AGM questions – 30 September 2024

Question 1: Submitted by Rick Mills, Practice Manager, Mytton Oak Surgery
What is the Trust's plan to build and maintain a better working relationship with primary care and stop the ever-tidal shift of workflow to primary care from secondary care, where a lot of that work is not included in the GMS contract?
Responder: Nigel Lee, Director of Strategy and Partnerships
It is evident that all partners across health and care are under significant pressure, and both primary care (and general practice) as well as the Acute Trust are seeing this. It is also important to see this recognised in the recent national report led by Lord Darzi. Locally, SATH (alongside other partners such as the Integrated Care Board) are keen to develop further the relationship with GPs and primary care more broadly; SATH representatives have attended the GP Board on occasions, and recently the ICB held a session looking at how we (collectively) could take this forward. In parallel, work on the Local Care Transformation pathways is gathering momentum – and together we are all focused on providing optimum care for patients.
Question 2: Submitted by Amanda Jones, CEO, Shropshire Supports Refugees (Reg charity)
My organisation is obviously refugee and migrant based so I will be very interested to hear how you're coping with the new load of cohorts that are now in the county and how we as an organisation can assist.
Responder: Nigel Lee, Director of Strategy and Partnerships
Supporting refugees and migrants is important to the system, and the Integrated Care Board is coordinating actions in this area with partners. There has been a couple of confirmed Tuberculosis cases which will have impacted the TB service. GPs are being asked to refer this cohort for chest xrays. We are aware that there are higher DNA (Did Not Attend) rate, and therefore any help to support this cohort to attend any healthcare appointments would be beneficial.

Question 3: Submitted by a member of the public
Why is the reporting of blood tests and scans for cancer follow ups taking so long?
Responder: Dr John Jones, Medical Director:
Whilst we are unable to comment on individual patient issues, we always prioritise cancer tests and scans. Some specialist blood tests are sent to other laboratories located elsewhere, and these can take longer to process than those done at SaTH. The demand for scans has increased by 15 - 20% in the last 6 months for patients referred on an urgent cancer pathway and all need to be reported by specialist consultant radiologists, of which there is a national shortage and difficult to recruit. We have had some success in recruiting but continue to go out to recruit more. We use external reporting providers to help minimise reporting delays and are investigating other providers who can provide the highest level of quality that is comparable with our substantive consultants. Finally, for patients who are receiving treatment for cancer, NICE guidance has changed on the number and frequency of scans to be provided, meaning that cancer patients are receiving more scans. These all need to be reported by a specialist consultant radiologist and often take much longer to report because changes in the new scan must be examined and compared with the previous scan.
Question 4: Submitted by Becky Smith, People Promise Manager, Shropcom
There has been a lot of talk about collaboration with the ICS, is there any more clarity on what this may look and feel like? Are there any specific plans to move forward with this collaboration?
Responder: Nigel Lee, Director of Strategy and Partnerships
Collaboration between partners will take a number of forms across the Integrated Care System, and a number of developments continue. For SATH, we are a core partner in the Musculo-Skeletal (MSK) programme, where standardisation of referrals, therapy support and other pathways has been implemented. SATH is working closely with Shropshire Community Health Trust in delivering the virtual ward capacity and pathways. SATH also has a collaborative programme with the University Hospitals North Midlands (Stoke), including joint work on Robotic Surgery pathways, Urology and Pathology. Importantly, as a group of partners, we will collaborate on the continued development of Integrated Neighbourhood teams – this is coordinated at the 2 Place Partnership Boards (Telford & Wrekin and Shropshire) – improvements in outcomes for residents will involve multiple partners in collaborative working.

The following questions were submitted by Dianne Peacock, Co-Chair of Riverside Medical Practice PPG
Question 5: What is the clinical and/or financial explanation for the differential percentages in WTEs of the two staff groups over the last two years?
Responder: Rhia Boyode, Director of People and Organisational Development
This relates to Medical and Dental. We have increased our medical workforce in the previous year mainly driven by increases in our trainee doctor grades, but increase up to, and including, Consultant grades to support workforce demand in areas such as the Elective Hub, Community Diagnostic Centre, Acute Floor expansion and to meet demand for our Medicine Consultant workforce, which were areas identified and delivered as part of last year's operational plan. The Healthcare Assistant and other support staff will have increased marginally to meet operational demand. But the main reason for the significant reported increase is that the categorisation of roles changed for the last annual report – i.e. some types of roles were reported under a different staff category in the previous year and this year they have been grouped under other support staff.
Question 6: Question a: Is 'Galvanise' ongoing and now open to all ethnic minority members of staff? If the programme is ongoing, what is the criteria for participation and what percentage of which eligible staff group have attended the 'Galvanise' programme since CQC's visit? If 'no' on either count, why not? **Question b:** Has there been any longitudinal, evaluative feedback from participants on the impact of 'Galvanise' on the first 20 participants' experience of working in SaTH and their opportunities for development?
Responder: Rhia Boyode, Director of People and Organisational Development
a: We launched our third cohort of Galvanise on 25th September 2024. The programme is open to all colleagues from ethnic backgrounds (clinical and non-clinical), so far 18 people have completed the programme (6 on cohort 1, 12 on cohort 2) and we have 19 participants on cohort 3. To date all applicants have been successful in securing a place on the programme. Each participant on cohort 3 is supported by a mentor, line manager and a buddy from one of the previous cohorts. Cohort 2 also includes two participants from Shropshire Community Health, as part of ongoing conversations re: ST&W ICB Inclusive Leadership, Galvanise is one of the programmes that we are able to offer to the wider system in the future.
b: 40 % of the participants have gained a promotion following Galvanise with a further 30% actively seeking their next move. Participants have cited increased levels of confidence, building effective relationships, understanding self and others and gaining deeper insights through conversations with peers and mentors.

During the third cohort we have introduced a group pre and post programme questionnaire to assess learning and potential improvements in understanding and skills as a result of the programme. All participants complete a written essay and deliver a short presentation about their own personal leadership development through the programme.

Question 7: Question a: Given the centrality of these priorities to the 'Getting to Good' framework, why wasn't a brief critical evaluation of progress across priorities included in the Annual Report?

Question b: Why, in the Quality Account 2023/24 papers [p.7] was there an additional priority (nine in total) 'Address and improve care for people with Diabetes (System working)' that did not appear in the Annual Report?

Question c: Where can the public and staff access a succinct narrative annual and longitudinal qualitative and quantitative summary which critically evaluates the **impact** on patient health and wellbeing of achieving, or not achieving, all SaTH's stated priorities for improvement?

Responder to question a: Anna Milanec, Director of Governance

The substantive content of the Annual Report, and the Annual Quality Account, is determined by Trusts' regulators (not the Trust) and is approved by the Board of Directors. Due to the amount of prescriptive content that is required in both Reports and verified by the External Auditors as part of their annual audit, the Trust aims to include the large amount of material that is required, without making the documents too onerous, or repetitive.

With regard to the Getting to Good Framework in particular, progress on its elements is reported as part of as part of the Board of Directors' reports on the Trust website for each meeting held in public. The information also passes through internal governance processes each month to ensure that evidence is provided to verify progress, or not, of the items being tracked.

We also provide a substantial amount of information in our board papers regarding our healthcare targets.

Responder to question b: Hayley Flavell, Director of Nursing

On review of the annual report for 2023/24 it does reference 8 priorities- system diabetic foot priority was not included: page 40. This was included in the final version of the Quality Account for 2023/24 which was after the Annual Report was written.

We noted in the final version of the Quality Account 2023/24 the system diabetic foot pathway had not progressed as we had intended, and this indicator has been carried over into 2024/25. We acknowledged this is very much a system priority, we are keen to support. This was referenced in our final Quality Account uploaded on 1st July 2024.

Responder to question c: Hayley Flavell, Director of Nursing
In public board papers there are longitudinal data sets as part of an integrated performance report that provide information in relation to a selection of important metric relevant to quality and safety. The impact on patient experiences is contained thought quantitative and qualitive feedback in patient surveys, patient feedback PACE panels with specific papers that related to individual services such as maternity and individual sources of quality data such as incident reports and activities coordinated through our patient advice and liaison service. We are considering how we might develop a dashboard that might be of value in future quality accounts to collate information more succinctly.
Question 8: In the short term, what do non-executive Board members consider the main barriers and risks to achieving the further improvements needed to *restore public confidence* [Headline article Shrewsbury Chronicle 19th September 2024], improve patient outcomes by timely access to services, improve the financial balance and deliver the hospitals' transformation programme?
Answer: A response will be sent to the requestor as this question is based on opinion.
Question 9: I understand the Shrewsbury and Telford Hospital NHS Trust Annual General Meeting will not be recorded. When public engagement is being promoted by the NHS, what is the reason for this?
Responder: Anna Milanec, Director of Governance
The Trust has been more transparent in its business dealings over the last 3 – 4 years, than for several years prior to that. This is evident by the number of additional opportunities available to patients, members of our communities, and other stakeholders to engage with the Trust and vice versa: The Trust developed and recruited to a new role over three years ago - the Director of Public Participation - who has a long schedule of public meetings set up for stakeholders to attend, including those relating to the Hospital Transformation Programme. In addition to the activities specifically set up for members of the public to participate in as above, the Trust has also set up public / patient groups, colleagues meet regularly in person with members of the public and service users, increased press releases have been sent out, Board of Directors' meetings are now set up so that anyone can attend in person, and until recently, live streaming of the Ockenden Review Assurance Committee was available. The Trust has also seen a large increase over the last three years for information through our Publication Scheme. All of this is in addition to the substantial increase in scrutiny from healthcare regulators. This is the background as to where the Trust currently sits.

Invites are sent out for the AGM several weeks in advance of the meeting so that stakeholders are able to make arrangements where possible to attend in person, and the formal ‘recording’ of the meeting appears in the minutes of the meeting.

The Trust values meeting individuals face–to-face as this lends itself to building stronger links with members of our communities, patients and other stakeholders. The Trust has not previously been asked for the AGM to be recorded – and this is only the second AGM to be held in public for many years. However, it is something that we will look into for the future if there is demand.