The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 11 November 2021
Time: 1300hrs
Venue: Via MS Teams (link in meeting invitation)
Chair: Catriona McMahon

Time	Item no.	Item	Paper / Verbal	Page	Lead	Action
Procedural Items						
1300hrs	259/21	Welcome, introductions, and apologies	Verbal	-	Chair	For noting
	260/21	Patient Story	Enc. / video	3	Director of Nursing	For noting
	261/21	Quorum	Verbal	-	Chair	For noting
	262/21	Declarations of conflicts of interest	Verbal	-	Chair	For noting
	263/21	Minutes of the previous meeting held on 7 October 2021	Enc.	5	Chair	For approval
	264/21	Action log – *no outstanding actions*	n/a	-	Chair	For approval
	265/21	Matters arising from the previous minutes (not covered elsewhere on the agenda or action log)	Verbal	-	Chair	For discussion
Strategic matters						
1320hrs	266/21	Report from the Chair	Verbal	-	Chair	For noting
	267/21	Report from the Chief Executive	Verbal	-	Chief Executive	For noting
	268/21	Estates Plan	Enc.	17	Director of Finance	For approval
	269/21	Hospitals Transformation Programme (HTP) Report	Enc.	24	*Interim Deputy Chief Executive	For information
Quality and Performance Matters						
1340hrs	270/21	Integrated Performance Report	Enc.	28	Chief Executive	For noting
	271/21	Serious Incidents Report	Enc.	98	Medical Director Director of Nursing	For noting
	272/21	Director of Infection Prevention & Control Quarterly Report	*Enc.	102	Director of Nursing	For noting
	273/21	Public Participation Quarterly Report	*Enc.	120	*Director of Public Participation	For noting

	274/21	Feedback from Board Genba Walks and new Genba Walk Process	Enc.	124	*Director of People & OD	For information
Assurance Framework						
1500hrs	275/21	The Ockenden Report - Progress Report	*Enc.	140	Director of Nursing	For assurance
	276/21	Ockenden Report Assurance Committee Monthly Report	Enc.	144	Committee Chair	For assurance
	277/21	Freedom to Speak Up (FTSU) Q2 Report	Enc.	148	*Director of Governance & Communications	For assurance
	278/21	Health & Safety Annual Report	Enc.	160	Chief Operating Officer	For assurance
	279/21	Estates and Medical Engineering Services (MES) Quarterly Report	*Enc.	184	Director of Finance	For assurance
	280/21	Finance & Performance Assurance Committee Monthly Report	Enc.	188	Committee Chair	For assurance
	281/21	Quality & Safety Assurance Committee Monthly Report	Enc.	190	Committee Chair	For assurance
Regulatory and Statutory Reporting						
1545hrs	282/21	Responsible Officer Quarterly Appraisal and Revalidation Report	Enc.	193	Medical Director	For noting
Procedural Items						
1600hrs	283/21	Any other business – agreed by the Chair	Verbal	-	Chair	For discussion
	284/21	Date and Time of Next Meeting 13:00 on **Thursday 9 December 2021**	Verbal	-	Chair	Information
Stakeholder Engagement						
1610hrs	286/21	Questions from the public	Verbal	-	Chair	Information
Close of meeting						

* Non-voting director

* See supplementary pack for appendices

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	260/21			
Report	Patient Story: Steve's Story			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people		Effective	
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 2	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	The patient story has been shared with the Ward Team and at the Nursing, Midwifery and AHP Meeting (3rd November 2021)			
Dependent upon (if applicable)**:**				
Executive summary:	This patient story is shared by the son of a patient who was treated within the Trust prior to passing away in January 2021. The feedback is presented as a short digital story, the storyteller is using his own words to describe the experience. The Board are invited to listen to the son's story and note how the feedback is being shared to increase awareness the actions being taken to make improvements.			
Appendices:	None			
Lead Executive:				

1.0 Introduction

1.1 This story captures the experience of a son whose father passed away in the Trust. In his story the son describes his experience and the barriers he encountered in maintaining contact with his father. The storyteller has shared his feedback to enable learning to be taken and improvements to be made.

2.0 Background

2.1 The son's father was admitted into the Trust in November 2020, he went on to develop COVID-19 and his condition deteriorated.

2.2 Whilst his father had a mobile telephone, he struggled to use this, making it difficult to maintain communication between him and his family. This was especially difficult over the Christmas period. Due to the difficulty experienced in speaking to his father, on the 27th December 2020 the patient's son went to the ward, which provided him with a level of comfort and hope.

2.3 On the 9th January 2021 his condition had deteriorated, and his son was contacted by staff to visit his father who was being cared for in a side room on the Ward. He spent some time with his father and then left the Trust, planning to return later in the evening. On his return he found that his father had passed away.

2.4 The son reflects how staff awareness of the Swan symbol could have been better and how tools such as the patient radio could be used more appropriately to benefit the patient if their needs are considered.

2.5 The patient's son describes how he feels that barriers in communication and contact with his family impacted upon his father's deterioration.

3.0 Actions

3.1 Following this patient story being shared the subsequent actions have been taken:

- The son's story has been shared with the ward team to support reflection and learning
- The digital story will be shared in a range of meetings across the Trust to share the feedback, raise awareness and enable learning to be taken
- 71 mobile telephones were obtained in February 2021 and provided to all inpatient areas across the Trust
- The importance of supporting patients in contacting people important to them by telephone or through a virtual visit was reinforced to Ward and Department Managers
- The son's digital story is being incorporated into Championing End of Life Care training to raise awareness throughout the Trust
- Compassionate visiting has been reinforced across inpatient areas to provide clarity and ensure that support is in place for patients and those important to them who meet the criteria
- Inpatient areas have been risk assessed by the clinical, Infection Control and Health and Safety Teams to identify measures to support the reintroduction of visiting
- A pilot to reintroduce visiting across the Trust is due to commence on two wards in November 2021

4.0 Conclusion

4.1 The Board is asked to listen to the son's story and note the work being undertaken to learn from feedback from people accessing services within the Trust to improve future patient and carer experience.

The Shrewsbury and Telford Hospital NHS Trust
Board of Directors' meeting in PUBLIC

Thursday 7 October 2021 via MS Teams (and live streamed to a public audience)

MINUTES

Name	Title
MEMBERS	
Dr C McMahon	Chair
Mrs L Barnett	Chief Executive
Mrs T Boughey	Non-Executive Director
Mr A Bristlin	Non-Executive Director
Mr D Brown	Non-Executive Director
Prof C Deadman	Non-Executive Director
Mrs H Flavell	Director of Nursing
Dr J Jones	Acting Medical Director
Dr D Lee	Non-Executive Director
Mr N Lee	Chief Operating Officer
Prof T Purt	Non-Executive Director
Mrs H Troalen	Director of Finance
IN ATTENDANCE	
Ms R Boyode	Director of People and OD
Ms A Milanec	Director of Governance & Communications
Mr C Preston	Interim Deputy Chief Executive
Mr M Wright	Programme Director, Maternity Assurance
Mrs J Clarke	Director of Public Participation *In attendance for Agenda Item 245/21*
Ms E Wilkins	Deputy Director of People & OD *In attendance for Agenda Item 256/21*
Ms K Parkash Mr D Cousins	Equality, Diversity & Inclusion Lead Assistant Director, Leadership, Workforce & Education *In attendance for Agenda Item 257/21*
Ms B Barnes	Board Secretariat (Minutes)
APOLOGIES	
No formal apologies were received, but Mr Steyn, Co-Medical Director and Ms West, Improvement Director, were unable to attend the meeting.	

No.	ITEM	ACTION
PROCEDURAL ITEMS		
234/21	**Welcome, Introductions and Apologies** The Chair welcomed all those present, and observing members of the public attending the meeting via the live stream. No formal apologies had been received. Dr McMahon referred to the recent internal announcement from the Chief Executive relating to Dr Rose who, following discussions, had stepped down as Medical Director with effect from 30 September 2021. Dr Rose remained a valued employee of the Trust and he was being supported to commence a secondment at University Hospitals Derby and Burton in their Emergency Departments, during which he wished to refocus on his clinical work and revalidate as a doctor. Dr Rose was looking forward to resuming his clinical work and contributing, in the future, within the Trust's Emergency Department. The Board of Directors wished to express its gratitude to Dr Rose for his hard work, and everything he and his teams had done for the Trust, especially regarding the COVID-19 effort. In the meantime, the chair confirmed that Dr John Jones would continue as Acting Medical Director (with Board voting rights), and Mr Steyn would continue as Co-Medical Director, until a recruitment strategy had been finalised.	
235/21	**Staff Story** The Director of Governance & Communications introduced Beth, an Occupational Therapist, who joined the meeting to talk about her experience of using the Freedom to Speak Up (FTSU) process, and how it led to her becoming one of the Trust's FTSU ambassadors. Ms Milanec confirmed that this was the first FTSU staff story to come to Board and was being heard as part of the celebrations and awareness raising for October's 'freedom to speak up' month. Beth explained that she and a colleague had unfortunately been subjected to derogatory comments by another member of staff with regard to how they had dealt with a patient, which were shouted across a ward, in front of countless other colleagues. Beth and her colleague were very embarrassed and shocked at such behaviour, and continued to feel upset throughout that evening. Unfortunately, the same individual repeated this behaviour the following day, and whilst Beth and her colleague tried to calmly explain the reasoning for their actions, they were not listened to. This resulted in them becoming very disheartened, in addition to feeling the verbal	

	abuse they had been subjected to had impacted upon their professional identity. At this point, they decided to speak to the Acting Lead FTSU Guardian. The Lead Guardian arranged to meet with them the following morning, and upon listening to the issues they raised, Beth and her colleague received assurance that their concerns would be raised promptly. The Lead Guardian also offered to 'check in' with them regularly from that point to see how they were doing. The end result was that Beth and her colleague received a written apology from the individual concerned, and other colleagues have now gained greater awareness of the effectiveness of the therapy role. The responsiveness and understanding they received from sharing their experience and concerns inspired Beth to become a FTSU ambassador, as she felt she needed to encourage and support colleagues whose voices may not be heard. Beth also highlighted the dramatic difference she had seen over the last year around the awareness of FTSU. Discussion followed on what actions were being taken as a Trust, and what further could be done, to support colleagues who observed, or were the recipients of, unacceptable behaviour, and promote the message that it is 'okay to speak up'. The following key points were covered: • All Leaders were invited to development sessions, which included participating in difficult conversations; • In parallel, the Trust ensured Leaders were supported when dealing with difficult situations; • The FTSU message would be further built upon through the Trust's cultural programme; and • Induction and training programmes would include real examples and sharing of experiences The Board of Directors thanked Beth for taking the time to share her story, and was pleased to note and take assurance from the work being undertaken to embed the value of FTSU across the Trust, to improve patient and staff experience.	
236/21	**Quorum** The Chair declared the meeting quorate.	
237/21	**Declarations of Conflicts of Interest** No conflicts of interest were declared that were not already declared on the register. The Chair reminded the Board of Directors of the need to highlight any interests which may arise during the meeting.	

238/21	**Minutes of the previous meeting** The minutes of the meeting held on 5 August 2021 were approved by the Board of Directors as an accurate record, subject to the following minor correction: Item 216/21 IPR – Quality Summary: Second paragraph to be amended to 'Mrs Flavell was pleased to advise on areas of positive feedback from the CQC and confirmed with regard to areas for improvement, that the Trust was already aware of the issues which had been raised'.	
239/21	**Action Log** The Board of Directors reviewed the action log, and agreed with the recommendation to close the action against agenda item 222/21 of the meeting of 5 August 2021. Mr Wright clarified that there is now a formal Maternity Transformation Plan (MTP) Risk Register, managed by the Maternity Transformation Group. There were no further due or outstanding actions.	
240/21	**Matters Arising** There were no matters raised which were not already covered in the action log or agenda.	
STRATEGIC MATTERS		
241/21	**Report from the Chair** The Board of Directors received a verbal report from the Chair, and noted that Dr McMahon had no additional items to raise at this meeting which were not already covered in subsequent reports.	
242/21	**Report from the Chief Executive** The Board of Directors received a verbal report from the Chief Executive, and noted that Mrs Barnett had no additional items to raise at this meeting which were not already covered in subsequent reports.	
243/21	**Estates Plan** The Board of Directors received a verbal report from the Director of Finance. Mrs Troalen apologised that the Estates Plan had not been finalised in time for this meeting due to other interdependencies which required further work. The Board of Directors noted that the Plan would be included on the agenda of the November Board meeting in Public, along with a Hospitals Transformation Programme (HTP) report.	

244/21	**Green Plan** The Board of Directors received the report from the Director of Finance. Mrs Troalen clarified that the Green Plan was a successor to the Sustainable Development Management Plan (SDMP) and set out what the Trust needed to do over the next five years to further enhance its sustainability programme in continuing on the carbon net zero journey. The Board of Directors approved the Green Plan for publication on the Trust's website, subject to Finance and Performance Assurance Committee (FPAC) approval of the requested inclusion of strengthened wording with regard to the ICS interface, to recognise pledges from all providers within the system.	
245/21	**Public Participation Plan** *Mrs Clarke joined the meeting.* The Board of Directors received the report from the Director of Public Participation. Mrs Clarke advised that the 2021-2026 Plan strongly reflected the first of the Trust Values of 'Partnering', and outlined how colleagues in Clinical Divisions would be supported in engaging and involving the public, thus increasing community involvement in all aspects of service planning and delivery. It was noted that the Public Participation Plan had been shared with the wider ICS network, and that the ICS Head of Communications and Engagement was leading on the coordination of developments and activities across the system. The Board of Directors approved the Public Participation Plan, and looked forward to future quarterly updates. *Mrs Clarke left the meeting.*	
QUALITY AND PERFORMANCE MATTERS		
246/21	**Integrated Performance Report (IPR)** The Board of Directors received the report from the Chief Executive, who referred to her executive colleagues in order to provide more detailed information for the Board. **Quality Summary** The Director of Nursing, Mrs Flavell, referred the Board of Directors to the full detail contained within the Quality Section of the IPR, and provided a summary of some of the key points: • The number of falls continued to remain an area of concern, which were consistently higher than the improvement target, and quality standards continued to be a particular area of focus;	

- The response time for complaints remained unsatisfactory. Trajectories had been set for each Division which were being monitored weekly, and Mrs Flavell was encouraging her senior teams to communicate in person with complainants from the outset;
- There had been eight serious incidents (SIs) during the reporting month, with a number of those reported in the Women and Children's Division. The Division had 50% of the open SIs. No SIs were overdue for closure.

Workforce Summary
The Director of People & OD, Ms Boyode, reported on the following key points:

- The annual Junior Doctor induction had taken place during August, with 136 new Doctors joining the Trust, and many others rotating internally;
- Overall workforce growth had continued to increase however was below plan due to delays with the 2021 international recruitment programme. The Trust expected the arrival of a further 84 nurses before Christmas 2021, and recruitment was underway of an additional 45 nurses who it was hoped would join by February 2022;
- COVID-19 related absence continued at high levels with increasing numbers of staff and household members testing positive and requiring to isolate;
- Noting that work life balance had been identified as one of the key reasons for staff leaving, Ms Boyode advised of her intention to ensure that more flexible monthly working hours and limited days per month were implemented.

Operational Summary
The Chief Operating Officer, Mr Lee, provided a summary of the following key points, referring the Board of Directors to the fuller detail contained in the IPR:

- COVID-19 activity had risen once again, and both sites maintained a COVID-19 ward for high risk and COVID-19 patients;
- Flow through the Emergency Departments (EDs) had been very pressured at times over the month, due to the volume of demand at peak periods, workforce pressures, and flow to and out of wards on both sites;
- The Trust was working across the health and care system on the whole system patient flow;
- Cancer pathways were under significant pressure, with some specialist workforce challenges, and also capacity pressures, especially in Imaging. The Trust had secured mobile CT capacity for the next six months to assist with the capacity pressures.

Finance Summary
The Director of Finance, Mrs Troalen, highlighted the following key points:

	• The Trust reported a deficit of £4.196m after five months of the 2021/22 reporting period. This position was £1.672m adverse to the Year to Date (YTD) plan, which continued to be driven by the impact of the delivery of the Elective Recovery Fund (ERF); • The Trust had incurred £3.939m of expenditure cumulatively associated with the elective recovery programme, with £2.215m of income estimated to be achieved YTD, leaving a shortfall of £1.724m. System leaders were aware of this pressure, largely driven by the change in the thresholds at short notice. To date no mitigation action had been requested by NHSE; • The Board of Directors were referred to further detailed commentary within the report on the Trust's financial position **Transformation Summary** Mrs Troalen reported on the following key points: • The majority of the nine programmes within the Getting to Good Programme were progressing well; • It was noted that governance and risk management were key areas of concern, and work was underway on key actions to unblock barriers, in particular resource; • A request to report outcomes rather than milestones was noted, and Mrs Troalen undertook to consider how that could be built into reporting going forward. The Board of Directors noted the Integrated Performance Report.	
247/21	**Serious Incidents (SI) Oversight Report** The Board of Directors received the report presented by the Acting Medical Director and Director of Nursing. It was noted that the report highlighted the patient safety development and forthcoming actions for October/November 2021 for oversight; an overview of the SI reporting rates year to date; and detail of the number and themes of newly reported and closed incidents; together with the number of current open SIs. The Board of Directors acknowledged that the report was in its infancy, and were invited to provide feedback on how it could be developed going forward, with particular regard to capturing learning outcomes. The Board of Directors noted the report, and welcomes the openness and transparency it provided through presentation to the Board meeting held in public.	
248/21	**Safeguarding Annual Report** The Board of Directors received the report from the Director of Nursing. Mrs Flavell highlighted the following key points:	

	• There had been an increase in the number of Deprivation of Liberty Safeguards (DoLS) applications made for patients in the Trust's care; • There had been improvements in monthly Safeguarding audits; and • Ongoing work continued to improve compliance with Level 3 Adult Safeguarding and MCA/DoLS training The Board of Directors was advised of the recognised need to strengthen safeguarding processes for Children & Young People (C&YP), and the work that was underway in this regard. The Board of Directors noted the report.	
ASSURANCE FRAMEWORK		
249/21	**The Ockenden Report - Progress Report** The Board of Directors received the report, providing an update to the Trust's Ockenden Report Action Plan and other related matters. The following points were highlighted: • The number of actions delivered currently stood at 31 out of 52, ie 60%; • The Board of Directors was referred to the commentary within the report detailing the five actions that were currently off track, with assurance provided that work continued with the aim of addressing them; • Assurance was also provided that the action plan was reviewed and discussed at depth in the Ockenden Report Assurance Committee (ORAC) which was live streamed in public. The Board of Directors noted and took assurance from the report.	
250/21	**Ockenden Report Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Co-Chair, covering the sixth live streamed meeting of the committee which had been held on 23 September 2021. Dr McMahon highlighted that Mr Steyn, Co-Medical Director, was meeting with Dr Lorien Branfield (Consultant Anaesthetist) to determine what additional executive and medical leadership support could be provided, following the issues covered in the July meeting.	
251/21	**Guardian of Safe Working Hours (GoSW) Report** The Board of Directors received the report from the Acting Medical Director on behalf of Dr Bridget Barrowclough, GoSW, who was unable to attend the meeting.	

	Discussion took place on the following points: • During Q4 concerns regarding the working practice of Foundation trainees had been escalated to the Surgery Divisional Director and Medical Directorate. Themes had been raised of working outside of rostered hours, workload weekend activity, missed educational opportunities, lack of Junior Doctor Forums and the perceived inability to Exception report. Assurance was provided that a considerable amount of work had taken place to address the concerns, and actions had been taken which would be reflected in future reports; • It was noted that a comprehensive review of rostering was taking place. Once complete, Dr Jones would provide greater clarity around the reasons for the trainees who had exceeded the average 48 hour weekly limited and had not opted out of Working Time Regulations (WTR), and assurance that clinical safety was being addressed. The Board of Directors noted and took assurance from the report.	
252/21	**Emergency Preparedness, Resilience and Response (EPRR) assurance process sign off** The Board of Directors received the report from the Chief Operating Officer, providing an overview of the Trust's EPRR statutory requirements. The Board of Directors noted the following: • The Trust's current compliance against the NHSE Core Standards for EPRR; • The training and exercising programme for 2020/21; and • The national learning lessons from the first wave of the pandemic along with other concurrent disruptive challenges that the Trust had managed The Board of Directors approved the EPRR report.	
253/21	**Audit and Risk Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Chair. Prof Purt drew the attention of the Board of Directors to the Alert section of the report, and in particular the lack of progress against completion of internal audit recommendations. Mrs Barnett reiterated executive commitment to ensuring the process was improved and audit actions closed down.	
254/21	**Finance and Performance Assurance Committee Monthly Report**	

	The Board of Directors received and noted the report, presented by the Committee Chair. Prof Deadman expressed his concern in particular around the operational pressures which had been discussed at the meeting, and the Winter challenges ahead. It was noted, by way of assurance, that the Winter Plan had been helpful in providing details such as mutual support, and focus on the issues which included a resolve to support acute pressures.	
255/21	**Quality and Safety Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Deputy Committee Chair. Ms Boughey highlighted that the Committee had been disappointed to note the operational issues with the newly introduced Badgernet system within maternity. It was noted that Midwifery management were mitigating this using manual recording, with staff being asked to record any instances in Datix to support monitoring.	
256/21	**Policies for Approval** *Ms Wilkins joined the meeting.* Updated Trust Disciplinary and Employee Investigations Policies were presented for approval by Ms Wilkins, Deputy Director of People & OD. It was noted that improvements had been made to the policies in light of recommendations from Baroness Dido Harding and, more recently, the NHS Chief People Officer. The improvements to these policies were in line with the Trust's People Strategy ambitions to support wellbeing, improve staff engagement and retain great people. Subject to some minor changes highlighted during discussion, the Board of Directors approved the Trust Disciplinary and Employee Investigations Policies. *Ms Wilkins left the meeting.*	
REGULATORY AND STATUTORY REPORTING		
257/21	**Equality Diversity & Inclusion Reports** *Ms Parkash, ED&I Lead and Mr Cousins, Assistant Director, Leadership, Workforce and Education joined the meeting.* The Board of Directors received the following reports: • Annual EDI Report • Gender Pay Report • Workforce Disability Equality Standard Report (DRES)	

	• Workforce Race Equality Standard Report (WRES) It was noted that the Equality Reports were based on the Trust's ESR data and NHS Staff Survey results, and Staff Networks had worked alongside the EDI Lead to develop the action plans. The Board of Directors acknowledged with thanks the work that had been undertaken on the Trust's ED&I agenda, and expressed their appreciation in particular to Ms Parkash for her commitment during her time at the Trust, wishing her well in her next opportunity. The Board of Directors approved all of the above reports for publication on the Trust's website. *Ms Parkash and Mr Cousins left the meeting.*	
PROCEDURAL ITEMS		
258/21	**Any Other Business** • The Chair advised that the Trust's live streamed virtual Annual General Meeting (AGM) would take place on Tuesday 26 October 2021 at 2pm. Details were available on the Trust's website, and members of the public were invited to submit any questions on the Annual Report and Accounts 2020/2021, in advance, via the website.	
259/21	**Date and Time of Next Meeting** **The next meeting of the Board of Directors was scheduled for Thursday 11 November 2021, commencing at 1300hrs. The meeting would be live streamed to the public.**	
STAKEHOLDER ENGAGEMENT		
260/21	**Questions received from the public** The Chair reminded observing members of the public that questions were welcome on any items covered in today's meeting, which could be submitted via the Trust's website. Dr McMahon confirmed that responses were provided to individual questionners, in addition to the publication of the Questions and Answers on the Trust website. Dr McMahon stressed the importance of the Trust receiving questions from the public as they helped to quantify the content of Board meetings. Dr McMahon clarified that all questions were tracked to identify themes, which would be included in the Trust's Public Participation Plan.	

	Analysis of the themes would also be included in a quarterly report to the Board of Directors.	
The meeting was declared closed.		

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11th November 2021

Agenda item	268/21			
Report	Estates Plan			
Executive Lead	Executive Director of Finance			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	
	Our partners		Responsive	
	Our governance		Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 5 / BAF 6	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion		1075	
	For noting			
	For information			
	For consent			
Presented to:	SaTH Leadership Committee – Transformational 16.9.21 Finance and Performance Assurance Committee 28.9.21 – recommended for approval			
Dependent upon (if applicable)**:**	Completion of options appraisal for 5 year capital programme prioritisation exercise currently underway with the support of HTP team.			
Executive summary:	The Estates Plan is subject to agreement of the 5 year strategic capital programme of works linked to agreed operational and strategic priorities and subject to approval of HTP SOC option. There is also ongoing work around the clinical services strategy that is being finalised while considering expediting a number NHSI for bids against regional allocation in 21/22 and 22/23. In conjunction with this work a Trust-wide review of space utilisation, focusing on zoning and clinical adjacencies has now been completed and will inform future decisions around occupancy. The Board of Directors are asked to note the contents of the paper and approve the Estates Plan as it is currently presented, noting that this is subject to change.			
Appendices	Appendix 1: Can be found in the supplementary board pack			
Lead Executive:				

1.0 Introduction

A review of the strategic 5-year capital programme is now progressing in line with capacity planning and alignment and subject to approval of HTP SOC option. Further review would be required to the Estates Plan. This "domino" effect will provide an integrated and joined up approach to estates developments aligning with the future approved HTP SOC solution and the capital programme.

2.0 Estates Plan Contents

The Estates Plan covers the following areas of estate planning and performance. It is important to note that often the focus is on new capital schemes but it is essential that we also focus on the critical issue of a safe and effective environment through addressing the important issue of backlog maintenance.

2.1 Total Backlog Liability / 5- Year Backlog Programme (breakdown below)

Backlog reported in ERIC 19/20 (Estates Return Information Collection) is approximately £55M. The total gross backlog liability covering the next five years is estimated at £96m. The Estates backlog survey is refreshed yearly to ensure that the latest condition information is captured. The backlog survey for FY20/21 is now complete and updated ERIC submission has been made. The current backlog position is shown graphically at RSH on slide 7 (along with current planned projects to address the critical areas on slides 8/9). The PRH position is shown slide 15 (with the current planned programme on slide 16).

The total 5-year backlog programme funding availability over the coming five years is estimated at £25m approximately. This equates to £5m/yr investment in estates backlog depending on CRL and central funding for Critical Infrastructure. The Trust successfully bid for Critical infrastructure funding of £5.6m FY20/21 the works for which is being successfully delivered.

An estimated investment of £1.5m will be required to address need to replace SSD autoclaves is included in the Estates backlog programme and will be spread over a 3 years.

Ventilation upgrades will continue to be a focus over the coming 5 years to address areas of high risk. A ventilation survey is underway to cover patient areas on both sites. It has become apparent that over the years rooms have had their purpose changed without involving Estates and subsequently may not be compliant with HTMs/HBNs etc in term of air changes p/min. An estimated £1.2m/yr investment on ventilation Air Handling Units (AHUs) is planned to ensure compliance.

Continued investment in steam main repairs and calorifiers will be required with £0.4-0.5m earmarked per annum.

Investment in the Building Management System (BMS) will be required in FY21/22 and is estimated at £0.6m. This is required due to the obsolescence of the existing system due to parts unavailability and the need to shift to an open protocol system. This will provide an intelligent system that links to other systems as well as heating and security ventilation.

Electrical infrastructure replacements include UPS / IPS (Uninterrupted Power Supply batteries) equating to £0.3m/yr. Additionally investment in nurse call systems

(£0.1m/yr) will be needed as wards have changed designation of rooms and some areas are not linked or audible, which clearly presents patient risk.

A total of £0.3m/yr has been earmarked to address fire compliance; £0.15m for alarms and detectors with another £0.15m for compartmentation. Roughly £0.15m has been earmarked for asbestos removal focussing on debris and areas with potential deterioration.

A separate £0.5m has been identified in FY 21/22 for subway duct structural work and asbestos removal.

Building fabric investment in floors (£0.15m/yr), roof replacements (£0.35m/yr) and windows replacements (£0.1m/yr) are also planned.

Slides 24 and 25 show the detail around the current five year capital plan, subject to approval.

2.2 5-Year Strategic Project Plan

A large number of capital schemes will be delivered by the end of 20/21, which is far in excess of any investment in recent years. A total of **£22.65m of centrally funded investment** across **FY 20/21 (£10m)** and **FY 21/22 (£12.65m)** is being delivered. These are covered in slides 10 and 19-23 and are as follows:

1. Modular SDEC (RSH) £3m
2. Ward 36 (PAU PRH) £2m
3. Fracture Clinic (RSH) £1.75m
4. SAU(RSH) £1.7m
5. SAU Office Accommodation £0.9m
6. MRI-CT(RSH) £3.5m
7. Modular Offices – Ironbridge Suite (PRH) £0.5m – Ironbridge Suite
8. A&E Refurbishment £9.3m

All projects identified above are now complete apart from A&E Refurbishment £9.3m.

2021/22

RSH A&E refurbishment commenced in April 21 and is being phased, with main clinical space delivered by Dec 21 and project fully complete by March 22. These timings have been agreed with NHSI.

RSH MRI/CT ground works commenced in March 21 and was completed in August 21.

Work has also been completed to fit-out the **Ironbridge Suite** at PRH which is a new 60-desk office modular located adjacent to the pre-existing Malling Health modular.

The **Malling Health** building and land is in the process of being transferred to the Trust from NHS Property Services via a **zero cost** asset transfer process. The PRH land housing the rear car park and helipad is also being legally transferred from NHS Property Services following an uncompleted Transfer in 2013/14 when the Women & Children's centre transferred from RSH to PRH.

Proposals for a developer-funded new two-storey **commercial front entrance at PRH** are currently being worked-up. This development would house retail offerings and waiting space for patients and staff and potentially create additional capacity on the second floor by re-providing the Education Centre which is located within a ward

template. It would also demonstrate our continued investment in the Princess Royal Hospital.

Estates have successfully completed and handed over **Ophthalmology department (Cataract Suite) in Ward 20** and **W18 fire compartmentation** works in the **Copthorne building was complete in April 21**.

Bids against NHSI capital allocations to create additional capacity in 21/22 are in development. Currently this includes providing **modular ward(s) at RSH**, **and the PRH Renal Dialysis Unit moving off-site** to create a 20-bedded ward, with the **PRH Cardio-respiratory service moving to an on-site modular building to release the 10-bedded en-suite Apley Ward** to use as an isolation /infectious diseases ward. We are currently awaiting feedback form the centre.

HTP SOC proposals are still being processed and for this purpose the Estates Plan cannot be finalised until this work is completed and aligned with the current site review of clinical adjacencies and space maximisation. Clinical service plans will be revisited and Strategic Projects programme will adapt to the services plan as it is developed.

Options that are being investigated within estates for RSH and PRH are shown on slides 26 and 27 respectively, but are subject to the finalisation of the five year capital plan.

2.3 Sustainability

The Trust, along with all NHS organisations, commits to delivering the NHS plan of a 'Net Zero Carbon Health Service' by 2040. The Trust will adopt the Net Zero Carbon Standard when it is released. In order to deliver the aspirations of the health services estates nationally, the Trust will need to **'Green Plan' and 'Heat Decarbonisation Plan'**, both of which are currently being progressed. This will include construction standards, energy, waste and transport. The Trust has a multi-professional Good Corporate Citizen Group that has been in place for many years, led by the Director of Corporate Services.

The Estates department has already been investing in sustainable technologies where possible as part of backlog investment and on occasion via central funded grants. To date there has been considerable investment in **LED lighting, building management systems (BMS) controls, steam calorifiers, motor controls as well as u-value** building fabric improvements including **window replacements**. Helpfully energy consumption savings have been identified as a CIP where there is an element of investing to save. In order to deliver higher carbon reductions investment a new energy centre will be required and is subject to Salix PSDS funding (Public Sector Decarbonisation Scheme) application is being developed.

With reduced reliance on fossil fuels, additional electrical power capacity will be required to both sites to offset carbon base energy generation. Estates are working closely with system partners to deliver the sustainability aspirations for the STW STP. A business case to introduce a revenue-neutral electrical vehicles charging points as now been approved. It is recognised that "plug-in" vehicles now represent 10% of all new car sales.

Details of the Trust's sustainability agenda can be found on slides 29-33 of the Plan.

2.4 Model Hospital

Slides 35-37 cover the Trust's performance in terms of Estates and Facilities Costs per metre squared.

Estates and Facilities performs generally well in Model Hospital with the exception of critical infrastructure risk (backlog maintenance) and hard facilities management (FM) costs including waste. Due to issues with the national waste contracts cessation, SaTH has incurred significant extra costs due to the temporary waste contract implemented by NHSI, however a new clinical waste contract has been awarded from April 2021 so these figures will significantly reduce.

Space Management

Slide 36 and 37 refers to the amount of empty and under-utilised space at SATH, which is higher compared to our peers. This has been largely as a result of works underway in the Copthorne building and empty RSH residence blocks which will be updated with next model hospital information output.

A number of areas of accommodations are expected to come into play over the next five years.

In FY 21/22 **145m2 of Mytton Oak** will be vacated when the MLU moves back into Copthorne W18. This could be considered as alternative accommodation for Therapy Services which are currently located on the William Farr site as their current accommodation is not satisfactory. This will be dependent on a wider review of ongoing service provision.

In addition the **Faculty of Health Building and Learning Centre** on the RSH site lease will end in FY 24/25 meaning this building could be used for other services, although it is likely that Staffordshire University will wish to extend the Lease to provide nurse training on-site. Currently they pay a peppercorn rent and should the lease be re-negotiated a commercial rent will be set. The services SLA is also being reviewed currently as it does not meet current costs incurred by SaTH.

There is a business case being developed for Phase 2 which involves moving the Renal Dialysis Unit across to Ward 35 at RSH.

The **old nurse residence** at the back of the RSH site continues to be under used. Estates have brought some of these areas back into use due to urgent need for office space during COVID-19. The Trust is also paying a **200% council tax premium** on these empty building of around **£60k pa**.

2.5 Compliance

Slides 38-41 cover Estates compliance, which previously has been very poor largely due to gaps in the estates compliance structure as well as having a lack of compliance reporting framework. This is now gradually improving since approval was given for additional compliance resources (APs) and the setup of compliance reporting with the different estates disciplines (elect/vent/water /decon/fire/asbestos/PSSR/ lifts/med gas). The estates structure still suffers from lack of CP roles, for which a business case for five Band 5s has been submitted. This would be revenue neutral as there would be a concomitant reduction in external contractors who currently provide services. Estates also has an aging workforce and the Directorate is working closely with the Trust's Apprenticeship Lead to maximise support available from the national Apprenticeship Levy in 2021/22.

Estates statutory and mandatory maintenance (PPM) has **averaged 64%**. Estates are targeting increase to **80% by December 2021**. (One year ago it was under 40%). This means that planned maintenance is delayed, increasing the risk of failure. It should be noted that PPM delivery is inversely proportionate to reactive maintenance due to limited resources, i.e. if there is an increase in reactive requests PPMs are adversely affected.

Estates led the **PAM (Premises Assurance Model) audit** in 2020. Overall **PAM compliance** achieved was **65%** with the **target** that this increases to **80% by December 2021** due to improved efficiencies and the investment in some key estates infrastructure**.**
The appointment of an estates compliance manager has significantly improved compliance reporting and monitoring and provided assurance around policy and procedure updates.

2.6 ICS / STP Estates Group

Slides 42-46 cover the wider system co-ordination and the work being led by the ICS/STP Estates forum. The SATH Estates department has been engaging with the ICS system partners to ensure alignment of system capital plans and better work collaboratively. While the system's meetings were paused due to COVID-19 pandemic they have now recommenced.

The SaTH Estates Lead (Associate Director of Estates) will be taking a lead role in organising and supporting ICS Estates Group to ensure that the necessary estates work is managed and supported by all stakeholders.

The Cavell Centre is one of a number of community hubs proposed to house such activities and SaTH is working closely with partners as options are being developed.

3.0 Risks and actions

Risk	Action	Lead
1. Lack of alignment with HTP	Once HTP SOC option is approved, co-ordination of 5 year programme will be required	WN – AD Estates & Hospital Site Transformation / HTP Programme Dir
2. Scarce NHS capital	Ensure viable VFM options are included in business case and bid submissions	WN – AD Estates & Hospital Site Transformation / AEM – Strategic Capital Programme Manager Nigel Lee - CFO
3. Estates capacity to undertake projects	Ensure forward planning of estates resources and reporting structures with regular delivery updates over 12-24 months period.	WN – AD Estates & HTP Transformation
4. Under-invested compliance structure eg CPs	12 months forward planning of contractor(s) needs to be included in budget setting	WN – Estates & Hpt Transformation PP – Estates Finance Lead
5. Zero Carbon NHS by 2040	Commission 'Green Plan' and 'Zero Carbon Plan' and define roadmap to zero carbon at SaTH. Work with system partners to ensure sufficient power in the grid to enable the zero carbon transformation	WN – Estates & Hpt Transformation TH – Sustainability Lead
6. Energy Centre Contract	Energy centre contract coming to end. The contract will need to be extended before the construction of the energy centre. New energy centre will need to be designed according to the site decarbonisation plans.	WN – Estates & Hpt Transformation TH – Sustainability Lead

4.0 Conclusion

The Estates Plan is partially dependent on HTP programme of works and will therefore be updated as HTP SOC and OBC approvals come through.

The Board of Directors are asked to note the contents of the paper and approve the Estates Plan as it is currently presented, noting that this is subject to change.

Helen Troalen
Executive Director of Finance
October 2021

Board of Directors' Meeting
11 November 2021

Agenda item	269/21			
Report	Hospitals Transformation Programme (HTP) Report			
Executive Lead	Chris Preston – Interim Deputy Chief Executive			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		1,2,3,5,6,8,9	
	For decision / approval		**Link to risk register:**	
	For review / discussion		1429, 1430, 1436, 1438, 1439, 1440, 1769, 1998, 2000, 2020, 2060, 2132, 2156, 2157	
	For noting			
	For information	√		
	For consent			
Presented to:	Circulated to HTP Committee members virtually (3 November 2021)			
Dependent upon (if applicable)**:**				
Executive summary:	This paper provides an update on the progress that has been made since the last HTP public Trust Board paper in July 2021. Since then, further work has continued at pace to finalise the draft SOC and to begin discussions with regulatory bodies about both the content and the approval process. Last month, the Shropshire, Telford, and Wrekin CCG Governing Body and the Shropshire, Telford, and Wrekin Integrated Care System provided formal letters of support for the draft Strategic Outline Case (SOC). After receiving these letters of support, the Trust Board also reviewed the draft SOC and supported submission to NHSEI for review and approval. The draft SOC has now been submitted to NHSEI for regional and national approval and when approved, a summary of the content will be made available. The Board of Directors are requested to **NOTE** the content of this paper.			
Appendices	N/A			
				

1. Introduction

This paper provides an update on the progress that has been made since the last HTP public Trust Board paper in July 2021.

The draft SOC has been finalised over the last few months through a detailed process of options development and appraisal. The work has been completed with the close involvement, input, and oversight of the HTP Programme Board, which includes members from key system-wide stakeholders. It has also been subject to internal scrutiny, particularly through the HTP Committee and SaTH Trust Board, providing further challenge on the detailed proposals.

Last month, the Shropshire, Telford, and Wrekin CCG Governing Body and the Shropshire, Telford, and Wrekin Integrated Care System provided formal letters of support for the draft Strategic Outline Case (SOC). After receiving these letters of support, the Trust Board reviewed the draft SOC and supported submission to NHSEI for review and approval.

The draft SOC has now been submitted to NHSEI for regional and national approval. When it has been approved, a summary of the content will be made available, in line with national protocols.

The Trust is working closely with regulatory colleagues to ensure that the review process is as short as possible.

2. Developing the Strategic Outline Case (SOC)

The development of the revised Strategic Outline case is the latest stage in implementing the Future Fit consultation decision to reconfigure services across the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH).

During the finalisation of the draft SOC, we have carefully considered the strategic context and case for change to make sure it remains fully aligned with the configuration confirmed through the Future Fit consultation, which was ratified by the Secretary of State for Health and Social Care, and also remains fit for purpose in today's environment.

As previously set out in the Future Fit consultation and approved Decision-making Business Case (DMBC), the current clinical service configuration does not meet the needs of patients. The Trust has two inadequately sized Emergency Departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly impacting planned care services), mixing of planned and unplanned care pathways and poor clinical adjacencies. If the reconfiguration does not progress, there is a real and increasing risk to the quality, availability, and continuity of core clinical services at both the Shrewsbury and Telford hospital sites.

The new clinical service model proposed in the draft SOC establishes an emergency care centre on the Shrewsbury site and a planned care centre on the Telford site. Both hospitals will also provide 24/7 urgent care services. The new clinical service model will ensure that most people will continue to receive their care at their local site and that all our communities will benefit from improvements to the quality of care provided.

In line with national guidance, we have considered a range of options to deliver the agreed configuration of services that offer the best value for the taxpayer and local communities. The options that have been considered have undergone a robust appraisal against a range of critical success factors, both qualitative and quantitative.

The draft strategic outline case (SOC) is seeking approval from NHSE/I to proceed with an accelerated delivery option (the preferred way forward) that will involve a rapid approval process and early access to a proportion of the capital funding. The draft SOC has been developed in line with the latest relevant national guidance and is in line with the standard gateway process for NHS investment.

3. Support for the Strategic Outline Case

Following consideration of the draft SOC, a letter of support was received by SaTH from the Shropshire, Telford, and Wrekin CCG Governing Body on 29 September 2021 and subsequently from the Shropshire, Telford, and Wrekin Integrated Care System.

In their letters of support, both bodies recognised the importance of the Hospitals Transformation Programme in contributing to improved care for patients and welcomed the proposals to accelerate elements of the programme if funding could be secured to do so.

Both bodies supported the recommended way forward and both the CCG and ICS noted that further detailed work will be undertaken as part of the Outline Business Case (OBC) and Full Business Case (FBC) stages:

- Ensuring ongoing alignment of the activity and other key assumptions within the SOC and the OBC with those set out in the NHS Long Term Plan (LTP)
- Putting in place any further infection prevention measures if needed in the longer term because of the COVID19 pandemic and any learning taken from our experience of caring for patients safely during this time
- Further detailed work around the options for delivery of the scheme and the financial affordability for SaTH and for the STW system recognising the need to achieve a balanced position across the system
- Delivering robust and ambitious workforce transformation plans across the system and appropriate new or expanded roles
- Continued alignment with the system's Local Care model and engagement with our wider aspiration for Place Based Care
- Ongoing engagement with the public and patients about what the care model will mean for patients in Shropshire, Telford & Wrekin and mid-Wales.

The CCG governing body, the ICS and other key stakeholders continue to be closely involved in the development of the programme through the HTP Programme Board, the system wide Implementation Oversight Group (IOG) and the ICS Sustainability Committee as well as many other informal groups.

In summary, all key stakeholders supported the full solution with acceleration as the preferred way forward, primarily because this option offers a lower capital cost coupled with earlier quality improvements and significant benefits for patients and the local health system.

4. Next steps

The draft SOC is now being appraised by NHSEI and the DHSC and will be subject to a rigorous assurance review. Once the SOC has been reviewed, it will require formal approval by the national Joint Investment Committee before the case can proceed to the next stage of development.

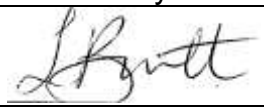
In line with national protocols, when the draft SOC has been approved a summary of the content will be made available.

5. Recommendation

The Board of Directors are requested to **NOTE** the content of this paper.

Board of Directors
November 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	270/21			
Report	Integrated Performance Report			
Executive Lead	**Louise Barnett CEO**			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1,2,3,4,5,7,8 and 9	
	For decision / approval		**Link to risk register:**	
	For review / discussion	√	CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27	
	For noting			
	For information			
	For consent			
Presented to:	SaTH Leadership Committee (Operational) 28.10.21. QSAC 27.10.21. FPAC 2.11.21.			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides the Board with an overview of the performance indicators of the Trust to the end of September 2021. Key performance measures are analysed over time to understand the variation-taking place and the level of assurance that can be inferred from the data. Where performance is below expected levels an exception report has been included that describes the key issues, actions and mitigations being taken to improve the performance. Planned year-end positions have been included in the overall dashboard and planned monthly performance trajectories have been included on a number of the SPC charts. The executive summary is included at the front of the report and metrics reported under functional headings for: Quality, Workforce, Operations, Finance and Transformation.			
Appendices	1. Key Performance Indicators reported where performance is in-line with plan/target. 2. Understanding SPC charts 3..Glossary of terms			
Lead Executives:				

Integrated Performance Report

Purpose

This report provides the Board with an overview of the quality of care and patient safety performance of the Trust. It reports the key performance measures determined by the board using analysis over time to demonstrate the type of variation taking place and the level of assurance that can be taken in relation to the delivery of performance targets. Where performance is below expected levels an exception report is provided. This outlines the key issues, actions and mitigations being progressed to improve the performance. The end of year targets are provisional and will be confirmed when the operational plan is formally approved.

The report is aligned to the Trust's functional domains and includes an overarching executive summary. The measures relevant to the remit of the Quality and Safety and Finance and Performance committees are scrutinised by these committees ahead of the board.

Contents

1. Executive Summary

Louise Barnett, Chief Executive

- October has seen the continuation in the prevalence and number of patients admitted with COVID-19. We are offering COVID-19 boosters and flu vaccinations to our staff and remain vigilant in application of infection prevention and control measures. However, our sickness absence has increased this month in part due to the increased contacts with COVID-19.
- Recruitment of both nursing and medical staff is progressing well, with additional international nurses and radiographers helping to improve service sustainability in hard to recruit areas such as theatres and x-ray. Of particular note are the commencement of 10wte midwives. Staff shortages are significant in a number of areas and actions continue to be taken to optimise these according to the needs and pressures of services.
- The COVID-19 and emergency admissions are resulting in loss of our flexibility which unfortunately is impacting on admissions for routine surgery. To expand our capacity we are using our vanguard theatre throughout the week and insourcing services for day surgery at weekends. We have brought a mobile CT unit back to site to improve time to diagnosis for patients.
- During September and into October, our operational challenges have intensified with significant number of delays to discharges resulting in difficulties in admission of patients to our wards and patients waiting both in our emergency departments and within ambulances to access the emergency department. We are working with system partners to address the bottlenecks to discharge which include shortages in domiciliary care staff in the community leading to delays to care packages for patients. We are facing significant pressures with long waits and further work is in train to improve this position and manage risk as we go into the winter period.
- We are continuing to work as part of the whole system to address the unscheduled care pressures over the forthcoming winter, with schemes which include alternatives to admission and support for discharge of patients.
- In September we opened the new majors' area in the emergency department at Shrewsbury as part of the 1st phase of an expanded emergency department. We have received approval to proceed with the development of an additional 32-bedded ward at Shrewsbury which we aim to have open from April 2022. At Telford a 20-bedded admissions facility is planned.
- Our patients continue to report good experiences through our Friends and Family scores .We are also seeing continuing good scores for cleanliness. We are actively working through multiple routes to appoint additional staff for these important roles.
- Our income and expenditure has been adversely affected by the reduction in the elective recovery and the change in the ERF threshold introduced in July 2021. We are working to finalise our H2 activity plans and looking to balance the needs of our elective recovery with the increasing demands we may face over the winter months. Our efficiency plans continue to show a positive variance in the year to date and are seeking to increase the recurrent element of our efficiency savings.
- Our Phase 2 Getting to Good plans are showing all 9 programmes making progress. Through this we are seeking to improve outcomes for our patients. During September, the CQC undertook a Well-Led inspection. The draft CQC report has been received by

the Trust for factual accuracy checking. The final report will be published by the CQC in due course.

2. Overall Dashboard

Quality - KPI	Scruitinising Committee	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH Year End Plan
Mortality										
HSMR	QSAC	Jun 21	63.8	100	100			No		100
RAMI	QSAC	Sep 21	96.1	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Sep 21	2		<2.3			No	13	28
HCAI - MRSA	QSAC	Sep 21	0	0	0			No	1	0
HCAI - C.Difficile	QSAC	Sep 21	4	<4.08	<2.5			Yes	13	30
HCAI - E-coli	QSAC	Sep 21	4	<10.17	<3.16			Yes	25	38
HCAI - Klebsiella	QSAC	Sep 21	0	2	<1			No	8	13
HCAI - Pseudomonas Aeruginosa	QSAC	Sep 21	0	<0.83	0			No	3	3
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Sep 21	11		<13			No	71	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Sep 21	0.50							tbc
VTE	QSAC	Aug 21	94.2%	95%	95%			Yes		95%
Falls - total	QSAC	Sep 21	118		<89			Yes	652	1074
Falls - per 1000 Bed Days	QSAC	Sep 21	5.4	6.60	<4.5			Yes	5.80	4.50
Falls - with Harm per 1000 Bed Days	QSAC	Sep 21	0.05	0.19	<0.17			No	0.08	0.17
Never Events	QSAC	Sep 21	0	0	0			No	0	0
Coroners Regulation 28s	QSAC	Sep 21	0		0			No	1	0
Serious Incidents	QSAC	Sep 21	10		n/a				50	57
Mixed Sex Breaches	QSAC	Sep 21	30	0	0			Yes	184	tbc
Patient Experience										
Complaints	QSAC	Sep 21	68		<56			Yes	373	672
Complaints Responded within agreed time	QSAC	Jul 21	45%	85%	85%			Yes		85%
Complaints Acknowldeged within agreed time	QSAC	Sep 21	100%		100%			No		100%
Compliments	QSAC	Sep 21	30 letters of thank you received.						265	tbc
Friends and Family Test	QSAC	Sep 21	97.2%	80%	80%			No	93.80%	80.00%
Maternity										
Smoking rate at Delivery	QSAC	Sep 21	11.5%	6.0%	6.0%			Yes	12.5%	6.0%
One to One Care In Labour	QSAC	Sep 21	98.3%	100.0%	100.0%			Yes	99.2%	100.0%
Delivery Suite Acuity	QSAC	Sep 21	50.0%	85.0%	85.0%			Yes		85.0%
Caesarean Sections rate of Robson Group 1 Delive	QSAC	Sep 21	19%	3.4%	3.4%			Yes	16.9%	3.4%
Caesarean Sections rate of Robson Group 2 Delive	QSAC	Sep 21	50.6%	42.0%	42.0%			Yes	42.2%	42.0%
Caesarean Sections rate of Robson Group 5 Delive	QSAC	Sep 21	88.2%	85.0%	85.0%			Yes	74.9%	85.0%

Workforce - KPI		Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Activity										
WTE Employed**Contracted	FPAC	Sep 21	5809		6173			Yes	5809	6173
Total temporary staff -FTE	FPAC	Sep 21	664					Yes		tbc
Staff turnover rate (excludes junior doctors)	FPAC	Sep 21	1.4%	0.8%	0.75%			Yes	1.2%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Sep 21	5.6%		4.00%			Yes	4.9%	4%
Agency Expenditure	FPAC	Sep 21	£2.682m	£2.860m	£2.860m			No	£18.547m	
Appraisal Rate	FPAC	Sep 21	85%	90%	90.0%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Sep 21	88%	90%	90.0%			Yes		90%
Vacancies	FPAC	Jul 21	378(6.5%)	<10%	<10%			No		<10%
Statutory and Mandatory Training	FPAC	Sep 21	85%	90%	90.0%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	Sep 21	76%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	Sep 21	89%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	Sep 21	89%	90%	90%			Yes		90%

Operational - KPI		Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Elective Care										
RTT Waiting list -total size	FPAC	Sep 21	30784 (English)					Yes		26209 English
18 Week RTT % compliance -incomplete pathways	FPAC	Sep 21	56.7 % (English)	92%				Yes		40% English
52 Week breaches	FPAC	Sep 21	2522 (English)	0				Yes		4156 English
78 Week breaches	FPAC	Sep 21	955 (English)	0				Yes		
104+ Week breaches	FPAC	Sep 21	26 (English)	0				Yes		
Cancer										
Cancer 2 week wait	FPAC	Aug-21	87.2%	93%	93%			Yes	82.1%	93%
Cancer 62 day compliance	FPAC	Aug-21	65.9%	85%	85%			Yes	69%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Sep 21	63.6%	99%				Yes		tbc
DM01 Patients who have breached the standard	FPAC	Sep 21	4423	0	1254			Yes		tbc
Emergency Department										
ED - 4 Hour performance	FPAC	Sep 21	58.4%	95.0%	66%			Yes	66.4%	78%
ED - Ambulance handover > 60mins	FPAC	Sep 21	863	0				Yes	3603	tbc
ED 4 Hour Performance - Minors	FPAC	Sep 21	88%	95%	95%			Yes	92.5%	95%
ED 4 Hour Performance - Majors	FPAC	Sep 21	32%	95%				Yes	42.1%	tbc
ED time to initial assessment (mins)	FPAC	Sep 21	47	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Sep 21	131	0	0			Yes	363	tbc
Total Emergency Admissions from A&E	FPAC	Sep 21	2794					Yes	17452	29744
% Patients seen within 15 minutes for initial assessr	FPAC	Sep 21	26.5%					Yes	45.5%	
Mean Time in ED Non Admitted (mins)	FPAC	Sep 21	260					Yes	205	
Mean Time in ED admitted (mins)	FPAC	Sep 21	527.5					Yes	411	
No. Of Patients who spend more than 12 Hours in E	FPAC	Sep 21	870					Yes	3132	
12 Hours in ED Performance %	FPAC	Sep 21	6.8%					Yes	4%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Sep 21	85.8%	92%	92%			Yes		92%
ED activity (total excluding planned returns)	FPAC	Sep 21	12764		13297			Yes	77749	118403
ED activity (type 1 excluding planned returns)	FPAC	Sep 21	10831		10975			Yes	65570	tbc
Total Non Elective Activity	FPAC	Sep 21	5034		5623			Yes	30461	62349
Outpatients Elective Total activity	FPAC	Sep 21	52430		58650			Yes	319202	558021
Total Elective IPDC activity	FPAC	Sep 21	5240		6105			Yes	31770	58789
Diagnostic Activity Total	FPAC	Sep 21	16434		16500			Yes	100839	tbc
Finance - KPI		Latest month	Latest Value (£m)	National Standard for month	Plan for year (£m)	Perfomance	Assurance	Exception	Year to Date(£m)	Year End Planned Trajectory (£m)
Cash	FPAC	Sep 21	18.602		1.700			Yes		1.700
Efficiency	FPAC	Sep 21	0.472		2.400(H1)			Yes	2.878	2.400(H1)
Income and Expenditure	FPAC	Sep 21	(1.570)		(3.219)(H1)			Yes	(5.766)	(3.219)(H1)
Cumulative Capital Expenditure	FPAC	Sep 21	1.010		34.537			Yes	5.032	34.537

3. Quality Executive Summary
Hayley Flavell, DoN, Richard Steyn and John Jones Acting Medical Directors

- Mortality indices remains better than the reference level of 100 and is forecast to continue to perform better than peers. Both HMSR and RAMI exclude COVID-19 deaths from the indices. Recent data from CHKS indicators that SaTH is not an outlier for deaths associated with COVID-19 during the second wave of the pandemic October 2020-March 2021.RAMI data from April 2021 should be treated with caution while national checks are being made on the length of stay HES data applied.
- Following the work undertaken to ensure patients are not admitted to wards without a VTE assessment completed a slight dip in performance has been seen this month. Performance is below target in the Medicine and Emergency Care division. Staff are being reminded of the importance of completing assessments prior to admission.
- We are retaining our current stretch improvement targets for infection prevention and control and exceeding the expected national performance set. No further cases of MRSA, Klebsiella or Pseudomonas Aeruginosa are reported this month, however the incidence of E.Coli and C.Difficile is above the monthly standard set. Both remain better than the national target. MSSA and C.Difficile remain on course to achieve better than the local improvement trajectory for the year.
- The number of pressure ulcers remain in line with delivery of the improvement plan. However of the 11 pressure ulcers reported this month, 3 are of grade 3 and one has been classified as a serious incident.
- The number of falls continues to remain an area of concern, with 118 reported this month. This month we have seen 3 of these falls result in fractured neck of femurs. These are being reviewed as serious incidents.
- There were 10 serious incidents this month, with a total of 29 incidents being open at month end and 14 closing within the month. There are no overdue incidents. This is important so as to ensure learning from the incidents can be applied in a timely manner to reduce the risks of recurrence.
- There were 30 mixed sex breaches this month. These are largely arising from delays to discharge from critical care units.
- The response time for concerns remains unsatisfactory at 45%. Updated figures for August are awaited. The improvement trajectory for elimination of the overdue responses by December 2021 is showing the plan is on track at the end of September 2021. Each division has its own improvement trajectory feeding into the trust trajectory. This is monitored weekly to ensure progress is being maintained.
- The rates of smoking at onset delivery have improved and are the best they have been in recent years but remain well above the national target. We look forward to a new service to address smoking rates during pregnancy commencing following completion of recruitment. This service will support smoking cessation, weight management, feeding support and flu vaccination of pregnant women as well as providing partner support across STW, with hubs being established in areas of deprivation.
- Staff recruitment in maternity has improved with 10 new midwives coming into post during the month and once completed training these will assist in improving our delivery suite acuity as well as continuing to support 1-2-1 care in labour.
- Maternity benchmarking data shows that performance is not an outlier compared with other English trusts reporting their performance. It is noted that there is a time-lag to this data and therefore caution needs to be applied and more recent data kept under review.
- There are no never events or further section 28s to report this month.
- Work is taking place to consider Health Inequalities across our elective waiting lists and within maternity care. The outcome from this analysis will be reported in future meetings.

3.1. Quality Exception Reports – Harm

VTE Report

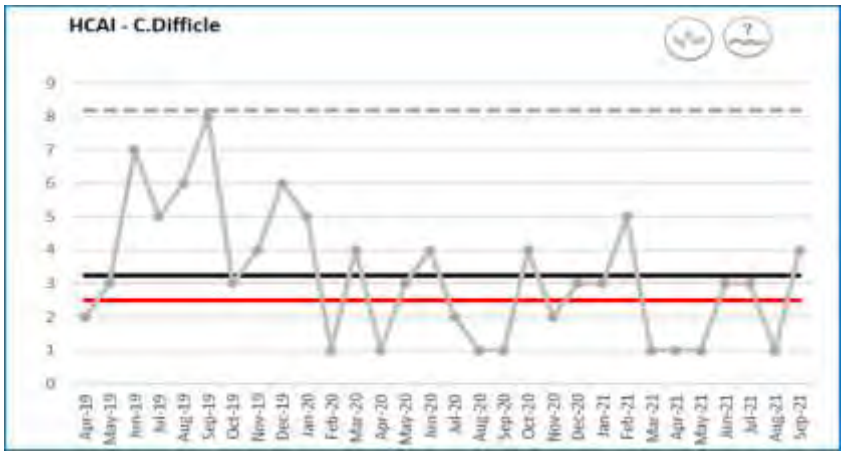
August 2021 actual performance
94.2%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery continues to be close to target

Background	What the Chart tells us	Issues	Actions	Mitigations
This is clinically important in order to protect inpatients from harm.	Common cause variation.	Concern would be that our staff are under extreme pressure and performance is reducing slightly from the improvements made.	Close monitoring. Raise awareness with teams.	None.

Hospital Acquired Infections-The national standard for the Trust performance on reportable infections has been received. Our local standards are more ambitious than the national expectations set out below:

HCAI	National threshold set	Local Improvement target	Year to date	Forecast to year end (straight line)
C.Difficile	49	30	13	26
E. coli	122	38	25	50
Pseudonomas.Aeruginosa	10	3	3	6
Klebsiella spp.	24	13	8	16

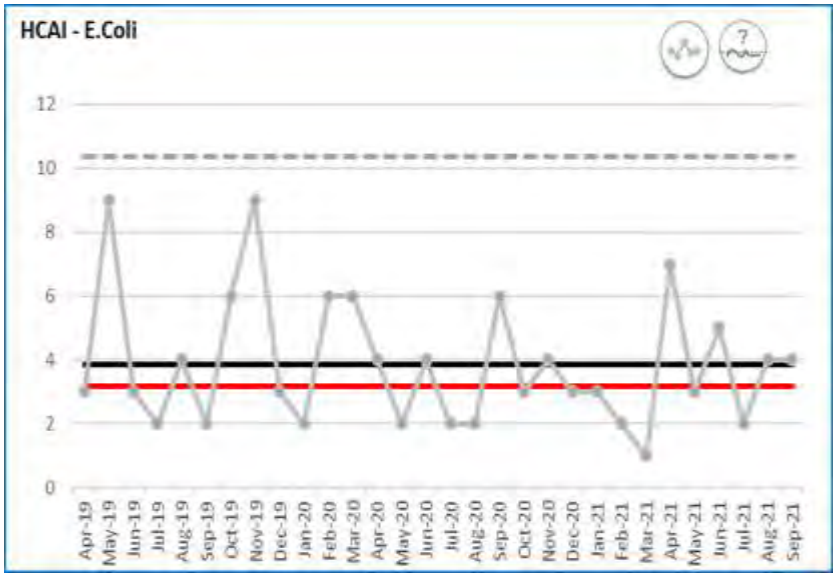
C-Difficile



September 2021 actual performance	
4	
Variance Type	
Common Cause	
Local Standard	National Target
<ave.2.5pm	<ave 4.1pm
Target / Plan Achievement	
Sustain or improve on 2020/21 performance	

Background	What the Chart tells us:	Issues	Actions	Mitigations
Locally agreed continuous improvement target is set at 30, compared to the target of 43 agreed with the CCG for 2019/20 and the nationally set target for 2021/22 of 49. We are seeking continuous improvement in line with our locally set measure.	There were 4 cases of C.Diff. in September 2021. YTD there have been 13 cases against a target of no more than 15 by month 6. We remain on course to deliver our local improvement target.	Root cause analysis investigations are undertaken on all Clostridium Difficile cases. Common themes identified continue to be: • timely stool sample. • timely isolation. • completion of stool charts. • antimicrobial prescribing.	Increased number of Redi-rooms to enable prompt isolation if side rooms not available Reinforce to staff the need for timely isolation of patients with diary and accurate completion of stool chart and obtaining stool samples.	Divisional reporting of cases and monitoring through IPC Operational Group.

E-Coli



September 2021 actual performance	
4	
Variance Type	
Common Cause	
Local Standard	National Target
<ave.3.16pm	<ave.10.17
Target / Plan Achievement	
Local standard of no more than 38 cases is unlikely to be delivered at the current run rate. However performance is significantly better than national target.	

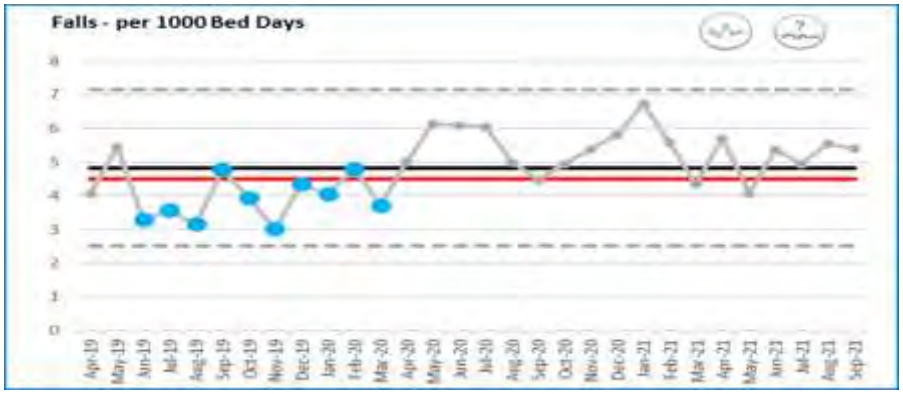
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting E. Coli bacteraemia has been a mandatory requirement since 2011.	There were 4 cases of post 48 hour E.coli bacteraemia in Sept 2021. YTD there have been 25 cases which is above the Trust internal target for this time in the year but well below the target set for the Trust by NHSE/I of no more than 122 cases for 2021/22.	The number of cases YTD is above the internal Trust target.	All cases, which are deemed to be device related or where the source of infection cannot be identified, have an RCA completed. There is ongoing work being undertaken to ensure that the new catheter insertion documentation and catheter care plan is consistently used across the Trust.	Catheter care is monitored via the monthly matron's quality assurance metrics audits, and high impact interventions audits.

Falls

September 2021 actual performance
118
Variance Type
Common Cause
Local Target
<89
Target / Plan Achievement
10% reduction on 20/21

Falls – Total per Division	Number Reported
Medical and Emergency Care	84
Surgical, Anaesthetics and Cancer	33
Clinical Support Services	1

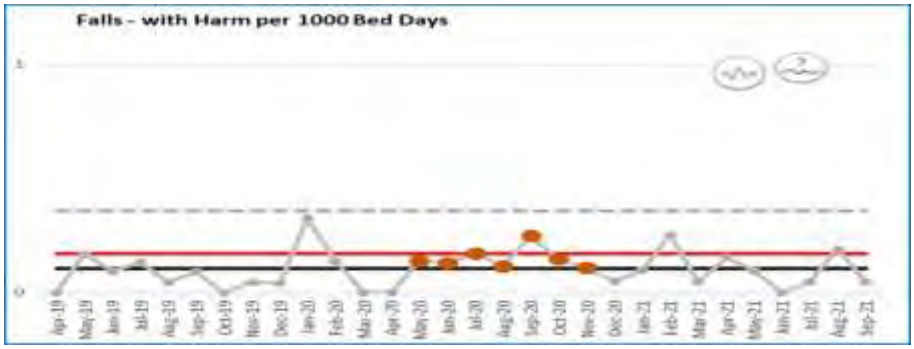
Falls – per 1000 Bed Days



September 2021 actual performance
5.4
Variance Type
Common Cause
Local Plan
4.5
National Standard
6.6
Target/ Plan achievement
Local Target set for 21/22

Background	What the Chart tells us	Issues	Actions	Mitigations
Falls amongst inpatients are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority.	Falls per 1000 bed days decreased slightly in Sept 2021 from the previous month.	Falls per 1000 bed days remains below local Trust Target however; we are lower than national benchmark and some of our peer organisations.	As per Falls with harm slide.	As per Falls with harm slide

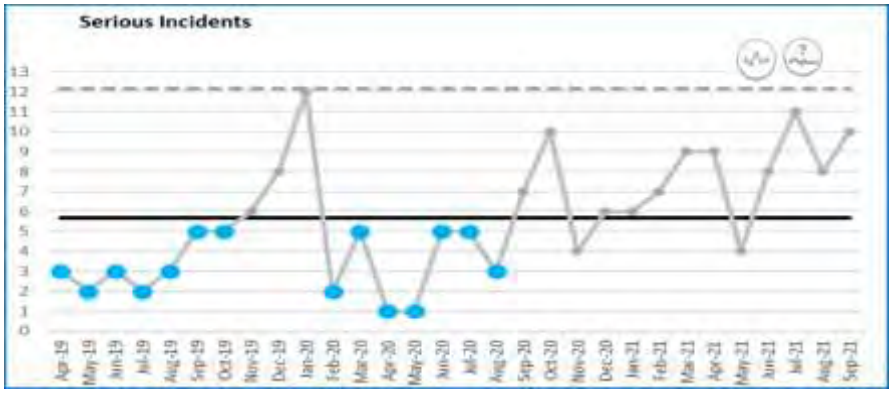
Falls – with Harm per 1000 Bed days



September 2021 actual performance
0.05
Variance Type
Common Cause
Local Standard
0.17
Target/ Plan achievement
Achieving target

Background	What the Chart tells us	Issues	Actions	Mitigations
Inpatient Falls are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority.	Falls with harm per 1000 bed days decreased in the first quarter of 2021/22 to 0.25. For quarter 2, there has been a slight increase to 0.29.	3 falls resulted in serious harm in Sept 2021 all resulting in the patient sustaining a fractured NOF, these were on ward 22SS, Ward 11 and Ward 35. This is the highest number of cases reported in a month since Sept 2020.	The 3 cases in Sept have been reported as Serious Incidents and the investigations are in progress. Ongoing work continues in relation to ensuring:: All patients have a falls risk assessment on admission. Falls care plans in place for patients assessed as at risk of falls. Lying and standing BP completed. Falls reassessments completed weekly or when patient's condition changes. Post falls care bundle consistently adhered to.	Monitoring via monthly nursing metrics audits and discussed/actions agreed at monthly monitoring meetings. Baseline exemplar peer reviews. Falls steering group continues to meet monthly and monitors falls data, falls SIs and falls improvement work. All SI investigations reviewed at NIQAM and summary report of cases will now go to RALIG.

Serious Incidents

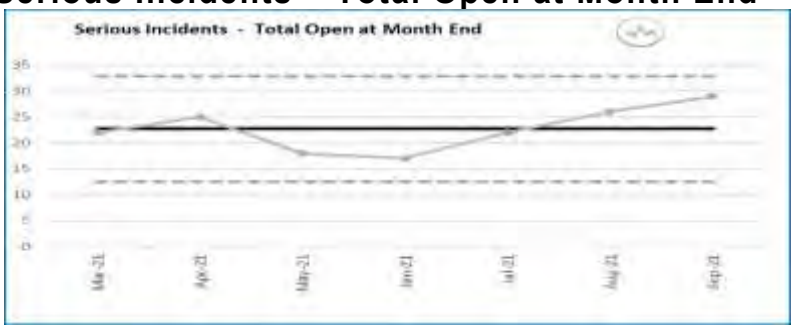


September 2021 actual performance
10
Variance Type
Common Cause
Local Standard
n/a
Target/ Plan achievement
Target removed –seeking to encourage reporting of incidents.

SI theme	Number Reported
Fall with fractured neck of femur Wards: 22 SS,11,35	3
Maternity – Potential missed opportunity for earlier delivery	1
Absconding patient/head injury	1
Maternity – Intra uterine death - HSIB	1
Surgical Invasive Procedure	1
Category 3 Pressure Ulcer Ward 9	1
Delayed Diagnosis fracture neck of femur	1
Delayed Diagnosis - ?TB	1
Total	10

Background	What the Chart tells us	Issues	Actions	Mitigations
Serious Incidents are adverse events with likely harm to patients that require investigation to support learning and avoid recurrence. These are reportable in line with the national framework.	September saw a small increase in the reporting of serious incidents with total of 10. There had been a reduction in August to a total of 8 SIs, and for the same period in 2020, where the Trust reported 7 Sis.	Over the coming months, COVID-19 related incidents such as delayed diagnosis due to access issues/outbreaks and COVID-19 related deaths may continue to be seen in reporting figures.	Monitor reviews. Maintain investigation reporting within national framework deadlines for timely learning. Embed learning from incidents.	Weekly Rapid Review of incidents. Early identification of themes. Standardised investigation processes. Early implementation of actions.

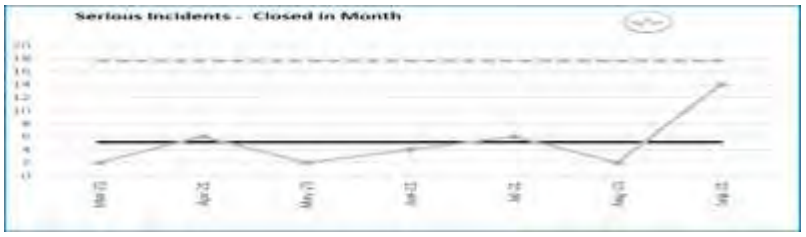
Serious Incidents – Total Open at Month End



SI – Total Open at Month End per Division	Number Reported
Medical and Emergency Care	10
Surgical, Anaesthetics and Cancer	5
Women and Children's	12
Clinical Support Services	1
Other – SaTH Division	1
Total	**29**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open Serious Incidents.	Number of open SIs.	29 open SIs. 3 have been to RALIG and will be sent for closure following minor amends and updated action plans. 3 are being managed by HSIB outside of the organisation.	Monitoring of progress of investigation.	Weekly review of progress.

Serious Incidents – Closed in Month

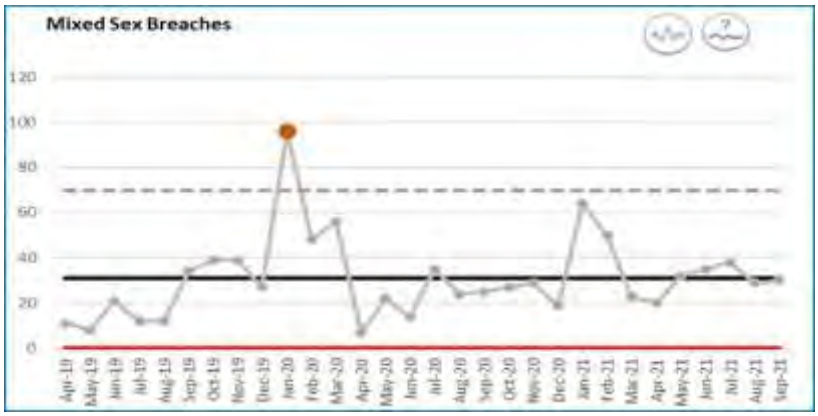


September 2021 actual performance
SATH
14

Background	What the Chart tells us	Issues	Actions	Mitigations
Serious incidents have a 60-day life cycle. The number of SIs closed in month will vary dependent on the number reported.	There were 14 SIs closed in month with a 100% completion within the 60 day target.	All SIs to be completed within 60-day timeframe.	Monitor reviews. Maintain investigation reporting within national framework deadlines for timely learning. Embed learning from incidents.	Weekly review of progress of investigations.

3.2. Quality Exception Reports – Patient Experience

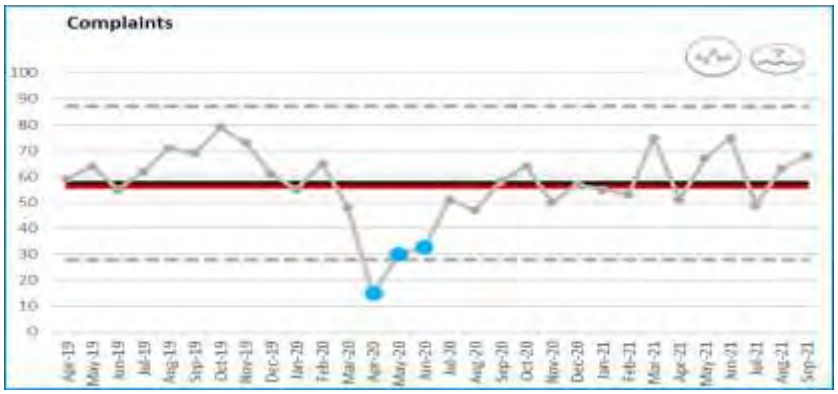
Mixed Sex Breaches Exception Report



September 2021 actual performance
30
Variance Type
Common Cause
National Target
0
Target/ Plan achievement
Continuing to breach this target month on month. Primarily related to timely discharges from ITU/CCU

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	5 Primary breaches	5 Medical
ITU / HDU (RSH)	20 Primary breaches	8 Medical and 12 Surgical
CCU (RSH)	1 primary breaches	2 Secondary breaches
CCU (PRH)	3 Primary breaches	3 Secondary breaches
Ward 32	1 Primary breaches	1 Secondary breaches

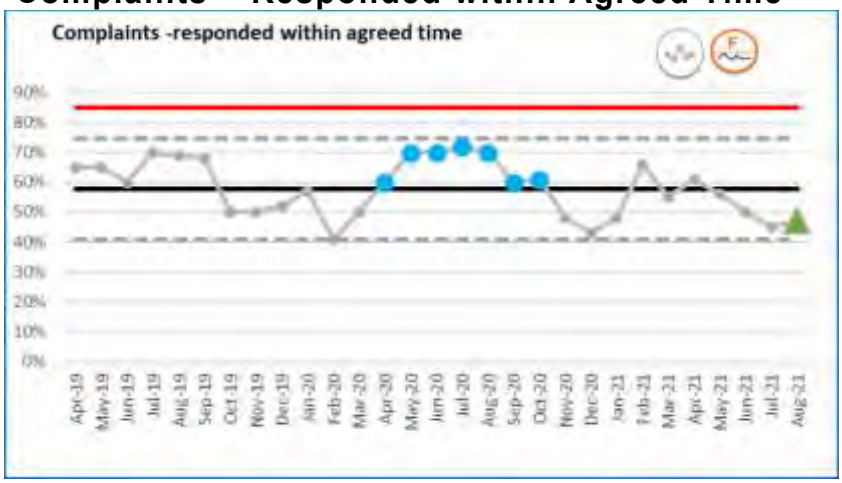
Complaints



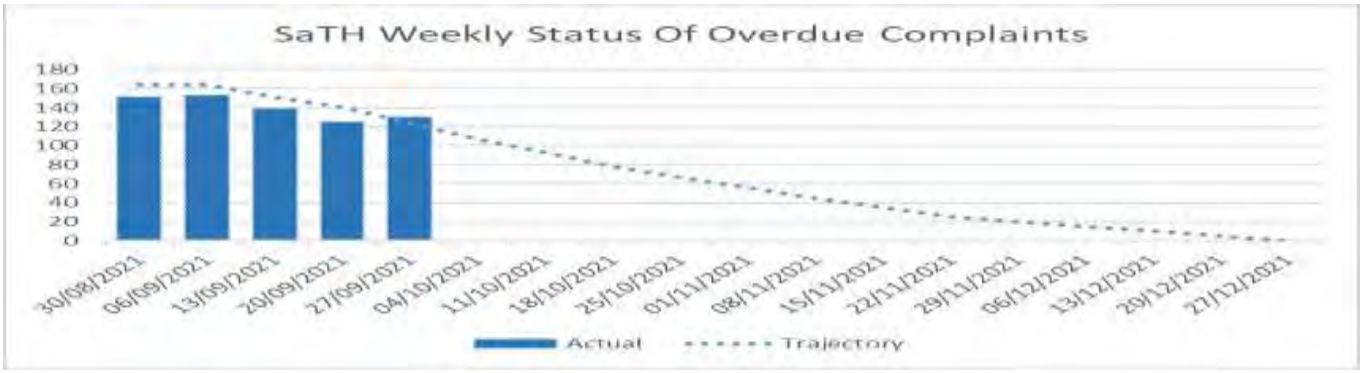
September 2021 actual performance
68
Variance Type
Common Cause
SATH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20 total complaints

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Numbers remain within common cause variation.	There has been an increase in complaints relating to Ward 9.	This has been escalated and is being reviewed by the Division.	None.

Complaints – Responded within Agreed Time

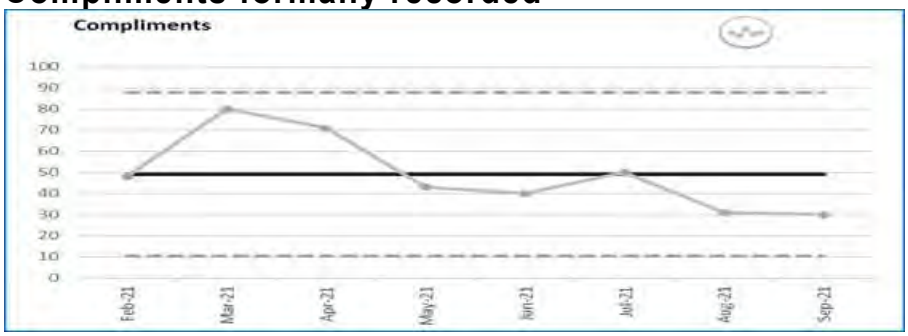


July 2021 actual performance	
45% (Forecast August 47%)	
Variance Type	
Common Cause	
National benchmark	**SaTH internal target**
85% compliant with time agreed with complainer	85% responded to within 30 days of receipt
Target/ Plan achievement	
Target is unlikely to be achieved within current processes.	



Background	What the Chart tells us	Issues	Actions	Mitigations
It is important that patients raising concerns have these investigated and the outcomes responded to in a timely manner as well as the Trust learning from these complaints.	Response rates remain lower than expected.	Response rates from divisions continue to be low, although Women & Children's have made some improvements recently.	Weekly monitoring continues, and the backlog of overdue complaints is reducing. Further work has been done on embedding new processes for managing complaints within the divisions.	Regular updates to complainants. Regular reviews of open cases to identify what is still needed from Divisions.

Compliments formally recorded



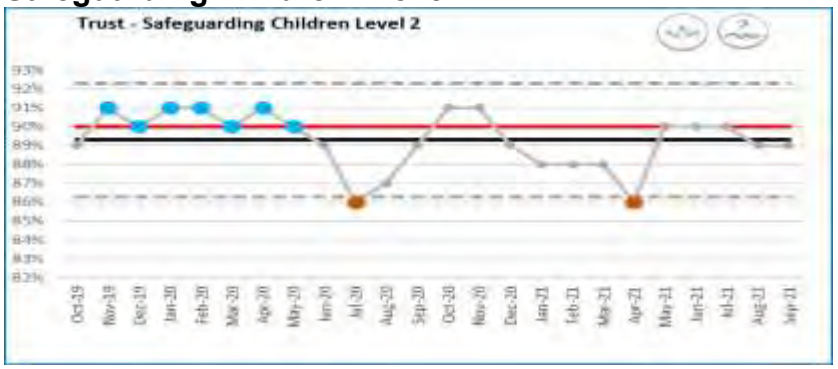
September 2021 actual performance
SATH
30
Divisions
MEC – 17
SAC - 9
W&C - 2
CSS – 2

Background	What the Chart tells us:	Issues	Actions	Mitigations
By collecting data on positive feedback, the Trust will be able to identify well performing areas, and seek to spread good practice.	The number of compliments recorded has dropped, although it remains within common cause variation; it is thought that this is due to low reporting.	This is still a new system, and staff may not be aware of the need to log thanks received.	Remind staff to use the Datix system to record positive feedback	

Trust Training - MCA – DOLS & MHA

September 2021 actual performance
76%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place to deliver at end of Q3

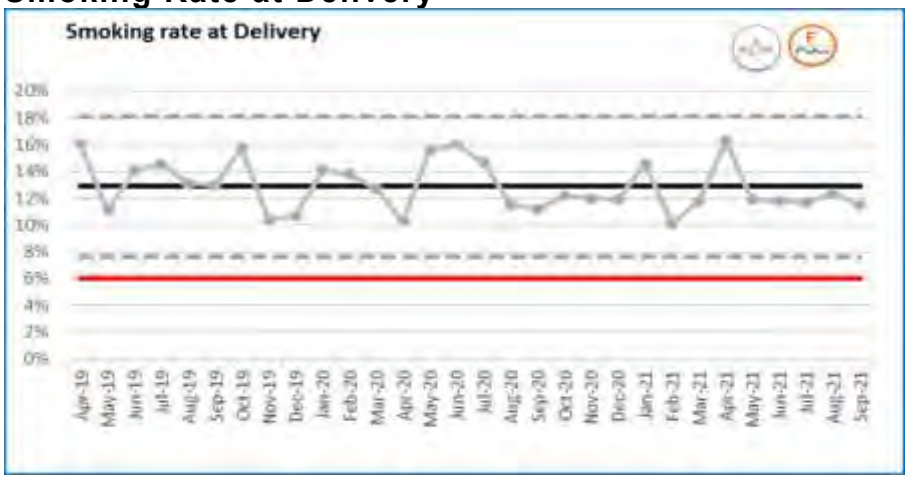
Safeguarding Children – level 2



September 2021 actual performance
89%
Variance Type
Common Cause
National Target
90%
Target Achievement
90%

4. Maternity Indicators

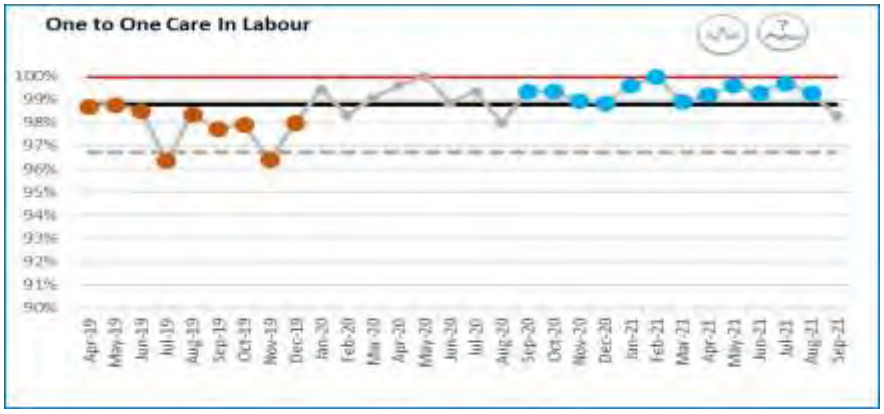
Smoking Rate at Delivery



September 2021 actual performance
11.5%
Variance Type
Common Cause
National Target
6% March 2022
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us:	Issues	Actions	Mitigations
The National Smoking at the onset of delivery (SATOD) government target for smoking at time of delivery has been set to 6% by March 2022. All pregnant smokers in Shropshire and Telford and Wrekin are referred to and supported by the Public Health Midwifery team based at PRH.	Smoking rates at delivery continue to decrease across the county, towards the current national average (9.5%) despite social deprivation and associated health inequalities/co-morbidities. One of lowest SATOD quarters on record for SATH from July-September 2021. 11.5% average for all women living in the county (offered SATH support) or 11.9% for all Trust births. Working towards government target-smoking cessation team has expanded and progress being made for new HPSS service to address barriers and health inequality.	Barriers such as lack of support for partners to quit smoking and social deprivation still exist and influence smoking status. These barriers need to be addressed. All aspects of public health require support-smoking cessation, weight management, increase vaccination uptake (offer internal hospital service-already run flu vaccination service.	In progress of recruiting to HPSS to be launched later this year. Band 7 recruited August 2021. Band 5 posts-sent to recruitment for advert. Band 4 posts-interviews completed and 4WTE posts filled. Band 2 administration-currently shortlisting for this WTE position. Team will provide smoking cessation support, including partner support. Hubs will be established in areas of deprivation to provide support close to home. Confirmation of likely impact is being sought from similar established services.	Not reaching 6% SATOD government target by March 2022. SATOD rates have fallen dramatically but difficult to achieve proposed target in 4 months' time.

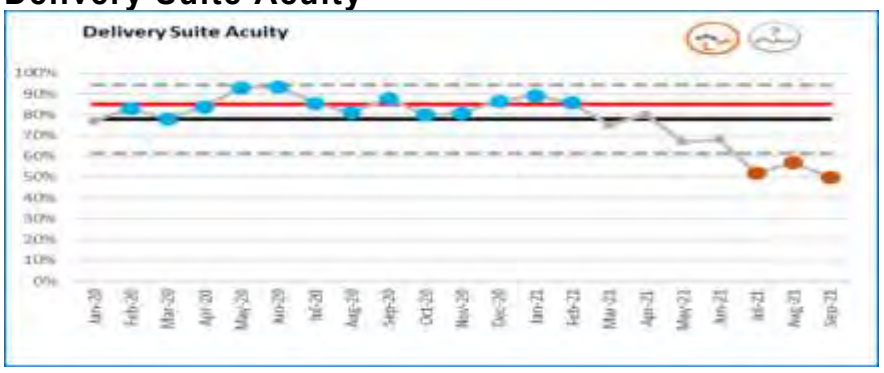
One to One Care in Labour



September 2021 actual performance
98.3%
Variance Type
Common Cause
National Standard
100% (Better Births)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
Midwifery safe staffing should include plans to ensure women in labour are provided with 1:1 care, including a period of 2 hours after the birth of their baby. The provision of 1:1 care is part of the NCST standard safety action number 5 which requires a rate of 100% 1:1 care in labour.	These results are reassuring that staffing is being managed with acuity tool to ensure 1-2-1 care in labour is achieved consistently above 98%.	Staffing levels variable due to vacancies, maternity leave and sickness.	Senior management team are reviewing each individual case to understand length of time for each occasion. 10.2 WTE band 5 midwives commenced 19/09/21. Ongoing recruitment to staff to recommendations in Birth Rate Plus.	Use of SMT huddles to assess acuity across unit to maintain safety – good use of escalation policy used.

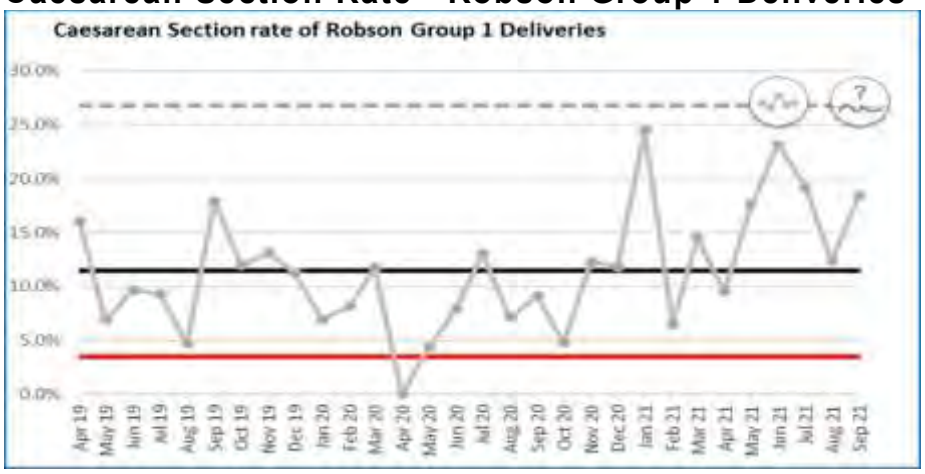
Delivery Suite Acuity



September 2021 actual performance
50%
Variance Type
Special Cause Concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

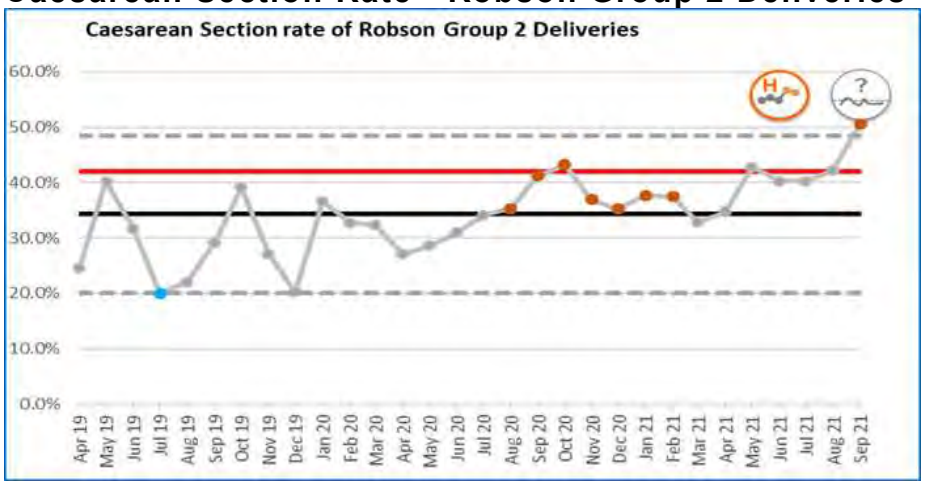
Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015 NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5.	There has been a decline in positive acuity since April 21.	Staffing levels variable due to vacancies, maternity leave and sickness. Recruitment planning in progress to backfill vacancies. Acuity tool consistently being completed – reassurance of data quality.	Identify all vacancies. Recruitment in progress. 10.2 WTE band 5 midwives commenced 19/09/21. Rotas look to improve from end of Oct.2021 after period of Supernumerary working.	Use of SMT huddles to assess acuity across unit to maintain safety – good use of escalation policy used.

Caesarean Section Rate - Robson Group 1 Deliveries



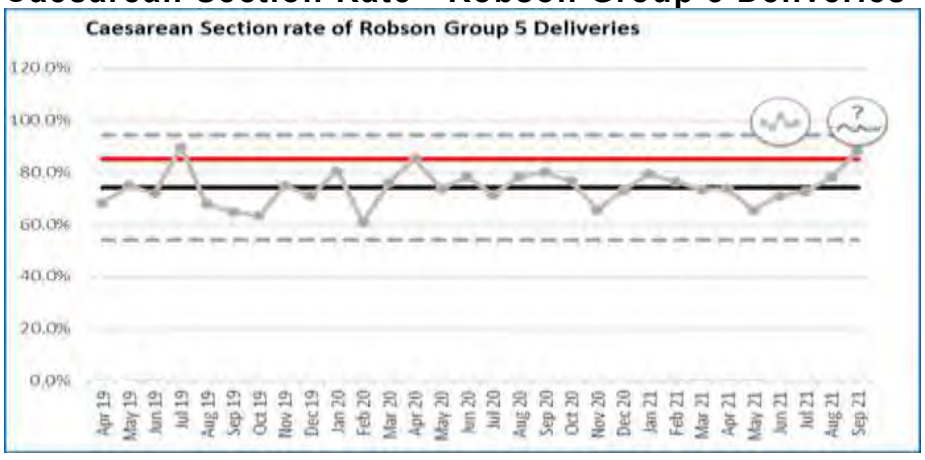
September 2021 actual performance
18.5%
Variance Type
Common Cause
Expected Range
3.4% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Caesarean Section Rate - Robson Group 2 Deliveries



September 2021 actual performance
50.6%
Variance Type
Common Cause
Expected Range
42% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Caesarean Section Rate - Robson Group 5 Deliveries



September 2021 actual performance
88.2%
Variance Type
Common Cause
Expected Range
85% (Public View)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Maternity Performance Benchmarking

This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator.

KPI	Latest month	Actual Performance Ranking
Emergency C-Section (out of 121)	Jun 21	42
Booking Appointment Before 10 Weeks (out of 120)	Jun 21	94
Breast Feeding Initiation (out of 112)	Jun 21	39
Elective C-Section (out of 121)	Jun 21	30
Instrumental Assistance (out of 120)	Jun 21	72
Premature Birth Rate (out of 120)	Jun 21	13
Skin to Skin Contact (out of 121)	Jun 21	39
Spontaneous Delivery (out of 120)	Jun 21	22
Robson Group 1 - C-section with no previous births (out of 61)	Jun 21	42
Robson Group 2 - C-section with no previous births (out of 40)	Jun 21	17
Robson Group 5 - C-section with 1+ births (out of 53)	Jun 21	4

Health Inequalities

The Trust is working to assess the impact of COVID-19 on health inequalities reviewing the make-up of our waiting lists pre and post the initial waves of COVID-19. Data is awaited from our partners to consider how the makeup of our waiting lists aligns to our population demographics and IMD. We continue to prioritise care in accordance with clinical need and length of wait.

We are also working with public health to review to understand health inequalities for maternity services.

The outcomes from this work will be reported to the quality operational group meeting and then included in this Committees report.

5. Workforce Summary
Rhia Boyode, Director of People and Organisational Development.

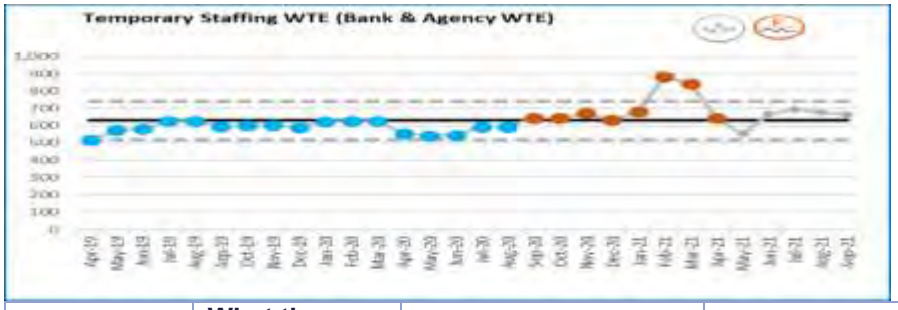
- September was an exceptionally busy month for medical recruitment with the annual junior doctor induction-taking place.136 new doctors joined the Trust, with many others rotating internally.19 bank appointments made in September, many of which are doctors in training who wish to continue working with SaTH. We have utilised permanent recruitment agencies to appoint to SAS grade doctors within ED to increase the workforce, with 12 doctors appointed in the last few weeks and further interviews planned throughout October.
- Overall workforce growth has continued to increase, however is below plan due to delays with the 2021 international recruitment programme. International recruitment continues with 25 nurses joining in October, 20 in November and 26 throughout December.
- 76 FTE leavers in September, which is above average for the previous 12 months. 33% of leavers in September had less than 12 months service. Interviews have taken place with these staff to provide a deep dive understanding of reasons for leaving. These include work life balance, relationships with colleagues or managers, promotion outside of the Trust and majority of reasons relating to personal circumstances. 42% (32FTE) of leavers in September had less than 2yrs service. Our on boarding team have been focused on supporting with 'stay conversations' and have targeted areas such as maternity services.
- SaTH have taken part in the NHSE/I roster improvement programme which has focused on a number of areas including roster approval and temporary staffing. Roster approval times have improved over the last month as a result of actions to raise awareness including regular review meetings with clinical teams and reminders to ward managers. Good progress made in the delivery of electronic rostering across our teams particularly for doctors. We will have our junior doctors set up on a new electronic rostering system in December. This will create better visibility and more efficient use of our workforce.
- COVID-19 related absence continue at high levels during September with increasing levels of staff testing positive and requiring to isolate due to members of the household testing positive. Lateral flow reporting rates have increased this month to 18%, reports now available showing managers which staff have returned results and to show rates for their teams and departments.
- Non- COVID-19 sickness has increased to 5.6% in September and nursing and midwifery sickness is at the highest level for the previous 12 months. Absence attributed to mental health continues to be high with 194 episodes equating to 96FTE in September. Particular increase in absences attributed to cough, cold, flu and headache/migraine
- Our People Systems team were finalists for a National Allocate Award this month for their work in developing our people systems during the COVID-19 pandemic, recognising the progress made but there is still more to go.
- The 90% appraisal target was achieved January to April 20 but has since reduced. In August we achieved 87% but this has reduced by 2% to 85% this month.
- Statutory training compliance has remained at 85% this month, however we have seen a reduction in DNA's which has reduced to 26% from 35% last month. E-Learning reminder emails continue to be generated and sent to all staff who are non-compliant. A further 3% increase in Safeguarding Children Level 3 training from 78% to 81%. New Learning Management System purchased and will be piloted in maternity in October.

WTE employed

September 2021 actual performance
5809
Variance Type
Special Cause Improvement
Local Target
6173
Target / Plan Achievement
Improvement month on month towards the target set

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the wte contracted staff in post.	wte numbers show special cause improvement since Apr 2020, although the rate of improvement has slowed.	Overall wte numbers have continued to increase. High patient activity levels and staff absences continue to present challenges to staffing levels along with higher overall levels of staff unavailability than planned. Increased levels of staff leavers also present issues.	Recruitment activity continues to increase staffing levels. Promote timely roster approvals to maximise opportunities for bank utilisation. Continue to monitor leavers and support with early intervention.	Utilisation of bank and agency staff to support workforce gaps.

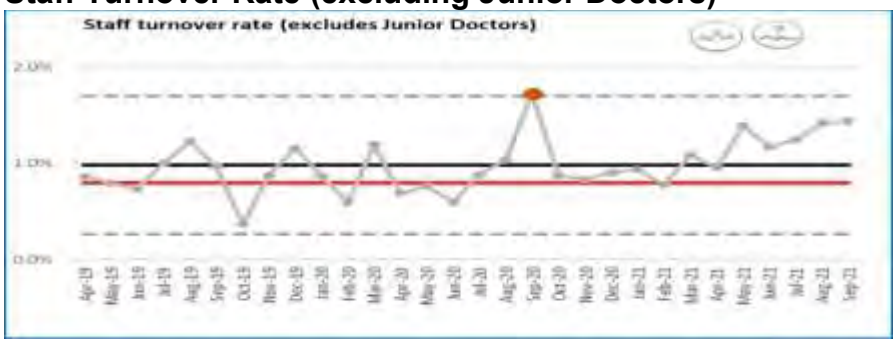
Temporary/ Agency Staffing



September 2021 actual performance
664
Variance Type
Common Cause
National Target
N/A

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as wte.	Special cause concern over winter period between Sep20 – Apr21. Normal variation in May21 and Sep21.	Staff absences attributed to both sickness (non-COVID -19) and COVID-19 related absence due to requirements to isolate continue to present staffing challenges along with high patient acuity levels and escalation.	Continue to monitor staff absence levels. Monitor roster approvals to help ensure unfilled duties are sent to temporary staffing in timely manner. Ongoing work with system to support agency utilisation cost improvement programme. Increase in bank workers over the last 12 month.	Escalated bank rates in at risk areas. Progress with recruitment activities to increase substantive workforce including international nurse recruitment.

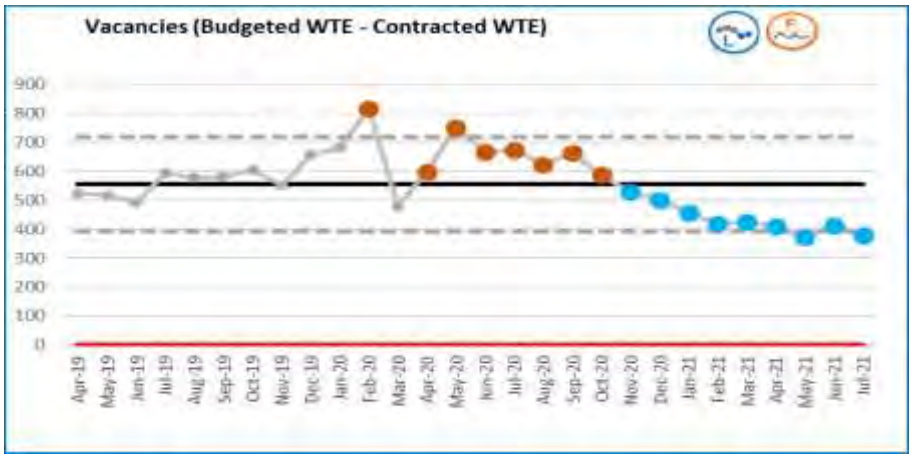
Staff Turnover Rate (excluding Junior Doctors)



September 2021 actual performance
1.44%
Variance Type
Common Cause
National Target
0.8%
Target / Plan Achievement
Target not achieved

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of the % of staff who have left the organisation.	Normal variation continues between Oct 20 and Sep 21.	Staff leavers in September (76 wte) is 38% (21 wte) above the average leavers per month of 55 wte. 42% (32 wte) of leavers in September had less than 2yrs service. Of leavers in September with less than 2yrs service, 31% (10 wte) had a leaving reason of work life balance and 25% (8wte) left with a reason of other/not known. Within the staff group Nursing and midwifery registered, work life balance remains the top reason for leaving over the last 12 months with 29% (15wte) of leavers attributed to this reason.	Interventions in place to try to identify potential leavers prior to leaving. Opportunity to complete exit questionnaires to help learn lessons from why people are leaving. Ongoing work to adopt recommendations within the NHS People Plan regarding supporting staff to adopt flexible working practices. Improvement initiatives to improve culture and work-life balance. Monitoring of roster approval times to promote better work-life balance.	Recruitment activity to help ensure minimal workforce gaps. Utilisation of temporary workforce to maintain suitable staffing levels. Escalated bank rates in challenged areas.

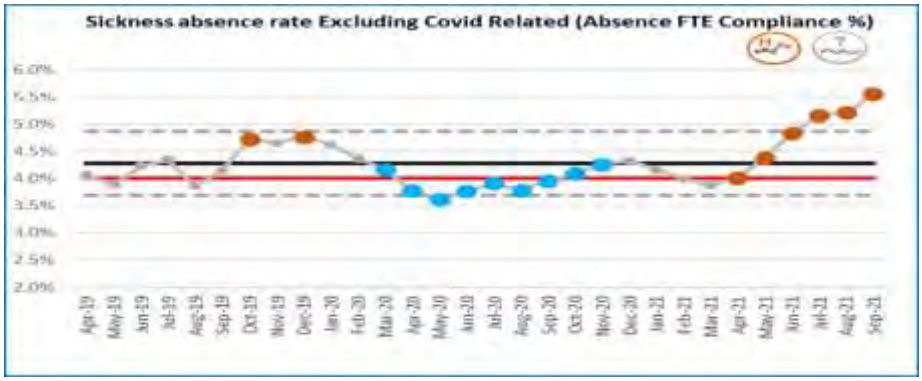
Vacancies



July 2021 actual performance
378 = 6.5%
Variance Type
Special Cause Concern
National Target
<10%
Target / Plan Achievement
Better than target level of performance

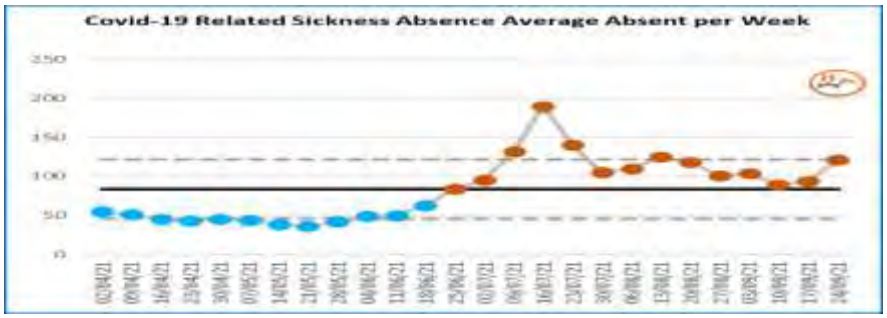
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted wte and contracted wte.	Special cause improvement between Nov20 – Jul21. Budget setting has resulted in a higher number of vacancies from August, the scale of this change is being reconciled at present and will be reported next month.	Shortfall in gap between contracted wte and budgeted wte continues to put pressure on bank and agency usage.	Continue recruitment activities to increase contracted wte staffing levels and reduce vacancy gap. Initiatives to help retain existing staff. Ongoing work to review vacancy gaps against temporary staffing usage to better understand workforce utilisation. Reconcile the revised budgeted establishment and the number of vacancies.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

Sickness Absence



September 2021 actual performance
5.6%
Variance Type
Special Cause Concern
National Target
4%
Target / Plan Achievement
4%

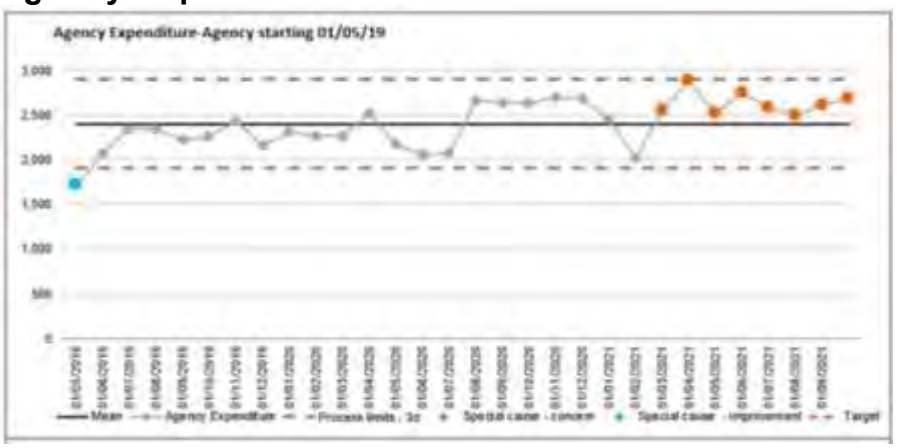
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of wte calendar days absent. COVID-19 related sickness and absence is not included.	Special cause concern from Apr21 – Sep21.	Higher absence levels than normally expected for this time of year. Absence rate of 5.6% equating to 329 wte. Absence attributed to mental health continues to be high with 194 episodes equating to 96 wte in September. Absence levels attributed to other musculoskeletal, other known causes and gastrointestinal all remain high. Particular increase in absences attributed to cough, cold, flu and headache/migraine. Estates and facilities remains the staff group with the highest absence % at 8.6% (43wte) with additional clinical services at 6.9% (81wte) and nursing and midwifery at (109wte) 6.3%. Medical and Dental sickness is particularly high at 4.15% (28wte) and above 12 month average of 1.9% (13wte).	Continue to promote health and wellbeing initiatives. HR team supporting with welfare conversations. Care for you days to help provide additional respite and recognise efforts made by colleagues. Embedding of new employee wellbeing and attendance management policy. Work to highlight importance of return to work conversations.	Work with temporary staffing department to ensure gaps can be filled with temporary workforce where necessary. Encourage bank uptake of shifts; escalated rates in challenged areas.



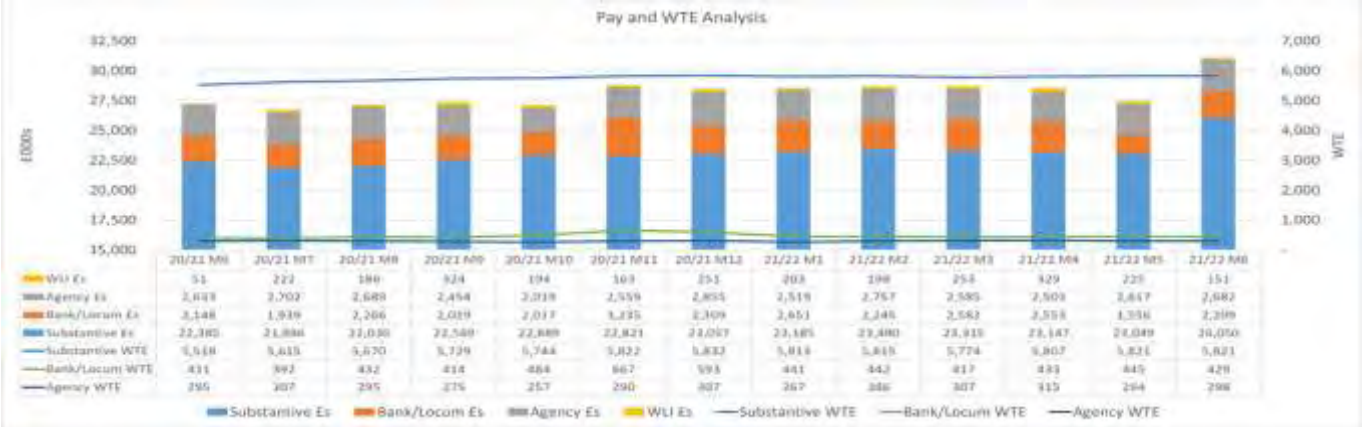
24th September 2021 actual performance
121
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff COVID-19 sickness absence average per week and is the number of staff absent due to COVID-19 related sickness.	COVID-19 related absence shows special cause concern in September.	COVID-19 related absence continue at high levels during September with increased levels of staff testing positive and requiring to isolate due to members of the household testing positive. High levels of COVID-19 related absences continue to add to staffing challenges.	Continue to encourage staff to follow government guidelines on isolation periods. Ensure PPE adherence and encourage social distancing. Continue to encourage undertaking of LFT testing and COVID-19 vaccine uptake including promoting of booster jab and flu vaccine.	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact tracing. Continue risk assessments for staff identified as contacts.

Agency Expenditure

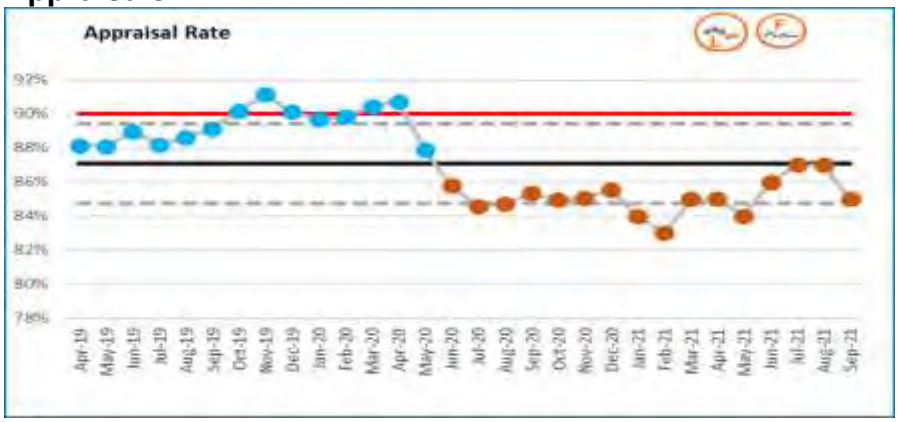


September 2021 actual performance	
£2.682m	
Variance Type	
Underspend	
National Target	**SaTH Plan**
£2.860m	£2.860m
Target/ Plan achievement	
£0.473m favourable variance.	



Background	What the Chart tells us:	Issues	Actions	Mitigations
Agency is a constituent element in the Trusts £3.219m deficit plan over the H1 period. The H1 agency plan has been set equivalent to Q3 20/21 spend. There is a strong expectation that the Trust will ensure agency expenditure is reduced and there is a recurrent requirement to substantially reduce agency expenditure.	Agency spend is significantly above the NHSEI ceiling, however this target needs to be updated to reflect the current regime. Agency costs were £2.682m in the month, which is higher than previous month mainly due to increased medical agency costs in medicine, primarily to cover sickness.	Due to workforce fragility the Trust is consistently overspent against its agency ceiling. There has been a significant increase in the use of agency health care support workers linked to an increase in acuity and 1:1 care.	Direct engagement groups now set up to focus on agency spend and approval hierarchy; including monthly dashboard review across key nursing metrics. Overseas registered nursing recruitment in 19/20, 20/21 and 21/22. Increased nursing bank rates in specific high agency areas. HCSW, Strands A & B NHSEI agreements to fund focussed substantive nursing recruitment. Recruitment and retention strategy approved key focus on brand and reputation, retention of staff and targeted recruitment campaigns for hard to fill roles. Review of agency procurement strategy with national procurement team (HTE). Action plan agreed to understand increase in HCSW agency usage.	Develop measurable metrics and action plans to understand where we can control agency spend. Build on increased medical bank fill rates since implementation of Locums Nest Deliver year one of the recruitment and retention strategy to increase substantive workforce and improve retention levels.

Appraisals

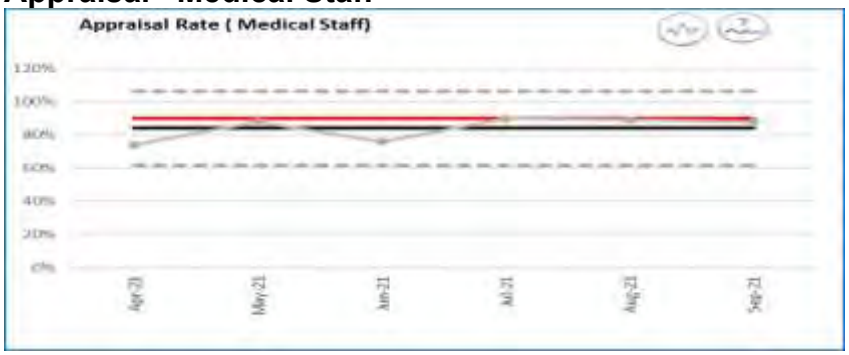


September 2021 actual performance
85% (88% Medical Staff)
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in	The 90% target was achieved January to April 20 then started to drop. In August we achieved 87%	COVID-19, staffing constraints and service pressure has reduced ability of ward staff to have time to	Focused support is being provided to the managers of any ward that is below target. This support has been extended to 1:1 advisor support for 70 wards/departments. A substantial review of appraisal will be undertaken once the behaviours and values work is complete to ensure alignment with overall Trust objectives.	Appraisal form has had an interim revision to include the new Trust values, health and

having completed their annual appraisal.	but this has dropped 2% to 85% this month.	complete appraisals.	Corporate Education will continue to send out reminder emails to all staff who are out of date and due their appraisal. Appraisal training sessions are available on the Training Diary.	well-being and flexible working discussions.

Appraisal –Medical Staff



September 2021 actual performance
88%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
90%

Statutory & Mandatory Training

September 2021 actual performance
85% (Medical Staff – 78%)
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
The target is above the upper process limit

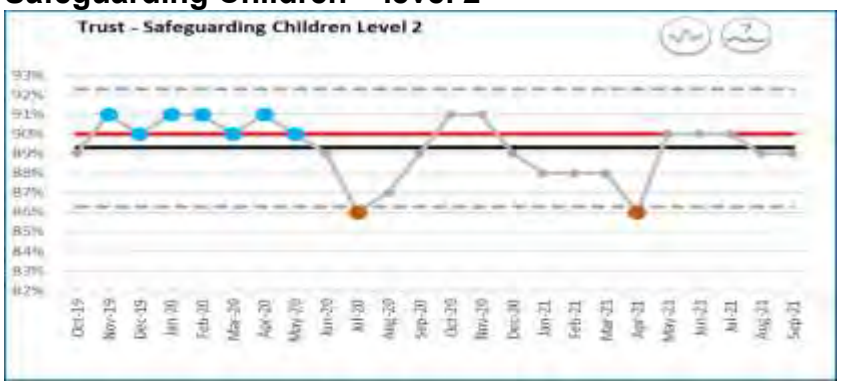
Fire Safety	Load Moving & Handling	Infection Prevention & Control	Hand Hygiene Competence	Patient Moving & Handling Class	Adult Basic Life Support	Paediatric Basic Life Support	Equality & Diversity	Information Governance	Health & Safety Level 1
83%	91%	80%	96%	87%	77%	75%	90%	80%	88%

Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their training needs.	Remained 85% DNA % dropped to 26% from 35% last month. A further 3% improvement in Safeguarding Children Level 3 from 78% to 81%.	CV-19 &, staffing constraints and service improvement have reduced ability of wards to release staff for training. Poor IT literacy impacting on e-learning completion. Some data validation issues.	Corporate Education is working with divisions to identify and reduce data conflicts. Corporate Education is supporting additional Ward/Dept. managers with 1:1 Advisor support to prioritise and schedule training completion and validate data within the report. New Learning Management System purchased – implementation started. Pilot in Maternity in October. E-Learning reminder email, Continue to be sent to all staff who are non-compliant. Corporate Education requested proxy facility to support remote e-learners effectively. From September – at the request of MLT & Dr Srinivasan the SSU for Medical CPD has been developed. This should hopefully see an increase in the Medical Staff SSU %.	E-learning and workbooks offered as alternatives to face to face training. Requirements made more transparent to divisional teams and staff. Libraries supporting learners to access e-learning Phone support for e-learning.

Trust MCA – DOLS & MHA

September 2021 actual performance
76%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place to deliver at end of Q3

Safeguarding Children – level 2



September 2021 actual performance
89%
Variance Type
Common Cause
National Target
90%
Target Achievement
90%

6. Operational Summary
Nigel Lee, Chief Operating Officer

As with the previous month of August, September saw significant pressure from Urgent and Emergency Care (UEC) demand. Activity at both Emergency Departments (EDs) has remained at high levels, with some peaks in demand at key times, and an increasing trend in Paediatrics, again at peak times and days. Our measures of performance have continued to remain lower than average as a result. The challenges on acute flow through the hospitals due to increased acuity, increasing COVID-19 inpatient numbers as well as community capacity constraints are leading to significant pressure at times in both EDs; this in turn is creating an increasing number of delays to ambulance handover, often for extended periods. The ED clinical teams have continued to work very closely with the ambulance services, ensuring that clinical prioritisation of patients remains paramount, and those patients with the most urgent need are highlighted. Both departments have also provided space to cohort ambulances, with excellent support from West Midlands Ambulance Trust staff, thereby releasing more crews back into the community. However, challenges and risk remain, and both internally within SATH and working across the Health & Social Care system, all partners are rightly focused on a range of actions and mitigations.

September saw the refresh of focused improvement actions on wards, beginning at RSH medicine wards; this work builds on the improvement methodology and work done in previous years, but given the changes in infection control, staffing pressures and system pressures, as well as the rise in ambulance handover delays, it has been timely to add fresh impetus to this work. The 'flow fortnight' will be held at PRH in early October, and follow up activities done at

both sites across all wards in the following weeks. Data on process and outcome measures is already in use to provide feedback to teams.

Discharge of the more complex patients (those requiring a greater level of care and support post-acute discharge) remains challenging given the staffing constraints being experienced by community services and social/domiciliary care, and the level of these patients remaining in the acute sites remains higher than earlier in 2021. SATH is working together with the community trust, CCG, Powys Health Board and all local authorities on maximising capacity and seeking alternatives for patients.

In parallel, the UEC pressures continue to impact capacity for elective care; the Trust continues to focus on the higher priority patients. Priority 1 are very urgent patients and are treated swiftly; the next priority is P2 including cancer, and this cadre of patients occupies much of the current elective surgery capacity. The very long waiting patients are the next priority and actions to limit the rise in long waits for the second half of 2021/22 ('H2') have been set out, subject to funding.

Diagnostics are a crucial step for many patient pathways, and the Trust has agreed investment in a mobile CT scanner to be on site from the start of October and remain for 6 months; these scarce assets were nationally prioritised in Apr-Sep and not available to SATH before this time. The extra CT capacity will also be bolstered by the new pod building at RSH from late October onwards, as extra staffing arrives and the new CT and MRI units are able to be used. The combined impact will be a steady reduction in waiting times for CT, which had risen despite the service running at 100% of 2019/20 levels. Crucially, this will especially help in cancer pathways.

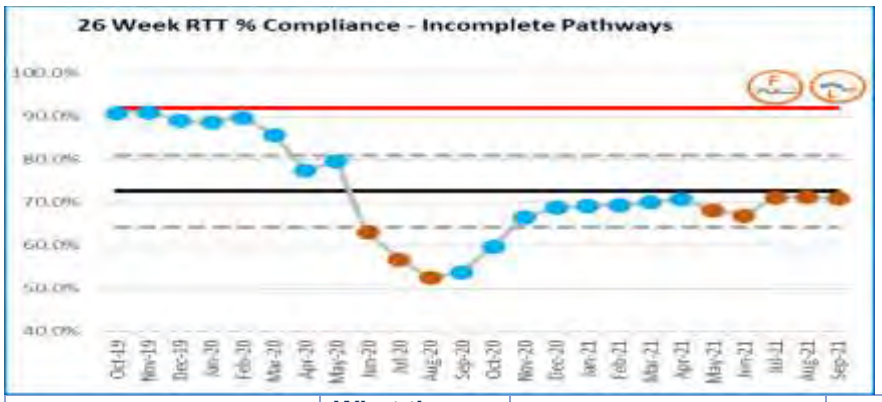
6.1. Elective Care
RTT Waiting List – Total Size

September 2021 actual performance
34443 (English 30784, Welsh 3659)
Variance Type
Special Cause Concern
Local Plan
26209 (English) by Mar 2022
Target / Plan Achievement
Overall plan will be revised in line with H2 guidance.

Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.	Continuation of the increase in the total waiting list size.	Referrals returning to pre-COVID-19 levels especially in relation to cancer services. Patients converting from outpatient to inpatient/day cases as more patients being seen in OPD. Reduced capacity to treat patients due to staffing absences and vacancies, bed and clinic space restrictions and impact of increasing emergency demands.	Referral demand/ capacity monitored through restore and recovery meeting and centre POD meetings align additional capacity where possible. H2 demand and capacity refreshed. Focus on improving utilisation of capacity and recruitment to vacant posts. Use of insourcing to provide additional out of hours working. Joint working with RJAH on orthopaedics and CT. Use of independent sector for additional capacity. Waiting list continues to be clinically prioritised for diagnostics and surgical procedures. Theatre staff recruitment continuing.	Need to address demand, outpatient transformation and midlands elective care improvement programme as a system. Additional 32 beds to be available from approx. April 2022 to mitigate some of the bed shortages may alleviate risk of loss of elective activity due to winter pressures. Supernumerary theatre staff being trained to be operational over next 6months.

18 week RTT Exception Report

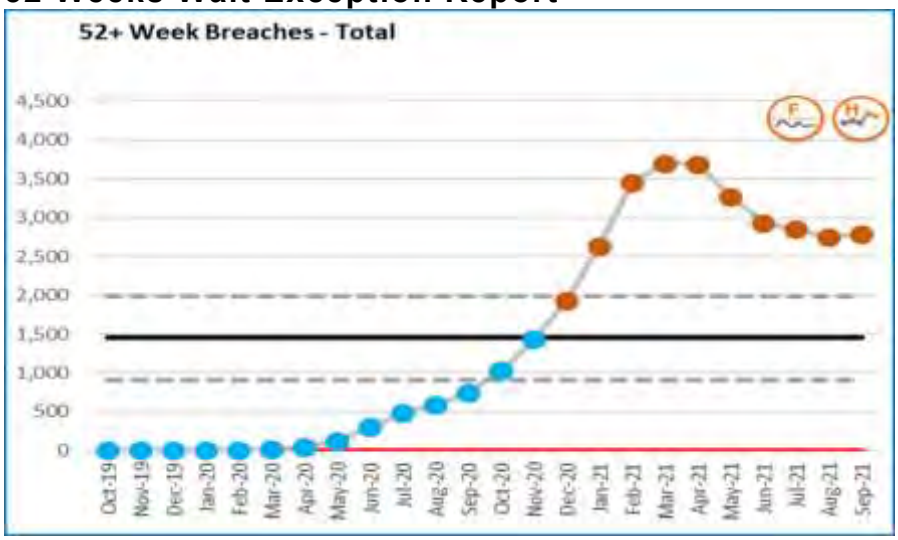
September 2021 actual performance
56.7%
Variance Type
Special Cause Concern
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed, the target will not be achieved. Local plan focuses on clinically prioritised patients.



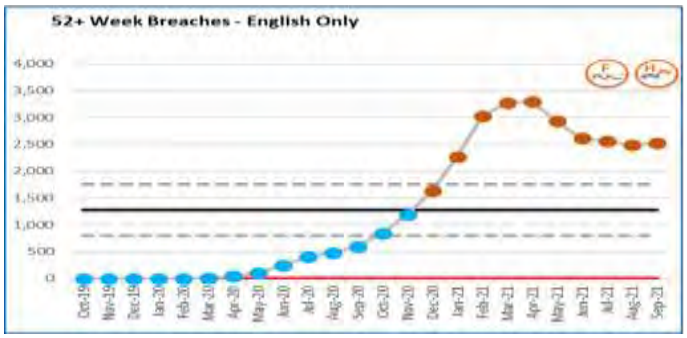
September 2021 actual performance
71%
Variance Type
Special Cause Concern
National Target
92%
Target / Plan Achievement

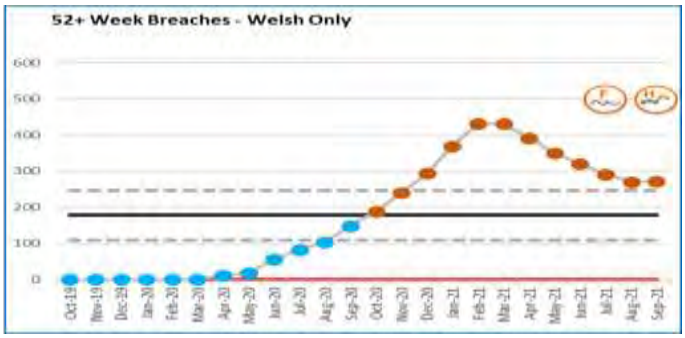
Background	What the Chart tells us	Issues	Actions	Mitigation
Headline performance against this measure has now stabilised (58.15% Aug compared to 57.48% at end July and 56.6% at end May 2021) but this compares to a much better performance with 18 week compliant pathways before the Pandemic commenced.	Incomplete pathway appear to have stabilised at a level significantly below the national target.	Limited outpatient capacity with 1m social distancing. Theatre capacity & staffing. COVID-19 and non COVID-19 related absences. Increase in urgent demand. Total list size increased due to above and inability to treat routines and close RTT pathways.	Referral demand/ capacity monitored through restore and recovery meeting and centre POD meetings align additional capacity where possible. H2 plans developed including consideration of opportunities for IS support (subject to funding).	System elective and cancer meeting established. Modelling to inform system actions. As per actions

52 Weeks Wait Exception Report



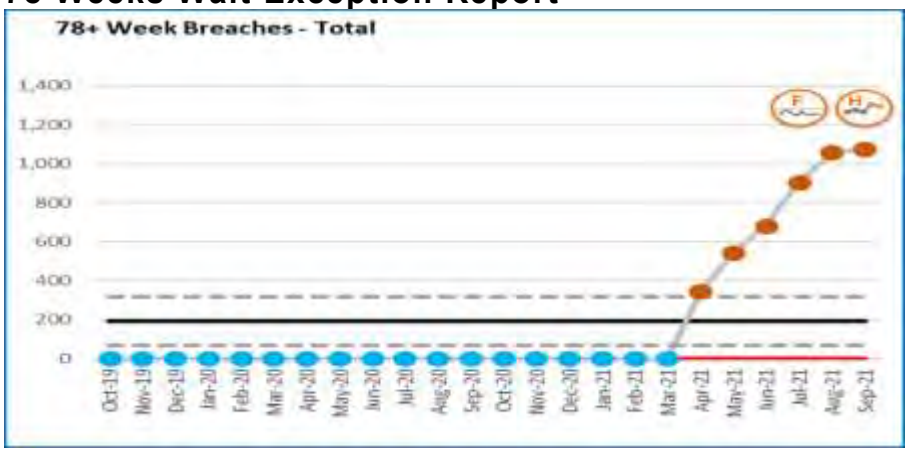
September 2021 actual performance	
2794 (English 2522, Welsh 272)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	4156
Target / Plan Achievement	
The target will not be delivered in 21/22. Local forecast developed aligned to the H1 plan.	



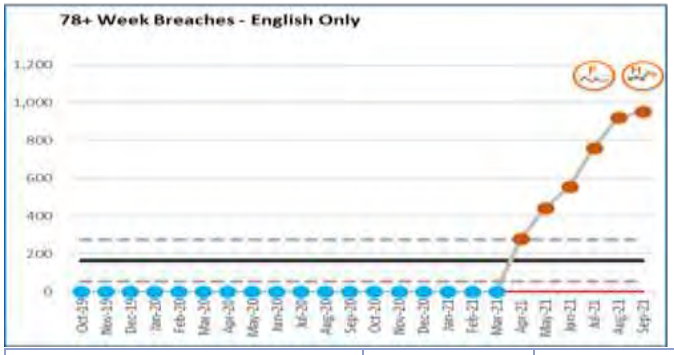


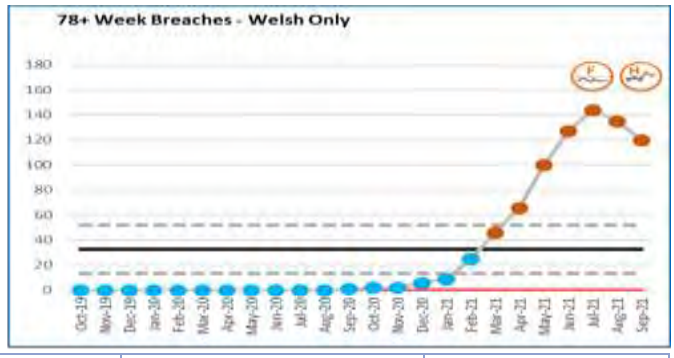
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being able to be prioritised for treatment.	The reduction seen in over 52 weeks at present is not forecast to be sustained. Total waiting list is forecast to reduce as the most urgent patients are treated. This means that the 18-week performance will continue to decline, as the most urgent patients tend to wait in shorter time bands.	Reduced theatre capacity and staffing vacancies. Urgent care bed pressures resulting in loss of elective beds. The volume of patients over 78weeks is continuing to increase	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 78 weeks date where possible. Avoidance of over 104 week breaches. ERF plan and use of Nuffield for suitable patients where possible and outsourcing to Rowley Hall for urology. Continue to date in chronological and clinical urgency	Monitored by weekly RTT meeting & cancer performance meeting

78 Weeks Wait Exception Report



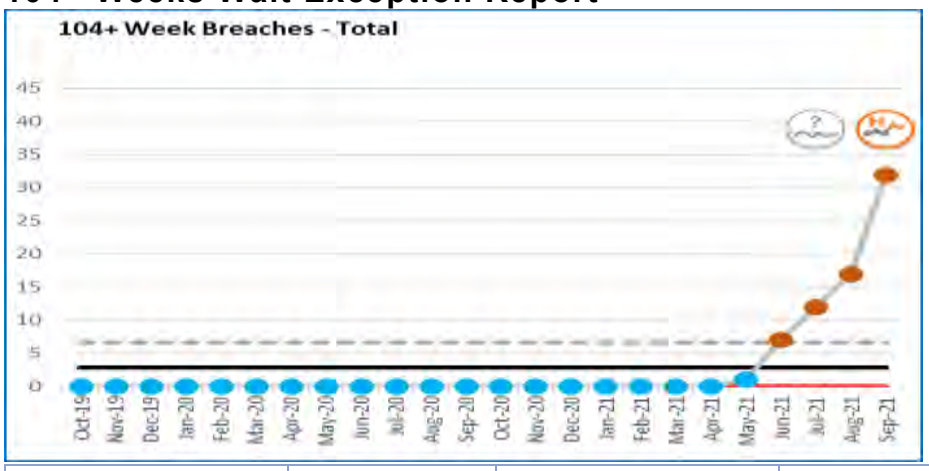
September 2021 actual performance	
1075 (English 955, Welsh 120)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	tbc
Target / Plan Achievement	
The target will not be delivered in 21/22...	





Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 21, the volume of patients waiting in excess of 78 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being prioritised for treatment.	The proportion of these long waiting patients who are over 78 weeks is increasing.	The volume of patients over 78weeks is continuing to increase. A small number of patients are requesting not to return to service at this time.	Reduced theatre capacity and staffing vacancies. COVID-19 and non COVID-19 related absences which are being closely monitored. Urgent care bed pressures resulting in loss of elective beds.	Monitored via weekly RTT meeting.

104+ Weeks Wait Exception Report



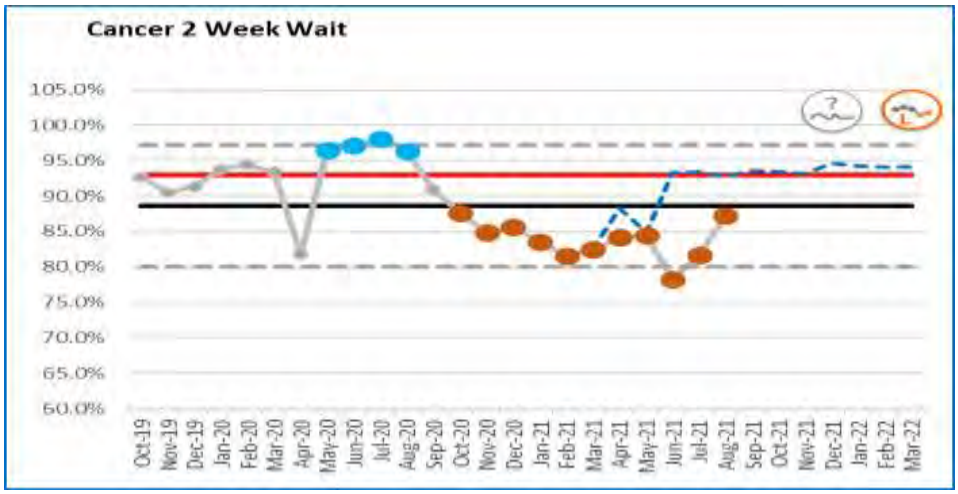
September 2021 actual performance	
32 (English 26, Welsh 6)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	74 with support
Target / Plan Achievement	
We will continue to strive to eliminate 104 week waits	

Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 21, the volume of patients waiting in excess of 104+ weeks on an open RTT pathway has increased. It continues to	Number of 104+ week waiters is increasing due to the proportion of long waiters.	Reduced theatre capacity and staffing vacancies. COVID-19 related staff absences. Level of non COVID-19 related sickness. Urgent care bed pressures resulting	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 78 weeks date where possible. Avoidance of over 104 week breaches. ERF plan and use of Nuffield for suitable	Monitored via weekly RTT meeting. Trajectory for 104 weeks position submitted to region with indication of support required

increase because routine patients are not currently being prioritised for treatment.		in loss of elective beds. The volume of patients over 104+ weeks is continuing to increase, with a small number of patients choosing to wait.	patients where possible and outsourcing to Rowley Hall for urology. Continue to date in chronological and clinical urgency. Decision around H2 funding needed urgently.	to reduce numbers.

Cancer

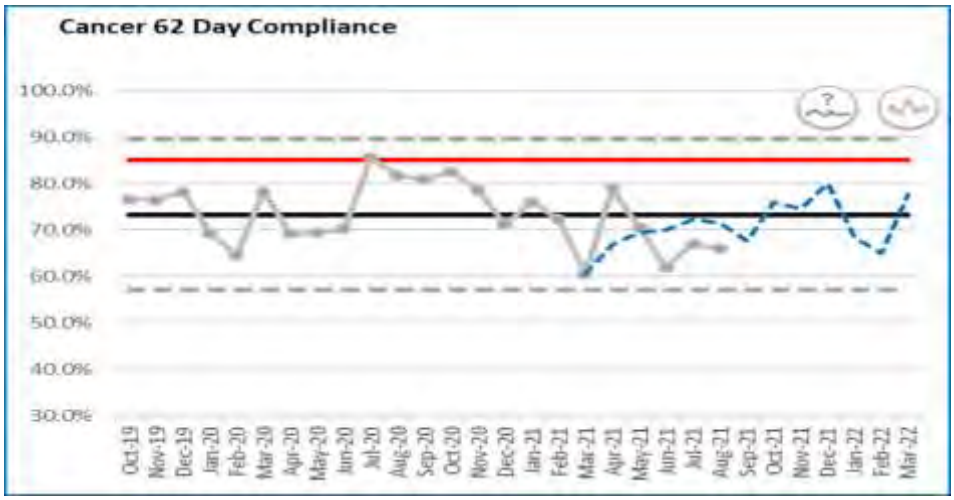
Cancer 2 week waits



August 2021 actual performance
87.2% (September Forecast 93.6 %)
Variance Type
Special Cause
National Target
93%
Target / Plan Achievement
Improvement trajectory being monitored weekly

Background	What the Chart tells us	Issues	Actions	Mitigation
This measure is a key indicator for the organisation's performance against the national cancer waiting times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer has a first appointment within 14 days.	The present system is unlikely to deliver the target. Compliance with this target has fluctuated since April 2019 – attributed to poor performance (capacity) within the breast service.	Capacity issues in the breast specialty has impacted negatively on SaTH's overall 2WW performance. Gynaecology PMB patients to be seen in one stop only, which will cause breaches of 2ww, but improve the 28 day target.	Breast pain only clinics to start in November, which will reduce the amount of 2ww breast referrals. Gynaecology working on extra capacity.	Implementation of revised 2ww breast referral proforma. Implementation of revised 2ww gynaecology proforma.

Cancer 62-day target



August 2021 actual performance
65.9% (September forecast 67.6%)
Variance Type
Common Cause
National Target
85%
Target / Plan Achievement
Performance worse than improvement plan

Background	What the Chart tells us	Issues	Actions	Mitigations
This measure is a key indicator for the organisation's performance against the national cancer waiting times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer is treated within 62 days of referral.	The present system is unlikely to deliver the target. Compliance with this target has been achieved once since April 2019.	Capacity does not meet demand (diagnostics a significant issue even prior to COVID-19). Surgical capacity not back to pre COVID-19 levels. Rise in 2ww referrals.	Weekly review of PTL lists using Somerset Cancer Register – escalations made as per cancer escalation procedure. New pod to house a CT/MRI scanner to be in place in Oct. 2021. Additional mobile CT in site from beginning of Oct. to increase diagnostic capacity.	Cancer performance and assurance meetings on going chaired by Deputy COO.

6.2. Diagnostics

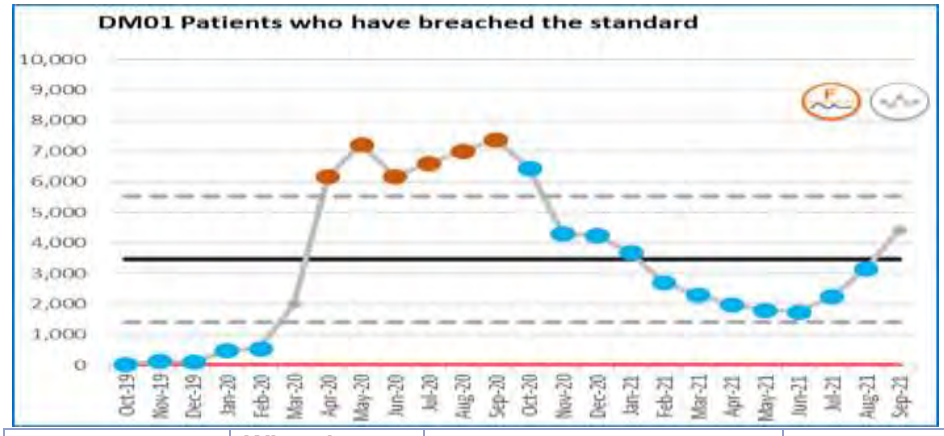
DM01 Diagnostic over 6 week waits

September 2021 actual performance
63.6%
Variance Type
Common Cause
National Target
99%
Target / Plan Achievement
Forecast delivery by March 2022

Background	What the Chart tells us	Issues	Actions	Mitigations

DM01 is the national standard for non-urgent diagnostics completed within 6wks.of referral.	Improvement seen since February not sustainable.	Lack of capacity to meet demand due to ongoing COVID-19 working restrictions and staffing difficulties. Improvement seen through to May reversed with loss of mobile CT at end of May.	Return of mobile CT from 11th October should demonstrate improved performance over the next 2-3 months. Imaging Pod now on-line but limited use due to inability to safely staff a unit.Recruitment ongoing.	Clinical prioritisation of appointments. Utilisation of all available mutual aid from RJAH and Nuffield.

DM01 Patients who have breached the Standard

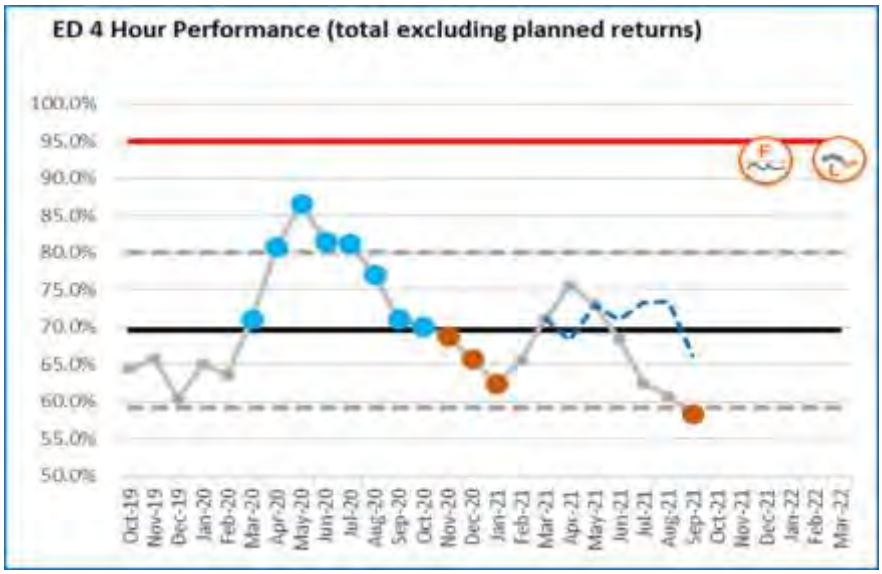


September 2021 actual performance
4423
Variance Type
Common Cause
National Target
0 - < 6weeks
Target / Plan Achievement
Deterioration in previous recovery noted

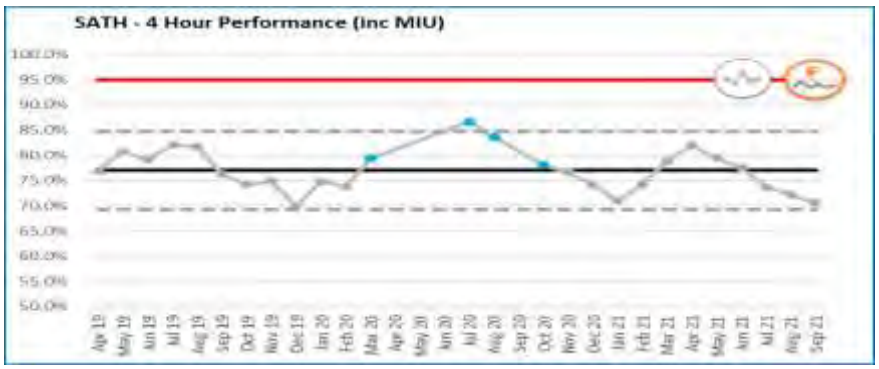
Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral. There must be no more than 1% of patients waiting longer than 6w.	Improved performance was seen through to June with a gradual worsening of performance since July 2021.	This change in performance correlates to the loss of the mobile CT scanner at the end of May 2021. The full effect took a couple of months to become evident. Compounding factor is ongoing staffing crisis, particularly affecting the cross-sectional team, reducing available capacity in CT and MRI.	Ongoing recruitment of cross sectional team. Approval of CT business case saw the mobile commence scanning on 11th October. This will feed through into DM01 performance in the next 2-3 months.	Deployment of staff between CT and MRI to maximise capacity across both modalities. Review of appointment templates in line with scan times. Continue to prioritise appointments according to clinical urgency.

6.3. Unscheduled Care/Emergency Department

A&E 4 hour performance



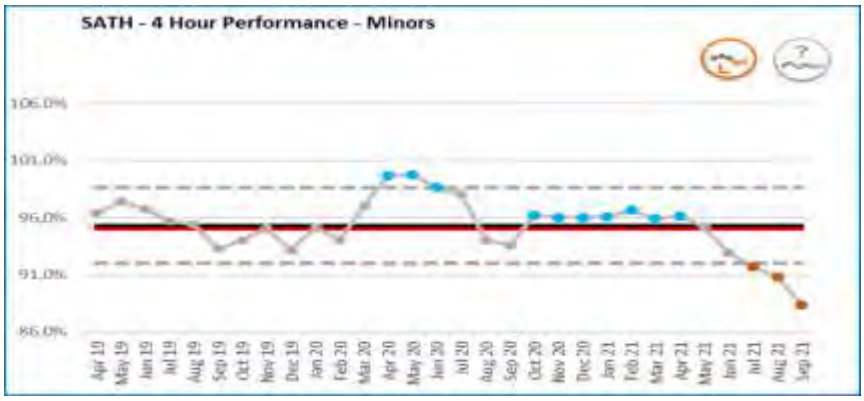
September performance
58.4%
Variance Type
Special Cause Concern
National Target
95%
SaTH Local Plan
66.1%
Target / Plan Achievement
Performance is worse than the improvement trajectory set. The 95% target cannot be achieved. Trust is working with system partners towards delivery of 85%.



September 21 performance
70.6%
Variance Type
Common Cause
National Target
95%
SaTH Local Plan
66.1%

Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	ED performance is forecast to continue to be below national target.	Flow out of ED restricted due to constraints associated with the different COVID-19 pathways and an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients and late in the day discharges.	Continued full use of SDEC for suitable patients. Focus on the reduction in MFFD patients occupying beds with system partners. Working with WMAS on conveyance improvements. Two-week improvement event held September to focus on medical wards at RSH so improve flow. Follow up actions agreed to ensure revised ward processes are embedded. Capital expansion of facilities in A&E at RSH to increase capacity to treat patients underway.	System UEC action plan. Support from NHSEI on flow. Modular ward from April 2022 to increase bed capacity.

ED Minors Performance



September 2021 actual performance
88.4%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
The target being between the process limits will not be delivered reliably each month

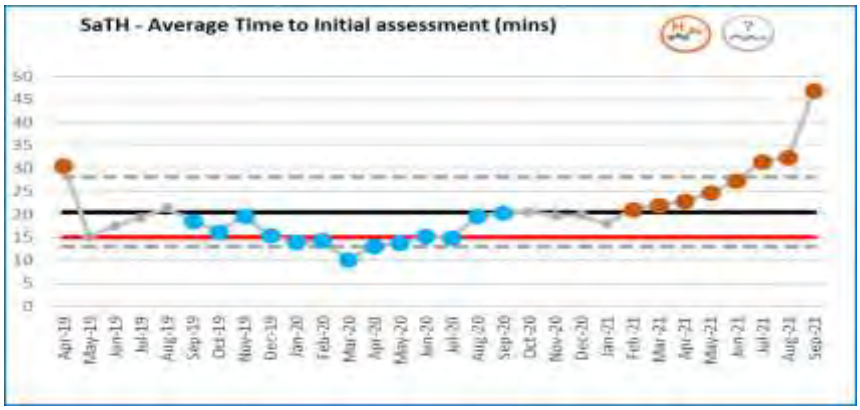
Background	What the Chart tells us	Issues	Actions	Mitigations
Maintaining streaming between minor and major conditions will support delivery of the 4-hour standard for patients with more minor presentations.	Deterioration in performance. Special cause variation.	Workforce constraints – sickness absence and COVID-19 isolation.	Issue will resolve as workforce issues improve.Optimising the minors and UTC streaming process.	Patients assessed on clinical priority need.

ED Majors Performance

September 2021 actual performance
32%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
The target is well above the upper process control limit and so will not be achieved without process re-design.

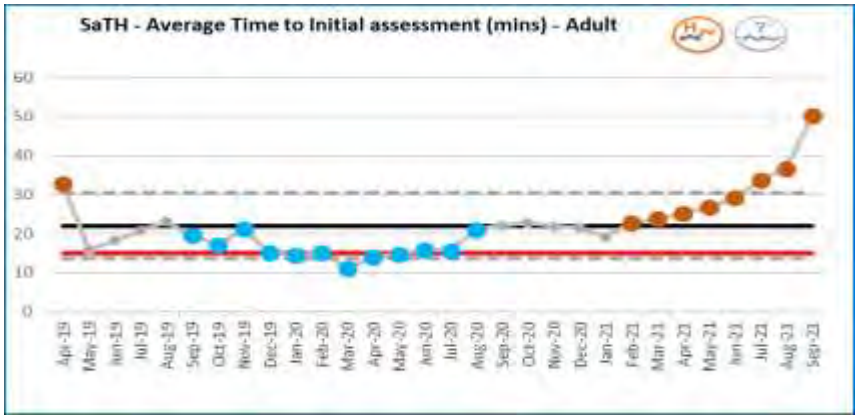
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	Deterioration in performance. Special cause variation.	Workforce constraints – sickness absence and COVID-19 isolation. Whole system working for patient flow.	An internal improvement programme on ward flow has been re-established, with focus weeks at RSH in September, and work at PRH in early October. Broader work with the wider community is also being maintained, to optimise use of community capacity.	Patients assessed on clinical priority need.

ED –Time of Initial assessment (mins)



September 2021 actual performance
47 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance has further deteriorated this month and is now above the upper process limit

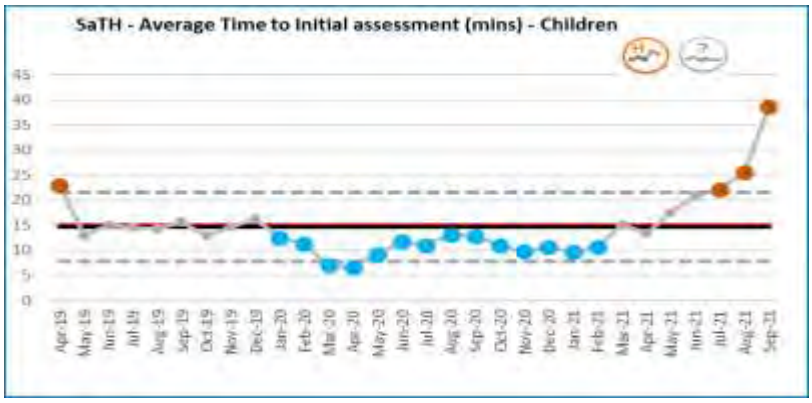
ED Time to Initial Assessment - Adult



September 2021 actual performance
50 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance worse than target and above upper process limit

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	Overall time to initial assessment is worse than the target. The performance for adult initial assessment is the key contributor to this although in recent months deterioration has been seen in the paediatric time to initial assessment.	Workforce and physical capacity constraints to meet the demand for both walk in and ambulance arrivals leads to bottleneck in departments.	Matrons focussing on restoration of initial assessment times – action plan developed, now in the process of being implemented.	ED assurance meeting chaired by COO.

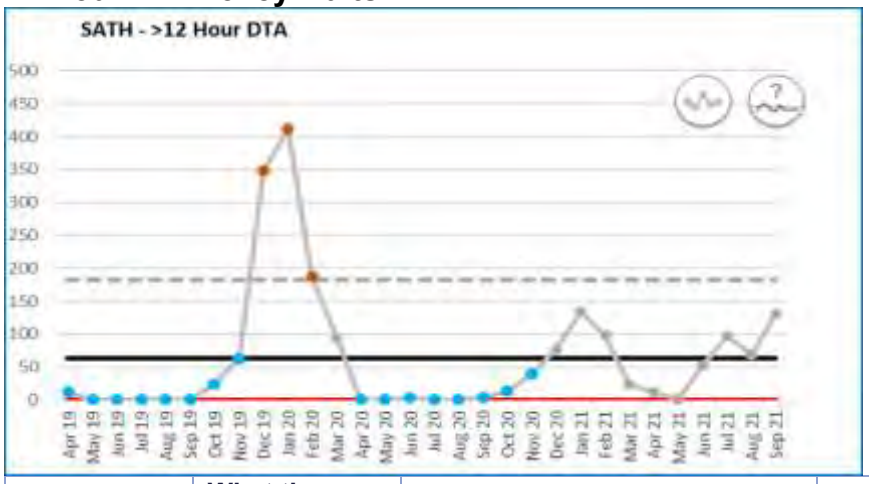
ED Time to Initial Assessment - Children



September 2021 actual performance
39 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance deteriorated and now above upper process limit

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	Overall time to initial assessment is worse than the target	Increase in paediatric attendances. Conditions placed on the Trust for paediatrics with mental health conditions mean these patients cannot be admitted to wards, requiring assessment in ED and so reducing clinical capacity and space. Closure of paediatric beds due to staffing constraints has an impact upon flow through the department and workforce capacity to support paediatric patients as staff are re designated from streaming to care for patients.	Matrons focussing on restoration of initial assessment times, improvement plan developed, in the process of implementation. Working with MPFT to increase support to children attending ED and transfer to CAMHs facilities where appropriate in a timely manner. Review of paediatric escalation processes underway to reduce times children's assessment unit closes and ensure sufficient support is provided to ED's when this does occur.	ED assurance meeting chaired by COO.

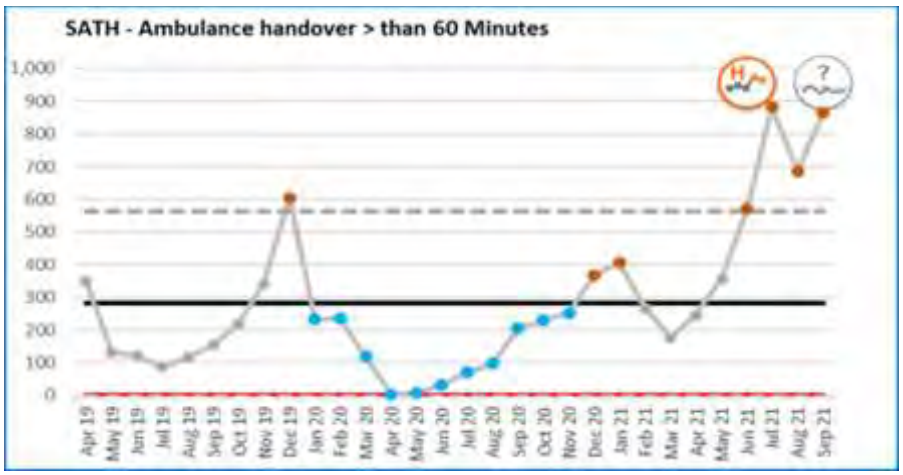
12 Hour ED Trolley waits



September 2021 actual performance
131
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The target was missed this month

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a patient experience and outcome measure.	Following a period of improvement from January 2021-May 2021 performance has deteriorated.	Increased volume of ED attenders especially in majors. There has been a significant increase in both the number and length of stay for MFFD patients which has impacted on flow from the departments. There is a known shortfall in medical bed capacity to meet demand. Increase in COVID-19 presentations has impacted on flow due to the necessity to segregate patients.	Bed modelling completed to inform winter planning. Improvement focus on morning discharges to release beds for admissions earlier in the day. Additional COVID-19 capacity opened with planning for further escalation agreed if required.	ED Safe Today processes in place to mitigate risk where possible within the department.

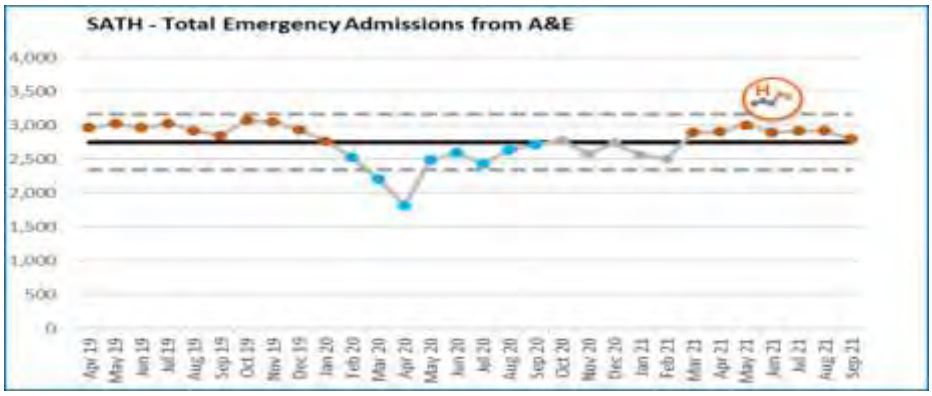
Ambulance handover> 60 Mins



September 2021 actual performance
863
Variance Type
Special Cause Concern
National Target
0
Target / Plan Achievement
Performance deteriorated to above upper control limit

Background	What the Chart tells us	Issues	Actions	Mitigations
Ambulance handover times are an important indicator for patient safety and to support the community response to 999 calls by release of ambulances to respond.	Handover delays have increased in volume and performance is showing special cause concern.	High volume of ambulance presentations with a large number presenting around the same time of day. The requirement to segregate patients arriving by COVID-19 pathway creates additional delays. Staffing of the departments has been challenging and has meant that some areas have not been able to open consistently to receive patients. Exit block associated with flow issues.	Working with WMAS to improve timing of arrivals and seek joint solutions to release ambulances from sites. Matrons and clinical staff working to escalate handover based on clinical need. Improving flow project work underway.	System UEC action plan with oversight of established ambulance handover improvement group chaired by WMAS.

Total Emergency Admissions from A&E



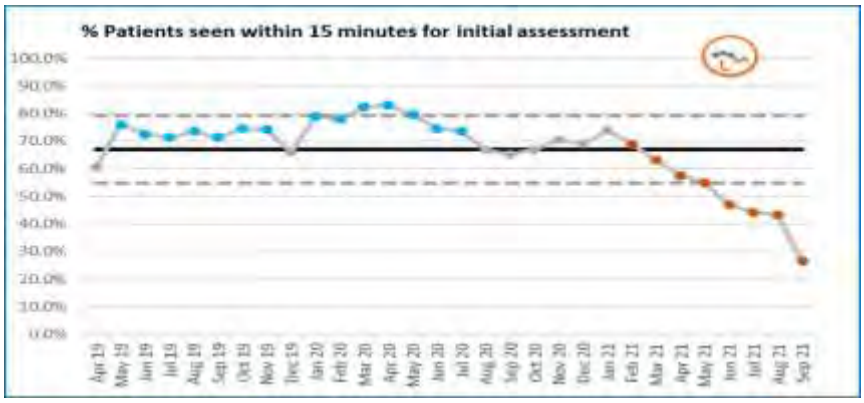
September 2021 actual performance
2794
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement
N/A

Background	What the Chart tells us	Issues	Actions	Mitigation
The number of emergency admissions is an indicator of system performance and a reflection of the prevalence of	Emergency admissions from ED have returned to pre-COVID-19 levels. The run rate for year to date is slightly higher than a straight 12th distribution would support. 49% of expected annual	Segmentation of patients continues to be necessary to ensure good IPC is maintained. Beds are required across elective	Beds have been re-allocated to specialties to support recovery. Trigger tool being developed to determine points are which capacity will need to switch from elective to emergency care and actions to be taken at this point. System wide	Development of system wide winter plan.

serious illness and injuries in the community.	admissions via ED have been received in the first 5months of the year.	and emergency care.	working to address capacity requirements and potential solutions to bed shortfall.	

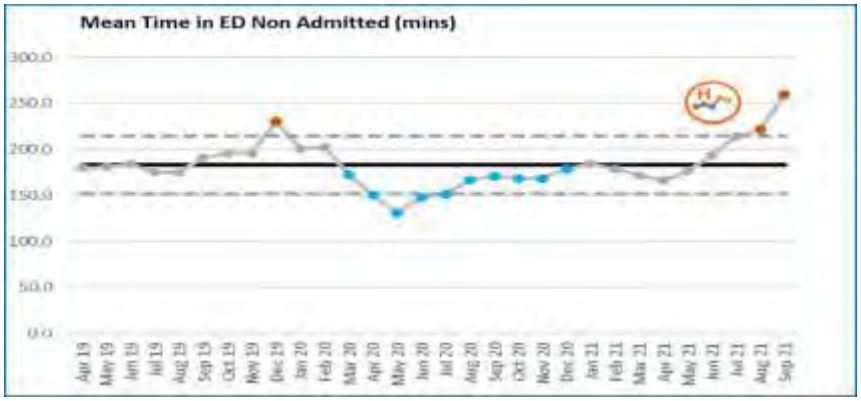
Shadow reporting of UEC measures
The trust is working to implement the new unscheduled and emergency care clinically focussed measures and is commencing recording these in shadow form ahead of formal reporting anticipated during 2022-23.

% Patients seen within 15 minutes for Initial Assessment



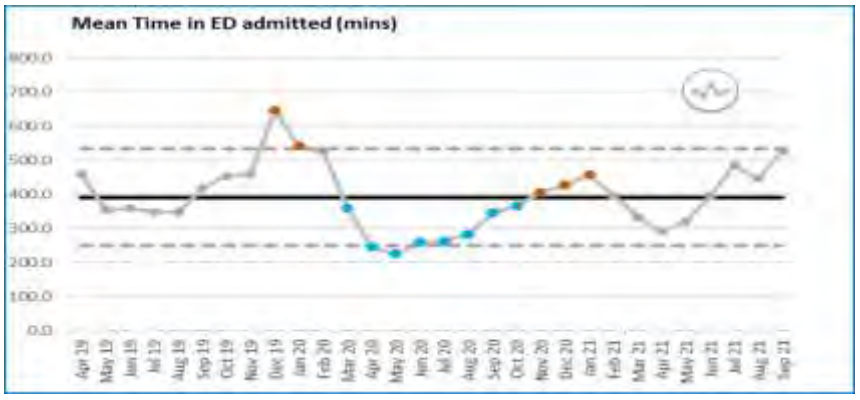
September 2021 actual performance
26.5%
Variance Type
Special Cause Concern
National Target
n/a
Target / Plan Achievement
Shadow reporting UEC measure

Mean Time in ED Non-Admitted (Minutes)



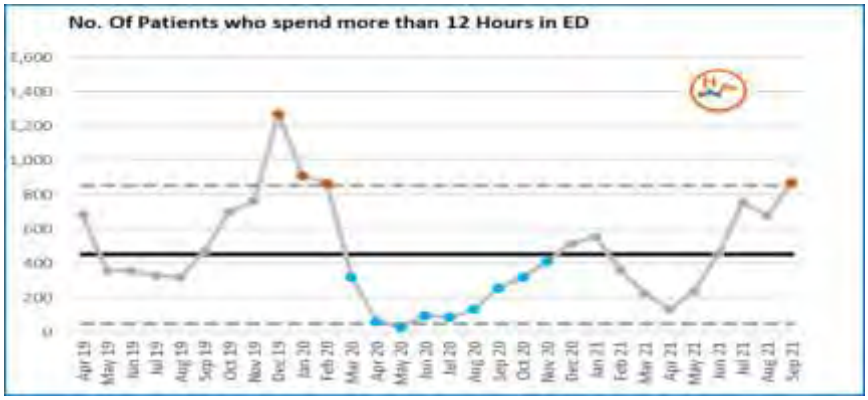
September 2021 actual performance
260
Variance Type
Special Cause Concern
National Target
n/a
Target / Plan Achievement
Shadow reporting new measures

Mean Time in ED Admitted (Minutes)



September 2021 actual performance
527.5
Variance Type
Special Cause Concern
National Target
n/a
Target / Plan Achievement
Shadow reporting new measures

Number of Patients who spend more than 12 hours in ED

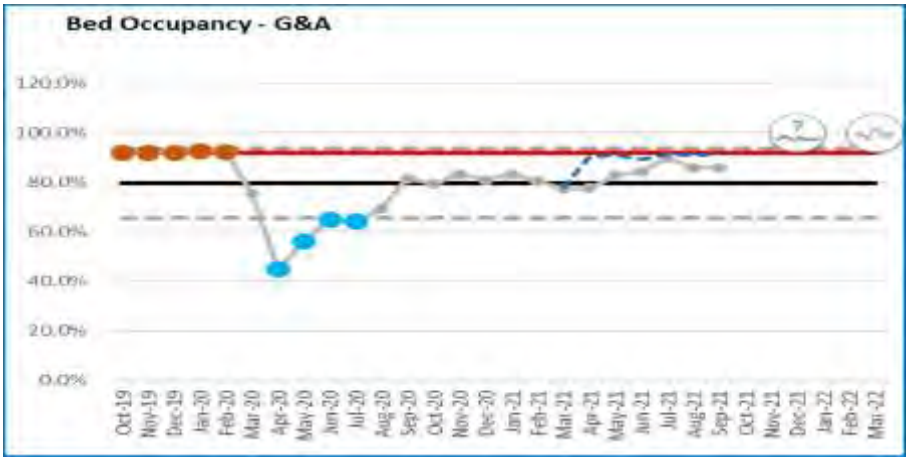


September 2021 actual performance
870
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement
Shadow reporting new measure

12 Hours in ED Performance %

September 2021 actual performance
6.8%
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
Shadow reporting new measure

Hospital Occupancy and Activity Bed Occupancy



September 2021 actual performance
85.8%
Variance Type
Common Cause
Local Target
92%
Target / Plan Achievement
Occupancy continuing to be lower than pre-COVID-19

Background	What the Chart tells us	Issues	Actions	Mitigation
Bed occupancy is an important measure indicating the flow and capacity	Bed occupancy has increased overall, however the majority of the increase	Segmentation of beds has created smaller bed pools and reduced flexibility. The increase in NEL occupancy has reduced capacity to	Bed base re-allocated to increase capacity for COVID-19 patients while protecting cancer activity within the day surgery unit. Focus on flow and discharge pathways with partners to increase bed capacity earlier in the day.	Additional 32 beds approved from April 2022 to reduce a portion of the

within the system.	represents an increase in emergency non-COVID-19 admissions. Occupancy levels remain slightly below the pre-COVID-19 levels but close to the forecast position.	restore elective activity. Occupancy in medical and surgical wards are considerably higher than the average overall occupancy. Re-allocation of beds to specialties means that some wards will have lower occupancy levels however their beds may not be clinically suitable to other specialty patients. Increase in MFFD times to discharge. Further work needed to mitigate against the forecast winter bed shortfall.	Improvement fortnight at RSH from 13th Sept.2021 to improve Board rounds and discharge processes, to be followed with fortnight in October on PRH site. Bed modelling completed demonstrating underlying bed shortfall for winter 2021-22. Winter planning and surge planning commenced and schemes under-development to continue admission avoidance. Impact assessment of system funded winter plans on beds to be completed and aligned to the current bed gap.	forecast bed gap.

ED Activity

September 2021 actual performance
12764
Variance Type
Special Cause Improvement
Local Target
12483 (H1 Plan)
Target/ Plan achievement
Trajectory Based on H1 plan

September 2021 actual performance
10831
Variance Type
Special Cause Improvement
Local Target
10397 (H1 Plan)
Target/ Plan achievement
Trajectory Based on H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The ED activity levels reflect the demand for unscheduled	Activity has significantly increased in the first quarter of 2021-22 with demand now above forecast	Flow out of ED restricted due to constraints associated with the different	Continued full use of SDEC for suitable patients. Focus on the reduction in MFFD patients occupying beds with system partners.	System UEC action plan.

care presenting at the A&E departments. Type 1 activity is the major A&E activity and excludes minor injury unit and urgent care centre activity.	levels and higher than seen in the winter of 2019 (pre-COVID-19) and at any time during the pandemic. The year to date run rate is higher than planned and higher than the recovery trajectory, although slightly lower than the baseline 2019 figure reflected in the H1 plan for this particular month.	COVID-19 pathways and an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients and late in the day discharges.	Working with WMAS on conveyance improvements. Two-week improvement event held September to focus on medical wards at RSH so improve flow. Follow up actions agreed to ensure revised ward processes are embedded. Capital expansion of facilities in A&E at RSH to increase capacity to treat patients underway.	Support from NHSEI on flow.

Non-Elective Activity

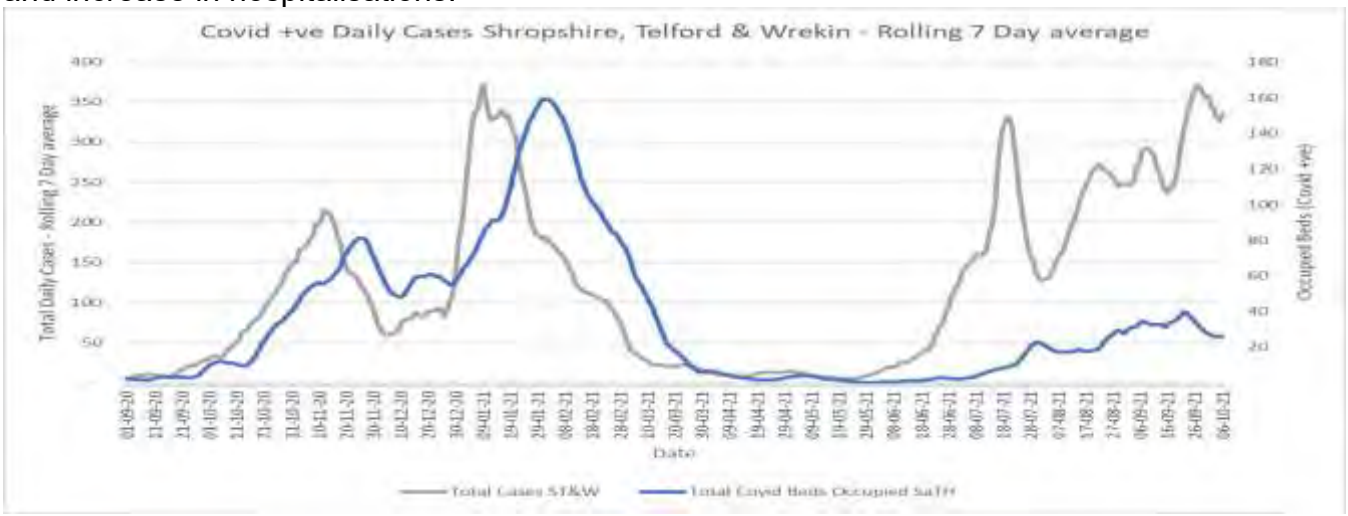
September 2021 actual performance
5034
Variance Type
Special Cause Improvement
Local Target
5426 (H1 plan)

Background	What the Chart tells us	Issues	Actions	Mitigations
Non-elective activity reflects the demand from unscheduled care for admissions to hospital. It represents the greatest demand on beds and increases can result in constraints on elective activity, while reductions impacts negatively on contract income.	Increase in non-elective activity across scheduled care. However, activity remains slightly lower than the 2019-20 baseline in the H1 plan and lower than the trajectory shown on the graph.	Increase in proportion of non-elective activity presenting via ED.Increase in time from MFFD to discharge, slightly increasing overall length of stay and resulting in flow issues within the sites. Increase in COVID-19 admissions and need to segment patients on both sites. Anticipated increase in surgical emergencies.	Dedicated CEPOD surgeon and list to support demand – clinical prioritised if needed by clinical teams. Elective capacity reduced to increase access to beds and segmentation of COVID-19 patients, with elective activity within day case unit.	See actions.

COVID-19

While we work through the recovery of elective services and manage the demand for urgent and emergency care, we are mindful of the increasing prevalence of COVID-19 in the community and the work needed to maximise the vaccination uptake to mitigate against further increases in hospitalisation in the coming weeks.

The graph below shows the rising prevalence of the virus in our communities into September and increase in hospitalisations.

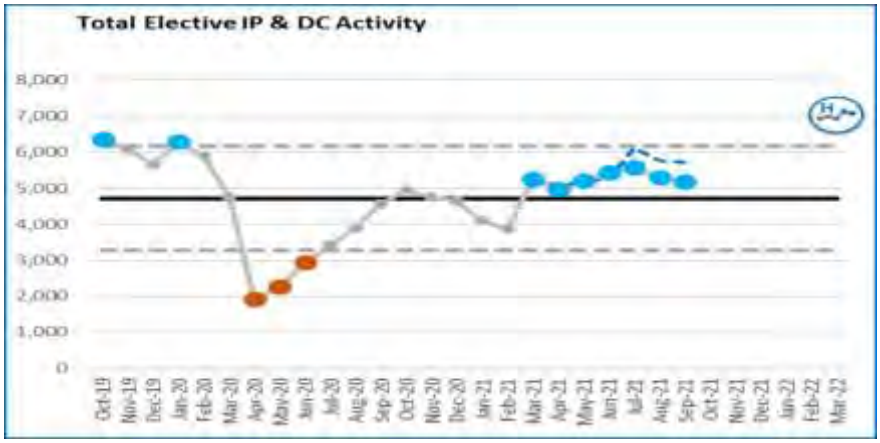


6.4. H1 recovery plan

The table below provides the unvalidated end of September recovery by POD of the 2019-20 baseline activity (all patients). The recovery is also shown against the activity planned. The threshold used for the red green rating is the 95% ERF threshold, although it is noted that the ERF is based on the value rather than volume of activity in H1. The final SUS frozen position will be known in November 2021.

September 2021 Provisional Activity v Plan v and recovery threshold	19/20 Baseline	21/22 H1 Pla	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseli	21/22 Actual % of 21/22 H1 Pla
Total number of Specific Acute elective day case spells in the period	5415	5345	4913	95.0%	91%	92%
Total number of Specific Acute elective ordinary spells in the period	421	364	274	95.0%	65%	75%
Consultant-led first outpatient attendances (Spec acute)	11829	11748	12810	95.0%	108%	109%
Consultant-led follow-up outpatient attendances (Spec acute)	20837	21795	20327	95.0%	98%	93%
Diagnostic Tests - Magnetic Resonance Imaging	2321	1289	2118	95.0%	91%	164%
Diagnostic Tests - Computed Tomography	6055	5043	5969	95.0%	99%	118%
Diagnostic Tests - Non-Obstetric Ultrasound	5380	5187	4896	95.0%	91%	94%
Diagnostic Tests - Colonoscopy	417	634	520	95.0%	125%	82%
Diagnostic Tests - Flexi Sigmoidoscopy	396	219	178	95.0%	45%	81%
Diagnostic Tests - Gastroscopy	615	751	527	95.0%	86%	70%
Diagnostic Tests - Cardiology - Echocardiography	822	924	1138	95.0%	138.4%	123%

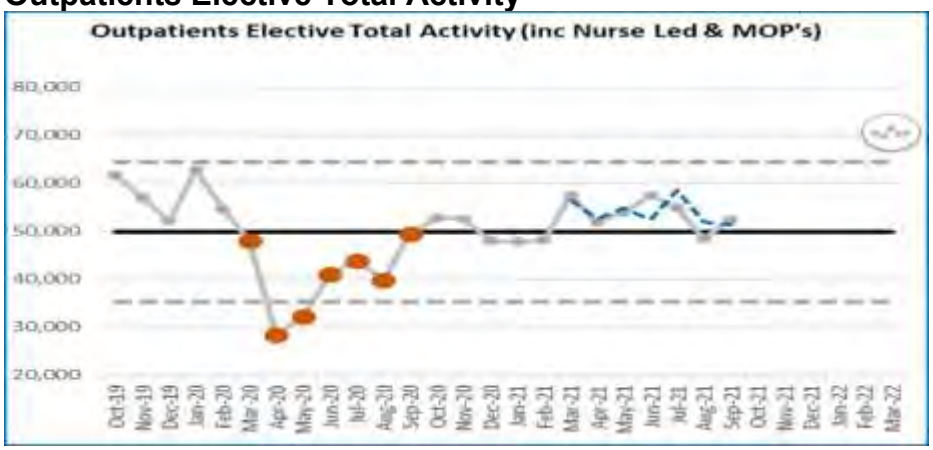
Elective IP & DC Activity v H1 recovery plan



September 2021 actual performance
5240 (Recovery 89.7%) (IP 273, DC 4967)
Variance Type
Common Cause
National Target
National DC & IP 95%
Target/ Plan achievement
H1 86.4% achieved –above original target, below revised target introduced mid-July

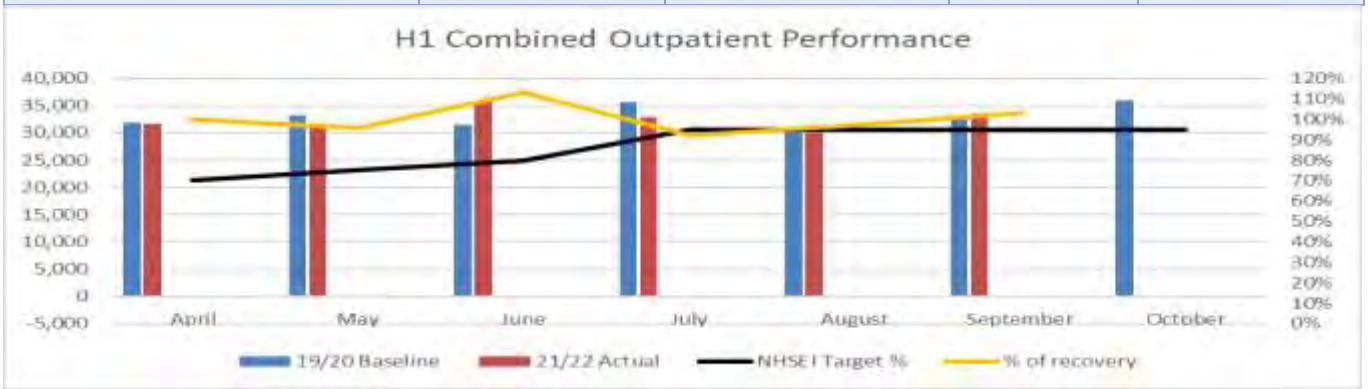
Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust is working to recover services in line with the level of activity delivered in 2019-20, which is being used as a baseline. The NHSEI threshold for recovery in July 2021 increased to 95% of the July 2019 activity. The trust has developed a recovery plan for the first half of 2020-21 (H1 plan) and is tracking performance against this and against the NHSEI threshold, which links, to the Elective Recovery Fund (ERF)..	Performance is tracking is slightly below the H1 plan trajectory and remains lower than September 19/20. Elective IP plan was not delivered. The plan is below the threshold set and in-patients particularly remains an area of challenge. The Daycase activity was also lower than plan. Therefore, the combined elective activity was lower than plan.	Controlled drug key holders are an issue in theatre and extra substantive staffing are require to support this. Short notice cancellations by patients and the inability to backfill due to swabbing. Staffing vacancies in theatre reducing the number of lists available. Staff absences due to COVID-19 related – isolation, family. Bed capacity reduced with loss of orthopaedic elective beds on Ward 36 to medical patients.	Review lists to ensure optimising throughput of lists running. Ensure 6-4-2 theatre meeting and theatre list planning optimises utilisation of lists. Recruitment & retention of theatre staff. Full approval of ODP apprenticeship programme, trust agreed to go at risk this year. Insourcing and outsourcing in place.	Patient clinically prioritised if lists need to be cancelled.

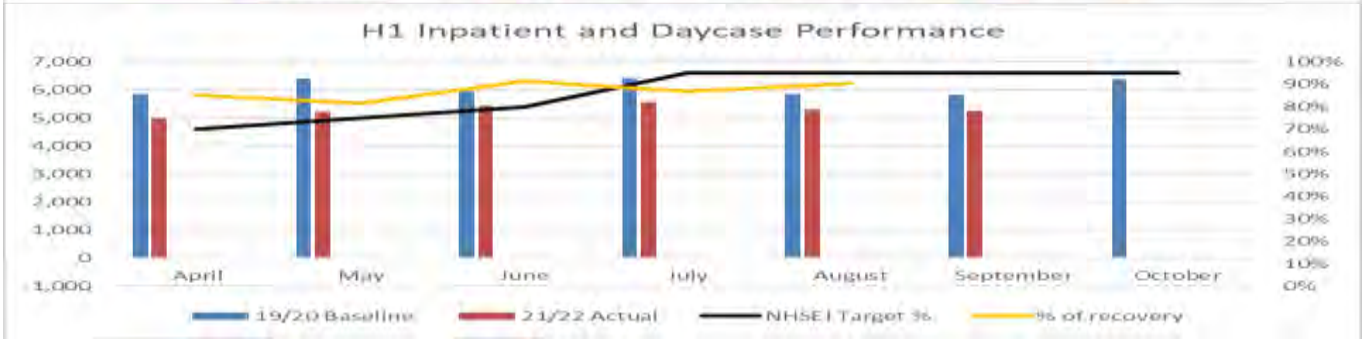
Outpatients Elective Total Activity



September 2021 actual performance
52430
Variance Type
Common Cause
Local Target
51429 (H1 plan)
Target/ Plan achievement
Aim to deliver H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The H1 activity plan aims to recover activity during Q1 and Q2 of 2021-22, using 2019-20 activity as a baseline. In addition, transformation is expected to support new ways of working such as virtual activity, patient initiated follow up (PIFU) and increased use of advice and guidance.	Activity below revised ERF threshold but in line with plan overall.	The availability of outpatient capacity remains constrained due to staff leave and COVID-19 Isolation. Staff absences due to self-isolation have some impact on lists running.	Waiting List Initiatives Bank staff to support outpatient staffing.	Patients prioritised in terms of clinical priority i.e. 2ww, urgent, longest wait.





Diagnostics recovery

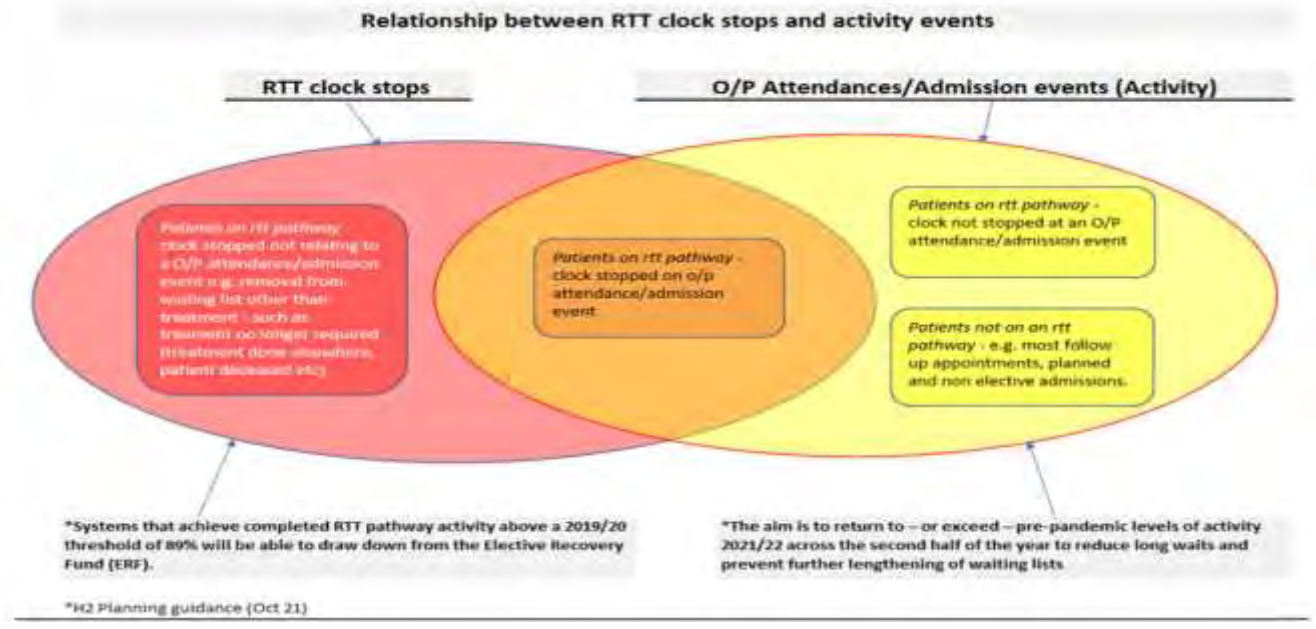
September 2021 actual performance
16434
Variance Type
Special Cause Improvement
Local Target
16500 (based on Apr-19-Feb-20 average)
Target/ Plan achievement
slightly better than H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures	Continued special cause improvement in overall monthly	Radiology activity is comparable to pre-COVID-19 levels, even without full restoration of services,	Review of appointment templates. Deployment of staff to maximise efficiency.	Ongoing recruitment. International Radiographers expected to

carried out during the month; it contains imaging, physiological measurement and endoscopy tests.	activity with performance close to the 2019-20 baseline.	demonstrating the increasing demand for imaging overall. Fluctuating staffing levels due to vacancies, sickness and COVID-19 affects performance month on month. While activity looks good, we are still not able to meet the overall demand with increasing waiting lists and continued failure to meet DM01.	Reliant on voluntary staff overtime. Continued use of agency Radiographers. Working with Medical Staffing to try and secure short-term locum Radiologists. Use of staffed mobile CT and MRI scanners.	join SaTH in December and January. Recruitment of 3 additional Radiologists, expected to take up posts from December and into new year.

H2 plan (October 2021-March 2022)

The H2 activity plan will be submitted to NHSE as a system plan in mid-November. The plan takes account of the likely capacity for elective care through the winter period and with a forecast of continuing levels of COVID-19 in line with the national guidance. The focus during H2 will continue to be on maximising the available capacity to balance the needs of emergency patients with those of cancer and urgent elective patients and reducing the longest waiting times for patients while improving access to diagnostics. Work will continue to improve outpatient access through implementation of patient initiated follow-up and via virtual consultations where clinically appropriate. Protected surgical capacity will include the use of the Vanguard and the eye care suite, while a green pathway for cancer and urgent cancer will continue at the RSH site. Orthopaedic elective care will continue to be jointly provided from a shared clinical prioritisation approach between RJAH and SaTH.
The H2 plans have been developed with and without interventions to demonstrate the benefits additional investment could bring. Additional independent sector capacity (insourcing and outsourcing) will be essential to support H2 electove activity.
The ERF mechanism for H2 changes from a threshold based on levels of recovery of 2019-20 baseline activity to levels of clock closures compared to 89% of clocks closed in the base year. The diagram below attempts to demonstrate the difference between the two mechanisms.

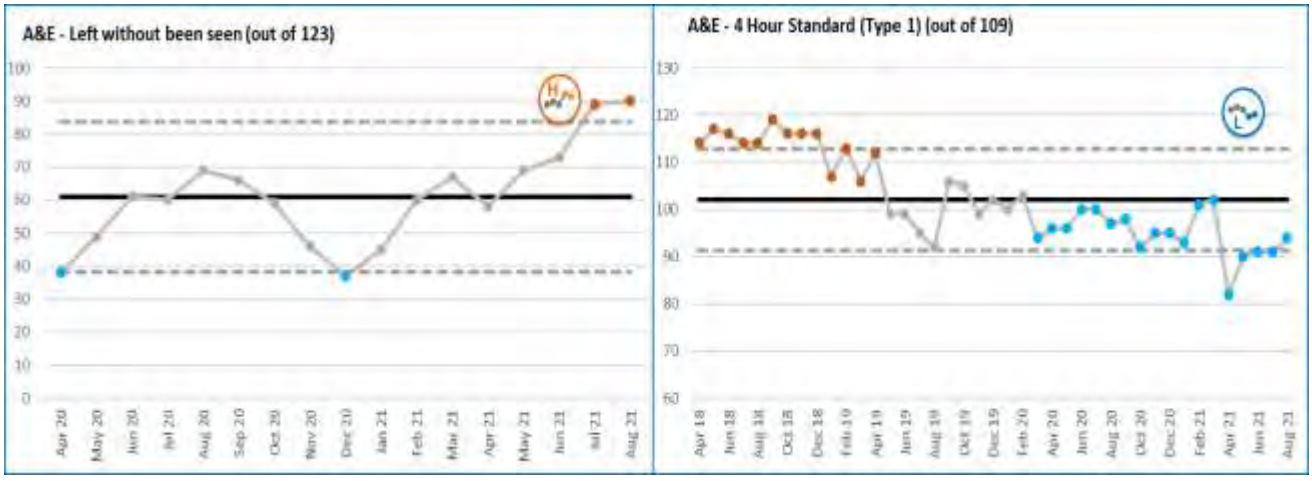


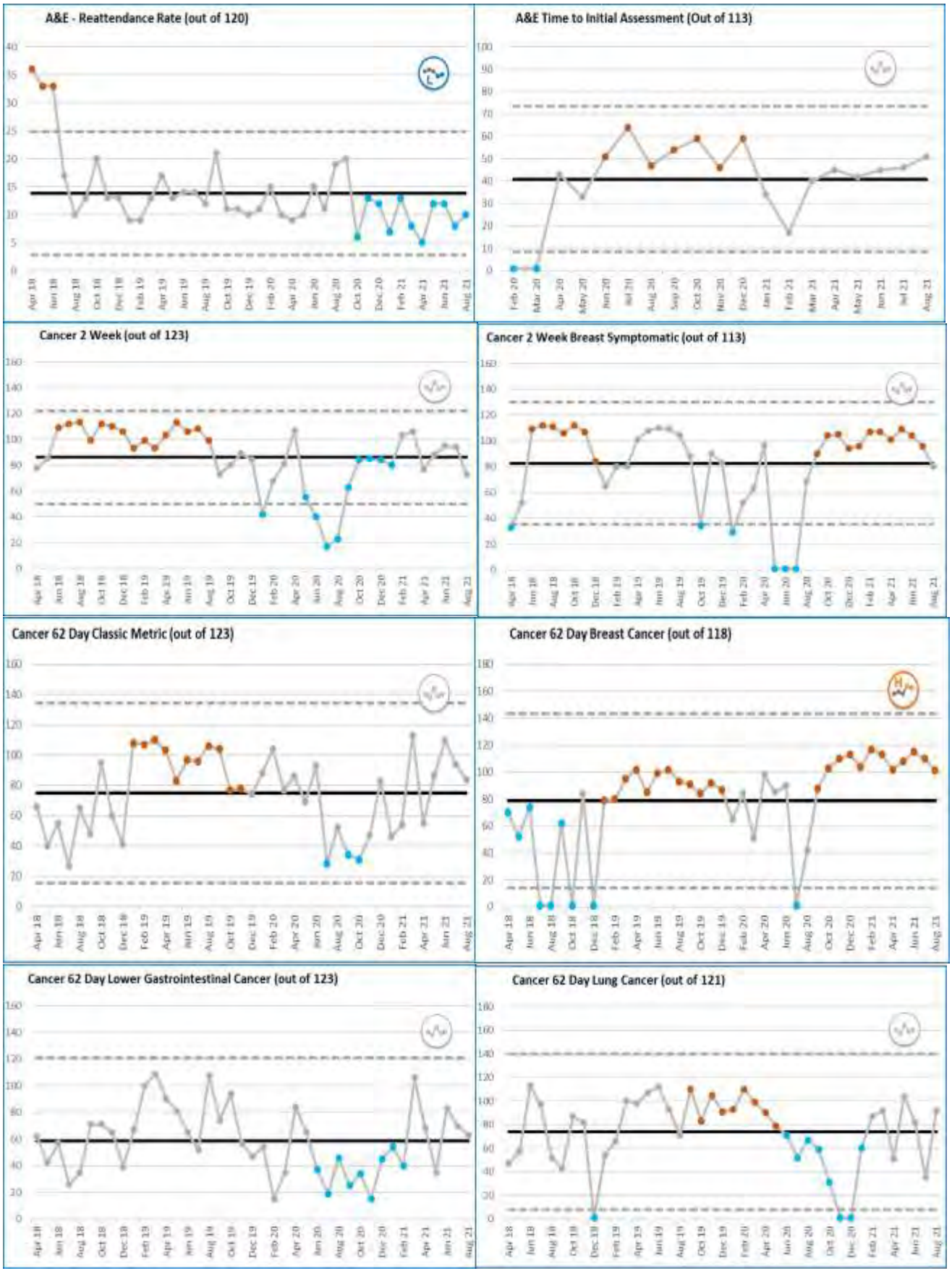
6.5. Operational Performance Benchmarking

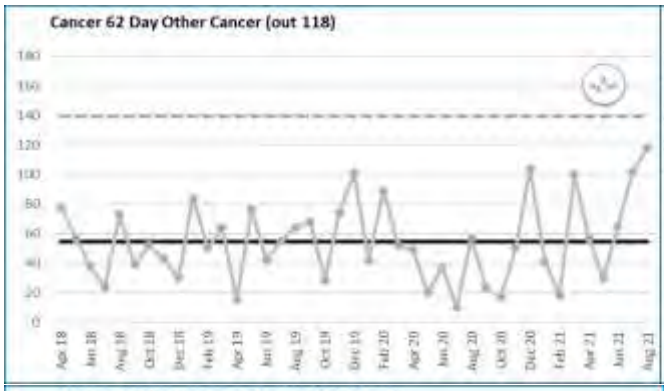
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

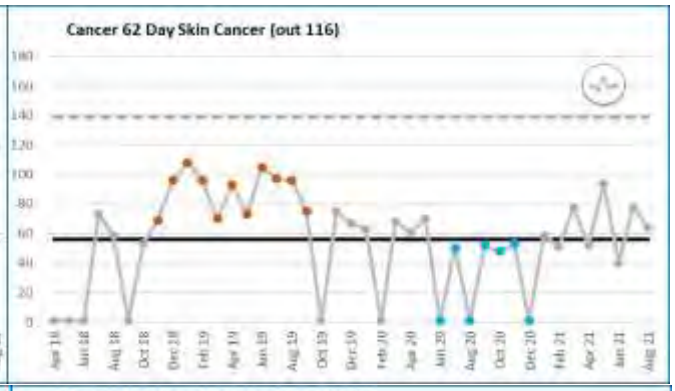
KPI	Latest month	Actual Performance Ranking	Performance
A&E - Left without been seen (out of 123)	Aug 21	90	
A&E - 4 Hour Standard (Type 1) (out of 109)	Aug 21	94	
A&E - Reattendance Rate (out of 120)	Aug 21	10	
A&E Time to Initial Assessment (Out of 113)	Aug 21	51	
Cancer 2 Week (out of 123)	Aug 21	73	
Cancer 2 Week Breast Symptomatic (out of 113)	Aug 21	80	
Cancer 62 Day Classic Metric (out of 123)	Aug 21	84	
Cancer 62 Day Breast Cancer (out of 118)	Aug 21	101	
Cancer 62 Day Lower Gastrointestinal Cancer (out of 123)	Aug 21	63	
Cancer 62 Day Lung Cancer (out of 121)	Aug 21	92	
Cancer 62 Day Other Cancer (out 118)	Aug 21	118	
Cancer 62 Day Skin Cancer (out 116)	Aug 21	64	
Cancer 62 Day Urological Cancer (out of 123)	Aug 21	48	
Diagnostic 6 Week Standard (out of 123)	Jul 21	65	
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)	Jul 21	6	
Diagnostic 6 Week Standard - Audiology Assessments (out of 110)	Jul 21	62	
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 103)	Jul 21	97	
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91	Jul 21	1	
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)	Jul 21	72	
Diagnostic 6 Week Standard - Computed Tomography (out of 123)	Jul 21	102	
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)	Jul 21	105	
Diagnostic 6 Week Standard - Colonoscopy (out of 123)	Jul 21	48	
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)	Jul 21	52	
Diagnostic 6 Week Standard - Cystoscopy (out of 120)	Jul 21	98	
Diagnostic 6 Week Standard - Gastroscopy (out of 123)	Jul 21	30	
RTT 52 Week Breach (out of 123)	Jul 21	94	
RTT Incomplete 18 Week Standard – (out of 123)	Jul 21	108	
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 122)	Jul 21	80	

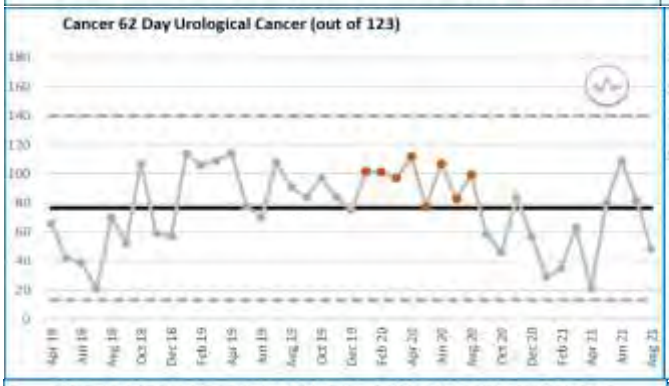
The SPC charts show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The lower the ranking the better the relative position of the Trust is compared to others.

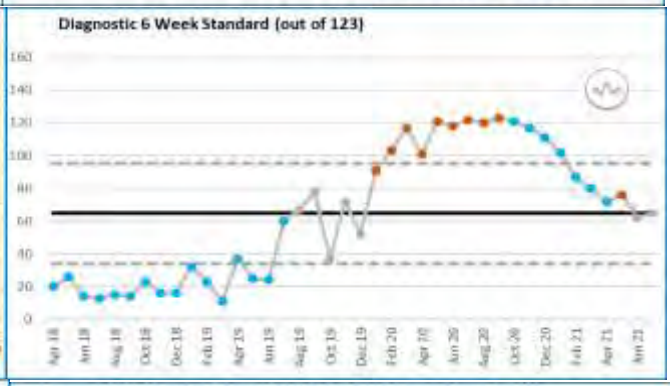


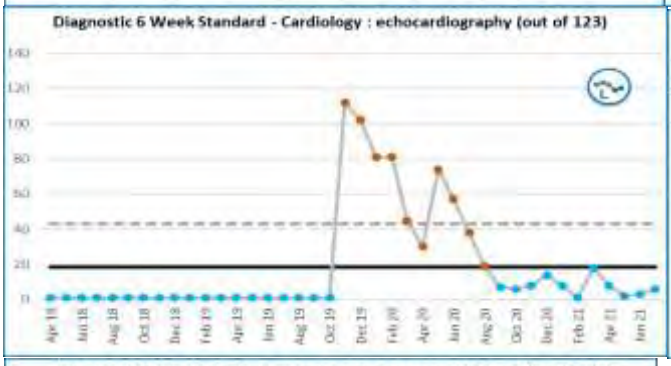

A&E - Reattendance Rate (out of 120)
A&E Time to Initial Assessment (Out of 113)
Cancer 2 Week (out of 123)
Cancer 2 Week Breast Symptomatic (out of 113)
Cancer 62 Day Classic Metric (out of 123)
Cancer 62 Day Breast Cancer (out of 118)
Cancer 62 Day Lower Gastrointestinal Cancer (out of 123)
Cancer 62 Day Lung Cancer (out of 121)

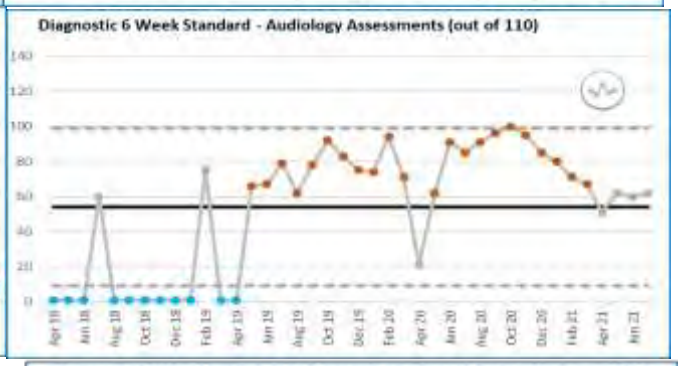

Cancer 62 Day Other Cancer (out 118)

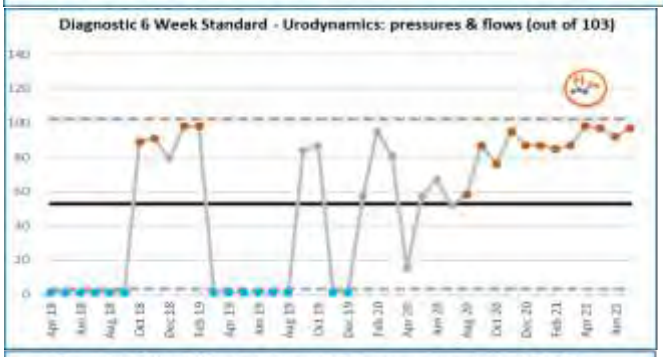

Cancer 62 Day Skin Cancer (out 116)

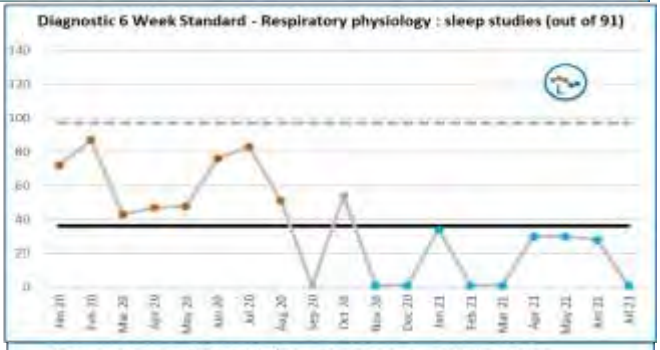

Cancer 62 Day Urological Cancer (out of 123)

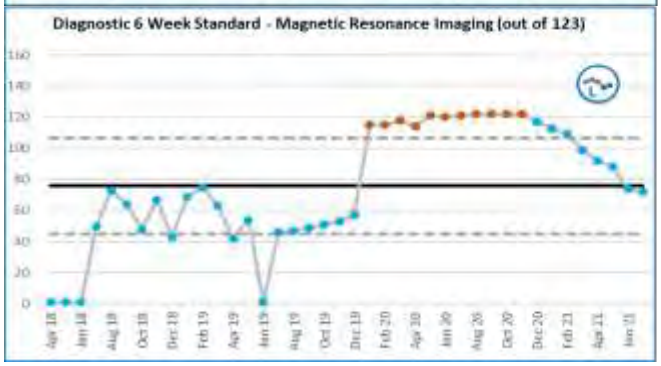

Diagnostic 6 Week Standard (out of 123)

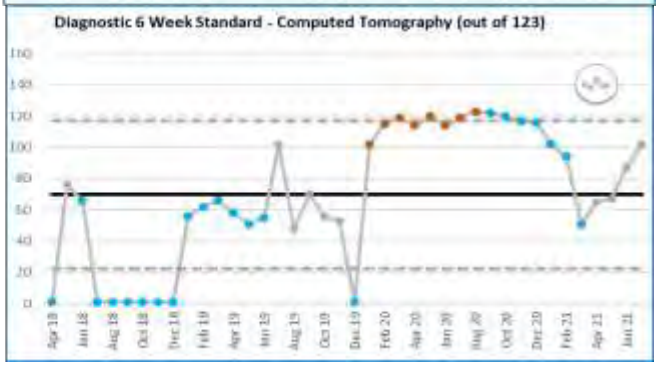

Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 123)

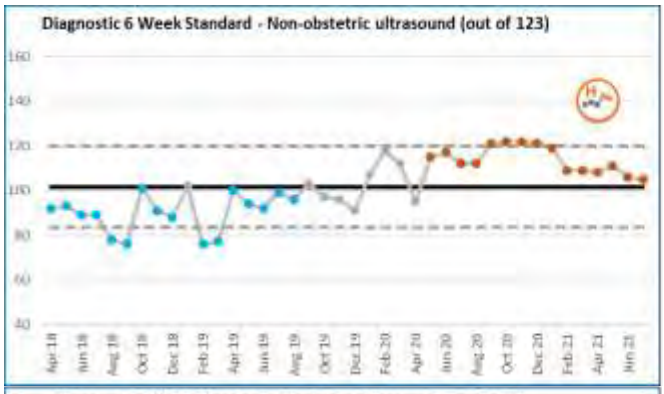

Diagnostic 6 Week Standard - Audiology Assessments (out of 110)

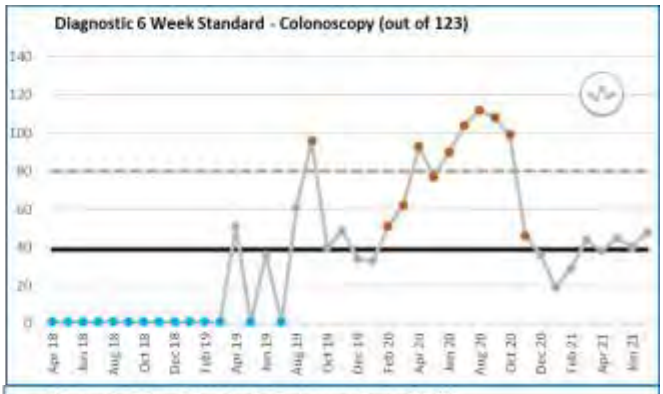

Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 103)

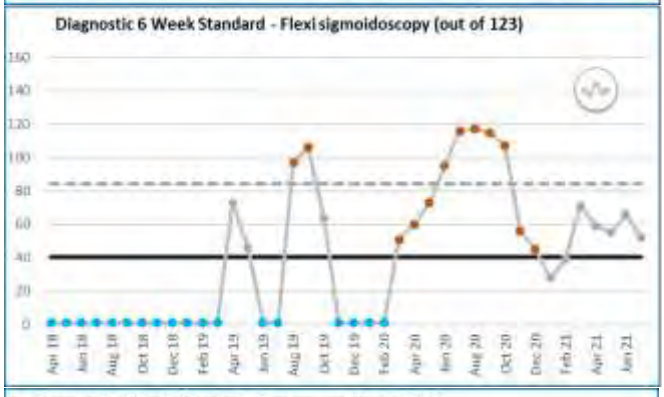

Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91)

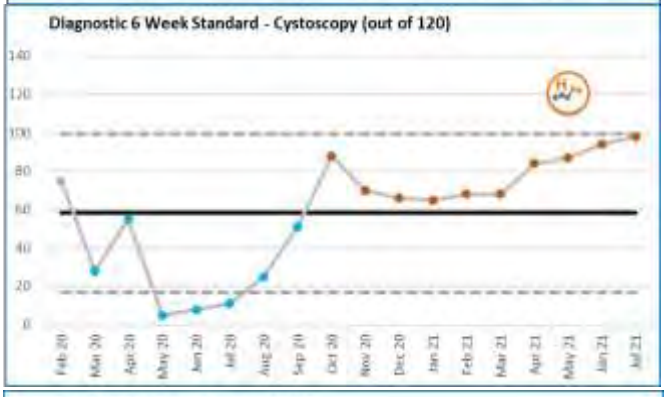

Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)

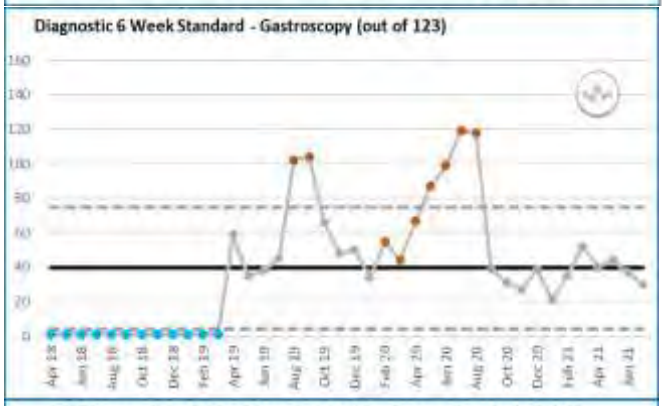

Diagnostic 6 Week Standard - Computed Tomography (out of 123)

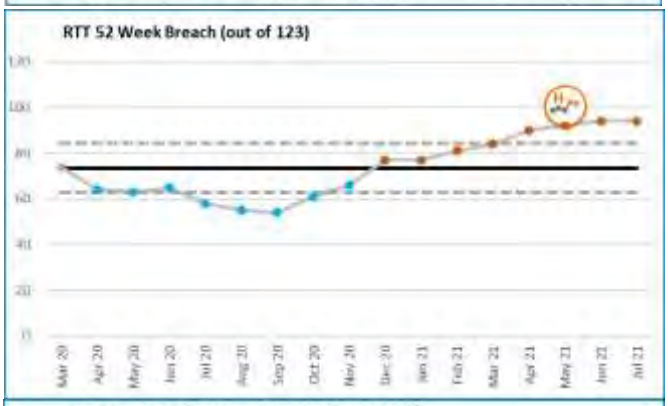

Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)

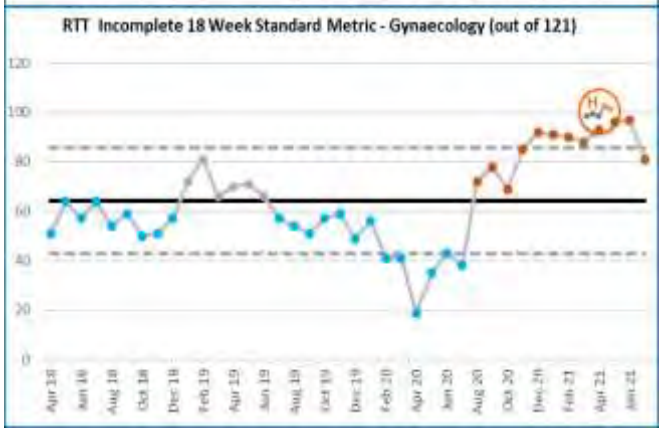

Diagnostic 6 Week Standard - Colonoscopy (out of 123)

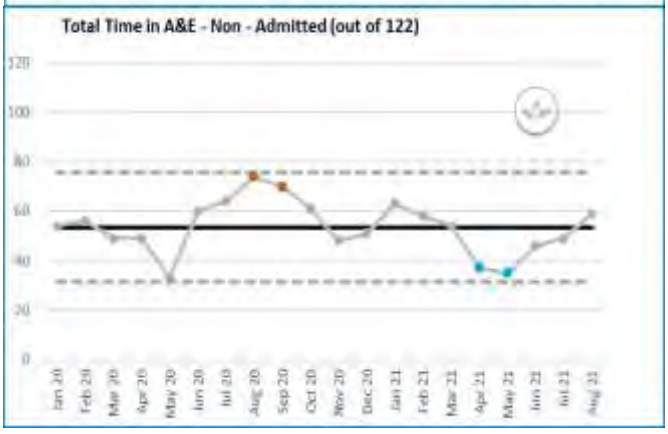

Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)


Diagnostic 6 Week Standard - Cystoscopy (out of 120)


Diagnostic 6 Week Standard - Gastroscopy (out of 123)


RTT 52 Week Breach (out of 123)


RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 121)


Total Time in A&E - Non - Admitted (out of 122)

7. Finance Summary
Helen Troalen, Director of Finance

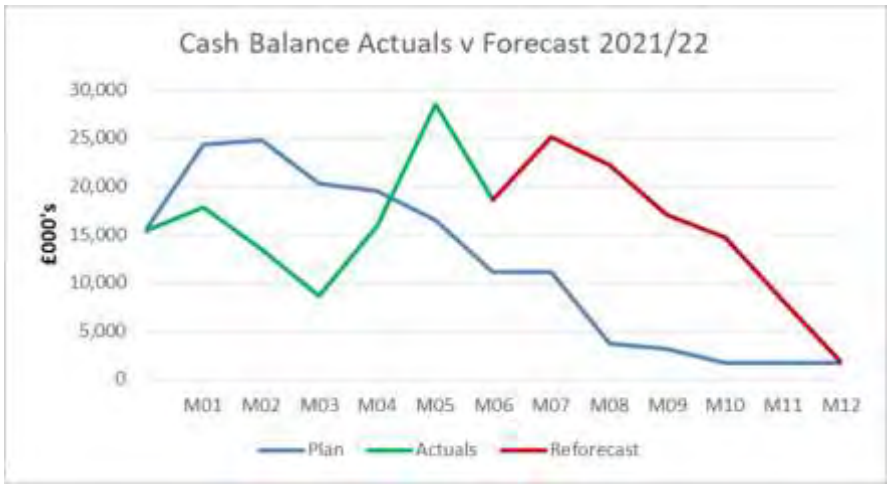
- The reported position at the end of the H1 period is a deficit of £5.766m, £2.547m adverse to the planned deficit of £3.219m. As reported previously, this adverse position to plan is a result of the costs incurred above the income earned against the Elective Recovery Fund (ERF).
- £4.795m of expenditure has been incurred by the Trust to create additional capacity to support elective recovery during the first 6 months with £2.239m of income earned through the ERF, part of this income shortfall is a consequence of the unexpected policy change ahead of Q2. To date no mitigation action has been requested.
- The Trusts financial position at the end of H1 excluding the impact of the ERF was slightly (£9k) favourable to plan.
- The Trust received £8.474m of additional funding during H1 to support the COVID-19 response. £6.670m of directly associated costs were incurred, however there are other incremental costs that are indirectly associated which continue to be charged to existing budgets. COVID-19 associated spend across the Trust is beginning to reduce, £0.855m of spend was incurred during the month, £0.475m lower than previous month.
- The Trusts income position is £6.253m higher than plan at the end of H1. It is important to note that £3.800m of this is funding to support the 3% consolidated pay award which was transacted during the month. The national guidance for month 06 is to neutralise the cost impact in the H1 period with funding to flow through the H2 system envelopes – Any variance to this will be reported from October once the H2 envelope is understood.
- The other most notable income variances are offset by incremental expenditure and include additional high cost drugs income £0.939m, £0.419m of additional activity funding from outside of the STW system, £0.388m of additional funding to support the maternity transformation programme, and £0.642m of hosted ICS income.
- The Trusts core pay expenditure, excluding spend associated with COVID-19, ERF and the ICS, is £7.160m above plan. £3.800m relates to the unplanned pay award mentioned above. The other key expenditure pressures continue to be driven by a higher level of nursing reliance mainly seen on medical wards due in part to an increase in 1:1 care and in part to the supernumerary impact of the newly recruited overseas nurses.
- The key non-pay variances are primarily driven by an increase in estates costs including higher equipment maintenance spend part of which relate to the set-up costs linked to the endoscopy maintenance contract (£0.450m). The other most notable variances are offset in full by additional income including a higher level of excluded drugs and devices spend, additional research & development and education & training spend.
- A minimum of £2.400m of efficiency savings were required to be delivered over the H1 period. £2.878m of savings have been delivered, £0.478m above plan (57% recurrent). The overall recurrent annual efficiency requirement is for £7.550m (1.6%) which the Trust is on track to deliver – the focus is on ensuring these savings are recurrent.
- Total capital spend YTD is £5.032m against a planned spend of £11.893m, this is a timing issue and the Trust is still forecasting to deliver the total capital programme for 2021/22 of £34.537m.
- The Trust held a cash bank balance at the end of September of £18.602m. The decrease in cash within the month is mainly due to payment of pay award and bi-annual payment of PDC Dividends.

Capital Expenditure

September 2021 actual performance
Spend year to date is £5.032m
Variance Type
Underspend to date £6.861m
SaTH Plan 2021/22
£34.537m
Target/ Plan achievement
To meet the Trust's Capital Resource Limit (CRL) at year end.

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust's total Capital Programme for 2021/22 as at month 06 has increased slightly to £34.537m, following additional early drawdown for HTP professional fees. Currently allocation is being matched to expenditure.	Within the Capital Plan submitted to NHSEI, the Trust forecast spend at month 06 of £11.893m. Only £5.032m has been expended giving an underspend of £6.861m to plan.	Capital expenditure to date lower than projected. However, the Trust is forecasting that all capital allocations will be spent during 2021/22. The expenditure, together with the commitments to date, total £16.251m being just under 50% of the Capital Programme for the year.	Revised capital project plans have been developed with project managers and will be discussed at October's capital planning group to gain assurance of the deliverability of the forecasts. Where any underspends for the year are forecast, schemes will be brought forward from next year.	No mitigations required.

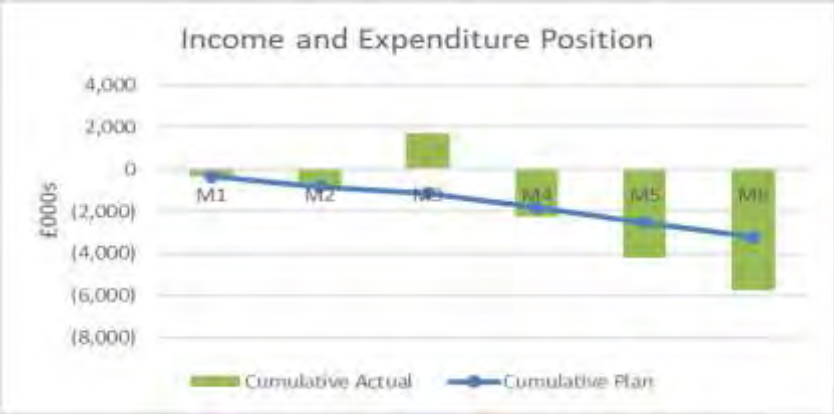
Cash



September 2021 actual performance	
£18.602m cash in Bank	
Variance Type	
Lower Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£11.094m	£21.034m
Target/ Plan achievement	
£2.432m lower Cash Balance than Rolling Forecast as at M05	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust has revised the cash flow forecasting and it is now based on a projected I&E deficit of £6.438m, which assumes that H2 outturn is the same as H1 Plan. The cash flow will be amended to reflect H2 Plan when submitted. This forecast has now been adjusted to take account of actual spend to date. The Trust reforecasts on a monthly basis.	The cash balance at the end of September was £18.602m (ledger balance of £18.521m due to reconciling items) which is £2.432m lower than the Trust's rolling cash flow forecast as at M05. The decrease in cash within the month is mainly due to payment of pay award and bi-annual payment of PDC dividends.	As the Trust has now revised the cash flow based on a much lower deficit than the original modelling, there are no issues currently projected in terms of cash and the Trust is not forecasting a requirement for cash support. The revised forecast currently projects a year-end cash balance of £1.700m in line with the required minimum cash balance.	The Trust to undertake a review of the assumptions within the cash flow. Rolling monthly forecasting to continue. The cash flow will be reforecast based on H2 plan when submitted.	No mitigations required.

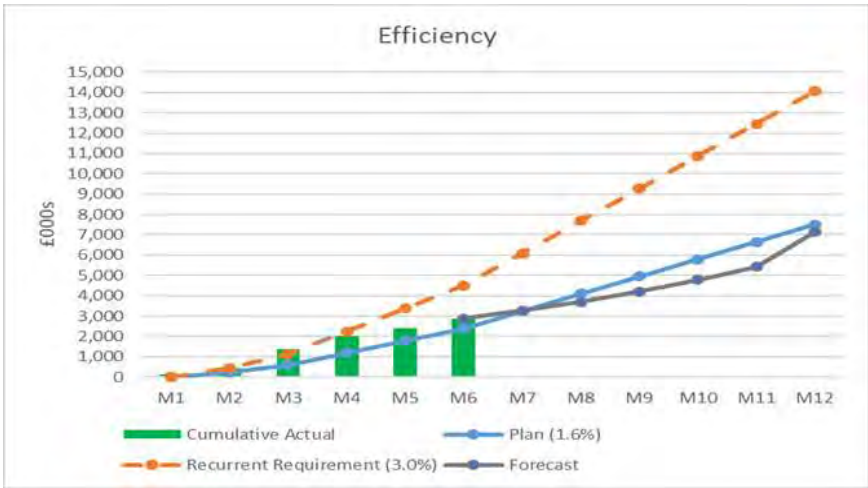
Income and Expenditure Position



September 2021 actual performance	
Income & Expenditure Position YTD (£5,766m)	
Variance Type	
Overspend to date (£2.547m)	
National Target	**SaTH Plan 2021/22**
(£3.219m)	(£3.219m)
Target/ Plan achievement	
£2.547m Adverse variance	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust continues to operate within a temporary finance regime for the first 6 months of 2021/22 (H1). The STW system has submitted a plan which is compliant with the H1 system funding received but with £6m of unmitigated risk. As part of this the Trust is plan is to deliver a deficit over the H1 period of £3.219m. This plan is compliant with the recurrent system sustainability plan.	The Trust recorded a net deficit of £1.570m in month, £5.766m at the end of H1, £2.547m adverse to plan. This position includes a £2.556m YTD overspend linked to the additional spend above income received against the ERF. Partly due to a lower level of activity delivery and partly due to the unexpected change in the national thresholds from July. Excluding this impact the financial position would be £0.09m favourable to plan at the end of the period. The surplus delivered in month 03 was driven by an estimate of the ERF income achievement provided to the Trust by the system.	Cost pressure linked to the capacity initially planned to be funded through the ERF. No mitigation plan has been requested. Spend will continue into H2 to support elective recovery.	Discussions with STW partners ongoing around risk management arrangements.	Additional system savings/ underspends Slippage against investments

Efficiency



September 2021 actual performance	
Efficiency year to date is £2.878m	
Variance Type	
Over performance to date £0.478m	
National Target	**SaTH Plan 2021/22**
£0.000m	£7,550m
Target/ Plan achievement	
£0.478m favourable variance YTD	

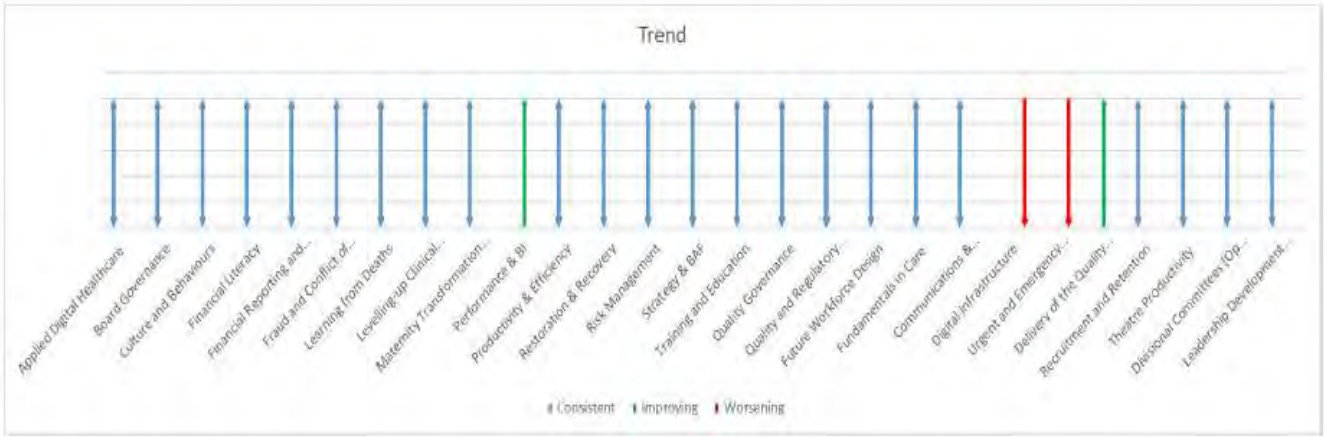
Background	What the Chart tells us	Issues	Actions	Mitigations
In order to achieve the £3.219m deficit plan over the H1 period the Trust is required to deliver £2.400m of efficiency savings. A minimum of 1.6% in year savings are required to deliver the recurrent system sustainability plan.	The Trust has delivered £2.878m of efficiency savings after 6 months, £0.478m ahead of plan and achieving the H1 target. 57% of the savings delivered are recurrent so the focus is on increasing the level of recurrent savings over the remainder of the year. £7.550m (1.6%) of recurrent savings are required over the period, the current forecast is £7.147m.	Whist the Trust is ahead of plan YTD the level of recurrent savings need to be increased. There is also an accelerated need to identify efficiency savings beyond the 1.6% in order to enable additional investments to be made. There is currently a heavy reliance on nursing workforce savings in the H2 forecast which could be delayed.	Increased programme focus in H2 to progress the material efficiency schemes. Additional PMO support to the agency reduction programme planned.	Non-recurrent opportunities.

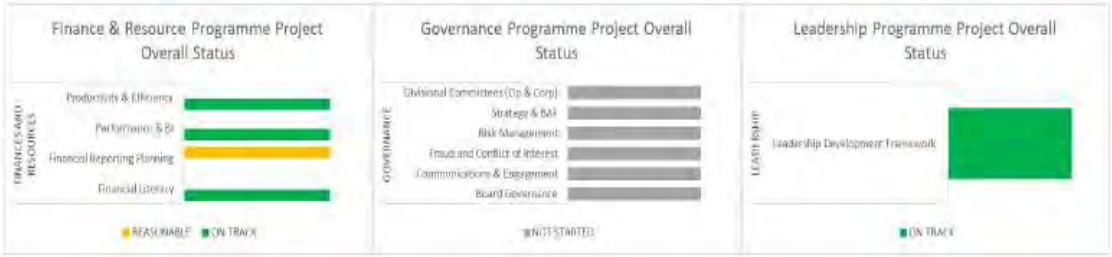
8. Transformation
Helen Troalen Director of Finance

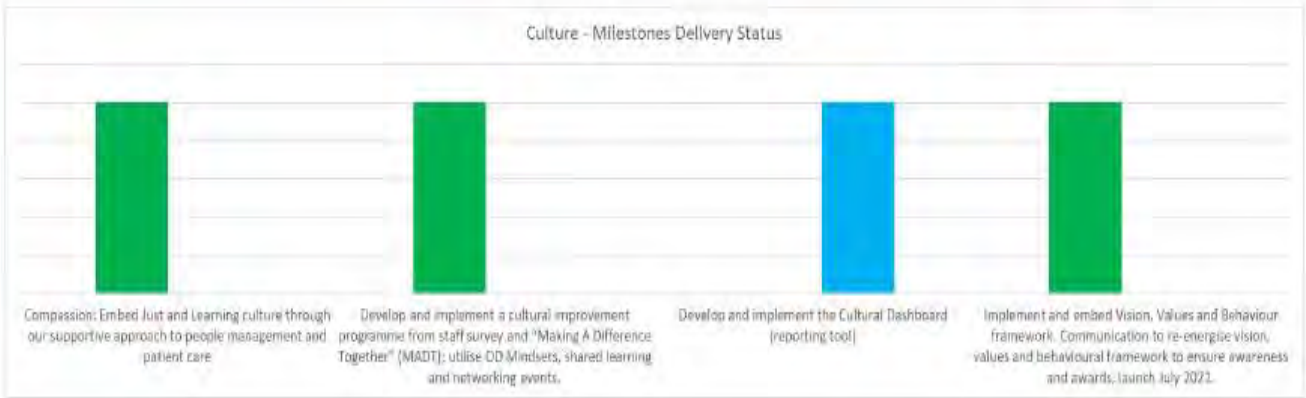
Following the principles laid out for Phase Two of Getting to Good, this section of the IPR summarises the progress on the 9 Programmes within the overarching Getting to Good programme. The full report of each programme of work is submitted to SLC-O.
Four of the nine programmes within Getting to Good are progressing well. The Quality and Safety, Workforce, Leadership, and Culture Programmes are all reporting their projects as being on track this period.
The Finance and Resources programme is progressing well with three out of four projects reporting as on track; however, a status of reasonable is being reported against the Financial Reporting and Planning Project.
Three programmes are reporting one or more projects with a status of reasonable. Digital Transformation is reporting a reasonable status within the Digital Infrastructure Project and the Operational Effectiveness Programme is reporting a reasonable status within the Restoration

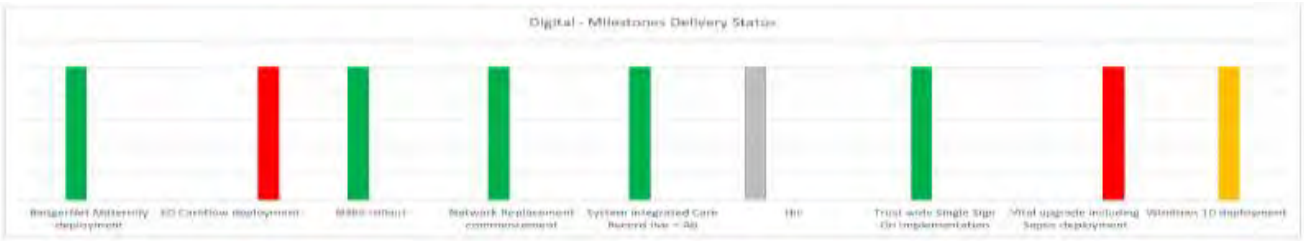
and Recovery and UEC projects. Finally, the Maternity Transformation Programme is reporting a reasonable status overall.
There are no programmes or projects reporting as off track in this period, however the Governance Programme has not yet started.
Appendix A gives oversight on the delivery status of all milestones across the nine programmes.
The highest risks to delivery are within the following projects:
Restoration and Recovery: Lack of capacity in radiology to meet the clinical demands for restoration and recovery of services post COVID-19 pandemic. In October additional capacity through the mobile and modular unit will be available.
Performance and Business Intelligence: There is a risk that focus on the work needed to implement the digital path products will limit the Data Warehouse capacity to automate existing reports.
Exceptions, Issues and Mitigations (for projects with a status below On Track)
There are five projects out of 27 currently reporting as reasonable. An explanation for this status is provided for each project below:
Urgent and Emergency Care (UEC): The planned rollout of Vitals 4.2 in September 2021 has been delayed owing to a serious functionality issue identified during the testing phase. This will also cause a delay in the planned implementation date of December 2021 for the Emergency Department Careflow system. There are already systems in place to mitigate the risk for both of the implementation delays. The Digital Team are awaiting the updated timescales from the provider.
Restoration and Recovery: Theatres - Staff absence, including COVID-19 related absence and the impact of supernumerary staff on theatre capacity has resulted in a gap in theatre staffing and subsequently has resulted in the closure of four elective theatres across the two sites. In response, a theatre re-opening plan has been produced, together with a theatre efficiency and recovery plan. This plan has set revised targets for theatre efficiency and has refined the weekly 6-4-2 process.
Outpatient improvement - The weekly information indicates there has been a deterioration in performance, to mitigate this, an improvement plan is in place and is being monitored each week at the recovery group.
Maternity: There are three off track milestones. Firstly resourcing of staff within the Maternity Clinical Governance Team, and secondly referral pathways to maternal medicine specialist centres. These two off track actions are being addressed by recruitment of three specialist midwives. The third off track item relates to additional actions with external dependencies relating to the nature and conduct of CQC inspections, LMNS being structured with more than one maternity service, and the establishment of independent senior advocates. Whilst SaTH cannot resolve these independently, measures are being taken to address those elements that are within our control.
Financial Reporting and Planning: There have been delays in the delivery of the Oracle 12.2 upgrade due to locating new servers. This issue has now been resolved, and the project board will meet in the first week of October to assess if this will impact on the overall delivery of the project.
Digital Infrastructure: The planned rollout of Vitals 4.2 in September 2021 has been delayed owing to a serious functionality issue identified during the testing phase. The SRO is working closely with the provider to resolve this issue, with a possible revised go live date of November 2021, provided a fix is available within that timeframe. This will also cause a delay in the planned implementation date of December 2021 for the Emergency Department Careflow system.

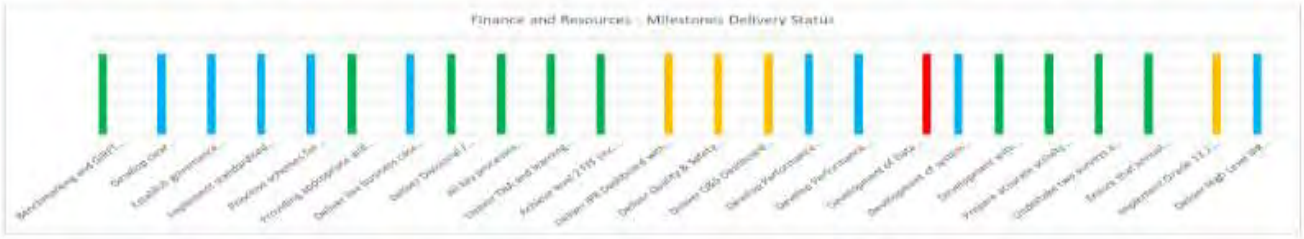
PMO Getting to Good Programme Dashboard - September 2021

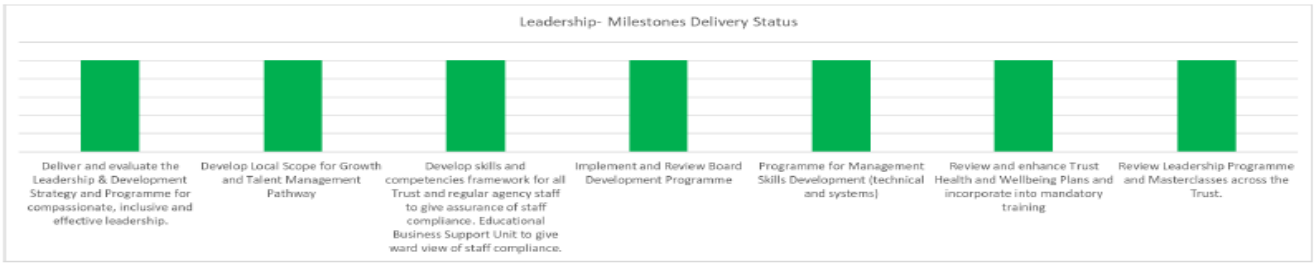


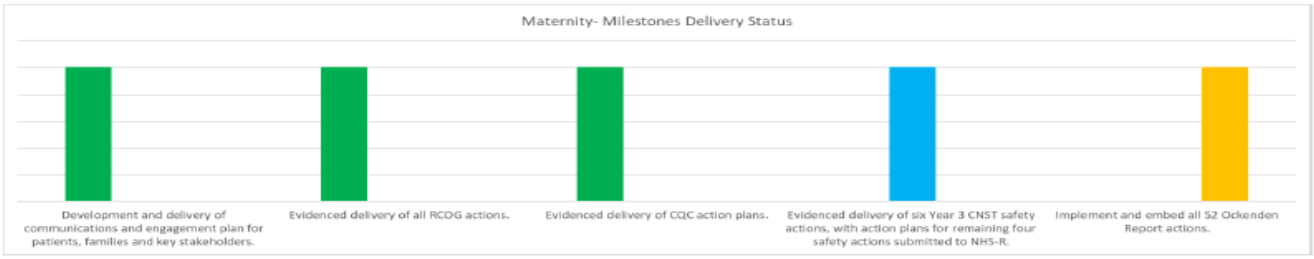





Digital - Milestones Delivery Status
Bridgefield Maternity deployment
IO Cashflow deployment
Network Replacement commencement
System Integrated Care Record live - A&E
Trust wide Single Sign On implementations
Vital upgrade including Sepsis deployment
Windows 10 deployment


Finance and Resources - Milestones Delivery Status


Leadership- Milestones Delivery Status
Deliver and evaluate the Leadership & Development Strategy and Programme for compassionate, inclusive and effective leadership.
Develop Local Scope for Growth and Talent Management Pathway
Develop skills and competencies framework for all Trust and regular agency staff to give assurance of staff compliance. Educational Business Support Unit to give ward view of staff compliance.
Implement and Review Board Development Programme
Programme for Management Skills Development (technical and systems)
Review and enhance Trust Health and Wellbeing Plans and incorporate into mandatory training
Review Leadership Programme and Masterclasses across the Trust.


Maternity- Milestones Delivery Status
Development and delivery of communications and engagement plan for patients, families and key stakeholders.
Evidenced delivery of all RCOG actions.
Evidenced delivery of CQC action plans.
Evidenced delivery of six Year 3 CNST safety actions, with action plans for remaining four safety actions submitted to NHS-R.
Implement and embed all 52 Ockenden Report actions.

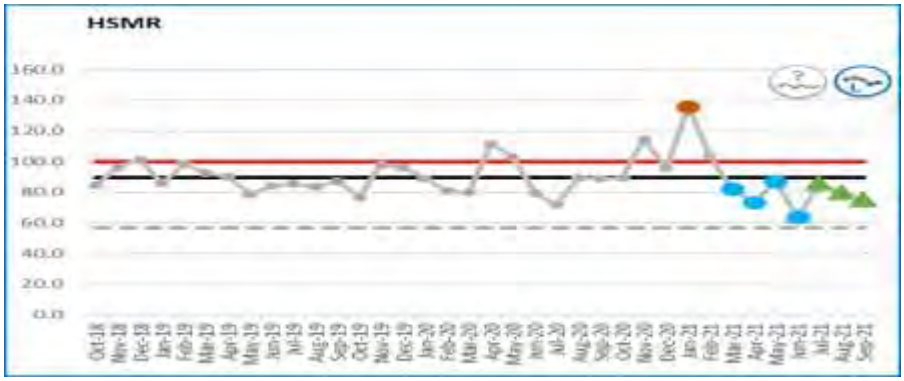

Operational Effectiveness- Milestones Delivery Status


Quality and Safety Milestones Delivery Status

BRAG Ratings Key
DELIVERED
ON TRACK
REASONABLE – THERE MAY BE ISSUES THAT IMPACT DELIVERY, MITIGATION IN PLACE
OFF TRACK – ISSUES IMPACTING DELIVERY, NO MITIGATION IN PLACE
NOT STARTED

Appendix 1: Quality KPIs performing in line with plan/target

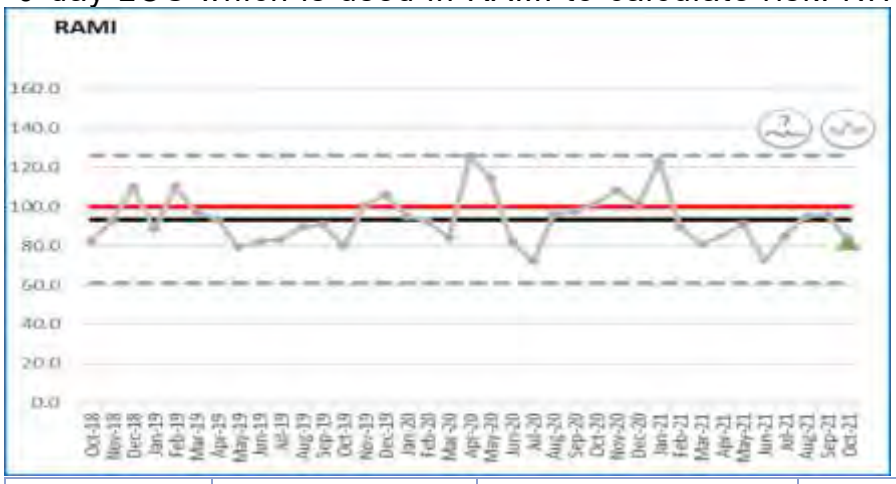
Mortality
HSMR



June 2021 actual performance
63.77
Variance Type
Special Cause Improvement
National Target
100
Target / Plan Achievement
Performance better than expected range

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Hospital Standardised Mortality Ratio (HSMR) is the quality indicator that measures whether the number of deaths across the hospital is higher or lower than expected.	No new HSMR is available. Forecasts only are therefore shown from July to October 2021. The Trust's HSMR position is slightly lower than the peer average over the 12 month period to June 2021 although higher than the peer in November 2020 and January 2021. The longer term trend shows a similar pattern to the peer. Patients coded with a primary diagnosis of COVID-19 are excluded from HSMR. This index value is likely to increase when the HSMR model is rebased. The date for rebase is not yet available.	Conditions where the number of deaths are higher than expected within the HSMR model are noted as urinary tract infections, pneumonia, acute and unspecified renal failure and aspiration pneumonitis. Whilst urinary tract infections continue to be identified on this list, some small improvement is noted over Q1 2021/22 and may be linked to work that has been undertaken to review the accuracy of coding for these patients. A slight upward trend is noted with septicaemia in both RAMI and HSMR data which may also correlate to this work, but will continue to be monitored. A higher HSMR at PRH for admissions on a Saturday versus the peer group is noted and remains under review.	All conditions are closely monitored. The level of clinical coding has a direct impact on mortality indicators. To improve and monitor accuracy and consistency of data, additional validation of all deceased patient's records on completion of coding has been introduced. This validation is carried out by a senior member of the coding team. There is ongoing monitoring of the HSMR index relating to sepsis and review by sepsis team for any potential areas of concern which may be related to the upward trend in septicaemia.	Mortality performance indicators are a standing agenda item at the monthly Learning from Deaths Group where all indicators that are above the expected range are discussed and appropriate action agreed.

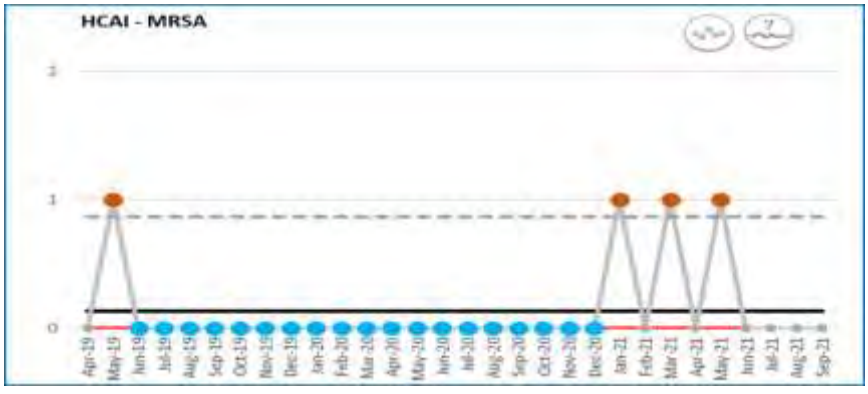
RAMI-note data from April 2021 under review due to issue with HES data excluding "0"day LOS which is used in RAMI to calculate risk. NHSD are working to resolve.



September 2021 actual performance
96.07
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Monthly variation means that the 100 reference level may not be delivered month on month

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Risk Adjusted Mortality Index is a quality measure used to predict death within the organisation.	The Trust's RAMI position is below the peer average. The RAMI indicator excludes COVID-19 patients.	The conditions with the highest number of 'excess deaths' (more deaths than expected within the RAMI model) over the last 12 month period to June 2021 are pneumonia, urinary tract infection, acute and unspecified renal failure and aspiration pneumonitis. In line with HSMR, the index is higher at Princess Royal Hospital but combined for both sites, remains lower than the peer.	All conditions are being closely monitored. The level of clinical coding has a direct impact on mortality indicators. To improve and monitor accuracy and consistency of data, additional validation of all deceased patient's records on completion of coding has been introduced.	Mortality performance indicators are a standing agenda item at the monthly Learning from Deaths Group where all indicators that are above the expected range are discussed and appropriate action agreed

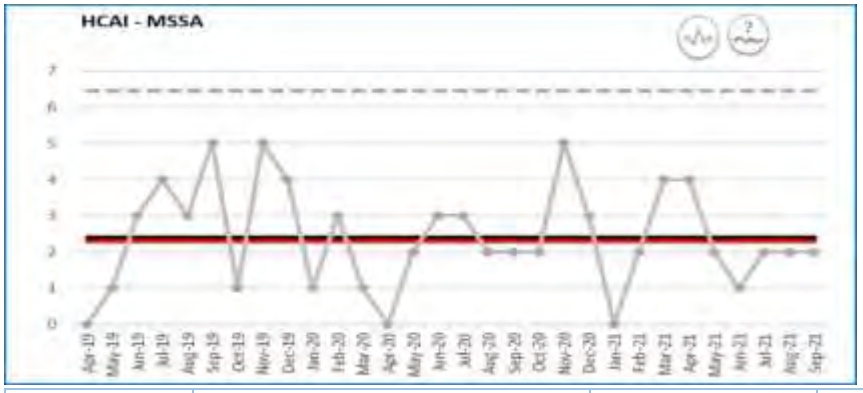
MRSA



September 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target / Plan Achievement
0 infections for 21/22 not achieved (1 infection in May)

Background	What the Chart tells us:	Issues	Actions	Mitigations
The target for all acute trusts is zero cases of MRSA bacteraemia.	There have been no MRSA Bacteraemia since May 2021.	No new cases.	No new actions.	Monitored monthly through IPC Operational Committee.

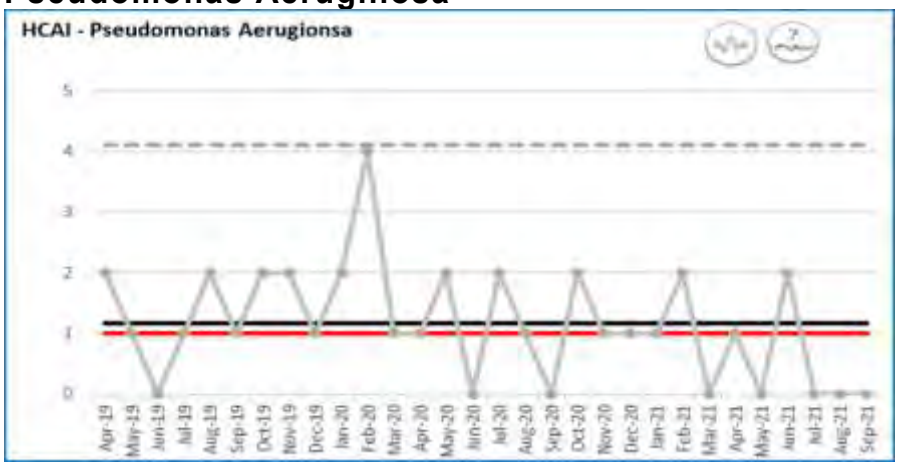
MSSA



September 2021 actual performance
2
Variance Type
Common Cause
Local Standard
<ave.2.3 per month
Target / Plan Achievement
<28 infections for 21/22 is on course for delivery

Background	What the Chart tells us	Issues	Actions	Mitigation
Reporting of MSSA bacteraemia is a mandatory requirement.	There were 2 cases of post 48 hour MSSA bacteraemia in Sept 2021. YTD there have been 13 cases against a Trust target for the year of no more than 28 cases. No NHSE/I target for MSSA cases has been set for the Trust	All cases deemed to be device related have an RCA completed.	Aseptic non-touch technique training (ANTT) is being delivered for those nurses who have not completed this competency in the clinical areas.	The number of staff who have completed this training will be reported through the IPC Operational Group.

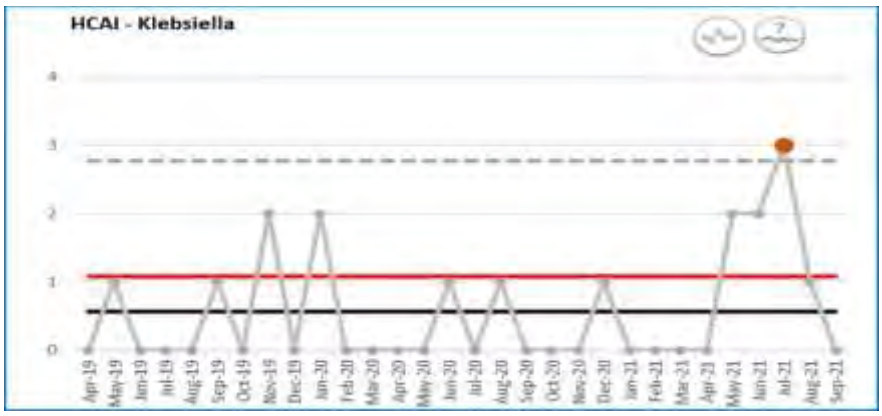
Pseudomonas Aeruginosa



September 2021 actual performance	
0	
Variance Type	
Common Cause	
Local Standard	National Target
No more than 3 per annum	No more than 10 per annum
Target / Plan Achievement	
The local standard is ambitious and YTD 3 infections have occurred.	

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There were no case of Pseudomonas bacteraemia in September 2021. YTD there have been 3 cases. National target set for Trust for 2021/22 is no more than 10 cases, which is on course to be delivered.	No new issues identified in September.	As for some of the other device related HCAIs associated with catheter associated urinary tract infections the embedding of the use of the newly implemented catheter insertion document and catheter care plan continue across the Trust supported by the quality team.	Ongoing monitoring of care through matrons audits discussed at monthly quality review meetings.

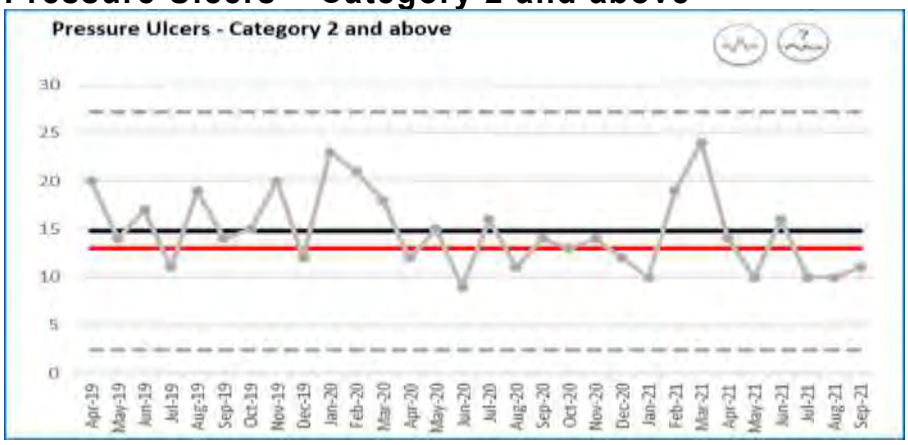
Klebsiella



September 2021 actual performance	
0	
Variance Type	
Common Cause	
Local Standard	National Target
<ave.1.1pm	2pm
Target/ Plan achievement	
Sustain or improve on 2020/21	

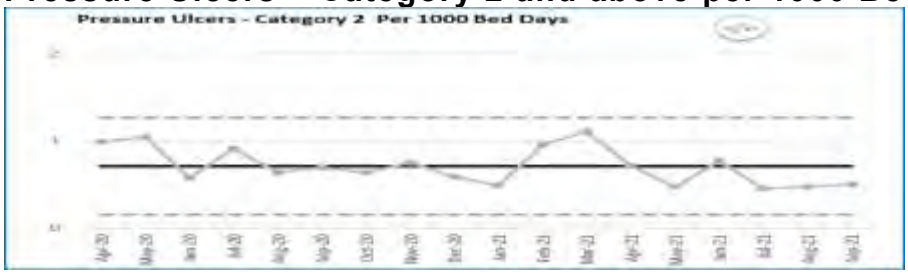
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement.	There were no cases of Klebsiella bacteraemia in Sept 2021. YTD there have been 8 cases of Klebsiella which is above the local Trust target but below the NHSE/I target set for the Trust for 2021/22 of no more than 24 cases.	The Trust will not achieve its Trust target and has had more cases of Klebsiella post 48 hour bacteraemia in 2021 than in 2020/21.	Embedding the catheter insertion documentation and catheter care plan ongoing.	Catheter care monitored through Nursing Quality Metrics audits undertaken monthly.

Pressure Ulcers – Category 2 and above



September 2021 actual performance
11
Variance Type
Common Cause
Local Standard
13
Target/ Plan achievement
10% Improvement on 20/21 prorata =<12.7pm (no more than 152 cases)

Pressure Ulcers – Category 2 and above per 1000 Bed days



September 2021 actual performance
0.50
Variance Type
Common Cause
Local Standard
tbc

Pressure Ulcers – Total per Division	Number Reported
Medical and Emergency Care	7
Surgical, Anaesthetics and Cancer	4

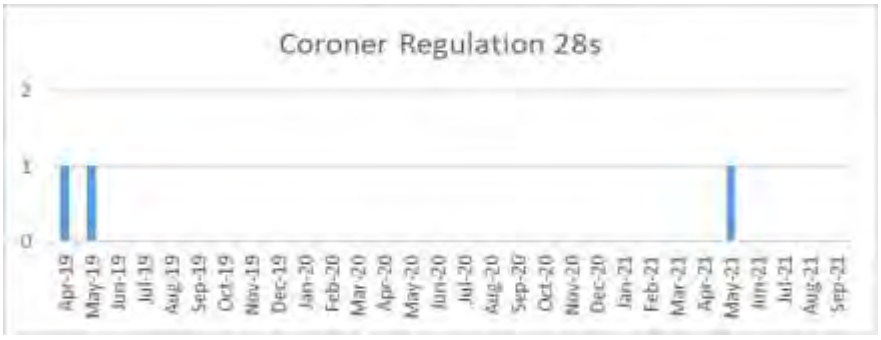
Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	There were 11 acquired pressure ulcers in Sept: 8 were category 2 3 were category 3 One category 3 pressure ulcer was reported as a Serious Incident	The Trust continues to see a number of Category 3 pressure ulcers, which have developed in our care. In Sept these occurred on wards: 9, 35 and 32.	Ongoing improvement work based on the outcomes from the RCA investigations include: • Ensuring risk assessments are completed on admission but also when patients condition changes or weekly • Completion of MUST nutritional Tool • Mandated Tissue Viability training • Additional support from TVN for areas with category 3 ulcers Revised SKIN booklet with additional education resources.	All category 2 pressure ulcers and above have RCA investigation. Those that meet the threshold for an SI are investigated and presented at NIQAM Monthly matrons audits of assessments and documentation.

Never Events

September 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target/ Plan achievement
Achieving target

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	No Never Events in September.	No Issues to report.	No Actions.	No Mitigations.

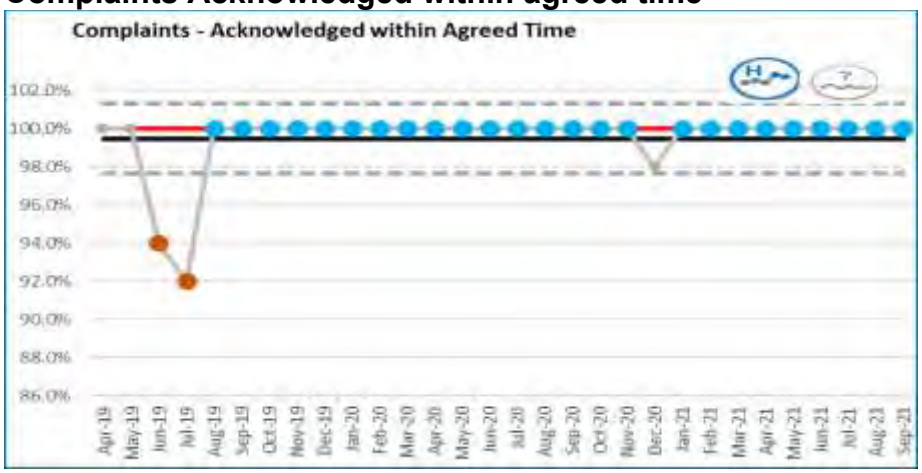
Coroner Regulation 28 Notices



September 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target/ Plan achievement
Achieving target

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	None reported in September.	No Issues to report.	No Actions.	No Mitigations.

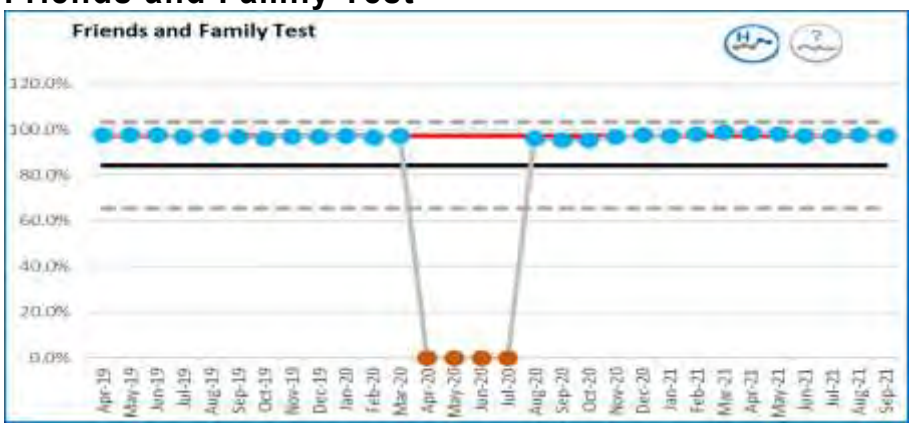
Complaints Acknowledged within agreed time



September 2021 actual performance
100% (88% within two days)
Variance Type
Common Cause
National Target
100%
Target/ Plan achievement
Target achieved consistently

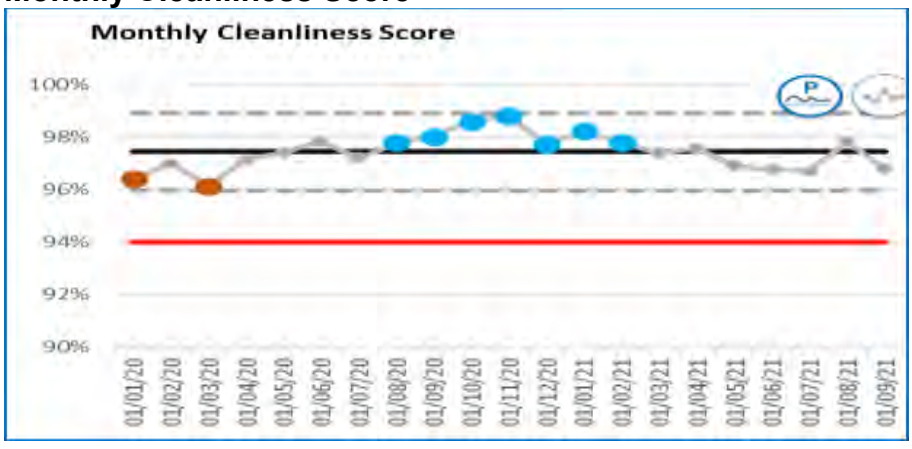
Background	What the Chart tells us:	Issues	Actions	Mitigations
Acknowledging a complaint on receipt is important for patients raising concerns to both ensure that the patient knows we have received the complaint and are addressing it.	The Trust continues to meet this target.	N/A	N/A	N/A

Friends and Family Test



September 2021 actual performance
97.2%
Variance Type
Special Cause
National Standard
85%
Target/ Plan achievement
Target achieved consistently

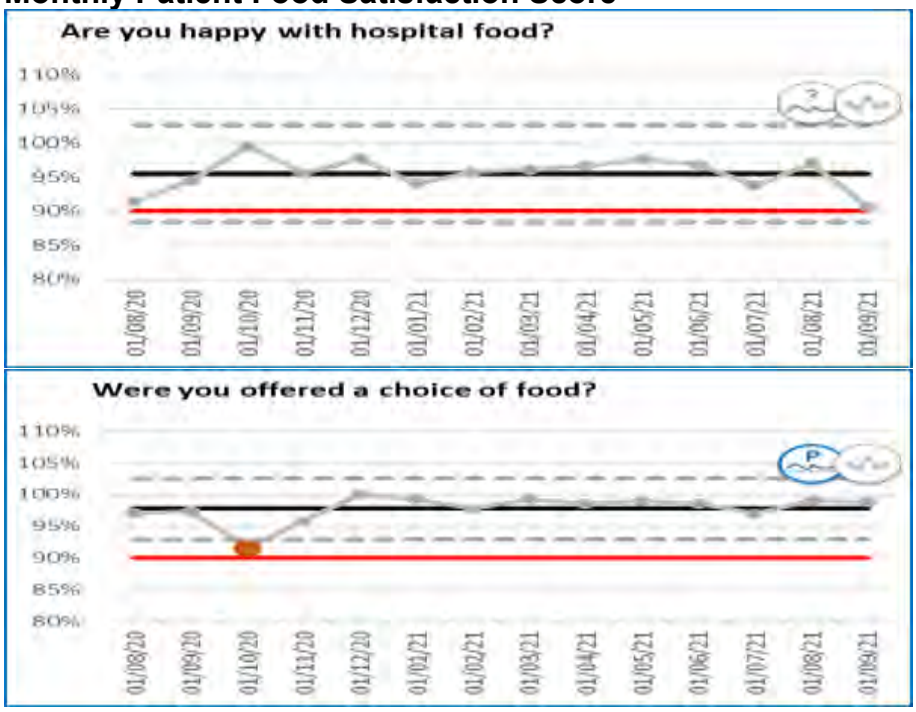
Monthly Cleanliness Score



September 2021 actual performance
96.8%
Variance Type
Common Cause
Local SaTH standard
94%
Target/ Plan achievement
On target to achieve above local standard

Background	What the Chart tells us:	Issues	Actions	Mitigations
This is an independent monthly audit which gives assurance of the standard of cleanliness undertaken by the Cleanliness Team.	Performing above the mean with some slight common cause variation.	The cleanliness score over the last 4 months has seen a slight decline which has taken them below the mean. There are still issues at RSH who are struggling to recruit. Circulation spaces and public areas have reduced scores because low staffing levels has meant that clinical areas have to take priority.	Due to the difficulty in recruiting Cleanliness Technicians at RSH the Cleanliness Management Team are working with the Temporary Staffing and Recruitment Teams to get agency staff to help out short term and to improve levels of recruitment. An open day has been arranged for 4th November with interviews/employment checks on 6th November in order to fast track recruitment. An advertising campaign has been developed for Shropshire Star and Radio Shropshire and social media platforms will be used as well as traditional methods of reaching potential candidates.	Not applicable

Monthly Patient Food Satisfaction Score

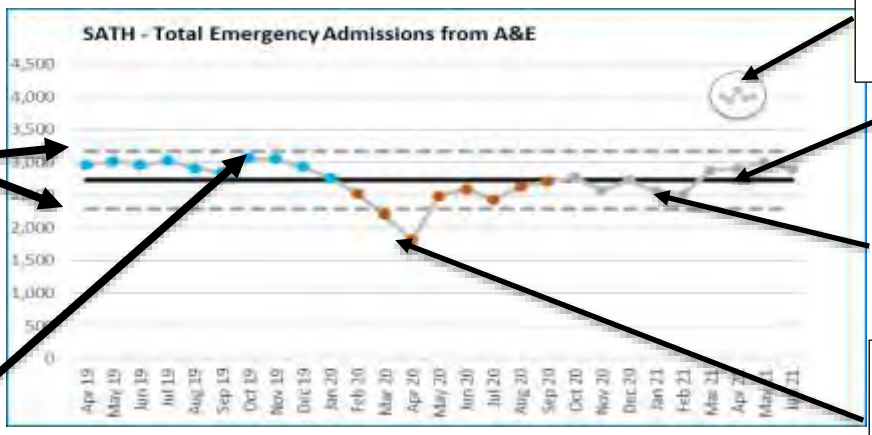


September 2021 actual performance
90.7% for satisfaction with food and 98.8% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

Background	What the Chart tells us:	Issues	Actions	Mitigations
This data is taken from the monthly Matron's Audit where 10 patients per month per ward are asked whether they are happy with the hospital food and the choice they were given.	There is common cause variation with both measures for hospital food and they remain within the upper and lower control limits. The score for being happy with hospital food has fallen to the lower control limit this month though it is not clear at this stage what has caused this.	There are concerns at present which should effect our ability to achieve the target.	The senior catering manager is arranging to meet with the wards that scored lowest to see if a reason for the drop can be identified.	Not applicable.

Appendix 2: Understanding Statistical control process charts in this report

The charts included in this paper are generally moving range charts (XmR) that plot the performance over time and calculate the mean of the difference between consecutive points. The process limits are calculated based on the calculated mean.



Icon showing most recent point type of variation

Process limits – upper and lower

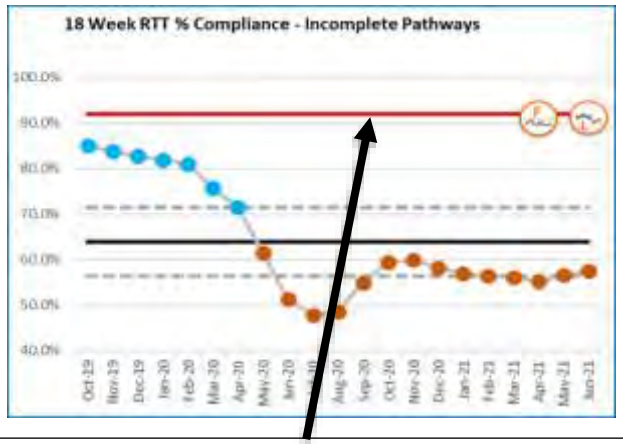
Mean or median line

Common cause variation

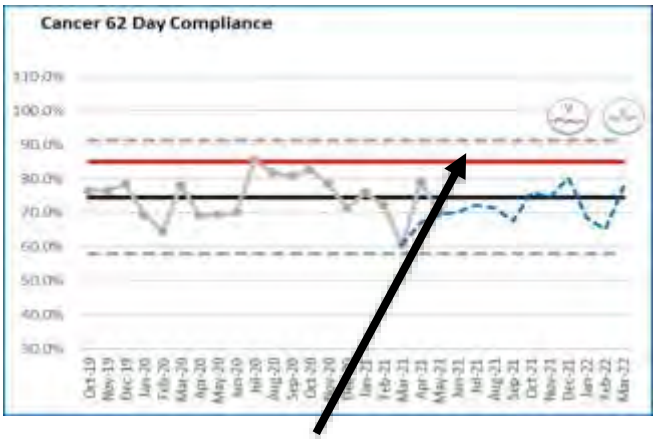
Special cause variation -7 consecutive points above (or below) the mean

Special cause variation – data point outside of the process limit

Where a target has been set the target line is superimposed on the SPC chart. It is not a function of the process.



Target line –outside the process limits. In this case process is performing worse than the target and target will only be achieved when special cause is present or process is re-designed



Target line – between the process limits and so will be hit and miss whether or not the target will be achieved

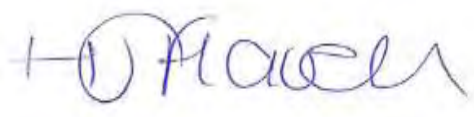
Appendix 3: Abbreviations used in this report

Term	Definition
CRR	Corporate Risk Register
CQC	Care Quality Commission
BAF	Board Assurance Framework
HSMR	Hospital Standardised Mortality Rate
RAMI	Risk Adjusted Mortality Rate
HCAI	Health Care Associated Infections
MSSA	Methicillin- Sensitive Staphylococcus Aureus
MRSA	Methicillin- Sensitive Staphylococcus Aureus
C.Difficile	Clostridium Difficile
E.Coli	Escherichia Coli
VTE	Venous Thromboembolism
SI	Serious Incidents
IPC	Infection Prevention Control
RCA	Route Cause Analysis
ANTT	Antiseptic Non-Touch Training
ITU/HDU	Intensive Therapy Unit / High Dependency Unit
FTE	Full Time Equivalent
WTE	Whole Time Equivalent
RTT	Referral To Treatment
DMO1	Diagnostics Waiting Times and Activity
ED	Emergency Department
SRO's	Senior Responsible Officer
PMO	Programme Management Office
QSAC	Quality and Safety Assurance Committee
UEC	Urgent and Emergency Care service
ERF	Elective Recovery Fund
OPD	Out Patient Department
WEB	Weekly Executive Briefing
OPOG	Organisational performance operational group
CCG	Clinical Commissioning Groups
IPR	Integrated Performance Review
F&P	Finance and Performance
NHSEI	NHS England and NHS Improvement
ICS	Integrated Care System
SOC	Strategic Outline Case
PIFU	Patient Initiated follow up
HTP	Hospital Transformation Programme
G2G	Getting to Good
POD	Point of Delivery
T&O	Trauma and Orthopaedics
SDEC	Same Day Emergency Care
OSCE	Objective Structural Clinical Examination
MADT	Making A Difference Together
MTAC	Medical Technologies Advisory Committee
CNST	Clinical Negligence Scheme for Trusts
MCA	Mental Capacity Act
DOLS	Deprivation Of Liberty Safeguards

MHA	Mental Health Act
EQIA	Equality Impact Assessments
CRL	Capital Resource Limit
CT	Computerised Tomography
NEL	Non Elective
COO	Chief Operating Officer
IPDC	In patients and day cases
C-section	Caesarean Section
IPC	Infection Prevention and Control
IPC Ops.	Infection Prevention and Control Operational Committee
RCA	Root Cause Analysis
VIP	Visual Infusion Phlebitis
NIQAM	Nurse investigation quality assurance meeting
TV	Tissue Viability
Q1	Quarter 1
HoNs	Head of Nursing
BP	Blood pressure
ITU	Intensive Therapy Unit
HDU	High Dependency Unit
CCU	Coronary Care Unit
SaTH	Shrewsbury and Telford Hospitals
RSH	Royal Shrewsbury Hospital
PRH	Princess Royal Hospital
RJAH	Robert Jones and Agnes Hunt Hospital
MEC	Medicine and Emergency Care
SAC	Surgery Anaesthetics and Cancer
CSS	Clinical Support Services
W&C	Women and Children
SATOD	Smoking at the onset of delivery
LMNS	Local maternity network
CCG	Clinical Commissioning Group
SMT	Senior Management Team
NICE	National Institute for Clinical Excellence
PPE	Personal Protective Equipment
LFT	Lateral Flow Test
HCSW	Health Care Support Worker
NHSEI	National Health Service England and NHS Improvement
Ed.	Education
A&E	Accident and Emergency
WMAS	West Midlands Ambulance Service
H1	April-September 2021 inclusive
ERF	Elective Recovery Fund
OPD	Outpatient Department
PIFU	Patient Initiated Follow Up
CT	Computed Tomography
MRI	Magnetic Resonance Imaging
PTL	Patient Targeted List
2ww	Two week waits
R	Routine

GP	General Practitioner
AGP	Aerosol-Generating Procedure
Exec	Executive
GI	Gastro-intestinal
MFFD	Medically fit for discharge
MD	Medical Director
CAMHS	Child and Adolescence Mental Health Service
DTA	Decision to Admit
HMT	Her Majesty's Treasury
YTD	Year to Date
PID	Project Initiation Document
FYE	Full year effect
QOC	Quality Operations Committee
KPI	Key performance indicator
TOR	Terms of Reference
MVP	Maternity Voices Partnership
Q&A	Question and Answer
RN	Registered Nurse
MSK	Musculo-Skeletal
PMB	Post-menopausal bleeding

Board of Directors' Meeting
11 November 2021

Agenda item	271/21			
Report	Serious Incidents Report			
Executive Lead	Director of Nursing Medical Director			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	
	Our service delivery		Caring	
	Our partners		Responsive	√
	Our governance	√	Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1, BAF 2, BAF 4, BAF 7, BAF 8, BAF 9	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	Details presented to QSAC			
Dependent upon (if applicable)**:**				
Executive summary:	This paper is intended to provide an overview of clinical incident management processes within the Trust. The following are included as part of the paper: • Overview of outstanding serious incidents, including days against the 60 day target, progress updates. • Open and overdue Datix Numbers and themes The Board is asked to review and note the contents of the report.			
Appendices:	None			
Lead Executive:				

1.0 Introduction

This report highlights the patient safety development and forthcoming actions for November/December 2021 for oversight. It will then give an overview of the Serious Incident reporting rates year to date. It will provide detail of the number and themes of newly reported incidents and those closed during September 2021, the number of current open serious incidents.

2.0 Serious Incidents (SI) Reporting

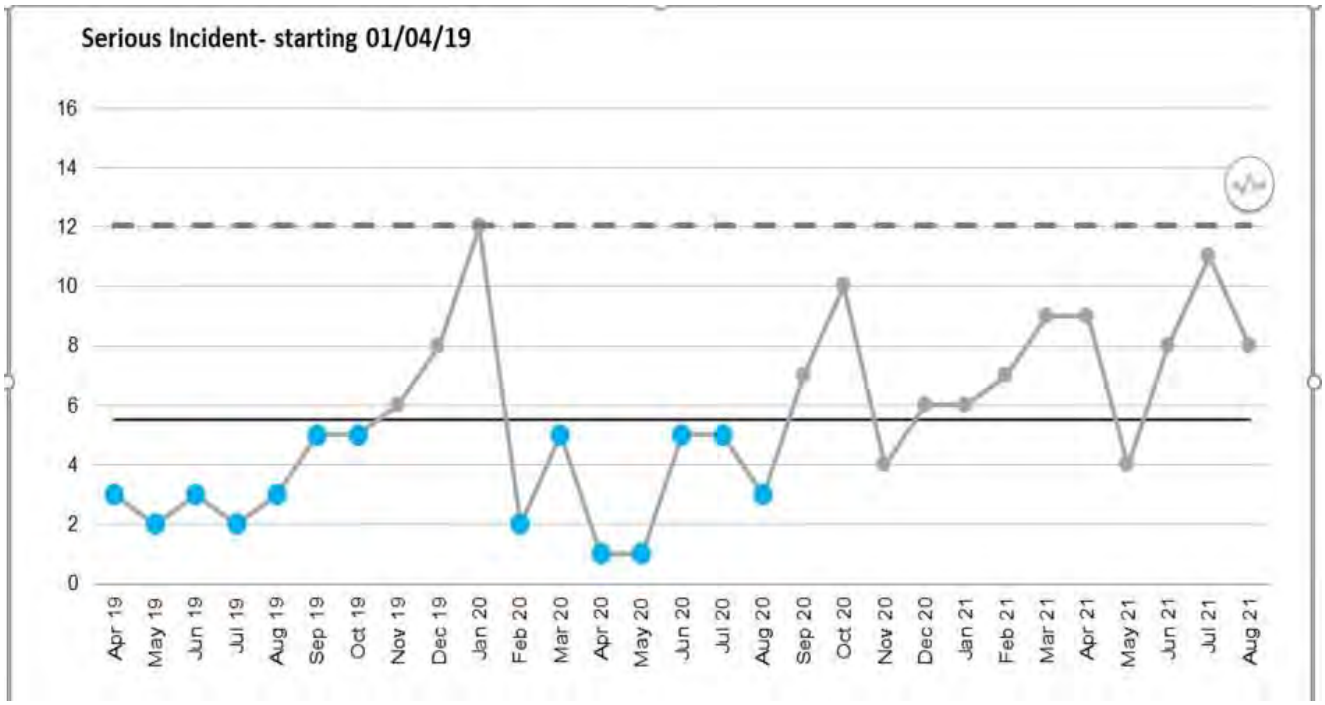
The outcome of all serious incident investigations are reported to the Review, Action and Learning from Incidents Group (RALIG) and Nursing Quality Assurance Meeting (NIQAM) where more detailed discussions about each investigation takes place. At these meetings there is open debate and challenge to each investigation's findings and actions as a means of seeking assurance that the Trust is identifying and acting upon any areas that require attention and improvement. An overview report is presented to Quality Operational Committee monthly. A more detailed learning report is presented quarterly.

The Trust meets with Commissioners each month to discuss investigation reports

2.1 Serious Incidents reported year to date

At the end of September 2021/22 the Trust had reported 50 Serious Incidents year to date. SPC 1 shows the serious incident reporting rate over time, which demonstrates common cause variation. In year 2020/21 56 serious incidents were reported, it is notable that in the 6-month period to September 2021 the reporting rate has significantly increased, which may be due to the effects of the pandemic or a more robust and open reporting culture.

SPC Chart 1



2.2 Serious Incidents reported in month

Table 1- 10 Serious Incidents reported in September 2021

SI	Number Reported
2021/xxx82 Fall with fractured neck of femur	1
2021/xxx24 Fall with fractured neck of femur	1
2021/xxx01 Maternity – Potential missed opportunity for earlier delivery	1
2021/xxx78 Absconding patient/head injury	1
2021/xxx93 Maternity – Intra uterine death - HSIB	1
2021/xxx03 Surgical Invasive Procedure	1
2021/xxx53 Fall with fractured neck of femur	1
2021/xxx54 Category 3 Pressure Ulcer	1
2021/xxx56 Delayed Diagnosis fracture neck of femur	1
2021/xxx55 Delayed Diagnosis - TB	1
Total	10

2.3 SI closed in month

Table 2 – 14 Serious Incidents closed in September 2021

Division	Brief Descriptor
Women & Children	2020/xxx83 Suboptimal Care
Surgical	2020/xxx18 Fall Intercranial Bleed
Surgical	2020/xxx50 Delayed Diagnosis Urology
Surgical	2020/xxx84 Delayed Diagnosis Urology
Surgical	2020/xxx80 Delayed Diagnosis Urology
Surgical	2020/xxx50 Delayed Diagnosis - Pancreatitis
Surgical	2021/xx5 Category 3 Pressure Ulcer
Women & Children	2021/xx08 Maternity Triage
Women & Children	2021/xx69 Treatment Delay
Surgical	2021/xx59 Delayed Treatment Urology
Medical	2021/xx85 Fall
Medical	2021/xx05 Category 3 Pressure Ulcer
Surgical	2021/xxx82 Delayed Diagnosis
Emergency	2021/xxx26 Delayed Diagnosis

2.4 Theme/Learning

The following themes have been identified from the investigations closed in month and actions in place for improvement.

- Communication with families, particularly listening when family members or patients are telling clinicians that something doesn't feel right.
- Escalation processes and handover from one team to another particularly in relation to the deteriorating patient
- Falls awareness for non-clinical staff who interact with patients

- Thematic reviews of incidents to understand themes and trends
- Escript adaptations as a result of learning from incidents to improve discharge processes.
- Planned audit of discharge summaries to support improvement
- Review of bookings processes and follow up checks
- Improvement in Triage processes
- Improvement in documentation and audit of documentation
- Review of diagnostics and results prior to discharge.

2.5 Never Events

No Never Events were reported during September, with the last reported Never Event in December 2020.

3.0 Top 5 incident themes during September 2021

Table 3 – Incident themes in September

Category
Pressure Ulcer / Skin damage
Falls from height or on same level
Appointment problems
Staffing Problems
Admission of patients

Kath Preece
Head of Patient Safety
October 2021

Board of Directors' Meeting
11 November 2021

Agenda item	272/21			
Report	Director of Infection Prevention & Control Quarterly Report			
Executive Lead	Hayley Flavell, Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community		Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk: BAF 1**	
	For assurance		BAF1, BAF2, BAF3	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	-			
Dependent upon (if applicable)**:**	*e.g. funding; national policy change; implementation*			
Executive summary:	This report provides an overview of the Infection Prevention and Control key metrics for Quarter 2, (July to September 2021). Key points to note by exception are: • The targets for C.Diff and MSSA was achieved in Quarter 2 of 2021/22. • The number of E.Coli bacteraemia is above the locally agreed Trust Target but below the NHSE/I target set for the Trust for 2021/22 • There have be 0 MRSA bacteraemia cases for Quarter 2 • The number of Covid-19 cases in the Trust in Quarter 2 has increased from Quarter 1, with 14 'Probable' Healthcare-Associated and 3 'Definite' Healthcare-Associated cases. • Lateral Flow Screening for staff compliance is low and actions to improve this across the Trust is ongoing • The revised NHSE/I IPC BAF was issued at the end of June 2021 and the Trust has undertaken another gap analysis and updated its IPC BAF, 9 items remain amber with mitigating actions in place. • The Trust Self-Assessment against the Hygiene Code (the Health and Social Care Act 2008) shows the Trust is 96.9% compliant			
Appendices:	IPC BAF September 2021 included as part of supplemental board pack			
Lead Executive:				

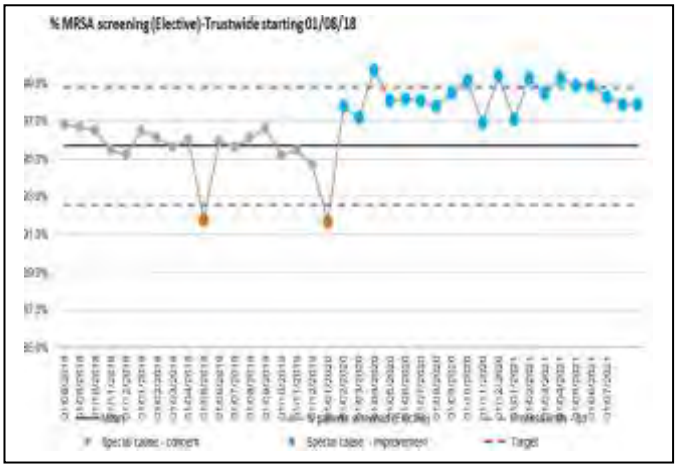
1.0 INTRODUCTION

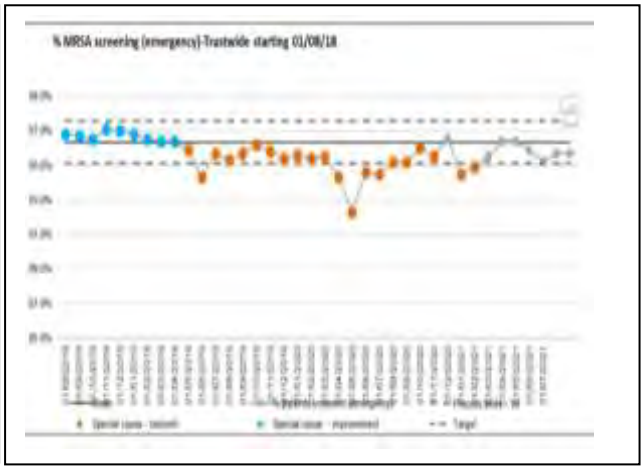
This paper provides a report for Infection Prevention and Control for Quarter 2 (July to September 2021) against the 2021/2022 objectives for Infection Prevention and Control. An update on hospital acquired infections (HCAI): Methicillin-Resistant *Staphylococcus aureus* (MRSA), Clostridium Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E.Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for July to September 2021 is provided. An update in relation to Covid-19 is also provided.

The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

2.1. MRSA Screening (Elective and Emergency)



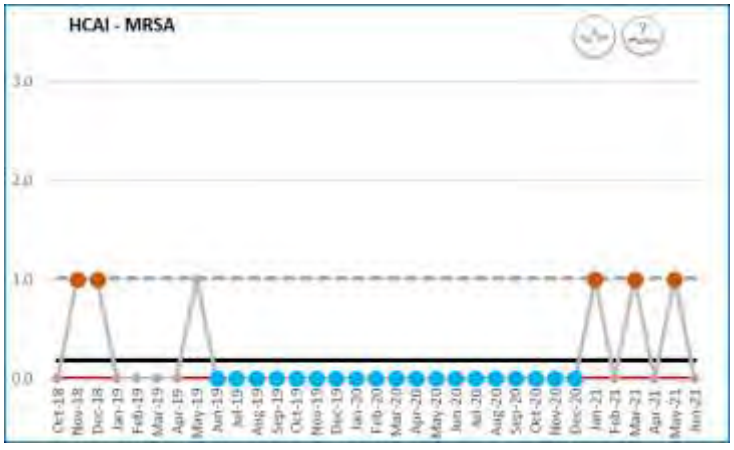


MRSA Elective Screening
Elective MRSA screening has been above the 95% target throughout Q1 and Q2. YTD performance is 98.6%

MRSA Emergency Screening
The MRSA emergency screening compliance has been above the 95% in Q1 & Q2 of 2021/22. YTD is performance is 95.9%.

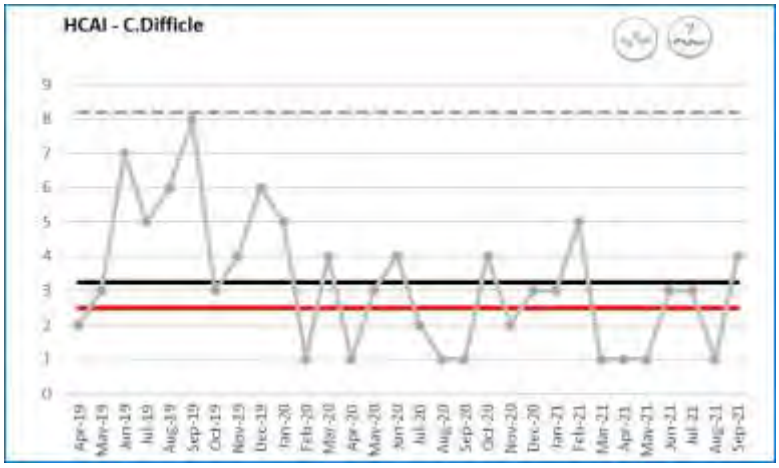
2.2 MRSA Bacteraemia

The target for MRSA bacteraemia remains 0 cases for 2021/22. There were 0 cases in Q2.



2.3 Clostridium Difficile

Total number of C-Diff cases reported per month is shown:

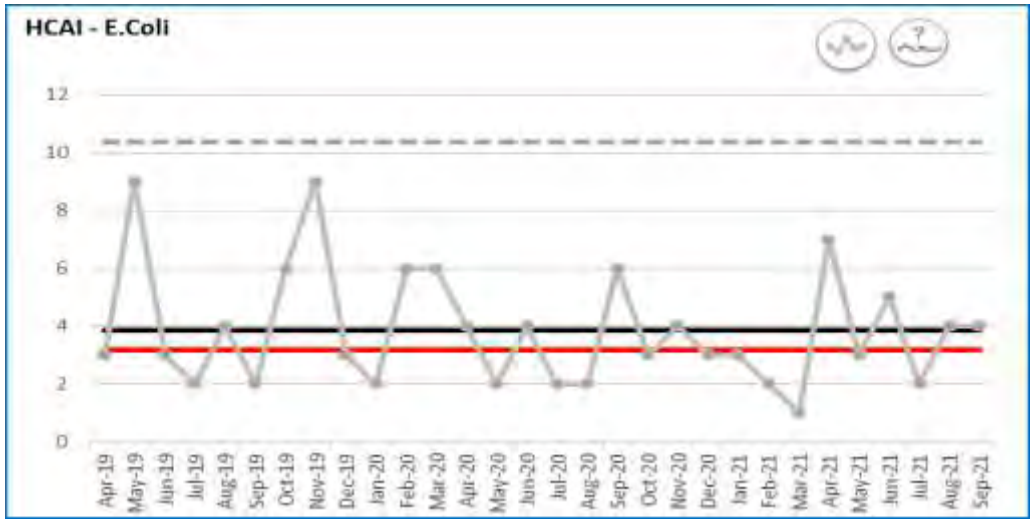
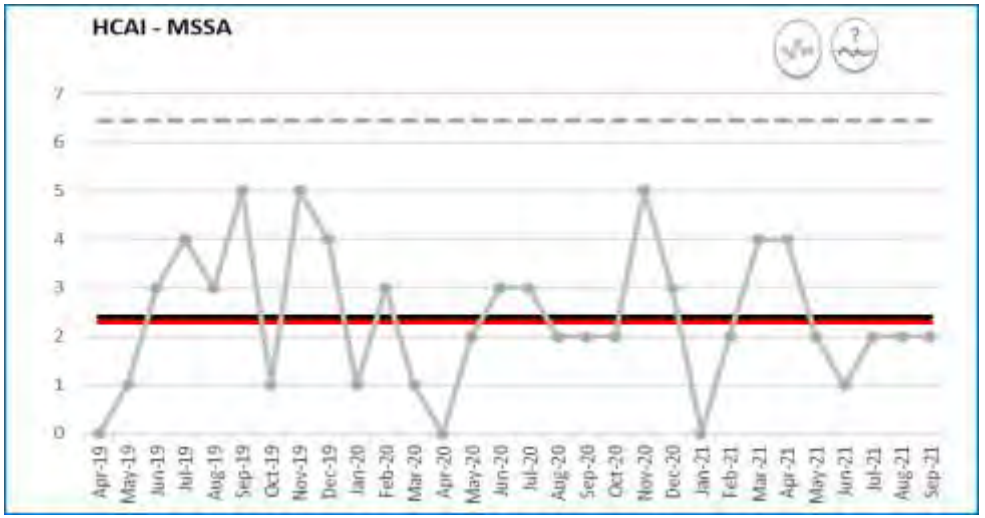


The national targets for 2021/22 have now been set at no more than 49 cases. Locally the Trust has agreed an internal improvement target of no more than 30 cases for 2021/2022. There have been 8 cases of C.Diff attributed to the Trust in Quarter 2 (July to September 2021). Four cases were post 48 hours of admission and four patient cases had been inpatients in the last 28 days prior to the positive sample. The total number of cases YTD is 13 against a local target of no more than 15 cases by month 6. The Trust is on target to achieve both its local stretch target and the nationally set target for 2021/2022.

Root cause analysis investigations are undertaken on all Clostridium Difficile cases. Common themes identified continue to be:

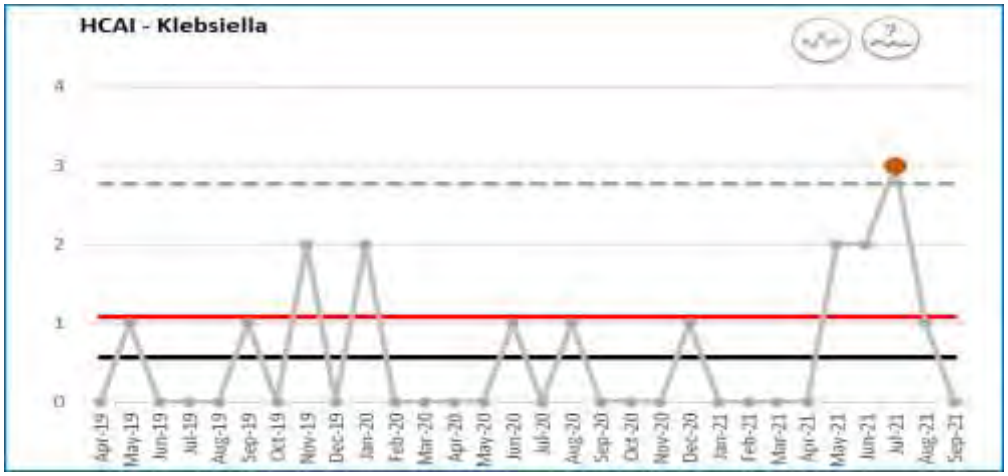
- Timely obtaining of stool sample
- Ability to isolate immediately due to side-room availability
- Timely and accurate completion of stool charts
- Antimicrobial prescribing remain the consistent themes.

Actions include increasing the number and availability of Redi-rooms as at times there are shortages of these due to the increasing number of COVID cases, this will enable more timely isolation of patients with diarrhoea. Ongoing education in relation to gaining stool samples, completing documentation and escalating if patient cannot be isolated continues.

2.4 E.Coli Bacteraemia The Number of E.Coli cases are shown: 	**2.5 MSSA Bacteraemia** The number of MSSA cases are shown: 
The nationally set target for 2021/2022 is no more than 122 cases. The Trust local target is no more than 38 cases. In Q1 there were 15 cases, this reduced to 10 cases in Q2. The total YTD is 25 cases of post 48 hour E.Coli bacteraemia against a target by month 6 of no more than 19 cases. The Trust is unlikely to achieve its local target but the national target will be achieved. All cases which are deemed to be device related or where the source of infection cannot be identified have an RCA completed. In the majority of cases the source of the infection was not considered to be related to a device. However, YTD there have been 6 cases were the source was deemed to be a catheter associated urinary tract infection (CAUTI), one was considered to be related to biliary stents and one was a post-operative infection. There is ongoing work being undertaken to ensure that the new catheter insertion documentation and catheter care plan is consistently used across the Trust, this is monitored via the monthly matron's quality assurance metrics audits, and high impact interventions audits.	There has been no national target set for MSSA bacteremia cases in 2021/22. The Trust locally agreed target for 2021/2022 is no more than 28 cases. YTD there have been 13 cases of post 48 hour MSSA bacteremia with 7 cases in Q1 compared to 6 in Q2. The Trust is likely to achieve its local target for 2021/2022. All cases deemed to be device related have an RCA completed. In total 5 cases of the 13 cases reported YTD were deemed to be device related. Of the 7 cases reported in Q1, there was one case where the source could not be determined and therefore an RCA was completed. Of the 6 cases in Q2, 4 were considered to be line infections (cannula/ hickman line). Aseptic non-touch technique training (ANTT) is being delivered for those nurses who have not completed this competency in the clinical areas. The number of staff who have completed this training will be reported through the IPC Operational Group.

2.6 Klebsiella Bacteraemia (Post 48 Hours)

The number of Klebsiella cases are shown:



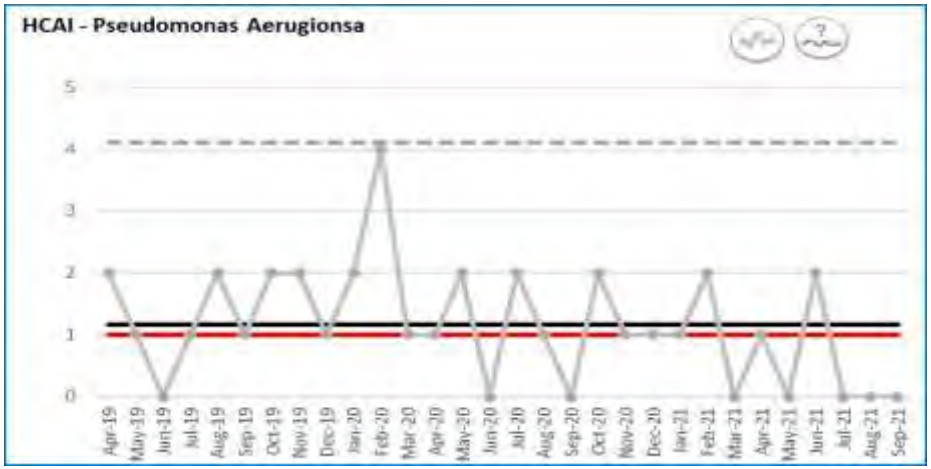
The nationally set target for 2021/2022 is no more than 24 cases.

YTD there have been 8 cases of post 48 hour Klebsiella Bacteraemia, with 4 cases occurring in Q1 and 4 cases occurring in Q2.

Two cases was deemed to be device related due to catheter associated urinary tract infections, and one case was sepsis post procedure, therefore was procedure related.

2.7 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)

The number of Pseudomonas cases are shown:



The nationally set target for 2021/22 is no more than 10 cases. YTD there have been 3 cases of Pseudomonas Aeruginosa all reported in Quarter 1

Two cases were deemed to be device related, one due to a catheter associated urinary tract infection and one was ventilator associated pneumonia. It is hoped that the Trust will be able to achieve the national target set for Pseudomonas infections in 2021/2022.

As for some of the other device related HCAIs associated with catheter associated urinary tract infections the embedding of the use of the newly implemented catheter insertion document and catheter care plan continue across the Trust supported by the Quality Team.

Root Cause Analysis Infections for MSSA and E.Coli Bacteraemia

All MSSA and E.Coli post 48 hour bacteraemia are reviewed by the microbiology team, those deemed to be device related or where the source of infection cannot be determined are expected to have a Root Cause Analysis (RCA) completed. In Quarter 2, 9 cases (5 E.coli and 4 MSSA) were deemed to be device related or source undetermined requiring an RCA; this equates to 56% of all post 48 cases for E.coli and MSSA

Learning from completed RCAs include:

- Samples not taken in a timely manner
- Documentation in relation to blood cultures does not always include the reason the culture was taken and who took it
- Urine sample not taken on admission for a possible UTI
- Inadequate documentation of line removal

Actions implemented in relation to improvements include:

- Blood culture 'top tips' poster distributed to all clinical areas to highlight best practice
- Monitoring of VIP scores daily by ward managers and compliance monitored at monthly nursing metrics meetings
- Urology specialist nurses asked to provide a catheter care SOP and a patient education SOP for catheter care.

3.0 PERIODS OF INCREASED INCIDENCE (PPI)

The periods of increased incidence are shown for Quarter 2 of 2021/2022.

	Ward	Infective Organism	Typing	Learning
July 2021	SITU	2 cases of Pseudomonas (Non BC)	Typing confirmed not the same therefore classed as a PII	Facilities to ensure taps are cleaned in the right order so not to contaminate the outlet
	C diff	3 cases of C diff	Typing of two cases were different, 3rd case unable to be typed therefore a cluster	Cleanliness hours to be increased by facilities Staff to ensure patient with type 5 stool are isolated Commodes/raised toilet seats need to be monitored as some were contaminated Some new staff were not aware of policy so encouraged to read policy as a refresher
Aug 2021	S25	2 cases of VRE	Typing confirmed not the same therefore classed as PII	Commodes/raised toilet seats need to be monitored as some were found to be contaminate
Sept 2021	TITU	2 cases of Pseudomonas (Non BC)	Typing confirmed not the same therefore classed as PII	PPE compliance – staff did not cover their gown with an apron Gowns need to be single use & not used sessionally

4.0 COVID 19 UPDATE

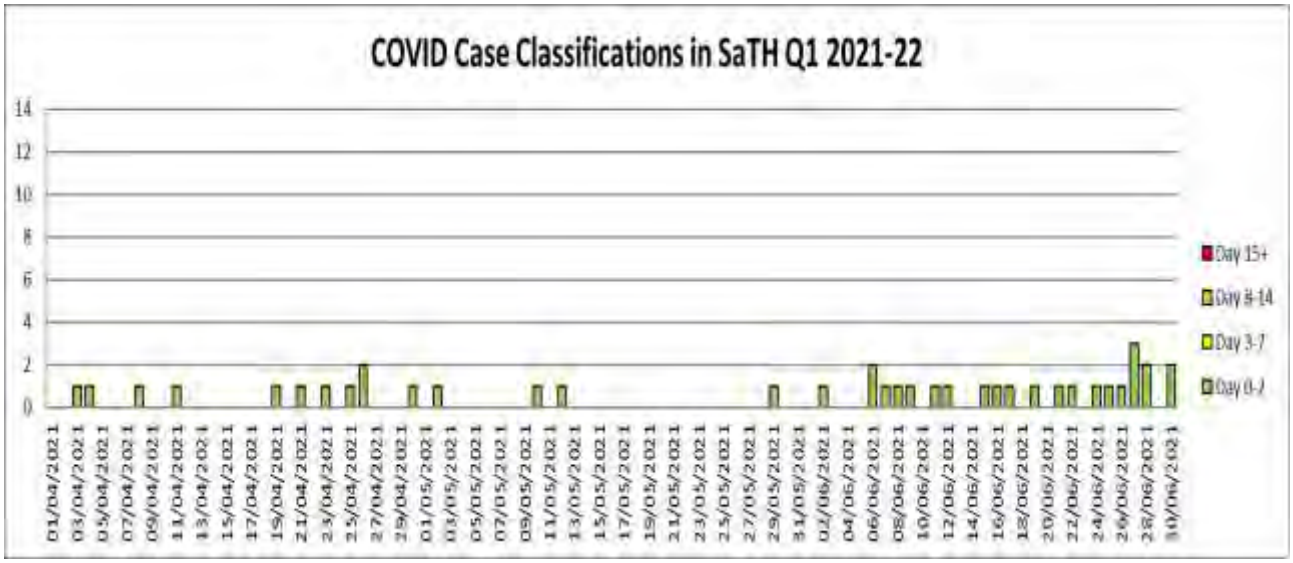
The number of Covid-19 cases in the Trust in Quarter 2 has increased. The Trust has seen a number of outbreaks since August 2021 which are shown below:

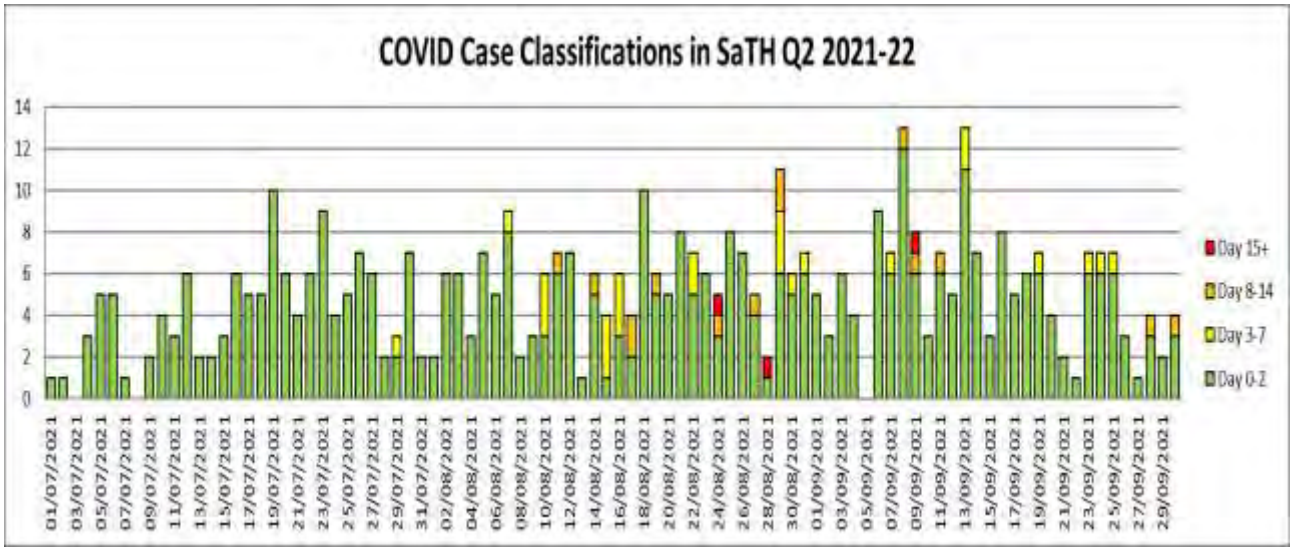
Month	Ward/ Dept	Number of cases	Learning
Aug 2021	SITU	3 staff cases of COVID	Staff to ensure they are socially distanced in staff room Staff reminded not to work if symptomatic
	S25	4 patient cases of COVID	Missed screening opportunity Patient moved from affected ward to non-affected
	IT Department	2 staff cases of COVID	Staff not socially distanced in office Staff not wearing masks Staff not completing LFT'S
	S27	24 cases of COVID (20 patients & 4 staff)	Missed screening opportunity Clear curtains not used appropriately
	S24	6 patient cases of COVID	Clear curtains not used appropriately & contacts of positive case became positive
	S28	4 cases of COVID (3 patients & 1 staff)	General PPE compliance
	Renal Unit	3 cases of COVID (2 staff and 1 patient)	Poor compliance LFT
Sept 2021	S28	3 patient cases of COVID	Clear curtains not used appropriately Patients who refuse to be screened – consideration needs to be given to isolate these patients
	S22TO	4 cases of COVID (2 staff & 2 patients)	Missed day 3 screens

In October 2020 NHSEI provided definitions of apportionment of COVID 19 in respect of patients diagnosed within hospitals as below:

- **Community Onset** – Positive specimen date <=2 days after hospital admission or hospital attendance
- **Hospital-Onset Indeterminate Healthcare-Associated** – Positive specimen date 3-7 days after hospital admission
- **Hospital-Onset Probably Healthcare-Associated** – Positive specimen date 8-14 days after hospital admission
- **Hospital-Onset Definite Healthcare-Associate** – Positive specimen date 15 or more days after hospital admission

The graphs below demonstrate the increases in cases between Q1 & Q2.





In Quarter 2 there were 14 'Probable' Healthcare-Associated and 3 'Definite' Healthcare-Associated cases. Only one of these cases was not involved in an outbreak, and an RCA was completed on this case.

Ongoing actions to reduce any transmission in the hospital remain in place and include:

- Ongoing patient screening on admission, Day 3, Day 5 and Day 15
- Plastic curtains around bed spaces
- Ensuring PPE compliance and social distancing by all staff
- Encouraging patients to wear face masks at all times but particularly when mobilising to the bathroom
- Robust cleaning of the ward environment with Tristell twice daily

Staff Lateral Flow Testing

There is an expectation that staff will undertake lateral flow tests twice weekly and report the results through on the Trust lateral flow app. The results are shown below and highlight there is further work required across all staff groups to encourage compliance with this.

Division	% Yes Reporting Results	% No Not Reporting Results	Total Frontline Headcount
Trust	**20%**	**80%**	**5581**
Medicine and Emergency Care	17%	83%	1564
Surgery, Anaesthetics and Cancer	22%	78%	1935
Women and Children's	14%	86%	825
Clinical Support Services	25%	75%	916
Facilities Directorate	15%	85%	91
Estates Directorate	27%	73%	30
Bank Workers	7%	93%	920

Managers now receive this information weekly. This has been discussed at the weekly senior nurses meeting and escalated to the Covid-19 Silver meeting for discussion and escalation to the Covid-19 Gold meeting.

5.0 SERIOUS INCIDENTS (SI) RELATED TO INFECTION PREVENTION & CONTROL

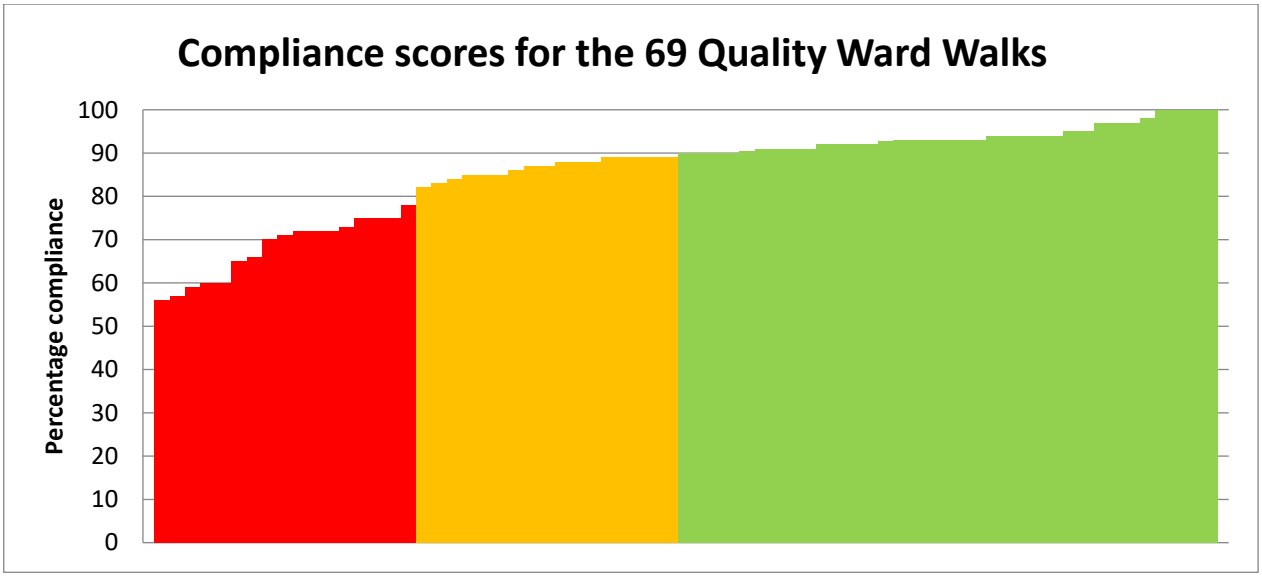
There were no IPC serious incidents reported in Quarter 2 of 2021/2022.

6.0 IPC INITIATIVES

During Quarter 2 (July to September 2021) the IPC team conducted 69 full Quality ward Walks (QWW).

The accepted standard is 90% compliant. If more than 90% complaint the area will be re-audited in line with current schedule (quarterly). If an area scores between 80-89%, the area will be reviewed in 1 month. If an area scores less than 80%, a repeat audit will be completed in a week.

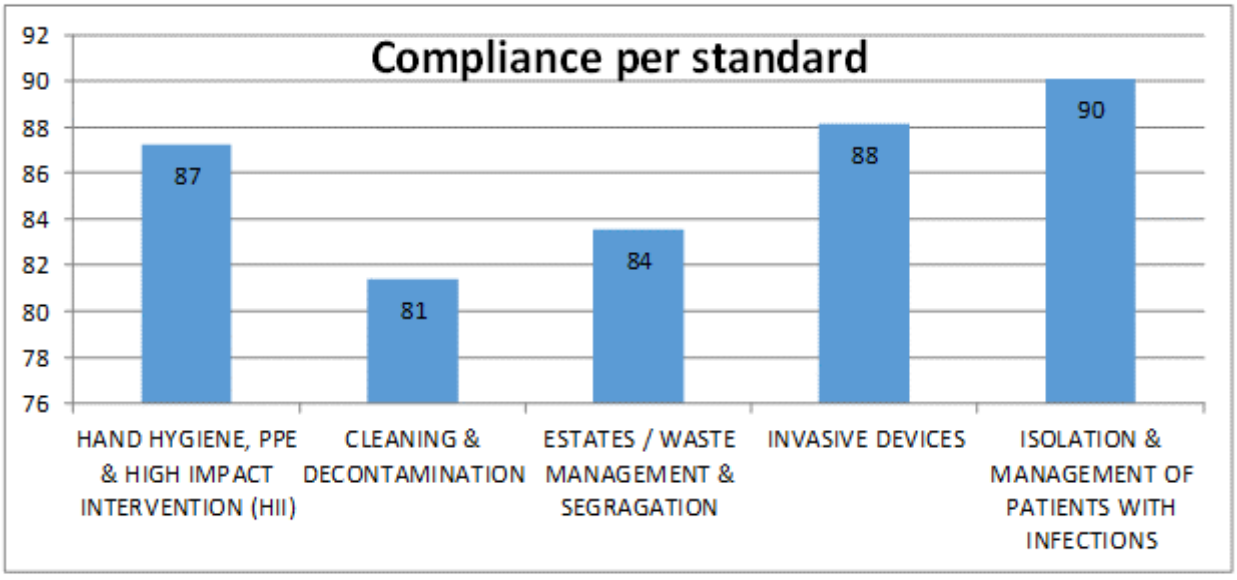
In Q2 compliance scores ranged from 56-100%. Of the 69 QWWs completed, 17 scored less than 80%, 17 scored between 80-89% and 35 scored above 90%.



The IPC QWW tool is sectioned into 5 standards:

- Hand hygiene, PPE & high impact intervention (HII)
- Cleaning & decontamination
- Estates / waste management & segregation
- Invasive devices
- Isolation & management of patients with infections.

The most commonly non-compliant area is that of cleaning and decontamination.



In all QWW it was observed that the following elements were compliant

- Patients were confident that staff were decontaminating their hands
- Staff needing to use FFP3 masks were fit tested.
- Staff were aware of the procedure for cleaning and returning mattresses

- Waste was segregated as per policy
- Correct signage was in place for patients who were isolated in a side room
- Clinical staff are able to articulate to correct procedure for patients with diarrhoea
- Clinical staff are able to articulate the symptoms of COVID-19 and are able to describe the process when onset occurs in hospital
- Clinical staff are aware that patients require rescreening for COVID-19 at day 3, day 5-7 and day 13 of admission
- All patients requiring isolation were isolated
- All COVID 19 contacts identified and flagged on SEMA

7.0 IPC NHSE/I REVIEW

In July 2021 an IPC Inspection was carried out at both the Royal Shrewsbury Hospital and the Princess Royal Hospital by the NHSE/I Director of IPC. The Trust was given a "Green" RAG rating overall following this inspection. A follow up inspection to ensure these standards have been maintained is planned for the 18th January 2022.

The IPC team continue to support the divisions with maintaining the improvements made. The CCG revisited Ward 27 in September 2021 as they had agreed to support the Trust with oversight of their improvement plan. The CCG reported that there were a number of areas of good practice observed & areas for improvement have been included in the current ward action plan.

The CCG were also invited in to undertake a rapid review of Ward 25 due to an outbreak of COVID, C.diff and VRE. The typing of two cases of C.Diff was different, the 3rd case was unable to be typed, this was therefore agreed to be a cluster rather than an outbreak. The VRE typing confirmed these cases were not the same so this was therefore classed as PII & not an outbreak. The CCG reported that there were a number of areas of good practice & areas for improvement have been included in the ward action plan which is monitored by the IPC Team.

8.0 RISKS AND ACTIONS

The Risk register for IPC is held by the Director of Nursing as the Director for Infection Prevention and Control (DIPC) and is updated monthly.

There are 11 risks on the risk register. 5 risks are RAG rated Red prior to risk controls which reduces the risks to Amber for 4 risk although risk 2077 remains red after mitigating controls have been but in place. These risks are:

- **Risk 1844**: Risk of poor monitoring of IPC outbreaks including COVID19 due to lack of electronic surveillance system
- **Risk 1749**: There is a risk associated with the isolation of patients who have airborne infections due to the lack of negative pressure isolation rooms in the Trust
- **Risk 1456**: There is a risk of Healthcare associated infection due to the lack of isolation facilities which may lead to delays when a patient needs to be isolated
- **Risk 2077:** Decontamination assurance for medical devices
- **Risk 2158**: Lack of deep clean programme for clinical areas. This is a new risk added in October 2021 after discussion at the last IPC Assurance 2021

9.0 IPC BOARD ASSURANCE FRAMEWORK

This Prevention and Control Board Assurance Framework (IPC BAF) was last updated by NHSE/I in June 2021 and consists of 10 domains and 109 key lines of enquiry (See Appendix 1). The Trust is RAG rated green for 101 of the key lines of enquiry and amber for the remaining 8 items which are outlined below.

Section	RAG Rated Green	RAG Rated Amber	Amber Key Line of Enquiry
Section 1: Systems are in place 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 posed by their environment and other service users	21	2	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative
Section 2: Provide and Maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	12	1	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. A gap analysis business case has been approved internally, but needs to go to ICS for approval (October)
Section 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	1	1	Antimicrobial group meetings have been difficult to hold and are often not quorate due to lack of clinical representation. Pharmacy continue to request engagement from clinicians.
Section 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	6	0	
Section 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	13	0	

Section 6: Systems 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	12	2	All staff (clinical and non-clinical) have appropriate PPE training, in line with latest PHE and other guidance, to ensure their personal safety and work environment is safe
			All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely Don and Doff
Section 7: Provide or secure adequate isolation facilities	5	0	
Section 8: Secure adequate access to laboratory support as appropriate	12	0	
Section 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	4	0	
Section 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	15	2	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported
			Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and elective care pathways and urgent and emergency care pathways, as per national guidance

Actions continue to be implemented to increase compliance with the key lines of enquiry currently rated as amber. Actions include a business case which has been approved internally for additional cleaning hours, between 10pm and 6am, but needs to go to the ICS for approval in October 2021. Pharmacy continues to request engagement from clinicians to the antimicrobial group.

10.0 HYGIENE CODE UPDATE

The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections, applies to all healthcare and social care settings in England. The Code of Practice sets out the 10 criteria with 243 elements against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained Trusts complete a self-assessment.

The Hygiene Code is reviewed now reviewed quarterly by the IPC team and presented at the IPC Operational Group. The Trust is 96.9% compliant, being RAG rated 'Green' for 233 elements, 'Amber' for 9 and RAG rated 'Red' for 1. The Trust self-assessment compliance against each of the 10 domains and the current gaps and actions are shown:

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
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.	97%	IPC arrangements & responsibilities policy in place and found in every Job description. All staff should receive mandatory update & induction training. Contractors receive IPC training via estates (part of their induction to the Trust) Uptake of training for 2020-21 was 84% which is the same as 2019/2020	Continue to monitor attendance and report quarterly to IPCOG Care Groups to report compliance with training on report to IPCOG monthly
			There is a lack of an efficient automated surveillance system that triangulates data on outbreaks.	ICNET due to be in place September 2021.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	95%	Daily Cleaning Checklists are completed by Cleanliness Technicians and housekeepers. These are reviewed by Ward managers and reported monthly through the ward assurance reports. Ward Managers complete (at least) Monthly verification checks that are also reported. IPCC Minutes. It is noted that these were inconsistently applied and the NHSE/I visit found failings in compliance	Daily cleaning checklists implemented Oct 2019 Meeting with facilities & IPC to have one check list for both technician & ward manager/matron to complete further meeting to be organised with Head of Nursing

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
				Agreement with facilities that cleanliness technicians will raise estate concerns when they complete audit" Clarify process for monitoring cleaning checklists
			Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle.	This is currently not in the remit of the Decontamination Group and therefore Decontamination Lead (AD Estates). The Terms of Reference have been agreed to exclude these items which remain in the remit of IPC group.
			a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	Following TRUS probe investigation (following outbreak) an audit is underway of all invasive devices requiring all departments to ensure they have adequate decontamination records, SOPs and training records. The responsibility is with the departments to ensure they have adequate processes and share information with the Decontamination Group to ensure satisfactory assurance is provided.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	94%	All antibiotic prescriptions are reviewed by a pharmacist. The Trust has no e-Prescribing system Proactive work being undertaken relating to sepsis.	E-prescribing system required

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	100%	None	None
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	100%	None	None
6	Systems 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.	100%	None	None
7	Provide or secure adequate isolation facilities.	83%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Patients may need to be cohort nursed if demand is high for example at outbreaks of norovirus or influenza during high activity periods. This is on the IPC Risk Register	Long term solution includes isolation facilities as part of planning regarding "Future Fit" and moving to possibly 50% of capacity being side rooms. Estates currently looking at the feasibility of having drop in pod to ITU & also side-room capacity including negative pressure

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
			The Trust has no negative pressure isolation room, this is on the IPC Risk Register	Bioquell Pods now installed in ITU and redi-rooms.
8	Secure adequate access to laboratory support as appropriate.	100%	None	None
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	99%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Require assurance from CPE's that competency based assessments for aseptic technique are in place	None
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	100%	None	None

11.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC for Quarter 2 (July to September 2021). Overall performance in relation to many of the IPC KPIs remains positive, with the improvement targets for C.Diff and MSSA achieved. The performance in relation to HCAIs is below all the national targets set by NHSE/I for 2021/2022 with the exception of MRSA as we had one cases of bacteraemia in May 2021 but none in Quarter 2.

E.Coli bacteraemia attributed to the Trust have decreased from 15 cases in Quarter 1 to 10 cases in Quarter 2 but is above the locally agreed improvement target. Of these 10 cases, 5 were considered to be device or intervention related, and there is ongoing work to improve catheter care across the Trust.

The number of COVID 19 cases being seen in the Trust has increased considerably in Quarter 2. There have been some outbreaks across the wards, this however, was not to the same level as in 2020-21. External outbreak meetings are held weekly, with the involvement of PHE and NHSEI, an internal outbreak meeting is also held weekly. Lateral flow testing compliance for staff still requiring improvement.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	273/21			
Report	Quarter 2 Public Participation Report			
Executive Lead	Director of Public Participation			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people		Effective	
	Our service delivery		Caring	
	Our partners		Responsive	√
	Our governance		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance			
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	Senior Leadership Committee- Operational October 2021			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This paper gives an update on the work of Public Participation (Community engagement, volunteering and SaTH Charity) for Quarter 2 of 2021/22. It is important that the Trust continues to engage and involve our local populations in a meaningful and inclusive way. COVID-19 has impacted on the ways we engage with our local communities, however, it is essential that we continue to have an ongoing dialogue with our communities, and ensure they have opportunities to be involved. This paper outlines how we have engaged with our local communities, including meeting our Section 242 statutory duties to engage. This presentation also provides an update on our charity and where funding has been allocated across the Trust. This paper will outline the Trust's forward plan around engaging our local communities over the next 3-6 months, taking into considerations the challenges around engagement and COVID-19			
Appendices	Public Participation presentation provided in supplement board pack.			

1.0 Public Participation Team

The Public Participation Team consists of three main inter-related public-facing services

- Community Engagement
- Volunteering
- Charity management

Under the banner of Get Involved – Make a Difference the team https://www.sath.nhs.uk/about-us/get-involved/get-involved-public-participation/ there are lots of different ways to Get Involved and it's easy to do. We reach out to engage with the public and the emphasis is on everything we do directly linking to our local communities. This can be by joining as a Community Member to be kept up-to-date about what is going on at SATH, having a say about hospital services, becoming a fundraiser for our charity or volunteering time to help at the hospitals.

2.0 Community Engagement

2.1 Provides support to the Divisions to ensure they meet their Section 242 duties to engage, this included engaging around the potential temporary change to cardiology inpatient services.

2.2 Our Public Participation Plan has been approved by Trust Board and a 5 year implementation plan is now being developed. David Brown is the Lead Non-Executive Director for the Public Assurance Forum.

2.3 The Public Participation Team continues to engage with the public with a regular series of virtual meetings and health lectures. The Autumn Health Lecture series is on COVID-19 in terms of research undertaken by the Trust and living with the effects of COVID-19.

2.4 Trends and themes from Trust Board questions are used to identified and plan future engagement events with our local communities.

2.6 Through our Social Inclusion project we have continued to work with our local communities to ensure that the views of seldom heard groups are listened to within SaTH. In Quarter 2 the Community Engagement Team have attended several events including the Windrush Generation Celebration.

2.7 The Director of Public Participation has also been invited to become a founder member of the ICS Digital Advisory Group

3.0 Volunteers

3.1 We currently have 192 volunteers (52 young volunteers) and have 74 individuals who are going through the application process

3.2 Following updated NHS guidance we are currently restoring some of our pre-covid volunteer services including the return of postponed volunteers and the reintroduction of volunteers onto ward areas. 69 volunteers have completed their non-clinical ward based training.

3.3 Our Response Volunteers continue to provide a service across both hospital sites, giving an additional 336 hours of support to our hospitals each week, with an emphasis on supporting nursing colleagues.

3.4 We have introduced two new volunteers roles within the Trust to support Patient Flow – an A&E role and a Pharmacy "volunteer" role.

3.5 Currently we are transferring to a new volunteer management system, Better Impact. This will support the recruitment of volunteers, as well improving communication with our current volunteers.

4.0 Charities

4.1 Income for the 3 months of Q2 2021 is £68,702 and expenditure for this same period was £63,381

4.2 SaTH Charity ran a number of staff engagement and support projects in Quarter 2, including the Rapid Relief Team and their volunteers giving over 1000 comfort bags to staff

4.3 Work has commenced on creating a Captain Tom's Garden at RSH. This is being funded following a successful grant application made to NHS Charities Together. The Team have been contacted by NHS CT to provide peer support to a Trust who are planning a similar project following a successful bid to NHS CT.

4.4 There is an increase in the number of patients, relatives and staff fundraising for SaTH Charity

5.0 Risks and actions

Risk	Action	Timescales
1. Fail to deliver wider public participation	Ongoing programme of events and meetings to keep the public informed and engaged with the Trust. Engagement with our communities around our Public Participation Plan.	On going
2. Fail to deliver statutory duties (s242) to engage with the public	Continue to support our Divisions to ensure they meet their Statutory Duties.	Ongoing
3. Public support through donations for SaTH Charity recede as country returns to the new normal after the pandemic lockdown	Plan developed to build on awareness of SATH charity to link to local fundraising from individuals groups and corporate organisations.	Ongoing
4. The risks of not having a joined up approach to fundraising and volunteering would be a potential decline in income and hours donated, impacting on staff workload.	Stronger links have been built between the Charity and Volunteering team to align them as areas that are supported by the population. Both are supported by giving their time, money or both.	In place

5.0 Conclusion

Board of Directors are asked to:

5.1 note the activity in Quarter 2 by the Public Participation Team

5.2 note the forward plan for the Public Participation Team for the next 3-6months

Director of Public Participation
November 2021

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	274/21			
Report	Feedback from Board Genba Walks (and new Genba Walk process)			
Executive Lead	Director of People and Organisational Development			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 3 and BAF 4	
	For decision / approval		**Link to risk register:**	
	For review / discussion		1029,1650,1707,1620, 2107	
	For noting			
	For information	√		
	For consent			
Presented to:	Trust Chair and SaTH Leadership Committee			
Dependent upon:	N/A			
Executive summary:	The Board of Directors are being asked to note and consent to a new Genba walk process which has been refreshed and presented to Catriona McMahon, Chair, and the CEO's SaTH Leadership Committee for agreement. This is being brought to board as it links to our people strategic pillar and provides additional controls so that the board can receive assurance for our inherent 2 risks. We are unable to attract, develop or retain its workforce to deliver outstanding services and we have a shortage of workforce capacity and capability leading to deterioration of staff experience, morale and wellbeing. The Board of Directors are also being asked to note that Genba walks took place in RSH Radiology and Ward 24, Cardiology / Endocrinology on 7th October 2021. Appendices are included which summarise the visit, the new plan and process which also aims to improve engagement for staff at all levels with Executives and Non-Executives.			
Appendices:	Appendix 1: Feedback from Genba walks (7th October) Appendix 2: Genba Action Plan Appendix 3: New process for Trust Board Genba Walks			
Lead Executive:				

1.0 Introduction

1.1 Genba walks are visits to areas in the organisation to see 'work as done'. The purpose of these will be to provide assurance to the Board of Directors regarding the quality of care provided to patients. Importantly, the visit provides a great opportunity for staff at all levels to engage with their Executives and Non-Executives, share learning and any concerns, and celebrate the work they are doing. This is being brought to board as it links to our people strategic pillar aligned with our PACT Values and provides additional controls so that the board can receive assurance.

1.2 The Trust has been undertaking these visits for a number of years, but upon the rebrand/restructure of the Trust's improvement function to the 'SaTH Improvement Hub' and the subsequent appointment of a new Head of Service Improvement the Trust saw an opportunity to improve the effectiveness of these visits. The Improvement Hub worked with the Trust chair, other organisations and other key internal stakeholders to design a new process, which is detailed in appendix 3.

1.3 The new proposed process is detailed in appendix 3. The key changes are:

1.3.1 Genba Walks previously took place on the morning of each Trust Board. It has been proposed that the timing of these moves to the 2nd Wednesday of each month between 14:30 and 16:30 from February 2022. This change is to facilitate better attendance and more adequate time for people to see the areas in question.

1.3.2 Two thirds of Genba Walks will be planned in advance however the board is requested to recommend an area to visit each month based on current Trust priorities.

1.3.3 An appendix has been added to aid reviewers in questions to ask when visiting areas. Further development for all leaders is being designed for roll out in February 2022.

1.3.4 The Improvement Hub will review actions monthly, escalating as appropriate.

1.4 The board is also being asked to note that Genba walks took place in RSH Radiology and Ward 24, Cardiology / Endocrinology on the 7th of October 2021 to gain board assurance that controls such as the Cultural and Leadership programme are working. A summary of the visits is within appendix 1. The visits were well received, and each visit identified opportunities intended to improve the experience for our service users and our colleagues.

1.5 Opportunities from the visits were captured and can be seen in appendix 2, these will be monitored through the Improvement Hubs based at RSH and PRH.. As referenced in the standard work for Genba Walks. This action plan will be reviewed regularly within the Improvement Hub, with escalation as appropriate.

2.0 Recommendation

2.1 The recommendation to the board is that the Improvement Hub will continue to facilitate Genba walks in the Trust, following a new process (appendix 3). This process has been agreed by the chair, and the SLC-T to commence from February 2022. Undertaking visits in this manner will reinforce our aim to improve outcomes for staff and patients through Just and Learning culture as detailed in Getting to Good.

2.2 Details of each of the visits is available in appendix 1. Actions from the visits will be monitored through the Improvement Hub (appendix 2).

Appendix 1 October 2021 Trust Board Genba Walk Summary

Genba Area / Lead	Genba Team	Summary
Radiology, RSH • Amanda Royle - Radiology Centre manager, • Dr Laurence Ginder - Clinical Director and Consultant Radiologist, • Claire Baker - Lead Superintendent radiographer, • Alison Allwood - Lead Ultrasonographer	• Nigel Lee – COO • Catriona McMahon - Trust Chair • David Brown - Non-Executive Director • Trevor Purt - Non-Executive Director • James Owen - Head of Service Improvement • Rebekah Tudor - Business Partner	**Physical Genba Reflections** The genba team thanked the radiology department for their hospitality and stated that it was clear that the teams had been through very challenging circumstances. The new equipment has added to the reliability of the service and the use of data to reliably inform business cases has been invaluable. Lots of credit was given to the leadership of the team and a special thanks from Nigel Lee to all involved. **Virtual Genba Reflections** The team were able to discuss staffing issues and business case support. The apprenticeship levy was explored alongside the need for greater input into the ICS and wider pathway discussion to ensure the service is fit for patients. Laurance Ginder was keen to explore additional support for patients recovering post-biopsy to ensure there is a safer way to care for the patient following the procedure. Nigel Lee advised that there is a mid-term solution which he will discuss with Sheila Fryer. **Overall Genba Reflections** The radiology team are experiencing difficult circumstances, however the hard work of the team, and new equipment has added to the reliability of the service in recent months. During the visit discussions took place around initiatives to try and aid in staff retention, remote reporting capabilities and safer patient care. The Genba team are planning to revisit the area to celebrate the opening of the new 'Pod' at the RSH site.

Genba Area / Lead	Genba Team	Summary
Ward 24 (Cardiology / Endocrinology) • Debbie Houliston - Medicine Centre Manager • Donna Moxon - Operational Manager • Claire Edwards - Ward Manager	• Chris Preston - Deputy CEO • Hayley Flavell - Director of Nursing • Tony Bristlin - Non-Executive Director • David Lee - Non-Executive Director • Teresa Boughey - Non-Executive Director • Clive Deadman - Non-Executive Director • Marie-Claire Wigley - Business Partner	The team on the ward have had good retention, which has led to a good level of expertise. They have recently had successful work undertaken with the support of the Improvement Hub, including involvement in the 'Flow Fortnight' programs and a '5s' of the treatment room. There are a lot of improvements the team would like to make, that are dependent on a ward move to a single site. It was taken as an action from the visit for the date for this move to be confirmed. The team are currently only undertaking TOE investigations at PRH, as there is no equipment at PRH. An action was taken to assist with this issue on the visit.

Appendix 2 Genba Action Plan

Genba Details	Genba Area	Division	Action No.	Action	Person Responsible	Due Date	Update	Action Status
07.10.21	Radiology	SD	R01	Explore the use of golden tickets for staff who are on training placement with the department.	Amanda Royle	Dec-21		
			R02	Visit to UHB to explore the digital capability possibilities	Amanda Royle	Dec-21		
			R03	Further genba walk around new facility	Catriona McMahon/ Nigel Lee/ Amanda Royle	Dec-21	Improvement Hub have contacted AR to confirm date of revisit.	
			R04	Explore the development of reporting hub	Amanda Royle	Dec-21		
			R05	Post-biopsy support	Nigel Lee/ Sheila Fryer	Oct-21	To be discussed at NL and SF 1:1 on 12/10/21	

Genba Details	Genba Area	Division	Action No.	Action	Person Responsible	Due Date	Update	Action Status
07.10.21	Ward 24	M&EC	E01	Speak with Nigel Lee regarding a date for the Cardiology move to facilitate starting the Estates work and ordering the equipment needed	Chris Preston	15.10.21	Paper taken to SLC-T to discuss the move on 21/10/21. Date to be confirmed.	Closed
			E02	Hayley to have a discussion with Will Nabih from Estates to clarify issues around decontamination regarding the use of the Ward 28 room for TOE	Hayley Flavell	15.10.21		

Appendix 3 - Standard Work for Trust Board Genba Walks

Purpose

The purpose of these will be to provide assurance to the Board of Directors regarding the quality of care provided to patients.

Each visit team will talk to patients, relatives and staff as well as reviewing the governance arrangements and overall environment. The visit teams will review the care provided to patients to identify areas of good practice and areas where improvement is required

Importantly, the visit provides a great opportunity for staff at all levels to engage with their Executives and Non-Executives, share learning and any concerns, and celebrate the work they are doing.

Planning cycle (Rhythm)

The Genba walks will take place on the second Wednesday of each month between 14:30 and 16:30.

To enable effective spread and reduce the volume of attendees to each area, three Genbas will be identified prior to the Board, with Board members being allocated on a rotational basis.

A standard process description is available in appendix 4.

Attendees

Each area will have:

- One or two Executive Directors as Genba lead, to facilitate the walk.
- One clinical Executive Director or their Deputy
- One Non-Executive Director
- A member of the Trust's improvement team will also accompany each walk to support facilitation and capture outcomes.

Visits can go ahead as long as one Non-Executive Director and one clinical Executive Director or their Deputy are present. A member of the Improvement team will also need to be in attendance to record the actions

Currently, due to PPE requirements, a hybrid version has been created with some nominated to visit the genba in person, with other members of the Board attending virtually. To facilitate this, two member of Staff from each Genba will be nominated to host. In 2022 the Trust will move Genbas to occur on a different date to the Board meeting to facilitate face to face attendance of Non-Executive members.

Genba Selection

Genba areas will be selected on a monthly basis, as an item placed in the Executives weekly meeting by the Director of People and Organisational Development. Areas will be selected at this forum to ensure those selected align with the "Getting to Good" programme and other improvement activity, such as the "Maternity Improvement Programme".

A rolling plan will be created and agreed as required at the Executive weekly meetings to ensure adequate time can be allocated to prepare the areas; this will ensure the highest value is achieved from the walks. The Organisational Development team will run an educational campaign, with the aspiration of making visits unannounced in the future.

A minimum of two areas will be reviewed at each session. Two sessions will be pre-planned 6 months in advance. Additional sessions will be selected a month before the visit.

Preparatory work

Genba Leads will be provided with a template [Appendix 1] to enable a standardised approach to providing preparatory data in advance of the Genba walks. The preparatory data will include:

- Statistical data relevant to the improvement work taking place (Baseline data and any subsequent data captured following improvements)
- Details of staffing levels and vacancy rates
- Update on improvement activity taking place
- Update on business cases being developed in support of the improvement work
- Brief financial update that has been impacted by the improvement activity.
- Patient/customer feedback
- Complaints
- Outstanding DATIX reviews/SIs

Completed templates will then be sent to Trust Board members one week prior to the Trust Board.

Genba Walk

- A standard agenda will be provided to all members of the Genba in advance.
- Genbas will commence on time at 14:30 hours and complete on time at 16:30 hours.
- Until the Trust is able to consistently allow all members of the Board attend in person at the Genbas, all Genba walks will be conducted virtually using Microsoft Teams alongside the physical walk.
- The Executive Lead will commence the walk by introducing all on the call, make the Genba team feel at ease and subsequently facilitate the discussions following

the agenda. A member of the Genba team will remain as a virtual host, whilst the rest of the team will undertake the physical Genba walk.

- Prompts of questions to ask are available in appendix 3
- The Improvement Hub will provide a copy of the outcomes and actions, from which, the Executive Lead will feedback to the Trust Board. A copy will be sent to the Genba.

Actions Post Genba Walk

- The Non-Executive Lead will be expected to feedback to the private board after the Genba
- One month post the Genba a written paper will be presented to the public board by the lead executive.
- Copy of Genba walk outcomes/actions to be provided to relevant Division.
- Division to discuss outcomes at appropriate meetings and agree an action plan.
- Outcomes for Executive leads will be monitored through their Executive meetings and will feedback to relevant Division.
- A monthly meeting will take place to specifically review Genba actions.

Administration

The Improvement Hub Administrator will follow the process as detailed below:

- Contact Genba Leads to ensure staff availability and confirm timings/dates.
- Ensure associated Divisional leads aware of Genba walk.
- Send copy of agenda and preparatory data template to Genba Leads after the Tuesday Executive meeting once the Genbas are confirmed.
- Provide completed agenda and preparatory documents to the Chairs EA one week prior to the Trust Board.

The Chair's EA:

- Send Microsoft Team invites for all three Genbas to appropriate Executives, Non-Executives, Genba Lead & Team, and allocated member of the Improvement team, with copy of agenda
- Improvement team member to capture outcomes and feedback from Genba walk and provide typed copy vie e-mail to the Lead Executive, the Chair's EA and all Genba members as soon as possible on completing the Genba Walk.

Notes:

1. All members of Trust Board will be initially provided with a recurring outlook invitation for Trust Board Genba walks in order to protect that time.
2. The Improvement Hub will provide any training as required, on how to effectively conduct Genba Walks.

Appendix 1: Preparatory Data Template

The purpose of this document is to give the genba attendees an overview of your genba. However, if there are specific points you wish to discuss please raise them on the day.

Genba:
Date:
Time:

Workforce (current)	
Staffing Levels	
Vacancy Rates	
Improvement Activity	
Has any improvement work taken place in the area recently	
Patient Experience (Last 3 months)	
Compliments	
Complaints	
Governance (Last 3 months)	
DATIX	
Serious Incidents	
Any other feedback you wish to share	

Appendix 2: Virtual Executive Genba Round Agenda and Record

Date:			
Time:			
Site:			
Pre meeting venue:			
Genba:		**Division:**	
Genba Attendees:	**Name**	**Title**	**Role**
			Exec Genba Lead
Genba Host Team:	To be provided by the host team		
	Name	**Title**	**Role**
			Genba host
			Virtual host
Additional Dress Code: (if applicable)	To be completed by host team		

Time	Topic
14:30	**Welcome and introductions by Executive Lead for Genba walk**
14.35	**On site Genba team leave meeting room** for Genba walk and a member of the Host Team remains for discussion with Virtual Genba attendees
14.35 – 16:00	**Genba Walk** Please refer to the questions in appendix 3 of the procedure for useful prompts of questions to ask during the walk.
16:00	**Discuss outcomes and actions**

Action	Owner	By

16:25	**Reflection by Executive Lead**
16:30	**End of Genba**

Appendix 3: Questions to ask on the Genba

Staff Questions	**Patient Safety** What are the main contributors to patient safety in your area? Have you discussed patient safety issues with your patients or their families? Do patients and families voice any safety concerns? Were you able to care for your patients this week as safely as possible? If not, why not? **Incident reporting** When you make an error, do you always report it? If you prevent/intercept an error, do you always report it? If you make or report an error, are you concerned about personal consequences? If a patient falls or there is an error in care do you discuss this with the patient and /or relatives and offer to share the incident form? Do you know what happens to the information that you report? **Organisational** Can you describe the unit's ability to work as a team? What would make these executive visits more effective? Examples: - Hallway vs. organised conversations - Individual vs. group discussions - Managers ensure you have free time to discuss issues Can you describe how communication between caregivers either enhances or inhibits safe care on your unit? Can you think of a way in which the system or your environment fails you on a consistent basis? Examples: - Not enough information available - Requirements that don't make sense or that seem unnecessarily time consuming Would you be happy for a member of your family to be treated in this area? (Good finishing question which can be profoundly indicative of a serious problem).

Family/Carers Perception	How do you feel about your overall care and treatment? • Attitude of staff Do you feel that you are involved in your care? Do the staff communicate the plan of care to be received? Do you know your expected date of discharge?
Paper Documentation	Last Entry in Patient Notes: Appropriate Time and dated Signed, legible clinician's name Patient has a wristband attached
Policy Adherence	Infection control, Data protection, Uniform
Environment	Clean and tidy, Noisy. Outstanding jobs
General	"2 things that you do very well within the Department?" "2 things that could be improved within the Department?"

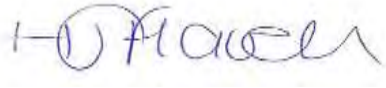
Appendix 4: Standard Process Description

Step	Role Responsible	Task Description	Date Required
Identify areas	Board to inform Improvement Hub	Identify 3 areas that require Genba and inform the Improvement Hub. The Improvement Hub is happy to advise on areas that have recently undertook projects. Allocate 2 as preplanned (6 months in advance including revisits) and one as a more urgent one to review.	6 months, and a month for urgent one.
Invitations	Executive Assistant (EA) to Chair	Send a "Save the date" to all Trust Board members for the genba walks	Set schedule. Prior to Trust Board
Preparation	Deputy Chief Executive (or nominated Exec)	The next Tuesday after Trust Board the Executive Team agree genba and allocate Executive Lead.	Tuesday after Trust Board
	EA	Update the Genba walk record	
Actions update	Executives	Discuss actions from previous Trust Board genbas and update the record.	
	Improvement Hub	Review actions and close them (as appropriate) at monthly meeting	
	EA	Email the updated excel to improvement team – this could be done on the master give access to EA	
Prepare the Genba & documentation	Improvement Team	Contact EAs to confirm availability of Execs/NEDs Contact genba areas and send out the Preparatory template for them to complete Book area for pre meeting / virtual Genba Update the plan for Trust Board Genba template in flow Compile the agenda	1 month before Genba

Dissemination of document	Improvement Team	Email the final Genba agenda and preparatory to the EA of the Chair one week before the visit	1 week before Genba
Dissemination of document	EA to the Chair	Monday prior to Trust Board genba send calendar invite with agenda, preparatory and Teams invite to all attendees	1 week before
Prep for Genba Team	Improvement Team	Improvement Team to offer to meet Genba lead	1 week before
Set-up	Improvement Team	Checking the room Layout (Covid Safe) Sound & visibility Equipment Documents available Trust Genba schedule x 2 Agenda x 5 Preparatory x 5	Day before Genba
On the genba	All Led by Exec Genba Lead	Genbas to commence on time at 08:30 Virtual host (Member of Staff from Each Genba) to remain in meeting room to provide feedback with virtual Genba team, while actual team walks around the Genba with nominated Staff members By 09:30, conclude with all team members back into meeting room to share feedback and agree actions/outcomes (30 mins)	On Genba day
Feedback	Improvement Team BP	Provide written feedback to Exec Lead within 2 hours Written feedback to be sent to Exec team, EA and Genba Leads. Request any feedback within a week	
Update Trust Board	Executive Genba lead	Executive Genba Lead to report out at Trust Board	
Put outcomes into Trust Board format	Improvement Hub	Send to EA and Comms team	1 week after Genba
Actions	Improvement Hub	Confirm and add the new actions to the genba log and email to EA for the next Executive meeting	1 week after Genba

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	275/21			
Report	The Ockenden Report – Progress Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 16 CRR 18 CRR 19 CRR 23 CRR 27 CRR 31	
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon	N/A			
Executive summary:	This report presents an update to the Trust's Ockenden Report Action Plan and other related matters. Good progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. The Board of Directors is requested to receive for assurance: • This report, the Ockenden Report Action Plan at **Appendix One** and Exception Reports at **Appendix Two**			
Appendices	**Appendix One:** Ockenden Report Action Plan at 24th September **Appendix Two:** Ockenden Report Action Plan Draft Exception Reports Both appendices are included as part of the supplemental board pack			
Lead Executive				

1.0 Purpose of this report

1.1 This report presents an update on all 52 actions in the Trust's Ockenden Report[1] Action Plan since the last meeting of the Board of Directors in Public on 7th October 2021. Updates are provided on other related matters.

2.0 The Ockenden Report (Independent Maternity Review – IMR)

2.1 The Board of Directors received the first Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews, at its meeting in public on 7 January 2021

2.2 The report sets out 52 specific actions for the Trust to implement comprising twenty-seven Local Actions for Learning (LAFL), and seven Immediate and Essential Actions (IEA's) which, in turn, comprise a further 25 related actions. In total, there are 52 actions for the Trust to implement. All of the Ockenden actions (LAFL's and IAE's) have been cross-referenced to the Trust's Maternity Transformation Plan.

2.3 There have been no changes to any action ratings since the last report as none were due during this period. As such, the tables remain as per the last report to the Board of Directors in October 2021 (actions as at 24th September 2021). The current version of the first Ockenden Report Action Plan is presented at **Appendix One,** for information.

3.0 Status of the required actions

3.1 The **'Delivery Status'** position of each of the 52 actions as at 24th September 2021 is summarised in the following table:

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Aug 21	Current	Aug 21	Current	Aug 21	Current
LAFL	27	14	12	13	5	0	10
IEA	25	9	8	15	10	1	7
Total	52	23	20	19	15	1	17

3.2 Using the same approach, the **'Progress Status'** position of each action as at 24th September 2021, is summarised in the following table:

Progress Status											
	Total # recs.	Not Started		On Track		At Risk		Off Track		Completed	
		Aug 21	Current	Aug 21	Current	Aug 21	Current	Aug 21	Current	Aug 21	Current
LAFL	27	0	0	21	14	1	0	5	3	0	10
IEA	25	2	2 **	21	16	0	0	1	0	1	7
Total	52	2	2	42	30	1	0	6	3	1	17

[1] www.gov.uk/official-documents. (2010) Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews.

3.3 Those actions 'Off Track' or 'At Risk' have not changed since 24th September 2021 and are now described. There are three Local Actions for Learning that are Off track. These are:

3.3.1. **LAFL 4.59 - The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.**

This governance review has not yet been completed. The new Head of Clinical Governance is now overseeing this work and the Trust's Head of Patient Safety is supporting the division. A revised date for expected delivery has not yet been set. This is an ongoing discussion at the Maternity Transformation Assurance Committee

3.3.2. **LAFL 4.60 - The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.**

The delivery of this action is linked to 4.59 above.

3.3.3. **LAFL 4.73 - Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.** This is a complex action as some of the actions falls within the Trust to deliver, whilst other components are dependent upon national action being taken to establish specialist maternal medicine centres, which is out of the Trust's control.

The exception reports that provide further details on each of these actions are provided at **Appendix Two.**

3.4 There are two Immediate and Essential Actions that are not yet delivered/not started. Again, these remain unchanged. These are:

3.4.1. **IEA 1.3 – LMS must be give greater responsibility and accountability so that they can ensure that the maternity services they represent provide safe services for all that access them, and;**

3.4.2. **IEA 1.4 - An LMS cannot function as one maternity service only.**

These two actions are linked closely. Efforts to try and resolve them are still underway; however, a final decision on the future model and arrangements is awaited. In the meantime the Trust and CCG are working together to improve the information flows and assurance mechanisms, albeit still within a single LNMS arrangement.

3.4.3. In summary, positive progress is being made in relation to the delivery of the actions from the first Ockenden Report. This work continues. There are some sticking points in relation to those that are off track; however, all of these still have work being undertaken to try and address them.

4.0 Ockenden Report Assurance Committee (ORAC)

4.1 The sixth Ockenden Report Assurance Committee took place on Tuesday 19th October. Three topics were presented: The Maternity Voices Partnership on Working with Women, the Maternity Safety Champions – roles of executives and non-executives, and colleagues from the CCG, LMNS and NHSEI Region presenting on the role of the system. The Chair will describe more about this committee in her report at today's meeting.

4.2 The schedule for the next ORAC meetings has now been set, as follows:

DATE	TOPICS (Provisional)
Monday 15th November 2021 1430-1700 hrs	Postponed to January
December 2021	No Meeting
Tuesday 18th January 2022 – 1430-1700 hrs	1. Obstetric Anaesthesia Update 2. Implementation of the National Bereavement Care Pathway 3. W&C Governance update
Tuesday 15th February 2022 – 1430-1700 hrs	1. Culture update 2. Psychological support to families
Tuesday 15th March 2022 – 1430-1700 hrs	1. Safety Culture 2. User experience system (UX) 3. Board oversight and learning

5.0 Summary

5.1 Good progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. There are some challenges; however, work continues to address all of them.

6.0 Action required of the Board of Directors

6.1 The Board of Directors is requested to receive for assurance:

- This report, the Ockenden Report Action Plan at Appendix One and Exception Reports at Appendix Two **(Both appendices are included as part of the supplemental board pack)**

Hayley Flavell
Executive Director of Nursing

November 2021

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	276/21			
Report	Ockenden Report Assurance Committee 19th October 2021 – Co-Chairs' Summary Highlight Report			
Executive Lead	Director of Governance & Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people	√	Effective	
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 4	
	For decision / approval		**Link to risk register:**	
	For review / discussion		970, 1083, 1930, 2027, 2065	
	For noting			
	For information			
	For consent			
Presented to:	N/A			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	1. The seventh meeting of the Ockenden Report Assurance Committee was held on 19th October 2021 and was livestreamed in public. This brief report provides a summary of key points/issues that the Co-Chairs wish to draw to the attention of the Board of Directors. 2. **Recommendation** The Board of Directors is asked to: • Take assurance from the contents of the report			
Appendices	None.			

Ockenden Report Assurance Committee

19th October 2021

Co-Chairs' Summary Highlight Report

1. The seventh meeting of the Ockenden Report Assurance Committee was held on 19th October 2021 and was live-streamed in public. This brief report provides a summary of the key themes discussed and highlights any particular matters which the Co-Chairs feel should be drawn to the attention of the Board of Directors.

2. Again, on this occasion, Ms Jane Garvey chaired the meeting. On this occasion the Committee received presentations on the work of the Maternity Voices Partnership (MVP), the role of the Maternity Safety Champions, and received an update regarding the Local Maternity and Neonatal System (LMNS).

3. **Maternity Voices Partnership (MVP)**

   Ms Louise Macleod, the MVP Development Co-ordinator for Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG), gave a comprehensive presentation about the work of the MVP. She explained that the MVP is a partnership made up of service users, their partners and families, service providers, the CCG and the local authority. There is a strong emphasis and reliance on volunteers. The MVP provides a way for this partnership of people to work together to share ideas and identify solutions for the design and improvement of maternity care with an emphasis on co-production. Ms Macleod went on to explain that the Local Maternity and Neonatal System (LMNS) had funded the development of the MVP locally which had been set up in 2018 and that it is now hosted by Healthwatch Telford & Wrekin.

   Ms Macleod explained that the work of the MVP is underpinned by five ley principles:

   - Co-production as equals, promoting and valuing participation
   - Seeking out and listening to service user experiences
   - Championing the use of service user experience when reviewing services
   - Understanding the interdependency of staff experience and positive outcomes
   - Pursuing continuous improvement in maternity services.

   To this end, Ms Macleod shared with the Committee details of a number of projects with which MVP are involved, including developing the 'labour and birth choices' leaflet. Importantly, the Committee heard about the MVP feedback survey, dealing with the whole perinatal experience, launched in April 2021 and hosted on the local Healthwatch website. There had been 100 respondents during the period April to June 2021 and the key themes that emerged related to continuity of care; language, communication and information; postnatal contact. This feedback is invaluable to the service and since 2020 the MVP has been working with the Maternity Transformation Programme sharing the feedback and developing a user experience card scheme. The work of the MVP going-forward would involve the need to improve its reach and offering to seldom heard groups.

4. **Maternity and Neonatal Safety Champions**

The Committee heard from Dr John Jones (Executive Safety Champion and Acting Medical Director) and Mr Tony Bristlin (Non-Executive Director Safety Champion) about the role of Maternity and Neonatal Safety Champions and how they each undertook their roles. Our Board Safety Champions (who are supported by other Safety Champions) embedded in the organisation play a central role in patient safety by promoting a culture in which better care can be delivered to women, babies and their families which is safe and evidence based.

Both Dr Jones and Mr Bristlin explained how Safety Champions carry out their roles. Specifically, we heard that Board Safety Champions engage with staff and service users through regular monthly walkabouts to obtain views on safety and hear about any safety issues which staff wish to raise. Feedback from these walkabouts is shared with service leads so that appropriate action can be taken, the details of which are also made available on the Safety Champions notice board so that staff are aware of progress. Complementing the two Board Safety Champions, there are frontline Safety Champions who are midwives, obstetricians and advanced neonatal nurse practitioners who work with the Board Safety Champions and the Local Maternity and Neonatal System with a role to advocate for safety in their clinical areas.

The Committee also heard in detail about the role of the Non-Executive Safety Champion who is able to provide a more independent oversight and challenge to the services. Finally, we heard about a number of actions which had resulted from the intervention of our Safety Champions and areas for further improvement of the role of the Safety Champion.

5. **The Local Maternity and Neonatal System (LMNS)**

Ms Zena Young (Executive Director of Nursing & Quality, Shropshire/Telford & Wrekin CCG & LMNS Senior Responsible Officer) and Ms Kerry Forward (Programme Transformation Lead & Perinatal Services & NHSE/I Improvement Lead – Midlands Region) provided and update on the role of the LMNS and, in particular, in relation to the Ockenden Report Immediate and Essential Actions 1.3 and 1.4.

A key and outstanding recommendation is that an LMNS cannot function as one maternity service only (IEA 1.4). Ms Young explained that there are arrangements for the local LMNS (Shropshire, Telford & Wrekin) to 'buddy' or work in partnership with jointly Staffordshire and Stoke LMNS and Derby and Burton LMNS, and the Black Country and West Birmingham LMNS. She confirmed that there were on-going discussions with formal plans and a Memorandum of Understanding to be finalised confirming the arrangements. The overall purpose is to enable teams to learn from other systems, ensure best practice and provide assurance.

6. **Future Meetings**

Finally, a word on future Committee meeting arrangements. We were hoping in November to have a presentation on the review of the Trust's Maternity Bereavement services and implementation of the National Bereavement Care Pathway. This is being audited by the Stillbirth and Neonatal Death Charity (SANDS) in November; however, the results of this along with the Trust's response

to its findings will not be ready by the scheduled November ORAC meeting date, regrettably. Also, these will need to go through the Trust's internal governance processes first before coming to an assurance committee such as ORAC. In view of this, we have decided to postpone the meeting scheduled for 15th November 2021. This will allow the time for this to be done properly.

Accordingly, we have revised the schedule for the next set of meetings, with provisional content, as follows:

DATE	TOPICS (Provisional)
Monday 15th November 2021 1430-1700 hrs	Postponed to January
December 2021	No Meeting
Tuesday 18th January 2022 – 1430-1700 hrs	1. Obstetric Anaesthesia Update 2. Implementation of the National Bereavement Care Pathway 3. W&C Governance update
Tuesday 15th February 2022 – 1430-1700 hrs	1. Culture update 2. Psychological support to families
Tuesday 15th March 2022 – 1430-1700 hrs	1. Safety Culture 2. User experience system (UX) 3. Board oversight and learning

Dr Catriona McMahon & Ms Jane Garvey
Co-Chairs, Ockenden Report Assurance Committee
3rd November, 2021.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 November 2021

Agenda item	277/21			
Report	Freedom to Speak Up (FTSU) Quarter 2 Report			
Executive Lead	Director of Governance and Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community		Safe	
	Our people	√	Effective	
	Our service delivery		Caring	
	Our partners		Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:				
Dependent upon (if applicable)**:**	N/A			
Executive Summary:	The following report provides the FTSU update for Quarter 2 2021/22 In total, 113 contacts were received by the FTSU mechanism in Quarter 2, which is a 13% increase on Q1 21/22 and a 38% increase on Q2 20/21. This takes the YTD total to 213 contacts raised overall. A significant factor in the increase in contacts is the visibility and engagement of the FTSU Guardians. If contacts continue to rise at the current rate, the Trust will see a 41% increase in contacts overall in 2021/22. The report provides more details on actions taken as a result of the concerns being raised.			
Appendices:	Appendix one: Colleague feedback			
Lead Exec:				

Executive Summary

1. Assessment of issues including themes and trends

In Quarter 2 SaTH received 113 contacts through the FTSU mechanism. The previous year's contacts are contained in the table below to enable quarter and year-on-year comparison.

	Q1	Q2	Q3	Q4	Total	Increase	National Avg Increase
2021/22	100	113	N/A	N/A	**213**	↑173%	N/A
2020/21	41	82	103	78	**302**	↑208%	26%
2019/20	22	17	57	49	**145**	↑119%	32%
2018/19	10	18	18	20	**66**	↑106%	73%
2017/18	4	7	12	9	**32**	N/A	N/A

As mentioned in previous Trust Board reports, the figures show that we can see clearly that SaTH has higher than average increase in contacts particularly compared to the national average increase of 26%. New data from the National Guardian's office also shows that Trusts with the same CQC rating of inadequate as ourselves, receive higher numbers of contacts through FTSU and on average receive 152 cases per annum.

The NGO requires all Trusts to submit their data to the national portal following the close of a quarterand is submitted in the following categories:

Category	**Q2 20/21**	**Q3 20/21**	**Q4 20/21**	**Q1 21/22**	**Q2 21/22**
Bullying and Harassment	8	13	13	8	4
Patient Safety	22	22	17	11	21
Anonymous	31	0	1	1	3
Detriment	1	1	0	0	0

However more granular themes for SaTH can be seen in the charts below:

Nature of issue	**Q2 20/21**	**Qtr 3 20/21**	**Qtr4 20/21**	**Qtr1 21/22**	**Qtr2 21/22**	**Total 21/22**
Behavioural /Relationship	15	27	28	46	31	77
Patient Safety /Quality	22	22	17	11	21	32
Bullying / Harassment	8	15	13	8	4	12
Staff Safety	12	13	11	9	12	21
Policies, procedures and processes	14	14	4	11	33	44
Leadership/Management	9	7	2	6	5	11
Lack of support Covid-19	2	1	0	0	0	0
PPE/Equipment	0	1	0	0	1	1
Service Changes	0	0	3	4	2	6
Cultural	0	0	0	0	0	0
Other	0	0	N/A	5	4	9
Total	**82**	**101**	**78**	**100**	**113**	**213**

Details by working group, appear below:

Profession	Qtr2 20/21	Qtr3 20/21	Qtr4 20/21	Qtr1 21/22	Qtr2 21/22	Total 21/22
Nurses	37	30	21	25	30	55
Allied health professionals (other than pharmacists)	9	16	8	24	24	48
Administrative / Clerical workers & Maintenance/Ancillary	15	25	10	21	20	41
Midwives	2	3	15	10	14	24
Healthcare assistants	6	11	10	6	15	21
Doctors	5	8	10	13	7	20
Other	1	2	0	1	3	4
Cleaning/ catering/ maintenance/ ancillarystaff	6	5	4	0	0	0
Corporate service staff	1	1	0	0	0	0
Total	**82**	**101**	**78**	**100**	**113**	**213**

At the May Board, members asked for context in terms of those speaking up in comparison with workforce numbers and these details are provided below in blue text.

Profession	Numbers who have spoken up in Q2	Total head count @ SaTH	% of that profession in Trust who have raised a concern in Q1	% of that profession in Trust who have raised a concern in Q2
Nurses	30	1683	1.4%	1.8%
Administrative / Clerical workers /Maintenance/Ancillary/Cleaning	20	2047	1.02%	1.03%
Allied health professionals including pharmacists and health care scientists.	24	690	3.5%	3.5%
Healthcare assistants	15	781	0.8%	0.8%
Doctors	7	626	2.1%	2.1%
Midwives	14	285	3.5%	3.5%
Corporate service staff	0	Included as admin/clerical staff	Included as admin/clerical staff	0
Other	3	N/A	N/A	3
Total	**113**			

Thirty four contacts out of 308 from the whole of the 20/21 period remain open, and out of 213 contacts up to the end of Quarter 2, 128 contacts remain open. We continue to work towards concluding these with colleagues as soon as possible.

Contacts	**Qtr 1 20/21**	**Qtr2 20/21**	**Qtr3 20/21**	**Qtr4 20/21**	**Qtr1 21/22**	**Qtr2 21/22**	**Total**
Open	2	8	3	21	45	83	163
Closed	39	74	100	57	55	30	354

Reasons for open cases are:

- Complex employee relations issues.
- Complex improvement suggestions.
- Complex cultural change in areas takes time to embed and therefore following up can be a further three – six months after the issue is dealt with.
- Sporadic engagement from those who have raised concerns.
- Lack of engagement from those dealing with concerns.

Themes

1. Policies and Procedures and Processes

The most significant rise in contacts has been in this category, with 33 contacts equating to 16 actual concerns raised. The concerns raised include inequity of on-call; staff delayed in being assigned to their substantive ward due to staffing issues; HR processes.

Actions taken in response:

1. On-call duty being reviewed in maternity.
2. Review of process relating to a grievance.
3. Reviewing an IT system to improve processes.
4. Review and assurance about comparison between nurse agency payment and Trust substantive payment for nurses.
5. Trust wide communication about scrubs policy by Medical Directors and Director of Nursing

2. Patient Safety

This quarter has seen a rise in patient safety concerns with 21 contacts equating to 14 concerns raised which is the same level as Q2 and Q3 in 2020/21. The largest number of concerns was about safe staffing levels in nursing, medical and clinical support services; patient care; clinical decision making; safeguarding; lack of junior doctor access to SCR.

Actions taken in response:

1. Full staffing complement recruited in one area with all posts filled starting 1st September alongside a return from maternity leave.
2. Review of patient care standards in areas.
3. Review of safe staffing on wards where concerns were raised by colleagues, although this continues to be an issue throughout the Trust and nationally

4. Potential review of junior doctor access to SCR by pharmacy and service improvement.
5. Communication to the wider team about safeguarding issues.

3. Behaviours/Attitudes/Bullying and Harassment

This quarter has seen a lower reporting of attitudes and behaviours and bullying and harassment compared to the previous quarter which is likely to be due to the lower levels of drop in sessions completed in quarter 2. Of the 35 contacts about behaviours etc., this equates to 27 concerns. The majority of the concerns raised were not about the culture of teams but about the behaviours of individuals.

Actions taken in response:

1. Values and Behaviours workshops rolled out throughout the Trust since September 2020, 93 teams have completed workshop1 and 42 teams have completed workshop 2, 135 workshops in total, 300 teams in the Trust.
2. A 'Change Team' has been convened for further cultural transformation within the Trust.
3. Civility and respect workshops being used in certain areas.
4. Formal and informal HR processes have been started where appropriate.
5. Escalation to executives who have visited areas and addressed individual issues.
6. Reflection piece written by individual who had been treated poorly will be shared with their wider team for learning.
7. Empowering conversations with some staff reporting concerns, to discuss issues with theirmanagers or with the member of staff they are struggling with
8. Triangulation of themes from different sources has triggered a comprehensive action plan to improve the culture of a team.
9. Human Factors project
10. Drop in session feedback has been escalated to matrons, HRBP and Clinical Lead for further actions to tackle cultural issues or if concerns over individuals these have been addressed directly.
11. Comprehensive leadership development across all levels.
12. Cultural review in targeted areas

4. Staff Safety

Staff safety contacts remain at the same level as previous quarters, with concerns raised about staffing levels; staff wellbeing; CoVID precautions; security

Actions taken in response

1. Action plan in place on ward to mitigate concerns around staffing levels and staff wellbeing.
2. Advice sought from infection prevention on COVID precautions
3. Support for worker from matrons dealing with a violent patient.

5. Leadership/Management

Issues include concerns over capability of management; communication in teams;

training/supervision

Actions taken to address issues

1. External review of service
2. Improved communication and dissemination of information
3. Review by HR of issues.

Professional Groups

In line with national trends, nurses are the group of workers who speak up most and there has been a rise in contacts to Q2 and Q3 2020/21 levels. In keeping with the Quarter 1 trend, midwives have also spoken up more and there has been an increase in HCA contacts to FTSU.

1. Nurses:

Concerns raised include behaviours of colleagues; patient safety; staff delayed in being assigned to their substantive ward due to staffing issues; equitable allocation of training; fairness of recruitment process; maternity pay; equity of on-call.

Although contacts are back to the Q2 and Q3 2020/21 levels the main concerns during those months from nurses was staffing levels on wards, however this is not applicable to Quarter 2 were the dominant concern was about behaviours.

Actions taken in response:

1. Behaviours tackled through a number of routes, formal and informal HR processes; escalation to various management levels including executive level.
2. Allocation of training reconsidered.
3. Communication to re-establish the importance of not interrupting during drug rounds.
4. Meeting between management and staff to resolve issues.
5. Review of how we communicate about maternity pay for international colleagues.

2. Midwives

Of the 14 contacts made to FTSU there were two issues, the inequity of on-call and safe staffing levels.

Actions taken in response:

1. Exploring with hospital midwives through pre-engagement and consultation the possibility of adding them to the on-call rota alongside community midwives
2. Review of staffing levels and staffing templates in Community by senior team, expressions of interest circulated for midwives to work at Community sites

3. Doctors

Of the concerns raised half were about safe staffing levels both medical and nursing; processes; safeguarding and aggressive patients

Actions taken in response:

1. Increased presence of senior staff on ward, and actions to deal with staffing levels and staff wellbeing.
2. Communication to the wider team about safeguarding issues.
3. Escalation of staffing issues to clinical leads.

4. Administrative/Clerical Workers/Cleaning/Catering/Maintenance and Ancillary Staff

Contacts in this quarter continue at the same level as last quarter and like the last quarter over half were about bullying and harassment/attitudes and behaviours.

Actions taken in response:

1. Signposting to HR where appropriate.
2. FTSU coaching staff to raise concerns directly with managers/supervisors
3. On-going review of team culture with external investigators.
4. Review of COVID-19 safety requirements for team.
5. Trust wide communication about scrubs policy by Medical Directors and Director of Nursing.
6. Exit interviews arranged.
7. IPC review of COVID prevention measures.
8. Values and Behaviours workshop in areas.
9. Cultural review in targeted areas

5. HCAs and Nursing Assistants

In Quarter 2 there was a significant increase in contacts from HCAs with 15 contacts equating to 12 individual concerns. These were about attitudes and behaviours of colleagues; worker safety, policies and procedures and patient safety

Actions taken in response:

1. Informal HR processes in train were appropriate
2. Review of HR process in relation to a grievance
3. Signposting to HR and Matron
4. Reflection piece written by individual who had been treated poorly will be shared with their wider team for learning.
5. Escalation to matrons and ward managers to action following drop in sessions
6. ED PRH trialling volunteers to assist with social distancing.
7. Supporting staff with leadership courses.
8. Action plan in place on ward to mitigate concerns around staffing levels and staff wellbeing.

6. Allied Health Professionals including pharmacists

The Board should note that due to changes in reporting requirements from the NGO, pharmacists are now included with AHPs. AHP contacts continue at the same rate as the previous quarter with 24 contacts made equating to 12 individual concerns

Actions taken in response:

1. Data from drop-in session being triangulated with other information and action plan put in place.
2. Staffing resolved with all posts filled starting 1st September alongside a return from maternity leave.
3. Values and behaviours workshops - outcomes behaviour framework for team and understanding of roles and responsibilities
4. Management addressed issues of individuals' poor behaviours.
5. Signposting to HR
6. Review of junior doctor access to SCR by pharmacy and service improvement.

The Board should be assured that all concerns raised with the FTSU team have been escalated to the relevant teams or person.

Actions taken to improve FTSU Culture

In Q2 a number of actions have been taken to improve FTSU process, culture and visibility.

1. This quarter has seen a focus on following up and closing concerns to ensure the high number of contacts through the mechanism does not become unmanageable.
2. 17 x team awareness and drop in sessions have taken place in Quarter 2.
3. 117 x visibility visits to teams across the main sites and community sites in Quarter 2.
4. Planning for October speak up month in collaboration with colleagues including OD, HWB and clinical colleagues, a review of the month will be included in Quarter 3 board report.
5. Improved relationships and regular meetings with stakeholders for action and to provide oversight of concerns raised. These include 121's with Chief Executive and Workforce Director; Director of Nursing; Director of Governance and Communication; NED Lead for FTSU HR, Head of Nursing, Medicine; monthly meeting with Surgery Division team; attendance at Junior Doctor Forums; attendance at weekly Head of Midwifery meeting; attendance at weekly Nursing meeting when possible; Guardian of Safe Working meeting; quarterly attendance at Corporate Nursing Senior Leadership Team meeting.
6. Further promotion of and engagement with FTSU ambassadors.
7. Column in Chatterbox
8. Presentation at monthly corporate induction.
9. Presentation at Junior Doctors FY1 and FY2 induction with Guardian of Safe Working.
10. Presentation at midwifery preceptorship.
11. Presentation at our international nurses induction
12. Refreshed intranet page.
13. Flashcards to leaders.
14. 150 values and behaviours workshops delivered across the Trust.
15. Executive visits to areas raised through FTSU.
16. Action plan in place and working with NHSE/I to achieve deadlines
17. Inclusion in information bulletin notifying and advertising to staff where the team will be doing talks/drop-in sessions.

18. Concerns raised have been acted upon in a timely and appropriate manner and recorded as per the National Guardian Office Guidelines.
19. Monthly catch ups with the on-boarding team to gain feedback on which areas in the trust are seeing a high volume of staff leaving.
20. Talks with Black Country Health Care to replicate their FTSU portal for storing and managing data.

National Update

In this Quarter the National Guardians Office has published a Case Review on Blackpool Teaching Hospitals and Difference Matters: the impact of ethnicity on speaking up by Roger Kline and Ghiyas Somra both will be reviewed and included in the Quarter 3 Board report and any actions being taken forward for SaTH to continue to improve its FTSU mechanism.

Difference_Matters.pdf (nationalguardian.org.uk)

Blackpool_Teaching_Hospitals_FT_case_review.pdf (nationalguardian.org.uk)

Learning and Improvement

Junior Doctors

Medical Education Team alongside operational colleagues are working towards improving the experience of less than full time colleagues by improved inductions; handbooks; clearer line management.

HR Process

HR colleagues are working with colleagues to 'Improve People Practices' through staff stories and their experience of the grievance process.

SaTH Feedback

NGO guidance expects that all those who have raised concerns to the FTSUG and ambassadors areexpected to be asked the following questions:

1. Given your experience would you speak up again?" Yes/No/Maybe/Don't know
2. Please explain your response"

Responses received up until the end of Quarter 2 can be seen at appendix 1.

Next steps and actions

The Board is asked to note that a more detailed FTSU improvement action plan is in progress, working in conjunction with NHSE/I.

Action	**Timescale**	**Who**	Status
Complete Board FTSU Self-Assessment	January 2022	FTSU Lead, Executive Team and NEDs	Open
FTSU Vision and Strategy - Following completion of Board FTSU Self-Assessment	February 2022	FTSU Lead, Executive Team and NEDs	Open
FTSU Database Review and Development	31st March 2021	FTSU – Lead/IT Developer/External FTSUG	Open In talks with Black Country healthcare toreplicate their systemwhich may be made available to the wider healthcare system at nil cost. Black Country Health Care are looking at a third party provider to host the portal and once commissioned, we will pursue this option.

Convene FTSU Steering Group/Summit to triangulatethemes with HR/Patient Safety	31st December 2021 Date adjusted to in line with agreed action plan with NHSE/I	FTSU-Lead/Deputy Head of Workforce/Patient Safety Lead	Open
Review FTSU Policy	Date tbc – NGO to release further policy guidance at the beginning of 2021, SaTH policy reviewed will bein line with this.	FTSU - Lead	Open

Appendix 1
Responses to Feedback Questions

	Given your experience would you speak up again	Please explain your answer
Colleague 1	Yes	We are here for the patient's good, nursing is a vocation not a choice/job, in the old nursing code it used to say be proud of your role, this was taken out when replaced with the new code but I still stand by that.
Colleague 2	Yes	I would definitely contact you again. I do feel after 15 years in this team there are a lot of people put into situations that are not great.
Colleague 3	Maybe	If it isn't going to cause too much hassle for myself.
Colleague 4	Yes	My situation has resolved thankfully, I will recommend that anyone should come to you if they have a problem. I had a very swift reply from you and the incident was resolved in the blink of an eye.
Colleague 5	Yes	The FTSUG facilitated a thorough and speedy resolution, to a valid and real concern, for myself and my colleagues A concern which, at the time of writing, has been unaddressed by my departmental management chain, despite having been alerted far sooner than "freedom to speak up".
Colleague 6	Yes	Thank you for your time. I felt listened to and I am now reassured.

Board of Directors' Meeting
11 November 2021

Agenda item	278/21			
Report	Health, Safety, Security and Fire Committee Annual Report 2020/21			
Executive Lead	Chief Operating Officer			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	
	Our service delivery		Caring	
	Our partners		Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion		1090 (Lack of active monitoring system for Trust documentation relating to compliance with H&S legislation)	
	For noting			
	For information			
	For consent			
Presented to:	Quality Operational Committee (18.10.21) Quality & Safety Assurance Committee (27.10.21)			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report addresses the work of the Trust's Health, Safety, Security and Fire Committee 1 April 2020 to 31 March 2021. It addresses the disruption to usual business arising from the Covid-19 pandemic. Finally, it makes recommendations for priorities in 2021/2022, including:- • To devise a Board Assurance Framework-style document for H&S, Security, Food Safety and Fire matters. • To improve reporting into the Committee, including initiatives to improve the availability and quality of H&S/ Food Safety/ Fire/ Security management information available to Divisions and Corporate Departments by means of adopting an electronic H&S risk management system. • To resume H&S-related training, audit and inspection programmes post-pandemic, and to relaunch staff health surveillance. • To develop a business case for a resilient RPE fit testing programme post-Q4 2021/22.			
Appendices:	Health, Safety, Security & Fire Committee Annual Report 2020/21			
				

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Health, Safety, Security and Fire Committee

Annual Report

2020/ 2021

1 Executive summary

This report addresses the work of the Trust's Health, Safety, Security and Fire Committee in the period 1 April 2020 to 31 March 2021.

The report assesses the Committee's performance against its own Terms of Reference, reviews performance against the previous year's objectives, and sets priority objectives for the year 2021/ 2022.

The main Committee met three times in the year compared to a planned schedule of four meetings, with an additional extraordinary meeting making four meetings in total. The first and second meetings reported to the Sustainability Committee on current issues, and the third and fourth meetings reported via items for escalation to Executives pending confirmation of the correct reporting route in the context of revised governance arrangements Trust-wide. The Committee was quorate for all meetings.

The Committee received updates on developments in legislation and guidance at the three main meetings and recommended appropriate actions in response.

Relevant policies were considered for consultation and approval, and each meeting received an update on current policy review status.

The three main meetings received updates on internal audit and inspection work, as per previously agreed priorities.

The Committee was regularly updated on the Trust's interactions with the Health and Safety Executive, the Shropshire Fire and Rescue Service, and the local authority Environmental Health Officers.

Trust-wide H&S, Fire, Security and Food Safety issues were considered by the Committee at the three main meetings and recommendations for action were agreed.

The Committee received reports from Care Groups and Directorates with varying compliance, and this will remain a focus for improvement in 2021/2022.

Annual reports for the year 2019/2020 addressing the Committee's performance, Security and Fire Safety were received and approved.

The report addresses the significant disruption to usual business arising from the Covid-19 pandemic which continued throughout the year, and describes work undertaken in relation to respiratory protective equipment in particular.

Finally, this report makes recommendations for improvements in 2021/2022, which highlight future monitoring activities and resourcing issues.

2 Introduction

2.1 The purpose of the Trust Health, Safety, Security and Fire Committee ("the Committee") is to consult staff on all matters related to health, safety, security, food safety and fire issues and to consider matters that have not been resolved by Centre or Departments, Health and Safety Committees.

2.2 The purpose of this report is to review the work undertaken by the Committee between April 2020 and March 2021, and to set out how the Committee performed against its responsibilities as defined in its Terms of Reference. It also makes recommendations for improvements where appropriate.

3 Committee Membership

3.1 The Committee's Executive Lead at the start of this reporting period was Julia Clarke, Director of Corporate Governance (from December 2019, Director of Corporate Services). Violet Redmond (formerly Head of Corporate Services) was Chair for Q1 2020, noting that the April 2020 meeting was cancelled as a non-essential meeting during the first wave of the Covid-19 pandemic. By Q2 2020 the chair was Angie Wallace, Interim Deputy Chief Operating Officer. By Q3 2020 the chair was Sara Biffen, Deputy Chief Operating Officer and this remains correct at the time of writing.

3.2 The general makeup of the Committee is to reflect the following:

- A Division Director (or their nominated deputy) from each Division
- The Head of Service (or their nominated deputy) from each Corporate Department.
- Health and Safety representatives from Trade Unions / Professional Organisations (or their nominated deputy)
- Health and Safety Team Manager
- Security Manager
- Fire Safety Advisor
- Food Safety Advisor
- Other specialist advisors including Infection Control, and Moving & Handling.

3.3 All administration relating to Committee business is undertaken by the Health and Safety Team. The minutes are taken by the Health and Safety Team Coordinator, who monitors attendance at meetings and compliance to reporting arrangements.

3.4 Attendance at meetings is monitored by means of an attendance matrix. (See Table 1, Section 4.)

4 Terms of Reference

4.1 The Terms of Reference for the Committee were reviewed in July to coincide with the change of Chair. At the time of the meeting there was no clear structure defining which Committee would receive reports on the work of the HSSF Committee, and so the review was deferred to October 2020, and then to February 2021 pending resolution. During this time the names of post-holders were updated and in October 2020 feedback on the content of the TORs was sought via email, and none was received from Committee members.

5 Meetings

5.1 The Committee met four times during the period, in July 2020, September 2020, October 2020 and February 2021. The Committee had been due to meet in April 2020 but was cancelled by the then Chair (Head of Corporate Services) in line with other similar meetings

that month due to operational pressures created by the pandemic first wave which peaked in the same month. The July and September meetings were chaired by Angie Wallace (Interim Deputy Chief Operating Officer) and the October and February meetings were chaired by Sara Biffen (Deputy Chief Operating Officer). All meetings were chaired by the current Chair at the time.

5.2 All meetings met the obligations regarding membership and quorum. For the meeting to be quorate two management representatives and two staff representatives need to be present in addition to the Chair. This was true at every meeting.

5.3 Attendance is set at a minimum of 75% for the year. The attendance of core members is shown in Table 1.

Table 1: Attendance at Health, Safety Security and Fire Committee

Title	July 2020	September 2020	October 2020	February 2021	Actual Attendance	Possible Attendance	% of attendance
Head of Corporate Services (Chair Q1)	N/A	N/A	N/A	N/A	0	0	N/A
Interim Deputy Chief Operating Officer (Chair Q2)	Y	Y	N/A	N/A	2	2	100
Deputy Chief Operating Officer (Chair Q3 on)	N/A	N/A	Y	Y	2	2	100
Health and Safety Team Manager	Y	Y	Y	Y	4	4	100
Security Manager	Y	Y	Y		3	4	75
Fire Safety Advisor	Y	Y	Y	Y	4	4	100
Food Safety Advisor	Y	Y	Y	Y	4	4	100
Infection Control					0	4	0
Unscheduled Care Group/ Medicine and Emergency Division			Y		1	4	25
Scheduled Care Group/ Surgery, Anaesthetics and Critical Care	Y	Y	Y	Y	4	4	100
Support Services Care Group/ Division**	Y	Y	Y	Y	4	4	100
Women and Children's Care Group/ Division	Y	Y	Y	Y	4	4	100
Corporate Nursing							
Estates (Capital and Operational)	Y		Y	Y	3	4	75
Facilities	Y	Y	Y	Y	4	4	100
Workforce					0	4	0
Emergency Planning and Resilience Officer*				Y	1	4	25
Finance*					0	4	0
Procurement*	Y	Y	Y		3	4	75
Occupational Health Service*					0	4	0
Education*					0	4	0
Senior Moving and Handling Advisor*		Y			1	4	25
Medicine Centre*					0	4	0
Emergency*					0	4	0
Capacity*					0	4	0
Patient Access and Outpatient Nursing Support*					0	4	0
Surgery*					0	4	0
Oncology and Haematology*			Y		1	4	25
Head, Neck and Ophthalmology*					0	4	0
Anaesthetics, Theatres and Critical Care*			Y	Y	2	4	50
MSK*	Y				1	4	25
Radiology*					0	4	0
Pathology*	Y			Y	2	4	50
Therapy*	Y	Y	Y	Y	4	4	100
Pharmacy*	Y	Y	Y	Y	4	4	100
Royal College of Midwives***	Y	Y	Y	Y	4	4	100

Title	July 2020	September 2020	October 2020	February 2021	Actual Attendance	Possible Attendance	% of attendance
Royal College of Nursing***					0	4	0
Unison***	Y	Y	Y	Y	4	4	100
Unite***	Y	Y	Y	Y	4	4	100
British Association of Occupational Therapists***					0	4	0
British Dietetic Association***					0	4	0
British and Irish Orthoptic Society***					0	4	0
British Medical Association***					0	4	0
Chartered Society of Physiotherapy***					0	4	0
Federation of Clinical Scientists***					0	4	0
Hospital Consultants & Specialists Association***					0	4	0
Society of Radiographers***					0	4	0

* Receives papers, 75% attendance not compulsory
** recorded as "in attendance" if any Centre represented
*** Staff side representative, 75% attendance not compulsory (2 members required for quoracy)

6 Assurance Arrangements

The remit from the Terms of Reference as at October 2020 are stated in the following section, with commentary on the work of the Committee below each point.

6.1 To review new legislation and guidance on health, safety, security, fire and food safety issues, and give advice to the Trust Board, Sustainability Committee, Divisions and Corporate Departments on actions required to ensure compliance.

The Committee reviewed the following legislation and guidance during the year.

Covid-secure guidance (July and October 2020, February 2021)

The Committee received updates on general covid-secure guidance as published and updated at Working safely during coronavirus (COVID-19) - Guidance - GOV.UK (www.gov.uk) and Making your workplace COVID-secure during the coronavirus pandemic (hse.gov.uk). These guides were the basis for the Trust's own covid-secure guidance, self-audit templates and covid-secure risk assessment templates published at SaTH Intranet - New Ways of Working which underpinned the Trust's own covid-secure risk assessments, also published there.

Arrangements for display of "H&S Law: what you need to know" posters and distribution of leaflets to new starters (July 2020)

During the covid-19 pandemic face to face Corporate Induction sessions were suspended, necessitating a different way to ensure that basic information on H&S law arrangements was communicated to new starters. With Committee support large H&S law posters were provided for display in the Apley and Mytton Oak Restaurants, and the leaflets are now included in information given to new starters by the Recruitment Team.

Social distancing and respiratory protection in construction (July and October 2020)

HSE bulletins emphasised the importance of covid-secure arrangements and adequate respiratory protection against biological, chemical and physical hazards during construction projects. This information was shared with Estates colleagues to inform review of contractor risk assessments and method statements for covid-secure arrangements, and prompted a review of information

shared with contractors regarding the Trust's own covid-secure arrangements to ensure that each contractor's own employees were equipped to protect themselves while working on Trust sites.

Air conditioning and ventilation during covid-19 (July 2020)

HSE issued guidance concerning the use of fans and air conditioning systems during covid-19. With respect to fans, this covered the need to avoid their use in poorly ventilated areas. With respect to air conditioning systems, this advised against the use of circulating-air systems without a fresh air supply. This guidance led to the temporary evacuation of the Shrewsbury Business Park buildings pending remedial works to ventilation systems prior to re-occupation.

Welfare facilities for drivers during covid-19 (July 2020)

HSE guidance noted the importance of allowing delivery drivers access to welfare facilities, including toilets and washbasins, during covid-19. Procurement colleagues confirmed that this was achieved through the pandemic by means of open access to public toilets for all delivery drivers to each site.

Reducing the risk of transmission during RPE fit testing (July 2020)

This guidance led to revised arrangements for infection control during RPE fit testing, which were implemented at local level by Division/ Corporate Department fit testers where active, and by the H&S Team during the open fit testing sessions which began at PRH and RSH in March 2020 and which have continued throughout the pandemic.

Protecting home workers, including DSE users (July and October 2020)

As staff adopted home working in order to improve social distancing and to meet covid-secure guidance focused on working from home where possible, this HSE guidance prompted the creation of the risk assessment document and arrangements published at SaTH Intranet - CORONAVIRUS and IT.

Managing the risk of legionella in closed buildings (July and October 2020)

This HSE guidance highlighted the importance of good management of water systems in empty or under-occupied buildings. Discussions confirmed that the Estates Team had existing arrangements in place to flush outlets where wards/ departments were known to be temporarily out of use, which continued to apply throughout the pandemic.

Working during heatwave conditions (October 2020)

The UK experienced heatwave conditions several times through the course of the pandemic, leading to increased risk of heat stress for staff wearing high levels of occlusive PPE, including respirators.

Risk assessments and SOPs for the use of portable air conditioning units were written and implemented with the RSH ITU/ HDU team, which was recognised to be particularly adversely affected by the summer heatwave temperatures due to ongoing issues with local cooling/ ventilation systems.

A review of the Trust's Heatwave Plan was included in the Covid-19 Debrief Report, Recommendations and Action Plan considered by the October 2020 Trust Board leading to the development of the Heatwave Plan, currently awaiting approval by Policy Approval Group.

RIDDOR reporting during covid-19 (October 2020)

HSE issued guidance on the application of RIDDOR 2013 to covid-19 infections and occupational exposures. This led to the development of Trust thresholds for reporting covid-19 infection in staff members, and for occupational exposures leading to increased infection risk with input from the H&S Team, the IPC Team and Microbiology colleagues. These thresholds were shared with local healthcare system partners and agreed for county-wide adoption, with case-by-case monitoring provided by Shropshire Community Health Trust's Occupational Health service.

During the course of the pandemic a total of 7 covid-19 related "Dangerous Occurrence" reports were submitted to HSE, and no Occupational Disease reports. All of the reports related to the provision, maintenance and use of disposable FFP3 respirators or PAPR units ("Hoods"). Remedial actions to prevent recurrence were monitored via the Infection Prevention and Control Assurance Committee.

Safety alert: gas detection in confined spaces (October 2020)

This HSE alert related to calibration methods which could lead to errors in the use of gas detection units. This was shared with Estates colleagues for information in the event of future confined space entry, including the RSH underground ducts.

First aid arrangements during covid-19 (October 2020)

HSE issued guidance on occupational first aid arrangements during the covid-19 pandemic, including a 6-month extension to first aid certificate expiry dates.

This guidance referred to the Resuscitation Council UK's advice on CPR during covid-19, which was incorporated into the algorithm published at SaTH Intranet - Resuscitation Advice during Covid-19 by the Trust's Resuscitation Officers. Note that the Trust's algorithm adopted advice to wear RPE during chest compressions, which created the requirement for very large numbers of Trust staff to remain fit-tested to an FFP3 in stock, often several times throughout the pandemic period due to changing PPE stocks.

Protecting vulnerable workers during covid-19 (October 2020)

HSE guidance highlighted the requirement to take into account individual differences in risk of serious illness following covid-19 infection. The Trust already had arrangements in place for individual risk assessments as published at SaTH Intranet - Self Risk Assessments incorporating all risk factors identified in the guidance with the exception of raised BMI.

Changes to recommended fire risk assessment methods (February 2021)

The Committee noted that revised national guidance for fire risk assessment methods had been reviewed by the Trust's Fire Safety Advisors, and the requirement to incorporate this into Trust fire risk assessment templates was acknowledged.

Post-Grenfell changes to residential building safety regulation (February 2021)

Fire Safety Advisors confirmed to the Committee that they were keeping a watching brief on developments in building safety regulation, with a view to understanding potential relevance to Trust premises.

6.2 To review quarterly health, safety, security, fire and food safety incident reports and trends, and to ensure that action is taken to prevent recurrence so far as it is reasonable to do so.

Reported incidents were discussed each meeting as a standing agenda item. These were presented in the form of reports on the following categories.

- Security incidents
- Health and safety incidents
- Fire safety incidents
- Food safety incidents

The reports included an overview of recommendations made to reduce the likelihood of recurrence, where appropriate.

The raw numbers of incidents reported are published at Appendix 1.

RIDDOR reports to HSE

The H&S incident reports included a comparison of the Trust's reporting rate for worker (staff, volunteers, contractors) RIDDOR reports of over 7-day and specified injuries compared to HSE's published benchmarking data for the "Human Health" sector, calculated over a rolling 12-month period at the end of each quarter.

Table 2 (below) demonstrates that in the rolling 12-month period ending 31 March 2021, the Trust was reporting staff RIDDOR reports of non-fatal injuries at a rate similar to the national benchmark compared to HSE's statistics for the "Human Health" sector overall. However, the reports were running at a much higher rate than benchmark for specified injuries compared to over 7-day injuries.

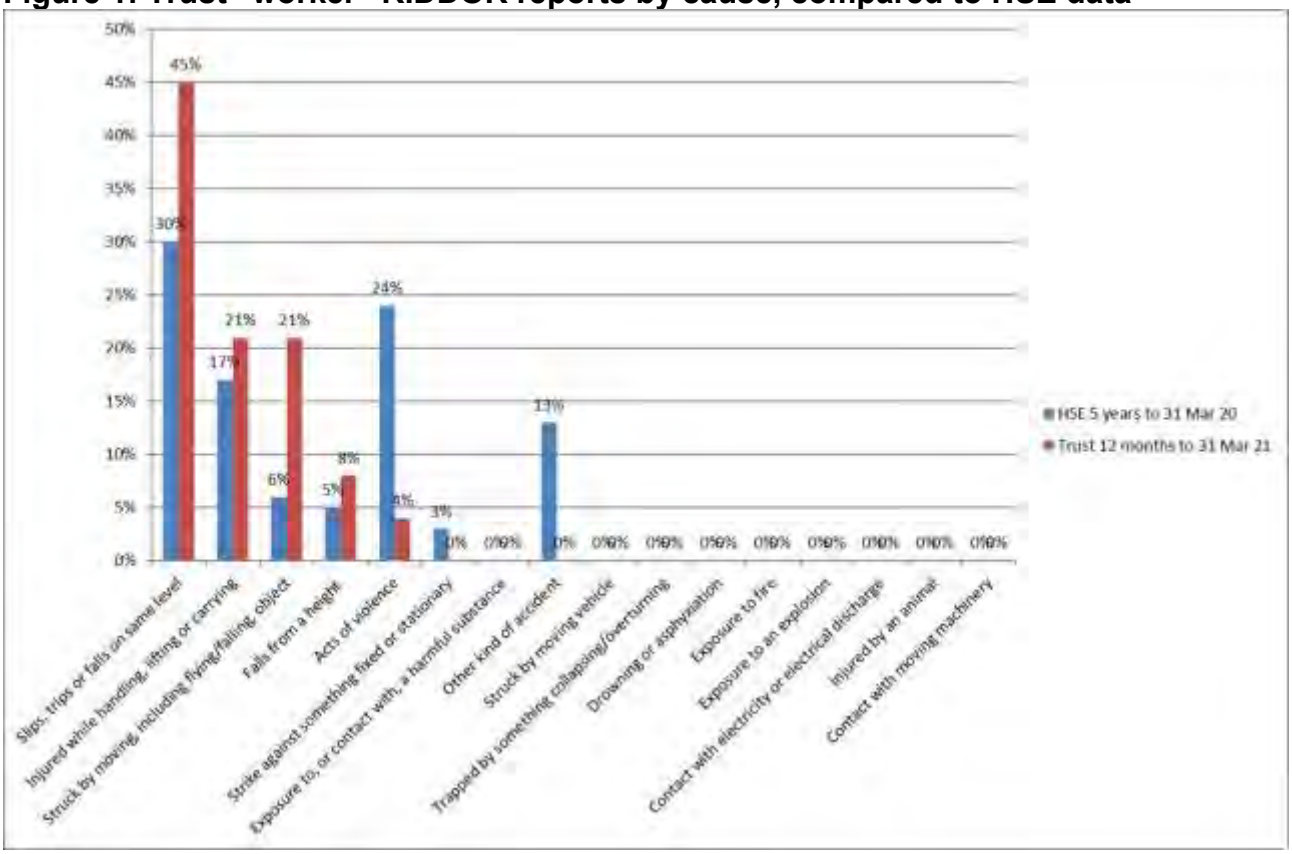
Table 2 RIDDOR reports per 100,000 workers

Category	**HSE***	**Rolling 12 months ending 31 March 2021****	**Raw number of "worker" RIDDOR reports submitted by Trust*****
Fatal injuries	0	0	0
Specified injuries	59	101	7
Over 7-day injuries	291	245	17
Total: all non-fatal injuries	*350*	*346*	*24*
Dangerous occurrences	No benchmark data	87	6
Occupational diseases	No benchmark data	14	1

* HSE data for years 2014/15 to 2019/20, Standard Industrial Classification code 86 "Human health activities", published at http://www.hse.gov.uk/statistics/tables/index.htm#riddor and last checked for updates on 21 April 2021.
** Derived using formula (number of RIDDOR reports/ headcount) x 100000 where ESR headcount = 6945 at 31 March 2021, and number of RIDDOR reports recorded in Datix in period 1 April 2020 to 31 March 2021.
*** Datix records injured person as staff member or volunteer, or contractor working on Trust sites.

Figure 1 (below) compares the reasons for "worker" RIDDOR reports to HSE data. it can be seen that compared to the industry national trend, the Trust is less likely to report injuries arising from acts of violence and more likely to report incidents arising from injuries relating to slips, trips and falls. Other reasons for reporting are broadly similar.

Figure 1: Trust "worker" RIDDOR reports by cause, compared to HSE data*



* http://www.hse.gov.uk/statistics/tables/index.htm#riddor (data table "RIDKIND – RIDDOR Table 2" and industry sector "Public administration and defence; compulsory social security; education; human health and social work activities") last accessed 25 April 2021.

Figure 2 (below) displays all staff incidents resulting in a RIDDOR report, broken down by HSE accident kind and employing Division/ Corporate Department.

Figure 2: Staff RIDDOR reports by Division/ Corporate Department and HSE accident kind, FY 2020/ 21

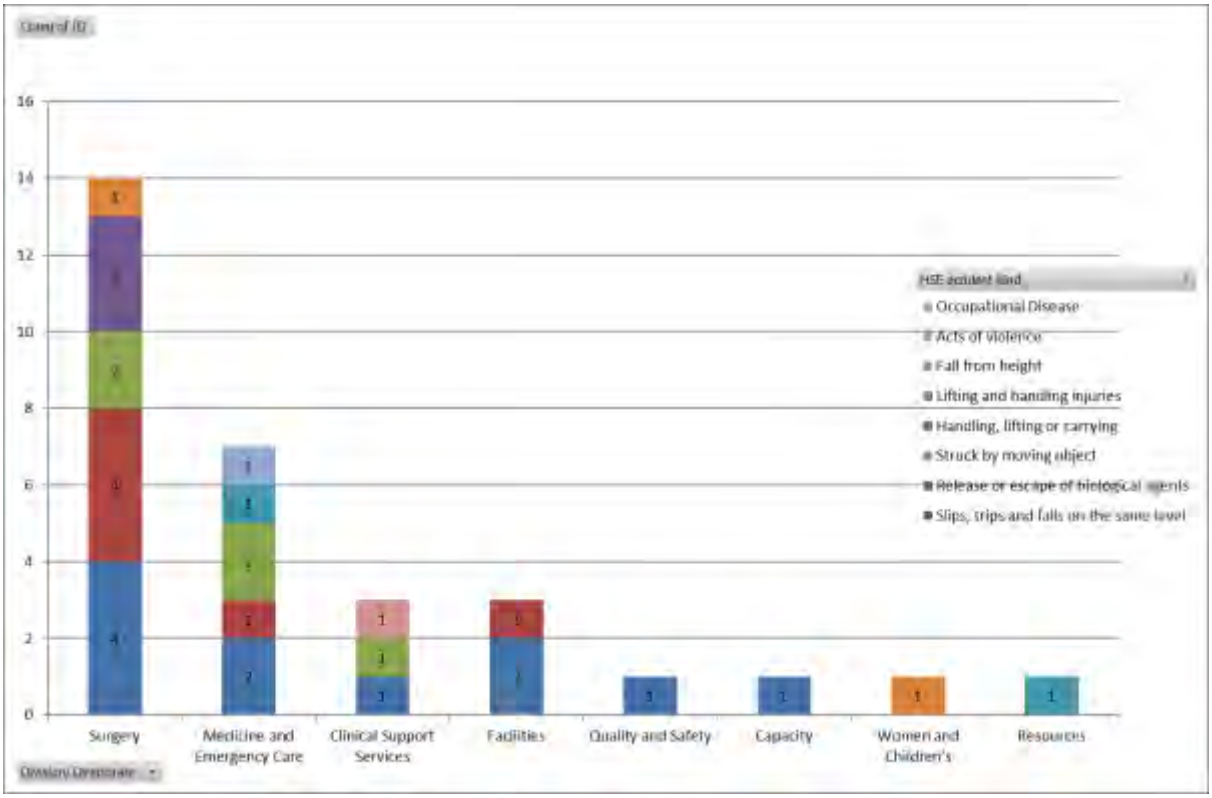


Figure 3 (below) outlines all incidents reported via Datix which were coded to health and safety-related categories (excluding inpatient falls), broken down by category and Division/ Corporate Department.

Note that each quarterly report focused on the top 5 most commonly reported reasons for incidents, and that this figure reflects the consistent pattern across quarters.

Figure 3: All H&S-categorised Datix incident reports by category and Division/ Corporate Department

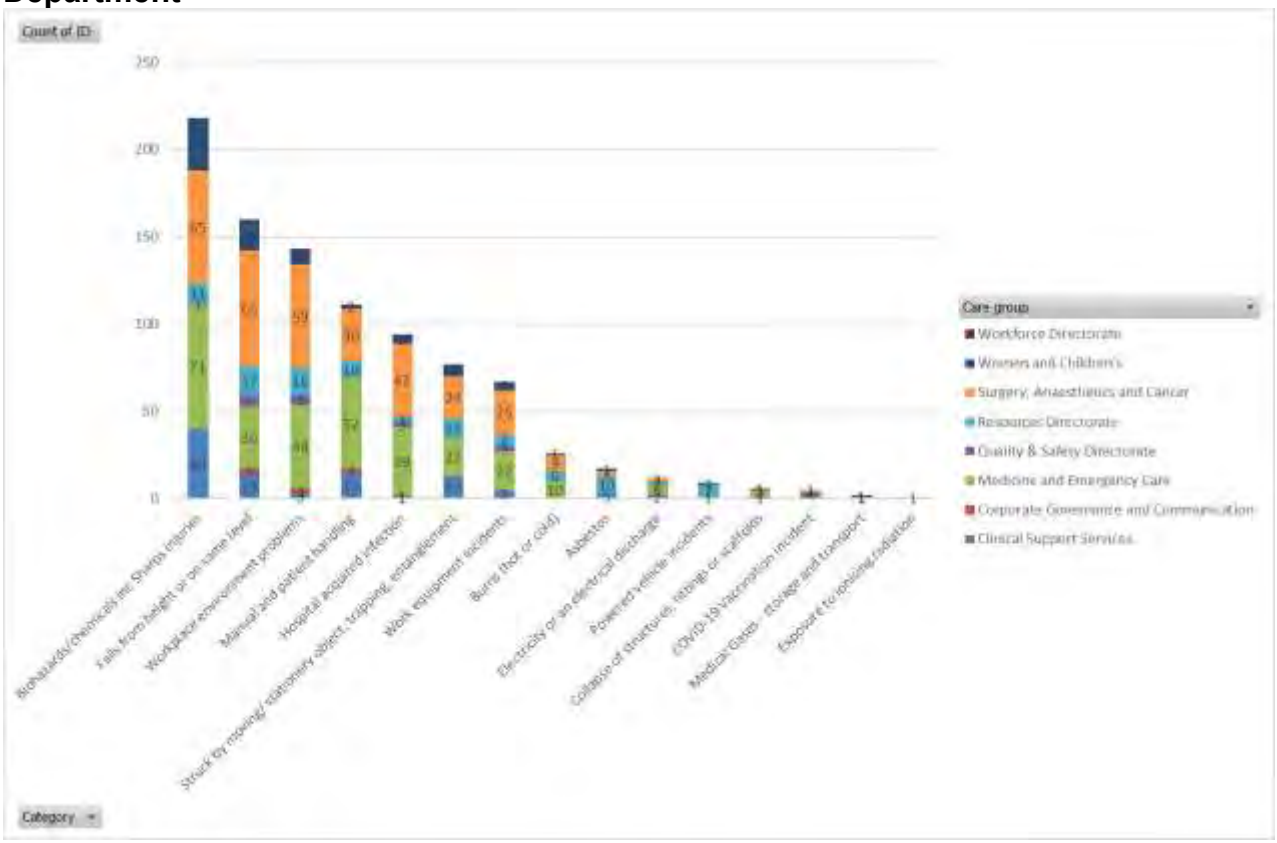
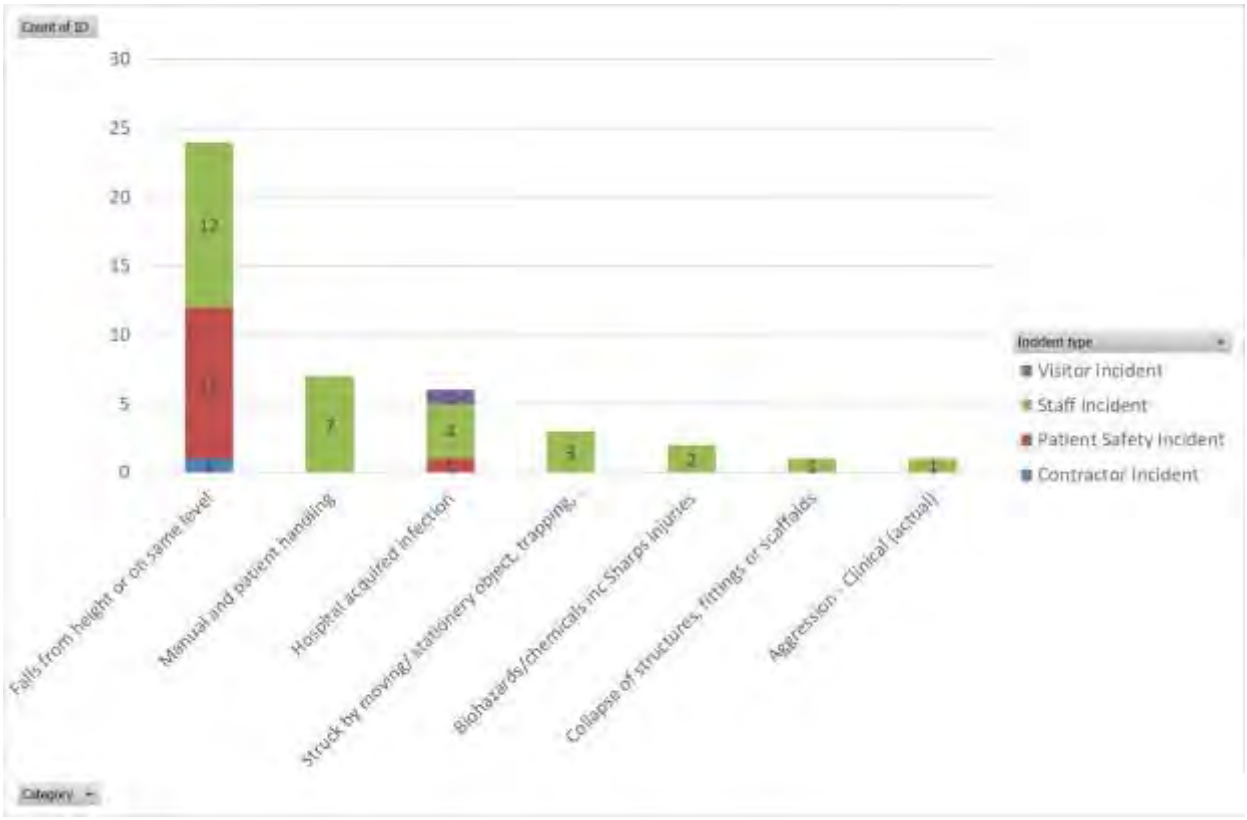


Figure 4 (below) displays all RIDDOR reports submitted to the HSE in the year, broken down by Datix category and type of person affected (staff, patient, visitor, contractor, other).

Figure 4 All RIDDOR reports in year, by Datix category and incident type



6.3 To review and update Trust Policies on health and safety, security, fire and food safety before submission to Policy Approval Group and the relevant Tier 2 Committee for adoption.

- HS20b Asbestos Management Plan (October 2020, February 2021. Current status - approved at Policy Approval Group, awaiting ratification route)
- HS19 Electrical Policy (October 2020, February 2021. Current status – remains in review)
- HS15 Slips, Trips and Falls Policy (October 2020. Current status – approved and published)
- HS32 Management of Ventilation Systems Policy (February 2021. Current status – remains in review)
- HS27 Pressure Systems Safety Policy (February 2021. Current status – remains in review)
- HS31 Permit to Work Policy (February 2021. Current status – remains in review)
- FSP003 Food Safety Policy (February 2021. Current status - approved at Policy Approval Group, awaiting ratification route)
- HS14 Ionising Radiation Policy (February 2021. Current status – pending approval by Policy Approval Group)
- HS20a Asbestos Management Policy (February 2021. Current status - approved at Policy Approval Group, awaiting ratification route)

A list of current Fire Safety, Food Safety, Security and Health & Safety policies with review dates and approval status is presented to each Committee meeting. Policy work has been significantly delayed due to the pandemic and more recently, lack of a clear ratification route.

A key objective for 2020/ 2021 will be to ensure that all policies considered by this Committee are brought back into date, and to ensure that future review dates are staggered to improve Committee work flow.

In February 2021 the volume of papers presented to each Committee was recognised to be difficult for members to engage with, and it was decided that meetings would move from quarterly to bi-monthly in FY 2021/22.

6.4 To review health, safety, security, fire and food safety internal audit and inspection programmes, and ensure that remedial action is taken so far as it is reasonable to do so.

Throughout the year the Committee was updated on a limited range of audits and inspection, and these are summarised below.

H&S audit/ inspection programme: H&S policy compliance check audits
The July and October Committee meetings heard that this stream of audit activities (among others) was suspended due to the H&S Team's adoption of their pandemic role in the provision of RPE fit testing.

Ligature points assessments
The Committee received an update in February 2021 that this programme of work had begun, consisting of H&S Team members conducting ligature points inspections to inform ligature points risk assessments with engagement of local managers. This work had been suspended in Q4 2019, and was re-started as a priority task for the H&S Team as it returned to a range of pre-pandemic duties.

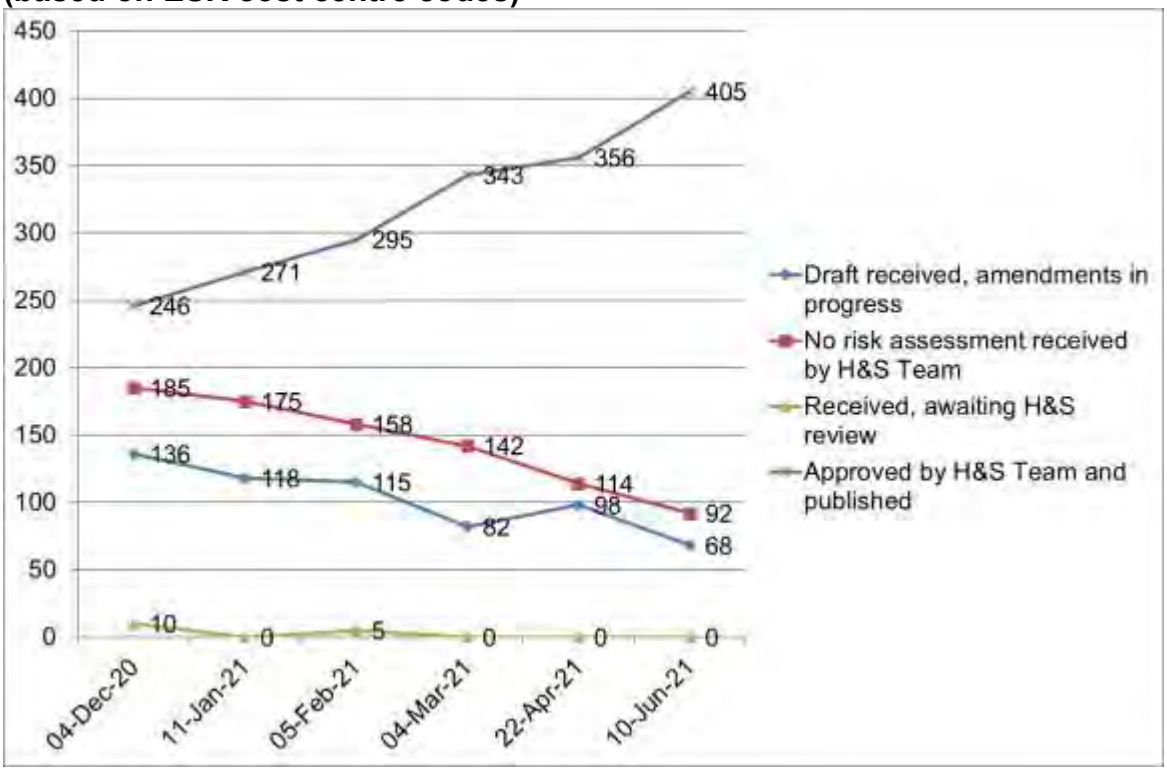
DSE workstation assessors competency assessments
This stream of work was paused during Covid-19 and will resume in 2021/2022.

FFP3 fit testers: refresher training and competency assessments
The February 2021 Committee received an update on progress with refresher training and competency assessments for RPE fit testers working locally across the Trust. At that time the Trust had 30 trained and active fit testers, and of those 16 held qualitative fit-testing kits for local use. Many other trained fit testers did not attend the 2020 fit testers refresher training sessions and therefore were no longer considered capable of conducting valid fit tests.

A full programme of FFP3 fit testing undertaken by the H&S Team, working alongside redeployed staff during the first wave and Ashfield/ DHSC contract fit testers by December 2020 was activated as part of the response to Covid-19 and is discussed elsewhere in this report. Throughout the course of the pandemic the vast majority of RPE fit tests were undertaken by the H&S Team and supporting staff.

Covid-secure risk assessments: inspection programme and monitoring activities
The July and October meetings heard that the H&S Team's key monitoring activity related to the Trust's covid-secure risk assessments. These records were maintained and published at http://intranet.sath.nhs.uk/coronavirus/waysofworking.asp. At 10 June 2021 the position with reference to completion of these assessments, expressed via ESR cost centre codes, is displayed at Figure 5 below.

Figure 5 Progress with publication of covid-secure risk assessments since December 2019 (based on ESR cost centre codes)



The Remote Worker Risk Assessment Checklist (template published at SaTH Intranet - CORONAVIRUS and IT) formed an additional strand of monitoring activity complementing the workplace risk assessments throughout the period.

The February meeting heard that between November 2020 and January 2021 26 non-clinical areas were inspected by a Senior H&S Advisor for compliance with covid-secure arrangements. Written feedback and verbal advice were provided following each inspection. Feedback included

the need to specify maximum room occupancies and display posters, and the need to ensure that all staff were aware of practical requirements arising from covid-secure risk assessments.

Safe use, storage and maintenance of PAPR units/ hoods
In response to Datix incident reports and learning from Covid-19 outbreak meetings, the February meeting heard that in December 2020 a Senior H&S Advisor visited 16 clinical areas where hoods were in use as an alternative to FFP3s. Written feedback was given to each area following inspection. Feedback included the need to ensure that staff had received user training from a Hood Library staff member, that the hood SOPs' routines for mid-shift doffing, cleaning and re-donning were not being adhered to and required attention, and that quaternary ammonium compound wipes (Clinell Universal Wipes, or PDI Sani-Cloth AF Universal Wipes) must be kept in stock in each area to facilitate the correct mid-shift cleaning routines.

Food safety audits
The February meeting heard that, since resuming audits in October 2020, 4 Protected Mealtimes audits, 12 Red Tray audits, and 19 Ward Kitchen audits had been undertaken by the Food Safety Advisor. Feedback and advice on remedial actions was provided to Ward Managers following each audit.

6.5 To be advised on live matters and/ or reports from the Health and Safety Executive, Shropshire Fire and Rescue Service and/ or Environmental Health Officers, and confirm/advise on action to ensure compliance with relevant legislation.

Shropshire Fire and Rescue Service letter following Ward 4 fire (July 2020)
The July 2020 Committee received a letter dated 4 June 2020 from SFRS advising the Trust on some measures to support their own Incident Command, with reference to accuracy of information from the Trust, situational awareness and decision-making when SFRS staff would require access to wards housing covid-positive patients.

Shropshire Fire and Rescue letter following audit of RSH Theatres, ITU/ HDU (October 2020, February 2021)
Following an audit at RSH the Trust received a letter dated 5 October 2020 which required remedial actions with respect to fire doors, fire risk assessment and storage of hazardous substances including medical gas cylinders. At the February 2021 meeting the Fire Safety Officer confirmed that the actions had been addressed.

Shropshire Fire and Rescue letter re: rising mains (February 2021)
The Committee heard that SFRS had asked the Trust to review its arrangements for maintenance of rising mains in a letter dated 5 November 2020.

Environmental Health Officer Liaison (July, October 2020, February 2021)
The July 2020 Committee continued to monitor the progress of the action plan resulting from the 2019 EHO inspections, and in October the Food Safety Advisor reported that a virtual inspection was conducted by telephone in August 2020. This culminated in refurbishment works to selected ward kitchens across PRH and RSH, beginning in Q4 2020/ 21.

HSE review of RIDDOR reportable fall from height (July 2020)

In November 2019 a Medical Records staff member fell from a kickstool, sustaining a head injury leading to loss of consciousness. The incident was reported to HSE under RIDDOR, and at HSE's request the Trust shared its internal investigation report. In March 2020 HSE wrote to the author to confirm that no enforcement action would be taken. Local equipment inspection and training issues within the department have since been addressed with support from the H&S Team. It was noted that the issues raised during the investigation may also be relevant elsewhere in the Trust, and so it was proposed that the H&S audit/ inspection programme, once fully resumed post-pandemic, should include low-level work at height as a focused health and safety survey and report back on findings to a future meeting.

6.6 To monitor and review matters associated with health, safety, security, fire and food safety; to monitor and review health, safety, security, fire and food safety improvement or risk reduction projects; to help resolve Trust health, safety and welfare issues.

Vertical evacuation training, July 2020
The Fire Safety Advisor reported that the vertical evacuation training programme was suspended, pending adequate resourcing.

Food allergens action plan, February 2021
The Food Safety Advisor presented an update on progress with the implementation of the issues arising from Estates and Facilities Alert EFA 2020/1 concerning food allergens. The Committee heard that most actions have been implemented with three outstanding, these relating to League of Friends' outlets access to Datix reporting, training of volunteers in food allergen management, and allergen management during charity bake sales with the two latter actions being on hold due to reduced volunteer numbers on site during the pandemic.

Estates compliance reports, February 2021
It was agreed that Estates would present a combined Estates compliance report summarising the work of the specialist engineering disciplines including electrical systems, pressure systems, asbestos management, etc. The aim was to improve escalation of relevant issues to the HSSF Committee and beyond, in a timely manner. The first report was presented to the February 2021 Committee.

6.7 To receive responses from Care Group quarterly reports issued following Committee meetings.

At the July 2020 meeting the Chair invited the Division/ Department leads to raise any health and issues verbally at the meeting, and none of significance were raised.

By October 2020 a different arrangement had been agreed and eight H&S information reports were sent out to Divisions and Corporate Departments ahead of the meeting, to aid their own reporting to Committee.

The following reported back verbally to the October meeting: Surgery, Anaesthetics and Critical Care Division, Medicine and Emergency Division, Women and Children's Division, Clinical Support Services, Estates, Facilities and Operations.

The following reported back verbally to the February meeting: Clinical Support Services, Women and Children's Division, Surgery, Anaesthetics and Critical Care Division.

Consistent reporting from the Divisions and Corporate Departments, and escalation of matters to the HSSF Committee must be a priority issue for 2021/22.

6.8 To consider exception reports from Care Group meetings where non-compliance with statutory duties is reported, and to refer items to the Sustainability Committee for consideration and appropriate action.

No significant issues were escalated from Division/ Corporate Department meetings.

6.9 To approve the Health and Safety, Security and Fire Annual Reports.

The HSSF Committee annual report was presented to members in advance of the extraordinary September 2020 Committee, and accepted for escalation to Finance and Performance Committee in the same month.

The Security annual report was considered by the July 2020 Committee, and was accepted for escalation to the Audit Committee.

The Fire annual report was considered by the July 2020 Committee, and was accepted by the HSSF Committee.

6.10 To review Health and Safety, Security, Fire or Food Safety risk register entries.

The Trust risk prioritisation list was presented to the July 2020, for noting. No risk register entries were presented to the October 2020 or February 2021 meetings, following changes to governance arrangements and the end of the Operational Risk Group meetings early in the reporting period.

7 Reporting from the Committee

The Terms of Reference at the start of the reporting period required that the Health and Safety and Security Committee reports to the Sustainability Committee.

However, a Trust-wide governance review conducted in year left the HSSF Committee without a clear reporting route until April 2021, when it was confirmed that the Committee will report to the Quality Operational Committee.

No report was issued following the July 2020 meeting. Items for escalation were reported to the Execs Committee by the Chair following the October 2020 and February 2021 meetings.

8 Review of Committee priorities set for 2020/21

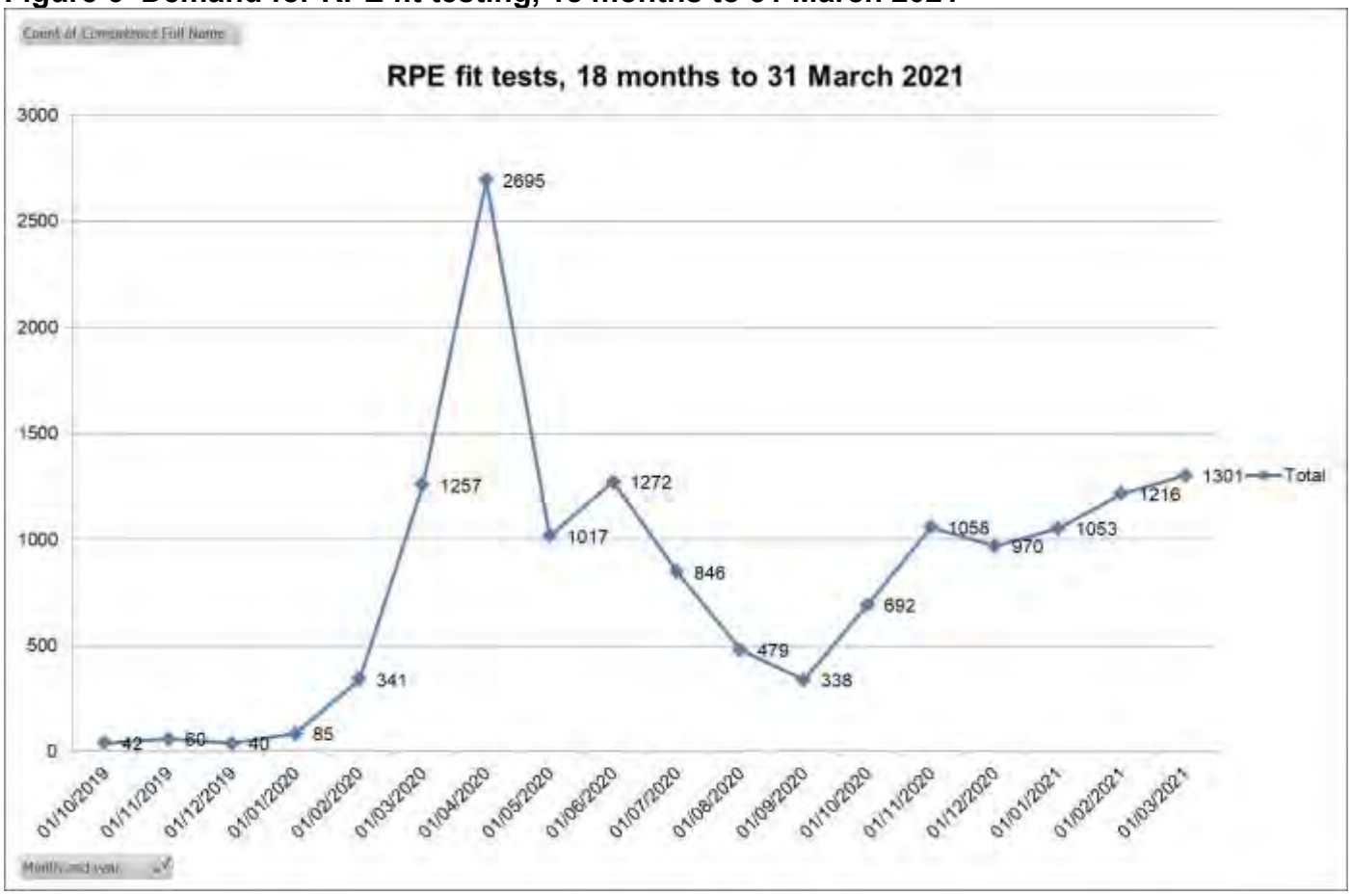
To ensure that the Trust has sufficient capacity for Respiratory Protective Equipment (RPE) fit testing to continue to meet Covid-19 PPE guidelines.
The change in demand for RPE fit testing across the reporting period is displayed in Figure 6 (below), which measures individual fit tests conducted (noting that one staff member is likely to have several fit tests).

During the first wave the H&S Team were supported by redeployed staff, who all returned to their substantive roles by 1 September 2020. In Q3 2020/21 the Trust sought assistance from Ashfield RPE fit testers working via DHSC contracts, with Ashfield staff working at RSH and PRH alongside H&S Team staff.

A business case for 3.0 WTE Band 3 H&S Assistants was developed and approved, with staff taking up post in January and February 2021 one one-year fixed term contracts. A resilient and

resourced RPE fit testing programme is now an expectation of acute Trusts, and a further business case will be developed by the H&S Team based on anticipated demand beyond Q4 2021/22.

Figure 6 Demand for RPE fit testing, 18 months to 31 March 2021



To evaluate current arrangements for health surveillance with a view to improving participation rates.
This work was not progressed significantly during the reporting period due to pandemic-related pressures, and should be carried forward to 2021/22.

To strengthen food safety arrangements by seeking assurances from the League of Friends outlets operating at RSH and PRH.
This work was not progressed significantly during the reporting period due to pandemic-related pressures and the closure or limited operation of these catering outlets during the reporting period, and should be carried forward to 2021/22.

To review and agree audit priorities for H&S, Food Safety and Security.
This work was not progressed significantly during the reporting period due to pandemic-related pressures, and should be carried forward to 2021/22.

To review the use of available incident and EL/ PL claims data to drive improvements in performance.
This work was not progressed significantly during the reporting period due to pandemic-related pressures, and should be carried forward to 2021/22.

To require Care Group and Directorate representatives to attend at least 75% of the year's meetings, as per Terms of Reference.

Attendance at meetings is addressed in Table 1 above, and reveals ongoing variation and compliance. Attendance will continue to be monitored throughout 2021/22.

To require Care Groups and Directorates to present a report on current compliance status and live H&S, Fire, Food and Security issues to each Committee meeting, using a reporting template to be agreed.
Progress against this priority is described at section 6.7 above. This will remain a priority issue throughout 2021/22.

To ensure that all F(ire)S-, F(ood)S-, SY- and HS-prefixed policies are within review dates, via consultation and agreement by Committee members, Policy Approval Group and the Sustainability Committee.
Each meeting received an update on current policy status, which highlighted where policy review dates were extended in recognition of the disruption to usual business leading from the covid-19 pandemic. This work will remain a key focus for the Committee throughout 2021/22.

To ensure that future policy review dates are staggered to improve Committee work flow.
At the time of writing the Committee is awaiting confirmation on Trust requirements for review dates for policies, and specifically whether this is to move from 5 years to 3 years. When this is clarified, the policy review status list will be reviewed with a view to bringing forward selected dates to achieve this aim.

In light of the recently implemented Improvement Alliance, to compare this Committee's Terms of Reference with UHB's, and more closely align this Committee's ToRs to those of UHB.
UHB's H&S Committee ToRs were obtained for review, and the key difference noted was UHB's emphasis on Divisions and Directorates more closely monitoring their own H&S-related performance and providing detailed reports to Committee. This prompted changes in emphasis at the July, October 2020 and February 2021 meetings, which will continue to remain a focus throughout 2021/22. Risk register entry 1090 (currently rated 15) relates, as it addresses the way in which H&S management information is collated and monitored.

To recommend that Board Directors attend externally accredited health and safety training to a nationally recognised syllabus.
The course "NEBOSH HSE Certificate in Health and Safety Leadership Excellence" was identified as the relevant course, with HSE Buxton identified as the preferred course provider and with a strong preference for a face to face course delivery. Face to face courses were not available during the reporting period in light of social distancing guidance, and so this will remain a live issue for resolution in 2021/22.

9 Priorities for FY 2021/22

- To pursue the priorities from 2020/21 which remain outstanding or in progress.
- To devise a Board Assurance Framework-style document for H&S, Security, Food Safety and Fire matters, to be monitored by the Committee.
- To devise a report on H&S, Food Safety, Security and Fire risks for monitoring by the Committee.

- To improve the quality and scope of quarterly Division/ Corporate Department reporting into Committee.

- To pursue initiatives to improve the availability and quality of H&S/ Food Safety/ Fire/ Security management information available to Divisions and Corporate Departments, to enable the item above by means of adopting an electronic H&S risk management system.

- To design and implement a comprehensive H&S training programme, post-pandemic.

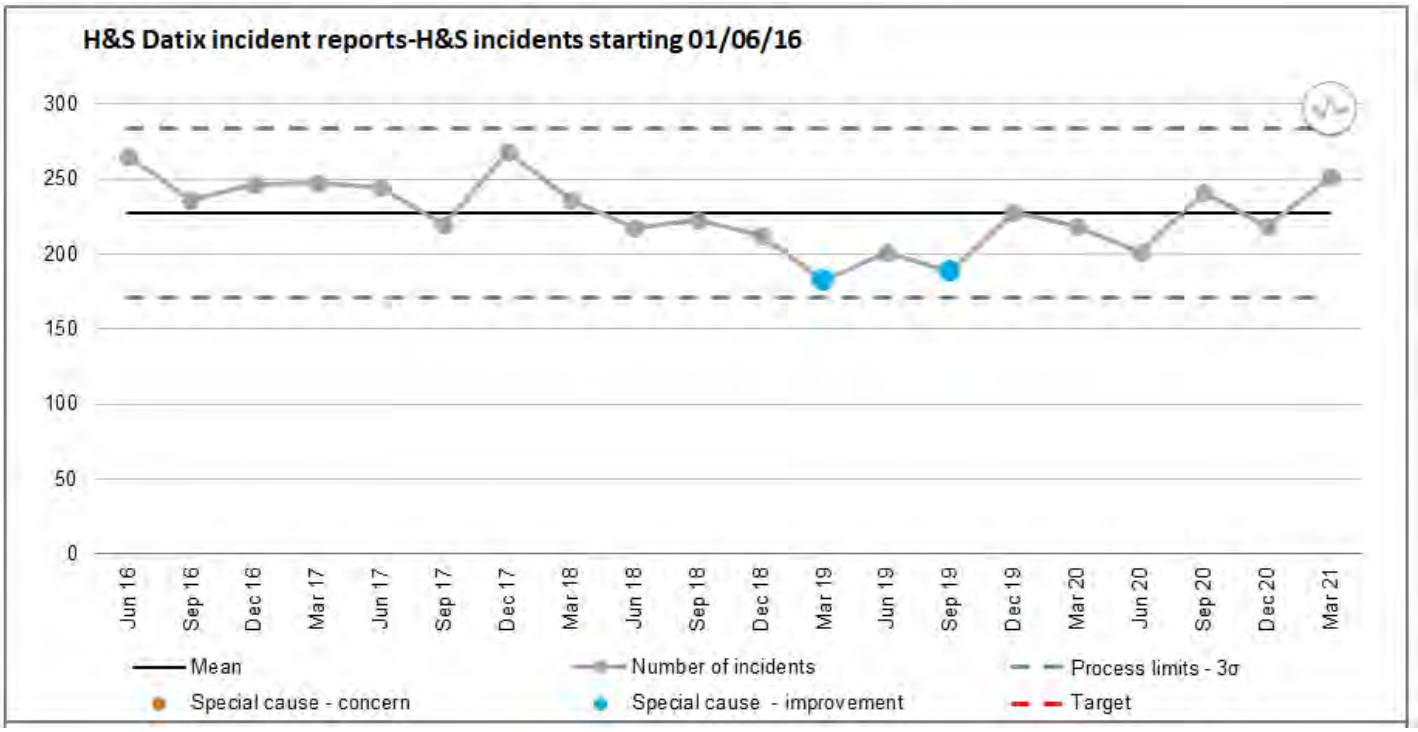
- To improve health surveillance arrangements, to include management information on the status of health surveillance by ward/ department and individual.

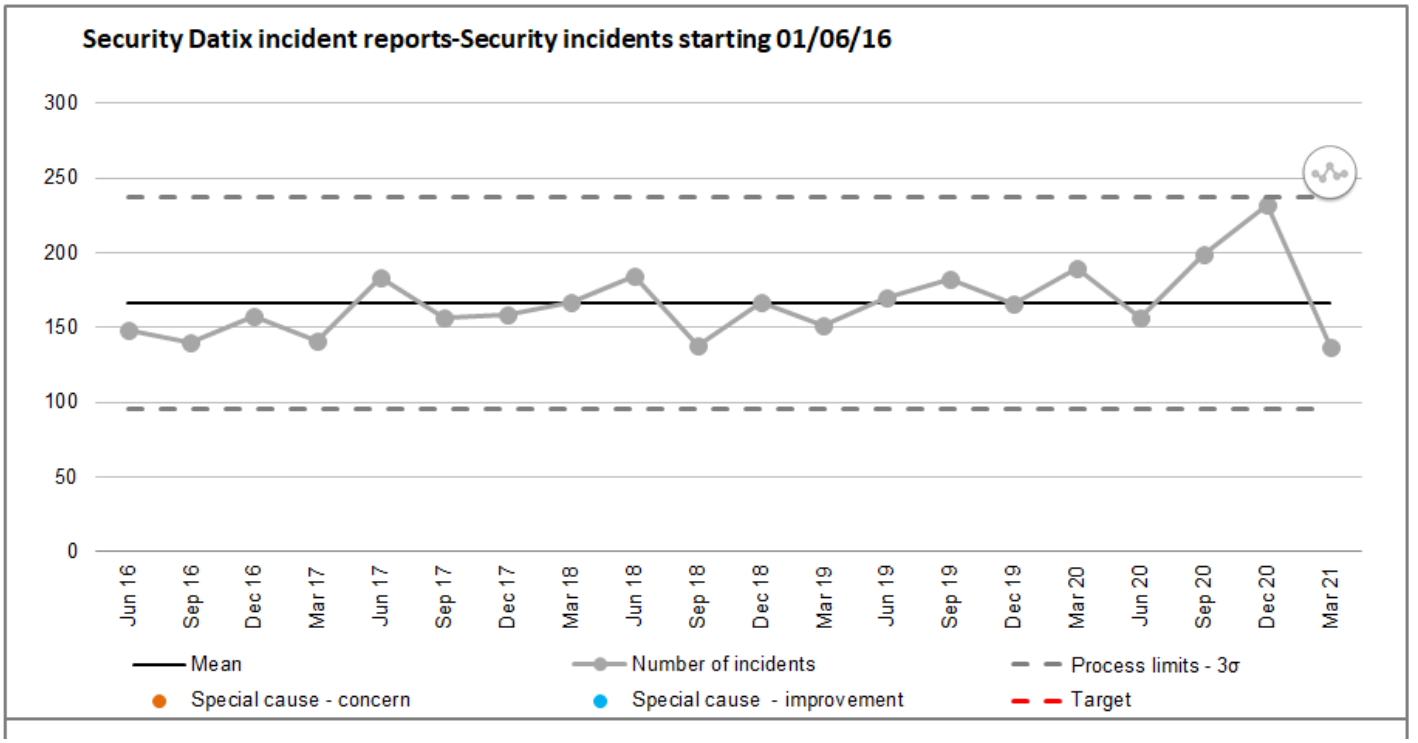
- To resume a comprehensive H&S audit/ inspection programme, post-pandemic.

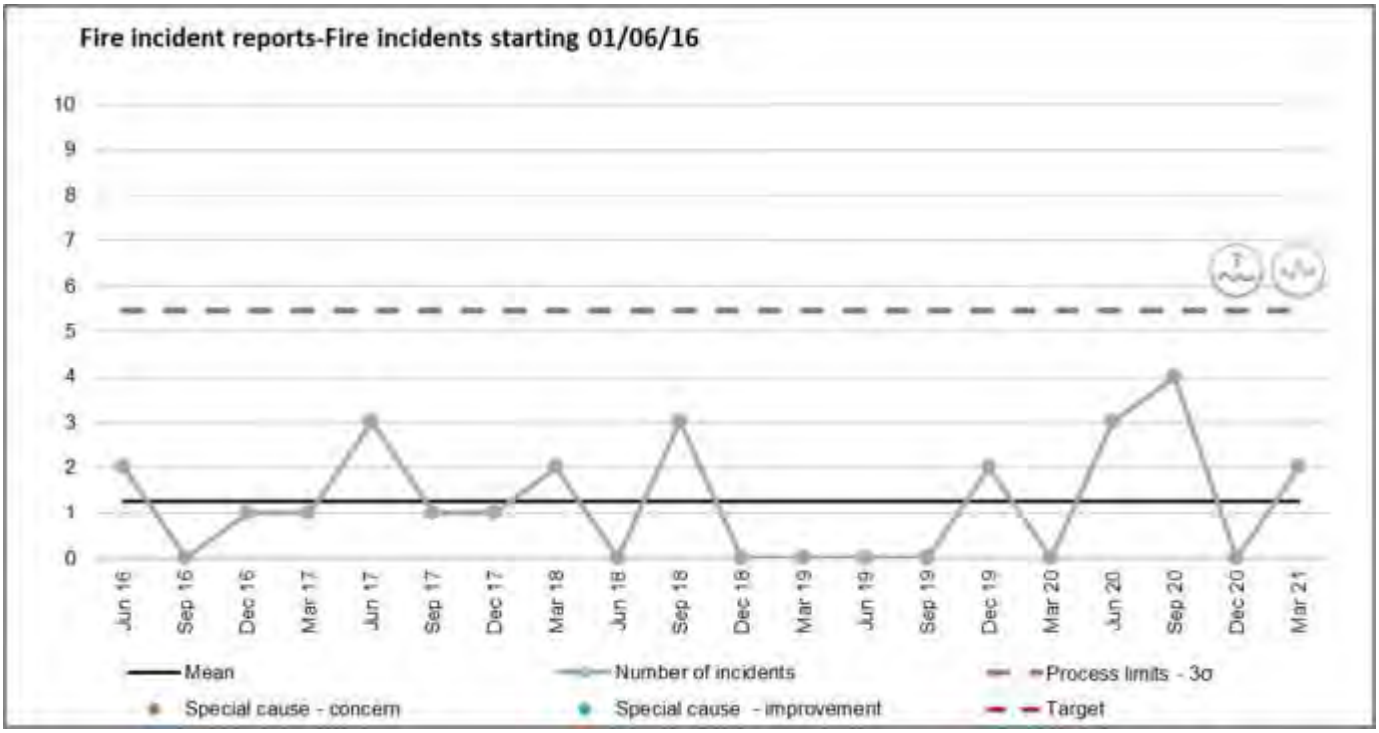
- To develop a business case for a resilient RPE fit testing programme post-Q4 2021.

Kath Titley
H&S Team Manager
29 June 2021

Appendix 1 5-year trends in incidents by safety discipline (source: quarterly reports)






Fire incident reports-Fire incidents starting 01/06/16
10
9
8
7
6
5
4
3
2
1
0
Jun 16
Sep 16
Dec 16
Mar 17
Jun 17
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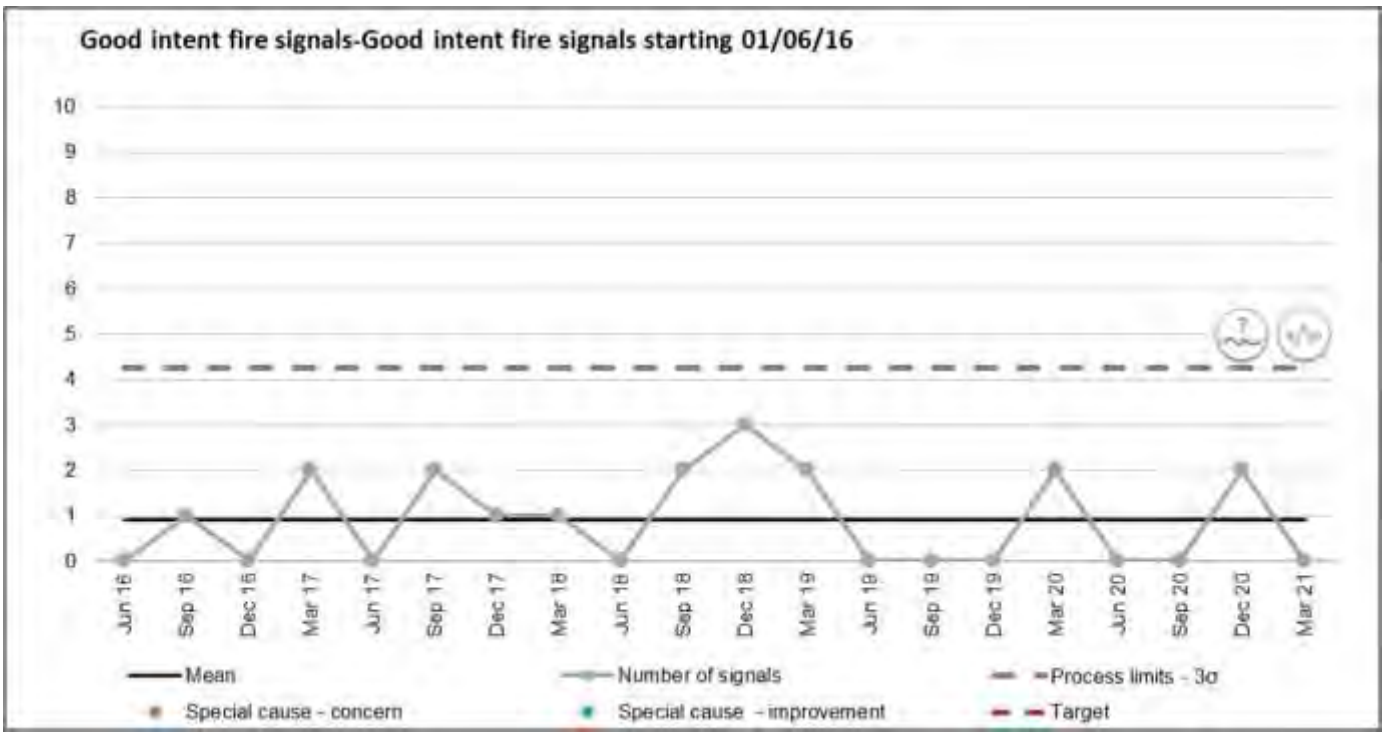
Mean
Number of incidents
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Good intent fire signals-Good intent fire signals starting 01/06/16
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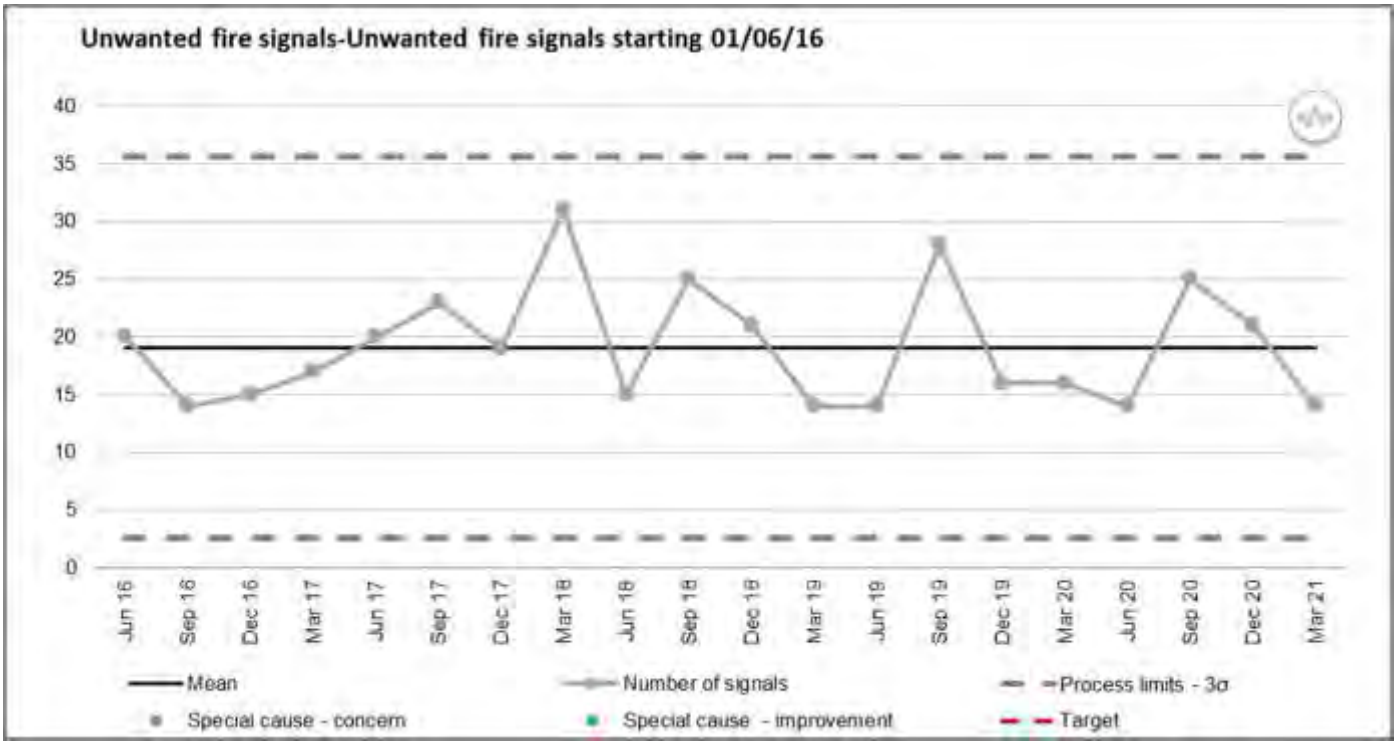
Mean
Number of signals
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target



NB: insufficient data to generate an SPC chart for quarterly Food Safety incidents.

Appendix 2 Committee forward plan for 2021/ 22

Item	Apr-21	Jun-21	Aug-21	Oct-21	Dec-21	Feb-22
Annual report: Fire	x					
Annual report: Health, Safety, Security and Fire Committee		x				
Annual report: Security	x					
Asbestos Management Plan: annual review				x		
Audit/ inspection programme update	x	x	x	x	x	x
Control of Contractors inspections: annual review		x				
Division and Directorate reports	x		x	x		x
Environmental Health interest in the Trust	x	x	x	x	x	x
Estates compliance report	x	x	x	x	x	x
FFP3/ RPE updates	x	x	x	x	x	x
Health surveillance programme review	x	x				
HSE interest in the Trust	x	x	x	x	x	x
HSSF Committee forward plan including current policy status	x	x	x	x	x	x
Legislation/ guidance updates	x	x	x	x	x	x
Minutes of the Fire Safety Group	x	x				
Minutes of the Radiation Protection Committee		x				
Policies for consultation and approval (as required)	x	x	x	x	x	x
Policy status update	x	x	x	x	x	x
Quarterly report - Fire	x	x				
Quarterly report - Food	x		x	x		x
Quarterly report - H&S	x		x	x		x
Quarterly report - Security	x		x	x		x
Shropshire Fire and Rescue Service interest in the Trust	x	x	x	x	x	x
Terms of Reference: annual review	x					
Training programme: annual review	x					

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11th November 2021

Agenda item	279/21			
Report	Estates and Medical Engineering Services (MES) Report			
Executive Lead	Director of Finance			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	
	Our partners		Responsive	√
	Our governance		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	5,6	
	For decision / approval		**Link to risk register:**	
	For review / discussion		1482, 1934, 1751	
	For noting			
	For information			
	For consent			
Presented to:	Finance and Performance Assurance Committee 2.11.21			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	The attached estates highlight report provides assurance by covering the estates functions and operations that are integral to the delivery of high quality clinical care ensuring that SaTH provides a safe, high quality and efficient estate. This report is a summary of Estates activity over Q2 21/22. It covers; • Strategic Estates Capital Programme; • Backlog Maintenance Capital Programme; • Estates Operations –statutory and mandatory maintenance as well as reactive maintenance performance; • and Medical Engineering. The Estates Strategic plan has been drafted and is being finalised. It is an integral part of service planning, national and local objectives and future planning.			
Appendices	Appendix 1 is included as part of the supplementary board pack			
Lead Executive:				

1.0 Introduction

1.1 The attached highlight report covers estates strategic and operational functions that are integral to the delivery of high quality clinical care ensuring that SaTH provides a safe, high quality and efficient estate.

2.0 Estates Capital Programme

2.1 The Estates Capital Programme Management Office (CPMO) is building on the successful investments made during FY20/21. Further significant capital investment is underway in FY21/22 of roughly £29.2m, a further £6.2m worth of ICS system funded are also being managed by the CPMO equating to a total or £35.2m.

In The impact of the investments (delivered on time and on budget*)* has provide a safer physical environment and is enabling system required changes to patient pathways and clinical models to support improved operational performance.

Of the planned investment a total of £5m is specifically allocated for SaTH backlog schemes with another £2.85m on Endoscopy and the remainder is centrally funded and system funded projects such as A&E reconfiguration and modular ward (See slides 2-6 in Annex).

Further projects are being developed pending funding such as Satellite Renal Unit in Telford and Critical Care.

2.2 Major Strategic Schemes planned for completion in FY21/22:

- RSH A&E Reconfiguration £9.3M
- RSH 32 Bed Modular Ward £7.1M
- RSH / PRH Endoscopy £2.85M
- RSH Lingen Davies Clinic Rooms £285K

2.3 Major Strategic developed schemes awaiting central capital approval:

- PRH Renal Move Offsite £4.5M
- PRH Cardio Respiratory (Apley) £3M

2.4 System schemes include:

- Community Diagnostic Hub £2M – (this is a community project supported by SaTH Strategic Estates Department)
- Newport X-Ray £500k

2.5 A number of significant backlog maintenance capital schemes are also currently underway will be completed in 21/22 including:

- PRH Uninterruptible Power Supply / Isolated Power Supply £1M (£500 approx. in FY21/22)
- RSH / PRH – Building Management System £1M (£500 approx. in FY21/22)
- RSH / PRH – Ventilation Replacements £800K

Some of these may slip into FY22/23 due to potential access issues. As a result a number of backlog projects could be brought forward.

3.0 Operations - Planned Preventative Maintenance (PPM) & Reactive Maintenance

3.1 Statutory and mandatory PPMs are a key area of compliance for each of the 9 estates operations disciplines. These disciplines are Decontamination, Electrical, Water, Medical Gas, Specialist Ventilation, Fire, Asbestos, Lifts and Pressure Systems. Each area must have its own compliance framework following HTM and HBN guidance. Each discipline also requires its own Authorising Engineer (AE), Authorising Persons (AP) and Responsible Persons (RP) and Competent Persons (CP) to be compliant. Historically the estates department at SaTH has not had the required AP resources to ensure such compliance. However over the last year Estates have been successful in recruiting too many of these roles with a remaining expected to be filled over the coming month. Recruitment to CP roles is also underway to ensure that the estates compliance framework is complete.

3.2 The current position is 89% of AP posts are now filled (compared to less than 45% in 2019) and this follows investment in FY20/21 and FY21/22 into these key roles. An Apprentice Programme is also underway to address estates age profile and ensure succession planning for the department. Six new apprentices are expected to start in November 21. (See slides 7-8 in Annex)

3.3 There has been a small deterioration in PPM compliance over Q2 (84% to 74%) due to increased activity in reactive maintenance required to address environmental improvements required as a result CQC and NHSI/E visits. Estates are targeting 90% PPM compliance by the end of FY21/22. PPM compliance is lower in comparison to Reactive completed lines due to the urgency of the reactive requests as a result of IPC / NHSI/E visit requests.

3.4 Reactive jobs have dropped in numbers since the peak in Q1 when there was an increased amount of activity NHSI/E visits (see slide 7 in Annex). Average response times for all reactive jobs is 14 hours and completion times are 2.3hours.

PPM completions continue to rise and are expected to reach a target of 90% by end of FY 21/22 when the investment in permanent workforce rather than contractors is implemented.

3.5 PPMs

- 3,318 PPMs completed.
- 74.4% of Statutory and Mandatory on time. Reduction in performance as a result of Covid period, backlog underway.

Reactive Jobs

- 7,297 reactive job lines assigned, 7,185 completed 98.5%.
- Average response time 14 hours.
- Average completion time 2.3 hours.

Over Q2 a total of 10,615 jobs were executed by estates equating to roughly 117 jobs per day. (Slide 7 of Annex)

3.6 Estates compliance - Policies
9 documented
4 draft to issue to PAG in October (Electric, Lifts, PSSR, BCP & Pest Control)
4 under review/updates to be submitted to HSSF in December (Decontamination, Medical Gases and Heating & Ventilation & BCP)

Note that as reactive performance jobs increase PPM is likely to decrease due to resource capacity.

4.0 Medical Engineering Services (MES)

4.1 Despite all the pressures of the pandemic the team undertook commissioning of 952 new medical devices in Q2 FY21/22.

4.2 Planning continues for £1.8M capital replacement programme in FY21/22.

4.3 Planned Preventative Maintenance (PPM) compliance targets for medical devices within the trust is set in line with benchmarking and best practice peer groups. SaTH traditionally achieves high compliance and reached 95% in Q1. However in Q2 MES PPM compliance has fallen 3.4% below target of 95%. This issue is being managed and expected to be rectified in Q3 performance report. MES handled **6,062 jobs** in Q2.

4.4 MES are providing support and planning of major medical device projects including Infusion and Bed/ Mattresses management as well as the Althea Endoscopy managed contract.

MES are also supporting total bed management project currently being developed.

4.5 Full Re-certification of Quality Management System ISO: 9001 (2015) achieved in September 2021.

(See slide 9 in Annex)

5.0 Conclusion

5.1 The Board of Directors are asked to receive this report for assurance and to note progress being made across key areas.

Finance and Performance Assurance Committee Key Issues Report

Report Date: 2nd November 2021		**Report of:** Finance and Performance Assurance Committee
Date of last meeting: 2nd November 2021		**Membership Numbers:** The meeting was quorate.
1	**Agenda**	The Committee considered an agenda which included the following: • Workforce Update • Efficiency Programme • Performance Highlights – Recovery and Urgent & Emergency Care • Estates Quarterly Report • Cleanliness Business Case • Green Plan • Public Dividend Capital Memorandums of Understanding • H2 ERF Plan • Integrated Performance Report (Operational, Finance and Workforce sections) Month 06 • Finance Report Month 06 • Recovery Programme Update • Contract Award Summary • COVID-19 Update
2a	**Alert**	The Committee wished to alert members of the Board that: • Sickness (excluding COVID-19 absences) is extremely high and approaching 10% in some groups. Nursing unavailability was reported at 33% which was 9% over budget. Exhaustion of certain groups was noted and a comparison to benchmark sickness and availability against other Trusts would be undertaken to fairly manage expectations and performance. • There were recovery constraints relating to elective care. Additional independent sector schemes are required. • Urgent and Emergency Care performance was exceptionally poor due to the high patient demand, workforce issues and the requirement to maintain COVID-19 pathways. The availability of community beds were also limited and the number of patients who are Medically Fit for Discharge has increased substantially. This was causing significant ambulance handover delays. • The poor levels of system support we are experiencing indicates the STW ICS winter plan carries a high level of risk. • There were 59 COVID-19 positive inpatients. We will experience serious issues during November if cases continue to rise.
2b	**Assurance**	The Committee wish to assure members of the Board that:

		• The committee were encouraged that a comprehensive Workforce Plan was being created with clinical and nursing sponsorship and ownership. Good progress in filling vacancies with substantive appointments was noted. • Following approval of the CT Scanner Business case, the Trust is seeing the benefits of that with reduced wait referrals. • Planning for the 2022/23 Efficiency Programme had commenced.		
2c	**Advise**	The Committee wish to advise members of the Board that: • There were a number of unmitigated risks and the risk of declining to approve business cases/invest in care was not visible for assurance at either the Finance & Performance Assurance Ctte or the ICS Sustainability Assurance Ctte. • No BAF was yet available. • The Cleanliness Business case was reviewed. More information was requested regarding benefits and the risks of not investing. • The H2 ERF Plan was reviewed and the £10m programme of activities were welcomed and supported. The £1.5m spend for October and £1.7m November spend were approved. • The Decarbonisation Scheme would be reviewed at a future meeting.		
3	**Actions to be considered by the Board**	• Committee Summary to be noted.		
4	**Report compiled by**	*Clive Deadman* *Chair*	**Minutes available from**	*Jo Wells* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee Key Issues Report

Report Date: 28th October 2021		**Report of:** Quality & Safety Assurance Committee
Date of last meeting: 27th October 2021		Membership- The meeting was quorate as defined by its Terms of Reference
1	**Agenda**	The Committee considered an agenda which included the following: • Bi-annual Staffing Report • Learning from Deaths • Trust Board Assurance regarding Mortuary and Body Store • Health & Safety Annual Report • Dementia Strategy Quarterly Report • Dementia Strategy Review • CQC/ Section 31 and 29a Update • Maternity Champion Report • Safeguarding Key Summary Report • Infection Control Key Summary Report • Maternity Dashboard • Emergency Department Key Summary Report • Quality Indicators Integrated Performance Report • Nursing, Midwifery and AHP Workforce Key Summary Report • Serious Incident Overview • Legal Report • PALS, Patient Experience and Complaints Q1 Report • CNST • Getting to Good highlights
2a	**Alert**	• Decontamination of medical devices is a risk. Lessons have been learned from the Serious Incident investigation into prostate biopsies (TRUS) but there are some wider concerns. It is generally accepted that Decontamination Leadership is a clinician. This is not currently the case. UHB are providing support. • Staffing challenges were reported in several areas including ED, Paediatrics, maternity and on the wards. There are significant red flags in staffing levels and skill mix on some wards when patient acuity is considered. Despite this, some "red rated" wards have achieved quality improvements • Consultant staffing levels may also impact upon achieving the NICE Guidance for Sepsis which indicate that a consultant should review any patient with probable sepsis who is not responding to treatment at 1 hour post treatment. SATH have taken a view that the local guideline should be that consultant advice must be sought. • Registered Nurse to Health Care Assistant ratios are not satisfactory. SATH currently delivers a skill mix of 50:50 when expectations are much higher (70:30 NHSE 65:35 RCN) There remains a heavy reliance on agency staff and HCAs have been used to supplement RNs.(although this is always risk assessed)

		• There has been a decline in the performance against the 15-minute triage target for paediatric A&E attendances. This target is under significant CQC scrutiny • Existing pressures on ED services will be enhanced with expectations of 15-minute ambulance handovers and the expectations of NHSE that it is unacceptable to hold patients in ambulances or to provide corridor care. Trust clinical and operational leaders suggest that these expectations cannot be met for the "foreseeable future". This is associated with volume of work, staffing levels departmental configurations and the availability of inpatient beds. SATH are determined to work collaboratively with WMAS to address this issue which must also be viewed as a system issue. • Linked to the above, the fit for discharge numbers across both sites were exceptionally high. This reflects the problems encountered in discharging people who require social support in the community • Fluid balance performance had not seen improvement. The nursing leadership are seeking to implement a patient level fluid balance report at shift handover as both good practice and to provide additional assurance that this important aspect of care is being addressed and documented
2b	**Assurance**	• The Mortuary at RSH and the body store at PRH were largely compliant against the requirements set out in a letter from the interim chief operating officer of NHS. There have been discussions about the appropriateness of DBS checks for a particular staffing level. Whilst security cameras are in place at PRH and they meet the HTA requirements, they may not fully meet the requirement set out in the letter from NHSE Mitigations are in place. Key requirements are: o Swipe card access to mortuaries (present at RSH but not PRH body store although this is mitigated) o CCTV presence o Risk assessments o DBS checks for staff • There had been a spike of SIs over the pandemic period. Clinical leaders feel that this reflects improvement in reporting culture as well as unprecedented pressures linked to the COVID-19 response. There has been an improvement in incident closure indicating that investigations are complete, shared learning has been identified and the report has been signed off by the CCG • There was also a spike in Datix incidents reported during September. All incidents are individually reviewed by nursing leaders and escalated if required. • There has been good progress with safeguarding training with an improving picture of training levels. The use of "Ask 5" assurance checks in clinical areas supports assessments that training is leading to embedded knowledge and clinical practice
2c	**Advise**	• A business case was required to ensure the overseas recruitment programme continued as the fixed term contract expires at the end of March 2022. • Funding was required for FIT testing resources. • There were ongoing capacity and recovery routine issues with Health and Safety activities. A reporting process had been established to report through the committee.

		• Smoking cessation in pregnancy remains a challenge. The drive to improved quit rates has been boosted by the re-implementation of carbon monoxide testing. Improvements against the targets is a system challenge. QSAC discussed a deep dive into this and discussion at the ICS Quality and Safety committee • Digital Infrastructure forming part of the Getting to Good work had been delayed due to a serious functionality issue identified during the testing phase. The Committee has previously commented upon the impact of IT implementation delays (for example Badgernet) and there are now further examples • The MTAC report indicate substantial assurance with evidence of strong oversight of relevant issues • Health and Safety reporting is to be included into the QSAC forward agenda. There is a health and safety backlog to recover due to the prioritisation of particular activities such as FIT testing during the pandemic. Leadership and governance of this function appears to have been unstable but executive colleagues are now confident that this is stabilised • The learning from deaths report indicated a requirement to review admissions for urinary tract infections, pneumonia and acute or unspecified renal failure and with a particular focus on admissions to PRH on Saturdays. • The dementia support team report significantly improved organisational buy in but asked QSAC to be aware of the lack of 7 day cover. This is a key function given increasing levels of dementia within an aging population. QSAC members suggested that the Hospital Transformation Project needs to carefully consider the environments created with respect to the suitability for people with dementia
2d	**Review of Risks**	

For Quality & Safety Assurance Committee the strategic risks that the committee was asked to consider are:

 BAF 1 Poor standards of safety and quality of patient care across the Trust results in incidents of avoidable harm and /or poor clinical outcomes

 BAF 2 The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience

 BAF 3 The Trust is unable to attract, develop and / or retain its workforce to deliver outstanding services

 BAF 4 A shortage of workforce capacity and capability leads to deterioration of staff experience, morale and well-being

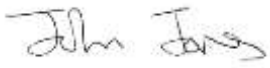
 BAF 8 The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards

The committee currently considers that these are appropriately rated

3	**Actions to be considered by the Board**	• Report to be noted		
4	**Report compiled by**	*Dr David Lee* *NED Quality and Safety Assurance Committee Chair*	**Minutes available from**	*Jo Wells* *Executive Support Team Supervisor*

Board of Directors' Meeting
11 November 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	282/21			
Report	Appraisal and Revalidation Report from Responsible Officer			
Executive Lead	Dr John Jones, Acting Medical Director and Responsible Officer			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	
	Our service delivery		Caring	
	Our partners		Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		-	
	For decision / approval		**Link to risk register:**	
	For review / discussion		-	
	For noting	√		
	For information			
	For consent			
Presented to:	-			
Dependent upon (if applicable)**:**	-			
Executive summary:	The purpose of this report is to present to the Board of Directors details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations. The purpose of medical revalidation and appraisal is to support and develop our medical workforce through reflection on clinical practice, whilst complying with GMC frameworks to protect patients. Appraisal rates **end of Quarter 2** (Trust Compliance): • Consultants: **92.1%** • SAS doctors: **81.4%** • SAS and Locally-Employed Doctors: **72.8%** • Overall Trust Total: **86.7%** Revalidations **April 2021 to September 2021** • **42** doctors have been revalidated • **16** doctors had their revalidation deferred • **1** non-engagement recommendation has been submitted and is under review by the GMC			
Appendices	1. Revalidation Recommendations			
				

1.0 Introduction

A national recommendation was made on 19 March 2020 to suspend appraisals due to the pandemic. This continued until 30 September 2020. Some appraisals were conducted during this time at the request of the individual and from August 2020 the decision was taken locally to instruct all doctors who were overdue prior to the pandemic to undertake their appraisal. NHS England released further guidance about restarting appraisals for doctors due from October 2020 and advised that the focus of appraisal should be supportive and reflective conversations, with less emphasis on written documentation. All missed appraisals during the suspension period were designated as 'approved missed' appraisals and catch up is not required. This is aligned to national guidance.

1.1 NHSE released further guidance on 30 April 2021. This mandated return to full participation in the appraisal process with flexibility for doctors who need to be excused and continued use of the Appraisal 2020 model for supportive appraisal. The 2020/21 Annual Organisation Audit was stood down and the annual Board report and Statement of Compliance were updated to support reporting on appraisal data and the impact of the Appraisal 2020 model. Framework for Quality assurance quarterly reports ceased from April 2021 onwards. These points were noted and SaTH is fully compliant with this guidance. SaTH's annual Board report and Statement of Compliance was submitted to NHS England and NHS Improvement on 6 August 2021.

2.0 Performance

2.1 At SaTH, we kept the focus of appraisal to be supportive and developmental, and to encourage doctors to take a thorough and professional approach to the opportunities offered by a supportive but challenging dialogue. For many, it is the only time someone sits down and focuses with them as an individual on their needs, anxieties, hopes and plans. The latest NHS England/Academy of Medical Royal Colleges guidance facilitates this approach with specific reference to exploring wellbeing, challenges, achievements and aspirations. At the same time we have maintained our focus on quality assurance specifically ensuring mandatory training, review of complaints and serious incidents, and quality improvement activity are reflected on and discussed. We continue to keep appraisals face to face where possible, with social distancing to facilitate this.

2.2 Feedback from completed appraisals for April to September 2021 suggests we have been largely successful in providing supportive appraisals, with a timely approach to reminding doctors of their appraisal needs and an enthusiastic team of appraisers. Doctors are encouraged to reflect on their experiences, feedback from patients and colleagues and professional development both during and after their appraisal meetings.

2.3 Our recent focus has been on improving the quality of the appraisal meeting between doctor and appraiser and the quality of the appraisal summary and personal development plan (PDP). With this in mind, we have implemented a new revalidation management portfolio system this year (Premier IT: PReP). This system is up to date, focused on simple input and output forms and allows our doctors to store evidence of performance and reflection in one place. Live online training opportunities for appraisees and appraisers have been provided and continue to be provided twice per week, alongside user guides, video guides, and support from the appraisal team.

2.4 For April to September 2021, many colleagues rated their experience of appraisal as either very good or good with an overall average score of 4.58 out of 5 (where the scale is poor (1) to very good (5)). The format for providing feedback on the appraisal process in the new PReP appraisal system appears to have encouraged a much

greater quantity of and level of detail within the qualitative feedback. Comments such as these below reflect the level of satisfaction: -

- *Many thanks for the time and effort taken to perform my appraisal. I feel that [name redacted] really takes the task to heart and thoroughly reviews my portfolio so that we can have a valuable learning conversation around the year to date and ongoing plans. Made me feel valued as part of the department.*
- *[Name redacted] had reviewed my entire portfolio prior to the appraisal meeting. The appraisal was robust but in an informal manner which put me at ease. This was a very useful review to help me prioritise my aims for the coming year. I felt very positive about work in general at the end of the appraisal. The discussion has really helped my professional development and I feel I am now ready for revalidation. The new PDP is excellent. [Name redacted] is an excellent appraiser and I will encourage other colleagues to approach him.*
- *Excellent discussion which has helped me focus on my needs for the coming year.*
- *[Name redacted] looked through all of my evidence thoroughly. She listened to me and I felt like I could be honest about any struggles I have had over the past couple of years. She provided me with really helpful feedback and advice. She is a really great mentor to have.*
- *I found [name redacted] excellent in communication, support and very accommodative during my appraisal process. He has the ability to bring items to a good discussion and I had a very productive appraisal. Very pleased with the process.*
- *Good appraisal. Thorough reviewed. Challenged appropriately.*
- *A thorough appraisal. I felt we were able to discuss some of the challenges of the past year and draw a line under them. I felt that it was a very supportive meeting.*
- *Excellent appraiser. Highly respected colleague. He had prepared very well, reading the pre information. Gave right amount of time for reflection and discussions. Skilled at facilitating and guiding the direction of the discussions. Excellent discussion. Came away from the appraisal with a feeling of having achieved a lot with regards to summarising my work over the year and a clear PDP, future plan over the next 5 years. Very good appraisal made possible by an excellent appraiser.*
- *My appraiser is obviously skilled in this aspect of their job. I particularly liked how he addressed the more tricky subjects and was able to be challenge with support. I actually enjoyed my appraisal meeting and came out feeling prepared and clear about the year ahead. It was really useful for me in particular being new to the Trust as it has been harder to establish support networks during COVID.*
- *I am extremely satisfied with my appraisal today. It helped to review my last 5 years progress and to reflect on my achievements and plan for my future educational needs. This process has been very smooth and the new software is easy to work with.*

2.5 Engagement remains high across the SAS and consultant body, although we are receiving a number of requests for short-term postponement of appraisal, largely due to exceptional personal circumstances or work pressures.

2.6 We continue to refresh, recruit, and retain our team of highly skilled appraisers. The appraiser and revalidation forum is held quarterly to share knowledge, skills and experiences. Training has been implemented for new appraisers, appraisees unfamiliar with the revalidation process, and mandatory refresher training for all current appraisers. 95% of current appraisers have received refresher training with a plan prepared to capture the final 5%. 20 new appraisers have been trained in the last 12 months using the recognised NHSE/I tool. They are delivering appraisal with an experienced mentor until the appropriate experience has been gained. Training for doctors who are new to the revalidation process has been established. This is complemented by an introduction to revalidation at each trust induction for clinical fellows. Guidelines and templates are available for all doctors working for the trust covering preparation for appraisal and revalidation. These guidelines and templates are accessed through secure share point request.

2.7 A quality audit was presented during the April 2019 to March 2020 appraisal year. Data collection is now underway for a repeat audit during the April 2021 to March 2022 appraisal year. This audit follows national guidance and evidence is collected using the Appraisal Summary and PDP Audit Tool (ASPAT).

2.8 Doctors due to revalidate between March 2020 and March 2021 had their revalidation date moved back by 12 months automatically by the GMC, though some have received positive recommendations earlier, if they have presented the appropriate evidence. Advice is offered to doctors where further evidence is required. Doctors due to revalidate between March and July 2021 had their revalidation moved back by 4 months by the GMC. This has resulted in a particularly high number of doctors due for revalidation in 2021/22 and the trust is now progressing through these recommendations. A Revalidation Team meeting chaired by the Responsible Officer has been established and is held every two weeks to assess evidence from appraisal and other appropriate sources, to provide the Responsible Officer with robust evidence to inform his recommendation to the GMC. In doing so the Responsible Officer is aiming to submit earlier revalidation recommendations where doctors have submitted their evidence of professional practice in good time.

2.9 The collection of patient feedback continues to be a challenge in the current working environment. Doctors are given advice and support for this, as required. Support is provided for all doctors who are engaged with the process but who are struggling to collect appropriate evidence because of the pandemic. This might include a recommendation of deferral to the GMC to allow additional time to collect more information.

2.10 Communication with the GMC regarding concerns continues. We continue to develop robust processes for assuring reflection on complaints and serious incidents in which our doctors are involved, including identifying themes that require further exploration and analysis.

2.11 Medical staff case management review meetings continue across all Divisions with additional specific decision-making groups being set up, as required to progress individual matters. Regular review, support and scrutiny meetings are held internally with the Non-Executive Director responsible for the oversight of medical staff case management and externally with the Trust's advisor from NHS Resolution Practitioner Performance Advice Service and the GMC Employer Liaison Adviser. Currently 2 members of medical and dental staff are excluded from full duties and a further 2 have restrictions on practice because of action under Managing High Performance Standards (MHPS) policy.

2.12 The medical appraisal and revalidation policy remains up to date. It is closely aligned to the NHS England framework, with the aim of setting our objectives and standards for medical appraisal and revalidation over the next 3 years.

2.13 Our goals for the year ahead include developing a senior appraiser group to facilitate one-to-one feedback meetings for all our appraisers whilst continuing to maintain our current standards. We are repeating the quality audit after recent training using our new revalidation portfolio software. We will feed back the findings to individual appraisers to support their development.

2.14 Appraisal rates end of Quarter 2 (Trust Compliance):

- Consultants: 92.1%
- SAS doctors: 81.4%
- SAS and Locally-Employed Doctors: 72.8%
- Overall Trust Total: 86.7%

Revalidations April 2021 to September 2021:

- 42 doctors have been revalidated
- 16 doctors had their revalidation deferred
- 1 non-engagement recommendation has been submitted and is under review by the GMC

3.0 Conclusion

3.1 Despite the pandemic, we continue to make our medical appraisal and revalidation processes more robust. We have implemented a new revalidation management system, improved peer networking, and retrained and recruited appraisers effectively. The medical appraisal and revalidation policy has been ratified setting our objectives and standards for the next three years. A Revalidation Team meeting is established to facilitate early and reliable revalidation recommendations. Quality audit and establishment of appraiser peer review remain priorities for the forthcoming year.

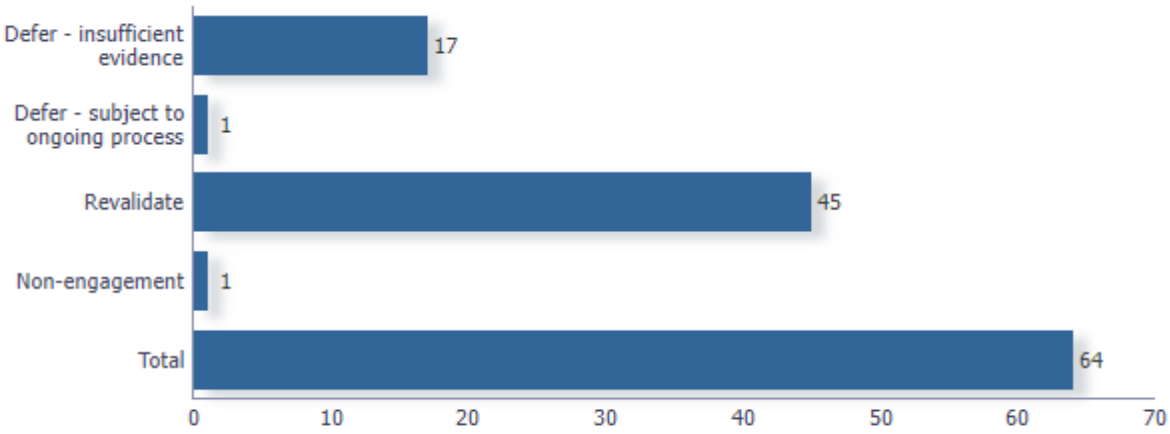
The Board is asked to **NOTE** the contents of this report.

Appendix 1: Revalidation Recommendations 01.04.2021-25.10.2021

Recommendations

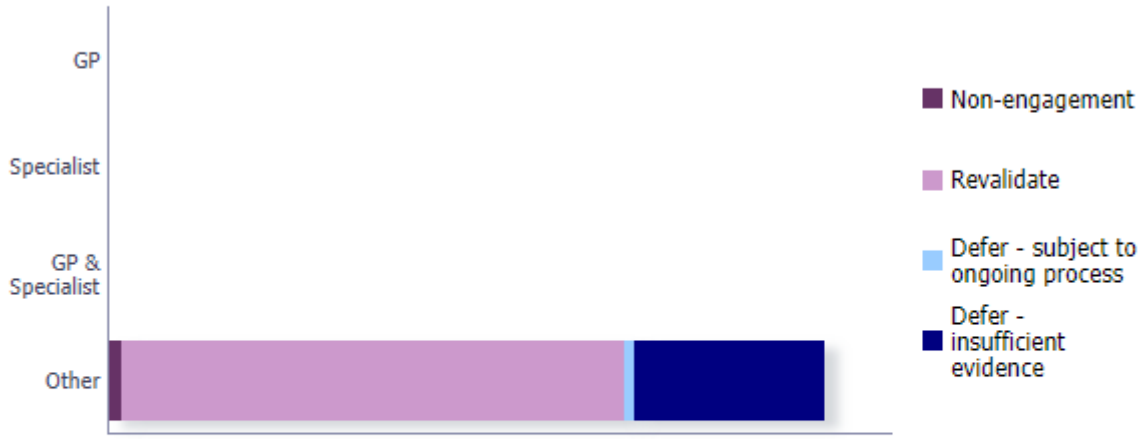
By type

Showing data for your selected organisation



By doctor type

Showing data for your selected organisation

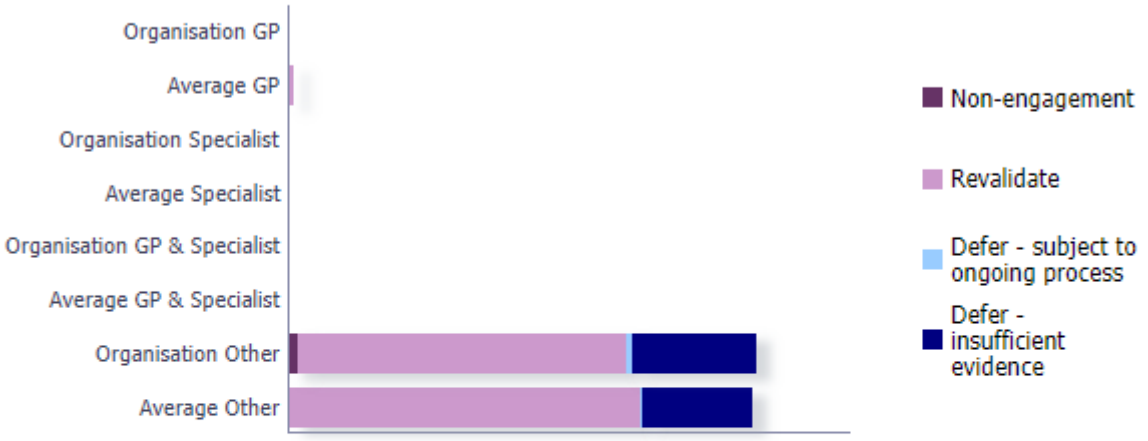


	GP	Specialist	GP & Specialist	Other	Total
Defer - insufficient evidence	0	0	0	17	**17**
Defer - subject to ongoing process	0	0	0	1	**1**
Revalidate	0	0	0	45	**45**
Non-engagement	0	0	0	1	**1**
Total	**0**	**0**	**0**	**64**	**64**

By doctor type

Showing the average for NHS Acute Trust Designated Bodies

Showing as a percentage of recommendations in the selected time period



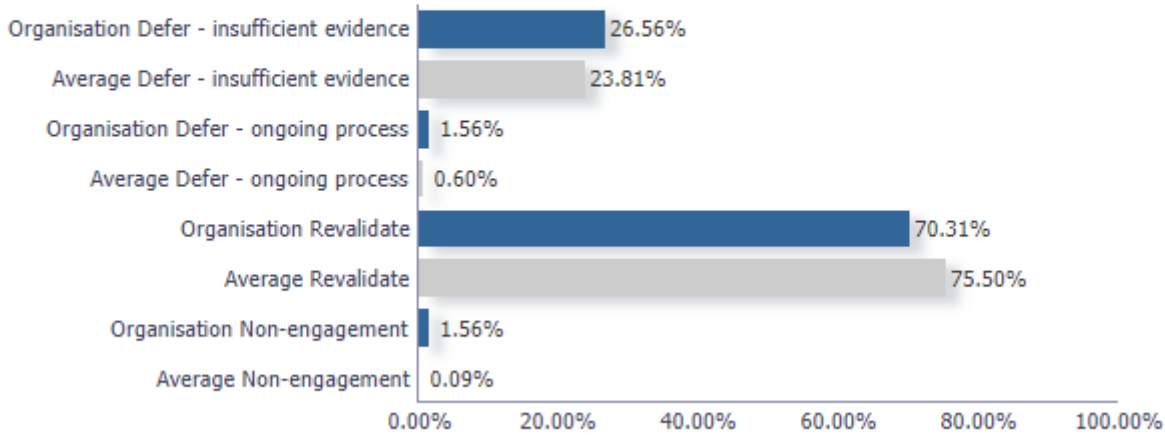
		GP	Specialist	GP & Specialist	Other	Total
Defer - insufficient evidence	*Organisation*	0.00%	0.00%	0.00%	26.56%	**26.56%**
	Average	0.24%	0.00%	0.00%	23.57%	**23.81%**
Defer - subject to ongoing process	*Organisation*	0.00%	0.00%	0.00%	1.56%	**1.56%**
	Average	0.00%	0.00%	0.00%	0.60%	**0.60%**
Revalidate	*Organisation*	0.00%	0.00%	0.00%	70.31%	**70.31%**
	Average	0.75%	0.00%	0.00%	74.75%	**75.50%**
Non-engagement	*Organisation*	0.00%	0.00%	0.00%	1.56%	**1.56%**
	Average	0.00%	0.00%	0.00%	0.09%	**0.09%**

Recommendations

Total recommendations

Showing data for NHS Acute Trust Designated Bodies

Showing as a percentage of recommendations in the selected time period



(Source: GMC Connect Revalidation Dashboard)

The revalidation dates of all doctors due for revalidation between 17 March 2020 and 16 March 2021 were automatically moved by the GMC by 12 months in response to COVID-19. The revalidation dates of all doctors due for revalidation between 17 March 2021 and 31 July 2021 were automatically moved by the GMC by 4 months. In total this affected 120

doctors at SaTH. From June 2020 the GMC began placing these doctors under notice to allow flexibility to submit recommendations where the requirements of revalidation have been met. As such several revalidation recommendations have been completed throughout this financial year. Collecting patient feedback, which is a revalidation requirement for all patient-facing doctors, has proved challenging for many doctors in the current working environment.