Public Trust Board - 6 June 2024

MEETING

6 June 2024 10:00 BST

PUBLISHED

31 May 2024

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MINUTES OF THE PRIVATE BOARD MEETING

**HELD AT THE LUDLOW MASCALL CENTRE, LUDLOW
AT 10.00 AM ON THURSDAY 4 APRIL 2024**

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 (Voting)

Ms. Jill Barker	(Associate Non-Executive Director)

Executive Members (Voting)

Ms. Patricia Davies	(Chief Executive)
Ms. Sarah Lloyd	(Director of Finance)
Dr. Mahadeva Ganesh	(Medical Director)
Ms. Clair Hobbs	(Director of Nursing)

Executive Members (Non-Voting)

Ms. Claire Horsfield	(Director of Operations and Chief AHP)

In attendance

Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)
Ms. Rhia Boyode	Director of People and Organisational Development (The Shrewsbury and Telford Hospitals NHS Trust)

Welcome

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

Apologies and Quorum

Apologies were received from Ms Shelley Ramtuhul, Director of Governance.

Declarations of Interest

None to declare.

Minutes of the Meeting held on 5 October 2023

Ms Hobbs clarified that the nomination for the Chair's Award was jointly made by her and Ms. Horsfield. Subject to the above amendment and the correct of typographical errors, the minutes were agreed as an accurate record of the meeting.

Patient Story

The Board from the Diabetes Health Education Team. Across Shropshire, Telford and Wrekin, there were 30,000 people with Type 2 diabetes and 2500 with Type 1, which equated to around 6.1% of the total population, the figure rose to around 9% of the population when those who were not diagnosed were included. 200 people each week were diagnosed with diabetes in Shropshire, Telford and Wrekin.

Overall, Shropshire, Telford and Wrekin needed to improve on non-elective admission for high blood sugar, the System was an outlier for foot outcomes and improvement was needed in relation to major and minor amputations. The NHS Right to Care Pathway for diabetes stated that structured education should be available within 12 months after diagnosis. There had been increasing demand for places and a variety of training courses had been established.

The group programme was a six week course, usually attended be around 15-20 people and in total offered 15 hours of support. The sessions included support from a wider team, including dieticians and specialist nurses. The programme included follow up blood testing after six and twelve months.

The results of the programme were audited and the completion rate was higher than the national average. The Team was award winning and had been commended for reduction in prescribing and in waist circumference.

The team would run courses wherever there was demand and had found that face to face courses worked most effectively.

Stephen, a former participant of the programme, spoke to the Board. He informed the board that he had been referred to the programme by a nurse, with his own personal goal of getting off medication. After attending the course, his weight had dropped 12kg and his HbA1c had dropped from 71 to 42. Stephen stated that the course was informative and structured and importantly did not blame attendees. Stephen advised that he was now no longer on medication.

The Board thanked the team and Stephen for attending and presenting to the Board.

Chair's Award

Ms Long presented the Chair's Award to:

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Richenda Treharne and Lauren Carter
They had been nominated by Clair Hobbs:
Following an email from a patients family for their care and compassion of a patient at the end of their life

Mark Goodfellow, Jake Fitchett, Liz Hagon, Lorna Martinali, Dave Pugh, Stephen Doolan, Claire Farnell, Jessica Knott and Hayley Lewis
They had been nominated by Sarah Venn for:
The help and support provided in the development and set up of the Revive Programme.

Helen Russell, Wendy Doherty and Jayne Grimes – the OT Team
They had been nominated by Fiona MacPherson for:
Their work on the health and wellbeing days and the flu campaign.

Chair's Communication

Mr Featherstone, as Deputy, presented the report. He advised that he and Ms Long had attended the National Chair's Event in London and had met with representatives of NHS England's leadership. Health Trusts within Shropshire, Telford and Wrekin had been progressing with a provider collaborative through Committees in Common.

A useful discussion on the strategy of the Trust had taken place, which would support the Trust's vision of supporting our communities so that everyone gets the right care, at the right time in the right place.

Non-Executive Director's Communication

Ms Purt advised she had Chaired the Integrated Care Board's Strategy Committee and had attended the ICP Board meeting. The digital strategy for Shropshire Telford and Wrekin had been approved, which would link the digital systems within the area.

Mr Darbhanga advised that he attended the Committees in Common meeting with Mr Featherstone and was pleased to inform the board that key strands of the workstreams were making good progress, although there was still some way to go.

Ms Barker stated she had attended a webinar on health in rural communities, where Professor Chris Witty had spoken about challenges in rural health. Ms Barker was able to share evidence of good practice from the Trust, such as the work for recruitment to Bishops Castle Community Hospital. Ms Barker, along with Ms Horsfield, had met with Philip Dunne, MP, at Ludlow Hospital the previous week, which had been very positive.

Mr Featherstone said he had attended the ICS Strategy meeting and two meetings of the System Finance Committee, where there were ongoing discussions in relation to outturn and planning for 2024/25.

Bishop's Castle Community Hospital

Ms Long reminded the Board of the decision made at the September meeting of the board in relation to Bishop's Castle Community Hospital (BCCH), that the Trust would have a new and focused recruitment campaign for the hospital. Ms Long stated that the Trust could not have achieved what has been done without the support of the local community and everyone else who contributed, particularly the 'Save our Beds' campaign.

Ms Davies thanked the members of the public for attending the meeting. Ms Davies summarised her report, which included the reasoning behind the decision in September 2023, and the progress made over the last six months.

Ms Davies confirmed that she was pleased to say that sufficient staff had been appointed and that the threshold had been met to safely reopen the wards, although some vacant posts remained. Ms Davies thanked the community for their efforts, support and compassion for the teams.

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Ms Davies continued that she had received a letter from the commissioners, which had been included as an appendix to the report, which outlined their position in regard to finances. Ms Davies advised that the letter was material and important to note, but it did not prevent the Trust from making the recommended decision. Ms Davies discussed the other ambulatory work that had been taking place at the hospital while the inpatient beds were closed.

Ms Horsfield thanked the teams for their efforts on this campaign and that learning from this would be taken forwarded and used in other campaigns.

Mr Darbhanga asked about lessons learnt, international recruitment and any financial impact reopening the beds would have. Ms Hobbs stated that one of the key lessons was the model of working with the community and how this was attractive to candidates. Staff had been recruited locally and further afield, although no international nurses had been appointed as the workforce was so small and would not be able to provide the required pastoral support, although this would be relooked at in the future. Ms Lloyd stated that the initial decision had been made on quality and safety grounds, not financial. She stated that since then, the cost of delivering inpatient services had increased, but the Trust were working through plans to deliver the services safely across all four sites. It did introduce financial risk, however, the Trust had a good record in managing its finances and managing risk.

Ms Sargent asked about retaining staff and Ms Barker queried if the roles were attractive for those at the start of their careers. Ms Hobbs stated that a 'pick and mix' approach was attractive to younger recruits and rotational posts had been offered to support this, including district nursing and rapid response, or within the wider System.

Mr Featherstone welcomed the report and discussed future-proofing of services. Ms Davies stated that this was part of the Trust's strategy and discussed links within the community, primary and acute care.

The Board
- ***Considered the information outlined in the paper regarding the recruitment that had taken place and the staffing levels achieved***
- ***Considered whether any additional information had come to light which may have affected the decision taken in September 2023***
- ***Approved the recommendation that staffing levels at Bishop's Castle Community Hospital (BCCH) had reached the threshold to enable the re-opening of inpatient beds***
- ***Approved the recommended next steps including the recommendation to develop and enact a mobilization plan to re-open the beds at BCCH in line with the decision taken in September 2023***
- ***Accepted the paper as information and assurance on the collaborative work to expand services from BCCH.***

The Board adjourned to allow the members of the public who had attended the meeting for the above item to leave.

STRATEGIC

Chief Executive's Update

Ms Davies summarised her report. Ms Davies congratulated Dr Ganesh on his appointment as substantive Medical Director, Dr Ganesh was a long standing paediatrician and supported the voice of the child to the Board. Ms Davies also advised that the Dudley 0-19 Service had transferred to ShropComm.

The Trust was on track to deliver to its financial plan, which was no mean feat in the context of national NHS finances, the Board was not under any illusions that next year would be an easy one.

The Trust had opened two Rehab and Recovery Wards (RRU) at the Princess Royal and Royal Shrewsbury Hospitals, which was groundbreaking. The Wards would support with reducing pressure within the acute hospitals.

The Trust had run a successful autumn vaccination campaign, as the lead provider across Shropshire, Telford and Wrekin. The team were now progressing with the spring campaign, which was due to start on 15 April, and would use a blended approach with support from PCNs and community pharmacies.

Performance and waiting times across the Trust had deteriorated, however, a trajectory plan was in place for improvement. Ms Davies shared that new governance systems would be implemented shortly, which would be more effective for the Trust.

Business / Operational Plan

Ms Lloyd stated that in regard to the National Plan, the Trust, along with all other NHS organisations, had submitted draft plans and that feedback was being received from the ICB and NHS England (NHSE). The deadline for submission of the final plan was 2 May, with the deadline for System submission slightly earlier.

For the local plan, the Plan was a public facing document of what the Trust intended to deliver over the next year, supported by national planning guidance. The draft could be bought before the private Board meeting in May and then to the public Board in June for final approval.

The Board
- ***Considered the update on national and local 2024/25 planning requirements and that final plan submissions are required by 2 May***
- ***Acknowledged the continued development of Shropcom's 2024/25 Operational Plan for review at the May Board meeting and approval by the Trust Board in June.***

QUALITY, SAFETY AND PEOPLE

Quality and Safety Chair's Report

Ms Barker verbally updated the Board. The Committee had received full assurance on the Learning Disability report and had requested that a further deep dive take place into District Nursing Caseloads.

The Board accepted the assurance provided by the update.

Quality and Safety Report

Ms Hobbs advised that in patient falls had fallen and there had been no patient safety incident investigations to report. Pressure ulcers remained a continued area of focus. Cases of C. difficile were a concern nationally, and there had now been 3 within the Trust in the last 12 months; Ms Hobbs had completed a post infection review and the case had been deemed unavoidable. There had been no unexpected deaths to report.

Mr Featherstone asked about pressure ulcers across the area, Ms Hobbs advised that some of the differences were due to caseloads and skill mix. Targeted work was in place and a deep dive was underway to understand the reasons.

Mr Featherstone asked about the 'care hours per day' metric, Ms Hobbs confirmed that this was a very small piece of data related to safer staffing; it was important to note but needed to be considered with the other metrics.

The Board
- ***Noted the information in the report***
- ***Took assurance from the report that appropriate actions were being taken to address any areas of concern***
- ***Noted that requests could be made for any future information that would increase assurance***

Quarterly Guardian for Junior Doctor's Safe Working Report

Dr Ganesh bought the report to the Board's attention. There were no exception reports to note and the Trust had received very high marks from the recent survey from The Royal College.

The Board noted the report.

Quality Strategy Refresh

Ms Hobbs advised that the communications team had supported the distribution on the survey regarding the quality strategy refresh, in order for the staff voice to be strong throughout the strategy. A word cloud had been produced on the responses received so far and it was noted that the key phrasing coming through included 'care', 'social care', 'digital' and 'support'.

PEOPLE

People Committee Chair's Report

Ms Purt advised that the People Committee had met and approved the Sickness Absence Policy. The sickness absence target had been reviewed and had been benchmarked across the West Midlands, it was important the target was realistic so a stretch target of 4.75% had been agreed.

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

Annual Staff Survey Results

Ms MacPherson presented the results of the NHS Staff Survey. The Trust was in cohort 2 of the People Promise Programme which would look at the Trust's performance over the last three years and this would be used to inform the Trust's actions to move forward. A comprehensive plan was being developed to support delivery of actions. Trusts from phase 1 of the programme had seen improvement in their staff survey results.

Ms Hobbs stated that the Trust were in a discovery phase but the work was already underway and Ms Boyode was providing support.

Ms Boyode spoke of the tools used within SaTH and the importance of the culture dashboard. Ms Boyode agreed the Trust was in the discovery phase and there was a lot of engagement taking place with staff at the moment. It was important that actions were embedded.

Mr Darbhanga asked about staff appraisals, Ms Hobbs noted that she was interested in the quality of these and if staff found them beneficials.

Ms Long stated that the staff survey was a board responsibility and it was important to act on this. The Board agreed culture did not change overnight and that further work was needed.

Annual Flu Report

The Board noted the update in relation to the flu campaign had been covered in the Chief Executive's Report.

RESOURCE AND PERFORMANCE

Resource and Performance Committee Chair's Report

Mr Featherstone summarised his report. He advised that it was proposed that the AAPC continue for a further period as the Committee were aware of further pressure to come.

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

Performance Report

Ms Lloyd stated that of the 60 KPIs within the report, 32 required attention. Each Committee was responsible for reviewing its own dashboard. 9 out of 11 areas that were off track related to waiting times and access to services and the Trust was working to develop its reporting towards action plans, which would be reviewed by Committee.

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

Finance Report

Ms Lloyd stated that the Trust was on track to deliver a surplus of £600k, which was a favourable variance to plan. There were no new risks to highlight and all risks had been mitigated. Ms Lloyd advised she was confident on delivery. Ms Lloyd noted that agency usage in February were the highest of the year, which was expected due to the opening of the RRU. Ms Lloyd noted that the Trust was exceeding its CIP target.

The Board

- ***Considered the adjusted financial position for the year to date is a surplus of £616k compared to the planned surplus of £165k which is a favourable variance of £451k***
- ***Recognised that agency costs continue to exceed our plan***
- ***Acknowledged the Trust's challenging CIP target for 2023/24 and that in-year and recurrent plans are forecast to deliver this target in full***
- ***Recognised that elective activity was expected to maintain the improvement seen in quarter 3 over the balance of the year to deliver our forecast outturn.***
- ***Acknowledged the known risks associated with delivering our financial plan had been fully managed and mitigated. The Trust therefore anticipates maintaining a small favourable outturn position compared to our forecast which is to breakeven in line with plan.***

Annual Budget Setting

Ms Lloyd presented the opening budget for 2024/25, based on the draft plan submitted to NHS England in March, following an extraordinary meeting of the Board. It was acknowledged that there would be changes between this and the final submitted plan. The plan had been reviewed in detail by the RPC and they had recommended the proposals.

The Board

- ***Approved the opening 2024/25 annual budget. The opening budget was a £0.80m surplus in line with our draft plan submission to NHSE on 21 March 2024***
- ***Recognised that the opening budgets were expected to be amended to reflect all changes agreed during the final stages of the national planning process and appropriate approvals would be sought as required***
- ***Acknowledged a capital programme totaling £8.39m was submitted in the draft plan submission on 21 March, although this also remained subject to change.***

Annual Declaration of IG Toolkit Status

Ms Lloyd presented the report which would be reviewed through the Audit Committee, with a final report being submitted in May. There were no exceptions to report at this time.

The Board noted the report.

AUDIT

Audit Committee Chair's Report

Mr Darbhanga summarised his report. The Audit Committee had met twice, as the Committee had also met to discuss the ongoing concern report and the accounting framework policies.

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

Board Assurance Framework

Ms Lloyd advised that each committee had reviewed its performance, the Board was asked to consider if there were any risks not captured, the controls in place and if appropriate actions were in place.

The Board noted the report.

ANY OTHER BUSINESS – with prior agreement of the Chair

Questions from members of the public

Ms Davies advised questions had been received from two members of the public and noted that the responses to the questions were to be included in the minutes of the meeting.

Q1. Were Community Trust staff moved from Community Hospitals to the new Sub-Acute wards at Shrewsbury and Telford? How many staff were lost to Community Hospitals through this initiative; from which of our hospitals; and from which occupational group and pay band? What steps have been taken to replace those staff?

Response: 3 members of staff applied for short term secondment posts within the sub-acute wards. Two members of staff were from Whitchurch CH and one from Bridgnorth. All are returning to their base site by the end of May. These moves have been made with no disruption to services within the existing Community Hospitals. Other staff have completed ad-hoc shifts but all have returned to their permanent positions with the Community Hospitals.

Q2. Informal information suggests a significant risk to the physiotherapy service at Ludlow Hospital. Can the meeting be updated on the availability of physiotherapists at Ludlow Hospital, and on the steps being taken by the Trust to ensure this core service is maintained at a satisfactory level?

Response: There is no significant risk to the physio service at Ludlow. The Ludlow Physiotherapy service has been impacted due to maternity leave within the team, however this was mitigated with the support of Locum Physio cover up until the end of March. The team is continuing to be supported by the wider Physiotherapy service with additional clinics being provided. The service is continuing to look at further recruitment to backfill any capacity vacated due to maternity leave.

Q3. What are the current arrangements for medical cover at Bridgnorth and Whitchurch Community Hospitals?

Response: All of our community hospital are appropriately covered medically in hours with a blend of consultant physician and General practitioners including the use and support of Shrop Doc for out of hours cover for the community hospitals.

QUESTIONS - Shropshire, Telford and Wrekin Defend Our NHS
Q1. Will the Board congratulate the Save Our Beds campaign and the communities of Bishop's Castle and rural SW Shropshire for their work in ensuring a future for Bishop's Castle Community Hospital?

Response: Yes, and this was covered in the meeting and interviews

Q2: At its meeting of 7 September 2023, the Board identified a Board-level Rural Health Champion. Seven months on, could the Board provide a brief update on the success of this initiative? Will the Board agree to hear an update on relevant rural issues from its Rural Champion at each public Board meeting? Will the Community Trust's Rural Champion commit to making herself more accessible to the rural communities who currently struggle to raise issues around access to NHS services?

Q3: In a largely rural county, striving to achieve equity of health provision across rural and urban communities is surely a necessity. I note Shropshire Council's impressive recent work on 'Rural Proofing in Health and Care', and the recommendation from Simon Whitehouse (ICB CEO) that STW ICS adopt the 'Rural Proofing for Health Toolkit' to support rural proofing of local services. This is a welcome shift in an area where NHS leaders have tended to treat rural services as an optional extra.

Will the Community Trust include a commitment to rural proofing in its Operational Plan for 2024/25? Will the Board commit to a fuller discussion at its next Board meeting on rurality, rural proofing and the need to develop a rural strategy? (I know that some level of discussion is underway at ICB level but financial matters are likely to dominate the ICB's agenda in the current period).

Response to 2 & 3: Jill Barker is the SCHT NED rural health Champion and has attended several meetings across STW relating to rural issues including the NHS SWT workshops and development sessions relating to rural health. Jill gave an update on the meetings attend and her input during the Board and this is contained within the minutes under NED reports. Jill is a member of the STW working groups relating to rural health. Given that SCHT is a member of the ICB and the operating plan for 2024/25 is a system plan which includes SCHT, we are part of the rural proofing health toolkit and fully support our commissioners in the use of the tool kit to ensure appropriate services are commissioned across STW.

Any Other Business

There was none.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 6 June 2024.

Chair's Update

0. Reference Information

Author:	Tina Long	**Paper date:**	6 June 2024
Executive Sponsor:	Shelley Ramtuhul	**Paper written on:**	28 May 2024
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
- Chair in Common

2.3. Conclusion

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

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Chair’s Update

3. Main Report

3.1 Meetings and Visits

Schwartz Round

I am a great advocate of the Schwartz Round and have attended some of the sessions. These are an excellent way of staff reflecting and learning from situations. For the Round in May where the theme was “When things didn’t go to plan” I told my story. It was a story from some years ago but has always stuck with me due to the impact it had on me and the learning that I have taken with me over the years into a number of different situations. That learning was about resilience, sticking with things even when the going gets tough and identifying where and who to get support from. I would encourage Board members to attend one of the rounds both to learn but also to show support for this amazing work.

Committees in Common

The Chief Executive, myself and our nominated Non-Executive Director have attended a Committees in Common meeting as well as a development session where we appraised progress over the past months and how we can further develop collaborative working across the providers in Shropshire, Telford and Wrekin.

3.2 Private Meetings of the Board

The Board met private in May and heard updates on activity and performance and benefits realisation.

3.3 Board Development

The Board has spent time reviewing Shropcom’s strategy recently. We approved it last May and we’re still confident that it focuses on all the right things: connecting with Primary Care, Acute providers, Local Authorities and specialist health and wellbeing services.

At our Board meeting last month, we heard from our teams how they have been bringing our strategy to life over the last year and the benefits this has delivered to patients across STW and beyond. It was a brilliant session, and I was very moved to hear about the difference our services make each and every day.

I know we are going to be sharing some more information on our strategy over the coming months, and the difference this is making, and I look forward to receiving feedback on this.

3.4 Chair in Common

In conjunction with our System partners, as previously announced we are working together with Shrewsbury and Telford Hospitals Trust to appoint a Chair in Common. We have a long history of working collaboratively across the System and to further support this approach, the appointed Chair in Common will oversee the duties of Chair for both ShropCom and SaTH. This joined up approach will mean that whilst each Trust will retain as Chair as separate statutory bodies, we will seek to appoint the same person for each of the roles.

Chair's Update

3.5 Conclusion

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

CHIEF EXECUTIVE'S REPORT – June 2024

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

2.2 Update Plan for Re-opening of Bishops Castle Inpatient Unit.

The Trust announced in the April Public Board, that following a dedicated period of recruitment we now have sufficient staff to be able to safely reopen the inpatient service at Bishop's Castle Community Hospital. The Trust Board made a commitment to re-open the beds if safe to do so and has been working to reopen in July. We are looking forward to welcoming staff to site from 1st July for their induction. Following the staff induction period the service will then re-open to patients from mid July.

2.2 Expansion of Ambulatory Care/service offer within Bishops Castle

The inpatient service is an important element of the community hospital at Bishops Castle, but the site represents a much wider opportunity for the delivery of health, care, and wider local services. This has been a key element of the work with the local community, Shropshire Council and primary care network and partners. This has resulted in the following developments on the site over the last few months; several charitable organisations are holding regular support groups there, Wellbeing Drop-in sessions are being held weekly and further work is progressing to increase attendance and awareness of these. A social prescribing community network will start meeting on the site from late May onwards to ensure that there is good knowledge across all sectors of the support that is available from non-NHS organisations. The ICB led Rural Health Strategy task and finish group will also be meeting on the site going forwards, this will facilitate the attendance and contributions from all aspects of the local community and partners. The Wellbeing Drop-in Sessions are being incorporated into the core offer within the 'One Shropshire' neighbourhood working system group and will be developed and rolled out into other localities.

2.3 Finance and Planning

As always, we're paying close attention to our finances. Our Finance and Governance teams are working with our external auditors to finalise our 2023/24 Annual Accounts and Report and we're also reporting on our April financial performance. We're currently on track but it's set to be another challenging year for Shropcom in line with the whole of the NHS. We can all play our part in managing our resources well by spending our funding wisely and considering different ways of doing things, even small changes can make a difference when we make them across the whole of the organisation and we've got a brilliant track record of doing this.

There's also lots of work going on planning for 2024/25 and beyond and we'll be considering our priorities for the year ahead during this meeting. It's important that we do this so the whole organisation is focused on the same key areas of delivery and it also helps our stakeholders to understand what we are setting out to achieve over the next year.

2.4 Urgent and Emergency Care:

Urgent and Emergency Care pressures have continued since my last report. However, we are seeing the improvements that our teams are making in terms of both preventing the requirement for admission to hospital and facilitating early discharge, through continuing to embed the sub-acute care model, which includes: two Rehabilitation and Recovery units (one at PRH and one at RSH equating to 52 beds), 167 Virtual Ward beds, Rapid Response and Anticipatory Care teams (ACT) and of course our Shrop Comm led integrated discharge team (IDT). These services continue to play a central role in the overall urgent and emergency care response; and something the system is committed to support as a more sustainable model of non-elective care. This work has been recognised by a recent visit to the system by the national team.

In terms of the benefits, over the last 18 months we have seen the following in relation to the VW, RR and IDT.

- Consistent delivery of the 2-hour response against the 70% target currently sitting at 74%
- Rapid Response activity is currently performing at 103% against their activity plan.
- The impact of Rapid Response along with Early Supported Respiratory community pathways and the Care Home MDT has meant that locally we can evidence a suppression in growth in relation to patients presenting in the local emergency departments equating to the equivalent of 40 acute hospital beds.
- Virtual Ward have supported over 4,150 patients.
- Within the acute sites, the total Complex No Criteria to Reside patient cohort For April averaged 135 patients per day (base line 172) showing a 22% improvement

- Average days for a complex patient once they are deemed safe to transfer to discharging from hospital is now 2.5 days against base line of 4.6.
- Consistent over achievement of the KPI to achieve 28 Complex discharges a day with average of 32 currently being delivered.

Since the opening of the Recover and Rehabilitation units in January just over 16 weeks ago, we have seen the following benefits:

- Between January – March 2024 220 patients have been admitted and discharged across both Rehab and Recovery units.
- 82% of patients who have received support on the wards have returned to their usual place of residence.

These units alongside our wider sub-acute care at home services and community hospitals, which provide far more than just bed based care, are central to the delivery of more sustainable model of urgent care for the population of STW. The plan moving forward is to further develop our clinical pathways onto the wards to ensure as soon as patients are safe to transfer, they have opportunity to access the ward and then step down to virtual ward. Partnership work continues with SaTH in relation to further building on the success with frailty, orthopaedics and stroke to really maximise the integrated working.

2.5 Vaccinations – COVID Spring Booster update.

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

The Spring 2024 campaign launched with Care Home visits on 15 April and opened to all eligible individuals on 22 April with an aim to vaccinate those due a bi-annual COVID-19 Vaccination. The eligible cohorts for spring are as follows:

- Adults aged 75 years and over (as at 30/06/2024),
- residents in care homes for older adults,
- individuals aged 6 months and over who are immunosuppressed.

The campaign will end on Sunday 30 June 2024.

In common with previous campaigns, SCHT is leading a blend of providers across the STW area including PCNs and Community Pharmacies. Pop-up clinics and roving teams are being utilised by the programme to ensure that we maximise our potential to reach all of our eligible cohorts.

- Based on previous campaigns, and the normally high demand from this campaign's eligible cohort, we are planning for an approximate uptake of 84% which equates to almost 60,000 vaccinations during the 10 week campaign.

- At 13 May, the campaign had delivered to approximately 50% of Care Home Residents and 36% overall. This equates to a total of over 26,000 vaccinations given in the first few weeks of the programme.

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

3. Other Areas of Performance

3.1 Elective RTT and non RTT

Recovery of performance is paramount and directly correlates to positive outcomes for our patients. As part of our improvement programme the following has been achieved:

- Improved governance structure to enable clear escalation routes.
- From the end of March there are no waits in the 104, 78 week and now 65 RTT cohorts. This is an over performance against the national trajectory requiring 0 65 week waits by September 2024.
- New divisional structure with all RTT applicable services under one division
- Performance Dashboards in line with NHSE Making Data Count inc SPC embedded within The Trust reporting structure.
- Transition of TeMS Rheumatology across to RJAH as part of Phase 3 MSST with Orthopedics transfer scheduled to go to SaTH commencing end of May 2024.

The MSST (Musculoskeletal Services Shropshire and Telford) has collectively aligned across the STW system providing:

1) Single Point of Access and Triage for STW MSK.
2) Integrated MSK Therapy (Level 2)
3) Integrated MSK Interface (Level 3).

This has enabled a much more equitable service delivery for our local population. The success of MSST has directly correlated with the well-established SCHT service- TeMs. MSST has further built on the premisses and model of care introduced through TeMs almost 10 years. As the service evolves it is ensuring that that intervention is targeted through community pathways, empowering patients and reducing reliance on high level medical and surgical intervention. This is evidence can be seen through the orthopaedic referrals demonstrating that 28% of referrals went through that pathway in Aug 24 compared to 12% in Nov 24.

4. Our People – Recruitment & Retention

Delivery of services and performance is only possible with a skilled workforce. Therefore, a key focus for the Trust is staff recruitment and expansion of our workforce alongside retention of skill and experience within the organisation and across the system.

4.1 Recruitment across the Trust

The Trust is engaged in several programmes of work looking at increasing the work force using domestic pipeline approaches with schools, colleges, and universities to employ apprenticeships and trainees through different routes who can then progress if they wish to professional qualifications across the Trust and system. For example, trainee nurse associate and therapy roles, blended and peripatetic administrative roles to name but a few. We have also had a focus this year on international recruits to increase our qualified numbers alongside the domestic pipeline approaches being taken. The Trust is also working positively with STW system partners on joint approaches to recruitment and retention that provide opportunities for working across a skill base.

We have seen some real positive results by tailoring approaches to recruitment, telling our story and linking directly with communities to draw on local expertise and support. For example, the recruitment for Bishops castle and also the sub-acute wards who are fully recruited to. However, we still have areas mainly related to core services which we are still finding challenging in terms of recruitment and retention of staff and our focus is on how we can build on the bespoke approaches to recruitment to make the offer as attractive as possible and continue to raise awareness of the breadth of skills we can offer within the community setting. To this end, the Trust is working with digital recruiters to get the widest reach in terms of advertisement and promotion of our services and, of course, the best advertisement for what we do is through our greatest asset – the staff themselves, through word of mouth and by using our staff to tell their story of what it is like to work in STW.

The collaborative approach taken to recruitment for Bishops Castle has been positive due to our tailored approach by telling our story and linking directly with communities to draw on local expertise and support. Additionally, our targeted campaign for the Rehabilitation and Recovery Units has seen us recruit successfully to the majority of posts. However, we still have areas mainly related to core services which we are still finding challenging in terms of recruitment and retention of staff and our focus is on how we can build on the bespoke approaches to recruitment to make the offer as attractive as possible and continue to raise awareness of the breadth of skills we can offer within the community setting. To this end, the Trust has used digital recruiters to get the widest reach in terms of advertisement and promotion of our services and, of course, the best advertisement for what we do is through our greatest asset – the staff themselves, through word of mouth and by using our staff to tell their story of what it is like to work in STW.

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4.2 Culture and Engagement work

Central to recruitment and retention and making Shrop Comm a great place to work is strengthening our culture through staff engagement. Whilst our 2023 staff survey results improved overall and for 6 of the 9 areas, we recognise that there is still much to do to improve the working experiences of our staff. This year we have empowered our managers to understand and cascade the staff survey results at a local level, giving managers the tools to engage with their teams to identify improvements that can be made. Additionally, our Listening Events continue and there are 'take 20' roadshows taking place throughout the geography of the Trust to enable all staff to attend, understand the results and the expectations of line managers and staff to work together to identify improvements. These interventions are an important part of ensuring our staff 'have a voice that counts' and are a good opportunity to promote our staff survey and other opportunities to increase staff engagement.

We know that there is no singular intervention that will improve staff engagement, and that changing workplace culture can take many years; multiple bundles of interventions are required to be delivered and prioritised according to the impact and resources available. This is why in Q2 2024/25 we will be launching our Culture and Engagement improvement plan; this programme is aligned to the national toolkits and best practice that we know improve culture and staff engagement and brings together all the work already underway by our People team to deliver on the NHS People Promise. This work will be supported by us joining cohort two of the national People Promise Exemplar programme; we are proud to be participating in this and will work collaboratively with our system partners SaTH and RJAH who are also taking part.

5. Minor Injury Units

Our MIU's (Minor injury units) continue to see increased activity particularly in Bridgnorth and Oswestry. Over the last 2 months there have also been some very complex clinical cases requiring rapid acute intervention. Our teams, as ever, have demonstrated incredible skill and responsiveness in these situations. There is a national piece of work exploring the long-term transition of MIU's to a wider Urgent Treatment offer which we are working closely with NHSE to explore and develop in partnership across STW.

The community hospitals in the last month have also transferred all patient records over to our RiO digital platform. This will hugely streamline process and benefit patients. Care records are now easily accessible to members of the in hospital and out of hospital multi-disciplinary team.

In April we also welcomed Atrumed our new provider for medical and clinical care across our community hospitals. This is a clinically stronger and more resilient model ensuing we have infrastructure in place to grow our sub-acute ambition. They also have strong home first philosophy and record of delivering great patient outcomes.

Community teams

The Dental team have also made some incredible progress in terms of their longest waits to access surgical intervention. The forecast indicates there will be 0 waits above 30 weeks by the end of May. This reduction has been achieved through successful waiting list initiatives and maximising our working relationships with both SaTH and RJAH.

6. Good News Stories

6.1 International nurses week and park run

International nurses day 2024 was marked by our Chief Executive and a number of Trust staff undertaking the Shrewsbury Park run. This saw a start of a week of celebration where the teams were visited by the senior team sharing cakes and gifts for all our hard working and deserving nurses. We also asked our staff to nominate their Nursing Hero and we had 51 nominations in total with some Nurses being nominated more than once, all nominees will receive a certificate that includes the reason for nomination demonstrating their commitment and dedication to the nursing profession.

6.2 Emergency Preparedness, Resilience and Response

In early April, the Trust took part in Exercise Redstreak, which was a multi-agency exercise across the West Mercia Local Resilience Forum. This is part of our Emergency Preparedness, Resilience and Response (EPRR) planning and preparation. The scenario was a waste fire within Shrewsbury resulting in a water pollution incident across a large geographical area. The Trust had 15 internal participants across 2 sites, testing our local command and control processes.

As the only Health representatives, ShropCom were critical to the identification of vulnerable community sites and patients. Our internal Incident processes stood up to the rigours of multi- agency, multi-site coordination. However the exercise did not go in to great detail on the impact to health or large casualties and was perhaps a missed opportunity.

A Trust follow up exercise is planned for June 24th, to use the same scenario and data with a different incident team. Community teams are testing their business continuity plans against similar scenarios to see the clinical and staffing impact of loss of sites and staff travel within a cordon area. There are currently 25 staff members taking part.

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Chair's Assurance Report

Quality and Safety Committee Thursday 30th May 2024

0. Reference Information

Author:	**Jessica Donegan, Executive Assistant**	**Paper date:**	**30th May 2024**
Executive Sponsor:	Jill Barker (Non-Executive Director & Chair of Committee)	**Paper written on:**	30th May 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing and Clinical Delivery	**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 and Safety Committee meeting held on Thursday 20th May 2024 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 with good attendance.
- Medicines Incidents Thematic review was presented to Committee.
- Update on visiting legislation was given.
- The Quality Account for 23/24 and the Performance Framework for the Committee for the coming year were both approved for submission to May's Trust Board.
- Phase 1 update on recommendations and actions from phase 1 of the Fuller Report were noted.

2.3. Conclusion

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

Chair's Assurance Report

Quality and Safety Committee Thursday 30th May 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Quality and Safety Committee which met on Thursday 30th May 2024. The meeting was quorate with a full list of the attendance outlined below:

Chair/ Attendance:	
Jill Barker	Non-executive Director (Chair)
Clair Hobbs	Director of Nursing, Quality and Clinical Delivery
Sara Ellis-Anderson	Deputy Director of Nursing and Quality
Martin Howard	Patient Experience representative
Lucy Manning	Medicines Safety Officer and Non-prescribing lead
Dr Ganesh	Medical Director
Tina Long	Interim Chair
Alison Sargent	Non-executive Director
Patricia Davies	Chief Executive
Claire Horsfield	Director of Operations
Jane Sullivan	Senior Quality Lead ICB
Holly Grainger	Specialist Practice Student (shadowing Clair Hobbs)
Jessica Donegan	Executive Assistant (minute taker)
Apologies:	
Shelley Ramtuhul, Director of Governance/Company Secretary	
Tracie Black, Associate Director for Workforce, Education & Professional Standards	
Susan Watkins, Chief Pharmacist	
Helen Cooper, Divisional Clinical Manager, Children, Families and Planned Care	

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 required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. SI Report		

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Chair's Assurance Report

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Whilst not in the report, CHob highlighted that the DATIX Manager post, which is a pivotal role for us to be able to succeed in terms of PSIRF was rejected by the system vacancy panel last week, it will be going back to panel 31st May and also be raised at System Quality and Performance Committee if there is opportunity. The weekly Patient Safety Incident Panel is working well and has full clinical representation at all meetings. The Committee decided going forward that this report needs to be an accurate representation of SI/PSIRF and will be addressed outside of the Committee to amend the report for future meetings. The two historic deaths in custody cases that were reviewed has currently not received any formal feedback at present, but confirmation we are no longer being monitored has been given.	Partial	
2. Integrated Quality and Safety performance		
Highlights from the report were given and include: - A decrease in falls in Month, we know from Q4 that we also decreased for the year overall last year. - There were no PSII to report in April. - The National Patient Safety Alert – bed rails. We are still not compliant, but we are in the same position as many other Community Trusts nationally. There is a massive amount of work to complete but the work is ongoing and on a risk based approach. The Patient Safety Committee has requested a hard deadline for this work to be completed alongside monthly updates. - The Governance Team should be congratulated as the complaint response is now at 100% compliance. - No unexpected deaths in April. - CDif is nationally becoming an issue, the target for the previous year was 1 for the Trust, we hit 4, for 3 of those there was no additional learning and everything we should have done was completed. The 4th, there was learning to be taken on the timely manner the test was completed as this clearly should not have been attributed to the Trust. The Committee commented on the upcoming Rehab complexity scale that will be used on the RRU when launched in July 2024 and will report quarterly to QSC.	Full	
3. Inspections flash report- CQC/SEND/Prison		
There is lots of positive work happening, in the Shropshire area, SEND, BOOST training is being rolled out and there has been new investment to increase ASD assessments from 20-40 a month, the partnership has been awarded the opportunity to also be a SEND change site also. SEND Telford has no outstanding actions for us as an organisation.	Full	

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Chair's Assurance Report

Quality and Safety Committee Thursday 30th May 2024

The CDC advice line is running and continues to have a low uptake, the areas for concern are not around the advice line itself, it is around the kind of queries parents are raising on the line itself and they require lots of intervention. A full update was given on the Prison last month, it is now a focus on sustaining those improvements. CQC Preparedness, we don't have any open enquiries with the CQC at the moment. There was an engagement meeting held on 20th May 2024. We are working hard with all our operational colleagues in terms of updating self-assessments and making sure the previous 12 months actions have been completed. CQC Steering group is about to begin internally, and it was agreed to establish sessions in every 2 weeks for the Executive team and Non-executive Directors.		
4. Chairs Reports		
Patient Safety Committee The Committee raised that there was no assurance for Duty of Candour following no papers seen, established that at the meeting to be held in July a paper needs to be presented to brief the Committee and allow full oversight. Medical Engineering Services at SaTH have recruited 2 new staff members, so we should start to see improvement on training courses extended to us. NEWS2 Audit has been completed and there is certainly more work to do on deteriorating patients. Staff are fantastic at identifying patients scoring 5, but not good at identifying 0-4. Which is where you would expect to prevent a patient reaching level 5. A SMART action plan has been requested to come back to next Committee. There is fantastic work ongoing for the core standards and business continuity plans and Brian McMillan has excelled in the number of exercises we as a Trust have completed compared to NHSE expectations. **Patient Experience Committee** The Committee received two patient stories, one has been to Board previously (Diabetes Education) and the other is the Childrens Asthma Programme. The Q4 patient experience report was viewed, and the Committee noted the increase in complaints. **Infection Prevention and Control Committee** Attendance at IPCOG (Operational Group for IPC) has been escalated to Clair Hobbs as the Ward Managers are not attending and it is vital they join. The Cleaning Policy is overdue from November 2023 and still hasn't been brought through to Committee for approval, an extraordinary meeting with CHob has been established with those needed to understand why it is not ready. Hand Hygiene and mandatory IPC training has seen a massive improvement in all areas, especially Childrens and	Full Full Full	

Chair's Assurance Report

Quality and Safety Committee Thursday 30th May 2024

Young People Division, who have shared their learning with the other teams to help improvement. Kirsty Morgan, NHSE is visiting 13th June and she will visit Oswestry, Ward 36 and Whitchurch. We are in a very positive position for the visit. Two risks were proposed to be added to the risk register and these were approved: - Housekeeper capacity and standardisation of the role across our Community Hospitals and sub-acute wards. - IPC Team capacity – it was agreed that there should be system discussions on a system wide IPC approach for the future. **Safeguarding Committee** A continued focus on MCA training is needed with adults' colleagues and level one and level three and improvements are required for our children's colleagues. The LAC dashboards were looked at in detail and the admin capacity was escalated, pleased to say this was now approved at VRF. We are seeing a growing log in backlog of referralswith incomplete information and this is being escalated to Vanessa Whatley (Chief Nurse for the ICB), as we have contacted the Local Authority's and we require further escalation on this now. There were updates on CDOP a transition and PREVENT as well as the domestic abuse and sexual violence charter. Further information on the CDOP transition will be looked at to provide assurance to Committee as communications have ceased so that our staff and services aren't aware. Clarity around the positions that are filled and vacant was requested by QSC. The Safeguarding Childrens Policy was approved also.	Full	
5. Medicines Incidents Thematic Review		
This report is the first of its kind and is the first Medicines Informatic review, which has looked at all the incidents from January to March 2024. The report looks for themes where the themes aren't directly reported. Looking at the highest reporting incidents, the categories were administration, storage, prescribing and documentation. Learning from this report has shown that going forward we do not pick as many categories to report on. The recommendations of the paper are for the Committee to approve the recommendations within the paper and turn them into an action log that will be monitored through the Medicine's Safety Group, it will include timescales, leads, appropriate use of how we ae going to achieve the action.	Full	Committee approved the recommendations to become an action log.
6. System Strategy for Adults Palliative and end of life care		

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Quality and Safety Committee Thursday 30th May 2024

The strategy has been developed collaboratively with system partners and those with lived experience. It is based on the national palliative and end of life care framework for the six national ambitions. The System Palliative and End of Life Steering Group meets every other month, and the strategy is part of the agenda to monitor progress against those aims that continue to be barriers to single shared care record from a digital perspective. A key focus this year is to make sure improvements happen internally, and we can feed back up to the group, this is also a priority for us this year and is featured in the Quality Account. The Committee requested that it is important to see further detail on how this strategy is being taken forward in regards to leads and timescales. Internally CHob reminded the Committee that there is still no designated Palliative and End of Care Lead within the Trust – mitigation is sat with the Quality Improvement Team for now which will not be sustainable moving forward.	Paper was requested at last Committee for information	
7. Clinical Effectiveness		
Highlights of the report: - 23 audits done, out which 22 were almost exactly in line and 13 are completed. - Having some challenges with the baseline assessment of certain NICE guidelines which are not very old but apply to our current. - Continuing to be part of the national clinical audits - Received the championship award for Joe Tomlinson our research lead. - Louise Warburton has published a paper that has been recognised. The District Nursing project that has been signed up to will help with benchmarking and be useful when looking at the community specification with ICB colleagues. Clinical Effectiveness Committee commenced in April 2024; the ToR has also been agreed. Dr Ganesh confirmed that the Clinical Effectiveness Committee has been launched and Terms of Reference agreed.	Full	
8. Visiting Legislation		

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Chair's Assurance Report

Quality and Safety Committee Thursday 30th May 2024

New legislation was introduced Saturday 6th April. Regulation 9A around visiting and what it looks like post covid for inpatient wards and Care Homes. On review, we meet the legislation, and we are now looking to ensure we have the evidence to support when visiting has to be restricted. We only restrict visiting when absolutely necessary and in the patient's, staff and visitors best interest. It is not explicit in regards to times of visiting only that these should not be restrictive. Sara Ellis-Anderson and Gemma Mciver are working together to look at visiting times across the three Community Hospitals and RRU wards, full paper to come to QSC September 2024.		
9. Fuller Report		
A summary of phase 1 of the Fuller report was shared alongside the recommendations with that apply to the Trust and the actions we are taking. The Committee were also informed of the fact phase 2 of the report is currently being reviewed and further updates will come to the Committee.	Full	
10. NHS Resolutions		
The report was taken as read. CHob shared that this had been to the Patient Safety Committee and that a request had been made to approach NHS resolutions to see if they would be willing to share data from other Community Trusts for further benchmarking.	Full	
11. Clinical Strategy briefing		
A brief update was given to Committee, the current strategy expired in April; frontline clinical staff have had the ability to contribute their thoughts to what needs to be in the new strategy. The document is now being developed and will be in draft form for sign off in June.	Update for information only	
12. Infected Blood Enquiry		
CHob verbally informed the Committee of the recent report that has been released. It has 7 volumes and is likely not to impact significantly on our Trust however a briefing report will come to the Committee with any appropriate recommendations and actions for monitoring. Immediate action has been taken by sending out comms form the Director of Nursing and Medical Director to inform staff and signpost as necessary any that are or anyone they come in contact with that might be affected by the detail of the report.	Update for information only	

3.4 Approvals

Approval Sought	Outcome

Chair’s Assurance Report

Quality and Safety Committee Thursday 30th May 2024

Patient Experience ToR	Approved
Quality Account for 23/24	Approved for Board following an inclusion of an index for acronyms

4. Conclusion

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

Performance Framework - Integrated Performance Report 2024/25 Update

Author:	Steve Price, Head of Information and Performance Assurance	**Paper date:**	30th May 2024
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	20th May 2024
Paper Reviewed by:		**Paper Category:**	Performance
Forum submitted to:	Quality & Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going Quality & Safety Committee and what input is required?

A key governance feature of the Trust's approved Performance Management Framework is an annual review of the Trust's performance measures reported within Integrated Performance Reports (IPRs).

This paper is presented to the Committee to review and to agree its key performance indicators for 2024/25, including any recommended changes, and recommend these indicators to the Trust Board for approval.

Given receipt of additional national performance guidance is likely, it is recognised that further changes will be made during 2024/25 and relevant approvals will be sought.

To ensure good governance it is recommended that any further changes; additions, redactions, or amendments to the key performance indicators within the IPR are noted and agreed through utilising the IPR front sheet for the relevant Committee and Trust Board.

2. Executive Summary

2.1. Context

The purpose of this paper is to undertake an annual review of the IPR, as set out in the Trust's Performance Framework. The paper recommends continuation of many existing measures as well as recommending changes to metrics to allow alignment with internal, local and national priorities.

As the NHS continues to focus on recovery, it is to be expected that further performance guidance will be released. Therefore, further reviews and amendments will be required to the IPR in-year to reflect all relevant of national guidance.

The paper summarises the suggested amendments, recommends new service measures. The detail is included in the appendix and it is clear where changes are proposed.

2.2. Summary

The paper summarises the KPIs that will be included in the Committee's specific IPR. The appendix provides full details, for reference, should members wish to review this. Some measures are still in development and this is clearly identified if relevant.

2.3. Conclusion

The Quality and Safety Committee is asked to review the proposed list of key performance indicators suggested for oversight through this Committee and provide a recommendation to the Trust Board to approve the proposed measures within its IPR.

Updates to the Trust's IPRs will occur through the year in line with Trust requirements and in response to the release of the NHSE System Oversight Framework or other relevant guidance.

3. Main Report

In line with the Trust's Performance Management Framework KPIs must be reviewed on an annual basis. This ensures the Board and its committees review and agree objectives and performance measures at least annually.

This paper is to propose some changes to performance measures for the financial year 2024/25 and these require review and agreement. It is anticipated that IPRs will further evolve during this year to ensure the Trust aligns with new guidance released.

The proposed measures outlined in this paper are a combination of the 2022/23 NHSE Oversight Framework measures (this is the most recently released national guidance), and some existing key local measures.

Further reviews and amendments will be required as plans are finalised and further guidance is released. It is anticipated that further guidance will be published in 2024/25, such as an updated NHSE Oversight Framework, and this will dictate how Trusts will be monitored including new measures that align to the priorities set out in the operational planning guidance. The Oversight Framework is usually published in June/July and this will trigger a review with Accountable Officers to assess both national and local priorities that need to be monitored through Committees and Board. Some of the proposed targets are nationally driven while others are based on contract arrangements or local knowledge.

As part of the annual review, each Accountable Officer (Director) has been given the opportunity to review the proposed list of KPIs and their use in the Performance Framework ahead of the updates being shared with Committees and Board.

The objective of this review is to ensure that key information is available that enables the Board and other key personnel to understand, monitor and assess the Trust's performance against current requirements and expectations.

4. Quality & Safety Committee

Initially the Quality & Safety Committee IPR will be launched with the KPIs identified in this paper and these will be monitored at Board but devolved to the Quality & Safety Committee for oversight and to agree any necessary actions.

Local KPIs:

- Access to Healthcare for people with Learning Disability
  - *In development - Definition to be established*
- Category 3 Pressure Ulcers
- Category 4 Pressure Ulcers
- Complaints - (Open) % within response timescales
- Compliance with CQC Medicines Management
- Compliance with Duty of Candour
- Deaths - unexpected
- Falls per Occupied Bed Days
- Medication Incidents with harm
- Never Events
- Patient Safety Incident Investigations

2022/23 Single Oversight Framework requirements:

- Acting to improve safety - safety culture theme in the NHS staff survey
- Clostridium difficile infection rate
- Consistency of reporting patient safety incidents
- E. coli bloodstream infection rate
- Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate
- National Patient Safety Alerts not completed by deadline
- Overall CQC Rating
- Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
  - *In development - Definition to be established*
- Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

On release of the 2024/25 NHSE Single Oversight Framework or equivalent requirements, the Quality & Safety Committee IPR will be updated to reflect those requirements.

It is anticipated that for metrics that are reported once per annum such as the staff survey results, this requirement may be fulfilled through a single standalone report to the committee.

Further details are included in the appendix that accompanies this paper should members wish to review further detail regarding measures, their targets, definitions and calculations.

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5. Summary

This paper has set out the proposed Quality & Safety Committee 2024/25 Integrated Performance Reports content and highlighted the requirement to review this in-year as further guidance and frameworks are published.

6. Conclusion

The Quality and Safety Committee is asked to review the current list of key performance indicators suggested for oversight through this Committee and provide a recommendation to the Trust Board to approve the proposed measures within the IPR.

Updates to the Trust's IPRs will occur through the year in line with Trust requirements and in response to the release of the NHSE System Oversight Framework or other relevant guidance.

Appendix – Quality and Safety Committee IPR Proposed 2024/25 Measures

Indicator	Domain	Accountable Role	Committee	YTD (Avg / Max / Latest)	Target 24/25	Bigger or Smaller	SOF KPI?	Definition	Changes 2024-25
Acting to improve safety - safety culture theme in the NHS staff survey	Well Led	Director of Nursing & Workforce	Quality & Safety Committee	Latest	6.42	Bigger is better	Y	Output from NHS Staff Survey - safe and healthy theme sub score Consistency with NHS staff survey output rather than recreating using SOF Technical Annex definitions	Target updated to national average from latest Staff Survey results
Clostridium difficile infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of Clostridioides difficile (C. difficile) infections by NHS organisation and prior trust exposure (from April 2019) in patients aged 2 years and over. Data source: https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure Numerator Number of incidences of Clostridium difficile Trust apportioned cases (‘Hospital-onset healthcare associated’ (HOHA) + ‘Community-onset healthcare associated’ (COHA)) OR Number of incidences of Clostridium difficile CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	
Consistency of reporting patient safety incidents	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	100	Bigger is better	Y	Number of months in which patient safety incidents or events were reported to the NRLS or LFPSE, by reporting trust. Data source: National Reporting and Learning System (NRLS) and its replacement, Learn from Patient Safety Events (LFPSE) Numerator Number of months in which data reported to NRLS or LFPSE within the most recent	

								published six-month period based on reported dates Denominator Six (the most recent published six-month period based on reported dates) Computation Percentage	
E. coli bloodstream infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of Escherichia coli (E.coli) bacteraemia by organisation and location of onset (from April 2019). Data source: https://www.gov.uk/government/statistics/e-coli-bacteraemia-monthly-data-by-location-of-onset Numerator Number of E.coli Trust apportioned cases ('Hospital-onset healthcare associated' (HOHA) + 'Community-onset healthcare-associated' (COHA)) OR Number of E.coli CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia by organisation and location of onset Numerator Number of MRSA bacteraemia (on an assigned basis) Trust apportioned cases (Hospital-onset) OR Number of MRSA bacteraemia (on an assigned basis) CCG cases (Total cases)	
National Patient Safety Alerts not completed by deadline	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	Number of National Patient Safety incidents that are not reported as completed at organisations by their deadline. Data Source: Central Alerting System (CAS)	

Overall CQC Rating	Well Led	Chief Executive Officer	Quality & Safety Committee	Latest	3 (good)	Bigger is better	Y	The CQC (Care Quality Commission) inspection rating is published by the CQC. The trust is rated on the basis of a physical inspection. Possible ratings are outstanding, good, requires improvement and inadequate. Data source: CQC website	
Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	Well Led	Director of Nursing & Workforce	Quality & Safety Committee				Y	In development - Definition to be established	
Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	Responsive	Chief Operating Officer	Quality & Safety Committee	Sum	92	Bigger is better	Y	This indicator is the percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral. Count of initial assessments undertaken within 6 weeks of referral / Total number of assessments in the reporting period *100	
Access to Healthcare for people with Learning Disability	Caring	Director of Nursing & Workforce	Quality & Safety Committee	Avg		Bigger is better	N	In development - Definition to be established	
Category 3 Pressure Ulcers	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of Trust Acquired Category 3 Pressure Ulcers	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC
Category 4 Pressure Ulcers	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of Trust Acquired Category 4 Pressure Ulcers	
Complaints - (Open) % within response timescales	Responsive	Director of Nursing & Workforce	Quality & Safety Committee	Avg	95	Bigger is better	N	Proportion of open complaints still within timescale. Timescales are 25 working days for single service complaints, 60 working days for complex cases	

Compliance with CQC Medicines Management	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Avg	95	Bigger is better	N	Proportion of actual compliances with standards against potential compliances	
Compliance with Duty of Candour	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Avg	100	Bigger is better	N	Percentage of incidents where Duty of Candour applies and is complied with	
Deaths - unexpected	Effective	Medical Director	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of deaths in community hospitals that are categorised as unexpected Unexpected Death An unexpected death is: "Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures". Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present then there is a requirement to begin resuscitation. The national resuscitation council has issued clear guidance for the circumstances where a patient is discovered dead and there are signs of irreversible death (Hospice UK, 2019). It is recognised that some patients may die as a result of age or fragility consequences to suffering various co-morbidities'. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition.	

Falls per Occupied Bed Days	Safe	Director of Nursing & Workforce	Quality & Safety Committee				N	Number of Inpatient falls in month per 1000 occupied bed days	KPI was originally in development, recently defined by Deputy Director of Nursing and Quality and Deputy DIPC
Medication Incidents with harm	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of medication incidents per month resulting in harm	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC
Never Events	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Count of never events	
New Birth Visits % within 14 days - Shropshire	Caring	Chief Operating Officer	Quality & Safety Committee	Avg	90	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Shropshire)	Move to RPC
New Birth Visits % within 14 days - Telford	Caring	Chief Operating Officer	Quality & Safety Committee	Avg	95	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Telford)	Move to RPC
Patient Safety Incident Investigations	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of Patient Safety Incident Investigations commenced in month	Name change from 'Serious Incidents (reported)'

1 2 3 4 5 6 7 8 9 10 11 12 13 …

Learning from Deaths 2023-4 Q4 Report

0. Reference Information

Author:	Judith Sansom, Senior Governance Manager; Amy Fairweather, Governance Officer	**Paper date:**	18 April 2024
Executive Sponsor:	Dr Mahadeva Ganesh, Medical Director	**Paper written on:**	11 April 2024
Paper Reviewed by:		**Paper Category:**	Governance/Quality and Safety
Forum submitted to:	Learning from Deaths Group Patient Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Learning from Deaths Group and Patient Safety Committee, and what input is required?

To provide the Learning from Deaths Group 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 Learning from Deaths Group 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, 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.

2.2 Summary

The key points of this report are:

- Deaths reported Q4 in Community Hospitals and Recovery and Rehabilitation Wards -15.

Learning from Deaths 2023-4 Q4 Report

- There was 1 unexpected but explainable death reported Q4.
- No patients had COVID-19 recorded as their primary cause of death in Q4.
- There were no reported deaths of Autistic People or people with a diagnosis of Learning Disability in Q4.
- Since January 2024 the Child Death Overview Process is managed by the ICS rather than the Trust.
- An SOP is in place to support the national requirement from April 2024 to report deaths in community hospitals to the Medical Examiner.

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
- Inviting SATH Learning from Deaths team to attend the Trust's quarterly Learning from Deaths meetings, and accepting an invitation to attend SATH meetings on a quarterly basis where workload and clinical commitments allow.

2.3. Conclusion

The Quality and Safety Committee is asked to:

- Note the report and themes detailed
- Discuss and question the issues and work highlighted in the report
- 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 and in addition taking 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, Virtual, Recovery and Rehabilitation Wards 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

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

Learning from Deaths 2023-4 Q4 Report

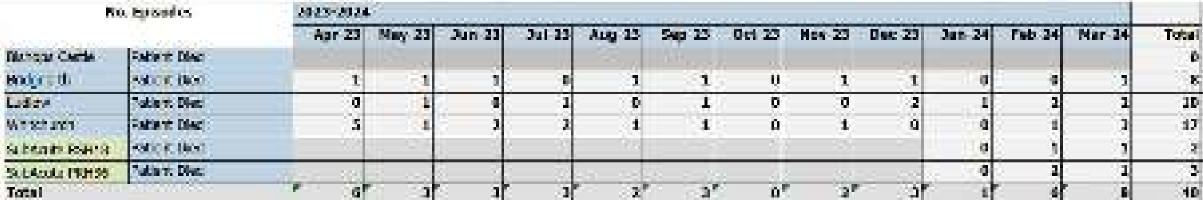
noted that we do carry out Learning from Deaths Level 1 reviews in the Community when instigated by our Teams.

At present the Trust does not have a designated Learning from Deaths Officer and administrative and reporting elements of this role are being undertaken by the Governance team.

3.2 Community Hospital and Sub-Acute Ward Deaths

Local Learning from Deaths Level 1 reviews are carried out on every patient death within the Community Hospitals and, since January 2024, in the two Recovery and Rehabilitation Wards (RSH Ward 18 and PRH Ward 36). These reviews are written by the staff involved in the care and treatment of the patient and reviewed by Clinical Governance and the Medical Director.

Patient deaths reported in Community Hospitals and Sub-Acute Wards are shown below.

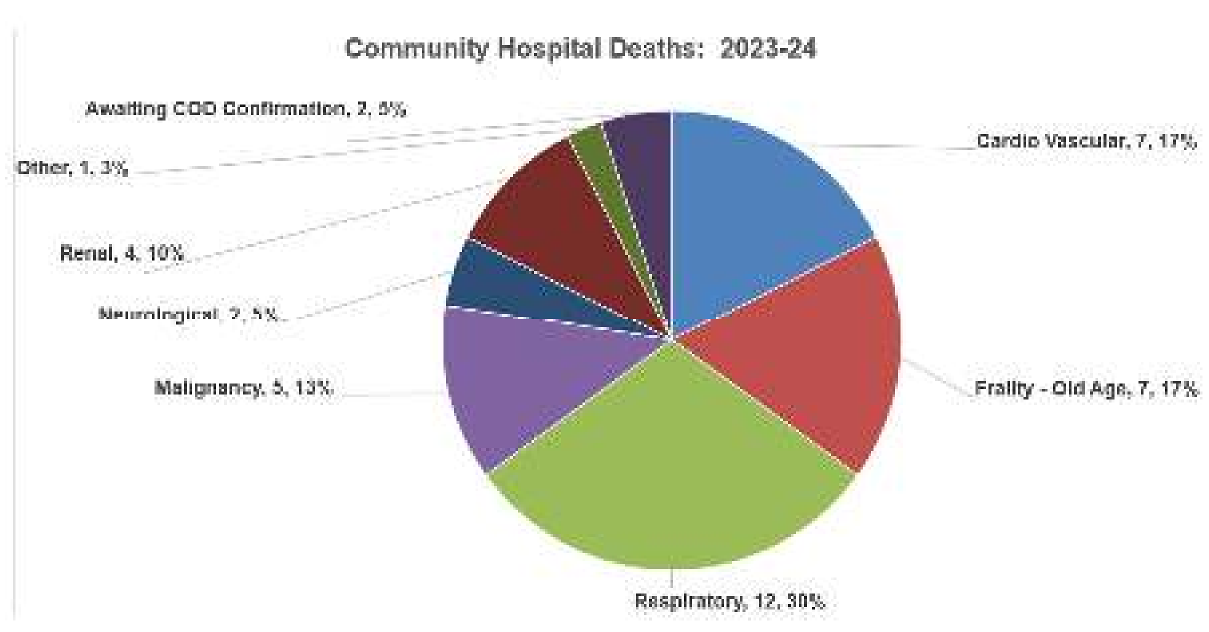


No. Episodes		2023-2024												
		Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Bishops Castle	Patient Died													0
Bridgnorth	Patient Died	1	1	1	0	1	1	0	1	1	0	0	1	8
Ludlow	Patient Died	0	1	0	1	0	1	0	0	2	1	2	2	10
Whitchurch	Patient Died	5	1	2	2	1	1	0	1	0	0	1	3	17
SubAcute RSH18	Patient Died										0	1	1	2
SubAcute PRH36	Patient Died										0	2	1	3
Total		6	3	3	3	2	3	0	2	3	1	6	8	40

Data is updated continuously and reported quarterly within the Trust to the Learning from Deaths Group, to the Patient Safety Committee, and to the Public Board in accordance with the national framework guidance.

3.3 Causes of Death

The main causes of the 40 deaths within Community Hospitals for the year 2023-24 were Respiratory (30%), Frailty of Old Age (18%), Cardio-Vascular (17%) and Malignancy (13%). Details are shown below.



Learning from Deaths 2023-4 Q4 Report

3.4 Unexpected deaths

There was one unexpected but explainable death in Q4. This concerned a 90-year-old male patient admitted to Whitchurch Hospital late March 2024 for confusion, fever, urosepsis, hyponatremia, hypomagnesia and vomiting. An urgent review was requested by the Medical Director. It was found that while the patient had responded well to IV ABX and fluids he deteriorated rapidly and staff should have considered the SEPSIS screening tool.

3.5 COVID-19

No patients had COVID-19 recorded as their primary cause of death on the death certificate for Q4.

4.0 Deaths in Custody

In Q4, The Trust received a completed Independent Thematic Review by Trust's Panel Solicitor of 2 "ligature" deaths. This identified a need for training in ACCT processes (Assessment: Care and Custody Teamwork); improved record-keeping for ACCT; closer liaison with other prisons and support for prisoners' mental health.

5.0 Deaths of 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 were no deaths of patients with a formal learning disability diagnosis in Q4.

6.0 Child Deaths

Since January 2024, the Child Death Overview Panel process is the responsibility of the ICS.

7.0 Medical Examiner's Role

From April 2024 all non-Coronial deaths in community hospitals must be referred to the Medical Examiner service for scrutiny before a medical certificate of death can be issued, and the Trust has a standard operating procedure in place as of January 2024, with accompanying patient and staff support resources.

8.0 Learning from Deaths Group

The Learning from Deaths Group met each quarter and received corresponding reports. Attendance at the two most recent meetings was disappointingly poor, with an imbalance of clinical vs administrative staff. The distribution list has been revised and the Medical Director

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

Learning from Deaths 2023-4 Q4 Report

has emailed all those on the distribution list to explain and highlight the importance of staff contribution to the quality of care for patients at the end of life.

9.0 Learning and Good Practice

The Trust takes the opportunity to learn from each Level 1 Learning from Death Review and these learning points are discussed and shared at the quarterly meetings. This section of the report brings together all the lessons and observations made throughout the year.

10.0 Opportunities to improve

- Level 1 Review forms updated to include frequency of medical reviews and when a patient's NEWS2 score reaches 5, observations should be done hourly.
  - Implement the cardiac arrest checklist to reduce cognitive load on staff in emergencies.
  - To create a symptom chart to help staff identify, prioritise, and treat the patient with their end-of-life plan.
  - Attempt should be made to ascertain the patient's capacity before their condition deteriorates.
    - Complete End of Life care plan as soon as possible
    - Document patients' spiritual needs information on admission
    - Discuss patient's wishes with family as soon as possible.
    - Make the earliest possible request for MCA assessment to avoid delays in treatment/transfer.

11.0 Good practice to share

- Staff kept a patient's son constantly informed of patient's deteriorating condition as he did not live locally and was supporting the patient's spouse.
- Several families have expressed their appreciation of the end of life room and support
- A patient who could not read or write was given time to discuss his wishes about care plan and place of death, and open visiting was offered to his family to ensure appropriate support.
- Inpatient of RSH18 was transferred to PRH so she could be with her husband who was dying and so their family could visit them in the same place.
- The wishes of a patient who did not want to be resuscitated or transferred for acute care were respected because staff followed the requirements that the patient had stated while they still had capacity.

12.0 Conclusion

The Learning from Death Group are asked to:

- Note the mortality data and themes detailed
- Discuss and question the issues and work highlighted in the report
- 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

Learning from Deaths 2023-4 Q4 Report

our direct care. The Trust continues to take opportunities to learn from all deaths within our direct care and in the wider Community Services.

LIST OF APPENDICES

Appendix 1**:** ***Community Hospital COVID-19 positive patient deaths*** gives details of the COVID-19 related deaths for 2023-24.

Appendix 2: **SCHT Learning from Deaths dashboard**. This is the Department of Health's suggested dashboard and categorises all patient deaths. All in this period were assessed as Score 6 – "Definitely not avoidable".

Appendix 3**:** ***Deaths in Community Hospitals*** over the past 12 months compared with those the previous year. This includes the average per month which is currently the same this year as last year.

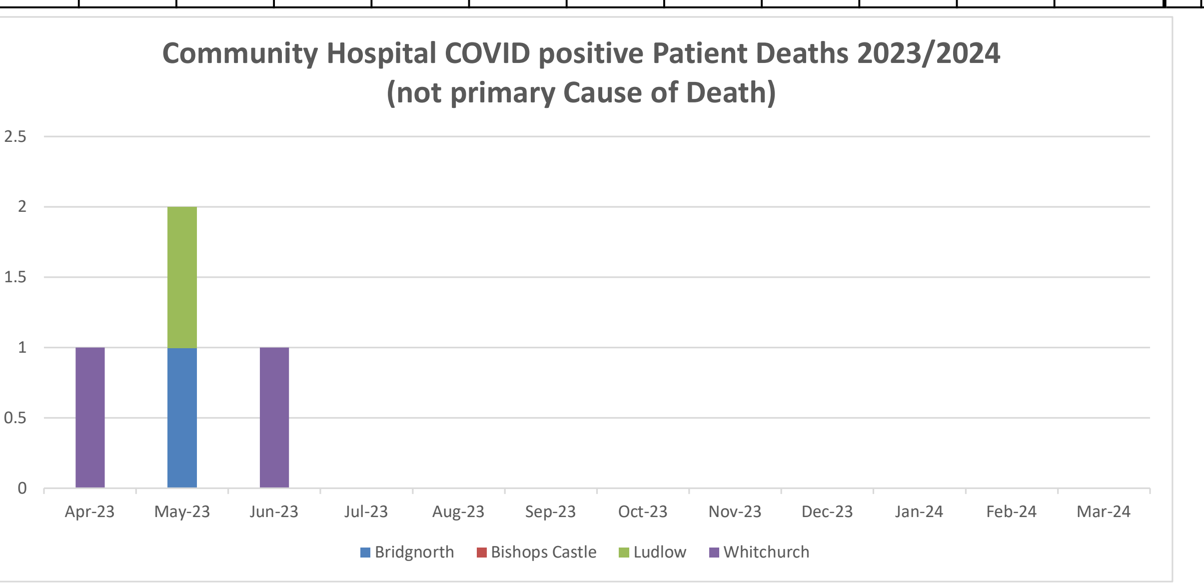
Appendix 4: Hospital Mortality Monthly Report: standard monthly report including reported deaths, categories by age banding and admission details.

Appendix 5: Mortality Analysis Report: mortality data going back to 2013 so the Trust can monitor and compare aspects and themes on a year-to-year basis.

Shropshire Community Health - Community Hospital COVID-positive patient deaths

	2023/2024													Grand Total from 2020
Hospital	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**		
Bridgnorth	0	1	0	0	0	0	0	0	0	0	0	0		7
Bishops Castle														0
Ludlow	0	1	0	0	0	0	0	0	0	0	0	0		13
Whitchurch	1	0	1	0	0	0	0	0	0	0	0	0		52
Sub-Acute Wards										0	0	0		0
Grand Total	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**72**

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24		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".	0	0	0	0	0	0	0	0	0	0	0	0		**29**



NHS Shropshire Community Health NHS Trust

Shropshire Community Health NHS Trust: Learning from Deaths Dashboard - March 2023-24

Department of Health

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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
8	6	8	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
15	5	15	5	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
40	54	40	54	0	0

Time Series: Start date 2017-18 Q1 End date 2023-24 Q4

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

Legend: Total deaths; Deaths reviewed; Deaths considered likely to have been avoidable

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)		
This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	20	100.0%

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

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

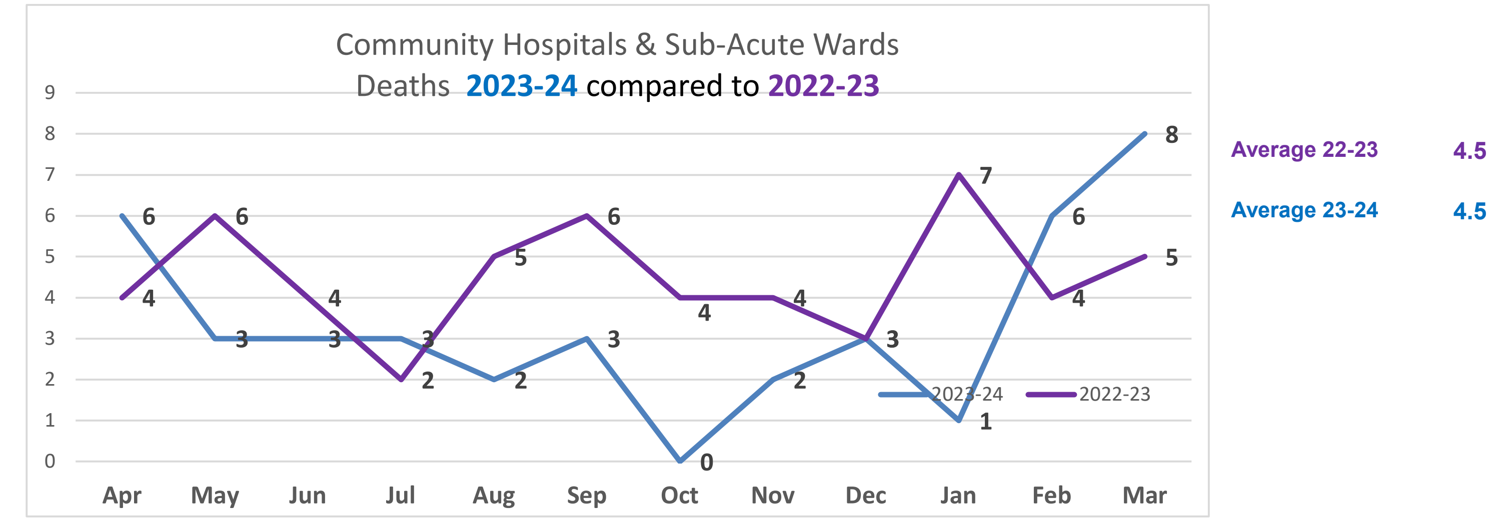
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2023-24 Q4

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

Legend: Total deaths; Deaths reviewed; Deaths considered likely to have been avoidable

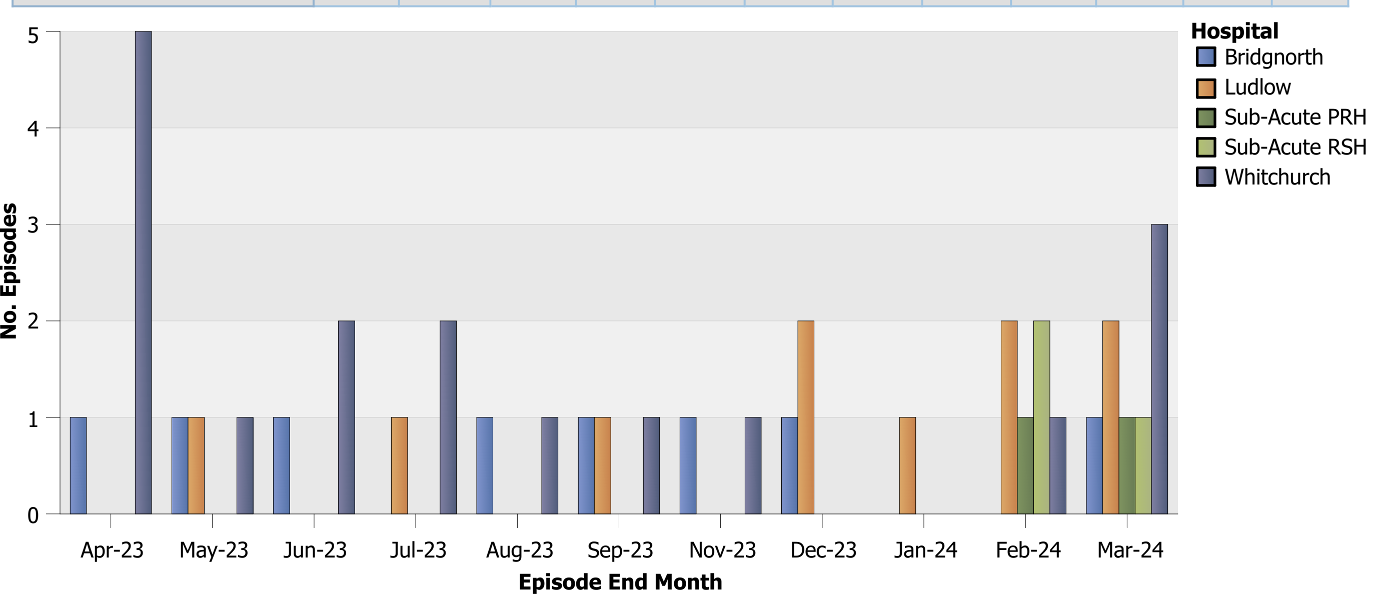
Appendix 3: Community Hospitals & Sub-Acute Wards Deaths - this year compared to last year



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	total
2023-24	6	3	3	3	2	3	0	2	3	1	6	8	40
2022-23	4	6	4	2	5	6	4	4	3	7	4	5	54

Community Hospitals - Patient Deaths

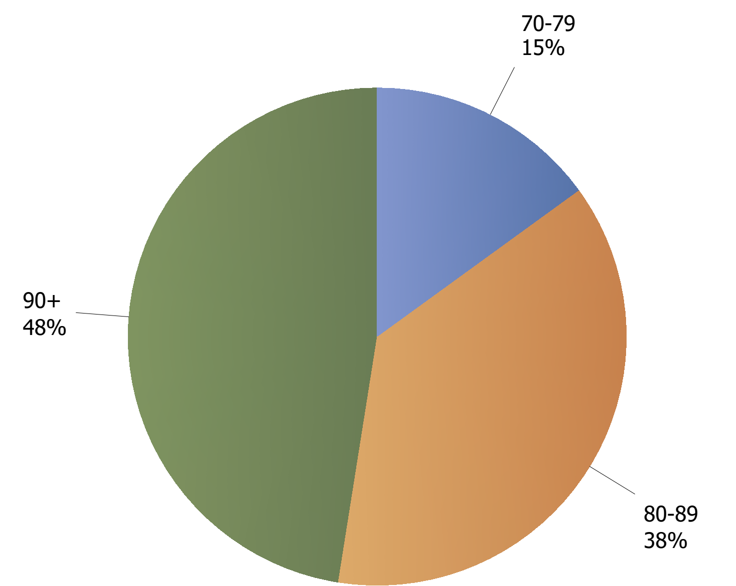
No. Episodes		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Bridgnorth	Patient Died	1	1	1		1	1	1	1			1	**8**
Ludlow	Patient Died		1		1		1		2	1	2	2	**10**
Sub-Acute PRH	Patient Died										1	1	**2**
Sub-Acute RSH	Patient Died										2	1	**3**
Whitchurch	Patient Died	5	1	2	2	1	1	1			1	3	**17**
Total		**6**	**3**	**3**	**3**	**2**	**3**	**2**	**3**	**1**	**6**	**8**	**40**



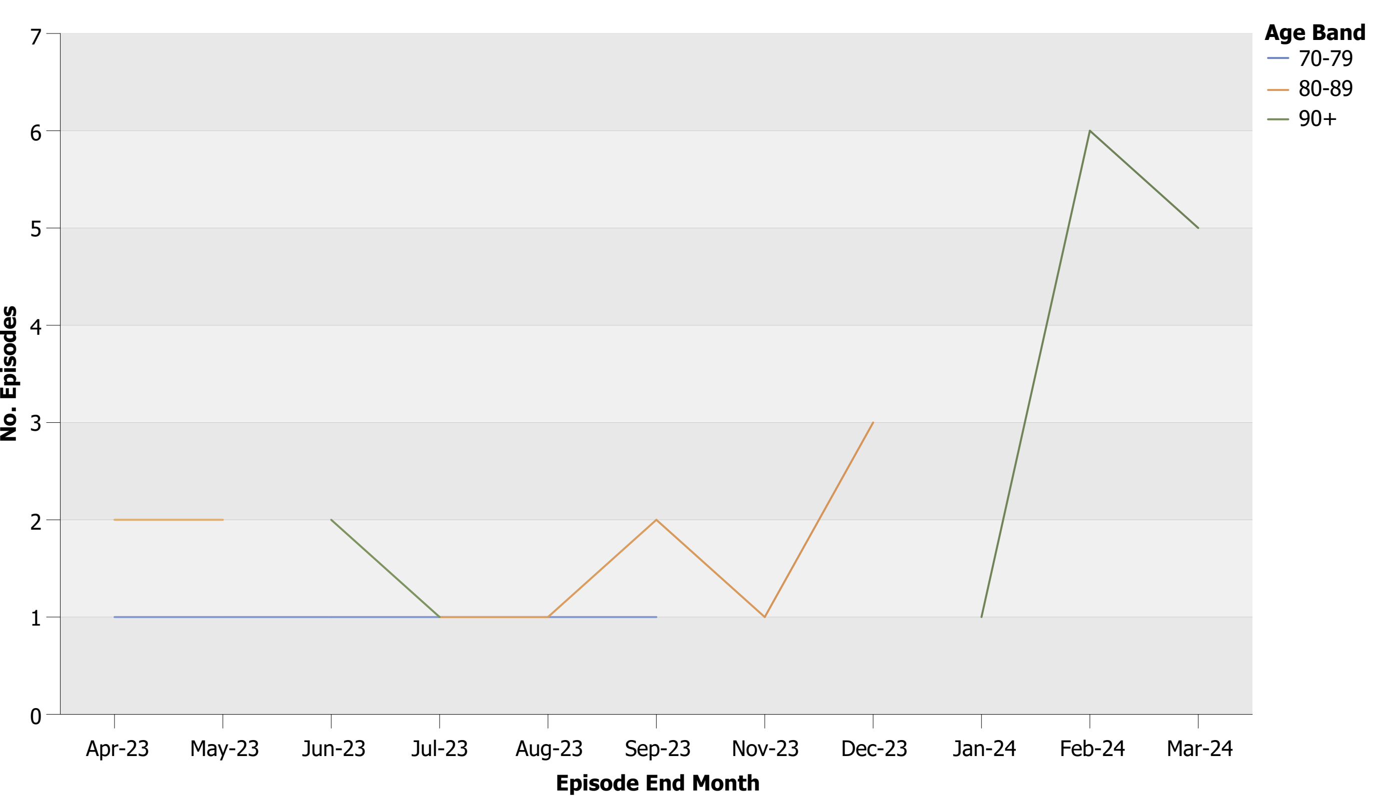
Community Hospitals - Patient Deaths by Age Band

No. Episodes		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
70-79	Bridgnorth					1							**1**
	Ludlow		1				1						**2**
	Whitchurch	1		1	1								**3**
	Total for 70-79	**1**	**1**	**1**	**1**	**1**	**1**						**6**
80-89	Bridgnorth	1	1				1		1				**4**
	Ludlow								2			1	**3**
	Whitchurch	1	1		1	1	1	1				2	**8**
	Total for 80-89	**2**	**2**		**1**	**1**	**2**	**1**	**3**			**3**	**15**
90+	Bridgnorth			1				1				1	**3**
	Ludlow				1					1	2	1	**5**
	Sub-Acute PRH										1	1	**2**
	Sub-Acute RSH										2	1	**3**
	Whitchurch	3		1							1	1	**6**
	Total for 90+	**3**		**2**	**1**			**1**		**1**	**6**	**5**	**19**
Total		**6**	**3**	**3**	**3**	**2**	**3**	**2**	**3**	**1**	**6**	**8**	**40**

Community Hospitals - Patient Deaths by Age Band



Shropshire Community Health NHS
NHS Trust

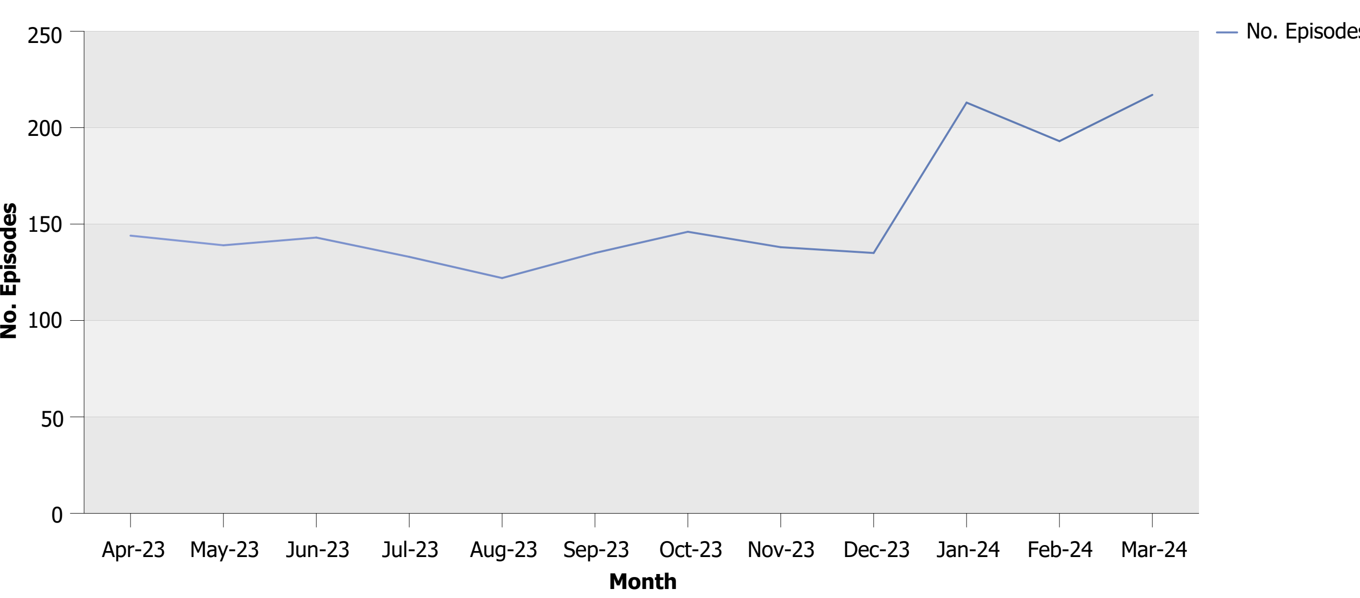


Community Hospitals - Admissions

No. Episodes		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Bridgnorth	[WARDS] - A&E Transfer (Inpatients)	7	8	5	5	1	6	4	8	4	2	5	6	**61**
	[WARDS] - GP Referral (Inpatients)			1				1		1	1			**4**
	[WARDS] - ICS - Admission Avoidance (Inpatients)	1			1				1					**3**
	[WARDS] - Readmission - care home declined						1							**1**
	[WARDS] - Ward Transfer (Inpatients)	42	30	34	34	36	37	33	31	35	34	38	35	**419**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure									1				**1**
	11 - [DAY CASE] - Waiting List (Day Case)	2	6	2				1	10		6		2	**29**
	12 - [DAY CASE] - Booked (Day Case)	5	7	6	5	15	7	12	1	7	5	6	3	**79**
	Total for Bridgnorth	**57**	**51**	**48**	**45**	**52**	**51**	**51**	**51**	**48**	**48**	**49**	**46**	**597**
Ludlow	[WARDS] - A&E Transfer (Inpatients)	8	9	4	4	2	4	7	7	9	4	6	3	**67**
	[WARDS] - GP Referral (Inpatients)	2	3	7	5	9	5	2	1	4	6	6	3	**53**
	[WARDS] - ICS - Admission Avoidance (Inpatients)			3		1	1		4		2	1	2	**14**
	[WARDS] - Readmission - care home declined	1					1							**2**
	[WARDS] - Ward Transfer (Inpatients)	24	25	26	16	19	27	24	27	25	19	21	19	**272**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure	1	4		3		2	1	1	2	1		1	**16**
	Total for Ludlow	**36**	**41**	**40**	**28**	**31**	**40**	**34**	**40**	**40**	**32**	**34**	**28**	**424**
Sub-Acute PRH	[WARDS] - A&E Transfer (Inpatients)										2	1		**3**
	[WARDS] - GP Referral (Inpatients)											1		**1**
	[WARDS] - Ward Transfer (Inpatients)										48	32	37	**117**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure												2	**2**
	Total for Sub-Acute PRH										**50**	**34**	**39**	**123**
Sub-Acute RSH	[WARDS] - Ward Transfer (Inpatients)										47	37	59	**143**
	Total for Sub-Acute RSH										**47**	**37**	**59**	**143**
Whitchurch	[WARDS] - A&E Transfer (Inpatients)	9	5	12	7	7	5	11	3	4	2	6	4	**75**

Community Hospitals - Admissions

No. Episodes		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Whitchurch	[WARDS] - GP Referral (Inpatients)			3		1		1					1	**6**
	[WARDS] - ICS - Admission Avoidance (Inpatients)		3	1	3	4	1	3	1	2	2	1	4	**25**
	[WARDS] - Readmission - care home declined		1	1	1									**3**
	[WARDS] - Ward Transfer (Inpatients)	42	38	38	49	27	38	44	42	41	31	29	35	**454**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure							2	1		1	3	1	**8**
	Total for Whitchurch	**51**	**47**	**55**	**60**	**39**	**44**	**61**	**47**	**47**	**36**	**39**	**45**	**571**
Total		**144**	**139**	**143**	**133**	**122**	**135**	**146**	**138**	**135**	**213**	**193**	**217**	**1,858**



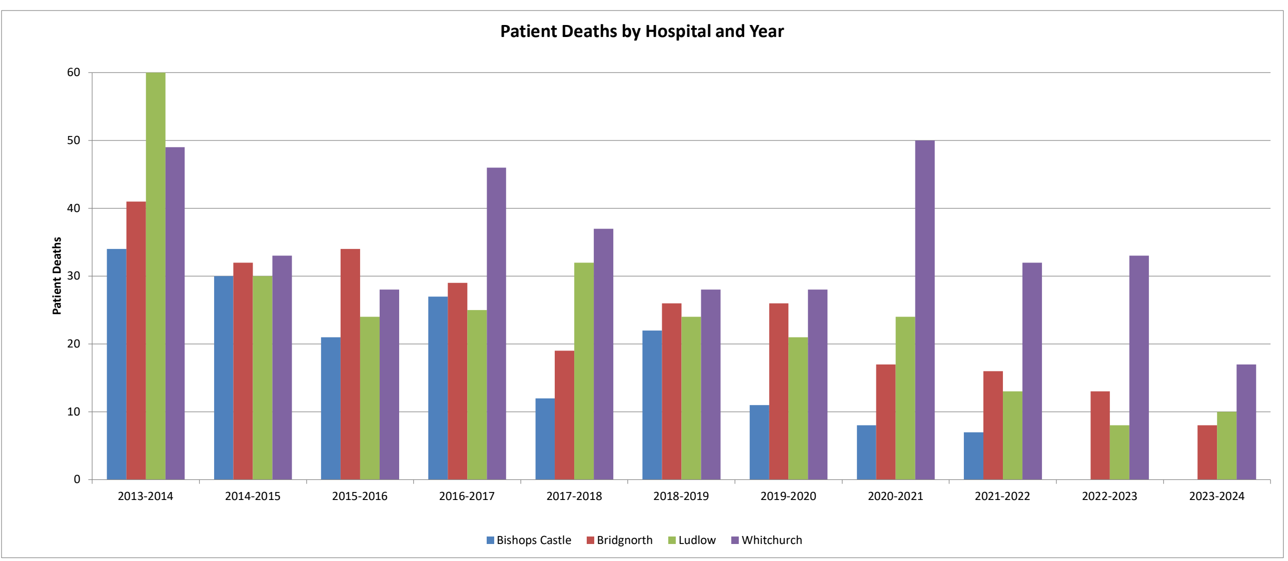
Mortality Analysis Report - Community Hospital Patients - Apr 2013 to March 2024

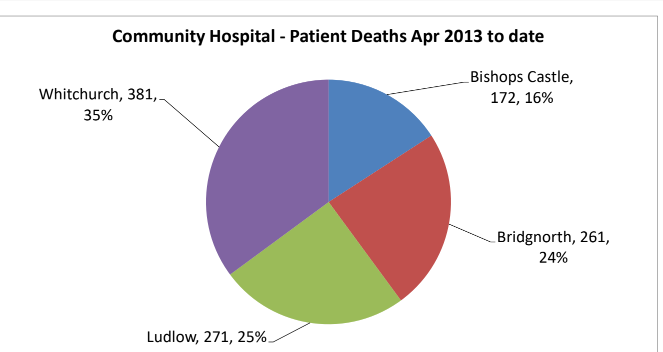
Patient Deaths by Hospital/Sub-Acute Wards and Year

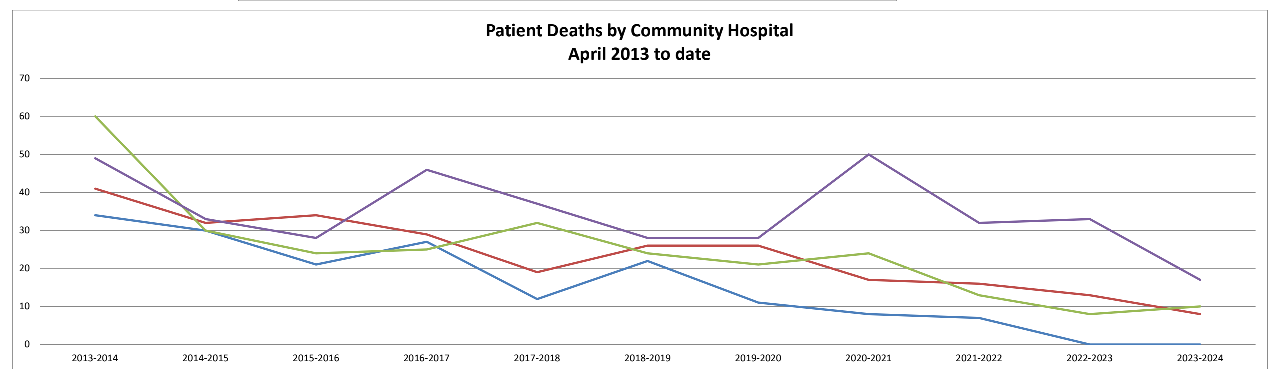
Community Hospital / Sub-Acute Ward	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total Patient Deaths 2013 to date
Bishops Castle	34	30	21	27	12	22	11	8	7	0	0	172
Bridgnorth	41	32	34	29	19	26	26	17	16	13	8	261
Ludlow	60	30	24	25	32	24	21	24	13	8	10	271
Whitchurch	49	33	28	46	37	28	28	50	32	33	17	381
SubAcute RSH18											2	2
SubAcute PRH36											3	3
Total	184	125	107	127	100	100	86	99	68	54	40	1,090
Annual Admissions Total	2,151	2,153	2,064	2,116	1,701	2,077	1,998	1,572	1,710	1,748	1,161	
% Deaths against admissions	8.55%	5.81%	5.18%	6.00%	5.88%	4.81%	4.30%	6.30%	3.98%	3.09%	3.45%	

Note: Day Cases Admissions not included in this data reporting

Community Hospital	Annual Total Admission 2018-2019	Annual Admissions v Deaths % 2018-2019	Annual Total Admission 2019-2020	Annual Admissions v Deaths % 2019-2020	Annual Total Admission 2020-2021	Annual Admissions v Deaths % 2020-2021	Annual Total Admission 2021-2022	Annual Admissions v Deaths % 2021 2022	Annual Total Admission 2022-2023	Annual Admissions v Deaths % 2022-2023	Annual Total Admission 2023-2024	Annual Admissions v Deaths % 2023 2024
Bishops Castle	317	7%	299	4%	232	3%	139	5%	0	#DIV/0!	0	#DIV/0!
Bridgnorth	570	5%	534	5%	412	4%	500	3%	545	2%	378	2%
Ludlow	537	4%	548	4%	379	6%	448	3%	495	2%	330	3%
Whitchurch	653	4%	617	5%	549	9%	623	5%	708	5%	453	4%
Total	2,077	5%	1,998	4%	1,572	6%	1,710	4%	1748	3%	1161	3%





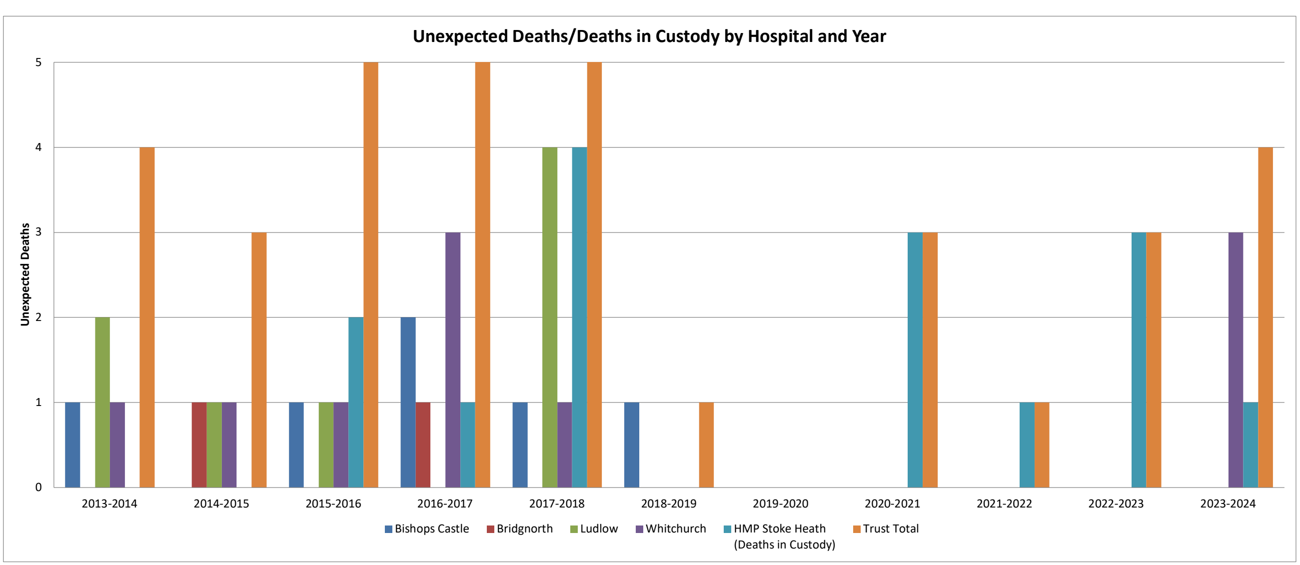


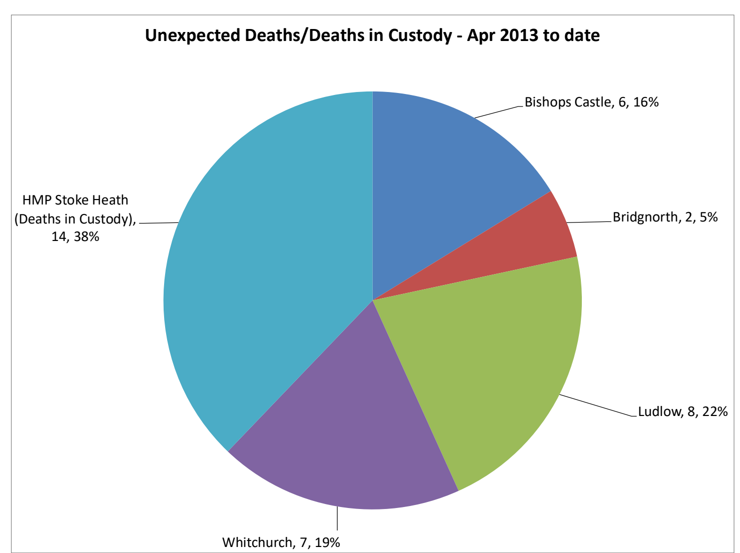
Bishops Castle Bridgnorth Ludlow Whitchurch

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

Unexpected Deaths/Deaths in Custody by Hospital and Year

Community Hospital & HMP Stoke Heath	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total Unexpected Deaths
Bishops Castle	1	0	1	2	1	1	0	0	0	0	0	**6**
Bridgnorth	0	1	0	1	0	0	0	0	0	0	0	**2**
Ludlow	2	1	1	0	4	0	0	0	0	0	0	**8**
Whitchurch	1	1	1	3	1	0	0	0	0	0	3	**7**
Community Hospital Total	**4**	**3**	**3**	**6**	**6**	**1**	**0**	**0**	**0**	**0**	**3**	**23**
HMP Stoke Heath (Deaths in Custody)	0	0	2	1	4	0	0	3	1	3	1	**14**
SubAcute RSH18											0	**0**
SubAcute PRH36											0	**0**
Trust Total	**4**	**3**	**5**	**7**	**10**	**1**	**0**	**3**	**1**	**3**	**4**	**37**

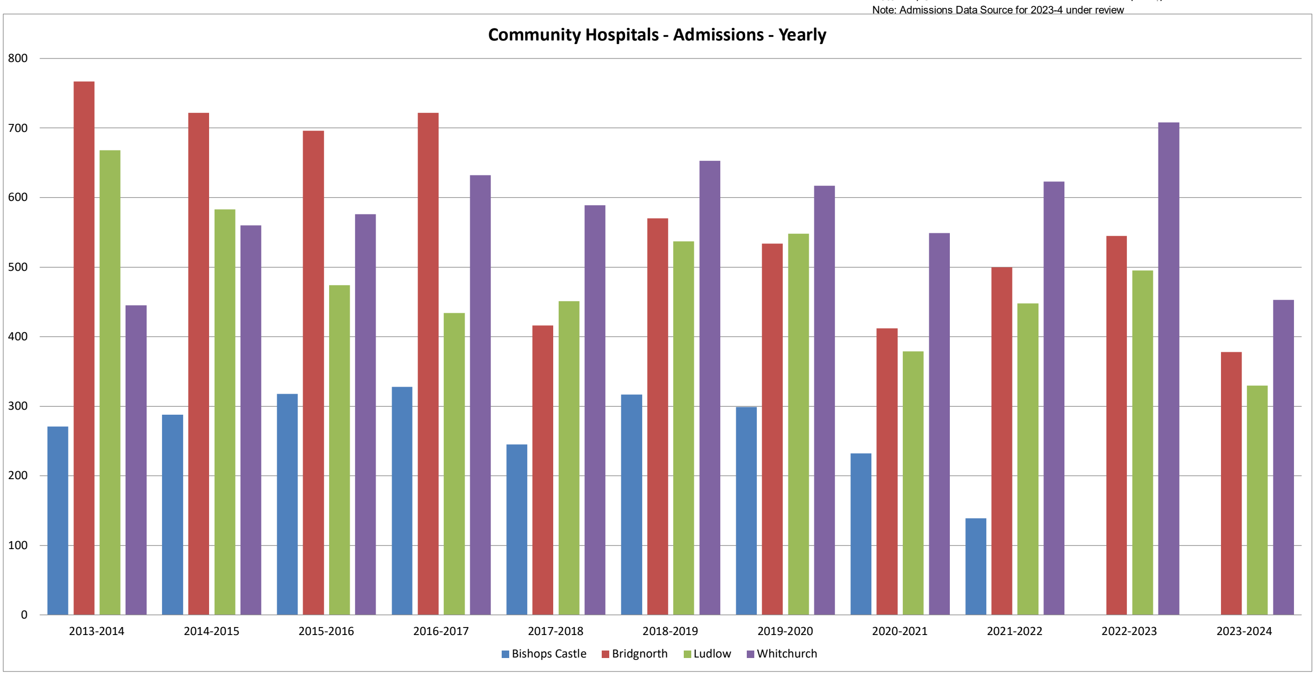


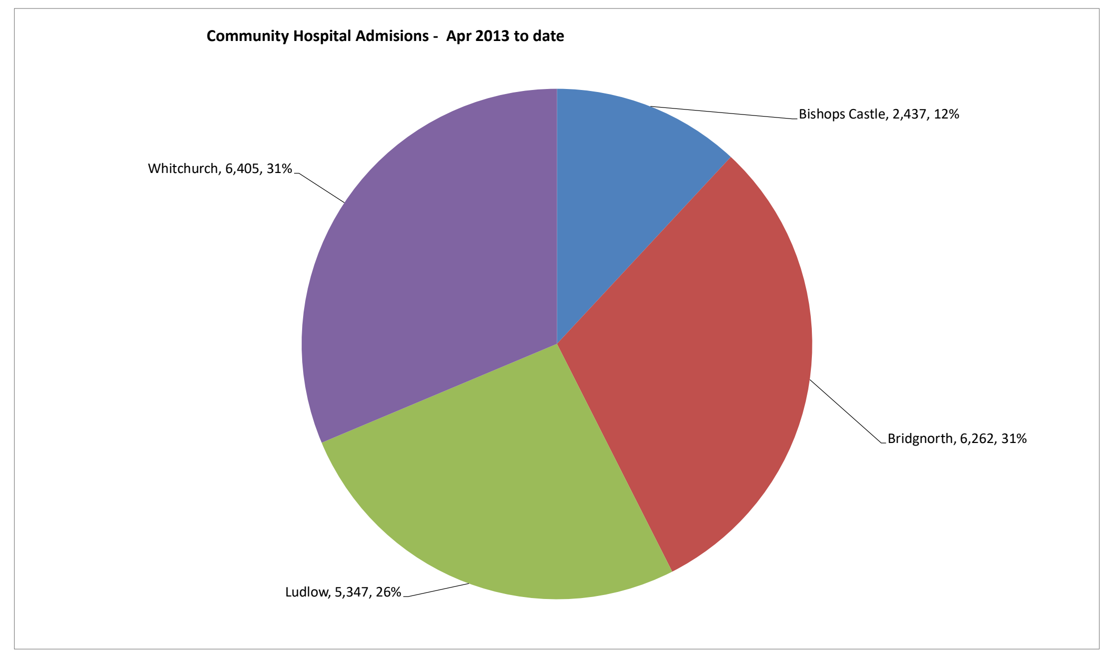


Community Hospital Admission Data

Community Hospital	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Totals
Bishops Castle	271	288	318	328	245	317	299	232	139			**2,437**
Bridgnorth	767	722	696	722	416	570	534	412	500	545	378	**6,262**
Ludlow	668	583	474	434	451	537	548	379	448	495	330	**5,347**
Whitchurch	445	560	576	632	589	653	617	549	623	708	453	**6,405**
Total	**2,151**	**2,153**	**2,064**	**2,116**	**1,701**	**2,077**	**1,998**	**1,572**	**1,710**	**1,748**	**1,161**	**20,451**

Note: Day Cases Admissions not included in this data reporting
Note: Admissions Data Source for 2023-4 under review





Cause of Death by Category Data

Note: categorising of deaths started in April 2014

Cause of Death Category	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Totals	
Awaiting Cause of Death Confirmation	0	1	6	2	4	13	6	0	2	2	**34**	*Awaiting COD*
Cardio Vascular	25	25	17	14	21	12	10	12	5	7	**141**	*Cardio Vascular*
Frailty - Old Age								27	11	7	**38**	*Frailty - Old Age*
Gastro Intestinal	2	0	4	1	2	3	1	0	3	0	**16**	*Gastro Intestinal*
Malignancy	43	42	38	46	33	30	23	13	9	5	**277**	*Malignancy*
Neurological	14	8	13	6	9	7	18	5	5	2	**85**	*Neurological*
Other	11	16	11	15	15	8	9	3	0	1	**88**	*Other*
Renal	2	3	6	0	1	6	2	0	0	3	**20**	*Renal*
Infectious Diseases							17	6	4	1	**27**	*Infectious Diseases*
Respiratory	28	14	31	16	15	7	13	2	15	12	**141**	*Respiratory*
Grand Total	**125**	**109**	**126**	**100**	**100**	**86**	**99**	**68**	**54**	**40**	**867**	

Deaths by Category - yearly - Apr 2014 to date

50, 45, 40, 35, 30, 25, 20, 15, 10, 5, 0

2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024

Awaiting Cause of Death Confirmation, Cardio Vascular, Frailty - Old Age, Gastro Intestinal, Malignancy, Neurological, Other, Renal, Infectious Diseases, Respiratory

Cause of Death Categories 2014 to date

Awaiting Cause of Death Confirmation, 36, 4%

Cardio Vascular, 148, 16%

Frailty - Old Age, 45, 5%

Gastro Intestinal, 16, 2%

Malignancy, 282, 31%

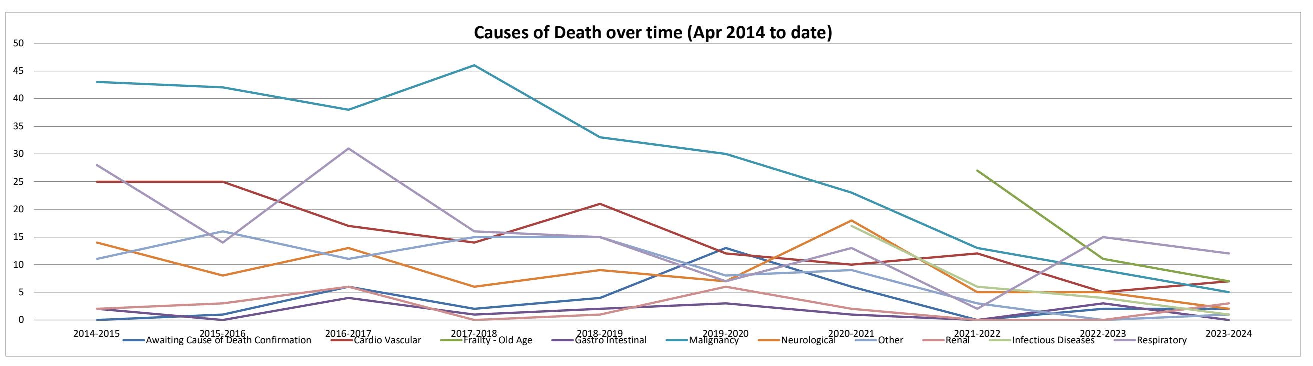
Neurological, 87, 9%

Renal, 24, 3%

Other, 88, 10%

Infectious Diseases, 28, 3%

Respiratory, 153, 17%



Quality Account 2023/24

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Document Purpose

The Shropshire Community Health NHS Trust Board 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 came into force on 1st November 2017. The Quality Account publication on the Trust website and submission to NHS England & Improvement fulfils the Shropshire Community Trust's statutory duty to submit the account to the Secretary of State.

Copies of this document are available from our website at www.shropscommunityhealth.nhs.uk, by email to communications@shropcom.nhs.uk or in writing from: Chief Executive's Office, Shropshire Community Health NHS Trust, Mount McKinley, Shrewsbury Business Park, Anchorage Ave, Shrewsbury. SY2 6FG

If you would like this report in a different format, such as large print, or need it in a different language, please contact our Patient Advice and Liaison Service who can arrange that on 0800 032 1107 or email shropcom.customerservices@nhs.net

Foreword & Welcome from Clair Hobbs - Director of Nursing & Clinical Delivery

It gives me great pride to introduce Shropshire Community Trusts Quality Account for the year 2023/24. There has once again been a huge amount of work and focus on our quality priorities with some excellent examples of success to share. 2023/24 was once again a challenging year for our Trust and whilst we have worked hard to deliver on our aims, we have also been completing large scale projects to benefit our staff and the population we serve. During the last 12 months, the Trust Board promised to work hard with local staff and residents of the Bishops Castle area to recruit staff so that we could reopen the inpatient facility after having to take the difficult decision in October 2021 to temporarily close the beds due to unacceptable staffing levels. I am pleased to note that the recruitment campaign has been a success and the Board in April 2024 agreed that we are now in a position to work up a plan to re-open. We have also seen our Virtual Ward service grow, offering patients requiring hospital based care within their own homes rather than in a Hospital and we have also successfully opened 2 Rehabilitation and Recovery Wards on the Telford and Shrewsbury Hospital sites to provide intense rehabilitation and sub-acute care via community pathways to our patients.

This year has seen success in recruitment practices, flexible working for our staff allowing us to become a more attractive employer and we are offering many Health and Well-being benefits including growing our numbers of Professional Nurse Advocates and delivering Health & Well-being days with very positive feedback. We recognise that looking after our staff contributes to the overall improvement of care and quality provided to our patients.

We have also seen great strides with our digital agenda, which is supporting both staff and patients alike, bringing the way we deliver services up to date. We have implemented a staffing E-Roster system to ease the administrative burden on busy clinical teams allowing them to spend more time with patients.

For infection prevention, we have had no blood stream infections and have achieved our target set for MRSA screening within our Community Hospital inpatient beds. Whilst we have breached the number of patients contracting Clostrdium Diffcicile infections, of the 4 attributed to us – investigations identified that there were no omissions or actions that contributed to these cases.

We have also seen the appointment of our Medication Safety Officer which has been a huge success in relation to mitigating risks related to medications and their administration across our services.

In this document we also set out our quality priorities for the coming year which have been done in conjunction with our staff and wider partners and so we have another busy year ahead supporting further improvements to the care we provide to our staff and service users.

It only leaves me to say, once again, thank you to our clinical and corporate staff that work hard every single day to provide the right care in the right place at the right time in the best way we can.

Clair Hobbs – Director of Nursing and Clinical Delivery

Statement from the Chief Executive

This quality account once again highlights all of the great work Shropshire Community Trust has achieved in 2023/24. Over the last 12 months in our Adult Services we have seen the creation and implementation of 2 new Rehabilitation and Recovery Units. Each of these inpatient units has been set in the footprint of our local Acute Trust. These units are there to support patients with rehabilitation and sub-acute needs prior to returning home and are the first for a Community Health Trust.

For Children's and Young People, our 0-19 Services are a core part of what we do as a Community Trust, as such over the last year we have actively looked to expand the footprint in which we provide these services to Dudley. Into next year having three 0-19 services, we will be able to take learning across teams and geographies to ensure we are providing the best services for children and their families as well as offering exciting roles for staff to work in.

Our Specialist Services such as Respiratory, Diabetes and Wound Care have continued to deliver excellent care to patients supporting them to stay well at home and to better manage their conditions. Our Dental teams have also worked incredibly hard to ensure to ensure waiting lists are managed as effectively as possible. Working collaboratively and innovatively with partners, they have managed to ensure dental treatment continues to be offered in a clinically prioritised manner. Plus wider than Dental, we have managed to meet our target of having zero patients waiting in excess of 104, 78 and 65 weeks.

In our Healthcare facility at HMP/YOI Stoke Heath, we have seen delivery of radical programmes through social prescribing including Food Behind Bars, a weight loss programme and relaxation and mindfulness groups.

The Trust continue to be a very active member of the Integrated Care System working collaboratively with partners – a good example of this recently was the Telford and Wrekin Local Authority SEND Inspection which concluded the local area partnership's arrangements typically lead to positive experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). There was recognition of the joined up working between partners and also that of the system wide plan for the significant increased demand on speech and language therapy.
I am also proud of the Research and audit work that has been conducted over the last 12 months and have also signed up to be a Research Champion myself; it has been great to see an increase in the number of champions across our Trust this year.

Recognising the importance of our staff is paramount to our success and so we have also held Listening events throughout the year and set up a Leaders Forum to ensure staff are engaged and communicated with on a regular basis.

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

The different models of care we are now providing such as Virtual Ward, administration of intravenous medications (OPAT) and the Rehabilitation and Recovery Units have further focused us on meeting the needs in the most agile way possible for local populations.

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

Part One
Introducing Shropshire Community Health NHS Trust

Our Vision / Key Strategic headline:

We will be at the heart of supporting our communities by providing fully connected services – so that everyone gets the right care, in the right place , at the right time, by the right people

Our Commitment

Working with primary care, we will provide evidence based, local care that is flexible and responsive.

We will move care from Hospitals to settings in or close to people's homes, with proactive treatment based on early interventions.

We will integrate community health and social care provision to ensure efficient and seamless services.

We will use our skills and expertise to support and provide a wider range of services that keep people well.

Achieving our Vision

To achieve our vision, we are building a culture on 3 foundations:-

1. **Agility** – We create simplicity to allow us to respond at pace to meet the needs of our community.
2. **Cohesion** – We work together to deliver our services for our community.
3. **Empowerment** – Decisions are made by those with the best information.

Our mission is to ensure that these shared behavioural values are embedded across the Trust, supporting a compassionate culture of openness and transparency through our core values:

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

Who we are and what we do:

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 are 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 its population throughout life, with a wide range of services including but not limited to; 0-19 Children'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 we serve.

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Our Services:

Childrens & Young Families

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 ▪ Looked After Children Team ▪ Wheelchair & Postural Services ▪ Community Childrens Occupational Therapy ▪ Community Childrens Physiotherapy ▪ Community Childrens Speech & Language Therapy ▪ Family Nurse Partnership ▪ Targeted Admin ▪ Paediatric Audiology ▪ Community Equipment Service

Community Services

Community Hospital Inpatients ▪ Adult Community Therapy ▪ District Nursing ▪ Admiral Nursing ▪ Advance Care Planning in Care Homes Team ▪ Adult Diabetes specialist Team ▪ Continence Service ▪ Respiratory Service ▪ Pulmonary Rehabilitation Service ▪ Telford Wound healing service ▪ Tissue Viability Service ▪ Community Neuro Rehabilitation Team

Planned Care

Day Surgery ▪ TEMS Rheumatology, Orthopaedics, Pain and Orthotics ▪ Physiotherapy Outpatients ▪ Advanced Primary Care Services (APCS) ▪ Falls Prevention ▪ Long Covid Clinic ▪ Community Neuro Rehabilitation Team (CNRT) ▪ Community Outpatients ▪ MSST ▪ Prison Healthcare ▪ Community Therapies ▪ Vaccination Service

Urgent & Emergency Care

Minor Injuries Units and Xray ▪ Single Point of Referral ▪ Diagnostic, Assessment & Access to Rehabilitation and Treatment ▪ Outpatient Parenteral Antibiotic Therapy (OPAT) ▪ Virtual Ward ▪ Urgent Community Response Team ▪ Integrated Discharge Team ▪ Recovery and Rehabilitation Units

Corporate and Support Services

Temporary Staffing Team ▪ Clinical Education Team ▪ Safeguarding Team ▪ Infection Prevention and Control (IPC) Team ▪ Medicines Management ▪ Patient Experience and Involvement ▪ Complaints & PALS ▪ Workforce Services ▪ Organisational Development ▪ Occupational Health ▪ Finance & Contracting ▪ Governance & Risk ▪ Quality Improvement Team ▪ Hotel Services ▪ Digital Services ▪ Strategy, Planning & Business Development ▪ 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 have four key purposes:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money;
- supporting 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 NHS Foundation Trust
- West Midlands Ambulance Service Foundation Trust

- 51 GP practices across eight Primary Care Networks.
- Shropshire Council
- Telford & Wrekin Council

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

Part 2.1 Looking back – Quality Account Priorities 2023/24

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.

Carry on with the redesign and improvement of our recruitment process to achieve timely and effective commencement dates.

- The TRAC recruitment system was launched 13th June 2023, and end to end application management tracking system, with training provided pre implementation. The system is now embedded, and recruiters are enabled to manage vacancies more efficiently.
- Full guidance for using the TRAC system has been published on the organisations staff Intranet.
- A VRF panel meets weekly to facilitate timely post approval.

Increase development roles within the organisation to strengthen career development, attract external candidates and retain staff.

- There is now a career pathway from band 2 Healthcare Assistants (HCA) to Band 5 Registered Nurse (RN).
- The Trust works with 5 universities / colleges to provide apprenticeships from Level 2-7 for clinical and nonclinical roles. The opportunities include; HR/Consultant/Partner, Occupational Therapy, Data Analysist, Healthcare Support worker and many more. The People Team have a Trust Intranet page dedicated to providing staff with helpful information of opportunities.
- Paramedic roles have been further introduced to SCHT with the role now represented in UEC, the Prison, MIU's and as a Locality Service Manager.

Development of a trust wide one stop education calendar to promote training available in an accessible format.

- Completed in the summer of 2023 and can be accessed via the staff intranet.

Extend flexible and agile working opportunities when there is no known negative impact to service delivery, team cohesion or an individual's well-being.

- The 2022 updated flexible working policy is embedded into the organisation with a clear increase of clinical staff taking the opportunity to adjust their working hours or agile work where appropriate. This includes working 9 day fortnights, working 3 or 4 long days and term time arrangements. There is an upturn in flexible working satisfaction as reflected in the 2023 Staff Survey, further work is required.

Advocate prioritisation of regular clinical / nonclinical supervision across our workforce, continuing to provide a suite of resources via the trust website and Organisational Development

- 5 Schwartz Rounds have taken place during the year across the geography of the organisation, including a session held in HMP Stoke Health, Market Drayton. Subjects of sessions varied widely from 'a patient I'll never forget' to 'working in turbulent times'.
- The Trust has 10 Professional Nurse Advocates (PNA), with 5 further training places secured for 2024. The PNA's carried out 281 activities in 2023 that span across all

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the organisation directorates, including Corporate Services. Interactions included; providing 55 group supervision sessions, 158 individual sessions, plus attendance at all of the Occupational Health Wellbeing sessions held around the county. The service has embraced the use of digital solutions with the facility to book a PNA session using a QR code.

- Work is now beginning to extend the model to enable Allied Healthcare Professionals (AHP's) to train as Professional Advocates
- Jo Bettison – SCHT Family Nurse Partnership (FNP) Supervisor is a PNA and provides 7.5 hours a month to this. Jo in August 2023 had an article published in The Journal of Community Practitioners and Health Visitors Association (CPHVA) entitled 'Critical Leadership'. PNA learning was discussed within the journal in conjunction with reflective analysis. Jo has been asked to present on the role of the PNA at the CPHVA conference Birmingham in November 2024.

To me the PNA role aligns itself beautifully to my role as FNP Supervisor. I was fortunate enough to be new into both roles and have been able to weave the PNA role into my FNP role seamlessly. The heart of the PNA role lies in being an advocate for our colleagues across Shropcom offering a safe space to reflect on experiences so that they can develop coping strategies, build resilience and improve their health and wellbeing. Providing restorative clinical supervision for our colleagues as a PNA can reduce stress and improve inner confidence and self-efficacy. This to me can only lead to more positive outcomes such as quality improvements and more effective team working. As a FNP supervisor and PNA, I feel we need to demonstrate inclusive, compassionate leadership built on equality, integrity, openness and kindness across the Trust. The Supervisor training has equipped me with the firm foundation of all these skills and I am very keen for the two roles to continue to work together as they do. **PNA - Jo Bettison**

- Clinical supervision is embedded in many formats across our organisation, including patient handovers, safety huddles, learning from deaths reviews and team meetings, including line management one to ones.

Embed thirty, sixty and ninety day conversations for all our new employees. Plus implement the already developed stay conversation process.

- A thirty, sixty and ninety day conversation document has been developed and launched in the first part of the financial year, along with the implementation of the Stay conversation process. Work is ongoing to record these conversations to allow for analysis and a Communications campaign to promote these conversations is planned and due to go live in Q1 2024/25

Ensure transparency and clarity of our organisational structures

- Changes to very senior leadership posts are now routinely conveyed as they happen via communications emails, that include an updated Board structure poster for display. New appointments are also conveyed in the Chief Executives weekly email to all staff.

Roll out our updated and improved appraisal documentation and a separate Bank staff review process following positive feedback on the new format.

- The new appraisal paperwork for substantive and bank staff is now live and is overwhelmingly preferred to the previous version. In addition to this, the NHS Leadership Academy's - Scope for Growth career conversation tool is being considered as a bolt on to enable effective and inclusive career conversations.

Hold staff engagement and listening events periodically across the organisation.

- Executive listening events commenced in June 2023 and to date 17 sessions have been held with over 120 staff attending. Of these sessions, 8 were held face to face and 7 were online. These session are continuing into 2024/25.
- A new newsletter 'Your Voice' was created as a result of the listening events and the information included takes a 'you said, we did' approach. 'We did' actions have included; improving visibility of the Executive Team by increasing visits to services and the creation of a leadership forum - chaired by the Chief Executive.

Make time to acknowledge and celebrate success, share good practice and reward achievements Forums for protected characteristics.

- A Long Service Awards and International Nurse's Welcome event took place on 28th November 23. 2 long service awards for 40 years NHS Service were presented.

- Leaders in the Trust continue to use printed 'Thank you' cards to send positive messages to individuals or teams to recognise achievements.
- 10 Chairs awards have been presented during the year to recognise individuals and staff groups' dedication and innovation.
- The trust has BAME, Disability and LGBTQ+ networks to support employees and is proud to be part of a reverse mentoring programme. This supports senior colleagues to understand challenges and adapt their leadership style to achieve greater inclusivity and diversity in the workforce.

In addition to the set priorities:

- A Staff feedback button has been implemented on desktops/laptops to enable staff to provide suggestions that can be submitted anonymously.

- The Trust has introduced the Shiny Minds Wellbeing app to Trust phones and provided a website link for the service. The package is an evidenced method of supporting the mental health and wellbeing of a workforce.

- The Trust held a program of 5 Health and Well-Being Days across the county to engage with staff on various topics, including Flu and Covid vaccinations, Mini Health MOT's, retirement planning and access to the PNA Service. The events were well received, with 270 employees attending the sessions.

- Funding has been granted from – 'NHS Charities Together' to continue the successful staff wellbeing days throughout 2024/25.

- A People Promise Manager has now been recruited and is due to commence in the new financial year to support our ongoing work with the National People Promises.

- 2 HR members of staff are now trained to provide 'handling difficult conversations' training and 3 are trained to provide training on 'wellbeing conversations.

- Implementation of the Race Code has begun, with the work continuing into 2024/25.

- HR continue to collaborate with System partners to provide training. Sessions include; feedback is a gift, visible leadership and courageous conversations.

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)

Train our clinical staff in patient safety utilising the national Patient safety syllabus.

- Appropriate levels of Patient Safety Training for all SCHT employees have been established, conveyed to our workforce and included in the PSIRF policy.
- During September 2023, all SCHT staff had their mandatory training matrix updated on ESR to include the required Patient Safety training up to level 2.
- Current compliance stands at 92% for Level 1 and 87% for Level 2, which is a significant step forward to getting our workforce to understand and adopt the new mandated approach to patient safety.
- The Trust has identified the Associate Director of Governance as the Patient Safety Specialist who is due to commence level 3 & 4 Patient Safety training.

Create pathways to support the new mandated Medical Examiner role.

The Medical Examiner (ME) Service became statutory 1 April 2024, with a purpose to improve the death certification process across England and Wales by increasing scrutiny of accuracy and consistency.
Joy Pursglove - Deputy Ward Manager, conveys her journey to implement the ME Service in SCHT Community Hospital Wards:

I bought together stakeholders, which included GP's, ward clinicians, corporate services and the ME service to build a professional platform for pathway development. This enabled successful interaction, consultation, provided extensive knowledge, process mapped and facilitated identification of the learning required to support effective implementation. From this, I developed a Standard Operating Procedure (SOP) for the referral of non-Coronial Community Hospital Deaths to the ME and created a Summary Sheet to help staff identify their roles in this process.
I then met with ward staff to provide education on the new process ready for going live. A year later and a lot of hard work, the workstream launch begun before the statutory deadline. **'I feel privileged to have implemented the ME service process in SCHT' – Joy Pursglove**.

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

- A revised Governance structure has been developed and agreed that includes a Governance Manager dedicated to patient safety. An Associate Director of Governance has been appointed and will be the designated Patient Safety Specialist for the organisation. Recruitment into other posts is the next step.

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Understand SCHT patient safety incident profile and develop a patient safety incident response plan and policy.

- 4 priority areas for PSIRF have been identified; Transfer of Care, Pressure Ulcer Prevention, Falls and Medicines Management.
- The Patient Safety Response Plan and Policy have been formulated, presented and approved by Board and are live.

Embed the newly created Medicines Safety Officer (MSO) role into the organisation.

Lucy Manning – SCHT's first MSO joined the organisation in May 2023 and since then has taken responsibility for chairing the Medicines Safety Group, co-chairing the Medicines Governance Group, plus a range of other duties. Lucy's role works between the Medicines Management Team and Quality Improvement Team to promote a continuous improvement approach towards medicines safety. Since November 2023, the MSO role has also included being the Non-Medical Prescribing Lead for the Trust.

2023/24 MSO workstreams have included / include:

- Promoting medication incident reporting to facilitate learning within the organisation.
- Implementation of the Patient Safety Incident Response Framework in the Medicines Safety Group
- Medicines specific service improvement projects driven by trends in incident data and risk analysis.
- Completion of 'Safe and Secure Handling of Medicines' audits across the 3 Community Hospital in patient wards and the 2 Rehabilitation and Recovery Units with action plans now in place.
- A plan to complete 'Safe and Secure Handling of Medicines' audits in the 4 MIU's is in place. Audits are scheduled to take place in April 2024.
- Joint working with Severn Hospice to minimise the incidence of dexamethasone-related incidents.
- Participation in a System Working Group to encourage a reduction in number of incidents relating to patient's being discharged from the acute sector without a referral for continuation of insulin administration.
- Supporting transition to medicines management module on RiO which will enable trust to complete digital medicines reconciliation and provide the Community Hospitals with a new way to complete discharge letters within the Community Hospitals (currently in test phase).
- Introduction of a Medicines Safety section during the organisations Clinical Core Skills Week training. This promotes effective incident reporting and responses to aid learning.

Further develop pressure ulcer and falls prevention pathways, plus the implementation of Purpose T assessment tool to replace the current process.

- Pressure ulcer guidance packs were distributed the week of 13th November 2023 as part of the national 'stop the pressure' campaign which takes place each year. This information included pathways, education on wounds and patient information leaflets.

- The implementation of Purpose T has been nationally paused while a national training package is produced. The Tissue Viability Service continue to provide pressure ulcer prevention training monthly, plus bespoke sessions for teams when requested.
- A new e-learning resource has been identified to support effective education in falls for our workforce.
- 4 Falls Roadshows have taken place across our Community Hospital sites and there are plans for them to continue using the Falls Team delivering the sessions.
- A pilot involving Healthcare Support Workers having on the spot training on falls when working on the ward has commenced.
- Workstreams did pause from the autumn due to organisational changes and significant staffing difficulties, however, work recommencing with a Clinical Lead for Quality being allocated to support quality improvement.

Implement the use of a lower limb assessment tool across all relevant services.

- The lower limb assessment tool became live on the electronic patient record at the beginning of the financial year and the District Nursing Teams and Wound Healing Service are now using the tool to determine patient care.

Refresh Freedom to Speak up Guardian processes to ensure inclusivity of our non-clinical workforce.

- Changes to SCHT Freedom to Speak Up Guardian are ongoing with David Ballard - Organisational Development Business Partner recently being announced as the Trust Guardian. He will begin the role in the spring once the mandated training with the National Guardian's Office has been completed. David has been with the organisation since 2016 and is a well-respected individual through his work of providing essential Organisational Development support to employees.
- New Freedom to Speak Up Champions were created in October 2023 to tie in with the national initiative - Speak up Month. The organisation now has 1 Guardian and 4 champions, who are a combination clinical and non-clinical staff.

Work with system partners to improve the patient journey, including referrals, documentations transfers and discharges.

- This workstream has been identified as a PSIRF priority for 2024/25
- SCHT has become the lead provider for the Integrated Discharge Team (IDT) in the system. Workstreams have the included development of a single multi organisation dashboard plus a united approach to policy development and review.
- As a system approach, the Complex Discharge Team working within the Integrated Discharge Team have adapted processes to improve patient transfer by reviewing /

carrying out assessments with patients, requesting further information where gaps are identified and providing positive challenge to unclear information.
- Creation of 2 Recovery and Rehabilitation Units (RRU) sited at our ICS acute Hospital sites in the county to streamline the patient journey back into the community setting.

Developing a safe new Service, RRU Telford - Dorota Hewes (Dee) - Redeployed Ward Manager

As a newly redeployed manager tasked with establishing and overseeing operations in a new RRU, I was acutely aware of the significant challenges inherent in building a cohesive team and to ensure the highest standards of patient care. The primary hurdles faced were the reliance on agency staff to fulfil essential roles within the ward. While agency staff bring valuable skills and experiences, their transient nature poses obstacles in maintaining consistency and continuity of care.
To address this challenge, my immediate focus was establishing robust processes and protocols to ensure that patients receive safe and effective care. This included implementing comprehensive tailored care plans, strict adherence to infection prevention and control measures, and provision of robust orientation and training sessions for all staff, including agency personnel. By providing clear guidance and support, I aimed to equip our team with the knowledge and resources necessary to deliver high-quality care and mitigate potential risks.
I viewed building a new team from the ground up as a considerable challenge, particularly the recruiting and onboarding healthcare assistants and nurses. However, this was an opportunity to cultivate a culture of excellence and collaboration from the outset. Through meticulous recruitment processes and targeted training initiatives, I have been committed to assembling a dedicated and compassionate team capable of upholding our commitment to patient-centred care.
I have also enabled and promoted the fostering of strong partnerships with system stakeholders to enhance the overall patient journey. Collaborating closely with external partners, including referral sources and community resources, is instrumental in facilitating seamless transitions of care and improving outcomes for our patients.

To fully implement national safer staffing tools in our District Nursing Teams and Inpatient Wards

- Training for implementation has been completed across both services.
- Training packages have been developed for service leads for new employees / refresher training.
- The Implementation process is complete for all District Nursing Teams as 2 cycles (6 months apart) of caseload assessment has been accomplished.
- The implementation process for our inpatient wards is complete with cycle 2 completed in January 2024.

Review the prescribing processes for continence for Shropshire to optimise safe treatment.

- Work is currently in progress to seek investment to enable the Continence Service to roll out Telford's patients prescribing model across the whole organisation. A business case has been completed and engagement with the ICB is proving positive.

Patient engagement and experience

People and communities using health and care services are best placed to understand what they need, what is working and what could be improved.

Increase our stakeholder's involvement in recruitment processes, service development / redesign and governance processes to follow a co-production model.

- Volunteers continue to part of the leadership interview process and sit in at Trust Committee meetings. Further work is required to support clinical teams to adapt the culture
- League of Friends / Friends of Community Hospitals meet with the relevant Hospital Managers (Community Service Managers) and Directors at regular intervals and engage with local government to support proposed services and those already in place.
- The Trust has delivered a workforce and recruitment plan that focused additional efforts and resources to recruiting to the vacant posts for Bishop's Castle Community Hospital inpatient beds. This was delivered collaboratively throughout with the local community, key stakeholders including the 'Staff Our Beds' Campaign group and our staff.

Routinely collate and share patient, carer and staff stories

- Sharing stakeholder stories is a regular of SCHT ethos. 5 stories have been presented to Board and other meetings across all Directorates. 4 of the stories were in video format, to enable wider sharing and impact. The topics included the implementation of a Revive Programme, recruitment of Nurses internationally, Virtual ward – patient experience, the District Nursing Named Nurse implementation and Veterans and Armed Forces covenant.

Embed the use of the Friends and Family Test and Inpatient Survey QR business cards and posters throughout our clinical services.

- QR codes have been distributed using business cards and posters across clinical teams.

- Quality Team staff now routinely prompt the use of FFT QR codes use during clinical visits.
- Volunteers have recommenced supporting 2 of the Community Wards to aid the inpatient survey completion have also initiated this work in the two new Rehabilitation and Recovery Units.

Widen our volunteer membership with redesigned roles and responsibilities to align with the shift in culture following the Covid-19 pandemic.

Administrator support has now been allocated to support increasing the pool of volunteers within the Trust, further work is planned for 2024/25

Increase Observe and Act assessments across clinical services.

- Observe and Act visits have more than doubled this year with 54 visits recorded. The ambition to visit all 94 clinical teams within 2 years is above target at the half way point as 57% of services have been assessed. Feedback included:

Lots of great practice observed. Patient feedback was excellent, staff looked really smart – MIU Oswestry

Made the patient relaxed, offered numbing cream and allowed time for it to take effect and didn't rush, spoke with patient the whole way through, assuring them - Phlebotomy C&YP

Absolutely fabulous, cannot fault anything, staff go above and beyond. Top class, care unbelievable – Whitchurch Inpatients

Jargon free, clear and concise communication with plenty of time for questions - Physiotherapy Newport

Excellent service from all the team, relaxed and friendly service, never rushed – Ludlow Podiatry

Atmosphere seemed very calm and positive. Positive feedback from a patient 's relative – Rehabilitation and Recovery Unit - Telford

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.

Expand the use of remote patient monitoring in our community teams.

- Docobo - a patient monitoring system has been introduced into our Virtual Ward and Respiratory Services to support patient monitoring.
- The EMIS system is also in the process of being procured to facilitate Electronic Prescription Processes (EPS).

Identify and address areas for improvement in digital competency.

- Digital Services have recruited to a post which includes leading on digital competency. The post is now live and work in the background has been ongoing.
- A campaign has been devised that commences April 2024 that includes a staff survey to identify training needs, tailoring training based on reported need and creating a structured timetable of subjects and surgeries for staff to drop into. Further support will be created via a repository of short videos as quick reference guides. Furthermore, an enhanced MS Teams / intranet page planned as a portal to training.
- This project has slowed as the level of initiatives being delivered is rising, plus the requirement for the service to provide first line support / skills training to all Trust users.

Promote resources available via trust communications and a designated staff intranet page that facilitate digital literacy.

- A campaign to identify training needs, develop training packages and a resource centre has been mapped out, and commences April 2024.
- A significant upgrade to EPR happened 2023 that provided an extensive resource suite.

Implement the Electronic Patient Record (EPR) system in our Inpatient Wards

- Inpatient Allied Health Professionals and Discharge Coordinators have moved across to using the EPR for clinical record keeping, with proposals for the GP's, Advanced Practitioners and Nursing staff to Transition in Q1 2024/25.

Whitchurch in-patient Therapists and Well-Being Workers now use EPR for documenting patient interventions routinely.

- A working group is in place to move the initiative forward.
- Clinical Documentation has been reviewed and digital forms developed to support implementation. The digital forms include a falls, VTE and bowel function assessments, handover document, discharge letters, plus many more.
- Sufficient equipment has been ordered to allow the scheme to go ahead.
- A tactical deployment of Electronic Prescribing and Medicines Administration (EPMA) has been rolled out across the Community Hospitals to replace the use of E-Script and sets the foundations for an implementation of a full EPMA subject to the finance and resources being made available within the Digital Team.

Increase accessibility of patient information using digital solutions to facilitate timely intervention / treatment.

- The use of the patient summary care record in Rio is increasing which supports access to patient effective and timely access to required clinical information.
- Developments in the Integrated Discharge Team have allowed SCHT clinicians to have access to partner organisation systems to facilitate the sharing of information.
- The Trust is now successfully surfacing its community EPR data within One Health & Care which provides the Integrated Care Record across ST&W and Staffordshire.
- A successful pilot has been completed with Virtual Wards and Safeguarding to view the Integrated Care Record (ICR) within Rio. Next steps are outlined, with a communications campaign running through April 2024 and a go-live of the Single Sign On interface within Rio in mid-May.

Transition to using E-Roster across clinical Services.

- The E-Roster project plan is underway and is on target for the set timeframe. Three early adopters went live on the 01/02/24, with 19 modules now live and include all in-patient wards, District Nursing Teams and MIU's.
- A Bank staff module is in place which enables the Temporary Staffing Team to book Bank workers and /or agency into unfilled duties on live e-rostered areas.
- Submission of the first pay-file took place early March with payment to staff at month end. This has eliminated submission of timesheets for the live services.
- The new rostering policy to support the initiative is in final draft and is due to be published in the Spring 2024.

Identify, Increase and promote the use of Apps that enhance service provision.

- The Digital Innovation Group review apps with services and clinicians and roll out as appropriate.

The Digital Team moved its data centre to a new location due to organisation remodelling. This has resulted in an extended Cloud footprint and enhanced ability to innovate with Apps and available digital technology.

- The digital dictation tool T-PRO is currently being implemented in APCS. When in place, the next phase will be to onboard TeMS/MSST. Once completed the plan is to focus on implementation in Childrens Services, then take stock to identify all services where the technology would be beneficial
- The Digital Team is also working with third parties such as STRATA and the provider of Rio to deploy Referral Triage systems across TeMS/MSST in the new financial year, these integration services have been procured and will be deployed throughout 24/25 to provide end to end integration across the eRS system and Trust EPR.
- Virtual Ward / Urgent Community Response are due to trial a communications tool to support effective information and task allocation.
- A single point of triage has been established in Virtual Ward with internet telephony to support agile working and plans to introduce a single line to support patients. This is seeing faster response times and an increase in numbers of patients admitted to the caseload.

Modify our communication methods with patients and caregivers to optimise patient care by using digital solutions.

- A project in the District Nursing Teams to inform patients of when an appointment has been made, rearranged or cancelled using a texting system is in progress.
- The use of patient engagement portals are being explored by the Trust to enable improved patient interface.
- A pilot has been jointly run between the Rio Team and the Continence Service, giving patients an additional mechanism to view their future booked appointments. Using the Virtual Assistant, patients can opt to use the link supplied on a letter received from the service to view their appointment, or request to reschedule or cancel the appointment. Feedback has been overwhelmingly positive with 73% of responders confirming they 'liked' the approach. Future developments will include the roll out across SCHT service where Rio is used, and continued work with both technology suppliers to enable appointments to be directly rescheduled through the Virtual Assistant.
- The Digital Team are also implementing a performance management system to enhance data/performance reporting and analysis across services.

Implement a performance management system to enhance data/performance reporting and analysis across services

- An innovative Trust information portal has now been developed that builds on available Power BI technology, this portal now includes several dashboards that provide Statistical Process Control (SPC) charts across a number of the Trust's KPI's and can be viewed from an aggregated perspective but also through drill down to divisional and service level parameters.

Part 2.2 Looking forward - Quality Account Priorities 2024/25

In 2024/25 SCHT will be focusing on 3 priorities that incorporate national & local agendas. Staff engagement has been vital to formulation of the priorities, which took the form of a Trust wide staff survey and focus groups. Digital innovation will be integral to all 3 priorities.

Looking after our People

The NHS achieves extraordinary things for patients, but safety and health and wellbeing matter just as much for our people. If we don't look after ourselves, and each other, we cannot deliver safe, high-quality care. NHS England – People Plan

We will:

- Refresh our staff network offer to provide staff with the forum to share experiences and be a part of decision making
- Have a robust organisation framework that develops and embeds Equity, Diversity & Inclusion in everything that we do from Board and beyond.
- Develop staff reward and benefits including financial wellbeing
- Further develop the health and well-being offer to staff
- Explore digital options for Occupational Health Service to widen accessibility.
- Provide Managers and staff with the resources and tools to undertake their roles.
- Allow people to thrive, evolve talent management structures that are inclusive of corporate services.
- Streamline documentation to reduce workloads, including using digital solutions
- Embed Agility, Cohesion and Empowerment cultural behaviours across the organisation.

Fostering a culture of Continuous Improvement

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities. NHS IMPACT – NHS England

We will:

- Adopt NHS Impact Framework
  - → Build a shared purpose and vision
  - → Invest in people and culture
  - → Develop leadership behaviours
  - → Build improvement capability and capacity
  - → Embed improvement into management and systems
- Commence the implementation of Service / Ward accreditation

Enhancing Patient Experience and Safety

Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care. NHS England - Patient Experience Improvement Framework.

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

We will:

- Fully implement the PSIRF policy and plan and develop local safety improvement actions for the four identified local PSIRF priorities;
    - → Falls
    - → Pressure Ulcers
    - → Medication incidents
    - → Transfers of care.
- Further educate our staff on PSIRF processes
- Adopt new processes for Patient Feedback and to align with the new CQC ways of working
- Embed Learning Disability and Autism improvement standards
- Review and enhance our End of Life processes
- Increase patient engagement and co-production.

Part 3: 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

Clinical audit is a way to find out if healthcare is being provided in line with standards and let's care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits.

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.

Audits included on the Trust Annual Clinical Audit Programme are prioritised according to a system developed by the Healthcare Quality Improvement Partnership (HQIP).

Priority 1 – External 'must do'

National Clinical Audit and the Patient Outcome 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 2023/24.

- **National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACP).** Pulmonary Rehab. Our waiting times have improved, with 90% of patients now being assessed within 18 weeks of referral. The Trust has signed up to the Pulmonary Rehabilitation Accreditation scheme, which is a 12–18-month process for evaluating our service and identifying how we meet the pulmonary rehabilitation standards.

- **National Audit of Care at the end of Life (NACEL).** Inpatients. The Trust has registered for NACEL 2024 and is participating in all four elements of the project: case note review, quality survey, staff reported measure and hospital site overview.

- **National Diabetes Foot Audit**. Podiatry. The Trust has continued to submit data to this audit and will review the findings when they are published.

- **National Audit of Inpatient Falls**. Inpatients. This is an audit of the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone whilst in an inpatient setting. The 2023 Trust level report is due for publication in March 2024 and will be reviewed by the Trust to identify areas for improvement.

The Trust also participated in a National Point Prevalence Study on HealthCare Associated Infections (HCAI) and was only one of nine Community Trusts to do so. The survey was aimed at providing a snapshot of the burden of HCAI and describe Anti-Microbial Use to allow meaningful comparisons between organisations. Preliminary summary results have been shared with each participating trust and organisation and will allow benchmarking with peer-group hospitals in England to identify opportunities for improvement.

Commissioning for Quality and Innovation (CQUINs)
Quarterly audits were carried out in relation to the three CQUINs listed below.

- **Assessment and documentation of pressure ulcer risk** CQUIN (Commissioning for Quality and Innovation). Inpatients. This audit looks at whether patients have received a pressure ulcer risk assessment on admission to hospital and whether any risks identified have been managed effectively and in accordance with national guidance. Assessments were carried out in 94% of cases in the audit sample, although only 55% within 6 hours of admission. Treatment plans to manage the identified risks were initiated in 93% of cases where a plan was required. CQUIN Champions across a number of services have been identified, education has been provided and a clinician guidance leaflet on pressure ulcer assessment and management has been developed.

- **Assessment and diagnosis and treatment of lower leg wounds**. Community Nursing. This is an audit to identify whether patients referred to our Community Nursing teams with a lower leg wound were assessed within 28 days of referral, whether compression therapy was applied appropriately and whether a referral to vascular services had been made where indicated. An assessment had been undertaken in 30% of cases, 73% of applicable cases were treated with the appropriate compression therapy and 62% of cases requiring referral to vascular services were referred. A lower leg wound assessment form has been developed and built in the electronic patient record and training rolled-out across Community Nursing teams in its use.

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- **Malnutrition screening for community hospital inpatients**. Inpatients. For this CQUIN, malnutrition risk screening should be undertaken within 24 hours of admission and where indicated, a treatment plan initiated and actions or goals within the plan acted upon. Screening was undertaken in 93% of patients and within 24 hours of admission, 59%. A management plan was put in place in all of the 18 cases where one was required although there was evidence of the actions or goals being acted upon in 53%. CQUIN Champions across a number of services have been identified, education has been provided and a clinician guidance leaflet on assessment and management has been developed.

Other Priority 1 Audits

- **NHS England Learning Disability Improvement Standards.** The Trust is once again taking part in this project, which aims to measure the quality of service we provide to adults with learning disabilities, autism or both. It comprises an organisational survey, a staff survey and a patient survey. The organisational element has been completed and has highlighted several areas for improvement, such as the need to ensure that all patients with a learning disability or autism have an alert on electronic patient record, to better identify and disaggregate data such as that relating to clinical outcomes, complaints and investigations for this group of patients and to engage with patients and their families throughout all these processes. Learning disability/autism champions have now been identified within a number of services and a working group set up to oversee a programme of actions for improvement. An alert for Autism has been created on our electronic patient record and an initiative is underway to increase the use of the existing learning disability alert.

- **Audit of leaving care health summaries. Looked After Children**. The results showed full compliance with the majority of audit standards and all of the 13 summaries audited were rated as 'Good' overall in terms of their quality. No areas for improvement were identified.

Priority 2

- **Initial Health Assessments for Looked After Children (LAC) audit**. *Community Paediatrics.* Eleven out of 12 assessments audited were rated as 'Outstanding' in terms of their quality and one as 'Good'. Full compliance was achieved against 13/15 audit standards and over 90% in the remaining two. No areas for improvement were identified.

- **Review Health Assessments for Looked After Children (LAC) audit**. Looked After Children. 98.5% of assessments were rated as 'Good' overall with only one identified as requiring improvement. There was a decline on the proportion of young people who had attended the Dentist but a slight increase in the proportion who had seen an Optician. No areas for improvement were identified.

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Priority 3

- **Fetal Alcohol Spectrum Disorder (FASD) and Blood Born Infection (BBI) in the Looked After Children (LAC) population.** Community Paediatrics. The high incidence of alcohol and substance misuse amongst the parents of children who become looked after increases the risk of BBI and FASD in these children. A previous audit completed in 2018 highlighted the lack of information available at the time of the Initial Health Assessment (IHA) of LACs to assess BBI risk. In this re-audit, assessment of FASD was also included as this relies on many of the same information sources. The audit shows that there continues to be inadequate information provided by the Local Authority at the time of the initial health assessment (IHA) to allow these risks to be assessed. Recommendations include considering not completing IHAs in the absence of adequate information in the future, providing training to doctors in the documentation of antenatal alcohol exposure, facial features and head circumference, creating an alert on Rio for antenatal exposure to alcohol and including this information in the Health Care Plan produced at the IHA.

- **Audit of medical advice written for Education Health and Care Advice against standards derived from the Code of Practice for Special Educational Needs and Disabilities (SEND).** Community Paediatrics. Full compliance was achieved in 5 out of the 14 standards included in the audit and over 90% in a further five. Compliance was below 80% for standards relating to explanations of medical terminology, identification of medical conditions and health needs, recording of name and service of all the professionals involved and reflecting the Voice of the Child in the advice. A new exemplar and suite of examples for the team is to be developed as well as an induction package for new staff. Regular updates and CPD (at least annually) will be provided to ensure that learning is embedded.

- **Adherence to the Children's Occupational Therapy Service Mainstream Clinical Pathway**. Occupational Therapy. The purpose of this audit was to review the pathways that have been used by the service since 2014. The results identified that the formal route within the pathway for children with an identified Autistic Spectrum Disorder diagnosis was not utilised, 89% of children received the most appropriate treatment with 11% receiving treatment that did not follow the pathways, although there were clinical reasons as to why they did not. Treatment options and current evidence base are to be reviewed to allow further development of this part of the pathway.

- **Progress notes audit**. Community Nursing. The aim of this audit was to evaluate use of the progress note template introduced to Community Nursing teams in 2021, particularly in relation to the unnecessary duplication of information. Use of the template was high across the audit cohort. The main area of concern was the copying of information from assessment to progress notes which takes up vital clinical time by creating more admin and non-patient facing work for staff. The current progress note template is to be updated to

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incorporate the new SBAR (Situation, Background, Assessment, Recommendation) structured communication framework and the current assessment tools on electronic patient record enhanced to reduce the need for duplication and reduce patient admin time.

- **Audit of website SEND** (Special Education Needs and Disabilities) descriptors that link with the Local Offer. Multiple services within Children and Families Division. An audit has been undertaken to evaluate the quality, relevance and consistency of information on both Shropshire Community Health Trust (SCHT) service and local authority Local Offer webpages. The results identified some SCHT services with good examples of up-to-date information and links to the Local Offer for ease of families moving between sites. 80% of the service web pages audited contained a SEND section highlighted in yellow. However, all webpages within the division need to be reviewed to ensure the accuracy, consistency and relevance of the information they contain, that they are in date and that links to the Local Offer are included and that they work. There is no review date option on the Local Offer pages and this needs to be addressed.

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 (R&I).

- The R&I department undertook 19 studies in 2023/24 and recruited 715 participants into research, overperforming in several of these studies. This is an excellent outcome for a small team.

- 7 research studies are in the set-up phase.

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- One commercial study has commenced with recruitment completed and a second is in the follow up phase.

- The Research Team are supporting a National Early Diabetes Screening Programme for children aged 3 years to 13 years. SCHT have overperformed in the delivery of this study, becoming one of the top recruiters in the West Midlands. As a result, the team are supporting other NHS organisations in effective recruitment strategies and have been featured in local media networks.

- The Staff Research Champion initiative has continued to be well received by Trust staff. This initiative enables the Research Delivery Team to take research opportunities to patients and local communities across all Trust services. We have continued to support other NHS Trusts in setting up similar schemes within their own organisations.

- CEO – Patricia Davies has become a Staff Research Champion – this has produced an increase in Trust staff registering their interest in the role.

- One Clinical Research Practitioner (CRP) has been successful in gaining their CRP accreditation with the Academy for HealthCare Science, (AHCS).

- Bitesize research seminars to assist clinicians working towards Advanced level fulfil pillar four (research and evidence), are facilitated by the research team and are being delivered digitally to improve accessibility for staff.

Johanne Tomlinson OBE – Research Delivery Team Leader won the National Institute for Health and Care Research (NIHR) Clinical Research Network West Midlands training development award 2023 for the creation of our Research Champions Role within SCHT; which brings collaboration and research opportunities within our trust.

Commissioning for Quality Improvement (CQUIN)

Four CQUINs were pertinent to the Trust 2023/24

CCG1 54% Flu vaccination for frontline staff healthcare workers
The Trust was the joint highest performing Community Trust and ranked 6th in the Midlands region.

CCG12 Malnutrition screening in the community
CCG13 Assessment, diagnosis and treatment of lower limb wounds
CCG14 Assessment and documentation of pressure ulcer risk

CQUIN's 12,13 &14 have made progress throughout the year, although targets have not been met and further work is required. Work is continuing during 2024/25. The community wards are transitioning to EPR from April 2024 which will support the CQUIN initiatives 12 & 14 and the Tissue Viability Service are launching the nationally devised Lower Limb Pathway June 10th 2024.

Patients readmitted to hospital within 28 days of a hospital discharge

SCHT inpatient beds are for patients aged 18 or above
(i) 0 to 15 = 0%
(ii) 16 or Over = 100%

2023/24	2022/23	Comment
12.9%	NA	New addition for 2024

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 98.5%, which is above target and an improved picture from 2022/23

Infection Prevention and 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.

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We have agreed local and National thresholds for infections related to infection prevention and control measures. During 2023-2024, Shropshire Community Health Trust recorded four cases of Clostridioides Difficile infection in the Community Hospitals, three above our agreed target. Although these cases were attributed to the Trust, all cases were classed as unavoidable. This means that there was nothing we could do to prevent our patients developing this infection.

The Trust recorded no blood stream infections for 2023/24.

We aim to screen at least 97% of patients on admission for MRSA each month. For 2023-2024, our MRSA screening compliance score was 97% across our Community Hospitals, meaning our target was met overall.

Shropshire Community Health Trust Infection Prevention and Control (IPC) Team have delivered a robust IPC activity programme in 2023/24, focussing on quality assurance audits and targeted education campaigns including a 'Gloves off' Campaign aiming to reduce the inappropriate use of gloves; learning events around common alert organisms giving advice on when to screen and when to isolate a patient as well as some targeted awareness on antimicrobial stewardship and more recently a Spring Clean campaign aiming to reduce environmental clutter and promote good practice in storing unused equipment.

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 2023-2024 on the 30th June 2024. 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 and in the last year has transitioned to using PSIRF and the Patient Safety II (PSII) process to manage incidents and foster a learning response. All incidents are categorised and are copied to the relevant subject experts and line managers for review, comment and action. In addition, a Patient Safety Incidents Panel meets weekly to review incidents. The meeting is chaired by Directors and has representation from senior clinicians and the ICB.

4,663 patient safety incidents were reported in 2023/24 demonstrating a further increase in reporting. This can be attributed to the positive reporting culture of employees and the increase of services provided, including the introduction of the 2 Rehabilitation and Recovery Units.

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9 Serious Incidents were registered over the year. 2 were related to Information Governance, 4 to Falls, 2 related to Prison - Deaths and 1 pressure ulcer. As part of the Trust's transition to PSIRF, reviewing Patient Safety Incidents will follow an alternative methodology; with an emphasis on thematic review or cluster of incidents to understand common themes, links or issues to facilitate safety responses. Where an individual learning response has been agreed, the response will form of a Patient Safety Incident Investigation.

Falls

The Trust reported 163 inpatient falls in 2023/24, a 12% decrease on the previous year and 17% decrease over the last 2 years. The Trust's Patient Safety Improvement Plan incorporates falls under its local priorities and for thematic review to enable a quality improvement approach. Falls accounted for 45% of all serious incidents in 2023/24

Pressure Ulcers

Over the last 12 months: 614 in-service pressure ulcers were reported, 32 less than in 2022/23. Of the 614 instances, 22 were either a Category 3 or 4 pressure ulcers, a significant 33% drop from the previous year. The reduction in incidences is thought to align to the introduction of Named Nurse Concept in District Nursing. 1,187 pressure ulcers were reported on admission to a service. The Trust's Patient Safety Implementation Plan (PIRP) incorporates this workstream under its local priorities and for thematic review.

Patient Safety Incidents and the percentage that resulted in severe harm or death

6 incidents were reported as severe harm or death. 2 incidents resulted in death, one was in custody and the second was on release from custody. The 4 events that resulted in severe harm were all falls. 3 patients suffered from a fracture and a 4th suffered from a subdural haemorrhage. Falls reduction remains a priority for the organisation.

Patient Experience

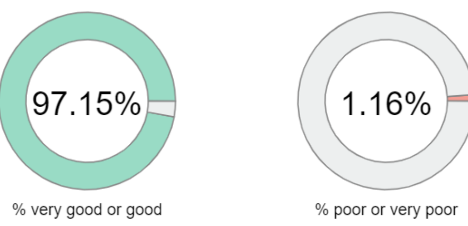
Patient Stories

5 In-depth stories were developed and shared across the organisation. 4 of these were including patients as patients are always at the heart of all we do. The topics were

- A new programme called REVIVE that promotes rehabilitation for those with reduced mobility.
- The Introduction of the Named Nurse in District Nursing to enable patients to have one individual Nurse who oversees and reviews their treatment at regular intervals. This provides patients with a clear understanding of who is coordinating their care.
- Veteran stories, that included patients and staff.
- The positive impact the roll out of Virtual Ward has on patients.

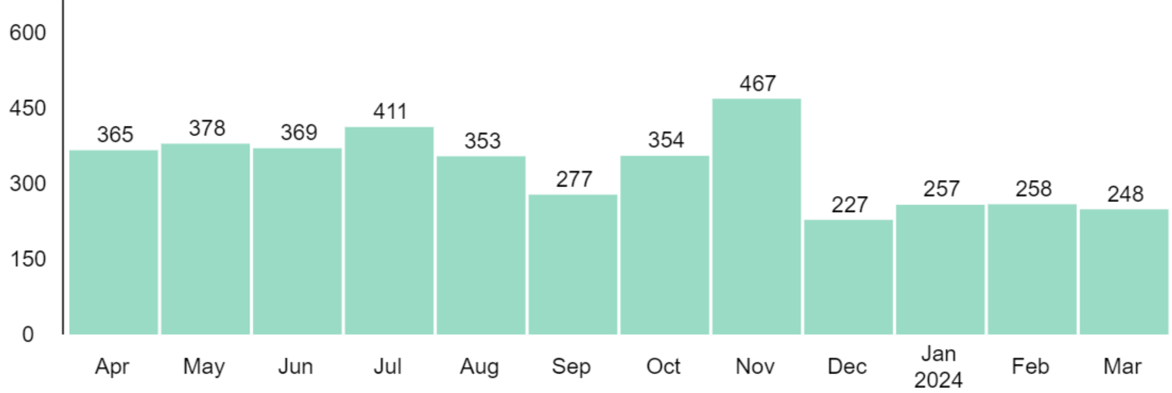
Friends & Family Test responses from our service users 2023/24

The Trust received **3962** Friends & Family Test results, with 97.15% of respondents reporting the service was either good or very good, an increase in positive patient experience from 2022/23.



Response	Percentage	Number of times response selected
Very good	88.29%	3500
Good	8.85%	351
Neither good nor poor	1.19%	47
Poor	0.45%	18
Very poor	0.71%	28
Don't know	0.50%	20

The graph below shows the distribution of the 3964 surveys completed across the year



Positive feedback received:

Karen is amazing! Speedy response from my initial text message. Next day visit. Lots of moral support in person and via text as well as practical tips. No judgment just help and encouragement. When she was off duty Karen referred me to her colleague who also checked in and made sure I was ok. Lots of useful links. Karen is a lovely person who instantly put me at ease during a very emotional and challenging time for me. I couldn't have asked for anything more - **Breastfeeding support**

She noticed things I haven't yet. She was friendly and nice and gave a lot of helpful information - **APCS Oswestry**

I have had from the Diabetes Specialist Nursing team over the last 18-24 months and I can honestly say that without them my life would be completely different. With their support my diabetes is now under control and this is life changing - **Adult Diabetes**

Nothing too much trouble for the staff. It was a pleasant experience -**Bridgnorth In-patients**

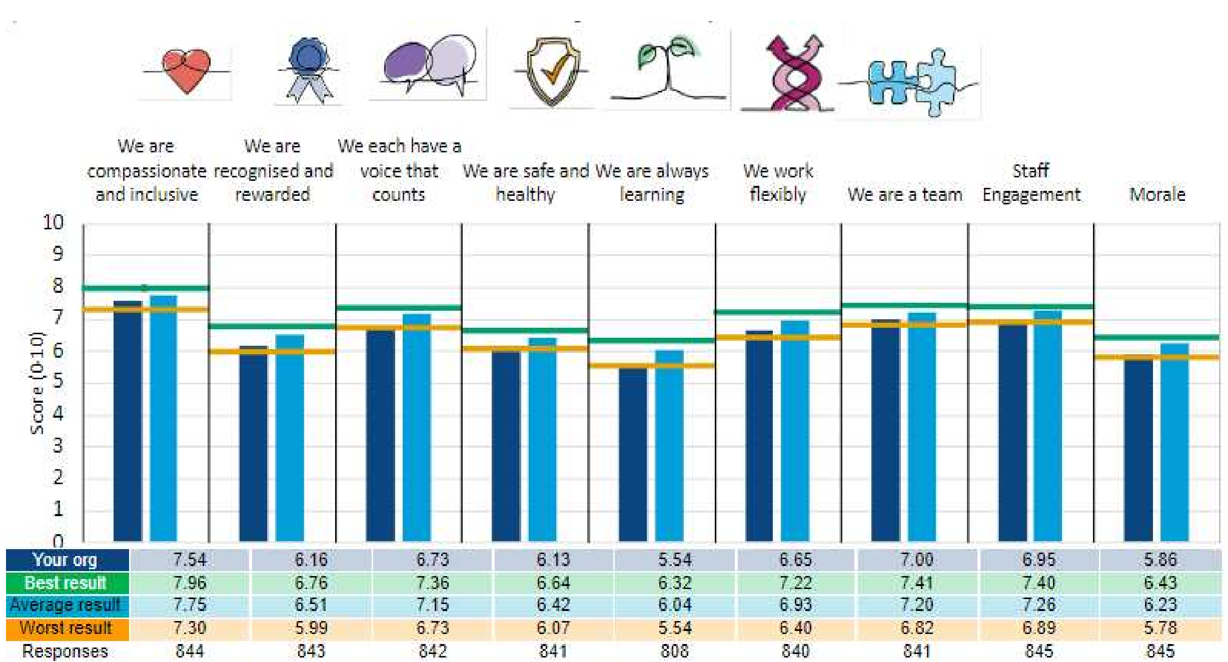
My child was made to feel at ease and comfortable right from the start of the session. The two members of staff involved with his assessment were so friendly, encouraging and reassuring. My son was cooperative and managed to complete all tasks put to him and was praised for his efforts. The session was also very informative for myself as a parent. **- Childrens Occupational Therapy**

I just wanted to send HUGE thank you to the Virtual Ward Team for their support to my husband over past few weeks- WOW what a Team/Service to have in Telford- we are so lucky. From the very first visit and all subsequent visits all the staff treated him with so much kindness and respect, which re assured him that they were doing all they possibly could to prevent him being admitted to hospital which is his worst fear. Every one of the team is a credit to their profession - **Virtual Ward.**

Amazing Care throughout all visits, efficient and knowledgeable. Empathetic during bereavement visit and very supportive - **South West District Nurses**

National NHS Staff Survey 2023

845 (52%) employees completed this year's survey, a marginal increase on the previous year. This completion rate is 10% lower than the average for similar organisations



	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	7.54	6.16	6.73	6.13	5.54	6.65	7.00	6.95	5.86
Best result	7.96	6.76	7.36	6.64	6.32	7.22	7.41	7.40	6.43
Average result	7.75	6.51	7.15	6.42	6.04	6.93	7.20	7.26	6.23
Worst result	7.30	5.99	6.73	6.07	5.54	6.40	6.82	6.89	5.78
Responses	844	843	842	841	808	840	841	845	845

Friends & Family Test response from our staff

56%	Would recommend the organisation as place to work
68%	If friend/relative needed treatment would be happy with standard of care provided by organisation
71%	Care of patients/service users is organisation's top priority

The Staff Survey results tell us we continue to have work to do to ensure we are a consistently great place to work, this is why the Trust has again committed to looking after Our People as a priority for 2024/25

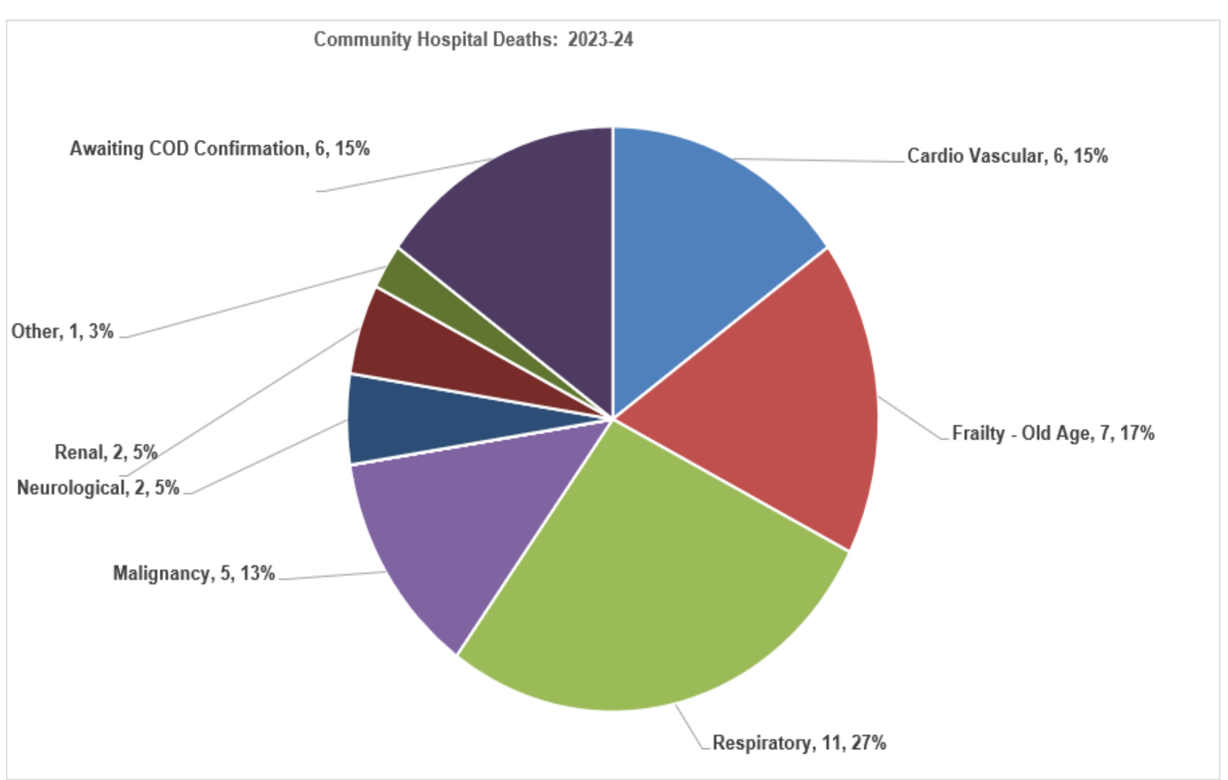
Engagement sessions following the publication of the Staff Survey results with the Chief Executive – Patrica Davies are scheduled for April 2024

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.

Deaths reported across the Community Hospitals and Rehabilitation and Recovery Units totalled 40 in the year, with 3 being unexpected deaths.

No patients had COVID-19 recorded as their primary cause of death in the year, and the main 3 causes identified were: Respiratory, Frailty and Cardio Vascular.



Our Care Quality Commission (CQC) Registration

The last SCHT CQC inspection was in 2019 and as an organisation we recognise that re-inspection will be in the near future. The Quality Improvement Team over last year have been preparing clinical and corporate services for the changes to CQC inspections. Service briefcases have been created and cascaded. These contain information on the CQC's new ways of working, how to guides, a process for to evidence performance and successes, a toolkit for service self-assessment using the CQC key questions and I/we statements and a service development plan tool.

	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

Majesty's Inspectorate of Prisons (HMIP)

No inspection during account period

Special Educational needs and/or Disabilities Inspection

No inspection during account period

Statements from Our Partners

Our Quality Account has been shared with key stakeholders; Healthwatch Shropshire, Healthwatch Telford & Wrekin and Shropshire, Telford and Wrekin ICB.

Shropshire, Telford and Wrekin ICB -response to SCHT Quality Account 2023/2024

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have had the opportunity to review the Shropshire Community Health NHS Trust (SCHT) Quality Account for 2023/24.

It is the ICBs view that the account accurately reflects the achievements made by SCHT in 2023/24 and the priority areas identified to the best of our knowledge. SCHT has collaborated with partners in the integrated care system (ICS) as we continue to develop our ICS to address the needs of the population and improve the quality of healthcare services within it.

The ICB would like to acknowledge the work undertaken by SCHT to develop the new service to provide Rehabilitation and Recovery Wards on the two Acute Hospital sites for patients to continue to receive rehabilitation prior to returning to their normal residence. Also the development of the Virtual ward enabling patients to remain in their own home or return home sooner from hospital to receive consultant led care supporting the ongoing improvements in urgent and emergency care.

The ICB is aware of the ongoing challenges faced by all local Partners to recruit and retain a substantive workforce thereby reducing the need for agency shift cover. Initiatives have been completed to streamline recruitment processes and strengthen retention through clear career development pathways. SCHT have continued to increase their Professional Nurse Advocates and are looking to extend the model to allied health professionals (Professional Advocates). SCHT have undertaken 17 Executive listening events and created a newsletter to share actions agreed following the events. It notes the introduction of an e-rostering system.

A significant patient safety initiative during the year at the trust has been the introduction of the Patient Safety and Incident Response Framework (PSIRF). The Trust formally adopted PSIRF in December 2023 transitioning away from the Serious Incident Framework. The key aims of PSIRF will provide a considered and proportionate response to patient safety incidents with compassionate engagement and involvement of those affected by these incidents and we look forward to seeing the outputs in terms of safety and organisational culture. The four priority areas for PSIRF have been identified; Transfer of Care, Pressure Ulcer Prevention, Falls and Medicines Management. SCHT also plan to develop pressure ulcer prevention pathways by implementing the Purpose T assessment tool.

The ICB was pleased to see the ongoing commitment to understanding and improving patient experience with a doubling of the Observe and Act visits to 54 in the last year. It notes the consistently high Friends and Family Test scores throughout the year for people rating the services as good or very good as above 97%.

The ICB notes the ongoing work to optimise the use of digital technology for patients and staff. This includes the remote monitoring of patients on the virtual ward and respiratory team and the use of clinical record keeping on in-patient wards. It notes the investment by SCHT for a new Electronic Prescribing and Medicines Administration system.

The Quality Account also acknowledges the National Audit Programme undertaken in 2023/24 and the participation in clinical research with the Chief Executive Officer becoming a Staff Research Champion which is very positive.

It is noted the summary of the NHS staff survey which showed SCHT were close to the National average for results in each category. It is positive to see that the Trust remains committed to supporting staff and it remains a priority for 2024/25.

The ICB acknowledges the quality priorities for 2024/25 for the Trust and will continue to work within the integrated care system adopting a systems-based approach to learning responses which will provide more insight into the systems and processes that can be improved.

In conclusion, the ICB views the 2023/4 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. The ICB recognises the Trust's commitment to working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin.

Yours sincerely

Vanessa Whatley - Interim Chief Nursing Officer

Healthwatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account.

Priorities for 2023 - 2024

Looking After Our Staff

We are very aware of the pressures that all health and social care staff are facing and our feedback indicates that patients have concerns about the impact on their care that can be caused by the pressures facing health and social care staff. As with last year we are encouraged to see all of the initiatives the Trust has embarked up to look after staff. However, as with last year, it is unclear if the initiatives have been effective, either in the selected aims stated by the Trust or in the wider aim of staff feeling that the Trust has become a better place to work.

Elsewhere in the Quality Account the results of the National NHS Staff Survey are reported. The staff survey results indicate that although there have been some improvements in 6 of the 9 'people promise elements' all the Trust scores are below average for similar trusts with 6 out of 9 element scores being either the lowest or next to lowest within the benchmark group of Community Trusts across the country.

The challenges facing the Trust management are also indicated by the proportion of staff agreeing with the statement, in the Staff Friends and Family Test, that they 'would recommend the organisation as a place to work', it has fallen this year to 56% from 59% in 2022-23 and 61% in 2021-22.

Patient Safety

Again, it is useful to see the initiatives but it is difficult to understand the extent of the impact the measures are having on improving patient safety. Elsewhere in this Quality Account significant increases in patient safety incidents are evident.

Patient Engagement and Experience

We were pleased to see the trust's commitment to 'Continue to strengthen our relationship with both local HealthWatch organisations' and it would be useful to hear the Trust's perspective of how they feel it has developed over the year. We continue to attend the Patient Experience Panel.
There were several other commitments under this priority which have also not been reported on in the Quality Accounts:

- 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 embed Patient Experience Committee into the Trusts Governance structure

With those commitments that have been reported it is difficult to understand the outcomes that has been achieved. For example, with the commitment to 'Widen our volunteer membership with redesigned roles and responsibilities to align with the shift in culture following the Covid-19 pandemic, there is no indication if this has happened.
It is encouraging to see that the programme of Observe and Act assessments are ahead of schedule and that have been collecting positive feedback. Some indication of the learning that has been taken from the assessments and how this might have informed the service being delivered would be welcome.

Digital Capability

It appears that many of the commitments are just being rolled out, we look forward to hearing about the impact they are having. It is encouraging to hear that the pilot of the 'virtual assistant' with the Continence service received positive reaction from patients and hope patients across other services will be able to access the benefits shortly.

Priorities for 2024 – 2025

Looking after Our People

The continued emphasis of making the workforce a priority is welcomed. Some of the commitments lack clarity to the lay person and we would encourage the Trust to engage more widely when initially drafting documents for the public to read. Healthwatch Shropshire would be willing to work with the Trust to ensure public facing documents are clear, easy to read and understand in line with the NHS Accessible Information Standard.

Fostering a culture of Continuous Improvement

The adoption of the NHS Impact Framework is welcomed and we look forward to hearing how it has improved patient care once implemented

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Enhancing Patient Experience and Safety

The commitment to fully implement the Patient Safety Response Framework (PSIRF) is welcomed as are the commitments to increasing patient engagement. We look forward to seeing the improvements resulting from the listed commitments.

Quality at the Heart of the Organisation

Participation in Audit & Research

The Trust's participation in all mandated national audits is noted and we welcome the commitment to improving the quality of patient care through the use of local clinical audit. While there is some very welcome positive evidence of good care in some of the audits other areas, in particular the CQUINs, there is room for improvement.

Participation in Clinical Research

We are pleased to see that the Trust's creation of a research champions role has been recognised by The Clinical Research Network West Midlands and congratulate the team.

Commissioning for Quality Improvement (CQUIN)

It is noted that the Trust has made progress in three out of 4 areas although it has not met its targets. It would be useful to understand the gap between performance and each target and some indication of how the Trust intends to meet individual targets. It is disappointing to see that the rate of flu vaccinations for frontline healthcare workers fell to 54% from 61% the previous year.

Patients readmitted to hospital within 28 days of a hospital discharge

The report indicates that 12.9% of patients discharged are readmitted to hospital within 28 days of discharge. There is no indication if this figure is within the bounds of what might be expected and it does not give any indication of how the quality of the original care or follow up care relates to those readmissions.

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

The Trust's performance in this area and improvement on 2022/23 is to be commended.

Infection Prevention & Control

The Trust is to be congratulated for implementing the measures set out in last year's QA which have obviously worked in raising the already high levels of MRSA screening to reach the target of 97%.

Information Governance

It is noted that the Trust meets all the National Data Guardian's data security standards.

Incident Reporting

It would be helpful to see a clear analysis of the reported incidents to have an understanding of patient safety. In 2022/23 the Trust reported 3,630 patient incidents which was a significant increase of 29% on the previous year, this year the figure reported is 4,663 a further year on year increase of 28%. As with last year this is attributed to a positive reporting culture and increased activity. With regard to increased activity, last year the patient numbers had dropped on the previous year and this year there are no patient activity figures provided in the QA to give context to the rise in patient incidents.
It would be useful to see some analysis that supports the argument that the rise is due to a positive reporting culture rather than a decrease in safety. It should be noted that in the 2022

NHS staff survey and 2023 NHS staff survey there has been a significant decline in the percentage of staff who 'would feel secure raising concerns about unsafe clinical practice' with the trust results now the worst results in its comparator group. This does not seem to support the view that the significant increase is due to a positive reporting culture.

Falls

We are encouraged to see the continued reduction in number of falls.

Pressure Ulcers

The overall fall in reported in-service pressure sores, with a large fall in the most serious, is very welcome.

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

There is no indication of the overall number of patient safety incidents nor the percentage that the 6 cases represent. Some indication of the learning that was taken from the incidents would be helpful.

Patient Stories

We very much welcome the sharing of patient stories. It is slightly confusing that only 4 of the 5 stories mentioned seem to include patients.

Friends & Family Test (FFT) responses from our service users 2023/24

We are pleased to see that the FFT results indicate a very high level of satisfaction with treatment and that it increased on last year. It is disappointing that despite the Trust's commitment to increase the number of FFT responses across services it in fact fell from 4445, with 1,113,269 patient contacts, in 2022-23 to 3965 in 2023-24.

National NHS Staff Survey 2023

The responses to the survey indicate that the Trust performs below average in 9 out of the 9 People Promise themes with 6 out of 9 element scores being either the lowest or next to lowest within the benchmark group of Community Trusts across the country. We welcome the Trust's initiatives to improve the workforce's experience of working for the Trust and its commitment to keep 'looking after our people' as a quality priority for the third year running in 2024/25.

Friends & Family Test response from our staff

It is disappointing that the percentage of staff who would recommend the Trust as a place to work has fallen from 61% in 2021/22 to 59% in 2022/23 and again to 56% in 2023/24 and that there was also a drop in those who agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation, 75% in 2021/22 to 72% in 2022/23 and 68% in 2023/24.

Learning from Deaths

There is no reporting on any learning taken from the deaths of patients in the care of the Trust. It is noted that 3 deaths were unexpected but there is no reporting on the avoid-ability of any of the 40 deaths as has been reported in previous Quality Accounts.

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Index of Acronyms

Academy for HealthCare Science	**AHCS**
Advanced Primary Care Service	**APCS**
Allied Healthcare Professional	**AHP**
Black, Asian & Minority Ethnic	**BAME**
Blood Born Infections	**BBI**
Care Quality Commission	**CQC**
Clinical Research Practitioner	**CRP**
Commissioning for Quality and Innovation	**CQUIN**
Community Neuro Rehabilitation Team	**CNRT**
Community Practitioners and Health Visitors Association	**CPHVA**
Community Service Manager	**CSM**
Data Security and Protection Toolkit	**DSPT**
Deep Vein Thrombosis	**DVT**
Electronic Patient Record	**EPR**
Electronic Prescribing and Medicines Administration	**EPMA**
Electronic Prescription Process	**EPS**
Family Nurse Partnership	**FNP**
Fetal Alcohol Spectrum Disorder	**FASD**
Freedom to Speak Up	**F2SU**
Friends & Family Test	**FFT**
General Data Protection Regulation	**GDPR**
Health Care Assistant	**HCA**
HealthCare Associated Infection	**HCAI**
Healthcare Quality Improvement Partnership	**HQIP**
Human Resources	**HR**
Integrated Care Board	**ICB**
Infection Prevention & Control	**IPC**
Integrated Care Record	**ICR**
Integrated Care System	**ICS**
Integrated Discharge Team	**IDT**
Lesbian, Gay, Bisexual, Transgender & Queer/Questioning	**LGBTQ+**
Looked After Children	**LAC**
His Majesty's Inspectorate of Prisons	**HMIP**
Medical Examiner	**ME**
Medicines Safety Officer	**MSO**
Minor Injuries Unit	**MIU**

Musculoskeletal Services Shropshire & Telford	**MSST**
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	**NACP**
National Audit of Care at the end of Life	**NACEL**
National Clinical Audit and the Patient Outcome programme	**NCAPOP**
National Data Guardian	**NDG**
National Institute for Health and Care Research	**NIHR**
Improving Patient Care Together	**NHS IMPACT**
Observe & Act	**O&A**
Outpatient Parenteral Antibiotic Therapy	**OPAT**
Patient Safety Incident Investigation	**PSII**
Patient Safety Incident Response Plan	**PSIRP**
Professional Nurse Advocate	**PNA**
Patient Safety Incident Response Framework	**PSIRF**
Recovery & Rehabilitation Unit	**RRU**
Registered Nurse	**RN**
Research and Innovation	**R&I**
Shropshire Community Health NHS Trust	**SCHT**
Shropshire, Telford, and Wrekin	**STW**
Situation, Background, Assessment, Recommendation	**SBAR**
Special Education Needs & Disabilities	**SEND**
Standard Operating Procedure	**SOP**
Statistical Process Control	**SPC**
Telford Musculoskeletal Services	**TeMS**
Urgent Emergency Care	**UEC**
Venous Thromboembolism	**VTE**
Vacancy Requisition Form	**VRF**

Clinical Effectiveness Report October 2023 – March 2024

0. Reference Information

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Executive Sponsor:	Dr M Ganesh Medical Director	Paper written on:	17 May 2024
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Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

1.1.

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 the Trust Bpard around implementation of the Clinical Audit, NICE guidance and Research and Development

programmes.

2.2 Summary

- A total of 23 audits were included on the Clinical Audit programme between 1 October 2023 and 31 March 2024. Implementation of the programme has progressed well over the period with only one audit being delayed.
- Sixteen audits were completed and in 13, areas for improvement identified and action plans drawn up in response to the findings.
- The Trust has continued to submit data to the four National Clinical Audits in which it is eligible to take part.
- Data was submitted to all elements of the NHSE Learning Disabilities Improvement standards project and a comprehensive action plan drawn up in response to the findings.
- The Trust has signed up to participate in the new NHS Benchmarking District Nursing project.
- The monthly review of NICE guidance has continued, with 7 clinical guidelines or quality standards requiring a baseline assessment of compliance to be undertaken. No completed baseline assessments were submitted over the period.
- A first meeting to discuss the role, remit and membership of the Clinical Effectiveness Committee has taken place.

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2.3. Conclusion

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.

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 in progress	Number delayed
Total	23	9	10	4	16	6	1
Corporate/Trust-wide	1	0	1	0	1	0	0
Adults	14	8	4	2	8	5	1
Children and Families	8	1	5	2	7	1	0

3.2.2 Clinical audit - delays in implementation

Only one audit was delayed at period end although this had been identified in the previous report and no progress has been made since then towards completion.

Table 2

Audit title	Priority	Service	Comments
Prison reception screening audit	2	Prison Health Service	The audit report has not been finalised and no action plan has been developed in response to the findings. This will be escalated to the Clinical Effectiveness Committee.

3.2.3 Clinical audit - outcomes

A total of 16 audits were completed during the reporting period, brief detail of which is provided below. All audit reports undergo a check-and-challenge process carried out by the Governance Manager and the Clinical Leads for Quality to ensure that all areas of non-compliance are addressed within the action plan. CQUIN and National Audit projects are addressed elsewhere in the report.

Priority 1

Audit of leaving care health summaries. LAC. This is a biannual audit conducted at the request of commissioners. The results for Q3 and 4 show full compliance with the majority of audit standards and that all of the summaries reviewed were rated as 'Good' overall.

Priority 2

Quality of initial health assessments for LAC. Community Paediatrics. Compliance with audit standards remains high, with 11/12 assessments in Q3 and 19/20 assessments in Q4 rated as 'Outstanding' in terms of their quality.

Quality of review health assessments for LAC. LAC. 98.5% of assessments in Q3 and 100% in Q4 were rated as 'Good' overall in terms of their quality, with just 1 assessment identified as requiring improvement.

Urinary catheter care audit. Inpatients. This audit reviewed compliance with the Trust's Urinary Catheter Care Policy for Adult patients. Areas for improvement were identified around the recording of information for catheters inserted prior to admission and in completion of the Catheter Care Pathway document. An action plan is in place around Rio and catheter records training, competencies and transfers of care documents. The audit is part of a wider QI project being undertaken to reduce the rates of urinary catheter infection on our wards. A re-audit is scheduled for Sep-24.

NEWS2 snapshot audit for ward-based observation monitoring. Inpatients. The frequency of observations recording was correct for 76% of patients with a NEWS2 score of 0 and 80% for a score of 1-4. Observations for the two patients with a score of 5+ were recorded hourly and medical teams alerted, in line with the guidance. Levels of consciousness were not always recorded. Band 6 ward staff are to attend refresher training allowing leadership and

regular spot checks/opportunities for education to be completed at ward level. A QI project is to be undertaken to determine the best way of highlighting patients at Ward Safety Huddle/Handover who require 6 or 12 hourly observations.

Clinical record keeping audit. ICS. Overall, the results identified a good standard of record keeping within the service. An improvement plan has been developed in relation to a number of areas including next of kin (NOK) recording, linking patient records to the spine, allergy checking, use of abbreviations and recording of consent. The issue around NOK recording will be addressed as part of a wider QI project underway within the Trust.

Clinical team meeting minutes audit. Trust-wide. This audit evaluated use of the standardised Trust meeting template and identified variation across teams in their use of the template and in the quantity and quality of the information recorded in minutes. A new standard template reflective of current organisational meeting changes needs to be developed and a minimum standard for documenting learning agreed.

Priority 3

Fetal Alcohol Spectrum Disorder (FASD) and Blood Born Infection (BBI) in the LAC population. Community Paediatrics. The audit shows that there is inadequate information provided by the local authority at the time of the initial health assessment (IHA) to allow risks to this vulnerable group of children and young people to be assessed. Recommendations include considering not completing IHAs in the absence of adequate information in the future, providing training to doctors in the documentation of antenatal alcohol exposure, facial features and head circumference, creating an alert on Rio for antenatal exposure to alcohol and including this information in the Health Care Plan produced at the IHA.

SEND (Special Educational Needs and Disabilities) descriptors that link to the local offer. Children and Families services. This audit looked at the quality, relevance and consistency of information on both SCHT and Local Offer webpages. 80% of SCHT service webpages contained a SEND section, although only 36% contained a working link to the Local Offer page. Key information such as eligibility criteria, description of SEND service provision and how to make a complaint was not always included. The link from the Local Offer page to the SCHT page worked in 82% of cases and the pages contained information summarising the SCHT service in 100% of cases. None of the Local Offer webpages contained a review date. A review is required of both local authority and SCHT pages to ensure consistent and reliable information is available to parents.

Progress note audit. Community Nursing (CN). Use of the Trust progress note template by teams was high across the audit cohort, however, the appropriate assessment tools had not always been utilised and there was evidence of copying and pasting of information from assessment to progress notes. An action plan is in place around the formulation of a new progress note template and enhancement of the assessment tools currently on Rio.

3.2.4 CQUINs

CQUIN1 Flu. Final compliance figure was 54.2%. The improvement plan includes looking to recruit more peer vaccinators and to install fridges into various teams to aid storage.

CQUIN12 Assessment and documentation of pressure ulcer risk. Inpatients. The trend in overall compliance is an improving one – 28% in Q3 compared with 15% in Q4 2022/23 –

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although it remains low. Pressure ulcer risk assessments were undertaken in 94% of cases and a care plan initiated in 93%, although the quality of the plans reviewed was often inadequate. Data for Q4 is still under review.

CQUIN13 Assessment, diagnosis and treatment of lower limb wounds. Community Nursing. Overall compliance with this CQUIN was 9%, although 30% of patients received a leg wound assessment and 73% were treated with the appropriate compression therapy where required. Data for Q4 is still under review.

CQUIN14 Malnutrition screening in the community. Inpatients. Overall compliance was 53% compared with 63% in Q2, an 8% decrease on the previous quarter, although nutritional screening remained high at 95%. Data for Q4 is still under review.

- An CQUIN improvement plan is in place and reviewed regularly by the CQUIN Delivery Group.
- During 2024-25 the mandatory CQUIN scheme will not operate, however, NHS England has produced a list of optional indicators that can be used by any systems that have agreed to operate a local quality scheme during the pause. This list is currently under review by the Trust.

3.2.5 National audits

The Trust submitted data to 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 Trust continues to submit data to this continuous audit.

- *National Audit of Care at the end of Life (NACEL).* The case note review element of this project is progressing well, although just two responses have been received to the staff survey element and the bereavement survey is delayed in implementation. The bereavement survey is to be included in the new bereavement packs under development and additional comms and discussions with ward managers will take place to try to improve the poor response rate to the staff survey.

- *National Diabetes Foot Audit.* Results from the most recent round of data collection show that we are the best performing trust within the West Midlands for patients being alive and ulcer-free at 12 weeks (61.1% SCHT, 38% WM avg) and the second-best for patients presenting at their first expert assessment (FEA) with a less severe ulcer (72.2% SCHT 53.5% WM avg). 71.4% of patients are seen within 0-13 days of ulcer onset (WM avg 58.7%). These results highlight the positive impact of new ways of working within the Podiatry service that began in response to Covid and the £100K transformation monies received to reduce pressure on SaTH multidisciplinary foot team.

- *National Audit of Inpatient Falls.* One patient who sustained a femoral fracture during an inpatient episode has been identified for inclusion in the audit via the National Hip Fracture Database. The organisational element of the project has been suspended for this year.

NHSE Learning Disability Improvement Standards project. Data has been submitted to all elements of this project and a comprehensive improvement plan drawn up in response to the findings. A Learning Disability Champions group has been set up and will support and oversee implementation of the improvement plan.

The Trust has signed up to take part in a new District Nursing project being run by NHS Benchmarking.

3.2.6 NICE guidance

An update of newly-published NICE guidance is produced each month and reviewed for relevance by the Clinical Effectiveness Lead, the Chief Pharmacist and the Clinical Leads for Quality prior to submission to Divisional Quality and Performance groups for approval. Over the period, there were 10 pieces of guidance relevant to the Trust for information only and 7 requiring completion of a baseline assessment of compliance – detail of which is provided in the table below.

Table 3

No.	Title	Publication Date	Type	Service
QS10	Acute respiratory infection in over 16s: initial assessment and management including virtual wards (hospital at home)	Oct-23	New	Inpatients Virtual Ward
CG191	Pneumonia in adults: diagnosis and management	Oct-23	Update	Inpatients Virtual Ward
NG236	Stroke rehabilitation in adults	Oct-23	New	CNRT
NG237	Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management	Nov-23	New	Inpatients Virtual Ward
NG136	Hypertension in adults: diagnosis and management	Nov-23	Update	Inpatients DAART RRU Virtual Ward
NG51	Suspected sepsis: recognition, diagnosis and early management	Jan-24	Update	MIU Community Nursing Virtual Ward Prison
NG240	Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management	Mar-24	New	MIU Inpatients Health Visiting School Nursing CCN

No completed baseline assessments were submitted during the period and the undertaking of these continues to be proving difficult and time-consuming for clinical teams. The majority of delays are in Adult services and this has been exacerbated by the repeated cancellation

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of Adult SDG meetings – the oversight group for NICE guidance implementation - due to pressures on clinical services. A list of delayed projects has been sent to Divisional Managers but this issue will need to be considered by the newly-formed Clinical Effectiveness Committee.

3.2.7 Research and Innovation update

Q3 2023/2024

Reports are 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 (October – December 2023)
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 2023/24 has yet to be announced but previously the following High Level Objectives which performance in measured against included: 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 2023/24 to December 2023 is 399. The team also achieved the 500 recruits for the period October 2022 to September 2023 to maintain research capacity funding next year.
NEW STUDIES OPENED	Studies in Set up: • Enhance-D • B-Well • Identification of Biomarkers of MS Studies Open to Recruitment: • BSR-PsA

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	• BSR-RA • CAMSTENT • Clinical and cost-effectiveness of alternative urinary catheter design • ELSA • EMPOWER Digital Intervention eHealth RCT • Genetic Links to Anxiety and Depression (GLAD) • IMID BioResource • National Centre for Mental Health (NCMH) • NCISH • PALLUP: Improving home-based care for older people with complex needs • Rare and Undiagnosed Diseases Study (RUDY) • SPaCe • UK MS Register • UKIVAS Studies in Follow up: • PRO SPIRIT • Tonic
MEETINGS/ EVENTS ATTENDED	• Patricia Davies Chief Executive and the Executive team visited the Research Team at their base in Gains Park in November 2023. • UK Lead Research Association meetings- networking with colleagues across the UK. • WMCRN Lead Nurse Regional meetings. • Further CPD and training opportunities for Trust staff have been added to the Research and Innovation page on staff zone. • Research presentations have been delivered to local schools in partnership with the CRN to increase engagement, these have been very positive. • Meetings have been held with the Diabetes service leads and teams to increase research opportunities. • The team are currently attending or have booked to attend the required Information Asset Training. • A Research showcase event is being considered for the Autumn.
QUALITY/SAFETY REPORTING	• The 23/24 Quality Operation Plan was updated for Q3
GOOD NEWS	• Jo Tomlinson WON the training and development category for the WM CRN Awards for her work on the Research Champions initiative. • The CEO – Patricia Davies – is now a Research Champion after the super positive visit by the board detailed above. • Sharen Painter Clinical Research Practitioner has been successful in gaining her CRP accreditation with the Academy for HealthCare Science, (AHCS). • A further 11 Staff Research Champions have been recruited into the scheme- this has allowed us to widen the breadth of SCHT services that

	are research active, increasing opportunities for patients and local communities to participate in research. • **Elsa**: This study is a national early diabetes screening programme for children aged 3 years to 13 years; ShropCom have been very successful in recruiting to the study, (becoming one of the top recruiters in the region). As a result, the ELSA study team are now looking at developing a recruitment model based on the strategy developed and used at Shropcom to be rolled out to all sites. • The NCMH study recruitment has now reached an amazing 100. • Our PRES activity has improved significantly; we are now receiving increased feedback from study participants on their research experience.
PPIE ACTIVITY	• Jo Tomlinson has now taken on the leadership for PPIE and is working with Mary-Anne Darby at the CRN. • The research team twitter account (Now known as X) has been successful in demonstrating the great research happening at ShropCom and our achievements. This is a great way to network.
CRN UPDATES	Ruth Lambley-Burke represented SCHT at the CRN WM Partnership Board. Frances Davies represented SCHT at the CRN WM R&D Managers Forum

Q4 2023-24

PERIOD	Quarter 4 (January – March 2024)
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 2023/24 has yet to be announced but previously the following High Level Objectives which performance in measured against included: 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 2023/24 to March is 742
NEW STUDIES OPENED	Studies in Set up: • Enhance-D • B-Well • Identification of Biomarkers of MS • Snacktivity • UK-EDI

	• Understanding the role of adult community health services in avoiding hospital admissions Studies Open to Recruitment: • BSR-PsA • BSR-RA • CAMSTENT • Clinical and cost-effectiveness of alternative urinary catheter design • ELSA • Genetic Links to Anxiety and Depression (GLAD) • IMID BioResource • National Centre for Mental Health (NCMH) • Rare and Undiagnosed Diseases Study (RUDY) • UK MS Register • UKIVAS Studies in Follow up: • PRO SPIRIT
MEETINGS/ EVENTS ATTENDED	
QUALITY/SAFETY REPORTING	• The Trust Quality Report was completed
GOOD NEWS	
PPIE ACTIVITY	• Jo Tomlinson has now taken on the leadership for PPIE and is working with Mary-Anne Darby at the CRN. • A new public/patient research champion has been identified as being interested in taking on the role. • Our PRES activity (Participant Research Experience Survey) continues to improve; we are receiving increased feedback from study participants on their research experience.
CRN UPDATES	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-completion of NICE guidance baseline 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
- to accept the Research and Innovation update.

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Clinical Effectiveness Report October 2023 – March 2024

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

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Quality Improvement Framework 2024-2025

Together for Quality

Threading Quality through Everything We Do

Foreword by Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce.

I am delighted to present our Quality Improvement Framework for 2024-2025 which sets out our ambitions for the next 12 months. Here at Shropshire Community Health Trust, we aim to be at the heart of supporting our communities by providing fully connected services as our teams strive each day to deliver high quality care for the patients that we care for. This framework has been developed to give a clear direction and a clear set of simple ambitions we can all work towards so that any member of staff, in any role, can understand the part you can play in helping to deliver high quality care through continuous improvement.

What is Quality Improvement?

Quality improvement (QI) should be in everything we do. Improvement is being curious about our work, having effective conversations, and challenging the status quo. It is to constructively challenge ineffective processes and aiming to reduce waste by the everyday use of improvement tools and methodology. This will ultimately improve the quality, safety, and experience of our patients and increase staff satisfaction.

Our Quality Improvement Framework.

Our Quality Improvement Framework sets out our commitments and aims to develop and sustain a culture of continuous improvement that drives quality in everything we do and is evident from the experience of our patients.

Using the five components of NHS IMPACT we join "the overarching ambition is to enable the creation of an NHS in which every organisation, including NHS England, has the leadership with the leadership behaviours, the capability and the capacity, to

enable our staff to solve the problems that matter to them, their patients and their populations. Collaborating with their partners to deliver better life chances and better outcomes for those patients.” NHS Impact 2024 **NHS England » About NHS IMPACT**

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding into management systems and processes

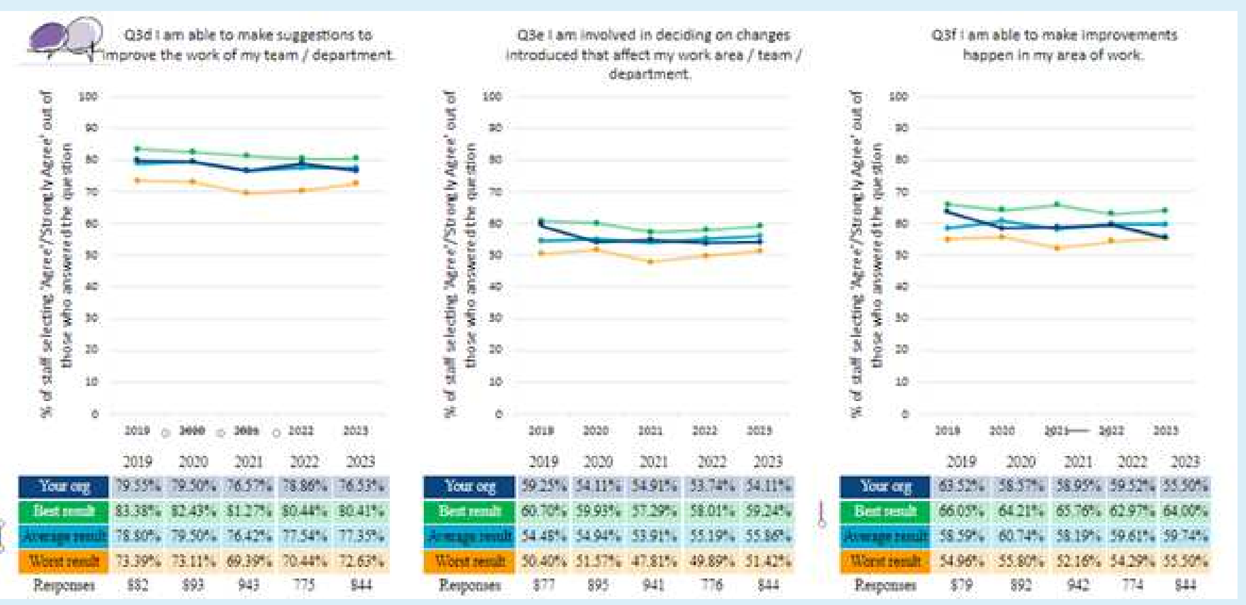
This framework allows us to outline the actions the Trust will take to make this happen and communicates the methodologies we use in the QI work we conduct across our Trust.

Therefore, this framework aims to function as an inclusive model to ensure all staff members to feel they can actively make suggestions and implement improvements within their areas. As discussed later within this framework, our fantastic staff are

experts within their areas so to provide them with support and empowerment towards improvement is essential.

Where are we now?

NHS staff survey results



Q3d

	2019	2020	2021	2022	2023
Your org	79.55%	79.50%	76.57%	78.86%	76.53%
Best result	83.38%	82.43%	81.27%	80.44%	80.41%
Average result	78.80%	79.50%	76.42%	77.54%	77.35%
Worst result	73.39%	73.11%	69.39%	70.44%	72.63%
Responses	882	893	943	775	844

Q3e

	2019	2020	2021	2022	2023
Your org	59.25%	54.11%	54.91%	53.74%	54.11%
Best result	60.70%	59.93%	57.29%	58.01%	59.24%
Average result	54.48%	54.94%	53.91%	55.19%	55.86%
Worst result	50.40%	51.57%	47.81%	49.89%	51.42%
Responses	877	895	941	776	844

Q3f

	2019	2020	2021	2022	2023
Your org	63.52%	58.57%	58.95%	59.52%	55.50%
Best result	66.05%	64.21%	65.76%	62.97%	64.00%
Average result	58.59%	60.74%	58.19%	59.61%	59.74%
Worst result	54.96%	55.80%	52.16%	54.29%	55.50%
Responses	879	892	942	774	844

Figure 1.

NHS IMPACT self-assessment

The self-assessment identified areas of improvement around staff training, agreed improvement methods and improvement teams.

How are we going to get there?

Quality Improvement underpins all our work, not just our clinical services. We will work across all our services to:

- Have a clear methodology in our Quality Improvement delivery. Build a shared purpose and vision.
- Train our staff to understand and confidently use Quality Improvement, building capability and capacity whilst investing in people and culture.
- Embed features into our processes that will prompt staff in using Quality Improvement methodology in everyday work. Embedding improvement into management systems and processes.
- Develop the quality team to support QI projects and develop staff in QI methods.
- Create a culture that nurtures continuous improvement, developing leadership behaviours across the Trust by bringing together services across the Trust to embed the five components of NHS IMPACT.

Our chosen Model for Improvement.

We will use the Model for Improvement to underpin the structure of the activities and projects that we conduct when making changes to strive for improvements. The Model for Improvement (Fig 2) was developed by Associates in Process Improvement's (API), it is the Institute for Health Improvement's chosen model for improvement and is widely used across the NHS. The Model for Improvement uses three simple but fundamental questions to test changes on a small scale using the PDSA cycle. It will allow us to use rapid cycles to plan and test changes on a small scale. Then to reflect upon the impact and causes for the outcomes observed. This will allow us to be confident in knowing what changes should be applied more widely and make informed decisions about the next steps.

The Model for Improvement

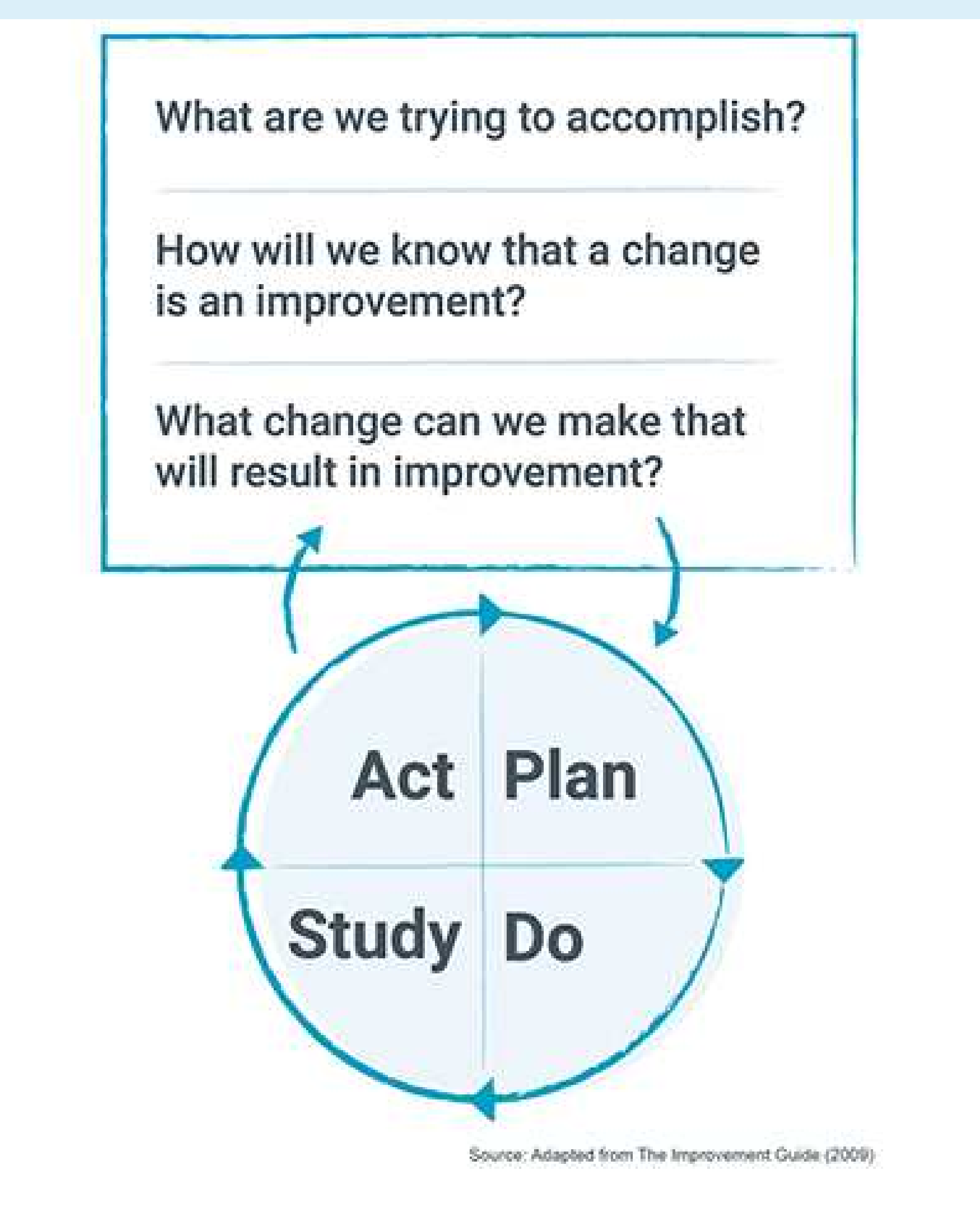


Figure 2.

Our delivery approaches.

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Co-production and co-design will be an essential. Our staff and patients are best placed to identify, create, and deliver the improvements that need to be made to our services. We will collaborate with staff and patients at the earliest opportunity after an issue has been identified to plan and test ideas for improvements. Using this approach will, ensure that there is greater insight into the issue, increase the success of proposed plans and reduce the number of rapid cycles required to achieve some improvement.

Training our staff.

Our staff's knowledge and understanding of QI will be crucial for our success. We plan to deliver a programme of continuous learning to keep staff up to date with QI practices and reinforce their understanding. Our aim is to train our staff to understand and confidently use Quality Improvement in everything they do.

Training for all staff at all levels.

Our ambition is for everyone who works within the Trust to understand QI and to adopt QI methods to make frequent improvements. We will make training available to all staff to increase their understanding and confidence in applying QI to everyday practice and large-scale change. The training will include use of QI tools.

The training will be through drop-in sessions, online opportunities and a one day offer from SATH Improvement Hub on Improvement Fundamentals which will ensure awareness of improvement methodology, awareness of the model for improvement and PDSA, awareness of the need for measurement and an introduction into tools and concepts.

Quality Improvement Advocates.

We will identify a variety of clinical, corporate, and clerical staff at varying levels, spanning from frontline to senior management and train them to become competent, confident users of QI. These individuals will become our QI Advocates, they will work within their divisions to provide peer support to their colleagues and raise the profile of QI. They will inspire a better understanding of quality and inspire those within the Trust to do their best and have influence by ensuring governance, assurance and improvement in the organisation. The QI Advocates will form a network where they

are able to share their experiences and learning with other Advocates this learning will then be cascaded across each division to support the sharing of good practice.

The training through online sources, drop in sessions and a six face to face session programme Improvement Practitioner provided by SATH Improvement Hub will ensure awareness of improvement methodology, awareness of the model for improvement and PDSA, awareness of the need for measurement, awareness how to identify waste, root cause analysis, a deeper understanding of tools and techniques and support completing a project through coaching.

Formal projects that are led by the quality team.

Formal QI projects will have touch points built into their delivery plan at the point of the project initiation. As well as ongoing advice and guidance, project leads/ project teams will meet with QI Leads to discuss the information, activity, assumptions, and data at each stage of their project. This will be a structured but creative process, which will provide the project lead/ project team the opportunity to exercise some "free thinking," challenge their own ideas, assess the robustness of their plans, delve deeper into findings, perform root cause analysis, assess the project team membership, progression of the project and more. The length of the touchpoints will be reflective of the needs of the project. The PDSA touch points will support projects to maintain their momentum and relevance whilst supporting the project team.

Other resources may be used by the quality and corporate teams such as National clinical audits, demand and capacity tools, benchmarking, model hospital and improvement science.

Monitoring.

Analysis of data from Audit, Patients Safety, Patient Experience and Performance

We will continue to analyse data and information gained from patient safety incidents, investigation incidents, medication incidents, serious incidents, complaints and PALs, audits, claims, cases and inquests, performance monitoring and compliments to identify areas for improvement, and areas of excellence. Then use QI methodology to understand the root causes of issues and excellence so that we can make improvements where there are issues and proactively do more of what works well. This process will trigger the onset of formal QI projects where relevant.

Sharing and learning.

A key component to continuous improvement is the ability to share learning across teams, departments, and other organisation and this will be ensured through projects being shared within Trust meetings and external sessions regionally and nationally. Submitting projects for awards and conferences for wider shared learning.

Working collaborative on projects across systems and pathways for wider improvement, sharing and learning.

Resources.

Development of a suite of tools and techniques with template documents for staff to use in everyday practice will enhance accessibility to resources to support staff in practice.

Development of a central resource on staff zone for resources, videos, shared learning and case studies to celebrate improvement and embed learning.

A series of learn at lunch virtual session will be introduced so staff can continuously learn tools and techniques from the quality and corporate teams to gain confidence and capability to make improvements in practice.

How we will track our progress.

How will we know that we are making progress?

- Have a clear methodology in our Quality Improvement delivery that is understood by all.
- We will track whether there has been an increase in the evidence provided by staff for the improvements made.
- We will track how many of our formal QI projects are initiated successfully first time around and the difference that has been made.
- Train our staff to understand and confidently use Quality Improvement in practice.
- Every quarter we will assess data on the number of staff that attend QI training.
- We will ask staff to rate their own confidence and understanding before and after training and engagement events.

- We will review the annual staff survey results for the questions rating how engaged staff feel with improvement.
- We will encourage staff to celebrate the improvements they make and share learning across the Trust.
- We will self-assess ongoing against NHS IMPACT self-assessment initial baseline to review the improvement made.

What will success look like?

The aim	The measure
The framework is shared and understood by all.	By June 2024, the framework will have been shared across the Trust through meetings and we can measure staff awareness and engagement through an internal survey.
All staff will have had the opportunity to attend training on QI.	From February 2024 the training offer will be circulated regularly to encourage uptake.
All new starters will have access to the QI video introducing QI.	From April 2024 the QI video will be part of the induction slides.
Staff are trained in QI methodologies.	By March 2025 there will be at least twenty-five staff who have completed the one-day fundamentals training and ten staff the practitioner's course.
QI Advocates will be in place.	By March 2025 we will have at least 10 Advocates across the Trust.
We will have QI projects completed within teams.	By Jan 2025 we will have a list of at least 10 QI projects completed.
QI will be embedded through patient safety learning responses.	By June 2024, the key areas within PSIRF will be supported by QI projects.
The staff survey questions on staff ability to make changes will improve.	There will be an increase in the 2024/25 staff survey on the ability to make improvements and change.

A network for staff engaged with QI will be in place with an opportunity to present projects and celebrate success.	By July 2024, a quarterly meeting will be established for sharing and learning. Along with Learn at lunch sessions for development opportunities.
An intranet page will be available for staff to access tools and resources.	By September 2024, the web page will be live.
External networking and learning opportunities will be promoted.	By March 2025 staff will be involved and engaged across networks and external events.
Self-assessment at Board level and staff level against the NHS impact self-assessment tool will show improvement from the baseline in 2023.	In September 2024 NHS Impact self-assessment will show improvement.

0. Reference Information

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1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

2.2 Summary

- The Community Safer Staffing tool was introduced to the Trust in January 2023, we have now completed 3 data sets with the first in January 2023 being a trial and so we now have 2 clean data sets. The detail of this has been removed form this Trust paper as Chief Nursing Officers have been advised by the NHS England (NHSE) national team to pause use of the tool while further verification checks are performed on its efficacy.
- The Community Hospitals undertook their first data collection in June/July 2023, and have undertaken the second data collection in January 2024.
- The Rehabilitation and Recovery Units (RRU) were opened in January 2024 based at Shrewsbury and Telford Hospitals. Both wards undertook a data collection in February 2024. This data will not be used to make a judgement on establishments.
- Vacancy rates in our Community Hospitals have increased to 13.08 WTE.
- The Trust has seen an overall reduction in agency staff usage. This is due to the increased controls that the Trust has put in place following further financial measures instructed by NHSE, we have however used large amounts of agency at the Rehabilitation and Recovery Unit (RRU) as both wards were opened in January 2024 without an established workforce.
- The International Nurses Programme has worked well. In January 2024 we saw the last of the 2023/2024 Nurses join the Trust and they will predominately fill the substantive gaps in the RRU wards but will also fill the gaps we have in the community inpatient wards.

2.3. Conclusion

The Trust Board is asked to **review** the information and **accept** the recommendation that there is a **moderate level assurance for safer staffing within the Community Hospitals**. The Trust has seen an increase in vacancies, this is mainly attributed to the opening of 2 the RRU's and good progress is being made with substantive recruitment. It is envisaged that by the end of June 2024, both wards will have a fully established substantive workforce. The Trust is partially compliant with the national policy (Developing Workforce Safeguards), the progress of this will be monitored at the Quality & Safety Committee quarterly to monitor compliance against the policy.

3. Main Report

3.1 Introduction

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

Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

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

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

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

The Trust commenced using the validated inpatient tool in June 2023 once they had received a licence, this tool is used widely in other Community Hospitals. The National Community Safer Staffing tool was introduced nationally in September 2022 but has been paused in May 2023 by the National Team whilst further checks are undertaken. This report outlines the second clean set of data for the community inpatient wards, the first set of data for the Rehabilitation and Recovery Units opened in January 2024 captured via this validated, evidence-based method.

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4.0 Nurse to Patient ratio – inpatient wards

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

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

4.3 Table 1 shows the average RN: Patient ratio at Shropcom during January 2024 for all 5 community and RRU inpatient areas. It demonstrates that during January 2024 all community and RRU inpatient wards met the national requirement of an overall 1:8 for day shifts at the time of the data collection although it should be noted this national guidance is based on acute inpatient facilities.

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

Hospital	RN: Patient Ratio- Day Shift
Ludlow	1:6.7
Bridgnorth	1:8.3
Whitchurch	1:7.6
Ward 36	1:5.7
Ward 18	1:6.6

4.4 At Whitchurch the bed base is 32 with 4 escalation beds in January 2024 which takes them to 36. The escalation beds were closed in line with winter plans, and staffing was reduced, however the escalation beds were again open utilising Bank and agency to support the extra staffing as these escalation beds were not funded. This was due to urgent and emergency care system pressures.

4.5 Nursing Associates (NA) are used in the Trust but have not yet been written into National Policy to be included into the registered numbers, this is being added to National Policy and it was planned to be launched in 2024. The use of NA to the Trust is a fairly new concept and so professional judgement is applied with triangulation of quality and safety data as a standard daily expectation of leaders and managers.

4.6 Actual versus planned staffing numbers for January 2024 showed that for the 3 community inpatient wards 71.83% of shifts were covered by substantive staff; this is a small increase from 71.4% on December 2024 data. 21.2% were filled by agency RN staff and 6.42% were shifts filled by Bank staff, a reduction of 5.6% from December data (12.1%). There were 4 shifts that were not filled at all. The

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breakdown for the RRU wards was not available but all shifts were covered with a higher staff ratio in this month due to the need for induction and supervisory periods for staff. Fill rate was over 100% due to this.

5.0 Safer Nursing Care Tool (SNCT)

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

5.2 The SNCT tool is designed to be used daily for a minimum, 20-day period twice per year not including the weekends (January & June) collecting individual patient acuity however the SNCT tool has been updated with 2 new categories added which will monitor the use of Enhanced Care and the tool now requires the data to be collection for a minimum of 30 days. The data collection is undertaken by the trained senior Nurses in the team.

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

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

5.5 In January 2024 the Trust opened 2 new Rehabilitation and Recovery Wards both based at the acute Trust, Telford ward 36 has 20 beds and Shrewsbury, ward 18 have 26 beds. As the wards had only just opened in January 2024 data collection was completed in February and at that point ward 18 were only open to 20 beds. It is to be noted that as the wards have only recently been opened, the mix of patients was not the full reflection of the expected demographic, this is due to the need to open quickly to decompress the acute sites that were struggling with urgent and emergency care pressures and so a proportion of patients were deemed no criteria to reside rather than Rehabilitation and Recovery patients.

5.6 Training for staff has been undertaken for the original SNCT version however training needs to now be undertaken on the updated tool ready for data collection in June 2024. At present daily acuity is not collected daily, however we are just launching Safecare and so this will be captured moving forward and will help with our understanding of patients with a higher dependency requiring enhanced support which has previously been difficult to identify.

5.7 Bridgnorth has 25 beds with the daily average at 23.7 patients at the time of the data collection. 9.3 patients scored level 0 and 13.8 scored 1b (See appendix 1 for the SNCT score). This scoring is appropriate and expected for the patients profile we see at for the type of patients in our Community Hospitals. The scoring suggests we should have 22.1 RN and 11.9.HCA. The actual establishment for the ward is RN 14.47 and HCA 20.49 a total of 35.07. The daily staffing is 3 RN on days and 2 RN on nights with 4 HCA on the early shift and 3 HCA's on the late shift with 3 HCA on night. When we look at the results of the data collection it suggests the ward needs 34.0 to run the ward and suggests that the ratio of RN to HCA needs to change. With the actual establishment at 35.07 WTE no change is required.

5.8 Ludlow has 24 beds with the daily average at 22.6 patients at the time of the data collection. 9.7 patients scored level 0 and 12.6 scored 1b. The data suggest we should have 20.6 RN and 11.1 HCA and a total of 31.7 The actual establishment for

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the ward is RN 14.21 and HCA 14.19 a total of 28.45. The daily staffing is 3 RN on days and 2 RN on nights with 3 HCA on days and 2 HCA on nights. When we look at the results of the data collection it suggests the ward needs 31.7 to run the ward and suggests the ratio of RN to HCA needs to change. With the actual Establishment at 28.45 there is a deficit of 3.25.

5.9 Whitchurch has 32 beds (with 4 additional escalation beds that are not funded for) with the daily average at 30.60 patients at the time of the data collection. 12.6 patients scored level 0,16.40 scored 1b and 1.60 1a. This scoring is appropriate and expected for the patients profile we see at for the type of patients in our Community Hospitals. The scoring suggests we should have 27.8 RN and 15.0 HCA. The actual establishment for the ward is RN 14.67 and HCA 19.79 a total of 34.67. The daily staffing is 4 RN on days and 3 RN on nights with 4 HCA on days and 3 HCA on nights. When we look at the results of the data collection it suggests the ward needs 42.8 to run the ward which would be an increase of 8.13 and suggests that the ratio of RN to HCA needs to change. At the time of the data collection 36 beds were open and it is important to collect data when the escalation beds are closed as 8.13 will take into account there are 4 extra beds open which are not routinely funded.

5.10 Ward 36 has 20 beds with a daily average of 19.8 patients at the time of the data collection. 9.1 patients scored Level 0, and 10.6 scored 1b. This scoring is appropriate for the patient profile in the Rehabilitation and Recovery units. The scoring suggests that the ward should have 17.8 RN and 9.6 HCA. The establishment for the ward is RN 14.78 and 10.39 HCA. The daily staffing is 3 RN on days and 2 RN on nights and 2 HCA on days and nights. When we look at the data collection it suggests the ward needs 27.4 and so the establishment covers the staffing need however this is the first data collection, we would not be making any recommendation until we have 2 sets of clean data. RN to HCA is appropriate on days but a 50:50 split for night duty.

5.11 Ward 18 has 26 beds but at the time of the data collection the ward was open to 20 beds. The daily average was 19.3 patients at the time of the data collection. 8.8 patients scored Level 0 and 10.5 scored 1b. this scoring is appropriate for the patient profile in the Rehabilitation and Recovery Units. The scoring suggest the ward should have 17.4 RNs and 9.4 HCA. As the ward was originally meant to open to 32 beds there is more funding in the establishment for these increased numbers.

5.12 For the community inpatient wards this is now a 2nd set of clean data and so would expect recommendations to be made, however due to the RRUs opening in January 2024, the Director of Nursing has instructed to maintain monitoring with no changes to establishments for a further 6 to 12 months within the Community Hospital bed bases. This is to allow chance for the impact of the RRUs to take effect. The mitigation to this is that staffing has not changed for many years and is monitored on a daily basis with risk constantly being assessed.

5.13 The gold standard for skill mix of staff would be 70% RN to 30% (Royal College of Nursing 2012) HCA linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of Care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021). Within the Community Wards the skill mix is often around 50:50. It is to be noted that when benchmarking, most Trusts including acute Trusts, do not reach the standard of 70:30, the aim is that once we have reviewed 2 clean data sets, we would look to increase the Nurse-to-patient ratio on a trajectory to eventually get to 65% and that the 65% would include Nursing Associates. This is the professional judgement of the Director of Nursing.

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6.0 Community Safer Care Tool (CNSST)

6.1 The data for the CNSST tool was reviewed at the Quality and Safety Committee but has now been removed from this Board report due to a national instruction to pause it's use whilst further testing is undertaken.

7.0 Fill rates for inpatient wards

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

7.2 As the RRUs opened in January 2024, fill rate data was not collected, this commenced in February 2024 once all the beds were full.

7.3 The position for January 2024 Source (January 1st – 31st January 2024) is shown in table 2.

Table 2 – Fill rates (January 2024)

	Day		Night	
Hospital Site	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	88.5%	99.8%	100%	119.2%
Ludlow	98.5.%	111.6%	100%	144.6%
Whitchurch	94.6%	132.5%	100%	160.1%
Ward 36	NA	NA	NA	NA
Ward 18	NA	NA	NA	NA

7.3 HCA day and night shifts were higher than planned to maintain ongoing management and safety for patients requiring enhanced supervision. This is particularly noticeable at both Whitchurch and Ludlow where they have seen high numbers of patients needing enhanced supervision.

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

7.5 Bed occupancy rates reported for January 2024 were 94.4%. This breakdown for bed occupancy at each site as 95.5% Bridgnorth, 94.6% Ludlow, and 94.9%, Whitchurch, Ward 36 PRH, 90.9% and Ward 18 RSH 95.2%.

7.6 For the 3 community inpatient areas two shifts were reported in January 2024 as 100% RN agency staff. These were in relation to two shifts at Whitchurch both night duty and staff on shift were regular agency to Whitchurch. Ward 18 had 19 shifts all night duty with ward 36 having 26 shifts, again night shifts, this was due to the wards opening without substantive staff in place. To mitigate the risk Bank and agency staff

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were block booked and senior staff were allocated to work on these wards to support staff.

7.7 Bridgnorth had less than 90% fill rate in January for RN shifts in the day, this was due to movement of staff to support the opening of the RRUs. Safety was however maintained by utilising staff such as Allied Health Professionals (AHPs) on the ward. There were no adverse incidents linked to staffing for this area in January.

8.0 Care Hours per Patient Day (CHPPD)

8.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Insight-Model Hospital website. SCHT data is now available on the Model Hospital site and on performing benchmark analysis, for the last quarter (up December 2023) the average overall for our Trust is 6.9 care hours per patient day (CHPPD, compared to with average of other similar community NHS trusts of 8.7 as shown in table 3.)

Table 3 - Model Hospital Benchmarking table

Organisation Name	CHPPD - overall
Derbyshire Community Health Service Foundation Trust	14.1
Central London Community Healthcare	11
Hertfordshire Community	10.1
Birmingham Community Healthcare	9.6
Hounslow and Richmond Community Healthcare	9.2
Kent Community Health NHS Foundation Trust	8.8
Lincolnshire Community Health Services	8.3
Leeds Community Healthcare NHS Trust	7.3
Norfolk Community Health and Care	7.2
Shropshire Community Health	6.9
Sussex Community	6.7
Bridgwater Community Healthcare	5.8
Overall average	8.7

8.2 Table 4 shows the rolling care hours per day for the last year. Care hours per patient day are calculated by dividing the total number of nursing hours on a ward by the number of patients in beds at midnight. The calculation proved the average number of care hours available each patient on the ward.

8.3 At present we do not have the CHPPD data for the Rehabilitation and Recovery Units but the Trust will be collecting this data going forward, but it must be remembered

that CHPPD does not take into account the skill mix and should not be viewed in isolation from other safer staffing metrics.

Table 4 – Care hours per patient day

	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Bridgnorth	8.1	7.9	7.5	7.2	6.7	8.0	8.0	7.7	7.9	7.5	6.7	6.9
Ludlow	7.6	7.9	8.0	7.2	6.2	7.0	7.1	7.4	7.7	8.7	8.3	6.6
Whitchurch	8.4	8.7	7.6	8.9	6.9	7.5	7.5	6.7	6.9	7.0	6.4	6.4

9.0 Substantive Unavailability

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

9.2 **Table 5** Shows the vacancy position for the Community Hospitals for January 2024. It is to be noted that although we show the vacancy position for Bishops Castle, this ward remains temporary closed however, since September 2023 there has been a targeted recruitment campaign which has been successful and at the April Board the decision to re-open the beds was made.

9.3 For the RN vacancies Whitchurch continues to carry the highest vacancy however with the arrival of the January and February 2024 International Nurse cohort most of this vacancy will be filled. For HCSWs, the WTE vacancy for January 2024 was 9.47, with the highest vacancy at Ludlow however these are in process.

Table 5 - Vacancy percentages for Community Hospitals

Community Hospital	Registered Nurse Vacancy Position Includes Bands 4,5,6 & 7		Unregistered Nurse Vacancy Position Includes Bands 2 & 3	
	WTE	**%**	**WTE**	**%**
Bishops Castle	6.97	68.1 →	8.09	74.3 ↑

Ludlow	1.95	14.8 →	4.75	21.8 ↑
Bridgnorth	0.55	3.9 →	2.54	10.3 ↓
Whitchurch	3.61	21.7 ↓	(1.04)	(4.4) ↑

9.4 In January and February 2024 a total of 13 International Nurses (IR) joined the Trust bringing the total to 32 with 1 more arriving in April 2024. Most of the IR Nurses have been placed in the Community Hospital wards and the IR Nurses that arrived in January/ February 2024 will largely be going to the new RRU Wards. A small number of the IR Nurses are working in the Community District teams, but this has been more difficult with the IR Nurses preferring the hospital environment on arrival.

10.0 Incidents

10.1 During January 2024 there were 2 reported staffing issues but with no patient harm.

10.2 During January 2024 there were 2 occasions that the Community inpatient wards had 100% RN agency on night duty, they were both in Whitchurch. There were no falls or incidents of any significance. For the RRU ward 18 had 21 nights and ward 36 had 15 nights shifts and day shift.

10.3 During February there were 18 inpatient falls reported which occurred in our care across the Community Hospital Wards and our two new RRU Wards, which equates to a rate of 5.29 falls per 1000 Occupied Bed Days (OBDs). This is a lower number and incidence rate than in M10 and represents an improvement in performance after a three-month trend of increased incidences. In February the rate of falls fell to below the average for 2022/23. Anecdotal evidence indicates that there has been a reduction in falls regionally as we head out of the winter months. Please see the table below detailing the rate of falls per 1000 OBDs for 2022/23 and 2023/24.

Table 6 – Falls Data

Year		M1 April	M2 May	M3 June	M4 July	M5 Aug	M6 Sept	M7 Oct	M8 Nov	M9 Dec	M10 Jan	M11 Feb	M12 Mar
2022/23	Falls	26	15	11	21	12	10	24	14	10	18	7	11
	Falls/ 1000 OBDs	11.46	6.69	5.18	9.01	5.35	4.29	9.87	5.79	4	7.29	3.08	4.38

2023/24	Falls	11	11	5	14	9	13	5	15	17	25	18	22
	Falls/ 1000 OBDs	4.56	4.5	2.15	5.84	3.79	5.43	1.97	6.09	6.67	7.11	5.29	5.88

11.0 Recommendations

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

11.2 To continue to work with the National Team to review results for assurance.

11.3 For the RRUs to go live on the health roster, this is a priority for the Roster Team.

11.4 Introduction of E-roster Safecare has been launched and training will commence in May 2024 to the Community Hospitals and the RRU. Safecare provides staff with live visibility of staffing levels and by matching with patient demand, can highlight areas with short workload-based care hours. It allows for the acuity of the patient to be visible daily so wards can demonstrate how dependant their ward at all times.

11.5 Work has commenced with the Virtual Ward to implement an acuity data collection tool, training needs to be undertaken for staff prior to their first data collection. This will be used as a local tool as there is no evidence-based tool for Virtual wards but will be useful in making professional judgement decisions in the absence of a nationally recognised tool.

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

11.7 Continue work on the recruitment and retention plan, to support the Trust in filling the vacancy gaps thus improving overall safer staffing substantive numbers.

11.8 For the inpatient data collection, January 2024 this has been the second set of data collected and whilst we could make recommendations for Whitchurch as their data demonstrates the need for increase, the recommendation would be to wait until the commissioners bed review has been undertaken and to allow for the RRU's to settle, as this may change the demographic of the patients within our Community Hospitals over time. This is the instruction and professional judgement of the Director of Nursing. Mitigations are in place and risk remains well controlled with daily staffing checks to maintain safety.

11.9 Introduce the safer staffing tool to Bishops Castle inpatient facility staff once they have reopened, this is unlikely to be for the June 2024 and is likely to be January 2025 before data is collected.

12.0 Conclusion

The Trust Board is asked to **review** the information and **accept** the recommendation that there is a **moderate level assurance for safer staffing within the Community Hospitals**. The Trust has seen an increase in vacancies, this is mainly attributed to the opening of 2 the RRU's and good progress is being made with substantive recruitment. It is envisaged that by the end of June 2024, both wards will have a fully established substantive workforce. The Trust is partially compliant with the national policy (Developing Workforce Safeguards), (attached), the progress of the document will be monitored at the Quality & Safety Committee quarterly to monitor compliance against the policy.

Supporting Literature

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Appendices

Appendix 1 – Inpatient Decision matrix

The Safer Nursing Care Tool – Decision Matrix

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (*Comprehensive Critical Care, DH 2000*). These classifications have been adapted to support measurement across a range of wards / specialties.

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	Care requirements may include the following • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • Early Warning Score is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	Care requirements may include the following • Increased level of observations and therapeutic interventions • Early Warning Score - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation / invasive monitoring • Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	Care requirements may include the following • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway and protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Respiratory or CNS depression / compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection

* this multiplier allows a 22% uplift for annual leave / study leave etc.
Software is being developed that will allow this to be adjusted and will be added to this site when available.

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Mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital.

0. Reference Information

Author:	**Sam Townsend Divisional Clinical Manager – Community Services**	**Paper date:**	**6th June 2024**
Executive Sponsor:	Claire Horsfield – Director of Operations and Chief AHP	**Paper written on:**	23rd May 2024
Paper Reviewed by:	Claire Horsfield – Director of Operations and Chief AHP	**Paper Category:**	Operational
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital (BCCH) for the Trust Board for information and assurance.

2. Executive Summary

2.1 Context

The Trust Board in April were assured that staffing levels to safely re-open the inpatient beds at BCCH had been met. The Board requested a detailed mobilisation plan to provide assurance that this is done in a safe timely manner.

2.2 Summary

- A high-level description of the approach to mobilisation plan is provided with indicative timescales.
- The approach to the governance and reporting of the mobilisation plan is also provided.
- A high-level milestone plan included for reference.
- In May the Board agreed to aim for an opening date of July and this was communicated to staff and the community group that had been established to support the recruitment campaign.

2.3. Conclusion

The Trust Board is asked to.

- **Accept** this report as full assurance that there is a detailed mobilisation plan and governance for oversight of delivery of the plan to reopen the in-patient beds at BCCH in July.

Mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital.

3. Main Report

3.1 Introduction

In April's Trust Board it was agreed that staffing had met the safe threshold, so in line with the decision made at September's, the Board agreed that the inpatient beds at BCCH were to re-open. The Board requested a detailed mobilisation plan to understand timelines. This report will describe the high-level approach to the delivery of the mobilisation plan and the indicative timescales as to when patients will be accepted into the BCCH beds in line with previous discussion regarding a July opening. The operational governance for delivery of the plan is also described.

3.2 Approach to the delivery of the mobilisation plan

3.2.1 Meeting structures and frequencies

A fortnightly Delivery Group has been set up which is chaired by the Divisional Clinical Manager for Community Services, BCCH sits within this division alongside the other three Community Hospitals.

The first Delivery Group took place on 17th April 2024 and the mobilisation plan was populated. This was based on learning from our colleagues who opened the Rehabilitation and Recovery Units in January 2024.

There are a series of Task and Finish Groups that sit below the Delivery Group and are chaired by the subject matter experts for their areas. These meet weekly and provide updates to the Delivery Group regarding completion of key actions to achieve milestones, escalate any risks and request support.

There are five Task and Finish Groups: Clinical, Workforce, Infection Prevention and Control (IPC), Estates and Equipment, Support Services (including soft facilities and digital). The Communications Team are a core member of the Delivery Group.

The first of these meetings took place the week commencing 22nd April 2024 and reported to the Delivery Group on 30th April 2024.

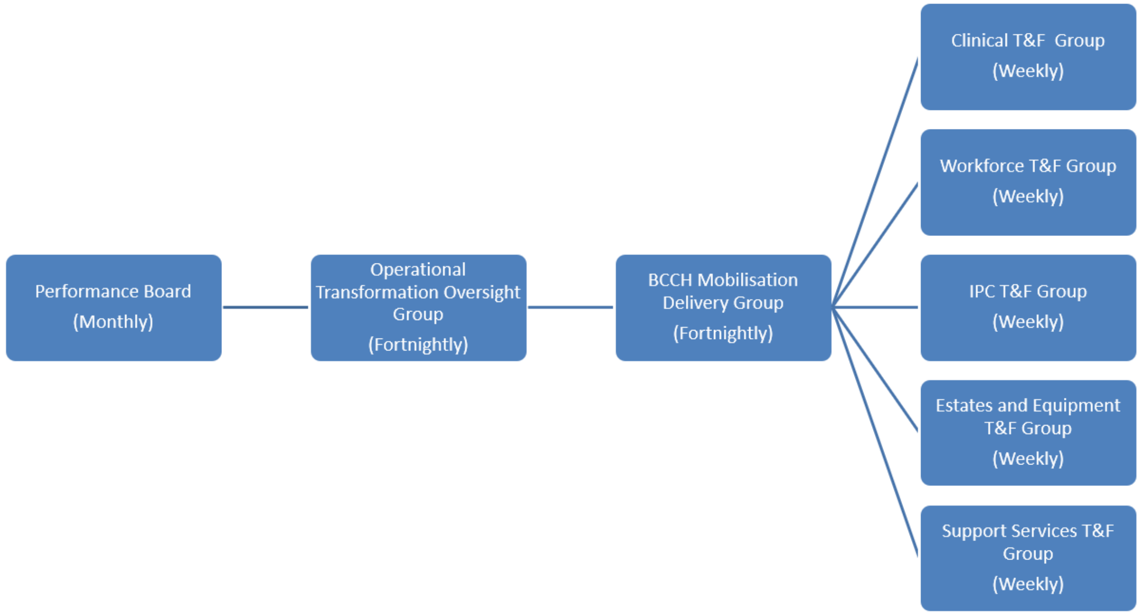
All of the Task and Finish Groups are currently on track and completing their milestone actions within the detailed project plan deadlines.

Mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital.

3.2.2 Operational governance and reporting of the mobilisation plan.

The Delivery Group provides a flash report fortnightly to the Operational Oversight Transformation Group (OTOG) chaired by the Deputy Director of Operations.

A monthly update will also be provided to the Trust Senior Leadership Team (SLT) at the Programme Board.



3.3.3 High-level milestone plan.

Below is a high-level milestone plan to describe current indicative timescales. As the Task and Finish Groups meet and report into the Delivery Group some of the timescales may need to be adjusted. As the mobilisation plan progresses some milestones will need to be added and some may be removed. The Delivery Group on 28th May 2024 confirmed that all workstreams are currently on track to achieve their milestones.

Task and Finish Group	May 2024	June 2024	July 2024
Clinical	On track	All tasks completed 26th	Patients accepted from 15th
Workforce	On track	All tasks completed 28th	Staff start from 1st
IPC	On track	All tasks completed 7th	Routine audits planned
Estates and Equipment	On track	All tasks completed 7th	Business as usual
Support Services	On track	All tasks completed 7th	Business as usual

Mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital.

The current timescales that the Delivery Group has briefed the Task and Finish Groups to work towards is July 2024. 1st July 2024 is when the in-patient area will bring its clinical and support team on site and begin working together to ready the area to receive patients. 15th July 2024 is when patients will start to be transferred in a phased approach into the beds.

Date	15/07/24	16/07/24	17/07/24	18/07/24	19/07/24	Total
Number of patients to be transferred.	5	5	6	0	0	16

3.3 Key Risks

A detailed risk register has been developed and maintained. This is reviewed by the Delivery Group and escalated through OTOG and Performance Board as required.

Below is the high-level risk register that is monitored and maintained by the Delivery Group.

Risk	Risk score prior to mitigation (c x l)	Mitigating actions	Risk score following mitigation (c x l)
Capacity Insufficient capacity across operational and corporate teams to deliver the plan within timescales.	**3 x 4 = 12**	Escalation to line managers. Escalation through governance route. Prioritisation and stand down less urgent tasks.	**3 x 2 = 6**
Workforce The staffing threshold for Registered Nursing drops below the level required to open.	**3 x 3 = 9**	Robust plans to communicate with all Registered Nurses regarding plans to open and timescales. Maintain 'keeping warm' measures.	**3 x 2 = 6**
Estates and equipment Issues with key estates and equipment are identified as	**3 x 4 = 12**	BCCH has remained open to deliver out-patient clinical activity, therefore maintenance	**3 x 2 = 6**

Mobilisation plan to reopen the in-patient beds at Bishops Castle Community Hospital.

part of Task and Finish Group actions which impact on the timescales.		of the site has been preserved. Key audits and checks are already planned so any issues can be identified and remedied early.	
Financial Known cost pressure of £454k to have 4 Community Hospital wards open.	4 x 5 = 20	In year cost pressure mitigated through opening from month 4 for 24/25 Ongoing work to mitigate recurrent cost pressure under way	4 x 2 = 8
Clinical / Quality Potential clinical risk if all beds are opened to admission with a new team in place at the same time	**5 x 4 = 20**	Phased approach to accepting patients onto the ward. Training and orientation to the ward of staff in the first 2 weeks prior to patients being accepted. Senior Nursing representation on site in initial phase.	**5 x 2 = 10**

3.5 Conclusion

The Trust Board is asked to.

- **Accept** this report as full assurance that there is a detailed mobilisation plan and governance for oversight of delivery of the plan reopen the in-patient beds at BCCH in July.

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

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance / Jon Davis, Associate Director of Digital Services Operational Leads	**Paper date:**	**6th June 2024**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**29th May 2024**
Paper Reviewed by:	Resource and 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 an assessment of the key areas of performance relevant to the Trust's updated Performance Framework.

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

2.2 Summary

The key points for the Trust Board to consider are:

- There are 59 performance indicators reported in this period across all committees.
- The table below summarises the number of KPIs highlighted as a concern against each responsible committee. 29 indicators are highlighted as a concern (49%), although there are interdependencies across many of these.

Committee	Variation concern	Assurance concern	Both Variation and Assurance	Total KPIs reviewed	Total Requiring Attention
People	2	8	4	**19**	**14 (73.7%)**
Quality & Safety	1	3	2	**16**	**6 (37.5%)**
Resource & Performance	1	2	6	**24**	**9 (37.5%)**

Performance Update

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

Action Plans have been developed by Operational colleagues and included as Appendix 3 for the measures flagged as a concern in this report for Resource and Performance Committee.

The time-limited Access and Activity Performance Committee was established to review performance in relation to waiting times and access to our services. A workshop was held at the May Private Board meeting to assess if this Committee should be stood down, with oversight returning to the Resource and Performance Committee, or whether it should be extended to allow additional focus to gain further assurance. The Board concluded that the time-limited Committee should be stood down as detailed assurance had been provided and action plans are now included with the performance report to Resource and Performance Committee.

In line with our Performance Framework and any available national guidance, each Committee has been asked to review its measures as we enter the new financial year. A recommendation has been made to the Board within a separate paper, in relation to the proposed changes for 2024/25.

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

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

2.3. Conclusion

The Trust Board is asked to:

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

- **Consider** the development of action plan reporting and if any amendments are required in order to provide adequate assurance to the Board in relation to the actions being taken to improve performance.

Performance Update

3. Main Report

3.1 Introduction

An agreed set of KPIs is in place to monitor the Trust's performance. The full list of KPIs monitored across all three of our committees is shown in Appendix 1 of this document.

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

3.2 Summary of key points in report

This report focuses on the 24 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 9 require particular focus with 8 of the 9 relating to access to services and waiting times, some of which is a consequence of the introduction of the system-wide MSK service.

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

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

One KPI is a variation concern only – special cause variation of a concerning nature.

1. Outpatient follow-up activity levels compared with 2019/20 baseline.

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

2. Total patients waiting more than 65 Weeks to start consultant-led treatment (National target).
3. Data Quality Maturity Index

Six KPI are both an assurance concern *and* special cause variation concern.

1. 18 week Referral to Treatment (RTT) incomplete pathways (National target)
2. Total patients waiting more than 52 Weeks to start consultant-led treatment (National target)
3. Proportion of patients within 18 weeks (Local target)
4. Total patients waiting more than 78 Weeks – All services (Local target)
5. Total patients waiting more than 65 Weeks – All services (Local target)
6. Total patients waiting more than 52 Weeks – All services (Local target)

The list of KPIs which are of concern is largely unchanged from the last report but there has been some movement between categories; Total elective activity undertaken compared with 2019/20 baseline is no longer flagged as an assurance concern, Total patients waiting more than 52 Weeks to start consultant-led treatment (National target) is now flagged as having a variation concern as well as an assurance concern.

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

Performance Update

As of April 2024:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	169	895
Patients waiting over 65 weeks	0	293
Patients waiting over 78 weeks	0	135
Patients waiting over 104 weeks	0	0

Overall, this position is a deterioration from last month and detail can be found in the action plans in relation to work underway to improve this performance.

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

18 week Referral to Treatment (RTT) incomplete pathways has shown a slight improvement this month from 48.08% in March to 49.81% in April, although the April position is still being validated at the time of preparing this paper. This is also the case for the local waiting list measure, Proportion of patients within 18 weeks, with 57.47% in March to 58.71% in April.

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

Action plans for all of the KPIs which require additional consideration from a resource or performance perspective are appended to this report, within Appendix 3. These plans set out the actions being taken to improve performance and associated timelines. As these action plans are under development the Board is asked to consider whether the templates require any refinement in order to deliver adequate assurance to Committees and the Board.

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Trust Board is asked to:

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

- **Consider** the development of action plan reporting and if any amendments are required in order to provide adequate assurance to the Board in relation to the actions being taken to improve performance.

Performance Update - Appendix1

Resource and Performance Committee – SPC Summary
Month 01 (April) 2024/2025 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance Committee	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2024-04-30		49.81%	92.00%	-42.19%	49.81%	92.00%	-42.19%	
Resource & Performance Committee	Use of Resources	Agency spend - compared to the agency ceiling	2024-04-30		71.67%	100.00%	-28.33%	71.67%	100.00%	-28.33%	
Resource & Performance Committee	Use of Resources	Agency spend - Price cap compliance	2024-04-30		55.65%	100.00%	-44.35%	55.65%	100.00%	-44.35%	
Resource & Performance Committee	Effective	Available virtual ward capacity per 100k head of population	2024-04-30		38.76	38.76	0.00	38.76	38.76	0.00	
Resource & Performance Committee	Responsive	CQC Conditions or Warning Notices	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Effective	Data Quality Maturity Index	2024-01-31		94.2%	95.0%	-0.8%	94.2%	95.0%	-0.8%	
Resource & Performance Committee	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2024-03-31		99.65%	99.00%	0.65%	99.65%	99.00%	0.65%	
Resource & Performance Committee	Use of Resources	Financial efficiency - variance from efficiency plan	2024-04-30		-11.76%	0.00%	-11.76%	-11.76%	0.00%	-11.76%	
Resource & Performance Committee	Use of Resources	Financial stability - variance from break-even	2024-04-30		-0.01%	0.00%	-0.01%	-0.01%	0.00%	-0.01%	
Resource & Performance Committee	Responsive	Number of patients not treated within 28 days of last minute cancellation	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2024-04-30		104.99%	75.00%	29.99%	104.99%	75.00%	29.99%	
Resource & Performance Committee	Responsive	Proportion of patients spending more than 12 hours in an emergency de...	2024-04-30		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	
Resource & Performance Committee	Responsive	Proportion of patients within 18 weeks	2024-04-30		58.71%	92.00%	-33.29%	58.71%	92.00%	-33.29%	
Resource & Performance Committee	Effective	Total activity undertaken against current year plan	2024-04-30		96.49%	100.00%	-3.51%	96.49%	100.00%	-3.51%	
Resource & Performance Committee	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2024-04-30		128.28%	120.00%	8.28%	128.28%	120.00%	8.28%	
Resource & Performance Committee	Effective	Total elective activity undertaken compared with 2019/20 baseline	2024-04-30		122.91%	103.00%	19.91%	122.91%	103.00%	19.91%	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks - all services	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks - all services	2024-04-30		895	0	895	895	0	895	
Resource & Performance Committee	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatme...	2024-04-30		169	0	169	169	0	169	
Resource & Performance Committee	Responsive	Total patients waiting more than 65 weeks - all services	2024-04-30		293	0	293	293	0	293	
Resource & Performance Committee	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatme...	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatm...	2024-04-30		0	0	0	0	0	0	
Resource & Performance Committee	Responsive	Total patients waiting more than 78 weeks - all services	2024-04-30		135	0	135	135	0	135	

Quality and Safety Committee – SPC Summary
Month 01 (April) 2024/2025 Performance

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Quality & Safety Committee	Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	2024-04-30		6.1	6.4	-0.3	6.1	6.4	-0.3	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-04-30		4.00	0.00	4.00	4.00	0.00	4.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-04-30		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-04-30		99.39%	95.00%	4.39%	99.39%	95.00%	4.39%	
Quality & Safety Committee	Safe	Consistency of reporting patient safety incidents	2023-06-30		83.33%	100.00%	-16.67%	83.33%	100.00%	-16.67%	
Quality & Safety Committee	Effective	Deaths - unexpected	2024-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-04-30		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-04-30		0	0	0	0	0	0	
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Shropshire	2024-03-31		81.22%	90.00%	-8.78%	79.99%	90.00%	-10.01%	
Quality & Safety Committee	Caring	New Birth Visits % within 14 days - Telford	2024-03-31		90.14%	95.00%	-4.86%	92.75%	95.00%	-2.25%	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-04-30		Good	Good		Good	Good		
Quality & Safety Committee	Responsive	Proportion of patients who have a first consultation in a post-covid servic...	2024-04-30		8.33%	92.00%	-83.67%	8.33%	92.00%	-83.67%	
Quality & Safety Committee	Safe	Serious Incidents (reported)	2024-04-30		0	0	0	0	0	0	

People Committee – SPC Summary
Month 01 (April) 2024/2025 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 ...	2024-04-30		7.4	7.5	-0.1	7.4	7.5	-0.1	
People Committee	Well Led	Appraisal Rates	2024-04-30		82.84%	95.00%	-12.16%	82.84%	95.00%	-12.16%	
People Committee	Well Led	CQC well-led rating	2024-04-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2024-04-30		11.82%	9.60%	2.22%	11.82%	9.60%	2.22%	
People Committee	Well Led	Mandatory Training Compliance	2024-04-30		92.64%	95.00%	-2.36%	92.64%	95.00%	-2.36%	
People Committee	Well Led	Net Staff in Post Change	2024-04-30		140.15	0.00	140.15	140.15	0.00	140.15	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME back...	2024-04-30		9.09%	20.00%	-10.91%	9.09%	20.00%	-10.91%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-04-30		72.73%	66.00%	6.73%	72.73%	66.00%	6.73%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled...	2024-04-30		4.55%	4.00%	0.55%	4.55%	4.00%	0.55%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regar...	2024-04-30		55.80%	63.90%	-8.10%	55.80%	63.90%	-8.10%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2024-04-30		7.1%	0.0%	7.1%	7.1%	0.0%	7.1%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2024-04-30		12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	
People Committee	Well Led	Proportion of staff who say they have personally experienced harassment...	2024-04-30		22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	
People Committee	Well Led	Proportion of temporary staff	2024-04-30		7.0%	3.4%	3.6%	7.0%	3.4%	3.6%	
People Committee	Well Led	Sickness Rate	2024-04-30		5.54%	4.50%	1.04%	5.54%	4.50%	1.04%	
People Committee	Well Led	Staff survey engagement theme score	2024-04-30		7.0	7.3	-0.3	7.0	7.3	-0.3	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-04-30		381	0	381	381	0	381	
People Committee	Well Led	Total shifts on a non-framework agreement	2024-04-30		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2024-04-30		12.30%	8.00%	4.30%	12.30%	8.00%	4.30%	

Icon Descriptions

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

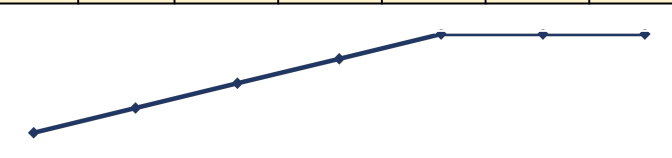
Exception Report - Action Plan

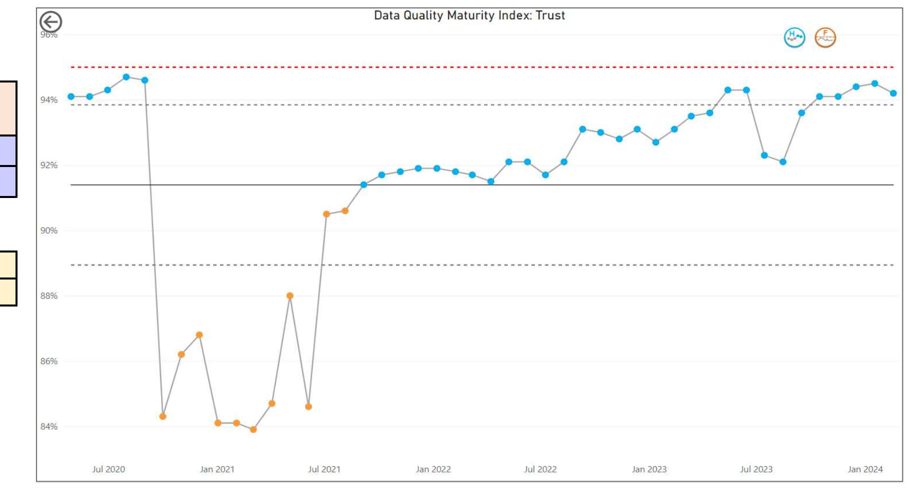
Data Quality Maturity Index

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

KPI Description	Latest 6 months	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD
DQMI	%	93.60%	94.10%	94.10%	94.40%	94.50%	94.20%	94.2%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	94.2%	94.4%	94.6%	94.8%	95.0%	95.0%	95.0%





Reason for performance gap:

Performance dropped in June/July 2023 following a number of errors highlighted in the dataset submissions as the Trust implemented the new version of a dataset submission standard. The datasets have been corrected and resubmitted.

However, data quality issues still exist in several data items of MIU eg Chief Complaint, Clinical Coding for Admitted Patient Care, Ethnicity and Spoken Language.

The main area of challenge impacting this metric is in relation to compliance re recording of ethnicity. Education to teams re importance and relevance of capturing this metric is ongoing. Challenges with admin capacity (aligned to NHS controls) to ensure this action is completed has had an impact however working with informatics to see how certain fields that support improving data quality become mandatory for completion.

Action Plan

Action	Start Date	End Date	Status	Outcome
Data Quality Sub-Group to have representation from all divisions	Jan-24	May-24	On track	Membership at the DQ meeting has been reviewed from an ops perspective with dedicated representation from each division aligned to support.
Implementation of new Divisional performance and Quality meetings in line with new divisional structure to ensure reporting is embeded into governance structures not just reflected in the improvment group	Mar-24	Apr-24	On track	Plans in place to include data quality as standard agenda item. Meetings are up and running with further action to include other corporate services. Separate items for Quality and Governance with further discussions required with the Governance Team. Information Analyst has attended CYP/Planned Care meetings to discuss data quality
Work with RIO teams re mandatory fields that must be completed before further data can be input	Jan-24	Jun-24	Ongoing	Ethnicity is a mandatory field in Rio, further investigation required for other areas

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

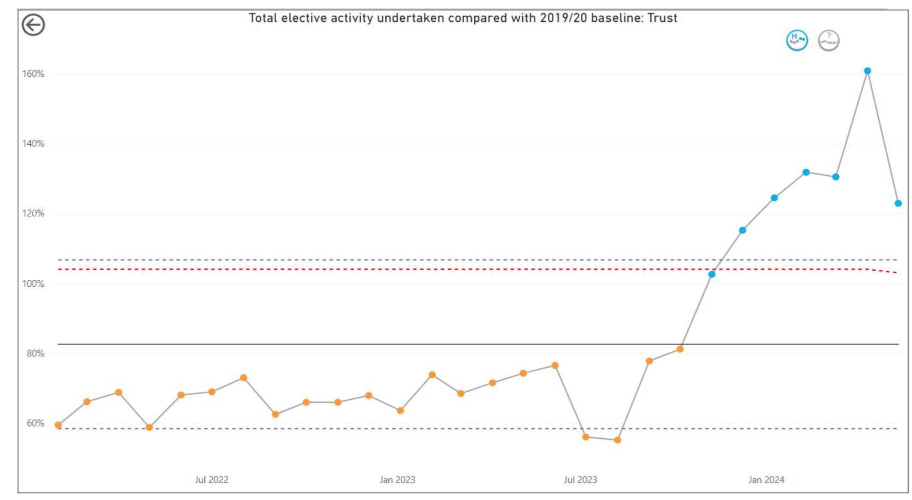
Exception Report - Action Plan

Total elective activity undertaken compared with 2019/20 baseline

Total elective activity undertaken compared with 2019/20 baseline. Calculated in line with NHSE SOF including working days comparison

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
Elective activity	%	115.21%	124.50%	131.86%	130.52%	160.93%	122.91%	
	Target	104.0%	104.0%	104.0%	104.0%	104.0%	103.0%	103.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	130.0%	130.0%	130.0%	130.0%	130.0%	130.0%	130.0%



Reason for performance gap:

An improving position can be seen in total elective activity undertaken compared with 2019/20 baseline. This has mainly been achieved through implementation of MSST. It is anticipated this will stablise in line with other actions regarding utilisation and transfer of Rheumatology/Orthopaedics

Some areas are below plan and MSST has enabled the Trust to provide an improved picture overall. Dental activity continues to be below the target due to the challenges with the theatre list provision.

APCS remains below plan with locum support being aligned to support this recovery.

Service	Apr-24 (Rounded to 0 dp)
APCS	97%
Bridgnorth Hospital - Day Surgery Unit	127%
Bridgnorth Outpatients	90%
DAART	77%
Ludlow Outpatients	83%
MSST	22938%
Oral Surgery	33%
TEMS	10%
Whitchurch Outpatients	10%

Plan

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology new patients into MSST transfering activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Off Track	Contract discussions continuing
Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	Off Track	2 adult list offered for April and 2 for May

Action					
	Recruitment of substantive APP in MSST to support increase in capacity	Feb-24	Aug-24	On track	Advert closed, shortlisting w/c 11th March. Successfully recruited, awaiting completion of recruitment process with aim to have staff in post Jun 24.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal. ETA Jun 24.
	Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	Agreement of agency Physio/AAP to support MSST activity	Oct-23	Mar-24	Declined	Adverts for workforce plan live to enable agency to end. No longer an agreement to have agency support due to the current financial pressures. Focus on imporving clinic utilisation to support reduction in agency.

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

Exception Report - Action Plan

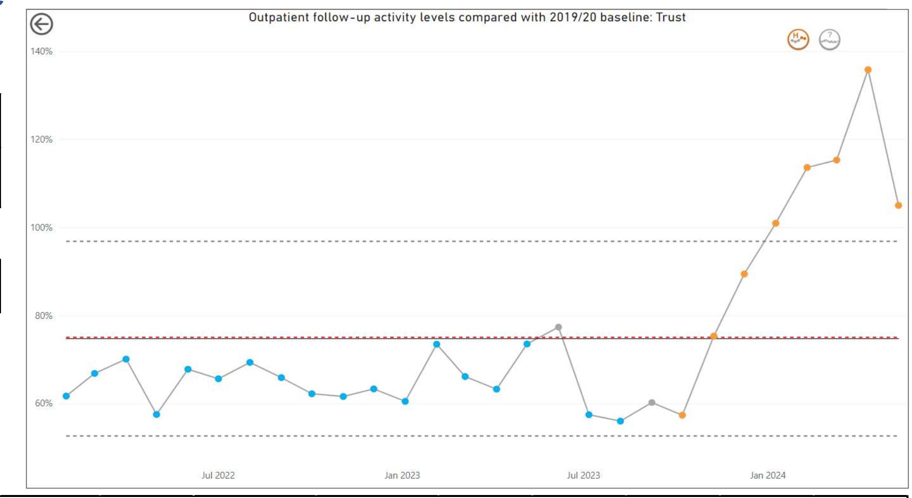
Outpatient follow-up activity levels compared with 2019/20 baseline

Outpatient follow-up activity compared with 2019/20 baseline. Calculated in line with NHSE SOF including working days comparison

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
Outpatient follow-up	%	89.39%	100.94%	113.61%	115.29%	135.83%	104.99%	
	Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	120.0%	120.0%	120.0%	120.0%	120.0%	120.0%	120.0%

To be updated



Reason for performance gap:

There continues to be a focus on ensuring clinically appropriate follow-up activity and the positive adherence to utilising PIFU (patient initiated follow up) across MSST.

The difficulty with this KPI is that MSST was not in existence in 19/20 so there is no baseline to compare to hence the continued demonstration of overperformance seen above. This would be similar for the TeMS service as the TeMS model is significantly different now than it was compared to 19/20.

Service	Apr-24 (Rounded to 0 dp)
APCS	92%
Bridgnorth Outpatients	71%
DAART	56%
Ludlow Outpatients	88%
MSST	13524%
TEMS	9%
Whitchurch Outpatients	15%

Action Plan

Action	Start Date	End Date	Status	Outcome
Continue to embedd PIFU across all clinically appropriate services and maintain peformance	Jun-23	Mar-24	On track	Currently overpeforming with processes and standards embedded in all areas
Work with informatics to look at approach in reporting this KPI due to the challenges with comparison for TeMS/MSST	Feb-24	Jun-24	Ongoing	Agenda item in peformance cycle meeting discussed initially in Feb pending feedback for March. Initial conversations taking place at a system level in reviewing 2019/20 elective baseline
Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation recieved from RJAH Chief Opertaing Officer. Majority of open clock pathways have been transferred. Transition agreed for follow ups too but all new/FU activity is now being reocrded via RJAH.
Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

Exception Report - Action Plan

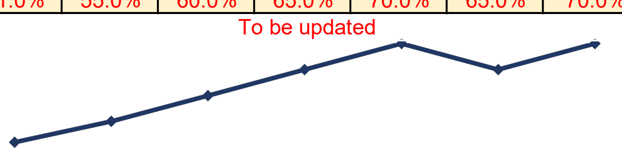
18 week Referral To Treatment (RTT) Incomplete Pathways

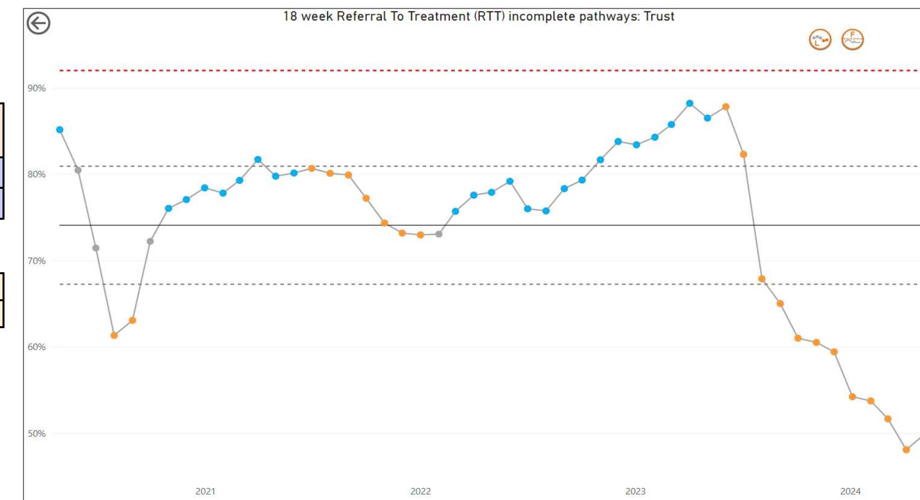
As at the end of the month, the percentage of patients that are still waiting for treatment and are within 18 weeks

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
RTT Incomplete Pathways	%	59.41%	54.21%	53.73%	51.65%	48.08%	49.81%*	49.81%*
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
%	51.0%	55.0%	60.0%	65.0%	70.0%	65.0%	70.0%

To be updated





Reason for performance gap:

The current position continues to be a challenge mainly due to the implementation of the MSST service which equates to C 80% of all activity at Trust level but is also impacted by other RTT applicable services. Performance has dropped below the trajectory due to the continuing challenge within the MSST service and increase in admin resources to support recovery.

MSST - The service went live with receiving referrals 6 months before clinics were available to be booked into as existing services continued to work on their existing caseloads/backlog. This has led to a significant backlog being generated. The service continues to systematically recover this position however its is challenged due to a number of factors including a lack of standardisation of processes and approach leading to underutilised clinics and high levels of DNA's. The appointment of a system admin lead hosted by SCHT will mitigate this considerably however the 47% admin vacancy gap is a risk to full recovery.

Streamlining the service will support greatly with recovery and Rhuematology was transferred to RJAH between Feb and April and Orthopaedics is due to be part of the next phase of MSST.

Dental also poses a risk due to access to consistent SaTH theatre provision, on average the standard offer is 2 lists a month

APCS also has a number of backlog patients following sickness within this area. The service is aiming to address this with changes being made to the clinic templates to enable greater new capacity to support reduction and recruiting additional clinicians to support.

Community Hospital Outpatients has a number of backlog patient pathways. This is due to ongoing challenges with consistent capacity being provided across all SLA, particualrly seen within ENT and Respiratory

There are other services which contribute to not meeting this performance target such as Bridgnorth Hospital Daycase

n	Start Date	End Date	Status	Comments
Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation recieved from RJAH Chief Opertaing Officer. Majority of open clock pathways have been transferred. Transition agreed for follow ups but all Open RTT pathways have been transferred.
Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Off Track	Contract discussions continuing
Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	Off Track	2 adult list offered for April and 2 for May
Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	On track	Advert closed, shortlisting w/c 11th March. Successfully recruited, awaiting completion of recruitment process with aim to have staff in post Jun 24.

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

Action Pla	Action	Start	End	Status	Update
	Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
	Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	MSST focusing on improving clinical utilisation and implementing waiting list initiatives within level 2 including additional clinics, blitz clinics etc.	Apr-24	Jun-24	Working Up	Aim to have regular blitz clinics by May 24 to support level 2 but the main concern is level 3 and the refrutiment of admin will support driving improvement in clinic utilisation.
	Agreement of agency Physio/APP to support MSST activity via agency scutiny and Finance Recovery Group	Oct-23	Mar-24	Declined	Adverts for workforce plan live to enable agency to end. No longer an agreement to have agency support due to the current financial pressures. Focus on imporving clinic utilisation to support reduction in agency.
	Additional capacity being sought to support Community Hospital Outpatient backlog	Mar-24	May-24	On Track	Additional Gynaecology sessions being provided. Further discussions taking place with SaTH regarding a more robust approach to the ENT SLA

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

**Please note that the actual performance for the month is subject to change as the validation for the national submission continued at the time of updating the action plan*

Exception Report - Action Plan

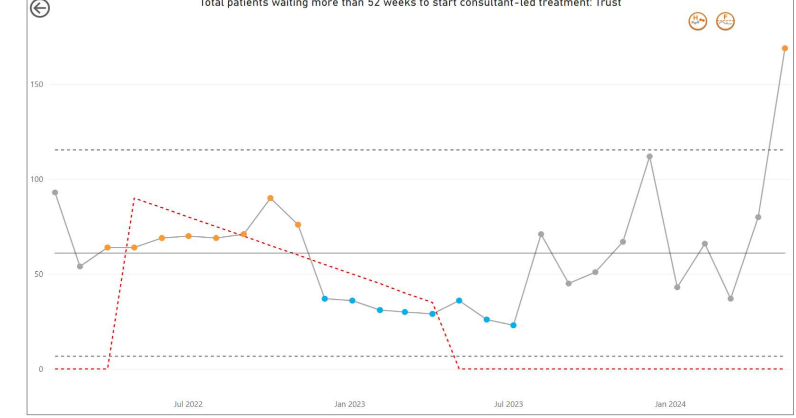
Total patients waiting more than 52 weeks to start consultant-led treatment

As at the end of the month, the number of patients that are still waiting for treatment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
RTT 52+ week waits	Number	90	43	55	37	80	169*	169*
	Target	0	0	0	0	0	0	0

Trajectory	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Number	59	53	0	0	0	0	0

To be updated



Reason for performance gap:	
	Main areas of concern are within TeMS Orthopaedics and MSST due to the delay in implementing Phase 3 of MSST. Rheumatology transferred to RJAH between February and April, with Orthopaedics to SaTH by end of May 2024. MSST Phase 2 has also seen a number of patients reaching 52 weeks due to capacity challenges within the level 3 element (Advanced Practice Practitioners & GPSIs). The 47% admin vacancy gap in MSST and TeMS is a key risk to delivering the improvement trajectory. This is significantly impact the teams' ability to validate, manage DNA rates, ensure full clinic utilisation and effectively manage patient pathways safely. An integration of admin pathways has commenced with RJAH to support with streamlining systems and processes however this will not mitigate the workforce gap it will focus on efficiency and productivity. Navigating the NHSE control measures effectively to ensure a balanced view on risk will be vital to support with the ongoing workforce gaps. Dental also continues to be challenged with patients reaching 52 weeks+ due to the lack of consistent theatre provision. While there has been improvement in recent months it is essential that the regular provision is established and maintained There are other services which contribute to not meeting this performance target such as Bridgnorth Hospital Daycase, Community Hospital Outpatients and APCS

Action Plan		Start Date	End Date	Status	Outcome
	Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation recieved from RJAH Chief Opertaing Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.
	Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
	Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Off Track	Contract discussions continuing
	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	Off Track	2 adult list offered for April and 2 for May
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	On track	Advert closed, shortlisting w/c 11th March. Successfully recruited, awaiting completion of recruitment process with aim to have staff in post Jun 24.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
	Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	Agreement of agency Physio/APP to support MSST activity via agency scutiny and Finance Recovery Group	Oct-23	Mar-24	Declined	Adverts for workforce plan live to enable agency to end. No longer an agreement to have agency support due to the current financial pressures. Focus on imporving clinic utilisation to support reduction in agency.

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Accountable Officer Approval	Claire Horsfield	Date	17/05/2024

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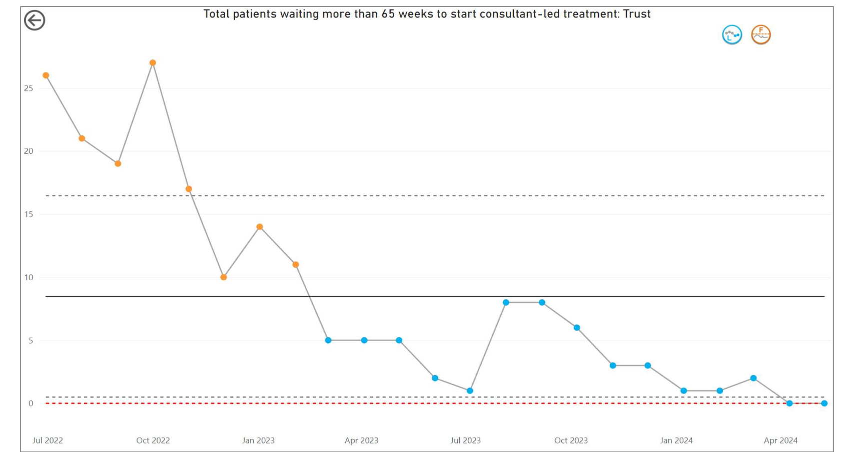
Exception Report - Action Plan

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

As at the end of the month, the number of patients that are still waiting for treatment and have been waiting 65 weeks and over

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
RTT 65+ week waits	Number	1	1	1	2	0	0*	0*
	Target	0	0	0	0	0	0	0

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Number	3	0	0	0	0	0	0



Reason for performance gap:	The trajectory remains on track to achieve and maintain 0 65 week waits.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation recieved from RJAH Chief Opertaing Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.
	Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
	Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Off Track	Contract discussions continuing
	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	Off Track	2 adult list offered for April and 2 for May
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	On track	Advert closed, shortlisting w/c 11th March. Successfully recruited, awaiting completion of recruitment process with aim to have staff in post Jun 24.
	Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
	Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	Agreement of agency Physio/APP to support MSST activity via agency scutiny and Finance Recovery Group	Oct-23	Mar-24	Declined	Adverts for workforce plan live to enable agency to end. No longer an agreement to have agency support due to the current financial pressures. Focus on imporving clinic utilisation to support reduction in agency.

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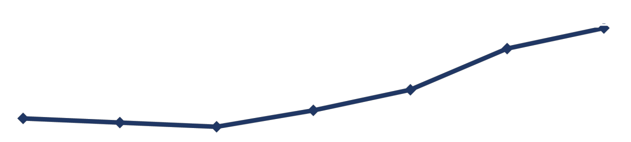
Exception Report - Action Plan

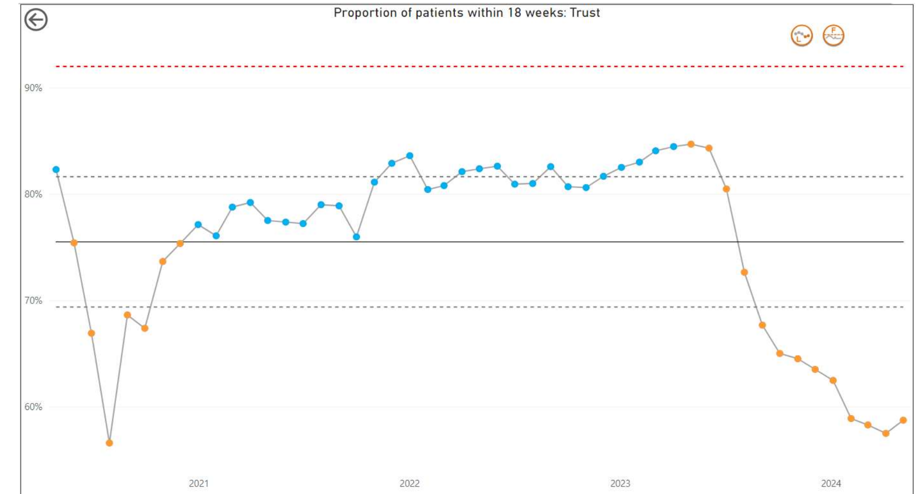
Proportion of patients within 18 weeks

The percentage of patients that are still waiting an appointment and are within 18 weeks

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
Proportion of patients within 18 weeks	%	63.50%	62.46%	58.87%	58.26%	57.47%	58.71%	58.71%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
%	53.0%	52.0%	51.0%	55.0%	60.0%	70.0%	75.0%





Reason for performance gap:

The deterioration in performance aligns to overall waiting list performance with MSST implementation being the main contributor to the decline. Performance has not dropped as much as anticipated in line with the trajectory. We anticipate further challenges with performance over the next few months as Rheumatology transferred to RJAH between February and April, with Orthopaedics to SaTH by end of May 2024. The aim is to work on improving the admin provision across MSST to help drive recovery and improvement from May onwards.

Community Paediatrician vacancies and sickness continue to have an adverse impact on the waiting list for Community Paediatrics in addition to the increased number of referrals for complex cases. This in turn also adversely affects the Child Development Centre waiting lists.

Speech and Language Therapy have also seen an increase within this cohort due to maternity leave, sickness, increased referrals from schools and a national shortage of qualified Speech & Language Therapists.

APCS also has a number of backlog patients following sickness within this area, particularly seen within the ENT element of the service.

There are other services which contribute to not meeting this performance target such as CNRT, Bridgnorth Hospital Daycase, Community Hospital Outpatients, Dental, Childrens Physio, LAC, Wheelchair Services and Post Covid

Action Plan

	Start Date	End Date	Status	Outcome
Agreement of agency Physio/APP to support MSST activity via agency scutiny and Finance Recovery Group	Oct-23	Mar-24	Declined	Adverts for workforce plan live to enable agency to end. No longer an agreement to have agency support due to the current financial pressures. Focus on imporving clinic utilisation to support reduction in agency.
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	On track	Specialist Doctor post out to advert
Focus on clinic utilisation across all services	Oct-23	Apr-24	Ongoing	Improvemnts seen in MSST with targeted support to APCS about to roll out, Golden patient model applied in dental and CNRT review commenced. Proving difficult to implement given the shortage of admin posts in validation and clinic bookings
GPwSI locum to support with APCS improving activity and review of clinic templates and utilisation	Feb-24	May-24	Awaiting Approval	Review of model arranged to look at how locum support can then reduce
Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March

	Action	Start	End	Status	Comments
	Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
	Continued implementation of PIFU to help support demand in services.	Apr-23	Mar-25	Ongoing	Overperformance of 10% against 5% target
	MSST focusing on improving clinical utilisation and implementing waiting list initiatives within level 2 including additional clinics, blitz clinics etc.	Apr-24	Jun-24	Working Up	Aim to have regular blitz clinics by May 24 to support level 2 but the main concern is level 3 and the refrutiment of admin will support driving improvement in clinic utilisation.
	One of the ELSEC Posts in SLT has gone out to advert. 2nd vacant post awaiting outcome of Exec approval.	Mar-24	May-24	Planned	No impact on waiting list until the post has been recruited to.
	Talk boost program implemented to support with appropriateness of referrals coming into the service which longer term will support with future demand.	Feb-24	Ongoing	Ongoing	Having impact on reducing number of new referrals
	Creation of Fortnightly waiting list meeting to review performance and discuss nescessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

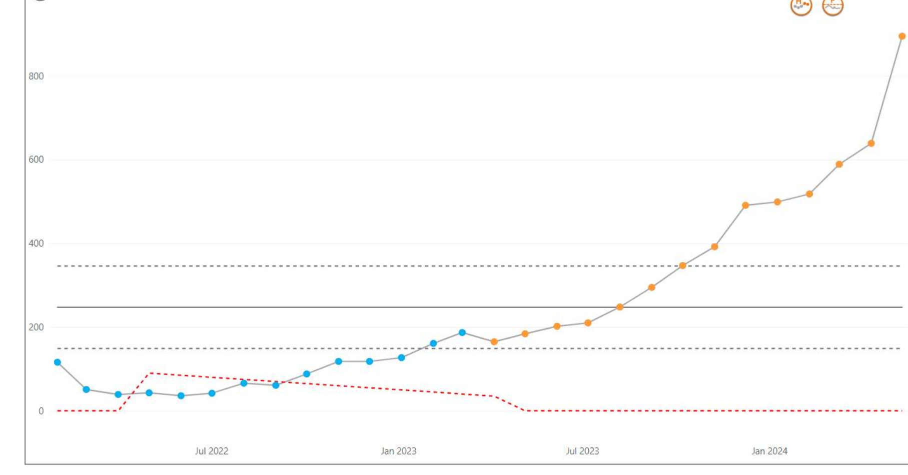
Exception Report - Action Plan

Total patients waiting more than 52 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
52+ Week waits - All services	Number	491	499	518	589	639	895	895
	Target	0	0	0	0	0	0	0

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Number	600	600	600	550	500	450	400



Reason for performance gap:

The majority of this activity is attributable to TeMS/ MSST and its Lower Limb Orthopaedic and Rheumatology elements of the Service. Rheumatology transferred to RJAH between February and April, with plans for Orthopaedics to SaTH by end of May 2024.

CNRT has a number of patients within 52 weeks due to the challenges with access to Psychology provision. An SLA is however progressing for this area of the service to support recovery. A full service review is planned to re explore the clinical model in its entirety to scope areas to increase productivity and more effectively manage wait times across the MDT moving forward.

MSST has a proportion of patients within 52 weeks and continues to be challenged due to the pressure on admin teams due to their vacancies. This is leading to challenges with fully utilising clinical capacity to support patients and recover the postion. The lack of standardised admin processes across MSST is also leading to increased DNA rates which is impacting on the services ability to recover and prevent 52 week breaches.

Community Paediatrician vacancies and sickness continue to have an adverse impact on the waiting list for Community Paediatrics in addition to the increased number of referrals for complex cases. This in turn also adversely affects the Child Development Centre waiting lists. Some of patients waiting longer than 52 weeks in Community Paediatrics are attributable to Children waiting for Schedule of Growth Skills (SOGS) appointments. This is due to capacity of our Specialist Nursery Nurse Team and reduced admin capacity to support with managing clinics and validation. These appointments are age specific so some take priority over others that could have been waiting longer on the waiting list. There are regular meetings with the team to review the waiting list and prioritise

Speech and Language Therapy have also seen an increase within this cohort due to maternity leave, sickness, increased referrals from schools and a national shortage of qualified Speech & Language Therapists.

There are other services which contribute to not meeting this performance target such as Bridgnorth Hospital Daycase, Community Hospital Outpatients, Dental, APCS and Wheelchair Service

Action Plan

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology to MSST	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics to MSST	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Awaiting Approval	SLA has been finalised, awaiting approval.
Comm Paeds - SOGS - looking at different approaches to increase throughput	Feb-24	Ongoing	Ongoing	Linked to recruitment for specialist nursery nurses
One of the ELSEC Posts in SLT has gone out to advert. 2nd vacant post awaiting outcome of Exec approval.	Mar-24	May-24	Planned	No impact on waiting list until the post has been filled.
Workforce skill mix to support CDC due to recruitment challenges	Apr-24	Ongoing	Ongoing	Advert out for specialist doctor
2 x band 5 specialist nursery nurses recurited to support with CDC assessments.	Feb-24		Complete	Recruitment completed. Training has started for the individuals
Talk boost program implemented to support with appropriateness of referrals coming into the service which longer term will support with future demand.	Feb-24	Ongoing	Ongoing	

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	Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
	Creation of Fortnightly waiting list meeting to review performance and discuss nescessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March
Author	Alastair Campbell/ Helen Cooper / Mark Onions	**Date**	15/05/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024		

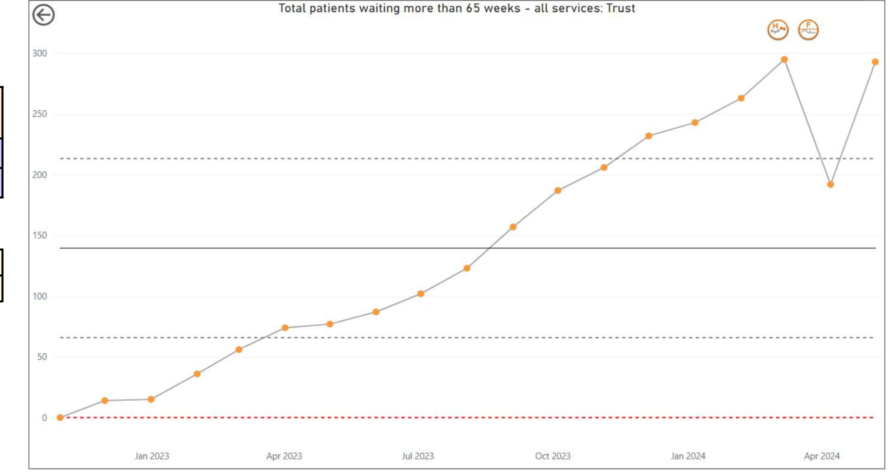
Exception Report - Action Plan

Total patients waiting more than 65 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 65 weeks and over

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
65+ Week waits - All services	Number	232	243	263	295	192	293	293
	Target	0	0	0	0	0	0	0

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Number	280	300	250	200	150	100	50



Reason for performance gap:

Majority of the patients within this cohort sit within TeMS/MSST. This is mainly the Lower Limb element of TeMS but also a proportion of Rheumatology. Rheumatology transferred to RJAH between February and April, with plans for Orthopaedics to SaTH by end of May 2024. We had antipcated that the numbers would increase before the transfer of Rheuamtology and Orthopaedics had begun.

CNRT has also seen some long waits within their waiting list due to signifcant challenges with Psychology provision an SLA will launch to mitigate this. A full service review of CNRT is also planned to scope further opportunities for productivity.

MSST admin within SCHT is heavily depleted due to vacancies with a vacancy rate of 47% being held at present. This is impacting the services ability to standardise admin processes across MSST, reduce DNA rates, increase clinic utilisation and manage and monitor patients pathways accurately and effectively. This has the potential to impact on the recovery of Non-RTT waiting lists if not addressed.

There are other services which contribute to not meeting this performance target such as Bridgnorth Hospital Daycase, Community Paediatrics and Childrens Speech and Language Therapy

Action Plan

Action	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Awaiting Approval	SLA has been finalised, awaiting approval.
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	On track	Advert out for Specialist Doctor
Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
Creation of Fortnightly waiting list meeting to review performance and discuss nescessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

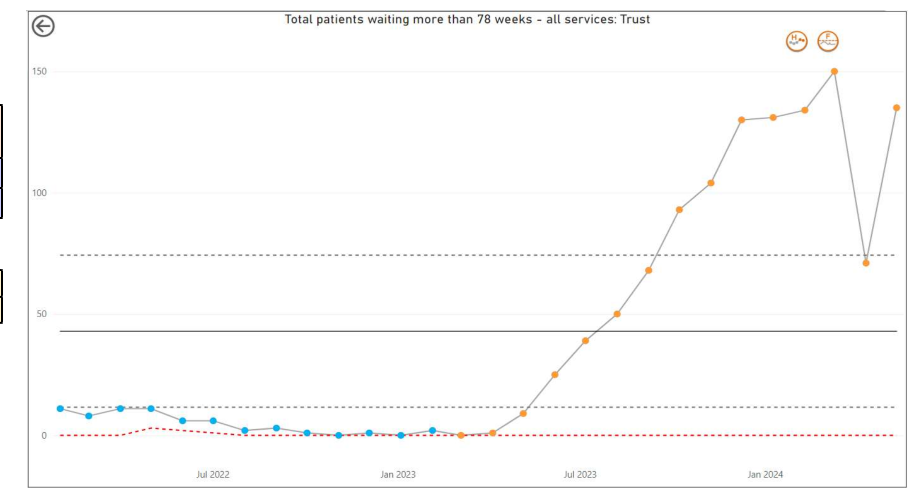
Exception Report - Action Plan

Total patients waiting more than 78 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
78+ Week waits - All services	Number	130	131	134	150	71	135	135
	Target	0	0	0	0	0	0	0

Trajectory	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Number	140	130	120	80	60	40	20



Reason for performance gap:

Majority of the patients within this cohort sit within the TeMS service. This is mainly the Lower Limb element of TeMS but also a proportion of Rheumatology. Rheumatology transferred to RJAH between February and April, with plans for Orthopaedics to SaTH by end of May 2024.

CNRT has also seen some long waits within their waiting list due to significant challenges with Psychology provision.

MSST admin within SCHT is heavily depleted due to vacancies with a vacancy rate of 47 % being held at present. This is hampering the services ability to standardise admin processes across MSST, reduce DNA rates, increase clinic utilisation and manage and monitor patients pathways accurately and effectively. This has the potential to impact on the recovery of Non-RTT waiting lists if not addressed.

There are other services which contribute to not meeting this performance target such as Community Paediatrics

Action Plan

Action	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transfering activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transfering activity/ pathway to SaTH	Apr-24	May-24	Planned	Initial conversations commenced with SaTH
Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Awaiting Approval	SLA has been finalised, awaiting approval.
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	On track	Advert out for Specialist Doctor
Alignment of admin within MSST to standardise approach/processes to booking of patients to impove clinic utilisation	Feb-24	Jul-24	Off Track	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Delay to implementation due to lack of admin to support proposal, new ETA Jun 24.
Recruitment of admin to support with the current 47% admin vacancies.	Apr-24	Jun-24	Planned	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
Creation of Fortnightly waiting list meeting to review performance and discuss nescessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	15/05/2024
Accountable Officer Approval	Claire Horsfield	**Date**	17/05/2024

Performance Framework - Integrated Performance Report 2024/25 Update

Author:	Steve Price, Head of Information and Performance Assurance Jon Davis Associate Director Digital Services	**Paper date:**	6th June 2024
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	30th May 2024
Paper Reviewed by:	RPC/QSC/People Committee	**Paper Category:**	Performance
Forum submitted to:	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?

A key governance feature of the Trust's approved Performance Management Framework is an annual review of the Trust's performance measures reported within Integrated Performance Reports (IPRs).

This paper is presented to the Board to review and to approve its key performance indicators for 2024/25, including any recommended changes.

Given receipt of additional national performance guidance is likely, it is recognised that further changes will be made during 2024/25 and relevant approvals will be sought.

To ensure good governance it is recommended that any further changes; additions, redactions, or amendments to the key performance indicators within the IPR are noted and agreed through utilising the IPR front sheet for the relevant Committee and Trust Board.

2. Executive Summary

2.1. Context

The purpose of this paper is to undertake an annual review of the IPR, as set out in the Trust's Performance Framework. The paper recommends continuation of many existing measures as well as recommending changes to metrics to allow alignment with internal, local and national priorities.

As the NHS continues to focus on recovery, it is to be expected that further performance guidance will be released. Therefore, further reviews and amendments will be required to the IPR in-year to reflect all relevant of national guidance.

The paper summarises the suggested amendments, recommends new service measures, with further detail included in the appendix to add more detail where changes are proposed.

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2.2. Summary

The paper summarises the KPIs that will be included in each Committee's specific IPR. The appendix provides full details, for reference, should members wish to review this. Some measures are still in development, and this is clearly identified if relevant.

2.3. Conclusion and Recommendations

The Board of Directors is asked to review and approve the proposed list of key performance indicators devolved to Committees of the Board.

Updates to the Trust's IPRs will occur through the year in line with Trust requirements and in response to the release of the NHSE System Oversight Framework or other relevant guidance.

3. Main Report

In line with the Trust's Performance Management Framework KPIs must be reviewed on an annual basis. This ensures the Board and its committees review and agree objectives and performance measures at least annually.

This paper is to propose some changes to performance measures for the financial year 2024/25 and these require review and agreement. It is anticipated that IPRs will further evolve during this year to ensure the Trust aligns with new guidance when released.

The proposed measures outlined in this paper are a combination of the 2022/23 NHSE Oversight Framework measures (this is the most recently released national guidance), and some existing key local measures.

Further reviews and amendments will be required as plans are finalised and further guidance is released. It is anticipated that further guidance will be published in 2024/25, such as an updated NHSE Oversight Framework, and this will dictate how Trusts will be monitored including new measures that align to the priorities set out in the operational planning guidance.

The Oversight Framework is usually published in June/July and this will trigger a review with Accountable Officers to assess both national and local priorities that need to be monitored through Committees and Board. Some of the proposed targets are nationally driven while others are based on contract arrangements or local knowledge.

As part of the annual review, each Accountable Officer (Director) has been given the opportunity to review the proposed list of KPIs and their use in the Performance Framework ahead of the updates being shared with Committees and Board.

The objective of this review is to ensure that key information is available that enables the Board and other key personnel to understand, monitor and assess the Trust's performance against current requirements and expectations.

Initially the IPR will be launched with the KPIs identified in this paper and will be monitored at Board but devolved by each responsible Committee for oversight and to agree any necessary actions.

Further information is included in the appendix that accompanies this paper should members wish to review further detail regarding measures, their targets, definitions and calculations.

On release of the 2024/25 NHSE Single Oversight Framework or equivalent requirements, the IPR and associated KPI's for each committee will be updated to reflect those requirements.

It is anticipated that for metrics that are reported once per annum such as the staff survey results, this requirement may be fulfilled through a single standalone report to the committee.

4. People Committee

Local KPIs:

- Appraisal Rates
- Mandatory Training Compliance
- Net Staff in Post Change
- Proportion of temporary staff
- Total shifts exceeding NHSI capped rate
- Total shifts on a non-framework agreement
- Vacancies - all

2022/23 Single Oversight Framework requirements:

- Aggregate score for NHS staff survey questions that measure perception of leadership culture
- CQC well-led rating
- Leaver rate
- Proportion of staff in senior leadership roles who are from a) a BME background
- Proportion of staff in senior leadership roles who are from b) are women
- Proportion of staff in senior leadership roles who are from c) are disabled staff
- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public
- Sickness Rate
- Staff survey engagement theme score

5. Quality & Safety Committee

Local KPIs:

- Access to Healthcare for people with Learning Disability
  - *In development - Definition to be established*
- Category 3 Pressure Ulcers
- Category 4 Pressure Ulcers
- Complaints - (Open) % within response timescales
- Compliance with CQC Medicines Management
- Compliance with Duty of Candour
- Deaths - unexpected
- Falls per Occupied Bed Days
- Medication Incidents with harm
- Never Events
- Patient Safety Incident Investigations

2022/23 Single Oversight Framework requirements:

- Acting to improve safety - safety culture theme in the NHS staff survey
- Clostridium difficile infection rate
- Consistency of reporting patient safety incidents
- E. coli bloodstream infection rate
- Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate
- National Patient Safety Alerts not completed by deadline
- Overall CQC Rating
- Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
  - *In development - Definition to be established*

6. Resource & Performance Committee

Local KPIs:

- New Birth Visits % within 14 days – Dudley
- New Birth Visits % within 14 days – Shropshire
- New Birth Visits % within 14 days – Telford
- 18 week Referral To Treatment (RTT) incomplete pathways
- CQC Conditions or Warning Notices
- Data Quality Maturity Index
- Diagnostics for Audiology and Ultrasound – DM01
- Number of patients not treated within 28 days of last minute cancellation
- Proportion of patients within 18 weeks
- Total activity undertaken against current year plan
- Total patients waiting more than 104 weeks - all services
- Total patients waiting more than 52 weeks - all services
- Total patients waiting more than 65 weeks - all services
- Total patients waiting more than 65 weeks to start consultant-led treatment
- Total patients waiting more than 78 weeks - all services

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2022/23 Single Oversight Framework requirements:

- Agency spend - compared to the agency ceiling
- Agency spend - Price cap compliance
- Available virtual ward capacity per 100k head of population
- Financial efficiency - variance from efficiency plan
- Financial stability - variance from break-even
- Outpatient follow-up activity levels compared with 2019/20 baseline
- Proportion of patients spending more than 12 hours in an emergency department
- Total diagnostic activity undertaken compared with 2019/20 baseline
- Total elective activity undertaken compared with 2019/20 baseline
- Total patients waiting more than 104 weeks to start consultant-led treatment
- Total patients waiting more than 52 weeks to start consultant-led treatment
- Total patients waiting more than 78 weeks to start consultant-led treatment
- Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

7. Summary

This paper has set out the proposed 2024/25 Integrated Performance Reports content and highlighted the requirement to review this in-year as further guidance and frameworks are published.

8. Conclusion

The Board of Directors is asked to review and approve the proposed list of key performance indicators devolved to Committees of the Board.

Updates to the Trust's IPRs will occur through the year in line with Trust requirements and in response to the release of the NHSE System Oversight Framework or other relevant guidance.

Appendix – IPR Proposed 2024/25 Measures

Indicator	Domain	Accountable Role	Committee	YTD (Avg / Max / Latest)	Target 24/25	Bigger or smaller	SOF KPI?	Definition	Changes 2024-25
Aggregate score for NHS staff survey questions that measure perception of leadership culture	Well Led	Director of Nursing & Workforce	People Committee	Latest	7.5	Bigger is better	Y	This indicator is the NHS Staff Survey compassionate leadership people promise element sub-score This sub-score score is comprised of 4 individual questions, used to report an overall score. The sub-score is scored on a 0-10 scale and reported as a mean score. A higher score indicates a more favourable result. Numerator Sum of individuals' scores for questions q9f-q9i Denominator Total number of individual scores for q9f-q9i KPI name change in technical annex but using Oversight Framework main doc. Aligns with annex definition. NHS Staff Survey compassionate leadership people promise element sub-score	Target updated to national average from latest Staff Survey results

CQC well-led rating	Well Led	Director of Governance	People Committee	Latest	3 (good)	Bigger is better	Y	The Care Quality Commission (CQC) inspection ratings are published by CQC. The CQC rating is based on a physical inspection, with possible ratings of: Outstanding - the service is performing exceptionally well; Good - the service is performing well and meeting CQC's expectations; Requires improvement - the service is not performing as well as it should and CQC has told the service how it must improve; Inadequate - the service is performing badly and CQC has taken action against the person or organisation that runs it. Key Lines of Enquiries (W1-W8) for which Well-led is inspected: W1: Leadership capacity and capability W2: Vision and Strategy W3: Culture W4: Governance and management W5: Management of risks, issues and performance W6: Information management W7: Engagement and involvement W8: Learning, continuous improvement and innovation	
Leaver rate	Well Led	Director of Nursing & Workforce	People Committee	Latest	9.6	Smaller is better	Y	% of staff who have left the NHS during a 12-month period Data source: The Electronic Staff Record (ESR) Data Warehouse FTE of all staff leaving the NHS during the 12 month period FTE of all staff in post at the beginning of the	

								12 month period Numerator / Denominator	
Proportion of staff in senior leadership roles who are from a) a BME background	Well Led	Director of Nursing & Workforce	People Committee	Latest	20	Bigger is better	Y	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are a) from a BME background Data source: Output of annual WRES collection	Staggered target in line with SOF
Proportion of staff in senior leadership roles who are from b) are women	Well Led	Director of Nursing & Workforce	People Committee	Latest	66	Bigger is better	Y	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are b) are women ESRData source: ESR Numerator [S071a] number of staff from denominator group who are from BME backgrounds - WRES [S071b]] number of staff from denominator group who are female – ESR [S071c] number of staff from denominator group who have a disability - WDES Denominator Number of staff at Agenda for Change band 8c + 8d + 9 + VSM. (This includes and executive board members) Computation Numerator divided by denominator multiplied by 100 i.e. 35 staff out of 100 are female: (35/100)x100=35%	Staggered target in line with SOF
Proportion of staff in senior leadership roles who are from c) are disabled staff	Well Led	Director of Nursing & Workforce	People Committee	Latest	4	Bigger is better	Y	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are c) are disabled Data source: Output of annual WDES collection	Staggered target in line with SOF

Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	Well Led	Director of Nursing & Workforce	People Committee	Latest	63.9	Bigger is better	Y	This is the weighted proportion of staff who, via the NHS Staff Survey, report that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. (q15) Data source: NHS Staff Survey Numerator The weighted number of staff who responded "Yes" to the question. Denominator The weighted number of staff responding to the question, including those who answered "don't know". Computation Weighted percentage (numerator/denominator) - the weighted percentage of "yes" responses to this question, divided by the weighted total number of responses to the question.	Target updated to national average from latest Staff Survey results
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	Well Led	Director of Nursing & Workforce	People Committee	Latest	0	Smaller is better	Y	This indicator is q14b within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from managers The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from managers, out of those who answered the question.	
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	Well Led	Director of Nursing & Workforce	People Committee	Latest	0	Smaller is better	Y	This indicator is q14c within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from other colleagues The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from	

								other colleagues out of those who answered the question.	
portion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	Well Led	Director of Nursing & Workforce	People Committee	Latest	0	Smaller is better	Y	This indicator is q14a within the NHS Staff Survey, relating to whether staff have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public. The result is reported as the proportion of staff saying they experienced at least one incident of bullying, harassment or abuse from patients/service users, their relatives or other members of the public, out of those who answered the question.	
Sickness Rate	Well Led	Director of Nursing & Workforce	People Committee	Latest	5	Smaller is better	Y	Sickness absence rates for NHS staff in England Data source: The Electronic Staff Record (ESR) Data Warehouse Numerator Full Time Equivalent (FTE) Number of Days Sick (including non-working days) Denominator FTE Number of Days available Computation Numerator / Denominator Technical Annex does not state whether 12 months rolling as per leavers rate, or in month. Using rolling for consistency with leavers and PWR return	Target change from 4.5 to 5 as requested at People Committee

Staff survey engagement theme score	Well Led	Director of Nursing & Workforce	People Committee	Latest	7.26	Bigger is better	Y	This indicator is the NHS Staff Survey Staff theme score (summary indicator) relating to staff engagement. This theme score is comprised of 9 individual questions, which form three sub scores used to report an overall score. The theme is scored on a 0-10 scale and reported as a mean score. A higher theme score indicates a more favourable result. PP Element / Theme Sub score Q no. Question text Staff engagement Motivation q2a I look forward to going to work. Staff engagement Motivation q2b I am enthusiastic about my job. Staff engagement Motivation q2c Time passes quickly when I am working. Staff engagement Involvement q3c There are frequent opportunities for me to show initiative in my role. Staff engagement Involvement q3d I am able to make suggestions to improve the work of my team / department. Staff engagement Involvement q3f I am able to make improvements happen in my area of work. Staff engagement Advocacy q21a Care of patients / service users is my organisation's top priority. Staff engagement Advocacy q21c I would recommend my organisation as a place to work. Staff engagement Advocacy q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	Target updated to national average from latest Staff Survey results

Appraisal Rates	Well Led	Director of Nursing & Workforce	People Committee	Avg	95	Bigger is better	N	Compliance of substantive staff having had an appraisal in the last 12 months. Excludes staff who have started within the last 3 months	
Mandatory Training Compliance	Well Led	Director of Nursing & Workforce	People Committee	Latest	95	Bigger is better	N	Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only (with the exception of Information Governance which includes bank staff) Excludes new starters (1 month) and long term absence (LTS, mat,pat, adoption leave, career break etc)	
Net Staff in Post Change	Well Led	Director of Nursing & Workforce	People Committee	Avg	0	Plan is best	N	Net staff in post change (FTE) FTE starters in month minus FTE leavers, taken from ESR	
Proportion of temporary staff	Well Led	Director of Nursing & Workforce	People Committee	Avg	3.4	Smaller is better	N	Cost of agency and locum as a proportion of total staffing costs for the month expressed as a percentage	
Total shifts exceeding NHSI capped rate	Well Led	Director of Nursing & Workforce	People Committee	Avg	0	Smaller is better	N	Taken from total agency rule overrides section of the NHSE Monthly bank and agency collection. The number of shifts filled by on framework agencies that exceeded the price cap (cap is per shift)	
Total shifts on a non-framework agreement	Well Led	Director of Nursing & Workforce	People Committee	Sum	0	Smaller is better	N	Taken from total agency rule overrides section of the NHSE Monthly bank and agency collection. The number of shifts filled by off framework agencies	
Vacancies - all	Well Led	Director of Nursing & Workforce	People Committee	Avg	8	Smaller is better	N	Percentage of vacancies (budgeted WTE minus contracted WTE) over budgeted WTE.	

Acting to improve safety - safety culture theme in the NHS staff survey	Well Led	Director of Nursing & Workforce	Quality & Safety Committee	Latest	6.42	Bigger is better	Y	Output from NHS Staff Survey - safe and healthy theme sub score Consistency with NHS staff survey output rather than recreating using SOF Technical Annex definitions	Target updated to national average from latest Staff Survey results
Clostridium difficile infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of Clostridioides difficile (C. difficile) infections by NHS organisation and prior trust exposure (from April 2019) in patients aged 2 years and over. Data source: https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure Numerator Number of incidences of Clostridium difficile Trust apportioned cases (‘Hospital-onset healthcare associated’ (HOHA) + ‘Community-onset healthcare associated’ (COHA)) OR Number of incidences of Clostridium difficile CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	
Consistency of reporting patient safety incidents	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	100	Bigger is better	Y	Number of months in which patient safety incidents or events were reported to the NRLS or LFPSE, by reporting trust. Data source: National Reporting and Learning System (NRLS) and its replacement, Learn from Patient Safety Events (LFPSE) Numerator Number of months in which data reported to NRLS or LFPSE within the most recent published six-month period based on reported dates Denominator Six (the most recent published	

								six-month period based on reported dates) Computation Percentage	
E. coli bloodstream infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of Escherichia coli (E.coli) bacteraemia by organisation and location of onset (from April 2019). Data source: https://www.gov.uk/government/statistics/e-coli-bacteraemia-monthly-data-by-location-of-onset Numerator Number of E.coli Trust apportioned cases ('Hospital-onset healthcare associated' (HOHA) + 'Community-onset healthcare-associated' (COHA)) OR Number of E.coli CCG cases (Total cases) Denominator Threshold for 12 months ending Mar-23	
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	12-month rolling counts of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia by organisation and location of onset Numerator Number of MRSA bacteraemia (on an assigned basis) Trust apportioned cases (Hospital-onset) OR Number of MRSA bacteraemia (on an assigned basis) CCG cases (Total cases)	
National Patient Safety Alerts not completed by deadline	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	Y	Number of National Patient Safety incidents that are not reported as completed at organisations by their deadline. Data Source: Central Alerting System (CAS)	
Overall CQC Rating	Well Led	Chief Executive Officer	Quality & Safety Committee	Latest	3 (good)	Bigger is better	Y	The CQC (Care Quality Commission) inspection rating is published by the CQC. The trust is rated on the basis of a physical inspection. Possible ratings are outstanding,	

								good, requires improvement and inadequate. Data source: CQC website	
Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	Well Led	Director of Nursing & Workforce	Quality & Safety Committee				Y	In development - Definition to be established	
Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	Responsive	Director of Operations	Quality & Safety Committee	Sum	92	Bigger is better	Y	This indicator is the percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral. Count of initial assessments undertaken within 6 weeks of referral / Total number of assessments in the reporting period *100	Move from QSC to RPC – with RPC agreement 29/05/24
Access to Healthcare for people with Learning Disability	Caring	Director of Nursing & Workforce	Quality & Safety Committee	Avg		Bigger is better	N	In development - Definition to be established	
Category 3 Pressure Ulcers	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of Trust Acquired Category 3 Pressure Ulcers	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC
Category 4 Pressure Ulcers	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of Trust Acquired Category 4 Pressure Ulcers	
Complaints - (Open) % within response timescales	Responsive	Director of Nursing & Workforce	Quality & Safety Committee	Avg	95	Bigger is better	N	Proportion of open complaints still within timescale. Timescales are 25 working days for single service complaints, 60 working days for complex cases	
Compliance with CQC Medicines Management	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Avg	95	Bigger is better	N	Proportion of actual compliances with standards against potential compliances	

Compliance with Duty of Candour	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Avg	100	Bigger is better	N	Percentage of incidents where Duty of Candour applies and is complied with	
Deaths - unexpected	Effective	Medical Director	Quality & Safety Committee	Latest	0	Smaller is better	N	Number of deaths in community hospitals that are categorised as unexpected Unexpected Death An unexpected death is: “Any death not due to terminal illness or, a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death. Patients transferred from an Acute Hospital Trust to Intermediate Care Facilities with post-surgical conditions, or fractures.” Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present then there is a requirement to begin resuscitation. The national resuscitation council has issued clear guidance for the circumstances where a patient is discovered dead and there are signs of irreversible death (Hospice UK, 2019). It is recognised that some patients may die as a result of age or fragility consequences to suffering various co-morbidities’. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition.	

Falls per Occupied Bed Days	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Avg	4	Smaller is better	N	Number of Inpatient falls in month per 1000 occupied bed days	KPI was originally in development, recently defined by Deputy Director of Nursing and Quality and Deputy DIPC
Medication Incidents with harm	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of medication incidents per month resulting in harm	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC
Never Events	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Latest	0	Smaller is better	N	Count of never events	
New Birth Visits % within 14 days - Dudley	Caring	Director of Operations	Quality & Safety Committee	Avg	90	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Dudley)	New KPI for 0-19 Dudley following contract award
New Birth Visits % within 14 days - Shropshire	Caring	Director of Operations	Quality & Safety Committee	Avg	90	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Shropshire)	Move from QSC to RPC
New Birth Visits % within 14 days - Telford	Caring	Director of Operations	Quality & Safety Committee	Avg	95	Bigger is better	N	Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Telford)	Move from QSC to RPC
Patient Safety Incident Investigations	Safe	Director of Nursing & Workforce	Quality & Safety Committee	Sum	0	Smaller is better	N	Number of Patient Safety Incident Investigations commenced in month	Name change from 'Serious Incidents (reported)'

Agency spend - compared to the agency ceiling	Use of Resources	Director of Operations	Resource & Performance Committee		100	Smaller is better	Y	Agency spend compared to the agency ceiling Data source: Provider financial returns Numerator Agency spending Denominator Planned agency spending Computation Agency spending is calculated as a proportion of the planned agency spending. If under 100%, spending is within limit.	
Agency spend - Price cap compliance	Use of Resources	Director of Operations	Resource & Performance Committee		100	Bigger is better	Y	Price cap compliance Data source: Temporary staffing data collection returns Numerator Compliance to price caps Denominator Compliance to price caps Computation Percentage of agency spend complying with the price cap	

Available virtual ward capacity per 100k head of population	Effective	Director of Operations	Resource & Performance Committee	Latest	167 (factor to be applied)	Bigger is better	Y	The indicator aggregates reported virtual ward capacity – the number of patients who can be simultaneously managed within a virtual ward service – across all such existing services, and divides by the adult population (those aged 16 and over) to give a measure comparable between different geographies. Numerator Aggregate of the capacity – the number of patients who can be simultaneously managed within a given virtual ward service – across all virtual ward services. Denominator GP-registered population aged 16 and over, as of April 2022 Data published here: Patients Registered at a GP Practice, April 2022 - NHS DigitalComputation Sitrep data associated virtual ward services and their capacity with the ICS on whose behalf the service is provided. Summing across services provided to each ICS, region and nationally and dividing by relevant population figures will report the indicator at different geographic levels.	Change to target from 119 phased to 250, to 167. Please note calculation in SOF is 16+ population whereas locally it has been agreed at 18+ with ICB
Financial efficiency - variance from efficiency plan (recurrent)	Use of Resources	Director of Finance	Resource & Performance Committee	Latest	0	Smaller is better	Y	This metric will measure how close the organisations are to meeting their efficiency plans as agreed in their overall financial plans. Numerator Variance from plan using recurrent achievement Denominator Efficiency plan Computation Variance from plan/plan	

Financial stability - variance from break-even	Use of Resources	Director of Finance	Resource & Performance Committee	Latest	0	Smaller is better	Y	This indicator assesses an organisation's plan followed by how far the organisation is away from plan and breakeven plus a number of other factors which indicate whether the organisation is financially stable. In assessing stability, the latest forecast, known risks (based on local reporting if relevant), PSPP performance, run rates plus judgement as to whether or not an organisation will manage to breakeven or not will be used Data source: Financial results reported by organisations Variance from balanced plan and then variance from breakeven Allocation for ICBs and turnover for providers Variance from balanced plan Variance from breakeven/allocation (ICBs) or turnover (providers)	
Outpatient follow-up activity levels compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	75	Smaller is better	Y	Relative number of follow-up outpatient attendances (consultant and non-consultant led) in 2022/23 compared to baseline (2019/20*) expressed as a percentage. Numerator: Total follow-up outpatient attendances (all TFC; consultant and non-consultant led) within the period divided by the number of working days** (A) Denominator: Total follow-up outpatient attendances (all TFC; consultant and non-consultant led) in the same period for 2019/20 divided by the number of working days** (B) Computation A / B	

Proportion of patients spending more than 12 hours in an emergency department	Responsive	Director of Operations	Resource & Performance Committee	Sum	1.99	Smaller is better	Y	The number of patients that spend more than 12hrs between arrival and admissions, transfer or discharge, as a proportion of total attendances Numerator Sum of attendances where difference between arrival and departure time is greater than 12 hours Denominator Sum of attendances Computation Numerator/Denominator * 100	
Total diagnostic activity undertaken compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	120	Bigger is better	Y	Numerator The number of diagnostic tests for the specified test group carried out during the month, based on monthly diagnostics data provided by NHS and independent sector organisations and reviewed and validated by NHS commissioners. This should include planned, unplanned and waiting list tests, but does not include screening. Denominator Counterfactual March 2020 activity, working day adjusted. Counterfactual calculated by applying 3-year national average growth factor from Feb-Mar to the February 2020 activity, adjusting for working days. Factor = 1.011228978	

Total elective activity undertaken compared with 2019/20 baseline	Effective	Director of Operations	Resource & Performance Committee	Sum	103	Bigger is better	Y	Valued weighted elective activity as a percentage of 2019/20 baseline, including effect of specialist advice. Valued activity (at HRG level) in the reporting period divided by the number of working days plus additional Specialist Advice activity that resulted in a diverted pathway (valued at average tariff for a first outpatient attendance without procedure) per working day. Where: additional Specialist Advice activity that resulted in a diverted pathway per working day = (valued Specialist Advice activity that resulted in a diverted pathway in the reporting period divided by the number of working days) – (valued Specialist Advice activity that resulted in a diverted pathway in the same period for 2019/20 divided by the number of working days) Valued activity (at HRG level) in the same period for 2019/20 divided by the number of working days There is an exception for March 2020 which will be an estimated counterfactual. The counterfactual is: Mar-20 activity = Working days in Mar-20 * (Feb-20 / Feb-20 wd) * average (((Mar-17/Mar-17 wd)/(Feb-17/Feb-17 wd)), ((Mar-18/Mar-18 wd)/(Feb-18/Feb-18 wd)), ((Mar-19/Mar-19 wd)/(Feb-19/Feb-19 wd))) Where wd = working days This counterfactual needs to be calculated separately for each term in the weighted formula. Counting and coding adjustments to the baseline will be used to adjust the denominator.	Target change from 104% to 103%

Total patients waiting more than 104 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y	The number of incomplete Referral to Treatment (RTT) pathways of 104 weeks or more at the end of the reporting period.	
Total patients waiting more than 52 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y	The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.	
Total patients waiting more than 78 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	Y	The number of incomplete Referral to Treatment (RTT) pathways of 78 weeks or more at the end of the reporting period.	
18 week Referral To Treatment (RTT) incomplete pathways	Responsive	Director of Operations	Resource & Performance Committee	Latest	92	Bigger is better	N	Proportion of incomplete Referral to Treatment (RTT) pathways within 18 weeks at the end of the reporting period.	
Community Equipment Store - Response within 7 days	Responsive	Director of Operations	Resource & Performance Committee	Avg	95	Bigger is better	N	Proportion of items delivered to a patient within 7 days	Removed KPI as Community Equipment Stores have transferred to another provider
CQC Conditions or Warning Notices	Responsive	Chief Executive Officer	Resource & Performance Committee	Sum	0	Smaller is better	N	CQC Conditions or Warning Notices imposed	
Data Quality Maturity Index	Effective	Director of Operations	Resource & Performance Committee	Latest	95	Bigger is better	N	NHSE Published performance rating the completeness and validity of provider datasets	
Diagnostics for Audio/Ultrasound	Responsive	Director of Operations	Resource & Performance Committee		99	Bigger is better	N	DM01 statutory return - Percentage of patients waiting within 6 week standard	
Number of patients not treated within 28 days of last minute cancellation	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Number of daycase/inpatients cancelled on same day as admission, not treated within 28 days of surgical date	

Proportion of patients within 18 weeks	Responsive	Director of Operations	Resource & Performance Committee	Latest	92	Bigger is better	N	Proportion of patients still on a new waiting list, waiting less than 18 weeks - all services as of end of month	
Total activity undertaken against current year plan	Effective	Director of Operations	Resource & Performance Committee	Sum	100	Bigger is better	N	Proportion of activity delivered against seasonally adjusted plan	
Total patients waiting more than 104 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 104 weeks - all services as of end of month	
Total patients waiting more than 52 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 52 weeks - all services as of end of month	
Total patients waiting more than 65 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 65 weeks - all services as of end of month	
Total patients waiting more than 65 weeks to start consultant-led treatment	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	The number of incomplete Referral to Treatment (RTT) pathways of 65 weeks or more at the end of the reporting period.	
Total patients waiting more than 78 weeks - all services	Responsive	Director of Operations	Resource & Performance Committee	Latest	0	Smaller is better	N	Total patients still on a new waiting list, waiting more than 78 weeks - all services as of end of month	

Month 1 2024/25 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	6 June 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	28 May 2024
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Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance as at month 1 and is for assurance.

2. Executive Summary

2.1. Context

The Trust's 2024/25 Income and Expenditure (I&E) plan is to achieve a surplus of £1,268k; this reflects our financial plan submission to NHS England (NHSE) on 2 May 2024. The Trust's 2024/25 Capital expenditure plan is £3,203k. This paper summarises the Trust's financial performance for the period ended 30 April 2024 against both the I&E and Capital plan. At this early stage of the financial year, only summary information is provided within this report.

2.2. Summary

The Trust is reporting a £69k adjusted surplus for month 1 compared to the planned surplus of £90k, which is an adverse variance of £21k.

Key areas for consideration, at this early stage of the financial year, are:

- **Agency** spend was £496k in April. This is favourable to plan by £196k. Agency remains a key area of external scrutiny, and the Agency Scrutiny Group is focused on reducing agency spend as far as possible, without compromising patient safety. Agency usage will need to remain within planned levels to deliver the financial plan.
- **CIP -** delivery of the Trust's £3,088k recurrent CIP target for 2024/25 remains a significant financial risk. 77% of the full year target is identified to date and teams are working at pace to identify the remainder by the end of May and deliver the CIP target. To deliver our planned financial position for 2024/25, we must deliver our CIP target in full.
- **Elective Income** – The MSST service was introduced in 2023/24 and is expected to be fully implemented in 2024/25. April elective activity information was not available at the time of reporting and it is assumed that activity is in line with our plan, however this remains a financial risk until the activity information is available for review.

Month 1 2024/25 Financial Performance

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position for month 1 is a surplus of £69k compared to the planned surplus of £90k, which is an adverse variance of £21k.
- **Recognise** that agency costs need to remain within planned levels to ensure total pay costs remain within planned levels.
- **Acknowledge** the CIP target for 2024/25 and that plans are not yet fully identified to deliver this level of efficiency.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.

3. Main Report

3.1. Introduction

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

3.1.1. Summary of key points in report

The following dashboard summarises key areas of performance in relation to our financial plan.

Financial Performance against Plan (£k)	M1 Plan	M1 Actual	M1 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Annual Variance
(Surplus)/ Deficit In Year	(90)	(69)	21	(90)	(69)	21	1,268	1,268	0
Agency Expenditure	692	496	(196)	692	496	(196)	4,898	4,898	0
Capital Expenditure				0	0	0	3,203	3,203	0

3.2. Adjusted Financial Performance – adverse variance to plan £21k

The adjusted financial position for month 1 is a surplus of £69k compared to the planned surplus of £90k which is an adverse variance of £21k. Table 1 summarises the position.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(9,996)	(9,995)	1
Expenditure excl. adjusting items	9,906	9,927	21
Adjusted financial performance total	**(90)**	**(69)**	**21**
Adjusting items	11	12	1
Retained (surplus) / deficit	**(79)**	**(57)**	**22**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 30 April 2024

Month 1 2024/25 Financial Performance

3.2.1. Income – adverse variance to plan £1k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	Variance £k
System Income	(7,487)	(7,487)	0
Non system Income	(2,509)	(2,508)	1
Total Income	**(9,996)**	**(9,995)**	**1**

Table 2: Income Summary as at 30 April 2024

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. Month 1 data for elective activity is not yet available therefore income is assumed to be in line with plan, which is a risk until confirmed.

Non system income includes Dudley 0-19 services from 1 April 2024.

3.2.2. Expenditure – adverse variance to plan £22k

Table 3 shows a summary of expenditure, by key categories, incurred in month 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	6,217	6,407	190
Bank	183	195	12
Agency	692	496	(196)
Total Pay	**7,092**	**7,098**	**6**
Supplies & Services Clinical	889	926	37
Prison Escorts and Bedwatch	22	43	21
Drugs	160	162	2
Premises	762	762	(0)
Travel	145	130	(15)
Other	410	415	5
Non-Pay	**2,388**	**2,438**	**50**
Trust wide Central Charges	437	402	(35)
Total Non-Pay	**2,825**	**2,841**	**16**
Total Expenditure	**9,917**	**9,939**	**22**

Table 3: Expenditure Summary as at 30 April 2024

3.2.3. Pay – adverse variance to plan £6k

The overall pay position is a small adverse variance of £6k. Substantive staff in post is currently higher than planned due to the recent successful recruitment into key vacancies, especially the two Rehab and Recovery Units. Agency spend is £196k favourable to plan. Our overall pay costs require continued, careful monitoring to ensure we manage these costs within the available resources.

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

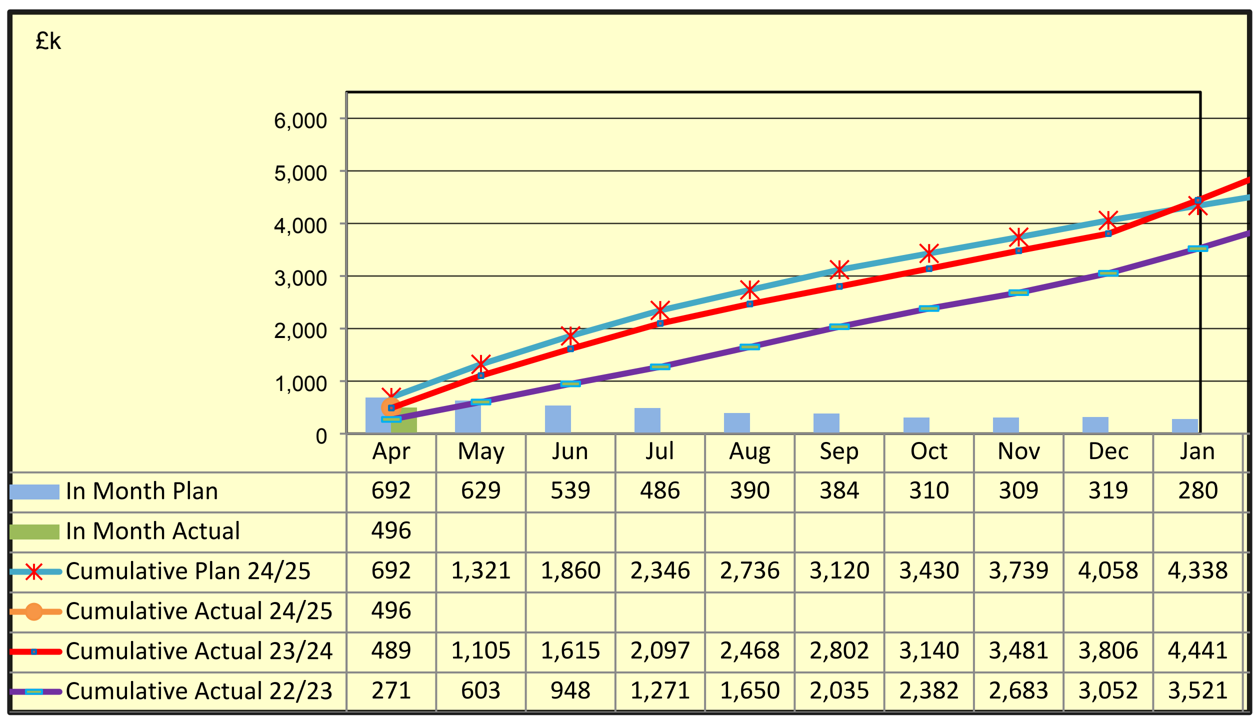
Month 1 2024/25 Financial Performance

3.2.4. Non-Pay and Central Charges – adverse variance to plan £16k

There are currently no material variances to bring to the Board's attention at this time and detailed variance analysis will resume from month 2 onwards.

3.2.5. Agency and Locum Expenditure – favourable variance to plan £196k

Table 4 shows agency spend is £496k in month 1 which is £196k below the plan of £692k.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
In Month Plan	692	629	539	486	390	384	310	309	319	280
In Month Actual	496									
Cumulative Plan 24/25	692	1,321	1,860	2,346	2,736	3,120	3,430	3,739	4,058	4,338
Cumulative Actual 24/25	496									
Cumulative Actual 23/24	489	1,105	1,615	2,097	2,468	2,802	3,140	3,481	3,806	4,441
Cumulative Actual 22/23	271	603	948	1,271	1,650	2,035	2,382	2,683	3,052	3,521

Table 4: 2024/25 Agency and Locum Expenditure – April 2024

Agency spend in April was £496k, a reduction of £265k compared to March's spend of £761k. As shown in Table 4, the agency plan for 2024/25 shows a gradual reduction as the year progresses. A total of 56 WTE agency staff were engaged during April. Agency usage will need to remain within planned levels to deliver the financial plan.

There is continued careful review of all agency usage through the Trust's Agency Scrutiny Group. All agency is for clinical roles, with no agency staff used to support non-clinical areas.

3.2.6. Cost Improvement Programme

The Trust's CIP target for 2024/25 is £3,088k which is 3% of planned expenditure. To date 77% of the full year CIP target has been identified with the aim of identifying 100% by end of May and this work is progressing well.

At this time, there is significant delivery risk in relation to full delivery of the CIP in year and this is overseen by the Trust's Financial Recovery Group, chaired by the Chief Executive, which is now meeting weekly to ensure progress.

To deliver our planned financial position for 2024/25, we must deliver our CIP target in full.

Month 1 2024/25 Financial Performance

3.2.7. Statement of Financial Position

The summarised Statement of Financial Position for period ended 30 April 2024 is shown in Table 6.

	31 Mar 24 Balance £k	30 Apr 24 Balance £k	Movement in Month £k
Property, Plant & Equipment	40,654	43,810	3,156
Inventories	185	185	0
Non-current assets for sale	0	0	0
Receivables	2,846	3,270	424
Cash	19,839	19,970	131
Payables	(8,827)	(9,349)	(522)
Provisions	(3,078)	(3,078)	0
Lease Obligations on Right to Use Assets	(9,870)	(13,003)	(3,133)
TOTAL ASSETS EMPLOYED	**41,749**	**41,805**	**56**
Retained earnings	32,823	32,879	56
Other Reserves	8,926	8,926	0
TOTAL TAXPAYERS' EQUITY	**41,749**	**41,805**	**56**

Table 6: Statement of Financial Position (SoFP) as at 30 April 2024

The increase in Property, Plant and Equipment recognises the additional leases required to provide the new 0-19 services in Dudley.

3.2.8. Capital Expenditure

The plan for 2024/25 is to spend £3,203k on capital and these plans have been agreed with the ICS and submitted to NHSE as part of the Trust's financial plan.

NHSE funding of £700k for digital capital investment is yet to be confirmed. If this is not confirmed during quarter 1 the Capital and Estates Group (CEG) will reprioritise the capital expenditure plans to ensure this high priority capital investment can still be made in 20204/25.

NHSE has issued new business rules which are currently being reviewed and assessed. It is probable that this will result in a reduction in capital allocation to STW in 2024/25 which may then affect Shropcom's capital funding. This risk is being considered by the CEG but it will be challenging to safely reduce planned capital spend at this stage of the year.

IFRS 16 – Capitalising Leases. The risk during 2024/25 and future years is that we can expect constraints on taking on leases to manage IFRS 16 expenditure within the capital plan. The CEG will mitigate this risk by improving its planning and forecasting of costs of taking on future leases.

3.2.9. NHSE Expenditure controls

The triple lock process implemented as an additional control measure by NHSE continues into this financial year. All recruitment and expenditure above £10k (excluding clinical supplies, drugs, utilities, rent and rates) is subject to the process and requires prior approval from the providers, the ICB and NHSE.

Month 1 2024/25 Financial Performance

3.2.10. Forecast Outturn and Financial Risk

A forecast outturn position and key risks to delivery of the financial plan will be included within this report from month 3.

3.2.11. Monthly Monitoring Return

Provider financial returns and forecasts will resume in line with the NHSE timetable.

3.2.12. 2024/25 Financial Planning Return

The Trust's 2024/25 plan submission was approved by the Trust Board on 2 May and submitted to NHSE on the same day. Work is continuing across the system to further improve our system plans. Approval for any proposed changes to our plan will be in line with our governance arrangements.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position for month 1 is a surplus of £69k compared to the planned surplus of £90k, which is an adverse variance of £21k.
- **Recognise** that agency costs need to remain within planned levels to ensure total pay costs remain on plan.
- **Acknowledge** the CIP target for 2024/25 and that plans are not yet fully identified to deliver this level of efficiency.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.

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Planning Update – 2023/24 Operational Plan Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	06 June 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	29 May 2024
Paper Reviewed by:		**Paper Category:**	Planning
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

Purpose of Paper

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

This paper provides an end of year performance update in respect of delivery of our 2023/24 Operational Plan.

2. Executive Summary

2.1. Context

Each year the Trust Board approves our Operational Plan which sets out our strategic priorities for the year ahead. These priorities are the key areas of focus for the entire organisation and describe to our patients, public and our partners where we intend to focus our resources.

We monitor performance against our Operational Plan throughout the year and our Board Assurance Framework considers the key risks in relation to delivery of these strategic priorities.

Our 2023/24 Operational Plan included 3 Strategic Objectives and 8 Strategic Priorities and set out an ambitious programme of delivery.

This update presents the outcomes in relation to delivery of our 2023/24 Plan and learning for the year ahead.

Whilst it was another challenging year for the NHS, both nationally and locally, and not all outcomes have been delivered in full, Shropcom has much to be proud of as we have demonstrated a significant amount of development and transformation with a range of benefits delivered.

2.3. Conclusion

The Board is asked to:

- **Recognise** the good progress made in delivering the Trust's 2023/24 Operational Plan
- **Consider** the benefits delivered to patients, the public and our people through delivering the 2023/24 Operational Plan
- **Acknowledge** the lessons learnt as we prepare to agree the 2024/25 Operational Plan

Shropshire Community Health NHS Trust

Planning Update:

2023/24 Operational Plan Outcomes

Trust Board 06 June 2024

Accountable Director: Sarah Lloyd, Chief Finance Officer

Contents

1. 2023/24 Operational Plan - Context
2. 2023/24 Operational Plan - Delivery
3. Achievements
4. Challenges and lessons learned for 2024/25

Appendix – Benefits Achieved

- Looking After Our People
- Caring For Our Communities
- Managing Our Resources

2023/24 Operational Plan - Context

Each year the Trust Board approves our Operational Plan which sets out our strategic priorities for the year ahead. These priorities are the key areas of focus for the entire organisation and describe to our patients, public and our partners where we intend to focus our resources.

We monitor performance against our Operational Plan throughout the year and our Board Assurance Framework considers the key risks in relation to delivery of these strategic priorities.

Our Operational Plan is developed using feedback from:

- Front-line staff and service leads
- Members of the Board
- National planning guidance
- Partner organisations

2023/24 Operational Plan - Context

Our 2023/24 Operational Plan was summarised in our 'Plan on a Page' format and shared widely. It is shown on the following page and presents:

- Our **Vision**
- Our **3 Strategic Objectives**
- Our **8 Strategic Priorities**

Our 2023/24 Operational Plan was ambitious. It included 121 milestones and outcomes which were designed to deliver our priorities. **This update presents the outcomes of this work and learning for the year ahead**.

2023/24 Plan on a Page

Vision

We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people.

Strategic Objectives	Strategic Priorities
Looking After Our People	**Invest in our workforce** Addressing existing gaps ensuring a compassionate and inclusive culture for all staff.
Caring For Our Communities	**Embed a culture of continuous quality improvement** Ensuring robust systems are in place and actions identified for priority areas.
	Tackle the problems of ill health, health inequalities & access to health care Using data and analytics to redesign care pathways and measure outcomes
	Restore and recover our services Tackling the backlog and reduce long waits.
	Build community care capacity Supporting people to stay well and out of hospital.
	Develop strong partnerships Expanding the range of services provided out hospital settings
Managing Our Resources	**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
	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.

Trust Values

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

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2023/24 Operational Plan – Delivery

2023/24 was another challenging year for the NHS, both nationally and locally, as we focused on recovering from the pandemic.

The Board received an update on delivery of our 2023/24 Operational Plan in February and whilst it was clear that good progress was being made across many of the milestones, a number of areas were delayed.

The Appendix to this report sets out the end of year performance against our Plan and describes the benefits delivered.

Whilst not all of our ambitions were delivered in full, it is clear Shropcom has much to be proud of in terms of delivering a wide range of benefits to patients and our staff.

2023/24 Operational Plan Achievements

Key successes in 2023-24

- **Collaborative Working** with system partners to develop children's community one stop shops and the proof of concept in the South West for Neighbourhood Hubs to support our older population.
- **Digital innovation** including the implementation of Trac, ESR improvements and Healthroster, Patient Virtual Assistant and reintroduction of SMS messaging which are improving efficiencies, releasing capacity and supporting the cost improvement programme.
- **Reduction in hospital admissions** and **improving patient flow** through Dental, Virtual Ward and Rehab and Recovery Units.
- **MSST has gone live**, and work continues to improve outpatient clinic utilisation, enhanced by Patient Initiated Follow Up and virtual consultations.

2023/24 Operational Plan Challenges and Lessons Learnt for 2024/25

Challenges in 2023-24

- Some schemes and milestones in the operational plan are still to be completed and will move to business as usual as they are finalised and embedded.
- System-wide recruitment controls delayed recruitment to key posts required for full delivery of some schemes.
- Conflicting priorities due to diverting capacity to Rehab and Recovery Units, Dudley 0-19, Community Equipment Service transition and EPMA have impacted on some of the delivery schemes.

Lessons learnt for 2024-25

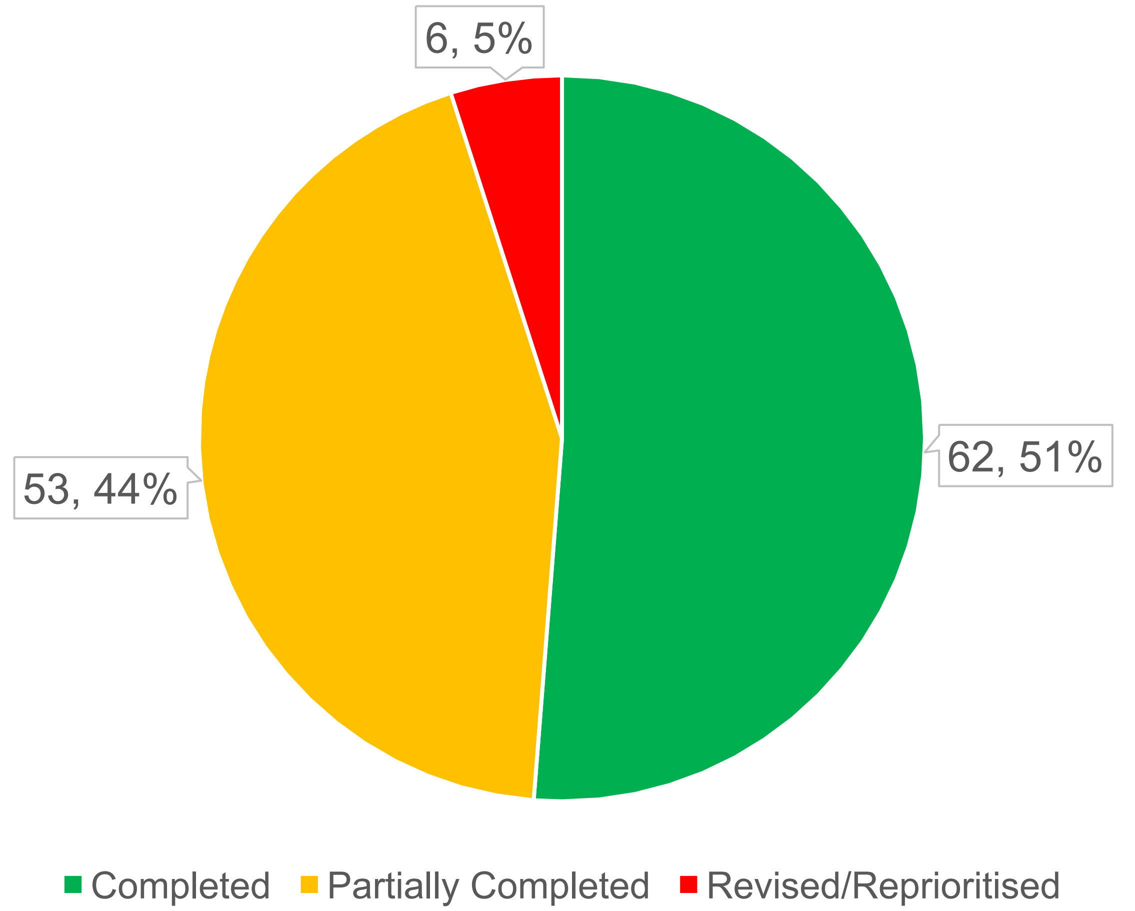
- Recognise the challenging environment within which we operate when considering our plans for 2024-25
- Consider how a reduced number of milestones and outcomes for the 2024-25 Operational Plan will further improve focus and delivery

Recommendation

The Board is asked to:

- **Recognise** the good progress made in delivering the Trust's 2023/24 Operational Plan
- **Consider** the benefits delivered to patients, the public and our people through delivering the 2023/24 Operational Plan
- **Acknowledge** the lessons learnt as we prepare to agree the 2024/25 Operational Plan

Appendix



2023/24 End of Year Performance

- 121 milestones and outcomes were identified and monitored in relation to delivery of our Operational Plan.
- Good progress was made, with 95% of all milestones and outcomes confirmed as completed or partially completed.
- Those which are partially completed have been delayed due to the impact of other projects or recruitment limitations or have become business as usual.
- 5% have been revised or reprioritised and consideration is being given as to whether these are a focus for 2024/25 delivery.

2023-24 Operational Plan RAG Status of Milestones Overall Final Position at 31-03-24

Strategic Objective	Trust Priority	Completed	Partially completed	Revised/ Reprioritised
		Total Milestones & Outcomes due at Q4 end		
	Total	**62**	**53**	**6**
Looking After Our People	Invest in our workforce addressing existing gaps ensuring a compassionate and inclusive culture for all staff	14	6	0
Caring For Our Communities	Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas	16	12	2
	Tackle the problems of ill health, health inequalities and access to health care using data and analytics to redesign care pathways and measure outcomes	4	1	0
	Restore and recover our services tackling the backlog and reduce long waits	7	2	0
	Build community care capacity supporting people to stay well and out of hospital	0	8	0
	Develop strong partnerships expanding the range of services provided out hospital settings	2	2	0
Managing Our Resources	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	7	1	0
	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	12	21	4

The following 8 slides provide further detail of the benefits delivered against each of our Strategic Priorities

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	Delivery Scheme	Completed	Partially completed	Revised/ Reprioritised
	Total	14	6	0
Invest in our workforce addressing existing gaps ensuring a compassionate and inclusive culture for all staff	Develop and implement a 5-year workforce plan and a development programme that builds strong leadership and increases our training and apprenticeship opportunities in order to support a reduction in vacancies and ensure a workforce fit to meet the demands of our patients and progress the implementation of Healthroster.	0	6	0
	Aligned to the NHS People Plan and Promise and linked closely to the cultural development work: identify and implement actions to improve staff experience and engagement, including those identified in our Staff Satisfaction Improvement Plan.	9	0	0
	Recognise and celebrate success and learning from success across all services.	5	0	0

Key Benefits Realised

- **Civility & Respect programme developed.** This will be rolled out Q1 2024/25; Just & learning culture principals embedded in HR policy & processes
- **H&WB days delivered**, supportive sickness absence policy developed & launched, expanded on H&WB offer and trained for delivering H&WB conversations. Sickness absence on a decreasing trend
- **Significant decrease in leavers over the year**. Recruitment and Retention improvement plan in place with majority of actions completed. Some actions ongoing into 2024/25.
- **Improving staff survey results overall.**

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**16**	**12**	**2**
Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas	Implement and embed the new Patient Safety Incident Response Framework (PSIRF) across the Trust	1	0	0
	Continue to deliver quality improvements, identifying learning needs, and supporting staff to enhance pressure ulcer management and reduce inpatients falls.	7	9	1
	Strengthen our use of patient experience information supported by robust governance processes to ensure that we are listening and improving our services.	8	0	0
	Develop and embed robust processes to undertake research and identify areas for clinical developments.	0	3	1

Key Benefits Realised

- **Standardisation of pressure relieving equipment** and Pressure ulcer risk assessments are now being implemented Trust wide. The Patient Safety Incident Response Framework (PSIRF) has been implemented improving patient safety.
- **A record number of Observe and Acts** were carried out in Quarter 4.
- **Our annualised mean incidence of falls per 1000 Occupied Bed Days has reduced,** it was previously 6.41 and now at 4.94. This is below national average.

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**4**	**1**	**0**
Tackle the problems of ill health, health inequalities and access to health care using data and analytics to redesign care pathways and measure outcomes	Promote uptake of vaccinations to improve health and reduce emergency admissions.	2	0	0
	Further develop health inequalities measures and embed "Making Every Contact Count" for all services.	2	1	0

Key Benefits Realised

- **Delivery of just over 125,000 COVID-19 vaccinations to residents in the STW** area during the Autumn/Winter 2023 programme, with percentage uptake at or above national and regional averages.
- **Reduction in paediatric hospital admissions requiring elective and emergency for preventable dental disease**, and concurrent reduction in paediatric GA requirements. Improved oral health for more children as more settings are added to the targeted programme.
- **Reduction in hospital admissions for dental care under general anaesthetic for vulnerable elderly.** Reduction in preventable dental disease.
- **Specialist paediatric dental care now available for the population of STW.**

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**7**	**2**	**0**
Restore and recover our services tackling the backlog and reduce long waits	Aligned to commissioning intentions increase capacity through improved efficiency and new models of care developing robust capacity plans to deliver predicted demand and reduce waiting lists.	3	2	0
	Implement system wide outpatient transformation pathways including increasing patient initiated follow ups, advice, and guidance.	4	0	0

Key Benefits Realised

- **MSST has gone live** and provides a single front door and waiting list for all MSK referrals across the county.
- **The waiting list position and clinic utilisation is improving**, particularly since the reintroduction of appointment reminders through SMS messaging.
- **Further digital innovation is being developed with other partners** to further reduce waiting lists, improve clinic optimisation and enable patients to self-manage their appointments in the future.

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**0**	**8**	**0**
Build community care capacity supporting people to stay well and out of hospital	Improve on the integrated discharge team improvements across STW, further reducing the Length of Stay (LoS) for patients with 'No Criteria to Reside', thereby supporting patient flow across STW, and where appropriate move towards an integrated therapy model.	0	4	0
	Develop care models for sub-acute and post-acute care based on the needs of our population, making best use of our community bed base capacity and community assets and expand community-based services to provide more care and treatments and prevent hospital attendances.	0	1	0
	Continue the planned expansion of the Virtual Ward (as part of our sub-acute care model) to enable patients to receive medical care in their home or usual place of residence, supporting improved outcomes and experience for patients and reducing demand on acute hospital beds.	0	2	0
	Play an active role in working with system partners to develop person centered and proactive models of care for the most vulnerable patients in our community and ensure that these models are embedded in our community services' and working with system partners to develop neighborhood models of care, with a clear focus on the alignment of community staff to geographical localities.	0	1	0

Key Benefits Realised

- Sub-Acute Wards renamed **Recovery and Rehabilitation Units were successfully opened**. They have improved flow and benefits are being seen across the system.

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**2**	**2**	**0**
Develop strong partnerships expanding the range of services provided out hospital settings	Seek opportunities to strengthen links with mental health services including Children and Young People (CYP) Learning Disability and Autism (LD&A) and Special Education Needs and Disabilities (SEND)	1	1	0
	Building on the success of the Oswestry Test and Learn Project and the Brighter Futures Multi-agency Programme, continue to strengthen partnerships and expand services for Children Young People and their Families across Shropshire, Telford, and Wrekin (STW).	1	1	0

Key Benefits Realised

- **Co production and joint working has further developed relationships**. Improved outcomes for early years.
- **One stop shops planned across the County** where early years can access for more joined up support.
- **Early Language Support for Every Child has funded support for high level teaching to support children in schools**, which will reduce the number of clinical referrals. In future, this will reduce clinical waiting lists for children with SLT difficulties.
- **Working towards becoming an Approved Provider**, which will reduce the need for Tenders, through developing healthy professional relationships with Children's Commissioners in Shropshire and Telford and Wrekin.

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**7**	**1**	**0**
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	Building upon the benefits released through Virtual Assistants, Digital Consent and improved agile working technologies, further extend digital channels to give patients better options to access health and social care services and support patients to manage their own health and care.	2	0	0
	Maintain strong systems and processes and strengthen the Trust's cyber security capabilities working with the Integrated Care System (ICS) to optimise our capabilities in this area.	1	0	0
	Develop robust digital training plans to up skill our workforce to maximise the potential associated with digital development made to date and connect with the ICS to enable our staff to drive through a digital first approach to delivering care and offer a greater digital choice for how citizens can access and manage health and care services.	0	1	0
	Supporting implementation of ICS wide Electronic Prescribing and Medicines Administration (ePMA) for hospitals and community services to reduce medicines related errors, waste and to optimise the use of the system medicines formulary	4	0	0

Key Benefits Realised

- **Focussing capacity to support high priority projects** such as RRUs, Dudley 0-19 tender, MSST, CareFlow and EPMA to optimise delivery.
- **Keeping us digitally safe.** Several audits provide assurance cyber security and resilience. Allows SCHT to innovate more digitally as increased opportunity to digitise due to our cyber assurance.
- **Positive feedback from parents for e-Consent** in School Aged Immunisation Service. Full suite of vaccination campaigns now in place.
- **Reduction in pharmacy / medication errors** due to discharge summaries being generated from Rio and Medication database becoming embedded.
- **Empowering patients through pilot for Appointment Management** with Continence Service.

Operational Plan 2023-24 RAG Status Final Position at 31-03-24		Total Milestones & Outcomes due at Q4 end		
Trust Priority	**Delivery Scheme**	**Completed**	**Partially completed**	**Revised/ Reprioritised**
	Total	**12**	**21**	**4**
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	Develop 3-year cost improvement programmes informed by benchmarking intelligence.	4	0	0
	Develop an Estates Plan, which ensures buildings are safe and fit for purpose, and all associated backlog maintenance requirements are priorities and addressed accordingly.	8	13	2
	Support the development of a broader approach to carbon reduction towards Net Zero extending beyond the built environment.	0	8	2

Key Benefits Realised

- **Disruption of services is kept to a minimum for estates planned maintenance** through activity schedules.
- **Estate is being reviewed** to establish requirements of services and develop an estates maintenance and upgrade programme.
- **Coral House building is being updated** to meet the needs of Children's services operating from there.
- **Benchmarking** has informed some CIP schemes throughout the year.

2024/25 National and Local Planning Update

0. Reference Information

Author:	Jonathan Gould Deputy CFO	Paper date:	6 June 2024
Executive Sponsor:	Sarah Lloyd, CFO	Paper written on:	29 May 2024
Paper Reviewed by:	RPC/Board	Paper Category:	Planning
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

Purpose of Paper

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

This paper provides an update on planning for 2024/25 and the progress of plan submissions to the ICB and NHSE.

2. Executive Summary

2.1. Context

At the Trust Board meeting on 2 May, the 2024/25 Shropcom plan including Activity, Performance, Workforce and Finance was approved and this was incorporated into the Shropshire ,Telford and Wrekin (STW) System plan. Both the Shropcom plan and the System plan were submitted to NHSE by the deadline of 02 May.

Further updates are expected to STW system plan following discussions with NHSE in relation to the May plan submission. This work is currently in progress and it may result in further changes to Shropcom's plan. Any required changes will be considered in line with our standard governance arrangements.

2.3. Conclusion

The Board is asked to:

- **Recognise** Shropcom's 2024/25 plan was approved at Trust Board and submitted alongside the STW plan to NHSE on 2 May

- **Acknowledge** that work is underway to review the STW System plan which may result in amendments to Shropcom's own plan and appropriate governance arrangements for approval will be used, if required.

2024/25 National and Local Planning Update

3. Main Report

3.1. 2024/25 Plan Submission

Members may recall that the Trust Board approved the 2024/25 Shropcom plan including Activity, Performance, Workforce and Finance at its meeting on 2 May. The Shropcom plan was incorporated into STW System plan, and both plans were submitted to NHSE to meet the submission deadline of 02 May.

Key headlines from Shropcom's plan are:

- The submitted plan is compliant with NHSE planning guidance, with the exception of our Agency usage percentage. The national requirement is for Agency spend to be no greater than 3.2% of our pay bill; our plan submission is 5.6%. Whilst this is not compliant with the national requirement, our agency usage percentage shows a year on year reduction and is considered to be challenging given the recent introduction of a number of new services.
- The Activity plan remains largely unchanged from 2023/24, with the exception of changes in relation to new services and the full year impact of the new services introduced during 2023/24.
- The performance elements of the plan are compliant with NHSE guidance including in relation to the Urgent and Emergency Care pathway.
- The workforce plan shows a small number of changes in relation to new services and the impact of anticipated efficiencies.
- The financial plan shows an a £1.3m surplus and £3.2m capital spend.

All details of the plan have been reviewed and approved by the Trust Board prior to submission. Performance against the plan will now be monitored each month in Board committees so members can seek assurance of delivery against the agreed plan.

3.2. NHSE feedback on the STW plan

STW continue to work with NHSE in relation to the May plan submission to agree any final changes to plans. Should any changes be agreed, these may affect Shropcom and will be approved through our usual governance processes.

Shropcom has set 2024/25 budgets and performance targets to reflect the plan submitted on 2 May. These may need to be updated if any changes to our plan are agreed over the coming weeks.

3.3. Conclusion

The Board is asked to:

- **Recognise** Shropcom's 2024/25 plan was approved at Trust Board and submitted alongside the STW plan to NHSE on 2 May

- **Acknowledge** that work is underway to review the STW System plan which may result in amendments to Shropcom's own plan and appropriate governance arrangements for approval will be used, if required.

2024/25 Operational Plan

0. Reference Information

Author:	Jonathan Gould Deputy CFO	Paper date:	06 June 2024
Executive Sponsor:	Sarah Lloyd, CFO	Paper written on:	28 May 2024
Paper Reviewed by:		Paper Category:	Planning
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

Purpose of Paper

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

This paper presents Shropcom's 2024/25 Operational Plan for discussion and approval.

2. Executive Summary

2.1. Context

Members of the Trust Board will recall that much of the key content of our 2024/25 Operational Plan has been discussed in previous meetings and board development sessions. This document brings together the outputs from these discussions and presents the Trust's 2024/25 Operational Plan for review and approval.

Our proposed 2024/25 Operational Plan reflects the national NHS priorities as well as the local Shropshire, Telford and Wrekin ICS priorities. It has been developed in conjunction with our teams and supports delivery of our Vision, Strategic Objectives and annual Strategic Priorities.

Our Vision - *We will be at the heart of supporting our communities by providing fully connected services so that everyone gets the right care, in the right place, at the right time, by the right people.*

It is important to set out our plan for the year ahead as this provides a focus for our teams and enables us to monitor progress. The plan presented today is based on information known at this time. We will review our plan if any significant changes occur.

Our plan describes our continued commitment to '**Look After Our People**' including living the NHS People Promise and ensuring we have a compassionate and inclusive culture that embraces diversity.

We will continue to '**Care For Our Communities**' through working in partnership with others to redesign patient pathways and embed quality improvement methodology to improve staff and patient experiences.

We know that we are operating in a financially challenging environment and that we must '**Manage Our Resources**' well and ensure value across the health and care system by maintaining our focus on productivity.

All of the above is supported by strong governance frameworks and processes ensuring both oversight and accountability.

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2024/25 Operational Plan

To ensure robust plans and monitoring are in place, each sub-committee of the Board will be asked to agree specific improvement targets and timescales.

2.3. Conclusion

The Board is asked to:

1. **Approve** our 2024/25 Operational Plan and the key interventions
2. **Request** that each sub-committee of the Board reviews and approves the targets and timescales for the key interventions
3. **Acknowledge** the number of key interventions in the 2024/25 Operational Plan has significantly reduced, reflecting learning from 2023/24

Shropshire Community Health NHS Trust

2024/25 Operational Plan

Message from Patricia Davies, Chief Executive

Welcome to Shropcom's 2024/25 Operational Plan!

This is an important document as it sets out what we will achieve over the next year to benefit our people, our patients and our communities. We will balance operational excellence in our services today, with supporting our workforce to make service improvements for the future and making the best use of our resources. These priorities are aligned to our vision - so everyone gets the right care, in the right place, at the right time, by the right people.

In the year ahead, we will focus on operational improvements – to ensure we are at the heart of supporting our communities by providing high quality, fully-connected services. We will prioritise patient safety; timely access to healthcare; strengthen our urgent care and community services resilience; optimise use of our inpatient beds; and ensure children and young people services embrace a family approach. We will also; increase our focus on preventive actions and improved integration of care; address inequalities in access, experience and outcomes; and continue our journey to becoming a fully inclusive organisation.

We can only achieve all of this with the skills and commitment of the people who work at Shropcom and with the support of our partners. Therefore, we will continue to prioritise the health and wellbeing of our people and focus on engagement and satisfaction, alongside addressing national workforce challenges.

We are ideally placed as a community health provider to support Primary Care, Acute Care, Social care and the voluntary sector and focus on improving health and wellbeing and our plan sets out to do this.

This is an ambitious plan, but it is what our people and our communities deserve, and I am confident we will deliver.

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Our population and patients

Our patients live in Shropshire ,Telford and Wrekin and surrounding areas

Shropshire, Telford & Wrekin

- We provide a range of community-based health services to nearly 511,000 people of all ages in over 40 different locations and in homes across 1,347 square miles of Shropshire, Telford & Wrekin.

Dudley

- We provide community based 0-19 integrated health services to more than 75,000 children and families across Dudley.

Beyond Our Borders

- We also provide clinical services to patients and carers living closely beyond our Shropshire, Telford and Wrekin and Dudley borders.

Shropshire	Telford & Wrekin	STW Totals	Dudley
325, 415 66,266 (0-19)	185,542 45,467 (0-19)	**Population – 510,957**	323,488 75,030 (0-19)
44.9 years	39 years	**Average age**	41 years
101 persons per square kilometre	639 per square kilometre	**Population density**	3,302 per square kilometre
Male 49.5% Female 50.5%	Male 49.2% Female 50.8%	**Gender**	Male 49.2% Female 50.8%

Our Vision and Strategy

We will be at the heart of supporting our communities by providing fully connected services so that everyone gets **the right care**, in the **right place**, at the **right time**, by the **right people.**

We are ideally placed to support and connect Primary Care, Acute Care, Social Care and other Health and Well-being services

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1. Our Operational Plan…..

….is the 'golden thread', that links our vision to our priorities for the year ahead

….provides an overview of how we aim to deliver the best quality patient care through our community services, to the people of Shropshire, Telford & Wrekin, Dudley and beyond

….has been carefully developed in consideration of national, system and local priorities

….was developed over a period of several months, and included valuable input from a broad range of our teams, from frontline staff to board and system partners

….is key for ensuring we optimise the use of our resources and respond to the changing needs of our communities, reducing health inequalities and addressing issues associated with rurality

Our Operational Plan for 2024/25 incorporates views from a wide range of individuals, teams and organisations that work alongside us and especially feedback from those we care for.

2. NHS National Priorities for 2024/25

Each year NHS England sets out operational planning guidance for the year ahead. Shropcom and the Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) must ensure these national priorities are fully considered and addressed in local planning. The three key areas of focus are illustrated below.

NHS England sets out three key focus areas for 2024/25

Recovering core services

Supporting the workforce

Improving productivity

Which are underpinned by…

"Maintaining focus on quality and safety of services, particularly maternity and neonatal services, and reduce inequalities in line with Core20PLUS5"

"Making it easier to access community and primary care services, particularly general practice and dentistry"

"Improving ambulance response and A&E waiting times by supporting admission avoidance and hospital discharge"

"Reducing elective long waits and improve performance against core cancer and diagnostic standards"

"Improving access to mental health services so that more people of all ages receive the treatment they need"

"Improving staff experience, retention and attendance"

Our Operational Plan for 2024/25 reflects the NHS national priorities.

1 2 3 4 5 6 7 8 9 10 11 …

3. Integrated Care System Priorities for 2024/25

We are a partner in the STW ICS. The partners of the STW ICS are responsible for how health and care is planned, paid for and delivered.

Community
NHS Shropshire Telford & Wrekin
Shropshire Council (our Shropshire place)
Telford & Wrekin Council (our Telford and Wrekin Place)
Shrewsbury and Telford NHS Trust (SaTH)
Shropshire Community Health Trust
Robert Jones and Agnes Hunt Orthopaedic NHS FT
Midlands Partnership NHS FT
West Midlands Ambulance Service NHS FT
Primary Care Networks (General Practice)
Healthwatch Shropshire and Healthwatch Telford & Wrekin
Community and Voluntary Sector organisations

Partners of STW ICS

STW ICS produce a Joint Forward Plan (JFP) setting out how best to commission health services from providers in the ICS over the next five years. The STW JFP focusses on 3 key areas:

Area	Focus
Patient-centred approach	•proactive prevention •self-help •population health •tackle health inequalities and wider inequalities
Place-based delivery	•having integrated multi-professional teams •providing a joined approach in neighbourhoods, •supporting our citizens and providing care closer to home
Hospital Transformation	•Providing additional and specialist hospital services

Our Operational Plan for 2024/25 reflects all relevant local priorities.

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

4. Partnerships and Collaborations

Our operational plan reflects our role as a key partner in the STW ICS. We also have a number of partners outside of the STW ICS, as shown below. Together we take collective responsibility for planning services, improving health, and reducing inequalities across geographical areas.

- NHS Shropshire, Telford and Wrekin Integrated Care Board
- Shropshire Council, Telford and Wrekin Council, Dudley Council
- Community and Voluntary Sector organisations
- Ministry of Justice
- Midlands Partnership NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust
- Primary Care Networks - GPs
- Shrewsbury and Telford NHS Trust (SaTH)
- Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
- NHS England

Our Operational Plan for 2024/25 recognises the importance of our partnerships

5. Our culture is essential to delivering our plan

Our Vision:

We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people

Our Culture:

To enable us to deliver our vision and strategy, we need a culture that values:

Agility
We create simplicity to allow us to be responsive at pace to meet the needs of our community - continuously improving and learning as we go

Cohesion
We work together to deliver our services for our community - acting with integrity, inclusivity and transparency

Empowerment
Decisions are made by those with the best information – people have permission to act - safely, quickly and accurately

We Will Embed The Culture Dynamically

We will ensure that the Executive Team and other senior leaders are role modelling the behaviours

1. Define expectations
2. Show people how they rate against those expectations and help them to improve
3. Measure behavioural performance and apply positive and negative consequences

We will ensure that the infrastructure supports and enables those behaviours

High quality, sustainable performance

Our Operational Plan for 2024/25 reflects the importance we place on our culture

6. Our Strategy and Priorities

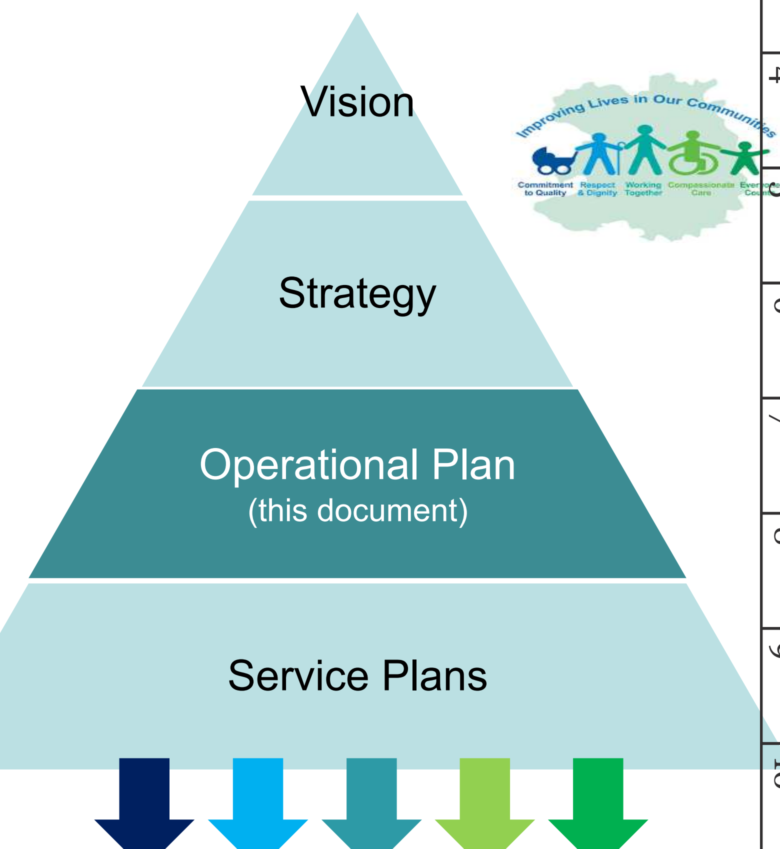
Connecting our vision to our patients

- Our vision - ***'We will be at the heart of supporting our communities by providing fully connected services so that everyone gets the right care, in the right place, at the right time, by the right people.'***

- Our strategy has 3 objectives to support our vision and 8 priorities for 2024/25 (see our 'Plan on a Page' next slide)

- Our Operational Plan includes a number of interventions to ensure we deliver our strategic priorities for 2024/25

- Our Service plans illustrate how patient care will be delivered and continuously improved



Our Operational Plan for 2024/25 connects our vision to improving the care of our patients

7. Our Plan on a page

Vision

We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people.

Strategic Objectives	Strategic Priorities
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive
	We will establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
	We will build a valued and engaged workforce, where health and wellbeing is supported
Caring For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways
Managing Our Resources	We will maximise our productivity and efficiency
	We will use all available digital technologies to modernise our services and our environment

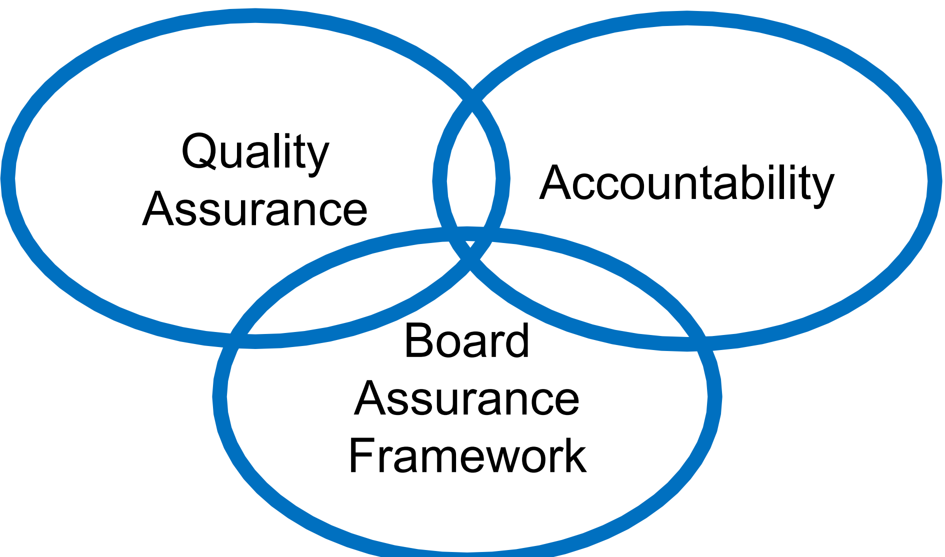
Trust Values

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

Our Operational Plan for 2024/25 includes key interventions that meet our strategic objectives and deliver our strategic priorities. These interventions are explained in the Appendix.

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

8. Governance



Our robust approach to governance has been instrumental for our teams delivering our annual Operational Plans and will continue to ensure the delivery of 2024/25 Operational Plan

8. Governance – Quality Assurance

Our commitment to quality underpins our decisions and our actions. We will focus on the things that matter to people who receive our services and to our teams who provide those services. A continuous quality improvement process supports us to learn and to identify areas for clinical development.

Our quality assurance cycle allows us to assess or evaluate quality; identifying problems or issues with care delivery and to design quality improvement activities to overcome them; followed by effective monitoring to make sure the activities did what they were supposed to.

It is important to ensure that **we have robust processes and frameworks** in place to inform the development and delivery of our plan. It is just as important to ensure that we monitor our performance and outcomes.

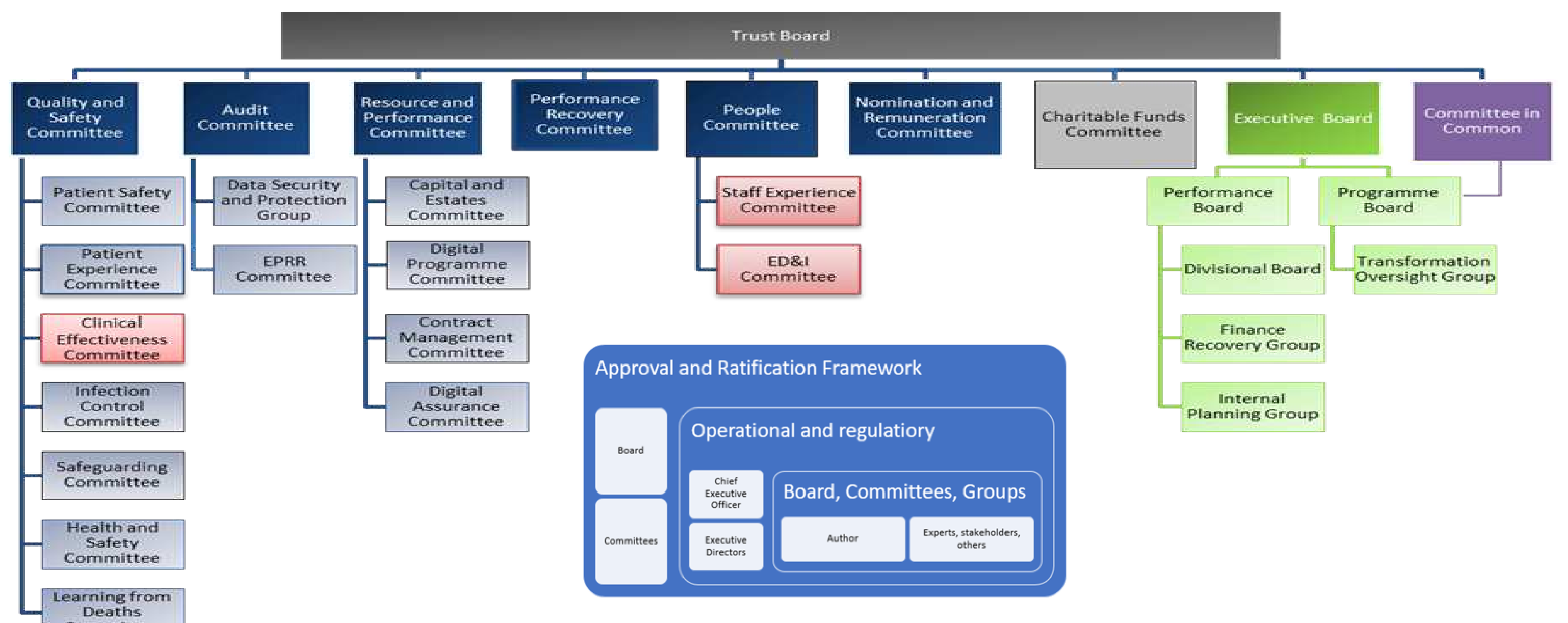
Our Board receives regular performance information relating to patient safety and quality, performance, workforce, and finance. Actions are set out in the Board report, and progress is monitored and reported via the appropriate governance forums, including the Trust Board.

These reports and our wider governance **forums allow us to triangulate information across a range of indicators** and help us to identify and address any issues arising.

Shropshire Community Health NHS Trust

8. Governance – Assurance and Accountability

Operational Plan delivery assurance for the Board is managed through our committee structure



8. Governance – Board Assurance Framework

Our Board Assurance Framework (BAF) is a further element of governance to ensure Operational Plan delivery. Identifying and managing the risks to delivering our plan is at the heart of our BAF

Risk Management plays a key role in informing decision making and is significant for our planning process where public accountability in delivering health services is required. Risk management is the responsibility of all staff and imperative to providing safe quality care for patients.

Responsibility for Risk Management: The Board has overall responsibility for the management of risk and provides leadership by ensuring that we have an effective Risk Management Strategy and clear assurance reporting pathways.

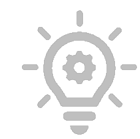
Board Assurance Framework (BAF) brings together in one place all the relevant information on the key risks to the delivery of our Strategic Objectives. Our Board Assurance Framework currently identifies the strategic risks.

Internal Risk Control Systems: We will continue to monitor strategic risks through bi-monthly review of the Board Assurance Framework (BAF) and through receipt of Audit Committee reports providing assurance on the effectiveness of our internal risk control systems.

9. Our services demonstrate success

Our Operational Plan for 2024/25 builds on the success already demonstrated by our services

Systemwide **programmes of work** inc. virtual ward, integrated discharge team and Rehab and Recovery wards



→ **Caring for our communities in the most appropriate way**

First cohort of **international recruits**

→ **Ensuring we have a wider pool of skilled resources**

Continued to successfully deliver our **Covid Vaccination Service**

→ **Preventing escalation to previous levels and keeping our communities safe**

Signing of the **Armed Forces Covenant & Veteran** Aware accreditation

→ **Recognition of dedicated, skilled and valued staff**

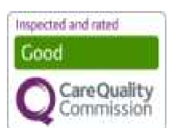
90% of our **staff are residents** within STW

→ **We care for our communities as we live and breathe them every day**

Brighter Futures Network Events with children's services

→ **Backing the Best Start in Life theme, giving our children the best we can**

CQC rating of **Good overall** for its services



→ **Continued recognition of the services we deliver**

Over 2000 patients through virtual ward

→ **Contributing to keeping patients at home where they feel comfortable and safe**

Recognised through **national awards**

→ **Highlighting the work all staff contribute to delivering our offer**

Golden Ticket Awarded to staff

→ **Commitment to retaining an excellent staff base**

9. Our Service Teams

Our Operational Plan for 2024/25 will be delivered by our teams to improve patient care in the following services

Urgent Care and Specialist Services

Rehab and Recovery Units
Virtual Ward

Rapid Response
Minor Injury Units (MIU's)
Integrated Discharge Team
Diagnostics, Assessment, Access to Rehab and Treatment

Single Point of Referral
Outpatient Parenteral Antibiotic Therapy (OPAT) Service
Urgent Care Management

Adult Community Services

Community Nursing
Community Hospital

Wound Care Healing Service
Continence Service
Podiatry

Respiratory Shropshire
Community Neuro Rehab Team
Shropshire Integrated Care Services
Diabetes Service
Advanced Care Planning in Care Homes
Community Services Management
Admiral Nursing
Pulmonary Rehabilitation
Tissue Viability Nurses
Falls Prevention
Management
Oswestry Primary Care Centre
Isle Court Nursing Home

Children and Families, and Planned Care

0-19 Services
Physio and MSK Services

Children's Therapies
Prison Healthcare
Special Care and Access
Community Paediatrics
Outpatient Services
Wheelchair Service

Advanced Primary Care Services
Dentistry, Oral Health Services, PDS Out of Hours
Community Children's Nurses,
Paediatric Psychology, Paediatric Diabetes,
Immunisations and Vaccinations,
Looked After Children,
Child Development Centres, Special Schools Services
Children's Audiology and Asthma Services
Children's Home Respite and Continuing Healthcare,
Paediatric Phlebotomy
COVID-19 Vaccination Service

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

10. Next steps

The Board is asked to:

1. **Approve** our 2024/25 Operational Plan and the key interventions

2. **Request** that each sub-committee of the Board reviews and approves the targets and timescales for the key interventions

3. **Acknowledge** the number of key interventions in the 2024/25 Operational Plan has significantly reduced, reflecting learning from 2023/24

11. Appendix

The following 5 slides provide information about the interventions (actions) that underpin our 2024/25 Operational Plan, summarised in our Plan on a Page shown below

Vision

We will be at the heart of supporting our communities by providing fully connected services - so that everyone gets the right care, in the right place, at the right time, by the right people.

Strategic Objectives	Strategic Priorities
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive
	We will establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
	We will build a valued and engaged workforce, where health and wellbeing is supported
Caring For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways
Managing Our Resources	We will maximise our productivity and efficiency
	We will use all available digital technologies to modernise our services and our environment

Trust Values

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

Interventions

How we will achieve our priorities: Looking After Our People

Looking After Our People	**We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive**
	We will establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
	We will build a valued and engaged workforce, where health and wellbeing is supported

Intervention Title	**Brief description** (of key milestones)
NHS Long term workforce plan – Retain and Transform	• Deliver Civility and Respect programme throughout the Trust. • Deliver Equality, Diversity and Inclusion (EDI) six high impact actions. • Collaboratively deliver Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) Reform and Transform workstream. • Deliver Recruitment and Retention improvement plan actions. • Utilisation of Healthroster to effectively manage our resources. • Grow apprenticeships **Outcomes** - Improve staff Turnover, Improve Sickness Absence, Improve Staff survey results
NHS People Promise Exemplar programme	• Deliver training and development interventions to build compassionate and inclusive leadership capability. • Grow leadership training and development offer. • Establish STW recruitment hub. • Optimise automation of Human Resources (HR) processes. • Evaluation of Healthroster. • Targeted communications to grow workforce bank. **Outcomes** - Improve staff Turnover, Improve Sickness Absence, Reduce use of Agency Staff

Interventions

How we will achieve our priorities: Looking After Our People

Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive
	We will establish the Trust as a great place to work that attracts, trains and retains the best talent to meet the needs of our services
	We will build a valued and engaged workforce, where health and wellbeing is supported

Intervention Title	Brief description (of key milestones)
Culture and Engagement programme	• Promote and celebrate diversity awareness and inclusiveness. • Deliver and embed Ways to Stay. • Deliver actions from the Health and Wellbeing improvement plan. **Outcomes** - Improve staff Turnover, Improve Sickness Absence, Improve Staff survey results
Admin Academy Development	• Review admin function and implement recommendations to ensure we have an admin function that; feels valued and supported; has clearly defined roles and standards; has rewarding career pathways; digitally skilled; embraces digital solutions. **Outcomes** - Improve staff Turnover, Improve Staff survey results

1 2 3 4 5 6 7 8 9 10 11 …

Interventions

How we will achieve our priorities: Caring For Our Communities

Caring For Our Communities	We will support our staff to embed quality improvement methodology to improve staff and patient experiences
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways

Intervention Title	Brief Description (of key milestones)
Learning and Improving Patient Safety and Engagement	• Strengthen our use of patient experience information. • Embed Patient Safety Incident Response Framework (PSIRF) across the Trust. **Outcomes** – Learning From Patient Safety Events (LFPSE) compliance, improve patient engagement
Establishing a continuous quality improvement framework based on NHS Impact	• Review and implement recommendations to establish a continuous quality improvement framework, sharing tools and techniques to empower people to make changes as required. **Outcomes** – Increase staff training and awareness, set a base for avoidable errors to improve upon
Developing and implementing Clinical Quality Strategy	• Implement refreshed three-year Clinical Quality Strategy across the Trust. **Outcomes** – Set a base for avoidable errors to improve upon
Better understanding the needs of our populations	• Make Every Contact Count (MECC) in alignment with Core20Plus5. • Work with rural communities to ensure expansion to meet local needs. **Outcomes** – Target services to make improvements across CORE20PLUS metrics

1 2 3 4 5 6 7 8 9 10 11 …

Interventions

How we will achieve our priorities: Caring For Our Communities

Caring For Our Communities	
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences
	We will recover our services inclusively
	We will work in partnership with others, to redesign patient pathways

Intervention Title	**Brief Description** (of key milestones)
Recovering Elective Services in line with national mandates	• Implement improvements in Referral To Treatment (RTT), referral triage, partnership working, application of productivity and efficiencies. **Outcomes** – Improve DNA, Increase PIFU and virtual consultations
Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	• Review current offer and implement recommendations in collaboration with system partners. **Outcomes** – Improve occupancy and reduce LOS
Continuing to develop our Children and Young People's Services	• Focus on improved productivity to reduce waiting lists within our CYP services • Build on the success with our 0-19 services and seek out opportunities for new business aligned to our strategy as appropriate. **Outcomes** – Increase patient access to our successful services

Interventions

How we will achieve our priorities: Managing Our Resources

Managing Our Resources	**We will maximise our productivity and efficiency**
	We will use all available digital technologies to modernise our services and our environment

Intervention Title	**Brief Description** (of key milestones)
Maximising the sustainability of our Estates	• Review and implement recommendations to optimise the alignment of service demand, location and reducing the Trust's carbon footprint **Outcomes** – Reduce carbon footprint, Improve occupancy
Delivering in-year Cost Improvement Programme (CIP) and a 3-year rolling CIP plan delivery	• Deliver 24/25 CIP. • Implement processes to ensure the 3-year plan is regularly reviewed and updated to maintain a continuous 3-year horizon **Outcomes** – Deliver efficiencies
Automating manual administrative processes to increase productivity	• Promote the benefits of interactive tools for automating systems to save time and resource. • Support corporate and operational teams in developing their automation requirements. **Outcomes** – Demonstrate productivity improvement and freeing up time to care
Implementing 24/7 Single Point of Access (SPoA) through digital, technological and process improvement	• Review and implement recommendations for automation using technology, Artificial Intelligence (AI), including Virtual Assistant, for referrals and triaging in SPoA, Virtual Wards (VW) and 0-19 services **Outcomes** – Improve patient access to Shropcom services
Maximising Return On Investment (ROI) of Electronic Prescribing Management (EPMA)	• Fully implement an EPMA system to maximise ROI and improve prescribing of medicines **Outcomes** – Continuously improve medicine management, Financial improvement

Chair's Assurance Report

Charitable Funds Committee 14th March 2024

0. Reference Information

Author:	Poppy Owens, Executive Assistant	**Paper date:**	
Executive Sponsor:	Alison Sargent Chair of the Charitable Funds Committee	**Paper written on:**	14th March 2024
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	SCHT Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Charitable Funds Committee meeting held on 14th March 2024, for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was quorate.
- The agenda items included:
  - Quarterly Report for Q3 2023/24
  - NHS Charities Together – Covid-19 Appeal Stage 3
  - Approval of Expenditure over £20k
  - Staff Lottery – Funding issues
  - AOB – Legacy for Telford/Southeast Locality Patient Welfare

2.2. Conclusion

The Board is asked to note the Chair's Report for assurance purposes.

Chair’s Assurance Report

Charitable Funds Committee 14th March 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Charitable Funds Committee meeting which met on 14th March 2024. The meeting was quorate with one Non-Executive Director and two Executive Director in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Alison Sargent	Non-Executive Director (Chair)
Sarah Lloyd	Chief Finance Officer
David Court	Head of Financial Accounting
Clair Hobbs	Director of Nursing, Clinical Delivery and Workforce
Poppy Owens	Executive Assistant

Apologies:	

The Committee reviewed the updated actions and noted a number of actions remain open; however progress has been made in most cases. Notably, the Terms of Reference for this Committee are overdue and the Director of Governance is due to present these to the April Trust Board meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
4. Quarterly Report for Q3 23/24		
The Committee acknowledged the total balance of Charitable funds held by the Trust increased during this quarter from £110k to £132k. There are commitments totaling £65k which reduces the fund balance to £66k. The income for the quarter is £39.8k which includes the first payment of the NHS CT Grant of £35.2k and the expenditure for the quarter totals £18.4k. The cash balance as of 31st December was £178k with £2k interest being earnt in this period. **The Committee noted the current financial position on fund balances.**		

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

Chair's Assurance Report

Charitable Funds Committee 14th March 2024

5. NHS Charities Together – Covid-19 Appeal –Update Stage 3		
The Committee noted that £3k has been spent on computers and that the agreed health and wellbeing expenditure is anticipated in the near future.		
6. Approval of Expenditure over £20k		
None presented for approval.	N/A	
7. Staff Lottery – Funding issues		
The Committee acknowledged there has been an agreement moving forward to improve staff engagement for the staff lottery and communications will be issued soon.	N/A	
8. AOB – Legacy for Telford/Southeast Locality Patient Welfare		
The Committee heard the 22/23 annual accounts and report were submitted on time to the Charity Commission in January. Confirmation has also been received that we are no longer in the NHSCT membership.	N/A	

3.4 Approvals

None.

3.5 Risks to be Escalated

In the course of its business the Committee did not identify any risks that required escalation. However the Committee would welcome a discussion with Board Members, as the Corporate Trustee, in relation to its appetite to move towards active fundraising for the Trust's Charitable Funds.

4. Conclusion

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

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

Chair’s Assurance Report

Charitable Funds Committee 16th May 2024

0. Reference Information

Author:	Poppy Owens, Executive Assistant	**Paper date:**	
Executive Sponsor:	Alison Sargent Chair of the Charitable Funds Committee	**Paper written on:**	16th May 2024
Paper Reviewed by:	Sarah Lloyd Chief Finance Officer	**Paper Category:**	Governance
Forum submitted to:	SCHT Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Charitable Funds Committee meeting held on 16th May 2024, for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was quorate.
- The agenda items included:
  - Quarterly Report for Q4 2023/24
  - NHS Charities Together – Covid-19 Appeal Stage 3
  - Approval of Expenditure over £20k – Bridgnorth Cystoscopes LoF (£191k)
  - General – Separate Fund for Dying Well funding

2.2. Conclusion

The Board is asked to note the Chair’s Report for assurance purposes.

Chair's Assurance Report

Charitable Funds Committee 16th May 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Charitable Funds Committee meeting which met on 16th May 2024. The meeting was quorate with one Non-Executive Director and two Executive Director in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Alison Sargent	Non-Executive Director (Chair)
Sarah Lloyd	Chief Finance Officer
David Court	Head of Financial Accounting
Clair Hobbs	Director of Nursing, Clinical Delivery and Workforce
Poppy Owens	Executive Assistant
Apologies:	**None received**

The Committee reviewed the updated actions and noted a number of actions remain open; however progress has been made in most cases. The Terms of Reference for this Committee are overdue and there is further work being completed on this currently.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
4. Quarterly Report for Q4 23/24		
The Committee acknowledged the total balance of Charitable funds held by the Trust increased during this quarter from £132k to £172k. There are commitments totaling £35k which reduces the fund balance to £137k. The income for the quarter is £97.5k which includes donations of £12.3k and the expenditure for the quarter totals £56.9k. The cash balance as of 31st March 2024 was £182.7k with £2.5k interest being earned in this period. **The Committee noted the current financial position on fund balances.**		

Chair's Assurance Report

Charitable Funds Committee 16th May 2024

5. NHS Charities Together – Covid-19 Appeal –Update Stage 3		
The Committee heard there has been progress and the equipment is now available. There will be a further meeting in December to agree release of the balance of the NHSCT funding (20%).		
6. Approval of Expenditure over £20k – Bridgnorth Cystoscopes LoF (£191k)		
The Committee requires clarification on the whether this is a replacement or additional item of equipment and evidence of meeting the conditions within the League of Friends (LoF) letter prior to purchase. The Committee approve the purchase of Cystoscopes subject to the circulation of the supporting documents.		
7. General Fund – Separate Fund for the Dying Well Fund		
The Committee agreed Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce will become the authorised signatory for the Dying Well fund.		

3.4 Approvals

The Committee approve the purchase of Cystoscopes subject to the circulation of the supporting documents. Virtual confirmation to proceed will be given on receipt of the required supporting information.

3.5 Risks to be Escalated

In the course of its business the Committee did not identify any risks that required escalation. However the Committee would welcome a discussion with Board Members, as the Corporate Trustee, in relation to its appetite to move towards active fundraising for the Trust's Charitable Funds.

4. Conclusion

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

Chair's Assurance Report

Audit Committee – May 2024

0. Reference Information

Author:	Stacey Worthington	**Paper date:**	6 June 2024
Executive Sponsor:	Shelley Ramtuhul, Director of Governance	**Paper written on:**	28 May 2024
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit Committee meeting held on 22 May 2024 for assurance purposes. The Audit Committee is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

The Committee met on 22 May 2024 and was quorate with 3 Non-Executive Directors and 2 Executive members attending, along with other attendees. The Committee considered several items on the agenda, as outlined below. Members had the opportunity for a full and detailed discussion of each item and made recommendations as required. Details on assurance levels received can be seen within the main report.

2.3. Conclusion

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

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Chair's Assurance Report

Audit Committee – May 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Audit Committee which met on 22 May 2024. The meeting was quorate with 3 non-Executive and 2 Executive members. A full list of the attendance is outlined below:

Chair/ Attendance:	
Harmesh Darbhanga	Chair – Non-Executive Director
Peter Featherstone	Non-Executive Director
Jill Barker	Non-Executive Director
Sarah Lloyd	Director of Finance
Shelley Ramtuhul	Director of Governance
Stacey Worthington	Executive Assistant / Corporate Office Manager (Minute Taker)
Apologies:	
Cathy Purt (Non-Executive Director) and Clair Hobbs (Director of Nursing)	

3.2 Actions from the Previous Meeting

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

Agenda Item / Discussion		Assured (Y/N)	Assurance Sought
3.	**Declarations of Interest** None declared.	N/A	
4.	**REVIEW OF THE ACTION LOG** The Committee reviewed the action log and noted the actions that could be removed. Review of Directorate Risk Registers –an update on Medicines Management to be bought to the next meeting Business Continuity Audit – regular update reports to continue to be provided to the Committee	FULL	
5.	**EPRR Update** The Committee accepted the verbal updates noting that the BAF would be presented at the committees	PARTIAL	**Continued updates on the progress of compliance**
6.	**BAF ASSURANCE**	FULL	

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Chair’s Assurance Report

Audit Committee – May 2024

	The Committee accepted the report and noted that the Trust was making good progress but that there was still further work to do.		
7.	**RISK MANAGEMENT UPDATE** The Committee accepted the update and assurances provided.	N/A	
10.	**ANNUAL COUNTER FRAUD REPORT 2023** The Committee heard of the work undertaken, including the new e-learning and compliance rates. The Committee noted the upcoming work on purchases without a Purchase Order.	FULL	
11.	**ANTI-FRAUD PLAN 2024/25** The Committee received the plan.	FULL	
12.	**INTERNAL AUDIT REPORTS** The Committee reviewed and discussed the internal audit reports, following on from the discussion earlier in the agenda on Business Continuity.	PARTIAL	
19.	**EXTERNAL AUDIT PROGRESS REPORT** The Committee noted that planning for next year was underway and that work was progressing well on completion of last years audit.	FULL	

4. Risks to Escalate

There were no risks to escalate.

5. Conclusion

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

Provider Licence Declaration

0. Reference Information

Author:	Shelley Ramtuhul, Director of Governance	**Paper date:**	6 June 2024
Executive Sponsor:	Patricia Davies, Chief Executive	**Paper written on:**	30 May 24
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 2024 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**.**

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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.

The NHS Oversight Framework (NOF) bases its oversight on the Licence and 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 2024/25)

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. NHS England 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 the self-certification to NHS England, but they may 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 2024

Note: References in the License to Monitor now refer to NHS England 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 NHSE/regulators with information they require and quality assure it • Performance and Quality reporting measure included in local Performance Framework. • Records of meetings with NHSE and other regulators 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	• 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 deputies	• 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 and recently reviewed and updated in light of new FPPT Framework.
G5: Monitor guidance	Have due regard to guidance issued by Monitor	• Regular horizon scanning for new guidance by means including NHSE 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 NHS E 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.	• 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 NHSE; 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 make choices	Requires trust to inform patient when they have a choice and where to find such	• Trust web site information • Use of RAS and TRAQs which facilitate patient choice where applicable

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

Provider Licence Declaration

	information regarding their choices	
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 financial management	Trust must have due regard to adequate standards	• Full range of systems of corporate governance and control, as described in Trust Annual Governance Statement • Internal and external audit outcomes • Oversight by Audit Committee • NHSE oversight rating with plan in place to address any areas of concern

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 2024

	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 shortly.
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.	• Horizon scanning mechanisms to review NHSE guidance, then reflected in CEO's Reports, and Governance Reports, to each Board meeting in public • Records of monthly meetings with NHSE and ICB • Regular engagement with NHSE and ICB over local arrangements and issues eg sustainability process and associated governance
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 NHSE 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 NHSEs Framework was carried out by GGI in 2022.

Shropshire Community Health

NHS Trust

Provider Licence Declaration

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.	• 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, 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 2019 with rating of Good • 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 • Range of systems for escalating and resolving quality
	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.	The Quality and Safety Committee oversees any quality issues including risk management; Incident investigation and lessons learned review meetings; complaints, 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. • Enhanced governance structure approved and in the process of being implemented with a new Associate Director of Governance in place. • Quality team in place and clinical leads for quality and supporting staff

Shropshire Community Health
NHS Trust

Provider Licence Declaration

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 which has been updated following introduction of the new FPPT framework in 2023 • 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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Shropshire Community Health NHS Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" Financial Year to which self-certification relates: 2024 — Please Respond

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.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Shropshire Community Health NHS Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2024

Please complete the explanatory information in cell E36

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)

	Statement	Response	
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:

	Statement	Response	
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.		Please Respond

OR

	Statement	Response	
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.		Please Respond

OR

	Statement	Response	
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.		Please Respond

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	**Capacity**	Chair
Date	06 June 2024	**Date**	06 June 2024

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.