Shropshire Community Health NHS Trust

Public Board - 1st June 2023

MEETING
1 June 2023 10:00

PUBLISHED
26 May 2023

Agenda

Location	*Date*	*Owner*	*Time*
President's Suite, Shrewsbury Town Football Ground	1/06/23		10:00
1. Welcome and Chair's Awards		Chair	10:00
2. Apologies and Quorum - C Hobbs, S Ramtuhul		Chair	
3. Declarations of Interest		Chair	
4. Patient Story (Named Nurse Project)			10:05
5. Minutes of the meeting held on 6th April 2023		Chair	10:20
6. Matters Arising and review of action log		Chair	10:25
7. Chairs Communication		Chair	10:30
8. Non-Executive Directors Communication		NEDs	10:35
9. Chief Executive's Report		CEO	10:40
10. Bishop's Castle Update		CEO	10:50
QUALITY AND SAFETY			
11. Quality and Safety Committee Chair's Report		J Barker	10:55
12. Integrated Quality and Safety Performance Report		C Horsfield	11:00
13. Annual Quality Account		C Horsfield	11:10
Refreshment Break			11:20
14. Learning from Deaths Report		M Ganesh	11:30

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
President's Suite, Shrewsbury Town Football Ground	1/06/23		10:00
15. Guardian of Safe Working Report		M Ganesh	11:35
16. Annual report - Research & Development and Clinical Effectiveness Report		M Ganesh	11:40
PEOPLE			
17. Staff Survey - Listening Events			11:50
RESOURCE AND PERFORMANCE			
18. Resource and Performance Committee Chair's Report		P Featherstone	11:55
19. Performance Report		S Lloyd	12:00
20. Finance Report		S Lloyd	12:10
21. 23/24 Planning Update		S Lloyd	12:20
GOVERNANCE AND AUDIT			
22. Audit Committee Chair's Report		H Darbhanga	12:25
23. Board Assurance Framework (BAF)		S Lloyd	12:35
24. Provider Licence Certification		S Lloyd	12:40
25. Questions or Comments from Members of the Public		Chair	12:45
26. Any Other Business		Chair	
27. Meeting Evaluation		Chair	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
President's Suite, Shrewsbury Town Football Ground	1/06/23		10:00

28. Date of Future Meeting - 3rd August 2023

DRAFT MINUTES OF THE BOARD MEETING

HELD AT THE SHREWSBURY TOWN FOOTBALL CLUB, SHREWSBURY AT 10.00 AM ON THURSDAY 6 April 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)
Ms. Clair Hobbs	(Director of Nursing & Workforce)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
In attendance	
Ms. Lucy Morris	Executive Personal Assistant (to take the minutes of the meeting)
Katie Turton	To accept the Chair's Award only
Mark Donovan	Patient Story item
Sarah Venn	Patient Story item
Rebecca Podmore	Patient Story item
Gill George	Member of the Public (via Teams)
Julia Davies	Bridgnorth League of Friends (in person)

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:

Jane Grimster, nominated by Gemma McIver, Deputy Chief Operating Officer. Ms McIver said:

Jane Grimster is currently redeployed from Bishops Castle community hospital into the Integrated Discharge Team. Jane is an Occupational therapist and her skill set, approach and advocacy for patients has been key in enabling us as a Trust to really move forward with our IDT vision and show casing the impact of community trust professionals in reaching to the acute and working with acute therapy to consider alternative options for patients. Janes drive and passion for a 'home first approach' for all has helped deescalate complex cases and supported better outcomes for patients by helping to reduce delays. Jane is incredibly solution focused but her personality is always professional, supportive and non-confrontational which has been pivotal in the integration and relationship building with SaTH. The changes over in BC were challenging for many but Janes approach to this has been exemplary she is a credit to The Trust and despite not having an outcome for herself she has not let this impact her drive for delivering great patient care and improvement. Jane is an absolute asset to the IDT hub and a hugely valued member of the integrated team.

Katie Turton, attended the Board meeting and accepted the award on behalf of Jane, which was presented by Ms Long.

Apologies and Quorum

Apologies were received from Angie Wallace (Chief Operating Officer).

Declarations of Interest

None to declare.

Patient Story

In attendance at the Board meeting were Sarah Venn, Clinical Lead Advance Care Planning in Care Home Team, Rebecca Podmore, Physiotherapist, who shared with the Board a presentation on the Revive Exercise Programme. Mr Mark Donovan, Quality Facilitator, was also in attendance.

The Advance Care planning in care home team provide proactive support and guidance to the care homes of Shropshire, Telford & Wrekin. The initiative is to develop a programme of short, prescribed exercise videos that people can follow as part of Anticipatory Care Planning. The Board viewed two videos included in the presentation and had also received a copy of the Quality and Equality Impact Assessment in advance of the meeting.

Ms Venn explained that a programme of 14 exercise videos have been recorded and Phase one is currently being implemented, starting with 10 patients this week. A research paper will be written to record the progress, discuss findings and to share progress and impact on patient experience and quality of life. She said the programme has the potential to expand and transform self-care provision within all healthcare services.

Ms Podmore spoke about how the project echoes the Trust priorities and alignment with the Patient Safety domains. The project aims to slow down the progression of frailty within the cohort of patients within the care homes, focusing mainly on the moderate to severe frailty caseloads. They are aiming to reduce the scores for falls, both the risks and the number of falls as well as the paramedic callouts and hospital admissions. They are also looking to reduce pressure ulcer incidents, as well as the DVT risk, which is associated with inactivity. This is based on evidence-based practice, embedding the recommendations from the NICE guidelines, and providing exercise programmes that are both individualised and targeted to all patients. Ms Podmore continued that the project is digitally innovative and has the potential to transform virtual treatment planning. It increases accessibility as well as reducing the wait for referral. They are looking at supporting clinicians as well as the services, to deliver a safe exercise programme that can be prescribed effectively and efficiently within the resources already in teams. Ms Podmore spoke about the positive patient experiences which will be reflected in the research paper.

The team said they are also asking families to participate and join in with the programme, so when they are visiting relatives, they can join in and take part in the physical exercises with them as a joint activity.

Ms Purt thanked Rebecca and Sarah and asked if the project had been shared with the frailty wards at the Royal Shrewsbury Hospital. The team said they would like to do that, and said the plan is being rolled out first of all over the next two weeks, to trial it in the first instance, and then look to share it across all services, with potential for expansion.

Ms Hobbs also said thank you for the fabulous work and made links to falls around the virtual wards and community hospitals. Ms Hobbs said she would like to see the research project that is being set up, including what is being measured, and Ms Hobbs can then help and support the team to build on this and where to take it to next to ensure the right areas are being targeted. Ms Hobbs commended the programme and said it would reduce the Trust's quality and safety risks as well as helping patients. The team welcomed the input from Ms Hobbs and said they have started some outcome measures and it is about making sure they have the right tools from the offset.

Mr Darbhanga said the team were inspirational and the programme should be rolled out throughout the NHS. He said he was impressed with the amount of work that has gone into it and asked how the Board could support and help take it forward further. The team said it is time consuming and said that some support from that perspective would be helpful. Mr Darbhanga asked if the team had received the right level of support from our IT department. They confirmed the support they have received from everyone has been amazing and spoke about the YouTube platform channel that had been set up, and where the videos will be located. Patients can access the videos that they have been prescribed and then regular reviews will take place.

Ms Barker thanked the team and praised their innovative ideas, and particularly commended the quality of how the team taught the exercises in the video and the risk assessment. Mr Featherstone thanked the team also and said he liked the pace of the video and the language used. He suggested the team could bring an update to the Board in 12 months time to report on the impact and the benefits to our patients. Ms Sargent said she particularly liked the visuals used and suggested linking the programme to some national charities. Dr Ganesh echoed the support for the programme and said the research paper will be really impactful and asked Sarah and Rebecca to ensure that they ask for the help and support that they require.

Ms Long thanked Sarah and Rebecca for sharing the programme with the Board and acknowledged it is a great initiative that has huge potential and said it was a wonderful example of staff being innovative and using technology. Mr Donovan was also thanked for his support.

Minutes of the Meeting held on 2 February 2023

The minutes were agreed as an accurate record of the meeting subject to the following amendments:

- Dr Ganesh to be added to Executive Director attendance
- Mr. P Featherstone's apologies to be recorded

Matters Arising and Review of action log

Minute No 2022.2.9 Appendix 3 2022/23 Budget Setting – Ms Lloyd to consider once the plan is finalised if it is appropriate to send the letter to the Sustainability Committee Chair. The action will remain on the action log until the plan for the year ahead is closed.

February 2023, Q&S metrics – Letter to ICB regarding wider support has not yet been sent. Ms Hobbs and Ms Ramtuhul will discuss further and update at the next Quality and Safety Committee.

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

Chair's Communication

Ms Long referred to the staff survey and the importance of getting out and about to meet with staff. Ms Long and Ms Barker are due to visit teams in the Oswestry area.

With regard to Bishop's Castle, Ms Long acknowledged the difficult position that the staff are in. Ms Davies outlined the communication that is taking place with staff and said it was important to remember that active services are still running from Bishop's Castle Community Hospital. Ms Davies said the weekly meetings take place with staff and once per month, Ms Hobbs or a member of the Executive Team attends the meetings to provide updates on the position. This is in addition with regular one to one meetings with staff.

Ms Long attended the Integrated Care Board meeting last week and reported a positive meeting, with lots of new developments and good discussions taking place. Ms Long said it would be useful to have a focus on population health at a future Shropcom Board meeting.

Mr Darbhanga said it was good to hear of the engagement taking place with the Bishop's Castle staff and asked if there was anything else that could be done to ensure full engagement with members of staff. Ms Davies said that the staff communications across the organisation are going to be refreshed. The staff Facebook page has recently been launched and a number of different communication mechanisms are being explored. Ms Davies noted the importance of getting out and about physically in terms of the Board meetings being held around the County. Mr Darbhanga noted the importance of communication across the board, including partners, Unions etc. Ms Davies noted the JNP meetings that take place monthly with the Unions involvement and she paid tribute to them during the Industrial Action and for keeping services safe. Ms Ramtuhul said she had visited Whitchurch Community Hospital last week and options are being considered for a more tailored staff bulletin.

Non – Executive Directors' Communication

Ms Long welcomed any updates from the Non-Executive Directors.

Ms Barker attended the ICB Quality and Performance Committee and said that Health Watch want to work with us to gain feedback on the Virtual Wards. The new programme manager for the Local Maternity Network fed back on the continued theme on the lack of postnatal support.

Ms Purt chaired the ICB Strategy Committee which passed the Hospitals Transformation Programme (HTP) and said they look forward to seeing the community programme coming to the Committee. In addition, Ms Purt attended the ICB People Committee. A discussion took place about staff passports and joint posts whilst still retaining skillsets and said there would be further work around this.

Chief Executive's Report

Ms Davies highlighted some of the key areas from her report. The Virtual Ward (VW) programme expansion is continuing, with the team exceeding 100 patients at one time on their caseload in March. Ms Davies said that there is clear and robust place in plan to continue the growth of the service and ensuring targets are met. In addition, there have been a number of discharges over the last 48 hours, with the impending bank holiday and junior doctors strike taking place next week. Ms Davies reported positive patient feedback to date. She referred to the IDT model which is designed and led by ShropCom and utilises existing workforce from both SaTH and Shropcom.

With regard to workforce, the recruitment and retention workstream improvement plan is in place, and other initiatives are being put in place for example the golden ticket scheme, nurses training. The Trust are working with both the People Team and Occupational Health to revise the health and wellbeing offers to staff. The next wellbeing offer to staff is being developed and will be launched in the Spring.

Ms Davies spoke about the Referral to Treatment (RTT) waiting times and said there were no patients currently waiting longer than 78 weeks and acknowledged this was a phenomenal

achievement by staff. Across all waiting lists the trust has also seen a 22% reduction in 52 week waits compared to the previous month.

Ms Davies confirmed the Trust is the lead provider for the STW vaccination programme and remains a strong deliverer against the national requirements, with good partnership working continuing.

Ms Davies referred to some of the good news stories. She said the staff Facebook page had been launched and staff are interacting well. There have been a number of awards both nationally and locally. In particular, Emma Parker, Community Nurse, received the Cavell Award after being nominated by her colleagues and relates to the work she has done rolling out the Named Nurse Concept. The first Golden Ticket had been issued to a student nurse who has been offered a substantive post with the Trust from September 2023. Amanda Hall, Health Visitor, has received a Silver Chief Nursing Officer Award, and was nominated for the award by colleagues after developing and delivering The Rainbow Baby Health Visiting pilot. The award has been commended by Donna Ockenden. Finally, Ms Davies referred to International Women's Day on 8th March. The Trust celebrated all women at the Trust which demonstrated the work the Trust is doing in terms of female leadership.

Board members thanked Ms Davies for her comprehensive report. Mr Featherstone said there has been some great work by the Executive and staff teams regarding Virtual Wards and IDT and said the focus on delivering care close to home and reducing lengths of stay was brilliant. He asked if we had deployed both the VW and IDT to the maximum, or whether there is future potential to develop and if so, what do we need to do and asked how the Board could support with it.

Ms Davies said that more could be done, and the Trust is required to meet the trajectory of 249 beds by December, which is based on the funding agreed and approved by the ICS. There has been positive recruitment for the Virtual Wards, which gives confidence in reaching the target. Ms Davies said the focus of the VW has been with the consultant body and which has been very effective this last week. Mr Featherstone said it would be useful for the Board and Committee meetings to be cited on the key performance indictors around. the VW.

Ms Hobbs confirmed that she has a performance dashboard that she could bring to a future Board meeting. Ms Davies confirmed there was a strong clinical governance wraparound across the STW System, and it has been nationally monitored. Ms Hobbs said that patients are being tracked in terms of their VW experiences and these are starting to be built upon and will come through the Quality and Safety Committee.

Ms Purt referred to the forthcoming junior doctors strike, the potential impact and how staff are being supported during this time. Ms Purt also referred to primary care engagement and particularly around the VW and GPs, and the engagement with GPs. Ms Hobbs said there was a recent visit from the ICB to the VW team at Halesfield and some of the GPs were in attendance and feedback had been positive. A presentation was made to the GP Board last week and some of their questions raised have now been answered and the GP Board are going to provide further names of who should sit on the Clinical Reference Group moving forwards. Ms Purt asked if there was a rolling engagement plan with the GPs. Ms Hobbs said that is already a System wide Clinical Leadership group, which is also attended by GPs.

Ms Davies said there had been some events taking place along staff to look at which patients would be better supported at home, and in preparation for the Easter break. Ms Davies confirmed the Trust are continuing to support and discharge patients where it can and are working with SaTH to ensure patient safety is maintained.

Mr Darbhanga referred to the People workstream around the improvement plan and the actions within it. He asked if there were any quick win actions and if any of those could be brought forward earlier. Ms Hobbs confirmed there were 69 actions in total, and 27 actions had already been completed. She confirmed that they have tried to target the actions where they can have the quickest impact first of all and where good progress can be made.

Mr Darbhanga also spoke about the Covid Vaccinations and asked in relation to the community pharmacy recruitment issues, if the targets could still be met. Ms Davies said she was confident that

we can continue to perform well and said that funding has been approved for the next 12 months for the vaccination programme.

The Board accepted the assurance provided by the report.

QUALITY, SAFETY AND PEOPLE

Quality and Safety Committee Chair's Verbal Update

Ms Barker had Chaired her first Quality and Safety Committee meeting. She referred to the Thematic Review of Pressure Ulcers and said that a further update would be received by the Committee in Quarter 2. An inspections report was received by the Committee and Ms Barker commended the SEND Inspection. The Committee also approved some policies.

The Board accepted the assurance provided by the update.

Integrated Quality & Safety Performance Report

Ms Hobbs reported that MRSA compliance was a concern before Christmas, but this is now in a better position and compliance was achieved for the third consecutive month. There were no Serious Incidents reported in February for the second consecutive month. Triangulation has been carried out for assurance, confirming this is correct. The number of falls and development of pressure ulcers in our care, have reduced in February.

Ms Hobbs reported an improved position with vacancies, some of which are linked to the International Recruits.

Ms Long spoke about sustained improvement and noted that we are starting to see some improvements which she said is encouraging. Mr Darbhanga referred to the well-led mandatory training compliance target and the confidence with this. He asked if 92% is more than last year and what lessons are being learnt. Ms Hobbs said the target is similar to last year and is yet to be achieved. She said there is a plan in place to reach the compliance levels and noted the operational challenges. She said that hotspot areas have been identified and those are being targeted in terms of managers understanding and accepting accountability and for staff to understand it is their own responsibility to complete their training. Moving forwards, Ms Hobbs is confident there will be improvement in next 6 months. Workshops have been arranged and are running well. In addition, metrics for line managers are in place.

Ms Long reminded all Board members to ensure their training compliance. Ms Purt asked for there to be a push on the high-risk fire training. Ms Hobbs agreed and said that additional training sessions had been put in place and operational challenges were having an impact. Ms Hobbs said that at least one compliant member of staff is on sites per shift, and this was being checked in terms of quality and safety.

Ms Long asked about the response times for complaints. Ms Ramtuhul confirmed there are a small number of complaints received and therefore each complaint represents a large percentage. There had been a few complex complaints which included other providers and had led to delays in responses. She also said that is staff sickness within the team and she is looking at putting additional support in place. Ms Ramtuhul confirmed that all complainants are notified if their complaint cannot be responded to within the required timeframe and acknowledged the importance of keeping them updated on the situation.

Mr Featherstone referred to the staff appraisal rates and the important of ensuring that staff feel valued, and they achieve their ambitions with the Trust. Appreciating the Covid challenges and the winter pressures, Mr Featherstone said nevertheless there is work to do to reach the 95% target, as we come out of the winter pressures and asked what would be done to bridge the gap. Ms Hobbs said this was underway and the Appraisal Policy had been reviewed by Associate Directors. A pilot had been conducted and is ongoing. Ms Hobbs believes the feedback will be positive and should be easier for line managers to carry out the appraisal conversations. She added that development sessions for managers are also taking place. Mr Featherstone asked whether the target of 95% is

being maintained and if work is happening at pace in order to achieve this over the next 3-6 months. Ms Hobbs confirmed this was the case.

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

PEOPLE

Staff Survey Results – Engagement Plan

Ms Purt, as Chair of the People Committee, referred to the last committee meeting which was held to primarily discuss the disappointing Staff Survey results. The emphasis was about full engagement with staff and Ms Hobbs is leading on this piece of work. The governance arrangements are in place and there has been expansion to other sub-committees and groups to engage with staff. Assurance was provided to the Board, that this has the full attention from the People Committee for a full engagement plan.

Ms Hobbs provided the Board with an overview of the Trust's engagement plan following receipt of the 2022 Staff Survey results which were released on 9th March 2023.

Ms Barker welcomed the listening exercises and said they will identify important information in terms of moving forwards. Mr Darbhanga spoke about the listening exercises and said that it should be made clear that Executives don't have to be a part of those conversations and asked about the arrangements for staff who are unable to attend.

Ms Hobbs confirmed that links are being made with line managers to meet with staff and the Trust are trying to set up a desktop button for staff to provide anonymous feedback. Ms Hobbs reported that staff are starting to talk to us and give feedback, suggestions etc and this would be an opportunity to track this and feedback on progress to the Board.

Ms Long asked about the timescales for the listening events. Ms Hobbs confirmed they would take place in April and May. Ms Purt said that a review has been requested of learning opportunities and courses. Ms Long thanked Ms Hobbs for her leadership.

Ms Davies said that the results were disappointing, and it was not where we want to be. She said it was also important to focus on the positive results, whilst using this as an opportunity to understand and engage more. Referring to the results from October, lots has happened and been put in place since then. A People Plan is in place and was co-designed with the JNP and Unions and it had 69 actions. Recognising it is an iterative plan, 27 actions have already been completed. There are some obvious quick wins and flexibility and responding to that is important. Staff have told us the importance of clearer priorities, and staff being pulled in different directions. Ms Davies said the Trust Strategy is soon due to be published and which gives greater clarity as to the direction of travel. It was recognised that clarity on the the direction of travel to staff is important.

Mr Darbhanga said that he recognised that lots of working is being done and referred to partnership working and getting the message across that the staff survey has shown low morale and questioned how we get the partnership to work. Ms Davies responded that joint work is taking place with SaTH and there has been positive feedback. She said there are lots of opportunities with other organisations who will support the Trust's endeavour. Ms Purt will ensure the Board are sighted on the Key Performance Indicators.

The Board approved the governance and monitoring arrangements for staff satisfaction improvement

RESOURCE AND PERFORMANCE

RPC Chair's Report

Mr Featherstone commended Ms Lloyd and her team on the way they engaged in the recent RPC meeting agenda. The Committee had a wholesome and worthwhile discussion regarding RPC and its future direction.

Mr Featherstone spoke about the finance update from the report and national staff issues, relating this to our role in the System and how we wish to be a full system partner and contribute as whole. He referred to the Trust's performance and recovery plans and red indicators. Mr Featherstone said the focus on recovery plans was important and that future assurance would be sought on the meetings ahead. Referring to operational benchmarking, Mr Featherstone said it was about understanding our performance and best ways of working with partners. The Committee had welcomed the progress on PMO development.

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 meeting held on 27th March 2023.

Ms Lloyd reported an elevated number of 'red' RAG rated performance measures and said that measures out of tolerance exist in nearly all areas. Ms Lloyd referred to the responsiveness and waiting times, which Ms Davies has picked up in the Chief Executive's Report and also within the Quality and Safety Chairs Report. The benefits of the work are being seen but recognised there is still more to do.

Ms Lloyd spoke about the high number of 'Well Led' measures outside of tolerance, particular in relation to HR and People and the expected level of performance is not currently seen. She said this is being overseen through the People Committee for assurance.

Ms Lloyd said that the Resource and Performance Committee was not fully assured in relation to recovery plans and said there is more work to do, and which is being picked up. Ms Lloyd highlighted that the Board had approved the new Performance Framework and work is underway to implement this in the new financial year. The Board Development session following the Board meeting today, will introduce the new performance reporting.

Ms Purt referred to the Green Plan and asked in relation to assurance about the expansion of this, and how it will be measured. Ms Lloyd said the Richard Best, Associate Director of Estates, had set up a Green Working Group, and there were a number of people who have volunteered to be on the group across staff, including People leads. There will be communication going out to ask for more people to be involved. Ms Lloyd said the group is setting up an action plan and this will feed through RPC and the Board through the Chairs Reports.

Mr Darbhanga spoke about benchmarking data. Ms Lloyd said that having a PMO will make it clearer about what we are doing, who owns etc. She said that we have been good at identifying and having benchmarking but said we could do better in terms of the actions to be taken from this. She said there was more to do, but confirmed the right systems and processes are being put in place.

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 11 financial performance, forecast outturn, for assurance. Ms Lloyd said the annual plan is to delivery a deficit of £1.3m and the report summarised the Trust's financial performance for the period ended 28 February 2023 against the plan.

Ms Lloyd said the adjusted financial position for the year to date is a surplus of £1.2m, compared to the planned deficit of £1.1m, which is a favourable variance of £2.3m. The forecast outturn had been revised to £1.1m surplus and which is £2.4m favourable completed to plan. Ms Lloyd said this was driven largely by the pay costs being lower than expected, due to the high number of vacancies. The net increase was 11 WTE in February, and again in March and said that we are starting to see sustained increase month on month. Ms Lloyd highlighted the high level of agency spend, which as exceeded planned levels by £1.5m and is above the ceiling. Ms Lloyd said that was largely due to the high level of vacancies and confirmed that Ms Hobbs has put additional controls in place to manage the situation.

Ms Lloyd said there weren't any new risks to highlight and confirmed that the Trust remains on track to deliver its forecast outturn. She confirmed that the financial year would be closed down in the next few days.

Mr Darbhanga said it was positive news that the Trust was still on track with the forecast planned. He congratulated Ms Lloyd and her team for keeping this on track. Mr Darbhanga referred to the agency spend position and asked how we would increase numbers and fill substantive posts in the new financial year.

Ms Lloyd referred to the WTE position and said that by the end of the financial year, there will be an equivalent number of staff to the previous March position. She said the plan assumed that there would be an increase in WTEs, but this hasn't happened. The high number of vacancies is recognised, and Ms Lloyd confirmed that further work and an action plan is being picked up by the People Committee to address the issue. There are still a significant number of vacancies to be recruited to and Ms Lloyd acknowledged that it was great to see the International Recruits coming on board.

Board members spoke about recruitment and retention and Mr Featherstone said he looked forward to seeing a future paper about the growing the Trust's own recruiting pipelines. Ms Long said that during a recent call, there was a clear message from the national team about the links between workforce increases and productivity and said it would be important to demonstrate this as both an organisation and System.

Ms Lloyd said that acute services have numerous productivity benchmarks. She said community services don't yet have the standard metrics, but it was her understanding that these will be introduced in the future, and we are waiting for this information to be shared. Ms Lloyd commented that the Trust had the lowest level of workforce growth in 2019/20 and 2021/22 and there is expected to be a substantial increase in WTE next year. Ms Lloyd will keep the RPC and Board updated on the productivity metrics.

Finally, Ms Lloyd acknowledged that the Trust will be reporting a substantial variance to plan and that Shropcom is committed to supporting the system to deliver the challenging ICS Financial Plan.

The Board confirmed they had considered the adjusted financial position at Month 11 and recognised that agency costs will exceed the plan and ceiling despite the controls in place

2022/23 Plan - Summary of Achievements

Ms Lloyd's report presented an update on the achievements on delivery of the 2022/23 Operational Plan and details of how this informs future plans.

Ms Lloyd spoken about the recover of services and said the report shows the progress that has been made in the last 12 months, despite the challenging environment. Ms Lloyd congratulated all teams who have worked so hard over the last year and who have really focussed on the priorities.

Ms Long acknowledged that significant achievements had been made and congratulated all teams across the organisation. Ms Purt said that the progress on the green agenda, in the achievements sections, should be highlighted. Ms Lloyd will action this.

The Board confirmed they had received details of the progress against delivery of the 2022/23 Plan and noted that this has informed the development of the 2023/34 Plan.

GOVERNANCE AND AUDIT

Modern Slavery Annual Statement

Ms Ramtuhul provided the Board with a proposed statement in relation to the modern slavery and human trafficking for approval, which is reviewed annually.

Mr Darbhanga said that he welcomes the statement and asked in terms of the monitoring processes that are in place and the evidence based around the statements. Ms Ramtuhul explained that the statement sets out the different measures that we take, covering all areas which would come through the various assurance committees as part of the business as usual. Mr Darbhanga sought assurance on instances that may occur and how these are picked up. Ms Ramtuhul said that the statement is not intended to provide assurance on the outcomes of the actions rather it is stating the measures that are in place as per Trust policy, assurance would be obtained by checking adherence to policy.

Ms Sargent referred to the six checks that make up the NHS Employment Check Standards and said from the point of view from direct employees these would be sufficient but said the area that is open to high risk is sub-contractors and the procurement process.

Ms Lloyd commented in relation to the procurement process and set that we set out the NHS Terms and Conditions to suppliers for compliance. In terms of flagging any concerns, Ms Lloyd said that the Internal Auditors could look at this and carry out some checks. She said that compliance is a legal requirement and wondered whether Internal Audit could work with the Trust to provide independent assurance in the area. Dr Ganesh said that he hadn't seen the statement presented in this way.

The Board approved the statement, and Ms Ramtuhul will check through the document regarding mechanisms that are in place and if any gaps are identified, further consideration can be given as to whether Internal Audit support is required.

The Board approved the statement

Board Development Plan for Approval

Ms Ramtuhul presented the draft Board Development Plan for approval and to reflect on this year to date and the forthcoming year. Board members were asked to feedback separately, any ideas or suggestions, to Ms Ramtuhul.

The Board noted the Board Development Plan

Annual declaration of IG Toolkit Status

Ms Ramtuhul presented the report which provided the Board with confirmation of the Trust's compliance against the Data Security and Protection 21/22 Toolkit Status. Ms Ramtuhul said it forms part of the Annual Governance Statement and confirms that the Trust has met the standard for 22/23.

The Board noted the status of 'Standards Met' for the National Data Guardian's 10 data security standards and the assurance provided in relation to the data security controls within the Trust and the management of personal information.

QUESTIONS OR COMMENTS FROM MEMBERS OF THE PUBLIC

Questions or Comments from Members of the Public

Questions from two members of the public were submitted in advance of the meeting. Full responses were provided following the meeting and were uploaded to the Trust's Website. The full response is attached as an Appendix to the Minutes.

Ms Long welcomed the questions received from members of the public and thanked them for their submission in advance.

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. Mr Darbhanga said the meeting had addressed key areas and the Board have been open and transparent. Ms Purt questioned whether there should be more focus on risk, given the System challenges. Mr Featherstone said that good conversation had taken place and commended the continued focus in relation to healthcare inequalities and outcomes and would appreciate a future Board session to understand the role of the Trust and the impact we could have. Ms Long agreed and said it would be a key item for a future Public board meeting, and Health colleagues could be invited to attend. Ms Barker said it would be helpful to have some feedback in future on patient outcomes and experiences on the new model of care.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 12.30pm, Thursday 1st June 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

Question	Responses
Staff Survey	
(A) A quick glance at the NHS Staff Survey 2022 Benchmark report shows Shropcom as having below average results on almost every one of the 'People Promise' (staff support) elements. Key areas where Shropcom is below average include morale, staff engagement, raising concerns, health and safety climate, staff development and support for work-life balance.	**(A)** The results of the recently released staff survey is based on data collected in October last year. We have been engaged in improvement work for several months in response to the initial results and through staff feedback from other channels. In addition, we are embarking on a series of listening events with staff to further understand what support is needed and how we can further improve staff experience. We have a well-developed health and wellbeing package of support for our staff. The Trust continues to implement strategies to support staff wellbeing with several central and bespoke packages, alongside the health and wellbeing offer to support staff psychological wellbeing. This includes support with the with the cost-of-living crisis. The support packages are constantly reviewed through the JNP with Trade Unions and a relaunch of the health and wellbeing offer in response to staff feedback is taking place in the Spring.
(B) Does Shropcom agree that these things may well be a significant factor in its ongoing difficulties with recruitment and retention? Will Shropcom prioritise working with staff and with trade unions to improve staff experience of working for you? Will Shropcom also ensure that it provides really robust support for its newly recruited international nursing staff?	**(B)** Public sector recruitment nationally is challenging, and this is reflected across the STW health and care system. We have, however, seen very positive improvements in recruitment and fill rates in a number of areas. For example, rapid response and into the Virtual Ward, which has been recognised by NHSE. Where we have developed integrated roles with the opportunity for broader skill set and development, this has been met with a more positive response and therefore we are keen to continue to develop multi-disciplinary and across organisational roles that have better outcomes for patients in terms of joined up care as well as more meaningful and attractive opportunities for staff. In addition, the People and Clinical teams within ShropCom are exploring and exploiting every avenue of expanding workforce. Through apprenticeships, development of Trainee Nurse and therapy Associates, work with education and our wider STW colleagues to attract and retain staff. In terms of International Recruits, we have a robust pastoral package for each of our international recruits who we meet regularly to gain live feedback on their experiences, to ensure ongoing support and to continuously learn and improve for the next group of recruits that commence with us. We meet monthly with our union colleagues and share details with them.
The duty to involve	
(A) Does the Board acknowledge that it has statutory duties as an NHS	**(A)** The Board recognises its statutory duties to involve services users and the wider public to develop and consider any changes in the provision of services. It also recognises that this involvement needs to take place whilst proposals are at a formative stage and prior to any decisions being made.

Question	Responses
provider under Section 242 of the National Health Service Act 2006 (as amended) to involve service users/ the public in the planning of the provision of services; the development and consideration of proposals for changes in the way services are provided; and decisions to be made… affecting the operation of those services? Does the Board understand the legal requirement for involvement to take place whilst proposals are at a formative stage?	
(B) When will Shropcom share its proposals for a changed model of care in Shropshire's community hospitals? What is your timescale for implementing the required patient/public involvement?	**(B)** The Trust plans to engage with its staff, patients and public prior to the formulation of any proposal for a changed model of care. This will be done jointly with NHS STW who are the commissioners and have the duty to ensure services are commissioned which meet the health needs of the local population. The Trust is finalising the engagement plan with NHS STW with a view to commencing this in May.
Bishops Castle Hospital **(A)** What plans does the Board have to re-open Bishop's Castle Community Hospital? What concrete steps will be taken and what is your timescale for these?	**(A)** The Trust still remains unable to safely staff the inpatient beds at Bishop's Castle Hospital, however, the hospital itself remains open with a number of services still operating from the site. As above the Trust plans to engage with staff, patients and the public prior to making any decision regarding the inpatient facility and is finalising the engagement plan with NHS STW as above.
Virtual Wards **(A)** What risk assessment has taken place to ensure patient safety? What are the patient eligibility criteria?	**(A)** Risk assessments and Quality and Equality Impact Assessments are performed throughout the inception of new clinical pathways with clear governance and oversight. Several pathways are already agreed and in action such as Frailty and Cellulitis.

Question	Responses
	Eligibility - 16 years and above but we are reviewing the opportunities for children also. The Focus is currently on Frailty, Respiratory and Cardiology patients both as step up from community and step down out of the acute setting including ED.
(B) What level of medical, nursing and care provision are patients able to receive? What are the staffing arrangements for this?	**(B)** The level of medical, nursing and care provision very much depends on the agreed pathway for individual patients. Some require remote monitoring as the main source of support alongside education, other patients require more intensive nursing and therapy support. We have GP led and Geriatrician led support for patients on the virtual ward with step down patients from the acute area also having acute consultant oversight. The Trust has been success with its recruitment plans and has been recognised nationally for our ability to recruit into virtual wards where other organisations have struggled.
(C) What evaluation of patient outcomes has or will take place? What evaluation of patient and relative feedback has or will take place?	**(C)** We are overseeing feedback form patients through our Patient Experience Committee and in the last month have gratefully accepted offered support from Health Watch in capturing further patient experience feedback. We have several patient case studies that have been shared with wider partners to demonstrate the patient journey through the virtual ward and so far, have received positive feedback from our patients. We have had 0 patients so far been readmitted following discharge from Virtual ward which is positive. This includes evaluation of patient and relative feedback.
(D) When will information on this new model of care be made available to the public?	**(D)** The virtual ward is a nationally designed model of care and there is a wealth of information on virtual wards available to the public via the NHS England website.

Question	Responses
Medical cover **(A)** What arrangements are currently in place for medical cover at each of our community hospitals? Have these changed recently? Are there any plans to change the arrangements for medical cover in the foreseeable future?	**(A)** We currently have a blended model of GP cover (historical) and Geriatrician cover via 2 new staff members which has improved the robustness of medical cover both in our community hospitals and virtual ward. As we continue to see more sub-acute patients being cared for closer to home, we envisage increasing the high-level clinical expertise to include Advanced Care Practitioners on a 7-day basis alongside medical cover.
Recruitment and Retention Premia **(A)** When will the Trust consider the implementation of Recruitment and Retention Premia to support recruitment and retention to nursing posts at Shropshire's community hospitals?	**(A)** The Trust already has RRP in place where deemed appropriate. We are seeing improvements in vacancy levels for our Community Hospitals mainly due to International Recruitment hence there is not a need to consider this as an option at this time; with the exception of BCCH where we know IR would not be safe at this time.

Meeting Date: 01 June 2023

Trust Board Meeting Action Log

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

Meeting Date	Minute Ref and Agenda	Issue	Action	Update	Lead	Target Date
April 2022	Minute No 2022.2.9 Appendix 3 2022/23 Budget Setting	Budget Setting	Ms Lloyd to send a letter to the Sustainability Committee Chair to recognise the left shift investment needed in system transformation after the final financial plan is agreed.	The letter will be sent following agreement of final 2022/23 ICS plans. This is likely to be late June 2022, but is yet to be confirmed July – this is under discussion Sept - agreed at Board that this will be delayed until 23/24 planning is complete. October – Update to be added to March workplan **April 2023 - The draft plan for 2023/24 includes significant investment in community services. Consideration to be given as to whether this letter would now be appropriate. Agreed to keep on action log until close plan for year ahead.**	S Lloyd	June 2023
October 2022	Non-Executive Director's Communications	Engaging people and communities	Future board development session regarding the 10 principles on engaging people and communities (following presentation from Edna Boampong at ICB Quality & Performance Committee	Board Development session took place following Private Board meeting on 4th May 2023.	P Davies	May 2023
October 2022	EDI Update including WRES and WDES	International Recruits	International Recruits to attend future Board meeting	Update: Added to workplan August 2023	C Hobbs	August 2023
February 2023	CEO Report	International Recruits	Ms Hobbs and Ms Sargent to discuss Housing Association links	Conversation occurred and contact numbers given. 2 contacts have been spoken to with 1 offering support which has resulted in some	C Hobbs A Sargent	March 2023

				accommodation being found for our recruits. Action complete.		
February 2023	Q&S Committee Chair's Verbal Update	Quality and safety metrics	Ms Hobbs to write letter to the ICB regarding wider support	Letter drafted but not sent due to recent internal incidents linked to capacity. Discussion has occurred but letter to be formalised and checked by Director of Governance. Update April 2023 - Ms Hobbs and Ms Ramtuhul will discuss further and update at the next Quality and Safety Committee	C Hobbs S Ramtuhul	June 2023
February 2023	Learning from Deaths Report	Cost of living impact	Cost of living / impact on families to be included in next quarterly update	To be included in Q4 report – June 2023	Dr Ganesh	June 2023
April 2023	Chairs Communication	Population Health	Population Health to be a future Agenda item		S Ramtuhul	September 2023
April 2023	Patient Story/Video	Revive Exercise Programme	Programme update/feedback in 12 months time	To be added to Board Workplan for April 2024	S Ramtuhul	April 2024
April 2023	Modern Slavery Annual Statement	Assurance regarding actions/outcomes	Ms Ramtuhul will check through the document regarding mechanisms that are in place and if any gaps are identified, further consideration can be given as to whether Internal Audit support is required.	Mechanisms in place for each of the policy requirements and therefore any gaps should be identified through business as usual governance framework	S Ramtuhul	May 2023
April 2023	Board Development Plan	Feedback	Board members were asked to feedback any ideas or suggestions, separately to Ms Ramtuhul	The Board Development Plan continues to be a live document and will be brought back to the next meeting for further consideration	Board Members	May 2023
April 2023	Meeting Evaluation	Healthcare Inequalities	Healthcare Inequalities to be a key item for a future Public board meeting. Health colleagues to be invited to attend.	To be added to Board workplan	S Ramtuhul	October 2024

April 2023	Chief Executive's Report	Virtual Ward dashboard	KPI Performance Dashboard to be shared at Board meeting	To be added to Board workplan	C Hobbs	July 2023

Shropshire Community Health NHS Trust

Chair's Update

0. Reference Information

Author:	Tina Long	**Paper date:**	1 June 2023
Executive Sponsor:	Shelley Ramtuhul	**Paper written on:**	24th May 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 May
- Outline of recent Board Development Session

2.3. Conclusion

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

Chair's Update

3. Main Report

3.1 Meetings and Visits

It has been a busy few months since I took up the post as Acting Chair. Other Non-Executive Directors and I have been out and about visiting services and talking with staff.

We have visited:

- Whitchurch Hospital and Minor Injuries Unit
- Bishops Castle Hospital
- Bridgnorth Hospital
- Oswestry Community Nurses, minor injuries unit and other services based in Oswestry
- Neurorehabilitation Service
- Shrewsbury Community Nurses
- Wheelchair Service

The visits have been very positive, and we have heard about all the great work our staff and teams are doing as well as some of the challenges they face. We have been able to feed issues raised with us to executive colleagues and thank all the staff we have met for spending some of their valuable time with us.

These visits will continue with a visit to Ludlow Hospital planned early in June.

Along with our Chief Executive I attended the Integrated Care Board meeting which was followed by presentations from colleagues from both Shropshire Council and Telford and Wrekin Council on the excellent work which is being done by the Councils and their partners to develop services locally at both Place and Neighbourhood levels.

I have also spent time meeting with Chairs from other organisations which has been very valuable as well as attending Regional briefings.

Our Non-Executive Director Equality, Diversity and Inclusion Board Champion, Harmesh Darbhanga, and I joined our Chief Executive and HR colleagues for a session on the RACE Equality Code where we began to assess the organisation against several standards from which some key actions will be identified. This is an important piece of work to ensure that Equality, Diversity and Inclusion are at the heart of the organisation.

3.2 Private Meetings of the Board

In May the Trust Board met in private at Bridgnorth Hospital where we discussed several important issues, including:

- Bishop's Castle Community Hospital
- Board Membership
- Trust Strategy Presentation
- In-Year Performance Update
- 2023/24 Integrated Performance Update
- Integrated Quality and Safety Performance Update

Chair's Update

- 2022/23 End of Year Financial Performance
- 2023/24 Planning Update

This was another opportunity for some of the board members to visit clinical areas and talk to staff.

3.3 Board Development

On 4th May 2023, The Board received a presentation from Edna Boampong, Director of Communications and Engagement, ICS. The presentation covered the following areas:

- Overview of the system Involving People and Communities Strategy
- Defining involvement and consultation
- Our involvement vision and principles
- Delivering, Informing and evaluating involvement

3.4 Conclusion

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

CHIEF EXECUTIVE'S REPORT – June 2023

1. Introduction

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.

2. Key Issues

2.1 Local Care Programme & Hospital Transformation Programme

As stated previously, Shropshire Community NHS Trust (SCHT) is leading the Local Care Transformation Programme (LCTP) of work on behalf of the Integrated Care System (ICS). The Hospital Transformation Programme (HTP) led by the Shrewsbury and Telford NHS Trust (SaTH) and Local Care Transformation Programmes are the two major change programmes within the ICS. They are interdependent pieces of work, which are central to the long-term sustainability of health and care across Shropshire, Telford, and Wrekin (STW) but are connected to ensure each programme delivers together the improvements for our residents.

The focus of LCTP is on implementing a **community based integrated health and care model** that supports prevention and early intervention and can respond to the physical and mental health needs of residents and communities. In addition, contribute to **reducing pressure on the acute** parts of the system through reducing non-elective bed days.

Both programmes of work are overseen operationally by the SCHT/SaTH joint provider transformation committee. Whilst the HTP timescales has a medium to longer term (2026 plus) focus, the LCTP programmes of work is focused on the 'left shift' of care over the next 3 -5 years, enabling the HTP programme of work to be realised in line with the proposed timelines. The key immediate priorities for the joint committee are:

1. **Virtual Ward (VW)** – Joint programme of delivery between SCHT and SaTH. This national initiative requires us to have operational 249 virtual beds by Dec 2023. As reported previously, the system is on track to achieve the overall virtual bed numbers with higher numbers of step down being reported over the last 4 weeks in line with target.

2. **Integrated Discharge Team (IDT)** – Expansion of the successful pilot within PRH and RSH across the Trust. This in reach community team run jointly with Sath and the Local Authorities aims to support timely and supported discharge. This multi-professional team links to all key services within the community to ensure that patients continue to get support where they need it in the right place. The numbers of complex discharges across the week facilitated by the IDT continues to remain consistent and above that seen (c35% higher) for complex discharges than the previous year. This equates to 7 additional beds per day being freed up within Sath, through this team's intervention alone. SCHT who lead the IDT has committed to support 475 complex discharge patients per month, working with system partners to provide seamless, timely step-down support for individuals (wherever possible in their own homes) to enhance flow consistently across our system and reduce length of stay for this cohort of patients by a minimum of 1.7 days. This team also oversees the flow across the community hospital bed base which continues to run at an average 95% occupancy level with an average LoS of 14 days.

3. **Rapid Response teams** – Again a multi-professional team of health and care professionals that aim to prevent unnecessary admission to hospital by providing crisis intervention. The rapid response team form the core part of our 2-hour statutory crisis response time target alongside the care home team and falls response service, which we consistently achieve over 97% compliance (Highest in the region). Last year (2022/23), these teams interventions reduced A&E attendances by 3826, ambulance conveyances by 1148 and acute non-elective admissions by 1377

2.2 Our People

Our workforce is our greatest asset and the greatest challenge we have in the system. We are committed to improve both our retention and recruitment rates as a Trust and system.

Like many health and social care areas we have seen continued pressure related to workforce numbers in the last year, where we did see a decline in our contracted whole-time equivalents (WTE) every month from April '22 to November '22. However, since that time (Nov 2022) we have seen a steady increase in our contracted WTEs through initiatives such as international recruitment, apprenticeships, and new models of trainees such as therapy and nurse trainee associates, as well as a rise in recruitment in non-clinical and non-patient facing areas such as digital, estates and corporate services. We report our WTE each month in the finance report. In terms of the year end position for the 22/23 financial year, in March 23 our WTE were roughly the same as at the end of March 22. Our biggest area that we struggle in terms of recruitment relates to community hospitals (particularly in the Southwest of Shropshire) and community nursing teams. We did cover key roles during these times and where we currently have gaps with bank and agency to ensure safety. However, there is a balance to be had with the use of agency in

terms of safe staffing levels, which is why we have a clear focus on substantive recruitment through several pipelines and through different ways of working with partners. Our vacancy gap for the 22/23, doesn't quite reflect the balance position and that is because, we received investment for expansion in Local Care services as stated above. That is virtual ward, expansion in Rapid response and IDT. The Virtual Ward is a new national initiative and requirement and therefore, whilst the investment increased our headcount from the original baseline, it has taken time to recruit to these new roles. Hence a gap recorded reflecting the time lag in terms of investment coming online and time for recruitment process and getting people into post and trained.

We have seen a positive response to recruitment for the Virtual Ward, Rapid Response teams and areas of sub-acute care delivery, which reflects the type of posts which offer real opportunities for skill expansion and cross sector working and we are keen to expand and rotate staff across these areas so that we can build meaningful career pathways for staff that also offers the greatest opportunities to local people and communities.

I reported last month on our Equality, Diversity and Inclusion (EDI) workstream and the work it has been doing in relation This is Me: Celebrating Disabilities event, which was well attended by staff with some wonderful guest speakers covering a range of topics. We also had our celebratory event for the first cohort of our Reverse Mentoring scheme; some staff shared powerful stories about the positive impact the scheme had had upon them as individuals and in supporting their career development.

We are making much wider progress in this area by inviting in RSM to review our EDI processes and provide advice and further recommendations about the Race Code. Board members attended the first of these sessions in early May and whilst Board Development is always uplifting and challenging, this session (which is a first of a series with leaders and staff) was inspirational, challenging and really positive in terms of a different way of thinking that will pay dividends, I am absolutely sure and determined, in terms of staff recruitment and retention and ultimately improved care and outcomes for the people we serve.

This work will feed into the work on our values and the cultural engagement leadership programme we have in place, which focuses on developing our staff.

3. Other Areas of Performance

3.1 Elective RTT and non RTT

The Trust continues to experience challenges with performance of recovering services and this has been seen particularly in services where patients require diagnostic investigations or Orthopaedic consultant support. The diagnostic challenges are not exclusive to SCHT; this is a national pressure due to shortages of Radiologists and an increase in demand for imaging studies. We are working closely with our system partners

to ensure we are prioritising our longest-waiting patients and those whose clinical needs are highest. We are utilising support from the independent sector to provide additional Radiology resources and increasing our clinical outpatient capacity to further support recovery. There has been some positive reduction seen in waiting times for the majority of diagnostics with Ultrasound remaining the exception.

In terms of non-RTT planned services, the Trust is applying the same process of managing waiting lists and backlog based on clinical priority as for RTT services. For reference, non RTT planned services provided by the Trust include, but are not limited to, the following: Community Nursing/Therapy; Pulmonary Rehab; Diabetes Services; CNRT; Continence.

Whilst there has been significant progress seen in many services, the Trust has seen an increase in the number of patients waiting 52 weeks and above. This increase is due to the level of demand on Lower Limb Orthopaedic services. The Trust is hopeful of securing additional capacity shortly which will support the reduction of patients waiting above 52 weeks.

3.2 Covid Vaccinations

The Trust is the lead provider for the STW vaccination programme and remains a strong deliverer against the national requirements.

We are currently in the mists of the Spring Booster Vaccination programme as recommended by the Joint Committee on Vaccinations and Immunisations (JCVI). The spring programme runs from 3 April 2023 for residents in a Care Home for older adults and from 17 April 2023 for all aged over 75 and those aged 5 and over who are immunosuppressed. The campaign will end on 30 June 2023, with an ambition to prioritise older adult care homes prior to 28 May. In terms of current performance in line with the care homes, we are currently at 75% achievement which is the highest in region and now focusing on the other cohorts mentioned above.

There are a blend of providers delivering the vaccine and ShropCom is planning to deliver a higher percentage of the activity from fixed sites at Coral House and William Farr House alongside roving and pop-up clinics delivered via the Vaccination Bus and in Community centres and Fire Stations across the STW footprint.

It should be noted that the 'evergreen' offer (1st and 2nd doses) will end after the close of this phase on 30 June and will only be available during 'active' phases of the programme. It is expected that the next phase will be the Autumn programme delivered to a similar cohort as Autumn 2022 and run from September to January. This will be confirmed by NHSE during the summer but is subject to change.

4. Good News stories

IPC Visit

The Trust's Infection Prevention and Control (IPC) activities have remained a priority through 2022 and into 2023 due to the changes and challenges of exiting the pandemic while re-balancing and innovating IPC practices in line with Government guidance. This provided the impetus to develop and launch the first IPC Strategy Ambitions against which the Trust has already made significant progress.

The first joint IPC Summit was held with The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) and quarterly IPC campaigns are now rolled out across SCHT, including 'gloves off' managing IPC risk against environmental impact of plastics. The Trust's IPC Team have been liaising closely with NHSE and secured 1 year's funding for a new Band 3 Clinical IPC support worker role as a proof of concept. Integrated working to consolidate a joint approach to IPC will continue, combining team meetings to share new knowledge and work in partnership across the ICS.

The Trust has restructured IPC governance with the launch of the IPC Operational Group, focussed on IPC practices which provides a platform for Estates and Facilities, working together with teams to achieve compliance with IPC. This gave rise to an assurance visit by NHSE IPC Deputy Director where the Trust was able to evidence the improvement works completed, and the plan for further improvements and upgrades to the environment that will continue throughout the forthcoming year.

International Nurses Day 2023

As a way to celebrate International Nurses Day, the future of nursing, a number of ShropCom nurses went to local schools to deliver assemblies. During their visit, they spent time talking about what a nurse is, what it means to be a nurse and what a nurse should be like. The floor was then opened up to the children to ask some questions. The assemblies received media coverage in the Shropshire Star: **Nurses talk to children in primary school| Shropshire Star**

The Professional Nurse Advocates congratulated on their contributions

The Professional Nurse Advocates (PNA) were joined by Clair Hobbs to be congratulated on their contributions to date and three staff were presented with their PNA certificates and badges this week. The Trust now has nine PNA and four in training, with expressions of interest being received for the next available training places.

Veteran Aware accreditation for Shropshire Community Health NHS Trust

Shropshire Community Health Trust (ShropCom) has received the Veteran Aware accreditation. As a result, members of the Armed Forces Community living across Shropshire and the surrounding areas are set for a strengthened approach towards their care.

New Director of Operations announced

I am pleased to announce that Claire Horsfield has been appointed as the **Director of Operations** for the Trust. Claire is a Shropshire Lass and has worked within STW all her professional career in the acute Trust initially, and for the last 9 years in ShropCom. She is a registered physiotherapist with a special interest in MSK and has a wealth of clinical and operational expertise. Claire will continue to be the professional responsibility for AHPs within the Trust as Chief AHP, alongside the role of Director of Operations.

Shropshire Community Health
NHS Trust

Bishop's Castle Engagement Plan

0. Reference Information

Author:	Shelley Ramtuhul	**Paper date:**	1 June 2023
Executive Sponsor:	Patricia Davies	**Paper written on:**	24th May 2023
Paper Reviewed by:	N/A	**Paper Category:**	Quality and Safety / 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 on the situation with Bishop's Castle for information purposes and to ensure that the Trust's plans are put into the public domain.

2. Executive Summary

2.1 Context

The inpatient beds at Bishop's Castle Community Hospital were temporarily closed in October 2021 due to staffing shortages which were impacting on safety and the quality of care. Since this time the Trust has attempted further recruitment without sufficient success to enable the beds to re-open. In light of this the Board has concluded that it cannot see any reasonable prospect of being able to staff and re-open the beds. The Trust therefore needs to consider the contract it holds for the inpatient service and whether it must now relinquish the contract on the basis that it cannot meet the requirements.

2.2 Summary

- The Board agreed that prior to making any decision regarding whether or not to relinquish the contract it should embark on a period of engagement with its staff, patients, the wider public and stakeholders.
- This paper sets out the engagement plan which commenced on 22 May 2023 and is planned to conclude on 3 July 2023.

2.3. Conclusion

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

Bishop's Castle Engagement Plan

3. Main Report

3.1 Background

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

The Board agreed to formally advise NHS Shropshire, Telford and Wrekin (NHS STW), as the commissioner, of the lack of reasonable prospect to the Trust reopening the beds in the view of the current staffing situation and that it therefore intended to now engage with the public prior to making any final decision on whether to relinquish its contract with the ICB for the inpatient service or not.

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 can feed into a final decision for the Trust and further inform any next steps or considerations required by NHS STW.

3.2 Purpose of the Engagement

By law, NHS Commissioners and Trusts must ensure that users and potential users of health services that they commission and/or provide are involved in certain decisions that affect the planning and delivery of those services.

- We want to explain why the beds have been temporarily closed and why SCHT have not been able to reopen them.
- We want to explain why SCHT have concluded that there is at present no realistic prospect that the Trust can reopen the beds.
- We wish to engage patients, carers, staff and stakeholders in the Bishop's Castle area and the wider Shropshire community to understand the impact the temporary closure has had.
- We wish to engage with patients who receive community health services in their own home and carers to understand what could improve the service we provide.
- We wish to understand and consider the likely impact that the Trust relinquishing its contract for inpatient services at Bishop's Castle would have.
- This engagement is not formal public consultation on the future provision of the community beds but rather to inform the decision the Board must now take on whether or not to relinquish its contract with the ICB for the inpatient beds at Bishops Castle.
- We want to explain what the next steps will be after the Trust has made it's decision. This will cover both what will happen if the Trust decides to relinquish the contract with the ICB and what will happen if it does not.
- We want to reassure the public and staff that SCHT has no intention of ceasing the other services it provides at Bishop's Castle and these do not form part of the contract under consideration.

3.3 High Level Summary of the Engagement Plan

The Engagement Plan is separated into two distinct parts, the first is the inform stage which will run from 22-29 May. This will involve informing staff, patients, the wider public and stakeholders of the continuing position with regard to Bishop's Castle and the Trust's plans

Bishop's Castle Engagement Plan

to engage and involve them in the decision it must now take on the contract for inpatient services.

Phase one of the Engagement Plan has commenced and at the time of writing a meeting with the affected staff had taken place, stakeholder briefings had been issued, the website updated and a statement released to the media.

Phase two of the plan will commence from week two (w/c 29 May) and involves a number of different ways to engage and involve staff, patients, stakeholders and the wider public and the detail of this is set out below:

Period of Engagement with the Public and Stakeholders: Weeks 2-6				
Stakeholder	**Date**	**Purpose**	**Owner**	**Mechanism**
Patients Carers and Public	W/C 29 May	Obtain views and opinions	SCHT Comms / External Researcher	Public survey (also available to staff), update on website followed by promotion via social media and the press
Patient Carers and Public	June 2023	Bishop's Castle focussed engagement to support input into the survey and obtain views and opinions	External research companies	Researchers present in the town centre for two weekends plus three focus groups representative of the local population
Patient Carers and Public	June 2023	Discuss the situation and the decision that needs to be made and obtain views from the public	SCHT CEO	One afternoon and one evening meeting to be held
JHOSC	June 2023	Share information of current situation, next steps and proposed timeline for information.	NHS STW CEO and SCHT	Email and in person
NHS STW Board meeting	July 2023	Update on current situation and progress of engagement	SCHT CEO	Presentation at Board
Health and Wellbeing Boards	June 2023	Share information of current situation, next steps and proposed timeline and approach	SCHT CEO	In person

Bishop's Castle Engagement Plan

Period of Engagement with the Staff: Weeks 2-6				
Stakeholder	**Date**	**Purpose**	**Owner**	**Mechanism**
Bishop's Castle staff	W/C 29 May – 3 July	To provide staff with the opportunity to raise questions and concerns	Director of Nursing and Workforce / Hospital Manager	Ongoing weekly meetings to include invites to those on sick leave / maternity leave
Staff Side Chair	W/C 29 May – 3 July	To provide regular updates	Director of Nursing and Workforce / Director of Governance	Weekly meeting
SCHT staff	W/C 29 May – 3 July	To provide staff with updates	SCHT Comms	Include an update in the weekly staff comms and staff Facebook
Bishop's Castle staff	June 23	Bishop's Castle staff focussed engagement to support input into the survey and obtain views and opinions	External Researcher	Focus Group

Period of engagement is to close on 3 July with the website to be updated at this stage. This will be followed by an extra-ordinary meeting of the Board of Directors during July (date TBC) to consider the output of the engagement and make a final decision regarding the contract for inpatient services.

3.4 Engagement to inform a Quality and Equality Impact Assessment

We aim to treat our population, patients and employees fairly and with respect. When we think about making changes to our services or policies, it is important that we fully consider the positive and any negative impacts for the local population as a result of the proposed change or new service. At the time of the temporary closure of the beds at Bishop's Castle the Trust undertook an Impact Assessment. This will be revisited and informed by the outputs of the engagement. The updated Impact Assessment will be presented to the Board with the final report on the outputs of the engagement to ensure that all necessary information is available to the Board when making its decision on the contract.

3.5 Conclusion

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

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

0. Reference Information

Author:	**Diane Davenport Executive Assistant**	**Paper date:**	**1st June 2023**
Executive Sponsor:	Clair Hobbs, Director of Nursing & Workforce	**Paper written on:**	24th May 2023
Paper Reviewed by:	Claire Horsfield Deputy Director Quality & Chief AHP	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

The Quality and Safety Committee is a sub-committee of the Board of Shropshire Community Health NHS Trust (the Trust) and has delegated authority from the Board to oversee, co-ordinate, review and assess the quality and clinical safety arrangements within the Trust.

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

2.2 Summary

- The meeting was quorate.
- Updates were provided on:
  - Radiation Protection
  - Community Dental
  - Learning from National Maternity reports
  - Patient Experience report
  - Serious Incidents
  - Performance update
  - Annual Quality Account
  - Clinical Effectiveness
  - Quarterly Guardian for Junior Doctor Safe Working
  - BAF Update

2.3. Conclusion

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Quality & Safety Committee 18th May 2023
The Trust Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality & Safety Committee which met on 18th May 2023. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership	
Jill Barker	Non-Executive Director - Chair
Clair Hobbs	Director of Nursing & Workforce
Alison Sargent	Non-Executive Director
Claire Horsfield	Deputy Director of Quality & Chief AHP
Dr Ganesh	Medical Director
In attendance:	
Tina Long	Non-Executive Director (Chair of the Trust)
Jane Sullivan	Senior Quality Lead - ICB
Patricia Davies	Chief Executive
Helen Cooper	Head of Nursing AHP & Ops (CYP)
Lucy Manning	Medicines Safety Officer & Non-Medical Prescribing Lead
Tom Seager	Clinical Director Community Dental Services – Item 5
Diane Davenport	PA to Director of Nursing & Workforce (Note Taker)
Apologies:	
Apologies received from: Angie Wallace Chief Operating Officer, Martin Howard, Patient Safety Partner, Shelley Ramtuhul Corporate Secretary/Director of Governance, Gemma McIver Deputy Chief Operating Officer, Susan Watkins Chief Pharmacist, Tracie Black Associate Director of Workforce, Education & Professional Standards, Cathy Purt Non-Executive Director, Sam Young Associate Director of Infection Prevention Control	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

Chair's Assurance Report

Quality & Safety Committee 18th May 2023
The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There were no declarations shared.	N/A	
2. Minutes of the meeting held 20th April 2023		
The draft minutes of the meeting held on 20th April 2023 were approved as a truce and accurate record.	Y	
3. Review of the Action log		
The Committee reviewed the action log and updates were provided on each of the actions due. The summary of actions from the Extra Ordinary Quality & Safety Committee on 12th December 2022 to be circulated to Committee members. **Update on cleaning Standards at Oswestry Health Centre** – as part of the recent NHSE IPC visit, a visit was undertaken to Oswestry Health Centre. The Trust is still waiting for a formal letter from NHSE following the visit. However, following the visit, NHSE has raised the cleaning issues with NHSPS, and a meeting is to be arranged with the ICB.	Y	
Radiation Protection Update – the Committee received an update on radiation Protection monitoring in the Trust. Assurance was provided that Radiation Protection is being undertaken in the Trust. There is a vacancy in the Trust for a sonographer that has been out to advert five times. The Committee agreed that the sonographer vacancy is a system issue as radiology and diagnostics delivery is a system service.	Partial	The vacancy re the Sonographer to be progressed and the Service SLA to be reviewed.
Community Dental Update – escalation of risk of lack of General Anaesthetic Provision for children and adults with complex needs at Shrewsbury & Telford Hospital NHS Trust (SaTH). Since March 2020, SaTH have reduced the theatre allocation provision of care for both adults and children with complex needs, with no elective route now available for their dental care under general anaesthetic (GA) in Shropshire. SaTH have offered no future allocated lists from April 2023 for both these groups of patients, and SCHT as an organisation hold two waiting lists with no available route for patient appointment.	Partial	The lack of GA Provision to be escalated to the Chief Executive of SaTH as a matter of urgency. The SLA with SaTH to be reviewed, enquire if RJAH could provide support, however caution was advised on this route as RJAH are not an Acute

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

The Committee discussed the risk and agreed a set of actions to be taken to address the lack of GA provision at the Trust.		setting if an emergency arose.
4. Learning from National Maternity Reports		
An update on the transferable learning from recent National Maternity reviews and suggestions how the Trust may adopt for the Quality & Safety Committee for information and approval. The Ockendon Report identified 4 broad areas of learning apply to the Trust: Incidents & Complaints, Listening to Families, Governance & Assurance and Workforce. The Reading the Signals review identified there are lessons within the 4 key areas identified: Monitoring Safety Performance, Standards of Clinical Behaviour, Flawed Teamwork and Organizational Behaviour.	Full	
5. Patient Experience Report (including Complaints & PALS) 1st January – 31st March 2023		
Friends & Family Test (FFT) - scores were over 96% for the last quarter. Observe & Act plans have been put in place in quarter 4 to enable a number of visits for the next quarter to go ahead. A Children's Patient Story was presented to the Board in February. Total number of complaints received was 15 with Children's Therapies receiving the most complaints.	Partial	A new Patient Experience Delivery Group has been established and will meet in the next quarter, incorporating lead managers from Adults and Children's SDGs. This will improve feedback co-ordination and more effective ways of closing the loop which will provide assurance to the Quality & Safety Committee that learning is being embedded in the Trust.
6. Serious Incidents Report		
There are less Serious Incidents being reported, as previously were over reporting, and can provide assurance that reporting is at the right level. There is now a robust Serious Incident review process with Executive oversight and a SI Panel review panel has been established where SI's are discussed before being escalated to the ICB.	Full	
7. Learning from Deaths 2022-20-23 Quarter 4		

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

Quarter 4 there have been 16 deaths reported within the Community Hospitals. Seven of these deaths were recorded as having a COVID-19 positive swab within the last 28 days. Five deaths occurred in January 2023 which was the highest number of COVID-19 positive occurrences in the financial year. All deaths were reported on the COVID-19 Patient Notification System (CPNS). Two patients had COVID-19 recorded as their primary cause of death on their death certificate. There were no reported deaths in Custody in Quarter 4. Actions from previous Death in Custody Case and PPO investigations continue to be reviewed. The Trust is waiting for final PPO report on two previous deaths. One case is going to the Coroners Court in the week commencing 22 May 2023, however the final PPO report for this death made no clinical recommendations. The Committee noted the risk with provision of the Mental Health Service at the Prison which has been picked up by NHSE. Number of Shropshire & Telford & Wrekin child death nonfictions for 2022/2023 year to date is 41 (this includes 17 SUDICs). The Committee discussed the Thematic report 'Sudden and Unexpected Deaths in Infancy and Childhood' review that identified 10 recommendations and the need for a multi-agency response should be triggered if a child death is sudden and there is no immediate apparent reason. The report highlighted the unexpected death of children under 1, a review of the sleeping environment should be carried out. The Committee discussed how the recommendation links with New Birth Visits, and it was noted that Safely Sleeping is already embedded with the New Birth Visit. There is a challenge with CDOP provision and is on the Risk Register. The ICB have commissioned a peer review of CDOP	Full	
8. Integrated Quality & Safety Performance report		
MRSA Compliance fell below the 97% target for the first time in five months with 96.2% reported. Work to obtain compliance next month. **Falls** – number of inpatient Falls (11) in the care of the Trust, was the same in April as in the previous month and the rate of falls per 1000 occupied bed days (4.56) although slightly increased from M12 remains lower than	Full	

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

the 21/22 and 22/23 average. Two falls resulted in fractures both of which are being investigated as SI's. Ongoing issue with arm's length care and working with the teams to embed the policy. CHob informed the Committee that a falls quality improvement review is under way and looking to move to a sub-acute model. The Trust are seeing more patients who are confused, and acuity is increasing in community hospitals and good work by the operational teams. **New Birth Visits (NBV)** – a decline for the last month with 85.63% reported in March. There were no incidents of harm linked to late visits. Some of the delays are out of the control of the Trust and the Shropshire team have capacity issues. As from next month the NBV data will be split into Shropshire and Telford & Wrekin. **Mandatory training** – overall target of 95% was not achieved in January with 93.61% reported. Basic Life Support, High Risk Fire training and Oliver McGowan training are the low compliance areas. **Appraisal compliance** – April compliance is reported as 80.55%, with a slight improvement from 79.64% reported in March. Robust monitoring meetings are in place to ensure recovery occurs along with plans to launch new appraisal paperwork.		
9. QS Performance Dashboard		
This is the inaugural report of the new Quality & Safety Committee Performance Dashboard and is still work in progress. The New Birth Visit data requires splitting between Shropshire and Telford & Wrekin. An area of concern is the report identifies a case of CDIF in April and the Director of Infection Prevention Control has not been notified of a CDIF in the Trust. The IPC team are reviewing the data	N	The data to be reviewed.
10. External Inspections Flash report		
Shropshire Area SEND Joint Re-inspection Still waiting the final report and will circulate when the report is received. **HMIP Prison Inspection** Concern raised from NHSE regarding the Psychiatry services and mitigations in place through escalation with North Staffs Combined Trust. **Telford & Wrekin Area SEND Joint Full Inspection** Publication of the inspection letter from CQC & OFSTED is expected at the end of May 2023. **CQC Readiness** The Quality Team have reviewed readiness work and have plans to relaunch. Teams will not be asked to re-assess. A comprehensive prioritised list of services	Full	

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

based upon triangulated quality data and self-assessment will be developed to allow a programme of quality assurance visits to take place by the team. An analysis of any new services such as Virtual Ward will be identified to be added to the list for self-assessment. Chor shared with the Committee that CQC assessments are being conducted differently and CHOr is linking with Community Trusts who have had a recent CQC Inspection to gauge their experience and any lessons learnt. There is no definite date for a CQC visit as the CQC Organisation are undergoing a re-structure. The Trust are being pro-active in trying to arrange meetings with the Engagement Officer. There are issues in the System which could trigger a CQC visit.		
11. Annual Quality Account		
The draft Quality Account was discussed at the April Quality & Safety Committee. The Quality Priorities have been shared with Stakeholders and still waiting for comments from the ICB and Healthwatch. The draft Quality Account will now be shared with Stakeholders for their comments to be incorporated before it is submitted to Trust Board on 1st June 2023 for approval before being published on 30th June 2023.	Full	
12. Clinical Effectiveness Report October 2022-March 20232		
CQUINS – the CQUIN targets have not met compliance. A delivery group to oversee the implementation of CQUINS has been established and meets on a weekly basis. Compliance with CQUIN targets will be regularly and closely monitored as will implementation of any actions identified to improve performance. This will then report into a monthly CQUIN Oversight meeting to provide assurance on progress and seek support through escalation. The Committee discussed the CQUIN Assessment, diagnosis and treatment of lower leg wounds and unable to record on RiO and are we assured that patients are receiving the additional screening. CHob commented that will be picked up by the District Nursing teams and patients are being assessed. The issue is how to capture the data in RiO and working with teams to roll out the training across the Community Nursing teams. **National Diabetes Foot Audit** – this is on the ICB Risk Register. A Business Case was submitted to the Finance Panel; however, funding was not secured as it	Full	

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

did not meet the criteria. The Trust is undertaking a piece of work to review the diabetes service and this needs to be a wider piece of work as a system approach is needed. JS noted there is a Diabetes ICB Board and foot care is top of the list as a risk across the system. A Clinical Group has been instigated to review the pathways across the group and review the pathways. The NHSE did provide transformation money for diabetes, however this has been stopped and no money in the system to support innovation and transformation services and reviewing what can be implemented with current funding.		
13. Quarterly Guardian for Junior Doctor Safe Working		
The report presents assurance to the Committee that trainee doctors at the Trust have safe working hours and conditions to maintain doctor and patient safety. The assurance is collated from Shrewsbury and Telford Hospital NHS Trust (SaTH) as the trainees are employed by SaTH. There are three trainees working in the community currently and there were no Exceptions reports received in this period.	Full	
14. BAF Update		
There are no changes to the BAF Risk register, the Covid Risk has been removed from the Risk Register	Full	
15. Chairs Reports		
Chairs Report from Health & Safety Committee – the meeting was quorate. The report offers the level of assurance, there is a risk with recruitment of a Manual Handling Officer and the post is being reviewed as unable to recruit to the role.	Full	
16. Any Other Business		
None raised		

3.4 Approvals

Approval Sought	Outcome
Quality Account	Approved for submission to Trust Board for final Approval

3.6 Risks to be Escalated.

In the course of its business the Committee identified the following risks to be escalated:

- Provision of the Mental Health Service at Stoke Heath Prison

Chair's Assurance Report

Quality & Safety Committee 18th May 2023

- Escalation of risk of lack of General Anaesthetic Provision for children and adults with complex needs at Shrewsbury & Telford Hospital NHS Trust (SaTH).

4. Conclusion

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

Quality and Safety Report – May 2023

0. Reference Information

Author:	Chris Panayi – Quality Facilitator Claire Horsfield, Deputy Director of Quality & Chief AHP	**Paper date:**	18th May 2023
Executive Sponsor:	Clair Hobbs, Director of Nursing and Workforce	**Paper written on:**	10th May 2023
Paper Reviewed by:	Clair Hobbs, Director of Nursing and Workforce	**Paper Category:**	Quality and Safety
Forum submitted to:	Quality and Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.
This paper aims to provide assurance to the Quality and Safety Committee members and 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 Committee and 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
- MRSA compliance fell below the 97% target for the first time in five months with 96.2% reported.
- 2 Serious Incidents (SI) were reported in April, compared to 1 reported in the previous month.
- The number of inpatient falls (11) in our care was the same in April as in the previous month and the rate of falls per 1000 occupied bed days (4.56) although slightly increased from M12 remains lower than the 21/22 and 22/23 average. 2 falls resulted in fractures both of which are being investigated as SI's
- The development of pressure ulcers in our care was reported as 50 in April, compared to 64 in March.
- VTE compliance was reported at 98.4% in April, achieving compliance for the 23rd consecutive month.

Caring

- New Birth Visits reported a decline for the latest month with 85.63% reported in March. There were no incidents of harm linked to late visits.

Responsive

- The 18-week RTT data improved slightly for the latest month with 88.2% reported in March. 316 harm proformas have been completed to date with 68% indicating no harm and 32% indicating low harm.

Well Led

- Mandatory Training overall target of 95% was not achieved in January with 93.61% reported.
- Appraisal position in April is reported as 80.55%, with a slight improvement from 79.64% reported in March. Robust monitoring meetings are in place to ensure recovery occurs along with plans to launch new appraisal paperwork.
- Sickness rates in April were 5.2% which is a slight increase from 5.1% reported in March.

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 is 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 is caused to the patient.

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

Total number of Falls in month 11 ↔

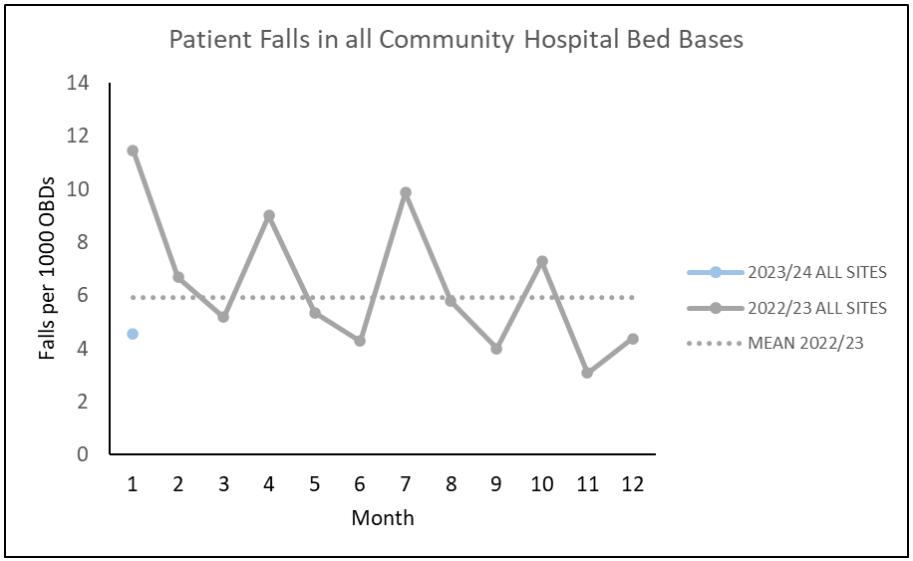
During April there were 11 inpatient falls reported which occurred in our care across the Community Hospital wards, involving 10 patients, which equates to a rate of 4.56 falls per 1000 Occupied Bed Days (OBDs). This is a small increase in rate since last month, however it is significantly less than both the average for 2021/22 (7.63) and 2022/23 (6.41). The regional average for M1 is not yet available but we will benchmark with this in M2.
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	11	21	12	10	24	14	10	18	7	11
	Falls per 1000 OBDs	11.46	6.69	5.18	9.01	5.35	4.29	9.87	5.79	4	7.29	3.08	4.38
2023/24 ALL SITES	Falls	11											
	Falls per 1000 OBDs	4.56											

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



Once we have more than a single data point for the year, we will also include a second graph showing the incidence of falls per inpatient bed base. This information is contained in the narrative below.

In total 10 individual patients fell in M1 with 1 patient falling twice (both with no harm) at Bridgnorth. This is the same number of repeated falls as in the previous two months.

In April, only 3 falls occurred between the hours of 22:00 and 07:00 which is a slight increase (3 vs 2) on the number of night hour falls compared to Q4. There is no clear reason for this. All of the patients were mobilising or transferring at the time of their fall, with only two of these falls being witnessed. These latter incidents involved the same patient and the inpatient team have reviewed their care plans for this individual to ensure they are being supported to rehabilitate whilst remaining safe.

This month there was a significant number of falls in patient toilets/bathrooms (5 falls). Of these 5 patients, 2 had been identified as being confused and requiring supervision, however at the patient's request they were left unattended in the toilet. We have already been able to hold discussions at safety huddles regarding how to balance the need to protect a patient's dignity whilst maintaining their safety. The remaining 6 falls occurred in patient bays. This narrative will also be added to the ongoing work to review the Enhanced Supervision Policy. Confusion was identified as a contributory factor in 6 of the patient falls and supervision and bed location was considered following all of these. Again, this will be included in discussions regarding how we use the same policy. For the second month in a row, one individual was identified as having a behavioural contribution to their fall, has been reviewed by one of our Mental Health Nurses and has had their care plan reviewed to ensure it meets their specific needs.

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

- Whitchurch = 3 (2 no harm, 1 severe harm) = 3.07 Falls per 1000 OBD's
- Bridgnorth = 7(4 no harm, 2 low harm, 1 severe harm) = 9.66 Falls per 1000 OBD's
- Ludlow = 1 (1 low harm) = 1.42 Falls per 1000 OBD's

This month Bridgnorth has a significantly higher incidence compared with other sites, and on further investigation these falls were split between 2 separate 24 hour periods. This is being further investigated by the Ward Manager, Locality Manager and Quality leads to identify any contributory factors and any themes will be reported in M2. Although Whitchurch has a reduced falls incidence compared to previous months, there were in addition 2 near miss incidents where patients were lowered to the ground during transfers. Learning that has been identified and cascaded is to ensure that members of staff that are new to the Trust are sighted on the mobility status signs used above patient beds.

Unfortunately in M1 there was an increase in harm. There were 3 low harm incidents and two patients experiencing severe harm as a result of their fall – one suffered a fractured neck of femur and one suffered two upper limb fractures. Both fracture falls are being investigated as SI's. Ongoing bed occupancy data does not demonstrate a correlation between bed fill rate and incidence, and staffing was not cited as a contributory factor this month (and review of fill rate does not seem to indicate a correlation with falls incidence).

In month Quality Improvement activities included:

- Further enrolment of staff across all inpatient areas for Falls prevention training
- Continuation of review of SCHT Falls Policy for completion in Q1 23/24 with a focus on relating this to PSIRF
- Continuation of falls engagement events at the Community Hospitals and increased presence of Falls team practitioners on the wards.
- Commencement of Quality Improvement initiative relating to lying and standing blood pressure

Safe - Serious Incidents

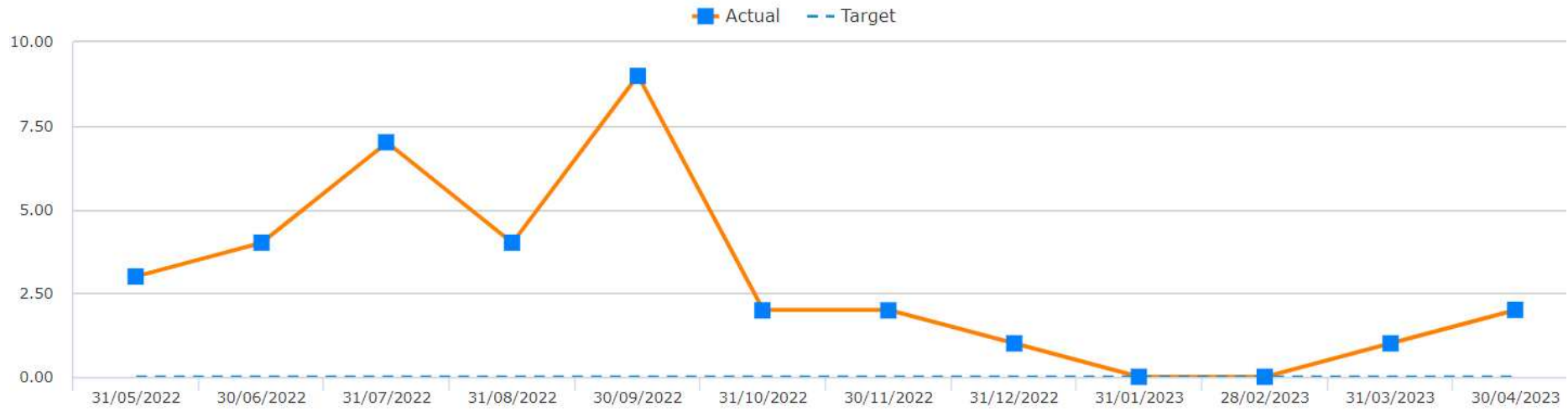
Serious Incidents (SI) are events in healthcare where the potential for learning is so great, or the consequences to patients, families or carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
All patients will receive safe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

Total reported = 2 ↑

There were 2 serious incidents reported in April, an increase on the previous month where 1 had been recorded. One incident was reported as a fall at Whitchurch Inpatient Ward, where the patient fell in a toilet area resulting in a fractured arm.
The second was a category three pressure ulcer reported by the Telford North Community Team.

Ongoing monitoring is in place to ensure oversight of all potential Serious Incidents through Panel meetings chaired by the Director of Governance, Director of Nursing & Workforce and Deputy Director of Quality and Chief AHP

Serious Incidents reported



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 = 50 developed in service ↓

50 pressure ulcers were reported as developing in the care of the Trust in March. This is a decrease of 14 from 64 reported in March.

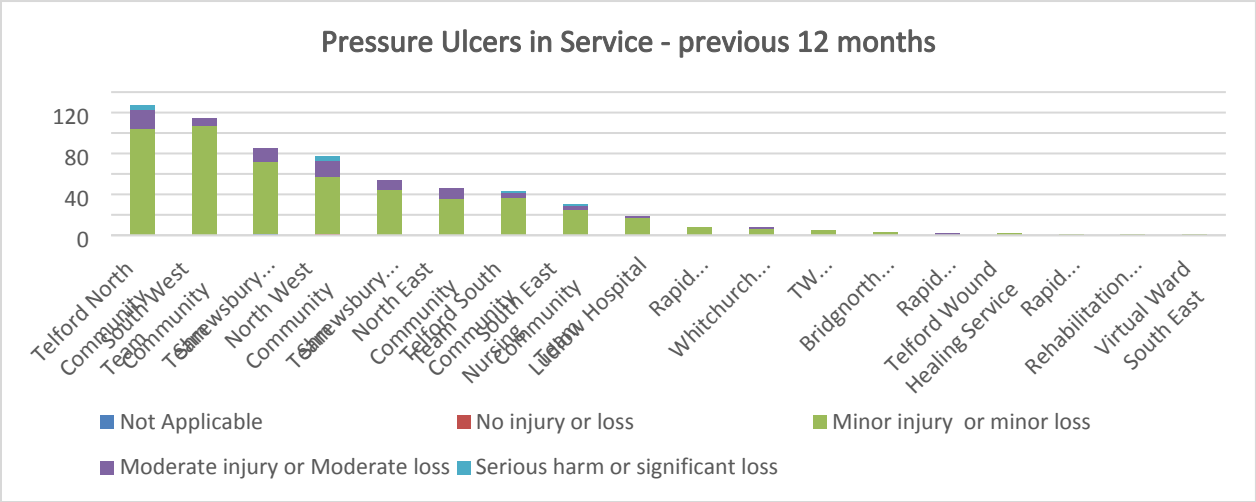
One was reported as a Serious Incident. This was a category 3 pressure ulcer reported by the Telford North Community Team.

There was 1 category three pressure ulcer reported, 11 unstageable pressure ulcers, 28 category two, 7 suspected deep tissue injuries, and 3 category one.

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

Service/Team	1	2	3	Unstageable	Suspected Deep Tissue Injury	Total	Low Harm	Moderate Harm
Telford North Community Team	2	16	0	1	1	20	20	0
Shrewsbury South Community Team	0	5	0	2	0	7	7	0
South West Community Team	0	3	1	1	2	7	6	1
North West Community Team	0	1	0	1	2	4	4	0
Telford South Community Nursing	0	1	0	3	0	4	3	1
Shrewsbury North Community Team	0	1	0	1	0	2	2	0
South East Community Team	0	0	0	1	1	2	2	0
Ludlow Hospital	0	0	0	1	0	1	0	1
North East Community Team	0	0	0	0	1	1	1	0
Rapid Response Telford	0	1	0	0	0	1	1	0
TW Respiratory Service	1	0	0	0	0	1	1	0
Total	3	28	1	11	7	50	47	3

The graph below shows the distribution of pressure ulcers across the Teams and associated levels of harm.



Telford North Community Team account for the majority of pressure ulcers reported in April (20), and for the majority over the previous 12 months. Reasons for higher pressure ulcer reporting for Telford North could be attributed as follows:

- Telford North experience a higher than average income deprivation affecting older people and have an older age profile in line with the rest of Shropshire particularly within the age band of 75-90+.

Actions in place to improve:

- Educational plans for 2023 to focus on pressure ulcer prevention and management – bi-monthly virtual sessions for all Community Teams which commenced in April
- Supporting Community Hospitals with the current pressure ulcer CQUIN
- PURPOSE-T workstream in process – with the current progress to date;
    - Stakeholders impacted by PURPOSE-T have been identified and initial contact made.
    - Actions from National and Regional group meetings have been prioritised, owners identifed and scheduled
    - Oversight takes place via Patient Safety Committee and Quality & Safety Committee
    - Initial meeting with RiO Team to implement on EPR (Electronic Patient Record) system has occurred. Through this issues with RiO not being able to produce the risk assessment in colour were identified. This has been escalated to NHSE and a meeting is awaited to discuss issues and how they can be resolved
    - Education is scheduled to take place from July through to October
- From April the Tissue Viability Team have commenced monthly caseload reviews 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
- Benchmarking of District Nursing caseloads against population health data is underway with an estimated completion date of Q3
- Implementation of the Community Nursing Safer Staffing Tool will provide a workforce model to map demand against.

Safe – Proportion of admissions screened for MRSA

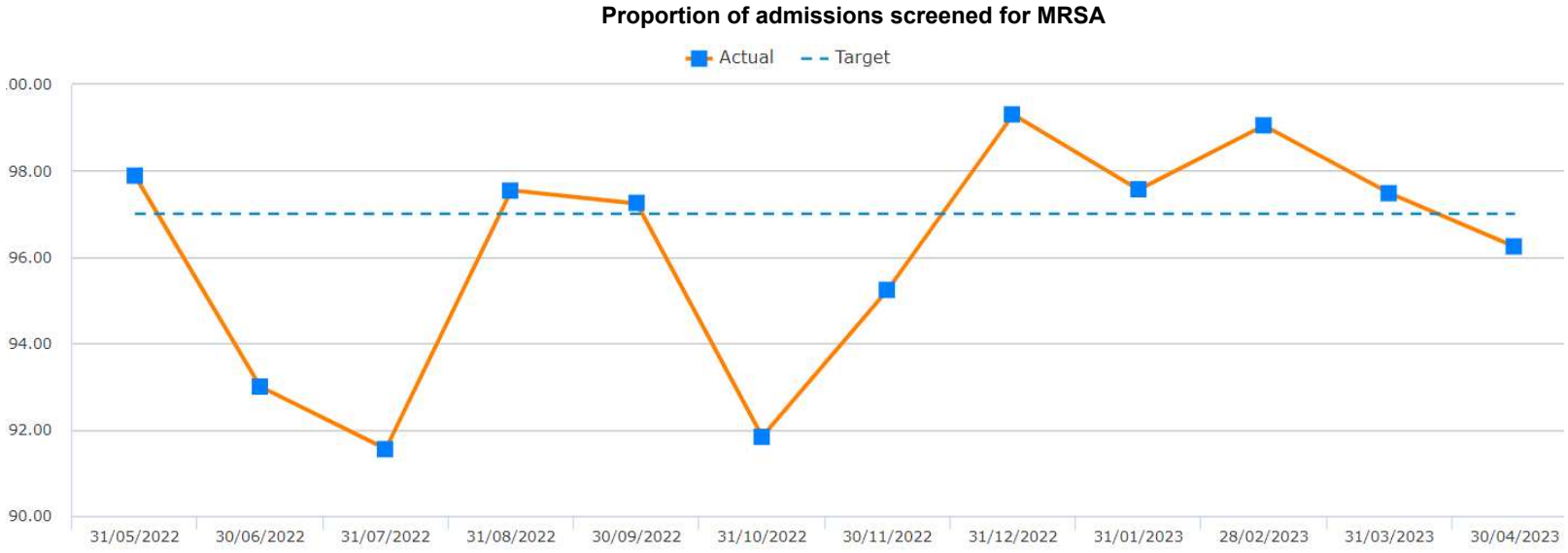
Achievement of this target demonstrates our standard of practice in relation to control of infection, links to quality of patient care and to managing our reputation as a healthcare provider, plus our registration with the Care Quality Commission (CQC).

Performance = 96.2% ↓ (target 97%)

There has been a decline in MRSA screening compliance reported in April for the first time in five months with 96.2% being achieved overall compared to 97.5% reported in March. Overall there were 5 missed MRSA screenings for the Trust.

- Bridgnorth missed 2 screenings in total, both of those were nose swabs. Although these were taken, they were missed in the transport due to them not being in a central point.
- Ludlow missed 1 screening, which was a nose swab. The patient was discharged to the acute and then readmitted but no re-swab was completed.
- Whitchurch missed 2 screenings, both were nose swabs, which were taken out of the 48 hour period from admission.

Due to the increase in missed screenings, the Locality Managers will be ensuring that the RN's on duty have more oversight on the admissions. Other mitigations in train are the provision of a red box in a central location on the wards for all swabs, and to arrange for the porters to collect out of the box when they collect the post. Missed screenings will also be discussed with staff, and continue to be raised at Safety Huddles, as a double check process in order to maintain compliance.



Safe – Safer Staffing

The National Quality Board (NQB, 2016) recommend a 'triangulated' approach to staffing decisions. The Trust now has a validated tool for acuity and dependency for the Community CNSST (Community Nursing Safer Staffing Tool) this will enable a robust triangulated approach. The first acuity data collection has been undertaken for January 2023. We received the licence for the Safer Nursing Care Tool (SNCT) for the inpatient areas in May 2023 and training will commence and data will be collected in June 2023. These tools will form part of planned biannual staffing reviews to allow SCHT to comply with National safer staffing guidelines.

Whilst these tools are being implemented, 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.

Community Hospital Inpatient ward fill rates

April 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	97.1%	102.1%	100%	115.8%
Ludlow	83.3%	137.8%	98.3%	171.3%
Whitchurch	93.2%	153.6%	131%	166%

March 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	94%	112.2%	99.2%	125.2%
Ludlow	89%	129.5%	100.2%	176.4%
Whitchurch	91.8%	150.1%	131.2%	166.8%

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day shifts during April at Bridgnorth and Whitchurch, however at Ludlow Hospital they were below, with the lowest average RN fill rate for the month reported as 83.35%. This was mainly due to sickness and vacancy. It is to be noted that the International Nurses that have joined our Trust will fill the vacancy gap at Ludlow during April and so the fill rate is predicted to improve.

The overall trend shows staffing levels on night shifts for both RN and HCAs were just on or above 100% to meet increased patient care needs. The increase in HCAs on day and night shifts was to maintain ongoing management and safety for patients requiring enhanced supervision. This is particularly noticeable at Ludlow for nights shifts where the fill rate is 171.3%, however this is a slight reduction of 5% from last month. The high percentage was due to the ongoing additional staff working to meet the needs of 3 one to one patients on all shifts. It should be noted that the fill rate data does not give insight into the skill mix and experience of the staff on duty, including how many of the fill is temporary staff.

Bed occupancy rates reported for the month of April were 94.4% overall which is slightly below March's position (95.2%). The breakdown for bed occupancy at each site was 96.7% Bridgnorth, 98.1% Ludlow, and 90.4% at Whitchurch. The overall target is 91%.

Overall, for all inpatient wards there were 853 RN shifts requiring cover with 518 being covered by substantive staff (60.7%), a 7% increase from 53.5% last month. 269 were filled by agency RN staff (31.5%), a 7.5% drop from last month. 55 with bank staff (6.4%), a 0.3% decrease from last month (6.7%). There were 11 shifts that were not filled at all, (1.3%). compared to 6 last month.

No serious incidents or incidents with harm were reported due to agency use.

For all inpatient wards, there were three reported throughout April where 100% RN agency staff were used, with all reported at Whitchurch for night shifts, compared to fourteen in March. This was due to a combination of increased RN vacancies, sickness and unavailability of regular agency and bank staff due to holiday. However, for all shifts patient safety was maintained and mitigations were in place to maintain assurance. All agency staff on these shifts work regularly on the ward and were supported by substantive bank staff and HCA's. All staff were up to date with their high-risk fire training.

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. Currently the CHPPD data for SCHT is not on Model Hospital and so benchmarking is not possible. This will be addressed going forwards.

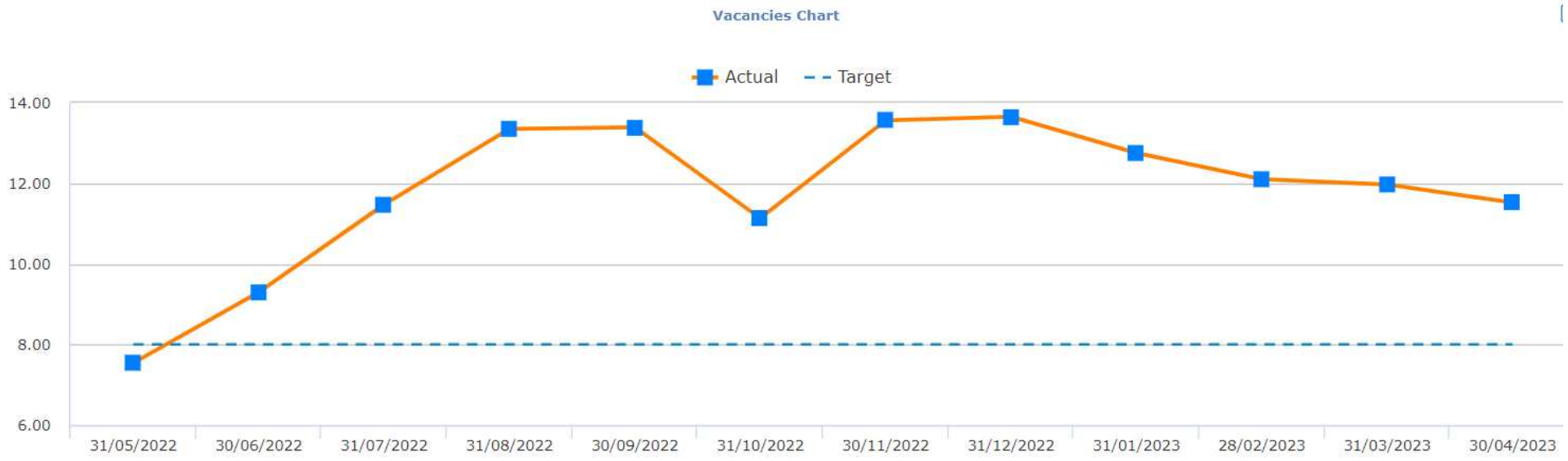
	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Bridgnorth	8	7.7	7.9	8.4	8.1	8.1	7.8	7.8	7.9	8.2	8.1	7.9
Ludlow	7.6	7.8	7.8	8.1	7.7	7.2	7.3	6.7	8.1	7.8	7.6	7.9
Whitchurch	6.8	7.2	6.9	7.4	6.9	6.6	6.9	6.7	7.2	8.4	8.4	8.7

Safe – Staff Vacancy Rates

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

Performance = 11.52%↓ (overall - all substantive staff), YTD target 8%)

For March there were 11.52% vacancies overall reported which is a 0.4% improvement from March (11.97%). The People Team are developing recruitment and retention initiatives including work at ICS level, this includes the system Health Care Suport Worker (HCSW) Academy.



There are 13 International Nurses within the Community Hospitals with 6 having passed their Objective Structured Clinical Examination (OSCE) exam and now able to practice as Registered Nurses. There are a further 2 International Nurses joining the Trust in May. Unfortunately 1 International Nurse has had to return home due to ill health.

Further international recruitment continues working towards the target of 30 by October 2023. This is providing some challenges due to a cap of 3 recruits per month due to the large cohorts SaTH are currently recruiting.

The Resourcing Team continue to look at other ways of recruiting hard to fill posts, scoping other efficiencies in recruitment systems, using a digital advertising platform and exploring branding with the Communications Team for use across social media. TRAC, a recruiting system as a replacement of NHS Jobs will be implemented during June. Weekly Vacancy Requisition (VRF) Panels have been introduced in April with the Associate Director of Workforce, Clinical Education & Professional Standards as the Chair to ensure appropriate scrutiny is place on all vacancies and to expedite the recruitment process.

The tables below illustrate the April 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	6.17	60.3% →	8.29	76.1% ↑
Ludlow	1.95	14.8% ↓	4.15	22.1% ↓
Bridgnorth	0.85	6.6% ↑	4.00	16.6% ↓
Whitchurch	4.58	27.5%↑	2.09	8.9% ↓

District Nursing Vacancies – Table 2

District Nurse Team	November 2022	December 2022	January 2023	February 2023	March 2023	April 2023
North Telford	17.7%	22.1%	22.1%	22.1%	13.3%	18.2%
South Telford	(5.5)%	0.6%	(5.8)%	(0.37)%	(4.4)%	(3.5)%
Central	8.5%	8.5%	8.5%	8.5%	13.4%	16.1%
North East	18.6%	23.7%	25.8%	25.8%	27.8%	24.7%
North West	15.7%	6.8%	4.1%	4.2%	4.2%	3%
South East	0	(2.9)%	1.9%	(2.9)%	(2.9)%	(2.9)%
South West	(3.2)%	1.5%	(0.9)%	(6.7)%	(6.7)%	(6.7)%

Responsive – New Birth Visits (NBV) % within 14 days

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

Performance = 85.63% March ↓

The overall percentage of New Birth Visits (NBVs) completed within targeted timescales declined during March to 85.63% from 90.63% in February.

The Telford Team achieved 92.75% target during March which is lower than the normal 95% that this team consistently achieves.

Of the 11 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 NNU
- 1 baby admitted to hospital on the day of the NBV
- 6 visits delayed due to parental choice
- 1 visit was late due to lack of birth notification

Shropshire Teams continue to work towards recovery of the NBV target but faced challenges during March and their achievement dropped to 80.42% compared to February's result of 90%.

37 visits were delivered out of timescales within Shropshire during March.

- 13 were due to parental choice of appointment date
- 6 due to babies being in neonatal unit (NNU)
- 17 NBV were late, because of workforce capacity
- 1 NBV attempted as planned, however no reply/no access, therefore HV calling card left requesting contact
- Staffing capacity during March was challenging due to increased sickness, both short and long term, commencement of two maternity leaves and awaiting the start of new staff following successful recruitment. To try to address this, extra clinics and visits were facilitated at weekends to meet need. As a result of the 37 NBV out of timeframe, 11 of these were completed on day 15.

Visits that were delayed due to parental choice were sometimes later than expected during March due to the HV workforce being available when parents wanted rescheduled visits. Any visits undertaken after these time periods were babies in hospital/NNU who were still under the care of the Acute Trust. As soon as they are discharged the Health Visitor booked and carried out a home visit.

Critical to the ongoing recovery of this workforce is the securing of Health Education England funding to continue to train our workforce for the future to continue to build and strengthen our teams to deliver the entire Healthy Child Programme. Working closely with the Associate Director of Workforce, Clinical Education & Professional Standards and Recruitment Team there is a plan to recruit 5 new HV Students to commence in September 2023.

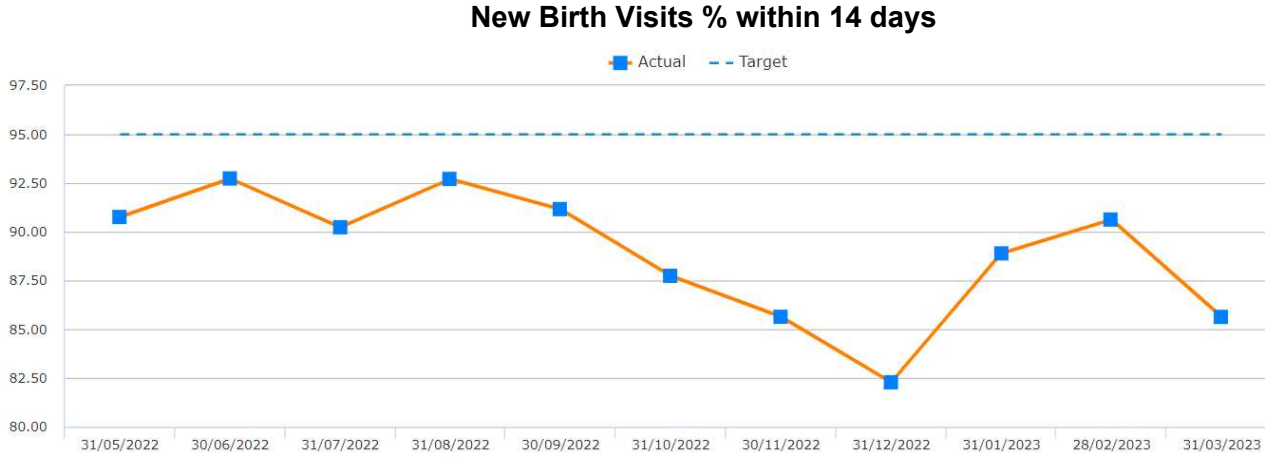
100% of all birth visits were undertaken and no harm detected due to any delays in visit. No complaints (formal or informal) were reported when a visit was completed out of timescales.

Actions being undertaken.

- 0-19 service recovery plan continues.
- Workforce plan is in place and running to schedule.
- Support to be accessed from other HV Teams and Bank workforce including the offer of extra hours.
- Human Resources support to manage long term sickness is in place.
- Lessons learnt following successful weekend working over Easter will inform working plans for the next three bank holidays during May.

The table below illustrates that families are now seen within 21 days with the overall seen within 21 days as 97.6%.

6 Month Summary					
Locality	**Within 14 Days**	**15-21 Days**	**22-28 Days**	**Above 28 Days**	**Grand Total**
Shropshire	883	175	17	9	1084
Telford	789	42	11	1	843
Grand Total	**1672**	**217**	**28**	**10**	**1927**
Shropshire Locality - Summary by Month					
Shropshire	**Within 14 Days**	**15-21 Days**	**22-28 Days**	**Above 28 Days**	**Grand Total**
Oct-22	82.22%	16.67%	1.11%	0.00%	100.00%
Nov-22	80.77%	15.87%	2.40%	0.96%	100.00%
Dec-22	75.29%	21.84%	1.72%	1.15%	100.00%
Jan-23	84.41%	11.83%	1.08%	2.69%	100.00%
Feb-23	86.39%	12.93%	0.68%	0.00%	100.00%
Mar-23	80.42%	17.46%	2.12%	0.00%	100.00%
Grand Total	**81.46%**	**16.14%**	**1.57%**	**0.83%**	**100.00%**



A change to the reporting of NBV will occur from April's data due to different targets set for Shropshire and Telford. Going forwards data will be split to show performace against the following; Shropshire NBV 90% and Telford & Wrekin NBV 95%

Responsive – Complaints

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

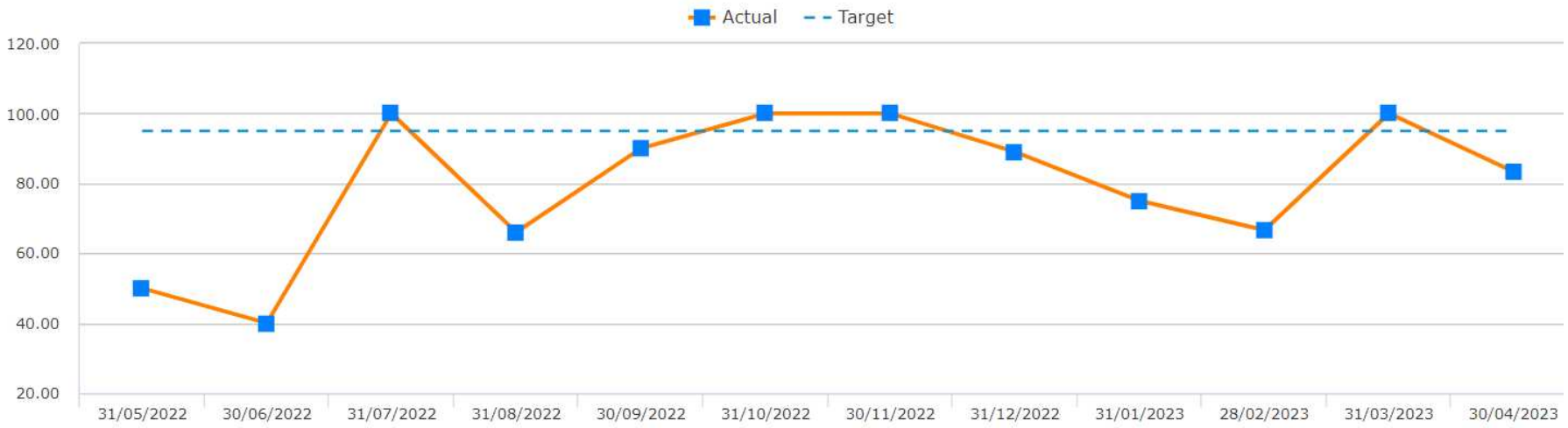
Performance = 83.3% ↓

6 Complaints were closed during April 2023 relating to the following services.

- Ludlow Hospital (1)
- Oswestry MIU (1)
- Whitchurch Hospital (1)
- Dental (1)
- Shropshire School Nursing (1)
- Vaccination Service (1)

5 (83%) out of the 6 complaints closed in April 2023 were completed within the response deadlines. Of the 6 complaints closed in April 2023, 1 was partly upheld.

Complaints responded to within time frame

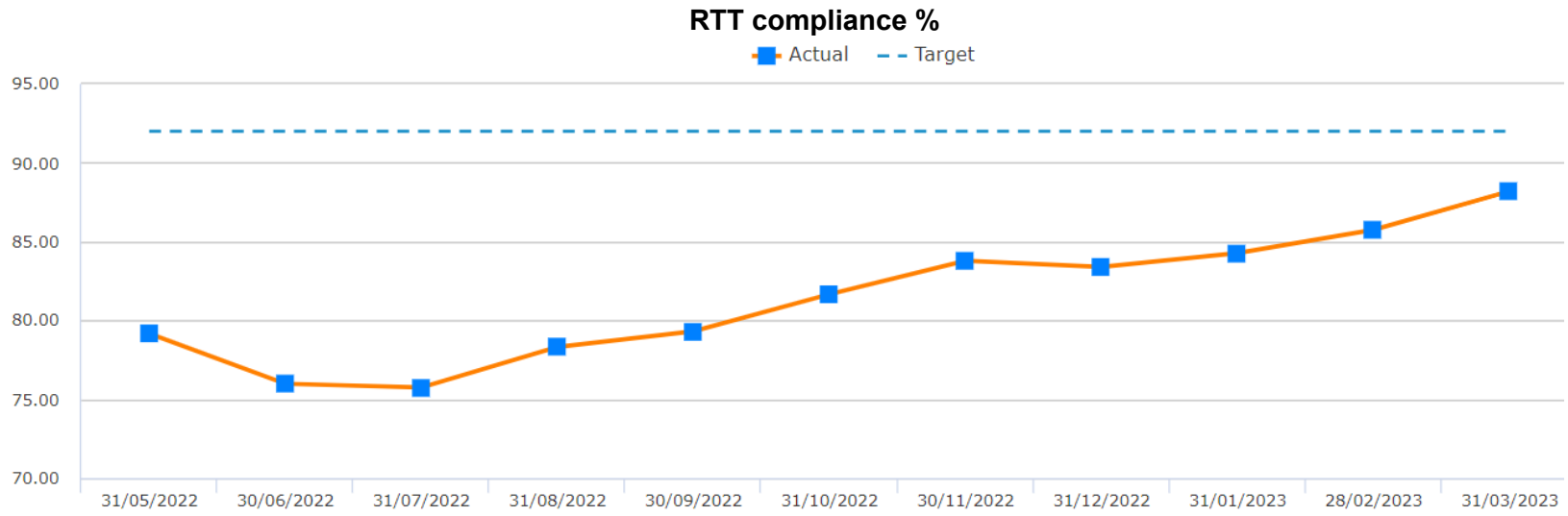


Responsive – Referral to Treatment (RTT) Pathways

The National standard is that over 92% of patients on RTT Pathways should be waiting under 18 weeks for start of definitive treatment.

Performance = 88.2% (March data) ↑

Continuous improvement has been made since January 2022 with the latest position in March 2023 of 88.2% reported against the 92% open clocks target. There has been a slight improvement in performance of 2.4% from February. The main challenges continue to be centred around Rheumatology, Diagnostics and Orthopaedic Consultant capacity in the Telford Musculoskeletal Service (TeMS), in particular lower limb orthopaedic capacity.

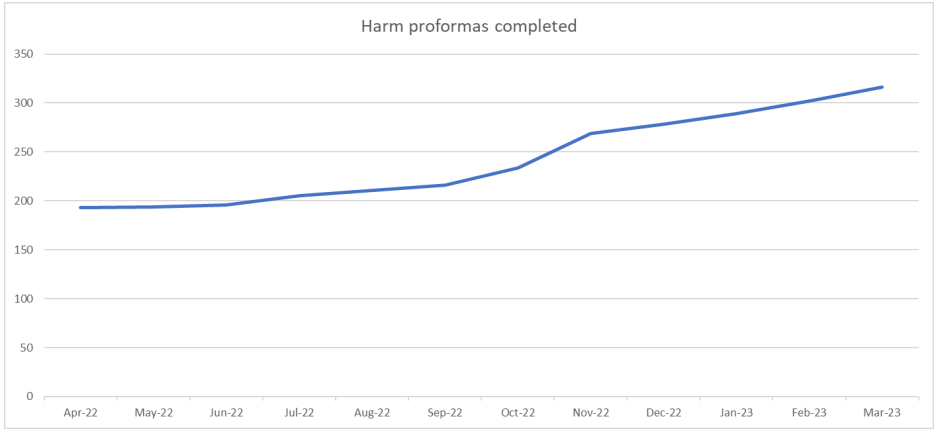


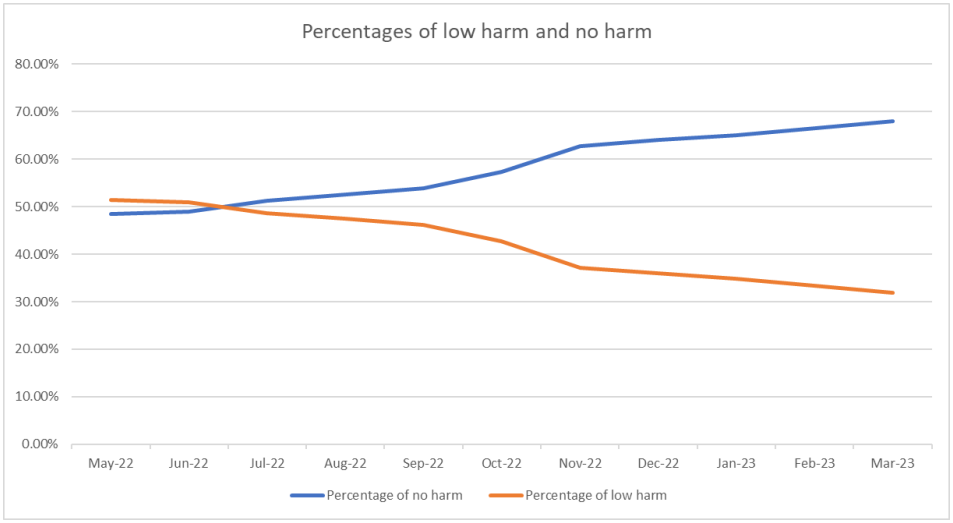
Harm Proformas have been completed for all new patients seen over 52 weeks as an essential, but also for follow up patients if the clinician deems necessary. 316 harm proformas have been completed to date; with 68% indicating no harm and 32% indicating low harm and can be treated and resolved. Looking into the cases where harm was identified the vast majority were rheumatology patients. By March 2022, all 52-week 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 30. Of these, 29 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 and was reviewed at the end of March. A further update and assessment are being made to establish any further harm.

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	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Harm proformas completed	194	196	205	211	216	234	269	278	289	302	316
Number of low harm	100	100	100	100	100	100	100	100	101	101	101
Percentage of no harm	48.50%	49.00%	51.30%	52.60%	53.80%	57.30%	62.80%	64.00%	65.10%	66.60%	68.04%
Percentage of low harm	51.50%	51.00%	48.70%	47.40%	46.20%	42.70%	37.20%	36.00%	34.90%	33.40%	31.96%



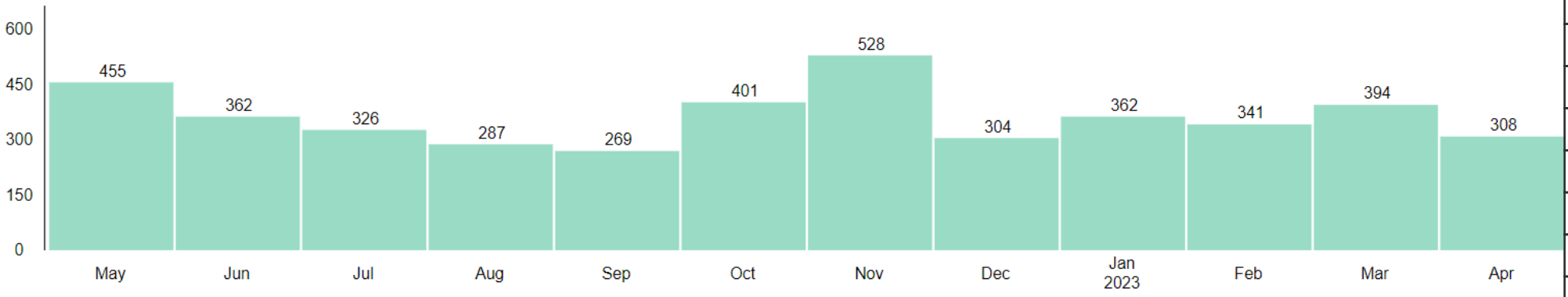


Caring - Friends & Family Test

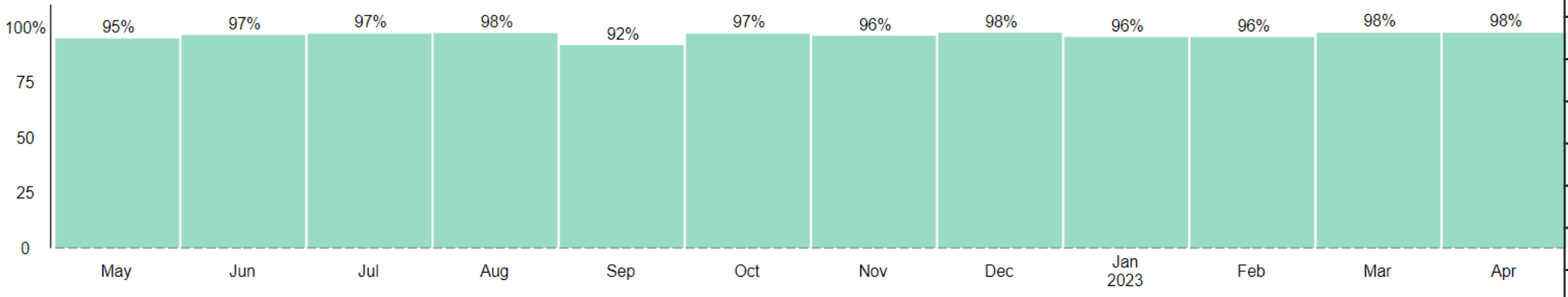
The table below is an extract taken from the patient experience web system (IQVIA) which indicates responses across all Friends and Family Test (FFT) responses for the previous 12 months. For the latest position in April, 97.86% positive feedback was reported, a 0.1% improvement from 97.78% reported for March.

In April, there was a decrease in responses received (308), compared to 394 in March. However, the Easter holiday period may have been a contributory factor, and responses received for April are comparable to the same period last year (301). 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.

FFT – Number of surveys completed over the previous 12 months



FFT Results – Very Good and Good over the previous 12 months



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 = 93.61% ↓

Overall performance against the target declined slightly this month by 0.3%

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 94.67%. As of the end of April 76.85% compliance with the new training had been achieved, showing continuing increase over quarter 4.

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

- High Risk Fire Training - compliance declined in April by 2% to 75.16% compared with 77.26% in March. Teams have many relevant staff booked onto sessions in March and April which will improve the compliance position from May.
  More classes are being provided than previously, with sessions being held at each site every two or three months and each session being three sets of classes. Ward Managers have communicated that they are ensuring staff are booked on for future dates, however staffing pressures continue to cause issues with releasing staff to attend. Further mitigation for low compliance for high risk training is that regular agency staff have been trained on the local high risk fire training, so whilst they don't show on the compliance figures through ESR, there is an additional level of compliant staff on the inpatient wards.
- Basic Life Support (BLS) Training has declined slightly at 89.66% for Adults, from last month (92.56%) and 89.37% for Paediatric BLS, a slight decline from last month (91.59%).
- Information Governance overall performance has improved in April, however, is below the target at 90.51% this month, a slight improvement compared to 90.41% from 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 contributing to the current position.

Well Led - Sickness Rates – Trust

Supporting staff attendance at work - aiming for less than 4.5% of our staff to be absent from work at any one time

Performance = 5.29% ↑

Sickness levels during the month of April slightly increased by 1.2% with 5.29% reported, compared to 5.17% reported in March.

Managers continue to be supported by the People Team to help staff with long term absence return to work. If line managers have not made contact with the Human Resources team (HR), contact is made with the line manager to discuss support and a planned way forward. Health and Wellbeing strategies continue to try to prevent sickness absence. Monthly Managing Attendance and Professional Standards meetings have been implemented with Service Delivery Group Managers to discuss and review absences within their Directorate.

In addition monthly meetings with Operational Managers are in place. These monthly meetings provide assurance that the appropriate support is in place for both long and short term absence. Further scrutiny and analysis of absences is monitored through the People Committee.

Monthly meetings between HR and Occupational Health are in place to discuss absence management and appropriate support and to monitor the time from referral to triage to appointment. Short term absence reports are discussed with Line Managers on a monthly basis to provide them with an overview of absence and individuals requiring support. The Occupational Health Team are launching a monthly newsletter which will highlight areas of support along with wellbeing tips. The Occupational Health team are also undertaking clinics at each Community Hospital on a monthly basis.

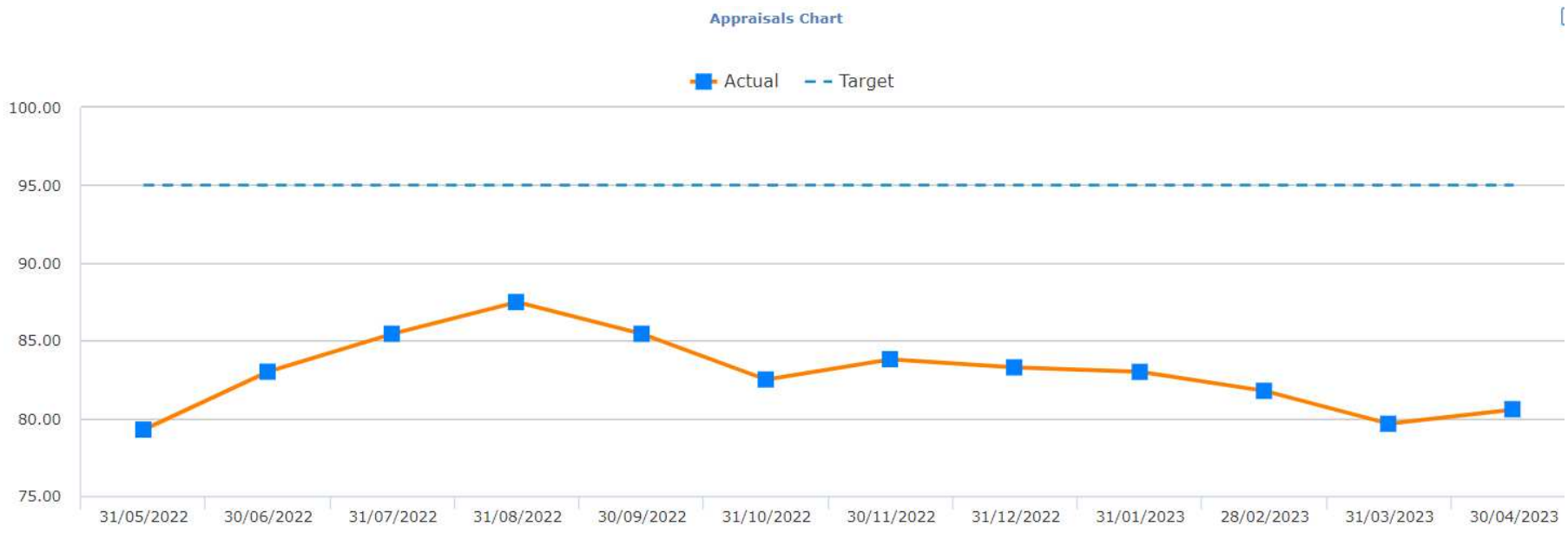
Well Led – Appraisal Rates

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

Performance = 80.55% ↑

Appraisal rates overall for the Trust improved by 1% in April with 80.55% reported, compared to 79.64% in March.

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.



Shropshire Community Health
NHS Trust

QUALITY ACCOUNT 2022-2023

Contents

The Trust Boar (Quality
Accounts) Reg per the
Regulation sch 7. These
Regulations ca ovement
fulfils the Shro

Copies of this c n writing
from: Chief Ex ropshire.
SY2 6LG

If you would lik n Service
who can arran

Foreword & Welcome from Clair Hobbs - Director of Nursing and Workforce

Welcome to the Quality Account for Shropshire Community Health Trust (SCHT) which relates to the year of 2022/23. Once again, the Trust has had an exceptionally busy and challenging year as we have started to return to a sense of normal following the Covid-19 pandemic. We have started to adjust to further guidance for controlling the effects of Covid whilst trying to maintain existing services and reduce backlogs that have developed as a result of the pandemic.

I remain exceptionally proud of our staff and the care that we have continued to provide to our patients and service users. Alongside continuing to provide a good level of care in existing services, we have this year grown our partnership working with system colleagues to benefit our patients and staff. We are working hard to deliver on national initiatives such as Virtual Wards which provides care closer to, and indeed in patient's homes to avoid a hospital admission or allow an earlier discharge out of the main hospital environment. Our work in delivering Virtual Wards has received regional recognition with many other provider organisations nationally making contact with us to learn from our successes.

This report will highlight some of the wonderful work our teams have achieved over the last year demonstrating our ongoing commitment to patient safety and quality of care. In particular we have seen excellent quality improvement work with inpatient falls and their reduction and a greater system of governance internally to monitor and support important functions such as Infection Prevention and Control.

This year has also seen great strides made to support our staff and ongoing workforce challenges and we have welcomed our first set of International Nurses into the organisation who are already having a positive impact on our reduction in vacancies. This is helping to improve our safe staffing numbers so that we can ensure we are providing the right levels of staff and skills to our patients at the right time.

This account also narrates our priorities for the coming year which once again includes our need to look after our staff if we are to provide the levels of care we would want to see to our patients, patient experience and feedback also features alongside becoming more digitally enabled.

I remain delighted by our staff and humbled by their achievements this year and look forward to supporting and guiding over the next 12 months as we aim to move to a more partnered approach to care both with our provider colleagues and our staff and patients.

Part One

Introducing Shropshire Community Health NHS Trust (SCHT)

Our aim is to be a provider of high quality, innovative health services near people's homes, working closely with health and social care partners so people receive well-coordinated, effective care. We provide community-based health services for adults, children and young people in Shropshire, Telford and Wrekin.

Our focus is on enabling people to receive the care and support they need at clinics, community hospitals, at home or their place of residence to enable people to return to as independent life as possible. We are committed to helping people of all ages; supporting parents with new-born babies to achieve the best start in life, throughout our patients' life journey, and supporting our patients, families and loved ones, in end of life.

Our vision

We will work closely with our health and social care partners to give patients more control over their own care and find necessary treatments more readily available. We will support people with multiple health conditions, not just single diseases, and deliver care as locally and conveniently as possible for our patients. We will develop our current and future workforce and introduce innovative ways to use technology

Our Values

Improving Lives
We make things happen to improve people's lives in our communities.

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

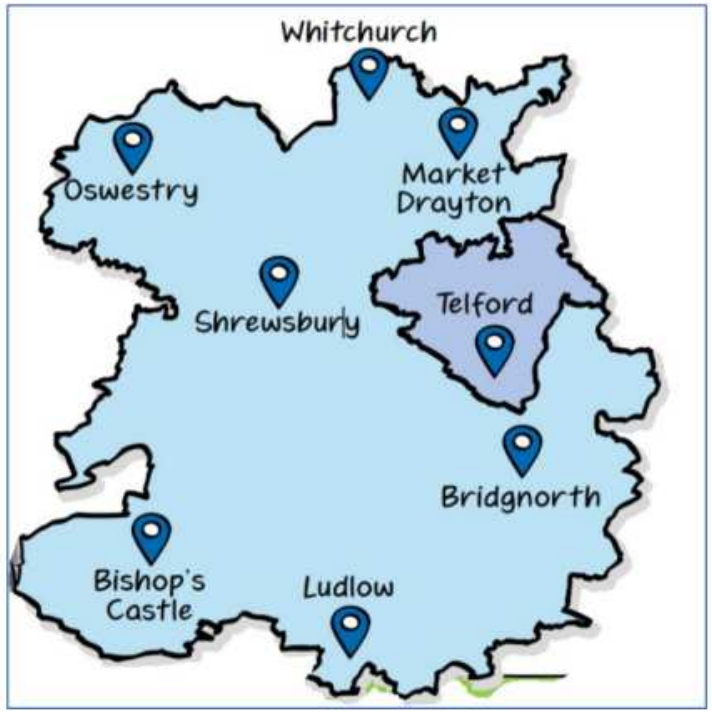
Commitment to Quality
We all strive for excellence and getting it right for patients, carers and staff every time.

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

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

Our 3 Strategic Objectives

Shropshire Community Health NHS Trust provides a range of community and community hospital services for the people of Shropshire, Telford and Wrekin, serving a population of around 506,000 people.



Shropshire is a mostly rural, diverse county with over a third of the population living in villages, hamlets and dispersed dwellings, a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation.

By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England. As over a third of our population live rurally, our services are on the main organised geographically to enable us to be as responsive as possible to meet the needs of our service users, their carers and families.

The Community Trust serves it population throughout life, with a wide range of services including but not limited to; 0-19's Services, Community Therapy and Nursing, Urgent Care such as Minor Injury Units and Virtual Ward, Outpatients and Community Inpatient Wards.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to transform the provision of our services by working in partnership with others to meet the needs of those serve.

We have continued to be innovative and improve in 2022/23 while we re-model services following lessons learnt during the Covid-19 Pandemic.

This year:

- Community contacts reduced by 39,260 although remain 52,916 contacts higher than 2020/21, an 8% increase.
- Prison Healthcare contacts have increased by 23%, Radiology contacts by 13%, Minor Injury Unit contacts by 9%, Outpatients activity by 5%
- Inpatient rehabilitation episodes have marginally overtaken last year's figures, indicating improved performance

Patient activity information

Patient Activity Figures 2022/23	
Community contacts	710,982
Outpatient attendances	38,235
Inpatient and day cases	563
Inpatient Rehabilitation Episodes	1,729
Radiology examinations	12,690
Minor injuries attendances	34,887
Equipment and products supplied	285,197
Prison Healthcare contacts	28,986
Total	**1,113,269**

Our Services

Community Services and Urgent Care		Childrens & Families
Community Hospital Inpatients at Bridgnorth, Ludlow and Whitchurch Minor Injuries Units (MIU) Adult Community Therapy District Nursing Virtual Ward & Rapid Response Day Surgery Single Point of Referral (SPR) Diagnostic, Assessment & Access to Rehabilitation and Treatment (DAART) Admiral Nursing Advance Care Planning in Care Homes Team Integrated Discharge Team	   	Community Children's Nurses Special School Nurses Paediatric Diabetes Team Paediatric Asthma Service Paediatric Psychology Service Child Development Centres Community Paediatrics School Age Immunisation & Vaccination Service Community Dental Services 0-19 Public Health Nursing Service – Telford & Wrekin 0-19 Public Health Nursing Service - Shropshire Looked After Children Team Wheelchair & Postural Services Community Childrens Occupational Therapy Community Childrens Physiotherapy Community Childrens Speech & Language Therapy Family Nurse Partnership (FNP) Telford & Wrekin Family Nurse Partnership (FNP) Shropshire Targeted Admin Paediatric Audiology Community Equipment Service

Planned Care		Corporate and Support Services
Diabetes Service – Adults Tissue Viability Service Wound Healing Service Rheumatology Outpatients Physiotherapy Outpatients Podiatry Services Advanced Primary Care Services (APCS) Falls Prevention Long Covid Clinic Radiography Community Neuro Rehabilitation Team (CNRT) Consultant Outpatient Clinics Telford Musculoskeletal Service (TeMS) Prison Healthcare Respiratory Nursing Pulmonary Rehabilitation Vaccination Service	   	Bank and Temporary Staffing Clinical Education Team Safeguarding Team Infection Prevention and Control (IPC) Team Medicines Management Patient Experience and Involvement Complaints & PALS Human Resources & Workforce Organisational Development Occupational Health Finance & Contracting Governance & Risk Quality Hotel Services Digital Services Business Development, Transformation and Strategy Communications Estates Emergency Planning

Integrated Care System (ICS)

Shropshire Community Health NHS Trust is part of the Shropshire, Telford and Wrekin ICS.

ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in their area. 'NHS Shropshire, Telford and Wrekin' is the statutory commissioning body within our ICS

ICSs exist to achieve 4 aims

- ✓ Improve outcomes in population health and healthcare
- ✓ Tackle inequalities in outcomes, experience and access
- ✓ Enhance productivity and value for money
- ✓ Help the NHS support broader social and economic development

Our fellow Health & Care providers are:

- The Shrewsbury and Telford Hospital NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership University NHS Foundation Trust
- West Midlands Ambulance Service Foundation Trust
- 51 GP practices across eight Primary Care Networks
- Shropshire Council
- Telford & Wrekin Council
- Community & voluntary Sector organisations

Our relationships with our partners are essential to help us provide the best care possible for our local population.

Part Two: Reviewing the Quality of our Care looking back at 2022 - 2023

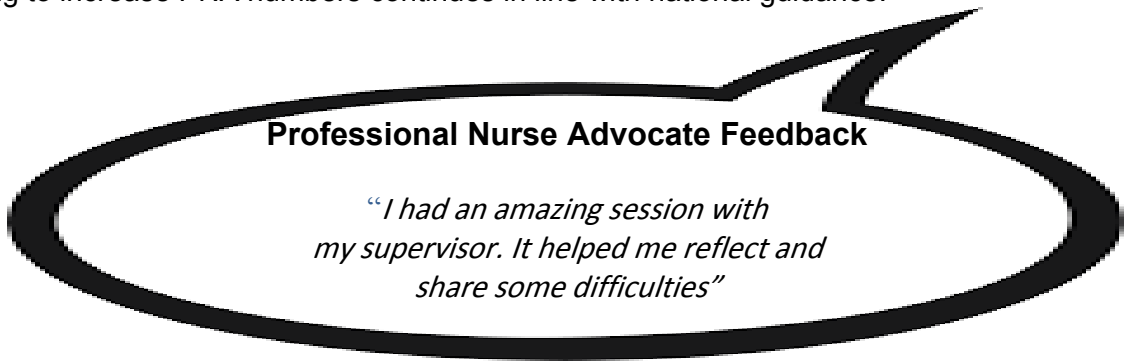
Priority One – Looking After Our Staff

Over the last year our focus has been on supporting our workforce to attend to and move forward from their covid experiences and building on our existing Health & Wellbeing offer by implementing the national Health & Wellbeing Framework. We aimed to see a reduction in sickness absence and an increase in workforce availability

Measure of success

Focus on retention and employment experience, supporting line managers to manage people compassionately and in line with our Values through our Just, Learning & Inclusive Culture programme and implementing the 6 High Impact Actions identified through our approach to Equality, Diversity & Inclusion. We will see an increase in retention, a reduction in turnover and a reduction in our vacancies for substantive posts.

- ✓ A 'Stay conversation' process has been developed, with supporting documentation produced to support staff who have been identified as likely to leave or are leaving the Trust. This is to understand and explore opportunities and solutions that may encourage them to stay in the organisation. The initiative is expected to be launched Q1 2023/24.
- ✓ A Just Learning and Inclusive Culture Group has been established.
- ✓ 'The Foundations to Leading Inclusively for an Inclusive Workplace Culture' course open to all Trust staff to enhance leadership and culture.
- ✓ A Recruitment and Retention Working Group has been created to develop and lead on a recruitment and retention action plan. The group is currently working on 30, 60 and 90 day 'How are things going' conversations process and documentation with an aim to nurture newly recruited employees. The process and documentation will be launched in Q1 2023/34
- ✓ We now have 9 Professional Nurse Advocates (PNA) with a further 4 in training. Over the last year 140 sessions have been delivered, with 85 recorded as restorative supervision. Training to increase PNA numbers continues in line with national guidance.



- ✓ Approval for implementation of the Race Code has been given with work continuing into 2023/24.
- ✓ Review and refresh of Appraisal paperwork to increase its value and ease of use. The name of the process has changed from Personal Development Review to Appraisal following feedback in the 2021/22 staff survey. Following pilot roll out District Nursing Team Leads in the county have already conveyed the new layout is more conducive to meaningful conversations. Full implementation will continue into 2023/24
- ✓ We held a 'This is Me – celebrating Disabilities' event in March 2023. The event included information on topics such as dyslexia, sight-loss and mental health in the workplace.
- ✓ Reverse mentoring program now in place and a celebrity event for the first Cohort took place on 13th March 2023

Reverse Mentoring – Deputy Ward Manager Paulson Arancheril's Viewpoint.

Reverse mentoring was a real eye opener and motivator to uncover my hidden skills and knowledge. Being a mentor to a senior leader has aided me gain confidence in raising concerns, plus I have been able to share my experiences and my professional journey which facilitated building a positive professional relationship.

The programme meetings have enabled me to identify and explore different leadership styles and skills, allowing me to professionally grow, I now have the skills to adapt my style of leadership to suitably match the task to be carried out. I also supported peers by sharing my experiences in terms of building a relationship with my mentee with an aim to increase their confidence.

As part of the individual sessions with my mentee I was able to share my keen interest and involvement in the Trusts International Recruitment project and convey the hard work being carried out. During another meeting my mentee shared information on the Virtual Ward service started in Shropcom. Following this conversation, I researched the roles and responsibilities for the service as I wanted to know more. I then applied and was successful in a obtaining a Pathway Coordinator post in Virtual Ward. The programme created the opportunity to seek new ventures and support my career progression from a Band 6 to a Band 7.

I believe all the senior leaders would benefit from participating in reverse mentoring as it identifies their team members skills, widens skill sets and facilitates career progression. It also provides senior leaders with a wider view of Trusts functions.

Due to the success of the programme, I have volunteered myself to participate in the next cohort of reverse mentoring as I recognised the benefits

Focus on specialist roles and skills, recruiting, and developing career pathways and pipelines as well as succession plans to support teams to stay at optimum levels of people and skills. We will have articulated which specialist roles and skills are critical to our workforce and will have created recruitment, career pathways and succession plans for these.

- ✓ September 2022 saw the commencement of the Associate Director for Workforce, Clinical Education and Professional Standards in the Trust.
- ✓ Recruitment days have been held in all of our Community Hospitals and 1 Community Nursing Team during the year, With successful recruitment of Staff Nurses, Health Care Support Workers, Occupational Therapists and an Emergency Nurse Practitioner.
- ✓ Recruitment of Paramedic, Advanced Nurse Practitioners and Advanced Clinical Practitioners into our Virtual Ward and Rapid Response Teams.
- ✓ 13 International Nurses are currently working in Shropcom, with 6 of these employees now holding an NMC registration, 2 further Nurses are due to arrive in May and interviews to recruit continue.
- ✓ We currently have six 0-19 Specialist Public Health Nursing students (Health Visiting and School Nursing) as part of the growing our workforce plan.
- ✓ The introduction of Health Visiting and School Nursing Professional Development leads to improve knowledge and skills post pandemic and facilitate professional development
- ✓ The introduction of band 5 Community Nurses development posts in Health Visiting to address the band 6 recruitment difficulties due to a National workforce shortage.
- ✓ Introduction of a Clinical Digital Lead role in the Virtual Ward Team
- ✓ Introduction and recruitment to a Medicines Safety Officer & Non-Medial Prescribing Lead for the Trust to start in 23/24

Education and learning - a focus on development and apprenticeships that support career pathways and the transformation of our services. We will develop a plan of which apprenticeships can support our specialist roles and will have successfully implemented business cases for apprentices in all of these new roles.

- ✓ Resource suite on Staff Zone developed for Apprenticeships which showcases a wide range of careers
- ✓ 3 Occupational Therapy, 3 Physiotherapy and 1 Podiatry apprentices are in post across our Community Teams
- ✓ Plan for Assistant Practitioner Apprenticeships with a Therapy focus has been developed and is to commence with Chester University in the summer.

Maximise the opportunities associated with new roles like Nursing Associates, Therapy Assistant Practitioners, Advanced or Enhanced Practice and First Contact Practitioners. We will employ more of these roles across our services.

- ✓ 5 trained Nurse Associates are now training to become Registered Nurses and are due to qualify early 2024
- ✓ First Contact Practitioner Physiotherapist provision has reached 1.96wte, with clinicians working in Whitchurch, Market Drayton and Newport
- ✓ Advanced Practice Practitioners are now in MSK and Podiatry Services. These highly skilled clinicians provide a single point of access triage system to ensure patients are seen by the right person at the right time. They carry out extended roles including diagnostic requesting, injection therapy, ultrasonography & non-medical prescribing, plus determine clinical diagnosis and formulate treatment and management plans
- ✓ We have 14 Nurse Associates working in the Trust, increasing our number by 1. While this number is lower than expected there are plans in place, with a trajectory of doubling the volume of Nurse Associates working in the Trust within the next 2 years. We currently have 23 Trainee Nurse Associates, 15 of whom commenced training in March this year.

Lynette Gissop shares her journey from joining Shropcom as a Health Care Assistant (HCA) to becoming a Trainee Nurse Associate (TNA)

In July 2019 after a work history of elderly care, adults with learning disability and childcare, I became a HCA on Dinham Ward at Ludlow Community Hospital. This role was my first healthcare job within a hospital setting and I found that I really enjoyed it. I learnt that rehabilitation of patients and watching them progress is very rewarding. I decided that Shropcom was where I wanted to progress my career and decided to go back to college to do my functional skills level two in maths so that I could apply for TNA, then Covid happened, and everything stopped.

It was an extremely challenging time and I saw things that I would never have seen unless I was working in that environment. As upsetting as it was, I am glad I had work to focus on in those times. While people were home alone, I was working side by side with amazing staff, looking after the patients and this reinforced my desire to become a Nurse.

When I was able, I went back to college but due to the pandemic restrictions I was unable to attend lessons. I therefore got in contact with a private teacher who would provide lessons although there needed to be a class of 6 or more.

With the support of the hospital manager and a successful recruitment campaign, I was able to arrange weekly lessons in the hospital for 9 students.

During this time, I took the opportunity of a secondment to widen my knowledge base and was appointed the first and only Infection, Prevention and Control Support Worker in the Trust. The team were understanding of my TNA goal and provided me with a weekly study day to continue with my study. The team also supported me when I was offered an interview for TNA to which I was successful and was offered the position on the condition I achieved the Maths qualification. Unfortunately, I failed my first attempt at the exam but being determined, I rebooked and passed the second time. I received my pass result exactly a week before the University start date and it was a crazy race to get there on time. I am now on the course and loving every minute. I am currently on my first placement with a District Nursing Team, and everyone has been fantastic.

I have had so much support on my journey, and it just goes to show that with hard work and determination you can achieve what you want. I plan to complete TNA and hopefully top up to Band 5 within the Trust.

Develop our staff to gain more sub-acute skills both within the Community Hospital inpatient beds and the Community Teams including Virtual Ward.

- ✓ The use of the Rockwood Clinical Frailty Score and The National Early Warning Score (news2) is used more consistently, with implementation work continuing.
- ✓ There is an increase in clinicians with and using the V300, plus training is on a rolling program therefore more staff will achieve this skill in the coming year. Six clinicians have successfully completed the training during the year and a further six are currently studying to gain the competency.
- ✓ Virtual Ward have planned training for 10 staff to attend Comprehensive Assessment of the Older Person Training in April, with plans to send more later in the year. There is a plan for training in Upskilling of ECG interpretation, understanding blood results and minor injury and Illness
- ✓ Docobo Point of care testing is in the implementation phase in our Virtual Wards
- ✓ A hoist assessor training program is in place with 6 out of 8 sessions already taken place and further dates added
- ✓ A moving and handling Training suite is up and running at Bishops Castle Community Hospital to enhance hands on Training

Support the design and successful implementation of new models of care and their workforce as part of our Local Care Transformation Programme. We will work on transformation of these new models of care with development programmes supporting behaviour change, management of change, and transforming patient pathways. Each pathway and programme will develop and deliver improvements in quality of care.

- ✓ The Virtual Ward programme, led by SCHT launched in September 2022. This has involved working closely with colleagues across our Integrated Care System, Acute Hospital, Primary Care Partners and Local Authority Colleagues. At the end of Q4 the service reached the key milestone of having 100 patients on the caseload.
- ✓ Implementation of a Community Nursing Shared Care process to empower self-care and improve well-being and independence. The project uses a treatment plan as framework to enable patients and their caregivers being a key component in their care and treatment.

Priority Two – Patient Safety and Reducing Avoidable Harm

Patient safety is about maximising the things that go right and minimising the things that go wrong. This is integral to Shropshire Community Trusts definition of quality in healthcare, and we will aim to improve the quality of our services and reduce avoidable patient harm in several key areas by:

Measure of success

Improve reporting and investigation of patient safety events by updating our online reporting system to enable linking with other care areas and system partners, supporting a workplace culture of fairness, openness and learning

- ✓ Implementation of the Review of Serious Incidents (ROSI) Group, utilising the Trusts incident reporting system to triage new incidents in order to escalate, provide feedback, request actions / further information as necessary whilst maintaining a clear data trail.
- ✓ Just Culture working group in place
- ✓ Just Culture ethos and future promoted across the organisation by the Patient Safety Specialist

Showing sustained improvement in avoidable patient safety events or harm, including, falls, pressure ulcers and long waits for services.

- ✓ Over reporting of Serious Incidents has occurred during 2022 resulting in a higher level of incidents being submitted, nevertheless there has been a reduction in Serious Incidents being upheld compared to 2021.
- ✓ A program of pressure ulcer training has been delivered by our Tissue Viability Service and is continuing in 2023
- ✓ Whilst the reporting of pressure ulcers has increased, this is seen as open and transparent reporting as the level of Serious Incidents has reduced.
- ✓ Introduction of Falls per 1000 Occupied Bed Days as our reporting mechanism to replicate a National standard of measurement.
- ✓ Falls policy under revision to align with system partners.
- ✓ Falls levels have reduced by 5.7% across the year.
- ✓ 2 virtual Falls Summits took place over the summer, with system partners involvement to ensure wider learning and engagement.
- ✓ Procurement of falls detection and management technology and equipment for our Community Inpatient settings and Community Teams.
- ✓ Harms Policy & Proforma developed and approved

Aiming to restore and recover our services by prioritising those who are long waits for elective care or procedures.

- ✓ Outpatient appointment waiting list have reduced by 58% in the last 12 months with work continuing into 23/24
- ✓ Short term enhanced clinic provision in Children's Speech and Language Therapy to reduce lists
- ✓ Waiting list triage in place across services for assessing risk of delay and prioritisation

Work with our system partners to address Health Inequalities, and Equality Diversity and Inclusion of our services by supporting the development and delivery of a local strategy.

- ✓ Protected characteristics data has started to be included and collated.
- ✓ Open staff invitation to Integrated Care System Cultural Diversity Event in May 2022
- ✓ Over 80% uptake in mandated Oliver McGowan Training for awareness and learning on Learning Disabilities and Autism

Rebalancing existing Infection Prevention and Control (IPC) Team priorities and developing new programmes of work as we move into a post Covid pandemic world.

- ✓ Successful first IPC Summit in collaboration with The Robert Jones and Agnes Hunt Orthopaedic Hospital (RAJH)
- ✓ Development of the first IPC Strategy Ambitions launched on 30th January 2023
- ✓ Quarterly campaigns rolled: delivered 'Gloves off' and the current campaign: introducing new cleaning and decontamination wipes
- ✓ Integrated working across organisations to consolidate approach to IPC: Combined monthly RJAH and SCHT team meetings to share new knowledge and work collaboratively, sharing policies, audit tools and external peer audits to enhance objectivity
- ✓ IPC Team restructure: new Band 7 role as Clinical Lead and a Band 3 Clinical IPC Healthcare Support Worker working on targeted IPC training and education
- ✓ IPC Team are members of NHSE working groups
- ✓ Regular IPC newsletter with introductions from Senior Leaders and Executives
- ✓ All Job Descriptions now include specific responsibilities for IPC
- ✓ The development of an overarching Trust wide IPC Quality Improvement Plan
- ✓ Re-structured IPC governance with the launch of the IPC Operational Group – operationally focussed

Priority Three - Improve the End-of-Life Experience for Patients, Children, Young People, and their Families and Loved Ones

We use key frameworks to continuously improve our services for people, children, young people and their families and loved ones as part of our end-of-life care. We have highlighted areas for improvement for Shropshire, Telford and Wrekin and Shropshire Community Health Trust aim to address this by:

Measure of success

Be a key member of a system wide and collaborative approach to shape the design of End-of-Life care services for the future with other organisations including GP's, the Hospice and the Acute Hospitals.

- ✓ EoL Lead participation in system meetings
- ✓ The Trusts End of Life Strategy has been updated to align with our partners.

Develop and support a recognised care pathway across all services for the care of our End-of-Life patients to ensure communication and documentation between organisations is shared and supports the planned care of our patients, families and loved ones to meet their wishes.

- ✓ The Rockwood Frailty scoring has started to be embedded across clinical services
- ✓ Completion and use of Advanced Care Plans has increased along with clinical competency in using the document resulting in reduced reliance on medical input

The Advance Care Plan (ACP) in Care Home Team were proud after being nominated for not one, but three awards at the Nursing Times Awards.

The categories were 'Enhancing Patient Dignity', 'Managing Long Term Conditions' and 'Nursing in the Community'. These nominations recognise the team's ongoing work and commitment to supporting care home staff, patients and their families in elderly Care Home setting.

Sarah Venn, Clinical Lead Advance Care Planning in Care Home Team for said
"I am incredibly proud of the team for being shortlisted for three national awards. They have worked so hard to advocate our patient centred approach and they deserve recognition for their achievements in terms of improvements in quality of care and the outcomes achieved.'

Establish an End-of-Life Support Team to include education and clinical support relating to both Advance Care Planning and End of Life care.

- ✓ Contract for End-of-Life education with Severn Hospice in place.
- ✓ Geriatrician input in Advanced Care Plan completion and staff guidance.

Extend the Learning from Death reviews to include reviews from the Community Teams as well as from the Community Hospitals, alongside the extension of the Medical Examiner role in their scrutiny of non-coronial deaths in the Community, working closely with GPs and Community Services.

- ✓ Learning from deaths initial Level 1 form has been adapted to incorporate Community Teams.
- ✓ Engagement sessions work to Community Nursing Leads on the use, purpose and benefits of the level 1 review paperwork have taken place.
- ✓ An information sheet and service expectations of Level 1 reviews has been developed and cascaded to Community Nursing Leaders.
- ✓ The completing of Level 1 reviews from Community Nursing Teams and Care Home Advanced Care Plan Team has commenced resulting in learning opportunities and documented reflective practice for staff
- ✓ Medical examiner service engagement sessions have taken place, with a task and finish group working on full implementation of the role in Q1 2023/24
- ✓ Learning needs for the Medical Examiner Service and Community Teams have been identified to support effective implementation and written guidance formulated.

Learning From Deaths (LFD), Level 1 review. A Clinicians' Viewpoint

Over the last year a process to review the care and treatment of patients prior to death in our Community Hospitals has been extended to include District Nursing and the Advance Care Planning in Care Homes Team. While Community Team clinicians often debrief and reflect collectively following a patient's death, the LFD Level 1 Review document formalises the practice and provides further opportunities.

Andrea Walton – a nurse in the Advance Care Planning in Care Homes Team provides her view on how the team have implemented the document into practice

How has the LFD Level 1 Review document been used in your team?

It collates information around a patients journey and how each patient and care givers have been supported through the difficult process of dying. Being able to use this tool to piece together how efficient/or not and effective/or not the support and all-round care given has made a difference/or not. The LFD form has been shared within the team meetings to open discussion and learning from deaths. We as a service use this process as a learning to inform our practice of Advance Care Planning and quality end of life care, supporting patients/ relatives wishes and preferences.

What is good about the LFD Level 1 Review process?

It's an easy-to-follow tool highlighting where things could or couldn't have gone better, highlighting where the need for improvements in training and regular updates for staff are required to improve services provided available. It is useful tool for the team, as it provides learning for all using a reflective process.

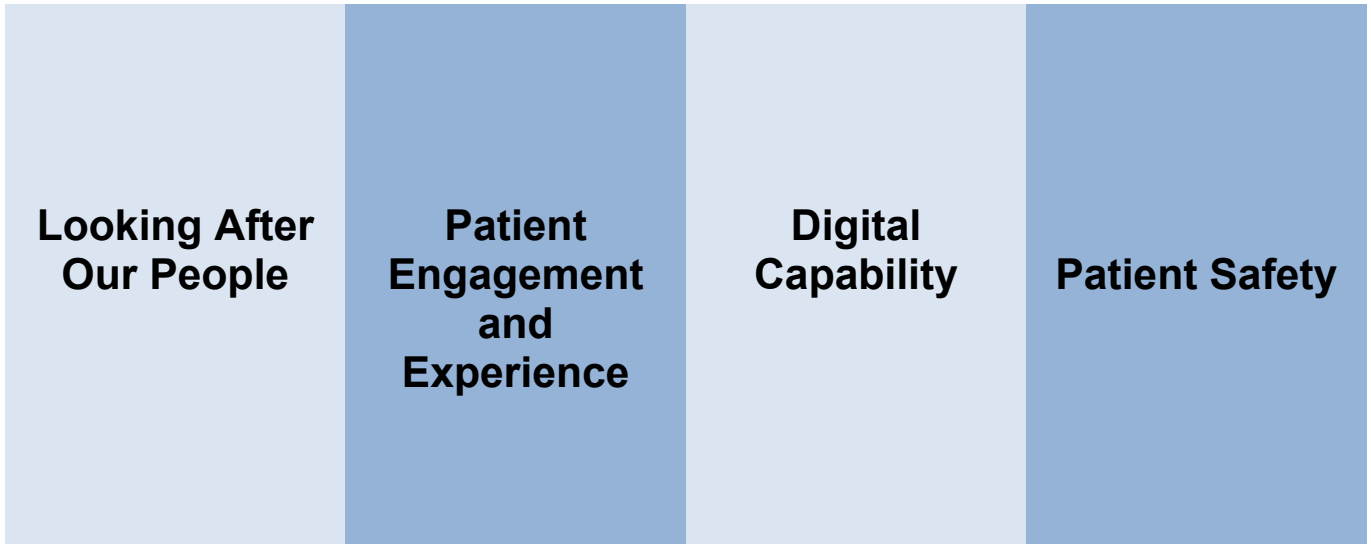
Personal learning:

It has helped me reflect on my practice and highlight training needs and opportunities.

Part Three: Our Commitment to Quality – Our Priorities for 2023 - 2024

As we continue to re-model following what has been the most arduous period for the NHS, our priorities are set for the year ahead. We will continue to focus on staff well-being, gain momentum in patient safety using the National Patient Safety Strategy, aim to improve our digital capabilities and keep patient experience and the heart of all we do. These key priorities set out to improve delivery of care to our population while valuing our workforce.

Our 4 Key Priorities for 2023–2024



Looking After Our People	**NHS England emphasises the importance of making the NHS a better place to work for all staff members and investing in our workforce remains a priority within our organisation**.	**We will**... → Carry on with the redesign and improvement of our recruitment process to achieve timely and effective commencement dates. → Increase development roles within the organisation to strengthen career development, attract external candidates and retain staff → Development of a Trust wide one stop education calendar to promote training available in an accessible format → Extend flexible and agile working opportunities when there is no known negative impact to service delivery, team cohesion or an individual's well-being. → Advocate prioritisation of regular clinical and nonclinical supervision across our workforce, continuing to provide a suite of resources via the Trust website and Organisational Development, → Further embed thirty-, sixty- and ninety-day conversations for all our new employees. Plus further implementation of the already developed stay conversation process → Ensure transparency and clarity of our organisational structures → Roll out our updated and improved appraisal documentation and a separate bank staff review process following positive feedback on the new format. → Supporting and encouraging staff with mandatory training → Hold staff engagement and listening events periodically across the organisation → Make time to acknowledge and celebrate success, share good practice, and reward achievements → Develop staff networks for protected characteristics, and further increase staff awareness. → Complete NHS health and wellbeing diagnostic tool kit to support and enable the development of the staff health and wellbeing action plan. → Increase our engagement with staff for wellbeing and service development

Patient Engagement and Experience	**People and communities using heath and care services are best placed to understand what they need, what is working and what could be improved.**	**We will...** → Increase our stakeholder's involvement in recruitment processes, service development / redesign and governance processes to follow a co-production model. → Routinely collate and share patient, carer and staff stories → Increase Observe and Act assessments across clinical services. → Embed the use of the Friends and Family Test and Inpatient Survey QR business cards and posters throughout our clinical services. → Widen our volunteer membership with redesigned roles and responsibilities to align with the shift in culture following the Covid-19 pandemic → Increase FFT feedback across services → Implement a Patient Experience Delivery Group to ensure we learn, action and share to close the loop → Deliver a Power of Feedback away day to showcase the benefits of service user feedback → Continue to strengthen our relationship with both local HealthWatch organisations → Continue to embed Patient Experience Committee into the Trusts Governance structure
Digital Capability	**Digital technology is a critical component to optimising and transforming the NHS. This year we will further develop digital pathways and competencies to empower our patients and develop our workforce.**	**We will...** → Expand the use of remote patient monitoring in our Community Teams → Identify and address areas for improvement in digital competency. → Promote resources available via Trust communications and a designated staff intranet page that facilitate digital literacy → Implement the Electronic Patient Record system in our Inpatient Wards → Increase accessibility of patient information using digital solutions to facilitate timely intervention / treatment → Transition to using E-Roster across clinical services → Identify, increase, and promote the use of Apps that enhance service provision. → Modify our communication methods with patients and caregivers to optimise patient care by using digital solutions. → Implement a performance management system to enhance data/performance reporting and analysis across services

Patient Safety	**Shropshire Community Health NHS Trust strives to continuously improve with patient safety being at its centre. Over the next year we aim to further embed The NHS Patient Safety Strategy and begin implementing the Patient Safety Response Framework (PSIRF)**	**We will...** → Train our clinical staff in patient safety utilising the national Patient safety syllabus → Orientate PSIRF leads at all levels of the organisation to the revised framework and associated requirements. → Define oversight structures and ways of working for the transition to PSIRF → Understand SCHT patient safety incident profile and develop a patient safety incident response plan and policy → Create pathways to support the new mandated Medical Examiner role → Embed the newly created Medicines Safety Officer & Non-Medical Prescribing Lead role into the organisation → Further develop pressure ulcer and falls prevention pathways, plus the implementation of PURPOSE T assessment tool to replace the current process. → Implement the use of a lower limb assessment tool across all relevant services. → Refresh Freedom to Speak up Guardian processes to ensure inclusivity of our non-clinical workforce. → Work with system partners to improve the patient journey, including referrals, documentations transfers and discharges. → Fully implement National safer staffing tools in our District Nursing Teams and Inpatient Wards → Review the prescribing processes for continence for Shropshire to optimise safe treatment.

Part Four: Quality at the Heart of the Organisation

This section of the Quality Account will show how we measure our day-to-day work in order to meet the requirements and standards that are set for us and how we evaluate that the care we provide is of the highest standard. Much of the wording of the statements in this section of the Quality Account is mandated by the NHS (Quality Accounts) Regulations.

Participation in Audit & Research

National Clinical Audit and the Patient Outcomes Programme (NCAPOP)

The National Clinical Audit and Patient Outcomes Programme is commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP). The programme comprises audits relating to some of the most commonly occurring health conditions. Participation by NHS Trusts in all relevant National audits is mandatory.
The Trust participated in 4 National audits throughout 2022/23.

- ***National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACP).*** The latest report to be published was for the period October 2021 to March 2022. The Trust is achieving above the National average in relation to walk test distances and Quality of Life outcome measures. Our patients continue to wait longer than the recommended 90 days to be assessed and enrolled onto a programme but with the recent focus on reducing waiting lists, this position has improved considerably.

- ***National Audit of Care at the end of Life (NACEL).*** *Round 3.* The Trust submitted data to the organisational, case note review, staff survey and quality survey elements of this audit. Our scores were above the National average in relation to governance, meeting the needs of families and carers, families' and others' experience of care, staff confidence and staff support. Areas identified for improvement included communication with the dying person and with their families and others. The results have been incorporated into a comprehensive End of Life Care action plan.

- ***National Diabetes Foot Audit.*** The audit results highlighted that we have an aging population with higher-than-average levels of Peripheral Arterial Disease (PAD). We are not achieving the 8 care checks for people with diabetes as recommended by NICE with foot screening as an area in need of improvement. We are not seeing patients quickly enough and our patients are presenting with more severe ulcers. Despite, this we are achieving outcomes in line with the National average on the majority of measures contained within the audit.

- ***National Audit of Inpatient Falls***. The Trust submitted data to the Facilities element of this audit and was compliant with all criteria except for one, relating to the absence of a Non-Executive Director with responsibility for falls.

Participation in Local Clinical Audit

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary. The Trust is committed to a process of continuous quality improvement in the care and treatment we provide to our service users and recognises clinical audit as a validated and reliable means of achieving this. Audits where areas of non-compliance are identified result in an action plan for improvement, implementation of which is monitored by the relevant Service Delivery Group.

A total of 11 local clinical audits were completed by the Trust in 2022-23. Audits are aligned to one of three priority levels derived from a prioritisation model developed by HQIP.

Priority 2

Clinical record keeping audit. *Children's Occupational Therapy service*. Overall, the records met the record keeping standards required by the Trust. Minimal paper records are used and the move to Electronic Patient Record has reduced errors in patient and healthcare professional identification, timing and signing of entries. Improvements were seen in the involvement of the child/patient in care plans and records were clear in terms of their meaning. Areas for improvement were identified around the use of abbreviations, recording of risk assessments, recording of outcomes and evidence and the documentation of consent. A comprehensive action plan has been developed and is being implemented to address all areas of non-compliance. Clinical staff who took part in the survey element of the project demonstrated excellent understanding and awareness of good record keeping practice.

Initial LAC health assessments. *Community Paediatrics*. The results remain outstanding/good across all sections with 4/6 reports rated as outstanding in terms of their quality. Two reports had the necessary information in part B but this was not transferred to Part C which is the summary of the report (these were ST trainee reports). The ST trainee has been given feedback and the importance of transferring detailed information emphasised in the ST trainee induction. Trainee reports will also be reviewed by supervisors to ensure that good reports improve to outstanding.

Bed rails re-audit*. Ludlow inpatients ward*. A targeted re-audit was undertaken at Ludlow in response to the findings of the previous audit, where 1 case was not compliant with any of the 4 audit criteria. The re-audit showed full compliance in 9 cases and partial compliance in 1: the decision and rationale were not recorded on the back of the initial assessment. The need to complete this part of the documentation has been communicated with staff on the ward. No further actions were identified

Duty of Candour audit *(DOC). Trust-wide*. This audit was undertaken following identification that compliance with the duty was not being carried out to an expected standard. Incidents for the month of June 2022 on Datix were audited. A verbal apology had been completed in 35% of cases and a written apology completed and documented in 4%. SDG Managers were made aware of the audit findings and were asked to provide an improvement plan to Patient Safety Committee to ensure compliance increases. Awareness sessions have been delivered to managers/leaders. A re-audit was undertaken in October 2022, but the results show a static picture with little or no improvement. No further audit work will take place until the action plan from the initial audit has been implemented and overseen by Patient Safety Committee.

Mental Capacity Assessment (MCA) audit*. Inpatients. An M*CA assessment had been completed in 98% of the Deprivation of Liberty (DoLS) applications. This represents an improvement from the previous audit, where only 40% had been completed. The overall quality of these assessments as measured against the audit criteria was 75% rated green, 22% amber and 3% red. Areas for improvement included providing space for practicable steps to be added to the MCA form on RiO to guide staff and to facilitate decision-making and audit of MCA forms and 'live' feedback to be given to staff upon completion.

Clinical record keeping audit*. Community Nursing*. All Community Nursing Teams took part in this audit. Overall, the records met the required record keeping standards, however, the audit highlighted areas relating to record keeping processes and practice that require improvement to ensure a consistent approach and standard for all patient records across all teams. The key areas for development were the completion of holistic assessments and treatment planning and review. A comprehensive action plan has been developed to address areas of non-compliance.

Medicines management audit*. Severndale School.* The audit reviewed the medicines management processes within Severndale Specialist Academy School against the combined School and Trust Medicines Policy, Shropshire Community Health NHS Trust Medicine Policies, and the related medicines Standard Operating Procedures (SOPs). Two areas of partial compliance involved the correct recording of minimum and maximum ambient and fridge temperature, although actual temperature was recorded each day the service was open. This represented an improvement on the previous year's audit. Two areas of non-compliance involved the publishing of the current medicine policy and SOPs. These delays have now been addressed. The previous two years' audits had highlighted an issue with the Controlled Drugs register with the medication form not being documented. This has now been resolved. Whilst improvements on timely reviews of medicine related paperwork is required, the audit still provided assurances that medicines are administered safely and stored securely within school. A document tracker will be used to highlight documentation that is due for review six months before the expiry date, so that a full review can be completed and published before the expiration date.

Medicines management audit*. Bridge School*. Out of the 26 criteria 6 were deemed 'not applicable' due to the differences in medicines administration between The Bridge and Severndale Schools. The audit identified 5 areas of non-compliance. Two compliances involved having the latest version on medicines policy and consent forms available and one the timely reviewing of Standard Operating Procedures (SOPs). Two non-compliances involved the young person's rescue medication. Whilst the storage non-compliance highlighted on last year's audit has been resolved, incorrect medicine administration records were seen with the rescue medicines, highlighting the importance of recognising 'Look Alike Sound Alike' medicines (buccolam vs baclofen), and date checking had not been completed for September, in line with SOPs. The Special School Nurse Team Leader has carried out a re-visit to the school and has confirmed that all of the areas of non-compliance have been addressed.

Clinical team meeting minutes audit. Trust-wide. A re-audit has been undertaken to identify whether team meetings have been reinstated after they were stood down during Covid and to gain assurance around use of the standardised Trust agenda template. The audit findings identified significant variation across teams in relation to the frequency of meetings held, use of the Trust agenda template and in the overall quality of the minutes audited. A minimum standard for the required frequency of meetings will be agreed, the current agenda template will be reviewed and revised and guidance on the content of minutes produced.

Priority 3

Educational Health Care Plans (EHCP) re-audit. *Children's Therapy services, Children's Community Nursing Service, Child Development Centre (CDC).* The audit results identified that outcomes did not always link to the parent/child goals/aspirations, outcomes were not always written according to SMART (Specific, Measurable, Achievable, Relevant, Time-bound) standards, each provision identified to meet a need did not always contain required information, e.g., hours/frequency of support, level of expertise of provider. The advice from Health Care Professionals (HCPs) was well-represented in the final EHCP in only 56% of cases. Actions for improvement include providing more opportunities for teams to access training, supervision and peer support, providing HCPs with access to goals/aspirations prior to writing an Educational, Health and Care Needs Assessment (EHCNA) report and offering more training/support on writing SMART outcomes.

Participation in Clinical Research

The Trust is committed to providing its population with evidenced based care and believes all service users, care givers and staff should have the opportunity to participate in Research and Innovation (Re&I).

We are proud to share that the Re&I Teams hard work was recognised at The Clinical Research Network West Midlands annual awards ceremony in June 2022

'Research Team of the Year'

Key achievements include

- The Re&I department undertook 12 studies in 2022/23 and recruited 520 participants into research (both staff and patients)
- The Team completed one commercial study over performing in recruitment and asked by the study sponsors to assist with further recruitment as some sites had not managed to achieve their recruitment target.
- A Research Showcase event was held on the 16th of November 2022- the event was delivered virtually to increase accessibility to staff across the Trust and attended by over 100 colleagues. The journey and achievements of SCHT Research and Innovation to date was shared plus stories of colleague's experiences
- The Trust recruited the largest cohort of participants nationally for both the NHS 111 and MINDARISE studies
- A staff research champion initiative has been created and well received by Trust staff in all departments. The initiative takes research opportunities to both staff and patients across all Trust services. The initiative was featured by the NIHR Clinical Research Network West Midlands, and we have advised other Trusts in setting up similar schemes.
- The Research web page on staff zone is now live and provides staff with both an overview of what is happening with research in the Trust and CPD opportunities to develop staff knowledge of clinical research in health and social care with access to online learning courses.

Commissioning for Quality Improvement (CQUIN)

2022/23 saw the recommencement of CQUIN's following a pause during the Covid-19 pandemic. Four CQUINs were pertinent to the Trust

CCG1	Flu vaccination for frontline staff healthcare workers	61%
CCG13	Malnutrition screening in the community	9%
CCG14	Assessment, diagnosis and treatment of lower limb wounds	Unable to report
CCG15	Assessment and documentation of pressure ulcer risk	14%

As per the National picture, systems have been working on restore and recovery of services and therefore the targets set have not been met, Internal structures are now in place to support meeting the quality indicators as the CQUIN's continue into 2023/24. Actions taken include weekly Delivery Group meetings, and monthly Director led Oversight meetings. Work is underway to ensure data for CCG14 can be captured, recorded and reported in 23/24

Information Governance

The Trust completes the Data Security and Protection Toolkit (DSPT) which sets out the National Data Guardian's (NDG) data security standards and currently has a status of "Standards Met". The Trust is due to publish a final assessment for the year 2022-2023 on the 30th June 2023. By completing the Toolkit self-assessment, the Trust provides evidence to demonstrate that it is working towards or meeting the NDG Ten Standards. The NDG Standards are aligned to the General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

The Trust adopts a best practice approach from the DSPT guidance for conducting clinical coding audits

Incident Reporting

The Trust monitors all incidents using the electronic reporting system - Datix. All incidents are categorised and are copied to the relevant subject experts for review, comment, identification of required actions and investigation level required. The Trust currently use a Root Cause Analysis (RCA) approach to review Serious Incidents (SI), with a plan to transfer to the Patient Safety Incident Response Framework (PSIRF) in the coming year. SI's in healthcare are adverse events where the consequences to patients, families and caregiver's, staff or organisations are so significant or the potential for learning is so great, that the heightened level of response is justified.

Pressure Ulcers

Over the last 12 months the number of reported pressure ulcers in SCHT Community Nursing Teams has increased by 62%, from 411 reported in 2021/22 to 656 in 2022/23. In 2022/23 there was an increase of 28 in category three and four pressure ulcers, with 34 reported, compared to 6 reported in 2021/22.
As for Serious Incidents, the increase in incident reporting can be attributed to the introduction of a new Patient Safety Specialist, which has resulted in a more positive reporting culture and identification of incidents as and when they occur. An action plan to implement Purpose -T, a tool to identify the risk of developing a pressure ulcer and supports decision making to reduce that risk is underway, with an ambition to roll out the assessment tool by November 2023.

Falls

The Trust reported 185 inpatient falls in 2022/23, a decrease of 5.7%, compared to 196 Inpatient falls in 2021/22.
2 of the 185 falls were reported as Serious Incidents. This compared to 3 reported in 2021/22.
With a further breakdown this shows that 1 was reported as serious harm, 6 as moderate harm and 35 as a low harm.

Our Falls Action Team which is comprised of stakeholders across operational and corporate teams has identified the following areas of focus for 2023/24 which should reduce the incidence and impact of Falls in our Community Hospital bed bases:

1) Review and implementation of updated SCHT Falls management guidance in line with PSIRF and ensure improved learning from incidents
2) Review and implementation of SCHT Enhanced Supervision policy
3) Implementation of assistive technology – essential simple solutions with potential for complementary more complex systems
4) Support and education of our staff with respect to Falls prevention and management
5) Support and education of our patients, families, and carers regarding falls prevention
6) Implementation of equipment to best manage patients following a fall
7) Review of our ward environments to ensure we are supporting our patients to remain safe
8) Review of our inpatient management to ensure a personalised multidisciplinary approach which includes ward-based activities when appropriate and prevents deconditioning

Patient safety incidents and the percentage that resulted in severe harm or death

In 2022/23 the Trust reported 3,630 patient incidents which is a significant increase of 29% demonstrating the increasing acuity and volume of patients, plus the work the Trust has carried out to promote a positive reporting culture. In contrast the level of declared Serious Incidents has reduced from 38 in 2021/22 to 23 2022/23 representing a 30% decrease, plus an indication patient care and treatment has improved over the period. There were two Serious Incidents that lead to death, both patients had Covid-19 and died following admission to an inpatient setting. The Trust was unable to determine in one case if the patient was Covid-19 on admission and was admitted for a respiratory long-term condition. The second patient contracted Covid-19 while an inpatient.

Infection Prevention & Control

Shropshire Community Health Trust Infection Prevention and Control (IPC) Team deliver a robust programme of activities designed to meet and comply with the standards expected in the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections.

We have agreed local and National thresholds for infections related to infection prevention and control measures. During 2022-2023, Shropshire Community Health Trust recorded two cases of Clostridioides difficile infection in the Community Hospitals, one above our agreed target. Although these cases were attributed to the Trust, both were classed as unavoidable. This means that there was nothing we could do to prevent our patients developing this infection. We aim to screen at least 97% of patients on admission for MRSA each month. For 2022-2023, our MRSA screening compliance score was 96%, just below the 97% target. We have identified areas for improving our scores for next year which includes supporting our clinical teams with digital solutions to form filling and helping reduce the amount of paperwork on admission to our hospitals.

The Trust recorded one blood stream infection involving Klebsiella species. Other organisms including Meticillin Resistant Staphylococcus aureus (MRSA) and Meticillin Sensitive Staphylococcus aureus, Escherichia coli, Carbapenemase-producing Enterobacteriaceae, Pseudomonas Aeruginosa and Vancomycin Resistant Enterococci blood stream infections (bacteraemia) are recorded although there is no agreed local threshold. We had zero blood stream infections for these micro-organisms.

For all infections, the IPC Team conduct a review of cases alongside our Integrated Care Board partners to identify and share good practice and where we need to improve.

Shropshire Community Health Trust Infection Prevention and Control (IPC) Team have had a year of change and innovation. We saw the Covid-19 pandemic begin to reduce and we kept our teams and patients safe by ensuring the guidance on screening and prevention on infection met our local healthcare needs. At the same time, we continued to deliver a robust IPC activity programme, this time focussing on our Estate and Community Hospital facilities.
This year, we restructured the IPC Team, promoting one of our IPC nurses into our new IPC Clinical Team lead position. They are guiding our IPC Team and Cleaning Team through improvement projects and assuring compliance with the new National Cleaning Standards. We introduced a new Clinical IPC Healthcare Support worker role who is working with our clinical teams on training and education in the clinical space.
In December 2022, we saw the first revision of the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections in 8 years and as the ICS grew and developed, our IPC became integral members of several working groups across the region and ICS, raising our profile and contributing to the development of National policies and procedures.

Patients admitted to hospital who were risk assessed for venous thrombus embolism (VTE)

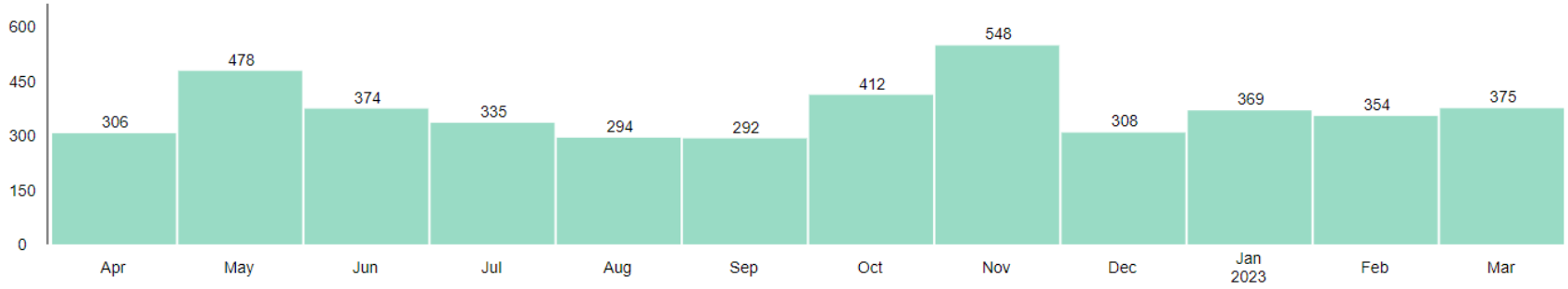
All inpatients should undergo a risk assessment for VTE to reduce their risk of Venous Thromboembolism (VTE) and Deep Vein Thrombosis (DVT). The risk assessment aims to help healthcare professionals identify people most at risk and describes interventions that can be used to reduce the risk of VTE. The target is 95% for patients admitted to our Community Hospitals must be assessed for the risk of developing a VTE. throughout the year we have surpassed this quality indicator each month with an overall average of 98%

Patient Experience

Friends & Family Test responses from our service users 2022/23

The Trust received 4445 completed Friends & Family Test results, with 96.47% of respondents reporting the service was either good or very good. Returns have increased for the second year running, with 473 more responses received in the last 12 months

The graph below shows the volume of retunes across the year



Positive feedback received

First person that listened to me. The allocated nurse helps me to continue. She gives me hope and strength to care and I don't cry as much. They have started things happening and help sort out my husband's medication and dementia care **– Admiral**

Very happy to finally have something. I was too embarrassed before. It has been brilliant. **– Continence Service**

The clinician was amazing with my son when we visited our OT appointment. She made us feel very comfortable and encouraged my son to engage with all the activities set out, which he really enjoyed. She explained everything she had noticed clearly and gave us advice on how to improve my sons fine and gross skills. I felt a great sense of relief after leaving that appointment as the reassured me that my concerns were valid, and I was doing the right thing by seeking help. I really couldn't fault the staff and the service, they were so helpful

Patient Stories

Patient stories are fundamental in organisational learning. Stories have been shared at Board, Service Delivery Groups and Team meetings throughout the year, with the most poignant being when patients and care givers tell their story either through film or a face-to-face meeting. A range of services have participated, including;

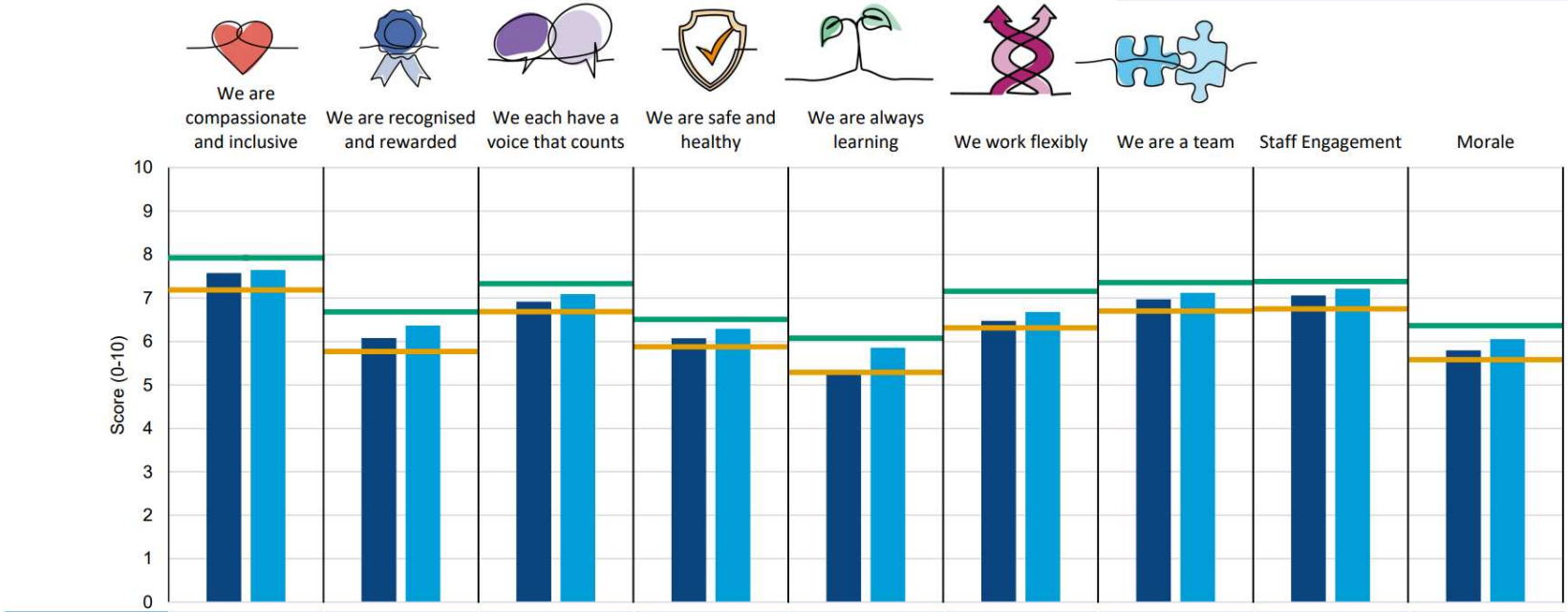
- The Respiratory and Pulmonary Rehabilitation Teams -The care of a patient with a late diagnosis of Idiopathic Pulmonary Fibrosis
- Healthcare in HMP Stoke Health - The personal experience of three Health and Wellbeing Champions within the prison system.
- School Nursing - Children's toilet training in Schools

National NHS Staff Survey 2022 – the findings

777 (50%) staff completed this year's survey, an 11% reduction on the previous year.

Initiatives for 2023/24 include:

- Staff Listen events which commence Q1
- Formulation of a staff engagement action plan
- Implementation of a continuous staff feedback button
- Wellbeing feedback boxes across Shropcom sites.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.6	6.1	6.9	6.1	5.3	6.5	7.0	7.1	5.8
Best	7.9	6.7	7.3	6.5	6.1	7.2	7.4	7.4	6.4
Average	7.6	6.4	7.1	6.3	5.9	6.7	7.1	7.2	6.1
Worst	7.2	5.8	6.7	5.9	5.3	6.3	6.7	6.7	5.6
Responses	776	775	771	768	759	772	775	776	775

Friends & Family Test response from our staff

777 (50%) of our workforce completed the questions regarding recommending Shropcom as a place to work and/or for their family or friends to receive care.

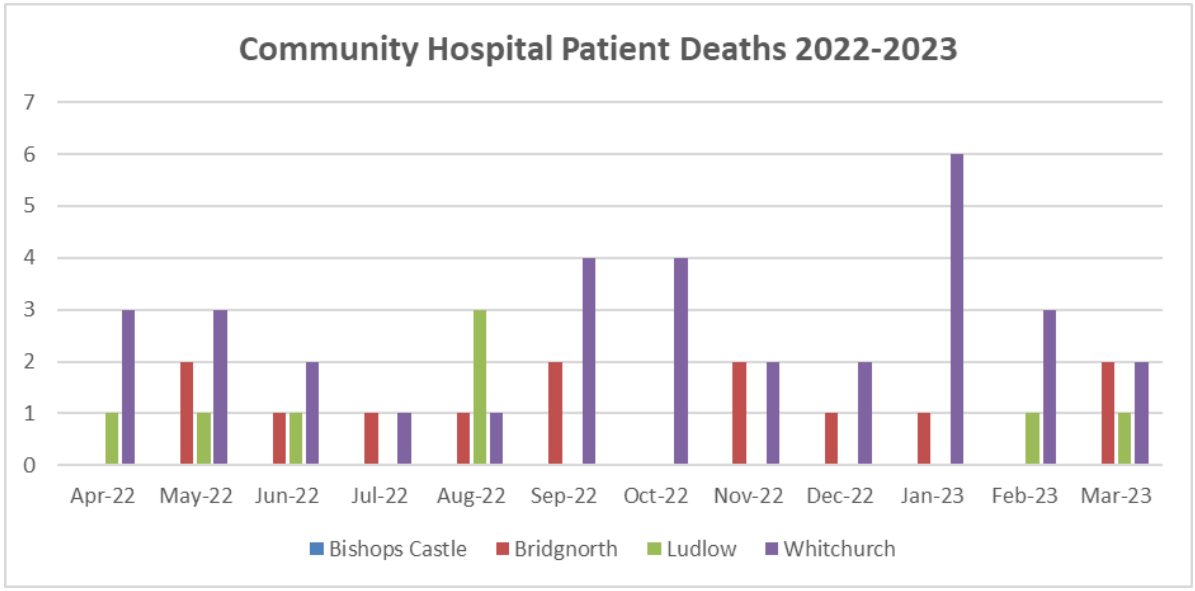
59%	Would recommend the organisation as place to work
72%	If friend/relative needed treatment would be happy with standard of care provided by organisation
75%	Care of patients/service users is organisation's top priority

The Staff Survey results tell us we have more work to do to ensure we are a consistent great place to work, this is why the Trust has committed to looking after Our People as a quality priority for 2023/24

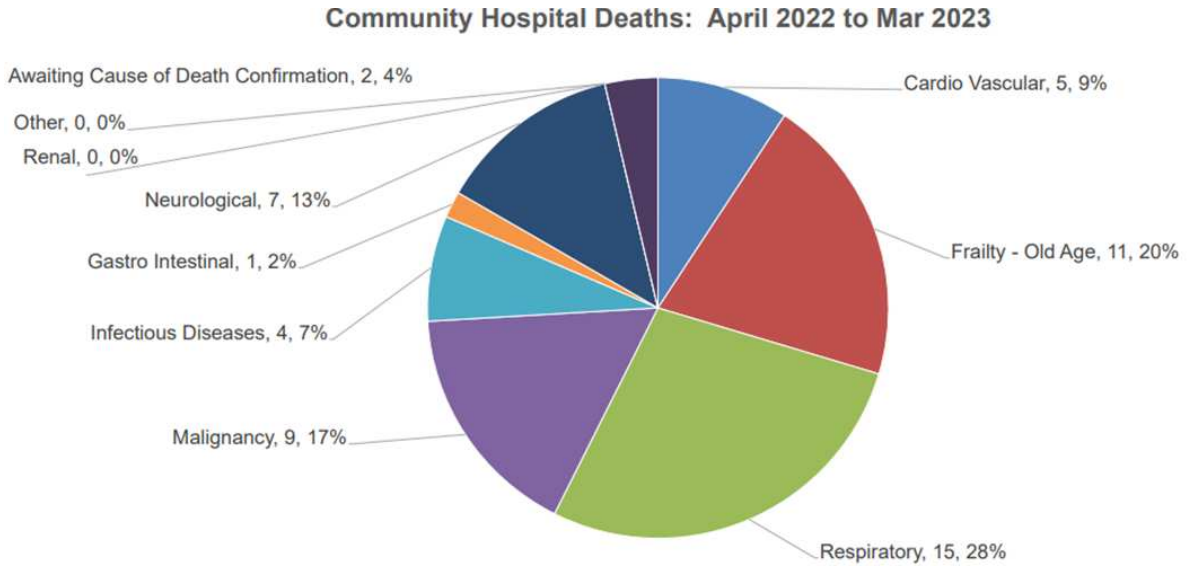
Learning from Deaths

Learning from a review of the care provided to patients who die should be integral to a Trust's clinical governance and quality improvement work. To fulfil the standards and reporting set out for community NHS Trusts, we should ensure that we give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not, to have resulted from problems in care. SCHT also ensure that we share and act upon any learning derived from these processes.

Since April 2022 there have been 54 deaths within Community Hospitals, none of which were reported as unexpected deaths. The graph below shows the number of deaths in each of our Community Hospital throughout the year:



The main causes of death within Community Hospitals for this year are Respiratory (28%), Frailty (20%) and Malignancy (17%).



In the Infectious Diseases category, four deaths were recorded as COVID-19 as primary cause of death.
There were another eleven patient deaths who previously swabbed as COVID-19 positive although their cause of death was recorded under Malignancy, Respiratory, Cardiovascular, Other (Frailty and Old Age) and Neurology categories. One of these cases was identified as a Nosocomial COVID death due to acquiring the COVID Infection while in the hospital. This was investigated and no lapses in care or treatment were identified. The patient did not have COVID recorded as their primary cause of death, this was recorded as Dementia.
As part of the National Quality Boards guidance on learning from deaths we also provide quarterly mortality data via the agenda of the Trust Public Board meetings. We use the recommended Department of Health Learning from Deaths Dashboard and report under the following scoring categories:

- Score 1 – Definitely avoidable
- Score 2 – Strong Evidence of avoidability
- Score 3 – Probable avoidable (more than 50-50)
- Score 4 – Probable avoidable but not very likely
- Score 5 – Slight evidence of avoidability
- Score 6 – Definitely not avoidable

All patient deaths during 2022/23 were assessed as Score 6 – Definitely not avoidable

Our Care Quality Commission (CQC) Registration

The CQC is responsible for ensuring health and social care services meet essential standards of quality and safety. Healthcare providers must register their service with the CQC in order to operate.
Our current registration is 'Registered without restrictions'

The CQC inspected the Trust between January and March 2019 where we attained a rating of Good which was an improvement upon our previous rating of Requires Improvement. Our CQC inspectors witnessed the strong positive culture we have within our organisation, the focus we have on patient experience and patient outcomes, and our commitment to continual quality improvement.
In addition to the overall rating of Good we attained a rating of Good in all core service areas against all 5 domains; Safe, Effective, Caring, Responsive & Well Led

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Community health services for children and young people	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Community health inpatient services	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019
Community end of life care	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑↑ Aug 2019	Good ↑ Aug 2019
Community dental services	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Urgent care	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Overall*	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019

His Majesty's Inspectorate of Prisons (HMIP)

The Trust is the lead provider of healthcare in His Majesty's Prison in Stoke Health, a men's and young offenders' facility. The prison had an unannounced HMIP Inspection in January 2023. While CQC are the main inspectorate for healthcare in prisons, analysis of some healthcare workstreams are carried out and feedback given during a HMIP inspection.

Key findings:

- Health and Wellbeing Champions (HAWCs) were flagged as good practice and assist service delivery and engagement in many areas. Inspectors had not seen peer support as effectively provided in any other prison.
- Long term conditions were well managed, with diabetes management being sighted as good practice.
- Governance structures were effective and demonstrated integrated partnership working
- Joint working in respect of death in custody and serious incidents and learning from serious incidents was effective.
- It was clear vaccinations and screening are being offered. Work to improve uptake could be of benefit
- External appointments- high wait times and backlog due to NHS waiting times. Appointments are well managed and urgent appointments are facilitated with few cancellations from the prison which is a good position.
- Safer prescribing meetings have a multi-disciplinary focus, demonstrating an improvement from the previous inspection
- Medicine administration rooms require modernisation and investment to change to improve access and clinical space.

.

Statements from our Directors and Partners

Our Chief Executive

The Trust Board Shropshire Community Health NHS Trusts produce this document as required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the NHS Quality accounts Amendment Regulations 2011 and with additional reporting arrangements as per the Regulation schedule for 2017/18. These Regulations are cited as the National Health Service (Quality Accounts) (Amendment) Regulations 2017. These Regulations come into force on 1st November 2017. The Quality Account publication on the NHS England and NHS Improvement website fulfils the Shropshire Community Trust's statutory duty to submit to the account to the Secretary of State.

In preparing the Quality Account Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board.

Patricia Davies
Chief Executive – Shropshire Community Health NHS Trust
May 2023

Statements from Our Partners

Our Quality Account has been shared with key stakeholders these are their comments.

Shropshire, Telford and Wrekin ICB – response to SCHT Quality Account 2022/2023

STW ICB would like to recognise the work Shropshire Community Health NHS Trust (SCHT) have undertaken during 2022/23 to support the local Covid 19 response and during the challenge of continuing to provide services during this time. This has included being the lead for the Covid 19 vaccination programme and Long Covid Service.

SCHT have demonstrated work undertaken during the year to achieve the priorities identified in their 2021/22 Quality Account. This has included;

- Supporting the Professional Nurse Advocate role
- Creating an Inclusive Workplace Culture
- Identifying new ways to recruit staff and support them to remain in posts within SCHT including opportunities for career progression, oversees recruitment and apprenticeship schemes
- Providing new out of hospital services as part of local transformation programme to allow people to remain in their own home environment if possible
- Advocating a Just Culture when looking at how to improve when things go wrong
- Working with system partners as part of the review of end of life care

Priority areas for 2023/24 focus on investing in the workforce, strengthening patient engagement and understanding of patient experience, optimising digital innovations and implementing new patient safety strategy. The ICB supports the priorities identified and await future sharing of how the aims are being implemented across the Trust.

Learning from Deaths 2022-2023 Quarter 4 Report

0. Reference Information

Author:	Judith Sansom, Senior Governance Manager	**Paper date:**	18 May 2023
Executive Sponsor:	Dr Mahadeva Ganesh, Interim Acting Medical Director	**Paper written on:**	6 April 2023
Paper Reviewed by:	Learning from Deaths Group (11 May 2023)	**Paper Category:**	Governance/Quality and Safety
Forum submitted to:	Committee paper being submitted to Quality and Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

To provide the Trust Board with assurance that Shropshire Community Health NHS Trust (SCHT) has a robust internal Learning from Deaths review process to ensure that we learn from any patient deaths and ensure patient safety, clinical effectiveness and user experience form the core practice and principles of services.

To meet the National Learning from Deaths Framework requirement to collect and publish data to monitor trends in patients' deaths within the Trust and report quarterly to the Trust Public Board meeting.

To provide an update on work to learn from deaths beyond that required by statute and the emergent system (ICS) approach to Learning from Deaths.

2. Executive Summary

2.1 Context

This report provides the Trust Board with assurance that the Trust is meeting its requirements under the National Learning from Death Framework and the Learning from Deaths in relation to patients who have died within our direct care. This report also notes how SCHT is learning from these deaths and the impact of this work, led by the Learning from Deaths Group, with the aim of providing high quality, integrated and personalised care.

This includes our wider ambition both to demonstrate impact of learning from Community Hospital deaths but also to learn from deaths in the wider Community (where patients are in the direct care of another organisation, but we have been involved in their care) and play a part in evolving a system approach to learning from deaths. As previously noted, the Medical Examiner's role is expanding into the non-acute hospital settings and this is hoped to assist in review of deaths within the Community across organisations. The SaTH Medical Examiners Service have been in contact with the Trust and work on how this process will operate within SCHT is under way.

Learning from Deaths 2022-2023 Quarter 4 Report

2.2 Summary

The key points of this report are:

For Quarter 4 there have been 16 deaths reported within the Community Hospitals.

Seven of these deaths were recorded as having a COVID-19 positive swab within the last 28 days and the Trust's infection Control Team were duly notified; 5 deaths occurred in January 2023 which was the highest number of COVID-19-positive occurrences in the financial year. All such deaths were reported on the COVID-19 Patient Notification System (CPNS).

Two patients had COVID-19 recorded as their primary cause of death on their death certificate (1) a 96-year-old female admitted to Whitchurch Community Hospital, with a covid positive diagnosis from Royal Shrewsbury Hospital (RSH), length of stay 12 days i.e. covid not acquired under our care (2) a 90-year-old female patient admitted to Whitchurch Community Hospital from RSH, length of stay 11 days admitted on 03.02.2023, positive covid test 06.02.2023. Covid 19 identified on day 3 of admission – when Patient became unwell – no lateral flow completed on admission as per Infection Control Policy.

There were no reported Deaths in Custody in Quarter 4.

Actions from previous Deaths in Custody cases and PPO investigations continue to be reviewed and monitored by the LfD Group. The Trust is waiting for final PPO report on two previous deaths.

One case is due to go to the Coroner's Court in the week commencing 22 May 2023; however the final PPO report for this death (September 2022; ligature-related) made no clinical recommendations.

There have been no reported deaths of People with a Learning Disability and Autistic People

The number of Shropshire and Telford & Wrekin child death notifications for 2022/2023 year to date is 41 (this includes 17 SUDIC's).

The Trust is working with the SaTH Medical Examiner's Service on the introduction of the Medical Examiner's role within Community Hospitals to provide independent scrutiny of non-coronial deaths in non-acute healthcare settings. One of the Hospital Managers has drafted a Standard Operating Procedure (SOP) which is currently being discussed by all the Community Hospital teams.

In addition to exploring and responding locally to learning from each Community Hospital death, the following themes continue to be addressed and impact demonstrated through our Learning from Deaths Lessons Learnt Improvement Plan

Improving the early recognition of the need for End of Life care and appropriate care planning put in place

Improving inter-organisational collaboration for Learning from Deaths and End of Life care including systems for promoting continuity of care

2.3. Conclusion

The Trust Board is asked to:

Learning from Deaths 2022-2023 Quarter 4 Report

Note the report and themes detailed

Discuss and question the issues and work highlighted in the report

To agree the level of assurance provided by this report, proposing:

- Substantive Assurance that the Trust are meeting their requirements under the National Learning from Death Framework including Learning from Deaths in relation to patients who have died within our direct care. In addition the Trust continues to take opportunities to learn from all deaths within our direct care and in the wider Community Services

3. Main Report

3.1 Introduction

The Trust's Learning from Deaths process is covered in the Learning from Deaths Policy and details the processes we undertake to carry out a review or investigation of a death of a patient under our direct care (Community Hospitals and HMP/YOI Stoke Heath). We are also willing to be involved in any investigation of a patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation. It is acknowledged that, for patients not under our direct care, we will sometimes have to rely on those other organisations to notify us of a patient's death as there is currently no national system in place that will notify us directly. It is noted that we do carry out Learning from Deaths Level 1 reviews in the Community when instigated by our Teams and will look at linking in with the Medical Examiner's role when it expands into the non-acute settings in our area.

3.2 Community Hospital Deaths

Local Learning from Deaths Level 1 reviews are carried out on every patient death within the Community Hospitals and include staff involved in the care and treatment of the patient. For this reporting period (Jan to March 2023) there have been 16 patient deaths reported. This brings the total since April 2022 to 54 deaths within Community Hospitals.

Community Hospitals Patient Deaths 2022 to 2023

Data is reported monthly within the Trust and to the Public Board in accordance with the national framework guidance. COVID-19 deaths are required to be reported within 24 hours as part of the NHSI COVID-19 Patient Notification System (CPNS). In this reporting period there have been 2 COVID-19 related patient deaths, which had COVID-19 recorded as their primary cause of death on their death certificate.

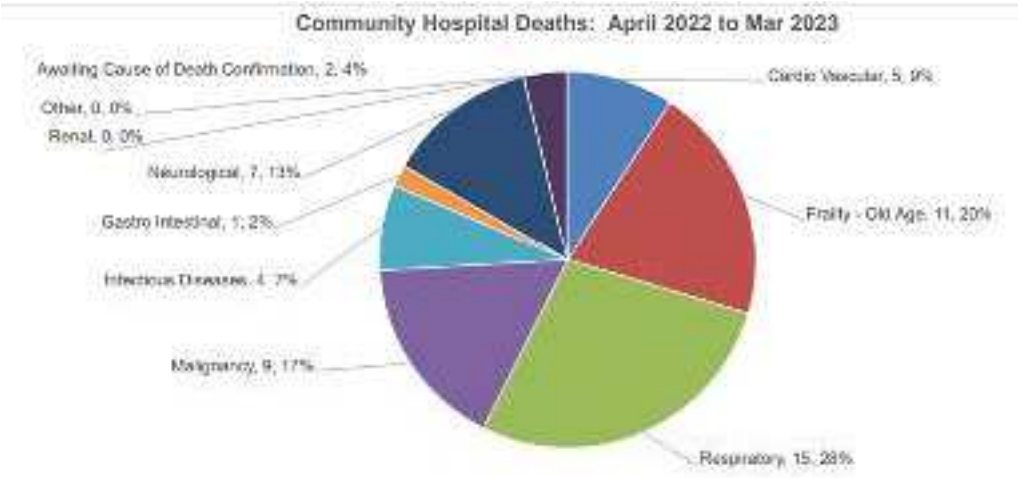
Appendix 1: Community Hospital COVID-19 positive patient deaths gives details of the COVID-19 related deaths for Q4 of 2023-23.

Under the Department of Health suggested dashboard and categories all patient deaths in this period were assessed as Score 6 – "Definitely not avoidable". See *Appendix 2* for the Shropshire Community Health NHS Trust (SCHT) Learning from Deaths dashboard.

Learning from Deaths 2022-2023 Quarter 4 Report

Appendix 3 compares deaths in Community Hospitals over the past 12 months with those the previous year.

The main causes of deaths within Community Hospitals for the year 2022-23 are Respiratory (28%), Frailty of Old Age (20%), Malignancy (17%) and Neurological (13%). Since generation of the graph below, it has since been confirmed that of the two-awaiting cause of death, one (which was a death that occurred in Quarter 4) was identified as Frailty (Old Age) as the Primary Cause of Death. The other awaiting cause of death is historical data from August 2022 for a case which went to the coroner and upon which the Trust has not been updated.



3.3 Deaths in Custody

There were no reported Deaths in Custody in Q4 of 2022-23.

Of the three Deaths in Custody reported previously in 2022-23, the final clinical review has been received for one, and the initial PPO report has been received for another. For the third death in custody, the final PPO report has been received. This noted that the reception health screen was good. The Coroner's Office has advised that a Pre-Inquest Review Hearing (PIRH) for this patient will be held on 13 April 2023 and the inquest is listed for 22 to 26 May 2023, with a jury.

3.5 Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

LeDeR is responsible for facilitating local reviews of deaths of people with learning disabilities (aged 4 to 74 inclusive) and autistic people registered with a GP in England at the time of their death. All deaths will be reviewed, irrespective of the cause or place of death. There have been no such deaths of LeDeR adults in our Community Hospitals to report in Q4 of 2023-23.

The CDOP Lead has advised that there was one child (i.e 0-18 years) LeDeR death for Quarter 4 and 5 outstanding reviews into previous quarters in respect to child LeDeR which are jointly overseen by the ICB.

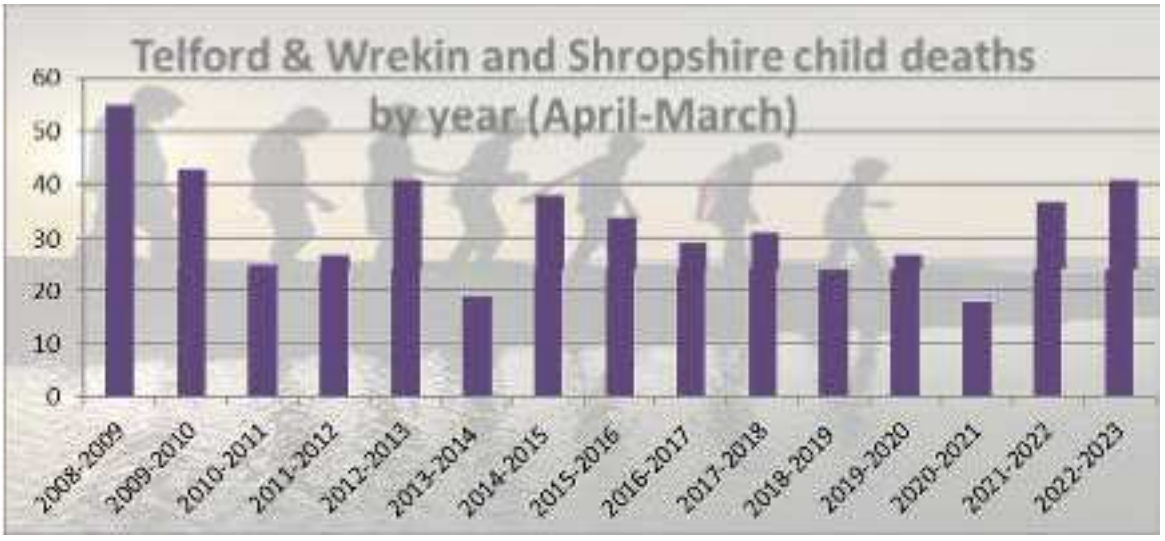
Learning from Deaths 2022-2023 Quarter 4 Report

3.4 Learning from Child Deaths

The Child Death notifications for Q4 ended at 41, this is the highest amount of child deaths we have seen for 10 years. There were 17 Sudden Unexpected Deaths which triggered a Joint Agency Response, this is the second year we have seen an increase and it has put huge workload pressures on the team to fulfil the statutory responses required at stated in The Child Death Review ; Statutory and Operational Guidance. The child death review statutory and operational guidance states that a coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death is sudden and there is no immediately apparent cause. The guidelines state that a joint home / scene of collapse visit by health and police should take place with 48 hours of the death. For staffing reasons there have been several cases when this has not happened and the visit has been single agency, by police only; this visit is also part of Recommendation 8 in the SUDIC thematic review. (Appendix 4 -National Child Mortality Database Programme: Action Plan)

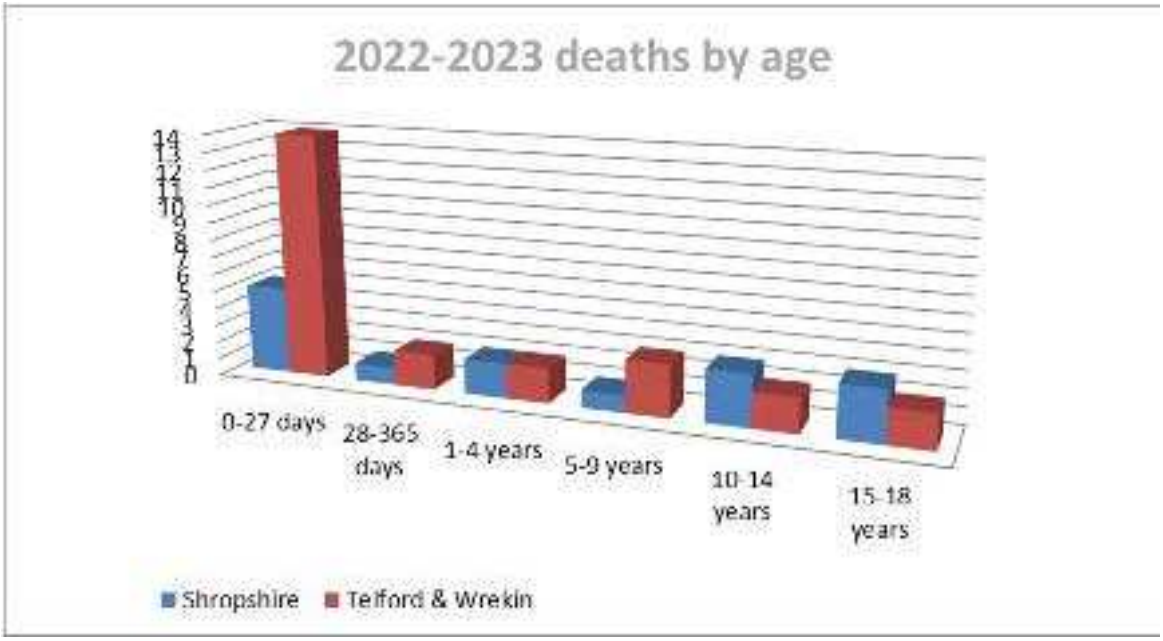
The increase in deaths has also had an impact on the quality of support we are offering to bereaved families and not all families are having a key worker allocated to them. It is hoped the Independent Review will address these issues and make recommendation to improve the Child Death Review Processes.

The following graph includes the total child death notifications for the 15 years since CDOP commenced.



Number of Deaths in 2022/2023 broken down by TWSP and SSP and age range:

Learning from Deaths 2022-2023 Quarter 4 Report



SUDIC Thematic Report NCMD: The NCMD recently published a thematic report 'Sudden and Unexpected Deaths in Infancy and Childhood.' (Appendix 5). This report draws on the unique data that CDOP's supply to investigate sudden, unexpected, and unexplained deaths in both infants and children and young people, and to draw out learning and recommendations for service providers and policymakers. We are currently working on an action plan to achieve the recommendations The recommendations from this thematic report are:

1. Importance of SIDS awareness.
2. Health Visitors VIWEING sleeping arrangements.
3. High quality care following death of an Infant.
4. Importance of following the statutory guidance for joint agency response when a child dies suddenly and unexpectedly.
5. Families are well supported and the right information is collected to support investigations and future research.

Safer Sleep in Winter Resource: Due to the current cost of living crisis, the Lullaby Trust issued specific advice for families on safe sleep during the winter months. This will allow practitioners to support families to follow safe sleeping advice when they may not be able to heat their homes. This resource was shared with colleagues and circulated via social media.

CDOP Risk Register: CDOP risk (nurse specialist cover for child death reviews) which was increased to high risk in Q3 remains a high risk on the Trust risk register due to staffing and lack of cover for the Joint Agency Response (JAR) and a director-level meeting to discuss CDOP as a system approach was planned for the end of March 2023. Since then a peer review of CDOP commissioned by ICB has commenced at the beginning of April 2023 with all Directors sighted.

3.5 Learning from Deaths Group

The Learning from Deaths (LfD) Group record related actions in the LfD Lessons Learnt Implementation Plan which is a combination of an Action Log and Assurance Tracker. Any

actions are monitored and when completed assurance visits/initiatives planned to ensure the relevant lessons learnt are being implemented. Recent key themes requiring ongoing attention and improvement are:

- Improving the early recognition of the need for End of Life (EOL) care and the appropriate implementation of appropriate and relevant Care Planning
- Improving inter-organisational collaboration for Learning from Deaths and End of Life care

Improvements achieved to date include:

Continue to ensure End of Life care is considered when patients are assessed on admission even if not initially identified on any transfer documentation. Also to review deteriorating patients and initiate discussions with patients and relatives in a timely manner. Ensuring any ReSPECT forms are up to date and reflect the patient's current wishes.

3.6 Medical Examiner's Role

The SaTH Medical Examiner's Service have been in contact with the Trust to plan the implementation of the Medical Examiner (ME) role within the Community Hospitals to provide independent scrutiny of non-coronial deaths in non-acute healthcare settings. The SaTH ME Service have had initial discussions with the Trust. Currently the Trust's Locality Clinical Managers and Ward Teams are consulting on a draft SOP created by one of the Hospital Managers to define how the Community Hospitals will work with the ME Service.

3.7 Conclusion

The Trust Board are asked to:

Note the mortality data and themes detailed

Discuss and question the issues and work highlighted in the report

To agree the level of assurance provided by this report, proposing:

- Substantive Assurance that the Trust are meeting their requirements under the National Learning from Death Framework including Learning from Deaths in relation to patients who have died within our direct care. The Trust continues to take opportunities to learn from all deaths within our direct care and in the wider Community Services.

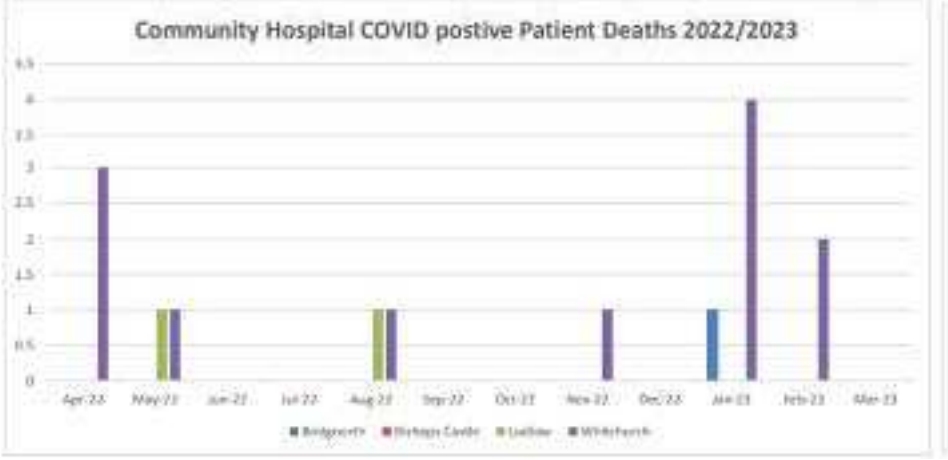
Learning from Deaths 2022-2023 Quarter 4 Report

Appendix 1: Community Hospital COVID positive patient deaths – April 2022 – March 2023:

Shropshire Community Health - Community Hospital COVID postive patient deaths

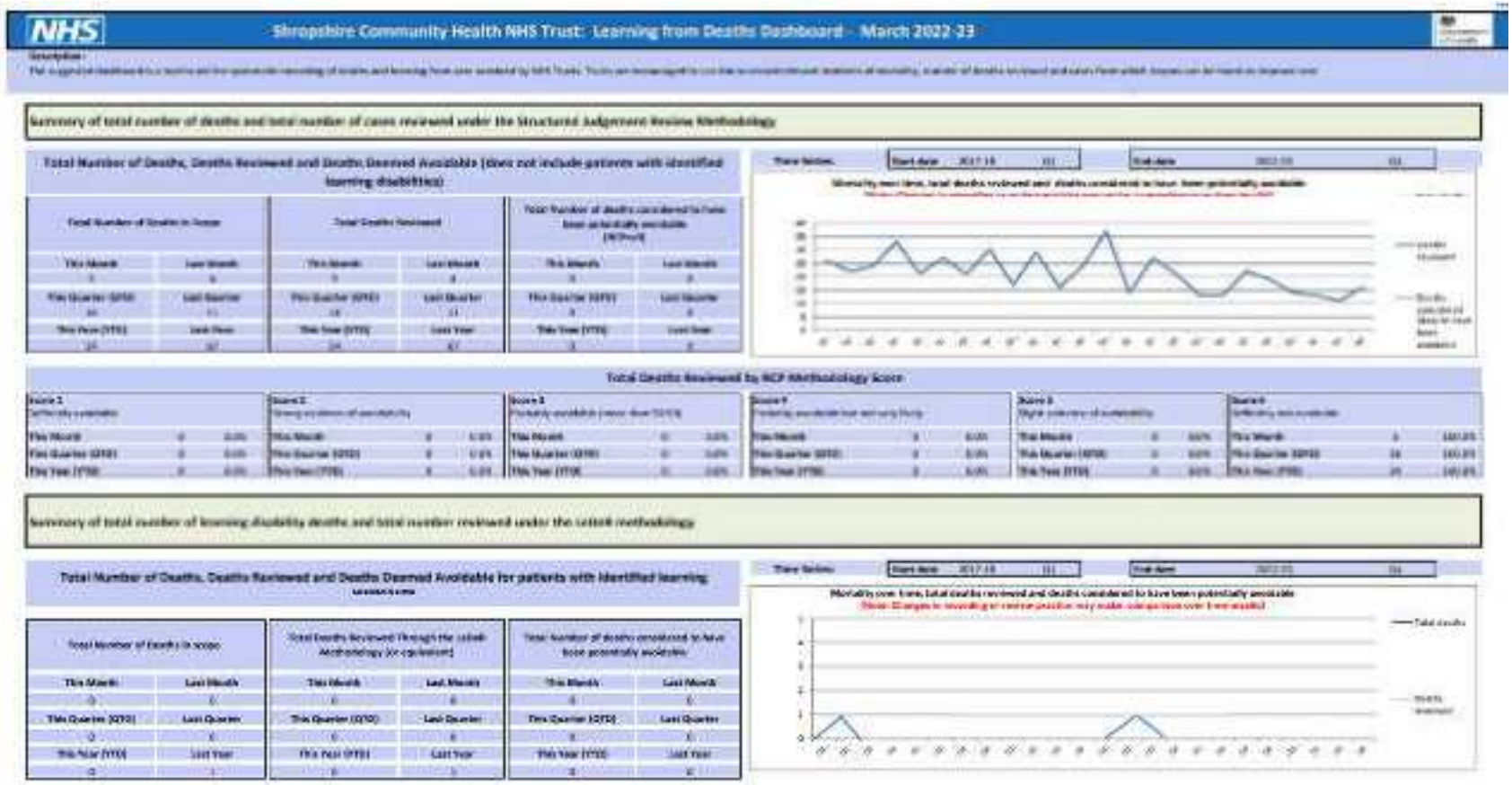
	2022/2023												Grand Total from 2020
Hospital	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	
Bridgnorth	0	0	0	0	0	0	0	0	0	1	0	0	6
Bishops Castle	0	0	0	0	0	0	0	0	0	0	0	0	0
Ludlow	0	1	0	0	1	0	0	0	0	0	0	0	12
Whitchurch	1	1	0	0	1	0	0	1	0	4	2	0	50
Grand Total	**1**	**2**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**5**	**2**	**0**	**68**

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Grand Total from 2020
Patients where Covid 19 was recorded as the primary cause of death. i.e. COVID 19 was noted in part 1 of their Death Certificate as "Disease or condition directly leading to death".	1	0	0	0	1	0	0	1	0	1	1	0	30



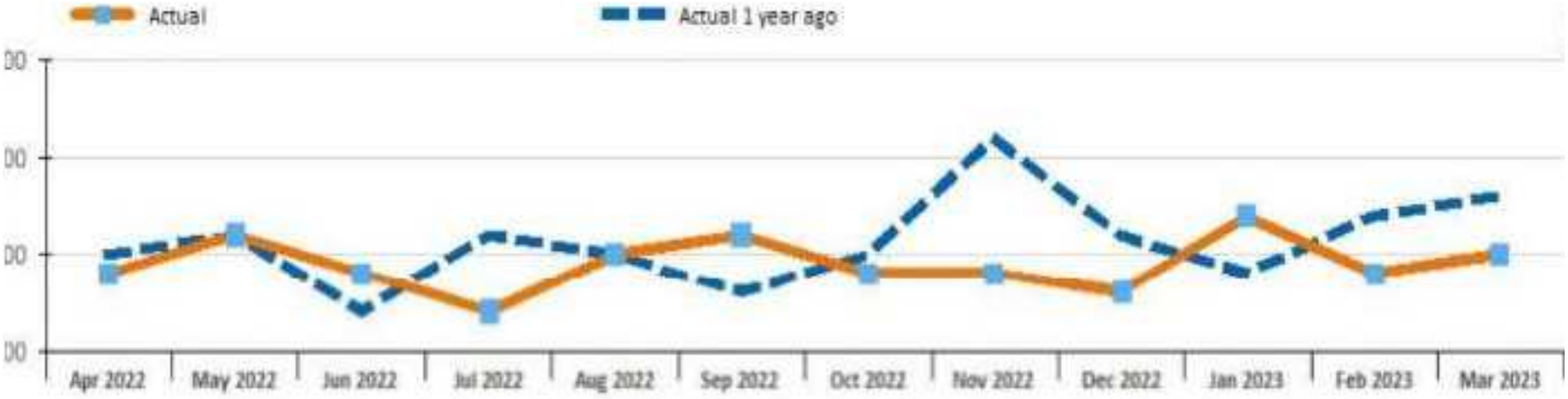
Learning from Deaths 2022-2023 Quarter 4 Report

Appendix 2: Shropshire Community Health NHS Trust (SCHT) Learning from Deaths dashboard – March 2023



Learning from Deaths 2022-2023 Quarter 4 Report

Appendix 3: Community Hospital Patient Deaths January 2021 to March 2023



1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	**14**	15.	16.	17.	18.	19.	20	21.	22	23	24	25	26	27.	28

Shropshire Community Health
NHS Trust

Guardian of Safe Working Hours (GoSW) Quarterly Report 1st February 2023 – 30th April 2023.

Author:	**Dr Bridget Barrowclough Guardian of Safe Working Hours (GoSW)**	**Paper date:**	**1 June 2013**
Executive Sponsor:	Dr Ganesh	**Paper written on:**	April 2023
Paper Reviewed by:		**Paper Category:**	Quality & Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents assurance to the Board that trainee doctors at Shropshire Community Health NHS Trust have safe working hours and conditions in order to maintain doctor and patient safety for the Trust Board and the paper is for assurance.

2. Executive Summary

2.1 Context

This report is presented to the Trust Board with the aim of providing the context and assurance around safe working hours for Doctors in Training (Junior Doctors) in Shropshire Community Health NHS Trust, have safe working hours and conditions in order to maintain doctor and patient safety. This assurance is collated from Shrewsbury and Telford Hospitals NHS Trust's (SATH) Guardian of Safe Working Hours (GOSW), our trainees being employed by SATH.

To respond to the committee's request to receive feedback from our junior doctors on their experience working in SCHT.

2.2 Summary

This report is presented to the Committee with the aim of providing the context and assurance around safe working hours for Doctors and Dentists in Training (Junior Doctors) in SaTH. It provides the Committee with data on safe working hours, missed rest periods and any concerns raised regarding service commitments that impact our Junior Doctors in Training.

There are three trainees working in the community currently.

Exception Reports

There were no Exception Reports received in this period.

2.3. Conclusion

The Trust Board is asked to agree the level of assurance provided by this report.

Shropshire Community Health
NHS Trust

Clinical Effectiveness Report October 2022 – March 2023

0. Reference Information

Author:	**Michelle Bramble Quality Facilitator Chantel-lea Grocott Research Support Team Leader**	**Paper date:**	**1 June 2023**
Executive Sponsor:	Dr M Ganesh Medical Director	**Paper written on:**	10 May 2023
Paper Reviewed by:	Claire Horsfield, Deputy Director Quality & Chief AHP	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

This paper presents a 6-monthly update on delivery of the Clinical Audit, NICE guidance and Research and Development programmes for Trust Board and is for information and approval.

2. Executive Summary

2.1 Context

This biannual paper is required to provide assurance to Trust Board around implementation of the Clinical Audit and NICE guidance programmes. It also provides an update on our evolving Research and Innovation programme and ambition.

2.2 Summary

- A total of 22 audits were included on the Clinical Audit programme between 1 October 2022 and 31 March 2023. Implementation of the programme has progressed well over the period with only one audit being delayed.
- Thirteen audits were completed and in all areas for improvement identified and action plans drawn up and monitored for implementation.
- The Trust has continued to submit data to all of the four National Clinical Audits in which it is eligible to take part. We have signed up to participate in Round 5 of the National End of Life Care Audit (NACEL) although at present, there is no clinical lead to oversee the project until the new Lead ACP starts in post.
- The process for the monthly review of newly-published NICE guidance has continued, with 6 pieces of guidance being relevant to the Trust for information only and four relevant and requiring a baseline assessment of compliance to be undertaken.
- Two major reviews of NICE guidance across multiple services within Children and Young People's SDG have been carried out.

2.3. Conclusion

The Trust Board is asked to

- **receive** and **accept** as assurance around implementation of the Clinical Audit and NICE guidance programmes
- **accept** the Research and Innovation update.

Clinical Effectiveness Report October 2022 – March 2023

3. Main Report

3.1 Introduction

The purpose of this report is to provide assurance to the Trust Board around the delivery of the Clinical Audit, NICE Guidance and Research and Development Programmes. The report will form the basis of discussion on how to evolve these programmes going forward, with the focus being on their impact of the quality and safety of care provided to patients.

3.2 Update

3.2.1 Clinical audit - overall summary

Table 1 provides high level detail about implementation of the clinical audit plan, both at SDG and priority level. Audits are given a priority on the programme using a model developed by the Healthcare Quality Improvement Partnership (HQIP). An explanation of the three priority categories used can be found at Appendix 1.

Table 1

	Total number of audits listed	Priority 1	Priority 2	Priority 3	Number completed	Number delayed
Total	22	9	11	2	13	1
Corporate/Trust-wide	3	1	2	0	3	0
Adults & TeMS SDG	10	7	3	0	6	1
Children and Families SDG	9	1	6	2	4	0

Clinical Effectiveness Report October 2022 – March 2023

3.2.2 Clinical audit - delays in implementation

Only one audit was delayed at period end compared with three in the previous report.

Table 2

Audit title	Priority	Service	Comments
CQUIN CCG14: Assessment, diagnosis and treatment of lower leg wounds	1	Community Nursing	Data for Q3 and Q4 has not been submitted. The lower leg wound assessment form in RiO has now been finalised and training in it's use is being rolled-out across Community Nursing Teams. The data collection tool for the CQUIN has been built in MS Forms.

3.2.3 Clinical audit - outcomes

A total of 13 audits were completed during the reporting period, brief detail of which is provided below. All audit reports go through a check-and-challenge process undertaken by the Quality Facilitator and the relevant Clinical Lead for Quality to ensure that all areas of non-compliance are addressed within the action plan and prior to submission to SDG Quality and Safety meetings.

Priority 1

The 3 CQUIN audits completed are reported on in Section 3.2.4 and the 4 National audits in Section 3.2.5.

Leaving care summary audit. Looked After Children. This is a continuous audit with biannual reporting. The results for Q3 and 4 show full compliance on the majority of measures, with all 11 summaries included in the audited rated as 'Good' overall in terms of their quality. There was 1 case where some items of information were not available because the child was new to the country.

Priority 2

Initial LAC health assessments. Community Paediatrics (Qs 3 & 4). The results remain good across all sections with 5/6 reports rated as outstanding in terms of their overall quality. There continues to be excellent documentation of assessments and the reports give a clear picture of the children. Evidence of the use of all available information was documented in the assessments. The ST trainee/Doctor training will continue and the importance of quality emphasised in the current ST trainee induction. Trainee reports will be reviewed by supervisors to ensure that the overall quality improves from good to outstanding in all cases.

Medicines management audit. Severndale School. The audit reviewed the medicines management processes within Severndale Specialist Academy School against the combined School and Trust Medicines Policy, Shropshire Community Health NHS Trust Medicine Policies, and the related medicines Standard Operating Procedures (SOPs). Two areas of partial compliance involved the correct recording of minimum and maximum ambient and fridge temperature, although actual temperature was recorded each day the service was open. This represented an improvement on the previous year's audit. Two areas of non-compliance

involved the publishing of the current medicine policy and SOPs. These delays have now been addressed.

The previous two years' audits had highlighted an issue with the Controlled Drugs register with the medication form not being documented. This has now been resolved.

Whilst improvements on timely reviews of medicine-related paperwork is required, the audit still provided assurances that medicines are administered safely and stored securely within school. A document tracker will be used to highlight documentation that is due for review six months before the expiry date, so that a full review can be completed and published before the expiration date.

Medicines management audit. Bridge School. Out of the 26 criteria 6 were deemed 'not applicable' due to the differences in medicines administration between The Bridge and Severndale Schools. The audit identified 5 areas of non-compliance. Two non-compliances involved having the latest version of medicines policy and consent forms available and one, the timely reviewing of SOPs. Two involved the young person's rescue medication. Whilst the storage non-compliance highlighted on last year's audit has been resolved, incorrect medicine administration records were seen with the rescue medicines, highlighting the importance of recognising 'Look Alike Sound Alike' medicines (buccolam vs baclofen), and date checking had not been completed for September, in line with SOPs. The Special School Nurse Team Leader has carried out a re-visit to the school and has confirmed that all of the areas of non-compliance have been addressed.

Clinical Team meeting minutes audit. Trust-wide. A re-audit has been undertaken to identify whether team meetings have been reinstated after they were stood down during Covid and to gain assurance around use of the standardised Trust agenda template. The audit findings identified significant variation across teams in relation to the frequency of meetings held, use of the Trust agenda template and in the overall quality of the minutes audited. A minimum standard for the required frequency of meetings will be agreed, the current agenda template will be reviewed and revised and guidance on the content of minutes produced.

Audit of compliance with industrial action harm proforma. Trust-wide. This audit reviewed the use of a pilot proforma devised for the recording of harm on RiO in a new Trust policy. The aim was to establish whether harm had been considered for all cancellations during the recent industrial action and whether the proforma was fit for purpose in its current form. The audit results confirmed that adoption of the proforma by teams was limited, giving little assurance that harm was being routinely considered, or that the proforma worked in practice. The Harms policy needs to be fully implemented within the Trust, the proforma reviewed and revised if necessary and piloted during a subsequent phase of industrial action.

3.2.4 CQUINs

The CQUIN scheme for 2022/23 was published in January 2022, with four indicators being of relevance to the Trust. There was no financial penalty for non-compliance during this financial year. The same CQUINs will apply for 2023/24 although the financial penalty for non-compliance has been reintroduced.

A delivery group to oversee the implementation of CQUINs has been established and meets on a weekly basis. Compliance with CQUIN targets will be regularly and closely monitored as will implementation of any actions identified to improve performance. This will then report into a monthly CQUIN Oversight meeting to provide assurance on progress and seek support through escalation.

Table 3

Indicator number	Indicator title	Service/s affected	Start date	Submission
CCG1	Flu vaccinations for frontline healthcare workers	Trust-wide	Sep-22	Monthly
CCG13	Malnutrition screen in the community	IDT/Community Nursing and Inpatients	Apr-22	Quarterly
CCG14	Assessment, diagnosis and treatment of lower leg wounds	IDT/Community Nursing	Apr-22	Quarterly
CCG15	Assessment and documentation of pressure ulcer risk	Inpatients	Apr-22	Quarterly

CCG 1 Flu vaccinations for frontline healthcare workers. The proportion of frontline staff vaccinated as at 28/2/23 was 61%, falling short of the minimum target of 70%. Although compliance was lower than in previous years, it is reflective of the overall Regional picture which saw uptake figures drop and SCHT was one of the better-performing Trusts within the Region.

CCG13 Malnutrition screening in the community. Overall compliance with the CQUIN was 3% in Q3 and 9% in Q4 against a 50% minimum and 70% maximum target.

CCG14 Assessment, diagnosis and treatment of lower leg wounds. Data was not submitted for either Q3 or Q4. The lower leg wound assessment form in RiO has now been finalised and training in its use is being rolled-out across Community Nursing Teams. The data collection tool for the CQUIN has been built in MS Forms on MS Teams.

CCG15 Assessment and documentation of pressure ulcer risk. Overall compliance with the CQUIN was 9% in Q3 and 14% in Q4, against a 40% minimum and 60% maximum target.

3.2.5 National Audits

The Trust submitted data to all of the four national audits in which it was eligible to take part. Progress in relation to each one is provided below.

- *National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACP).* The latest report to be published was for the period October 2021 to March 2022. The Trust is achieving above the national average in relation to walk test distances and Quality of Life outcome measures. Our patients continue to wait longer than the recommended 90 days to be assessed and enrolled onto a programme but with the recent focus on reducing waiting lists, this position has improved considerably.

- *National Audit of Care at the End of Life (NACEL). Round 4.* The Trust submitted data to the organisational and case note review elements of this audit. Our scores were above the national average in relation to governance, meeting the needs of families and carers, families' and others' experience of care, staff confidence and staff support. Areas

identified for improvement included communication with the dying person and with their families and others. The results have been incorporated into a comprehensive End of Life Care action plan. The Trust has signed up for participation in NACEL Round 5, however, currently there is no clinical lead to oversee the project until the new Lead ACP starts in role.

- *National Diabetes Foot Audit.* The audit results highlighted that we have an aging population with higher-than-average levels of Peripheral Arterial Disease (PAD). We are not achieving the 8 care checks for people with diabetes as recommended by NICE and foot screening is definitely an area in need of improvement. We are not seeing patients quickly enough and our patients are presenting with more severe ulcers. Despite, this we are achieving outcomes in line with the national average on the majority of measures contained within the audit.

- *National Audit of Inpatient Falls.* The Trust submitted data to the Facilities element of this audit and was compliant with all criteria except for one, relating to the absence of a non-Executive Director with responsibility for falls.

3.2.6 NICE guidance

An update of newly-published NICE guidance is produced each month and reviewed for relevance by the Quality Facilitator, the Chief Pharmacist and the Clinical Leads for Quality prior to submission to SDGs for approval.

Between 1/10/22 and 31/3/23, 109 separate pieces of guidance or advice were published by NICE, 6 of which were relevant to the Trust for information only and consequently shared with relevant teams/services. Four guidelines or quality standards required a baseline assessment of compliance – either with newly-published guidance or with updates to older guidance.

As at 31/3/23, 10 baseline assessments were on the NICE implementation programme, 2 of which had been completed and 8 were in progress. Full detail of the programme can be found at Appendix 3.

NG204 Babies, children and young people's (CYP) experience of healthcare. All children's services were asked to complete a baseline assessment. Full compliance with recommendations was high at 95%+ and there were no areas of non-compliance, only full or partial. Each service produced an action plan to address any specific areas of partial-compliance but a number of themes were identified across the SDG, such as staff knowledge and understanding of the role of the independent advocate, development of written and digital information that is produced in partnership with children, young people and their families and children and their families not having to repeat healthcare history. A staff survey was also undertaken which identified a high level of understanding and awareness of the guideline recommendations, both in terms of the quantitative and qualitative responses provided. The survey results reiterated the need to improve staff understanding around independency advocacy, involving CYP in service experience and improvement and in their healthcare record.

NG213 Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education. Again, all children's services were asked to complete a baseline assessment, with the majority of services declaring full compliance with the guideline recommendations. Areas identified for improvement included development of a palliative care pathway to link with the Trust's End of Life policy review, further work on the Trust Transition pathway to provide a clear route for CYP with complex needs leaving our services and improving understanding of the processes that underpin the Educational, Health and Care needs assessment.

3.2.7 Research and Innovation update

Report presented to the Research Steering Group Quarterly and then circulated to Trust Quality Committees and Clinical Forums as required. This update provides assurance and updates on the key aspects of progress and performance of Research within the Trust.

The report will note the Trust's current position and progress against National Institute for Health Research (NIHR) and Clinical Research Network West Midlands (CRN WM) Performance Metrics.

The report will highlight work and development to ensure the continued increase in research activity and development of a research culture across the organisation.

PERIOD	Quarter 3 and 4
PROGRESS AGAINST TARGET	The research portfolio sits at the centre of the National Institute of Health Research (NIHR); a collection of high-quality studies from both academic and life science partners, the Department of Health monitors delivery of these studies as a measure of research engagement. The Trust is actively engaged with this portfolio, reporting directly to the NIHR on research activity for these studies on a quarterly basis; and is awarded funding to support their delivery. The CRN Performance Operating Framework for 2022/23 has the following High Level Objectives which performance is measured against 1. Efficient Study Delivery – recruiting to target (achieved and projected) on all studies 2. Provider Participation – recruiting to CRN portfolio studies in every quarter 3. Participant Experience – the number of research participants responding to the Participant in Research Engagement Survey (PRES) The accrual total for SCHT for 2022/23 is 520.
NEW STUDIES OPENED	Studies in Set up: • ELSA Studies Open to Recruitment: • CADET • UKIVAS • PROGRESS • GLAD • MS REGISTER • RUDY • Prevent RA

	• NCISH • BSRBR PSA • IMID BIOResource Studies in Follow up: • PRO SPIRIT • Tonic • SIREN
MEETINGS/ EVENTS ATTENDED	In March the team presented our children's studies to the Community Paediatric Consultant's CPD away day and as a result we have now linked in with the team and are starting to get patient referrals from them.
QUALITY/SAFETY REPORTING	Louise Warburton and Frances Davies are now registered as information asset managers for the research team.
GOOD NEWS	Louise along with Prof Ian Maidment and Ruth Lambley-Burke were successful in their application for CRN Innovation & Improvement funding for a project to interview research staff in Community Trusts to seek out barriers to research (the HANDLE project). The team were shortlisted in two categories for the SCHT staff awards. A fourth team member was successfully recruited to the team in March, Tina will join the team as Clinical Research Assistant in May. The team over-recruited to a dental study (PROGRESS) and were mentioned alongside the fabulous effort from the Dental Team in the Weekly Update. They were also the highest recruiting site for the MINDArise study.
PPIE ACTIVITY	Jo Tomlinson has now taken on the leadership for PPIE and is working with Mary-Anne Darby at the CRN.
CRN UPDATES	A small amount of additional funding has been awarded by the CRN to cover the costs of pay awards for staff. Ruth Lambley-Burke represented SCHT at the CRN WM Partnership Board. Frances Davies represented SCHT at the CRN WM R&D Managers Forum

3.3 Key Risks

- Non-submission of Q3 and Q4 data for CQUIN CCG14 Assessment, diagnosis and treatment of lower leg wounds.
- Poor compliance for CQUINs CCG13 on malnutrition and CCG15 on pressure ulcers in both Q3 and Q4. This provides a low level of assurance about the extent to which assessments are being carried out and the quality of those assessments.

3.4 Conclusion

The Trust Board is asked to

- **receive** and **accept** the report as assurance around implementation of the Clinical Audit and NICE guidance programmes
- **accept** the Research and Innovation update.

Appendix 1

Healthcare Quality Improvement Partnership (HQIP

Clinical audit priority model

Priority Level		Description
1	External 'must dos'	Externally monitored audits driven by commissioning and quality improvement requirements. These can include projects on the National Clinical Audit and Patient Outcome Programme (NCAPOP) and audits to demonstrate compliance with nationally and locally developed CQUIN targets
2	Internal 'must dos'	Link directly to the organisational and strategic priorities of the Trust or are undertaken in response to patient feedback, clinical risk issues, serious untoward incidents/adverse incidents. The clinical record keeping audit programme is included in this category
3	Local clinical priority and interest	All other audits on the programme

Appendix 2

Clinical audit programme October 2022 – March 2023

Current Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken.
Amber	Delayed, with evidence of actions to get back on track.
Green	Progressing on schedule, evidence of progress.
Blue	Completed, evidence of compliance with standards or action plans to achieve compliance.

Priority 1 audits

Title	SDG	Service	Status
National audit of care at the end of life (NACEL)	Adults	Inpatients	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP). Pulmonary Rehabilitation audit. **Continuous audit.**	Adults	Respiratory Service	
National Audit of Inpatient Falls. **Continuous audit**	Adults	Inpatients	

Clinical Effectiveness Report October 2022 – March 2023

Title	SDG	Service	Status
National Diabetes Foot Audit. **Continuous audit**	Adults	Podiatry	
Quality assessment of leaving care health summaries Q3 & 4	Children and Families	Looked After Children	
CQUIN CCG1 Flu vaccinations for frontline healthcare workers	Corporate	Occupational Health	
CQUIN CCG13 Malnutrition screen in the community	Adults	Inpatients IDT/Community Nursing	
CQUIN CCG14 Assessment, diagnosis and treatment of lower leg wounds	Adults	IDT/Community Nursing	
CQUIN CCG15 Assessment and documentation of pressure ulcer risk	Adults	Inpatients	

Priority 2 audits

Title	SDG	Service	Status
Quality assurance audit of the Looked After Children (LAC) initial health assessment form Q3 & 4	Children & Families	Community Paediatrics	
Quality assurance audit of the Looked After Children (LAC) review health assessment form Q3 & 4	Children & Families	Looked After Children	
Audit of NICE NG19 standards for all major amputation patients	Adults	Podiatry	
NICE guidance CG161 on falls prevention	Adults	Inpatients	
Clinical team meeting minutes audit	Trust-wide	All clinical services	
Audit of compliance with industrial action harm proforma	Trust-wide	All clinical services	
Medicines management audit	Children & Families	Severndale School	

Clinical Effectiveness Report October 2022 – March 2023

Title	SDG	Service	Status
Medicines management audit	Children & Families	Bridge School	
Clinical record keeping audit	Children & Families	Paediatric Psychology	
Clinical record keeping audit	Children & Families	Physiotherapy	
Reception screening audit	Adults	Prison Service	

Priority 3 audits

Title	SDG	Service	Status
Mainstream pathway audit	Children & Families	Occupational Therapy	
Outcomes audit	Children & Families	Speech & Therapy	

Appendix 3

NICE guidance baseline assessment programme October 2022 – March 2023

Current Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being
Ambe	Delayed, with evidence of actions to get back on track.
Gree	Progressing on schedule, evidence of progress.
Blue	Completed, evidence of compliance with standards or action plans to achieve

Title	Type	Publication date	New or update	SDG	Service	Status
NG204 Babies, children and young people's	NICE guideline	Aug-21	New	NICE guideline	All services	
NG213 Disabled children and young people up to 25 with severe complex needs	Quality standard	Mar-22	Update	Children and families	All services	
NG220 Multiple sclerosis in adults: management	NICE guideline	Jun-22	New	Adults	CNRT	

Clinical Effectiveness Report October 2022 – March 2023

Title	Type	Publication date	New or update	SDG	Service	Status
CG189 Obesity: identification, assessment and management	Clinical guideline	Sep-22	Update	Children & Families	Health Visiting, School Nursing, CCN, Community Paediatrics, Prisons	
NG226 Osteoarthritis in over 16s: diagnosis and management	NICE guideline	Oct-22	New	Adults	Physiotherapy	
QS87 Osteoarthritis in over 16s	Quality standard	Oct-22	Update	Adults	Physiotherapy	
QS207 Tobacco: treating dependence	Quality standard	Dec-22	New	Adults	Prison, Inpatients, Dental	
CG103 Delirium: prevention, diagnosis and management in hospital and long-term care	Clinical guideline	Dec-22	Update	Adults	Inpatients	
QS208 Type 1 diabetes in adults	Quality standard	Mar-23	New	Adults	Diabetes	
QS209 Type 2 diabetes in adults	Quality standard	Mar-23	New	Adults	Diabetes	

Shropshire Community Health NHS Trust

Staff Survey – Listening Events Update

0. Reference Information

Author:	Shelley Ramtuhul	**Paper date:**	1 June 2023
Executive Sponsor:	Patricia Davies	**Paper written on:**	25th May 2023
Paper Reviewed by:	N/A	**Paper Category:**	Quality and Safety / 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 on the Trust's response to the Staff Survey results.

2. Executive Summary

2.1 Context

The Trust Board received and considered the staff survey results and agreed that an action plan was required to make the necessary improvements for our staff. Whilst the Trust already had in train a number of improvement actions being overseen by the People Committee it was agreed that further work was required to fully understand the experiences of the Trust's staff before agreeing the improvement actions required

2.2 Summary

- This paper sets out the programme of listening events that are being held and the way in which the outputs of these are being collated with a view to informing an overarching action plan and feedback to staff.

2.3. Conclusion

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

Staff Survey – Listening Events Update

3. Main Report

3.1 Programme of Listening Events

The programme commenced in May and is due to continue throughout June, the uptake of the events will be monitored with further dates added as required:

Date / Time	Venue
17 May 23 1500-1630	Online #1
26 May 23 1300 - 1430	Halesfield Aldridge Room
5 June 23 1500 - 1630	Online #2
8 June 23 1000 - 1130	Online #3
9 June 23 1000 - 1130	Bridgnorth Community Hospital Seminar Room
14 June 23 1400 - 1530	Ludlow Community Hospital Clee Meeting Room
15 June 23 0930 - 1100	Oswestry Health Centre Seminar Room
15 June 23 1215 - 1345	Whitchurch Community Hospital Seminar Room
TBC	K2 William Farr House (currently 9th June but David is sorting room issues)

3.2 Process of the Listening Events

The Listening Events are intended to be in informal forum where staff can talk about the issues they face at work, as well as what is going well. Most of the forums have a minimum of one of the Executive Team present in order to agree the actions that will be taken away or, if possible to resolve the issue in the room. There are also forums planned without an Executive present in cases some staff feel this would be more comfortable.

Staff Survey – Listening Events Update

Following the events the discussion topics and agreed actions are collated and allocated to an Executive Lead to take forward. The full action plan will be presented to People Committee for oversight but in the meantime the Communications Team are establishing a 'You Said, We Did' bulletin to ensure that feedback is provided to staff. This is key to ensuring that staff can see that their concerns have been heard and will hopefully encourage more staff to feel able to raise any issues in the future.

3.3 Listening Events Held

So far the Trust has held two events with similar themes cutting across each. It has been encouraging to hear that many of the issues raised are already being addressed through programmes of work that have been put in place but it is clear there is also more to do. The full detail of these events is still being collated and will be shared through the People Committee.

4.0 Conclusion

The Board is asked to note the progress being made with the listening events and the plan for People Committee to have oversight of the outputs.

Shropshire Community Health
NHS Trust

Performance Update

Author:	Jon Davis, Associate Director of Digital Services	**Paper date:**	**1st June 2023**
Executive Sponsor:	Sarah Lloyd, Director of Finance	**Paper written on:**	**24th May 2023**
Paper Reviewed by:	Resource & Performance Committee	**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

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

2. Executive Summary

2.1 Context

The purpose of this report is to provide oversight and includes an assessment of the key areas of performance relevant to the Trust's updated Performance Framework. It summarises the performance of measures within the overarching Performance Framework, using Statistical Process Control (SPC) charts, and provides further narrative across several of the measures relevant to the Resource & Performance Committee. Actions being taken in relation to performance indicators considered by the Quality and Safety Committee and People Committee will be reported separately to the Trust Board.

It is acknowledged that this report will be further developed and refined as we progress through the year.

2.2 Summary

The key points for the Trust Board to consider are:

- There are 55 performance indicators reported in this period across all committees in the new format that include SPC reporting processes.

- The Resource and Performance Committee recently reviewed 20 of these KPIs and considered there were positive trajectories across the following KPIs however without a process review under the SPC methodology they are due to fail to meet their targets:-

    - Data Quality Maturity Index
    - 18 Week Referral to Treatment Incomplete Pathways
    - Proportion of Patients Within 18 Weeks

Performance Update

- That Special Cause Variation of a concerning nature has been identified in the following KPIs
  - Diagnostics for Audiology and Ultrasound
  - Total Patients Waiting More Than 52 Weeks – All services
  - Agency Spend – Compared to the Agency Ceiling.
- The Committee also considered that there are currently 184 patients waiting over 52 weeks. In addition, there are 9 patients waiting over 78 weeks although these are not in nationally measured RTT services.
- There were no patients waiting over 104 weeks.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the new performance indicators and the revised reporting process using SPC charts and the actions being taken to minimise risks and improve performance where required.

3. Main Report

3.1 Introduction

The Trust Board will be aware that the Performance Framework has been revised in line with the Making Data Count framework and was approved by the Board on 2nd February. This revised approach includes the use of Statistical Process Control (SPC) charts which identify variations and control limits.

The Information Team have now developed the required changes in Power BI for the agreed list of KPIs. The full list of KPIs monitored across all three committees is shown in Appendix 1 of this document.

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

3.2 Summary of key points in report

There are 55 performance indicators reported in this period across all committees; 20 of these were recently considered at the Resource & Performance Committee with 7 felt to be worthy of particular focus and discussion. Actions being taken in relation to performance indicators considered by the Quality and Safety Committee and People Committee will be reported separately to the Trust Board.

The Resource and Performance Committee also considered data is not yet available for 3 KPIs, which will be reported to the next Committee.

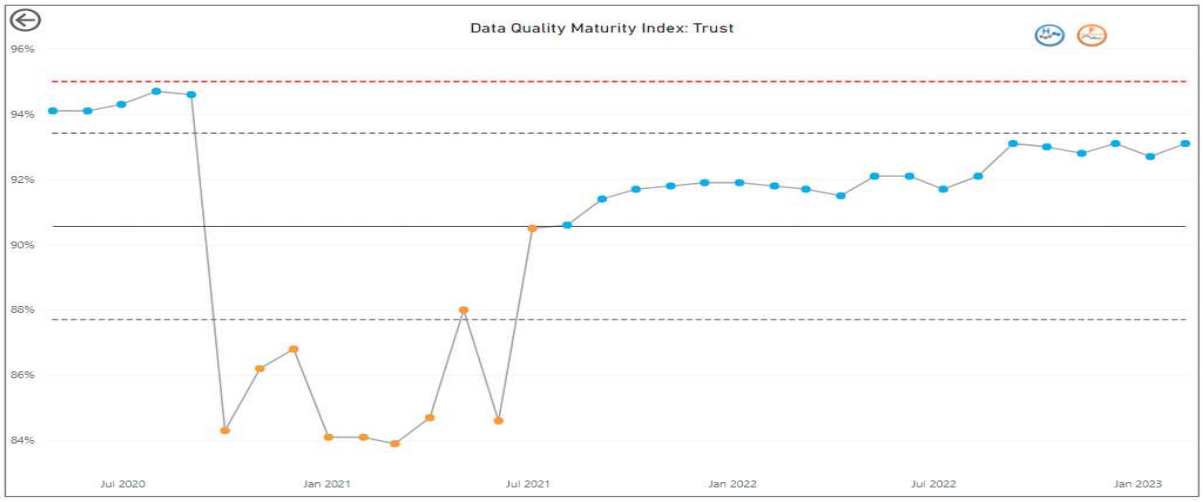
- Agency Spend (Price Cap Compliance)
- Financial Efficiency
- Financial Stability

Performance Update

It was also noted that whilst data is populated for Virtual Ward Capacity, the service only goes back to August 2022, therefore there is not yet sufficient history to generate a full SPC chart.

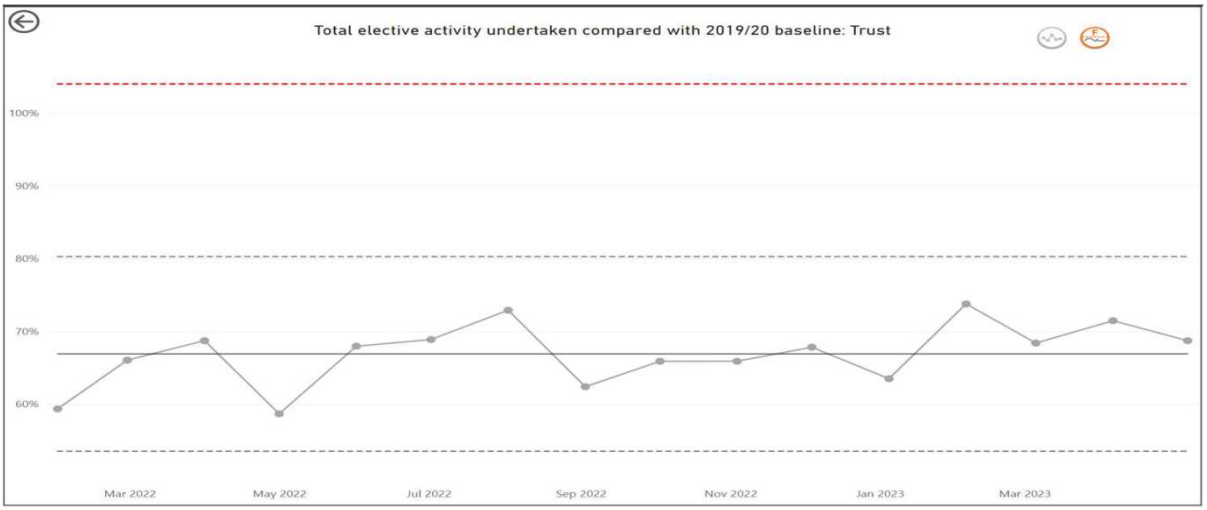
The Committee considered each of the SPC charts shown below. As well as the actual trend line itself, the red dotted line is the target and the two dotted grey lines the control limits one upper and one lower. The blue shading indicating an improving nature and the amber a concerning one.

Data Quality Maturity Index:-



In this measure, although there is an improving trajectory, as the blue variation icon depicts, this KPI will fail to meet the target without some intervention and process redesign to shift the control limits and improve trajectories as the amber assurance icon illustrates. This measure will be further reviewed at the Trust's Data Quality sub-group to consider existing processes and put in place further actions needed to improve trajectories

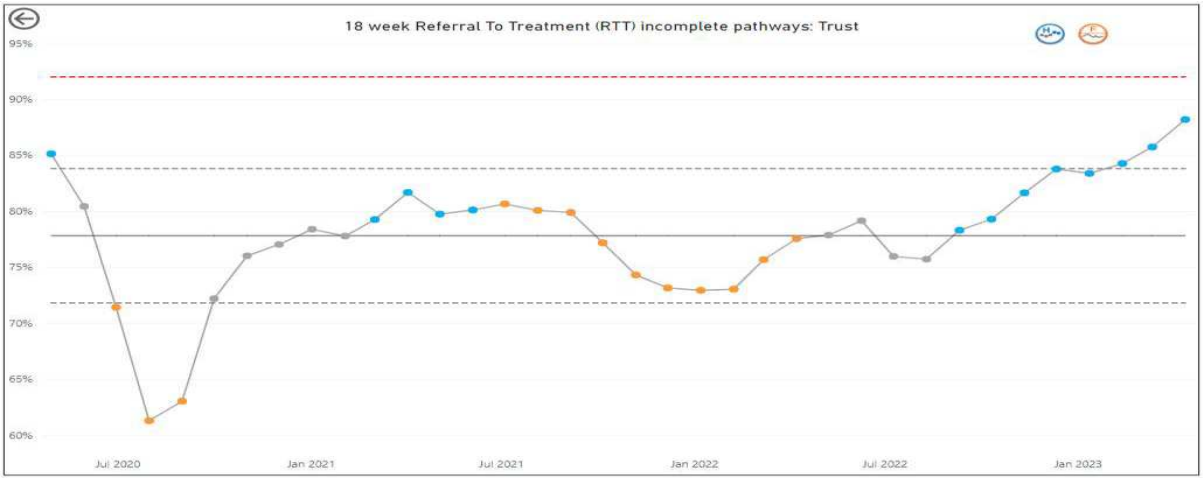
Total Elective Activity Undertaken compared with 2019/20 Baseline:-



Performance Update

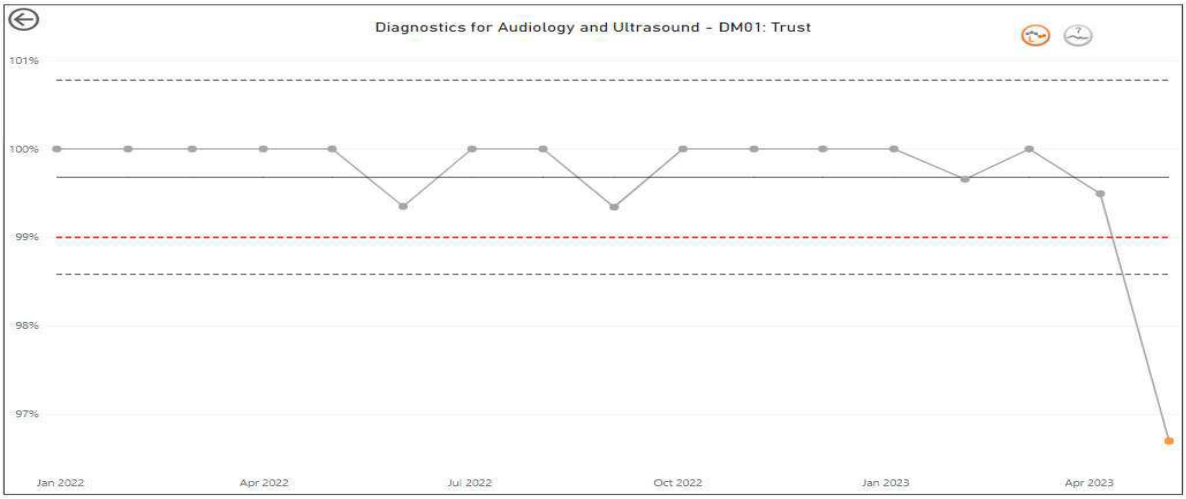
Given there is no significant change and common cause variation is evident, as the grey variation icon suggests, this KPI will fail to meet the target without some intervention and process redesign to shift the control limits in line with the expected targets as shown by the amber assurance icon.

18 Week Referral to Treatment (RTT) Incomplete Pathways:-



Although there is an improving nature and trajectory, as the variation icon and blue shading depicts, from an assurance perspective this KPI will fail to meet the target without some intervention and process redesign to shift the control limits and further improve trajectories as the amber assurance icon illustrates.

Diagnostics for Audiology and Ultrasound – DM01:-



Considering there has been no significant change over a significant period of time and performance had been above target, special cause variation is evident as shown by the amber variation icon. Considering this is a national target some intervention is necessary to understand the cause of the breaches shown in the SPC chart above.

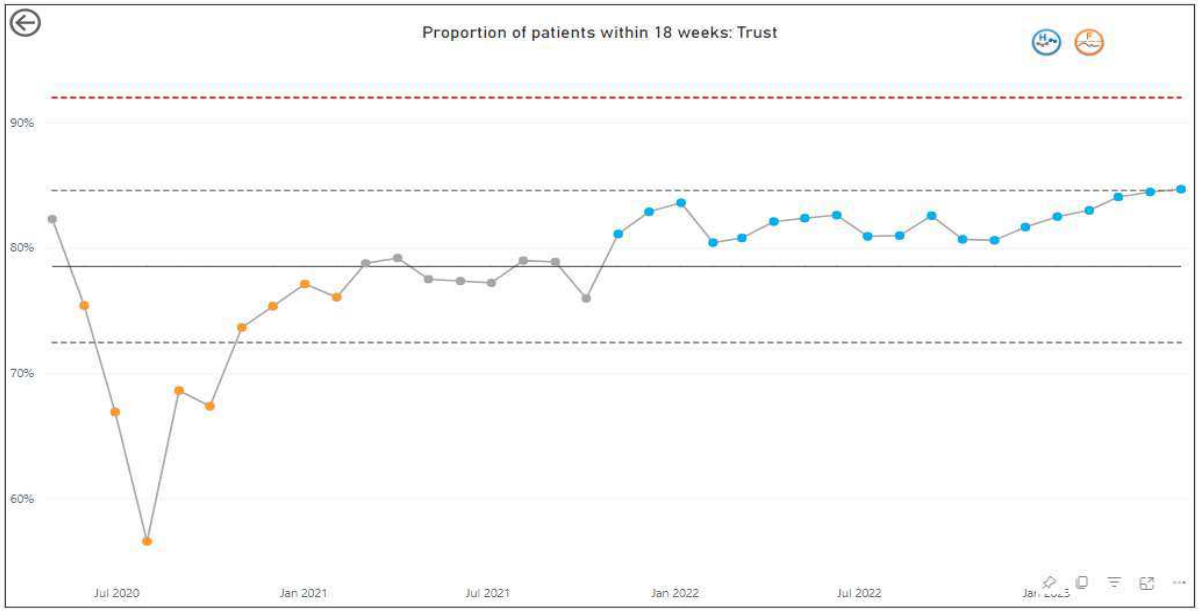
Performance Update

As performance reported within the three previous SPC charts demonstrates, the Trust continues to experience challenges recovering services and this is particularly the case in services where patients require diagnostic investigations or Orthopaedic consultant support. The diagnostic challenges are not exclusive to SCHT; this is a national pressure due to shortages of Radiologists and an increase in demand for imaging studies.

As a mitigation, our operational and clinical teams are working closely with system partners to ensure we are prioritising the longest-waiting patients and those whose clinical needs are highest.

Process amendments to improve performance include utilising support from the independent sector to provide additional Radiology resources and increasing our clinical outpatient capacity.

Proportion of Patients within 18 weeks:-

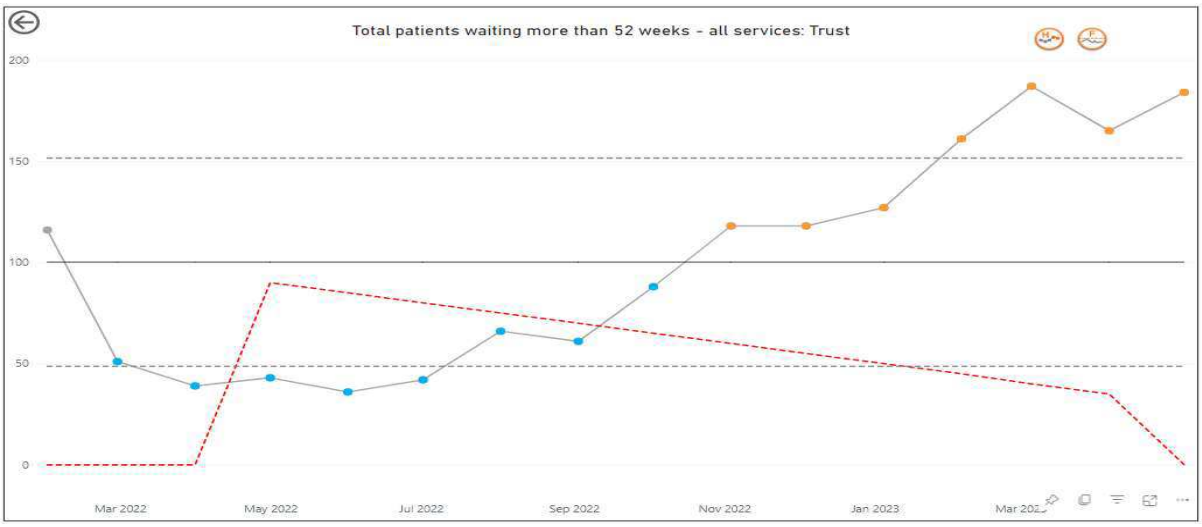


As with 18-week incomplete pathways measure, although there is an improving nature and trajectory from an assurance perspective this KPI will fail to meet the target without some intervention and process redesign to shift the control limits and further improve trajectories.

In this case and as discussed previously work is ongoing to ensure adequate capacity is available to improve the process and position as described earlier.

Performance Update

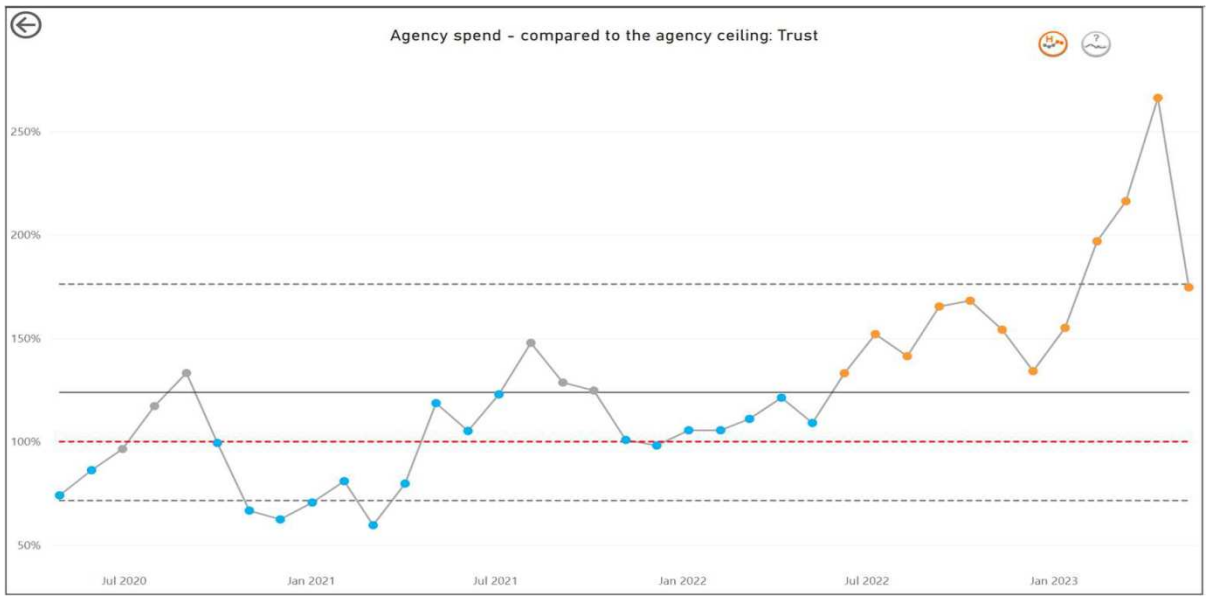
Total Patients Waiting More than 52 weeks – All Trust Services:-



This SPC chart shows there is special cause variation, as depicted by the amber variation icon that suggests the measure is significantly higher than target and currently failing to meet requirements without process re-design. At the end of April there were 184 patients waiting over 52 weeks across Trust services and 9 patients waiting over 78 weeks, although there are no patients waiting over 104 weeks.

This increase is largely due to the level of demand on Lower Limb Orthopaedic services. To amend process and improve performance, the scoping of additional capacity is underway which will support the reduction of patients waiting above 52 weeks.

Agency Spend – Compared to the Agency Ceiling:-



Performance Update

Special cause variation is evident in this SPC chart and it is concerning given the exponential increase in spend during quarter four of the last financial year although it is worth considering the marked decrease at the end of April.

To improve performance, agency approval processes are being designed and implemented across the Trust to provide a robust control mechanism to monitor and provide further oversight.

The Resource & Performance Committee also considered that to support the revised approach to performance reporting, and as part of this collective re-design, colleagues from both corporate and operational areas of the Trust will be meeting regularly to review the SPC charts and formulate a revised approach to recovery planning.

Initially, working groups are being set up to review and improve 4 of the trust-wide KPIs which include:-

- Sickness Rate
- Proportion of Patients Within 18 weeks
- Agency Spend
- New Birth Visits

These groups will provide focus and put in place a best practice and agile approach to improvement to address any variation as necessary and report back through the relevant committees on progress against plans.

In conjunction, with this and whilst a best practice approach is developed, the full suite of SPC charts will be reviewed at monthly operational senior management venues 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.

Although it is very early days, it is anticipated that through this re-designed model and approach, Committees and the Board should expect an increase in the level of assurance will develop as the SPC dashboards and supporting structures further embed.

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 new performance indicators and the revised reporting process using SPC charts and the actions being taken to minimise risks and improve performance where required.

Shropshire Community Health
NHS Trust

Performance Update

Appendix 1

Resource and Performance Committee – SPC Summary
Month 01 (April) 2023/2024 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance Committee	Effective	Available virtual ward capacity per 100k head of population	2023-04-30		27.38	118.00	-90.62	27.38	118.00	-90.62	
Resource & Performance Committee	Effective	Data Quality Maturity Index	2023-01-31		93.1%	95.0%	-1.9%	93.1%	95.0%	-1.9%	
Resource & Performance Committee	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2023-04-30		67.73%	75.00%	-7.27%	67.73%	75.00%	-7.27%	
Resource & Performance Committee	Effective	Total activity undertaken against current year plan	2023-04-30		99.79%	100.00%	-0.21%	99.79%	100.00%	-0.21%	
Resource & Performance Committee	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2023-04-30		138.62%	120.00%	18.62%	138.62%	120.00%	18.62%	
Resource & Performance Committee	Effective	Total elective activity undertaken compared with 2019/20 baseline	2023-04-30		68.71%	104.00%	-35.29%	68.71%	104.00%	-35.29%	
Resource & Performance Committee	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2023-03-31		88.20%	92.00%	-3.80%	88.20%	92.00%	-3.80%	
Resource & Performance Committee	Responsive	Community Equipment Store - Response within 7 days	2023-04-30		90.25%	95.00%	-4.75%	90.25%	95.00%	-4.75%	
Resource & Performance Committee	Responsive	CQC Conditions or Warning Notices	2023-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2023-04-30		96.70%	99.00%	-2.30%	96.70%	99.00%	-2.30%	
Resource & Performance Committee	Responsive	Number of patients not treated within 28 days of last minute cancellation	2023-04-30		1	0	1	1	0	1	
Resource & Performance Committee	Responsive	Proportion of patients spending more than 12 hours in an emergency de...	2023-04-30		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	
Resource & Performance Committee	Responsive	Proportion of patients within 18 weeks	2023-04-30		84.69%	92.00%	-7.31%	84.69%	92.00%	-7.31%	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks - all services	2023-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2023-03-31		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks - all services	2023-04-30		184	0	184	184	0	184	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatme...	2023-03-31		29	35	-6	29	35	-6	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatm...	2023-03-31		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks - all services	2023-04-30		9	0	9	9	0	9	
Resource & Performance Committee	Use of Resources	Agency spend - compared to the agency ceiling	2023-04-30		174.63%	100.00%	74.63%	174.63%	100.00%	74.63%	

Performance Update

Quality & Safety Committee – SPC Summary
Month 01 (April) 2023/2024 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Shropshire	2023-03-31		80.42%	90.00%	-9.58%	84.30%	90.00%	-5.70%	
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Telford	2023-03-31		92.75%	95.00%	-2.25%	95.08%	95.00%	0.08%	
Quality & Safety Committee	Effective	Deaths - unexpected	2023-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2023-04-30		61.54%	95.00%	-33.46%	61.54%	95.00%	-33.46%	
Quality & Safety Committee	Responsive	Proportion of patients who have a first consultation in a post-covid servic...	2023-04-30		5.88%	92.00%	-86.12%	5.88%	92.00%	-86.12%	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2023-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2023-04-30		1.00	0.00	1.00	1.00	0.00	1.00	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2023-04-30		96.99%	95.00%	1.99%	96.99%	95.00%	1.99%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-03-31		100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2023-04-30		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2023-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2023-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2023-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Serious Incidents (reported)	2023-04-30		2	0	2	2	0	2	
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2023-04-30		6.1	6.3	-0.2	6.1	6.3	-0.2	
Quality & Safety Committee	Well Led	Overall CQC Rating	2023-04-30		Good	Good		Good	Good		

Performance Update

People Committee – SPC Summary
Month 01 (April) 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 ...	2023-04-30		7.2	7.3	-0.1	7.2	7.3	-0.1	
People Committee	Well Led	Appraisal Rates	2023-04-30		80.55%	95.00%	-14.45%	80.55%	95.00%	-14.45%	
People Committee	Well Led	CQC well-led rating	2023-04-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2023-04-30		13.66%	9.60%	4.06%	13.66%	9.60%	4.06%	
People Committee	Well Led	Mandatory Training Compliance	2023-04-30		93.61%	95.00%	-1.39%	93.61%	95.00%	-1.39%	
People Committee	Well Led	Net Staff in Post Change	2023-04-30		10.94	0.00	10.94	10.94	0.00	10.94	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME back...	2023-04-30		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	2023-04-30		66.67%	64.00%	2.67%	66.67%	64.00%	2.67%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled...	2023-04-30		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...	2023-04-30		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...	2023-04-30		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...	2023-04-30		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...	2023-04-30		21.1%	0.0%	21.1%	21.1%	0.0%	21.1%	
People Committee	Well Led	Proportion of temporary staff	2023-04-30		8.3%	3.4%	4.9%	8.3%	3.4%	4.9%	
People Committee	Well Led	Sickness Rate	2023-04-30		5.46%	4.50%	0.96%	5.46%	4.50%	0.96%	
People Committee	Well Led	Staff survey engagement theme score	2023-04-30		7.1	7.2	-0.1	7.1	7.2	-0.1	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2023-04-30		388	0	388	388	0	388	
People Committee	Well Led	Total shifts on a non-framework agreement	2023-04-30		3	0	3	3	0	3	
People Committee	Well Led	Vacancies - all	2023-04-30		11.52%	8.00%	3.52%	11.52%	8.00%	3.52%	

Performance Update

Appendix 2

Icon Descriptions

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

Shropshire Community Health NHS Trust

Month 1 2023/24 Financial Performance

0. Reference Information

Author:	Sukjit Kooner, Head of Management Accounts	**Paper date:**	1 June 2023
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	19 May 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 provides a summary of financial performance as at Month 1 and is for assurance.

2. Executive Summary

2.1. Context

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

This paper summarises the Trust's financial performance for the period ended 30 April 2023 against the financial plan. At this early stage of the financial year, summary information only is provided within this report, with additional detail to be added from month 2.

2.2. Summary

The Trust is reporting a £25k adjusted surplus compared to the planned surplus of £45k, which is a small adverse variance of £20k.

Key areas for consideration are:

- **Agency** spend was £489k in April. This exceeded planned levels by £209k (75%), although it is a reduction of £145k compared to the March spend. Agency usage will need to reduce to planned levels to deliver the financial plan
- Delivery of the Trust's £4,108k **CIP** target for 2023/24 is a significant financial risk, particularly the £1,072k non-recurrent 'stretch target' agreed with STW ICS partners in late April

2.3. Conclusion

The Board is asked to:

- **Consider** the adjusted financial position for the year to date is a surplus of £25k compared to the planned surplus of £45k which is an adverse variance of £20k
- **Recognise** that agency costs continue to exceed our plan despite the controls in place and continued growth in substantive workforce
- **Acknowledge** the Trust's challenging CIP target for 2023/24 and that plans are not yet fully identified to deliver this level of efficiency

Month 1 2023/24 Financial Performance

3. Main Report

3.1. Introduction

The Trust is measured on its financial performance in several ways, but the principal measure is total Income & Expenditure at adjusted financial performance level. This excludes several technical accounting adjustments and is the level at which performance is reported to and managed by 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. Financial performance is an adverse variance of £20k compared to plan.

Financial Performance against Plan (£k)	M01 Plan	M01 Actual	M01 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Annual Variance
(Surplus)/ Deficit In Year	(45)	(25)	20	(45)	(25)	20	0	0	0
Agency Expenditure	280	489	209	280	489	209	3,735	3,735	0
Capital Expenditure	0	(188)	(188)	0	(188)	(188)	2,500	2,500	0

At this early stage of the financial year, key areas of consideration are:

Our 23/24 Annual Plan is a break-even position on an income budget of £106,874k. The plan profile expects a surplus position each month for quarter 1 and quarter 2 and deficits for the latter half of the year. This largely reflects increases in our planned expenditure over the year due to investments linked to approved and pending business cases

AGENCY - actual spend in April 23 was £489k - a 75% in excess of plan. Controls are in place to minimise the use of agency whilst ensuring patient safety.

CIP - the target for 2023/24 is £4,108k. This includes £1,072k non-recurrent 'stretch target' agreed with STW ICS Partners in late April. Delivery of the Trust's CIP remains a key financial risk. Additional CIP detail will be provided from month 2 onwards

Month 1 2023/24 Financial Performance

3.2. Adjusted Financial Performance – adverse variance to plan £20k

The adjusted financial position for Month 1 is a surplus of £25k compared to the planned surplus of £45k which is an adverse variance of £20k. Table 1 summarises the position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(8,493)	(8,425)	69
Expenditure excl. adjusting items	8,448	8,399	(49)
Adjusted financial performance total	**(45)**	**(25)**	**20**
Adjusting items	14	14	0
Retained (surplus) / deficit	**(31)**	**(11)**	**20**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 30 April 2023

3.2.1. Income – adverse variance to plan £69k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System income	(6,850)	(6,793)	57
Non system income	(1,643)	(1,631)	12
Total income	**(8,493)**	**(8,425)**	**69**

Table 2: Income Summary as at 30 April 2023

System income comprises of agreed block income, 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 income variance mainly reflects lower income from the Covid-19 vaccination service, which is matched by lower costs, and an estimate for a low level of underachievement against the month 1 elective activity plan noting that activity performance data is not yet available.

3.2.2. Expenditure – favourable variance to plan £49k

Table 3 shows a summary of expenditure incurred in month 1.

	YTD Plan £k	YTD Actual £k	YTD Variance £k
Substantive	5,864	5,186	(679)
Bank	114	244	130
Agency	3	489	486
Total Pay	**5,981**	**5,919**	**(62)**
Non-Pay	2,239	2,213	(26)
Trust-wide Central Charges	242	282	39
Total Non-Pay	**2,481**	**2,495**	**14**
Total Expenditure	**8,462**	**8,414**	**(49)**

Table 3: Expenditure Summary as at 30 April 2023

Month 1 2023/24 Financial Performance

3.2.3. Pay – favourable variance to plan £62k

The favourable variance is driven by high levels of substantive vacancies in the SDGs (£568k) and Corporate Services (£132k). These underspends are partially offset by bank and agency staff costs covering vacancies, sickness and demand pressures.

Substantive WTE in the SDGs increased by 7 in the month although the vacancy rate remains high at 11%. Workforce recovery plans are in place to increase the pipeline of new starters and retain existing staff and the position is being kept under close review through the People Committee.

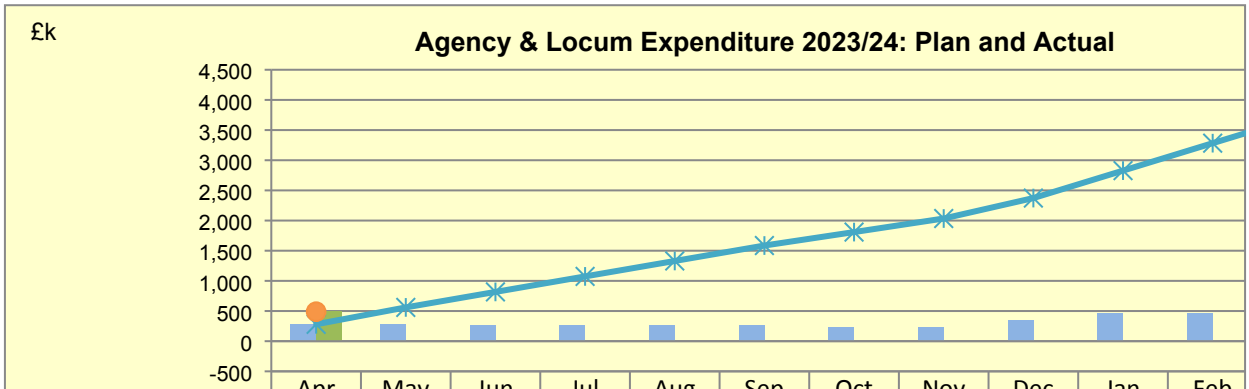
It should be noted that the annual CIP target has not yet been allocated to budgets, given the late changes to this value, and this will happen for month 2 reporting. Once the CIP target is allocated against budgets, the current pay underspend position currently reported will be reduced or removed entirely.

3.2.4. Non-Pay and Central Charges – adverse variance to plan £14k

There are currently no material variances at this time and a detailed variance analysis will resume from month 2 onwards.

3.2.5. Agency and Locum Expenditure – adverse variance to plan £209k

Table 4 shows agency spend is £489k in month 1 which is £209k higher than the plan of £280k.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
In Month Plan	280	280	257	257	256	256	223	225	339	455	455
In Month Actual	489										
Cumulative Plan	280	560	817	1,074	1,330	1,586	1,809	2,034	2,373	2,828	3,283
Cumulative Actual	489										

Table 4: 2023/24 Agency and Locum Expenditure

Agency controls were enhanced in January 2023 with the introduction of a 'triple lock' process. A business case for all non-clinical agency must first be approved internally then forwarded to the ICB, and if approved by the ICB it will then be submitted to NHSE for final approval.

The planned increase in agency spend from December relates to the introduction of the Modular Wards and acknowledges that there is likely to be some agency usage whilst substantive recruitment is completed, should this development be approved.

Month 1 2023/24 Financial Performance

3.2.6. Agency and Locum Expenditure – by Service

Table 5 shows year to date expenditure and the final three months of 2022/23 for comparison.

Area of Agency Expenditure £k	2022-23 M10	2022-23 M11	2022-23 M12	2023-24 M01	2023-24 YTD
Bridgnorth Hospital	45	54	54	60	60
Ludlow Hospital	78	73	52	47	47
Whitchurch Hospital	121	133	148	104	104
Stoke Heath	7	18	18	11	11
MIU and DAART	34	35	27	11	11
Total for Community Hospitals & Stoke Heath	**285**	**312**	**299**	**234**	**234**
Urgent Care including Virtual Ward	68	85	151	114	114
Children & Families	46	47	92	53	53
Community Services	66	56	53	54	54
Admission Avoidance	(1)	0	0	20	20
Covid-19	14	13	37	14	14
Covid-19 Vaccination	0	0	0	0	0
Total for all Services	**469**	**515**	**634**	**489**	**489**

Table 5: Agency and Locum Expenditure by Service 2023/24

There was a decrease in agency spend in April compared to the previous quarter at the community hospitals, despite the use of locum GP cover at Bridgnorth and Whitchurch.

Urgent Care (Adults) includes £93k agency spend for the Virtual Ward on nursing, occupational therapist, physiotherapists and 3 medics. This level of agency spend was not allowed for within the budget and is one of the drivers for agency spend materially exceeding plan in month 1.

The operational team continues to review the requirements and options to safely reduce agency usage where possible as this is essential to deliver the Trust's challenging financial plan.

3.2.7. Agency and Locum Expenditure – by staff group

Table 6 shows agency expenditure by staff group and the final three months of 2022/23.

Agency & locum category £k	2022-23 M10	2022-23 M11	2022-23 M12	2023-24 M01	2023-24 YTD
Medical and Dental	42	52	137	110	110
Registered Nurses	269	275	280	240	240
HCAs	96	115	113	78	78
Admin and Clerical	4	2	3	3	3
Allied Health Professionals	54	65	100	50	50
Pharmacist Locum	5	3	4	8	8
Total for all staff groups	**469**	**515**	**634**	**489**	**489**

Table 6: Agency and Locum Expenditure by staff group 2023/24

- Medical and Dental spend relates to GP cover at Bridgnorth and Whitchurch, Virtual Ward, Post COVID clinics, dental and paediatric consultants
- Nursing expenditure reduced in the community hospitals, MIU and Virtual Ward; it increased in community services and in admission avoidance
- There was a reduction in HCAs compared to the previous quarter in community hospitals
- AHP expenditure reduced on the Virtual Ward, children's speech and language therapy and physiotherapists

Month 1 2023/24 Financial Performance

3.2.8. Cost Improvement Programme

The Trust's CIP target for 2023/24 is £4,108k which is 4.2% of turnover. The recurrent CIP element is £2,386k and the non-recurrent element is £1,722k. These values were included in our final 2023/24 plan re-submission to NHSE on 4 May 2023 and reflect changes agreed in order to improve the system's financial plan.

Detailed reporting of delivery to date and the forecast against the target will begin in month 2, and this month's update presents the current summary position only.

Table 7 shows that close to 50% of the target is either high risk or unidentified at this stage, which is not unexpected given that an initial stretch efficiency target of £930k was requested in March and an additional stretch target of £1,072k was agreed in late April/early May.

Category / Delivery Risk	High £k	Medium £k	Low £k	Unidentified £k	Total £k
Agency	200	400	80		680
Digital Benefits	92	108	39	-	239
Estates and Premises transformation	102	6	41	-	149
Procurement	187	163	-	-	350
Service re-design	233	582	83	-	898
Skill mix reviews	17	-	6		23
Other	108	119	470	-	697
Unidentified stretch				1,072	1,072
Total	**939**	**1,378**	**719**	**1,072**	**4,108**
Percentage	**23%**	**34%**	**18%**	**26%**	**100%**

Table 7: CIP in 2023/24 NHSE financial plan submission

3.2.9. Statement of Financial Position

A summarised Statement of Financial Position (SoFP) as of 30 April 2023 is shown in Table 8.

	31 Mar '23 Balance £k	30 Apr '23 Balance £k	Movement in Month £k
Property, Plant & Equipment	38,420	38,131	(289)
Inventories	612	609	(3)
Non-current assets for sale	189	0	(189)
Receivables	5,318	5,893	575
Cash	18,580	18,324	(256)
Payables	(11,601)	(11,767)	(166)
Provisions	(1,546)	(1,546)	0
Lease Obligations on Right to Use Assets	(7,928)	(7,589)	339
TOTAL ASSETS EMPLOYED	**42,044**	**42,055**	**11**
Retained earnings	32,949	32,960	11
Other Reserves	9,095	9,095	0
TOTAL TAXPAYERS' EQUITY	**42,044**	**42,055**	**11**

Table 8: Statement of Financial Position as of 30 April 2023

- Receivables increased by £575k
- Payables increased by £166k
- Cash decreased by £256k due to the above movements

These movements are within the expected range and there are no exceptions to report at this point in the year.

3.2.10. Capital Expenditure

The plan for 2023/24 is to spend £2,500k on capital and these plans were agreed with the ICS and submitted to NHSE as part of the Trust's financial plan. There are no risks to highlight at this stage of the financial year, and it is anticipated that the full value of capital will be utilised during year.

3.2.11. Monthly Monitoring Return to NHSE

A month 1 provider staff costs template, consistent with figures set out in this report, was submitted to NHSE on 17 May 2023. Full monitoring returns to NHSE will resume from month 2.

3.2.12. 2023/24 Financial Planning Return

Final changes to the 2023/24 plan submission were agreed at an Extraordinary RPC on 3 May and submitted to NHSE on 4 May 2023. A summary of changes made to the opening budgets to reflect this plan will be presented in month 2.

3.3. Key Areas for consideration

Key areas for consideration are:

- **Agency** spend was £489k in April. This exceeded planned levels by £209k (75%), although it is a reduction of £145k compared to the March spend. Agency usage will need to reduce to planned levels to deliver the financial plan
- Delivery of the Trust's £4,108k **CIP** target for 2023/24 is a significant financial risk, particularly the £1,072k non-recurrent 'stretch target' agreed with STW ICS partners

3.4. Conclusion

The Board is asked to:

- **Consider** the adjusted financial position for the year to date is a surplus of £25k compared to the planned surplus of £45k which is an adverse variance of £20k
- **Recognise** that agency costs continue to exceed our plan despite the controls in place and continued growth in substantive workforce
- **Acknowledge** the Trust's challenging CIP target for 2023/24 and that plans are not yet fully identified to deliver this level of efficiency

Shropshire Community Health NHS Trust

2023/24 Trust Planning Update

0. Reference Information

Author:	**Tricia Finch, Associate Director of Transformation and Planning**	**Paper date:**	**1 June 2023**
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	24 May 2023
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Strategic
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

To provide details of 2023/24 plans and submissions comprising:

- Trust Contribution to Revised System Plan.
- System Revised Plan Submission
- Trust 2023/24 Operational Plan
- National Developments

2. Executive Summary

2.1 Introduction

Since the development of Integrated Care Systems annual plans are submitted to NHSE at system level. Submitted plans are considered as a single plan therefore all adjustments must be reflected and aligned across all partners.

The system submission in March 2023 was not considered acceptable and for this reason a revised plan was developed and submitted 4th May. Details of our contribution are provided in this report.

2.2 Context

As a system we face significant financial challenges. To secure NHSE acceptance of our plan we have included an ambitious cost improvement programme. For the Trust that equates to £4.1m.

In addition to delivering these cost reductions we are also committing to a significant programme of change. This programme comes with investment but on the basis that it will deliver wider system benefits. Ensuring that we can demonstrate these benefits is key to retaining investment and for securing future investments.

2023/24 Trust Planning Update

2.3 Revisions to 2023/24 Plan

Throughout the planning process the Board has received updates on our plans and the Resource and Performance Committee has received detail on the changes. The need for system agreement to plans, and a challenging timetable, has impacted on the level of detail available and the dates at which this has been available.

This month's report provides the Board with a high-level reconciliation of the material changes since our first submission. Through a significant effort by teams, our DRAFT plan was an accurate and robust submission, changes since that time have predominantly been a result of decisions made with system partners.

The distribution of income across the system resulted in a proposed financial deficit for the Trust. System leaders agreed that this was misleading and as result, a non-recurrent, technical adjustment has been included for the Trust to report a breakeven position. The Board is advised that this is not an increase to our expenditure budgets or the funds available to us.

2.4 Other Updates

Internal

Feedback received from the Board in April has been reflected in our final 2023/24 Operational Plan. We are now commencing on a comprehensive communication and engagement programme to share our priorities with our teams, ensuring that the plan is live at service level.

Progress against delivery of the plan will be monitored in line with the Performance Management Framework that the Board approved in February. Updates against milestone will be reported to Board.

National

Earlier this year the Board was advised of a national review being undertaken by Patricia Hewitt that was asked to consider the oversight and governance of Integrated Care Systems. The report is both detailed and lengthy and available on request. A copy of the recommendations is included in this report. Whilst change takes time there are positive messages that could help to support the delivery of community services.

2.5 Recommendations

The Board is asked to:

- **RECEIVE** details of our final contribution to the systems REVISED plan for 2023/24.
- **CONSIDER** the increased risks associated with the plan and the increased efficiency requirements.
- **DISCUSS** the system proposal for the addition of two modular wards and associated community led / sub-acute beds.
- **CONSIDER** the assurances provided and **IDENTIFY** any additional actions if required.

Shropshire Community Health NHS
NHS Trust

2023/24 Planning Update

Trust Board, 1st June 2023
Accountable Director Sarah Lloyd, Chief Finance Officer

Contents

1. Introduction

Since the planning process commenced in September 2022 regular updates have been brought to the Board. System Plans were submitted in February (DRAFT) in April (FINAL) and in May (REVISED).

This month's update provides details of our contribution to the most recent submission and our internal plan that describes how we will deliver that commitment and our wider ambitions. The focus now is on delivery and through internal frameworks we will monitor progress and outcomes.

Last month the Board were advised that the national report into the review of Integrated Care Systems had been published. Headlines from this review are included for consideration.

Recommendations

The Board is asked to:

- **RECEIVE** details of our final contribution to the systems REVISED plan for 2023/24.
- **CONSIDER** the increased risks associated with the plan and the increased efficiency requirements.
- **DISCUSS** the system proposal for the addition of 2 modular wards and associated community led / sub-acute beds.
- **CONSIDER** the assurances provided and **IDENTIFY** any additional actions if required.

2. Trust Contribution to System Plan

Through this year's planning processes we have:

- Reviewed our baseline and considered future demand.
- Assessed efficiencies and changes resulting from new models of care.
- Contributed and informed further development of community led services.

Many of these changes were reflected in previous submissions and have been approved by the Board. The most recent changes were reviewed and approved by Board representatives through Extraordinary Resource and Performance Committee meetings.

Since the last Board update there has been:

- Ongoing discussions relating to the wider system financial position. We now have an agreed position that we feel will be accepted by the national team.
- Progress on existing and new developments that will provide benefits to our patients will also have a significant impact on our workforce. The value and impact of these has been included in our plans.

Our 2023/24 Plan includes:

- £8.3m of investments in service developments.
- £2.0m of funding for cost pressures.
- £4.1m Cost improvement requirement.

A summary of our final position is shown on the following slides.

2.1 Revised 2023/24 Activity Plan

POD	19/20 Normalised Outturn	22/23 plan	23/24 plan	23/24 percentage of 19/20
Community	659,256	673,942	**684,050**	103.8%
Diagnostics	10,176	11,194	**11,194**	110.0%
Elective Daycases	828	836	**814**	98.3%
Equipment/Items	312,408	261,785	**267,464**	85.6%
Immunisations	44,448	64,190	**64,190**	144.4%
Inpatient Rehab	1,956	1,956	**1,956**	100.0%
MIU	33,036	33,036	**34,053**	103.1%
OPAT			**0**	
Outpatients	57,168	40,583	**57,573**	100.7%
Prison Healthcare	20,976	20,976	**31,639**	150.8%
Virtual Ward			**4,999**	
	1,140,252	1,108,498	**1,157,932**	
COVID		122,688	**91,246**	
Modular Wards			**316**	
Total	1,140,252	1,231,186	**1,249,494**	101.0%

2019/20 remains what is considered the baseline for NHS activities and the restoration and recovery targets. Our plan delivers a higher level of activity than the baseline and growth when compared to last year.

2.2 REVISED 2023/24 Workforce Plan

	Budget	Actual		
	Establishment	Baseline	Plan	
	2022/2023	Staff in post outturn	As at the end of Mar-24	
Shropshire Community Health NHS Trust	Year End (31-Mar-23)	Year End (31-Mar-23)		Change
Total Workforce (WTE)	1493.68	1433.90	1680.48	246.58
Total Substantive	1493.68	1301.07	1567.65	266.58
Total Bank		67.28	67.28	0.00
Total Agency		65.55	45.55	-20.00
Substantive WTE				
Registered nursing, midwifery and health visiting staff	500.30	464.78	576.49	111.71
Registered scientific, therapeutic and technical staff	217.50	201.86	239.26	37.40
Support to clinical staff	330.47	286.71	366.76	80.05
Total NHS infrastructure support	419.71	324.88	359.76	34.88
Medical and dental	25.70	22.84	25.38	2.54
Any other staff	0.00	0.00	0.00	0.00
Bank WTE		67.28	67.28	0.00
Agency WTE		65.55	45.55	-20.00

Our workforce plan includes an ambitious increase across all staff groups however, most of this is driven by the development of new services.

2.2 REVISED 2023/24 Workforce Plan

The 2023/24 Workforce Plan includes the following adjustments:

Change	W.T.E.	
• Modular Ward:	103.86	
• Virtual Ward:	56.52	(5 already included in establishment)
• IDT:	25.60	
• CIP International Nurses:	20.00	
• TNA Project:	20.00	
• Vacancy Gap:	20.00	
• MSK:	19.60	
• Other	1.00	
• Agency Use:	-20.00	
Total Workforce Increase:	**+ 246.58**	

2.3 REVISED 2023/24 Finance Plan

Income & Expenditure Summary Position

£'000	30 Mar 2023 Submission	04 May 2023 Submission	Movement	Notes
Income	99,662	106,727	7,065	Partial, non-recurrent income IFP adjustment for 23/24 of £3.8 million to achieve breakeven. Modular Ward Income of £3.3 million, matched with cost.
Pay	(71,106)	(72,816)	(1,710)	. Trust share of System Stretch increased CIP non-recurrently. Currently unidentified. Modular Ward Pay costs of £2.4 million.
Non Pay	(33,438)	(33,911)	(473)	Trust share of System Stretch increased CIP non-recurrently. Currently unidentified. Modular Ward non-Pay costs of £0.9 million
Surplus / Deficit	(4,882)	0	4,882	Final Position as at 4th May 2023

Following system agreement to partially reverse the IFP (income) adjustment on a non-recurrent basis our position moves us to break-even position for the year.

2.4 REVISED 2023/24 Efficiency Programme

£'000	04 May 2023 Submission
Recurrent	
February Planning assumption @ 2.2%	2,106
Direct Engagement agreed in March	80
Unidentified stretch agreed in March	200
Recurrent total	*2,386*
Non Recurrent	
Vacancy slippage agreed in March	400
Children's waiting list recovery agreed in March	250
Unidentified stretch – April System Stretch target	1,072
Non-recurrent total	*1,722*
Total Efficiency Target	4,108
Efficiency Target %	4.2%

2.5 2023/24 Funded Investments and Cost Pressures

£'000	04 May 2023 Submission
Investments	
Virtual Wards	3,105
Integrated Discharge Team (IDT)	1,210
MSK Transformation	473
Modular Ward (non-recurring PYE)	3.255
Community Equipment Stores (CES)	300
	8,343
Cost Pressures Total	
Including inflationary uplifts above existing funding and financing adjustments relating to depreciation and public dividend capital	
	2,028

System Invest to Save:

- Virtual Ward and Integrated Discharge Team: return on investment of approx. 1.50:1 system-wide
- MSK Transformation: savings realised from growth suppression predominantly in RJAH and SaTH.
- Modular Ward: reduction in current escalation costs as a result of improved patient flow and reduction in acute escalation costs in SaTH.

2.6 Summary of Changes

A summary of material changes between submissions is shown on the following slides.

For completeness activity figures have been provided, these figures include vaccination activity.

Trust Contribution to 23rd February DRAFT System Plan Submission					
Workforce growth	+125.58 wte	Finance position	£5,845k deficit	Activity sum	1,249,300

Changes

Activity - revision to the Virtual Ward to reflect a slower growth rate in line with step down referrals agreed by the acute Trust.

Workforce - inclusion of vaccination staff in the establishment to enable a like to like comparison and amended Workforce Return numbers that resulted in a change/reduction (actual not plan)

Finance – adjustments associated with an increased CIP target of £0.9m which resulted in a reduction in expenditure.

Trust Contribution to 30th March FINAL System Plan submission					
Workforce growth	+161.72 wte	Finance position	£4,882k deficit	Activity sum	1,249,178

2.6 Summary of Changes

Trust Contribution to 30th March FINAL System Plan submission					
Workforce growth	+161.72 wte	Finance position	£4,882k deficit	Activity sum	1,249,178

Changes

Activity – Modular Ward

Workforce – Modular Ward

Finance – additional £1,072k Efficiency Stretch Target + £3,810k IFP income adjustment + Modular Ward £3.3m (cost neutral)

Trust Contribution to 4th May REVISED System Plan submission					
Workforce growth	+256.13	Finance position	£0	Activity sum	1,249,494

3. System Revised Plan Submission

The submission that provides details of all partners is long and complex and difficult to extract in a meaningful format. Key Headlines:

- The system is not expecting to achieve all national targets. Urgent care and elective recovery continue to be very challenging.
- Across the system we have ambitions workforce plans. Plans reflect recruitment and developments but at this time there is little progress expected on tackling 'historic vacancies'.
- The financial position that was submitted reflected the ask from NHSE i.e. no greater than a £60m deficit, this was made up of:

Organisation	Deficit £m
SATH	(45.5)
RJAH	0.2
SCHT	-
STW ICB	(14.7)
TOTAL	(60.0)

4. Assurance

Assurance

- All changes have been modelled and agreed through the Internal Planning Group that includes operational and corporate teams.
- Internal plans have been triangulated through the Internal Planning Team.
- Alignment and triangulation across the system has been discussed through the System Planning Group and the relevant component Planning Leads.
- All adjustments have been discussed and signed off by Chief Executive, Directors and operational teams.
- Our contribution to the system plan has been presented and scrutinised by the Resource and Performance Committee throughout the process. Extraordinary Meetings for sign off have been opened to all Board members.

Whilst we are waiting for national feedback, we need to focus on delivery of the plans that we have committed to. Our component elements that contribute to the system plan are described in our internal 2023/24 Operational Plan.

5. Next Steps

Our internal plan was approved by Board subject to a couple of small amendments. The final plan is now available. We need ensure that this is communicated throughout the whole organisation and all our teams are familiar with it. A plan of communication activities was presented to Senior Leadership Team on 23rd May.

Performance against plan will be monitored through regular performance reports and key performance indicators that are provided to Committee and Board. The development of the PMO will provide a process to monitor the projects identified in the plan. Updates against the milestones and outcomes in our plan will be reported to Board.

Improving our internal information to support planning and monitoring will continue to progress through the Internal Planning Group. One of the most urgent actions will be to ensure that our activity plans are consistent and aligned to how are operational services are organised. This will also inform workforce and finance coding. Resource from both the Digital Team and Operational Teams is critical to this exercise.

We are expecting a significant level of scrutiny from the national and regional teams on the performance against plan both at Trust level and as a system overall.

A Lessons Learned Review is planned across the system similar to previous years. Headlines from the review will be reported back to the Board when available. The System Planning Group are now about to start work on developing winter plans.

6. National Updates: Hewitt Report

Last month the Board was advised that the national review undertaken by Patricia Hewitt has now been published. The national review was asked to consider the oversight and governance of Integrated Care Systems.

The report emphasised that the development of the ICS framework provides an opportunity to break out of organisational silos, enabling all partners to work together to tackle challenges.

The report stressed that the framework should not be seen as "just another NHS reorganisation“. All organisations should draw together their collective skills, resources and capabilities around their 4 core purposes, to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader social and economic development

The review identified 36 recommendations designed to shape how the wider system including the government and national teams, work together in the coming months and years, not only strengthening collaboration at local level but ensuring the breadth of partnership within ICSs is mirrored nationally.

Details of these are provided in Appendix 1. A full copy of the report is available for all Board members who want further information.

6. National Updates: Hewitt Report

So what….

It is sometimes difficult to see how national reviews impact on individual organisations. The key aspects within the recommendations that could have a direct impact on us both on how we operate and areas that we need to focus on include:

- System working must succeed in delivering benefits for patients.
- The review recognises the need for shift to prevention and health improvement.
- Good information must be readily accessible.
- The digital profile remains high.
- Systems should develop focused number of locally co-developed priorities
- A new framework for GP primary care contracts.
- A strategy for the social care workforce, complementary to the NHS workforce plan
- Improvement resources to help understand productivity, finance and quality challenges and opportunities.
- Effective payment models to incentivise and enable better outcomes and significantly improve productivity.

The above changes could address some of the challenges that we face associated with partnership working and integration across all aspects of health and social care.

7. Recommendations

The Board is asked to:

- **RECEIVE** details of our final contribution to the systems REVISED plan for 2023/24.
- **CONSIDER** the increased risks associated with the plan and the increased efficiency requirements.
- **DISCUSS** the system proposal for the addition of 2 modular wards and associated community led / sub-acute beds.
- **CONSIDER** the assurances provided and **IDENTIFY** any additional actions if required.

Appendix 1

Appendix 1: Hewitt Report Recommendations

1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years.

2. That the government leads and convenes a national mission for health improvement and publish, as soon as possible, the proposed shared outcomes framework.

3. That a national Integrated Care Partnership Forum is established.

4. The government establish a Health, Wellbeing and Care Assembly.

5. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework.

6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations.

7. NHS England should invite ICSs to identify appropriate digital and data leaders to join the Data Alliance and Partnership Board.

8. The NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.

9. The government should set a longer-term ambition of establishing Citizen Health Accounts

10. HOSCs (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees.

11. Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these.

Appendix 1: Hewitt Report Recommendations

12. The ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from region as required.

13. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

14. A national peer review offer for systems should be developed, building on learning from the LGA approach.

15. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.

16. An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'.

17. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the running cost allowance (RCA)for 2025 to 2026 financial year should be reconsidered before Budget 2024.

18. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

19. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.

20. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.

Appendix 1: Hewitt Report Recommendations

21. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.

22. Ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.

23. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.

24. As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors.

25. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability. ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose (within 3 months)

26. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

27. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

28. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

Appendix 1: Hewitt Report Recommendations

29. Ministers and NHS England should work with trade unions as quickly as possible to resolve the issue associated with the limitations resulting from the agenda for change framework such as local rates etc.

30. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.

31. Ensure greater financial freedoms and more recurrent funding mechanisms including a) ending the use of small in-year funding pots with extensive reporting requirements, b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries c) National guidance for payment mechanisms for inter system allocations.

32. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

33. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations to simplify them.

34. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

35. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.

36. A cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

Shropshire Community Health
NHS Trust

DRAFT - Chair's Assurance Report

Audit Committee

0. Reference Information

Author:	Lucy Morris	**Paper date:**	1st June 2023
Executive Sponsor:	Harmesh Darbhanga	**Paper written on:**	23rd May 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 20 April 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 20th April 2023 and was quorate with 2 non-Executive, 1 Associate non-Executive and 2 Executive members attending, along with other attendees. The Committee considered 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. several items on

2.3. Conclusion

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

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 20 April 2023. The meeting was quorate with 2 non-Executive, 1 Associate non-Executive and 2 Executive members. A full list of the attendance is outlined below:

Shropshire Community Health
NHS Trust

DRAFT - Chair's Assurance Report

Audit Committee

Chair/ Attendance:	
Harmesh Darbhanga	Non-Executive Director (Chair)
Tina Long	Trust Chair/Non-Executive Director
Jill Barker	Associate Non-Executive Director
Shelley Ramtuhul	Company Secretary/Director of Governance
Sarah Lloyd	Director of Finance
Keith Chaisewa	External Audit
Gurpreet Dulay	Internal Audit
Anthony Hadjirousos	Internal Audit (Items 8.3.2 and 8.3.3)
Lucy Morris	Executive Assistant/Corporate Secretariat Office Manager (Minute Taker)
Apologies:	
Angie Wallace, Jonathan Gould, Cathy Purt, Peter Featherstone and Alison Sargent	

3.2. Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3. Key Agenda

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

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
1	**Declarations of Interest** None declared.	N/A	
2	**Minutes from the previous Meeting – 19th January 2023 and The Minutes from the Extraordinary Meeting – 22nd March 2023** The minutes of the meetings were approved as an accurate record. No amendments were suggested. Agreed by all present.	N/A	
3	**Review of Action Log** The Committee noted the actions of the previous meeting and received an update on the progress of each. The actions from previous meetings had been progressed with most now complete or nearing completion, with the exception of the	PARTIAL	

DRAFT - Chair's Assurance Report

Audit Committee

	following for which the Committee received an appropriate update: **Risk Management Performance Report** – Director of Governance to continue to provide monthly progress updates **Care Plans Final Report** – Director of Governance to continue to provide monthly updates to the Quality and Safety Committee **Pressure Ulcers** - Thematic review complete. Draft report will be taken through the Quality and Safety Committee **Review system for ensuring compliance with CQC Key Lines of Enquiry** – The Chair requested confirmation of when the briefing paper was presented to Board		
4	**NOTIFICATION OF ANY OTHER BUSINESS** There were none.	N/A	
.	**GOVERNANCE**		
5	**BOARD ASSURANCE FRAMEWORK** The Committee received the BAF which had been updated with the full year's performance against objectives. An update was provided to address any actions and gaps. Key risks were highlighted and discussed. The risk around temporary posts was discussed and the Committee were informed that the majority of the vaccinators are bank staff and it was more around the management of the programme itself. No risks were being flagged at this particular time, and a review will take place in Quarter 1. The Harms Policy had been discussed at the Quality and Safety Committee and an action plan was in place and assurance provided. The Committee were informed regarding Virtual Ward and IDT, and the clinical pathways have been signed off, which had also been discussed the Quality and Safety Committee. It was confirmed that the Director of Nursing and Workforce was keeping a close eye on the	Y	

DRAFT - Chair's Assurance Report

Audit Committee

	number of referrals which had dropped due to the Junior Doctors strike action and the Easter bank holiday. E-Rostering was discussed and the Committee were informed that a business case had been approved and the implementation timetable is to be picked up by the People Committee. The Committee approved the Board Assurance Framework.		
6	**RISK MANAGEMENT PERFORMANCE** The Committee received the performance information relating to the Trust's risk management processes and system and the current level of assurance against the previously agreed performance targets for achievement by March 2023. The Committee were provided with an update on the key performance indicators. The Senior Governance Manager is focussing on cleaning the data on Datix to ensure the correct data is being captured and separating the data out. The Director of Governance will identify the KPIs that have been met, in the next Audit Committee Report. The Committee noted that regular meetings are in place with the Senior Governance Manager to review risks and close them down wherever possible. The Committee: • Considered and approved the proposed performance indicators for risk management • Noted the performance information relating to the Trust's risk management processes and system and the current level of assurance • Approved the proposed targets for achievement by March 2023.	Y	
7.	**USE OF THE TRUST SEAL AND REGISTER UPDATE** The Committee were notified that the Trust Seal had been used for the sale of The Lodge in Much Wenlock on 4th April 2023, which was	Y	

DRAFT - Chair's Assurance Report

Audit Committee

	signed by Sarah Lloyd (Director of Finance) and Patricia Davies (Chief Executive).		
8.	**ANNUAL GOVERNANCE STATEMENT** The Committee received an initial draft of the Annual Governance Statement for comments and observations and were informed that the yellow highlights were to be updated once final financial and audit positions are known. The Committee were asked to consider the draft Annual Governance Statement and to feedback any comments to the Director of Governance.	Y	
9.	**DECLARATIONS OF INTEREST / HOSPITALITY** The Committee received the final Declarations of Interest (DOI) Datix report for 2022/23 and the Director of Governance presented this for information and assurance for compliance purposes. The Committee were informed there were 15 outstanding staff declarations that have been escalated to the Deputy Director of Operations, and robust assurance was provided in terms of compliance. The Director of Governance will consider if the full Datix report is required in future, and to consider if it could be presented in a better format for future meetings.	Y	
10.	**BOARD GOVERNANCE PACK** The Director of Governance has collated all of the Board and Committee information into a combined helpful reference document for the Trust's governance. The Committee were informed that the document is an initial proposal and the Director of Governance is aware that some roles and job titles have evolved and these will be updated and reflected in the Terms of Reference. The Director of Governance will update Diagram 1.2, The Board Composition diagram and asked Committee members to feedback any comments. The final draft pack will be circulated to the Committee prior to Board approval.	Y	

DRAFT - Chair's Assurance Report

Audit Committee

11.	**RISK APPETITE TOLERANCE** The Committee were asked to consider and approve the risk appetite and tolerance proposed for 2023-24 in order that it may be recommended to the Board of Directors for final consideration and approval. The Committee noted the improved report and discussed the role that artificial intelligence plays in decision making and discussed ways this could be incorporate into the Trust. The Director of Governance noted that a new version of Datix (Datix Cloud), which offers more functionality, could be considered. The Director of Governance will link in with the Trust's Digital Innovation Group (DIG) to explore options around some of the Governance aspects. The Committee confirmed they had considered and approved the proposed Risk Appetite and Tolerance Statements for recommendation to the Board of Directors for final approval.	Y	
12.	**SINGLE SOURCE ARRANGEMENTS FOR GOODS AND SERVICES** The Committee received three waivers. The Committee ratified the single source requests and noted the significant reduction in the number of requests.	Y	
13.	**LOSSES AND COMPENSATIONS REPORT** The Committee received the report for information and the Director of Finance provided clarity about some of the written-off debts which go back a number of years due to the Trust continuing to pursue these. SL said the Trust can only pursue to a certain extent and the Trust are exploring ways of ensuring contact details for debts are provided in future. i.e. prescription charges in MIUs. The Committee discussed the salary overpayments that had been made. The Director of Finance explained the Trust's internal controls and processes, and confirmed that these were in place, but that these instances had been due to human error, whereby the necessary leavers	Y	

DRAFT - Chair's Assurance Report

Audit Committee

	documentation had not been completed and submitted in a timely manner. The Committee were informed that monthly nominal roll checks are sent to managers and there has also been follow up with managers regarding the completion of the necessary leavers documentation.		
	INTERNAL AUDIT		
14.	**INTERNAL AUDIT REPORTS** The progress report provided the Committee with information on progress made against the 2022/23 internal audit plan. It summarised the work Internal Audit have done, together with their assessment of the systems reviewed and the recommendations they have raised. It was confirmed that everything has been completed and there were no limited opinions, compared to the previous year. The follow reports were presented to the committee: **Cyber Security Final Report** The final report for Cyber Security was presented, which received an overall moderate opinion. The positive findings were highlighted as well as the areas for improvement and the findings. The Chair noted the comprehensive report and also the technical details in the report and sought assurance on those around Cyber Security. An overall moderate opinion was given, and it was noted that some areas were strong than others, and there was room for improvement. It was acknowledged that there were not any gaps in the Trust's front-end controls and that there were reasonable arrangements in place to prevent people from getting into the system. In relation to business continuity, the Committee noted that the Trust's new EPRR lead had now started and that this should move us on in this area.	Y	

DRAFT - Chair's Assurance Report

Audit Committee

	The Committee commended the comprehensive management responses received with clear actions that could be tracked and monitored, and asked for the Director of Finance to feed this back to the teams. **Data Security and Protection Toolkit Draft Report** The draft report was presented, with the key findings. It was explained that the purpose of the audit was to provide an independent review of the assertions and evidence items in the Trust's DSP Toolkit self-assessment return as at the time of the audit and, where necessary, to identify how compliance could be improved for the year-end return. One low risk finding was highlighted relating to the medical devices policy. Based on the review of the assertions included in the sample and using the risk and confidence evaluation methodology provided in NHS Digital's independent assessment guide, the Trust was given **substantial** assurance over the design and operational effectiveness of the Trust's data security and protection controls. The Auditors rated confidence in the Trust's DSP Toolkit return as high because they noted that the work completed on the DSP Toolkit has been in line with the requirements of the DSP Toolkit, with only two exceptions, and the Trust's latest self-assessment was 'Standards Exceeded'. The Chair noted the positive executive summary in the report and asked for the Director of Finance to pass congratulations onto the teams **Recruitment and Retention Draft Report** The report gave an overall moderate opinion and Auditors talked through the findings. The length of time it took took to receive the evidence for the review was noted. The Committee were informed of the applicant tracking system which is expected to be implemented. Initially there was a limited opinion but as more evidence was provided and validated, the opinion moved to moderate.		

DRAFT - Chair's Assurance Report

Audit Committee

	Auditors spoke about the findings regarding the pre-employment checks, one instance of non-compliance was identified, meaning 13 out of 15 were valid, as there was one that couldn't be identified. Exit interviews were discussed and the findings showed this was not always documented effectively or there is a difference in understandings of what should and shouldn't be recorded when someone leaves the Trust. The Trust's own arrangements talked about having deep dives and discussions at meetings, and that these have not always taken place, or been documented. Auditors advised that due to the instances of non-compliance being lower in some areas, a moderate opinion was given, and said this was an area to keep monitoring, as the new system and its implementation will be key. The Committee welcomed the report and noted the importance of exit interviews being a key part to understanding the turnover of staff. The Committee also noted disappointment in management responses which don't always answer the questions, and some responses were the same, and specific actions were not always clear. The Committee suggested further action from the People Committee and suggested a deep-dive takes place and it would be helpful to understand more about the increased workload and KPI's. **Annual Report and Annual Statement of Assurance 2022/23** This report detailed the work undertaken by internal audit for the Trust and provided an overview of the effectiveness of the controls in place for the full year. The reports issued for the financial year were highlighted in the report. Overall, internal audit provided a Moderate Assurance that there is sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently,		

DRAFT - Chair's Assurance Report

Audit Committee

	and which Audit noted to be in line with many other Trusts. The Chair thanked the teams who have worked hard to get the Trust to this level of opinion, and said it was reassuring to see significant progress since last year. The Chair noted the positive substantial assurance provided on the key financial systems. The Chair also noted the hard work from the Director of Governance in particular on the recommendations and getting them on track. **Annual Plan 2023/24** The Annual Plan for 2023/24 was presented and which sets out what work will be covered in the year ahead. The Committee approved the 2023/24 plan and noted that the Auditors will update the follow-up recommendations report in liaison with the Director of Governance.		
	EXTERNAL AUDIT		
15	**INFORMING THE AUDIT RISK ASSESSMENT FOR SCHT 2022/23** The purpose of this report was noted to contribute towards the effective two-way communication between the Trust's external auditors and the Trust's Audit Committee, as 'those charged with governance'. The report covered some important areas of the auditor risk assessment where they are required to make inquiries of the Audit Committee under auditing standards. As part of the risk assessment procedures the External Auditors are required to obtain an understanding of management processes and the Trust's oversight in a number of areas as detailed in the report. The report included a series of questions on each of these areas and the response received from the Trust's management. The Audit Committee were asked to consider whether these responses are consistent with its understanding and whether there were any further comments to make. Audit said some of the questions that would have been asked would have been around key	Y	

DRAFT - Chair's Assurance Report

Audit Committee

	events that would have taken place during the year, any incidents of laws and regulations, matters in relation to related parties, and an understanding of the key accounting estimates, as well as any fraud incidents. In relation to the fraud element, the Auditors were advised of two fraud cases that were identified, and following analysis and discussion, they did not perceive that the cases would have an impact on the audit procedures, and it was about understanding what the Trust has done to ensure these events will not reoccur in future. Referring to the key accounting estimates, the key areas highlighted are in relation to the valuation of Property, Plant and Equipment (PPE), IFRS 16 and depreciation. **SCHT Audit Plan** Auditors presented the Audit Plan for the year ending 31 March 2023. The report detailed the significant risks have been highlighted in terms of the financial statement, and two areas were identified as management override of controls and the valuation of PPE. . Auditors noted that as part of the Audit, they also look at the value for money. No risks were identified of significant weaknesses, but the work is still ongoing and if there are any instances that are identified, discussions would take place with Sarah Lloyd, Anthony Simms and David Court, as the work progresses. The management responses were noted and the Chair acknowledged the Trust has a good local counter fraud service to look at fraud issues.		
	ITEMS FOR INFORMATION ONLY		
16	**Quality and Safety Committee Minutes** No comments received. **Resource and Performance Committee Minutes** No comments received. **Charitable Funds Committee Minutes** No comments received.	N/A	

DRAFT - Chair's Assurance Report

Audit Committee

	PEOPLE COMMITTEE MINUTES No comments received.		
	WORKPLAN REVIEW		
17	The Committee received and approved the current Workplan.	N/A	
	MEETING EVALUATION		
18	**REFLECTIONS ON THE MEETING: EFFECTIVENESS AND ANY NEW RISKS AND ASSURANCES** No new risks or assurance were identified. The risks on the BAF were accepted as they currently stand and the risk appetite and tolerance item provided a good overview from the Director of Governance. The concerns with the workforce Internal Audit report were noted and there was an action for the People Committee to pick this up regarding recruitment and retention. Committee Members noted the positive meeting and the progress being made. The discussion on the Cyber report was noted positively. The Chair thanked all for their contributions.	N/A	

4. Risks to Escalate

In the course of its business the Committee did not identify any new risks that required escalation.

5. Conclusion

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

Shropshire Community Health
NHS Trust

Board Assurance Framework
0. Reference Information

Author:	**Shelley Ramtuhul, Director of Governance**	**Paper date:**	**1 June 2023**
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	26 May 2023
Paper Reviewed by:		**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**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 year end performance position against the Trust's objectives and ***consider and approve*** the risks 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 updated BAF. Each Committee has received and considered the relevant extracts of the BAF with no significant changes made to the risks cited.

The Board is asked to consider the following:

- Are the risks identified correct and in line with the Board's knowledge? Are there any other risks that should be included?
- Are there adequate controls and assurances identified 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.

Caring for Our Communities — OBJ 1

Principle Objective: Meet the needs of patients with COVID 19 and deliver the NHS COVID-19 vaccination programme.

This objective can be broken down into two key components, establish a robust infrastructure to support and deliver the ongoing vaccination programme and implement sustainable models of care to deliver care to patients including anti-viral treatments and Long Covid services.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Key Measures:

- ✓ COVID-19 Vaccination service embedded into Trust operational and governance structures and recruitment of core roles completed.(Q2)
- ✓ Robust modelling supporting future vaccination booster, surged activity and outreach rollout to address inequalities and hard to reach communities.(Q4)
- ✓ Sustainable models developed, staff in place and funding secured.(Q2)
- ✓ New models of care for anti-viral treatments fully operational.(Q4)

Progress Update:

Operational and governance structures in place for Vaccination Service, service provision as per financial envelope achieved. Autumn campaign successfully delivered, achieved performance across the board and recognised as one of the top performers in the region. Inequalities and hard to reach communities targeted with good performance reported. NHS England funding is allocated on an annual basis and as such planning for 23/24 campaign has commenced but awaiting confirmation of final funding agreement. New models of care for anti-viral treatments are fully operational.

Supporting Programmes of Work:

- N/A

Key Assumptions

- N/A

Risks:

Recruitment risk – see BAF 3.1

Lead Director:

Chief Operating Officer

Lead Committee:

Quality and Safety Committee

Caring for Our Communities — OBJ 2

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

This objective can be broken down into four key components, increase capacity through improved efficiency and new models of care developing robust capacity plans to deliver predicted demand and reduce waiting lists, embed a robust governance framework and assessment processes ensuring that Harm Assessment are undertaken, monitored and reported in a timely manner and implement system wide outpatient transformation pathways including increasing patient initiated follow ups

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Key Measures:

- ✓ As part of the planning process develop robust demand and capacity modelling to support future service redesign. (Q2)
- ✓ Robust access policy and waiting list management processes embedded.(Q4)
- ✓ Process and governance for Harm Assessments reviewed and implemented. (Q2)
- ✓ Harm Assessment process integrated into patient pathways across Trust. (Q3)
- ✓ Review of current pathways completed including new : follow up ratios, virtual consultations and patient initiated follow ups. (Q2)
- ✓ Implementation plan, reporting and governance process developed for new pathways. (Q3)

Progress Update:

- Access Policy completed and signed off by the system and has been implemented
- Zero 78 week waiters as of 13 March with predicted to remain at zero as per target for end of March 2023.
- Zero 52 week waiters is the target by end of March 2024 and currently ahead of plan
- Revised Harms Policy drafted and going to Patient Safety Committee and Q&S Committee in March
- Patient pathways have been reviewed for RTT and learning being utilised to also apply to non-RTT

Supporting Programmes of Work:

- System planned care programme

Key Assumptions

- Further impact of Covid

Risks:

BAF2.1	Demand exceeds capacity
BAF 2.2	Potential for patient harm due to waiting times
	Recruitment risk – see BAF 3.1

Lead Director:

Director of Nursing / Chief Operating Officer

Lead Committee:

Resource and Performance Committee / Quality and Safety Committee

Restore and recover our services tackling the backlog and reduce long waits — BAF 2.1

Principal Risk: Demand exceeds capacity

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	3	3
Likelihood	4	4	2
Total	20	12	6

Risk Details:

Opened: April 2022

Reviewed Date: April 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
- ✓ New performance framework and metrics being reviewed an agreed for ongoing monitoring and early identification of risk
- ✓ Strategic commissioning review taking place for Community Teams (District Nursing)
- ✓ Internal Planning Group in place for monitoring
- ✓ Planning sign off process with COO in place for Service Delivery Teams

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

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

Gaps In Controls:

- C1: Planning processes to be embedded into business as usual
- C3: Further opportunities for efficiencies

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Internal Planning Group to take forward the embedding of planning in the delivery groups	Director of Finance	Mar 2023	From April, Service Delivery Teams have in place sign off process with COO
C3:	Service reviews to be undertaken to enhance business acumen and identify opportunities for efficiencies	Director of Finance	Dec 2022	Service reviews have been undertaken in Children's Delivery Group but are currently paused due to operational pressures. These will be revisited for FY 23-24

Restore and recover our services tackling the backlog and reduce long waits — BAF 2.2

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 2022

Reviewed Date: April 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ 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 to oversee policy

Gaps In Controls:

- C1: Completion of harms reviews and embedding in patient pathway
- ~~C2: Lack of tailored harms proforma leading to inconsistency of assessments~~

Gaps in Assurance:

- A2: Lack of formal tracking 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	Chief Operating Officer / Director of Nursing	July 2023	Revised policy ratified by Quality and Safety Committee in March, planned care delivery group have harms as a standing agenda item to consider the output of reviews
C2	Harms Assessment Group to develop proforma	Director of Nursing	~~September 2022~~ January 2023	Completed
A2	Tracking of harms process to be developed and implemented	Director of Governance	~~October 2022~~ ~~December 2022~~ March 2023	Revised policy ratified by Quality and Safety Committee in March, planned care delivery group have harms as a standing agenda item to consider the output of reviews

Caring for Our Communities — OBJ 3

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

This objective can be broken down into several key components, develop robust alternative to admission pathways including roll out of 2 hour rapid response service across the county, ensure timely discharge from all inpatient services, expand community-based treatments and increase referrals to out of hospital services, as part of the Local Care Programme contribute to the review of community beds, expand and embed pathways to maximise utilisation of Virtual Wards and non-hospital based care, aligned to the Local Care Programme, develop Anticipatory Care models for the most vulnerable patients in our communities and working with primary care roll out and embed Enhanced Health in Care Homes across the county

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Key Measures:

- ✓ Recruitment process completed and staff in post. (Q2)
- ✓ Evaluation of new model and any changes identified with action plans. (Q3)
- ✓ Community MADE schedule planned and linked into SaTH MADE. (Q1)
- ✓ Learning cycle in place for developing action plans and implementation to embed themes and learning after events and fed into next MADE. (Q2)
- ✓ Process developed for scoping of opportunities and governance completed. (Q1)
- ✓ To be determined by development of the Local Care Programme Year 2 Priorities.
- ✓ Project governance in place and implementation plan developed including development of digital enablers. (Q1)
- ✓ Clinical model signed off. (Q2)
- ✓ Recruitment process commenced. (Q2)
- ✓ To be determined by the Virtual Ward roll out
- ✓ IDT and Virtual Ward business case system sign off and agreed future investment

Progress Update:

- Recruitment plan for virtual ward aligned to trajectory in place – currently exceeding trajectory
- Revised step down trajectory agreed with SaTH
- MADE events continue to take place as BAU
- New Local Care Programme Director in place
- Year 2 priorities to be confirmed in April 23 once planning round completed
- Clinical model for virtual ward have been signed off, further clinical pathways being worked on
- Rapid Response Teams now embedded across both PLACEs
- Ongoing substantive recruitment and mitigated with temporary staffing to ensure capacity is available
- Virtual Ward and Integrated business cases have been presented to system investment panel

Supporting Programmes of Work:

- Local Care Programme
- Virtual Ward programme

Key Assumptions

- Recruitment of key staff

Risks:

BAF 3.1 — Recruitment challenges

Lead Director:

Chief Operating Officer

Lead Committee:

Resource and Performance Committee / Quality and Safety Committee

Build community care capacity supporting people to stay well and out of hospital — BAF 3.1

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: April 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
- ✓ New clinical roles to mitigate gaps in workforce
- ✓ Recruitment & Retention Improvement plan agreed and monitored through People Committee
- ✓ Increased numbers of student placements
- ✓ Increased numbers of Trainee Nursing Associates being offered in 2023/24
- ✓ TRAC system being implemented
- ✓ ERoster to be implemented in 2023

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

- ✓ People Committee oversight
- ✓ Quality & Safety Committee oversight
- ✓ RPC oversight for recruitment & Retention improvement plan
- ✓ Safe staffing reporting to Board
- ✓ Quality metrics
- ✓ System People Board oversight

Gaps In Controls:

- C1: Line of sight on vacancies and agency usage
- C2: Gaps within HR team
- C3: New clinical roles in development

Gaps in Assurance:

- A2: System People Board has not met with any frequency

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing	March 2023	Business case has been approved and recruitment to project team commenced
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, initial meeting has taken place to discuss scope and remit of the committee
C3	Development of new clinical roles	Director of Nursing and Workforce	September 2023	

Caring for Our Communities — OBJ 4

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

This objective can be broken down into three key components, aligned to the Local Care Programme work closely with our partners in Local Authority and the Acute Trust to transform community pathways including proactive care and prevention, develop a system wide integrated therapy model offer to provide a single out of hospital therapy service and seek opportunities to strengthen links with mental health services including CYP LD&A and SEND

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Key Measures:

- ✓ To be determined by development of the Local Care Programme Year 2 Priorities (Q1-Q4)
- ✓ Evaluated action and impact associated with system SEND review and developed action plan (Q2)
- ✓ Process developed to review actions from previous LD Audits including Adult services and implement changes (Q4)

Progress Update:

- SEND review completed for Shropshire and indicative findings received, action plan being developed and to be finalised when report received
- SEND review completed for Telford – awaiting feedback report
- Year 2 priorities to be completed once planning round has been signed off by system
-

Supporting Programmes of Work:

- HTP interdependency

Key Assumptions

- New ways of working across partner organisations

Risks:

BAF 4.1 External pressures impact on capacity (wider system escalation or rising pandemic levels)

See also risk 2.1 relating to demand exceeding capacity

Lead Director:

Chief Operating Officer

Lead Committee:

Resource and Performance Committee / Quality and Safety Committee

Develop strong partnerships expanding the range of services provided out of hospital settings — BAF 4.1

Principal Risk: External pressures impact on capacity (wider system escalation or rising pandemic levels)

Immediate operational pressures could reduce focus and prioritisation of the transformative work required to deliver new pathways. Differing priorities of partner organisations

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	3
Likelihood	4	3	1
Total	16	9	3

Risk Details:

Opened: April 2022

Reviewed Date: April 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Work to build capacity and reduce waiting lists (see objective 2)
- ✓ Critical incident escalation processes in place system wide and has been strengthened as part of ICB partnership arrangements to include the system control centre
- ✓ Winter Plan in operation
- ✓ Multiple operational groups overseeing management
- ✓ Bronze, silver, gold for both internal and system level decisions
- ✓ Virtual ward and integrated delivery team established in partnership

Assurance: Source of Assurance 3

- ✓ System Delivery Committee
- ✓ Board Committee oversight
- ✓ RPC Oversight
- ✓ Joint Partnership Committee oversight of key workstreams

Gaps In Controls:

- C1: Management of urgent care plan
- ~~C2: Winter plan identifies gaps in bed availability~~
- C3: Funding challenges relating to left shift

Gaps in Assurance:

- A1: Link between system and organisational governance

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Completion of urgent care action plan system wide	Chief Operating Officer	March 2023	Completed and monitored via the urgent care system group which meets monthly

Caring for Our Communities — OBJ 5

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 three key components, develop capacity and capabilities to ensure pathways and service redesign are driven by local heath need informed by population health data, aligned to the national core areas of clinical priority develop respiratory pathways and promote uptake of vaccinations to improve health and reduce emergency admissions, Embed robust data capture and reporting processes to measure outcomes and monitor health inequalities for all

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Key Measures:

- ✓ Business Intelligence lead recruited (Q2) - Completed
- ✓ Developed access to data appropriate feeds and processes to provide support to Trust planning and business development (Q3)
- ✓ Respiratory Transformation Group agreed priorities for 2022/23 (Q2)
- ✓ Redefined the KPI metrics captured across the Trust in line with national guidance and local requirements (Q4)
- ✓ Deployed Power BI dashboards with drill down for more intuitive reporting (Q4)
- ✓ Developed dashboards using Population Health Analytics and Integrated Care Record processes to illustrate outcomes and health inequalities (Q4)

Progress Update:

- Exploring support with performance framework to improve oversight and ensure alignments with national guidance and local requirements.
- System programme called Aristotle which will give segmentation on health inequalities. Local BI Teams to link with system BI Teams
- Update on Power BI went to Senior Leadership Team Meeting in November
- BI Lead has been appointed
- Respiratory Transformation Group has been stood down by the system, respiratory pathways have been connected into virtual ward for red pathways
- National metrics for virtual ward and in development by the national team, expected 2023-24
- Power BI dashboards have been piloted and continue to be rolled out.
- Power BI to be used for integrated performance report going forward

Supporting Programmes of Work:

- Performance Framework Review

Key Assumptions

- Recruitment takes place

Risks:

See risks 2.1 and 4.1

Lead Director:

Director of Finance / Chief Operating Officer

Lead Committee:

Quality and Safety Committee

Looking after our People — OBJ 6

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, build on the existing staff wellbeing offer developing a compassionate and inclusive workforce and develop and implement a 5 year workforce plan and development programme that builds strong leadership, develops and maximises opportunities associated with new roles and provides opportunity to attract new staff via training routes

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Refreshed our Vision, Values and Behaviours (Q2)
- ✓ Improved personal health and wellbeing and reduced sickness absence (Q4)
- ✓ Maximised our flexible bank workforce and used technology to help us maximise flexible working opportunities for our entire workforce (Q4)
- ✓ Implemented the 6 EDI High Impact Actions and further strengthened the contribution of our staff networks (Q4)
- ✓ Implementation of the RACE Code
- ✓ Continued to improve the employment experience of our people by implementing our Just, Learning and Inclusive Culture and Civility programme and our Management and Leadership Progressive Development Framework (Q4)
- ✓ Maximised opportunities for people to come and work for us, stay with us and return to our employment after retirement (Q4)
- ✓ Supported new ways of working and delivering care through digital innovation for people processes, improved ESR data quality, expanding our recording of role specific essential training and workforce reporting (Q4)
- ✓ Fresh focus to our development, talent management and apprenticeship approaches to support specialist skills, roles and career pathways (Q4)
- ✓ Embedded the planned use of new roles and flexible employment models for our services (Q4)
- ✓ Developed career pathways, succession plans and strategic workforce plans for key roles and services (Q4)
- ✓ Supported service change and transformation by completing our Moving Forward Working Well programme, sharing OD models and approaches and supporting the transformation of people and services in our Local Care Programme (Q4)
- ✓ Listening events
- ✓ Cultural programme and strategy development
- ✓ Improvement plan as a consequence of staff satisfaction survey results

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Progress Update:

- Engagement with internal and external stakeholders on vision, values and behaviours with further work undertaken by Executive Team during recent culture and leadership development session. Specification for more extensive culture and leadership work has been developed and a preferred provider has been identified
- Some of the work is currently behind plan due to resource challenges but additional support has been commissioned to enable delivery of the objectives.

Supporting Programmes of Work:	Key Assumptions:
○ Cultural programme	○ Recruitment takes place

Lead Director:

Director of Nursing ~~/ Chief Operating Officer~~

Risks:

See Risk 3.1 relating to recruitment challenges

Lead Committee:

People Committee
Board

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 five key components; as part of the wider ICS progress the development and roll out of an integrated patient record and develop the digital patient interface, development of Rio system to enhance monitoring and reporting of clinical activity, implement robust cyber security across all Trust systems, develop robust digital training plans to up skill our workforce to maximise the potential associated with digital developments and working with the ICS to develop system wide banks and integrated recruitment and rostering systems

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Implemented Integrated Care Records, data sharing arrangements and Single Sign On from RiO and a training programme (Q2) – to be completed by December 2022
- ✓ RiO mobilise technology deployed on most mobile devices to streamline data inputting (Q2) - Completed
- ✓ Created a Digital channel with Virtual Assistants for patients to book and schedule appointments, view clinical assessments and their clinical record. (Q3)
- ✓ Implemented Power BI to improve reporting and information dashboards. (Q4)
- ✓ Developed and shared cyber security skills and resources across ICS. (Q3)
- ✓ Supported options with ICS partners and shared service in Staffs for Cyber Security and Application Development (Q3)
- ✓ Worked with Trust leads to identify and implement technology to optimise staff and patient time and benefits of Digital Initiatives with appropriate training resources planned to up skill the workforce. (Q4)
- ✓ Implemented digital solutions for flexible working requests, risk assessments, sickness absence management and bank working.(Q4)
- ✓ Implementation of Docobo as a telemedicine route for virtual monitoring of patients on Virtual ward

Supporting Programmes of Work:

- Power BI development
- RIO Mobilise

Key Assumptions

- Operational capacity to support digital developments

Lead Executive

Director of Finance

Objective Details:

Opened: April 2022

Reviewed Date: April 2023

Progress Update:

- Power BI has been piloted and continues to be rolled out and will be utilised for the Integrated Performance Report
- To build on the progress so far, several tablet devices have been purchased and are being tested in conjunction with the deployment of the RiO Mobilise application, demonstrated at Trust Board
- Single Sign On, that provides seamless access to the Integrated Care Record, are ready to be implemented once our data is surfaced in the Integrated Care Record, we are waiting for a slot in the overarching onboarding schedule to push our data up to the shared record.
- Integrated Care Record implementation has progressed well, the upload of information is currently going through data quality checks before the final switch on

Risks:

Cyber security risk to be worked up and included in the BAF in future

Lead Committee:

Resource and Performance Committee

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 four key components; develop 3 year cost improvement programmes informed by benchmarking intelligence, maximise opportunities to digitise systems and processes to support service transformation and pathway redesign increasing capacity whilst ensuring digital inclusion, Undertake all actions associated with backlog maintenance requirements to ensure premises are safe and fit for purpose and as part of the wider One Estate Programme, linked to the Local Care Programme, undertake a review of estate utilisation to reflect integrated working and alternative models of delivery

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2022

Reviewed Date: June 2023

Key Measures:

- ✓ Completed and reviewed the analysis of efficiency opportunities and confirmed 3-year efficiency targets.(Q2)
- ✓ Agreed efficiency targets / priorities for the next 3 years, reflected in future plans (Q3)
- ✓ Improved mobile access to RiO and create digital channels for appointment management and information exchange with patients. (Q3)
- ✓ Digitised appropriate existing paper processes and digitally interact with the population to reduce the carbon footprint, use of paper and postage. (Q4)
- ✓ Apply digital innovation for transforming existing services where possible and practical. (Q4)
- ✓ Review of maintenance backlog completed with SaTH and identified targeted areas for recovery plan, including prioritisation of work. (Q1) -
- ✓ Carried out independent assessments and audits in specialist areas. (Q3)
- ✓ Implemented revised maintenance regimes /schedules with service providers. (Q4)
- ✓ Submitted capital bids and delivered schemes, as appropriate. (Q4)
- ✓ Delivered training programme around safe use of buildings. (Q4)
- ✓ Data collection for Shropcom site utilisation completed. (Q2)
- ✓ Reviewed data collection to differentiate between COVID-19 response and new normal. (Q2)
- ✓ Reviewed technology required to support agile and remote working. (Q3)
- ✓ Reviewed lessons learned relating to estates and developed action plans from the findings. (Q3)
- ✓ Developed models with operational teams to optimise estate and staffing based on clinical, administrative and shared space requirements. (Q4)

Progress Update:

- CIP schemes identified and still on track to deliver CIP for financial year in full.
- Working with system partners to agree CIP targets for the coming three years
- Costs not expected to exceed plan in year and recurrent costs have informed future financial planning
- Utilising benchmarking information to inform our backlog maintenance prioritisation and this will be taken through the Capital Estates Group
- Bridgnorth estate utilisation being revisited and work underway to inform future plans

Supporting Programmes of Work:

- TBC

Key Assumptions:

- TBC

Risks:

BAF1.1 Costs exceed plan

Lead Director:

Lead Committee:

Director of Finance | 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: April 2023

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Local Care Programme work expected to reduce demand
- ✓ 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
- ✓ Collaborative working with acute colleagues to transform services moving more to community care rather than acute delivery – modelling in progress

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

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

Gaps In Controls:

- ~~C1: Shortfall in schemes currently identified~~

Gaps in Assurance:

- A2: System Delivery Committee only just being established
- A3: Effectiveness of PPME

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Ongoing work through CIP Delivery Group	Director of Finance	October 2022 – March 2023	Completed and in year delivery of CIP
A2	Ensure engagement and representation at System delivery Committee and link into Trust governance framework	Chief Executive / Director of Governance	September 2022	Terms of Reference reviewed by the Director of Governance, attendance at Committee by Shrop Comm representative, updates to go through RPC going forward and added to the work plan - completed
A3	Effectiveness of PPME to be reviewed	Chief Executive / Director of Governance	November 2022	New performance framework being introduced which will inform the re-set of PPME.

Shropshire Community Health NHS Trust

Provider Licence Declaration

0. Reference Information

Author:	Shelley Ramtuhul, Director of Governance	**Paper date:**	1 June 2023
Executive Sponsor:	Patricia Davies, Chief Executive	**Paper written on:**	25 May 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 the proposed Provider Licence Declarations for 2023 for consideration and approval.

2. Executive Summary

2.1 Context

NHS Trusts are required to give assurance that they have complied with the NHS Provider Licence, NHS Acts and have regard to the NHS Constitution. To support the Trust's self-certification, an assessment of assurances available on each aspect of the license conditions has been made.

2.2 Summary

This report provides the following:

- Self assessment undertaken against licence requirements
- Proposed declarations

2.3. Conclusion

The Board is asked to **consider** the NHS Provider licence self-certification templates indicating compliance and **approve** the self-certification.

Provider Licence Declaration

3. Main Report

Self-Certification for Provider Licence

The Health and Social Care Act 2012 introduced the concept of a Licence for providers of NHS services, and the NHS Provider Licence was subsequently introduced in February 2013.

Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014, but it was later confirmed that the Licence would not apply to NHS Trusts. Despite this, in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption, directions from the Secretary of State required NHSI to ensure that NHS Trusts complied with conditions equivalent to the Licence, as it deemed appropriate.

As NHSI's Single Oversight Framework (SOF) bases its oversight on the Licence, NHS Trusts are therefore legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

These conditions are:

Condition G6

Condition G6 (2) requires trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Providers must annually review whether these processes and systems are effective.

Condition CoS 7- Availability of resources (scope = next financial year 2020/21)

The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate.

Condition FT4

The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

Provider Licence Declaration

- a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
- b) comply with the following paragraphs of this Condition.

The Licensee shall establish and implement:

- a) effective board and committee structures;
- b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and clear reporting lines and accountabilities throughout its organisation

It is up to providers how they do this, but board understanding and sign off is required. NHSI supply templates which trusts can use to confirm their compliance. Providers must have processes in place to ensure they check compliance and manage risks of non-compliance on an ongoing basis and must publish their G6 self- certification within one month following the deadline for sign-off.

There is no requirement to submit self-certification to NHSI, but NHSI will select some Trusts to ask for evidence that they have self-certified.

To support the Trust's self-certification, a written assessment of assurances available on each aspect of the license conditions has been prepared. The standards are the same as previous years, hence the evidence to support them is also broadly the same.

3.5 Conclusion

The Board is asked to **consider** the NHS Provider licence self-certification templates indicating compliance and **approve** the self-certification**.**

Provider Licence Declaration

PREPARATION FOR SELF CERTIFICATION AGAINST PROVIDER LICENCE

SELF-ASSESSMENT May 2023

Note: References in the License to Monitor now refer to NHSI for the purpose of our assessment

Licence condition	Licence key requirement	Assurances/ Self-assessment finding
G1: Provision of information	Furnish Monitor with such information and documents as they require to exercise their function. Take reasonable steps to ensure information is accurate, complete and not misleading.	• Trust systems are in place to provide NHSI/regulators with information they require and quality assure it • Performance and Quality reporting measure included in local Performance Framework. • Records of meetings with NHSI indicate appropriate information supplied when required • Audit Committee exercises its role to assure accuracy of certain Trust-wide information
G2:Publication of information	Comply with Monitor direction to publish information about NHS services	• Range of methods in place to publish this information – website, patient information material, use of accessible information standard
G3: Payment of fees to Monitor	Pay fees to Monitor	• Meet other regulators' requirements; would meet requirement if and when arose
G4: Fit and proper persons	No person who is 'unfit' can become/remain a director or governor. Also applies to those performing similar roles eg interims and to a body corporate	• Specific policy and Standard Operating Procedure in place • Annual background checks and annual declarations completed on relevant individuals • Arrangements reviewed and found compliant by CQC at last inspection.
G5: Monitor guidance	Have due regard to guidance issued by Monitor	• Regular horizon scanning for new guidance by means including NHSI bulletins and networks, horizon scanning reports by the business development team to the management team, CEO's reports to Board, external auditors reports to Audit Committee.

Provider Licence Declaration

G6: Systems for compliance with licence conditions and related obligations	Take all reasonable precautions to avoid failure to comply with the License, NHS Act or NHS Constitution	• Self assessment findings in this review indicate precautions and assurances in place to mitigate against risk of failing to comply with individual license conditions • Risk management system in place.Risk of failure to comply with legislation incl NHS Act is included on Trust corporate risk register, with associated mitigations. Trust legal advisors in place. • Wide-ranging systems for internal and external control described in Annual Governance Statement • Overarching role of Audit Committee to seek assurance on systems and compliance • Submission of statutory returns • Trust's local Performance Framework is aligned with the NHSI Single Oversight Framework • Monitoring of Constitution-related targets in performance reports • Submission of statutory returns
G7: Registration with the Care Quality Commission[1]	Required to be registered with CQC	• Trust has established process for CQC registration
G8: Patient eligibility and selection criteria	Required to set and publish transparent patient eligibility and selection criteria	• Covered on Trust web site - service information for patients.
G9: Application of Section 5 (Continuity of Services)	Requires trust to provide agreed Commissioner Requested Services (CRS) as contracted. Requires trust to inform Monitor where (i) change to CRS, and (ii) no agreement for extension/renewal of CRS	Not applicable

Provider Licence Declaration

P1: Recording of information	Monitor may require the trust to record information such as that related to its costs.	• (NOTE: National costing requirements not currently applicable to community trusts in same way as to acute.) • Compliant with reference cost requests – the mandated national costing process with set reporting currencies • Use national tariffs for all those services where applicable • Local agreements in place with commissioners about cost recording where services are not covered by national arrangements
P2: Provision of information	As P1, but relates to provision of information	• Provide reference cost information to NHSI; see response to P1.
P3: Assurance report on submissions to Monitor	Monitor may require the trust to provide assurance that condition P2 has been complied with	• Internal assurance processes in place to cross check and assure costing information
P4: Compliance with the National Tariff	Trust can only provide services at prices that comply, or are determined in accordance, with the national tariff	• Contract monitoring reports provide evidence of our use of national tariffs for those services where they apply • Internal assurance processes in place to cross check and assure costing information
P5: Constructive engagement concerning local tariff modifications	Trust required to engage constructively with commissioners.	• Notes of contracting meetings with commissioners show engagement over arrangements for services where national tariffs do not apply eg price and activity matrix. • specific approach agreed with commissioners regarding Service Development and improvement Plans (SDIP), which will include the Price Activity Matrix (PAM)
C1: The right of patients to	Requires trust to inform patient when	• Trust web site information

Provider Licence Declaration

make choices	they have a choice and where to find such information regarding their choices	• Use of RAS and TRAQs which facilitate patient choice where applicable
C2: Competition oversight	Prohibits agreements and conduct that either have the effect, or likely to have the effect, of preventing, restricting or distorting competition	• Framework of SFI's and SO's in place, plus SLAs • Governance in place around partnerships, many of which have been under commissioner-led processes
IC1: Provision of integrated care[1]	Trust must not do anything that is detrimental to the integration of services	• Active engagement in integrated working and representation at all ICS meetings • Provision of range of services in close partnership or integration eg ICS, Out of Hospital Care
CoS1: Continuing provision of Commissioner Requested Services	Trust must not stop or change the way CRS services are provided without the agreement of the commissioner	Not applicable
CoS2: Restriction on the disposal of assets	Trust must keep an up to date register of all relevant assets used for CRS. And get Monitor approval prior to disposal of such assets when they raise a concern re on-going capability of trust	Not applicable but note that • Asset register identifies assets by service and location so links can be made
CoS3: Standards of corporate governance and	Trust must have due regard to adequate standards	Not applicable but note that: • Full range of systems of corporate governance and control, as described in Trust Annual Governance Statement

Provider Licence Declaration

financial management		• Internal and external audit outcomes • Oversight by Audit Committee • NHSI oversight rating

Provider Licence Declaration

CoS4: Undertaking from the ultimate controller	Legally enforceable agreement required with parent companies to prevent their action causing a breach to licence conditions	• Currently not applicable
CoS5: Risk pool levy	May require Trust to contribute towards fund to pay for vital services if a provider fails	• Currently not applicable
CoS6: Cooperation in the event of financial stress	Trust must cooperate with Monitor under such circumstances	• Currently not applicable
CoS7: Availability of resources	Requires trust to ensure that it has the required resources available to deliver CRS.	• Not applicable

Provider Licence Declaration

Provider License Self Declaration: Assurance for Corporate Governance Statement, Condition FT4 (8) May 2023

	STATEMENT	ASSURANCES /EVIDENCE
1.	The Board is satisfied that the Licensee applied those principles, systems and standards of good corporate governance which reasonably would be regarding as appropriate for a supplier of health care services to the NHS.	• Trust governance structure is set out in the SO's, SFI's, Schemes of Reservation and Delegation and the Risk Management Policy. Systems for internal control are set out in the Annual Governance Statement • Governance is tested by the Audit Committee through risk management, individual audits and the opinions of internal and external auditors. • The Audit Committee reports its findings to the Board after each meeting and through its Annual Report • The Trust was last inspected by the CQC in 2019 and is expecting a further CQC inspection in due course.
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	• Horizon scanning mechanisms to review NHSI guidance, then reflected in CEO's Reports, and Governance Reports, to each Board meeting in public • Records of monthly meetings with NHSI • Regular engagement with NHSI over local arrangements and issues eg sustainability process and associated governance

Provider Licence Declaration

3.	The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	• Clear governance structures and reporting lines/accountabilities/responsibilities documented. Structures are reviewed and updated regularly and are shared with Regulators, and published on Trust web site • Governance structures are assessed against the CQC and NHSI Well Led frameworks • The Board and supporting Committees (Audit , Quality & Safety, People Committee, Resources and Performance, Nomination and Remuneration) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. • CQC report and action plan (completed) • Board and Committees evaluate effectiveness at conclusion of business • An independent review of the Well Led" CQC standard and NHIs Framework has been carried out by Niche Consulting with a further well led review undertaken by GGI in 2022.
4.	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the	• Detailed arrangements as described in Trust Annual Governance Statement • Clear governance structure covering these matters including Resources and Performance Committee, Quality and Safety Committee and their respective sub Committees. • External Value for Money opinion, and other relevant internal and external audits • CQC re- Inspection in 2019 No significant issues raised,

Provider Licence Declaration

	Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.	the report is currently awaited . • Internal and external audit opinions; going concern opinion • Risk management system with risk registers at all levels, overseen ultimately by Audit Committee • Regular reviews by Board of the well-led standard, including information provision • Progress on strategies and business plans feature strongly on Board and Committee agendas; clear governance structure for the handling of business plan issues via working groups reporting to Resources and Performance Committee and from there to Board. Performance reports are organised around organisational aims. • Access to and regular briefings from legal advisors • Systems for horizon scanning reinforced by professional networks

Provider Licence Declaration

	The board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the board receives and takes in to account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the	• CQC Inspection report 2016 with rating of 'Requires Improvement' and 'Good' for caring The Trust awaits the CQC follow up inspection report, carried out in February/March 2019 • Clinical background of a number of Board members including non-executive director with clinical background. • Quality of care considerations inbuilt to Board's work via a range of information received by Board for example, timely quality performance reports, dashboards from service delivery groups, use of quality impact assessment ,Board visits, key topic reports eg safeguarding, infection control, clinical audit reports; patient surveys; staff surveys; CQC Inspection Reports; Board Assurance Framework (BAF); • Internal Quality Review Reports and Senior Leaderships clinical teams visits • Quality and safety Committee receives comprehensive range of information • Strong record of engagement with patients, staff and stakeholders • Well-established Patient Panel acting as a conduit for feedback; evidence of "you said, we did" • CQC inspection recognised positive patient engagement activity • Above average composite result for staff engagement • Range of systems for escalating and resolving quality

Provider Licence Declaration

	Licensee including but not restricted to the systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	issues include Service Delivery Group dashboards to Quality and Safety Committee; risk management register reviews; Incident investigation and lessons learned review meetings; deep dive reviews at Quality and safety on specific topics of concern; use of flash reports. • All risks scored above a certain level are reviewed in detail. Sources of risk include the analysis of incidents, complaints, clinical audit, concerns and claims reported throughout the Trust, the Divisional Performance Review Process, the Trust/Divisional Clinical Effectiveness Groups and other specialist committees and groups. • Quality team in place with Associate Director for Quality, Divisional Heads of Quality, and clinical leads for quality and supporting staff
6.	The Board is satisfied that there are systems to ensure that the Licensee has in plane personnel on the board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• Robust selection, appraisal, development and 'Fit and Proper' assurance processes in place for Board members • Assessments of staffing in quality reports; use of tools to assess staffing; triangulation with other quality indicators • Where appropriate NEDs have suitable qualifications and backgrounds e.g. chair of Audit Committee has a financial background

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2022-23

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		[including where the Board is able to respond 'Confirmed']	Please Respond
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature | **Signature**

Name Patricia Davies | **Name** Tina Long

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | Please Respond

Worksheet "G6 & CoS7" Financial Year to which self-certification relates: 2022-23

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Patricia Davies	**Name**	Tina Long
Capacity	Chief Executive Officer	**Capacity**	Acting Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.