Shropshire Community Health NHS Trust

Public Trust Board - 1 August 2024

MEETING

1 August 2024 10:00 BST

PUBLISHED

29 July 2024

Agenda

Location	Date	Time
Oswestry Memorial Hall	1 Aug 2024	10:00 BST

	Item	Owner	Time	Page
1	Welcome	Chair	10:00	-
2	Apologies and Quorum	Chair	10:02	-
3	Declarations of Interest	Chair	10:04	-
4	Minutes from the previous meeting	Chair	10:06	6
5	Action Log	Chair	10:11	15
6	Patient Story	Chair	10:12	-
7	Chair's Award	Chair	10:22	-
8	Chair's Communication	Chair	10:32	16
9	NEDs Communication	NEDs	10:37	-
10	Notification of Any Other Items Of Business (with prior approval of the Chair)	Chair	10:42	-
	Strategic			-
11	Chief Executive's Update	Chief Exeuctive	10:47	18
	Quality & Safety			-
12	Quality & Safety Committee Chair's Report (verbal)		11:02	-
13	Integrated Quality and Safety Performance Report	Director of Nursing	11:07	29
14	Quarterly Mortality and Learning From Deaths Review	Medical Director	11:17	47
15	Annual Report - Infection Prevention and Control	Direction of Nursing	11:22	66
16	Maintaining focus and oversight on quality of care and experience in pressurised services	Director of Operations	11:32	97
17	IPC BAF	Director of Nursing	11:47	-
	People			-
18	People Committee Chair's Report (verbal)		11:52	-

	Item	Owner	Time	Page
19	Culture Report	HR Director	11:57	143
	Resource & Performance			-
20	Resource and Performance Committee Chair's Report		12:12	166
21	Integrated Performance Report	Director of Finance	12:17	172
21.1	Performance Framework			201
22	Finance Report	Director of Finance	12:27	224
23	2024/25 Planning Process	Director of Finance	12:37	233
	Audit			-
24	Audit Committee Chair's Report (verbal)		12:47	-
25	Board Assurance Framework	Director of Governance	12:52	240
26	Board Development 24-25		13:02	261

Contents

Shropshire Community Health NHS Trust

MINUTES OF THE PUBLIC BOARD MEETING

HELD AT THE RAMDA HOTEL, TELFORD AT 10AM ON THURSDAY 6 JUNE 2024

PRESENT

Chair and Non-Executive Members (Voting)	
Ms. Tina Long	(Chair)
Mr. Peter Featherstone	(Non-Executive Director and Vice Chair)
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)
Executive Members (Non-Voting)	
Ms. Claire Horsfield	(Director of Operations and Chief AHP)
Ms. Shelley Ramtuhul	(Company Secretary/Director of Governance)
Ms. Rhia Boyode	(Director of Human Resources)
In attendance	
Ms. Stacey Worthington	Executive Personal Assistant (to take the minutes of the meeting)
Ms. Sara Ellis-Anderson	(Deputy Director of Nursing and Quality and Deputy DIPC)
Ms. Tracie Black (Part, Remote attendance)	(Associate Director for Workforce, Education & Professional Standards)

Welcome and Chair's award

Ms Long welcomed all to the meeting and noted that this was a meeting of the Board held in public.

The Chair advised that today was the 80th anniversary of the D-Day landings and, as a mark of respect, a minutes silence was held in remembrance.

Ms Long presented the following Chair's Awards:

The ICP Team
They had been nominated by Clair Hobbs for:
Our IPC Team are small but cover a wide range and workload continuously throughout the year. They work so well as a team and take great pride and professionalism in everything they do. I always receive positive feedback form our clinical colleagues on the support they offer and recently their flexibility and hard work to improve IPC standards and compliance and assurance to me as DIPC within our new Rehab and recovery Units has been exceptional. They are always flexible in their approach and are extremely visible across our services. Management of outbreaks is always slick and timely and I am very proud to say the Team along with Sara have ensured all of our IPC policies have been reviewed and are up to date.

Sara Ellis-Anderson
Who had been nominated by the Quality Team, Safeguarding Team and the IPC Team:
in the short time she has been in post she has made a massive impact on our teams, the wider teams in the Trust and us as individuals. She has gone over and above to ensure safe, quality care and support for patients. Taken time to listen and understand ways of working, improvements that can be made whilst also supporting staff to overcome barriers and looking after staff wellbeing. She has also supported the establishment and ongoing implementation of new services. She is a role model and influencer for all, she consistently leads by example and has demonstrated active clinical support when it has been needed most.

Karen Pountney
Who had been nominated by Amanda Hall:
In addition to being the most inspirational, kind, caring, passionate and humble manager, I do also believe that she fits perfectly within the first two targets you shared for the year ahead within your weekly news on 09.04.24:

1. More innovation to deal with the challenges – the best, most productive and most cost-efficient care is that which is as close to home as possible and that's us.

2. Continuing the drive to deliver great 0-19 services which we are experts in.

Karen absolutely supports innovation within our 0-19 public nursing service, she is the driving force behind our success and integral to every aspect of it.

I feel really privileged to work with Karen and really hope her hard work and commitment can be acknowledged with a chair's award.

Apologies and Quorum

Apologies were received from Ms Clair Hobbs, Director of Nursing and Mr Harmesh Darbhanga, Non-Executive Director.

Declarations of Interest

Ms Purt advised that her husband has recently been appointed as the Interim Chair of the Shrewsbury and Telford Hospitals Trust and would take up the post in the following week.

Mr Featherstone informed that he had recently been appointed as a Non-Executive Director of the Dudley Group NHS Foundation Trust.

Ms Barker declared that she had been appointed as Vice Chair of The Movement Centre, Children's Charity.

Ms Ramtuhul advised she was providing tutoring in governance.

Dr Ganesh stated that he had been appointed as interim Chief Medical Officer at the ICB, alongside Dr Chan.

Minutes of the Meeting held on 3 April 2024

Ms Barker clarified that under item of Non-Executive Director Communication, Professor Witty's report had been discussed at the meeting. The minutes were agreed as an accurate record of the meeting.

Notification of Any Other Item of Business

There was none.

Chair's Report

Ms Long stated that she had recorded a short video for a Schwartz round, and she encouraged the Board to attend one. A positive development session had been held relating to the Committees in Common with actions to progress.

The Chair in Common post was currently live and Ms Long believed there would be great benefits to both organisations in terms of collaboration and integration

The Board noted the report.

Non-Executive Director's Communication

Ms Purt advised that the next meeting of the ICB's Strategy Committee would be in its new format; focusing on strategic commissioning and primary care commissioning.

Mr Featherstone advised that he had attended the ICS System Finance Committee. He had also visited Stoke Heath Prison and was pleased to hear that relationships had improved, the staff were very complimentary of the new ways of working.

Patient Story

The Chair welcomed representatives of the Children's Asthma Service, Laura Scott, Kate Perkins and Kate Medhurst, to the meeting.

The Children's Asthma Service provided the Board with a short presentation on the service. Shropshire, Telford and Wrekin (STW) had been identified as an outlier for asthma care. The project had launched in September 2022, funded by monies from NHSE and the ICB and had recently been extended for a further 12 months.

The programme had been multifaceted. The team had engaged with 42 GP practices and had contact with over 100 children and young people. The vital 8 week follow up appointments had been undertake by the team and was now an integrated part of the service provision. Over 70% of STW schools had been accredited as asthma friendly.

Ms Long stated this was an excellent example of advanced practice. Mr Featherstone asked about the reasons behind the previously poor outcomes, Ms Perkins advised that some were in well known areas of deprivation, there was some poor general health literacy and engagement from the GPs had been very good.

Ms Lloyd asked about funding, Ms Medhurst advised that they were waiting to see if there was to be central funding of children's asthma services, Ms Lloyd offered to link with the team to see if there were other options of funding available.

A discussion took place regarding the clinical coding of asthma and that it was, nationally, not consistent. The Board were informed that the aim of the service was to reduce the readmission rate to secondary care, and that there had been only very small number of readmissions.

Ms Purt asked about the remaining 30% of schools and what was being done to encourage them to become asthma friendly, Ms Perkins assured the Board that this was being worked through.

The team advised that the results of the pilot project were due to be published shortly.

Chief Executive Update

Ms Davies advised that the recruitment of a Chair in Common was underway, and that Ms Long would remain Acting Chair throughout the interview process. Ms Davies thanked Ms Long for Chairing in the past 18 months.

Ms Davies noted that the decision to reopen the inpatient beds at Bishops Castle Community Hospital had been made at the last meeting of the Board. It was noted that other services had continued at the site and the Trust was looking at expansion of further services at the hospital.

The Trust was in the midst of the annual planning round and it was noted that Urgent and Emergency Care continued to be a significant challenge in STW. ShropCom was continuing to support the System with its work on Virtual Wards and the Rehabilitation and Recovery Units (RRU), which were having a demonstratable impact on admission rates to secondary care.

With regard to recruitment, the campaign at Bishops Castle had been hugely successful, as had the RRU, with 100% recruitment at the Princess Royal site and 90% at the Royal Shrewsbury. The Trust had celebrated International Nursing Week. Ms Davies congratulated a member of staff, physiotherapist Anita Evans, who had achieved four silver and a gold medal at the White Water Rafting World Championships.

The Board noted the report.

QUALITY, SAFETY AND PEOPLE

Quality and Safety Committee Chair's Report

Ms Barker summarised the report and highlighted that the complaint response was now 100% and that the Committee had asked for a further, in depth review of pressure ulcers.

The Board accepted the assurance provided by the update.

Quality and Safety Report

Ms Anderson-Ellis summarised the report.

Ms Long stated she was pleased that there had been a sustained reduction in falls and noted that since the removal of the escalation areas at Whitchurch, which were non-compliant with standards, the number of falls had dropped, showing the importance of space.

Mr Featherstone welcomed the report and asked what the key factors were in the improvement. Ms Horsfield said it had been many different things but importantly, the staff that were in place.

The Board reviewed the proposed Key Performance Indicators and approved the measures within the report.

Quarterly Mortality Learning from Deaths Review

Dr Ganesh summarised his report; there had been 15 deaths in the last quarter, similar to previous years. All the deaths had been expected, bar one, which had been deemed explainable. None of the deaths were a patient with autism or a learning difficulty.

The Board
- ***Noted the report and the themes detailed***
- ***Agreed the full assurance provided by the report.***

Annual Quality Accounts

Ms Ellis-Anderson advised that the Quality Accounts had been reviewed by the QSC and the requested acronym list had been included. Subject to Board approval, the Quality Accounts would be submitted to NHSE.

The Board approved the report and recommended it be submitted to NHS England.

Annual Report – Research & Development and Clinical Effectiveness

Dr Ganesh advised there had been 23 audits completed and the Trust had participated in national audits, ensuring that learning was implemented within the Trust. The Trust was very active with research and a paper from one team had recently been published and nationally accepted.

The Board requested a presentation on research at a future Board meeting.

Ms Purt praised the level of research done by the Trust and suggested that our research achievements be shared widely across the System. Ms Davies advised that the Trust were part of the West Midlands Research Network.

The Board
- ***Received and accepted the report, as assurance around implementation of the Clinical Audit and NICE guidance programmes.***
- ***Accepted the Research and Innovation Update.***

Quality Improvement Framework

Ms Ellis-Anderson outlined the report. The report set out the Trust's ambitions for the upcoming 12 months. It was noted that training was being provided to staff on the framework.

The Board approved the Framework document.

Bi-Annual Review of Safer Staffing

Ms Black summarised the report and noted that the Trust now had three clean sets of data, however, due to the opening of the RRUs, it was recommended that further data sets were required before any changes were made.

Ms Purt asked about the introduction of the E-Roster System and how it had been received by staff. Ms Black advised that the system had been introduced at different times in different areas so staff were aware of the system, many staff members had also used the system in previous Trusts and had found it very useful.

Mr Featherstone welcomed the report and noted that the report was very clear, he asked about benchmarking of care hours per patient day. It was noted that care hours was just one element used in safer staffing and noted that it did not include staffing from other professionals, such as AHPs. It was requested that some triangulation of this data was provided to the QSC for assurance.

The Board reviewed the information in the report and accepted that there was a moderate level of assurance for safer staffing within the Community Hospitals.

BCCH Mobilisation Plan

Ms Horsfield advised that the paper summarised the governance in place to over see the reopening of the inpatient beds at Bishops Castle. The work would be completed in a phased approach, with staff beginning work at the start of July 2024, with a two week period of induction and training, with 15 July the beginning of the phased opening to patients.

Ms Sargent asked about stakeholder communication, Ms Davies assured the Board that stakeholders had been kept informed and that a regular report goes out to them.

Ms Long thanked the community for their hard work on getting these beds reopened.

The Board accepted the report as full assurance that there is a detailed mobilization plan and governance for oversight of delivery f the plan to reopen the in-patient beds at BCCH in July.

PEOPLE

People Committee Chair's Report

Ms Boyode advised that the committee had discussed the operational workforce plan and discussed the metrics that the Trust needed to focus on. The Committee had also had discussion on the staff survey and culture.

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

Integrated People Performance Report

Ms Boyode noted the operational workforce plan and noted that the Trust needed to be clean on the Key Performance Indicators that it would consider progress against.

The Board noted the report.

RESOURCE & PERFORMANCE

Resource & Performance Committee Chair's Report

Mr Featherstone stated that the meeting had been very productive; there were 9 items which required further attention and actions had been put in place to address these. There was strong reporting around waiting times. The auditor had reviewed the CIP actions and delivery and the Trust had received substantial assurance.

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

Integrated Performance Report

Ms Lloyd advised that the reports summarised the Trust wide position. There were currently 29 KPIs which were off track; each Committee had reviewed their KPIs and set action plans to address any outstanding. It was noted that of the RPCs 9 off track KPIs, 8 related to waiting times and the action plan for this was appended to the report. Due to the remaining issues from Covid, benchmarking was hard to achieve, and, although the Trust was not meeting the target, it was performing better than peers. The Trust would not be complacent and would continue to work hard on reducing the waiting times.

The Board

- ***Considered the Trust's performance to date and the actions being taken to minimize risk and improve performance where required.***
- ***Considered the development of action plan reporting and if any amendments were required in order to provide adequate assurance to the Board in relation to actions being taken to improve performance.***

Performance Framework – Integrated Performance Reporting Update 2024/25

Ms Lloyd noted that it was good practice to review the framework and KPIs at regular intervals to ensure that they were correct. Each Committee had reviewed its KPIs for the year ahead and each had put forward a list of KPIs for approval.

There were two sets of measures; one was national requirements which were subject to amendment by NHSE and local requirements, which would be agreed by each Committee.

For RPC, the Committee had requested an additional KPI around occupancy on Virtual Wards, which was supported by the Board.

For People Committee, the Committee had requested reducing the KPI on appraisals from 95% to 90%. Ms Boyode explained the reasoning behind this, noting that the reduced target was realistic and aligned with other Trusts, there would always be staff who were not able to complete appraisals, for example those on long term sickness absences or on maternity leave. Ms Boyode noted that quality appraisals were important. Ms Barker noted that the Committee had a detailed discussion on this and she was comfortable with the recommendation.

Ms Davies stated that it seemed counter-intuitive to change the KPI but Ms Boyode's approach was realistic and that quality appraisals were vital. Ms Barker noted that the Trust was an outlier in terms of a 95% KPI.

Dr Ganesh noted the message that reducing the target sent to staff and recommended that instead the Trust focus on the teams with the lowest appraisal rates and supported them to increase these. Ms Boyode agreed this was a risk but the strategy would explain the mitigations and reasoning.

Mr Featherstone suggested a 'tolerance' approach, with a target of 95% but a tolerance of 90%, which was supported by the Board. The Board agreed that the target on the dashboard would be set at 90% but would be inline with the tolerance approach.

Ms Lloyd stated that the People Committee had also recommended an increase in the sickness absence rate target from 4.5% to 5%. Ms Boyode explained about the impact on staff culture and the Board agreed to amend the target, taking into account the tolerance approach.

Finance Report

Ms Lloyd presented the Month 1 Financial report and noted that there were a lot of estimates within the report due to the time of year. The Trust was broadly on track, with a small adverse variance of £21k. Agency rates were already below plan which was good news.

The System would have a reduced capital allocation of around 10% and System partners needed to agreed how this would be allocated, Ms Lloyd noted that this was a risk to the Trust and the impact was unknown.

Ms Purt noted the disappointing System investment in digital, which was desperately needed.

The Board

- ***Considered the adjusted financial position month 1 is a surplus of £69k compared to the planned surplus of £90k which is a adverse variance of £21k***
- ***Recognised that agency costs need to remain within planned levels to ensure total pay costs remain within planned levels***
- ***Acknowledged the Trust's CIP target for 2024/25 and that plans are not yet fully identified to deliver this level of efficiency***
- ***Considered if any additional actions were required in respect of the Trust's financial performance and monitoring arrangements.***

Planning Update

2023/24 Operational Plan Performance

Ms Lloyd advised that the reports updated on the 2023/24 operational plans and noted that what the teams had delivered was incredible. The plan was challenging and made in difficult circumstances but 95% of what had been set out had either been delivered or was a good way to being delivered. There had been real benefits from this work to patients, families and staff. Ms Lloyd congratulated all staff on what they have delivered.

Ms Davies noted that the System was particularly challenged, and the Trust had continued to be innovative and led projects.

Ms Long asked how this would be communicated to staff, Ms Lloyd stated that briefings had been prepared and that there was a programme of Executive Team visits. Ms Davies suggested a provider conference be considered.

The Board
- ***Recognised the good progress made in delivering the Trust's 2023/24 Operational Plan***
- ***Considered the benefits delivered to patients, the public and our people through delivering the 2023/24 Operational Plan.***
- ***Acknowledged the lessons learnt as we prepare to agree the 2024/25 Operational Plan.***

2024/25 National and Local Planning

Ms Lloyd advised that this report pulled together information that had previously been shared. A further version of the plan was due shortly which would be bought to Board.

The Board
- ***Recognised ShropCom's 2024/25 plan was approved at Trust Board and submitted alongside the STW plan to NHSE on 2 May***
- ***Acknowledged that work was 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 ShropCom Operational Plan for Approval

Ms Lloyd stated this was an important document, which set out what the Trust wanted to achieve. There had been reflection and learning from last year and the plan had been produced with teams, following a series of workshops. A summary plan on a page had been produced.

Ms Long noted that the document was easy to understand. Ms Purt asked about digital services and resourcing for this. Ms Lloyd agreed this needed to be looked at and each Committee would need to review.

The Board
- ***Approved our 2024/25 Operational Plan and the key interventions***
- ***Requested that each sub-committee of the Board reviews and approves the targets and timescales for the key interventions***
- ***Acknowledged the number of key interventions in the 2024/25 Operational Plan had significantly reduced, reflecting on learning from 2023/24.***

Charitable Funds Committee Chair's Report

Ms Sargent noted that there had been two meetings. The Committee had looked at NHS Charities Together Funding.

A discussion took place regarding ShropCom actively fundraising rather than supporting and overseeing. Ms Davies supported this and stated that fund raising would allow for opportunities for staff engagement. The Board agreed that this needed to be in conjunction with the League of Friends for the community hospitals and was not to be in competition with them, but to work in partnership.

Ms Lloyd stated that work would need to be undertaken to understand what this would involve as the Trust's Constitution with the Charities Commission stated that the Trust would not actively fundraise.

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

GOVERNANCE

Audit Committee Chair's Report

Ms Ramtuhul stated that the DSP Toolkit received a high level of assurance. In relation to the CIP audit, the auditors took the unprecedented step of changing their opinion during the meeting, which started as moderate assurance but was changed on reflection to significant. With relation to EPRR, the Committee heard that good progress had been made but there was still work to do.

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

Provider License Certification

Ms Ramtuhul advised that the declarations must be made on an annual basis. There were few changes from last year.

The Board considered the NHS Provider license self-certification templates indicating compliance and approved the self-certification.

DATE OF FUTURE MEETING

Date of Future Meeting

10am – 1.00pm, Thursday 1 August 2024.

Shropshire Community Health NHS Trust

TRUST BOARD
6 JUNE 2024

ACTIONS FROM THE MEETING

Actions from Last meeting	Lead Responsibility	Progress
A presentation to be provided to the Board on Research and Development within the Trust	Dr Ganesh	Identification of an appropriate date is being undertaken
Outstanding Actions from Previous Meetings	**Lead Responsibility**	**Progress**

Shropshire Community Health NHS Trust

Chair's Update

0. Reference Information

Author:	Tina Long	**Paper date:**	1 August 2024
Executive Sponsor:	Shelley Ramtuhul	**Paper written on:**	24 July 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 July
- Outline of recent Board Development Session

2.3. Conclusion

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

Chair's Update

3. Main Report

3.1 Recent meetings and visits

The last two months since the previous Public Board have again been busy months.

It is that time of year when Appraisals take place as Chair the Senior Independent Director completed my appraisal and I have completed appraisals with the Non-Executive Directors and the Chief Executive. It is always a time to reflect back on the last year, both the achievements of which there have been many as well as any challenges faced.

Along with some of the executive team we attended a call with the National Director for NHS Impact (Improving Patient Care Together) which is a Quality Improvement approach, we have undertaken a self assessment to identify our strengths as well as areas to focus on.

The Chief Executive and Vice Chair attended a meeting with NHSE national and regional colleagues along with other partners from STW ICB.

Following the July Board meeting we had a Board development session on Equality, Diversity and Inclusion. This was an opportunity to identify priorities and reassert our commitment to being an inclusive organisation at every level and challenging if we fall short of that commitment.

I attended the Induction Day for new staff which is held every month and either myself or one of the Non-executive Directors always attends to welcome staff to the organisation and to thank them for choosing Shropshire Community Health NHS Trust as a place to work.

3.2 Private Board Meeting in July

During the meeting in July which was held in private, the Trust Board considered and discussed the following items:

- Orthopaedic Options Appraisal Update
- Infection, Prevention and Control Annual Report
- Performance Reports
- 2024/25 Planning

3.3 Board Development Session

The Board held a development session covering two key areas:

- Committee Management
- Equality, Diversity and Inclusion

The Board recognised that equality, diversity and inclusion is an ongoing discussion for the Board with a commitment to agree individual and collective objectives.

3.2 Conclusion

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

CHIEF EXECUTIVE'S REPORT – August 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

2.1 Re-opening of Bishops Castle Inpatient Unit.

The Trust announced on the 4th April, that following a dedicated period of recruitment we had 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. On Monday 1st July we welcomed back our existing inpatient staff and new recruits, for their induction. It was a very proud day for us all to be able to re-open the ward to patients on 15th July. I want to thank again everyone at the Trust, the ward manager and wider community within Bishops Castle who worked tirelessly to make sure that the re-opening was as smooth as possible and in welcoming new staff so warmly. Of course, the work doesn't stop here and we look forward to building on the work that we have done not just in terms of inpatient care but wider ambulatory care and health and wellbeing services to ensure that we as a health and care system see the Bishops Castle hospital site as a thriving resource for Bishops Castle, the wider community of South West Shropshire, and bordering communities within Wales, Hereford and Worcester and of course the wider population of Shropshire, Telford and Wrekin.

We are truly humbled and excited to welcome new staff to Bishops Castle and all our services across Shropshire, Telford and Wrekin and Dudley. We know from those working in the community hospitals and across our community services that these staff are highly valued and integral to the quality care provided to our patients wherever they are from. We would like to reiterate that our organisation is proud to be inclusive and diverse and that we celebrate the skill and expertise that our community of fabulous folk bring to our organisation and therefore to our patients. Thank you for joining us!

2.2 Expansion of Ambulatory Care/service offer within Bishops Castle

I outlined in my June report, the joint programme of work focused on the expansion of ambulatory care and services, given the site represents a much wider opportunity for the delivery of health, care, and local services. This work includes the local Primary Care Network, the local community, Shropshire Council, and wider partners. Initial outputs of this work include regular support groups delivered by charitable groups, wellbeing drop-in sessions, and a social prescribing community Network, which commenced in June. 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.

These facilities are running alongside the existing ambulatory and outpatient health services such as Physiotherapy and Ophthalmology, which we also seek to increase in range over the coming months directly and with local health partners as part of the Enhancing Services in the Southwest Group.

This is clearly the beginning of a very exciting time for us in Bishops Castle and the wider community. The learning and approach seen here has and is leading to a greater understanding of differences across our communities and in particular rural communities. The learning from models of care developed and approach taken can and will be transferred and adapted across our organisation, the Local Authority and the ICB.

2.3 Urgent and Emergency Care:

We are saddened by some of the images and stories displayed on the recent Dispatches programme. We recognise that staff across the system are working tremendously hard in what has been challenging times nationally during and post COVID. However, we cannot allow this to impact on the quality of care provided. We have as a Board and senior clinical leadership team taken the time to reflect on the programme with our staff and colleagues across the system to ensure that we have robust systems and processes in place to prevent a shortfall in standards of care.

While we must take the time to have these very necessary conversations, it's also important we support staff not to lose sight of the fact that there are many reasons to be

positive about the contribution they make for patients every day across Shrop Comm services and the system.

On that point of positive contribution, whilst urgent and emergency care pressures remain within the acute trust, we are seeing the improvements that our teams are making both in terms of keeping patients safe and healthy and out of hospital and facilitating early discharge. We are doing this by 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 (VW) beds, Rapid Response (RR) 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.

We have had the opportunity to share and be scrutinised by the regional team on the supporting services that we provide and have received very positive feedback in terms of our outputs and key metrics in relation to our admission avoidance services, the IDT, virtual ward and interest in the early benefits being demonstrated within the Rehabilitation and Recovery Units. We are also liaising with PPL who have recently published using Nigel Edwards as an advisor, the first definitive piece of longitudinal research on the benefits of Virtual Wards, which was conducted across the Southeast (both rural and urban communities) and published in May 2024. The outputs of the research demonstrate clear benefits of Virtual Wards in terms of clinical outcomes, continued independence, and life benefits to the individual and more efficient use of resources. We are keen to 'add to the body of knowledge' with the approach we are taking and learn and understand how we can further develop the virtual ward offer across STW.

2.4 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 were 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 ended on Sunday 30 June 2024, and I am pleased to report that we completed over 47,000 vaccinations, which equates to 63.7% of the eligible population against our internal target of 61%.

We completed 100% of our care homes with an overall uptake of 78.57% - the highest uptake in the Midlands Region.

In common with previous campaigns, SCHT has led 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 our eligible cohorts.

We are expecting planning guidance for the upcoming Autumn/Winter campaign shortly and will update Board members in the next report.

3. Other Areas of Performance

3.1 Elective RTT and non RTT

The trusts RTT long waits position continues to improve, and the Trust successfully achieved zero 65 weeks by the end of March. This is ahead of the national target to achieve zero 65 week waits by end of September 2024. We are currently proactively targeting the over 52 week wait cohort.

Vacancies within the Community Paediatrician team has impacted not only their clinical ability to see high numbers of complex children but also the provision available to support the Child Development Centre (CDC) where diagnosis and statutory provision are delivered.

Demand for consultant led interventions outweighs current capacity despite using a locum paediatrician. Clinicians and commissioners have therefore undertaken a revision of the model that is delivered within the CDC to drive a more efficient and integrated service and reduce waits for children with complex needs.

Speech and Language Therapy services have seen an ongoing increase in demand over the last twelve months due to higher referrals from school and parents seeking more support. The team currently have vacancies which have been challenging to fill due to a

national shortage of Speech & language therapies. We are supporting recovery of these services through a number of initiatives and a recruitment drive.

4. Our People – Recruitment & Retention

4.1 Our Strategy

The Board are continuing to disseminate the Trust Strategy for 2023-2028 and share key priorities going forward. We understand to achieve the priorities of our strategy we need to continue to work hard towards creating a culture where every one of us feels empowered to use our skills and expertise to make a difference - Not only in providing the best possible care for our patients but to make ShropCom a great organisation to work in.

As an Executive team we have worked together with senior leaders across the Trust to develop a strategy that reflects our ambitions to keep care as close to home as possible for our service users. Our Strategy has been developed to focus on 4 key priorities.

Our Strategic Vision:

As a Community Trust we are integral to the delivery of the health priorities of our local community. Therefore, the partnerships we have with acute and primary care and our local authorities as well as directly with the communities we serve is pivotal to delivering

safe, sustainable, and effective care and often we are the ones that can best 'connect the dots.'

As a Community Trust we are fortunate to have a wealth of talent and experience across our organisation, with many staff and their families living within the communities we serve. This provides us with both a personal and professional perspective on the health needs of our communities. And enables us to keep a finger on the pulse on how best to join up the dots of health care for our community.

Our Strategy has been developed to enable us to connect these dots by focusing on our 4 key priorities:

1. To keep care as close to home as possible for our patients, providing proactive treatment based on early interventions.
2. To empower our staff to use their wealth of expertise to support and provide a wider range of services that answer the specific health needs of our community.
3. To work cohesively with our primary care partners to provide evidence-based, local care that is agile and responsive.
4. To integrate community health and social care provision to ensure our services are efficient and seamless.

Working together to achieve our ambitions.

Throughout the rest of 2024 and into 2025 we will be drawing upon the insight and expertise of our staff to support and deliver a wide range of services and doing all we can to keep the care we provide as close to people's homes as possible. It is a community affair in more ways than one here at ShropCom. Therefore, across our 6 areas of enablers we will be pulling together as a community of fabulous folk to deliver our priorities through our 5 key commitments.

Our Commitments

1. Inter-operability: We will provide connected and seamless services for our patients, that includes end-to-end joinedup technology, processes, structure and governance.
2. Integrated care: We will form strong partnerships, so our patient needs and our staff's ability to perform optimally, always comes before organisational self-interest.

3. Locality of provision: We will provide services as locally as possible, including in people's own homes to minimise both staff and patients need to travel for safe and high-quality services.
4. Clinical excellence: We will better define, benchmark, manage and measure our services to ensure they are demonstrably clinically excellent and continuously improving.
5. Committed and engaged people: We will further develop an environment where everyone is committed and engaged with the delivery of the strategy keeping patients at the heart of everything we do.

Shaping Our Future – We all have a role to play

Culture plays an integral part in helping an organisation to deliver its ambitions and is key to creating an environment where staff are both empowered and enabled in its delivery. Here at ShropCom we want our culture to provide strong foundations for our future, our staff, and our service users.

It is, therefore, important that our culture is one that encourages and enables staff to pull together and work cohesively. One that ensures staff feel empowered to use their expertise to provide and develop services. And is one that is agile enough to provide flexibility and speedy responsiveness for staff and service users alike.

With this in mind, we have developed a set of ACE cultural characteristics that we are committed to promoting and embodying in our day-to-day working lives and we are working with our fabulous staff across the organisation to embody them as a Trust. In addition, Rhia and the workforce team are implementing exciting opportunities to ensure staff have a voice when it comes to our Trust culture including #WeAreShropcom Shaping our Future programme because we all have a role to play in shaping the future of the Trust's services and culture.

Introducing our ACE Cultural Characteristics

Agile - 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.

Cohesive - We work together to deliver our services for our community - acting with integrity, inclusivity, and transparency.

Empowered - Decisions are made by those with the best information – people have permission to act - safely, quickly, and accurately to create a healthy staff culture where

we all work as one team to deliver our ambitions, we need to ensure we are providing staff with the tools to enable them to be.

The ACE cultural characteristics have been launched to staff to provide feedback and comment on what they mean to them.

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 of: **Commitment to quality, Respect and Dignity, Working Together, Compassionate Care & Everyone Counts.**

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. We are now starting to see some excellent examples of line managers and staff working together to make things better.

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. In 2024/25 we have committed to implementing two NHS transformation programmes; the first being the NHS Culture and Leadership programme which will see us recruit a multidisciplinary change team and launch an improvement plan in Q2 and this is complimented by us joining cohort two of the national People Promise Exemplar programme. We are proud to be participating in this and our new People Promise Manager joined the Trust in July to support this important work, collaborating with our system partners SaTH and RJAH who are also taking part. We have already seen great progress on the People Promise Exemplar programme having launched our flexible working, freedom to speak up and menopause campaigns to raise awareness and improve the working lives of our people.

These transformational programmes are aligned to the national toolkits and best practice that we know improve culture, leadership and staff engagement and brings together all the work already underway by our People Team. These programmes work in synergy

with the release and implementation of our Trust strategy and vision to shape our future making this an exciting time to be part of Shrop Comm.

5. Prison/Dental

Over the last eight months the workforce at HMP/YOI Stoke Heath has been transformed. The introduction of Paramedics has helped develop a robust clinical model which is evaluating well by both the patients and the prison staff.

Agency usage has been almost eradicated with only the odd occasion where it is required. Due to the increase in substantive staff the focus is now on business as usual and recovering some elements that were previously affected.

HMP Stoke Heath has been recognised at a national level as leading the way in supporting inequality work with the management of diabetes in the prison setting. This has now led to our Chief Pharmacist and Prison Nurse Practitioner supporting further consultation work on the use of technology within the prison setting following their successful introduction of Freestyle libre to simplify glucose monitoring for patients living with diabetes. More recently, this work has been presented on a national webinar. This work should open the door for other prisons to follow suit.

The healthcare team have also been collaborating with Food Behind Bars, Shropshire Bee Keeping Society and Good Vibrations as part of a Social Prescribing project. Food Behind Bars bring their expertise in kitchen gardening and food facilitation together under a bespoke project for HMP Stoke Heath to help support prisoner's health and wellbeing. By having access to more time in the fresh air, learning how to grow vegetables from seed and learning to cook healthy nutritious meals individuals see an improvement in their own health. The healthcare exercise yard has been repurposed to be used as a kitchen garden with raised beds, doubling up as a wellbeing hub. Food Behind Bars are also designing a mural for the fences that will enhance the working space. A meal was prepared by participants recently utilising vegetables and herbs grown within the prison.

Social prescribing means that prisoners can start to take back some control around their health and wellbeing by learning how to manage their own stress, anxiety, and depression rather than just relying on the medical model. By having access to more outdoor activities, groups, and connection through a sense of community an improvement is expected in the participants mental, physical, and emotional wellbeing. Targeting prisoners that come under mental health, neurodiversity and substance misuse is expected to yield the greatest effect. By offering smaller groups confidence, self-esteem and social skills can

be developed, which will help the men to gain vital life skills in an environment where they feel safe.

Shropshire Bee Keeping Society are supporting a 12-month programme and have trained 3 staff members as beekeepers. Through involving and training prisoners these skills are being passed on to prisoners on long term sentences, thus being able to offer a sense of purpose and nurturing. Workshops will be on offer to men throughout the prison, with speakers coming from the society throughout the year. At the end of the programme a Stoke Heath recipe book will be produced by the group participants and the team have already produced some Stoke Heath honey.

As part of the healthy man group the team are supporting a weight loss programme to help men that would like to lose a few pounds. There was an amazing Good News story about 'Hot Dog Tom' who lost over 5 stones with the support of the gym staff and Health and Wellbeing Champions before he left the establishment recently.

Dental Services

The ongoing challenges facing the Dental Services due to the lack of regular, clearly identified, and suitable theatre provision has adversely effected waiting times for both adults and children this year. Working closely with the service and partners, temporary and now longer-term solutions have been sought to address concerns. Both The Robert Jones & Agnes Hunt Hospital (RJAH) and Shrewsbury and Telford Hospital (SATH) have provided sessions which has led to a dramatic reduction in long waiting times. This position is anticipated to continue to improve due to the launch of the SATH Elective Hub with a new theatre due August 2024 and an agreement that dedicated theatre space will be aligned to SCHT to support consistent Dental theatre provision.

6. Good News Stories

A member of our Paediatric Psychology team has been on secondment in SaTH since October 2023 in a new role bringing Psychology to the Telford neonatal unit working with babies, families, and the staff team. The evaluation of the impact from introducing/embedding this new role has been outstanding. This has led to permanent funding being secured for this post. Additionally, the resource has been doubled to ensure that the positive outcomes are available to more families.

Welcoming the 0-19 team from Dudley to SCHT is ongoing and has been humbling and exciting to bring on such a dedicated and talented team of people. The executive team

visited Dudley in June and were blown away by the welcome and innovation they have brought to their service and something we can now share across STW too. All three 0-19 teams work together, which means best practice is being shared. One service which is being highlighted as exception within Dudley is the commencement of the Video Interaction Guidance (VIG) programme delivered by Health Visitors. VIG focusses on enhancing relationships whilst supporting parents to understand their child's communication by exploring strengths and successes in their parenting through video clips. VIG is an Evidence based intervention which support parents with mild to moderate Mental Health issues. Specially trained Health Visitors work with parents from the Antenatal period until the child starts school.

Below is a quote from a service user demonstrating the impact of this intervention and I think it is fitting to leave the last words from one of our service users.

Motherhood is hard and I realised that from the moment I was left alone in a small cubicle six hours after giving birth through Caesarean to my beautiful daughter. I didn't have that initial glowing bond. I was a first time Mum and my husband had been sent home. There were three other women on the ward who all seemed to know what they were doing, and my baby was the one that was triggering everybody else's baby to be crying throughout the night.

Because of this I really struggled in allowing myself to enjoy the better moments of motherhood. I wasn't allowing myself to see her smiles and see her joy. I was only focusing on how difficult everything was. It wasn't until I was supported by my health visitor to take part in the VIG program that filmed moments between myself and my daughter that I was able to see those golden moments. Dawn has been invaluable in showing me the bond between my daughter and myself at zeroing in on the small moments between us that are perfect and showing me how to enjoy motherhood and helping me get past the barriers that I'd put up to enjoying the motherhood that I was now experiencing.

I'm so grateful to the VIG that was offered because I feel now in hindsight, I am truly aware of how bleak my thoughts were and how dark the path was that I was going down. I truly believe that Dawn and the team and the service that she provided stopped me from heading into a form of postnatal depression. This service should be available for every woman and every new Mum.

End

0. Quality and Safety Report – July 2024

Author:	Chris Panayi – Governance Data Manager Tracie Black – Associate Director for Workforce, Education & Professional Standards	**Paper date:**	25th July 2024
Executive Sponsor:	Clair Hobbs, Director of Nursing, Quality & Clinical Delivery	**Paper written on:**	15th July 2024
Paper Reviewed by:	Clair Hobbs, Director of Nursing Quality & Clinical Delivery	**Paper Category:**	Quality and Safety
Forum submitted to:	Quality and Safety Committee	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1.

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

Note: **This report is currently under review with the Governance, Quality, and Information Team to ensure that the report is of good quality and is aligned to the Power BI measures and that it reflects an accurate Trust position that is consistent with other reports.**

2. Executive Summary

2.1 Context

The report aims to:

- Provide the Committee with an executive summary focusing on areas for and areas of improvement.
- Provide access to the suite of detailed quantifiable information from the Trust's single data performance repository for reliability and accuracy.
- Analysis to provide evidence through external benchmarking, Trust historical performance and triangulation of softer intelligence to strengthen both reliability and confidence in content.
- Report improvement headlines from the Divisions.

2.2 Summary

Safe

- The number of inpatient falls (17) in our care increased in M3 as did the rate of falls (4.65 per 1000 occupied bed days).
- 0 Patient Safety Incident Investigation (PSII) were reported in June same as for May.
- The development of category 3 and 4 pressure ulcers in our care was reported as 2 for category 3's and zero for category 4's in June.
- The count of Never Events reported by the Trust for June was 0.

- The count of National Patient Safety Alerts not completed by the deadline reported by the Trust for May was 0. There is still one outstanding National Patient Safety Alert, that was due at the end of March 2024 in relation to Bed Rail safety. Health and Safety Lead is leading the task and finish group, and progress is monitored through Patient Safety Committee.
- The 12-month rolling count of MRSA Bacteremia reported in June was 0.
- The 12-month rolling count of E. Coli Bacteremia reported in June was 0.
- The 12-month rolling count of Clostridium Difficile (C. Diff) infections in June is 4 with cases in August 2023, February, March 2024, and June 2024.

Responsive

- Complaint response has been maintained at 100% in June, with all complaints replied to within the deadline.
- 18-week RTT. 528 harm proformas have been completed to date; with 76.9% indicating no harm and 21.59% indicating low harm and can be treated and resolved. Looking into the cases where harm was identified, the vast majority were Rheumatology patients.

Effective

- There were no unexpected deaths reported for June 2024.

Well Led

- The overall CQC rating for the trust for June was Good.

Recommended changes approved at Trust Board 6th of June 2024.

- Falls and Category 3 and 4 Pressure ulcer data will be presented in SPC chart format going forward.
- A new metric will include the number of medication incidents resulting in harm as this is one of SCHT PSIRF priorities.
- Appraisals, mandatory training and sickness rates are reported at People Committee.

2.3. Conclusion

The Committee is asked to:

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

Safe - Inpatient Falls

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

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

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

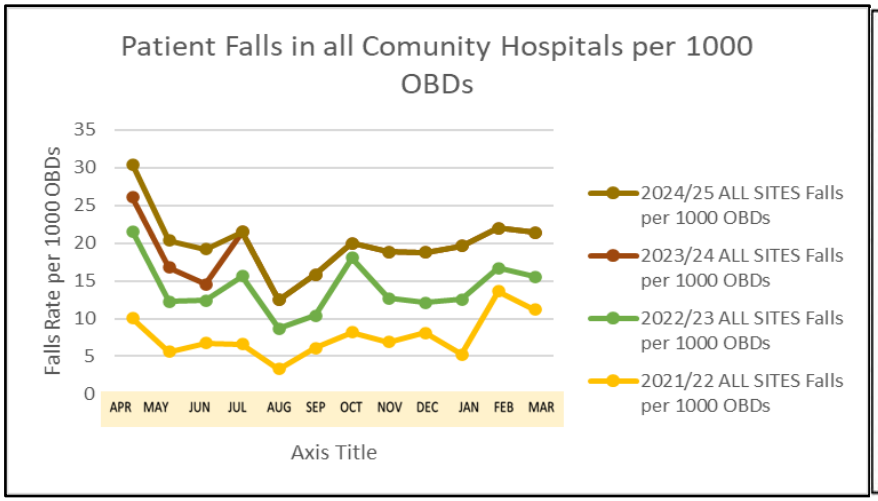
Total number of Falls in month 17 ↑
Falls per 1000 Occupied Bed days 4.65↑

In June 2024 there were 17 inpatient falls reported within our care at the Community Hospitals and Rehabilitation and Recovery Wards(the Rehabilitation and Recovery wards data has been included since April 2024) This equates to a rate of 4.65 falls per 1000 Occupied Bed Days (OBDs), which represents a higher incidence rate than M2. This is attributed to a slight increase in falls at PRH RRU Ward 36 and Bridgnorth Community Hospital. In acknowledgment, falls heat mapping has been undertaken for each site and has been seen as a useful tool for identifying good practice and when change is required. For a consecutive month there were zero falls at Whitchurch Community Hospital, this is following the reduction of the four escalation beds but further investigation would need to be completed to understand if this is linked.

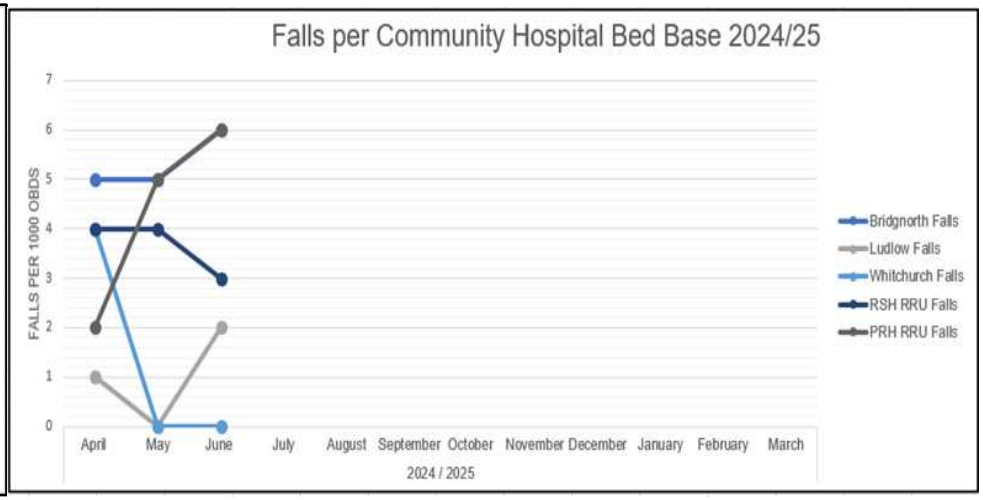
Graph 1 below shows the occurrence of falls per 1000 OBDs across 2022/23, 23/24 and 24/25.

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 ALL	Falls	19	11	16	14	7	12	14	15	18	12	28	24
	Falls per 1000 OBDs	10.06	5.57	6.73	6.63	3.34	6.1	8.17	6.92	8.1	5.25	13.58	11.18
2022/23 ALL	Falls	26	15	12	21	12	10	24	14	10	18	7	11
	Falls per 1000 OBDs	11.46	6.69	5.66	9.01	5.35	4.29	9.87	5.79	4	7.29	3.08	4.38
2023/24 ALL	Falls	11	11	5	14	9	13	5	15	17	25	18	22
	Falls per 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
2024/25 ALL	Falls	16	14	17									
	Falls per 1000 OBDs	4.31	3.58	4.65									

Falls Graph 1 Falls per 1000 Occupied Bed



Falls Graph 2 Falls Per Community Hospital Base



In total there were 17 patients falls in M3, 4 falls were witnessed, 13 falls were unwitnessed in which, 6 falls occurred in patient bathroom/ toilets. The 13 unwitnessed falls happened when patients were mobilising or attending to individual personal care. A Falls heat map for each environment has been

completed by ward staff, the results, and actions to maintain optimal safety for all our patients taken will be demonstrated in the Quarterly Thematic falls review report.

13 of the patient falls were recorded as no harm obtained, 2 patients were identified as low harm with bruising/ marking to the skin. The remaining 2 falls were categorised as moderate harm, which resulted in skin lacerations and a haematoma head injury.

In total 7 patients were conveyed to ED, 5 patients were on anticoagulation therapy and were reviewed as per policy, 2 patients were conveyed for treatment of a skin laceration and a haematoma head injury. All patients were medically reviewed and returned to the Community Hospital following assessment.

All patient's falls were reassessed in terms of bed visibility and supervision requirements, which resulted in 8 patient transfers into alternative safe bay cohort beds to optimise care and provide enhanced supervision. 2 falls at Ludlow on the 03.06.2024 and 14.06.2024, reduced staffing was cited as the reason for the falls, on review staffing, it is clear that these were at the appropriate level and for the fall on the 14.06.2024 a staff member was in the bay.

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

Community Hospital Site	Total number of falls	No Harm/ very low	Low Harm	Moderate Harm	Severe Harm	Falls per 1000 OBD's
Whitchurch	0	0	0	0	0	0
Bridgnorth	6	5	1	0	0	9.43
Ludlow	2	0	0	2	0	3.18
Ward 18 RSH	3	2	1	0	0	3.21
Ward 36 PRH	6	6	0	0	0	13.6

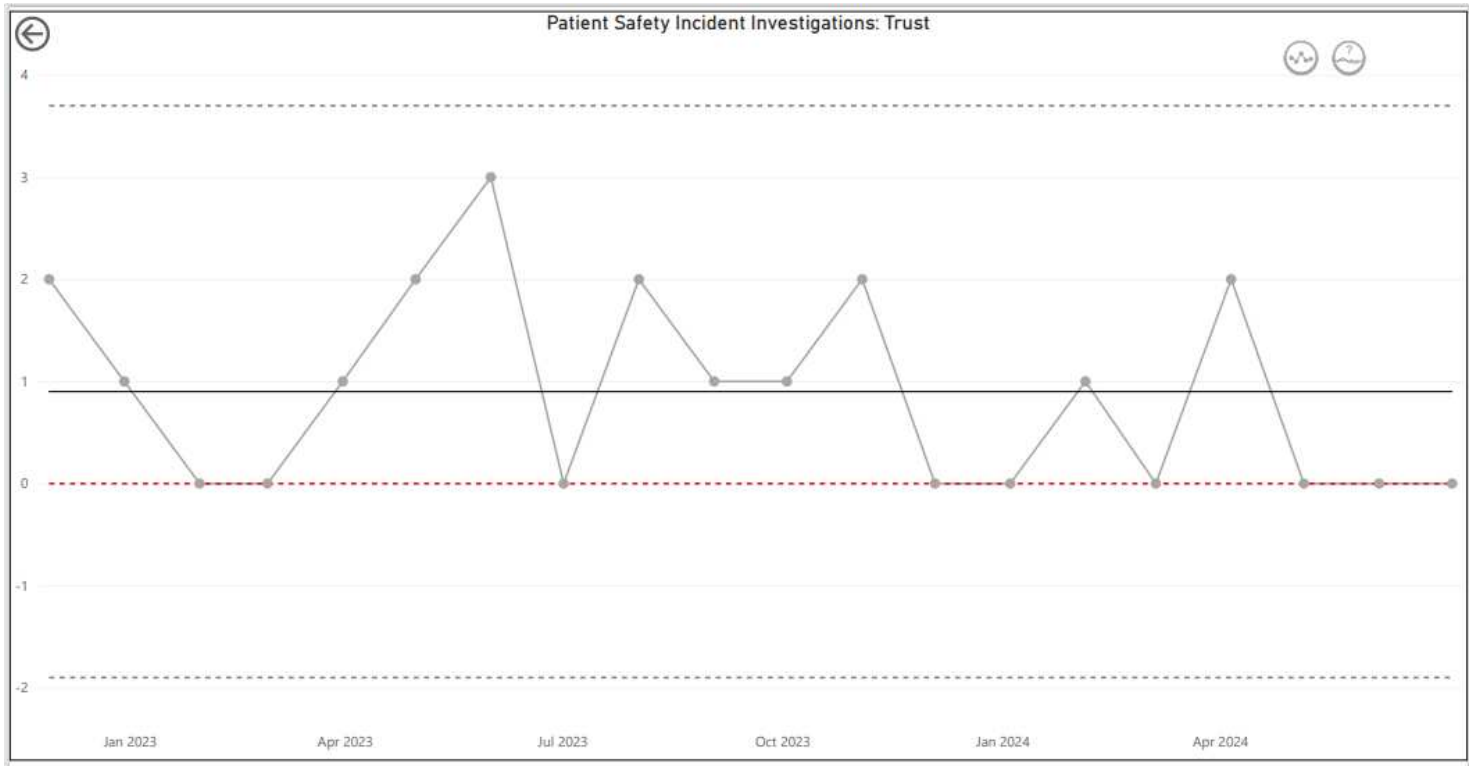
Review of DATIX relating to Falls in M3 demonstrated further reduction and variation in the quality and completeness of reporting with many DATIX reports missing key information including details specific to the individual patient and the circumstances of the incident. This continues to make it

challenging to identify common themes and contributory factors. Falls have been identified as one of the Trust's PSIRF priorities and the existing and incoming Locality Clinical Managers will work with their teams to support them with quality improvement in falls prevention and management in conjunction with members of the Quality Team. Discussion with Ward Managers regarding the development of SWARM huddles / After Action Reviews post falls is in process and the actions will be highlighted in the quarterly thematic falls report. The Director of Nursing has also requested further work so that our assessments fully align to existing NICE guidance working with the RiO Team.

Safe - Patient Safety Reporting

As part of the Trust's transition to the Patient Safety Incident Response Framework (PSIRF) replying in response to a Patient Safety Incident may take different methods; 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 this will, usually, be in the form of a Patient Safety Incident Investigation (PSII)

Total reported = 0
There were 0 Patient Safety Incident Investigation (PSII's) reported in June, same as for May. Regular ongoing monitoring remains in place to ensure oversight of all Patient Safety Incidents, through Panel meetings chaired by Directors and with representation from the ICB. This has transitioned to a weekly MDT panel (Patient Safety Incident Panel) as part of PSIRF.



Safe – *Category 3 and 4 Pressure Ulcers *(KPI Updated for July 2024 report)

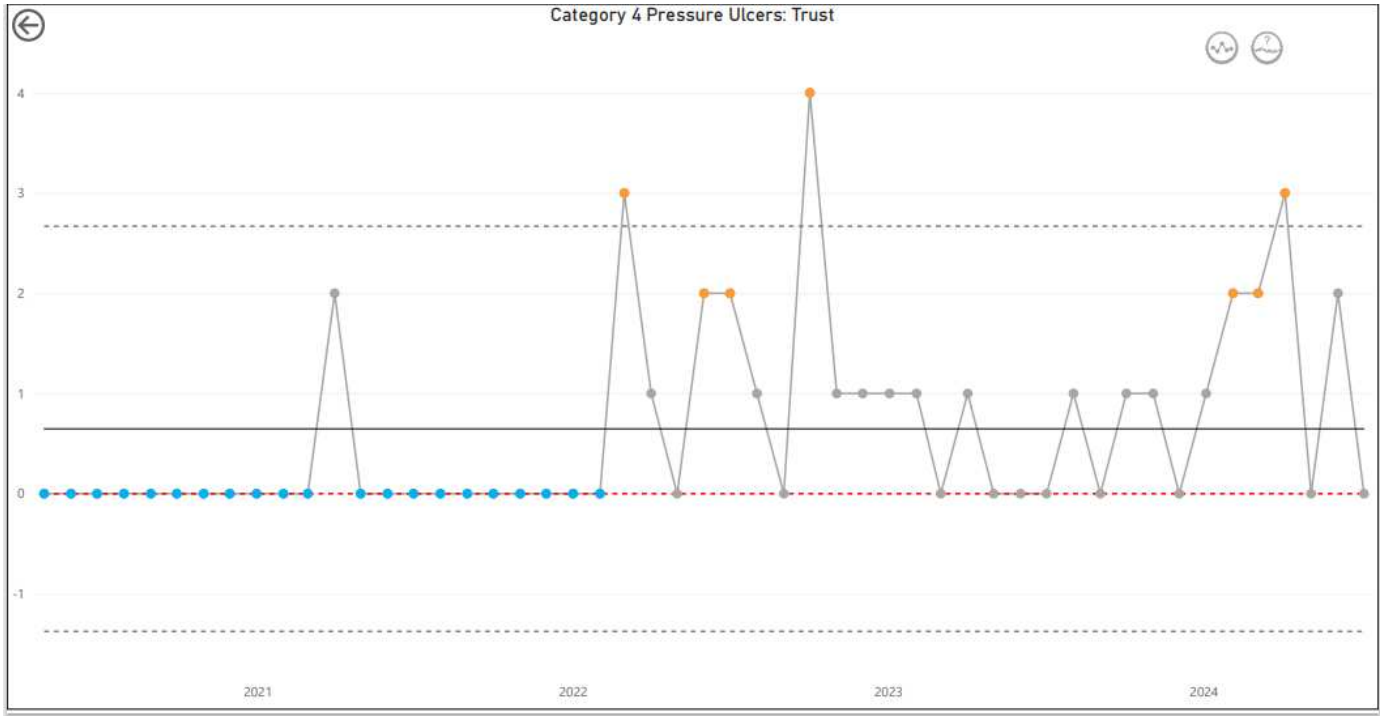
We aim to reduce the number of patients in our care from developing a pressure ulcer attributable to our acts or omissions.

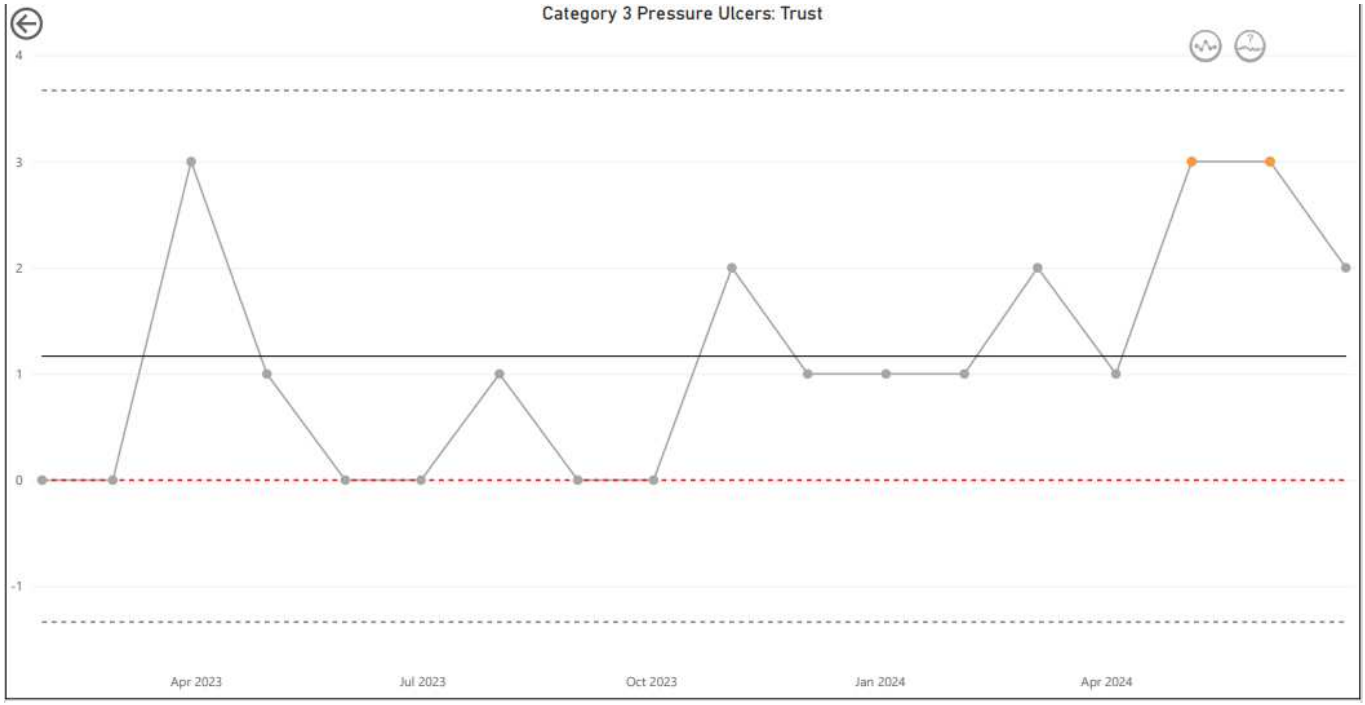
Category three total = 2 developed in service

Category four total = 0 developed in service

2 category 3 and 0 category 4 pressure ulcers were reported as developing in the care of the Trust in June.

The distribution of Category 3 and 4 Pressure Ulcers across the Community Nursing Teams in June was as follows including the level of harm associated:





Actions in place to improve:

- Stop the Pressure planning has commenced – conference will be on Thursday 21st November 2024, the TVN Team also will plan a week's worth of events around the county.
- PURPOSE T final documents have now been released from NHSE (which includes E-Learning package and pathways) so planning in place to launch and make changes to Pressure Ulcer Policy in line with new guidance with associated pathways based on patient risk level.
- PURPOSE T launch planned for November 2024 as part of Pressure Ulcer awareness month.
- E-Learning package for PURPOSE T to be discussed at Patient Safety Committee to approve to add to ESR for clinical staff.

- Bitesize face to face sessions and virtual sessions to be planned for October/November to support launch of PURPOSE T and policy update
- Tissue Viability Team continue with monthly caseload reviews with teams to support with Pressure Ulcers and wounds, also to be present during safety huddles
- TVN Team are reviewing Datix's daily, confirming category of Pressure Ulcer and giving advice to teams through Datix

Safe – Compliance with CQC Medicines Management

Proportion of actual compliances with standards against potential compliances

Performance = 98.57%

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

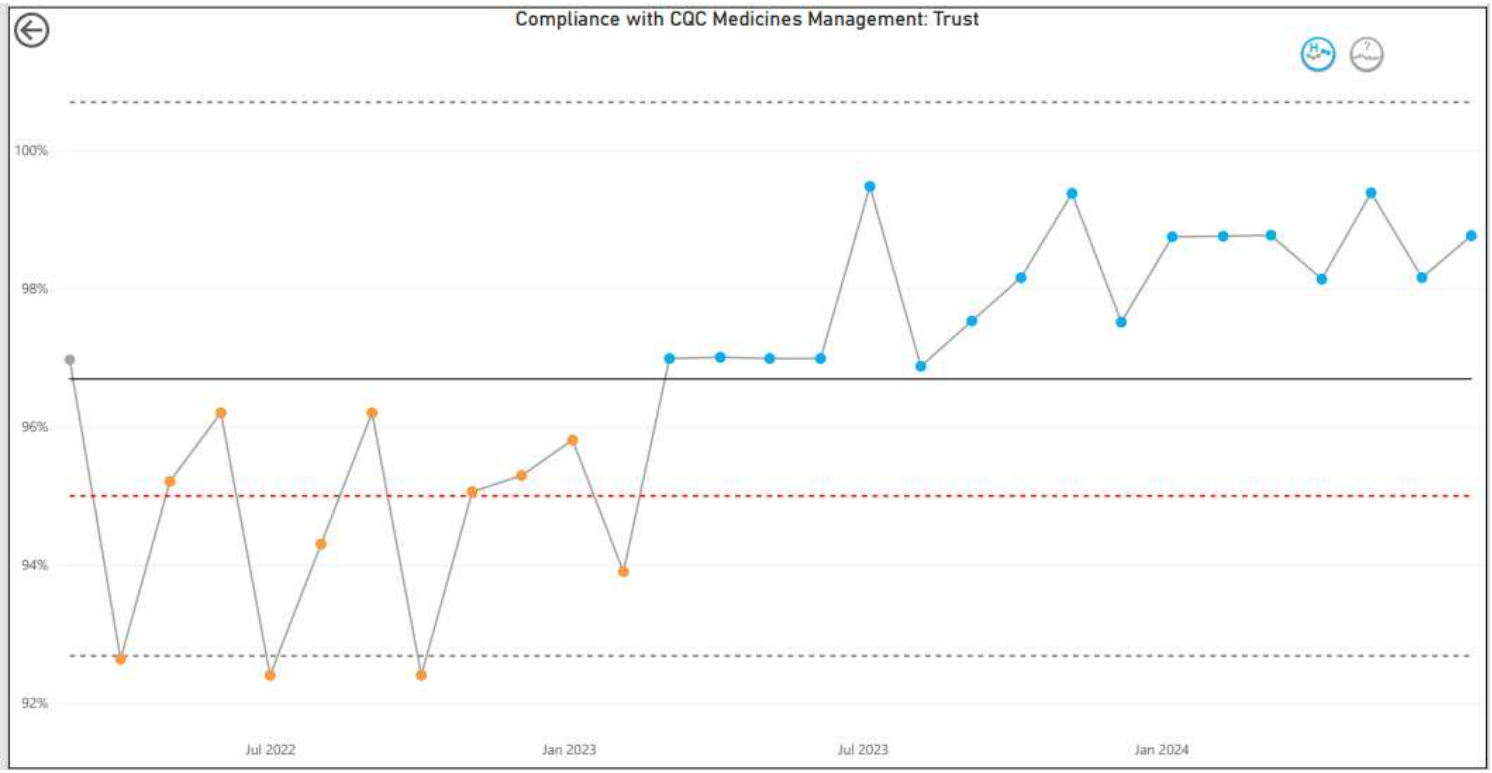
A Standing Operating Procedure (SOP) supports staff and defines expected actions. The minimum target for compliance is set as 95% which was agreed by the Quality and Safety Committee in 2019. The results from the last quarter can be seen below:

	Service	
Month	**Adults (%)**	**CYP&F (%)**
March	97.1	100
April	99.07	100
May	97.14	100

Non-compliance with temperature monitoring was observed at Whitchurch Hospital during May. The Ward Manager is aware. Once the pilot of the new temperature monitoring paperwork is complete, there are plans to roll this out to all sites.

Ludlow Hospital now have 100% compliance with their drug key accountability which finally provides assurance, unfortunately though, a missed day was observed with respect to CD registers not being checked on one occasion. No discrepancies were found when it was next checked. It is the Trust goal for in patient settings to have daily checks completed, however, there is no legal requirement for this to take place, so there are no concerns per se.

Children's Services continue with their 100% compliance. The Pharmacy Team will continue to monitor and support.
The graph below shows the Trust's overall trust position at 98.57% for May.



Safe – Safer Staffing

The National Quality Board (NQB, 2016) recommend a 'triangulated' approach to staffing decisions. The Trust has a validated tool for acuity and dependency for both the Community CNSST (Community Nursing Safer Staffing Tool) and Inpatient Wards SNCT (Safer Nursing Care Tool) this will enable a robust triangulated approach. Data collection is collected twice a year and this data forms part of planned biannual staffing reviews to allow SCHT to comply with National safer staffing guidelines. The National Team has paused with the CNSST tool as there some issues with the data collection and so data will not be collected in June 2024. The National Team plan to relaunch in September 2024. We continue to utilise Fill Rates. A description of both is below. Fill Rate is calculated by comparing planned hours to that of actual hours worked. A figure over 100% indicates more hours worked than planned.

Community Hospital Inpatient ward fill rates

June 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	97%	105%	105%	104%
Ludlow	110%	131%	101%	183%
Whitchurch	96%	100%	100%	100%
Ward 18 RSH	102%	95%	101%	100%
Ward 36 PRH	100%	135%	100%	115%

May 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	90.2%	121.5%	100.2%	118.2%
Ludlow	107.0%	131.8%	100.3%	173.3%
Whitchurch	99.0%	102.9%	101.1%	118.3%

Ward 18 RSH	99.0%	91.4%	98.9%	98.2%
Ward 36 PRH	99%	148.4%	99.8%	112.9%

Fill rates for Registered Nurse (RN) numbers were above the 90% threshold on day and night shifts during June 2024 for all five open inpatient wards.

The overall trend shows staffing levels on day and night shifts for both RN and HCAs were above 90% for all areas day and night. The HCA cover on night duty is over 100% on many of the wards in particular Ludlow and this is due to the amount of enhanced care required in order to maintain safety.

Bed Occupancy Rate

Hospital Site	Bed Occupancy Rate
Bridgnorth	**96.1%**
Ludlow	**99.9%**
Whitchurch	**95.6%**
Ward 18 RSH	**98.1%**
Ward 36 PRH	**98.8%**
Overall **Target 91%**	**97.5%↑ by 1.8% on previous month**

Registered Nurse shifts covered in Community Wards- June 2024

Total number of RN shifts covered	1199
Substantive staff	**897**
Percentage	74%
Percentage change from previous month	**3.6%** ↓
Bank	103
Percentage	9.2%
Percentage change from previous month	No change
Agency	**188**
Percentage	16.8%

Percentage change from previous month	**3.7% ↑**

There were 3 shifts all at Whitchurch with 1 on the 26th of May 2024 (was not reported in the June report) and 2 on the 7th and 9th June 2024 that were 100% agency. There were no datixes reported of any patient harm due to 100% agency.

Safe – Rehabilitation and Recovery Units

- RRU Ward 18 Royal Shrewsbury Hospital (RSH) opened on 5th January 2024 (20 beds) earlier than expected due to unprecedented urgent and emergency care demand across the system. A further 6 beds opened at RSH on the 11th of March 2024.
- Incidents have been reviewed for M4 with 16 recorded on DATIX for RSH and 13 at PRH. The top themes remain as Falls, Medicines Management and challenges relating to patient admissions and transfers.
- We have completed a review of our medical model and proposed a review of our current arrangements. Conversations continue between SCHT and SaTH leadership regarding the out of hours medical cover and potential for this to be fulfilled by SaTH, providing improved patient and staff experience.
- In M4 we will continue to focus on patient pathways and experience and have a series of meetings planned with the clinical teams from SaTH focussing on better use of the Orthopaedic, Stroke and Frailty pathways. We will also be seeking to understand how to support flow through the newly launched Frailty Assessment Units onto our community pathways including the RRU's.
- Our Ward Managers at both sites continue to work on actions aligned to improvement plans for Food Safety/Kitchen audits, Medicines Management audit and IPC audits. We continue to recruit to our full Housekeeper establishment which will support compliance.
- MRSA swab data was 100% for Ward 36 yet only 76% for Ward 18 in M3 – we have now instigated a rapid improvement plan on Ward 18 led by our CSM and Ward Manager after compliance issues were identified, this has included the roll out of a new safety huddle guide and change in labelling process.
- The Rehab Complexity Scale will be implemented as our outcome measure from day 1 of M4 and we will report on this next month.
- We have started capturing use of the different pathways into the RRU's and discharge pathways – M3 data is as below. We will now report this monthly and interrogate for trends.

Discharge pathway	RSH	PRH
0	0	0
1	26	15
2	2	1
3	13	5
Readmitted to secondary care	3	6

Admission Pathway	RSH	PRH
Orthopaedic	14	3
Stroke	0	1
Frailty	33	24

Responsive – Complaints (open) % within response timescales

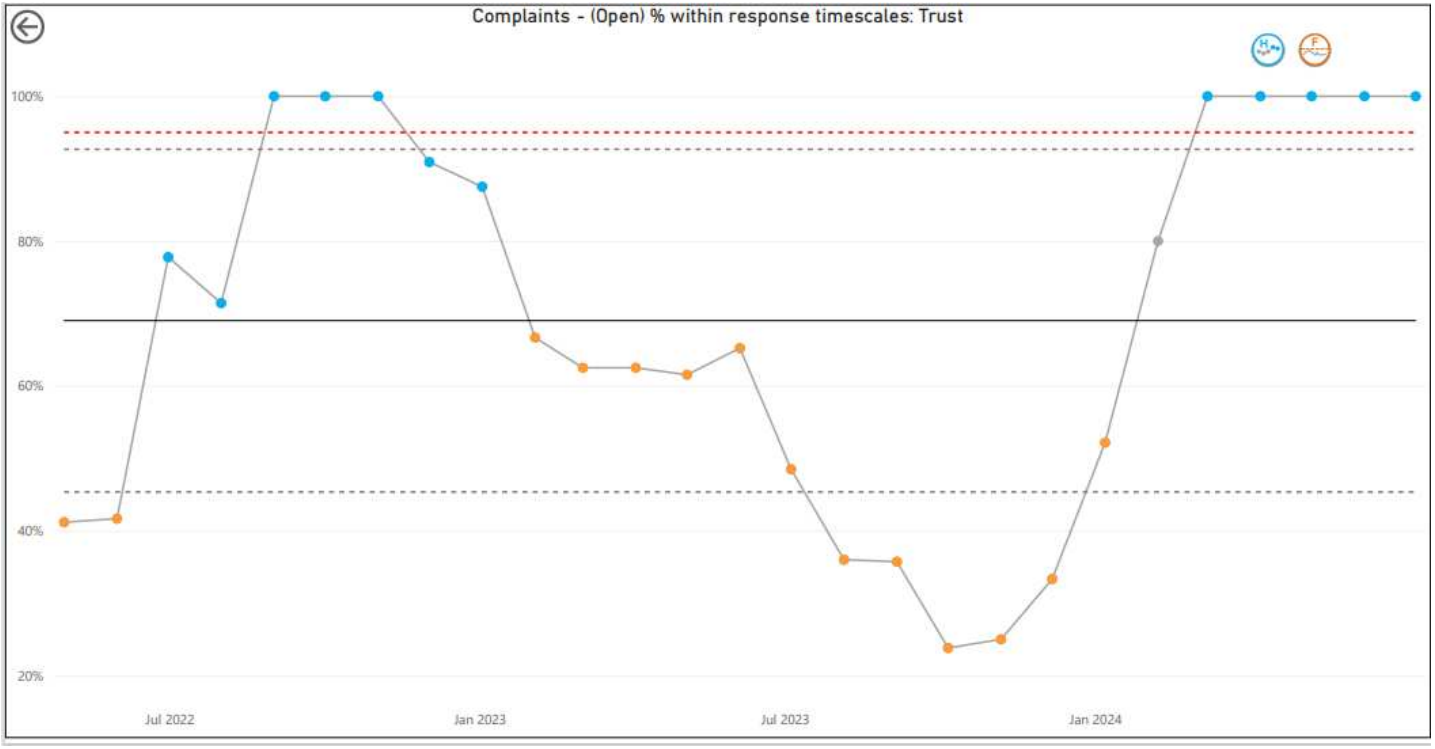
Complaint's response performance is measured by the percentage of complaints answered within the timescale that has been agreed with the complainant; the target is set at 95%. Complaints provide valuable feedback to improve care & outcomes.

Performance = 100.00%

As of 4 July 2024, 6 complaints are being investigated. 6 (100%) complaints are currently within their deadlines for reply. A total of 3 complaints were received in June 2024 as follows.

- 1 in Adults Services – Bridgnorth Hospital (1)
- 2 in Children and Young People's Service – Community Equipment Stores (1), and Dudley Health Visitors Central (1)

2 (100%) out of the 2 complaints closed in June 2024 were replied to within their deadlines. Of the 2 complaints closed in June 2024, both were not upheld, there are no lessons learnt / action taken to report for this period.



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

Harm Proformas have been completed for all new patients seen over 52 weeks as an essential, but also for follow up patients if the clinician deems necessary. 528 harm proformas have been completed to date; with 76.9% indicating no harm and 21.59% indicating low harm and can be treated and resolved. Looking into the cases where harm was identified the vast majority were Rheumatology patients.

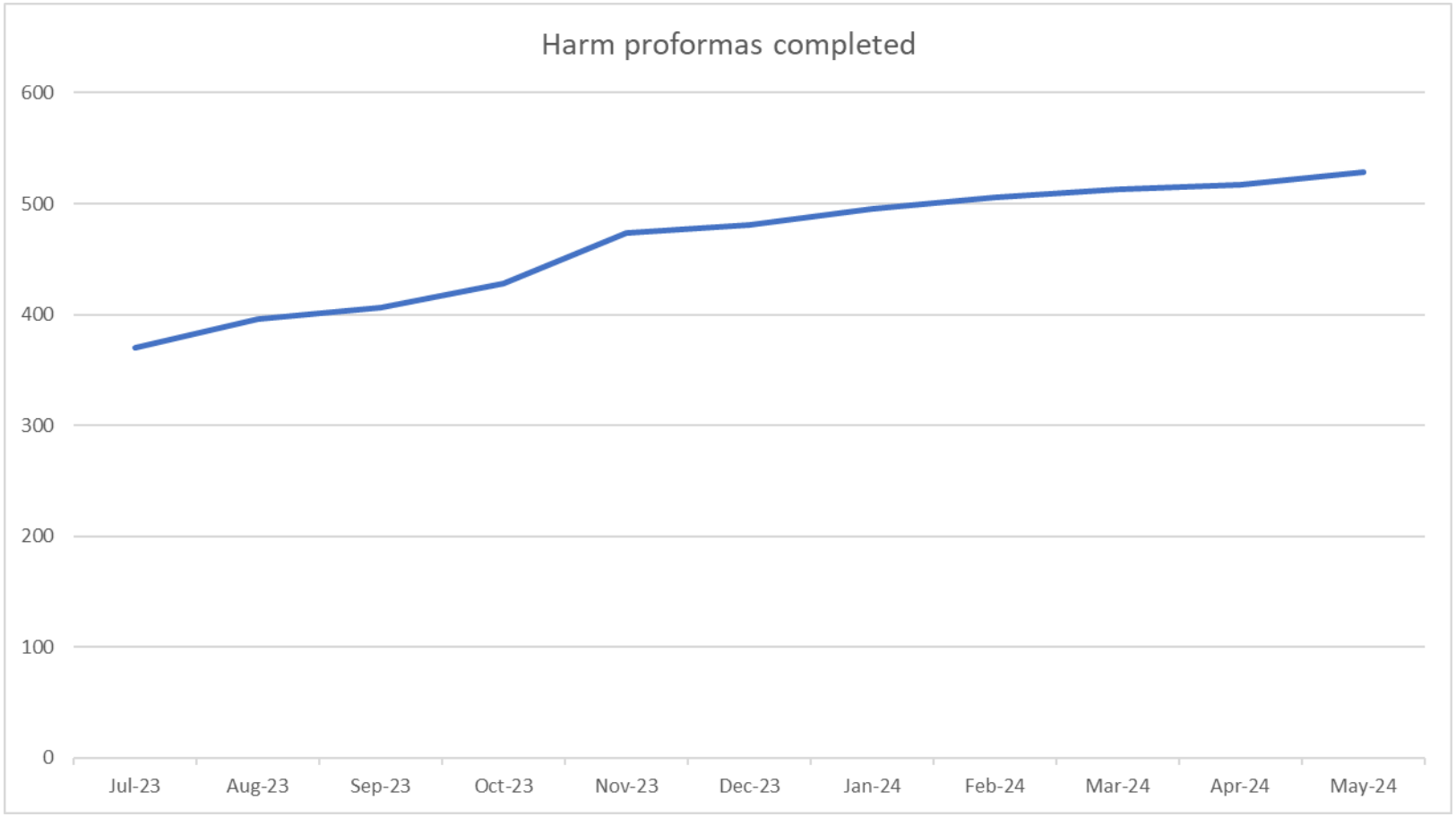
There have been 8 cases (1.51%) of moderate harm identified in November 2023 – May 2024; 5 following delays to first appointment, 2 due to delayed follow up appointments in Rheumatology and 1 due to patient choice delay to commence medication. All cases have been reviewed by the Clinical Lead who has agreed with the assessment of moderate harm. These cases have been escalated via the quality team and then onto governance team for discussion at weekly panel meeting. The Patient Safety Incident Panel have reviewed 2 of the 8 cases and further work is required to understand the rationale for the level of harm.

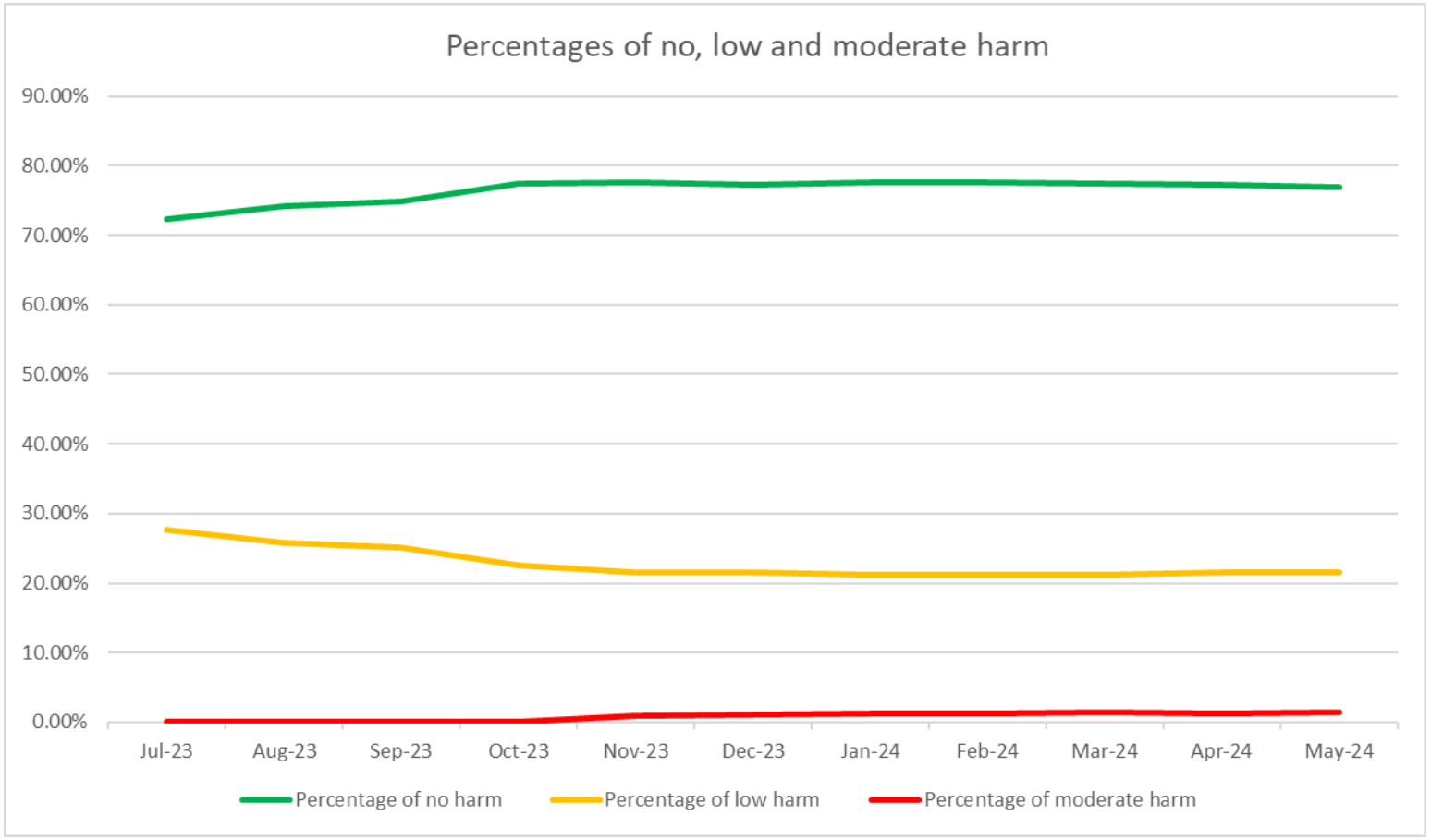
The service is routinely conducting a review of 10% of the harm proformas completed which equates to 52. Of the most recent review, 2 were revalidated as having no further harm occurring.

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

18-week RTT	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Harm proformas completed	370	396	406	428	474	481	495	506	513	517	528
Number of low harm	102	102	102	102	102	104	105	107	109	111	114
Number of moderate harm	0	0	0	0	4	5	6	6	7	7	8
Percentage of no harm	72.40%	74.20%	74.90%	77.50%	77.65%	77.34%	77.58%	77.66%	77.39%	77.18%	76.90%
Percentage of low harm	27.60%	25.80%	25.10%	22.50%	21.51%	21.62%	21.21%	21.15%	21.25%	21.47%	21.59%
Percentage of moderate harm	0.00%	0.00%	0.00%	0.00%	0.84%	1.04%	1.21%	1.19%	1.36%	1.35%	1.51%

The current harms policy will be reviewed to ensure all services that have patients waiting over 52 weeks have harm reviews completed. Outcomes of harms reviews will be reviewed at Divisional Governance meetings with escalation to Patient Safety Committee.


Harm proformas completed
600
500
400
300
200
100
0
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24


Percentages of no, low and moderate harm
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Percentage of no harm
Percentage of low harm
Percentage of moderate harm

Shropshire Community Health NHS Trust

Learning from Deaths 2024-5 Q1 Report

0. Reference Information

Author:	Amy Fairweather, Patient Safety Officer	**Paper date:**	18 July 2024
Executive Sponsor:	Dr Mahadeva Ganesh, Medical Director	**Paper written on:**	12 July 2024
Paper Reviewed by:	Dr Mahadeva Ganesh, Medical Director	**Paper Category:**	Governance/Quality and Safety
Forum submitted to:	Learning from Deaths Group	**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:

- Nine deaths reported Q1 2024-25 across Community Hospitals and Recovery and Rehabilitation Wards
- Of these nine, two were unexpected but explainable deaths.

Learning from Deaths 2024-5 Q1 Report

- No patients had COVID-19 recorded as their primary cause of death in Q1.
- There were no reported deaths of Autistic People or people with a diagnosis of Learning Disability in Q1.
- Since January 2024 the Child Death Overview Process is managed by the ICB rather than the Trust.
- All Deaths across the Trust's Community Hospital and Recovery and Rehabilitation Wards are referred to The Medical Examiner Service for independent review of the Cause of Death.

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

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

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

Learning from Deaths 2024-5 Q1 Report

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 Recovery and Rehabilitation Wards are shown below.

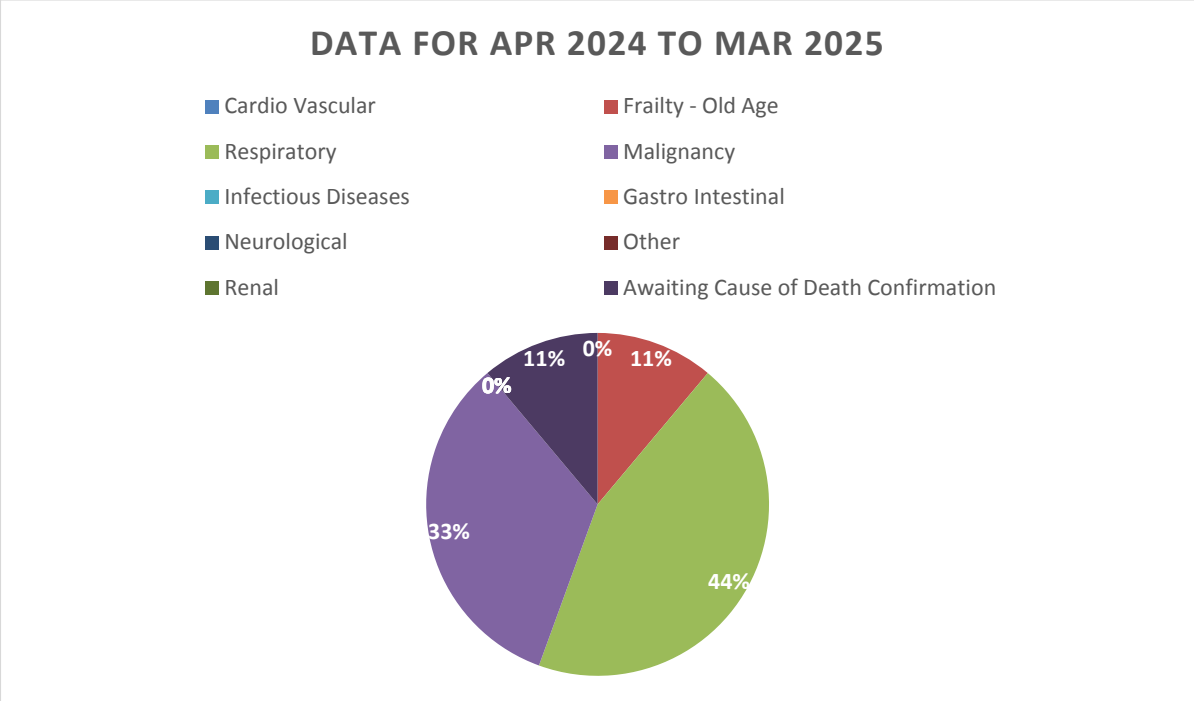
No. Episodes		Apr-24	May-24	Jun-24	Total
Bishops Castle	Patient Died				0
Bridgnorth	Patient Died	1	0	1	2
Ludlow	Patient Died	0	0	0	0
Whitchurch	Patient Died	2	2	0	4
SubAcute RSH18	Patient Died	0	2	0	2
SubAcute PRH36	Patient Died	1	0	0	1
Total		4	4	1	9

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 deaths within Community Hospitals for Quarter 1 of the year 2024-25 were, Respiratory (45%), and Malignancy (33%) as shown in the graph below.

Learning from Deaths 2024-5 Q1 Report



3.4 Unexpected deaths

There were two unexpected but explainable deaths in Q1. The first concerned a 73-year-old male patient admitted to Whitchurch Hospital early April for rehabilitation from SaTH following a fall at his home. The patient had various co-morbidities including heart failure, a spinal tumour, type 2 diabetes, and community acquired pneumonia. The patient deteriorated rapidly. The patient's next of kin was kept updated throughout his admission and he died peacefully albeit sooner than had been expected. The second concerned a 93-year-old female patient admitted to Ward 18 RSH, Recovery and Rehabilitation Ward from SaTH in early May. The death happened peacefully during the night and following the patient's admission to the ward earlier that day. All pre-admission assessments had been conducted as appropriate and Cause of Death was recorded as Frailty of Old Age with no concerns lodged by the family, who were supported by the team.

3.5 COVID-19

No patients had COVID-19 recorded as their primary cause of death on the death certificate for Q1.

4.0 Deaths in Custody

No deaths in custody reported in Q1.

Learning from Deaths 2024-5 Q1 Report

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 Q1.

The Integrated Care System (ICS) published its LeDeR Annual Report into Adults Reports (for 2023-4) on the 26th June 2024. Its key recommendations and next steps for 2024-25 are as follows:

- To promote the appropriate completion of DNACPR's and ReSPECT documents,
- Continue to utilise opportunities to promote learning from all LeDeR reviews.
- The implementation of a communications plan and user friendly ICB website incorporating resources and links associated with LeDeR and the learning disability and autism programme.
- Putting learning from reviews into action and undertake quality improvement projects linked to our LeDeR priorities to ensure we make tangible change for individuals with a learning disability and autistic people across Shropshire, Telford & Wrekin

The communications from the LeDeR one-minute briefs this quarter have been around Autism and Epilepsy and have been shared with Team Leaders.

The National Child Mortality Database, also shared its review into child deaths (for 2019 to 2022) on the 18th July 2024 and its recommendations and next steps are as follows:

- Ensure reasonable adjustments are discussed with and provided for all children with a learning disability, autistic children, and where necessary their families and carers, and that the details of these needs are appropriately captured in the Child's Clinical Record.
- Ensure that there is a recognition that infants and children with a learning disability and autistic children with underlying health conditions may be at higher risk of death from infection and as a consequence, improved guidance and training is needed to highlight this risk to healthcare professionals. A low threshold for urgent transfer to hospital, senior review, and early initiation of treatment should be considered.
- Ensure a designated Named Lead Healthcare professional is identified to support autistic children and children with a learning disability, with multiple co-morbidities and complex health care needs, to help in the co-ordination of healthcare provision.
- Ensure improved consideration and account of the needs of children with a learning disability and autistic children, is included in future revisions of national clinical standards and guidance with respect to transition from paediatric to adult healthcare services.
- Ensure increased focus to ensure that children and young people are not waiting inappropriately long times for autism assessment, in line with NICE and NHS national framework and operational guidance for autism assessment services.

- Ensure that autistic children, and those waiting for an autism assessment, have timely access to appropriate support with mental health services, including talking therapies.
- Review relationships, sex and health education (RSHE) guidance to include on the curriculum appropriate education on self-harm and suicide prevention for all children, including how to access support if they are in need. This should be age appropriate and accessible by all children and especially children who are or who may be autistic or neurodivergent, noting that children may not be diagnosed by the time of the education offer being presented to them.

6.0 Child Deaths

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

7.0 Medical Examiner's Role

All non-Coronial deaths in community hospitals are now referred to the Medical Examiner service for scrutiny before a medical certificate of death is issued. The Trust has a standard operating procedure in place, 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. The distribution list has been revised and the Medical Director 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. An attendance log was implemented further to the last meeting in Q4 23-24 to monitor and track attendances.

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 form reflect one instance of a delayed start (by one day) to the EOL Pathway. However, all pain relief was provided to the Patient.
- Level 1 Review Form reflect one learning action to consider use of oral/ Sub cut analgesia when attempting to re-dress wounds when patient not wishing to re-position.
- Level 1 Review form reflects one instance whereby verification of death had not been completed by ward staff meaning the case was referred to the Coroner for Death Certificate. The learning around this was discussed in team.

Learning from Deaths 2024-5 Q1 Report

11.0 Good practice to share:

- L1 Review forms reflect instances of good practice across teams in collaborative working with families and patients in end-of-life care planning.
- L1 Review forms reflect several instances of Patients' pain being well managed to ensure a peaceful death.
- L1 Reviews reflect several instances whereby patients' wishes to not want to be resuscitated were respected. This is demonstrated through prompt use of side/palliative room for dignity with evidence of repositioning and oral care. Positive feedback given to staff by relatives for support and comfort given to them in the period of their relatives' death.

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 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: **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 2**: *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 3: Hospital Mortality Monthly Report: standard monthly report including reported deaths, categories by age banding and admission details.

Appendix 4: Mortality Analysis Report: mortality data so the Trust can monitor and compare aspects and themes on a year-to-year basis.

Shropshire Community Health NHS Trust

Shropshire Community Health NHS Trust: Learning from Deaths Dashboard - June 2024-25

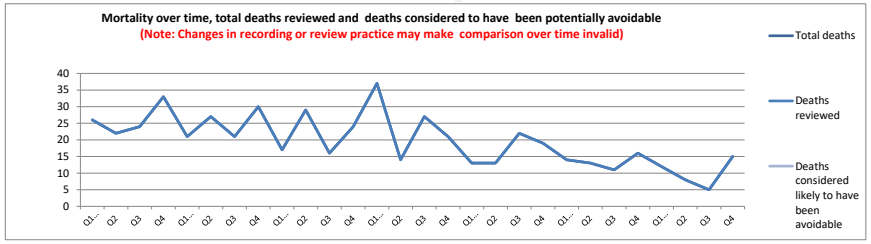
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
1	4	1	4	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
9	15	9	15	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	40	9	40	0	0

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



Total Deaths Reviewed by RCP Methodology Score

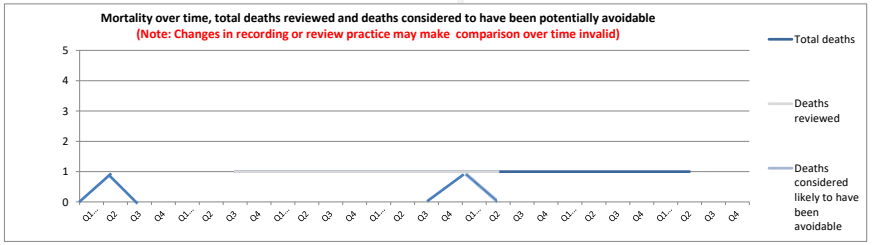
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month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

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

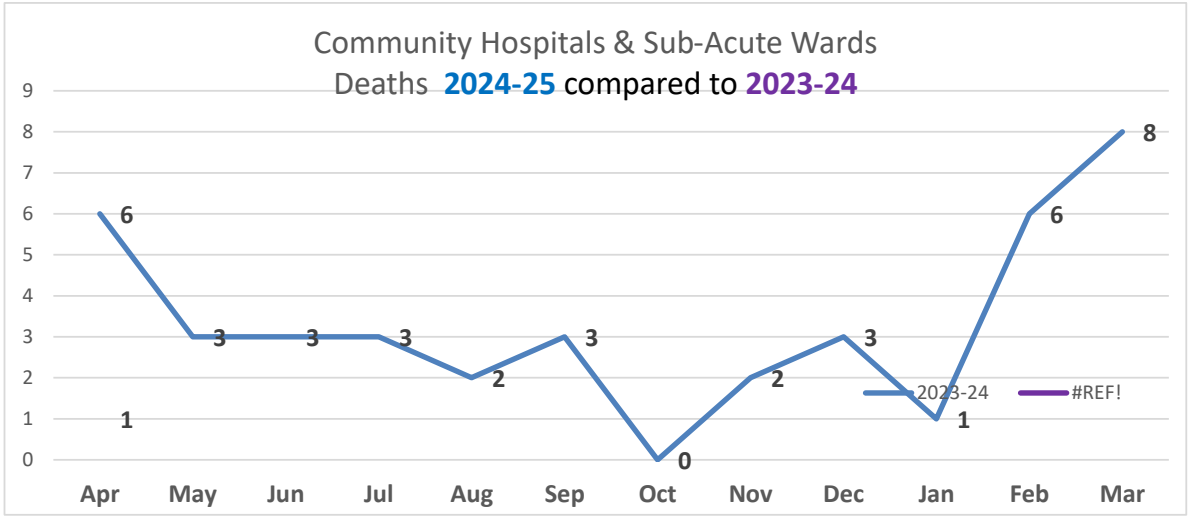
Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

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

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



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



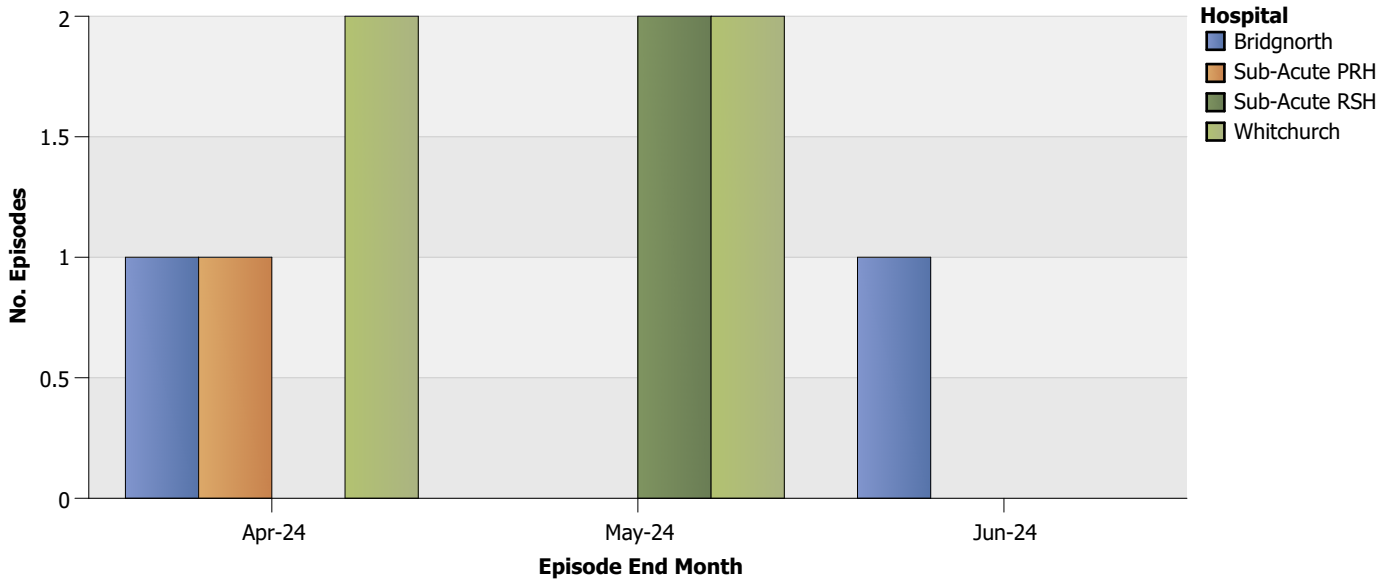
Average 23-24 3.3333

Average 24-25 3

	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
2024-25	4	4	1										

Community Hospitals - Patient Deaths

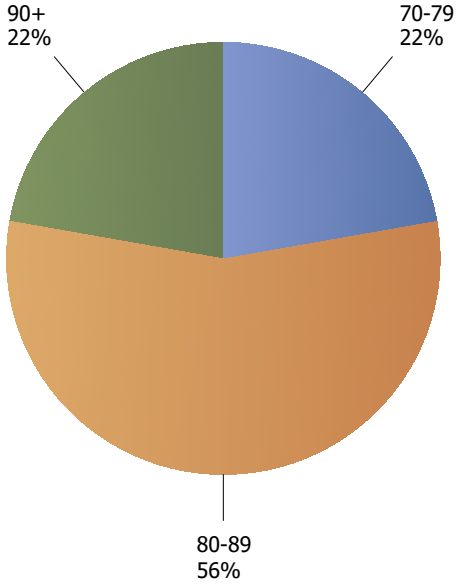
No. Episodes		Apr-24	May-24	Jun-24	Total
Bridgnorth	Patient Died	1		1	**2**
Sub-Acute PRH	Patient Died	1			**1**
Sub-Acute RSH	Patient Died		2		**2**
Whitchurch	Patient Died	2	2		**4**
Total		**4**	**4**	**1**	**9**



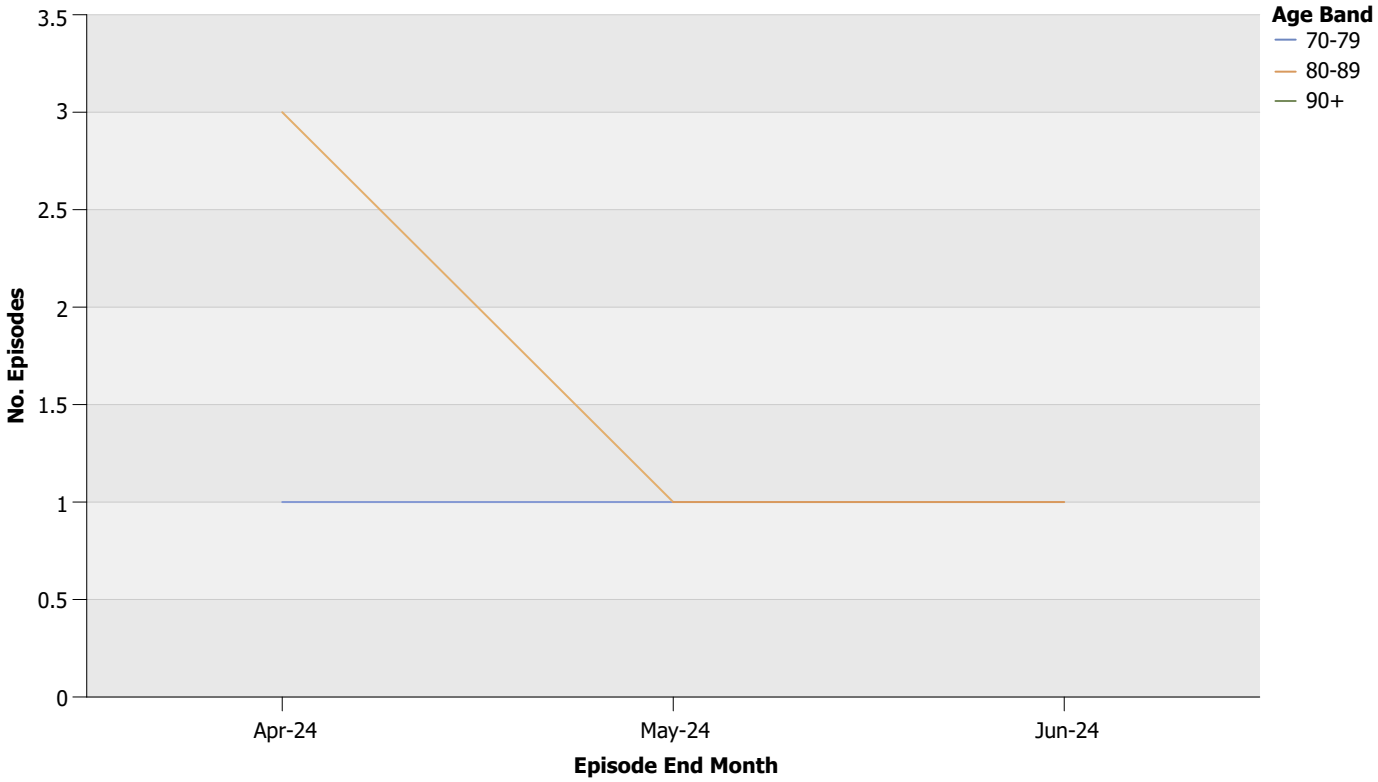
Community Hospitals - Patient Deaths by Age Band

No. Episodes		Apr-24	May-24	Jun-24	Total
70-79	Whitchurch	1	1		**2**
	Total for 70-79	**1**	**1**		**2**
80-89	Bridgnorth	1		1	**2**
	Sub-Acute PRH	1			**1**
	Sub-Acute RSH		1		**1**
	Whitchurch	1			**1**
	Total for 80-89	**3**	**1**	**1**	**5**
90+	Sub-Acute RSH		1		**1**
	Whitchurch		1		**1**
	Total for 90+		**2**		**2**
Total		**4**	**4**	**1**	**9**

Community Hospitals - Patient Deaths by Age Band



Community Hospitals - Patient Deaths by Age Band

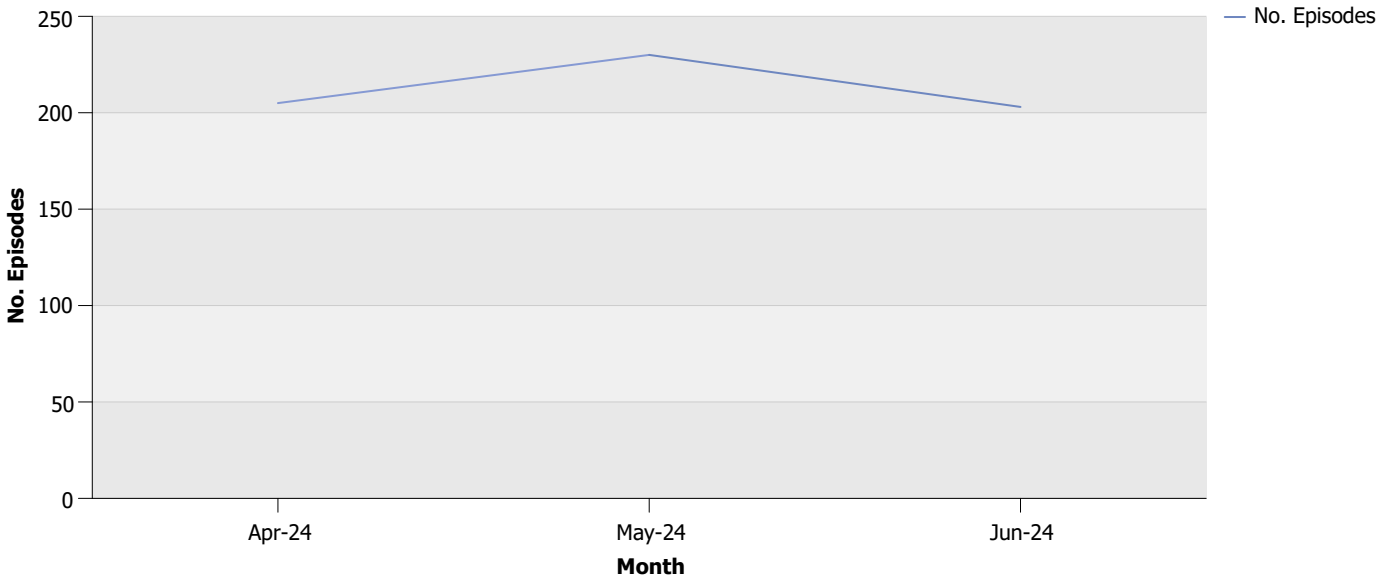


Community Hospitals - Admissions

No. Episodes		Apr-24	May-24	Jun-24	Total
Bridgnorth	[WARDS] - A&E Transfer (Inpatients)	4	4	1	**9**
	[WARDS] - GP Referral (Inpatients)		2	3	**5**
	[WARDS] - ICS - Admission Avoidance (Inpatients)			2	**2**
	[WARDS] - Ward Transfer (Inpatients)	38	42	37	**117**
	11 - [DAY CASE] - Waiting List (Day Case)	1		1	**2**
	12 - [DAY CASE] - Booked (Day Case)	11	13	7	**31**
	Total for Bridgnorth	**54**	**61**	**51**	**166**
Ludlow	[WARDS] - A&E Transfer (Inpatients)	4	6	6	**16**
	[WARDS] - GP Referral (Inpatients)	4	2	5	**11**
	[WARDS] - ICS - Admission Avoidance (Inpatients)	2	1	1	**4**
	[WARDS] - Ward Transfer (Inpatients)	25	27	23	**75**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure		1		**1**
	Total for Ludlow	**35**	**37**	**35**	**107**
Sub-Acute PRH	[WARDS] - A&E Transfer (Inpatients)		2		**2**
	[WARDS] - Ward Transfer (Inpatients)	46	47	30	**123**
	[WARDS] - Ward Transfer (Inpatients) – Return/Re-admission following Procedure		1		**1**
	Total for Sub-Acute PRH	**46**	**50**	**30**	**126**
Sub-Acute RSH	[WARDS] - A&E Transfer (Inpatients)		1	1	**2**
	[WARDS] - ICS - Admission Avoidance (Inpatients)		2		**2**
	[WARDS] - Ward Transfer (Inpatients)	27	46	44	**117**
	Total for Sub-Acute RSH	**27**	**49**	**45**	**121**
Whitchurch	[WARDS] - A&E Transfer (Inpatients)	6	4	10	**20**
	[WARDS] - GP Referral (Inpatients)	1			**1**
	[WARDS] - ICS - Admission Avoidance (Inpatients)	3		1	**4**
	[WARDS] - Ward Transfer (Inpatients)	33	29	31	**93**
	Total for Whitchurch	**43**	**33**	**42**	**118**

Community Hospitals - Admissions

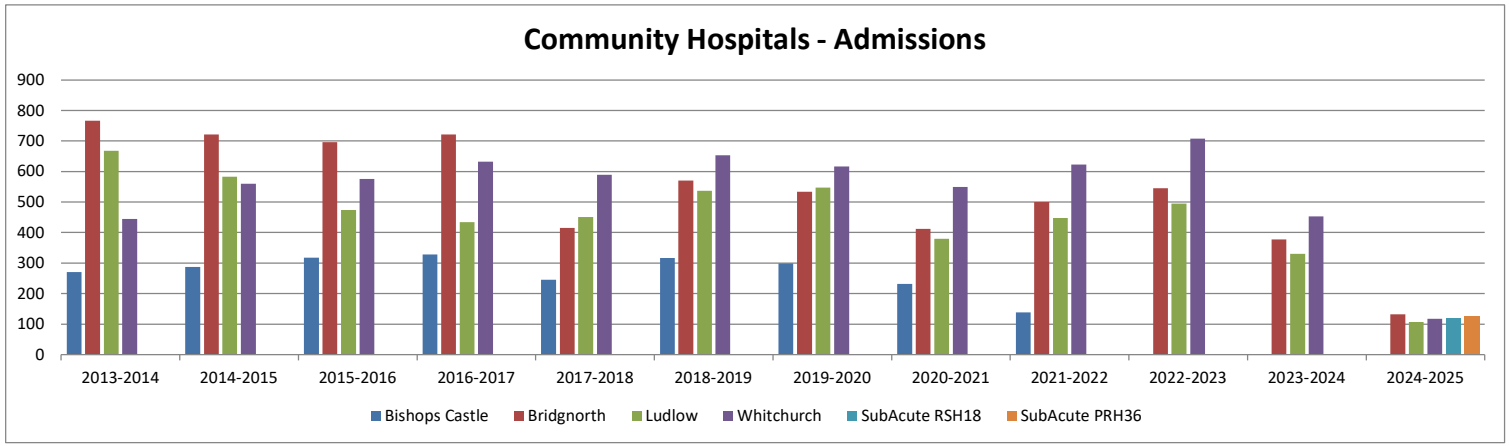
No. Episodes	Apr-24	May-24	Jun-24	Total
Total	**205**	**230**	**203**	**638**



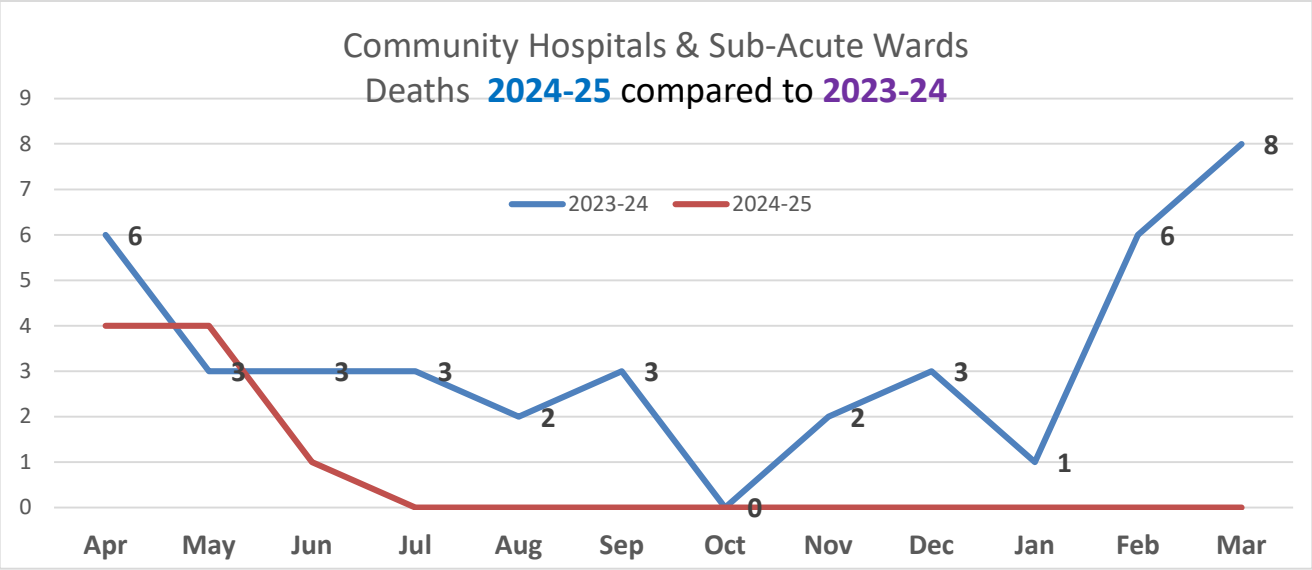
Community Hospitals - Admissions

Community Hospital	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Totals
Bishops Castle	271	288	318	328	245	317	299	232	139	0	0	0	**2,437**
Bridgnorth	767	722	696	722	416	570	534	412	500	545	378	133	**6,262**
Ludlow	668	583	474	434	451	537	548	379	448	495	330	107	**5,347**
Whitchurch	445	560	576	632	589	653	617	549	623	708	453	118	**6,405**
SubAcute RSH18	0	0	0	0	0	0	0	0	0	0	0	121	**0**
SubAcute PRH36	0	0	0	0	0	0	0	0	0	0	0	126	**0**
Total	**2,151**	**2,153**	**2,064**	**2,116**	**1,701**	**2,077**	**1,998**	**1,572**	**1,710**	**1,748**	**1,161**	**605**	**20,451**

Note: [



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



Average 23-24 3.3333

Average 24-25 3

	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
2024-25	4	4	1	0	0	0	0	0	0	0	0	0	9

Community Hospitals & Sub-Acute Wards - Patient Deaths by Hospital - 2012 to 2024 (to date)

Community Hospital	2012 to 2013 Total	2013 to 2014 Total	2014 to 2015 Total	2015 to 2016 Total	2016 to 2017 Total	2017 to 2018 Total	2018 to 2019 Total	2019 to 2020 Total	2020 to 2021 Total	2021 to 2022 Total	2022 to 2023 Total to date	2023 to 2024 Total to date	2024 to 2025 Total to date
Bishops Castle	33	34	30	21	27	12	22	11	8	7	0	0	0
Bridgnorth	43	41	32	34	29	19	26	26	17	16	13	8	2
Ludlow	56	60	30	24	25	32	24	21	24	13	8	10	
Whitchurch	40	49	33	28	46	37	28	28	50	32	33	17	4
SubAcute RSH18												2	2
SubAcute PRH36												3	1
Total	172	184	125	107	127	100	100	86	99	68	54	40	9

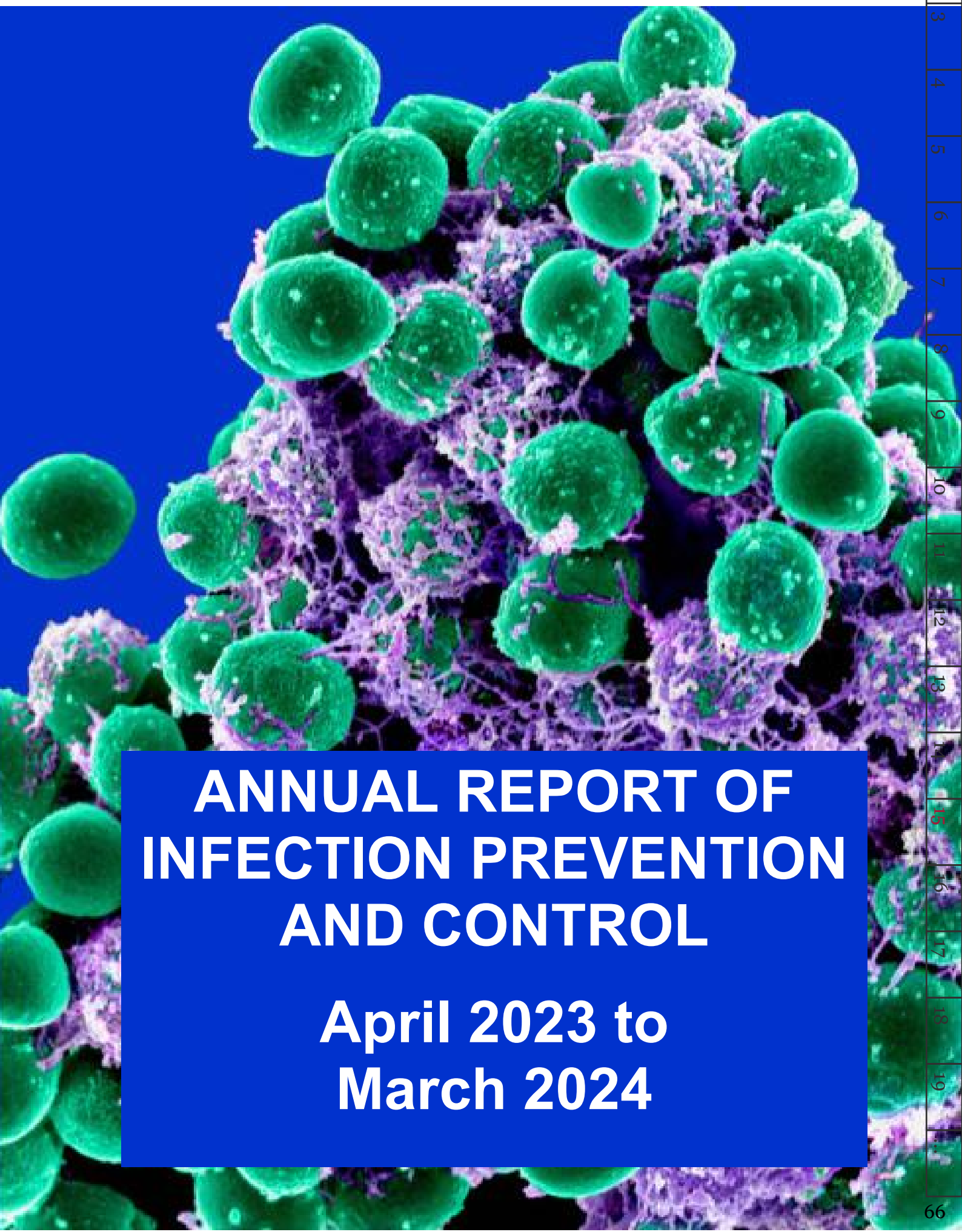
Appendix 1

Shropshire Community Health - Community Hospital COVID-positive patient deaths

	2023/2024				Grand Total from 2020
Hospital	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	
Bridgnorth	0	0	0	0	7
Bishops Castle			0	0	0
Ludlow	0	0	0	0	13
Whitchurch	0	0	0	0	52
Sub-Acute Wards	0	0	0	0	0
Grand Total	**0**	**0**	**0**	**0**	**72**

	Mar-24	Apr-24	May-24	Jun-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	**29**

Shropshire Community Health
NHS Trust



ANNUAL REPORT OF INFECTION PREVENTION AND CONTROL

April 2023 to March 2024

Table of Contents

Foreword by Clair Hobbs, Director of Infection Prevention and Control

As Director of Nursing and Director of Infection Prevention and Control (DIPC), this annual report summarises the infection prevention and control work that has been undertaken for the year 2023/24 and once again shows the wonderful achievements over the last 12 months. This report once again highlights the huge amount of work and dedication shown by our small but incredibly skilled Infection and Prevention Team led by Sara Ellis-Anderson as Deputy Director for Infection Prevention & Control.

The Team have continued to robustly support clinical areas with outbreaks, cleanliness standards, staff practices and Estates Improvement work helping to provide clean, safe and effective environments and practices across our services.

In 2023/24 we have seen further growth in the services we provide including an Outpatient Parenteral Antimicrobial Therapy Service (OPAT) giving wider opportunities for clinical staff to extend their skills safely whilst providing even better services to patients requiring additional therapy that is not required in an acute hospital setting. We have also seen the opening of 2 new Rehabilitation & Recovery Wards and in April 2024 welcomed the Dudley 0-19 Teams and the much-awaited re-opening of Bishops Castle inpatient Ward facility is imminent.

We have seen vast improvements in what has been an incredibly busy year for many clinical areas in regard to cleaning and environment, not least that of Oswestry Health Centre and Whitchurch Community Hospital Ward which now have better Estates and cleaning provided to aid keeping staff and visitors safe and well and with further continued work carrying on into 2024.

There have been significant improvements in overall governance, communication and assurance for Infection Prevention and Control across all the Trust. The engagement with clinical teams and leaders this year has improved dramatically, and this excellent engagement has resulted in improvements to training compliance in all areas.

We have as an organisation participated in a National UKHSA Point Prevalence Survey relating to Healthcare Associated Infections and Antimicrobial Prescribing and working closely with Infection Prevention and our Chief Pharmacist Susan Watkins and her teams, we are now able to nationally benchmark ourselves and take further actions with these topic areas to further enhance the care we provide.

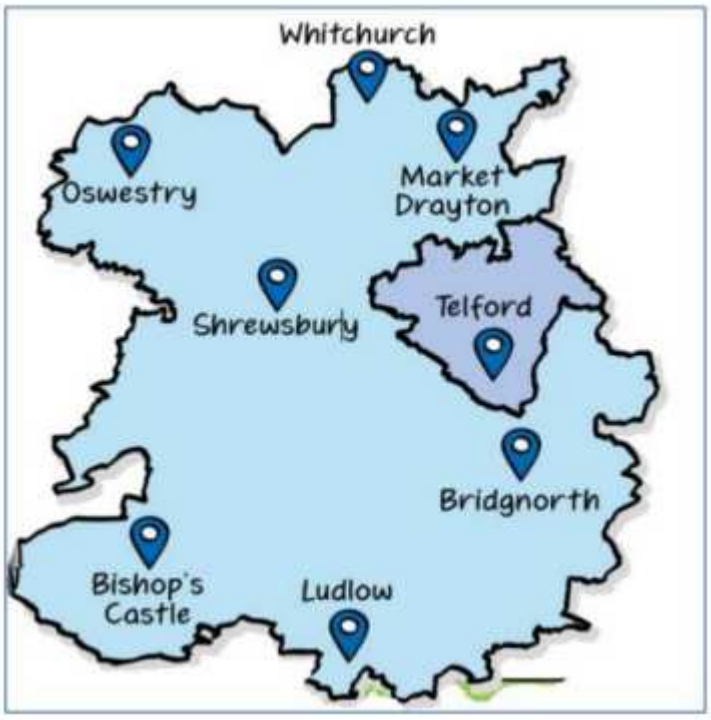
Our Infection Prevention & Control Team continue to work hard every day, visiting our sites regularly offering advice and completing audits and in line with the new Patient Safety Incident Response Framework (PSIRF), we are starting to see After Action Reviews undertaken where there is wider learning to share; an example of which is in this document.

It only leaves me to say a huge thank you once again to all of our staff and leaders for their continued support in helping to keep staff and patients safe and to Sara Ellis-Anderson and the IPC Team, Richard Best, Associate Director of Estates, the Hotel Services teams and Susan Watkins, Chief Pharmacist and their teams in what once again has been a very productive and positive year for us on this important topic area.

Clair Hobbs, Director of Nursing, Clinical Delivery and Workforce and Director of Infection Prevention and Control

Introduction

Who We Are and What We Do

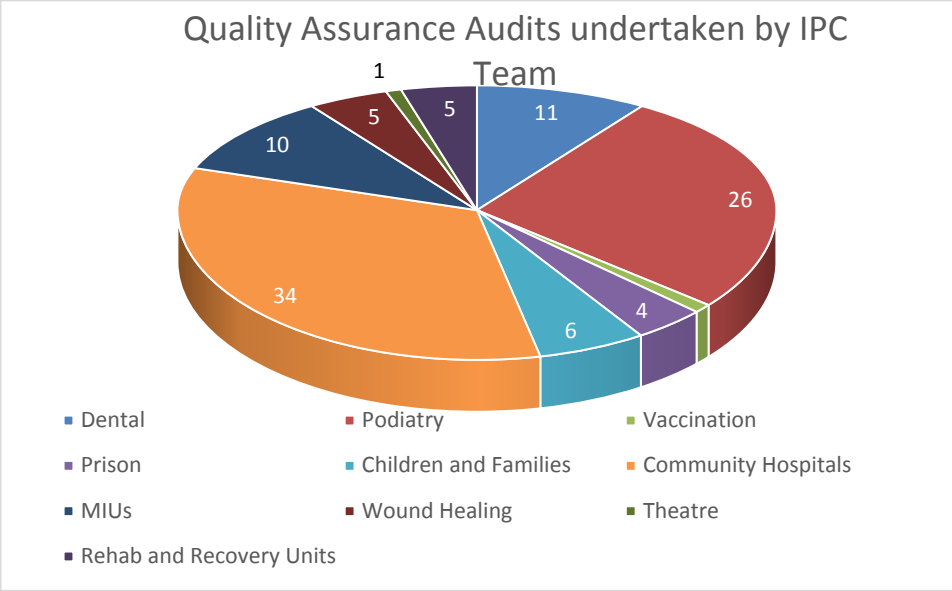


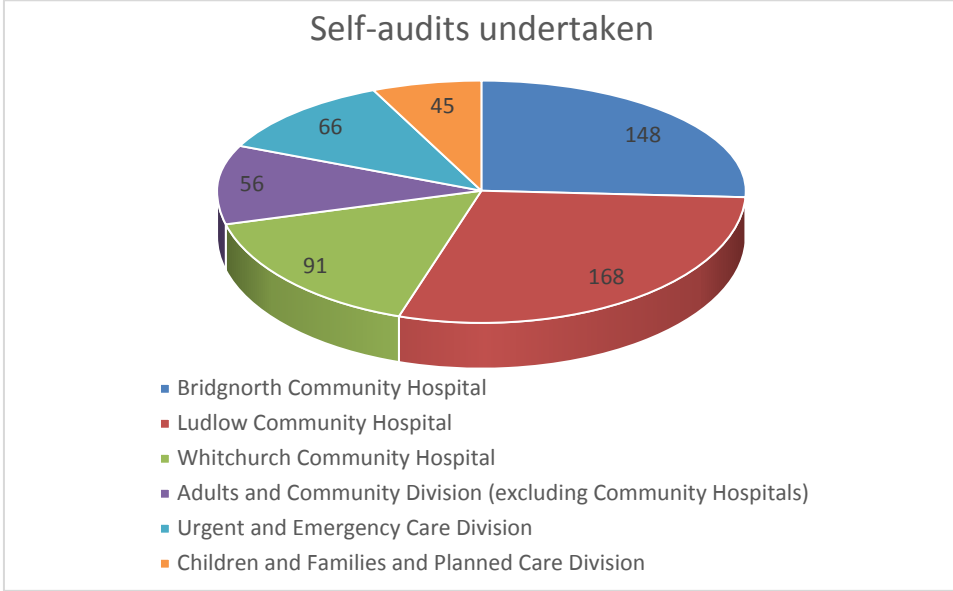
Shropshire Community Health NHS Trust (SCHT) provides a range of community and community hospital services for the people of Shropshire, Telford and Wrekin, serving a population of around 506,000 people. Shropshire is a mostly rural, diverse county with over a third of the population living in villages, hamlets and dispersed dwellings, a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England. As over a third of our population live rurally, our services are on the main organised geographically to enable us to be as responsive as possible to meet the needs of our service users, their carers and families. SCHT serves its population throughout life, with a wide range of services including but not limited to; 0-19s 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 served.

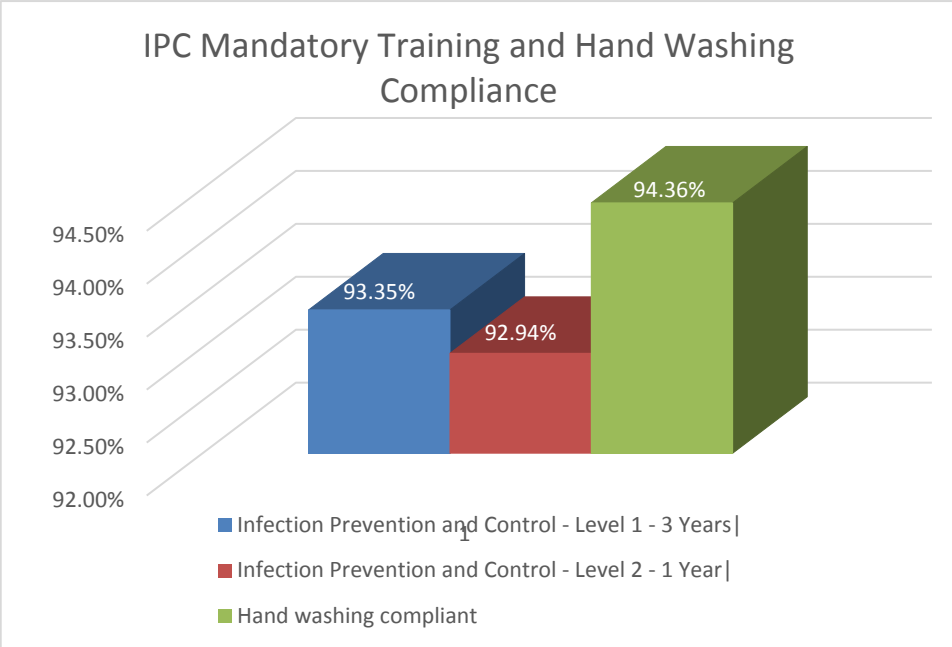
This annual report outlines the activities of SCHT relating to Infection Prevention and Control (IPC) for the year from April 2023 to March 2024 and discusses the arrangements SCHT have in place to reduce the spread of infections. It also reviews governance arrangements, policies and procedures relating to monitoring and surveillance, the environment, cleaning, audit and education. The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised December 2022), which sets out 10 criteria of which a registered provider must be compliant. This sets the framework on which we base our annual programme that is monitored at SCHT's Quality and Safety Committee and IPC Committee (IPCC). The prevention and management of infection is the responsibility of all staff working in SCHT and is an integral element of patient safety programmes. The aim of the IPC Team is to maintain organisational focus and collaborative working to ensure continued compliance with IPC practices, and to actively contribute to quality improvement and safer patient care.

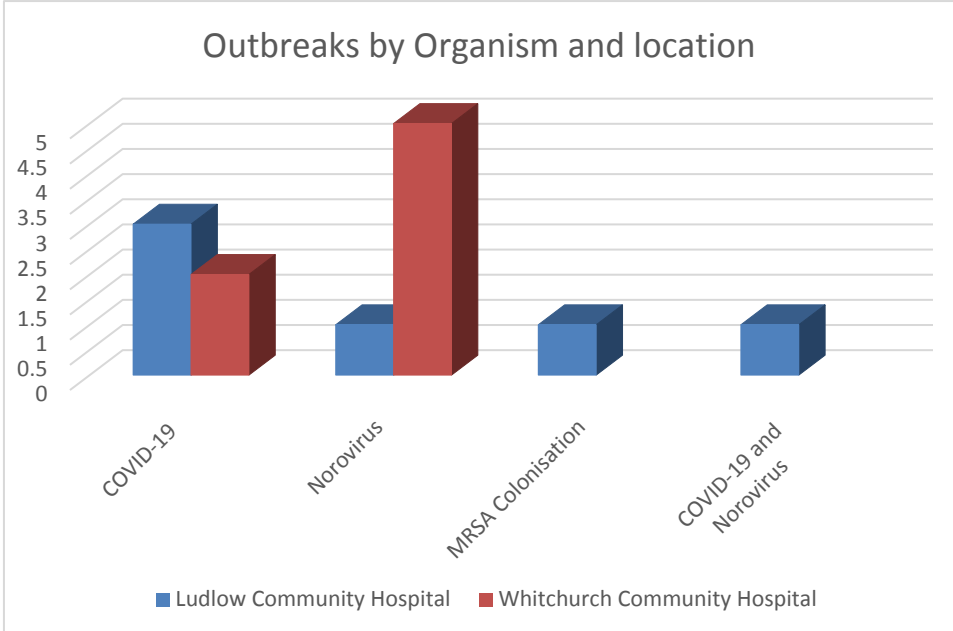
Key Achievements of 2023/24

Our year in numbers









MRSA Bacteraemia and *Clostridioides difficile* cases in SCHT in 2023/24

	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 to date	Threshold
Healthcare Associated Infections – KEY: Green – below threshold Red – above threshold														
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridioides difficile	0	0	1	0	1	0	0	0	0	0	1	1	4	1

MRSA Screening on admission to SCHT inpatient areas 2023/24

Percentage of inpatients screened for MRSA on admission to Community Hospitals – KEY: Green – above 97% Red – below 97%														
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23	Mar-23	Total to date	Threshold
Average over Trust	96%	97%	100%	98%	98%	98%	98%	97%	94%	96%	97%	97%	97%	97%

Key Achievements

The pressures facing our NHS and the IPC Team continued into 2023-24 following the national pandemic. The Trust launched their first IPC strategy in January 2023 and the IPC team have continued to deliver against the four ambitions set out; integrated working, education and training, digital technology and enhanced engagement.

Our IPC Team key achievements were:

- The IPC Team remained actively involved in managing COVID-19 and Norovirus outbreaks in our inpatient services by providing up to date specialist advice to support our teams and our people in a timely way.
- The IPC Team worked with our operational teams, attending meetings and huddles to increase awareness that IPC is the responsibility of every member of SCHT staff working collaboratively and supporting our colleagues to prevent and manage infection.
- We continued to collaborate with operational areas regarding Estates improvement works all over our Trust, with notable refurbishment works happening at Whitchurch Community Hospital and Oswestry Health Centre.
- We continued to work on the overarching IPC Improvement plan, capturing actions from the Health and Social Care Act, the Board Assurance Framework, the National IPC Manual, our own audits and visits to ensure we can map how we are improving as an organisation and providing assurance that we are a Trust engaged with IPC and safe patient care.
- The IPC Team continued to investigate all infections acquired within our Community Hospitals. The Team provided in depth reports to support investigations and identified areas for improvements. This included improving our screening of CDI and MRSA.
- In relation to IPC training at the end of March 2024, 93.35% of our staff completed IPC Level 1 training, and 92.94% of clinical staff were up to date with IPC Level 2 e-learning.
- The IPC team are now delivering regular face to face IPC training sessions on the Clinical Skills induction programme.
- The IPC team supported the opening of two new Rehabilitation and Recovery wards based at Royal Shrewsbury Hospital and Princess Royal Hospital. After opening the Team made regular visits to advise and support the new teams including delivery of the ‘Back to Basics’ education campaign.
- SCHT were one of nine Community Trusts that that participated in the UKHSA Point Prevalence survey of hospital associated infections and antimicrobial use last September. All three community hospital wards were included. The results will enable us to have a benchmark of our infections nationally and identify those types of infections we need to focus on and prevent.
- The IPC Team developed several campaigns throughout the year to engage staff with IPC. These campaigns included a Spring Clean Campaign to encourage clinical areas to tidy and declutter, a Back to Basics Roadshow and leaflet and Antimicrobial Awareness drop-in sessions provided jointly with Pharmacy which provided education and training on alert organisms, aseptic non touch technique and Anti-Microbial Resistance (AMR).
- The IPC Team developed isolation posters to give staff guidance as to what precautions to take, according to what organism isolated patients are infected by.
- The Associate Director of IPC for NHSE in the Midlands visited the Bridgnorth Community Hospital, Oswestry Health Centre and Whitchurch Community Hospital in April 2023. Recommendations included a long-term review of bed spacing at Whitchurch Hospital, a review of the cleaning provision at Oswestry and identification and replacement of damaged equipment such as foot stools, leg troughs and pressure cushions. These recommendations have been addressed. Areas of good practice included the knowledge of the IPC team and

IPC practices demonstrated by staff, catheter care plans completed and up to date and all commodes checked were clean.

- We have continued to support Local Hospices by providing advice and guidance and sharing policies.
- Engagement and collaboration have improved with the dissemination of the monthly IPC newsletter, the establishment of non ward-based IPC link worker meetings and the IPC team lead WhatsApp group to ensure the delivery of key messages across the organisation.

The Criteria of the Health and Social Care Act (2008: revised 2022)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

NHSE's Health and Social Care Act (H&SCA) guidance, builds on the previous H&SCA code of practice and contains statutory guidance about compliance with the registration requirement relating to IPC, including cleanliness. The H&SCA and regulations are law and must be complied with. The CQC has enforcement powers that it may use if registered providers do not comply with the law.
Any gaps in compliance and actions to address these are captured on the overarching Trust IPC Improvement Plan.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

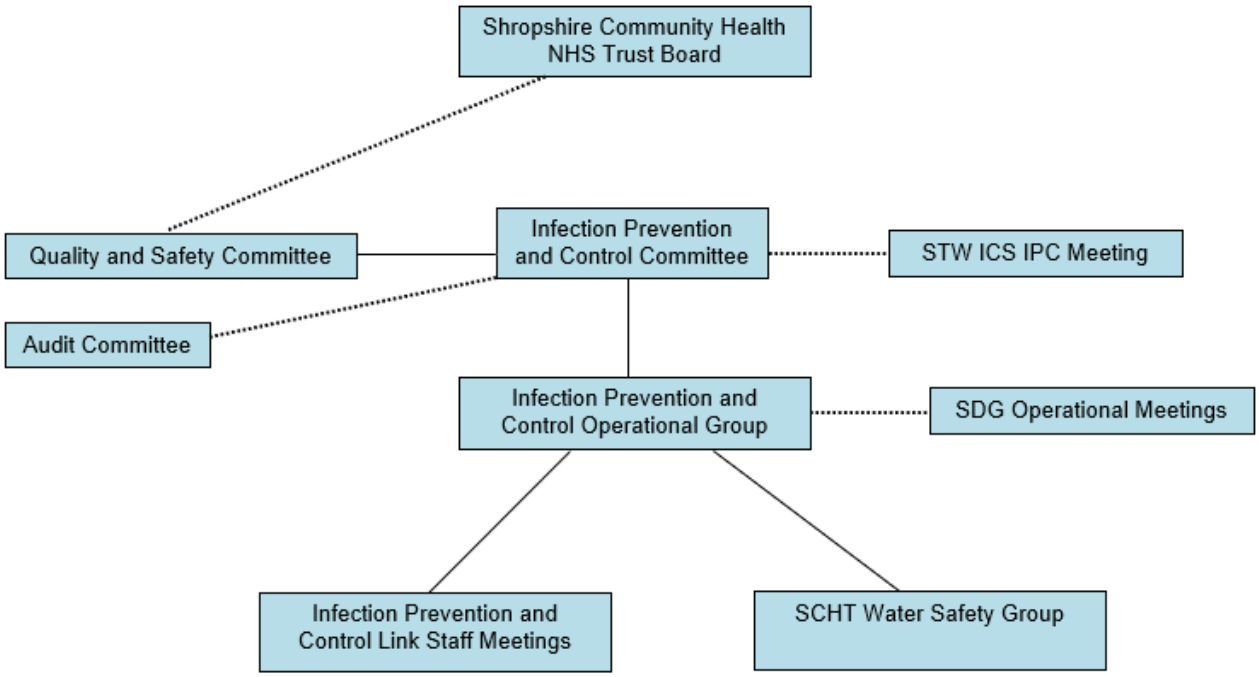
Duties, arrangements and assurance

The SCHT Board and ultimately the Chief Executive carries responsibility for ensuring that systems and resources are available to implement and monitor compliance with IPC and is a vital component of Quality and Safety. The Director of IPC (DIPC) provides oversight and assesses assurances on IPC (including cleanliness), the built environment and antimicrobial stewardship reported to the Trust Board. The responsibilities of the DIPC are discharged by the Deputy Director for IPC who is responsible and manages IPC for the Trust. All managers and clinicians must ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff is expected to demonstrate commitment to reducing the risk of Healthcare Associated Infections (HAI) through the application of standard IPC measures aligned to the National IPC Manual. The IPC Team provide a comprehensive proactive

service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC. Reports on all IPC activity are submitted through a series of operational Groups, Committees and to Private and Public Board for oversight and assurance purposes.

Governance and Assurance Arrangements for 2023/24

Shropshire Community Health NHS Trust
Infection Prevention and Control Governance Framework



The Infection Prevention and Control Team

The Trust's DIPC is Clair Hobbs, who is also Director of Nursing and Clinical Delivery, and reports directly to the Chief Executive.

Deputising for the DIPC and leading the IPC Team and IPC programme, is Sara Ellis-Anderson, in the role of Deputy Director of IPC. Sharon Toland is the Clinical Lead Nurse for IPC. Ian McCabe and Eve Sampson are IPC Nurses.

SCHT has a committed IPC Team that is very clear on the actions necessary to deliver and maintain patient safety and quality of care. Equally, it is recognised IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC Team utilises a proactive approach to engage with staff to develop systems and processes that lead to sustainable and reliable improvements in applying IPC practices.

Infection Prevention and Control Service

- Director of IPC (also Director of Nursing and Clinical Delivery) (1.0 WTE)
- Deputy Director of IPC (also Deputy Director of Nursing and Quality) (1.0 WTE)
- Clinical Lead Nurse, IPC (1.0 WTE)
- IPC Nurse (0.8 WTE)
- IPC Nurse (0.8 WTE)
- IPC Secretary (1.0 WTE)

SCHT has a Service Level Agreement for specialist support from a Consultant Microbiologist at SaTH to act as SCHT's IPC Doctor. Medical microbiology support is provided 24 hours a day, 365 days a year through on-call arrangement. SCHT also seek advice from the UKHSA and NHSE IPC when required.

Trust Board – SCHT's performance against the MRSA Bacteraemia, Clostridioides Difficile Infection (CDI) national reduction thresholds and the MRSA screening threshold are included in the monthly Integrated Quality Report. The IPC Board Assurance Framework (IPC BAF) is completed and presented at the SCHT Public Board Meetings bi-annually and this IPC Annual Report is presented annually at the Public Board.

Infection Prevention and Control Committee (IPCC) – This group, together with the IPCOG below, replaced the IPC Governance Meeting. Membership is multi-disciplinary and includes representation from the operational and quality directorates, estates department, medicines management and SCHT IPC Doctor. The meeting is chaired by the DIPC and meets monthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

Quality and Safety Committee (QSC) – IPCC chair reports, the IPC Board Assurance Framework and the IPC Annual report are presented to Quality and Safety Committee meetings.

Infection Prevention and Control Operational Group (IPCOG) Meeting – This group, together with the IPCC (above), replaced the IPC Governance Meeting. Primary membership is from higher risk areas within the Trust, such as Community Hospitals, dental services and podiatry as well as Health and Safety and Estates representatives. Team leaders from other services are invited to join if they have any IPC issues to discuss and/or address. The meeting is chaired by the Deputy DIPC and meets monthly. The Terms of Reference (TOR) and membership are reviewed every year to ensure responsibility for IPC continues to be embedded across the organisation.

Learning from Deaths Meeting – The membership is multi-disciplinary and includes representation from the operations and quality directorates, IPC and medical directorate.

SCHT Water Safety Group – The membership is multi-disciplinary and has representatives from Midlands Partnership Foundation NHS Trust (MPFT) and an Authorising Engineer. The Terms of Reference and Governance structure is reviewed every two years. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, Automated Endoscope Reprocessor (AER) and capital developments and reports to the QSC. The annual SCHT Water Safety audit was undertaken in October 2023. The Deputy Director of IPC is also a member of the MPFT Operational Water Safety Group for Shropshire chaired by MPFT to oversee operational delivery of Water Safety.

Integrated Care System IPC Meeting/IPC and Anti-Microbial Resistance Group – These System groups aim to ensure a strategic overview across the local health economy and SCHT is represented by the Clinical Lead Nurse for IPC.

In addition to the meetings mentioned above, the IPC Team also attend other regular and ad hoc meetings where specialist IPC knowledge is required.

Infection Prevention and Control Link Staff – All IPC link staff and their line managers are asked to sign a Roles and Responsibilities agreement. Our IPC link staff support the operational delivery of IPC practice ensuring high standards of quality and patient safety in relation to IPC. Our IPC link staff are also responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

Divisional Clinical Managers, Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders – Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of

cleanliness. Our leaders are responsible for ensuring the IPC link staff are supported in performing their role and have appropriate time and resources to do this effectively.

Organisational Development Team – Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Training compliance is reported monthly to the QSC.

Roles and Responsibilities of all Staff – All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow standard IPC precautions at all times and are familiar with IPC policies, procedures and guidance relevant to their area of work and this responsibility is included in all SCHT job descriptions.

Alert Organism Surveillance and Management and Healthcare Associated Infection

All organisms of IPC significance are monitored by the IPC Team and are termed Alert Organisms. The local acute Trust, whose microbiology laboratory process specimens from SCHT patients, submit data on SCHT's behalf on MRSA Bacteraemia, MSSA Bacteraemia, Escherichia coli (E.coli) Bacteraemia infections and CDI to UKHSA, as part of the national mandatory surveillance programme for HCAIs.

SCHT does not have nationally set thresholds for reducing HCAIs. These thresholds are set for acute Trusts and ICBs. However, SCHT recognises it does have a responsibility in contributing to the overall reduction thresholds of Shropshire and Telford & Wrekin ICB and therefore agree local infection thresholds.

Healthcare Associated Infections in SCHT 2023/24

	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	Threshold
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium difficile	0	0	1	0	1	0	0	0	0	0	1	1	4	1
E-coli Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Klebsiella spp	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MSSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A
CPE Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A
VRE Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A

Green – under or equal to threshold
Red – exceeding threshold

MRSA Bacteraemia Trust Threshold

In the event of a patient contracting an MRSA Bacteraemia whilst under the care of SCHT, the Trust would review the case through a Patient Safety Investigation to identify any potential lapses in care or any common themes that may have contributed to the infection.

Clostridioides difficile Infection (CDI) Thresholds

The local threshold set for SCHT was to have no more than one case of CDI diagnosed post 48 hours after admission in the community hospitals attributed to SCHT.

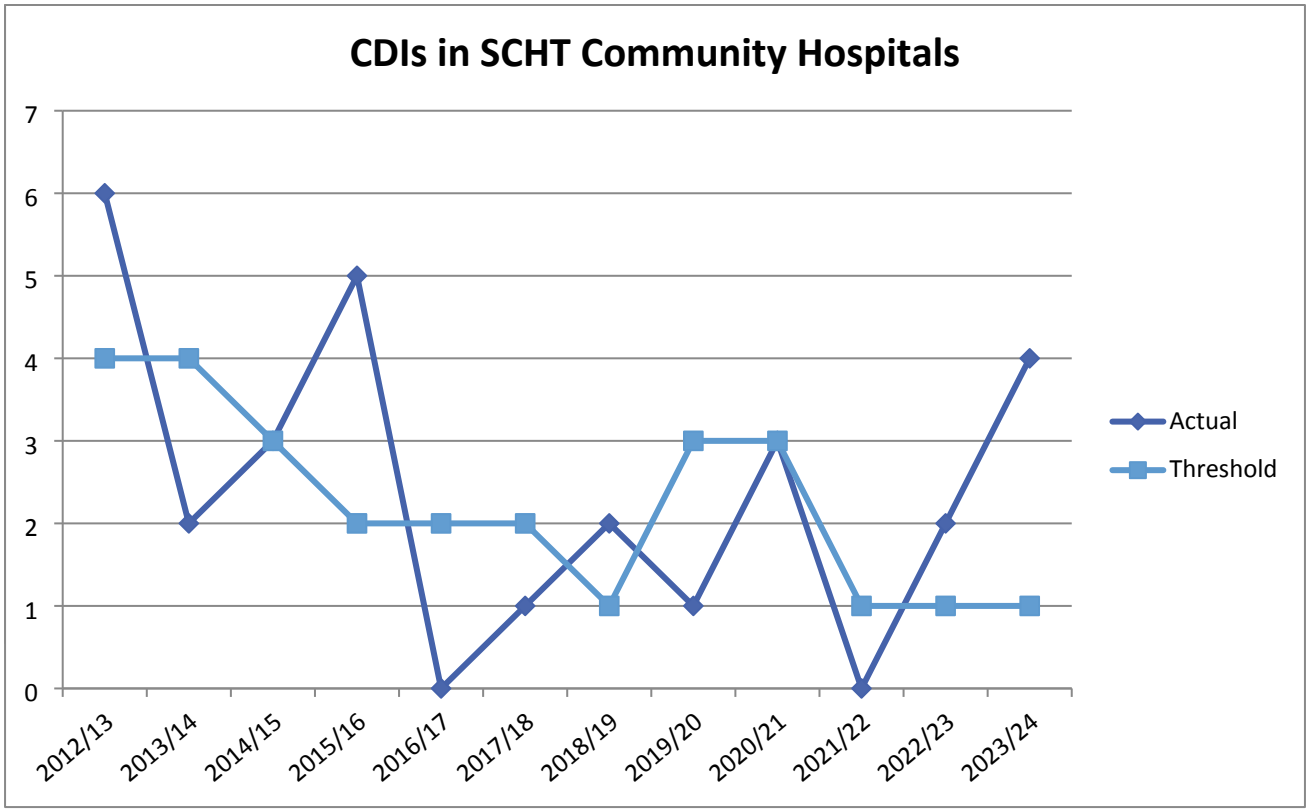
There were four incidences of CDI attributed to SCHT in 2023/24. Each case is reviewed to identify learning, three out of the four cases demonstrated good practice and the fourth case identified lessons to be learned in terms of timely isolation and sending of sample on identification of symptoms, these were discussed at an infection review meeting and fed back to ward staff.

The IPC Annual Programme continues to focus on key actions to reduce the number of CDI cases which includes appropriate antibiotic prescribing and advice, with the earliest detection of CDI and prompt isolation of all patients with diarrhoea. SCHT IPC team have contributed to a Shropshire Telford and

Wrekin (STW) collaborative CDI improvement plan to share best practice and learning in response to the increased incidence being seen across all system providers during 2023/24.

The graph shows the cases of CDI diagnosed in SCHT Community Hospitals since 2012/13 against the threshold set by the commissioners.

Incidences of CDI in SCHT since 2012/13



CDI 30-day Mortality Rate

The Consultant Microbiologist at SaTH monitors the local health economy CDI mortality data which includes patients in SCHT. There were no deaths attributed to CDI at our Community Hospitals.

Periods of Increased Incidence (PII)

Since April 2010, all Trusts have been asked to report PII of infections on the Trust's electronic incident reporting system, Datix. SCHT reported no PII during 2023/24.

Other Alert Organism Surveillance and Management

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia.

Mandatory reporting of all MSSA bacteraemia commenced in January 2011. There is currently no target associated with MSSA bacteraemia incidence. SCHT continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance scheme.

Carbapenemase-producing Enterobacteriaceae (CPE)

CPE are Gram negative bacteria which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics, are ineffective. CPE continues to be included in the SCHT revised Prevention and Control of Multi-Resistant Gram-Negative Bacteria policy and advice is included in the Guide to Multi Resistant Gram-Negative Bacteria information leaflets available to all staff, patients and visitors.

Glycopeptide-Resistant Enterococci (GRE) also known as Vancomycin-Resistant Enterococci (VRE)

In all cases of GRE/VRE, IPC recommend source isolation for all community hospital patients as prevention of transmission is through effective transmission-based precautions.

Extended Spectrum Beta-Lactamase (ESBL) including Escherichia *coli.* and *Klebsiella/AmpC Beta-Lactamase*

Within the community hospitals the most common site for these bacteria is in patients' urine. Upon notification of a positive result, the IPC Team contact the ward to discuss isolation, other precautions and if treatment is required.

Outbreaks

An outbreak of infection is described as two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample and are linked through a common exposure, personal characteristics, time or location.

The table below summarises the outbreaks declared in SCHT community hospitals during 2023/24.

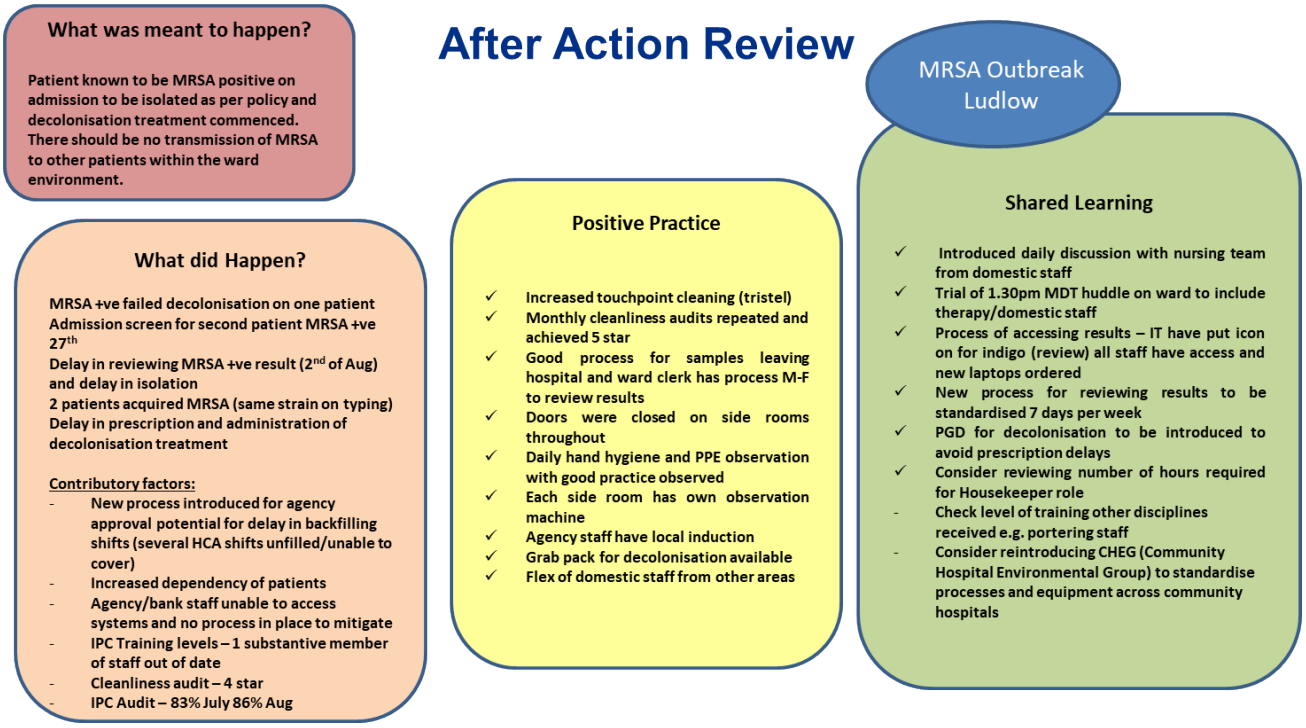
Total outbreaks declared in SCHT in 2023/24

Hospital/Team	Date	Causative Organism
Ludlow	03/08/23	MRSA (colonisation)
Ludlow	15/12/23	Covid-19 and Norovirus
Whitchurch	19/12/23	Norovirus
Ludlow	02/01/24	Covid-19
Whitchurch	04/01/24	Norovirus
Ludlow	15/01/24	Norovirus
Whitchurch	26/01/24	Covid-19
Ludlow	30/01/24	Covid-19
Whitchurch	17/02/24	Covid-19
Whitchurch	25/02/24	Norovirus
Whitchurch	11/03/24	Norovirus
Whitchurch	24/03/24	Norovirus
Ludlow	30/03/24	Covid-19

SCHT has continued to follow and adhere to National Guidance regarding COVID-19. In each of the outbreaks, whether for COVID-19 or Norovirus, the IPC Team conducted Quality Ward Walks to offer guidance on patient management and placement, adherence to control measures and advised the use of a range of tools designed to assist in the care and monitoring of affected patients. Daily discussions were conducted with Operational colleagues and Ward teams. Close monitoring in this way meant that the disruption to patients and SCHT services and teams was kept to a minimum.

Internal and external outbreak meetings were held on declaration of an outbreak with the ICB, UKHSA and NHSE, and the Care Quality Commission were notified of any disruption of services.

An After Action Review process was completed following the MRSA outbreak in Ludlow to identify contributory factors, areas for improvement and shared learning.



Auditing Programme

Auditing is the mainstay of the systems we use to manage and monitor the prevention and control of infection and a summary of our audits is provided below.

Hand Hygiene Assessments

Effective and timely hand decontamination is acknowledged as the most important way of preventing and controlling infections. The IPC Team continued its concerted efforts to ensure that hand hygiene compliance remained a high priority.

Training on the importance of hand hygiene, being “bare below the elbow” and the World Health Organisation (WHO) “5 moments for hand hygiene”, was provided locally to new clinical staff on induction and was reinforced by members of the IPC Team at all IPC training events, during clinical visits and whilst auditing.

Assessments to monitor effective hand washing are undertaken by all new staff within one week of commencement of employment, and annual assessments undertaken for existing staff, including students on placement. Hand washing assessments are included in clinical areas’ reports to the IPCC meeting.

IPC Quality Assurance Audits

In total 112 audits were undertaken by the IPC Team. The objectives of the audits were to inform services of their level of compliance to the NIPCM, local policy and procedures and allow improvements to be made based upon the findings. It also identified target areas for IPC training.

Common themes identified within these audits were Estates remedial works required, missed moments of hand hygiene and inappropriate use of and compliance with PPE.

As well as audits undertaken by the IPC Team, IPC have encouraged the use of the self-audit/checklist by ward staff and community staff to monitor ongoing IPC compliance. Any issues identified are addressed immediately to ensure safety for the individual patient, other patients, and staff, and for assurance as all self-audits are reported through IPC Committee meetings.
407 self-audits were undertaken at the community hospitals by ward staff – 148 at Bridgnorth Community Hospital, 168 at Ludlow Community Hospital and 91 at Whitchurch Community Hospital.

Self-audits were also undertaken in non-inpatient areas. These monitored areas such as the environment, cleaning standards and the condition and cleanliness of equipment, 56 such self-audits were undertaken in the Adults and Community Division, 66 in Urgent and Emergency Care Division and 45 in Children and Families and Planned Care Division.

External Audit

The Associate Director of IPC for NHSE in the Midlands visited the Bridgnorth Community Hospital, Oswestry Health Centre and Whitchurch Community Hospital in April 2023. Recommendations included a long-term review of bed spacing at Whitchurch Hospital, a review of the cleaning provision at Oswestry and identification and replacement of damaged equipment such as foot stools, leg troughs and pressure cushions. Areas of good practice included the knowledge of the IPC team and IPC practices demonstrated by staff, catheter care plans completed and up to date and all commodes checked were clean.

The The Trust were assessed as requiring enhanced monitoring and support on the NHSE IPC internal escalation matrix following the audit in April 2023 and key recommendations were made to improve the estate and cleanliness of Oswestry Health Centre.

In response to the external audit a comprehensive improvement plan was developed for Oswestry Health Centre and monitored fortnightly through a multi-agency meeting involving NHS Property Services, the ICB and SCHT estates, operational and IPC teams. As of March 2024, 93 actions out of 99 have been completed, this included significant refurbishment works, procurement of a new cleaning provider for the site and implementing the National Standards of Cleanliness to ensure clear roles and responsibilities. The 6 actions remaining continue to be monitored through IPCC.

Criterion 2 – The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The 2021 cleaning standards encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results. The 2021 standards reflect modern methods of cleaning, IPC and other changes since the last review and important considerations for cleaning services during a pandemic; and emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

All hospital wards have a hospital cleaning schedule and charter specific to the ward clearly displayed. Key policies for this criterion are in place.

- Quality reviews and IPC audits are undertaken in all areas that include general cleanliness.
- Monthly cleaning scores for sites maintained by MPFT are reported to the IPCC meeting.
- Formal assessments using Patient Led Assessment of the Care Environment were re-established and were reported through the Patient Experience Group.
- IPC Team continue to advise on refurbishment or redevelopment and new build projects to ensure IPC is adequately considered at all stages in line with Health Technical Memorandum and Health Building Notes.
- All laundry is reprocessed at Elis Laundry Services via a contract agreement with Mid Cheshire Hospitals NHS Foundation Trust. Compliance evidence against the contract

specifics is reviewed by the Trust and auditing of the laundry facilities is shared with colleagues from RJAH.

- The Central Sterilising Services Department (CSSD) in Telford, operated by SaTH, undertakes most of the decontamination of reusable instruments for SCHT.
- The Trust employs an Authorised Engineer who leads on Decontamination. Visits and audits were undertaken during 2023/24 to ensure compliance with training, process and guidance.
- The SCHT dental service is compliant with the “essential quality” requirements contained in the Health Technical Memorandum 01-05 – Decontamination in Primary Care Dental Practices and use the NHSE Dental Audit tool to monitor IPC.
- An automated audit reporting system is now used for completion and monitoring of cleaning audits at the community hospitals.

Water Safety

SCHT Water Safety Group meets quarterly with representatives from MPFT and NHS Property Services (NHS PS) and reports through IPCC. The Trust employs an Authorised Engineer who conducts an annual audit, and an action plan is developed to address any issues arising. The Group monitors and manages water risks, especially around Legionella and Pseudomonas, flushing regimens, annual disinfection and capital developments.

Criterion 3 – Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance

Medicines Management Report

The IPC specific organism policies have guidance contained around appropriate antimicrobial prescribing. The Trust has access to a Consultant Microbiologist to advise on appropriate antimicrobial prescribing.

The Trust follows local prescribing guidelines and a community antibiotic policy. All non-medical prescribers have an induction competency assessment with a pharmacist which includes antimicrobial prescribing. Ward Pharmacy Technicians review all prescription charts daily and advise on antimicrobial stewardship.

There are no dedicated AMS staff within the medicines management team at SCHT however as the covid vaccination service moves to a business as normal model the Lead Pharmacy Technician is being developed in order for them to take on the role of AMS pharmacy technician. As part of the development plan, we have received funding for this Technician to undertake a Level 4 enhanced program AMS pathway with Buttercups. This will further strengthen oversight of SCHT prescribing.

There are numerous services in the Community Trust where we would expect to see antibiotic prescribing and administration.

UKHSA Point Prevalence Survey

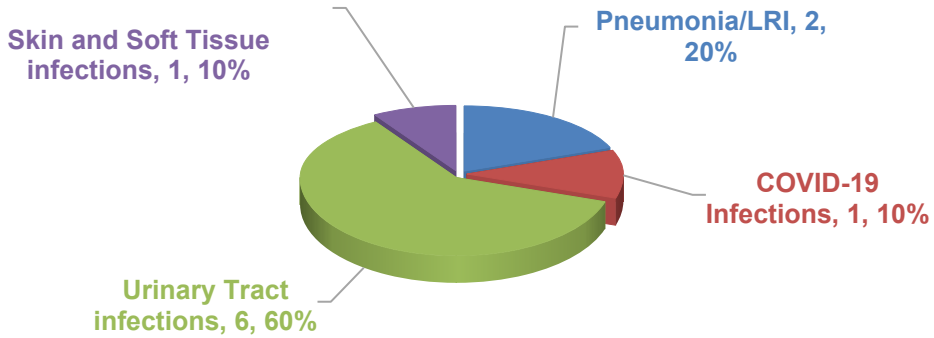
The Trust participated in the point prevalence survey on healthcare associated infections, antimicrobial use, and antimicrobial stewardship in England on the 20th, 25th and 27th of September 2023.

Overall, 124 Trusts / Independent Sector providers contributed to the 2023 PPS with data on more than 56,000 patients. Participation was voluntary, SCHT was one of only 9 community trusts to participate.

The aims and objectives of the survey were:

- To determine the prevalence of HCAI (Healthcare associated infections) and AMU (Antimicrobial use) within community hospitals and contribute to the national picture.
- Describe patients, invasive procedures, infections, and antimicrobials prescribed by patient demographics, specialities, or healthcare facilities.
- To have information of the above for our local trust in addition to contributing to regional and national data to help identify priorities and targets for quality improvement at local and national level.
- To provide a standardised tool for hospitals to identify targets for quality improvement.

HCAI prevalence, overall and distribution by infection site



9 patients were identified with an HCAI, please note 1 patient had 2 HCAIs.

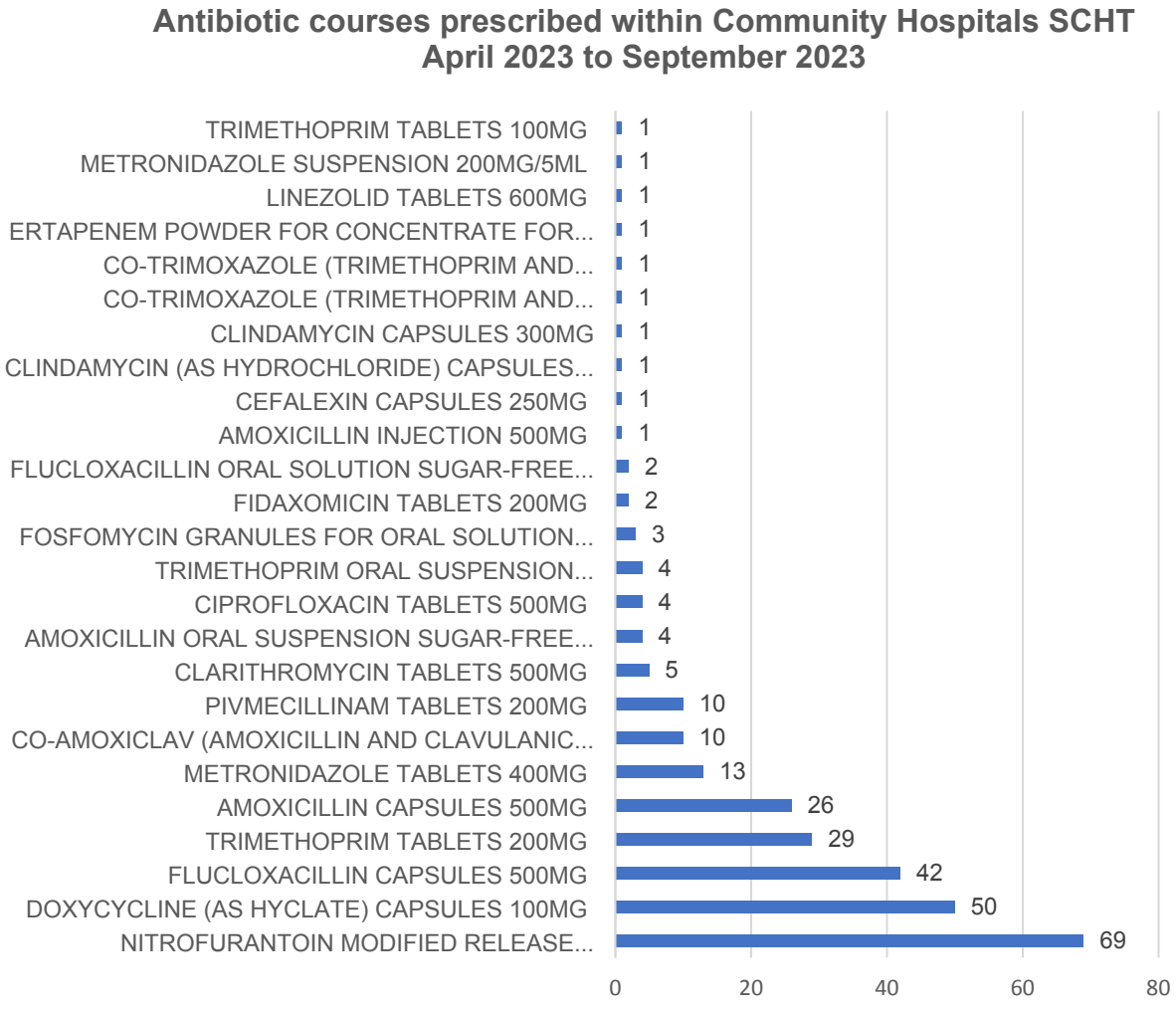
Recommendations because of the Point Prevalence Survey

- **Develop a framework** to prevent UTIs with a focus on maintaining hydration, and prompt removal of catheter when no longer required.

- **Develop a framework** for the prevention of hospital acquired lower respiratory infections / pneumonia with a focus on mobility, sitting out and mouthcare.
- **Repeat** a simplified version of the surveillance every quarter to provide benchmarking data, identify trends and improvements and as a tool to further improve antimicrobial stewardship.

Community Hospitals:

- Antibiotic prescribing is monitored electronically daily by a designated member of the Clinical Medicines Management Team.
- Team huddles take place daily for pharmacy staff within community hospitals - led by the lead pharmacist for community hospitals. Part of this huddle is to reiterate the AMS message and the importance of checking antimicrobial prescribing, technicians are reminded to check every patient's drug chart daily. Antimicrobial prescribing is then highlighted to the pharmacist who will clinically check the prescribing against Micro Guide to ensure it is being prescribed within our local guidelines.
- Any prescribing outside of guidance is challenged by the pharmacist with the prescriber. Where prescribing is outside of guidance and there is no microbiology to support the prescriber's decision, they will be highlighted to the Medical Director within SCHT who will challenge this prescribing. Any prescribing that fails to meet the guidance is questioned and a Datix completed.

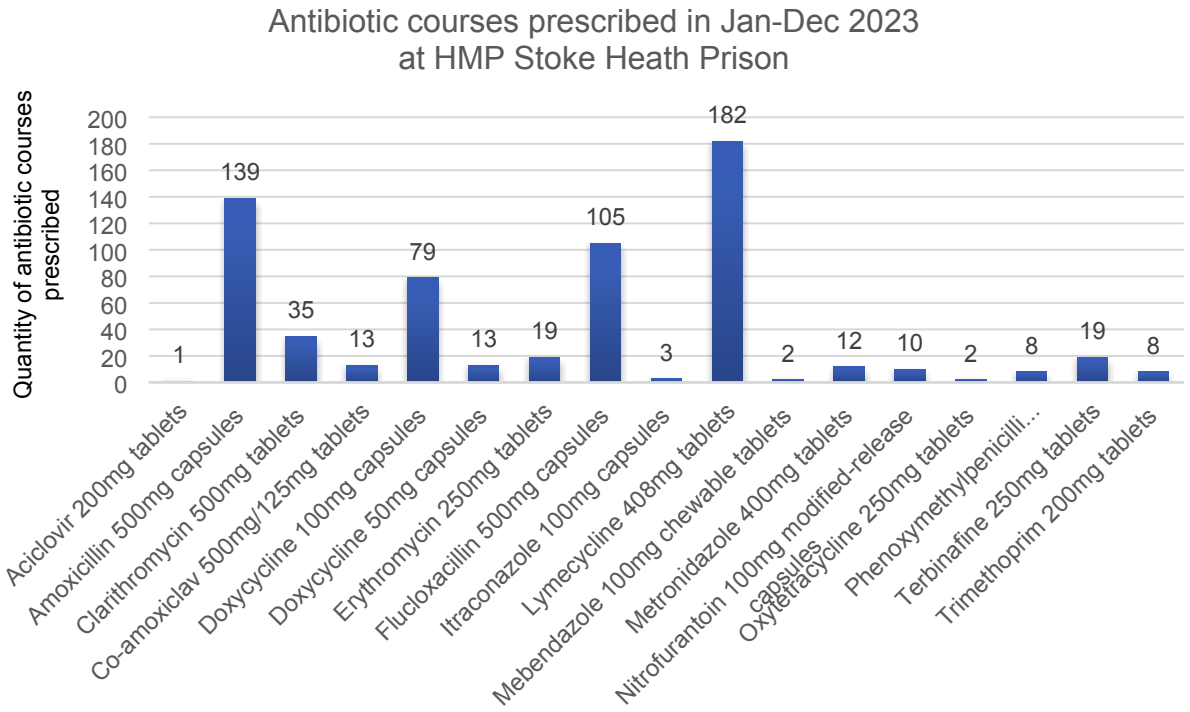


- A spreadsheet is also used to monitor antimicrobial use. The spreadsheet is used to record initiation of antibiotics along with the indication, chosen antibiotic, dose and course length as assurance. This is reviewed daily by the Lead Pharmacist for Community Hospitals and MIUs. Any queries are relayed back to the specific hospital team.

- Any antibiotic courses prescribed are added to each patient's RiO record along with the name of the prescriber for auditing purposes.
- The System Microguide is the reference source used to provide the most up to date information on resistance patterns.
- The use of Intravenous (IV) antibiotics occurs in one Community Hospital only (Whitchurch Rehab), however, use is low.

Prison Healthcare:

- The electronic patient record in prison (SystmOne) allows reporting on antibiotic use. Antibiotic prescriptions are scrutinised and verified as clinically indicated.
- Antibiotic prescribing within HMP Stoke Heath occurs at an average rate of 34 acute prescriptions per month and15 prescriptions for lymecycline 408mg- Lymecycline is prescribed on repeat for up to 6 months for the treatment of acne or recurring folliculitis. The reason why this level of prescribing is seen for these conditions is due to the use of plastic mattresses in cells which leads to back acne.
- The prison GP has a good understanding of anti-microbial stewardship. The electronic prescribing system facilitates adherence to formulary as the dose and the number of tablets (course length) are automatically populated from the formulary.
- Antibiotic audits are pulled from the SystmOne software and shared with the Chief Pharmacist.
- A report is produced and shared with the prison team at the prison Medicines Management Meetings which take place bi-monthly.



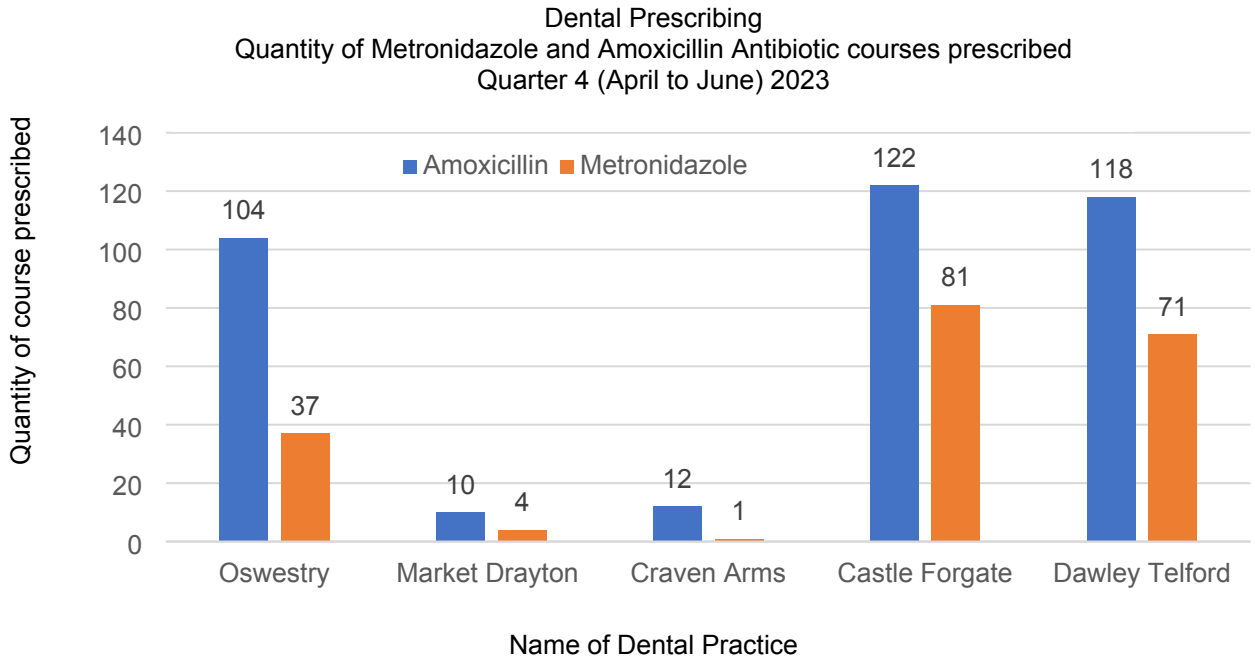
- The prison also has remote assistance from another Pharmacist from the SCHT team who clinically screens prescribing on SystmOne to further support the antimicrobial stewardship by challenging any antimicrobial prescribing that doesn't follow Microguide/NICE guidance.

Dental emergencies:

- The Dental service is supported by a member of the Medicines Management Team. They monitor the prescribing of antibiotics at all five dental clinics, these include Oswestry, Market Drayton, Castle Foregate, Craven Arms and Dawley Telford.

- Antibiotic prescribing will generally occur during working hours. Clinics which are specifically set up for emergencies have the highest rate of antibiotic prescribing. In these clinics, antibiotic prescribing can be 50% of all prescribing.
- Most of the prescriptions continue to be metronidazole and amoxicillin which is in line with Micro guide for antibiotics that should be used to treat dental infections.

- Clinics, which predominantly have a special care role, prescribe the least number of antibiotics.
- Antibiotic use has been assessed against the dental formulary along with prescribing guidance and found to be compliant.



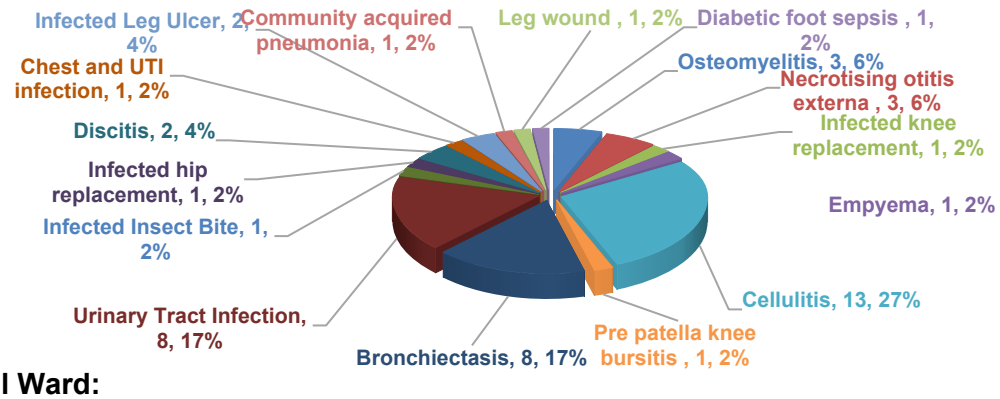
Patient Group Directions (PGDs):

- Patient Group Direction (PGD) are used to provide antibiotics to patients under strict criteria, e.g., in Minor Injury Units.
- PGDs when reviewed are checked against evidence-based references such as NICE guidance and the Shropshire, Telford, and Wrekin Microguide
- All PGD's for supply of an antimicrobial have microbiology approval before publishing.

OPAT

- Outpatient parenteral antimicrobial therapy (OPAT) refers to outpatient or community-based management of an infection via the administration of an intravenous (IV) antimicrobial while residing at home.
- Patients are managed without admission or may transition to OPAT following hospitalisation. By minimising hospital stay, OPAT is increasingly recognised as a cost-efficient management strategy for a variety of patients requiring either short- or medium-to long-term IV antimicrobial therapy, while also reducing pressures on the acute hospitals by reducing the need for hospital admissions
- The main antibiotics prescribed by OPAT are Cefuroxime, Ceftazidime, Ertapenem and Teicoplanin this is mainly due to their OD/BD regimes as these are logistically easier to manage by the team. Antibiotics are prescribed either on a PSD or an authorisation to administer form by the prescribers in the OPAT team.

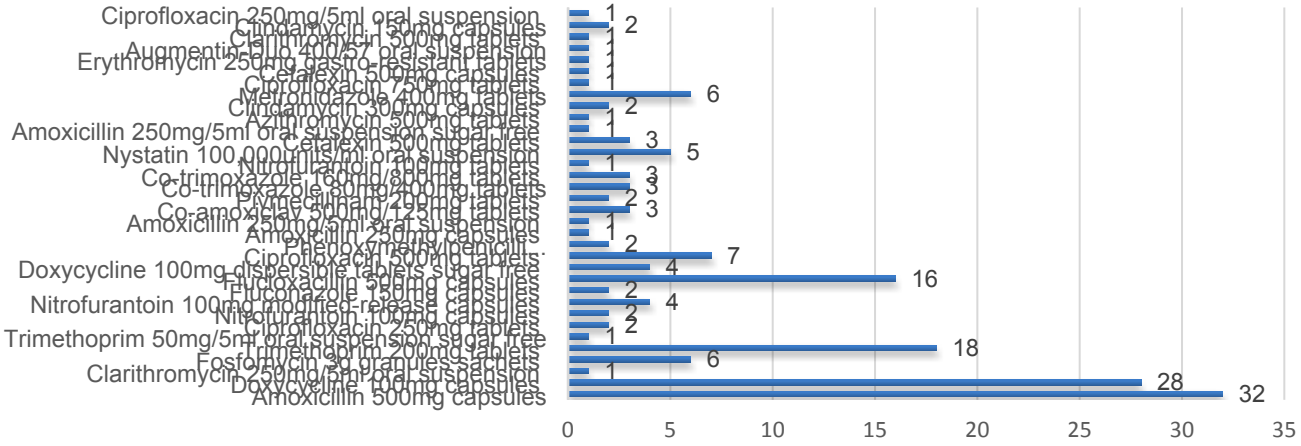
The chart above shows the indications treated by OPAT October 2023 to January 2024



Virtual Ward:

- Virtual ward allows patients to access hospital-level care in familiar surroundings at home, safely to speed up recovery while freeing up hospital beds for patients that are more in need.
- There is a mixture of NMP's and Doctors working within this service. All antibiotics prescribed are either provided by OPAT for IV or on FP10 prescription for oral medicines.
- Antibiotics are prescribed to patients following agreed pathways that mirror guidance in Microguide or via OPAT with medication then being supplied via SaTH pharmacy.
- We have a Principal Pharmacist in virtual ward who has a specialist interest in antimicrobial stewardship, all prescriptions are clinically screened to ensure that they are following local antibiotic guidance.

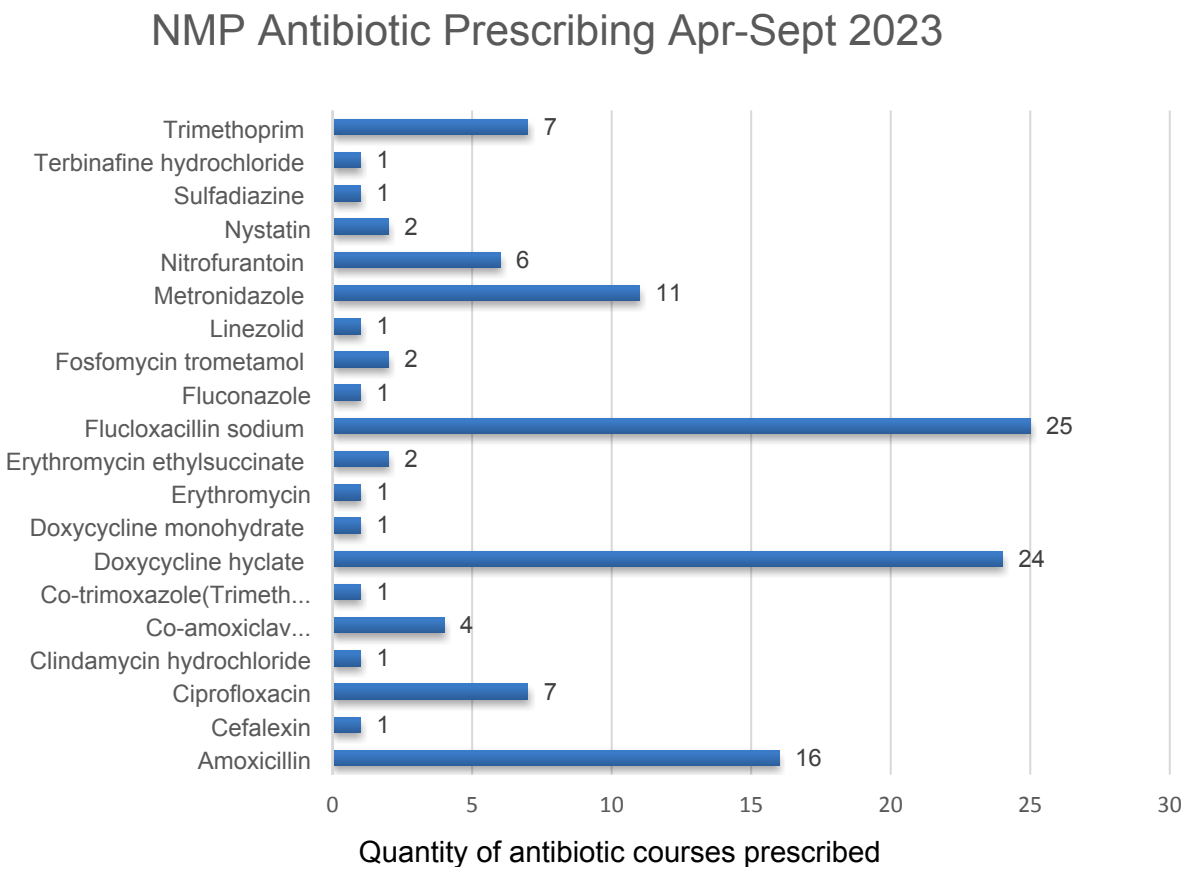
Virtual Ward Oral FP10 Antimicrobial Prescribing May to November 2024



Community Nursing:

- With the introduction of OPAT, the amount of IV antibiotics prescribed by community nurses has been reduced. Non-medical prescribing by appropriately qualified community nurses is monitored via ePACT2 data by the trust medicines management team and the Integrated Care Board.
- Appropriate justification for prescribing is sought where necessary.

Antimicrobial prescribing (in Items) for the April to September 2024 period by non-medical prescribers can be seen in the chart above.



Recovery and Rehabilitation Units:

In January 2024, SCHT opened two new wards which are based within the acute hospital (SaTH), with one being on the Royal Shrewsbury Hospital site and the other at the Princess Royal Hospital (PRH) in Telford.

Data is being gathered for the first quarter to review antibiotic use for these sites. It should be noted that intravenous antibiotics are used in these units, with PRH in particular a high user.

The pharmacy department managing the units are employed by SaTH.

Summary:

- Frameworks to reduce HCAI's are being developed to prevent HCA LRTI's and UTI's in collaboration with the IPC team.
- The Medicines Management Team are active in ensuring compliance with the Antimicrobial Stewardship.
- The Medical Director will support the medicines management team by challenging prescribing when identified by SCHT pharmacy that it is outside of guidance and there is no microbiology to support the request.
- Any issues with the prescribing undertaken by SCHT are highlighted at the Trusts Infection, Prevention and Control Governance or Committee meetings.
- The opening of RRUs will bring additional data in future reports.

Susan Watkins, Chief Pharmacist, SCHT

Criterion 4 – The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion

Communication regarding appropriate guidelines has continued to be a key requirement in the provision of care, the instigation of IPC initiatives as well as public and visitor safety as we moved to "business as usual" introducing a traffic light system for wearing masks and face coverings in our hospitals, visits and clinics.

The Communications Team are invited to attend IPC outbreak meetings if these may result in media interest because of the nature or impact of the outbreak. The Communications Team also provides the support and guidance and to prepare proactive and reactive media statements where required.

The IPC Team Secretary is responsible for updating the IPC Team intranet site and for the production of staff and visitors' leaflets. IPC updates are also provided to Team leads and IPC monthly newsletter is designed, sent to all staff and published on the intranet.

As in Criteria One, SCHT report on all Alert Organism monitoring and surveillance through IPCC meetings and Quality and Safety Committees. Our IPC Annual Report is a public document and available to view or download on our Website. Details of Alert Organism cases and MRSA screening compliance are also published on the intranet and the public website.

Criterion 5 – That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people

The IPC Team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of IPC; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organism surveillance and managing outbreaks of infection.

MRSA Screening

In addition to the local infection thresholds, a compliance threshold of 97% for MRSA screening for in-patients on admission was agreed with the ICB. Compliance results are reported monthly to the Quality and Safety Committee and the Board and IPC Committee bi-monthly with oversight by the DIPC to ensure good practice is shared and action plans are completed and show improvement.

MRSA Screening Compliance for in-patient areas

	Bishops Castle	Bridgnorth	Ludlow Dinham	Whitchurch	Overall
Apr-23	Temporarily Closed	96.00%	97.22%	95.74%	96.24%
May-23		94.74%	97.22%	97.73%	96.61%
Jun-23		100.00%	100.00%	100.00%	100.00%
Jul-23		100.00%	92.59%	98.21%	97.56%
Aug-23		100.00%	100.00%	94.74%	98.10%
Sep-23		100.00%	94.59%	97.73%	97.60%
Oct-23		100.00%	96.88%	98.33%	98.46%
Nov-23		100.00%	89.74%	100.00%	96.83%
Dec-23		95.00%	94.59%	93.33%	94.26%
Jan-24		100.00%	93.94%	94.12%	96.12%
Feb-24		97.62%	100.00%	97.44%	98.26%
Mar-24		97.56%	100.00%	95.45%	97.30%
Overall		98.35%	96.31%	97.06%	97.28%

We aim to screen at least 97% of patients on admission for MRSA each month. For 2023/24, our MRSA screening compliance score was 97.3%, just above the 97% target. Work continues to ensure that this figure is maintained or improved for 2024/25 which includes supporting our clinical teams with digital solutions to form filling and helping reduce the amount of paperwork on admission to our community hospitals.

Criterion 6 – Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

The Trust has information and processes in place to ensure that its staff, including agency staff, contractors, and volunteers, are able to meet the requirements of this criterion.

All clinical staff receive induction and updated training and education in current IPC practices. IPC mandatory training for clinical staff was delivered via e-learning and out of a possible 992 clinical staff (92.94%) were up to date with mandatory Level 2 IPC training as of March 2024.

The IPC team have been engaging with the Clinical Education team and have a regular 2 hour training session being delivered to SCHT staff as part of the clinical induction week programme. The IPC team also support the Shropshire Telford and Wrekin (STW) Healthcare Support Worker (HCSW) academy by delivering IPC training to new HCSW staff that have been recruited.

Other systems in place include:

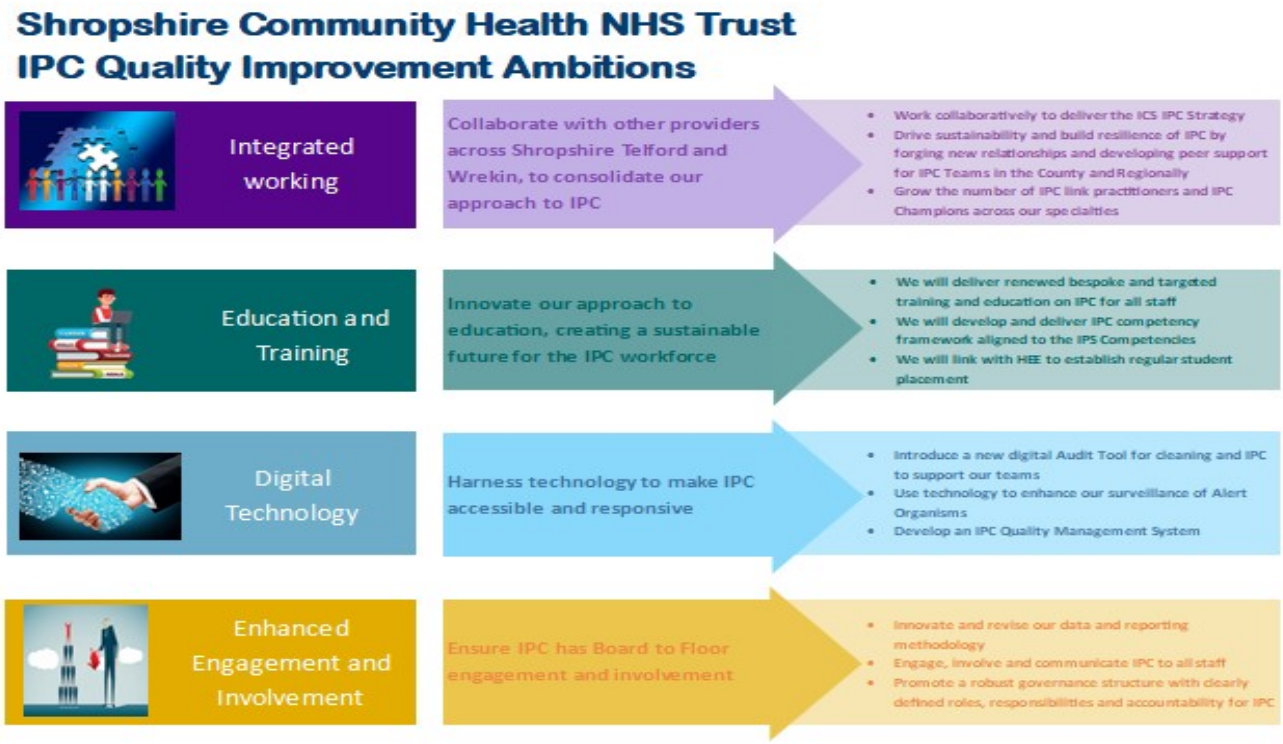
- SCHT job descriptions include IPC compliance alongside mandatory training to show that responsibility for IPC is delegated to every member of staff.
- “IPC working with patients in community hospitals” information booklet developed with the Feedback Information Group, provides IPC advice and information for all volunteers working with SCHT.
- An IPC information leaflet for health professional staff is available and is given to all temporary and agency staff as part of their local induction.
- IPC Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in the community hospitals.
- Information leaflet for contractors working in community hospitals.
- Monthly hand hygiene observational audits tools include volunteers and students.

It is important that the Trust can demonstrate that responsibility for IPC is effectively devolved to all groups involved with delivering care and that we have the arrangements in place to inform relevant authorities and System partners of outbreaks or incidents relating to infection. Surveillance of Alert Organisms is covered under Criteria 1.

- Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.
- Responsibilities of groups and of staff are included in all SCHT IPC policies.
- IPC Link Staff Roles and Responsibilities for both community and community hospitals has been revised and updated. The IPC link staff receive additional training in IPC and act as a resource and role model and liaise between their clinical area and the IPC team.
- The IPC Self-audit programme encourages teams to own IPC practices and compliance as part of their day to day work.
- IPC Team access SaTH Laboratory IT systems to allow enhanced alert organism surveillance and on notification, the IPC team report all outbreaks and incidents of infection to the CQC, ICB, UKHSA and NHSE.

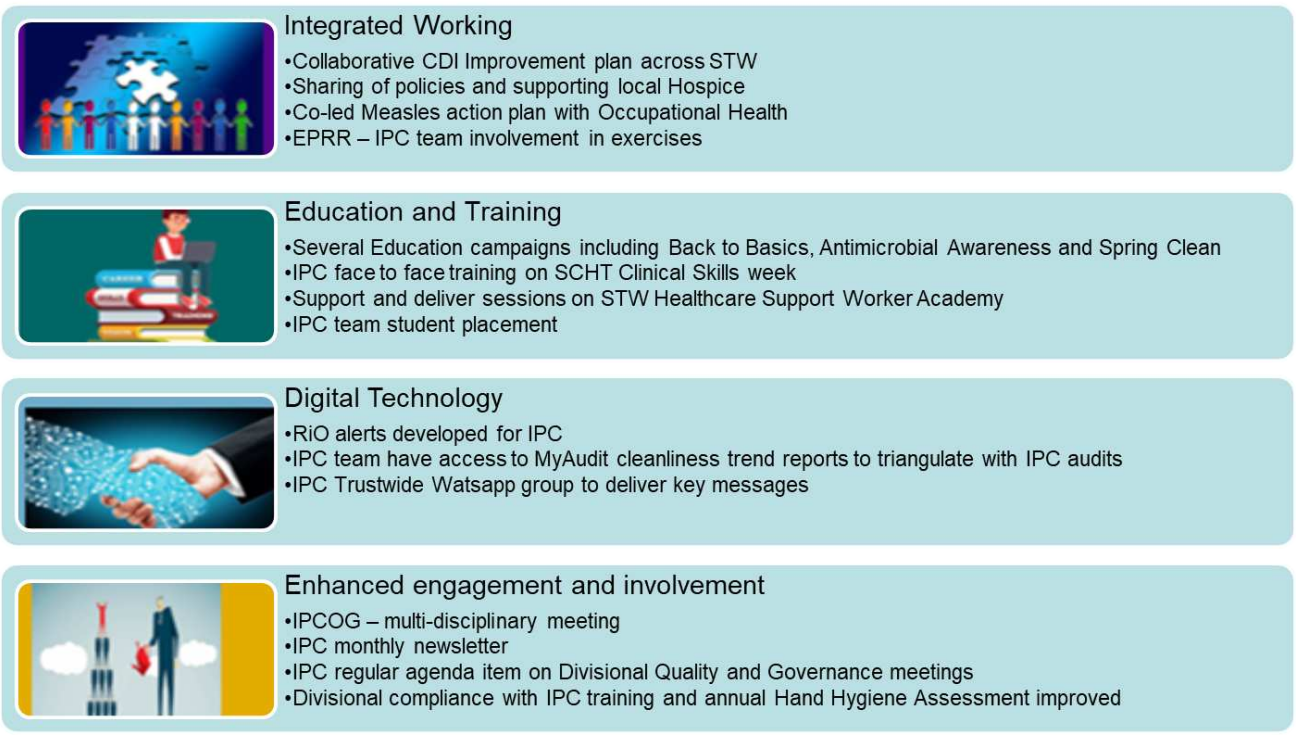
SCHT IPC Ambitions were launched in January 2023 and a report on progress against the milestones has been updated through the IPC report received at IPCC.

Figure: SCHT IPC Ambitions



The IPC Team have maintained 100% compliance with their own mandatory training programme and personal development reviews that support increasing knowledge and skills to assist in the delivery of improved quality of care. IPC Nurses have revalidated with the Nursing and Midwifery Council.

The image below demonstrates significant progress against the 4 ambitions within the first 12 months of the strategy.



Criterion 7 – The provision or ability to secure adequate isolation facilities

The Trust has robust isolation policies in place and has single room accommodation available to isolate patients when this is required. The Trust is also able to implement cohort isolation processes within the current estate and this process has been assured by NHSE Deputy Director of IPC. The Isolation policy includes an Isolation Risk Assessment Tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis.

Criterion 8 – The ability to secure adequate access to laboratory support as appropriate

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The IPC Team have a good working relationship with our IPC Doctor who is the Consultant Microbiologist at SaTH. Medical microbiology support is provided by SaTH 24 hours a day, 365 days a year and the Trust is currently fully compliant with this criterion.

Criterion 9 – That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections

The Trust has many policies and Standard Operating Procedures (SOPs) in place to ensure it meets the requirements of this criterion. The IPC Team have a rolling programme to update and review policies and compliance with the programme is monitored through IPCC. In addition, policies are updated prior to review date if national guidance changes to ensure they reflect up to date, evidence based, best practice. All policies are ratified and approved through SCHT governance arrangements.

Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

Occupational Health Report

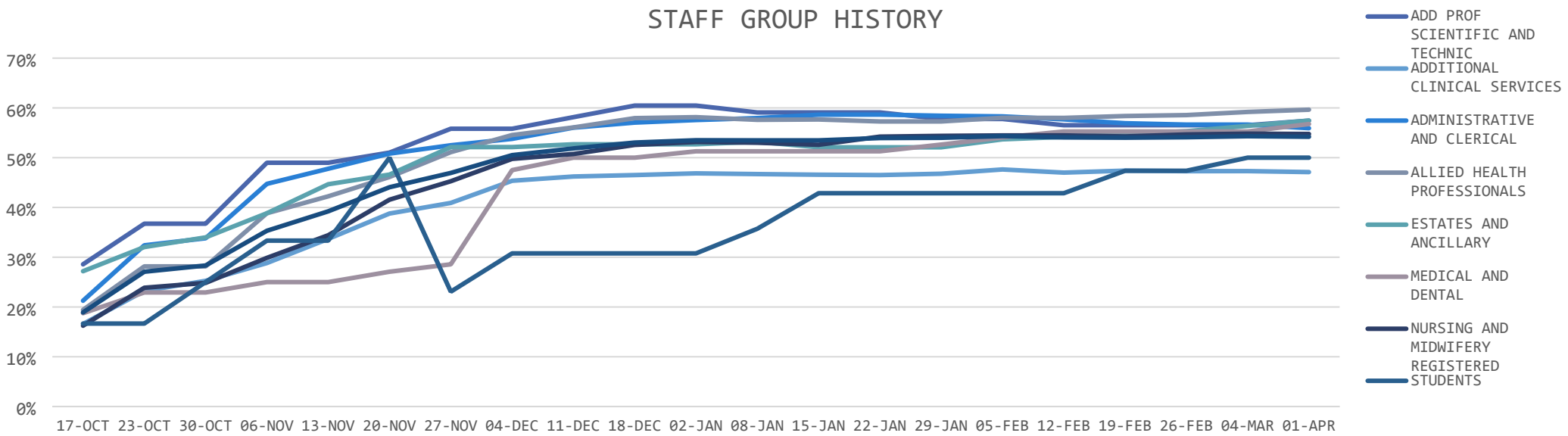
Occupational Health continue to support IPC and the wider trust with project work, advice and support.

Information regarding MRSA in staff is available in the MRSA policy to help support any member of staff and their manager(s) to ensure that they do not put others at risk of acquiring the organism. In addition to the MRSA policy a number of OHS policies, including Staff Immunisation policy, are available. The IPC policies Prevention and Management of Needlestick Injuries: including Inoculation Incidents and Exposures to Blood Borne Viruses (BBV) Policy (includes safe sharps handling) policy (inoculation injury flow charts available to staff and audited by IPC Team during HCAI audits); Standard Infection Control Precautions: Hand Hygiene and Personal Protective Equipment Policy all support staff health.

From April 2023 to March 2024 there were 10 reported sharps/splash or scratch injuries reported through Occupational Health -- 1 was noted to be a student doing a placement within the trust but was supported as any other member of staff would be. The Occupational Health Team also supported a member of staff who joined the trust part way through the policy/process whose form trust did not offer any ongoing help or support.

The Flu campaign for 2023/24 was a huge success and was supported by 6 peer vaccinators and a Bank Nurse. It should be noted that Shropshire Community Health were the top performer in STW ICS and in the top quartile for England (54.3% of staff vaccinated).

Measles



Occupational Health are currently working to assess the Measles status of any staff who have a patient facing role. They are looking at staff needing 2 x MMR Vaccines or Measles Serology as proof of immunity. The Health Protection Agency suggest that having had 2 x MMR Vaccines offers 95% efficacy. Each staff member with neither vaccines or serology recorded are being offered serology testing but we are noting that there is a high percentage who are ignoring their invitation to attend – when they are invited to attend they are being sent information from The UK Health Security Agency as reference.

Looking Forward to 2024/25

An Overview of Infection Prevention and Control Programme

The key aim in 2024/25 will be to continue to prevent HAI and to manage and control infections. This will include meeting thresholds and to evidence compliance with the Health and Social Care Act through completing the IPC BAF. In addition, we will strive to achieve the IPC objectives and four ambitions in our IPC Strategy.

Our focus will be to:

Ambition 1: Integrated Working

- Collaborate with other providers across Shropshire Telford and Wrekin to consolidate our approach to IPC.
- To establish relationships with local higher education establishments
- Participate in the system wide Antimicrobial Group partnership contributing to the worldwide antimicrobial resistance campaign.
- Participate and support in local EPRR exercises

Ambition 2: Education and Training

- Innovate our approach to education, creating a sustainable future for the IPC workforce. This will include implementing the IPC National Education Framework and ensuring that IPC training for our staff is fit for purpose and meets the new guidance set out in the Health and Social Care Act.
- IPC team members to attend Quality Improvement fundamentals course

Ambition 3: Digital Technology

- Harness technology to make IPC accessible and responsive. This includes implementing software platforms to enhance our audit and reporting and surveillance software increasing and maximising our response to risks of infections.

Ambition 4: Enhanced Engagement and Involvement

- Ensure IPC has Board to floor involvement. This includes enhanced communications, introducing IPC campaigns and engaging with all staff on IPC Roadshows.
- Ensure approach is aligned with the organisation Patient Safety Incident Response Framework and promote the use of After Action Reviews following outbreaks or HAIs
- Engage with Quality Improvement team to deliver identified Quality Improvement projects

Conclusion

SCHT IPC Team have had a year of change and innovation. We saw the impact of COVID-19 continue to reduce and we kept our teams and patients safe by ensuring the guidance on screening and prevention on infection met our local healthcare needs. At the same time, we continued to deliver a robust IPC activity programme, this time focussing on our Estate and Community Hospital facilities.

The IPC Team have strengthened their approach to IPC this year, delivering numerous improvements to improve the cleanliness of our premises, prevent HAI and control infection to keep our patients, staff and the public safe. Our Strategy clearly defines our ambitions for 2024/25, and the IPC Team remain dedicated and motivated to deliver our ambitions while continuing to provide a safe and effective IPC service for the Trust.

Glossary of Terms

Bacteraemia	A bloodstream infection
BSI	Bloodstream Infection
CDI	*Clostridioides difficile* infection. *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
COVID-19	Coronavirus disease
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CSSD	Central Sterile Services Department
DAART	Diagnostics, Assessment and Access to Rehabilitation and Treatment
Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DIPC	Director of Infection Prevention and Control
E.coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ePACT2	Prescription database for authorised users
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HAI	Healthcare Associated Infection
ICB	Integrated Care Board. Previously known as the Clinical Commissioning Group.
ICS	Integrated Care System. Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCOG	Infection Prevention and Operational Group
IPCN	Infection Prevention and Control Nurse
LFD Test	Lateral Flow Device Testing
MPFT	Midlands Partnership NHS Foundation Trust
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.

MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NHS PS	NHS Property Services
OHD	Occupational Health Department
Outbreak	Two or more persons with the same signs, symptoms in time place and space.
PII	Period of Increased Incidence
PPE	Personal Protective Equipment e.g. gloves, aprons and goggles
SaTH	Shrewsbury and Telford Hospital NHS Trust
SCHT	Shropshire Community Health NHS Trust
SENDS	Safety engineered needleless device systems
SOP	Standard Operating Procedure
TEMS	Telford Musculoskeletal Service
TOR	Terms of Reference
UKHSA	United Kingdom Health Security Agency

Acknowledgements and Further Information

Thank you for reading the IPC Annual Report for 2023/24.

If you require any further information about IPC in SCHT please email the team at Shropcom.IPCTeam@nhs.net or visit our webpage at https://www.shropscommunityhealth.nhs.uk/safehands

This report was prepared by SCHT's IPC team:

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Eve Sampson – Infection Prevention and Control Nurse
Alison Davies – Infection Prevention and Control Team Secretary

In conjunction with:

Susan Watkins – Chief Pharmacist,
Helen Russell – Occupational Health Advisor

References

Department of Health: The Health and Social Care Act 2008

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

NHSE: National Infection Prevention and Control Manual

NHS England » National infection prevention and control manual (NIPCM) for England

National Standards of Healthcare Cleanliness 2021

B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

Shropshire Community Health NHS Trust

Maintaining focus and oversight on quality of care and experience in pressurised services

0. Reference Information

Author:	Gemma McIver, Deputy Director of Operations Tracie Black Associate Director for Workforce, Education & Professional Standards	**Paper date:**	**1st August 2024**
Executive Sponsor:	Clair Hobbs, Director of Nursing & Clinical Delivery & Claire Horsfield, Director of Operations & Chief AHP	**Paper written on:**	15th July 2024
Paper Reviewed by:	Quality & Safety Committee	**Paper Category:**	Quality and Safety
Forum submitted to:	Trust Board	**Paper FOIA Status:**	

1. Purpose of Paper

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

This paper presents evidence and recommendations for ensuring quality and safety within pressurised services for the Trust Board for assurance.

2. Executive Summary

2.1 Context

Following the Channel 4 programme Dispatches that aired filming from within the ED at RSH, NHSE wrote to all Trusts to ensure their Boards had assurance on quality and safety within pressurised services. The paper was presented and discussed at Quality & Safety Committee in July.

2.2 Summary

- The letter from NHSE sets out 6 areas for Boards to assure themselves against.
- Evidence is presented to provide assurance against all 6 areas.
- In addition, evidence is provided for assurance regarding care in unconventional care areas.
- Recommendations to take forward are outlined to provide further oversight, triangulation and assurance.

2.3. Conclusion

The Trust Board is asked to

- **Receive** the paper as assurance on the Trusts oversight of pressurised services to ensure quality and safety.
- **Discuss & approve** the recommendations to provide greater oversight.

Maintaining focus and oversight on quality of care and experience in pressurised services

3. Main Report

3.1 Introduction

Channel 4 aired a Dispatches programme on 24th June 2024 which was filmed in the Emergency Department at Royal Shrewsbury Hospital. Following this NHSE wrote to all Trusts (26th June) asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to;

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at Trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

1. their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
2. basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
3. services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
4. Executive Teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
5. there is consistent, visible, Executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both Trust and system level
6. regular Non-Executive Director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

The letter is attached in appendix A for information and reference.

Maintaining focus and oversight on quality of care and experience in pressurised services

3.2 Assurances against the outlines points 1-6

3.2.1 UEC Recovery Plan year 2 letter actions (appendix B for information and reference)

Operational planning guidance asked systems to focus on 3 areas to deliver UEC recovery ambitions.

I. maintaining the capacity expansion delivered through 2023/24

Shropshire Community Health Trust have led on behalf of the system three key service developments with the core aim to increase capacity across the UEC footprint in STW:

- *Alternatives 2 Hospital Admission (A2HA) (Rapid Response, Care Home MDT, Respiratory Early Supported Discharge)*

This was a 3-part programme of work designed to prevent the predicted demand through the front doors of SaTH by providing alternative community pathways and capacity. The A2HA services launched in 2020 and are now well established across STW. The Local Care Programme has triangulated output measures between 2021/22 and 2022/23 and been able to demonstrate a sizeable reduction in ED attendances and non-elective admissions following the launch of A2HA services. The impact of these schemes has stemmed growth and provided the equivalent of 40 beds worth of acute capacity. Currently Rapid Response are running consistently at 120% against their planned activity demonstrating ongoing delivery of the capacity expansion seen in this area through 2023/24.

- *Virtual Ward (VW)*

Virtual Ward has a workforce model to support the equivalent of 167 beds worth of capacity. The national target is 80% occupancy The capacity is consistently available for VW and month on month improvement can be seen in both step up and step-down referrals.

Month	Revised Capacity Target	Average Occupancy	Performance against target	Actual Referrals
October 2023	115	103	90%	252
November 2023	115	104	90%	248
December 2023	125	92	74%	223
January 2024	135	90	67%	214
February 2024	145	100	69%	166
March 2024	167	91	54%	188
April 2024	167	106	63%	187
May 2024	167	103	62%	221

The main challenge with Virtual Ward is maintaining utilisation and supporting clinical referrals particually from the acute to ensure safe and effective utilisation of available capacity. SCHT have presented at many clinical forums locally to promote utilisation of the service and

routinely in reach into the acute to support identification of patients who are appropriate for step down. SCHT Medical Director continues to lead on discussions with SaTH MD to ensure a medical drive from the acute for VW referrals.

- *Rehab and Recovery Units (RRU's)*

Plans were established early 2023 for two modular wards to be constructed on the RSH (Royal Shrewsbury Hospital) site creating 64 beds worth of General & Acute (G&A) capacity. Following SaTH's internal bed reconfiguration, it was agreed that 52 beds worth of capacity would be aligned for community sub-acute pathways and two wards (one at Princess Royal Hospital and one at RSH). Due to delays in the modular build project the volume of beds offered to SCHT is 46, both wards opened early January 2024. In the first 6 months 467 patients have been supported through the RRUs. This is a consistent occupancy of 98.45%. 65% of all admissions have returned to their usual place of residence and an ongoing 'home first culture' is continuing to be driven through the units with a constant focus to streamline pathways with Local Authorities, Community Therapy and Virtual Ward.

II. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes

SCHT became lead provider for the Integrated Discharge Team (IDT) in September 2022. The IDT focusses on early discharge planning and creating a resilient team that specialises in complex discharges. A 2 day Length of Stay (LoS) improvement for No Criteria to Reside (NCTR) patients in the acute has been demonstrated. The service consistently hits the target to discharge 32 patients daily from the NCTR cohort. The percentage of NCTR in Q3 and Q4 2023 was 21.26% and is now 14.58%. There has also been a significant increase of 5% for patients being discharged through pathway 0, which prevents long term dependency on services and promotes individuals' independence. The significant on-going improvements demonstrated by the IDT evidence improved flow, system capacity, efficiency, and most importantly enhanced outcomes for patients.

Through the Care Home MDT and IDT when care home residents are admitted there is an increased number with Advance Care Plans (ACP) in place. This has empowered patients and their families to promote early discharge planning and provided a robust clinical handover and plan for this complex cohort of patients when they require acute care. This has resulted in a decrease in acute length of stay locally for care home patients of 8.7% and as a result this has equated to a decrease in bed days of 1601. Again, this is supporting to enhance acute capacity but also prevents risk of decompensation for the most vulnerable and frail cohort of people in our local population.

Community Hospital (CH) occupancy sits regularly around 95%. The average LoS when benchmarked with comparable peer providers in April 24, was within the top two of the second quartile with a length of stay of 23.6 days. A month-on-month improvement has been achieved with May's position at 21.7 days and June's at 19.4 days. This supports patient flow

significantly and has been achieved through aligning pathways more closely with Local Authority partners. Additional CH capacity has been introduced following the re-opening of Bishops Castle CH in July.

III. continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

Rapid Response Teams consistently deliver against the 2 hour 70% response target. Additionally activity performance is 122% against commissioned plan.

The system UEC Improvement Plan has 5 workstreams, one of these is Alternatives to Emergency Department (AtED) and Integrated Care Coordination (ICC) of which the SRO is the SCHT Director of Operations. The programme is targeting better alignment of the systems Directory of Services (DOS) locally for professionals and patients to navigate making access to alternatives to front door admission more streamlined and clinically appropriate. Stakeholders from across the system are actively engaged and invloved. This work will then help to inform several planned improvement events for the care coordination element of our system with the core aim to enhance single point of access in time for Winter. Alignment of community pathways to this work will be essential to secure delivery and improved patient experience.

Developing proactive and prevention services has also commenced in Southwest Shropshire, this has been facilitated by a good developing relationship between SCHT and the Southwest Primary Care Network. SCHT are contributing to the membership of the Proactive Care Multi-Disciplinary Meetings to identify support for people to prevent them reaching crisis point. The locality team within the Southwest also successfully piloted a series of wellbeing drop-in sessions for members of the community to speak to a healthcare professional to support them to access the support they needed avoiding crisis events that could result in ED access.

SCHT has engaged in the National programme to review all Minor Injury Units (MIU's) and assess based on demand and capacity, appropriateness to designate to Urgent Treatment Centres (UTC's). A self-assessment facilitated through NHSE has been completed.

3.2.2 Basic standards of care, based on the CQC's fundamental standards, are in place in all care settings

The fundamental standards of care that everybody has the right to expect are:

- Person Centred Care
- Visiting and Accompanying
- Dignity and Respect
- Consent
- Safety

Maintaining focus and oversight on quality of care and experience in pressurised services

- Safeguarding from Abuse
- Food and Drink
- Premises and Equipment
- Complaints
- Good Governance
- Staffing
- Fit and Proper Staff
- Duty of Candour
- Display of Ratings

These are assured from floor to Board through quality and governance structures, meetings, committees and visits.

The Quality Team support teams to ensure compliance with CQC standards through self-assessment, quality visits and facilitating ICB visits with visit reports identifying celebrations and ideas for improvement. The Board receives a quality report and improvement plans and quality improvement projects are monitored through meetings and committees.

Service visits are completed in several formats across teams and disciplines for example quality visits, Observe and Act visits, Executive visits, IPC visits, Safeguarding visits, ICB visits and Senior Leadership Team back to the floor visits.

IPC audits, Safeguarding audits, clinical audits, review of NICE guidance, quality improvement projects all review compliance and improvements with the standards. All areas comply with the cleaning standards and are rated in line with assessments.

The people we support, care and treat have individual treatment plans, care plans or outcome plans developed with them and reviewed regularly. Ongoing work is in progress across our ward areas to ensure these plans are within the electronic patient record roll out. The plans have been reviewed and developed to ensure essential standards are incorporated. Teams completed audits on record keeping ensuring continuous improvement.

Recently a committee paper outlined the extension of visiting and an updated procedure to ensure visiting and accompanying people to appointments is in line with new legislation and CQC regulation.

All patients in our Community Hospitals' have their nutrition needs assessed and provide for on admission. The Trust has made improvements that continue through CQUINS framework. All our in-patient sites have on site catering provision.

Dignity, respect and consent all patients is maintained by single bed spaces that met the need of the patient e.g. call bells curtains etc. Care and treatment plans are developed reviewed and planned with the patient. Single sex bays are maintained inline with national guidance. Consent is obtained both verbally and written appropriate to the treatment or care being delivered and assurance is gained by sites and clinical visits.

SCHT is meeting its statutory responsibilities regarding safeguarding and promoting the welfare of children, adults and families that come into contact with our services as set out in the Children Act 1989 and 2004 and The Care Act 2014, supporting staff to raise any safeguarding issues and concerns confidently and competently.

Maintaining focus and oversight on quality of care and experience in pressurised services

To support staff to meet high standards of safeguarding practice, staff access safeguarding training, have access to the safeguarding team for advice, guidance and supervision. There is a safeguarding page on the staff website offering advice, guidance around identification of decision making and referrals around safeguarding practice.

Ongoing quality visits continue to each Community Hospital, Specialist clinical teams and services by the Nurse Specialist for Safeguarding Adults and Children, providing additional safeguarding advice and support increasing visibility and enhancing professional relationships with Trust staff. This integrated approach to delivering safeguarding encourages professional curiosity around practice minimising the risk to the trust by giving staff the confidence and competences around raising safeguarding practice.

Additional scrutiny and assurance is monitored through the Safeguarding Committee which is attended by ICB partners.

Governance and quality meetings take place at individual division level for assurance and learning, Reports are then reviewed through Trust level committee meetings. Patients' safety incidents and Duty of Candour are reviewed in line with PSIRF and oversight through the incident panel. DATIX is used by staff to record any concerns and for investigation and learning.

Safer staffing is monitored daily, monitoring of staffing has been improved by the introduction of E-roster and whilst the whole of the trust is not yet onboarded 75% of clinical staff have been. The Trust uses a validated Safer Staffing Care Tool where data is collected bi-annually with the report being seen at Quality and Safety Meetings and the Board to give assurance of staffing within the Trust.

Mandatory training is monitored via the Quality and Safety meetings and through to Board for oversight. The education team along with our specialist teams provides in house training, as well the Trust outsourcing training for staff . CPD funding is available for registered staff within the Trust and the TNA identifies the areas of training need.

SCHT is an equal opportunities employer and as such promotes the efficient, effective, fair and consistent recruitment and selection practices for all staff in the Trust. It is our policy to recruit the best person for each vacancy regardless of age, disability, race, religion and belief, sex, sexual orientation, gender reassignment, pregnancy and maternity or marriage and civil partnership.

Our processes in place ensure that all checks for individuals are undertaken before commencement in role and we undertake the 6 standards which make up the NHS Employment Checks Standards and includes the process which is required by law with regard to eligibility to work in the UK. (Right to Work):

- Verification of identity checks
- Right to work checks
- Professional registration and qualification checks
- Employment history and reference checks
- Criminal record checks
- Occupational health checks

For relevant Senior Roles, Fit and Proper Persons Checks also take place and at annual intervals.

There is an ongoing 3 yearly DBS programme to ensure our current staff are safe and to safeguard our patients.

The recruitment team are trained in pre-employment checks and up to date with any changes in legislation. There is on ongoing training programme for the team. The recruitment up to date position is reported quarterly to the People Committee.

CQC ratings are displayed on the Trust website and at venues across the Trust.

3.2.3 Services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund

The IDT is an integrated co-located service based within the acute. The development of this service has focused on streamlining pathways, risk assessment and trusted assessments to support seamless transition from acute to home or an alternative more appropriate setting for all complex patients. The IDT is expanding on this work through the system wide discharge alliance programme (overseen by UEC Delivery Board) which is focusing on transition into a Care Transfer Hub. SCHT will be pivotal in the development of this as it will elevate the IDT to have full oversight of flow throughout all intermediate care ensuring timely access for patients to return home as soon as they are clinically safe to do so.

Rapid Response (RR) and Virtual Ward take referrals directly from both ED's (as well as multiple agency's including Primary Care and ambulance service to avoid admission all together). RR consistently achieve the 70% 2-hour UCR response target (73.5% in May) providing timely alternative options to ED over a 7-day period. RR also has a trusted assessment model built in to secure swift access to social care provision if required.

3.2.4 Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance

Not currently relevant to SCHT as this applies primarily to the acute Trust.

3.2.5 There is consistent, visible, Executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both Trust and system level

The Director of Operations is responsible and accountable for the safe, effective timely delivery of UEC services in both a proactive and reactive response.

Out of hours the Director on call assumes this within their duties. To ensure a robust resilient approach to on call, handovers are undertaken. In addition, escalation WhatsApp groups are in place to pull on the wider team for support as and when needed.

OPEL levels are used within the Trust and across the system. When the system is at OPEL 3 strategic calls take place 3 times a week with representation as a minimum from the Director of Operations. When in OPEL 4, strategic meetings take place daily with representation as a minimum from the Chief Executive.

In the absence of the Director of Operations, the Deputy Director has delegated responsibility to attend and represent.

Maintaining focus and oversight on quality of care and experience in pressurised services

3.2.6 Regular Non-Executive Director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

There is a regular plan for visits along with participation with Observe and Act visits. Both the Chair and the Non-Executive Directors update at Board meetings on their visits to services on a regular basis.

3.2.7 Unconventional Care Areas

In ward areas a process is in place to ensure beds can be released by risk assessing patients that are fit for discharge and can sit safely awaiting discharge. A QEIA has been completed to support this with the plan that this will drive early system wide flow enhancing patient safety and experience by preventing late admissions and discharges.

As a result of a system risk summit in Winter 2021 a full risk assessment and QEIA process was completed exploring use of additional bed spaces during periods of extreme pressure and system critical incidents. These assessments were able to evidence that any additional beds would result in nursing in an unconventional area which does not support safe and effective care. As such The Trust have not supported the increase in the bed base with out designated bed spaces.

3.3 Recommendations to further strengthen Board assurance of pressurised services

Following Dispatches airing and the subsequent letter a series of briefings, reflective sessions and focused discussions relating to improvement locally have taken place internally and externally with clinical and operational leaders.

In addition to the targeted areas of work as detailed above further actions to ensure quality and safety within pressurised services have been identified:

- Implement a series of peer reviews to support with a fresh eye, open, transparent and continuous improvement culture. A 12-month rolling programme will be embedded commencing August.
- A targeted communications campaign and promotion of Freedom to Speak Up in services to support frontline teams to escalate concerns.
- A rolling programme of service reviews that evaluate performance, workforce, quality and safety practices to gain a wider perspective of service provision and areas of improvement.
- An internal model for improvement based upon the 'Tiger Team' methodology (endorsed by NHSE) is being established as a tool and approach for Operational and Quality Teams to adopt during challenging periods across any service. This will provide opportunity to act fast and rapidly improve an area of concern. This will utilise skills and leadership from across the organisation.

Maintaining focus and oversight on quality of care and experience in pressurised services

- Adoption of Gemba walks methodology to Exec and Non-Exec service visits to enable a quality focussed approach along with standardised reporting
- Forward work plan of Non-Exec visits to ensure all areas/services are being visited
- Strengthen the opportunities for service user feedback within all areas to enable a more structured approach to listening and acting on this feedback

3.5 Conclusion

The Trust Board is asked to

- **Receive** the paper as assurance on the Trusts oversight of pressurised services to ensure quality and safety.
- **Discuss & approve** the recommendations to provide greater oversight.

NHS England

To:

- All ICB and Trust:
  - chief executives
  - medical directors
  - chief nurses
  - directors of finance
  - chief people officers
  - chief operating officers
  - regional directors of operations

Cc:
- ICB and trust chairs
- Regional:
  - directors
  - directors of commissioning
  - directors of system transformation

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 May 2024

Dear colleague,

Urgent and emergency care recovery plan year 2: Building on learning from 2023/24

Thank you to you and your teams for the progress made over 2023/24 in delivering the actions set out in the Delivery plan for recovering urgent and emergency care (UECRP). Despite significant headwinds in the form of unprecedented industrial action and higher than anticipated demand, the hard work of NHS and social care colleagues across the country has seen marked year-on-year improvement in the headline ambitions set out in the plan.

2023/24 was the first non-pandemic year since 2009/10 that A&E 4-hour performance was better than the previous year, with over 2.5 million more people completing their A&E treatment within 4 hours compared to 2022/23. Response times for Category 2 ambulance calls also improved; over the year, the average response time was over 13 minutes faster compared to the previous year.

Other benefits for patients included:

- tens of thousands more people received the care they needed to return home quickly and safely thanks to the expansion of same day emergency care (SDEC) services
- on average, around 500 fewer patients a day had to spend the night in hospital because of a discharge delay, and 13% more patients received a short-term package of health or social care to help them continue their recovery after discharge

- urgent community response teams provided 720,000 people with an alternative to going to hospital between April and January
- virtual wards have supported more than 240,000 people to get the hospital-level care and monitoring they needed in the comfort of their own home

Maintaining progress

The UECRP is a 2-year plan. The level of ambition for 2024/25 was recently set out in the NHS priorities and operational planning guidance:

- improve A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025
- improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

This operational planning guidance asked systems to focus on 3 areas to deliver these ambitions:

1. maintaining the capacity expansion delivered through 2023/24
2. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

This letter and its supporting annexes aim to help systems and providers as they plan and prioritise over the coming weeks, in order to make progress over the summer and improve resilience ahead of winter, by bringing together in one place what we know works in support of the key requirements set out in planning guidance.

Evidence-based actions to support delivery

Over the last year we have learned a significant amount from systems and providers – both through engagement as well as the early findings of formal evaluation – about how best to deliver for patients and for staff in the context of a challenging financial environment.

Annex 1 summarises the actions that work, and maps these against the requirements set out in planning guidance. Annex 2 provides further detailed information on those evidence-based delivery actions that we know will make a difference, as well as providing the supporting evidence and case studies.

This document is focused on acute and community services, and the needs of people with mental health issues in those services. It does not specifically address mental health settings; however, many of the principles and delivery actions will apply, such as working jointly with local government and social care partners to make effective use of the Better Care Fund for mental health pathways.

Working with local government, adult social care and the voluntary sector

The effectiveness of UEC services relies on the NHS, local authorities, providers of health and social care services, and VCSE partners working together across the UEC pathway. Throughout the last year, there have been excellent examples of partnership working to prevent avoidable hospital admissions, speed up discharge and improve outcomes for patients.

During 2024/25, continued partnership working – including with patients, families and carers – will build on and strengthen this joint approach. Annex 3 sets out the shared objectives, and this letter is being sent in conjunction with a letter from the Department of Health and Social Care to local authorities to ensure alignment across systems. This will help sustain a joined-up, collaborative approach to improving UEC services and outcomes for patients.

Delivery support

NHS England has also heard from systems and local teams what support offers have been helpful, and the support offer in 2024/25 has been refined as a result.

The UECRP set out an approach to UEC tiering support. Over the last year, this approach has supported improvements for challenged systems and providers, and helped to reduce unwarranted variation. It has been aligned with support for local government through the joint NHS England and DHSC Discharge Support and Oversight Group, which works with challenged systems to support improvements in discharge across all local partners. Annex 4 provides an analysis of the progress made by systems in Tiers 1 and 2, as well as additional learning on success factors.

For 2024/25, NHS England will continue to apply the same tiering approach, providing support to systems that are below target and/or are outliers on key metrics. The support will take account of learning from our review of tiering work to date, in particular by better aligning with NHS England's other tiered offers to systems, the Recovery Support Programme team and cross-government offers such as the BCF support programme, and by ensuring clear agreement of priorities for improvement across national, regional and local teams.

NHS England also offered a Universal Support Offer (USO) to drive improvement and innovation across 10 high impact areas, which included working with the BCF support programme for those areas that require a joined-up approach across health and social care, such as capacity planning for intermediate care and effective implementation of care transfer hubs.

Feedback from participating systems highlighted benefits to working in this way, although other systems reported finding it difficult to engage with. This feedback has been built into our approach to supporting systems in 2024/25, and will also underpin future support packages for local systems to deliver improvement in clinical outcomes and productivity. There will be a continuing focus upon the 10 high impact areas for 2024/25 within the wider holistic approach; these have been incorporated into Annex 1 with additional detail and evidence-based actions to support further improvements within Annex 2.

Measuring progress

In addition to the 2 headline ambitions, the planning guidance sets out that systems and regions should focus on reducing the number of over 12-hour waits in emergency departments (EDs), including for mental health patients awaiting admission to a mental health bed.

NHS England will also be regularly considering the following supporting metrics in assessing performance and where additional support may be required:

- reducing ambulance handover delays
- reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients
- maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24, equivalent to at least 99,500 beds nationally, allowing for seasonality
- improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)
- reducing average delays post discharge ready date (combining the two published metrics (a) the percentage of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their DRD)
- improving length of stay in NHS commissioned community beds

Accountability

Building on the experience from 2023/24, the NHS will continue to ensure the key elements of implementation and delivery support are in place, starting with clear accountability for delivery through the NHS Oversight Framework. The new operating framework will also provide clarity on outcomes and priorities, while providing local flexibility on how to deliver.

The oversight framework sets out the key outcomes expected of integrated care boards (ICBs), and will be supported by regional UEC delivery boards as well as a national programme board that will review any issues occurring across regions.

On a day-to-day basis, a new OPEL framework has supported aligned accountability on operational risk management, managed at integrated care system (ICS) level through our system co-ordination centres. Over winter 2023, this new framework has supported the 24/7 National Co-ordination Centre, and enabled NHS England to provide targeted support when there has been pressure. NHS organisations continue to work routinely with local authorities to manage operational risks that require co-ordinated health and social care action.

The OPEL frameworks for mental health and community services are now being developed. The frameworks will use the same principles as the acute care OPEL 2023/24 (that is, digital, clinically relevant and consistent). NHS 111 OPEL and revised acute care OPEL will be part of a weighted system aggregated score, to increase both the pace and rigour of our response to patient safety within the entirety of the UEC pathway.

Transparency

Over the last 12 months the NHS has made strong progress on improving the availability of data to support service improvement and transparency for patients and the public. Key developments included:

- publication of 12-hour waits
- development and publication of a new dataset derived from the discharge ready date (DRD)

For 2024/25, a key priority will be to continue to improve the collection and quality of DRD data and data on reasons for discharge delays, and to improve data collection on community services. This includes ensuring that all relevant trusts are reporting high-quality data on DRD, to enable comparison at trust, local authority and ICS levels. This will help drive effective shared action across the NHS and social care to improve timely discharge. By July 2024, all community providers of NHS commissioned services should be reporting into the Community Services Data Set. These metrics will support better local and national assessment of flow and capacity.

Capital and incentives

A total of £250 million of operational capital was provided in 2023/24 to support estate and technology improvement relevant to UEC. A further £150 million of capital was also allocated in 2024/25, as part of a scheme to incentivise higher performance in 2023/24.

This year, £150 million of operational capital is being distributed for improvements that will support front door services and flow through EDs, to support improvements in ED performance. NHS England regional teams are working with systems to progress business cases; further details will be available once these have been agreed.

In addition, there will be up to £150 million of capital allocated within NHS operational capital budgets in 2025/26, to incentivise both highest performance and greatest improvement in performance since 2023/24. An outline of the scheme is set out below:

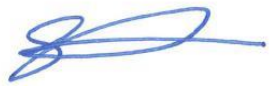
- improved 4-hour performance (measurement at year end, with a further element to incentivise improvement throughout the year)
- improved Category 2 performance (incentivised throughout the year)
- reduction in 12-hour delays in an ED (incentivised throughout the year)

Schemes will not be mutually exclusive. Capital will be allocated to the ICB for the Category 2 ambulance response performance and improvements, and to individual trusts and their nominated partners (which may include community and mental health trusts) for the A&E schemes.

Thank you again for the incredible work that you and colleagues have done together to improve the timeliness, quality and safety of care for patients requiring urgent and emergency treatment over the first year of the UECRP. We hope this further information is

helpful in the planning you are doing now for the second year, and we look forward to continuing to work with you to support further improvements over the course of 2024/25.

Yours sincerely,



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Annex 1: Summary of supporting actions

Operational planning guidance requirement	Evidence-based actions to support delivery
1. Maintain the capacity expansion delivered through 2023/424	
1A. Maintain acute G&A beds at the level funded and agreed through operating plans in 2023/24	• Maintain and monitor the 99,500 core G&A bed capacity over 2024/25. At system level this means maintaining the growth achieved by Q4 2023/24 on average over the course of the year, adjusting for seasonality.
1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals	• Maintain hours on the road/deployed ambulance staff hours. • Increase clinical assessments of calls in NHS 111 and ambulance control rooms compared to 2023/24. • Maximise opportunities to establish 'call before you convey' best practice models to increase direct referral to alternative services. • Continue the focus on deploying the paramedic workforce, including ambulance support staff, in the most effective way. • Embed culture improvement by implementing the recommendations set out in the Culture review of ambulance trusts.
1C. Focus on reduction in ambulance handover delays to support system flow	• Reducing handover delays will be a key focus and action for systems to deliver in 2024/25 and will remain a metric to better assess flow across UEC pathways and support improved patient outcomes. The delivery actions and best practice examples to support this are included across other domains above and below.
1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care	• Working jointly across ICBs and local authorities, ensure that commissioned intermediate care capacity meets projected demand, supported by the additional £400 million in the 2024/25 Discharge Fund. Plans should accurately forecast capacity needs, considering the most appropriate balance between different discharge pathways, and identify the workforce capacity and skill mix changes required to deliver sufficient rehabilitation and reablement activity to support discharge. Plans will be assured through the Better Care Fund (BCF) assurance process. • Use the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, to identify how to improve service and workforce models.
1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure, and children and young people	• Maintain capacity and improve occupancy of virtual wards, expand access to step-up and step-down capacity, and improve length of stay by pathway, through implementing best practice as set out in the virtual ward framework. • Work together locally, including with social care providers, to increase access to virtual ward services that provide an alternative to hospital attendance or admission ('step up' virtual wards) including increasing the home referrals and directing patients from ED and SDEC following initial assessment where appropriate. • Consider specialty pathways and teams according to local demand, including paediatric virtual ward services and capacity.

Operational planning guidance requirement	Evidence-based actions to support delivery
2. Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes	
2A. Focus on reductions in admitted and non-admitted time in ED	• Continue to focus on initial assessments, including continuing to increase the proportion received within 15 minutes of arrival, and increase the proportion of patients redirected to alternative services. • Work with providers to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways. • Review critical interventions along patient pathways in hospital and ensure they are aligned with best flow practice principles. • Review and audit trust internal professional standards, using the ECIST guide as a starting point. • Build on the rollout of psychiatric liaison services to support Type 1 EDs working towards ambition of responses within 1 hour of referral. • Reduce mental health patient time in EDs, including reducing length of stay for patients in acute beds waiting for a mental health bed, and in mental health beds. Systems, including local government, should focus on improving whole mental health pathway patient flow.
2B. Focus on reductions in the number of patients still in hospital beyond their discharge ready date (DRD)	• Continue to improve in-hospital discharge processes. Ensure early discharge planning, including effective involvement of patients, carers and families, in line with statutory guidance on hospital discharge and community support. • Working across the NHS and social care, maximise the effectiveness and maturity of care transfer hubs to improve quality and timeliness of discharge for patients with complex needs. • Working across the NHS and local authorities, implement trusted assessments to reduce duplication and ensure information is shared through the pathway.
2C. Focus on reductions in length of stay in community beds	• Increase productivity and capacity of community bed-based services based on maturity self-assessments. • Extend the implementation of best practice flow principles to community beds, including tracking length of stay. • Reduce discharge delays from community bedded units through process improvements, and through timely access to ongoing packages of care supporting transition and continuation of rehabilitation and reablement at home, building on good practice in care transfer hubs in acute settings.
2D. Improve consistency and accuracy of data reporting	• Ensure all trusts are consistently and accurately recording key metrics including SDEC activity in ECDS, community discharge information on the community SitRep/SUS, DRD, data on reasons for discharge delays, and the Ambulance Data Set. • Ensure system co-ordination centres are fully embedded and made ready for system OPEL. • Consider how to disaggregate data based on age, to understand demand and monitor performance for children and young people.

Operational planning guidance requirement	Evidence-based actions to support delivery
3. Continue to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge	
3A. Increase referrals to and the capacity of urgent community response (UCR) services	• Increase UCR referral volumes and number of patients treated. • Explore the use of technologies and point of care testing to optimise existing capacity, and consider referral pathways from technology enabled care (TEC) providers and SDEC.
3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week	• Ensure SDEC compliance of 12 hours a day, 7 days a week. • Increase utilisation by working with partners (including ambulance trusts) to increase the proportion of patients with direct access, direct referrals from outside the ED (NHS 111, 999 and primary care), and reduce variation in the proportion of ED patients who are treated through the SDEC. • Increase productivity by implementing the minimum standards of delivery outlined in the SAMEDAY strategy. • Improve consistency of reporting SDEC into the Emergency Care Data Set (ECDS) by March 2025.
3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week	• Ensure acute frailty service compliance of 10 hours a day, 7 days a week, implementing a comprehensive geriatric assessment at the front door, and the minimum standards in the FRAIL strategy, to increase patient flow and the proportion of patients over 65 with a Clinical Frailty Score. • Understand and work across systems to reduce numbers and variations in care home referrals to ED.
3D. Provide integrated care co-ordination services	• Work to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity holistically across all relevant services. Work with local authorities to link this to BCF demand and capacity planning for intermediate care. • Establish core operational integrated care co-ordination structures as a minimum by October 2024, with a focus on paramedic access to clinical advice to support alternative pathways to ED. • Ensure surge acute respiratory infection provision, including for children.

Annex 2: Further detail on supporting actions

Learning from the first year of UECRP

The approach to developing this document has been 2-fold. Learning has been drawn from regular conversations with systems across health and social care, which has highlighted the interventions and approaches that have been easier to implement, and what would need to be true to replicate this elsewhere.

Systems that are further ahead with implementation have documented their approach in case studies; examples are given in these annexes.

We have also begun to see emerging learning from the evaluation approach that was set out in the UECRP. This includes some insights from Sheffield University's literature review, alongside emerging findings from qualitative evaluation by the REVAL team at Manchester University. The National Institute for Health and Care Research (NIHR), a partner to NHS England in evaluating the UECRP, along with the case study authors, will make these findings available in due course.

Overall, NHS England has heard and seen that the broad approach set out in the UECRP is the right collection of activities to enable the NHS, working with local authorities, social care providers and VCSE partners, to deliver the ambitions of the plan.

NHS England has also heard from systems and local health and social care teams implementing the UECRP on the ground that they would value the opportunity to continue with their delivery and embedding of changes into Year 2. Teams have also asked for evidence-based, structured products to highlight the key components of the interventions, and to support prioritisation of their delivery.

We have been told – and seen in the data – that some of these interventions have been easier to implement routinely across systems than others. Both standardising the approach to delivering services across health and social care to improve support for frailty, and standardising the approach to inpatient flow and length of stay, have been raised as consistent challenges. Further work is underway with partners and stakeholders across the country to establish and document a more succinct approach to improving these pathways.

To help and support delivery into Year 2 of this plan, NHS England has responded to this learning in 2 ways. The approaches that work have been collated and refined into a set of evidence-based actions for health and social care systems to support delivery of and progress towards the headline ambitions, alongside links to further guidance, evidence and examples of best practice. These actions are set out below, grouped under the 3 UEC priority areas for this year: maintaining UEC capacity, improving the productivity of that capacity, and continuing to shift care out of acute hospitals.

In implementing these actions, working with social care and VCSE partners, systems should include, wherever appropriate, children and young people, patients with mental health needs and dementia, people with learning disabilities, autistic people and those experiencing homelessness within their plans.

In these newer pathways, or those that have been more challenging to implement, evidence of what works is being codified to support wider national learning. Some of this detail is already available, with some further detail to follow shortly.

Interventions for frameworks that are already available	Care transfer hubs SAMEDAY framework for same day emergency care Combined adult and paediatric acute respiratory infection hubs Discharge ready date guidance (includes DRD definitions) Discharge guidance (including homelessness checklist)
Interventions for frameworks that will be published shortly	Virtual wards Single point of access/integrated care co-ordination centres
Pathways for which work is ongoing with local and regional teams over the coming weeks	Standardisation of services to support older people with frailty Standardisation of inpatient flow and length of stay

Priority 1: Maintaining and increasing the capacity expansion delivered through 2023/24

During 2024/25, systems should continue to ensure that UEC capacity is maintained or, where appropriate, expanded. Alongside the increase in physical capacity, and in line with the NHS Long Term Workforce Plan, systems should continue to take action to support the UEC workforce, including enabling staff to work more flexibly.

Learning during 2023/24

During 2023/24, the NHS delivered significant capacity expansion, supported by over £1 billion of new revenue and £250 million of new capital investment. The NHS and local authorities also worked together to agree how to deploy the £600 million Discharge Fund, alongside the wider BCF, to improve capacity for supported discharges and reduce discharge delays, delivering a 13% increase in supported discharges in 2023/24 compared to 2022/23 and – despite a 6% increase in emergency admissions over this period – a 4% reduction in the average daily number of acute hospital patients with delayed discharges.

This capacity expansion has had an impact, as evidenced by the improved overall performance in the UECRP's 2 headline ambitions against the previous year. Modelling underpinning the planning guidance highlights the relationship between capacity increases and ED performance, largely driven by bed occupancy. Further modelling highlights the

relationship between handover performance and handover delays, and by extension Category 2 performance.

Evaluation from newer interventions, such as virtual wards, has also begun to build a picture of where and how improvement can have most effect. For example, there is strong evidence that virtual wards are associated with reducing avoidable attendances and admissions to hospital, as well as supporting early discharge and reducing length of stay in acute beds.

- There is growing positive evidence of impact from site evaluations:
  - East Kent's 50-bed step-up frailty virtual ward has seen a reduction in non-elective admissions for older frail cohorts (75+). A South East region-wide evaluation is due to be published demonstrating similar results across the region
  - South and West Hertfordshire Health and Care Partnership experienced a reduction in hospital bed days from the implementation of a COPD ward hospital at home pathway with an observed reduction in both inpatient length of stay and the number of repeated hospital admissions
  - evaluation of the Mid and South Essex frailty virtual ward found that readmission rates to an acute bed within 30 days of discharge were 26.5% lower than the 30-day readmission rate seen nationally for acute frailty wards.
- Virtual wards also deliver cost savings, as demonstrated in an economic analysis by NICE, which found that in aggregate the services have provided a significant net financial benefit due to avoided hospital activity. Across multiple evaluations, there is also consistent evidence of very positive patient experience of virtual ward services.

Learning from joint ICB/local authority capacity and demand planning for intermediate care through the BCF has reinforced the importance of actively reviewing projected need for different types of intermediate care, including both step-up and step-down care. It has also reinforced the importance of working with community and social care providers to plan services and associated workforce requirements so that they better match projected needs, including a focus on a 'Home First' approach to reablement and recovery. Local areas have also reinforced the importance of understanding the relationship between average length of stay in different types of intermediate care and the capacity available to meet projected demand.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

1A. Maintain acute core G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

- Core G&A bed numbers should be maintained through monitoring and maintaining the average of 99,500 beds over 2024/25, adjusted for seasonal trends.

1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals where appropriate

- **Ambulance trusts** maintaining the increase in deployed staff hours established in 2023/24, to maintain the peak increase in capacity agreed in operating plans.
- **Systems** increasing clinical assessment in NHS 111 and control centres compared to 2023/24, in line with national implementation principles for Category 2 segmentation. This will ensure that patients who do not need a face-to-face response are transferred to the most appropriate service and supports effective prioritisation for ambulances. This may include increasing access to paediatric expertise through a NHS 111 Paediatric Clinical Assessment Service, where supported by evaluation and business case development.
- **Systems** maximising opportunities to establish 'call before you convey' best practice models to increase direct referral to alternative services, where clinically appropriate. These best practice models include early access to a named senior clinical decision-maker so that patients with the most urgent need are seen sooner.
- **Ambulance trusts** deploying the paramedic workforce, including ambulance support staff, in the most effective way to meet ambulance capacity requirements in line with local need.
- **Ambulance trusts** embedding culture improvement alongside the delivery of operational targets, by implementing the recommendations set out in the Culture review of ambulance trusts.

Case study: Moorfields Eye Hospital NHS Foundation Trust – Virtual Eye Pathway

'The Virtual Eye Pathway' is an integrated virtual consultation pathway between NHS 111 and the Moorfields Eye Hospital within North Central London (NCL) and North East London (NEL) ICBs, which aims to reduce the number of calls related to urgent eye conditions that result in avoidable ED attendances.

With the new pathway, NCL and NEL ICB callers to NHS 111 with urgent eye conditions will be briefly assessed and then transferred to a virtual waiting room, after which they shortly receive a specialist ED virtual ophthalmology assessment provided by a Moorfields clinician. The clinician then streams patients to the most appropriate service (often an opticians, a minor eye condition service or Moorfields itself) or provides advice and guidance to enable self-treatment.

Since the Virtual Eye Pathway launched in March 2023, 30% of patient callers who would previously have resulted in a Type 1 ED attendance have been avoided, with patients directed elsewhere. Those referrals that do result in an A&E attendance have the benefit of being validated by a specialist clinician in advance of attendance. Wider benefits have included reduced patient wait times within NHS 111, especially where specialist ETC ophthalmology assessment is required, and reduced Type 1 ED referrals overall. In addition, access to this service has been expanded via the 111 Online channel so that users of NHS 111 Online can obtain urgent eye care assessment directly through this

online channel. The virtual eye service is also linked to the London 111 natural language pathway development, so that users who declare urgent eye problems will streamline directly to this service via NHS App/111 Online.

1C. Reduce ambulance handover delays to support system flow

- Handover delays still present a significant challenge to increasing ambulance service capacity, particularly in certain areas. Due to the impact on patient care, reducing these delays will be a key focus and action for systems to deliver in 2024/25. This will remain a metric to better assess flow across UEC pathways and support improved patient outcomes.

Case study: Barts Health NHS Trust – REACH service

The Remote Emergency Access Coordination Hub (REACH) is a UEC collaborative in North East London set up in October 2020. Developed and hosted by Barts Health NHS Trust initially as a response to COVID-19, it aims to co-ordinate and deliver the most appropriate secondary emergency care for patients.

Ambulance service paramedics, urgent community response (UCR) and primary care clinicians on scene with a patient are able to call the REACH service to receive emergency medicine consultant-led clinical advice regarding best options for the patient, including support for appropriate non-conveyance. The REACH service provides collaborative decision-making with the caller, facilitating remote treatment and discharge or direction to alternative care pathways where appropriate, which improves patient experience and optimises utilisation of both community and in-hospital resources such as UCR, SDEC and virtual wards.

In 2023, REACH took 11,600 calls from clinicians in the community (93% of those from London Ambulance Service) and 4,200 referrals from NHS 111, with 10,300 patients managed without in-person ED attendance. This equates to a 29% ambulance conveyance rate, a statistically significant reduction in ambulance arrivals in all boroughs served.

With strongly positive patient and staff feedback, a system-wide saving of over £1.5 million a year and an estimated saving of 156 tonnes of CO_2 emissions, REACH has proven to be a safe and effective clinical co-ordination service.

1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care

- **ICBs and local authorities** will need to review their BCF demand and capacity plans to ensure that commissioned capacity meets forecast need, to support both discharge and step-up care. Systems should ensure accurate estimates of demand from discharges and from community referrals are used to commission the appropriate volumes and types of intermediate care capacity, supported by the increase in the Discharge Fund (from £600 million in 2023/24 to £1 billion in 2024/25). Plans will

include making clear assumptions for average length of stay, and will actively consider the most appropriate balance between Pathway 0, Pathway 1, Pathway 2 and Pathway 3 discharges. They will take account of variations in demand over the course of the year and building potential ability to flex into forecasting models. Further support setting out the joint requirements for the NHS and local government to deliver the objectives of the BCF is included within the Better Care Fund 2024/25 addendum and associated demand and capacity planning templates. Plans will be assured through the BCF assurance process to ensure they are robust and deliverable.

- When conducting demand and capacity planning, **systems** should work with community and social care providers to ensure there is sufficient workforce capacity with the appropriate skill mix to deliver the required capacity. This 'right sizing' of capacity has been successfully achieved in some systems by making more effective use of both registered and unregistered workforce, and by using other community roles to support rehabilitation and reablement both in people's homes and, where appropriate, in community beds.
- The Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, set out the approach to service delivery.

Case study: Oxfordshire ICB – out of hospital care for people experiencing homelessness

Through start-up funding from the DHSC Out of Hospital Care Programme, Oxfordshire has implemented an excellent hospital in-reach and step-down service, which is helping transform patient's lives, prevent a return to rough sleeping, and dramatically reduce discharge delays and avoidable readmissions from acute and mental health hospitals.

Under the leadership of a dedicated programme manager, and with support and funding from the ICB, BCF and health and care partners, the programme has appointed experienced housing officers co-located in acute and mental health hospitals. They bring extensive legal knowledge related to housing applications in addition to working knowledge of local housing and homelessness services to support ward staff in planning individual's transition from the hospital.

Oxford has opened 4 step-down houses with 27 beds in the community, which include access to rehabilitation, reablement and recovery services, a social worker, occupational therapist, clinical psychologist and community based mental health workers. This service enables individuals to recover their mental health in the community and develop independent living skills, and facilitates services coming together collaboratively to support the individual.

The service has supported over 250 planned discharges from hospital (50% from mental health wards). Where a discharge has included a stay in a step-down house, there has been a 24% reduction in emergency hospital admissions and a 56% reduction in presentations to EDs. Over the 12-month evaluation period, mental health bed days were

reduced by 89% – saving the NHS £657,000. Patients are no longer ‘stranded’ in hospital and very rarely return to rough sleeping

1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure and children and young people

- **Systems** maintaining capacity of virtual ward/hospital at home (HaH) beds, and expanding access by ensuring utilisation is consistently above 80%. Guided by feedback from systems, a new virtual wards operational framework will be produced in spring/summer 2024 to help tackle variation, achieve further standardisation and ensure the benefits of virtual wards/HaH can be realised at scale.
- **Systems (including local authorities) and providers** working together locally to increase the proportion of virtual ward beds accessed from home ('step up' virtual wards), including directing patients from EDs and SDEC following initial assessment where appropriate. In doing so, it would be helpful to pay particular attention to improving the coverage of paediatric virtual ward services and capacity.
- A new patient-level dataset for virtual wards (the Virtual Ward Minimum Data Set [VWMDS]) is being developed. When launched, **providers** will be expected to submit to the VWMDS, supporting local systems to have enhanced operational oversight of virtual wards as well as to enable national benchmarking. Further information on rollout will be published in due course.

Case study: Cambridge University Hospitals – virtual wards

In November 2022, CUH developed a virtual ward designed to deliver hospital-level care for patients in their own homes, using remote monitoring technology. The focus was on delivering 45 occupied virtual ward beds by September 2023 that delivered step-down discharge care, to free up capacity in the hospital.

A significant amount of pathway development work was undertaken to make the service available to every specialty in the hospital. Key to this was use of a remote digital monitoring technology, which allowed the team to monitor the vitals of all their patients continuously and spot when a patient was deteriorating. This helped build confidence with clinicians to refer their patients, given assurance as to the level of care and monitoring they would receive.

In just over 1 year of being operational, the CUH virtual ward has onboarded over 1,500 patients from 23 different specialties, including frailty, oncology, surgery, orthopaedics, cardiology and respiratory. It has exceeded its occupancy figure by almost double and the patient experience survey has a 97% satisfaction score. The wider benefits are considerable, with significant length of stay and associated bed day savings. CUH is now developing its model further to start delivering step-up and admissions avoidance care, and eventually include access pathways from primary care and care homes too.

Virtual Ward Bed Day Savings	

Priority 2: Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes

It is important to ensure that UEC and acute capacity is being used as efficiently and productively as possible. This includes the NHS, local government and other system partners working together to improve the timeliness of discharge from hospital and community settings.

Learning during 2023/24

Actions taken in Year 1 of the UECRP to improve post-pandemic productivity have demonstrated a length of stay reduction in overnight emergency admissions of over 4% in 2023/24.

Health and care systems across the country have driven length of stay reduction through initiatives such as:

- Using the discharge ready date (DRD) metric (first published in November 2023) to understand the proportion of patients not discharged on the same day as they are clinically ready for discharge (that is, no longer meet the criteria to reside), the average length of stay, and the distribution of those delays (that is, the proportion discharged 1 day, 2–3 days, 4–6 days, 7–13 days, 14–20 days and 21+ days after their DRD). These data support systems to understand variation both between trusts and between local authority areas, and to identify where to target improvements.
- Implementing and maturing their care transfer hubs to manage discharges for patients with more complex needs. A Sheffield University NIHR review of reviews – with acknowledged limitations of the evidence base – found evidence in the published literature that care transfer hubs show promise both for patient flow and UEC performance and for quality of patient care, in areas such as reducing all-cause mortality, hospital readmissions and ED visits.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

2A. Reduce admitted and non-admitted patient time in emergency departments

- **Service providers (in and out of hospital)** working together to continue the focus on initial assessment. Continue to increase the proportion of assessments received within 15 minutes, and to increase the proportion of patients redirected to alternative services such as urgent treatment centres, SDEC and acute frailty services, as well as urgent care response and virtual wards.
- **Trusts** ensuring that their medical model of care for the first 72 hours is optimised to eliminate the longest waits in the ED.
- Building on the evidence that inpatient flow interventions are an effective way to decrease ED wait times, **systems working with providers** to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways.
- **Trusts** seeking to understand their non-elective length of stay in key medical specialties, particularly respiratory and cardiology, and how they compare to the national mean and best in class via GIRFT model hospital datasets. Where evidence-based, robust clinical pathways exist (for example, fractured neck of femur, stroke, STEMI, AF), trusts can review whether clinical pathways currently meet key time stamps and take steps to monitor current levels of adherence as well as instigate plans to improve this.
- **Trusts** ensuring critical interventions during a patient's in-hospital stay are in place, delivered in a timely way. This includes:
    - a review by a senior decision-maker within the first 12 hours in hospital
    - early planning and conversations around the patient's anticipated discharge needs with full involvement of patients, carers and families in line with statutory guidance on hospital discharge and community support
    - a care plan involving the patient and family/carer, and assessment against patient-centred questions
    - a daily ward and board round (including weekends) on each ward.
- **Trusts** reviewing and auditing their internal professional standards, using the ECIST guide as a starting point.
- Actions to address the long waits that occur for many mental health service users are also beneficial, including:
    - **systems** building on the successful rollout of psychiatric liaison services to all Type 1 EDs by working towards the ambition of responses within 1 hour of referral

- **systems and providers, including local government,** reducing mental health patient time in ED by tackling long length of stay of patients in acute beds waiting for transfer to a mental health bed, and the length of stay for those in mental health beds
- **systems, including local government,** focusing on improving whole pathway patient flow through mental health, including dedicated improvement action on discharge as set out in the 100 day mental health discharge challenge and GIRFT programme.

Case study: Lincoln County Hospital, United Lincolnshire Hospitals NHS Trust – admitted pathway criteria to admit (CTA) audit tool

Lincoln County has had long-standing challenges with exit block. Working with ECIST, it developed a pilot to incorporate the criteria to admit audit tool into its standard admission processes, via a designated shift within the consultant rota, 8am to 6pm, 7 days a week.

The CTA consultant reviewed all patients with a plan to admit to an inpatient bed, including those who had been seen by the acute medical or specialty teams. If the patient had improved clinically, or were deemed not to meet the criteria at the time of review, then alternatives to admission were sought.

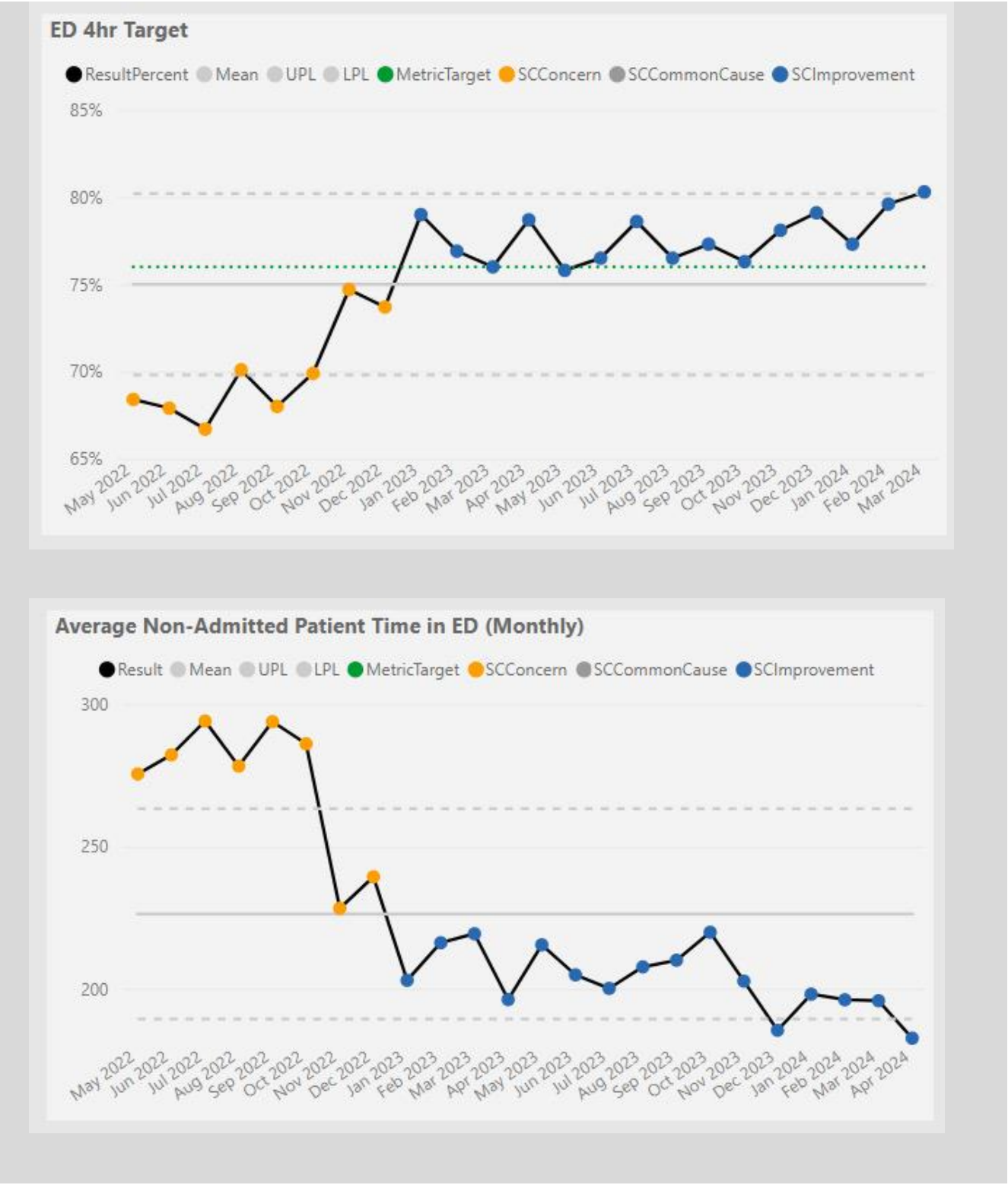
Early findings from the pilot have shown that this shift reduces admissions by 5–10 a day – approximately 8–16% of total admissions. Findings from an initial CTA audit suggest that over a week this equates to approximately 50 fewer admissions than pre-pilot with a resultant saving of 260 bed days a week. Every admission avoided also results in a decrease in bed wait time for the remaining admitted patients, improving overall performance as well as outcomes for those patients.

Case study: Norfolk and Norwich University Hospital – non-admitted pathway senior decision-makers

Norfolk and Norwich University Hospital prioritised a focus on the non-admitted pathway mostly utilised by walk-ins, identifying that ED crowding had a negative impact on efficiency and hypothesising that improvements in this area would yield multiple gains downstream.

Following a review of the ambulatory pathway model it established that placing a senior decision-maker (wherever possible at consultant level) as the first point of contact for the patient would yield the greatest dividends in terms of making better use of ED alternatives, ensuring patients received more guided work-ups, and resulting in more rapid turnarounds for those patients seeking primary care and not UEC.

This team was put in place in November 2022, made up of nursing, medical and healthcare assistants, and has seen a massive step change in the non-admitted pathway, with corresponding change in 4-hour performance.



2B. Reduce the number of patients still in hospital beyond their discharge ready date (DRD)

- **Acute providers** continuing to improve in-hospital processes to improve timeliness of discharge, including early discharge planning from the point of admission and early involvement of care transfer hubs where patients are likely to have more complex discharge needs.

- **ICBs and local authorities, working with acute trusts and community/social care providers** maximising the effectiveness of their care transfer hubs, and ensuring their care transfer hubs become increasingly mature over the course of the year. This includes extending the scope of care transfer hubs to discharge from community beds where practical and ensuring effective governance for care transfer hubs, including a senior responsible officer across the NHS and local authority, clear escalation routes and reporting, underpinned by high-quality, shared data. This includes ensuring the right mix of nursing, therapy and social work professionals are available to work directly with patients, families and carers to plan timely and effective discharge, with appropriate support for recovery and reablement, and effective arrangements through both ward-based teams and community/social care providers to ensure timely and effective transfers of care. Care transfer hubs should work closely with ward-based teams to ensure a 'Home First' approach to discharge, with a focus on strength-based, person-centred decision-making and full involvement of patients, carers and families.
- **Systems, including both the NHS and local authorities,** implementing trusted assessments to reduce duplication and ensure information is shared appropriately through the pathway. Care transfer hubs work best when they have the authority, knowledge of the local care landscape, processes and staffing mix to make effective decisions that provide the right support to go home, based on patient need and agreed by health and social care providers, supported by clear processes for case management from the point of admission until discharge, and escalation of challenges. Consideration may be given to holding a waiting list for each discharge pathway, so that if a discharge fails, the next person who could take up that bed or package of care is identifiable.
- **Systems and providers** ensuring patients no longer meeting the criteria to reside are discharged as early as possible in the day. Actions to deliver this include working with services outside the hospital to co-ordinate an early discharge, and avoiding bedding discharge lounges or, if there is no option, reverse boarding them with patients due for discharge the next day, reducing acuity (and therefore risk) within the discharge lounge.
- **ICBs and local authorities, working with acute trusts and community/social care providers**, using the new discharge metrics (derived from discharge ready date [DRD] data) and data on reasons for delay to identify how to increase the proportion of patients discharged on their DRD (that is, when they no longer meet the criteria to reside) and how to reduce the average length of discharge delays. This includes tackling the longest delays that are likely to be associated with poorer outcomes for patients.

Case study: South & West Hertfordshire – single point of contact

The Single Point of Contact (SPOC), South and West Hertfordshire's 'care transfer hub', merges health and social care discharge functions into one place to facilitate people to be discharged from hospital rapidly, safely and appropriately.

Operating since 2020, professionals from Hertfordshire County Council's Integrated Discharge Team, Central London Community Healthcare NHS Trust and West Hertfordshire Teaching Hospital NHS Trust work together to support on average 700 discharges a month; the majority of which are via discharge to assess. This is more than double the number of people discharged with support in 2019. The SPOC uses a 'discharge information form' completed by health professionals to fully understand a person's needs and take a strengths-based approach to supporting discharge to the most appropriate place, preferably home.

The SPOC enables:

- cross-organisation, person-centred triage and decision-making of referrals
- the person and their family carer to be involved in their discharge planning from the point of admission
- the person to be discharged with the support most appropriate for them with assessment being undertaken outside the acute hospital, achieving better long-term outcomes
- simplified referral and discharge processes, reducing the amount of time a person spends in hospital when there is not a medical reason to do so
- effective use of SHREWD, a shared data tool, to monitor real-time demand and escalate any issues or challenges, while also feeding in data to the 'DTA dashboard' which is used to inform system-level decision-making on capacity and demand activity
- West Hertfordshire to operate within national guidelines and best practice

The SPOC also works with the Impartial Assessor (Hertfordshire Care Providers Association) which supports timely transition from hospital to care homes by undertaking any assessments on behalf of the home and ensuring communication at every step.

Case study: Waltham Forest – care transfer hub

Waltham Forest's care transfer hub has representation from community services, their acute provider and the voluntary sector. It also has local authority input from Waltham Forest (including a dedicated broker and housing representative), Redbridge and West Essex to input into multidisciplinary team (MDT) discussion and provide updates on each patient awaiting discharge.

It has found success from its care transfer hub model for a number of reasons. It has established strong, partnership ways of working, which include twice daily attendance at MDT discussions that are held virtually. Data sharing agreements are also in place to support access to partner's systems and it has effective case management processes. Since introduction of its hub, Waltham Forest has achieved more discharges down Pathway 1 and fewer Pathway 3 discharges.

Waltham Forest also operates an in-house 'bridging service' where support workers and co-ordinators as part of the hub can provide care for Pathway 1 Waltham Forest patients for up to 5 days. This can support people to be discharged more quickly; an assessment of care needs is subsequently taken at home, the patient has quick access to equipment and reablement is provided at each care visit. It has found that as well as reducing length of stay in hospital, this has resulted in better outcomes for the patient.

Case study: Swindon – care transfer hub

In January 2023, Swindon launched its care transfer hub with representatives from the ICB, Swindon Borough Council, Great Western Hospitals NHS Foundation Trust, First City Nursing and acute and community therapy leads. The aims of introducing the hub included improving patient experience, streamlining referral processes and applying an MDT approach to triaging referrals and facilitating timely discharge to improve flow.

People who are identified as individuals who may require additional support on discharge are referred electronically to the care transfer hub by wards. This can happen at any time during their admission, from both acute and community hospital wards. Each day, including weekends, the MDT comes together to make a decision for their discharge pathway and relevant referrals are passed onto the appropriate team. The hub also holds daily NCTR calls to discuss discharges due that day and the following day, where actions are set to facilitate discharge and cases can be escalated.

The hub is also underpinned by a strong 'Home First' model. Individuals who are discharged down this pathway will be supported, via a multidisciplinary approach, for ongoing health and social care assessments. Staff make joint visits to minimise duplication and delays and, if required, ongoing care will be arranged for the individual. There is a system response in place under the SOP if there is a risk of readmission to maintain safety.

2C. Reduce length of stay in community beds

- **Systems** continuing with the actions identified to increase productivity of community bed-based services following the maturity self-assessment undertaken in July 2023.
- **Systems** extending the implementation of best practice flow principles to community beds.

- **Systems** reducing discharge delays from community bedded units through timely access to ongoing packages of care that support transition and continuation of rehabilitation and reablement at home, reducing days away from home.
- **ICBs and local authorities** exploring ways to track length of stay in intermediate care services locally, helping to improve the use of bedded and non-bedded intermediate care for people whose rehabilitation and reablement needs requires it.

2D. Improve consistency and accuracy of data reporting

- **Systems** ensuring all trusts are consistently and accurately recording key metrics, including SDEC activity in the Emergency Care Data Set (ECDS) and the Ambulance Data Set.
- **All NHS-commissioned community bed providers** being registered and submitting regular data to the Community Discharge SitRep, with updates to the dataset in mid-2024.
- **All acute and specialist providers** ensuring that they are submitting high-quality and timely DRD data for monthly publication, and that reasons for discharge delay are captured accurately in SitRep or Faster Data Flow returns.
- **Systems** ensuring system co-ordination centres are fully embedded, including operational standards and digital 'near real-time' footprint.
- **Systems** having arrangements in place to disaggregate data based on age, to understand demand and monitor performance for children and young people.

Priority 3: Developing services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs

During 2024/25, health and social care systems need to build on work underway to develop services that support a reduction in attendances and admissions to hospital, and to improve access to those services.

ICBs should work with local authorities, social care providers and VCSE partners to ensure an integrated approach to providing health and social care, where necessary, for people with urgent care needs – and to continue to strengthen proactive care for people most at risk of emergency admissions, including care home residents and people receiving domiciliary social care.

Parents and carers should be provided with access to clear, accurate information about common illnesses in children and young people, promoting self-care and access to the right care at the right time.

Learning during 2023/24

In Year 1 of the UECRP, health and social care systems have been working to build capacity that supports people to have their urgent needs met outside a traditional ED.

Zero-day length of stay (0LoS) has increased year on year since the introduction of a mandate to support SDEC service provision 12 hours a day, 7 days a week.

There has been a 11% growth in 0LoS emergency admissions during 2023/24, attributed in the majority to SDEC growth. Many systems have successfully introduced and matured their SDEC services to reduce both wait times and admission rates for some patients when compared to an ED or acute medical unit.

This learning has informed the planning guidance requirements and the supporting delivery actions set out below for 2024/25. Further evidence is set out in case studies and links throughout this section.

Based on evidence from last year, key supporting actions for 2024/25 include:

3A. Increase referrals to and the capacity of urgent community response (UCR) services

- Systems increasing referrals to, and number of patients treated in, UCR services, building on the success to date of these services in preventing patient deterioration and reducing pressures on other health services. This work has been most successful where:
  - there has been a focus on referrals from wider system partners including 999, NHS 111 and care homes to improve step-up pathways as forms of both attendance and admission avoidance
  - technologies (including point of care testing) have been implemented to optimise existing capacity
  - referral pathways from technology enabled care (TEC) providers and SDEC have been supported.

Case study: Oxford Health NHS Foundation Trust – urgent community response

The UCR service in Oxford, part of Oxford Health NHS Foundation Trust, delivers crisis response for people who are at risk of a hospital admission in the next 24 hours. It provides assessment, treatment and support in the patient's home to avoid a hospital admission.

To help keep people at home, Oxford's UCR team have developed strong collaborative working between themselves and secondary care. A 'consultant-on-call' service has been introduced where the UCR clinicians have direct access to an Oxford Health consultant geriatrician, which enables a clinical conversation to take place. Together they devise an agreed treatment plan for the person, often resulting in the person remaining at home instead of being conveyed.

Patients are reporting positive experiences of receiving care through UCR with patients saying the service is "amazing", "brilliant", "excellent" and one patient commenting that they were "grateful for remaining at home".

3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week

- **Systems** continuing to develop access components, and encourage specialist SDEC development (such as frailty or paediatric) according to local demographic need.
- **Systems, including ambulance trusts,** increasing utilisation of SDECs by:
  - increasing the proportion of patients with direct access, increasing direct referrals from outside the ED (NHS 111, 999 and primary care)
  - reducing variation in the proportion of ED patients who are treated through the SDEC
  - implementing the minimum standards of delivery outlined in the SAMEDAY strategy.
- **Providers** working to improve consistency of reporting SDEC into ECDS by March 2025.

Case study: Imperial College Healthcare NHS Trust – SDEC access improvement project

Imperial College Healthcare NHS Trust has focused on improving access to SDEC across both its sites, St Mary's Hospital and Charing Cross Hospital. Direct electronic booking was introduced in June 2023, allowing the local NHS 111 provider and the ambulance trust emergency clinical assessment service (ECAS) to book patients directly into a slot at either SDEC unit without the clinician having to telephone the unit first.

Utilisation of this pathway showed a slow but steady rise as clinicians became familiar with the service – supported by a range of engagement efforts – rising from an average of 15 referrals a month to 55 referrals a month, an increase of over 250%. Associated benefits include a reduction in clinical touchpoints, unnecessary triage and multiple handovers of care, as well as alleviating pressures within the ED.

Following the success of the direct electronic booking pathway, St Mary's then introduced a direct access trusted assessor model for the ambulance service, whereby paramedic crews could bypass ED and convey patients direct to the SDEC unit. Direct conveyances have increased from an average of 20 a month at pilot launch to 36 a month in March 2024. Imperial has since gone live with direct access at Charing Cross as well.

3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week

- **Acute frailty units** implementing the minimum standards in the FRAIL strategy supported by initiatives to increase patient flow through direct access, front door frailty identification, timely access to diagnostics and access to specialist clinicians where appropriate.
- **All acute trusts** implementing a comprehensive geriatric assessment at the front door, to increase the proportion of patients over 65 with a Clinical Frailty Score.

- **Systems** working to understand and reduce variation in care home residents' attendances at EDs.

Case study: Hillingdon Hospital – frailty assessment unit

Recognising the disproportionate impact that older adults with frailty have on ED performance, admissions and hospital bed days, Hillingdon Hospital used 2022/23 winter funding to develop its Frailty Assessment Unit in order to address these issues.

Following a successful pilot a business case was approved for the unit to continue operating under the new model throughout winter 2022/23 and is now business as usual. Through a combination of avoided admissions and reduced length of stay for patients admitted through the Frailty Assessment Unit, they were able to show a reduction of 127 bed days occupied by inpatients with a Clinical Frailty Score of 5 or more compared to the previous winter.

The frailty team continues to see between 150 and 200 patients a month including 26% of all patients with a Clinical Frailty Score of 6 or more who attend ED and SDEC, and have received good or very good feedback on 100% of the friends and family surveys.

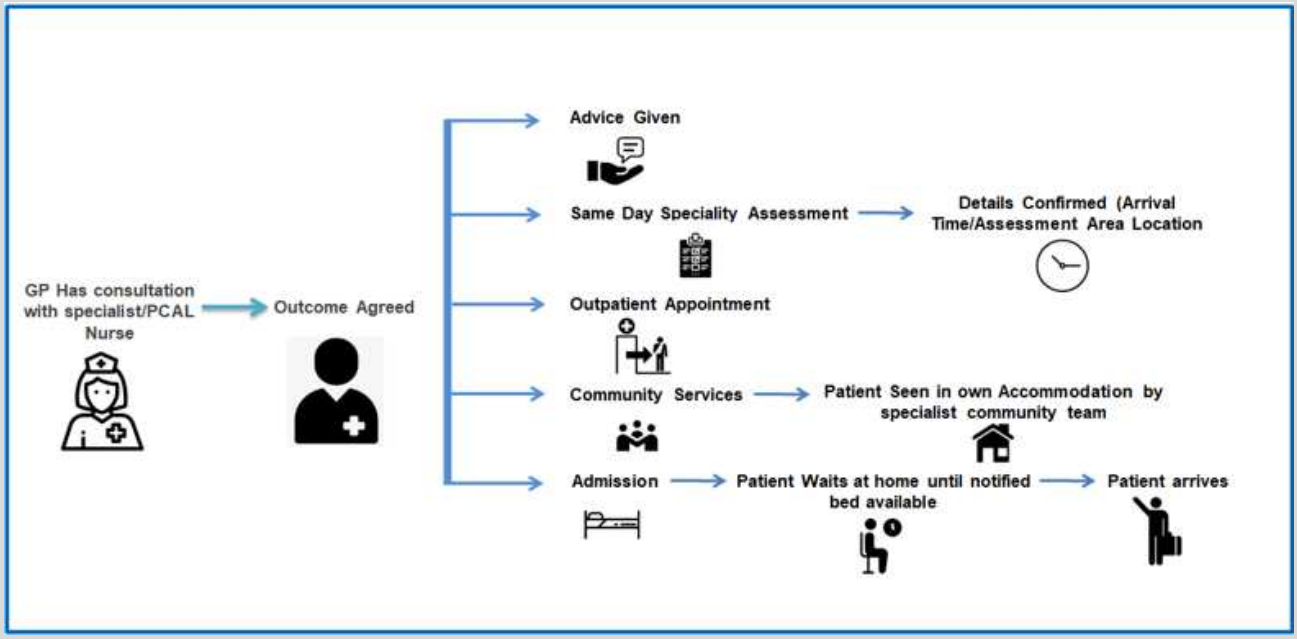
3D. Provide integrated care co-ordination services

- **ICBs and local authorities** working to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity across all relevant services, including UCR, community pharmacy and SDEC. Linking this to BCF demand and capacity planning for intermediate care.
- **Systems** working towards having core operational integrated care co-ordination structures as a minimum by October 2024, to help ensure the best response to patient needs, with a focus on paramedic access to clinical advice to support alternative pathways to ED.
- **Systems** ensuring they have plans to surge acute respiratory infection (ARI) capacity as required. For some systems, this may include the provision of ARI hubs, including paediatric ARI hubs for children. Analysis of ARI hub appointments from December 2022 found that ARI hubs can reduce pressure on ED attendance and free up capacity in general practice while improving same day access.

Case study: Leeds – Primary Care Access Line (PCAL)

The PCAL model aims to provide access to a range of services to prevent ambulance conveyance or attendance at ED, specifically for health and care professionals (HCPs), often GPs and ambulance CAS. HCPs are able to have a clinical conversation with PCAL and receive guidance such as direct booking and referrals to SDEC and other secondary care services, as well as pathways to community and out-of-hospital services. The model is nurse-led but the team are drawn from a variety of acute and primary care backgrounds.

The service has grown from 10 calls a day in 2003 to 225 calls a day (over 80,000 calls a year) in 2022/23, with access to over 50 clinical pathways, and Leeds showing lower than average ambulance waits in ED compared to regional peers. The service has particularly high levels of positive feedback from Yorkshire Ambulance Service clinicians and has been nominated by users for national awards.



Annex 3: Joint working between the NHS and local government

The effectiveness of UEC services relies on the NHS, local authorities, and providers of health and care services working together across the UEC pathway. Throughout the last year, there have been excellent examples of ICSs bringing together organisations across health, social care and wider community services to prevent avoidable hospital admissions, improve discharge from hospital, community and mental health settings, and improve outcomes for patients.

During 2024/25, the NHS and local authorities, working with the full range of relevant providers, VCSE organisations and patients, families and carers, will need to build on and strengthen this joint approach, working together with the following goals:

Build on progress in reducing discharge delays and improving discharge outcomes

- **Further improvements in demand and capacity plans for intermediate care,** based on reviewing patterns of demand and capacity in Year 1 and Year 2 and ensuring demand and capacity plans link with both NHS planning assumptions for UEC and local authority planning assumptions for adult social care.
- **Further optimisation of care transfer hubs** by implementing the 9 priority areas of focus as set out in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, with a particular focus on cohorts with the most complex needs, including patients experiencing homelessness, complex dementia or mental health conditions.
- **Enhanced focus on improving discharge from community settings,** building on the work done on implementing care transfer hubs in acute settings.
- **Sustained focus on early discharge planning and 7-day discharge arrangements,** working across hospital wards, care transfer hubs, care providers and care homes.
- **Embedding a 'Home First' approach** to support recovery at home.

A stronger focus on preventing avoidable hospital admissions

- **Improving proactive care** through collaboration across the NHS, adult social care and related services for people most at risk to prevent people's needs from escalating; for instance, through falls prevention, home adaptations and assistive technology, telecare, and healthcare input into residential and nursing home settings.
- **Providing rapid community-based forms of crisis response** to avoid, where possible, acute hospital stays, including strengthening social care input into virtual wards.

Joint planning of workforce interventions

- **Developing the therapy and reablement workforce** needed for high-quality intermediate care.

- Developing the workforce needed to provide **specialist care for people with more complex needs** (for example, dementia nursing).
- **I**mplementing **new workforce models** as set out in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

Case study: Stockport Place, Greater Manchester ICS and Stockport NHS Foundation Trust/Pennine Care NHS Foundation Trust – high intensity use (HIU) service

Stepping Hill Hospital ED is supported by a HIU service, which identifies the top 250 A&E attenders within a 3-month period for dedicated support. The service is non-punitive, non-medical and is focused on supporting people with 'chaotic' or difficult lives while offering social, emotional and practical support. The impact of HIU services is significant, with a broad estimate of between 300 and 400% ROI, as well as the immeasurable benefits to patients:

James, 47, lived alone and had Crohn's disease and was on a waiting list for a stoma, but his surgery was cancelled. In this time, his mental health rapidly declined, and he attended ED 80 times in 12 months, sometimes twice a day – the majority by ambulance – and resulting in 11 non-elective admissions.

The HIU service adopted an assertive outreach approach, working on meeting his wider social needs including linking into the Crohn's Network for peer support. Furthermore, the HIU lead expeditated the necessary procedure and joined up his care. James' attendances to A&E stopped altogether and his mental wellbeing has improved incredibly. He now feels he can live life to the full and is very grateful for the intervention, saying "I know I can, but I don't want to have to attend A&E ever again."

To support these objectives:

- **ICBs and local authorities** will already be planning how to make most effective use of the BCF, including the £1 billion Discharge Fund (an increase of £400 million over 2023/24), to provide services that best meet people's needs for community-based care and support and maximise health and independence.
- **NHS England and the Department of Health and Social Care (DHSC)** will continue to work with the NHS and local authorities with the greatest UEC pressures to help develop system-wide improvements, building on the work of the Discharge Support and Oversight Group but with an enhanced focus on admissions avoidance and on flow through intermediate care. This will include further work to spread good practice in capacity and demand planning for intermediate care and in the use of care transfer hubs.
- **NHS England and DHSC**, through the joint Discharge Support and Oversight Group, will use data on discharge delays and reported reasons for discharge delays, alongside other available data, to measure progress across the NHS and local authorities in improving discharge, including improving flow through both bed-based

and home-based intermediate care, whether NHS commissioned, local authority commissioned or jointly commissioned.

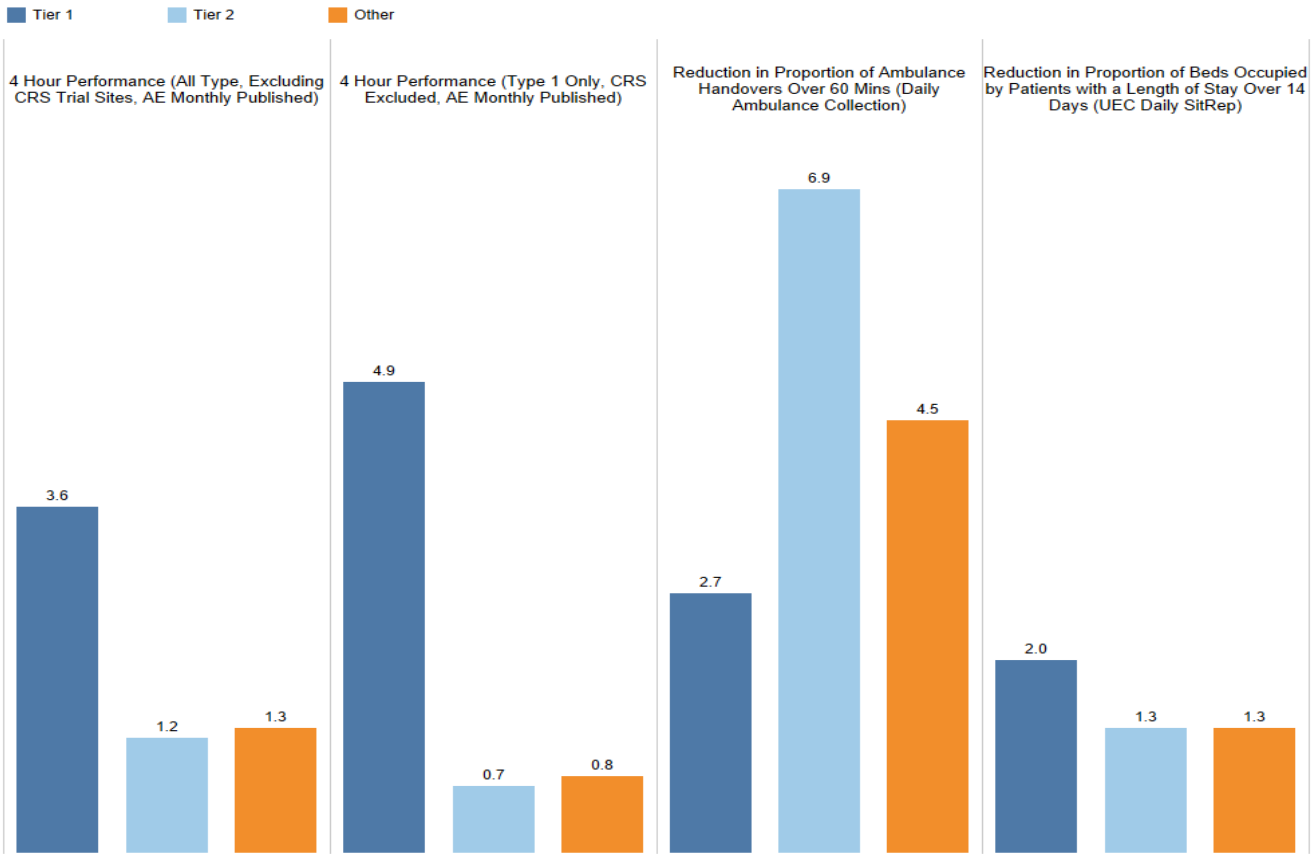
- **NHS England and DHSC** will go further to align and improve the universal and targeted support available through NHS England and the BCF support programmes.

Annex 4: Learning from UEC tiering

Analysis of the UEC tiering approach has shown that Tier 1 and Tier 2 improvement over the last year has been material, particularly in 4-hour performance.

Although all tiers have shown a percentage point increase in key metrics since UEC tiering support commenced. Tier 1 and Tier 2 systems with a Type 1 ED have shown a greater percentage point increase in some of these metrics. As can be seen in the chart below, Tier 1 trusts saw a 3.6 percentage point improvement in 'All Type' 4-hour performance and a 4.9 percentage point improvement in 'Type 1' performance. Tier 2 systems in turn showed a greater improvement than Tier 3 in reduced ambulance handover delays.

Improvement by percentage point in tiering metrics (original cohort)



Early findings from reviews of tiering support indicate that this approach works best where:

- strong system leadership provides system accountability and assurance of delivery and long-term, sustainable improvement
- collective, system-wide improvement is delivered through collaboration across the entire UEC pathway, including primary care, community services and mental health
- improvement approaches and performance oversight are supported and driven by data
- prioritisation of improvement opportunities is focused on the interventions that will have the greatest patient impact

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

NHS England
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26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh

National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer

NHS England

Dr Emily Lawson DBE

Chief Operating Officer

NHS England

Professor Sir Stephen Powis

National Medical Director

NHS England

Dame Ruth May

Chief Nursing Officer

England

Shropshire Community Health NHS Trust

Culture and Leadership Programme update report

0. Reference Information

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Paper Reviewed by:	Rhia Boyode	**Paper Category:**	Workforce
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1. Purpose of Paper

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

Following receipt of the Staff Survey results for 2023 (Appendix 1), the Board and The People Committee have been discussing for some months aspects of the culture and leadership capabilities in the organisation and the perceived impact of these on performance, staff engagement and morale.

The purpose of this paper is to recommend to the Board an organisational development programme to support a review of the prevailing culture of the organisation and the development of a leadership strategy to ensure that we consistently maintain a high-quality care culture.

It is proposed that to create a sense of urgency and energy (Appendix 2), describes our strategic response to phase 1 actions so far in conjunction with some of the staff survey actions in (Appendix 1).

The Board is asked to formally approve the implementation of this Culture and Leadership Programme and seek assurance on the progress to date. The Board is also asked to meet with the new change team and approve that the draft outcome measures in (Appendix 3) to support and compliment the planned work on our strategy and corporate objectives is brought back in August/September 2024.

2. Executive Summary

2.1 Context

Following the Board development day in June and the people committee in July, where the Board discussed where we are now and the Culture and Leadership programme.

It was recognised that the Culture of the organisation impacts all levels of the organisation and a renewed focus on culture and leadership will enable Shropshire Community Health NHS Trust to address the areas highlighted in the recent 2023 staff survey and ensure the interventions already in place improve staff experience.

Culture and Leadership Programme update report

2.2 Summary

The programme that is being proposed by the Director of People and OD is one that has been co-designed by NHS Improvement, the Kings Fund and a number of NHS organisations, to help Trusts develop a culture that enables and sustains safe, high quality, compassionate care.

Culture in organisations, often described as 'the way we do things round here' fundamentally affects the way staff treat each other and patients. The biggest influence on culture is the leadership in the organisation. Collective and compassionate leadership is the key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients and can support sustainable operational and financial performance.

This programme provides a series of practical resources to support trusts to diagnose their cultural issues, develop collective leadership strategies to address them and implement any necessary changes. The programme consists of three phases – diagnose, design and implement.

2.3 Conclusion

This programme would support the delivery of the Trust's Strategy and our aspiration to achieve our ambitions complimented by the NHS People Promise Exemplar programme which the Trust is also implementing to deliver on the elements of the NHS People Promise, Staff Survey and CQC Well Led Domain. Support and involvement from the Board of Directors is essential for the success of this programme.

3. Main Report

3.1 Introduction

This paper explains:

3.2 What the Culture and Leadership programme is and where are we now

3.2.1 Our strategic response and actions in response to the culture and leadership programme taken so far are listed in Appendix 1 as well as a list of actions over the last year in response to the staff survey results are listed in Appendix 2. The programme recommends that the culture of the Trust, and success be measured through a variety of quantitative data metrics and qualitative information; this should be in relation to both our staff and our patients are listed in Appendix 3 and will be presented back to the board in September 2024.

3.2.3 NHS Improvement has created a toolkit of resources that can be used to collect both the quantitative and qualitative data for Phase 1. The type of diagnostic tools used are described in Appendix 1. In addition to using the outcomes of staff and patient surveys a culture assessment tool and staff interviews are also used. During the discovery phase we use a set of diagnostic tools to establish what the culture is in our organisation, where there are strengths and where there are areas to develop.

3.2.4 For this programme to gain traction and commitment it requires the creation of a team to steer and direct the programme . The recruitment of the Cultural Change team (Appendix 1) will need to be supported with both protected time and work space to carry out the programme. Many people will be involved across the

organisation. However, the core team will include People and OD Director as Executive sponsor this team will:

- Create a sense of urgency and energy
- Develop the right vision
- Communicate effectively for buy in
- Empower action
- Create short term wins and will include representation from across the whole organisation and from all levels of leadership. It is important that it also includes representatives as part of the Trust's equality goals.

3.3 How the Board can support the programme

3.3.1 Support from the Board of Directors is essential for the programme as described in Appendix 1 and includes raising awareness with staff and stakeholders.

4.0 Conclusion

4.1 The programme has three phases:

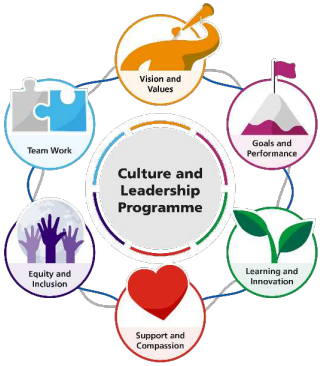
Phase 1: DISCOVER
• Diagnostics to identify the culture of the organisation
• 3- 6months (June 2024 – August 2024).

Phase 2: DESIGN
• Development of collective leadership strategies
• 3 months (August 2024 – October 2024).

Phase 3: DELIVER
• Implementation of collective leadership strategies
• 12 months (August 2024 – August 2025)

Work has commenced to test and refine the recommended criteria to ensure it is fit for a Community Trust setting, and to document the baseline against these outcomes in order to measure progress. Progress on this programme will be reported into the People Committee regularly including presentations at Board.

Shropshire Community Health
NHS Trust



Culture and Leadership programme

Rhia Boyode, Director of People and OD
1 August 2024

Improving Lives in Our Communities
Commitment to Quality | Respect & Dignity | Working Together | Compassionate Care | Everyone Counts

Shropshire Community Health NHS Trust

Culture and leadership programme

Programme outcome

To implement a collective leadership strategy to embed cultures that enable the delivery of continuously improving, high quality, safe and compassionate care.

Tools to identify the culture of our organisation

Development of collective leadership strategies

Implementation of collective leadership strategies

Phase 1: discover

Shropshire Community Health NHS Trust

Culture and outcomes dashboard

High level understanding of culture and related outcomes

Patient experience

Understand patient's experience of culture

Board interviews

Understand the board's approach to supporting effective organisational culture

Culture focus groups

Understand individuals' experience of current organisational culture

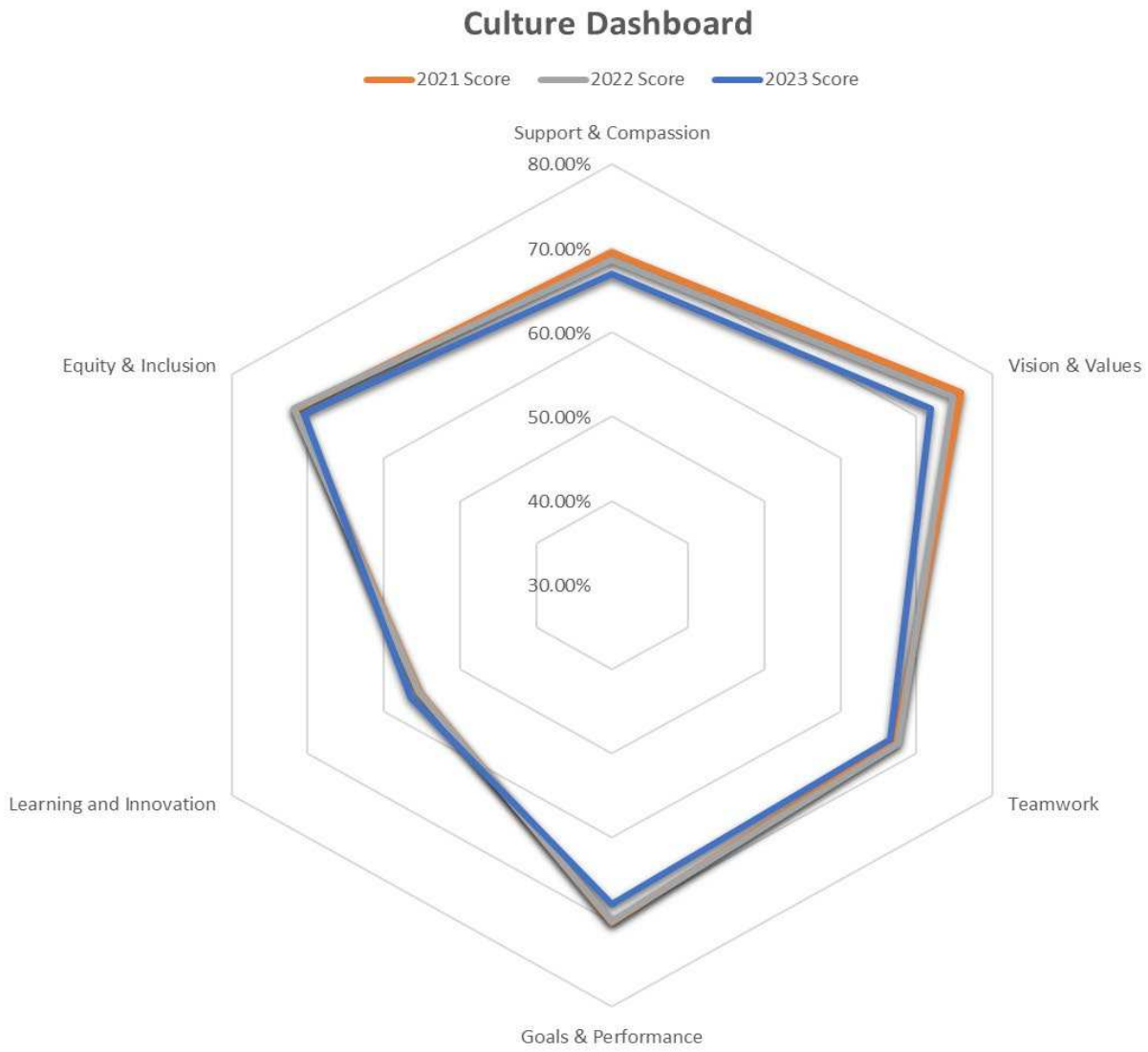
Leadership behaviours survey

Understand staff and stakeholder views on behaviours of your organisation's staff and leaders as a whole

Leadership workforce analysis

Understand the organisation's needs on leadership workforce capacity

Synthesis: Bring together the results of the diagnostic resources


Culture Dashboard
2021 Score
2022 Score
2023 Score
Support & Compassion
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
Vision & Values
Teamwork
Goals & Performance
Learning and Innovation
Equity & Inclusion

Delivery so far…

Strategic response to phase 1 actions

A key focus on our journey and in our People Plan is to make our Trust a great place to work for everyone

Culture

Divisional Culture Dashboards being created

Actions to be set by divisions supported by the HR and OD team and presented to the People Committee in September

Freedom to Speak up offer refreshed and relaunched

Annual recognition and awards

Annual EDI, Recognition and Celebration calendar developed

Work underway to plan resource for Long Service Awards Event and Trust Star Awards aligned to the Cultural Characteristics

Health and wellbeing

Wellbeing events included in calendar

Menopause & Andropause awareness and support sessions being delivered

Health & Wellbeing Days planned for delivery in Autumn

Progress -

Shropshire Community Health NHS Trust

Strategic response to phase 1 actions

A key focus on our journey and in our People Plan is to make our Trust a great place to work for everyone

Programme Planning

Change Team advert and expression of interest developed

Culture Champions opportunity advertised

Outcomes and success measures baseline being identified

Leadership

Leadership Masterclasses advertised

Leadership development programmes advertised

Strategy, Visions and Cultural Characteristics re-launched

Inclusive Leadership sessions delivered

Board EDI development session completed

Shrop Com Change Team

NHS
Shropshire Community Health
NHS Trust

Cultural Transformation at ShropCom - do you want to join our Culture Change Team?

When we talk about our culture, we mean 'the values lived by its employee's everyday' – these may not be the same as the stated values. Culture shapes our behaviours, our experiences, the quality of patient care and our overall performance. It determines everything we do.

NHS Improvement have partnered with the King's Fund and the Centre for Creative Leadership to provide practical support and resources to help providers (including Team ShropCom) across the UK to improve their culture, which has resulted in something called the Culture and Leadership Programme.

Several NHS organisations have already signed-up to the programme and are reaping the benefits. This programme is fully supported by both NHS Improvement and the NHS Leadership Academy.

Aligned to our ACE Cultural Characteristics, we want a type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across Shrop Com. This is in contrast to command-and-control cultures which are not conducive to achieving high quality care; we want '**Leadership of all, by all and for all**'. Through strategies which deliver collective, compassionate, and inclusive leadership, this programme aims to create high quality care cultures.

What better way to start our own Culture and Leadership Programme with the recent recruitment of our People Promise manager, Rebecca Smith?

Now we need your help to implement The Culture and Leadership Programme by recruiting a multidisciplinary team of people from different backgrounds, job roles, pay bands and professions...

- Do you want to influence the culture and leadership of ShropCom?
- Do you want to tackle the challenges facing our ShropCom head on and be part of the solution?
- Are you passionate about improving the working experience of all employees at ShropCom?
- Are you keen to develop and learn?
- Do you want to have a say when it comes to branding and creating an identity for the Trust?
- Are you happy to champion our culture ambitions and wins across the Trust and on social media?
- Are you a curious individual, motivated to work beyond your current role?
- Do you want to help bring the People Promise alive?

Then we want to hear from you: join the Change Team as we roll out The Culture and Leadership Programme, to understand our culture and influence a consistent compassionate, diverse and inclusive future. For you, for our colleagues and for our patients.

Why join the change team?

- Influence decision making: contribute your insights and expertise to influence strategic decisions for ShropCom.
- Collaborate across disciplines: working alongside colleagues from different areas and roles across ShropCom.
- Make a difference: drive meaningful change across ShropCom to enhance employee experience, review our culture and leadership behaviours, bring 'The People Promise' alive, and improve the care we provide to our patients and communities.

Once appointed the Change Agents will be responsible for:

- Attending the initial launch event
- Defining the questions to 'Discover' what the culture is like at ShropCom
- Establish the process for collecting information/views/data
- Gathering and processing data including conducting focus groups and interviews
- Communicating the process and emerging knowledge to the organisation
- Attending project team meetings
- Producing a high-quality report on the outcomes of the Discovery process and feeding back with recommendations to the Board
- Modelling collective leadership and supportive team working
- Planning the next steps for Design and Delivery phases of culture change for ShropCom.

In total we envisage that you will be spending up to 2 days per month on the Culture Change Team activities between September 2024 and February 2025 (6 months) and up to 1 day a month beyond that.

Want to sign up? Next steps:

- Gain line manager sign off and endorsement prior to submitting your application of interest.
- Complete the attached MS form: Link Below
- Expressions of interest will be reviewed by the People team against the above criteria and to ensure we have a representative group.
- Applicants will then be informed by 31st August.

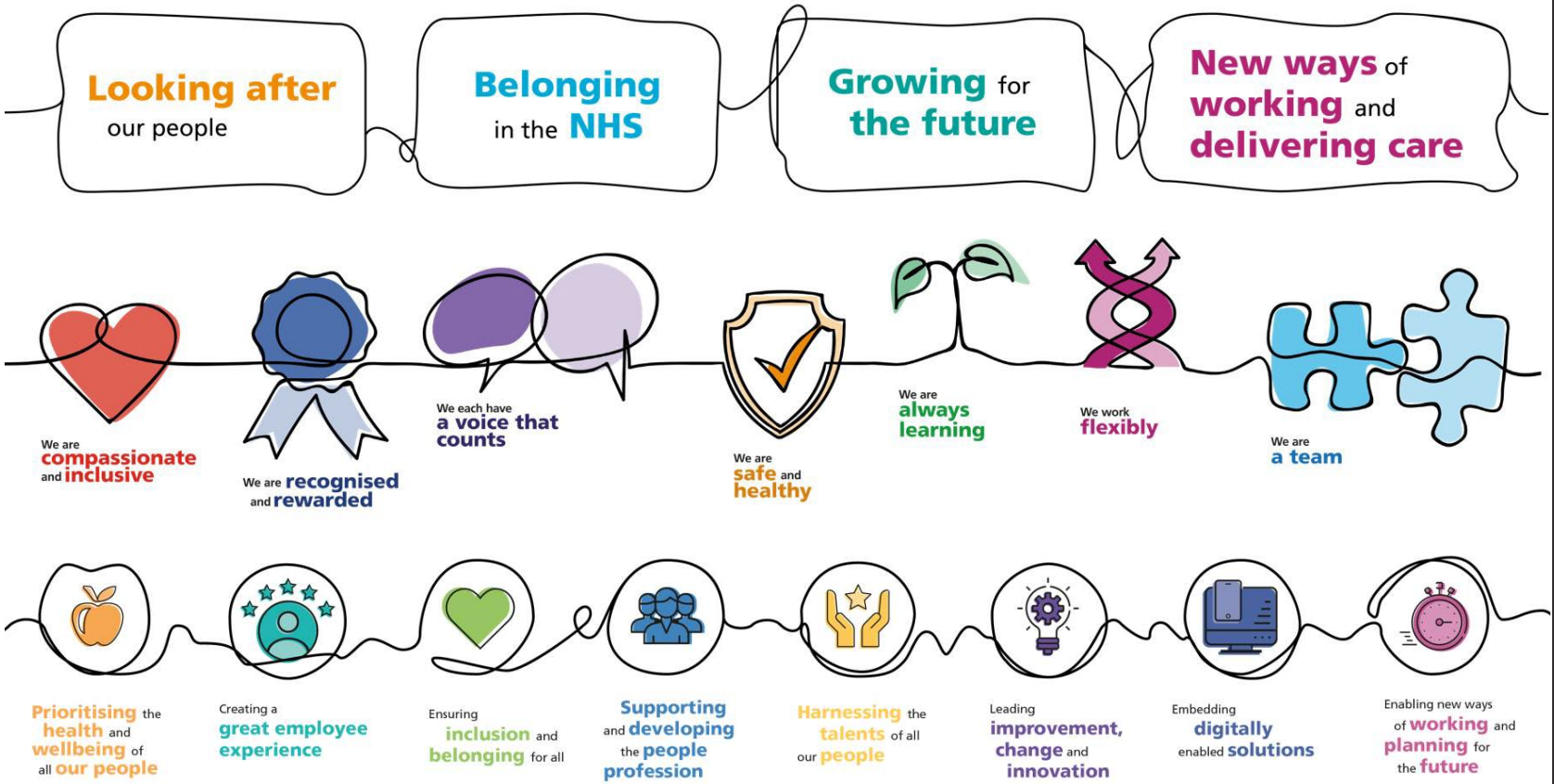
If you wish to be part of the programme but cannot commit to the Change Team, yet you are willing to support where you can, then please complete the MS form and check the required box at the end of the form.

Annual Calendar

NHS
Shropshire Community Health

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Local Initiatives	• Question Time (18th)		• Question Time (24th) • Schwarts Round – Shrewsbury (24th) • ACP Academy Conference 2024 (26th) • STAFF SURVEY? • Flu Campaign?	• Health & Wellbeing Days (8th & 31st) • Work life balance week (7th-11th) • Schwarts Round – Shrewsbury (20th)	• Health & Wellbeing Days (5th & 13th) • Question Time (22nd) • Schwarts Round – Shrewsbury (21st)	• Week of Celebration Long Service Awards Recognition • Volunteers Week/Celebration • Schwarts Round – Whitchurch (9th)	• Schwarts Round - Osweatry (28th)		• Values Week
Awareness Days	• National Schizophrenia Awareness Day (24) • World Hepatitis Day (28)	• Cycle to Work Day (1) • National Opportunity Day (13) • Bank Holiday (26) 	• Pension Awareness Week (9th – 15th) • World Suicide Prevention Day (10th) • Ask about Asthma Week (11th) • World Sepsis Day (13th) • World Patient Safety Day (17th) • National Alzheimer's Day (21st) • Falls Awareness Day (22nd) • World Biggest Coffee Morning (27th) 	• Stoptober • Breast Cancer Awareness Month • National Cholesterol Month • Speak Up Month • Baby Loss Awareness Month (9th -15th) • World Mental Health Day (10th) • World Menopause Day (18th) • Learning and Innovation Week 14th-18th • Infection prevention control week (13th – 19th)	• International Men's Health Month (Movember) • Mouth Cancer Action Month • International Community Health and Care Day (1st) • International Stress Awareness Week (5th – 9th) • Remembrance Day (11th) • National Self Care Week (13th) • Anti-bullying Week – (11th -17th) • Mental Health (13th) • Trans Awareness Week (13th – 19th) • World Diabetes Day (14th) • International Men's Day (19th) • 16 Days of Action Against Domestic Violence (25th)	• National Grief Awareness Week (2nd – 8th) • World Aids Day (1st)	• Dry January • Cervical Cancer Prevention Week (22nd -28th) 	• Digital Health Forum Time to Talk Day (1st) • World Cancer Day (4th) • Eating Disorder Awareness Week (26th Feb - 3rd Mar) • Rare Disease Day (29th) 	• Nutrition and Hydration Week (11th -18th) • National No Smoking Day (17th) • World Kidney Day (14th) • World Oral Health Day (20th) • World Down Syndrome Day (21st)
EDI Celebrations	• South Asian Heritage Month (18 Jul-17 Aug)	• South Asian Heritage Month (18 Jul-17 Aug)	• UK National Inclusion Week (23rd – 29th)	• Black History Month (1st - 31st) • Show Racism the Red Card (21st) 	• Diwali (1st) • Inter-Faith Week (12th - 19th) • Trans Awareness Week (13th -19th) • Disability History Month (16th Nov – 16th Dec) • Transgender Day of Remembrance (20th)	• Disability History Month (16th Nov – 16th Dec) • International Day of People with Disabilities (3rd) • Hanukkah (25th – 3rd) • Christmas (25th) 	• Orthodox Christmas (7th) • Kerala New Year (1st) • World Religion Day (21st) • Lunar New Year (10th) • Lent (14th Feb – 28th Mar)	• LGBTQIA+ History Month • World Interfaith Harmony Week (1st -7th) • Lunar New Year (10th) • Lent (14th Feb – 28th Mar)	• Zero Discrimination Day (1st) • Ramadan (10th Mar – 9th Apr) • Neurodiversity Celebration Week (18th -24th) • International Day for the Elimination of Racial Discrimination (21st) • Easter (29th Mar – 1st Apr) • International Transgender Day of Visibility (31st)
National Award Entry Deadlines				• HSJ Partnership Awards (7th) 			• Student Nursing Times Awards (TBC) • RCN Nursing Awards (TBC) • British Journal of Nursing Awards 2024 (TBC)	• HSJ Digital Awards (TBC) • Nominations open for NHS Parliamentary Awards (29th)	• National Institute for Health Research NIHR Awards (TBC) • Health Tech (TBC)

People Plan, People Promise and NHS HR and OD vision 2030



The End

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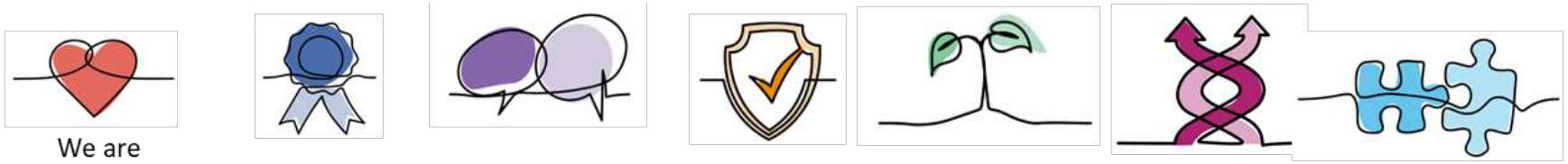
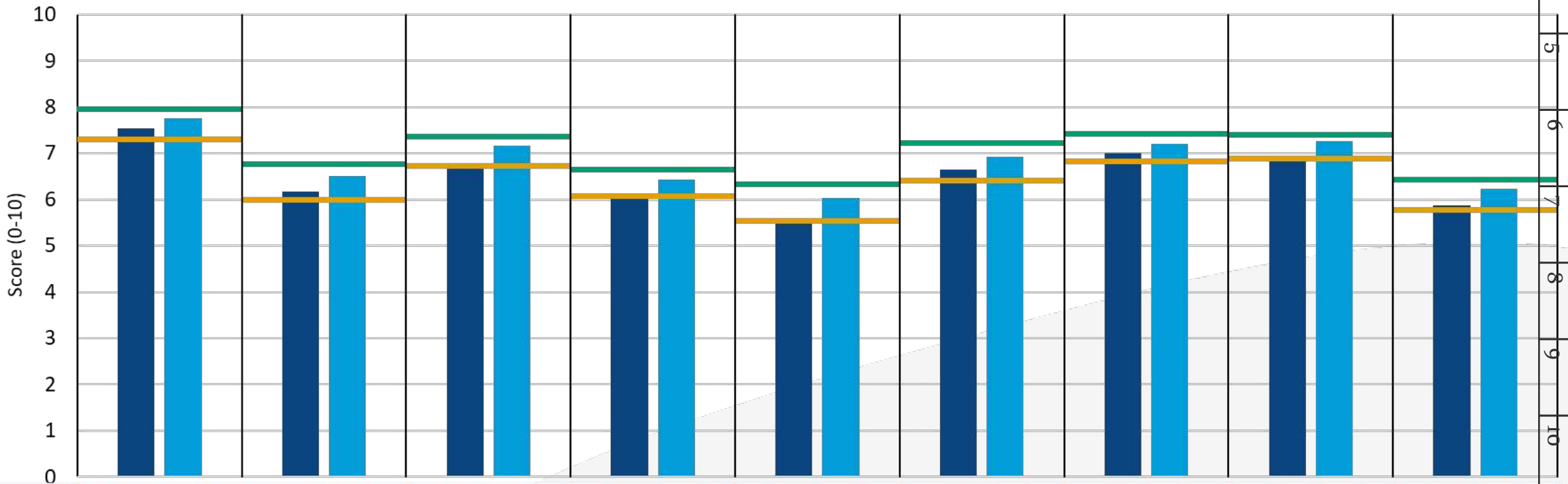
Staff Survey Summary 2023

Our 2023 Staff Survey Results





	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

2022/2023 Results Comparison

Staff Engagement

2023 Score: 6.9

2022 Score: 7.1

Morale

2023 Score: 5.9

2022 Score: 5.8

We are compassionate and inclusive

2023 Score: 7.5

2022: Score 7.6

We are recognised and rewarded

2023 Score: 6.2

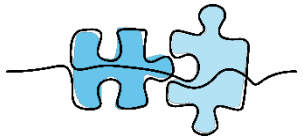
2022 Score: 6.1

We are always learning

2023 Score: 5.5

2022 Score: 5.3

We are a team



2023 Score: 7.0

2022 Score: 6.9

We each have a voice that counts

2023 Score: 6.7

2022 Score: 6.9

We work flexibly

2023 Score: 6.7

2022 Score: 6.5

We are safe and healthy

2023 Score: 6.1

2022 Score: 6.1

Theme Sub-Scores

Comparator Information			Picker Average 2023	Organisation 2023	Organisation 2022	Organisation 2021
Section	Q	Description	n = 17743	n = 845	n = 777	n = 950
People Promise element 1: We are compassionate and inclusive	PP1_1	Compassionate culture sub-score	7.5	7.0	7.1	7.3
	PP1_2	Compassionate leadership sub-score	7.5	7.4	7.2	7.2
	PP1_3	Diversity and equality sub-score	8.6	8.4	8.5	8.5
	PP1_4	Inclusion sub-score	7.4	7.4	7.5	7.3
	PP1	We are compassionate and inclusive score	7.7	7.5	7.6	7.6
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	6.4	6.2	6.1	6.1
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	7.2	7.0	7.2	7.1
	PP3_2	Raising concerns sub-score	7.0	6.4	6.7	6.9
	PP3	We each have a voice that counts score	7.1	6.7	6.9	7.0
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.7	5.2	5.2	5.2
	PP4_2	Burnout sub-score	5.3	5.1	5.0	4.9
	PP4_3	Negative experiences sub-score	8.2	8.1	8.1	8.1
	PP4	We are safe and healthy score	6.4	6.2	6.1	6.1
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.7	6.2	6.2	6.1
	PP5_2	Appraisals sub-score	5.4	4.8	4.5	4.4
	PP5	We are always learning score	6.0	5.5	5.3	5.3
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	6.8	6.7	6.5	6.4
	PP6_2	Flexible working sub-score	6.8	6.6	6.4	6.3
	PP6	We work flexibly score	6.8	6.7	6.5	6.3
People Promise element 7: We are a team	PP7_1	Team working sub-score	7.0	6.8	6.9	6.8
	PP7_2	Line management sub-score	7.4	7.2	7.1	7.0
	PP7	We are a team score	7.2	7.0	7.0	6.9
Theme: Staff Engagement	E_1	Motivation sub-score	7.3	7.2	7.3	7.3
	E_2	Involvement sub-score	7.1	7.0	7.1	7.0
	E_3	Advocacy sub-score	7.3	6.7	6.8	7.0
	E_4	Staff Engagement Score	7.2	6.9	7.1	7.1
Theme: Morale	M_1	Thinking about leaving sub-score	6.3	6.1	6.0	6.0
	M_2	Work pressure sub-score	5.5	5.0	4.9	4.9
	M_3	Stressors sub-score	6.7	6.5	6.6	6.5
	M_4	Morale score	6.2	5.9	5.8	5.8

Some of the Interventions delivered in 2023/2024

- ❑ Participating in the National People Promise Exemplar programme

- ❑ Delivery commenced on Civility and Respect training

- ❑ Delivery of Inclusive Leadership training

- ❑ Delivery of Wellbeing Conversations training
- ❑ Collaborative working with Shrewsbury and Telford Hospital NHS Trust
  - Enabled staff to access Masterclasses, Leadership and Manager training
  - Enabled staff to access SaTH Psychology Services
- ❑ Staff Listening Events and Feedback Button
- ❑ Wellbeing Days

- ❑ Long Service Awards afternoon Tea and International Nurses Welcome Event
- ❑ Appreciation Station on Staff Zone with digital cards

- ❑ Relaunch of Freedom to Speak Up and more champions appointed
- ❑ Flexible Working Campaign including toolkits, policy review and awareness/development sessions
- ❑ Menopause and Andropause Campaign including new policy and awareness/support sessions
- ❑ Introduced Pregnancy and Baby Loss policy
- ❑ Delivered Neurodiversity awareness training
- ❑ Policy and line manager development and toolkits to build competency in dealing with employee relations matters

NHS Culture & Leadership Programme: Outcome Dashboard

Vision_and_Values
q17a - I would feel secure raising concerns about unsafe clinical practice.
q21a - Care of patients / service users is my organisation's top priority.
q21b - My organisation acts on concerns raised by patients / service users.
care provided by this organisation.
q3b - I am trusted to do my job
q6a - I feel that my role makes a difference to patients / service users.
Emergency readmission rates 30 days
Summary Hospital Mortality Indicator (SHMI)
Cases reported to FTSU Guardians anonymously
Cases of detriment as a result of Speaking Up reported to FTSU Guardians

Goals_and_performance
q3a - I always know what my work responsibilities are
q3g - I am able to meet all the conflicting demands on my time at work.
q3h - I have adequate materials, supplies and equipment to do my work.
q3i - There are enough staff at this organisation for me to do my job properly.
q4a - The recognition I get for good work.
q9b - My immediate manager (who may be referred to as your 'line manager') gives
q9e - My immediate manager (who may be referred to as your 'line manager') values
RTT within 18 weeks
RTT clearance time (weeks)
Cancer - 62-day wait from urgent GP referral
A&E 4-hour wait performance
Clostridium Difficile - infection rate
Mean call answering time
Call to incident ratio
Total number of hours spent at hospital pre-handover (over and above 15min
Total number of hours spend at hospital post-handover (over and above 15min
Ambulance Response to Category 1 (Life Threatening) calls in 7 minutes on average
Ambulance Response to Category 2 (Emergency) calls in 18 minutes on average
Single Oversight Framework (SOF) Segment
Monthly CIP - variance to plan

Learning_and_Innovation

q3f - I am able to make improvements happen in my area of work.
team / department.
q3d - I am able to make suggestions to improve the work of my team / department.
q3c - There are frequent opportunities for me to show initiative in my role.
organisation would address my concern
need to
q20d - I feel supported to develop my potential
q20c - I have opportunities to improve my knowledge and skills
q20b - There are opportunities for me to develop my career in this organisation
q19d - It left me feeling that my work is valued by my organisation.
q19c - It helped me agree clear objectives for my work.
q19b - It helped me to improve how I do my job.
q19a - In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

Support_and_Compassion

q11a - Does your organisation take positive action on health and wellbeing
stress?
enough to perform
your duties?
q12a - How often, if at all, do you find your work emotionally exhausting?
q12b - How often, if at all, do you feel burnt out because of your work?
q12c - How often, if at all, does your work frustrate you?
during leisure time?
physical violence at work from Patients / service users, their relatives or other members of the public
physical violence at work from managers
physical violence at work from other colleagues
colleague report it?
harassment, bullying or abuse at work from managers?
q14c - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?
q21c - I would recommend my organisation as a place to work.
q21e - I feel safe to speak up about anything that concerns me in this organisation
q22a - I often think about leaving this organisation.
q4d - The opportunities for flexible working patterns.
q5a - I have unrealistic time pressures.
q5b - I have a choice in deciding how to do my work.
q6b - My organisation is committed to helping me balance my work and home life
q8b - The people I work with are understanding and kind to one another
q8c - The people I work with are polite and treat each other with respect.

encourages me at work.
q9c - My immediate manager (who may be referred to as your 'line manager') asks for my opinion before making decisions that affect my work.
positive interest in my health and wellbeing
problems.
challenges I face
q9h - I think my immediate manager cares about my concerns.
face
Staff engagement
Sickness absence rates
Voluntary turnover rate
Worker safety cases reported to FTSU Guardians
Bullying and harrassment cases reported to FTSU Guardians

Equity and Inclusion

q16a - In the last 12 months have you personally experienced discrimination at work from Patients / service users, their relatives or other members of the public?
q16b - In the last 12 months have you personally experienced discrimination at work
q15 - Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or
Learning Disability Employment Programme pledge
q11a - % staff from BAME background agreeing/strongly agreeing: Does your
q11a - % staff with disabilities agreeing/strongly agreeing: Does your organisation
NHS Trust Board Representation BME
Clinical (non medical) Workforce Skill Mix - (Bands 8a to 9) BME
Clinical (non medical) Workforce Skill Mix - VSM -Very Senior Managers BME
Relative likelihood of staff being appointed from shortlisting across all posts (BME)
entry into a formal disciplinary investigation (BME)
NHS Trust Board Representation Disabled
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
adjustment(s) to enable them to carry out their work.
NHS Trust Board Representation Female
working styles, backgrounds, ideas, etc)

Team_Work

q5c - Relationships at work are strained.
q7a - The team I work in has a set of shared objectives.
q7b - The team I work in often meets to discuss the team's effectiveness.
q7c - I receive the respect I deserve from my colleagues at work.

q7d - Team members understand each other's roles
q7e - I enjoy working with the colleagues in my team.
q7f - My team has enough freedom in how to do its work
q7g - In my team disagreements are dealt with constructively
q7h - I feel valued by my team
q7i - I feel a strong personal attachment to my team
q8a - Teams within this organisation work well together to achieve their objectives
q8d - The people I work with show appreciation to one another
Agency workers overall total staffing cost (%)

CQC
Overall
Caring
Effective
Responsive
Well Led
Safe

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

0. Reference Information

Author:	Poppy Owens, Executive Assistant	**Paper date:**	1st August 2024
Executive Sponsor:	Peter Featherstone, RPC Chair	**Paper written on:**	26th July 2024
Paper Reviewed by:		**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 Board and what input is required?

This paper presents a summary of the Resource and Performance Committee meeting held on 22nd July 2024 for assurance purposes.

2. Executive Summary

2.1 Summary

- The meeting was well attended.
- The agenda items included:
    - Waiting times – RTT and Non RTT
    - Elective Activity Plan and Delivery
    - Integrated Performance Report
    - Deep Dive Agency, Bank, Workforce
    - CIP Actions and Delivery
    - Benchmarking paper -Length of Stay in Community Hospitals
    - Finance & Capital Reporting Month 3
    - Contract Monitoring Report
    - Operational Plan Delivery – Approving milestones and outcomes
    - PMO Function Report
    - Procurement Strategy Update
    - Estates and Environment Quarterly Update
    - Review of BAF risks
    - System Transformation Group update
    - Digital Assurance Group Minutes

2.3. Conclusion

The Board is asked to note the Chair's Report for assurance purposes.

Shropshire Community Health
NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Resource and Performance Committee which met on 22nd July 2024. The meeting was quorate with two Non-Executive Directors and three Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Peter Featherstone	Non-Executive Director (RPC Chair)
Sarah Lloyd	Chief Finance Officer
Shelley Ramtuhul	Trust Secretary/Director of Governance
Claire Horsfield	Director of Operations
Harmesh Darbhanga	Non-Executive Director
Michael Price	Procurement Lead (part meeting)
Patricia Davies	Chief Executive Officer
Sarah Allan	Associate Director of Workforce & Resourcing (part meeting)
Tina Long	Interim Trust Chair
Jonathan Gould	Deputy Chief Finance Officer
Gemma McIver	Deputy Director of Operations
Jon Davis	Associate Director of Digital Services
Mark Mawdsley	Head of Costing and Contracting (part meeting)
Sara Ellis-Anderson	Deputy Director of Nursing, Quality and Deputy DIPC
Helen Cooper	Divisional Clinical Manager Children, Families, Planned Care
Sam Townsend	Divisional Clinical Manager, Adult Community Services
Amy Nicholls	Student Nurse (Shadowing)
Poppy Owens	Executive Assistant [Minutes]

Apologies:	
Richard Best	Associate Director of Estates
Clair Hobbs	Director of Nursing, Clinical Services and Workforce
Jill Barker	Associate Non-Executive Director
Cathy Purt	Non-Executive Director

3.2 Actions from the Previous Meeting

The Committee reviewed all open actions from previous meetings, none of which are now outstanding.

3.3 Key Agenda

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

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
7. Waiting times – RTT and Non RTT		
The Committee considered the 18 week RTT position which had improved in April and May but deteriorated during June. The Committee discussed the long waits position which has sustained with zero reportable 104, 78 and 65 weeks for RTT services. Action plans are in place to support recovery, with a focussed plan for Musculoskeletal Services Shropshire & Telford (MSST) that is being driven internally with support of system partners. The Committee reviewed the long waits for non RTT services, with a significant number over 52 weeks and a very small number exceeding 104 weeks. The Committee confirmed partial assurance and continued action and oversight is required.	Partial	Continued focus on long waits including reviewing pathways with system partners.
8. Elective Activity Plan and Delivery		
The Committee gained assurance around the governance and controls in place and sustained delivery of the plan. It was therefore agreed this element of reporting could be stood down and reviewed within the integrated performance report moving forward.	Y	
9. Integrated Performance Report		
The Committee heard approximately half of the KPIs relevant to this Committee are flagged as a concern, with all but one relating to waiting times and access to services. The list is relatively unchanged but to note are the diagnostics for ultrasound and audiology and the total patients waiting over 104 weeks for all services. The 'New Birth Visits within 14 days' for both Telford and Dudley are flagged as a variation concern. The Committee approved the alterations to the KPI details for New Birth Visits within 14 days (Dudley) and the addition of Virtual Ward bed occupancy.	Y	Relevant actions in relation to access to services are picked up through agenda item 7.
10. Deep Dive Agency, Bank, Workforce		
The Committee discussed the month 3 agency update which continues to show a favourable variance to plan, largely due to successful recruitment to key clinical posts. A number of pressures remain including within community nursing, due to unavailability of staff.	Partial	Bank worker usage authorisation process to be reviewed and implemented.

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

Planned actions include prioritising recruitment to community nursing vacancies and a continued focus on price cap compliance. A summary bank staff strategy was presented, together with a plan to develop this. The approval process for bank worker usage was discussed and further work is urgently required to provide assurance on the controls in place. Bank worker usage authorisation was identified as a risk, pending completion of the above work.		
11. CIP Actions and Delivery		
The Committee were advised 100% of CIP schemes have been identified. 62% of CIP schemes remain high risk in terms of delivery however the Committee acknowledged that this is an improving position with full oversight through the Financial Recovery Group (FRG). The stretch target agreed with system partners remains high risk in terms of delivery at this time and is included within this position.	Partial	Progress in relation to CIP delivery is being demonstrated but continued close oversight through FRG is required to continue de-risking the delivery plans.
12. Benchmarking paper – Length of Stay in Community Hospitals		
The Committee noted the positive benchmarking; our Community Hospital Length of Stay is in the top two of the second quartile when looking at benchmarking data. As with all providers there has been a significant increase in length of stay from April 21-24, mainly due to introduction of virtual ward. An action plan was provided and the Committee will receive an update eon progress in 6 months.	Y	
13. Finance & Capital Report Month 3		
The Committee heard the Trust is reporting a £276k adjusted surplus year to date compared to the planned surplus of £284k which is an adverse variance of £8k. The key financial risks for consideration include Agency, CIP, and Elective income and constrained Capital expenditure funding. The Committee identified constraints to capital funding as a risk which will continue to be reviewed through the Capital and Estates Group and the BAF will be updated to ensure this is fully captured.	Y	

Shropshire Community Health NHS Trust

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

14. Contract Monitoring Report		
The Committee considered contract performance at month 2 2024/25. In addition, the risks and issues log from the Contract Management Group was discussed. Progress agreeing a Service Level Agreement with SaTH was noted but an update is required within the next report to this Committee. The Committee noted the 2023/24 national cost collection submission has been made and the recent receipt of the 2022/23 exercise which will be considered and presented to the next meeting.	Y	
15. Operational Plan Delivery – Approving milestones and outcomes		
The Committee discussed the delivery of the Trust's Operational Plan and approved the proposed interventions and outcomes aligned to RPC. These are the actions and outcomes which are designed to deliver the Trust's Strategic Priorities. The Committee reviewed and approved the proposed interventions and outcomes that have been aligned to RPC.	Y	
16. PMO Function Report		
The Committee received an updated regarding the PMO function report and the digital tool which has now been developed and received well. The Committee were assured with progress made and agreed this agenda item could be stood down.	Y	
17. Procurement Strategy Update		
The Committee discussed that the NoPO NoPay policy has seen improvements in adherence and that there has also been an improvement in contracted spend compared to non contracted spend. An update on the ICS Procurement Strategy will be presented within the next update.	Y	
18. Estates and Environmental Quarterly Update		
The Committee received assurance that there are currently no significant concerns to raise, and any relevant actions are being picked up by relevant Groups.	Y	

Chair's Assurance Report

Resource and Performance Committee Part 1 – 22nd July 2024

The Committee discussed that the ICS has published their Estates Strategy and this will be added to the next quarterly update for discussion.		
19. Review of BAF risks for R&P		
The Committee discussed the 10 BAF risks for RPC and acknowledged that three additional risks have been noted today: • The authorisation process for bank workers, • CIP delivery risks • The potential impact of constrained capital funding		

3.4 Approvals

The Committee approved the alterations to the KPI details for New Birth Visits within 14 days and the addition of Virtual Ward bed occupancy.

The Committee reviewed and approved the proposed interventions and outcomes that have been aligned to RPC through the operational plan.

3.5 Risks to be Escalated

In the course of its business the Committee identified three risks;

- Authorisation process for bank workers
- CIP delivery risks
- Impact of constraints on capital funding

4. Conclusion

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

Shropshire Community Health
NHS Trust

Performance Update

Author:	Steve Price, Head of Information and Performance Assurance Operational Leads	**Paper date:**	**1st August 2024**
Executive Sponsor:	Sarah Lloyd, Director of Finance Claire Horsfield, Director of Operations	**Paper written on:**	**22nd July 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 64 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. 33 indicators are highlighted as a concern (51.6%), 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	7	5	**19**	**14 (73.7%)**
Quality & Safety	1	2	2	**16**	**5 (31.3%)**
Resource & Performance	4	4	6	**29**	**14 (48.3%)**

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

Performance Update

Action Plans have been developed by Operational colleagues and included at Appendix 3 for the measures flagged as a concern in this report for the Resource and Performance Committee. 'New Birth Visits % within 14 days – Dudley' is a new measure and an action plan will be requested for the next reporting cycle.

In line with our Performance Framework and available national guidance, each Committee reviewed its key performance measures as we entered the new financial year and this suite of KPIs was considered and approved by the Board at its June. All agreed changes have now been reflected within the dashboards.

The Resource and Performance Committee requested an additional measure for 'Virtual ward bed occupancy'. This has been included within the dashboard and the Board is asked to approve this change.

In addition, the Committee supported a change to the measure for 'New Birth Visits % within 14 days – Dudley', with an amendment of the target from 90% to 95% as advised by the Divisional Clinical Manager. The Board is asked to approve this change.

Please note that the RTT measures for June 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 current 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.
- **Approve** the alteration to the KPI details for New Birth Visits % within 14 days – Dudley and addition of Virtual ward bed occupancy.

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 29 indicators which are reviewed by the Resource & Performance Committee (RPC). Of these, 14 require particular focus with 13 of the 14 relating to access to services and waiting times.

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:

Four KPI are a variation concern only – special cause variation of a concerning nature.

1. Outpatient follow-up activity levels compared with 2019/20 baseline
2. Diagnostics for Audiology and Ultrasound – DM01
3. New Birth Visits % within 14 days – Telford
4. Total patients waiting more than 104 Weeks – All services (Local target)

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

1. Total patients waiting more than 65 Weeks to start consultant-led treatment (National target).
2. Data Quality Maturity Index
3. New Birth Visits % within 14 days – Dudley
4. Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

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)

Performance Update

The list of KPIs which are of concern is relatively unchanged from the last report to the Board but there have been some changes to note;

- Total patients waiting more than 104 Weeks – All services (Local target) is now showing a variation concern.
- Total patients waiting more than 52 Weeks to start consultant-led treatment (National target) is now showing as having both an assurance and a variation concern.
- 'New Birth Visits % within 14 days – Telford' is flagged as a variation concern and 'New Birth Visits % within 14 days – Dudley' is showing as an assurance concern.

As of June 2024:

Measure	Nationally Mandated Referral to Treatment (Consultant-led Services)	Local Waiting List Management (All Services)
Patients waiting over 52 weeks	524	1385
Patients waiting over 65 weeks	0	388
Patients waiting over 78 weeks	0	155
Patients waiting over 104 weeks	0	5

There has been significant deterioration across the high wait KPI, this is evident in the charts within the appendices and detail regarding actions being taken is included in the action plans.

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 deterioration from 54.74% in May to 52.99% in June, although June position was still being validated at the time of preparing the paper/dashboards. This deterioration is also the case for the local waiting list measure, Proportion of patients within 18 weeks, with performance of 59.87% in May to 58.65% in June.

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 the majority of 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.

Performance Update

3.3 Key Issues & Recommendations

The key issues are summarised within this report and appendices.

3.4 Conclusion

The Trust Board is asked to:

- **Consider** the Trust's performance to date and the actions being taken to minimise risks and improve performance where required.
- **Consider** the current 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.
- **Approve** the alteration to the KPI details for New Birth Visits % within 14 days – Dudley and addition of Virtual ward bed occupancy.

Resource and Performance Committee - SPC Summary

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance...	Responsive	18 week Referral To Treatment (RTT) incomplete pathways	2024-06-30		52.99%	92.00%	-39.01%	52.99%	92.00%	-39.01%	
Resource & Performance...	Use of Resources	Agency spend - compared to the agency ceiling	2024-06-30		74.54%	100.00%	-25.46%	74.54%	100.00%	-25.46%	
Resource & Performance...	Use of Resources	Agency spend - Price cap compliance	2024-06-30		50.37%	100.00%	-49.63%	50.37%	100.00%	-49.63%	
Resource & Performance...	Effective	Available virtual ward capacity per 100k head of population	2024-06-30		38.76	38.76	0.00	38.76	38.76	0.00	
Resource & Performance...	Responsive	CQC Conditions or Warning Notices	2024-06-30		0	0	0	0	0	0	
Resource & Performance...	Effective	Data Quality Maturity Index	2024-03-31		94.4%	95.0%	-0.6%	94.4%	95.0%	-0.6%	
Resource & Performance...	Responsive	Diagnostics for Audiology and Ultrasound - DM01	2024-05-31		87.11%	99.00%	-11.89%	87.11%	99.00%	-11.89%	
Resource & Performance...	Use of Resources	Financial efficiency - variance from efficiency plan	2024-06-30		4.13%	0.00%	4.13%	4.13%	0.00%	4.13%	
Resource & Performance...	Use of Resources	Financial stability - variance from break-even	2024-06-30		1.14%	0.00%	1.14%	1.14%	0.00%	1.14%	
Resource & Performance...	Caring	New Birth Visits % within 14 days - Dudley	2024-05-31		89.03%	95.00%	-5.97%	85.42%	95.00%	-9.58%	
Resource & Performance...	Caring	New Birth Visits % within 14 days - Shropshire	2024-05-31		85.45%	90.00%	-4.55%	87.41%	90.00%	-2.59%	
Resource & Performance...	Caring	New Birth Visits % within 14 days - Telford	2024-05-31		91.94%	95.00%	-3.06%	92.98%	95.00%	-2.02%	
Resource & Performance...	Responsive	Number of patients not treated within 28 days of last minute cancellati...	2024-06-30		0	0	0	0	0	0	
Resource & Performance...	Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	2024-06-30		90.35%	75.00%	15.35%	98.79%	75.00%	23.79%	
Resource & Performance...	Responsive	Proportion of patients spending more than 12 hours in an emergency ...	2024-06-30		0.00%	1.99%	-1.99%	0.00%	1.99%	-1.99%	
Resource & Performance...	Responsive	Proportion of patients who have a first consultation in a post-covid ser...	2024-06-30		5.26%	92.00%	-86.74%	8.33%	92.00%	-83.67%	
Resource & Performance...	Responsive	Proportion of patients within 18 weeks	2024-06-30		58.65%	92.00%	-33.35%	58.65%	92.00%	-33.35%	

Resource and Performance Committee - SPC Summary (continued)

Committee	Domain	Metric	Latest Date	Variation	Month Value	Month Target	Month Variance	YTD	YTD Target	YTD Variance	Assurance
Resource & Performance ...	Effective	Total activity undertaken against current year plan	2024-06-30		85.57%	100.00%	-14.43%	91.12%	100.00%	-8.88%	
Resource & Performance ...	Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	2024-06-30		272.73%	120.00%	152.73%	155.34%	120.00%	35.34%	
Resource & Performance ...	Effective	Total elective activity undertaken compared with 2019/20 baseline	2024-06-30		110.46%	103.00%	7.46%	116.38%	103.00%	13.38%	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks - all services	2024-06-30		5	0	5	5	0	5	
Resource & Performance ...	Responsive	Total patients waiting more than 104 weeks to start consultant-led treatm...	2024-06-30		0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks - all services	2024-06-30		1,385	0	1,385	1,385	0	1,385	
Resource & Performance ...	Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	2024-06-30		524	0	524	524	0	524	
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks - all services	2024-06-30		388	0	388	388	0	388	
Resource & Performance ...	Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	2024-06-30		0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks to start consultant-led treatme...	2024-06-30		0	0	0	0	0	0	
Resource & Performance ...	Responsive	Total patients waiting more than 78 weeks - all services	2024-06-30		155	0	155	155	0	155	
Resource & Performance ...	Effective	Virtual ward bed occupancy	2024-06-30		72.85%	63.81%	9.04%	72.85%	63.81%	9.04%	

Quality and Safety Committee - SPC Summary

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	2024-06-30		6.13	6.42	-0.29	6.13	6.42	-0.29	
Quality & Safety Committee	Safe	Category 3 Pressure Ulcers	2024-06-30		2	0	2	2	0	2	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-06-30		4.00	0.00	4.00	4.00	0.00	4.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-06-30		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-06-30		98.77%	95.00%	3.77%	98.77%	95.00%	3.77%	
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	2024-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-06-30		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Falls per 1000 Occupied Bed Days	2024-06-30		4.59	4.00	0.59	4.59	4.00	0.59	
Quality & Safety Committee	Safe	Medication Incidents with Harm	2024-06-30		9	0	9	16	0	16	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-06-30		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-06-30		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Patient Safety Incident Investigations	2024-06-30		0	0	0	0	0	0	

People Committee - SPC Summary

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 of leadership ...	2024-06-30		7.4	7.5	-0.1	7.4	7.5	-0.1	
People Committee	Well Led	Appraisal Rates	2024-06-30		85.11%	90.00%	-4.89%	83.33%	90.00%	-6.67%	
People Committee	Well Led	CQC well-led rating	2024-06-30		Good	Good		Good	Good		
People Committee	Well Led	Leaver rate	2024-06-30		11.36%	9.60%	1.76%	11.36%	9.60%	1.76%	
People Committee	Well Led	Mandatory Training Compliance	2024-06-30		93.13%	95.00%	-1.87%	93.13%	95.00%	-1.87%	
People Committee	Well Led	Net Staff in Post Change	2024-06-30		8.88	0.00	8.88	51.42	0.00	51.42	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	2024-06-30		9.52%	20.00%	-10.48%	9.52%	20.00%	-10.48%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from b) are women	2024-06-30		73.91%	66.00%	7.91%	73.91%	66.00%	7.91%	
People Committee	Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	2024-06-30		4.76%	4.00%	0.76%	4.76%	4.00%	0.76%	
People Committee	Well Led	Proportion of staff who agree that their organisation acts fairly with regard to career pr...	2024-06-30		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, bullying or a...	2024-06-30		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, bullying or a...	2024-06-30		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, bullying or a...	2024-06-30		22.0%	0.0%	22.0%	22.0%	0.0%	22.0%	
People Committee	Well Led	Proportion of temporary staff	2024-06-30		5.7%	3.4%	2.3%	6.8%	3.4%	3.4%	
People Committee	Well Led	Sickness Rate	2024-06-30		5.53%	4.75%	0.78%	5.53%	4.75%	0.78%	
People Committee	Well Led	Staff survey engagement theme score	2024-06-30		7.0	7.3	-0.3	7.0	7.3	-0.3	
People Committee	Well Led	Total shifts exceeding NHSI capped rate	2024-06-30		317	0	317	369	0	369	
People Committee	Well Led	Total shifts on a non-framework agreement	2024-06-30		0	0	0	0	0	0	
People Committee	Well Led	Vacancies - all	2024-06-30		11.56%	8.00%	3.56%	11.90%	8.00%	3.90%	

Icon Descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(none)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(none)				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.

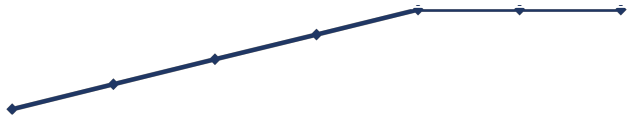
Exception Report - Action Plan

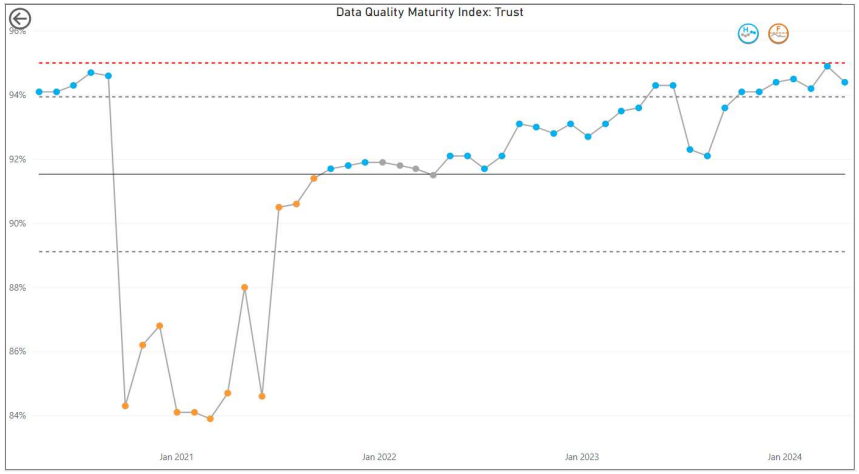
Data Quality Maturity Index

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

KPI Description	Latest 6 months	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD
DQMI	%	94.10%	94.40%	94.50%	94.20%	94.90%	94.40%	94.4%
	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 e.g. 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		**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 embedded into governance structures not just reflected in the improvement group	Mar-24	Apr-24	Complete	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
	CSDS Workshop to be held with leads from each SDG to explore areas of improvement	Jun-24	Sep-24	Planning	
	Clinical Audit Tool feedback to be strengthened through SDG meetings	Jun-24	Sep-24	Planning	

Author	Alastair Campbell/Helen Cooper/Mark Onions/Sam Townsend/Sarah Robinson	**Date**	12/07/2024
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024

Exception Report - Action Plan

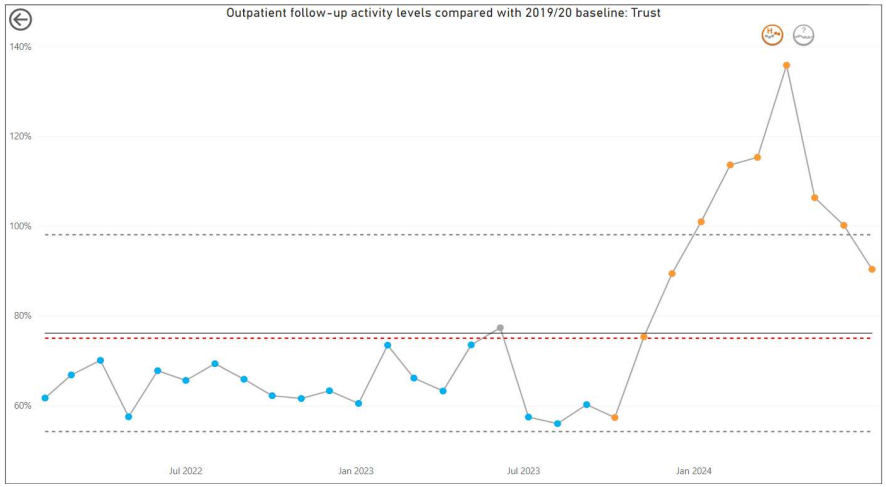
Outpatient follow-up activity levels compared with 2019/20 baseline

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

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
Outpatient follow-up	%	113.61%	115.29%	135.83%	106.31%	100.15%	90.35%	
	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	Jun-24 (Rounded to 0 dp)
APCS	73%
Bridgnorth Outpatients	70%
DAART	82%
Ludlow Outpatients	89%
MSST	12065%
TEMS	4%
Whitchurch Outpatients	59%

Action Plan

	Start Date	End Date	Status	Outcome
Continue to embed PIFU across all clinically appropriate services and maintain performance	Jun-23	Mar-24	Complete	Currently overperforming 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	On track	Agenda item in performance 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 transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Transition agreed for follow ups too but all new/FU activity is now being recorded via RJAH.
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024

Exception Report - Action Plan

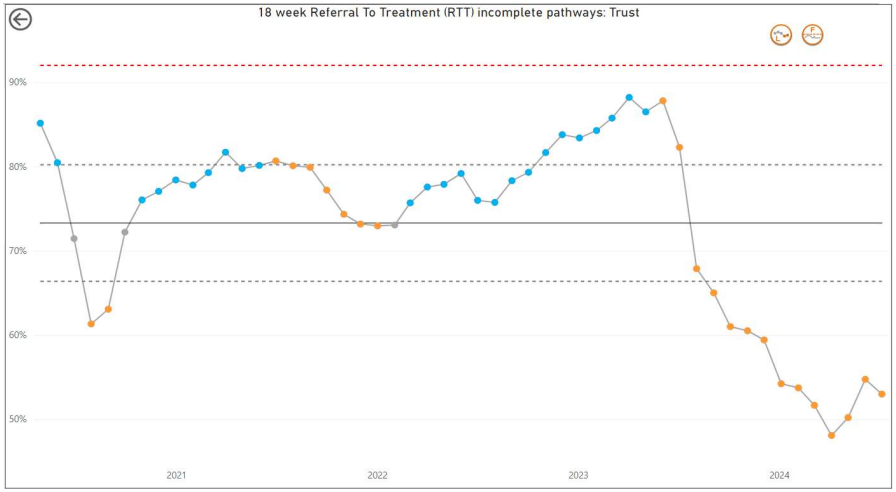
18 week Referral To Treatment (RTT) Incomplete Pathways

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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
RTT Incomplete Pathways	%	53.73%	51.65%	48.08%	50.20%	54.74%	52.99%*	52.99%*
	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 it 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 Rheumatology 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 this is planned to improve from December with SaTH now offering a permeant list at RSH for Adults. 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, particularly seen within ENT and Respiratory There are other services which contribute to not meeting this performance target such as Bridgnorth Hospital Day case

		Start Date	End Date	Status	Comments
	Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating 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 transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
	Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Complete	Contract discussions continuing for additional capacity however increased clinics are now in place and consistent

Action Plan	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.		Nov-23	Ongoing	On track	2 adult list offered for April and 2 for May. SaTH have offered 2 regular consistent slots at RSH from December for adults and have agreed to support with Paeds however scoping regular days and times.
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity		Feb-24	Aug-24	Complete	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 improve clinic utilisation		Feb-24	Jul-24	Complete	Case for need complete for triple lock process, Appointment internally to system admin lead complete. Posts offered and start dates in place for mid-June
	Recruitment of admin to support with the current 47% admin vacancies.		Apr-24	Jun-24	Complete	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	Complete	Regular blitz clinics now established to support level 2 but the main concern is level 3 and the recruitment of admin will support driving improvement in clinic utilisation. Triage event taken place to support with correct allocation to levels to support with clinic utilisation.
	Additional capacity being sought to support Community Hospital Outpatient backlog		Mar-24	Jul-24	On track	Additional Gynaecology sessions being provided. Further discussions taking place with SaTH regarding a more robust approach to the ENT and Respiratory SLA.
	Discussions with RJAH re agreement to have generalised APP clinics rather than sub-speciality to support recovery.		Jul-24	Aug-24	On track	Discussions with RJAH to support piece of work to book all 52 week cohort patients into any available APP capacity regardless of sub-speciality.
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Aug-24	On track	Implementation of myrecovery to support mSST waiting list management.
	System wide action plan for MSST		Jun-24	Jun-25	Complete	Action plan agreed with system partners to support recovery within MSST.
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024			

**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

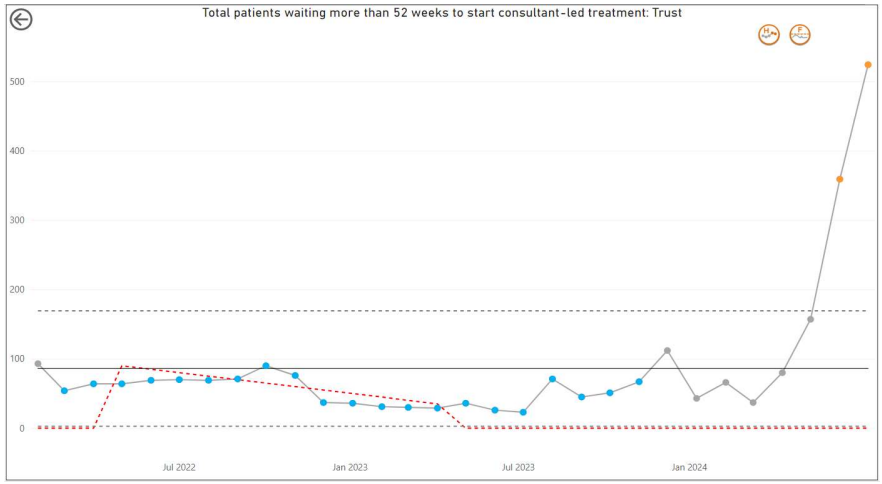
Total patients waiting more than 52 weeks to start consultant-led treatment

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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
RTT 52+ week waits	Number	55	37	80	157	359	524*	524*
	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 September 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 up to 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 Day case, Community Hospital Outpatients and APCS				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
	Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Complete	Contract discussions continuing for additional capacity however increased clinics are now in place and consistent
	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	On track	2 adult list offered for April and 2 for May. SaTH have offered 2 regular consistent slots at RSH from December for adults and have agreed to support with Paeds however scoping regular days and times.
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	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 improve clinic utilisation	Feb-24	Jul-24	Complete	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	Complete	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	Discussions with RJAH re agreement to have generalised APP clinics rather than sub-speciality to support recovery.	Jul-24	Aug-24	On track	Discussions with RJAH to support piece of work to book all 52 week cohort patients into any available APP capacity regardless of sub-speciality.
	Implementation of digital systems to support with validation and waiting list management.	Jul-24	Aug-24	On track	Implementation of My Recovery to support MSST waiting list management.
	System wide action plan for MSST	Jun-24	Jun-25	Complete	Action plan agreed with system partners to support recovery within MSST.

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024

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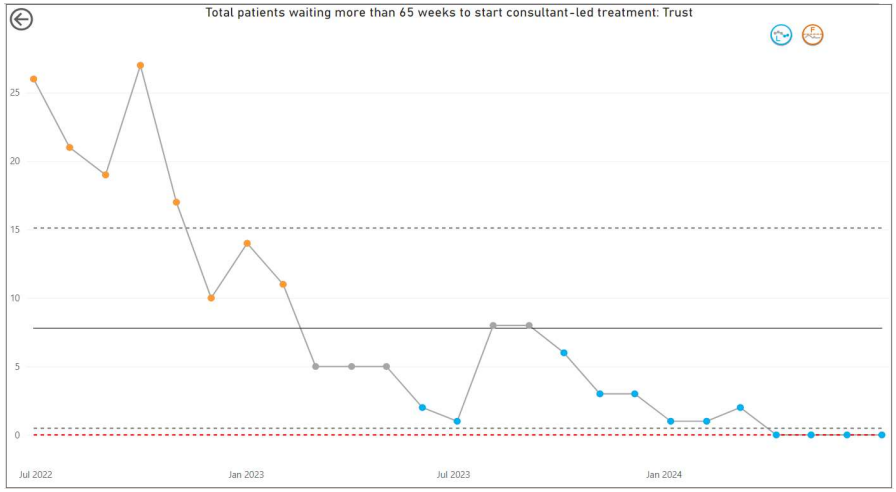
Exception Report - Action Plan

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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
RTT 65+ week waits	Number	1	2	0	0	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 transferring activity/ pathways to RJAH	Feb-24	Apr-24	Complete	Confirmation received from RJAH Chief Operating Officer. Majority of open clock pathways have been transferred. Only closed clock FU's remaining to be transferred.
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
	Continue to seek and formalise support from RJAH for Dental sessions.	Jan-24	Mar-24	Complete	Contract discussions continuing for additional capacity however increased clinics are now in place and consistent
	Gain an agreement with SATH for consistent ringfenced theatre provision on a regular basis.	Nov-23	Ongoing	On track	2 adult list offered for April and 2 for May. SaTH have offered 2 regular consistent slots at RSH from December for adults and have agreed to support with Paeds however scoping regular days and times.
	Recruitment of substantive Advanced Practice Practitioner (APP) in MSST to support increase in capacity	Feb-24	Aug-24	Complete	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 improve clinic utilisation	Feb-24	Jul-24	Complete	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	Complete	Approval provided for 5 WTE admin posts within MSST/TeMS. Recruitment process starting. ETA Jun 24.
	Additional Podiatry capacity being provided to MSST. Blitz style clinics being planned.	Jul-24	Aug-24	On track	SCHT Podiatry service has started planning to provide additional sessions to support MSST recovery both at Level 2 and Level 3 with future plans to implement blitz style clinics.

	Discussions with RJAH re agreement to have generalised APP clinics rather than sub-speciality to support recovery.		Jul-24	Aug-24	On track	Discussions with RJAH to support piece of work to book all 52 week cohort patients into any available APP capacity regardless of sub-speciality.
	Implementation of digital systems to support with validation and waiting list management.		Jul-24	Aug-24	On track	Implementation of My Recovery to support MSST waiting list management.
	System wide action plan for MSST		Jun-24	Jun-25	Complete	Action plan agreed with system partners to support recovery within MSST.
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024			

**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

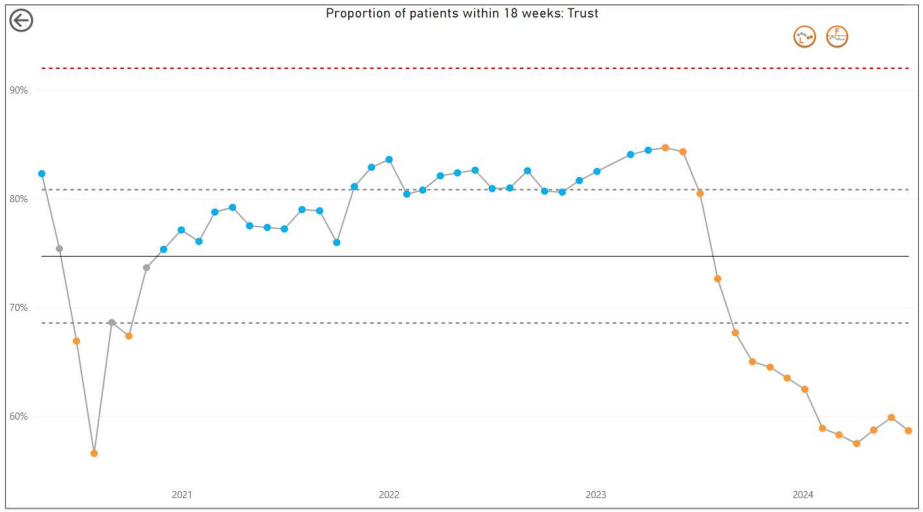
Proportion of patients within 18 weeks

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

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
Proportion of patients within 18 weeks	%	58.87%	58.26%	57.47%	58.71%	59.87%	58.65%	58.65%
	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%	62.0%	64.0%

To be updated



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 September 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 Day case, Community Hospital Outpatients, Dental, Wheelchair Services

Action Plan	**Start Date**	**End Date**	**Status**	**Outcome**
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps	Nov-23	May-24	Complete	Specialist Doctor post appointed to.
Focus on clinic utilisation across all services	Oct-23	Apr-24	Complete	Improvements 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. Main concern was MSST, clinic utilisation is reviewed as business as usual.
GPwSI locum to support with APCS improving activity and review of clinic templates and utilisation	Feb-24	Sep-24	On track	Reviewing all clinical options internally. Demand and capacity to be reviewed
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.

	Continued implementation of PIFU to help support demand in services.		Apr-23	Mar-25	Complete	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	Off track	Utilisation has remained at 80%. Work underway to review the clinic templates to convert FU slots to new to improve. Increase in admin capacity will help to improve utilisation.
	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	On track	Having impact on reducing number of new referrals
	Creation of Fortnightly waiting list meeting to review performance and discuss necessary actions		Mar-24	Mar-24	Complete	Completed - first meeting 11th March
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list		Mar-24	May-24	Off track	SLA has been finalised just requires signing by both parties and then long waits will be all booked with psychologist also completing review of harm associated with each long wait
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024			

Exception Report - Action Plan

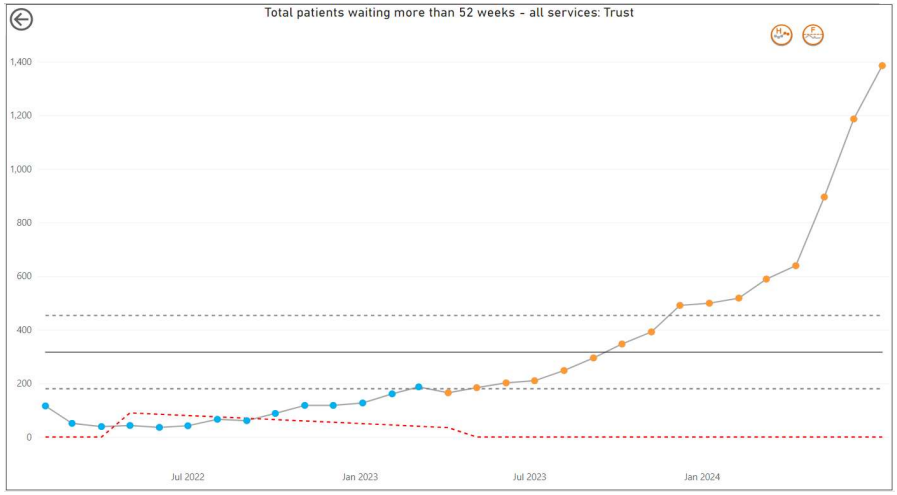
Total patients waiting more than 52 Weeks – All services

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

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
52+ Week waits - All services	Number	518	589	639	895	1186	1385	1385
	Target	0	0	0	0	0	0	0

Trajectory	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Number	550	1385	1485	1585	1385	1185	985

To be updated



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 Orthopaedics to SaTH by end of September 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 position. 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 Community Hospital Outpatients, APCS and Wheelchair Service

on 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	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Off Track	SLA has been finalised just requires signing by both parties and then long waits will be all booked with psychologist also completing review of harm associated with each long wait
Comm Paeds - SOGS - looking at different approaches to increase throughput	Feb-24	Ongoing	Complete	Post recruited to
Paediatrician workforce skill mix to support CDC due to recruitment challenges	Apr-24	Sep-24	On track	Specialist doctor appointed
2 x band 5 specialist nursery nurses recruited to support with CDC assessments.	Feb-24	Jun-24	Complete	Recruitment completed. Training has started for the individuals

Actic	Waiting list initiative being rolled out in CDC. Looking at different ways of working using specialist nursery nurses and speech and language therapists.		Jun-24	Jul-24	On track	Number of children waiting longer than 52 weeks has reduced from 55 to 32
	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	On track	Having impact on reducing number of new referrals
	5 week Speech and Language waiting list initiative commenced June 24 focusing on the early years complex care pathway where we have the highest waits		Jun-24	Jul-24	On track	over 52 week wait figure has reduced from 121 at beginning of June to 23 as at w/c 8th July
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation		Feb-24	Jul-24	Complete	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 necessary actions		Mar-24	Mar-24	Complete	Completed - first meeting 11th March
Author	Alastair Campbell/ Helen Cooper / Mark Onions	**Date**	12/07/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024			

Exception Report - Action Plan

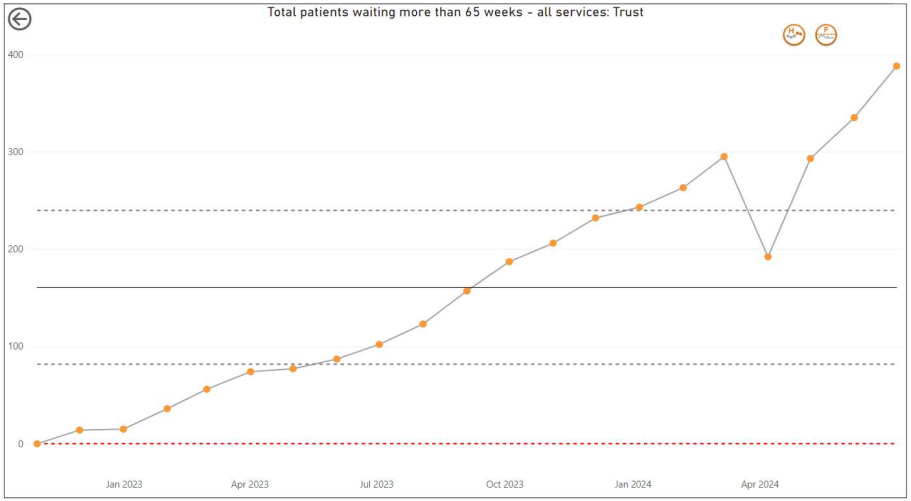
Total patients waiting more than 65 Weeks – All services

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

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
65+ Week waits - All services	Number	263	295	192	293	335	388	388
	Target	0	0	0	0	0	0	0

Trajectory	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Number	200	388	420	460	400	300	200

To be updated



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 Orthopaedics to SaTH by end of September 2024. We had anticipated that the numbers would increase before the transfer of Rheumatology and Orthopaedics had begun.

CNRT has also seen some long waits within their waiting list due to significant 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 CDC, Community Paediatrics and Children's Speech and Language Therapy

Action Plan

	Start Date	End Date	Status	Outcome
Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Off Track	SLA has been finalised just requires signing by both parties and then long waits will be all booked with psychologist also completing review of harm
Workforce review of Comm paeds provision with plan to mitigate Paediatrician gaps and also reduce locum costs.	Nov-23	May-24	On track	Specialist Doctor appointed to
Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Jul-24	On 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.
Waiting list initiative being rolled out in CDC. Looking at different ways of working using specialist nursery nurses and speech and language therapists.	Jun-24	Jul-24	On track	Number of children waiting longer than 65 weeks has reduced from 8 to 2
5 week Speech and Language waiting list initiative commenced June 24 focusing on the early years complex care pathway where we have the highest waits	Jun-24	Jul-24	On track	Numbers of children waiting more than 65 weeks has reduced from 39 to 7

	Recruitment to 2 x Band 5 SLT posts that will help with capacity of the team		Jun-24	Jul-24	On track	Currently have 6 applicants and shortlisting is planned early July
	Recruitment of admin to support with the current 47% admin vacancies.		Apr-24	Jun-24	Complete	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 necessary actions		Mar-24	Mar-24	Complete	Completed - first meeting 11th March
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024			
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024			

Exception Report - Action Plan

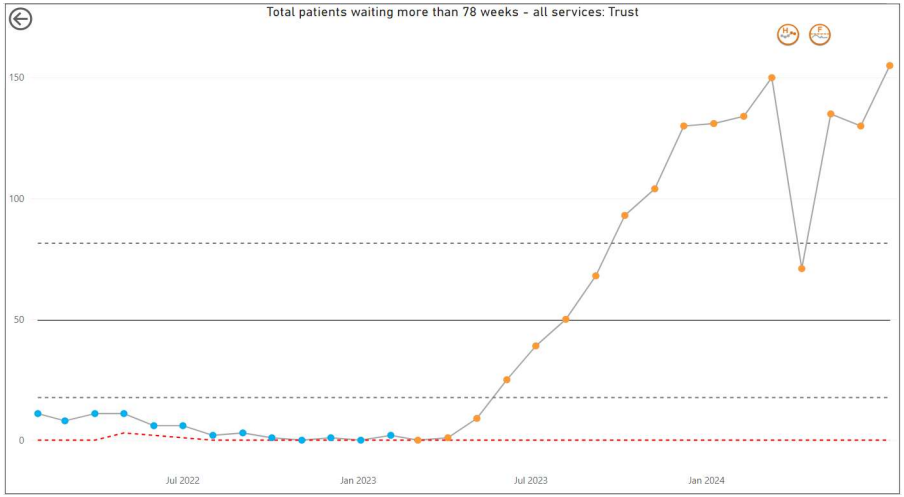
Total patients waiting more than 78 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
78+ Week waits - All services	Number	134	150	71	135	130	155	155
	Target	0	0	0	0	0	0	0

Trajectory	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Number	120	80	155	155	155	100	50

To be updated



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 Orthopaedics to SaTH by end of September 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.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Transition of TeMS Rheumatology into MSST transferring activity/ pathways to RJAH	Feb-24	Mar-24	Complete	New patients transferred to RJAH, completed 7th March
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	Jul-24	On track	SLA has been finalised long waits now all booked with psychologist also completing review of harm associated with each long wait
	Alignment of admin within MSST to standardise approach/processes to booking of patients to improve clinic utilisation	Feb-24	Jul-24	On 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	Complete	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 necessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March
Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024		

Exception Report - Action Plan

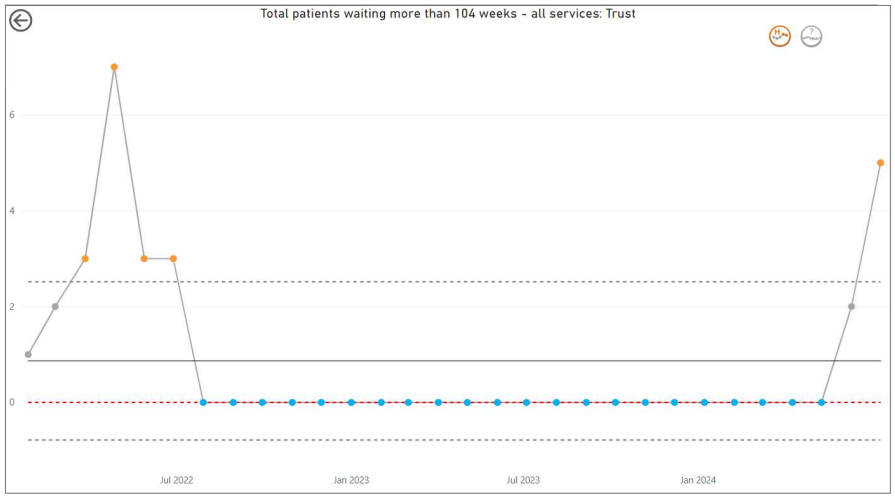
Total patients waiting more than 104 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 78 weeks and over

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
104+ Week waits - All services	Number	0	0	0	0	2	5	5
	Target	0	0	0	0	0	0	0

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Number	5	0	0	0	0	0	0

To be updated



Reason for performance gap:	CNRT				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Transition of TeMS Orthopaedics into MSST transferring activity/ pathway to SaTH	Apr-24	Sep-24	On track	Phasing plan shared with SaTH. Patients for upper limb are starting to be transferred to RJAH. SaTH have aligned consultant support to manage waiting lists preparing for full transfer of activity.
	Implementation of new CNRT Psychology SLA to provide capacity to manage the waiting list	Mar-24	May-24	Off track	SLA agreed internally with contracts and shared with provider mid-June. Awaiting signature from provider before implementation. 1 week lead in time once agreed to operationalise the service. Team now looking at alternative options as mitigation.
	Creation of Fortnightly waiting list meeting to review performance and discuss necessary actions	Mar-24	Mar-24	Complete	Completed - first meeting 11th March

Author	Alastair Campbell/Helen Cooper/Mark Onions	**Date**	12/07/2024	
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024	

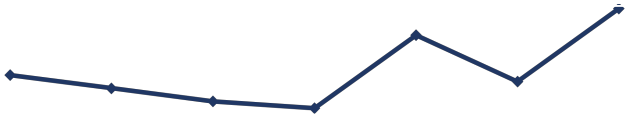
Exception Report - Action Plan

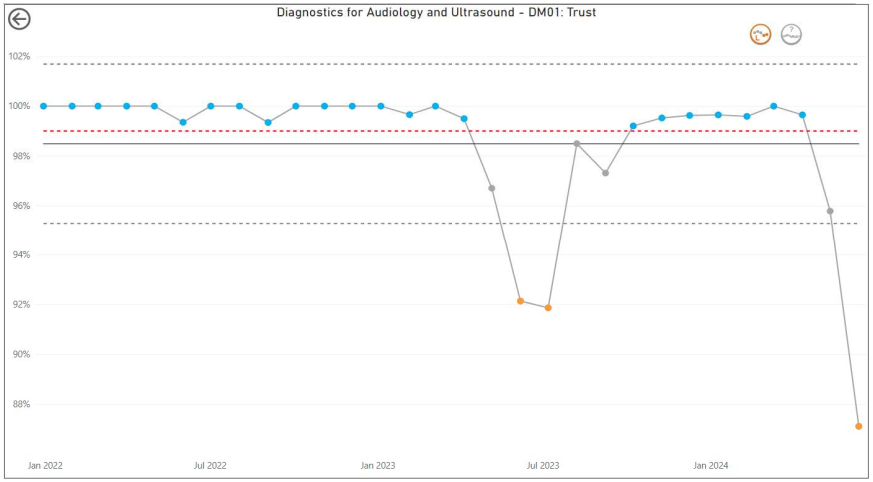
Diagnostics for Audiology and Ultrasound - DM01

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

KPI Description	Latest 6 months	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
DM01	%	99.65%	99.59%	100.00%	99.65%	95.78%	87.11%	87.11%
	Target	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Trajectory	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
%	93.0%	92.8%	92.6%	92.5%	93.6%	92.9%	94.0%





Reason for performance gap:	For Audiology we are now reporting any planned patients that are overdue for their appointment as active waits, as per National DM01 requirements. Figures are higher and there are more breaches due to this. Due to the changes in DM01 rules additional capcity is needed. This is alongside an increase in demand				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Review of SLA with SaTH	Jun-24	Sep-24	Planned	Service Review Planned to support an new SLA
	Service review	Jun-24	Sep-24	Planned	Service Review Planned to support an new SLA
Author	Nicola Greaves/Gemma McIver	**Date**	12/07/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024		

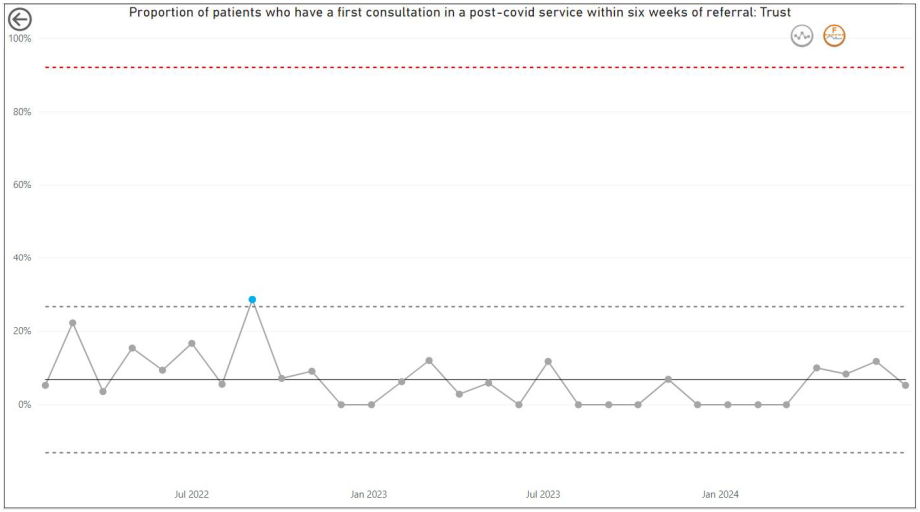
Exception Report - Action Plan

Proportion of patients who have a first consultation in a post-covid service within six weeks of referral

The percentage of patients who have an initial assessment in a Post COVID service within 6 weeks of referral

KPI Description	Latest 6 months	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
Proportion of patients within 6 weeks	%	0.00%	0.00%	10.00%	8.33%	11.76%	5.26%	5.26%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	40.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%



Reason for performance gap:	Waiting times within the Long Covid Service have been a challenge since the service commenced in November 2020. NHS England had high expectations from the beginning and this was evidenced by the main reportable national key performance indicator (KPI) focusing on waiting times. The aim was for all patients to receive an initial assessment within 6 weeks of referral. This has been a challenged KPI in Shropshire Community Health NHS trust (SCHT) due to multifactorial reasons including finance, workforce availability and high referral rates. When the service commenced, there were delays to funding and confirmation of funding amounts. This matched and linked heavily with a delayed workforce despite the referral front door being open for business. With high referral rates and decreased appointment capacity due to recruitment delays, a demand and capacity mismatch quickly became established.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Model has been revised to enable quicker access to a first assessment.	Jan-24	Apr-24	Complete	Revised Model
	Booking of patients into appointments within 6 weeks.	May-24	Aug-24	On Track	Appointments booked with 6 weeks for all patients
Author	Alastair Campbell	**Date**	12/07/2024		
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024		

Exception Report - Action Plan

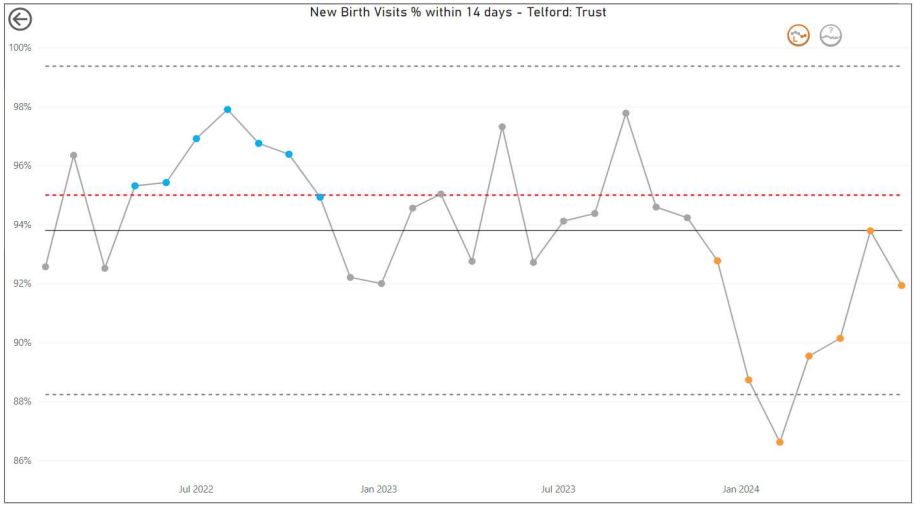
New Birth Visits % within 14 days - Telford

Number of babies born within month who have been seen by a Health Visitor within 14 days of birth (Telford)

KPI Description	Latest 6 months	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
Proportion of patients within 18 weeks	%	88.73%	86.62%	89.54%	90.14%	93.79%	91.94%	91.94%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
%	91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%

To be updated



Reason for performance gap:	Commissioning arrangements for the Telford Local Authority during tender outlined a reducing financial budget each year. This has resulted in the inability to replace Health Visitors when posts become vacant. This directly effects the ability of the team to reach the NBV delivery target. Both Dudley and Shropshire Local Authorities have reduced the NBV target to 90% due to impact of growing populations and parental choice impacting on the ability of providers hitting the targets. Parent choice of day of visit is having a dramatic effect on the ability of service being able to carry out the visits between 10 and 14 days. Monthly exception reporting demonstrated that 100% of all NBV are carried out. During May 24 10 out of 114 NBV were completed out of timescales. Of these 6 were due to parental choice and 4 babies were still in the Neonatal unit.

Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Team leaders to run allocation meetings to identify NBV that are at risk of breaching 14 days	Jul-24	Oct-24	On track	Focus on NBV allocation will increase NBV delivery
	Discussions with commissioners regarding funding for extra hours and weekend working	Jul-24	Oct-24	On track	Opportunity to utilise bank workforce and offer extra hours.
	Introduce weekend working for families that prefer weekend visits to facilitate choice.	Jul-24	Oct-24	Planned	Increase opportunities to deliver NBV over 7 days a week opposed to current 5 working days.
	Explore mutual aid from Shropshire and Dudley teams to build resilience in the workforce	Jul-24	Oct-24	Planned	Increased workforce to deliver more NBV within timescales
	Service Lead to analyse exception reports from last six months to identify any trends to ensure that NBV are booked and offered effectively.	Jul-24	Oct-24	Planned	Audit of late NBV may provide ideas of changing delivery model for NBV

Author	Helen Cooper/ Mark Onions	**Date**	12/07/2024
Accountable Officer Approval	Claire Horsfield	**Date**	12/07/2024

Shropshire Community Health
NHS Trust

Performance Framework Update 2024/25

Author:	Steve Price, Head of Information and Performance Assurance	**Paper date:**	**1st August 2024**
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	**22nd July 2024**
Paper Reviewed by:		**Paper Category:**	Performance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

The purpose of this report is to present the Trust's updated Performance Framework. The paper is to provide information and assurance and to **consider for approval**.

2. Executive Summary

2.1 Context

The Trust's Performance Framework has recently been reviewed and amended, largely to reflect ShropCom's updated governance structure and amended Executive team responsibilities.

This is an important document as it sets out how the organisation manages performance including roles and responsibilities.

2.2 Summary

The Trust Board most recently approved the Trust's Performance Framework in February 2023. The Framework was extensively updated at this time, and it was introduced alongside performance training and changes to the performance reporting process.

In line with best practice, the document has now been reviewed in detail and a small number of changes have been made. The Framework has been reviewed and updated by the Executive team and it is presented to the Board to consider for approval.

The amendments made largely reflect the updated responsibilities within the Executive team portfolios, changes to the Trust's governance arrangements and to reflect the NHS England Making Data Count guidance.

As we progress through the year, it is likely further revisions to the Performance Framework will be required as anticipated national guidance is published, such as the NHS Oversight Framework. Any alterations to the Framework will be presented to the Board for further approval.

Performance Framework Update 2024/25

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the updated Performance Framework and if any amendments are required in order to provide adequate assurance to the Board in relation to how performance is managed
- **Approve** the Trust's updated Performance Framework.

Shropshire Community Health
NHS Trust

Performance Management Framework

Date: 1 August 2024
Version: 1.6

Author	Chief Finance Officer
Owner	Chief Finance Officer
Client	Chair of Trust Board

Document History

Version	Date	Changes
1.0	09/09/2016	Updated to incorporate Single Operating Framework (SOF) – Consultation
	09/09/2016	Updated to reflect current reporting position
	09/09/2016	Updated to include development section
	07/10/2016	Updates to Business Planning and Delivery of Objectives
	07/10/2016	List of measures added from NHSI SOF
	07/10/2016	Update to section 3 following publication of SOF
1.1	15/09/2017	Update to Monthly Performance Assessment (Recovery Plans)
	15/09/2017	Integrated Dashboard with updated measures / measures by type
1.2	08/06/2018	Update to section 3 following Nov' 2017 SOF Publication
	08/06/2018	Review of appendix 1 and 3 following SOF revision
	08/06/2018	Update to Performance Review Cycle
1.3	18/11/2022	Review and refresh following external review.
1.4	11/01/2023	Final updates following review of measures against SOF requirements.
1.5	24/02/2023	Adjustments identified by Board 02/02/23 before wider circulation and implementation
1.6	10/07/2024	Updated to refer to: the Trust Performance Board and Performance Spectrum; references to action plans; definitions relating to monitoring and exceptions under NHSE Making Data Count; Director Titles; Committee KPI annual review; Updated diagrams and appendices

Distribution Record

Version	Date	Distributed to:
1.0	07/10/2016	Resource & Performance Committee (RPC)
	21/10/2016	Approved at RPC with minor changes needed
1.1	15/09/2017	Resource & Performance Committee (RPC)
1.2	18/06/2018	Resource & Performance Committee (RPC)
1.3	18/11/2022	Executive Team Meeting
	06/12/2022	Senior Leadership Team
1.4	23/01/2023	Resource & Performance Committee (RPC)
1.4	02/02/2023	Trust Board
1.5`	March & July 2023	Across organisation via SLT
1.6	July 2024	Executive Team meeting and SLT

1. Introduction

1.1. The Trust's Performance Management Framework (PMF), Board Assurance Framework (BAF) and other wider governance arrangements when combined, are integral to the Trust's governance framework. The Framework is designed to enable a full and comprehensive implementation of strategic and operational plans, including the delivery of quality and financial improvement programmes.

1.2. The Performance Management Framework (PMF) aims to foster a culture of responsibility and accountability at all levels in the Trust and helps teams and staff to understand the roles they play in successful delivery of the Trust's objectives. The PMF specifies the structure, systems and processes used to embed a performance management culture in the Trust and identifies the responsibilities for performance management.

1.3. A devolved accountability structure is in place at the Trust, managed through the Performance Framework. The underlying principles of this Framework are to ensure that delivery of the Trust's strategy and corporate objectives are managed in a systematic way from 'Community/Ward to Board' and 'Board to Community/Ward'.

2. Objectives of the Performance Management Framework

2.1. The PMF sets out the systems and processes through which the organisation will support teams and manage the delivery of our strategic and operational goals, as well as ensuring that the regulatory and statutory requirements that apply to the Trust are met (including those outlined in the NHS Constitution).

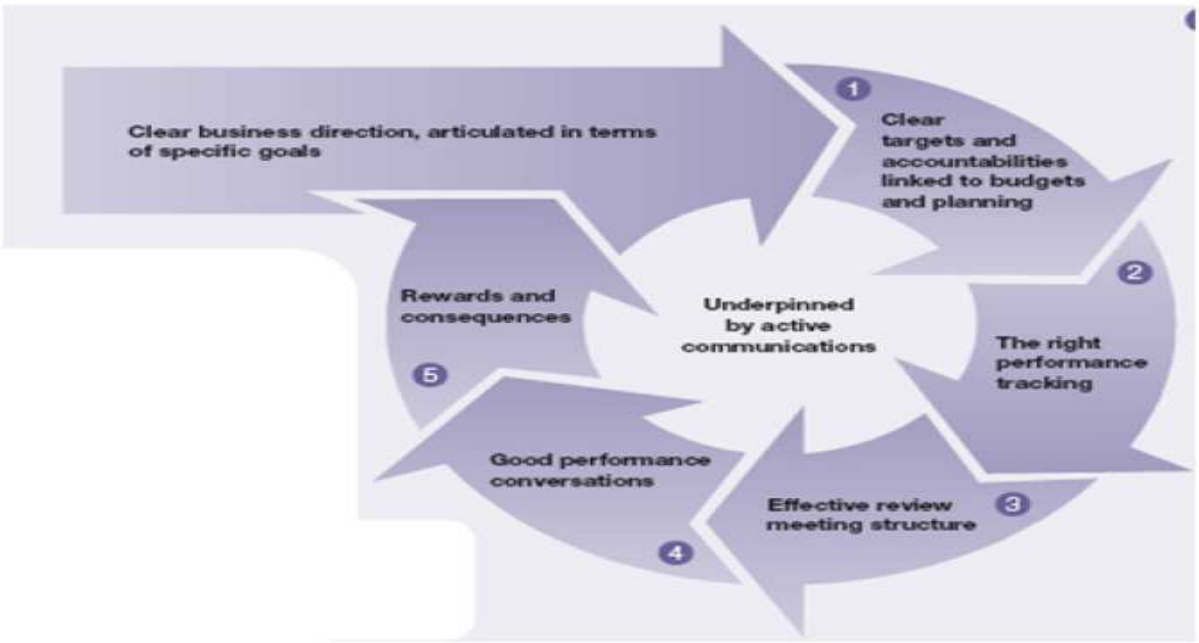
2.2. The PMF drives the implementation of best practice performance assurance processes throughout the organisation, aligned to our Board committees, ensuring that:

- Accountability arrangements are in place across the organisation to drive the delivery of all agreed objectives, targets, and standards. Performance is seen as a continuous process which is embedded in all aspects of organisational activity.
- Agreed performance objectives and targets are Specific, Measurable, Agreed, Realistic and Time bound (SMART) and transparent measurements are set to monitor performance.
- Timely information is available to enable appropriate understanding, monitoring, and assessing of the Trust's quality and performance, prompting appropriate action to be taken if performance is forecast to fall below set objectives and targets.
- Staff, teams, and Committees understand their roles and responsibilities and are supported and motivated to deliver, with a clear line of sight between their contributions and the overall success of the Trust.
- Action plans are developed as soon as risks to the achievement of required targets or standards and/or barriers to effective performance are identified.

3. Key Management Principles

3.1. The following key management principles underpin this framework:

- ***Focused on improvement -*** All teams and staff members are encouraged to embrace a culture of continuous performance improvement and to speak up with suggestions and concerns. Initial interventions will focus on recovery to sustain improvement and will include actions to address the root causes of issues.
- ***Transparent*** – Clear and pre-determined performance measures and interventions. Teams and individuals will understand how performance is being assessed and what to expect if performance falls below acceptable levels.
- ***Consistent*** - Clear accountabilities through a uniform approach across SCHT, at different levels of the organisation and across different departments will ensure that all parties are clear of where accountabilities lie.
- ***Proactive -*** Delivery focused on improved performance through an integrated and action-oriented approach, with thresholds for intervention that identify underperformance at an early stage so that it can be swiftly addressed.
- ***Proportionate -*** Performance management interventions and action are related to the scale of risk and maintains an appropriate balance between challenge and support.



4. The Performance Spectrum

4.1. The spectrum of performance stretches from unacceptable at one extreme, to outstanding or world class performance at the other, as illustrated:

Breach of requirements and/or multiple KPI targets across multiple domains	Non-compliance of requirements, not meeting several KPI targets, selected improvement standards or failure to meet improvement targets	Compliance with requirements, adoption of improvement standards and performance against KPI targets	Exceeding KPI targets, benchmarking and continued improvement
← **Unacceptable**	**Requires Improvement**	**Good**	**Outstanding** →

(the spectrum of performance must be measured in terms of metrics, targets and standards)

4.2. The Executive Team, through the Trust Performance Board, will assess how each Division is performing against the necessary Key Performance Indicators, using the dashboards and slides presented.

4.3. Where an exception occurs, the Executive Team will require assurance in the form of actions plans to evidence the reason for the performance gap and the associated actions required to improve performance.

4.4. Divisions and Corporate Services will attend the Trust's Performance Board on a rolling basis, however frequency may be increased at the discretion of the Executive Team, should there be particular areas of concern.

5. Link to Executive Director Roles and Responsibilities

5.1. Board of Directors

- The Board is required to ensure that the Trust always remains compliant with the relevant conditions of its NHS Provider License and has regard to the NHS Constitution.
- The Performance Management Framework works in conjunction with the Board Assurance Framework to provide the Board of Directors with the assurance required in relation to the full and comprehensive implementation of strategic and operational plans.
- The Board has overall accountability for the implementation of the Performance Management Framework.

5.2. Chief Executive

- The Board delegates responsibility for delivery of the objectives, targets and standards outlined in the Trust's Strategy and Operational Plan to the Chief Executive. The Chief Executive, supported by the Executive Directors, ensures that the associated activities are carried out efficiently, effectively, and economically and in a manner appropriate for the proper conduct of public affairs.
- This Performance Management Framework describes the governance arrangements through which the Chief Executive delegates and manages the delivery of those responsibilities.

5.3. Chief Finance Officer

- The CFO has delegated responsibility for the leadership, development, and implementation of the Performance Management Framework.

5.4. Divisional Leads, Directorate Leads & Divisional Meetings

- The management teams are responsible for ensuring services are delivered in line with commissioning requirements and meet the required safety and quality standards, financial targets, and regulatory requirements.
- Drive professional and managerial responsibility in delivering key performance indicators and promoting leadership across the Trust to deliver the performance agenda.

Responsibilities include ensuring that:

- The Performance Management Framework is implemented within their own sphere of responsibility.
- Steps are taken to secure resources for the implementation of associated controls following risk assessment.
- Targets for KPIs are agreed, communicated, and delivered.
- Governance arrangements to underpin the Performance Management Framework are in place.
- Services within their remit perform to the required standards/targets and maximise their potential.

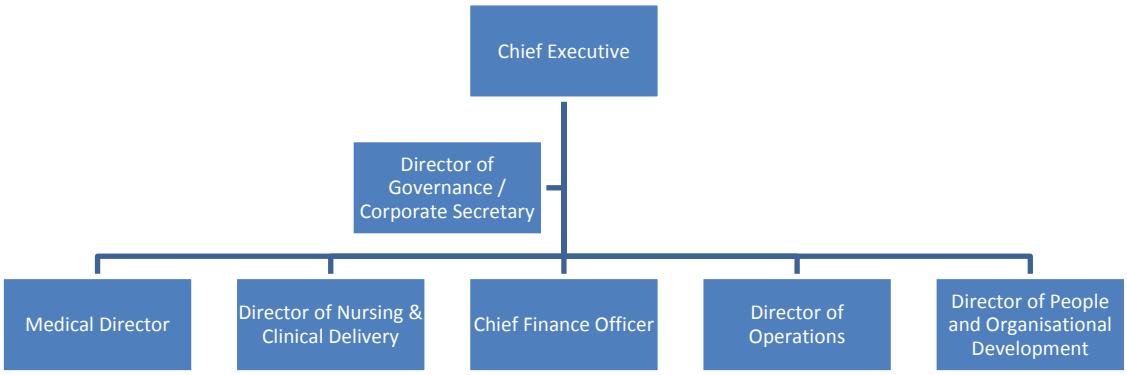
The management teams should:

- Acknowledge and reward excellent performance.
- Analyse service performance regularly, establishing variances, trends and discrepancies or gaps.
- Scrutinise the root cause of the above and act upon this to eliminate continued issues by developing actions plans to recover.
- Implement improvement plans as appropriate.
- Escalate to the executive Team via the Trust Performance Board areas of significant risk or opportunity.
- Divisional meetings are accountable for delivering performance targets within their respective Divisions. To ensure the efficient operation of the Performance Framework, Divisional meetings will need to ensure suitable time is available for the review of performance information and the preparation for Performance Board.
- Each Division will have its own Integrated Performance Report (IPR), which reflects the content of the Trust Board's IPR with the addition of drill down KPIs.

6. Performance Management Roles and Responsibilities

6.1. The Trust's Performance Management Framework describes how the Chief Executive delegates responsibility for the delivery of strategic and operational plans, targets, and objectives. There are two main ways in which those responsibilities are delegated – through line management structures and through a small number of management meetings.

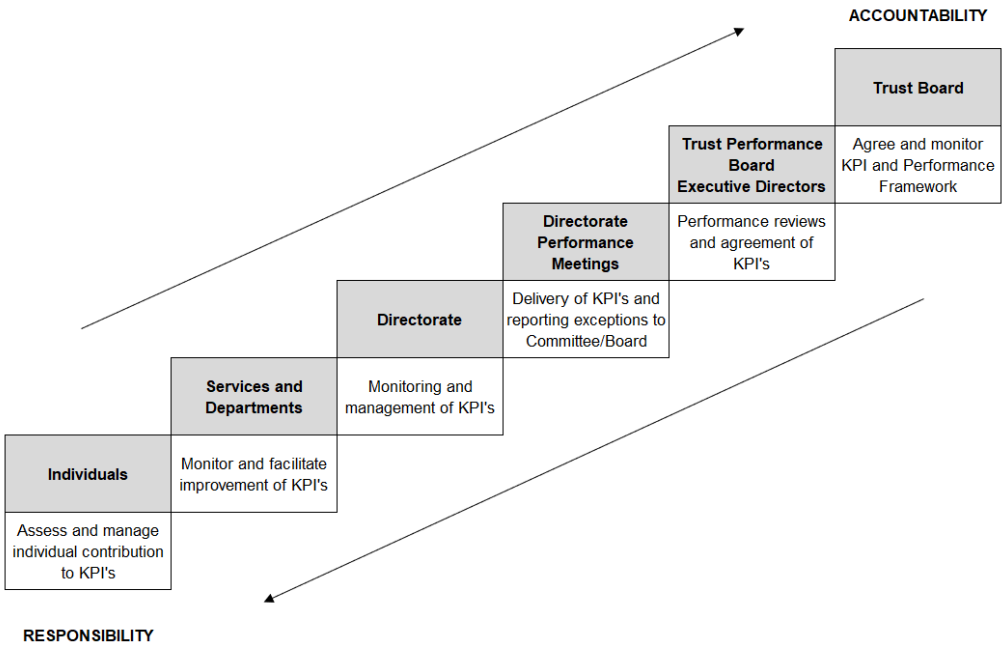
6.2. The primary way in which responsibilities are delegated is through the Trust's line management structure to individuals, and then through to relevant members of their teams.



6.3. The Executive Directors have individual responsibility for delivering the objectives that relate directly to their role, and for supporting their colleagues to deliver their objectives. Also, they are collectively responsible for delivering the Operational Plan objectives as a team.

7. Responsibilities and Accountabilities

7.1. To deliver the Performance Management Framework a stepped approach to performance management is required which clearly specifies roles, accountabilities, and responsibilities. It is essential that key targets, programmes, projects, and actions are disaggregated throughout the Trust and hierarchy to ensure delivery of targets at every level and across the organisation as a whole; to understand what is expected of them and the part they play in the overall success of the Trust.



8. Line Management Responsibilities

8.1. Responsibility for most of the Trust's performance objectives and targets is cascaded through to relevant line managers on an annual basis (or more frequently if required).

8.2. Line managers are responsible for delivery of their agreed targets in accordance with the key principles and approach outlined in this framework. Line management responsibilities include ensuring that:

- Teams and staff members have a clear understanding of their role, responsibilities, and performance targets (with individual targets agreed and documented through the appraisal process).
- Teams and staff members work in an environment that embraces feedback and learning and staff members are encouraged to speak up about issues and concerns.
- Performance delivery is actively and proactively managed.
- Performance issues and risks are captured, managed and escalated where appropriate.
- Excellent performance is recognised and rewarded.

9. Sub-Committee Responsibilities

9.1. A number of Sub-Committees support the Board and Executive Team in effectively discharging their obligations by taking responsibility for the delivery of agreed objectives and targets.

9.2. Directorate meetings and Sub-Committees are responsible for the delivery of relevant directorate and/or functional objectives and targets within their areas of accountability.

9.3. Various other forums also play an important role in taking responsibility for the delivery of specific objectives and targets and in securing wider organisational buy-in to plans and developments.

9.4. A review of sub-committees and other groups will be undertaken, with the aim of:

- Clarifying scope and alignment of scope to support plan objectives
- Improving effectiveness and efficiency
- Ensuring right people attend and right governance structures are in place

10. Performance targets, objectives and KPIs

10.1. The Trust's strategic and operational plans are updated on an annual basis (or more frequently if required) in accordance with the Trust's planning cycle.

10.2. The Trust's performance targets, objectives and KPIs are also updated on an annual basis (linked to the content of strategic and operational plans) and may be further updated during the financial year if needed.

10.3. Agreed performance targets, objectives and KPIs are cascaded to relevant line managers or to accountable Committees.

10.4. Effective and supportive performance management mechanisms are key to an organisation being 'well led' and are essential to the delivery of strong and consistent performance.

11. Performance monitoring and escalation

11.1. The Chief Finance Officer, and supporting personnel, monitors and assesses all aspects of the delivery of strategic and operational plan targets, having the following key responsibilities:

- Providing assurance that all statutory, regulatory, quality, operational, workforce, financial and project targets, objectives and KPIs are fully understood and have been assigned to an appropriate Executive Director, managerial lead, and assurance committee.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target (single version of the truth), proactively supporting projections to the end of the plan year.
- Driving consistency and alignment of performance dashboards and reports at all levels (including Trust Board) – using 'exception-based' reporting wherever possible.
- Constructively challenging performance delivery against agreed targets and recommending action(s) where appropriate.
- Reviewing performance against comparative benchmarks to recognise areas of good performance and identify areas where further improvement is needed.

11.2. All Directorate meetings and Sub-Committees are required to formally review progress against performance objectives and targets at least once a month (more frequently if required) and confirm that those targets are still expected to be delivered.

11.3. If a Directorate meeting and/or Sub-Committee forecasts that it is unlikely to be able to deliver the agreed objectives and/or targets at any point, then the associated issue(s) and/or risk(s) should be formally escalated to the next layer of the Trust's accountability matrix (N.B. escalation of an issue does not transfer the responsibility for delivery).

11.4. If a Directorate meeting or Sub-Committee or individual's performance regularly falls below the required levels, more formal escalation processes may be instigated (e.g., Performance Action Plans).

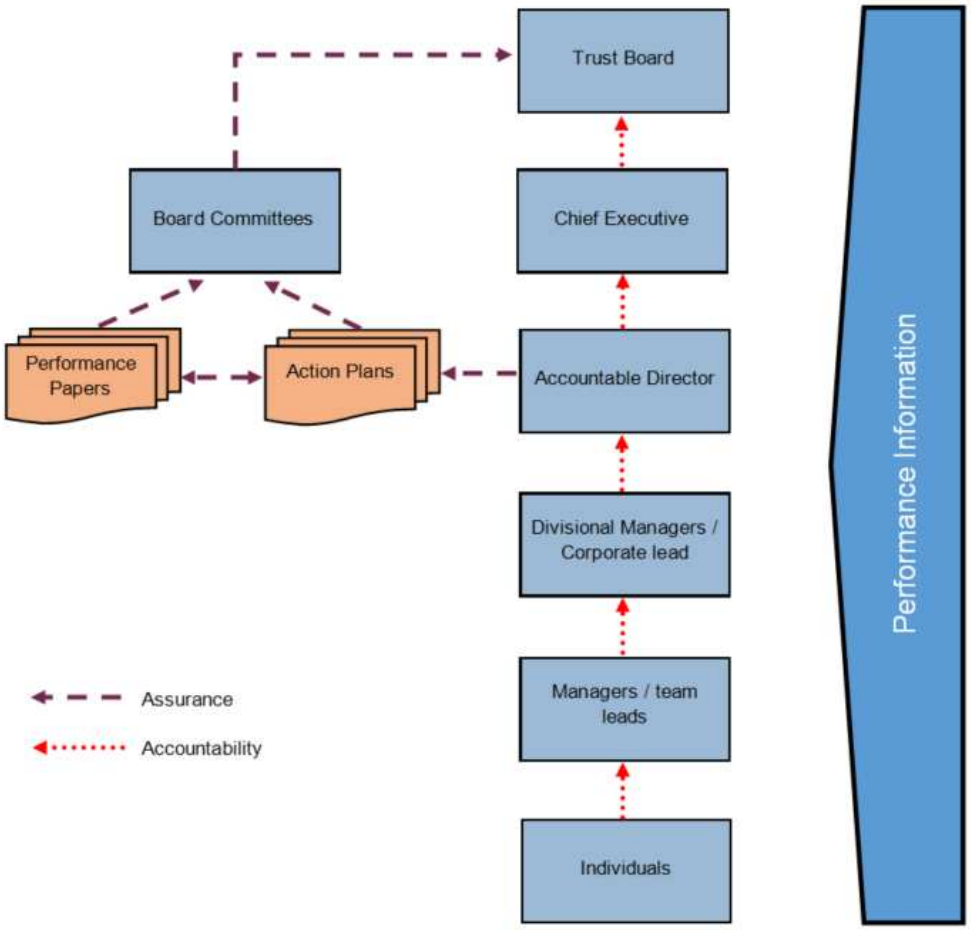
11.5. The Executive Team will meet regularly (monthly) with management teams to review performance and progress. The focus and content of those meetings will vary depending on the current performance levels and the level of assurance provided by the directorate management team.

11.6. Performance will be monitored and displayed in line with NHS England's Making Data Count guidance including the use of Statistical Process Control Charts (SPC).

11.7. The dashboards will include icons that highlight whether there are areas of concern from a variation or assurance perspective in line with this guidance. An example of the dashboards that are to be used by each Committee is in Appendix 4

11.8. Action plans will be developed for each Committee as a minimum for the indicators that have been identified as having a variation or an assurance concern. The action plan template is included as Appendix 5

11.9. The action plans will be developed by the appropriate lead and approved by the Accountable Director for the relevant indicator. This forms the basis of the exception reporting to Committee.



12. Recognition and Reward

12.1. Where objectives are delivered and/or performance is exceeded the Trust actively seeks to recognise and reward that good performance.

12.2. Recognising stable and/or good performance of a Directorate may be provided through a reward of time, in not attending the Trust Performance Board as frequently.

12.3. The successes of Directorates and other functions in delivering key elements of the Trust's Operational Plan, will be routinely reported, and celebrated as part of monthly communication processes.

12.4. There are a wide variety of routes through which performance is currently recognised and rewarded, including:

- Staff and team communication
- Chair's awards
- Long Service awards

13. Trust Board

13.1. The Board provides leadership and direction to the organisation and will receive regular reports assuring them of the quality and performance of services. This Performance Management Framework will form part of the assurance to the Board of Directors regarding achieving the performance objectives as detailed in the Board Assurance Framework (BAF).

13.2. The Board approves the annual operating plan ensuring it meets the Trust's overall strategic direction and NHSE's planning guidance together with the NHS Long Term Plan and ICS developments.

13.3. Agree the annual objectives including the accountable director ensuring the required outcomes key to delivery can be measured by key performance indicators.

13.4. The Board will state the risks to the Trust should an outcome not be delivered (through the Board Assurance Framework).

13.5. The Board assesses the performance of the Trust monthly via the Performance reports from each committee, these include NHSE Making Data Count dashboards and action plans for each Committee where assurance or variation is being flagged as a concern.

13.6. The key performance indicators presented to Board are aligned with the NHSE Single Oversight Framework. The data included in the IPR is underpinned by a robust rolling data quality programme which is overseen by the Audit Committee.

13.7. The Board may request that an appropriate Committee carries out 'deep dives' into certain performance indicators to ensure an appropriate level of granular review is carried out.

14. Board Committees

14.1. Board Committees provide an additional layer of independent assurance over and above organisational assurance processes, helping the Board to ascertain whether the PMF is operating effectively.

14.2. The responsible Committee for each indicator will approve definitions including targets that will drive the exception reporting process for the year. Any exception reported will include an understanding of the cause of variation as part of the action plan to rectify performance.

14.3. Indicators will be allocated to committees as follows:

- Safe – Quality and Safety Committee and People Committee
- Caring - Quality and Safety Committee and People Committee
- Responsive – Resources and Performance Committee and Quality and Safety Committee
- Effective - Resources and Performance Committee and Quality and Safety Committee
- Well Led - Resources and People Committee and People Committee

14.4. Board Committees provide an additional mechanism for Non-executive Directors to hold Executive Directors to account by testing the level of assurance available to support reported progress towards delivery of operational plan objectives.

14.5. Board Committees will routinely review performance reports but may also, from time to time and as necessary, undertake more in-depth assessments of aspects of performance delivery (where significant, this may involve establishing additional time-limited sub-committees or groups).

14.6. The effectiveness of the Board Committees will be reviewed annually or more frequently if required.

Shropshire Community Health
NHS Trust

Appendices - Performance Management Framework

Appendix 1 – Integrated Performance KPI Accountability

People Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Well Led	Aggregate score for NHS staff survey questions that measure perception of leadership culture	SOF 22/23	Director of People and Organisational Development
Well Led	Appraisal Rates	Existing KPI	Director of People and Organisational Development
Well Led	CQC well-led rating	SOF 22/23	Director of Governance
Well Led	Leaver rate	SOF 22/23	Director of People and Organisational Development
Well Led	Mandatory Training Compliance	Existing KPI	Director of People and Organisational Development
Well Led	Net Staff in Post Change	Existing KPI	Director of People and Organisational Development
Well Led	Proportion of staff in senior leadership roles who are from a) a BME background	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of staff in senior leadership roles who are from b) are women	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of staff in senior leadership roles who are from c) are disabled staff	SOF 22/23	Director of People and Organisational Development
Well Led	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	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients	SOF 22/23	Director of People and Organisational Development
Well Led	Proportion of temporary staff	Existing KPI	Director of People and Organisational Development
Well Led	Sickness Rate	SOF 22/23	Director of People and Organisational Development
Well Led	Staff survey engagement theme score	SOF 22/23	Director of People and Organisational Development
Well Led	Total shifts exceeding NHSI capped rate	Existing KPI	Director of People and Organisational Development
Well Led	Total shifts on a non-framework agreement	Existing KPI	Director of People and Organisational Development
Well Led	Vacancies - all	Existing KPI	Director of People and Organisational Development

Quality & Safety Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Caring	Access to Healthcare for people with Learning Disability	In development - definition to be established	Director of Nursing & Clinical Delivery
Well Led	Acting to improve safety - safety culture theme in the NHS staff survey	SOF 22/23	Director of Nursing & Clinical Delivery
Safe	Category 3 Pressure Ulcers	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC	Director of Nursing & Clinical Delivery
Safe	Category 4 Pressure Ulcers	Existing KPI	Director of Nursing & Clinical Delivery
Safe	Clostridium difficile infection rate	SOF 22/23	Director of Nursing & Clinical Delivery
Responsive	Complaints - (Open) % within response timescales	Existing KPI	Director of Nursing & Clinical Delivery
Safe	Compliance with CQC Medicines Management	Existing KPI	Director of Nursing & Clinical Delivery
Safe	Compliance with Duty of Candour	Existing KPI	Director of Nursing & Clinical Delivery
Safe	Consistency of reporting patient safety incidents	SOF 22/23	Director of Nursing & Clinical Delivery
Effective	Deaths - unexpected	Existing KPI	Medical Director
Safe	E. coli bloodstream infection rate	SOF 22/23	Director of Nursing & Clinical Delivery
Safe	Falls per 1000 Occupied Bed Days	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC	Director of Nursing & Clinical Delivery
Safe	Medication Incidents with Harm	New KPI - requested and defined by Deputy Director of Nursing and Quality and Deputy DIPC	Director of Nursing & Clinical Delivery
Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection count	SOF 22/23	Director of Nursing & Clinical Delivery
Safe	National Patient Safety Alerts not completed by deadline	SOF 22/23	Director of Nursing & Clinical Delivery
Safe	Never Events	Existing KPI	Director of People and Organisational Development
Well Led	Overall CQC Rating	SOF 22/23	Chief Executive Officer
Safe	Patient Safety Incident Investigations	Existing KPI	Director of Nursing & Clinical Delivery
Well Led	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	SOF 22/23 In development - definition to be established	Medical Director

Resource & Performance Committee

Domain	Measure	Rationale for inclusion	Accountable Role
Responsive	18 week Referral To Treatment (RTT) incomplete pathways	Existing KPI	Director of Operations
Use of Resources	Agency spend - compared to the agency ceiling	SOF 22/23	Director of People and Organisational Development
Use of Resources	Agency spend - Price cap compliance	SOF 22/23	Director of People and Organisational Development
Effective	Available virtual ward capacity per 100k head of population	SOF 22/23	Director of Operations
Responsive	CQC Conditions or Warning Notices	Existing KPI	Chief Executive Officer
Effective	Data Quality Maturity Index	Existing KPI	Director of Operations
Responsive	Diagnostics for Audiology and Ultrasound - DM01	Existing KPI	Director of Operations
Use of Resources	Financial efficiency - variance from efficiency plan	SOF 22/23	Chief Finance Officer
Use of Resources	Financial stability - variance from break-even	SOF 22/23	Chief Finance Officer
Caring	New Birth Visits % within 14 days - Dudley	New KPI for 0-19 Dudley following contract award	Director of Operations
Caring	New Birth Visits % within 14 days - Shropshire	Existing KPI	Director of Operations
Caring	New Birth Visits % within 14 days - Telford	Existing KPI	Director of Operations
Responsive	Number of patients not treated within 28 days of last minute cancellation	Existing KPI	Director of Operations
Effective	Outpatient follow-up activity levels compared with 2019/20 baseline	SOF 22/23	Director of Operations
Responsive	Proportion of patients spending more than 12 hours in an emergency department	SOF 22/23	Director of Operations
Responsive	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	SOF 22/23	Director of Operations
Responsive	Proportion of patients within 18 weeks	Existing KPI	Director of Operations
Effective	Total activity undertaken against current year plan	Existing KPI	Director of Operations
Effective	Total diagnostic activity undertaken compared with 2019/20 baseline	SOF 22/23	Director of Operations
Effective	Total elective activity undertaken compared with 2019/20 baseline	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 104 weeks - all services	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 104 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 52 weeks - all services	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 52 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 65 weeks - all services	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 65 weeks to start consultant-led treatment	Existing KPI	Director of Operations
Responsive	Total patients waiting more than 78 weeks to start consultant-led treatment	SOF 22/23	Director of Operations
Responsive	Total patients waiting more than 78 weeks - all services	Existing KPI	Director of Operations
Effective	Virtual ward bed occupancy	New KPI requested by RPC	Director of Operations

Appendix 2 – Lead Executive Director for Board Committees

Board Committee	Lead Executive Director
Quality and Safety Committee	Director of Nursing & Clinical Delivery and Medical Director
People Committee	Director of People and Organisational Development
Resource & Performance Committee	Chief Finance Officer
Audit Committee	Director of Governance
Remuneration Committee	Director of Governance
Charitable Funds Committee	Chief Finance Officer

Appendix 3 – Performance Delivery Meetings & Governance

Meeting	Frequency	Who	Report
Board of Directors	Monthly	Chair - Chair Trust Board	Trust level Integrated Performance Report Annual objective review (quarterly) Committees to review all Committee KPIs and present a performance overview through the Chair's report.
Execs/SLT	Monthly	Chair – CEO Execs Meeting	Trust level Integrated Performance Report and review of Trust operational performance review meeting Execs to review Directorate KPIs and present a performance overview through the Chair's report.
Execs	Weekly	Chair – CEO Execs Meeting	Key performance indicators weekly exceptions e.g. serious incidents, infection control, waiting times targets, activity and financial performance
Trust Performance Board	Monthly	Chair – Chief Finance Officer Execs, Directorate Management Team	Trust level Integrated Performance Report, unit exception reporting, strategic updates, financial performance, key risks, actions plans
Directorate Meetings	Monthly	Chair – Directorate Lead	Key performance metrics for directorate, departments and services. Performance against corporate objectives, strategic updates, unit scorecard exception reporting, financial performance, key risks, action plans and update of participation in organisational development programmes

Appendix 4 - Framework

Shropshire Community Health NHS Trust

Board of Directors (BoD)

The BoD holds the Executive Directors to account for delivery of plan targets and objectives.

The BoD receives progress/performance reports.

The BoD delegates assurance activities (focused on the areas identified in the Board Assurance Framework).

The BoD receives 'independent' assurance from Board Committees

The Executive Directors manage performance delivery by delegating responsibility through line management structure and to a number of responsible teams /Directorates

Principles underpinning the Performance Management Framework

- Ensuring all operational, financial and project targets, objectives and KPIs are fully understood and have been assigned to an appropriate unit owner.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target.
- Driving consistency and alignment of performance information and reports at all levels – exception based reporting were possible.
- Constructively challenge performance delivery against agreed targets, confirming escalation criteria and recommending timely actions where appropriate.

Board Committees

Board Committees:
Audit Committee
Quality and Safety Committee
Resource and Performance Committee
People Committee

Other Board Committees:
Remuneration Committee
Charitable Funds Committee

Additional Time-Limited Committees:

Shropshire Community Health
NHS Trust

Appendix 5 – Dashboard Example

Quality and Safety Committee – SPC Summary

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	2024-05-31		6.1	6.4	-0.3	6.1	6.4	-0.3	
Quality & Safety Committee	Safe	Category 4 Pressure Ulcers	2024-05-31		2	0	2	2	0	2	
Quality & Safety Committee	Safe	Clostridium difficile infection rate	2024-05-31		4.00	0.00	4.00	4.00	0.00	4.00	
Quality & Safety Committee	Responsive	Complaints - (Open) % within response timescales	2024-05-31		100.00%	95.00%	5.00%	100.00%	95.00%	5.00%	
Quality & Safety Committee	Safe	Compliance with CQC Medicines Management	2024-05-31		98.16%	95.00%	3.16%	98.77%	95.00%	3.77%	
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	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	E. coli bloodstream infection rate	2024-05-31		0.00	0.00	0.00	0.00	0.00	0.00	
Quality & Safety Committee	Safe	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection...	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	National Patient Safety Alerts not completed by deadline	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Safe	Never Events	2024-05-31		0	0	0	0	0	0	
Quality & Safety Committee	Well Led	Overall CQC Rating	2024-05-31		Good	Good		Good	Good		
Quality & Safety Committee	Safe	Serious Incidents (reported)	2024-05-31		0	0	0	0	0	0	

Shropshire Community Health
NHS Trust

Appendix 6 – Action Plan Template

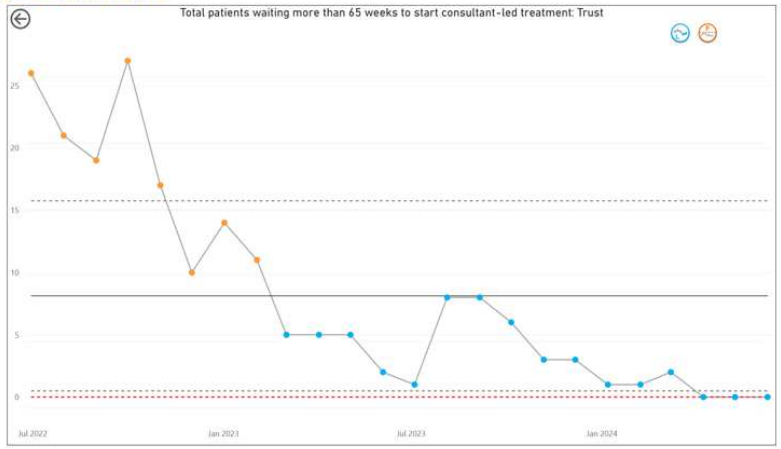
Exception Report - Action Plan

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	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
RTT 65+ week waits	Number	1	1	2	0	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:					
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
Author		**Date**			
Accountable Officer Approval		**Date**			

Shropshire Community Health NHS Trust

Month 3 2024/25 Financial Performance

0. Reference Information

Author:	Jonathan Gould Deputy CFO	**Paper date:**	1 August 2024
Executive Sponsor:	Sarah Lloyd, CFO	**Paper written on:**	24 July 2024
Paper Reviewed by:	Resource and Performance Committee	**Paper Category:**	Finance
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents key financial information in relation to our financial performance as at month 3 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 £1,768k; this reflects the financial plan submission to NHS England (NHSE) on 12 June 2024. The Trust's 2024/25 capital expenditure plan is £2,250k.

This paper summarises the Trust's financial performance for the period ended 30 June 2024 against both the I&E and Capital plan.

2.2. Summary

The Trust is reporting a £276k adjusted surplus for the year to date compared to the planned surplus of £284k, which is an adverse variance of £8k.

Key areas for consideration at this early stage of the financial year are:

- **Agency** spend at month 3 is £1,426k. This is favourable to plan by £433k. Our expectation is for agency costs to be in line with plan for the year as some slippage in our agency reduction programme is possible based on current information. **Agency usage and overall pay costs must remain within planned levels to deliver the financial plan.**

- **CIP.** Our performance to date is a small adverse variance to plan of £2k, with actual delivery of £186k efficiencies for the year to date. Delivery of the Trust's revised CIP target of £3,588k remains a significant risk to our financial plan. £2,238k of CIP schemes are currently rated as high risk in terms of delivery which is an improvement of £306k compared to the position reported at month 2. **We must deliver the CIP target in full to deliver the financial plan.**

- **Elective Income.** The Musculoskeletal Services, Shropshire and Telford (MSST) was introduced in 2023/24 and is expected to be fully implemented in 2024/25. At month 3 elective income is assumed to be in line with plan until work is complete on realignment of MSST activity and corresponding income across all three providers of the service. This is expected to be completed during July and the outcome reported in due course.

Month 3 2024/25 Financial Performance

- **Capital expenditure –** Maintaining our capital expenditure within available resources is a risk. Our capital funding has been reduced by 10% during this year, in line with new NHSE business rules, and we have been unsuccessful in gaining national digital funding. There is also a risk that there may be further pressures in relation to the system-wide capital allocation to cover lease obligations (IFRS 16). This position is being reviewed and considered externally and by the Trust's Capital and Estates Group.

2.3. Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 3 is a surplus of £276k compared to the planned surplus of £284k, which is an adverse variance of £8k.
- **Recognise** that agency costs, and overall pay costs, must remain within planned levels to ensure we deliver our financial plan.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3.6m although £2.2m of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that we are having to reprioritise our capital expenditure plans and work with system partners to assess potential further changes to our capital allocation.
- **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	M03 Plan	M03 Actual	M03 Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Annual Forecast Outturn	Annual Variance
(Surplus)/ Deficit In Year	(102)	(126)	(24)	(284)	(276)	8	(1,768)	(1,768)	0
Agency Expenditure	538	401	(137)	1,859	1,426	(433)	4,898	4,898	0
Cost Improvement Programme	121	126	5	188	186	(2)	3,588	3,588	0
Capital Expenditure	67	17	(50)	130	49	(81)	2,250	2,250	0

Month 3 2024/25 Financial Performance

3.2. Adjusted Financial Performance – adverse variance to plan £8k

The adjusted financial position is a surplus of £276k compared to the planned surplus of £284k, which is an adverse variance of £8k as summarised in Table 1.

	YTD Plan £k	YTD Actual £k	Variance £k
Income	(29,939)	(30,100)	(161)
Expenditure excl. adjusting items	29,655	29,824	169
Adjusted financial performance total	**(284)**	**(276)**	**8**
Adjusting items	36	36	0
Retained (surplus) / deficit	**(248)**	**(240)**	**8**

Table 1: Income and Expenditure (Surplus) / Deficit Position as at 30 June 2024

3.2.1. Income – favourable variance to plan £161k

Table 2 summarises the income position.

	YTD Plan £k	YTD Actual £k	YTD Variance £k
System Income	(22,461)	(22,461)	0
Non system Income	(7,478)	(7,640)	(162)
Total Income	**(29,939)**	**(30,100)**	**(161)**

Table 2: Income Summary as at 30 June 2024

System income comprises of agreed block income and an element of variable income linked to the delivery of elective activity.

Work is ongoing on the realignment of activity and corresponding elective income across all three providers of the Musculoskeletal Service, Shropshire and Telford (MSST). It is expected that overall system income will remain the same but the level of elective income received by each provider may change to reflect any movement in activity. Until this is resolved our reporting assumes elective income is in line with planned levels. It is of note that ShropCom's April and May actual MSST activity has shown some improvement on 2023/24 performance. The realignment work is expected to be completed during July and the outcome will be reported in due course.

The **Non-system income** overperformance is due mainly to additions to our Local Authority contracts and this will be offset with equivalent expenditure.

3.2.2. Expenditure – adverse variance to plan £169k

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

Month 3 2024/25 Financial Performance

	YTD Plan £k	YTD Actual £k	Variance £k
Substantive	18,898	19,052	154
Bank	553	634	81
Agency	1,859	1,426	(433)
Total Pay	**21,310**	**21,112**	**(198)**
Clinical Supplies & Services	2,667	2,999	332
Prison Escorts and Bedwatch	66	128	62
Drugs	480	465	(15)
Premises	2,780	2,539	19
Travel	556	324	8
Other	476	1,300	324
Non-Pay	**7,025**	**7,755**	**729**
Trust wide Central Charges	1,356	994	(362)
Total Non-Pay	**8,381**	**8,749**	**368**
Total Expenditure	**29,691**	**29,860**	**169**

Table 3: Expenditure Summary as at 30 June 2024

3.2.3. Pay – favourable variance to plan £198k

The overall pay position is a favourable variance of £198k year to date. This is largely due to agency spend being £433k favourable to plan. Substantive recruitment is ahead of planned levels and bank staff are utilised before agency use is considered.

The vacancy rate in month 3 was 11.5% which is 207 WTE vacancies, this is an improvement on month 2 vacancy rate of 12.3%, 219 WTE vacancies. Our financial plan assumed a relatively high vacancy rate from the start of the financial year which reduces during the year as recruitment into key roles continues.

Workforce recovery plans are in place to increase the pipeline of new starters in essential clinical roles and to retain existing staff. The position is being kept under close review through the weekly vacancy review panel and the People Committee. Improved recruitment and retention remain crucial to reduce the Trust's reliance on agency usage.

NHSE financial controls requires all recruitment to be subject to review and approval by system partners.

3.2.4. Non-Pay and Central Charges – adverse variance to plan £368k

The adverse variance on clinical supplies and services is driven largely by medical cover at two of our Community Hospitals and out of hours support for the Recovery and Rehabilitation Units (RRUs); this overspend is partly offset by reduced agency costs. Additionally, we are reporting financial pressures in relation to the secondary mental health service to Stoke Heath prison and discussions are underway with the provider and commissioner of this service to identify potential mitigations.

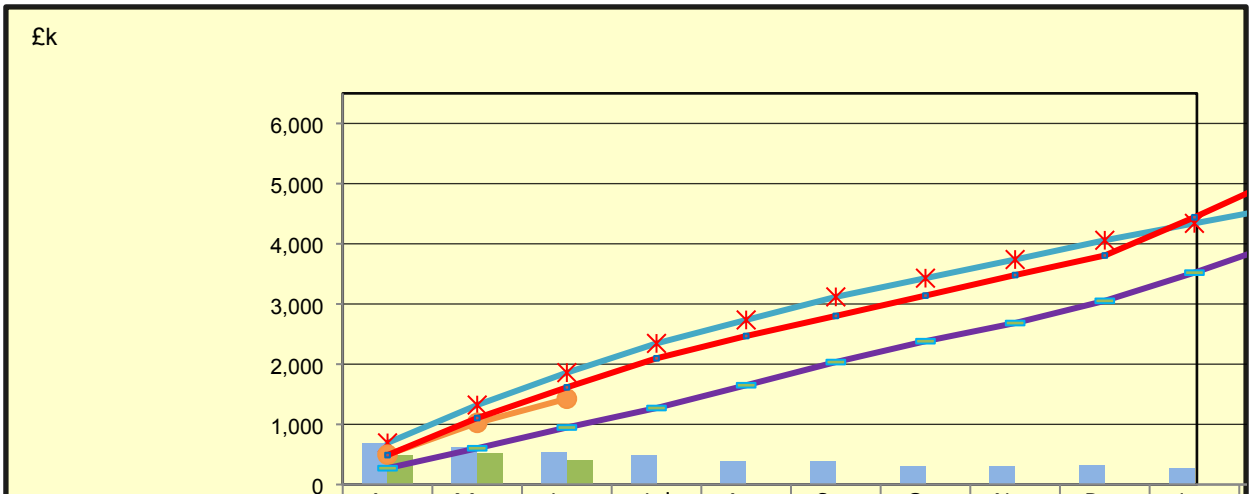
The adverse variance in 'Other' non-pay costs is due to the non-pay CIP budgets which have not yet been allocated to relevant non-pay budget lines; as CIP is delivered the budgets will be removed from the identified areas.

The favourable variance for central charges relates largely to interest received on our bank balance.

Month 3 2024/25 Financial Performance

3.2.5. Agency and Locum Expenditure – favourable variance to plan £433k

Table 4 shows agency spend is £1,426k at month 3 which is £433k favourable to the plan of £1,859k. The annual agency plan for 2024/25 is £4,898k.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
In Month Plan	692	629	538	486	390	383	311	310	320	281
In Month Actual	496	529	401							
Cumulative Plan 24/25	692	1,321	1,859	2,345	2,735	3,118	3,429	3,739	4,059	4,340
Cumulative Actual 24/25	496	1,025	1,426							
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 as at 30 June 2024

The favourable variance on agency spend is due largely to the two RRUs where recruitment to substantive posts is ahead of the planned trajectory resulting in a reduction in agency use. Further, general recruitment to vacancies across the Trust is ahead of plan, again resulting in a corresponding saving on agency usage. An average of 42 WTE agency staff were used in month 3 compared to an average of 56 WTE the previous 2 months. Non-agency medical cover at two of our Community Hospitals and out of hours in the RRUs has also resulted in a favourable agency cost variance, albeit there is currently a compensating adverse variance in non pay.

NHSE has imposed additional controls and monitoring for Integrated Care Systems which have planned for a deficit in 2024/25. This includes weekly reporting of bank and agency usage and monthly forecasts of agency spend for the year. Although our agency spend is favourable to plan for the year to date, we forecast agency costs will be in line with our plan at year end due to some anticipated slippage in our agency reduction programme.

STW ICB has established a System Workforce Agency Reduction Group which includes the three providers and the ICB. We also have an internal Agency Scrutiny Group which meets weekly to scrutinise all requests for agency usage; if the request is accepted by the group, it is then submitted to the Director of Operations for final approval. The above measures are designed to safely reduce agency spend; however, the agency reduction programme is closely monitored to take account of any patient safety risk. Quality, Equality Impact Assessments are undertaken for any changes as appropriate.

Month 3 2024/25 Financial Performance

3.2.6. Cost Improvement Programme

The Trust's CIP target for 2024/25 is £3,588k which is 3.5% of the Trust's overall planned expenditure for this year. The recurrent CIP element totals £3,088k and the non-recurrent element is £500k.

Table 5 shows actual CIP recurrent delivery for the year to date position at month 3 is £186k, this is £2k adverse compared plan. The £500k non-recurrent CIP target is profiled towards the end of the financial year, given the late agreement to deliver this stretch target.

Category £k	YTD Plan			YTD Actual			Variance adv/(fav)		
	Rec.	Non Rec.	Total	Rec.	Non Rec.	Total	Rec.	Non Rec.	Total
Internal									
Establishment reviews	0	0	0	0	0	0	0	0	0
E-Rostering / E-Job Planning	63	0	63	63	0	63	1	0	1
Corporate services transformation	7	0	7	0	0	0	7	0	7
Digital transformation	23	0	23	0	0	0	23	0	23
Service Re-design	38	0	38	57	0	57	(19)	0	(19)
Medicines efficiencies	4	0	4	24	0	24	(20)	0	(20)
Procurement	40	0	40	23	0	23	17	0	17
Estates and Premises transformation	10	0	10	15	0	15	(5)	0	(5)
Income Non-Patient Care	2	0	2	0	0	0	2	0	2
Other	1	0	1	5	0	5	(4)	0	(4)
	188	**0**	**188**	**186**	**0**	**186**	**2**	**0**	**2**
Non Recurrent Stretch									
June 2024 Stretch	0	0	0	0	0	0	0	0	0
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**188**	**0**	**188**	**186**	**0**	**186**	**2**	**0**	**2**

Table 5: CIP 2024/25 YTD Performance as at 30 June 2024

Table 6 shows that we have now fully identified schemes to deliver the 2024/25 CIP target of £3,588k. To date, £2,238k (62%) of our schemes are rated 'high risk' in terms of delivery, an improvement compared to month 2 when high risk schemes make up 71% (£2,544k) of our target.

Our CIP Working Group meets weekly and is overseen by the Financial Recovery Group. The Groups are focussed on de-risking our CIP schemes at pace and progress is being made at each meeting.

All relevant CIP schemes are reviewed by Quality, Equality Impact Assessments to ensure changes made are safe and the anticipated impact is considered.

In addition, it is of note that external support has been agreed for our ICS to assess CIP governance and delivery across the system.

Month 3 2024/25 Financial Performance

Category / Delivery Risk	Low £k	Medium £k	High £k	Unidentified £k	Total £k
Internal					
Establishment reviews	-	35	248		283
E-Rostering / E-Job Planning	-	250	-		250
Corporate services transformation	11	8	54		73
Digital transformation	10	35	235		280
Service Re-design	313	146	664		1,123
Medicines efficiencies	61	-	15		76
Procurement	90	350	-		440
Estates and Premises transformation	14	1	280		295
Income Non-Patient Care			20		20
Other	5	21	222		248
Total Internal	**504**	**846**	**1,738**	**-**	**3,088**
System Stretch Non-Recurrent					
June 2024 Stretch	-	-	500		500
Total System Stretch N/R	**-**	**-**	**500**	**-**	**500**
TOTAL PLAN	**504**	**846**	**2,238**	**-**	**3,588**

Recurrent / Non-Recurrent	Low £k	Medium £k	High £k	Unidentified £k	Total £k
Recurrent	504	846	1,738	-	3,088
Non-Recurrent	-	-	500	-	500
	504	**846**	**2,238**	**-**	**3,588**
Risk Percentages					
Recurrent	14%	24%	48%	0%	86%
Non-Recurrent	0%	0%	14%	0%	14%
	14%	**24%**	**62%**	**0%**	**100%**

Table 6: CIP 2024/25 full year breakdown

CIP delivery remains a significant risk to delivery our financial plan. **We must deliver the CIP target in full, in-year and recurrently, to deliver the financial plan.**

3.2.7. Statement of Financial Position

The summarised Statement of Financial Position as at 30 June 2024 is shown in Table 7. Receivables decreased by £129k and Payables increased by £287k. Cash increased by £916k, largely reflecting these movements and our year to date surplus. All movements are within the expected monthly range and there are no exceptions to bring to the Board's attention at this time.

Month 3 2024/25 Financial Performance

	31 May 24 Balance £k	30 Jun 24 Balance £k	Movement in Month £k
Property, Plant & Equipment	43,482	43,121	(361)
Inventories	185	185	0
Non-current assets for sale	0	0	0
Receivables	3,572	3,443	(129)
Cash	21,945	22,861	916
Payables	(11,257)	(11,544)	(287)
Provisions	(3,078)	(3,078)	0
Lease Obligations on Right to Use Assets	(12,975)	(13,000)	(25)
TOTAL ASSETS EMPLOYED	**41,874**	**41,988**	**114**
Retained earnings	32,948	33,063	115
Other Reserves	8,926	8,925	(1)
TOTAL TAXPAYERS' EQUITY	**41,874**	**41,988**	**114**

Table 7: Statement of Financial Position (SoFP) as at 30 June 2024

3.2.8. Capital Expenditure

Our 2024/25 capital expenditure allocation has two elements:

(1) Business as Usual (BAU) capital expenditure for maintenance, building projects, equipment replacement. BAU capital has been reduced by £0.25m to £2.25m due to a 10% reduction as per NHSE business rules. In addition, ShropCom has been unsuccessful in securing central funding for digital investment. The Capital and Estates Group (CEG) will reprioritise the capital expenditure plans to ensure high priority capital investment can still be made in 2024/25.

(2) Capital expenditure to cover additional lease obligations required by **IFRS 16**. The STW system capital allocation for IFRS 16 is less than the value required and we are working with NHSE Midlands to review this position. It is important to secure additional IFRS 16 allocation for 2024/25 because any shortfall is expected to be covered by reductions in BAU capital expenditure. If unresolved, this will pose a significant challenge to the Trust's IFRS 16 lease position and the system capital position as a whole.

The risks and mitigations in relation to the potential shortfall in ShropCom's 2024/25 capital funding were discussed and at the Resource and Performance Committee meeting in July.

3.2.9. NHSE Expenditure controls

The triple lock process implemented as an additional control measure by NHSE continues into this financial year. Non pay expenditure (excluding clinical supplies, drugs, utilities, rent and rates) above £10k is subject to the triple lock process which requires prior approval of expenditure from the relevant provider, the ICB and NHSE. There could be exceptions for emergency cases where retrospective approval will be sought.

3.2.10. Forecast Outturn and Financial Risk

At this early stage of the financial year, a summary forecast has been prepared which indicates that the Trust should deliver its financial plan, subject to mitigating our key financial risks. A more detailed forecast outturn position will be prepared from month 4 and presented to the Resource and Performance Committee for review and consideration.

Month 3 2024/25 Financial Performance

3.2.11. 2024/25 Financial Planning

The Trust's 2024/25 plan resubmission was approved at the 6 June 2024 Board meeting and submitted to NHSE on 12 June 2024. The plan included an additional £500k non-recurrent stretch CIP target and the plan figures and assumptions included within this report are consistent with the plan resubmission.

When agreeing to the additional efficiency requirement, our Board requested a commitment from the ICB to lead development of a system-wide Medium Term Financial Plan and this work is now underway. This is an important programme of work to support the STW ICS financial recovery.

The June plan resubmission also reflected an update to the NHS Finance Business Rules, circulated by NHSE National Finance team at the end of May. As referred earlier in the report, due to the STW system submitting a deficit plan for 2024/25, there is a 10% reduction in the STW capital allocation which has been allocated across all partners. Our business as usual capital plan reduced from £2.5m to £2.25m in respect of this change.

3.3 Conclusion

The Trust Board is asked to:

- **Consider** the adjusted financial position at month 3 is a surplus of £276k compared to the planned surplus of £284k, which is an adverse variance of £8k.
- **Recognise** that agency costs, and overall pay costs, must remain within planned levels to ensure we deliver our financial plan.
- **Acknowledge** that schemes are now fully identified to deliver the annual CIP target of £3.6m although £2.2m of identified schemes are rated as high risk in terms of delivery.
- **Recognise** that we are having to reprioritise our capital expenditure plans and work with system partners to assess potential further changes to our capital allocation.
- **Consider** if any additional actions are required in respect of the Trust's financial performance and monitoring arrangements.

Shropshire Community Health
NHS Trust

2024/25 Strategic Priorities – Interventions and Outcomes

Author:	Jonathan Gould, Deputy CFO	**Paper date:**	1 August 2024
Executive Sponsor:	Sarah Lloyd, Chief Finance Officer	**Paper written on:**	24 July 2024
Paper Reviewed by:	RPC, QSC, People Committee	**Paper Category:**	Strategy and planning
Forum submitted to:	Trust Board	**Paper FOIA Status:**	Full

1. Purpose of Paper

Within our 2024/25 Operational Plan the Board committed to delivery of 8 Strategic Priorities. This paper sets out the both the interventions (actions) we intend to take to deliver these Priorities and the expected outcomes.

Each intervention has been assigned to one of our Board Committees to ensure adequate oversight and to receive assurance on progress. In addition, regular progress updates will be provided to the Trust Board.

2. Executive Summary

2.1 Context

Members will recall that in June the Trust Board formally approved our 2024/25 Operational Plan which includes 8 Strategic Priorities. These are the 8 key areas of focus for ShropCom for the current year and support delivery of our Strategic Objectives, which are our longer-term objectives.

The approved 2024/25 Operational Plan is summarised within our 'Plan on a Page' shown in Appendix 1.

Each of the Strategic Priorities is supported by delivering a number of interventions. Each intervention is designed to deliver specific outcomes in 2024/25, to ensure delivery of our Priorities.

Senior Responsible Officers (SROs) have been agreed and have developed the proposed interventions, outcomes and delivery dates. The SROs are developing detailed delivery plans with milestones for each intervention and will propose how achievement of the outcomes will be measured and evidenced.

2.2 Interventions and Delivery

The Senior Responsible Officers (SROs), supported by the Planning Team, have developed the proposed interventions, outcomes and delivery dates shown in Appendix 2, using relevant available information and linking with stakeholders.

It is of note that lessons from previous years have been learnt, and we are therefore proposing to focus on a smaller number of interventions to maximise the opportunities for success.

The nominated SROs will lead delivery of the interventions and confirm the detailed delivery plan, milestones and measures of success for each intervention.

2024/25 Strategic Priorities – Interventions and Outcomes

Each of the Board Committees (Quality and Safety, Resource and Performance and People) has been asked to review and confirm approval of the proposed interventions and outcomes relevant to its remit, at July meetings. A verbal update on the outcome of these discussions will be provided to the Board.

Delivery of agreed outcomes will be monitored through the Trust's usual governance arrangements, using the PMO, and will include oversight through Board Committees. Recovery actions will be developed if delivery is not on plan.

Any material risks to delivery of the interventions will be recorded through the Trust's Board Assurance Framework, together with available mitigations, given the strategic importance of these programmes of work which focus on delivery of our Operational Plan Priorities.

2.6 Next steps

SROs are developing project plans, detailing key milestones and performance measures for the outcomes, and these will be presented to the relevant committees for review.

The Board is asked to consider the proposed interventions and outcomes and assess if these are sufficient to deliver our 8 Strategic Priorities or if there are any omissions which require attention.

2.7 Recommendations

The Board is asked to:

- **Recognise** that the Resource & Performance Committee, People Committee and Quality & Safety Committee are currently considering the proposed interventions and outcomes designed to support the delivery of the 2024/25 Strategic Priorities
- **Consider for approval** the proposed interventions, outcomes and delivery dates and assess if any further actions are required in order to deliver our Strategic Priorities
- **Note** that progress updates will be provided to the Trust Board and that any material risks to delivery will be reported in the Board Assurance Framework

Appendix 1 - Our 2024/25 '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

Appendix 2 – Interventions and Outcomes 2024/25

KEY: People Committee | R&P Committee | Q&S Committee

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	Interventions	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	Develop NHS Long term workforce plan–Train Retain and Transform	Improve sickness absence Improve Staff turnover Improve Staff survey results Reduce the use of Agency Staff	31/03/25 – Asso. Director of Wrkfrce & Resourcing, Asso. Director for People, Employee Relations and Occupational Health
	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	Implement NHS People Promise Exemplar Programme		
		Implement the Culture and Leadership Programme		31/03/25 – Associate Director for People, Employee Relations and Occupational Health
		Implement Admin Academy	Improve staff Turnover and staff survey results	31/03/25 – CYP & Planned care Division Manager
	We will build a valued and engaged workforce, where health and wellbeing is supported	Better understanding the needs of our population	Target services to make improvements across CORE20PLUS metrics	31/12/24 – Adult & Community service Division Manager
Caring For Our Communities	We will recover our services inclusively	Recovering elective services in line with National Mandates	Improve DNA, PFIU and virtual consultations	31/12/24 – CYP & Planned care Division Manager
		Continuing to develop our children and young people's services	Increase patient access to our successful services	31/12/24 – CYP & Planned care Division Manager
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	Establishing a continuous quality improvement framework based on NHS Impact	Increasing training and awareness Set a base for avoidable errors	30/9/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Learning and Improving Patient Safety and Engagement	Improve patient engagement. LFPSE - compliance	31/10/24 – Director of Governance
		Developing and implementing Clinical Quality Strategy	Set a base for avoidable errors	30/11/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Maximising ROI of EPMA	Continuously improve medicine management, Financial improvement	30/11/24 – Chief Pharmacist
	We will work in partnership with others, to redesign patient pathways	Optimising our Community Urgent and Emergency care offer through early supported discharge and alternatives to hospital admission	Improve pathways through collaboration with system partners	31/03/25 – Urgent Care Division Manager
Managing Our Resources	We will maximise our productivity and efficiency	Delivering in-year CIP and a 3-year rolling CIP plan	Deliver £3.5m efficiencies in 2024/25, add 3 yr CIP plan to the Med. Term financial Plan	31/03/25 – Deputy Ops Director
		Maximising the sustainability of our Estate	Reduce carbon footprint and improve occupancy	31/03/25 – Associate Director of Estates
		Implementing 24/7 single point of access (SPOA) through digital technology and process improvement	Improve patient access to Shropcom services	31/03/25 – Associate Director of Digital
	We will use all available digital technologies to modernise our services and our environment	Automating manual administrative processes to increase productivity	Demonstrate productivity improvement	31/03/25 – Associate Director of Digital

Appendix 2 – Interventions and Outcomes 2024/25

KEY: People Committee | R&P Committee | Q&S Committee

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	Interventions	Outcomes	Delivery date / SRO
Looking After Our People	We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive	Develop NHS Long term workforce plan–Train Retain and Transform	Improve sickness absence Improve Staff turnover Improve Staff survey results Reduce the use of Agency staff	31/03/25 – Associate Director of Workforce & Resourcing, Associate Director for People, Employee Relations and Occupational Health
	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	Implement NHS People Promise Exemplar Programme		
		Implement the Culture and Leadership Programme		31/03/25 – Associate Director for People, Employee Relations and Occupational Health
	We will build a valued and engaged workforce, where health and wellbeing is supported	Implement Admin Academy	Improve staff turnover and staff survey results	31/03/25 – CYP & Planned care Division Manager

Appendix 2 – Interventions and Outcomes 2024/25

KEY: People Committee | R&P Committee | Q&S Committee

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	Interventions	Outcomes	Delivery date / SRO
Caring For Our Communities	We will recover our services inclusively	Implement Admin Academy	Improve staff Turnover and staff survey results	31/03/25 – CYP & Planned care Division Manager
		Better understanding the needs of our population	Target services to make improvements across CORE20PLUS metrics	31/12/24 – Adult & Community service Division Manager
		Recovering elective services in line with National Mandates	Improve DNA, PFIU and virtual consultations	31/12/24 – CYP & Planned care Division Manager
		Continuing to develop our children and young people's services	Increase patient access to our successful services	31/12/24 – CYP & Planned care Division Manager
	We will support our staff to embed quality improvement methodology to improve staff and patient experiences.	Establishing a continuous quality improvement framework based on NHS Impact	Increasing training and awareness Set a base for avoidable errors	30/9/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Learning and Improving Patient Safety and Engagement	Improve patient engagement. LFPSE - compliance	31/10/24 – Director of Governance
		Developing and implementing Clinical Quality Strategy	Set a base for avoidable errors	30/11/24 – Deputy Director of Nursing and Quality and Deputy DIPC
		Maximising ROI of EPMA	Continuously improve medicine management, Financial improvement	30/11/24 – Chief Pharmacist
	We will work in partnership with others, to redesign patient pathways	Optimising our community Urgent and Emergency Care offer through early supported discharge and alternatives to hospital admission	Improve pathways through collaboration with system partners	31/03/25 – Urgent Care Division Manager

Appendix 2 – Interventions and Outcomes 2024/25

KEY: People Committee | R&P Committee | Q&S Committee

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	Interventions	Outcomes	Delivery date / SRO
Managing Our Resources	We will maximise our productivity and efficiency	Delivering in-year CIP and a 3-year rolling CIP plan	Deliver 24/25 planned efficiencies Add 3 year CIP plan to the Medium Term Financial Plan	31/03/25 – Deputy Ops Director
		Maximising the sustainability of our Estate	Reduce carbon footprint and improve occupancy	31/03/25 – Associate Director of Estates
		Implementing 24/7 single point of access (SPOA) through digital technology and process improvement	Improve patient access to ShropCom services	31/03/25 – Associate Director of Digital
	We will use all available digital technologies to modernise our services and our environment	Automating manual administrative processes to increase productivity	Demonstrate productivity improvement	31/03/25 – Associate Director of Digital

Shropshire Community Health
NHS Trust

Board Assurance Framework
0. Reference Information

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1. Purpose of Paper

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

The Board is asked to ***consider and approve*** the proposed risks to delivery cited on the Board Assurance Framework, noting that these need to link to the operational objectives that were agreed by the Board on 6th June with the operational deliverables and measures agreed through the committees week commencing 22nd July

2. Executive Summary

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

The BAF is been presented to each of the Board Committees to consider and review the risks that fall within their remit.

The Board agreed the Trust's objectives on 6 June 2024. Since this time there has been work to agree the deliverables and the measures of these via the Committees with these discussions taking place week commenced 22nd July 2024. As a result of these discussions risks from the 23-24 BAF have been agreed to still be relevant and therefore carried forward and a number of new risks have bene identified which are in the process of being worked up and will be included on the BAF going forward.

The Board is asked to consider the following:

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

Conclusion

The Board is asked to consider and approve the Board Assurance Framework noting the risks identified for further work up.

Looking after our People — OBJ 1

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive

This objective will focus on the development of the NHS long term plan – retain and transform

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 24

Reviewed Date: July 24

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage
- ✓ Improvement in staff survey results

Progress Update:

The deliverables and measurables were agreed at the People Committee on 25 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- Various national toolkits

Key Assumptions:

- N/A

Risks:

1.1 Workforce team capacity
1.2 Recruitment restrictions impacting on staff morale

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Principle Objective: We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **BAF 1.1**

Principal Risk: Workforce Team Capacity Carried forward from 23/24

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ongoing monitoring of team capacity and prioritisation
- ✓ Revised workforce team structure
- ✓ Streamlined workforce processes
- ✓ Recruitment of a designated HRD

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

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

Gaps In Controls:

- ~~C1: Ability to recruit substantively to Associate Director posts in workforce team~~
- ~~C2: HRD not yet in post~~

Gaps in Assurance:

- N/A
- ~~A1: People metrics being reviewed and will then need Board agreement~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Case of need to be presented to Executive Team for approval	Director of Nursing, Workforce and Clinical Delivery	November 2023	Case of Need presented and approved and appointments made - Completed
C2	Onboarding of HRD	Director of Nursing, Workforce and Clinical Delivery	April 2023	Completed
A1	Proposed people metrics to be put forward to people committee and then onto Board for approval	Director of Nursing, Workforce and Clinical Delivery	May 2023	Completed and approved by the Board

We will create a culture of civility and respect, with compassionate, inclusive leadership that supports our people to thrive **BAF 1.2**

Principal Risk: Recruitment restrictions impact on staff morale Carried forward from 23/24

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ QEIA process to ensure robust consideration of impact
- ✓ Scrutiny of vacancy panel decisions at Finance Recovery Group
- ✓ Case of Need proforma to assess options
- ✓ VRF panel chaired by Director of Ops and DoN
- ✓ VRF panel agreements – agreed and prioritised weekly by executive team
- ✓ System panel for vacancy approvals

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

- ✓ People Committee oversight
- ✓ Pulse checks
- ✓ System People Board Oversight
- ✓ Staff Survey
- ✓ Incidents
- ✓ Quality & Safety Committee

Gaps In Controls:

- ~~C1: Triple lock process not defined to allow for recruitment to progress~~
- ~~C2: No system process for agreeing recruitment~~

Gaps in Assurance:

- ~~Staff Survey Results a year out of date~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Triple lock process to be agreed	Director of Finance	January 2024	Process has been agreed for local approval of recruitment with ICB / NHS E challenge as appropriate - completed
C2	System vacancy panel to be agreed	Director of Nursing, Workforce and Clinical Delivery	April 2024	Completed

Looking after our People — OBJ 2

Principle Objective: 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

This objective will focus on the implementation of the NHS People Promise Exemplar Programme and the Trust's Culture and Engagement Programme

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

The deliverables and measurables were agreed at the People Committee on 25 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above

In addition the People Committee asked for consideration of the risk of age profile of our workforce and the risk of high leavers

Lead Director:

Director of HR and OD

Lead Committee:

People Committee

Looking after our People — OBJ 3

Principle Objective: We will build a valued and engaged workforce, where health and wellbeing is supported

This objective will focus on the implementation of the admin academy.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

- ✓ Improved staff turnover and staff survey results
- ✓ Reduction in sickness absence
- ✓ Reduction in agency usage

Progress Update:

The deliverables and measurables were agreed at the People Committee on 25 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- Various national toolkits
- People Promise Exemplar programme

Key Assumptions:

- TBC

Risks:

Risks 1.1 and 1.2 as above

Lead Director:

Director of HR and OD

Lead Committee:

People Committee, Resource and Performance Committee

Caring for Our Communities — OBJ 4

Principle Objective: We will support our staff to embed quality improvement methodology to improve staff and patient experiences

This objective can be broken down into the following key components; establishing a continuous quality improvement framework based on NHS impact, learning and improving patient safety and engagement, developing and implementing a clinical quality strategy, maximising return on investment of electronic prescribing management

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Op Key Measures:

- ✓ A baseline and improvement for avoidable errors
- ✓ Increased staff training and awareness of quality improvement
- ✓ Improved patient engagement
- ✓ Improved medicines management
- ✓ Financial improvement
- ✓ Evidence of learning from patient safety events

Progress Update:

- Quality improvement framework in place
- Staff training in PSIRF compliant safety investigations completed
- Thematic review on medicines safety completed and taken to quality and safety committee
- Recruitment underway for new Patient Experience Lead

The deliverables and measurables were agreed at the Quality and Safety Committee on 25 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- PSIRF Programme

Key Assumptions

- Upgrade / update to Datix

Risks:

BAF4.1	Ability to transition to LFPSE
BAF 4.2	Reliance on volunteer input for key patient experience workstreams such as observe and act

In addition risks in relation to the following are being worked up – quality improvement team capacity, operational pressures impacting on staff engagement with QI training, ability to measure clinical quality strategy implementation

Lead Director:

Director of Nursing, Quality and Clinical Delivery

Lead Committee:

Quality and Safety Committee

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.1**

Principal Risk: Ability to transition to LFPSE Carried forward from 23/24

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

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	5	1
Total	16	20↑	4

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ PSIRF Working group overseeing transition
- ✓ LFPSE testing completed with ongoing support from Datix
- ✓ System Working group
- ✓ System partner support (those also using Datix)
- ✓ National toolkit being followed
- ✓ Extension of NRLS and STEIS due to national issues with LFPSE

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

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

Gaps In Controls:

- Datix reconfiguration to be completed and resource constraints
- Datix software compatibility
- Lack of Datix expertise within the organisation (no trained lead)
- Datix does not capture the right quality of data

Gaps in Assurance:

- Timeline for datix reconfiguration dependent on onboarding of datix expertise

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1, A1	Reconfiguration timetable to be compiled and implemented	Director of Governance	~~November 2023~~ ~~March 2024~~ October 2024	New Datix system has been purchased and will be implemented when Datix lead in post. In the interim CSU are providing support with LFPSE compliance and are scoping the work required
C2	Ongoing support from Datix	Director of Governance	~~November~~ 2023 March 2024 October 204	Ticket logged with Datix to update the current version to enable transition to LFPSE
C3	Appointment of Datix lead	Director of Governance	October 2024	Appointment made and indicative start date of 1 October
C4	Reconfiguration of Datix to capture required data	Director of Governance	December 2024	This is dependent on the onboarding of the Datix Lead, with minor improvements possible through the interim bank / CSU arrangements. In the meantime to mitigate any risk, manual review of the data is being undertaken to enable reporting

Principle Objective: Embed a culture of continuous quality improvement ensuring robust systems are in place and actions identified for priority areas **BAF 4.2**

Principal Risk: Reliance on volunteer input for key patient experience workstreams such as observe and act Carried forward from 23/24

Loss of volunteers would impact on ability to delivery key workstreams

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

Assurance: **Source of Assurance** **1**

- ✓ Patient Experience Committee

Gaps In Controls:

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

Gaps in Assurance:

- A1: No tracking of recruitment and retention of volunteers

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Recruitment and retention plan to be devised	Director of Governance	~~December 2023~~ ~~April 2024~~ October 2024	Current patient experience lead is retiring, recruitment of new lead underway and plan to commence from their start date.
C2	Administrative support to be put in place	Director of Governance	December 2023	Support now in place as a temporary fix with plans to recruit permanently -completed
A1	Recruitment and retention tracking to be put in place once plan devised	Director of Governance	~~January 2024~~ October 2024	Not yet commenced – recruitment and retention plan to be devised in the first instance

Caring for Our Communities — OBJ 5

Principle Objective: We will recover our services inclusively

This objective can be broken down into three key components; better understanding the needs of our population, recovering services in line with the national mandate, continuing to develop our children and young people services

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

- ✓ Improvements across CORE20PLUS metrics
- ✓ Improvement in DNA, PIFU and virtual consultations
- ✓ Increased patient access to our successful services

Progress Update:

The deliverables and measurables were agreed at the Resource and Performance Committee on 22 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- OP Transformation programme
- MSK Programme

Key Assumptions

-

Risks:.3

5.1 Demand exceeds capacity
5.2 Potential for patient harm due to waiting times
5.3 Operational capacity to delivery the programmes of work
5.4 Recruitment challenges

In addition there is a further risk being worked up in relation to data quality to support health inequalities, this is based on the findings of a recent internal audit which has been presented to the Audit Committee

The Resource and Performance Committee asked for digital capacity to be added as a risk to this objective, particularly with regard to improvements with RTT performance, this is articulated at risk 7.2. The Committee also asked for a risk relating to incomplete MSST demand and capacity profiling.

Lead Director:

Director for Operations / Director of Nursing

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will recover our services inclusively — BAF 5.1

Principal Risk: Demand exceeds capacity **Carried forward from 23/24**

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

Risk Rating:

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

Risk Details:

Opened: April 2022

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

- C1: Gaps in service level data

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
A1	Operational teams to work with corporate services to improve the data drill down	Director of Operations / Director of Finance	Ongoing for 24/25	This is an ongoing piece of improvement work with the teams working through the data requirements in order of priority. Each month there is demonstrable improvement in the drill down data available.

We will recover our services inclusively **BAF 5.2**

Principal Risk: Potential for patient harm due to waiting times **Carried forward from 23/24**

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

Risk Rating:

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

Risk Details:

Opened: April 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Programme of work to eliminate waits of in line with nationally mandated requirements
- ✓ Patient Safety Incident Panel reviewing any harms assessments with moderate harm or above
- ~~✓ Harms assessment process~~
- ~~✓ Harms Assessment Group established to deliver process~~

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

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

Gaps In Controls:

- C1: Harms assessment process has only embedded in some areas

Gaps in Assurance:

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

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Harms review policy to be reviewed	Director of Nursing	September 2024	Review of policy underway
A2	Training on harms review process to be rolled out following revised policy being put in place	Director of Operations / Director of Governance	October 2024	

We will recover our services inclusively **BAF 5.3**

Principal Risk: Operational capacity to undertake all programmes of work Carried forward from 23/24

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

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	4	2
Total	20	20 ↑	10

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Revised operational structure
- ✓ Transformation Board and Programme Board in place for senior operational oversight

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

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

Gaps In Controls:

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

Gaps in Assurance:

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

Action Plan to Address Gaps:

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

We will recover our services inclusively **BAF 5.4**

Principal Risk: Recruitment challenges

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

Risk Rating:

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

Risk Details:

Opened: April 2022

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

~~C1: Line of sight on vacancies and agency usage~~

C2: Sustainable solution for medical cover across all sites

Gaps in Assurance:

- ~~A2: System People Board has not met with any frequency~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Implementation of e-rostering	Director of Nursing	March 2024	Collaboration with the system on e-rostering in its infancy with project plan developed ongoing
~~A2~~	~~Engagement with System People Board~~	~~Director of Nursing / Director of Governance~~	~~September 2023~~	~~New People Committee established for ICB, Shrop Comm NED representative agreed. - completed~~
C2	Options appraisal to be completed and progressed	Director of Operations / Medical Director	September 2024	

Caring for Our Communities — OBJ 6

Principle Objective: We will work with others to redesign patient pathways

This objective will focus on optimising our community, urgent and care through early support discharge and alternatives to hospital admission

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

✓ Improved pathways through collaboration with system partners

Progress Update:

- System transformation group in place
- Progress being made with a new collaborative structure in the system to support the operational collaboration required.

The deliverables and measurables were agreed at the Resource and Performance Committee on 22 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- UEC
- MSK
- Shared Services

Key Assumptions

- N/A

Risks:

6.1 Internal governance and operational oversight arrangements for system programmes

In addition RPC asked for a risk to be added regarding the transfer of orthopaedics to SaTH and this is being worked up

Lead Director:

Director of Nursing and Clinical Delivery, Director of Operations

Lead Committee:

Resource and Performance Committee, Quality and Safety Committee

We will work with others to redesign patient pathways

Principal Risk: Internal governance and operational oversight arrangements for system programmes Carried forward from 23/24

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Trust attendance at system programme meetings
- ✓ Establishment of CiC to improve collaborative working
- ✓ Weekly vacancy panel being established at system level

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

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

Gaps In Controls:

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

Gaps in Assurance:

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

Action Plan to Address Gaps:

Managing Our Resources

Principle Objective: We will use all available digital technologies to modernise our services and our environment

This objective will focus on automating manual administrative processes to increase productivity

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

✓ Demonstrable productivity improvement

Progress Update:

The deliverables and measurables were agreed at the Resource and Performance Committee on 22 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- EPMA Programme

Key Assumptions

- Operational capacity to support digital developments

Risks:

7.1 Risk of cyber attack
7.2 Digital team capacity

Lead Executive

Director of Finance

Lead Committee:

Resource and Performance Committee

We will use all available digital technologies to modernise our services and our environment

Principal Risk: Cyber attack

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

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

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

- ✓ Audit Committee Oversight
- ✓ Data Security Group

Gaps In Controls:

- ~~C1: Information asset owner processes still embedding~~
- C2: Information asset owner compliance
- C3: DSPT compliance only at working to standards

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Information Asset Owner Network meetings to be established	Director of Governance	December 2023	Schedule in place with holds in the diary - completed
C2	Additional training and support to be put in place for information asset owners	Director of Governance	September 2024	IG Manager appointed and additional support procured via CSU to address gaps in IG team and provide support with information asset owner records and training. Forms part of DSPT Toolkit Improvement Plan.
C3	Full DSPT compliance to be achieved	Director of Governance	December 2024	Improvement plan in place which is being reviewed by NHS Digital with a view to approval, this will be monitored via Audit Committee.

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

Principal Risk: Digital Team capacity

Lack of capacity results in programmes of work being paused or delayed, loss of momentum with digital agenda, staff unsupported with digital service needs. Potential to impact on improvement with RTT

Risk Rating:

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

Risk Details:

Opened: September 2023

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

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

- ✓ Digital Assurance Group

Gaps In Controls:

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

Gaps in Assurance:

- N/A

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Digital B7 Case of Need to be presented to Execs	Director of Finance	November 2023	Submitted to Execs and approved to proceed however additional controls in place and system approval required.
C2	Transformation Oversight Group to include digital input	Director of Operations	September 2024	Approved ToR in place and meetings established and reporting to Performance Board

Managing Our Resources — OBJ 8

Principle Objective: Maximise our productivity and efficiency

This objective can be broken down into three key components; delivering in year CIP and a 3-year rolling CIP plan, maximising the sustainability of our estate, implementing 24/7 single point of access (SPOA) through digital technology and process improvement

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: June 2024

Reviewed Date: July 2024

Key Measures:

- ✓ Deliver £3.5m efficiencies for 2024/25, add 3 year CIP plan to the medium term financial plan
- ✓ Reduce carbon footprint and improve estate occupancy
- ✓ Improve patient access to shropcom services

Progress Update:

The deliverables and measurables were agreed at the Resource and Performance Committee on 22 July and delivery and a progress update will be provided in the next report.

Supporting Programmes of Work:

- CIP Programme
- Net Zero Group
- Capital Programme

Key Assumptions:

- Operational delivery of CIP identified
- Elective activity delivery

Risks:

BAF8.1	Costs exceed plan
BAF 8.2	Capital funding insufficient (risk being worked up)

Lead Director:

Director of Finance

Lead Committee:

Resource and Performance Committee

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

Principal Risk: Costs exceed plan

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

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	5	3
Likelihood	5	3	2
Total	20	15↑	6

Risk Details:

Opened: April 2022

Reviewed Date: July 2024

Source of Risk:

Corporate Risk Register

Controls:

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

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

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

Gaps In Controls:

- C1: Shortfall in CIP schemes currently identified

Gaps in Assurance:

- A1: Performance and Programme Board to be embedded

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Ongoing work through CIP Delivery Group feeding into Financial Recovery Group	Director of Finance	March 2024	Weekly meeting continue to take place with Executive oversight
A1	Performance and Programme Board to continue to be embedded	Director of Finance / Director of Operations	September 2024	Four meetings have now taken place and continue to embed the performance framework

Shropshire Community Health
NHS Trust

Board Development Programme

0. Reference Information

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1. Purpose of Paper

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

The Board is asked to ***consider and approve*** the proposed Board Development Programme for the remainder of 24-25.

2. Executive Summary

The Board of Directors is continuously looking at how it can strengthen its skill set and decision making and has in place a Board Development Programme to support the development of the Board as a collective.

This paper presents the proposed programme for the remainder of the year along with a recap of the programme undertaken from 2023-date.

Conclusion

The Board is asked to consider and approve the Board Development Programme with particular regard to further items they would like to see included in the programme going forward.

Shropshire Community Health NHS Trust

Board development workshop programme for 2023

Month	Topic	Facilitators
January 2023	• Strategy Development • Local Care Programme • System Board to Board	Ignite Executive Led ICB Chair / Trust Chair
February 2023	• Effective Challenge	NHS Providers
March 2023	• Hospital Transformation Programme	Nigel Lee, SaTH
April 2023	• Performance Framework (3 hours interactive session) • Strategy Development	Kerry Robinson Executive Led
May 2023	• 10 principles on engaging people and communities (following presentation from Edna Boampong at ICB Quality & Performance Committee	ICB Director of Communications
June 2023	• Provider Collaboration	Executive Led
July 2023	• Safeguarding	Safeguarding Lead
September 2023	• Benchmarking	NHS Providers
October 2023	• PSIRF Training • CQC Standards • Freedom to Speak Up (Deferred)	Exec Led Exec Led
November 2023	• Making Data Count (Deferred)	NHS E

Board development workshop programme for 2024

Month	Topic	Facilitators
January 2024	• Strategy Refresh • Governance Framework	Executive Led Executive Led
March 2024	• Strategic Direction	Executive Led
May 2024	• Strategic Direction • Benefits Realisation • Local Care Programme • Race Equality Code	Executive Led Executive Led Executive Led RSM UK
June 2024	• Culture and Engagement	Executive Led
August 2024	• Risk Management	Executive Led
July 2024	• Equality and Diversity	Executive Led
September 2024	• Public Health • FTSU	Director of Public Health, Shropshire Council FTSU Guardian
October 2024	• Schwarz Rounds	Dr Camilla Johns
November 2024	• Patient Safety Oversight	InPractice
December 2024	• Collaborative Working – Board to Board	TBC