients being seen across the MSST service. This has led to SCHT taking all the responsibility for reporting the system wide service. The main concerns focus around clinical utilisation (mainly seen within RJAH) and capacity to validate the RTT position. Discussions are ongoing with providers and the ICB about the next steps to enable a robust recovery plan to be implemented. TeMS legacy services are also challenged particularly within the Lower Limb element of the service with the likely solution being the next Phase of MSST.

Community Paediatrician vacancies and sickness has had an adverse impact on the waiting list for Community Paediatrics and the Child Development Centre. Numerous attempts at recruiting to a Community Paediatrician post has been unsuccessful prompting a review of the skill mix within the team. A meeting is arranged for 20th November to discuss and plan the next steps.

Staff absences due to maternity leave and long term sickness and vacancies are affecting the performance in the Speech and Language Team. Recruitment to registered substantive posts is very challenging but we are continuing with the process. However, we have recruited successfully to 3 unregistered posts that start in November and December.

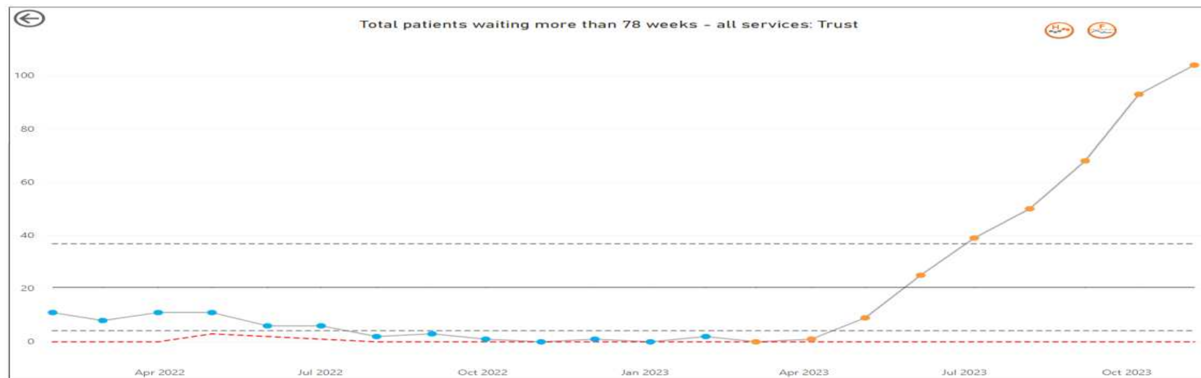
Pulmonary Rehab plans service delivery in line with waiting list – areas with highest demand have more frequent assessments and programme delivery whilst ensuring we undertake delivery in lower demand areas in a timely manner. This is why the overall wait has improved to 86.8% seen within 18 weeks with only 22 over 18 weeks, 12 are booked in this week, 4 booked in through December and 2 discharged leaving 4 to assess in Dec/Jan time once demand has increased in this area. The wait list will continue to reduce with this process in place and aim to have 0 18+ week waits by end January 2024.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Performance Update

There are other services which contribute to not meeting this performance target, such as APCS, Community Neuro Rehabilitation, Pulmonary Rehab, Childrens Physiotherapy, Dental, Wheelchairs, Long Covid and Community Hospital Outpatient/Daycase activity and operational narrative will again be requested for future reports.

Total patients waiting more than 78 Weeks – All services.



This SPC chart shows there is special cause variation of a concerning nature, as depicted by the amber variation icon, with actual performance outside of the upper control limit and with an increasing trend. i.e. the number of patients breaching/exceeding 78 weeks is increasing. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign.

Operational Narrative:- The main concern is with the TeMS service and particularly seen within the Lower Limb Orthopaedic element of the service. This is in part due to the delay in full implementation of the MSST system which would have enabled a system wide equitable approach to tackling backlogs and a reduction in capacity that should be provided via the sub-contract with SATH. Due to the phased approach of MSST this has led to TeMS maintain these elements of MSK separate to MSST.

Positively, there are now weekly meetings with NHSE/ICB/RJAH/SATH to look at a more system wide approach to managing the demand. The overall plan is to move towards the next phase of MSST to enable these elements to be managed by the most appropriate trusts.

Total patients waiting more than 52 Weeks – All services:-

Performance Update

This SPC chart shows there is special cause variation of a concerning nature, as depicted by the amber variation icon, with actual performance outside of the upper control limit and with an increasing trend. i.e. the number of patients breaching/exceeding 52 weeks is increasing. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign.

At the end of October there were 399 patients waiting over 52 weeks across Trust services, 206 patients waiting over 65 weeks and 104 patients waiting over 78 weeks, although there were no patients waiting over 104 weeks. This is a deterioration from the last report to the Board.

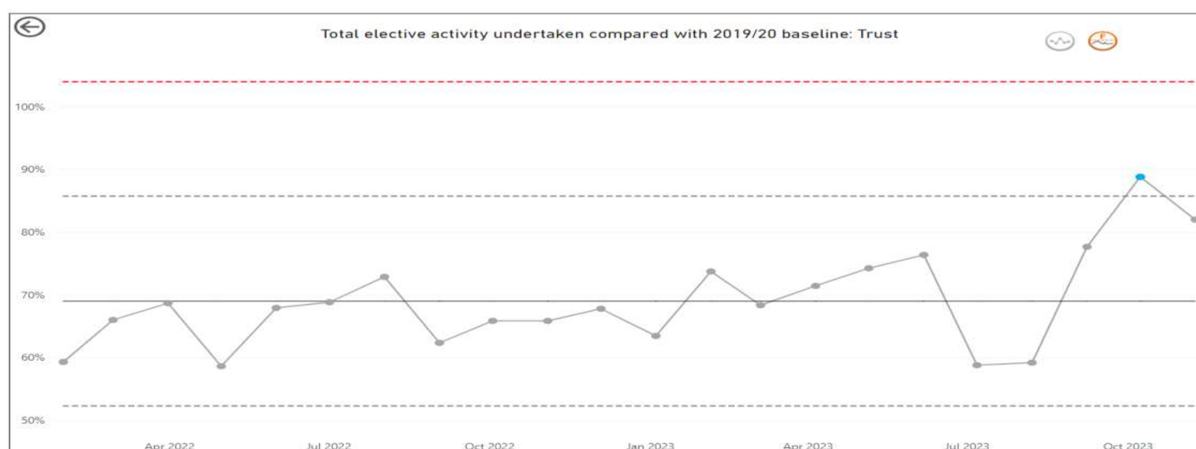
Operational Narrative:- The main concern sits within the TeMS service and particularly seen within the Lower Limb Orthopaedic element of the service. This is in part due to the delay in full implementation of the MSST system which would have enabled a system wide equitable approach to tackling backlogs and a reduction in capacity that should be provided via the sub-contract with SATH. Due to the phased approach of MSST this has led to TeMS maintain these elements of MSK separate to MSST. Positively, there are now weekly meetings with NHSE/ICB./RJAH/SATH to look at a more system wide approach to managing the demand. The overall plan is to move towards the next phase of MSST to enable these elements to be managed by the appropriate trusts RJAH/SATH.

There are a number of 52 week waits within the Community Outpatients service but this should dramatically reduce/cease imminently with the Gastro service being returned to SATH to manage.

Dental surgery continues to experience challenges with securing appropriate theatre capacity to manage the complex paediatric elements but there has been some additional support recently and the hope is through direct Chief Executive escalation that a more robust future plan is close.

CNRT has struggled due to vacancies and new starters and this has led to a delay in waiting list validation this will be recommence this week. This will be undertaken by senior clinical leads within the team to also provide clinical oversight.

<u>Total elective activity undertaken compared with 2019/20 Baseline:-</u>



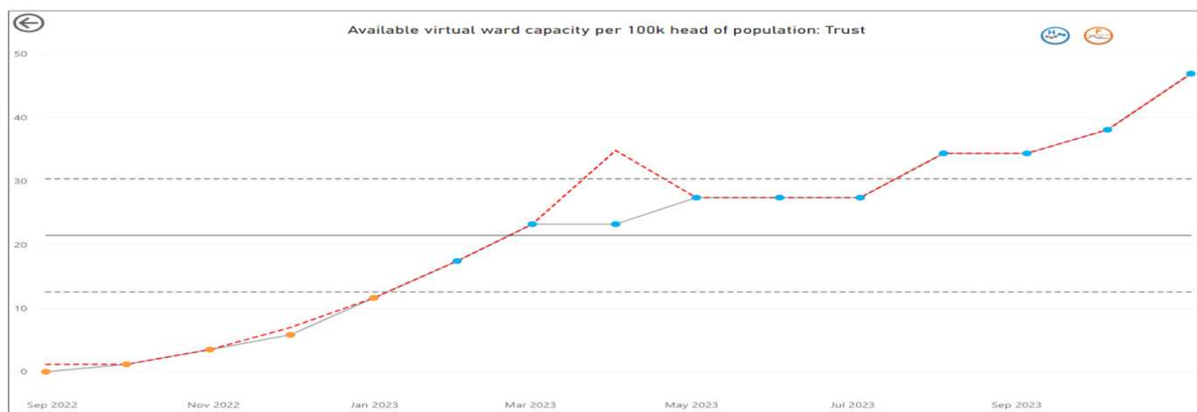
Performance Update

Common cause variation is evident as per the grey variation icon. From an assurance perspective this KPI is flagged as not capable and will fail the target without process redesign.

Operational Narrative:- Elective Outpatient activity continues to improve and October was above the equivalent in 19/20. There is now a clear plan and trajectory that shows continued improvement with a forecast outturn above plan by year end. There is potential the improvement could increase further with improvement in clinic utilisation within the MSST service and this will continue to be closely monitored.

Dental is also contributing to not meeting this performance target and operational narrative will again be requested for future reports.

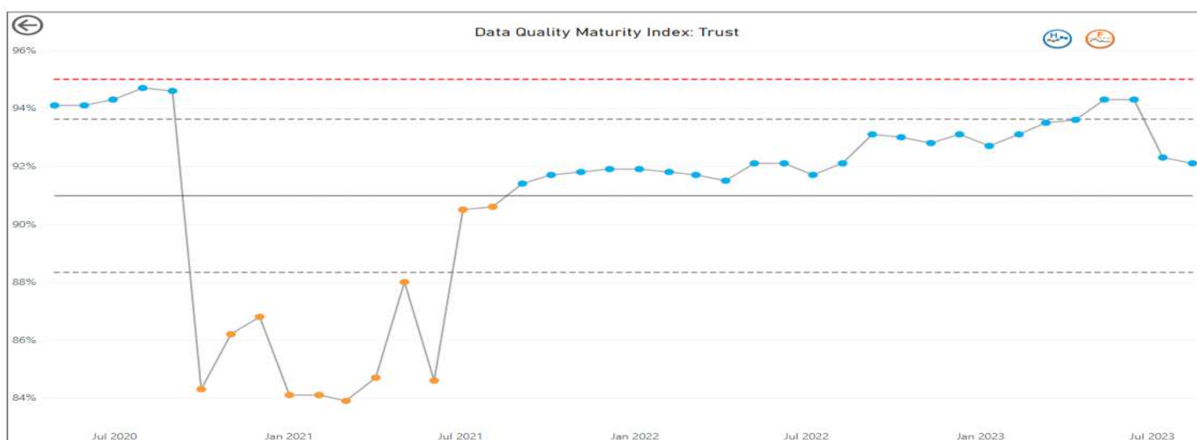
Available Virtual Ward Capacity per 100k head of population



Although this measure has been flagged as having special cause variation of an improving nature, as the blue variation icon depicts, this KPI is flagged as not capable and will fail the target without process redesign.

A review of the target in relation to the Virtual Ward is currently underway.

Data Quality Maturity Index:-



Performance Update

In this measure, although there is special cause variation of an improving nature, as the blue variation icon depicts, this KPI is flagged as not capable and will fail the target without process redesign.

Performance has dropped in June/July following a number of errors highlighted in the dataset submissions as the Trust implemented the new version of a dataset submission standard. The datasets have been corrected and resubmitted. However, data quality issues still exist in several data items of MIU, Clinical Coding for Admitted Patient Care, Ethnicity and Spoken Language. The Trust's Data Quality sub-group continues to review DQMI performance and has an unauthorised recovery plan which requires further development. The Information Team will need to liaise further with Operational Colleagues to determine actions that will improve the position.

Operational Narrative:- Operational leads have been discussing with Informatics colleagues how best to implement plans around improving ethnicity and language spoken data capture. Previous attempts at improving the compliance have not provided the uplift required and therefore a review of the plans and next steps is required. This is ongoing with a plan to be confirmed by early December about how to recover and improve the positions.

As previously reported, our agreed approach to performance improvement is to focus on 4 key priority areas. Working groups will be established to review and plan improvements for the 4 key priorities identified and approved by the Senior Leadership Team, although capacity restrictions has delayed this work. The KPIs are shown below:

- Elective Recovery including waiting times.
- Agency Spend
- Sickness Rate
- New Birth Visits

The groups will focus on the above KPIs, analysing and assessing the reasons for performance gaps, with Elective recovery and waiting times being the initial area of priority. They will then work as a team of experts to develop action plans that are both effective and realistic to drive improved performance.

In conjunction with this approach, the full suite of KPIs will be reviewed at monthly meetings with both operational and corporate colleagues to apply rigour and the principles discussed above to the other KPIs highlighted within this document that are of a concerning nature and failing target.

It is anticipated that through this re-designed model and approach, Committees and the Board should expect an increase in the level of assurance as the SPC dashboards and supporting structures further embed.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Performance Update

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required.

Performance Update - Appendix1

Shropshire Community Health NHS Trust

Resource and Performance Committee – SPC Summary
Month 07 (October) 2023/2024 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance Committee	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2023-10-31		59.31%	92.00%	-32.69%	59.00%	92.00%	-33.00%	
Resource & Performance Committee	Use of Resources	Agency spend - compared to the agency ceiling	2023-10-31		151.57%	100.00%	51.57%	151.57%	100.00%	51.57%	
Resource & Performance Committee	Use of Resources	Agency spend - Price cap compliance	2023-10-31		82.84%	100.00%	-17.16%	82.84%	100.00%	-17.16%	
Resource & Performance Committee	Effective	Available virtual ward capacity per 100k head of population	2023-10-31		46.88	46.88	0.00	46.88	46.88	0.00	
Resource & Performance Committee	Responsive	Community Equipment Store - Response within 7 days	2023-10-31		86.38%	95.00%	-8.62%	87.45%	95.00%	-7.55%	
Resource & Performance Committee	Responsive	CQC Conditions or Warning Notices	2023-10-31		0	0	0	0	0	0	
Resource & Performance Committee	Effective	Data Quality Maturity Index	2023-07-31		92.1%	95.0%	-2.9%	92.1%	95.0%	-2.9%	
Resource & Performance Committee	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2023-09-30		99.20%	99.00%	0.20%	99.20%	99.00%	0.20%	
Resource & Performance Committee	Use of Resources	Financial efficiency - variance from efficiency plan	2023-10-31		-47.56%	0.00%	-47.56%	-47.56%	0.00%	-47.56%	
Resource & Performance Committee	Use of Resources	Financial stability - variance from break-even	2023-10-31		-5.64%	0.00%	-5.64%	-5.64%	0.00%	-5.64%	
Resource & Performance Committee	Responsive	Number of patients not treated within 28 days of last minute cancellation	2023-10-31		0	0	0	0	0	0	
Resource & Performance Committee	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2023-10-31		58.48%	75.00%	-16.52%	65.19%	75.00%	-9.81%	
Resource & Performance Committee	Responsive	Proportion of patients spending more than 12 hours in an emergency de...	2023-10-31		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	
Resource & Performance Committee	Responsive	Proportion of patients within 18 weeks	2023-10-31		64.50%	92.00%	-27.50%	64.50%	92.00%	-27.50%	
Resource & Performance Committee	Effective	Total activity undertaken against current year plan	2023-10-31		90.63%	100.00%	-9.37%	98.80%	100.00%	-1.20%	
Resource & Performance Committee	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2023-10-31		262.67%	120.00%	142.67%	157.72%	120.00%	37.72%	
Resource & Performance Committee	Effective	Total elective activity undertaken compared with 2019/20 baseline	2023-10-31		82.03%	104.00%	-21.97%	74.16%	104.00%	-29.84%	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks - all services	2023-10-31		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2023-10-31		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks - all services	2023-10-31		399	0	399	399	0	399	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatme...	2023-10-31		82	0	82	82	0	82	
Resource & Performance Committee	Responsive	Total patients waiting more than 65 weeks - all services	2023-10-31		206	0	206	206	0	206	
Resource & Performance Committee	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatme...	2023-10-31		3	0	3	3	0	3	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatm...	2023-10-31		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks - all services	2023-10-31		104	0	104	104	0	104	

Quality and Safety Committee – SPC Summary
Month 07 (October) 2023/2024 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2023-10-31		6.1	6.3	-0.2	6.1	6.3	-0.2	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2023-10-31		1	0	1	1	0	1	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2023-10-31		3.00	0.00	3.00	3.00	0.00	3.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2023-10-31		25.00%	95.00%	-70.00%	41.32%	95.00%	-53.68%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2023-10-31		99.38%	95.00%	4.38%	97.95%	95.00%	2.95%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30		83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2023-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2023-10-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2023-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2023-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2023-10-31		0	0	0	0	0	0	
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Shropshire	2023-09-30		72.11%	90.00%	-17.89%	78.21%	90.00%	-11.79%	
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Telford	2023-09-30		94.59%	95.00%	-0.41%	95.11%	95.00%	0.11%	
Quality & Safety Committee	Well Led	Overall CQC Rating	2023-10-31		Good	Good		Good	Good		
Quality & Safety Committee	Responsive	Proportion of patients who have a first consultation in a post-covid servic...	2023-10-31		6.90%	92.00%	-85.10%	4.20%	92.00%	-87.80%	
Quality & Safety Committee	Safe	Serious Incidents (reported)	2023-10-31		2	0	2	11	0	11	

People Committee – SPC Summary
Month 07 (October) 2023/2024 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
People Committee	Well Led	Aggregate score for NHS staff survey questions that measure perception ...	2023-10-31		7.2	7.3	-0.1	7.2	7.3	-0.1	
People Committee	Well Led	Appraisal Rates	2023-10-31		81.26%	95.00%	-13.74%	82.08%	95.00%	-12.92%	
People Committee	Well Led	CQC well-led rating	2023-10-31		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2023-10-31		11.55%	9.60%	1.95%	11.55%	9.60%	1.95%	
People Committee	Well Led	Mandatory Training Compliance	2023-10-31		94.27%	95.00%	-0.73%	94.27%	95.00%	-0.73%	
People Committee	Well Led	Net Staff in Post Change	2023-10-31		14.17	0.00	14.17	8.96	0.00	8.96	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME back...	2023-10-31		9.09%	16.00%	-6.91%	9.09%	16.00%	-6.91%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2023-10-31		62.50%	64.00%	-1.50%	62.50%	64.00%	-1.50%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled...	2023-10-31		4.55%	3.60%	0.95%	4.55%	3.60%	0.95%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regar...	2023-10-31		56.50%	64.20%	-7.70%	56.50%	64.20%	-7.70%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2023-10-31		6.5%	0.0%	6.5%	6.5%	0.0%	6.5%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2023-10-31		10.6%	0.0%	10.6%	10.6%	0.0%	10.6%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2023-10-31		21.1%	0.0%	21.1%	21.1%	0.0%	21.1%	
People Committee	Well Led	Proportion of temporary staff	2023-10-31		5.5%	3.4%	2.1%	7.4%	3.4%	4.0%	
People Committee	Well Led	Sickness Rate	2023-10-31		5.48%	4.50%	0.98%	5.48%	4.50%	0.98%	
People Committee	Well Led	Staff survey engagement theme score	2023-10-31		7.1	7.2	-0.1	7.1	7.2	-0.1	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2023-10-31		37	0	37	209	0	209	
People Committee	Well Led	Total shifts on a non-framework agreement	2023-10-31		0	0	0	13	0	13	
People Committee	Well Led	Vacancies - all	2023-10-31		12.42%	8.00%	4.42%	11.81%	8.00%	3.81%	

Icon Descriptions

Variation	Assurance: Pass (P)	Assurance: Hit or Miss (?)	Assurance: Fail (F)	Assurance: No target
Improving – High (H)	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. Assurance cannot be given as there is no target.
Improving – Low (L)	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER. Assurance cannot be given as there is no target.
Common cause	Common cause variation, NO SIGNIFICANT CHANGE. This process is capable and will consistently PASS the target if nothing changes.	Common cause variation, NO SIGNIFICANT CHANGE. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Common cause variation, NO SIGNIFICANT CHANGE. This process is not capable and will FAIL the target without process redesign.	Common cause variation, NO SIGNIFICANT CHANGE. Assurance cannot be given as there is no target.
Concerning – High (H)	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. Assurance cannot be given as there is no target.
Concerning – Low (L)	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. This process is not capable and will FAIL the target without process redesign.	Special cause variation of a CONCERNING nature where the measure is significantly LOWER. Assurance cannot be given as there is no target.
Up arrow				Special cause variation of an increasing nature where UP is not necessarily improving or concerning. Assurance cannot be given as there is no target.
Down arrow				Special cause variation of an increasing nature where DOWN is not necessarily improving or concerning. Assurance cannot be given as there is no target.
Dashed circle				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Shropshire Community Health
NHS Trust

Month 7 2023/24 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	7 December 2023
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	29 November 2023
Paper Reviewed by:	Resource & Performance Committee	**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance at Month 7 (October) and is for assurance.

2. Executive Summary

2.1. Context

The Trust's 2023/24 Income and Expenditure (I&E) plan is to breakeven; this reflects our approved May financial plan submission to NHS England. The Trust's 2023/24 Capital expenditure plan is £2,500k.

This paper summarises the Trust's financial performance for the period ended 31 October 2023 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £355k adjusted surplus for month 7 year to date compared to the planned surplus of £296k, which is a favourable variance of £59k.

Key areas for consideration are:

- **Agency** spend as at month 7 year to date is £3,140k. This exceeds planned levels by £1,331k (74%). October's spend at £338k is at a similar level to September's agency spend. This continues the downward trend in the monthly run-rate compared to Q1. Agency remains a key area of focus, and the Agency Scrutiny Group is tasked with reducing agency spend as far as possible, without compromising patient safety. **In order to deliver our forecast outturn position of breakeven, we must contain agency spend within our overall pay budget.**
- **CIP -** our performance to date is an adverse variance to plan of £62k – with actual delivery of £1,911k year to date. Delivery of the Trust's £4,108k CIP target for 2023/24 remains a financial risk, particularly in relation to the £1,072k non-recurrent 'stretch target' agreed within the May plan submission. A CIP Working Group is in place to oversee the delivery of the Trust's CIP programme. Operational areas are working at pace to significantly increase recurrent CIP delivery, extend existing schemes where possible and identify additional schemes to address forecast shortfalls. **In order to deliver our forecast outturn position of breakeven, we must deliver our CIP target in full by year end.**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Month 7 2023/24 Financial Performance

- **Elective Income** - as at month 7 we are reporting this income as £400k adverse to plan for the year to date. Operational leads are working closely with Contracting and Information teams to focus on recovery of activity to ensure delivery of the annual plan. It is noted that Dental activity is unlikely to deliver to plan due to limited access to theatre sessions although alternative options are being explored. **In order to deliver our forecast outturn position of breakeven, our elective activity underperformance must not exceed £400k at year end.**

- **Forecast outturn** – the level of risk associated with delivering our financial plan is reducing but remains material at this stage of the financial year. An extraordinary Trust Board meeting was held of 17th November to review the current assessment of financial risk and confirm the actions necessary for Shropcom to deliver our 'best case' outturn of a breakeven position for 2023/24, in line with our plan. A commitment to achieve breakeven was approved, recognising the actions required to achieve this position and continued close management of financial risks.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position for the year to date is a surplus of £355k compared to the planned surplus of £296k, which is a favourable variance of £59k.
- **Recognise** that agency costs continue to exceed our plan despite the controls in place and increases in substantive staff.
- **Acknowledge** the Trust's challenging CIP target for 2023/24 and that both in-year and recurrent plans are not yet fully identified to deliver this level of efficiency.
- **Consider** that Elective activity is expected continue to increase over the balance of the year which is essential to delivery of our financial plan.
- **Consider** the ongoing actions required to deliver the financial plan of breakeven.

3. Main Report

3.1. Introduction

The Trust is measured on its financial performance in several ways, but the principal measure is total Income & Expenditure at adjusted financial performance level. This excludes several technical accounting adjustments and is the level at which performance is reported to and managed by NHS England (NHSE).

3.1.1. Summary of key points in report

The following dashboard summarises key areas of performance in relation to our financial plan. At month 7 our year to date financial performance is a favourable variance of £59k compared to plan, although our plan is becoming more challenging due to the increase in the CIP requirement and increase in elective activity requirement in later months.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Month 7 2023/24 Financial Performance

Financial Performance against Plan (£k)	M07 Plan	M07 Actual	M07 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Annual Variance
(Surplus)/ Deficit In Year	7	(4)	(11)	(296)	(355)	(59)	0	0	0
Agency Expenditure	223	338	115	1,809	3,140	1,331	3,734	5,743	2,009
Cost Improvement Programme	419	447	28	1,973	1,911	(62)	4,108	4,108	0
Capital Expenditure	-	-	-	1,044	949	(95)	2,500	2,500	0

3.2. Adjusted Financial Performance – favourable variance to plan £59k

The adjusted financial position for month 7 is a surplus of £355k compared to the planned surplus of £296k which is a favourable variance of £59k, as summarised in Table 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(61,594)	(60,905)	689
Expenditure excl. adjusting items	61,298	60,550	(748)
Adjusted financial performance total	**(296)**	**(355)**	**(59)**
Adjusting items	96	94	(2)
Retained (surplus) / deficit	**(200)**	**(261)**	**(61)**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 31 October 2023

3.2.1. Income – adverse variance to plan £689k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System Income	(47,609)	(47,081)	528
Non system Income	(13,985)	(13,824)	161
Total Income	**(61,594)**	**(60,905)**	**689**

Table 2: Income Summary as at 31 October 2023

System Income comprises of agreed block contract income, plus an element of variable income linked to the delivery of elective activity, plus non-recurrent funding from Shropshire, Telford and Wrekin (STW) ICB. The adverse variance for the year to date includes an estimated £250k potential clawback for elective delivery against plan based on current performance in respect of STW ICB commissioned services.

Elective Income Risk: At month 7 we have reported elective income as £400k adverse to plan year to date, when considering all commissioners of our services. The risks to receipt of planned elective income relate largely to a delay to the Musculoskeletal Services Shropshire and Telford (MSST) implementation, insufficient day-case capacity for Dental activity, and the overall elective performance across STW.

In order to deliver our forecast outturn position of breakeven, our elective activity underperformance must not exceed £400k at year end.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Month 7 2023/24 Financial Performance

3.2.2. Expenditure – favourable variance to plan £750k

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

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	40,065	38,184	(1,880)
Bank	824	1,385	561
Agency	1,829	3,140	1,311
Total Pay	**42,718**	**42,709**	**(8)**
Supplies & Services Clinical	5,803	5,566	(237)
Prison Escorts and Bedwatch	134	152	18
Drugs	738	1,023	285
Premises	4,069	4,047	(21)
Travel	819	852	33
Other	4,835	4,435	(399)
Non-Pay	**16,398**	**16,076**	**(322)**
Trust wide Central Charges	2,278	1,859	(420)
Total Non-Pay	**18,676**	**17,935**	**(741)**
Total Expenditure	**61,394**	**60,644**	**(750)**

Table 3: Expenditure Summary as at 31 October 2023

3.2.3. Pay – favourable variance to plan £8k

The overall pay position is a small favourable variance of £8k year to date. The saving accrued from substantive vacancies is being fully utilised to offset bank and agency usage above plan. Bank costs are exceeding plan as bank staff are being used across clinical services, whenever possible, to cover vacancies and other absences before agency use is considered. The year-to-date agency cost is exceeding plan by £1,331k, but the monthly run-rate for agency is on a downward trend with October's usage of £338k being a reduction of £129k on the average monthly run-rate during Q1 and Q2 of £467k.

The favourable variance on substantive pay is driven by vacancies in the Service Delivery Groups (SDGs) and the vacancy rate at month 7 was at 12.4%. Our financial plan has assumed growth in our workforce from the start of the financial year due to agreed service developments and we continue to utilise agency staff, at a premium rate, to cover some of these roles. Workforce recovery plans are in place to increase the pipeline of new starters in essential clinical roles and retain existing staff. The position is being kept under close review through the weekly vacancy review panel and the People Committee. Improved recruitment and retention are crucial to reduce the Trust's reliance on agency usage and international nurses play a key part in this regard with further onboarding of new recruits expected in the coming months.

3.2.4. Non-Pay and Central Charges – favourable variance to plan £741k

The adverse variance on drugs expenditure is largely the result of changing our pharmacy supplier at short notice, which has resulted in increased service charges.

The favourable variance in Supplies and Services General is due to reduction in non-pay spend on Community Equipment Services following the reduction in prices for a number of key items negotiated by the Procurement Team (this is contributing to the Trust's recurrent CIP).

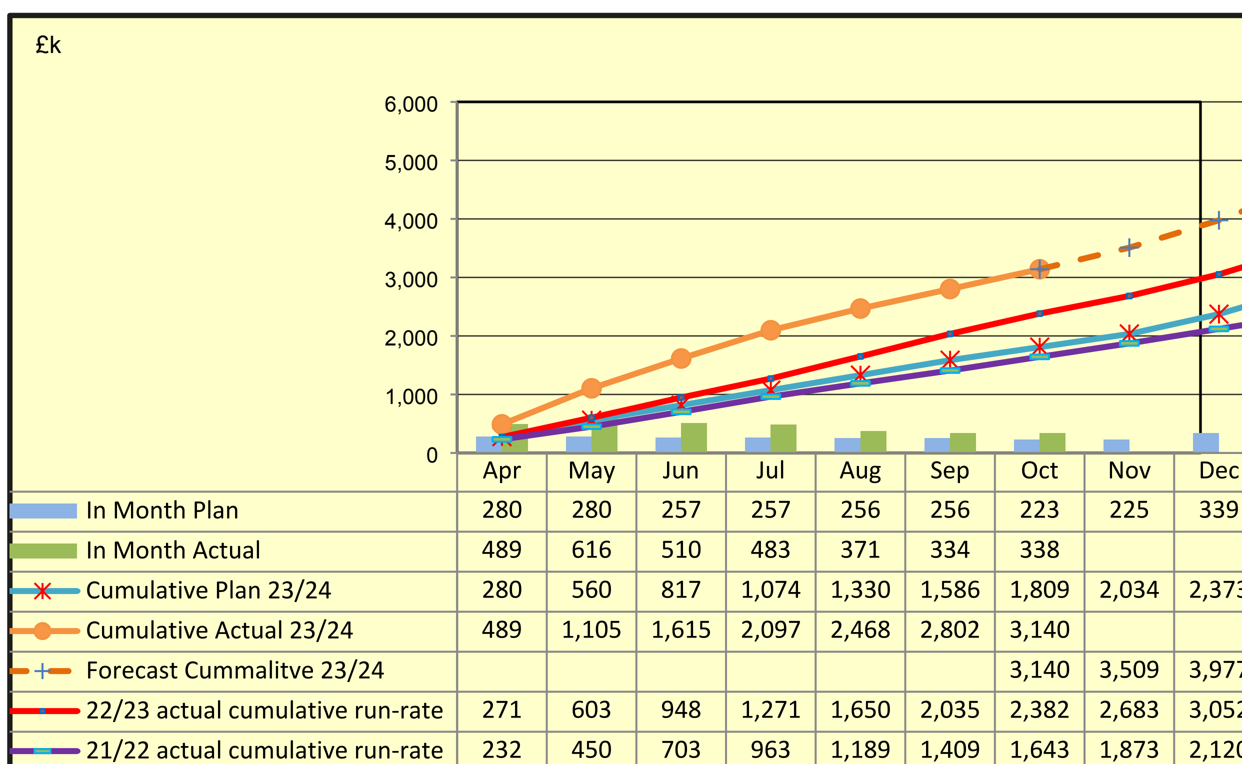
Month 7 2023/24 Financial Performance

The favourable variance in 'Other' is expected to reduce in the coming months as new services increase their capacity for example seeking a new estates solution for the Virtual Ward and IDT services.

The favourable variance Trust Wide Central Charges is mainly due to interest received on our current cash balance at the bank being above planned levels.

3.2.5. Agency and Locum Expenditure – adverse variance to plan £1,331k

Table 4 shows agency spend year to date is £3,140k at month 7 which is £1,331k (74%) in excess of plan. The forecast outturn agency spend for 2023/24 at month 7 is now £5,743k – which is £2,009k above plan. There remains a risk that this will increase above to £6m if substantive recruitment to the sub-acute wards does not deliver the anticipated staffing levels.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
In Month Plan	280	280	257	257	256	256	223	225	339
In Month Actual	489	616	510	483	371	334	338		
Cumulative Plan 23/24	280	560	817	1,074	1,330	1,586	1,809	2,034	2,373
Cumulative Actual 23/24	489	1,105	1,615	2,097	2,468	2,802	3,140		
Forecast Cummalitve 23/24							3,140	3,509	3,977
22/23 actual cumulative run-rate	271	603	948	1,271	1,650	2,035	2,382	2,683	3,052
21/22 actual cumulative run-rate	232	450	703	963	1,189	1,409	1,643	1,873	2,120

Table 4: 2023/24 Agency and Locum Expenditure

The Trust's Financial Recovery Group (FRG) continues to focus on delivering key aspects of our financial plan, notably agency expenditure reduction, CIP and elective activity at this time.

The Agency Scrutiny Group meets weekly to scrutinise all requests for agency usage, if the request is accepted by the group, it is then submitted to the Director of Nursing, Clinical Delivery & Workforce for final approval. These measures are designed to reduce agency usage down to levels which align more closely to plan. However, the agency reduction programme is closely monitored to take account of any patient safety risk. Quality, Equality Impact Assessments will be undertaken for any changes as appropriate.

In order to deliver our forecast outturn position of breakeven, we must contain agency spend within our overall pay budget.

Month 7 2023/24 Financial Performance

3.2.6. Cost Improvement Programme 2023/24

The Trust's CIP target for 2023/24 is £4,108k which is 3.6% of the Trust's overall expenditure forecast outturn for this year. The recurrent CIP element totals £2,386k and the non-recurrent element is £1,722k. Table 5 shows actual CIP delivery for the year to date at month 7 is £1,911k. This is £62k adverse compared to our plan.

Category £k	YTD Plan			YTD Actual			Variance adv/(fav)		
	Rec.	Non Rec.	Total	Rec.	Non Rec.	Total	Rec.	Non Rec.	Total
Internal									
Int. Nurses Impact on Agency	354	0	354	137	0	137	217	0	217
Digital Transformation	96	0	96	9	0	9	87	0	87
Estates & Premises Transformation	61	0	61	111	133	244	(50)	(133)	(183)
Procurement	175	0	175	260	0	260	(85)	0	(85)
Service re-design	315	0	315	236	325	561	79	(325)	(246)
Skill Mix / Establishment Reviews	12	0	12	9	12	21	3	(12)	(9)
Income Non-Patient Care	43	0	43	7	7	14	36	(7)	29
Other	62	0	62	68	0	68	(6)	0	(6)
	1,118	**0**	**1,118**	**837**	**477**	**1,314**	**281**	**(477)**	**(196)**
System Stretch Non Recurrent									
March Stretch		378	378		596	596	0	(218)	(218)
May Stretch	0	477	477			0	0	477	477
	0	**855**	**855**	**0**	**596**	**596**	**0**	**259**	**259**
	1,118	**855**	**1,973**	**837**	**1,073**	**1,911**	**281**	**(219)**	**62**

Table 5: CIP 2023/24 YTD Performance as at 31 October 2023

Of the £1,911k CIP delivered to date, £837k is recurrent and £1,037k is non-recurrent. Recurrent CIP is £281k adverse to plan year to date, which is a material concern as this will impact upon our financial plan for 2024/25 if not delivered during the year.

We have now identified schemes to the value of £3,884k which is 95% of the £4,108k target. £224k of schemes are yet to be identified which relates entirely to the £1,072k system 'stretch target' agreed in May. To date, 89% (£3,661k) of our schemes are rated Low/Medium risk in terms of delivery and the remaining 11% (£447k) are either high risk or still to be identified, which is an improvement in the month. All schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

A CIP Working Group is in place to oversee delivery of the Trust's in-year efficiency target and develop a three-year rolling CIP programme. Actions are agreed to progress red and amber schemes to green and to consider non recurrent mitigations whilst schemes are being developed. The Chair of the CIP Working Group provides weekly updates to the FRG.

In order to deliver our forecast outturn position of breakeven, we must deliver our CIP target in full by year end.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Month 7 2023/24 Financial Performance

3.2.7. Recurrent Financial Performance

The Trust's recurrent plan for 2023/24 is a deficit of £6,413k. The year to date recurrent (underlying) performance at month 7, after removing non recurrent items, is a deficit of £3,222k which is £519k favourable to plan. The overall position is summarised in Table 6. The key reason for the material underlying annual deficit of £6.4m relates to the previous acceptance of a share of the STW system deficit.

Details £k	Original Annual Plan	Year to Date		
		Plan	Actual	Variance
Income	(100,479)	(58,613)	(58,066)	547
Expenditure	106,892	62,354	61,288	(1,066)
Adjusted recurrent financial performance	**6,413**	**3,741**	**3,222**	**(519)**

Table 6: 2023-24 Recurrent Position

3.2.8. Statement of Financial Position

The summarised Statement of Financial Position (SoFP) for period ended 31 October 2023 is shown in Table 7. Receivables (amounts we are owed) increased by £270k and Payables (amounts we owe) increased by £1,263k which are both within the expected range. Cash increased by £849k due to movements noted above.

	30 September 23 Balance £k	31 October 23 Balance £k	Movement in Month £k
Property, Plant & Equipment	37,703	37,584	(119)
Inventories	502	497	(5)
Non-current assets for sale	0	0	0
Receivables	2,333	2,602	269
Cash	20,963	21,812	849
Payables	(10,317)	(11,580)	(1,263)
Provisions	(1,536)	(1,536)	0
Lease Obligations on Right to Use Assets	(7,335)	(7,074)	261
TOTAL ASSETS EMPLOYED	**42,313**	**42,305**	**(8)**
Retained earnings	33,218	33,210	(8)
Other Reserves	9,095	9,095	0
TOTAL TAXPAYERS' EQUITY	**42,313**	**42,305**	**(8)**

Table 7: Statement of Financial Position (SoFP) as at 31 October 2023

3.2.9. Capital Expenditure

The plan for 2023/24 is to spend £2,500k. Actual expenditure is £949k for the year to date compared to a plan of £1,044k. We are forecasting full utilisation of this allocation during the year.

IFRS 16 – Capitalising Leases. The Trust has an adverse forecast outturn risk of £1.6 million compared to our IFRS 16 plan of £2m. This is due to the IFRS16 impact of the Mount McKinley lease of £0.7m and Rent Reviews of NHSPS leases of £0.9m, which were not in the IFRS 16 plan. NHSE are expected to confirm whether they will increase our capital resource limit to cover the IFRS-16 forecast, or whether the ICS has to look to mitigate the issue.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Month 7 2023/24 Financial Performance

3.2.10. NHSE Announcement

NHSE has released guidance to address the significant financial challenges faced by the NHS due to industrial action and other pressures, which includes the release of £800m nationally. Updated forecast outturn positions for each system are being discussed with NHSE with an expectation that systems will now deliver agreed financial plans. For Shropcom, this requires us to deliver our planned position of breakeven.

3.2.11. Forecast Outturn and Financial Risk

The Trust's financial plan is to achieve a breakeven position by year end and the summary forecast compared to plan is set out in Table 8.

Details £k	Annual Plan £'000	Forecast £'000	Variance £'000
Income	(109,912)	(108,935)	977
Expenditure	109,912	108,935	(977)
Adjusted financial performance	**0**	**0**	**0**

Table 8: 2023-24 Forecast Outturn

As previously highlighted through Committee, Board and System discussions, the financial plan remains high risk in terms of delivery. The Resource and Performance Committee considered the current financial risk log and the mitigated position shows a likely position of £0.5m deficit.

An extraordinary Trust Board Meeting held on 17th November 2023 reviewed the actions necessary for Shropcom to deliver the best case; a breakeven position for 2023/24. A commitment to achieve breakeven was approved, recognising the actions required. These relate to full delivery of CIP, agency spend to remain within the total pay budget, and Elective activity to deliver the plan with the exception of the £0.4m under performance to date.

3.2.12. Budget setting

Whilst 2024/25 planning guidance is not yet received, plans for budget setting are well underway. A summary timetable was reviewed at RPC and opening budgets will be presented to the Trust Board for approval in March.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position for the year to date is a surplus of £355k compared to the planned surplus of £296k, which is a favourable variance of £59k.
- **Recognise** that agency costs continue to exceed our plan despite the controls in place and increases in substantive staff.
- **Acknowledge** the Trust's challenging CIP target for 2023/24 and that both in-year and recurrent plans are not yet fully identified to deliver this level of efficiency.
- **Consider** that Elective activity is expected continue to increase over the balance of the year which is essential to delivery of our financial plan.
- **Consider** the ongoing actions required to deliver the financial plan of breakeven.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Shropshire Community Health NHS Trust

Charitable Funds Annual Report & Accounts 2022/23

0. Reference Information

Author:	David Court Head of Financial Accounting	**Paper date:**	7th December 2023
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	27th October 2023
Paper Reviewed by:	Charitable Funds Committee	**Paper Category:**	Charitable Funds Annual Report & Accounts 2022/23
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

To request the Board, as the Corporate Trustee, formally approve the Charitable Funds Annual Report and Accounts for 2022/23, as recommended by the Charitable Funds Committee on 9th of November 2023.

2. Executive Summary

The Charitable Funds Committee has considered and endorsed the Charitable Funds Annual Report & Accounts 2022/23 on behalf of the Board in line with their delegated responsibility and recommended these for formal approval by the Board.

The accounts show an overall decrease in fund balances during the year of £26k from £118k to £92k, consisting of income of £179k and expenditure of £205k.

Income of £179k included generous donations of £171k, a Legacy of £4k and Bank interest of £4k.

Expenditure of £205k included £200k on patient welfare and amenities comprising of a £130k donation from the League of Friends to upgrade the End-of-Life suite at Whitchurch Hospital. A further £35k was spent at Whitchurch Hospital, £18k at Ludlow Hospital, £8k with Advanced Primary Care Services, £6k at Bridgnorth Hospital and £3k of smaller items across the Trust.

Given the value of the funds, they are not subject to a full external audit, however the Trust's External Auditors, Grant Thornton, have carried out an independent examination, resulting in no change in the reported position.

The annual report and accounts, and the draft audit findings report are attached. The draft report issued by Grant Thornton will be finalised following the adoption of the 2022/23 annual report and accounts by the Trust Board.

The Annual Report and Accounts will be submitted to the Charity Commission as part of the annual return prior to the deadline of 31st January 2024.

Shropshire Community Health
NHS Trust

Charitable Funds Annual Report & Accounts 2022/23

Key Recommendations

The Board is asked to formally adopt the 2022/23 Charitable Funds Annual Report and Accounts, as approved by the Charitable Funds Committee on the 9th November 2023 and in accordance with their delegated authority.

Shropshire Community Health
NHS Trust

Charitable Funds

Annual Report & Accounts 2022/23

Charity Registration Number 1056698

Statement of Trustees' Responsibilities in respect of the Trustees' Annual Report and Accounts

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgments and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The Annual Report and Accounts set out on pages 3 to 13 have been compiled from and are in accordance with the financial records maintained by the trustees.

Signed on behalf of the trustees:

Chair : ………………………………………………. Date : …………………………

Trustee : ………………….……………………… Date : …………………………

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Annual Report

Reference & Administrative Details

In accordance with the Charities Act 2011, the charity is included in the Charity Commission's Register of Charities with the following details:

Name of charity:	Shropshire Community Health NHS Trust General Charitable Fund
Registered charity number:	1056698
Address of charity:	Trust Headquarters, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL

There are 16 separate sub-funds registered within the group registration. There are further sub-divisions for the purpose of local management of funds.

The original governing document was a deed dated June 1996, as amended by supplementary deeds due to NHS re-organisations over the years.

Trustee Arrangements

The Trust is the sole corporate trustee of the charity. Since the Trust must act through individuals in order to express its will, trusteeship is assumed by the members of the Trust Board.

During 2022/23 they were as follows:

Patricia Davies
Sarah Lloyd
Jane Povey (1st April 2022 to 16th October 2022)
Dr Mahadeva Ganesh (17th October 2022 to 31st March 2023)
Angie Wallace
Clair Hobbs
Shelley Ramtuhul (1st October 2022 to 31st March 2023)
Nuala O'Kane (1st April 2022 to 16th February 2023)
Tina Long
Harmesh Darbhanga
Peter Featherstone
Cathy Purt
Alison Sargent
Jill Barker

Governance & Management

In its role as corporate trustee, the Trust Board takes into account the Charity Commission guidance on independence. A Charitable Funds Committee has therefore been set up with delegated responsibility for managing the charity, ensuring that the use of charitable funds is focussed on the needs of patients. This committee operates within the Terms of Reference and delegated powers as set by the Board.

The committee has responsibility for ensuring that:

- Spending is in line with agreed objects and priorities.
- Devolved decision making and delegation is in accordance with the policies and procedures set out by the Board.
- All legal duties and regulations in relation to charitable funds are complied with.

The charity is accounted for and administered on a day to day basis by the Finance Department of Shropshire Community Health NHS Trust.

Objectives & Activities

The objective of the charity is that the Trustees shall apply the income and, at their discretion, so far as may be permissible, the capital, for any charitable purposes relating to the NHS wholly or mainly for the services provided within Shropshire Community Health NHS Trust.

The charity is funded by grants received from NHS Charities Together, donations and legacies received from patients, their relatives, the general public and other organisations. The overall strategy of the charity is to provide support to the above Trust by the following means:

Patients Expenditure
- Purchase of medical equipment and provision of services not normally provided by or in addition to that normally provided by the NHS.
- Improving patient facilities and amenities to improve the environment.

Staff Expenditure
- Motivation of staff, by improving staff facilities and providing services that improve staff wellbeing.
- Education of staff by providing training over and above what would normally be provided.

Relationships with Related Parties/External Bodies

Grants to the related NHS organisation, Shropshire Community Health NHS Trust, are made in accordance with donors' wishes and in line with Charity Commission guidance on the public benefit.

The charity works closely with the Trust. Staff within the organisation identify and advise the charity on local priorities and assist the corporate trustee in monitoring the use of the charitable funds.

The strong relationship with members of staff is particularly valued and enables the charitable funds to be directed to ensure an effective contribution is made in support of local services.

Close links are also maintained with individual hospital League of Friends organisations. The charity is pleased to work with these organisations in the provision of charitable support to the related hospitals and health services.

Review of Finances, Activities, Achievements & Performance

The strategy of the charity is to provide support by providing funds to benefit patients and staff of Shropshire Community Health NHS Trust. It does this by purchasing supplementary and complementary equipment or services for which the Trust is unable to provide funding through exchequer sources.

The charity does not currently actively fundraise and recurrently relies upon the generosity of patients and their relatives and other donors who are familiar with, or have experienced the care of the Trust services and hospitals, or who are sympathetic and generous in their support to their local NHS services.

Finances

In the 2022/23 financial year the charity received Donations of £171k, a Legacy of £4k and Bank interest of £4k . Total incoming resources for the year were therefore £179k.

The charity can only continue to support the work of Shropshire Community Health NHS Trust as long as donations and legacies continue to be received. The charity is therefore indebted to the generosity of patients, their families and carers, well-wishers and friends, who have donated so generously to the work of the charity. This includes people who have left legacies in their will, and we are aware that we receive these monies at a sensitive time for the remaining family.

Patient welfare and amenities

Patients' welfare expenditure totalled £200k. The majority of this expenditure related to Building improvements and medical equipment with the most significant items being:

- £165k from the Whitchurch Hospital Patient Welfare Fund that relates to a donation from the League of Friends for the upgrading of an End of Life suite for £130k. The League of Friends also funded the following equipment: Chair £2k, Stand Assists £2k, Miano Chair £2k and £1k for a floor cleaning machine. From other donations the fund spent £7k on patient chairs, £6k on Smart Signs, £4k on an Electric Blood sampling chair, £2k on visitor chairs £1k on visitor chairs and and £8k on other items.
- £18k from the Ludlow Hospital Patient Welfare Fund and relates to donations from the League of Friends for a bladder scanner and associated kit £7k. From other donations the fund spent £6k on Bedside Lockers, £4k on Milano Chairs and £1k on other items.
- £8k from the APCS Patient Welfare Fund in relation to donations for Video Otoscopes £3k, Highlights with IO loops £2k and small items for patients £3K.
- £6k from the Bridgnorth Hospital Patient Welfare Fund and relates to the purchase of an Electrocardiograph £3k, Welch Allyn Ophthalmoscope and desks £1k and £2k on other items.

Staff welfare and amenities

Expenditure from the Staff welfare funds totalled £5k.

The overall financial performance recorded a net decrease in funds of £26k.

Future Plans

The trustees do not expect any significant changes in the objectives of the charity in the forthcoming years, and intends to continue to reduce fund balances where suitable projects and schemes can be identified.

Reserves policy

The charity's intention is that funds are spent within a reasonable period of receipt, and therefore reserves should not be built up. Managers are encouraged to spend the funds to continue to reduce the level of funds held.

Statement of Financial Activities for the year ended 31 March 2023

	Note	**Restricted Funds 2022/23 £'000**	**Unrestricted Funds 2022/23 £'000**	**Total Funds 2022/23 £'000**	Restricted Funds 2021/22 £'000	Unrestricted Funds 2021/22 £'000	Total Funds 2021/22 £'000
Income from:							
Grants	3	0	0	0	0	0	0
Donations & Legacies	3	0	175	175	0	35	35
Investments (Bank Interest)		0	4	4	0	0	0
Total Incoming Resources		**0**	**179**	**179**	0	35	35
Expenditure on:							
Charitable activities:							
Patient welfare & amenities	4	0	200	200	2	34	36
Staff welfare & amenities	4	0	5	5	35	10	45
Total Expenditure		**0**	**205**	**205**	37	44	81
Net Movement in Funds		**0**	**-26**	**-26**	-37	-9	-46
Reconciliation of funds	10						
Total funds brought forward		0	118	118	37	127	164
Total funds carried forward		**0**	**92**	**92**	0	118	118

Balance Sheet as at 31 March 2023

	Note	**Restricted Funds 2022/23 £'000**	**Unrestricted Funds 2022/23 £'000**	**Total Funds 2022/23 £'000**	Restricted Funds 2021/22 £'000	Unrestricted Funds 2021/22 £'000	Total Funds 2021/22 £'000
Current assets							
Debtors	8	0	4	4	0	0	0
Cash at bank & in hand		0	102	102	0	131	131
Total Current Assets		**0**	**106**	**106**	0	131	131
Liabilities							
Creditors : amounts falling due within 1 year	9	0	-14	-14	0	-13	-13
Total Liabilities		**0**	**-14**	**-14**	0	-13	-13
Total Net Current Assets/(Liabilities)		**0**	**92**	**92**	0	118	118
Total Net Assets or Liabilities		**0**	**92**	**92**	0	118	118
Funds of the charity	10						
Restricted funds		0	0	0	0	0	0
Unrestricted funds		0	92	92	0	118	118
Total Charitable Funds		**0**	**92**	**92**	**0**	**118**	**118**

The notes on pages 8 to 13 form part of these accounts.

The financial statements were approved by the trustees at the Charitable Funds Committee on 9th November 2023 and then subsequently approved by the Trust Board for issue on behalf of the committee on the 7th December 2023

Trustee :

Date :

NOTES TO THE ACCOUNTS

Note 1 : Accounting Policies

a) Basis of preparation

The financial statements have been prepared under the historic cost convention.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice : Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a "true and fair view" and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a "true and fair view". This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than Accounting and Reporting by Charities : Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

Update Bulletin 1 of the Charities SORP (FRS 102) was implemented in 2015/16.

Update Bulletin 2 of the Charities SORP (FRS 102) was implemented in 2019/20.

The trustees consider that there are no material uncertainties about the charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:
- An endowment fund - where the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent.
- A restricted income fund - where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

In 2022/23 the charity had no endowment funds or restricted income funds.

There are 16 separate sub-funds registered within the group registration with the Charity Commission, with further sub-divisions for the purpose of local management of funds.

c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met, then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

NOTES TO THE ACCOUNTS

d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when all the following conditions are met:
- Confirmation has been received from the estate representatives that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:
- There is a present legal or constructive obligation resulting from a past event.

- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement.
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

f) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment:
- Approval and authorisation have been granted in accordance with the Scheme of Delegation operated by the Trustee.
- Receipt of goods or services have been confirmed as appropriate and payment authorised in accordance with the Trustee's Standing Financial Instructions.

g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include costs of administration, internal and external audit costs and bank charges. Support costs have been apportioned across the categories of charitable expenditure on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 5.

h) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 4.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

NOTES TO THE ACCOUNTS

i) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

j) Cash and cash equivalents

All cash is held within interest bearing Government Banking Service (GBS) bank accounts.

k) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

l) Cash Flow Statement - Exemption

Charities preparing their accounts under FRS 102 must provide a statement of cash flows, except where the disclosure exemptions permitted by SORP have been taken.
Section 7 of FRS102 provides an exemption under the small entity provisions within S1A of FRS 102; small entities that are not subsidiaries can claim exemption from preparing a cash flow statement.
The turnover of the Shropshire Community Health NHS Trust General Charitable Fund is such that it meets the definition of a small entity.

Note 2 : Related Parties

During the year, members of the Charitable Funds Committee, which is empowered by the corporate trustee to act on its behalf in the day-to-day administration of all Funds Held on Trust, were also members of the Shropshire Community Health NHS Trust Board.

The charity has made revenue and capital grant payments to the Trust to the value of £188,000 as detailed in note 4. Other than these payments, there have been no further material transactions between the charity and the listed NHS body.

Board members of Shropshire Community Health NHS Trust, the corporate trustee, and members of the Charitable Funds Committee ensure that the business of the charity is dealt with separately from that associated with exchequer funds for which they are also responsible.

Note 3 : Income from Grants, Donations & Legacies

	Restricted Funds 2022/23 £'000	**Unrestricted Funds 2022/23 £'000**	**Total Funds 2022/23 £'000**	Total Funds 2021/22 £'000
Grants	0	0	0	0
Donations	0	171	171	34
Legacies	0	4	4	1
Total	**0**	**175**	**175**	35

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Note 4 : Analysis of Charitable Expenditure

The charity does not undertake any direct charitable activities on its own. All the charitable expenditure is in the form of grant funding. All grants are made to Shropshire Community Health NHS Trust, to provide for the care of patients in furtherance of the charity's aims. No grants are made to individuals.

Support costs are apportioned across the categories of charitable expenditure.

	Grant Funded Activity 2022/23 £'000	**Support Costs 2022/23 £'000**	**Total 2022/23 £'000**	2021/22 £'000
Patient welfare & amenities	187	13	200	36
Staff welfare & amenities	1	4	5	45
Total	**188**	**17**	**205**	81

Note 5 : Allocation of Support Costs

Support costs are apportioned across the categories of charitable expenditure based on average monthly fund balances.

	Patient Welfare 2022/23 £'000	**Staff Welfare 2022/23 £'000**	**Total 2022/23 £'000**	Total 2021/22 £'000
Governance - internal & external audit fees	5	1	6	5
Financial, administration & bank charges	8	3	11	11
Total	**13**	**4**	**17**	16

Governance costs of £6k are for External Audit fees and are covered further in Note 7.
The financial administration costs include £8k of staff costs for staff employed by the Trust.

Note 6 : Trustee Remuneration & Expenses

No trustees were paid any remuneration or expenses from the charity for the work they undertake as trustees.

The Trusts Remuneration Report describing the remuneration of Very Senior Managers (VSM) namely the members of the Board and hence the Trustees of this Charitable Fund can be found on the Trusts website in the Annual Report and Accounts section. See below link:

http://www.shropscommunityhealth.nhs.uk/annual-reports-and-accounts

Note 7 : Auditor's Remuneration

The external auditor's remuneration of £5,527 (2021/22 : £5,400) related solely to the independent examination of the annual accounts, with no other additional work being undertaken.

Note 8 : Analysis of Current Debtors

	2022/23	2021/22
	£'000	£'000
Accrued income	4	0
Total	**4**	0

Note 9 : Analysis of Creditors Due Within 1 Year

	2022/23	2021/22
	£'000	£'000
Trade creditors	14	13
Total	**14**	13

Note 10 : Summary of Fund Movements

	Balance B/Fwd £'000	Income £'000	Expenditure £'000	Balance C/Fwd £'000
Whitchurch Hospital Patient Welfare	53	142	-165	30
All other funds	65	37	-40	62
Net movement in funds	**118**	**179**	**-205**	**92**

The above table shows the movements on the significant sub-funds within the group registration, and is based on those funds which have a closing balance at 31 March 2023 in excess of £20,000. The only fund with a balance greater than £20,000 is the Whitchurch Hospital Patient Welfare fund and this relates to a legacy received in 2020/21.

The objects of the listed funds are as follows:

Whitchurch Hospital Patient Welfare - for patients who are or have been treated by Shropshire Community Health NHS Trust at Whitchurch Hospital.

The 4 community hospitals are each supported by active Hospital League of Friends who donate money to assist in the purchase of medical equipment and other patient amenities.

Note 11 : Events After the End of the Reporting Period

There were no events after the end of the reporting period.

Independent examiner's report to the trustees of Shropshire Community Health NHS Trust General Charitable Fund

I report on the accounts of Shropshire Community Health NHS Trust General Charitable Fund for the year ended 31 March 2023, which are set out on pages X to X.

Your attention is drawn to the fact that the charity's trustees have prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015)' issued in May 2014 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustees have done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

This report is made solely to the charity's trustees, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my work, for this report, or for the opinions I have formed.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011;
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met; or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Avtar Sohal, CPFA

Grant Thornton UK LLP
Chartered Accountants

Birmingham
XX December 2023

NHS
Shropshire Community Health
NHS Trust

Chair's Assurance Report

Charitable Funds Committee 9th November 2023

0. Reference Information

Author:	Poppy Owens, Executive Assistant	Paper date:	
Executive Sponsor:	Alison Sargent Chair of the Charitable Funds Committee	Paper written on:	9th November 2023
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	Paper Category:	Governance
Forum submitted to:	SCHT Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents a summary of the Charitable Funds Committee meeting held on 9th November 2023, for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was quorate.
- The agenda items included:
  - Quarterly Report for Q1 and Q2 2023/24
  - NHS Charities Together – Covid-19 Appeal
    - Stage 2 Update
    - Stage 3 Update
  - 2022/23 Charitable Funds Accounts – Review and recommend presentation to the Trust Board for approval
  - Approval of Expenditure over £20k
  - Future NHS CT Membership
  - Staff Lottery – Funding issues
  - Any Other Business

2.2. Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Charitable Funds Committee 9th November 2023

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Charitable Funds Committee meeting which met on 9th November 2023. The meeting was quorate with one Non-Executive Director and two Executive Director in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Alison Sargent	Non-Executive Director (Chair)
Sarah Lloyd	Chief Finance Officer
David Court	Head of Financial Accounting
Clair Hobbs	Director of Nursing, Clinical Delivery and Workforce
Poppy Owens	Executive Assistant

Apologies:	

The Committee reviewed the updated actions and noted the following updates:

- 127 - This action was covered on the agenda. Action closed.
- 124 – This action was covered on the agenda. Action closed.
- 126 – No further information to report currently.
- 117 – SR is reviewing ToR for all Committees that report to Board so this will be picked up as part of the overall review.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
4. Quarterly Report for Q1 & Q2 2023/24		
The 2023/24 1st and 2nd Quarter reports were presented to the Committee and discussed. The Committee noted the reports, income and expenditure across these periods and the current fund balances.	Y	
5. NHS Charities Together – Covid-19 Appeal –Update Stages 2 & 3		
The Committee heard that the Final Report for Stage 2, which is the STW System funding hosted by SaTH, has now been reviewed and signed off by NHSCT with one exception. An informal catch up in a years' time is planned to sign this off.	Y	

NHS
Shropshire Community Health
NHS Trust

Chair's Assurance Report

Charitable Funds Committee 9th November 2023

The Committee acknowledged the Stage 3 update which was a bid from SCHT. This bid includes the successful application for the Revive project and health and wellbeing sessions and includes the reporting schedule required. The health and wellbeing sessions have commenced and these have received positive feedback.		
6. 2022/23 Charitable Funds Accounts – Review and recommend presentation to the Trust Board for approval		
The Committee considered the 2022/23 Charitable Funds Annual Report and Accounts and noted that an independent examination had been undertaken by Grant Thornton with only minor changes suggested. The Committee approved the Annual Report and Accounts and recommended these to the Trust Board, as Trustees, for formal adoption before submission to the Charity Commission.	Y	
7. Approval of Expenditure over £20k (Bid in development LoF funded Neuro Rehab scheme)		
The Committee noted the development of a scheme with the Bridgnorth League of Friends in relation to neuro rehabilitation and acknowledged a final proposal will be presented once fully developed.	N/A	
8. Future NHS CT Membership		
The Committee discussed future NHS Charities Together membership and noted that from 2024 we would need to pay a small membership fee. It was decided that at the current time we do not remain members as we are unlikely to secure the full benefits as we are not actively fundraising. However it was agreed to reassess this position if conditions change, and it was noted that we can join at a future time.	N/A	
9. Staff Lottery – Funding issues		
The Committee discussed membership of the Staff Lottery and agreed that Comms support is required and information is to be given to staff when onboarding in relation to the scheme.	N/A	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 ...

Chair's Assurance Report

Charitable Funds Committee 9th November 2023

3.4 Approvals

The Committee approved the 2022/23 Annual Report and Accounts and recommended these to the Trust Board, as Trustees, for formal adoption before submission to the Charity Commission.

3.5 Risks to be Escalated

In the course of its business the Committee did not identify any risks that required escalation.

4. Conclusion

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

Shropshire Community Health
NHS Trust

Document Details	
Title	Patient safety incident response policy
Trust Ref No	
Local Ref (optional)	
Main points the document covers	
Who is the document aimed at?	
Owner	Shelley Ramtuhul, Director of Governance
Approval process	
Who has been consulted in the development of this policy ?	
Approved by (Committee/Director)	
Approval Date	
Initial Equality Impact Screening	
Full Equality Impact Assessment	
Lead Director	
Category	
Sub Category	
Review date	
Distribution	
Who the policy will be distributed to	
Method	Public website, Policy Library – Staff Zone
Keywords	Patient Safety Strategy, PSIRF, Serious Incidents, Datix
Document Links	
Required by CQC	
Other	

Amendments History		
No	Date	Amendment
1		
2		
3		
4		
5		

DRAFT

Patient Safety Incident Response Policy

DRAFT

Contents

Purpose 4
Scope 4
Our patient safety culture 11
Patient safety partners 12
Addressing health inequalities 13
Engaging and involving patients, families and staff following a patient safety incident 13
Patient safety incident response planning 15
Resources and training to support patient safety incident response 15
Our patient safety incident response plan 18
Reviewing our patient safety incident response policy and plan 18
Responding to patient safety incidents 19
Patient safety incident reporting arrangements 19
Patient safety incident response decision-making 19
Responding to cross-system incidents/issues ....**Error! Bookmark not defined.**
Timeframes for learning responses 20
Safety action development and monitoring improvement 20
Safety improvement plans 23
Oversight roles and responsibilities ....**Error! Bookmark not defined.**
Complaints and appeals 24

DRAFT

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach taken by Shropshire Community Health NHS Trust (SCHT) to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across SCHT. However, the principles of the policy, particularly the learning response methods described in the SCHT Patient Safety Response Plan (PSIRP), should be used to support learning and improvement in relation to other non-patient safety incident types alongside any other statutory or regulatory requirements applicable to those incident types (e.g health and safety regulations, information commissioner requirements).

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

DRAFT

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Roles and Responsibilities

Trust Board

The Trust board is responsible and accountable for effective patient safety incident management within SCHT. It is responsible for ensuring it has effective policies, oversight and resource in place to meet the national patient safety response standards. The Board is responsible setting the patient safety priorities and ensuring the Trust takes a proportionate response to safety incidents. The Trust must have in place a safety improvement plan through which the Board (or committee with delegated responsibility) will monitor and review the delivery of safety actions and improvement.

Quality and Safety Committee

The Board has delegated responsibility for quality and safety assurance to the Quality and Safety Committee which will quality assure learning response outputs. The Committee will have oversight of the Patient Safety Incident Investigations that take place and all other incident data for quality assurance purposes. The Committee will oversee the delivery of the Safety Improvement Plan to ensure that appropriate actions are put in place, monitored for completion and assessed for delivery of the required improvement.

Patient Safety Committee

The role and purpose of the Committee is to oversee all aspects of patient safety in order to provide onward assurance to the Quality and Safety Committee. Specifically, it advises on the Trust's Strategy for patient safety and monitors progress with implementation. It oversees

the clinical risk register and clinical incidents to ensure mitigating actions are taken and that cross organisational learning takes place. The Committee monitors the Trust's statutory and regulatory compliance in relation to patient safety and approves clinical safety policies.

Chief Executive

The Chief Executive has overall accountability for the safety of the Trust's patients, staff, and visitors. The Chief Executive is support with this through delegation of responsibilities to the following roles:

Director of Nursing, Workforce and Clinical Delivery and Medical Director

The Director of Nursing, Workforce and Clinical Delivery and Medical Director are jointly responsible for patient safety in the organisation and for identifying an appropriate learning response lead to undertake a proportionate response.

The Director of Nursing, Workforce and Clinical Delivery has responsibility for:

- overseeing the quality of the PSIRF process which includes the development, implementation, and review of this policy.
- ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Board.
- ensuring processes are in place for triangulating incident information for early identification of themes and trends.
- ensuring there are adequate mechanisms for learning and feedback of outcomes of incidents.
- overseeing compliance with the duty of candour
- Leading the assessment of incidents that fall outside of the local priorities for new and emerging themes (to be undertaken by the Chief Medical Officer in the Chief Nurse absence)
- ensuring that the Chief Executive is kept fully informed about any national priorities aligned to PSIRF reporting the details of the incident to the Quality and Safety Committee.

DRAFT

The Medical director and Chair for Learning from Deaths is responsible for how the Trust responds to and pays due attention to mortality of patients in our care and ensures that any lessons learned from care delivery and avoid ability are clear and cascaded. The aims are:

- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Promote organisational learning and improvement

Director of Governance

- Ensuring compliance with the statutory and regulatory responsibilities of the Trust in relation to patient safety incidents and providing advice to the Trust Board in relation to the same.
- Overseeing the governance framework to support the response to and oversight of patient safety incident management.
- Liaising with external bodies in relation to national priorities as required. This responsibility may be delegated where appropriate.

Associate Director of Governance and Patient Safety Specialist

- Ensuring the implementation and adherence to this policy and the Trust's Patient Safety Incident Response Plan and set timescales.
- Advise the Executive Leads on a proportionate response method in relation to patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's patient safety incident response plan.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.
- Advising on the adequacy of safety actions following an investigation and for bringing urgent risk matters to the attention of the Executive Leads.
- To monitor completion of organisational safety improvement actions, working with the Quality Improvement Facilitator.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool

DRAFT

- To lead on revising the Trust PSIRP and full PSIRF review as stipulated in the policy, including an evaluation of learning responses and effectiveness of safety actions.
- Provide training on PSIRF as required.

Patient Safety Specialist(s)

- Provide dynamic senior patient safety leadership
- Play a key role in supporting the development of a patient safety culture, safety systems and improvement activity
- Coordinate and support local patient safety priorities, help the Trust to review its PSIRP and a full review of the PSIRF policy
- Support learning response leads where required but in particular, where a full PSII is needed
- Ensure the rapid dissemination of key learning from patient safety events

Divisional Clinical Manager

- Ensuring that local and organisational safety actions are implemented and monitored.
- Dissemination of learning is facilitated using the SHARE debrief tool.
- As minimum Level 1 & 2 of the patient safety training is completed as indicated by the training needs assessment.
- Monitor through their respective Governance Meetings any new or emergent themes for their areas, that may require a learning response.

Governance Managers

- The Governance Managers are responsible for ensuring that all adverse incidents and near misses are reported and managed within their allocated SDGs in line with this policy; are discussed at the governance meetings and shared with staff as required.
- Ensure that any patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents

DRAFT

described in the organisation's plan are bought to the attention of the Head of Clinical Governance and Patient Safety Specialist.

- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- Act as the engagement lead for patients and families where required

Learning Response Lead

- The Learning Response Lead for local priorities (as defined in the PSIRP) will work with subject matter experts to use the defined learning method and frequency to review patient safety incidents, reporting their findings to the Patient Safety Committee.
- Learning response leads for National priorities will be responsible for completing a PSII. They will be responsible for identifying all staff, departments and key teams who have some involvement in the incident and for informing all appropriate managers of the investigation.
- Areas for improvement and findings from learning responses should be shared with those involved and the wider team, to share learning and gain feedback from patients and staff members in the involvement of patient safety incident.
- Safety actions must be produced in collaboration with those who understand 'work as done' the most.
- Ensure the relevant training has been completed and competencies acquired to be a learning response lead (see appendix 1).

Subject Matter Leads

- Subject matter leads within the Trust are expected to support the Learning Response Leads as indicated in the PSIRF priorities.
- The corporate subject matter leads are identified in Appendix 2
- In addition expertise may be co-opted as required, with a focus on independence where possible.

DRAFT

Engagement Lead (Staff /Manager/Governance Manager)

- Ensure that the patient and/or their family if appropriate is informed of the incident and is kept informed during the investigation process to ensure that Duty of Candour is followed.
- Facilitate a face-to-face meeting and / or a response to any queries the patient or their next of kin may have.
- Support the Learning Response Lead, to gain the patients perspective if appropriate to do so.
- ensure that should the patient or family are provided with the opportunity to review the outcomes and improvements identified on concluding the learning response.

Quality Leads

- The Quality Leads are expected to engage in the organisational safety improvement plan, to understand the priorities for Quality Improvement from a patient safety perspective.
- To ensure organisational quality improvement initiatives support the organisational safety improvement actions identified from patient safety incidents
- Quality Leads are expected to support the rapid dissemination of learning from patient safety incidents across the organisation
- Establishes procedures to monitor/review PSII progress and the delivery of improvements.

All Managers

- Line Managers are responsible for ensuring staff can access support following a patient safety event, should this be required, including giving the employee details of services available through Occupational Health and TRiM.
- Line Managers are required to support the release of staff to provide statements or attend interviews or meetings relating to the patient safety event.
- All managers are expected to complete Level 1 & Level 2 of the patient safety training syllabus.

DRAFT

All Staff

- All staff have a responsibility to report via DatixWeb all incidents and near misses, both patient safety and non-patient safety.
- All staff are required to co-operate with learning responses and provide any requested information, including statements and attend interviews when required.
- All staff are expected to complete Level 1 Patient Safety training.

Our patient safety culture

DRAFT

The SCHT is committed to developing an organisational culture focussed on safety and improvement and where a 'just culture' is embedded to ensure openness and transparency at all levels.

The implementation of PSIRF has provided an opportunity to review current systems and processes and whilst the Trust already had robust processes in place to respond to patient safety incidents areas for further strengthening have been identified to ensure the national patient safety standards are met and that the Trust transitions to PSIRF smoothly.

- Over the last 12 months the Trust has been moving to a systems based approach to the review of incidents with systems based review training rolled out to staff
- The decision making regarding the level of response required for an incident has been moved to a new multi-disciplinary panel which includes the Quality Lead of NHS STW. This panel is also open to all staff involved in the incident to ensure openness and transparency.
- The Trust has been on a journey to improve the involvement of patients by nominating patient liaison leads where appropriate to liaise with the patient and/or family involved in a safety incident.
- Mandated Patient Safety Level 1 training to all staff in the organisation and Patient Safety Level 2 training to those who have a responsibility to investigate patient safety events.

Areas for improvement are identified.

- Development of Datix system to improve the capture of incident data and ensure a systems-based approach to patient safety events at all levels of the organisation.

- More robust feedback to staff who submit Datix incidents.

- Effective ways to communicate shared learning from patient safety events, wider than the immediate team where the incident occurred.

- Greater evidence of organisational learning

- The Trust template for formal investigations reflected the human factors system model of Systems Engineering Initiative for Patient Safety (SEIPS), to ensure all contributing factors are explored.

Patient safety partners

The Trust has established the role of Patient Safety Partner in line with the NHSE guidance Framework for involving patients in patient safety. The Patient Safety Partners (PSP) will have an important role in providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

The Trust currently has one PSP in post who works alongside staff, volunteers and patients to co-design initiatives aimed at improving patient experience and patient safety. The PSP attends the Trust's Patient Safety Committee and Quality and Safety Committee to provide appropriate challenge from a patient perspective to ensure learning and change. As part of this attendance they have been involved in the development and implementation of relevant strategy and policy.

In addition to the formal role of patient safety partner the Trust involves other stakeholders and patient representatives to inform its safety systems and processes.

DRAFT

The Trusts Observe and Act checklist and Patient Story guidance are well established ‘systems’ designed by patients and volunteers and the feedback from this involvement contributes to providing safer healthcare.

The Trust’s governance framework provides for both patient safety and patient experience to input and provide assurance to its Quality and Safety Committee and the patient stories, observe and act, focus groups and friends and family test are all considered at Patient Experience Committee and Delivery Group which have patient representatives and use a co-production approach. We also engage regularly with partners who offer scrutiny such as Healthwatch and NHS STW Quality Lead.

Addressing health inequalities

As a provider of community services, the Trust has a key role to play in tackling health inequalities in collaboration with our system partners.

Through the implementation of PSIRF, we will utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and system partners on how to tackle these. The integrated approach to patient safety under PSIRF will see the Trust work more collaboratively with patients and make improve links between patient safety, patient experience and the inclusivity agenda. The learning responses are designed to ensure the wider health and societal agenda is not overlooked and that there is conscious consideration of health inequalities.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the

DRAFT

development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

In line with the PSIRF standard, engagement and involvement of those affected by patient safety incidents. The trust has in place the following systems and processes:

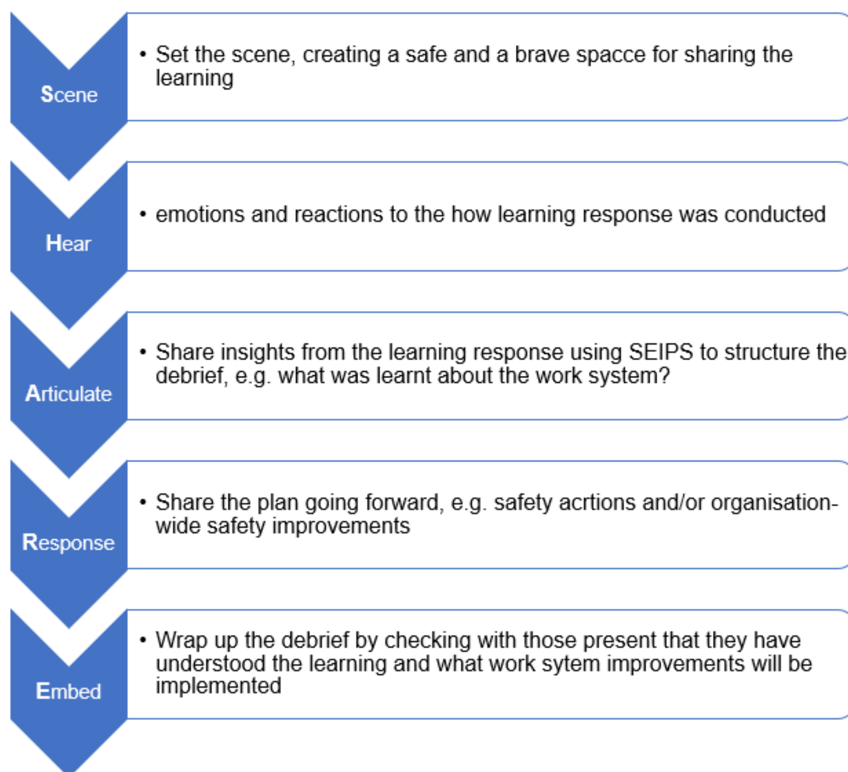
- Duty of Candour – a robust policy in place with appropriate governance oversight and monitoring at committee. The templates for patient safety incidents all require consideration of duty of candour as does the incident reporting system

- Patient Liaison Lead – Every patient safety incident which requires investigation will have a patient liaison lead identified to provide ongoing engagement regarding the investigation process and outcome.

- Sharing of information with those affected by patient safety incidents – any staff involved in the incidents are included in all panel meetings, patients and/or families are offered the opportunity to input into terms of reference and offered a copy of the final report along with an offer to attend an explanatory meeting.

Learning Response and Engagement Leads should use the SHARE debrief tool to not only share findings, areas for improvement and discuss safety actions but also gain feedback from the individuals involved as to how the learning response was conducted.

DRAFT



There is further information on this in the responding to patient safety incidents section of the policy.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. There are nationally set priorities such as meeting the Never Events criteria (2018) and deaths related to care which have mandated responses (set out in the Trust's Patient Safety Incident Response Plan) and then locally set priorities.

Resources and training to support patient safety incident response

All staff in the trust are required to complete the Level 1 Patient safety training and for those staff who have a responsibility for managing and investigating patient safety incidents at a local level, must complete Level 2 of the patient safety training.

For PSIRF - learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. The standards are as followed;

DRAFT

1. **Learning Response Lead Training**
   - Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
   - Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
   - Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
   - Learning response leads contribute to a minimum of two learning responses per year.

2. **Competencies for Learning Response Leads**

   All staff leading learning responses should be able to:
   - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
   - Summarise and present complex information in a clear and logical manner and in report form.
   - Manage conflicting information from different internal and external sources.
   - Communicate complex matters and in difficult situations.

3. **Engagement and Involvement training**
   - Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
   - Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
   - Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
   - Engagement leads contribute to a minimum of two learning responses per year.

4. **Competencies and behaviours for engagement leads**
   - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
   - Listen and hear the distress of others in a measured and supportive way.

DRAFT

- Maintain clear records of information gathered and contact with those affected.
- Identify key risks and issues that may affect the involvement of patients, families, and staff.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

5. **Oversight training**
   - All patient safety incident response oversight is led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.
   - Those with an oversight role on a provider board or leadership team (e.g., an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
   - All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

6. **Competencies for individuals in oversight roles**
   All staff in oversight roles can:
   - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
   - Apply human factors and systems thinking principles.
   - Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
   - Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
   - Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
   - Summarise and present complex information in a clear and logical manner and in report form.

The Trust has a responsibility to ensure that training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in

DRAFT

learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation is preferred.

A detailed training analysis is available in appendix one.

Our patient safety incident response plan

Our plan sets out how SCHT intends to respond to patient safety incidents over 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.Link to PSIRP

The SCHT PSIRP is in line with the following standards.

- Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.
- Responses are insulated from remits that seek to determine avoid ability/preventability/predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death.
- With reference to the just culture guide, referral for individual management performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.
- Patient safety incident investigation reports are produced using the standardised national template.
- Patient safety incident investigation reports are written in a clear and accessible way.
- National tools (or similar system-based tools) are used, and guides followed for learning response methods.
- Learning and improvement work are adequately balanced – the organisation does not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity

DRAFT

to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incidents are recorded and monitored through the Trusts Datix System, and this will remain the same under PSIRF.

The trust has a Governance Framework in place to provide assurance to the Trust Board that there are effective processes in place to monitor, action and improve quality and safety at SCHT.

As part of the implementation of PSIRF the Governance Framework has been reviewed and meeting functions and terms of reference have been updated to support PSIRF – a visual aid is detailed in appendix 2

Monitoring of patient safety incidents at a local level, through the delivery unit's governance meetings will remain the same, supported by their respective Governance Managers

For incidents identified as cross-system issues, these will be reported via the NHS-to-NHS Concern process, and dependent upon the nature of the incident with our Quality Lead partners at NHS STW. In addition, the NHS STW Quality Lead is in regular attendance at the Trusts Quality and Safety Committee.

Patient safety incident response decision-making

DRAFT

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents.

An assessment of incidents that fall outside of our local PSIRF priorities should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

Reactive Issues

Where a patient safety event is reported that that signifies an unexpected level of risk/harm and/or potential for learning and improvement an MDT Panel meeting will be scheduled by the Governance Team, chaired by the Director of Nursing / Director of Governance or designated deputy, where the incident will be reviewed, and proportionate learning response agreed and learning response lead allocated.

Emergent Issues

It will be the responsibility of the Patient Safety Committee chaired by the Director of Nursing to monitor for emerging issues regarding patient safety. Collectively the attendees of the meeting will agree a proportionate learning response agreed and learning response lead allocated. Responding to cross-system incidents/issues

Timeframes for learning responses

Patient safety learning responses start as soon as possible after the incident is identified.

- Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.
- Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

Safety action development and monitoring improvement

As part of a learning response, areas for improvement will be identified. These should set out where an improvement is needed rather than define how that improvement should be

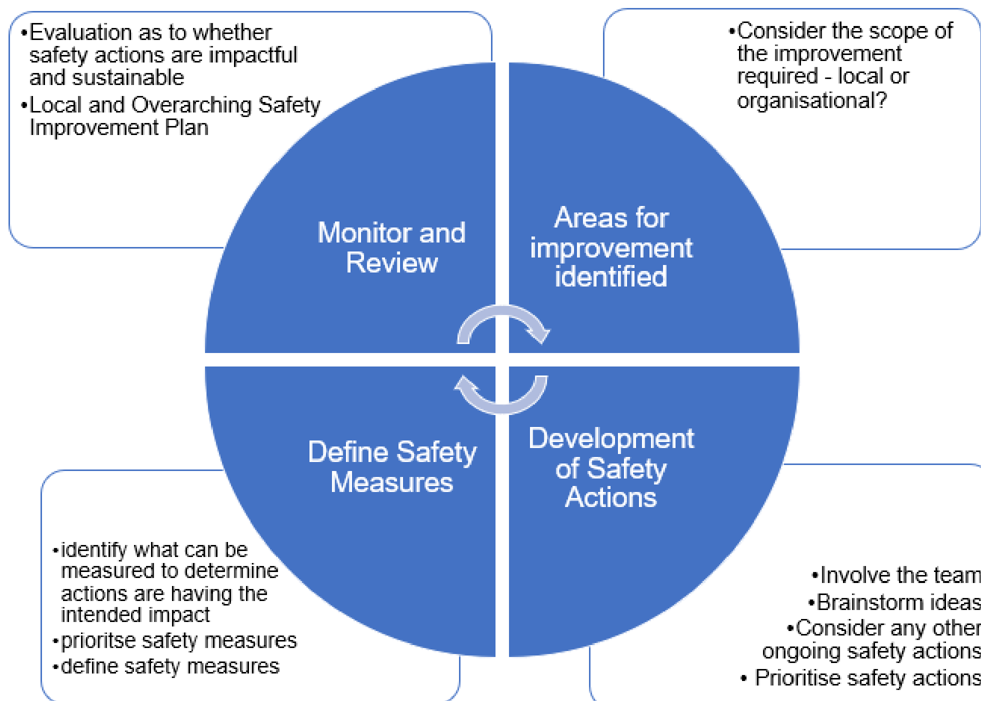
DRAFT

achieved. Once areas for improvement have been identified, then safety actions in collaboration with the relevant teams should be identified.

The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutioning at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The process emphasises a collaborative approach throughout, including involvement of those beyond the 'immediate and obvious' professional groups and working closely with those with improvement expertise. Imposed solutions often fail to engage staff and lack sustainability as a result.

The below diagram sets out the principles for the development and monitoring of safety actions for improvement.



Writing Safety Actions

Safety actions should be SMART (specific, measurable, achievable, relevant, timebound). They should also: •

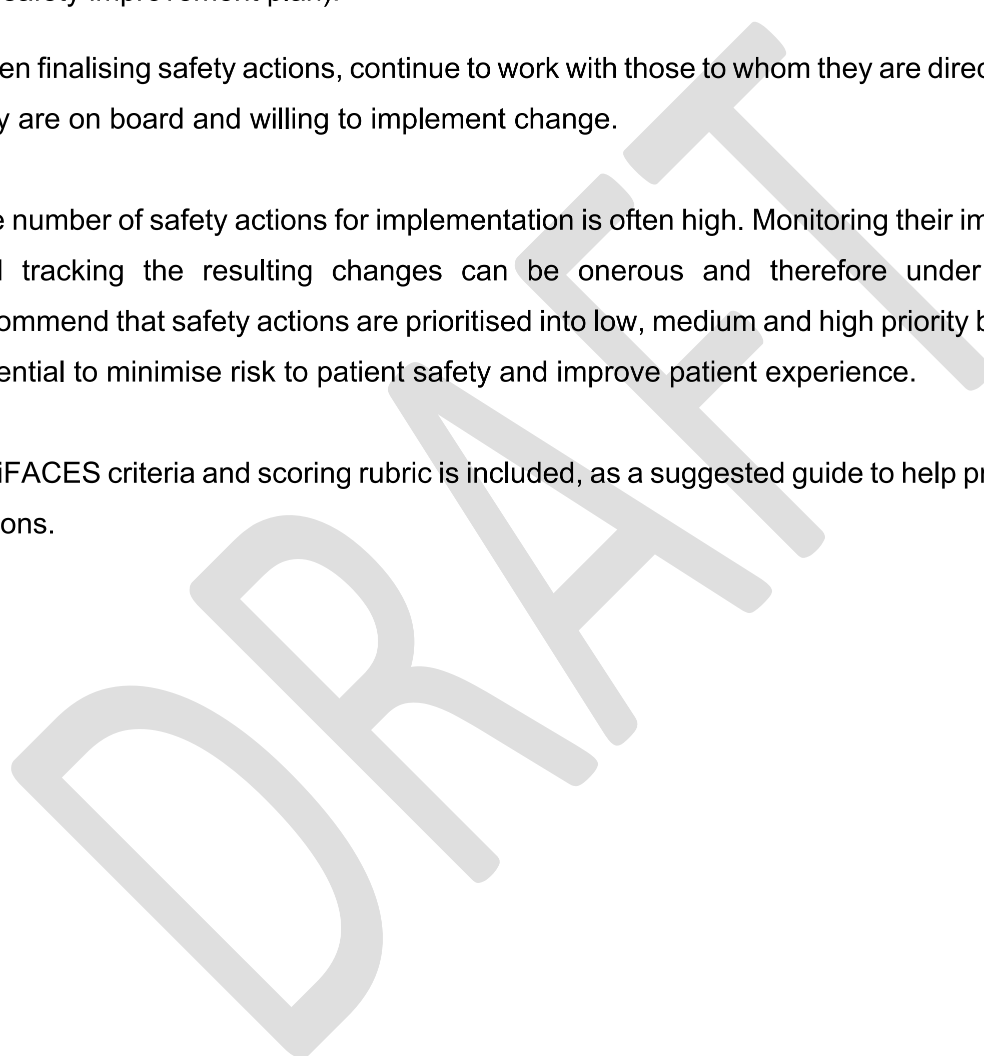
- Be documented in a learning response report or in a safety improvement plan as applicable.

- Start with the owner, e.g., “Head of patient safety to...”.
- Be directed to the correct level of the system: that is, people who have the levers to activate change (ideally this should include the person closest to the work and who has been empowered to act).
- Be succinct: any preamble about the safety action should be separate.
- Standalone: that is, readers should know exactly what it means without reading the report.
- Make it obvious why it is required (i.e., given evidence in the learning response report or safety improvement plan).

When finalising safety actions, continue to work with those to whom they are directed to ensure they are on board and willing to implement change.

The number of safety actions for implementation is often high. Monitoring their implementation and tracking the resulting changes can be onerous and therefore under PSIRF it is recommend that safety actions are prioritised into low, medium and high priority based on their potential to minimise risk to patient safety and improve patient experience.

An iFACES criteria and scoring rubric is included, as a suggested guide to help prioritise safety actions.



Criterion	Low	Medium	High
	1 — 2	3	4 — 5
Inequality Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.	The intervention accommodates some inequalities but further investigation is needed.	Inequalities are reduced by this intervention.
Feasibility Can the change be implemented relatively easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.	The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used.	The intervention is readily available and could be implemented in a relatively short period of time without much effort.
Acceptability Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.	The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread.	The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works.
Cost/Benefit Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.	The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.	The cost of the intervention is nominal relative to the expected impact on safety and performance.
Effectiveness How effective will the intervention be at eliminating the problem or reducing its consequences	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.	The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.	The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
Sustainability How well will the intervention last over time	The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working.	The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.	The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits.

Safety improvement plans

Areas for improvement can relate to a specific local context or to the context of the wider organisation. Whilst areas for improvement and developed safety actions, will align to the outcome of a learning response, a safety improvement plan will bring together findings from various responses to patient safety incidents and issues, allowing the Trust to monitor the improvements that are required, ensuring that these link and meet the same priorities as that of the Quality Improvement Team.

The Patient Safety Committee will be responsible for overseeing the delivery of the Trust Safety Improvement Plan, providing assurance to the Quality and Safety Committee that the improvements identified are being actioned and monitored for their impact.

As part of reviewing the Trusts Patient Safety Incident Response Plan, an evaluation of learning response completed and their methods to assess their quality and recommendations for improvements required.

Complaints and appeals

For any complaints or appeals relating to the Trusts response to patient safety incidents should be referred to the Trusts Complaint Policy if local resolution via the Patient Liaison Lead is not possible.

DRAFT

Appendix 1 – PSIRF Training Needs Analysis

SCHT PSIRF Training Requirements							
Training Topic	**Duration/ Frequency**	**Identified Training**	**All Staff**	**Subject Matter Lead**	**Learning Response Leads**	**Engagement Leads**	**Oversight Roles**
Systems approach to learning from Patient Safety Incidents	2 days/12 hours	Systems Based RCA Training Human Factors Study Day **OR** HSIB Level 2 Safety Investigation			✓		✓
Systems Based Review Training	1 day	In-House Training		✓			
Oversight of learning from patient safety incidents	1 day/6hrs	To be confirmed					✓

DRAFT

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

Involving those affected by patient safety incidents in the learning process	1 day/6hrs	To be confirmed / Engagement Development Day, hosted by Governance and FTSUG			✓	✓	
Patient Safety syllabus level 1: Essentials for patient safety	E-learning	E-learning module	✓	✓	✓	✓	✓
Patient Safety syllabus level 2: Access to practice	e-learning/ 1.5hrs	E-learning module **OR** Facilitated Session / HF Day		✓	✓	✓	✓
CPD	Annually	Contribute to a minimum of 2 learning responses			✓	✓	✓

DRAFT

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

Lead	Definition	Role
Learning Response Leads	Individuals who will take a lead of a learning response	Head of Clinical Governance/ Governance Managers / Corporate Subject Matter Experts
Engagement Leads	Individuals who will support both staff and patients through a learning response	Patient Experience Lead / Nominated staff members with support from Patient Experience Lead
Oversight Role	Individuals who have a responsibility for overseeing patient safety for the Organisation	Chief Executive, Director of Nursing, Workforce and Clinical Delivery, Medical Director, Director of Governance, Head of Clinical Governance

DRAFT

Appendix 2 – Corporate Subject Matter Leads

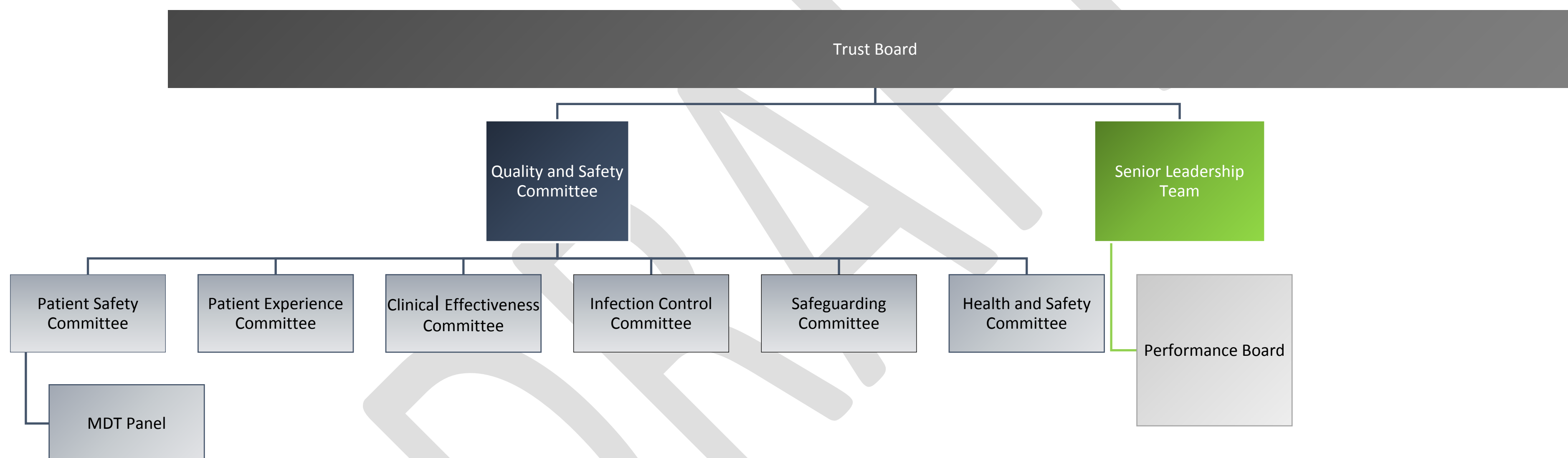
Subject	Lead	Contact
Tissue Viability	Jodie Jordan	jodie.jordan3@nhs.net
Health and Safety	Ian Gingell	ian.gingell@nhs.net
Falls	Lisa Manning	lisa.jordan-manning@nhs.net
Infection Prevention and Control	Sharon Toland	sharon.toland1@nhs.net
Information Governance	Gill Richards	gill.richards8@nhs.net
Integrated Discharge	Amber Bugler	amber.bugler@nhs.net
Medicines	Lucy Manning	lucy.manning3@nhs.net
Safeguarding	Julie Harris / Sarah Rock	julie.harris12@nhs.net sarah.rock1@nhs.net

DRAFT

Learning from Deaths	Dr Ganesh / Amy Fairweather	mahadeva.ganesh@nhs.net

DRAFT

Appendix 3 – Governance Framework



The MDT Panel consists of members of the operational, clinical, governance and quality teams and will review any incidents of concern that require a learning response. The panel will determine the appropriate level of response to an incident and will sign off any improvement actions.

DRAFT

Shropshire Community Health
NHS Trust

DRAFT

Patient Safety Incident Response Plan

Ratification date: xxx

Review date: xxx

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 …

Contents

Introduction .... Error! Bookmark not defined.
Our services.. Error! Bookmark not defined.
Defining our patient safety incident profile.................. Error! Bookmark not defined.
Defining our patient safety improvement profile .... Error! Bookmark not defined.
Our patient safety incident response plan: national requirements Error! Bookmark not defined.
Our patient safety incident response plan: local focus Error! Bookmark not defined.

DRAFT

Introduction

This patient safety incident response plan sets out how Shropshire Community Health NHS Trust (SCHT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

Urgent Care & Specialist Services

- Advanced Primary Care Services
- Capacity Hub
- Continence Services
- Diabetes
- Diagnotsitc Assessment and Access to Rehabilitation and Treatment (DAART)
- Integrated Community Services
- Minor Injury Units
- Podiatry
- Pulmonary Rehab
- Rapid Response
- Tissue Viability
- Community Therapies

Adults

- Admiral Nursing
- Adult Physiotherapy
- Community Consultant Out Patients
- Community Hospitals
- Community Neuro Rehab Team
- Community Nursing & Inter Disciplinary Teams
- Day Surgery Unit
- Falls
- Long-Term Conditions & Frail Elderly
- Long Covid
- TeMS Musculoskeltal Service
- Rheumatology
- Prison Healthcare
- Single Point of Referral

Children and Families

- Child Development Centres
- Child Health and Audiology
- Children's Therapy Services
- Community Children's Nurses
- Community Equipment Service
- Community Paediatrics
- Dental Services
- Family Nurse Partnership
- Health Visitors
- Immunisation and Vaccination
- Paediatric Diabetes Specialist Nursing
- School Nurses
- Shropshire Wheelchair Service
- Special School Nursing

Vaccination Service

- COVID-19 Vaccination Service
- Neutralising Monoclonal Antibodies (nMABs)

Corporate / Support Services

- Administration Support
- Assurance (nonclinical)
- Business Development
- Communications and Marketing
- Digital, IT, IG and Informatics
- Emergency Planning
- Finance
- Hotel Services
- Infection Prevention & Control
- Organisational Development
- Patient Experience and InvolvementComplaints and PALS
- Patient Safety
- Planning and Performance
- Quality
- Safeguarding
- Workforce/HR

DRAFT

The SCHT Patient Safety Incident Response will cover the services outlined above.

Defining our patient safety incident profile

Stakeholder Engagement

A project group was established in January 2023, to implement the Patient Safety Incident Response Framework. To establish the group key stakeholders were identified as the following:

- Director of Governance (SRO, Executive lead, Co-chair)
- Head of Patient Safety & Patient Safety Specialist (Co-Chair)
- Associate Director of Operations
- Project Manager – Strategy
- Service Delivery Group Leads (*SDG managers should identify operational leads from their teams to attend the meetings*).
- Clinical Service Managers – (TeMS, OP, APCS)
- Service Leads (Tissue Viability, Diabetes, Respiratory, Virtual Wards & Rapid Response, Vaccination Service)
- Falls Prevention Team Leader
- AHP Lead (Adults AHP Professional Lead and Workforce Lead)
- Clinical Quality Leads (Adult nursing, Children & Families)
- Medical Leads - Medical Director and/or Associate Medical Directors
- Medicines Management - Chief Pharmacist / Medicines Safety Officer
- Head of Governance & Risk
- Complaints/PALS/FOI Manager
- Patient Safety Partners
- Patient Representatives
- Head of Safeguarding
- Quality Facilitator
- Associate Director of Workforce
- Head of Digital Services
- Communications Officer

Data Sources

The group used a variety of sources to identify the safety incident profile, reviewing information from the previous two to three years. This included:

- Datix incident profiles
- Key performance indicators
- Reported Serious Incidents or Never Events
- Patient experience data
- Clinical Audit
- Trust Risk Registers

DRAFT

Defining our patient safety improvement profile

The Trust is developing strong governance processes across the Clinical divisions and the Governance Team and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, and partner agencies.

The Trust Quality and Safety Committee will retain oversight of quality improvement measures and safety improvement plans. Its' subcommittee, the Patient Safety Committee will ensure that the clinical divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues.

The Trust has a Clinical and Quality Strategy that describes our approach to improvement including:

- Identifying our starting position
- Identify and monitor improvement measures
- Aligning to our strategic objectives

The recommendations from our Patient Safety Investigations and Patient Safety thematic reviews will flow through these processes linking them in directly to the Trusts Quality Improvement work.

Our patient safety incident response plan: national requirements

There are several national priorities outlined by NHS England and those outlined below are considered applicable to this Trust.

National priorities require an external escalation, where the Trust may need to contribute to an investigation. A locally led Patient Safety Incident Investigation (PSII) may be required dependent upon the circumstances surrounding the patient safety event.

Patient safety incident type	Required response	Anticipated improvement route
National Priorities		
Incidents meeting the national Never Events criteria 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan

DRAFT

A patient death thought more likely than not due to problems in care, as indicated by NHS England Learning from Deaths guidance. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
Incident in Screening Programmes	Patient Safety Incident Investigation / After Action Review / Thematic Review (if applicable)	Organisational Safety Improvement Plan
Child Death should be reviewed to the Child Death Review Panel	Review by Child Death Review Panel Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Death of persons with Learning Disabilities, need to be referred to the Learning Disability Mortality Review (LeDeR) programme.	Referral to Learning Disability Mortality Review Programme Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Safeguarding, under the following categories must be referred to local authority safeguarding lead. ○ babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. ○ adults (over 18 years old) are in receipt of care and support needs from their local authority. ○ If the incident relates to FGM, Prevent	Referral to Local Authority Safeguarding Lead Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan

DRAFT

(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.		
Information Governance	Report to ICO if SI criteria met Investigation using PSIRF methodology / After Action Review	Organisational Safety Improvement Plan

Our patient safety incident response plan: local focus

Patient safety incident type or issue	**Planned response***	**Anticipated improvement route**
Transfer of Care Pathways	Datix investigation and MDT (multidisciplinary team) and multi-organisational review, reporting findings to the Patient Safety Working Group.	Co-production of safety improvement actions managed on a local/organisational safety improvement plan to feed into any wider system improvement plans.
Pressure Ulcers	Case by case review of all Cat 3 and 4 pressure ulcers by Safety Panel and proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Falls	Case by case review of all falls resulting in significant harm and/or meeting RIDDOR by Safety Panel and proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan

Commented [ES(CHNT1]: Have we got a Patient Safety Working group?

DRAFT

Medication Events	Case by case review of all medication events by Medicines Safety Group and escalation to Safety Panel of any incidents resulting in significant harm and proportionate response determined. Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Assessment of incidents outside of the identified priorities	Proportionate response dependent upon the circumstances surrounding the patient safety event	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.

*The Systems Engineering Initiative for Patient Safety (SEIPS) model will be used as a framework to guide all learning responses.

DRAFT