Acting Chairman
31 October 2013

TRUST BOARD MEETING
Held on Thursday 26 September 2013 at 9.30 am
Lecture Theatre, Education Centre,
Princess Royal Hospital

PUBLIC SESSION MINUTES

Present:

Mr M Beardwell  Acting Chair
Mr H Darbhanga  Non Executive Director (NED)
Dr R Hooper  Non Executive Director (NED)
Mr D Jones  Non Executive Director (NED)
Mrs D Leeding  Non Executive Director (NED)
Dr S Walford  Non Executive Director (NED)
Mr P Herring  Chief Executive (CEO)
Mrs S Bloomfield  Acting Director of Quality & Nursing (ADQN)
Dr E Borman  Medical Director (MD)
Mrs D Kadum  Chief Operating Officer (COO)
Mr N Nisbet  Finance Director (FD)

Mrs J Clarke  Director of Corporate Governance/Company Secretary (DCG)

In attendance

Mr A Osborne  Communications Director (CD)
Miss V Maher  Workforce Director (WD) – part meeting
Mrs D Vogler  Director of Business & Enterprise (DBE) – part meeting

Meeting Secretary

Mrs B Graham  Committee Secretary

Apologies:

None

2013.1/238 WELCOME : The Acting Chair welcomed everyone to the meeting. He was delighted to welcome three new members to their first Board meeting. The two new Non Executive Directors (NED) - Donna Leeding and Harmesh Darbhanga - have significant experience in customer service, finance and local government and their range of expertise will prove invaluable to the Board. The Acting Chair also welcomed Sarah Bloomfield in her capacity as Acting Director of Quality & Nursing.

The Acting Chair also recorded the following departures from the Board:

- Earlier in the month Vicky Morris took a secondment opportunity to Betsi Cadwaladr University Health Board and the Acting Chair on behalf of the Board took the opportunity to thank her for her hard work and contribution.
- Dr Peter Vernon, Non Executive Director, left the organisation on 12 September 2013. On behalf of the Board the Acting Chair wished to thank Dr Vernon for his contribution to the local NHS over the last six-and-a-half years. He said Peter had brought extensive experience from innovation and marketing and had been instrumental in strengthening the focus on quality and safety in this Trust in his role as Chair of the Quality & Safety Committee.

2013.1/239 DECLARATION OF INTEREST by members in relation to any matters on the agenda. None.

2013.1/240 MINUTES OF THE MEETINGS HELD IN PUBLIC on 25 July and 12 September 2013 were APPROVED. The DCG confirmed that membership had been quorate at the Annual General Meeting.
<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Description</th>
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<tbody>
<tr>
<td>2013.1/221</td>
<td>CEO’s Report - Pathology</td>
<td>The Chief Executive said he could confirm that the Commissioners will not proceed with the GP pathology services tender and therefore SaTH will continue to provide pathology services for GP practices in Shropshire and Telford. Item complete.</td>
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<tr>
<td>2013.1/224</td>
<td>Integrated Performance report</td>
<td>A&amp;E 4 hour target – Walk-In Centre activity is now included. Item complete. Ambulance Handover – The COO confirmed that the national standard of 60 minutes is a sub set of 30 minute target and that performance is continually under review. Item complete.</td>
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<td>2013.1/226</td>
<td>Booking and Scheduling</td>
<td>The COO advised that the Booking &amp; Scheduling action plan went to the Finance Committee in September but as Sara Biffen, Asst COO, did not attend she will be asked to present this at the next Finance Committee. Item on-going.</td>
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<tr>
<td>2013.1/227</td>
<td>Winter Plan</td>
<td>Item complete.</td>
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<tr>
<td>2013.1/231.2</td>
<td>Sustainable Development Annual Report</td>
<td>Action completed.</td>
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**FORWARD PLAN** for the period September to December 2013 was AGREED. The DCG confirmed that all items listed under 26 September had been included on the Agenda. The QIA element of CIPs was still being finalised and would be presented in the Finance section of the IPR at the next meeting. **Action: FD/ADNQ.**

**2013.1/241 CHAIR’S AWARD**

The Chair’s Award went to Eth Harris, Housekeeper on the Children’s Ward at PRH. Colleagues of Eth have said that her contribution to the ward as a whole goes above and beyond what would be expected and helps to provide the best possible environment for the children in our care. Eth had recently played a pivotal role in the temporary relocation of the Children’s Ward to Ward 14 and her contribution reflects the Trust’s values of Working and Collaborating Together and Taking Pride in our Work and Our Organisation.

**2013.1/242 CHAIR’S UPDATE**

**Update on current Board vacancies:**

- **Appointment of a new Chair** – the Trust Development Authority (TDA) is conducting interviews for a new Chair on 3 October 2013 and the Acting Chair’s term of office has been extended by one month to 31 October to ensure a full handover.
- **Tripartite Meeting** between SaTH and the two Clinical Commissioning Group (CCG) Chairs took place on 1 July 2013. The next meeting is due to take place on 7 October 2013. The Acting Chair said that there is a need to work together for a better health system for Shropshire and this was a very important step forward.
- **AGM and Trust Awards** – A very successful Trust Awards Ceremony and Annual General Meeting was held on 12 September 2013. Nearly 200 members of staff attended and the winners shared in a prize pot of over £5,000. Posters of winning finalists are on display in the corridors of both hospital sites. It was a great opportunity to celebrate the passion and commitment of NHS staff. Mr Darbhanga (NED) said he was impressed with the attendance of staff, however, it was noted that there were only five members of the public present. He asked how the Board could encourage the public to attend these events. The CEO said that the Trust advertises widely but attendance was disappointing and we will double our efforts next year. From his experience when an organisation becomes an FT with true membership it encourages more members of the public to attend.
- **Topping Out Ceremony at the Women & Children’s Unit following this meeting.** The Acting Chair said this is a very exciting time as it will mark the point when the roof is complete and the focus shifts from erecting the building to creating state-of-the-art clinical facilities.

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Acting Chair
31 October 2013
Members NOTED the following verbal report:

**Stroke Services** – the CEO reminded the Board that in June there were short term challenges around consultant staffing which coincided with the main holiday period and it was difficult to cover the Stroke Services on both sites. On a temporary basis it was decided to provide a single Stroke Service on PRH site for the months of July and August for hyper-acute and acute stroke services. Whilst the unification of hyper-acute and acute stroke services was only intended as a short term step in response to consultant staffing challenges, there have been some significant clinical outcome benefits during this period. Clinicians in the Trust therefore asked for a time extension to the single-site model and, in discussion with our Commissioners and with the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, a decision was taken to temporarily extend the unified service in the short-term. It is important to celebrate the positives because the temporary change has resulted in speedier and better service for patients.

For the medium term the Board will need to remain receptive to all possible options. This could include:

- Maintaining single site hyper acute stroke unit (HASU) and acute stroke unit (ASU) at Telford;
- switching to single site HASU and ASU at Shrewsbury
- reverting back to a two-site service

Factors for consideration will include clinical outcomes, feasibility, access, patient experience and wider service impact in the context of our wider plans for sustaining safe and timely services during the winter which will be discussed later. Clinicians and managers have been looking in detail at all aspects of the service, both in-hospital and the pre- and post-hospital care. A meeting will take place with Trust clinicians and managers and external partners before the end of the month to review, update the quality impact assessment and propose a way forward. The CEO said he will expect to update the Board on the proposed way forward at the next Board meeting. Any recommendation will be for the short term.

The CEO stressed that the longer term shape of stroke services will only be decided as part of the Clinical Services Strategy which is being developed over the next six to nine months (to be discussed later).

Dr Walford (NED) raised a concern that whilst reading the media coverage on this subject he felt that SaTH had not fully explained that whilst the Hyper/Stroke Service had been transferred on a temporary basis it did not include centralising the Rehabilitation pathway which remains on both sites close to where patients reside. The CEO accepted this point and said this message would be reinforced. Action: CEO/CD.

Mr Jones (NED) asked if the temporary arrangement would continue until Clinical Service Strategy. The CEO said that the clinical experts need to discuss this before the end of the month. The Medical Director added that there was general support of the unification from most of the clinicians and nurses. The CEO said the service would ultimately deteriorate if it reverted back given the bed pressures in Shrewsbury. The Board will receive a progress report at the next meeting. Action: CD – Oct 2013.

**The Audiology Team** has recently been awarded an Improving Quality and Physiological Diagnostic Services (IQIPS) Accreditation. This is a programme hosted by the Accreditation Unit of the Royal College of Physicians (RCP) with support from the Department of Health. SaTH was only one of five Trusts in England that achieved this accreditation. It is a great credit to the Audiology Department. The CEO said that this gives the Trust a commercial advantage however there is no strategy to market the service at the moment but it is feasible as a future development but that additional income of circa £1m net had already been received. Press coverage is being arranged with regard to the Accreditation.
CHIEF EXECUTIVE’S REPORT (Continued)

2nd Leadership Conference will take place next week at the Shropshire Education & Conference Centre in Shrewsbury. This will provide an opportunity for around 200 senior colleagues from the Trust to develop and share their skills for leading improvement in outcomes, safety and experience for our patients. The CEO said that he will be launching the organisational values which had been drawn up through staff engagement throughout the Trust to become a values driven organisation. This development will be fundamental to our processes to try to improve the way staff feel about the organisation.

2013.1/244

KEY SUMMARY UPDATES FROM TRUST COMMITTEE MEETINGS were RECEIVED and NOTED.

- Audit Committee meeting held on 19 September 2013 – Dr Hooper (NED) thanked the DCG and Finance Team for their support. He drew the Board’s attention to potential concerns from the External Auditors about the control and regulation of data, specifically “cashing up” following outpatient clinics, to ensure all actions required for the patients are followed up. The DCG advised that a number of reports had been submitted to the Finance Committee regarding this issue. The COO said that much of the problem relates to a lack of personal responsibility but this is being addressed through performance management and culturally through setting clear values in the organisation. The FD advised that work is also progressing to cleanse data and processes. The COO confirmed that there are now standard operating procedures in place. The CEO said that he and the COO had attended a Referral to Treatment Summit (RTT) on 25 September 2013 which demonstrated how far SaTH is behind other organisations in terms of poor processes and unclear responsibilities. Dr Hooper (NED) said that he was not assured of the issue of data because he felt the whole issue linked to appraisal, training and communication. The COO confirmed that there needs to be a massive shift in behaviour however there are parts of the organisation that are working extremely well.

- Charitable Funds Committee (CFC) meetings - minutes held on 9 May and key summary from 5 September 2013 were noted. The Acting Chair, as Chair of the CFC, said that the pilot Patient WiFi will be implemented at RSH during October and it is hoped that it will be rolled out throughout the organisation. He said it was a step forward and should prove of great benefit to patients receiving treatment. The CFC also gave support to a potential joint venture with the League of Friends to purchase Echocardiography Machines for the hospital.

- Finance Committee meeting held on 24 September 2013 – Key Summary Paper TABLED. Finance Committee and HEC key summary (below) raised serious concerns relating to the current financial position – this issue will be discussed under the Finance section of the Integrated Performance Report (IPR). On a positive note Mr Jones (NED) said the Future Configuration of Hospital Services (FCHS) project remains largely on track, on budget and is progressing well.

- Hospital Executive Committee (HEC) meeting on 24 September 2013 – Key Summary Paper TABLED. The CEO reported that the Escalation Plan had been agreed and ratified for implementation. Each Care Group delivered a presentation outlining their respective business plans. He said he was hugely impressed with their efforts and these will be shared with the Board in due course. He told the Care Groups that because of the historical issues within the organisation the road to recovery will be somewhat rocky but they need to remain very positive through significant change.

- Quality & Safety Committee meeting held on 19 September 2013 – Dr Walford (NED) referred to the good appointment of the new Complaints Manager to improve timeliness of complaints responses. The Committee discussed the Falls Action Plan and the associated cost (this would be discussed under the Finance section of the IPR). Also discussed the Trust’s response to Reports and Inquiries in relation to nursing ratio and the use of the “Safer Nursing Care Tool” however it was too early to make any informed assessment of likely resource implications.

- Workforce Committee meeting held on 16 August 2013. It was noted that sickness had deteriorated for one month but in general terms had improved. The CEO confirmed that the Trust aspires to reach 100% appraisal of eligible people.
KEY SUMMARY UPDATES FROM TRUST COMMITTEE MEETINGS (Continued)

- Risk Committee held on 14 August 2013. The CEO said that the Terms of Reference were reviewed. The Board Assurance Framework was reviewed (to be discussed later). The Falls related risk was escalated to 25 because there are still concerns over the number of serious RIDDOR reportable falls. It was highlighted that a number of risks on the risk register centred around staff engagement and people management and this would be considered as part of change programme around culture.

INTEGRATED PERFORMANCE REPORT (IPR), BOARD GOVERNANCE AND MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS

The Board RECEIVED the Integrated Performance Report (IPR) in respect of the month of August 2013 which summarised the Trust's performance against all the key quality, finance, compliance and workforce targets and indicators for 2013/14. The CEO said that the report showed that the Trust dipped in a number of key areas and although disappointing there were a number of underlying issues contributing to this and there is a need to learn from this and ensure in August next year we have more robust processes around the implementation of junior doctors handover; and delays in social care and discharge processes and getting a tighter grip of the financial position around income. The CEO said that he intended to convert the existing Cost Improvement Board into the Financial Recovery Board which would cover wider issues and which he would personally chair to demonstrate the importance of this issue.

QUALITY : Patient Safety, Effectiveness and Patient Experience - The Acting Director of Quality & Nursing (ADQN) introduced the report and briefed the Board of the following points:

- **Serious Incidents** (3.2) - There were twelve SIs reported in August. There were no Never Events. A reduction of outstanding SIs has been commended by the Commissioners.
- **RIDDOR Reportable Falls** (3.4) - There were four RIDDOR/SI reportable falls reported in the month of August. Two on the same ward and therefore the focus will be on this ward. The other two were of lesser harm to the patients. Generally the ADQN felt that standard of care is improving although it is disappointing that the number of serious falls is still unacceptable. Root Cause Analysis (RCAs) are ongoing and there has been a change in the process of holding staff to account and requirements have been communicated to Ward Managers.
- **Pressure Ulcers (PUs)** (3.3) – There were three Grade 3 pressure ulcers in August and no avoidable Grade 4 pressure ulcers reported since April 2013. Although there has been a 50% reduction the Trust aspires to achieve zero pressure ulcers.
- **Infection Control** (3.5): **MRSA Bacteraemia** – there was one case in July and it was the first case in 495 days. The bacteraemia was not a contaminant. Lessons are to be learnt and shared. **C difficile** – there were two cases in July and six cases in August resulting in the Trust being above the trajectory target. An internal action plan to drive the numbers down is being actively managed to return performance to within trajectory. It was noted that Elective MRSA screening is improving.
- **WHO Surgical Checklist Compliance Audit** (3.6) – performance remains at 100%. 63 operating lists were audited therefore a reasonable sample size for assurance.
- **Maternity Dashboard** performance is on “red” due to smoking cessation – women smoking at point of delivery. This is a local target and discussions are ongoing to improve performance.
- **Mortality – Risk Adjusted Mortality Indicator (RAMI)** (3.8) – the Medical Director (MD) said that the Trust achieved a risk-adjusted score of 79 in June against a National Peer Group score of all Acute Trusts in England of 95. This is a considerable improvement on the previous six months when we were consistently above the National Peer Group.
- **Venous Thromboembolism (VTE) Assessments** (3.9) - For the first time the Trust has managed to sustain delivery against the national target which is very pleasing. The MD said that he would like to see even better levels and therefore very soon individual VTE figures by Consultant and by Ward will be displayed for patients and relatives to view.
- **Friends & Family Test** (3.10) – the overall Trust rating for August was 4.7 out of a total scoring of 5. There is a revised plan in place for next month.
Wards subject to a Quality Improvement Framework (QIF) (3.12) – There were currently three Wards subject to a Quality Improvement Framework i.e. Wards 10, 12 and 22T/O. Each of the wards is being supported by a team of senior nurses, matrons and PEIP members to deliver sustained improvements to their care delivery. The ADQN will look to review two of the Wards (12 and 22T/O) during September, with a plan to remove them from the formal framework if there is evidence of sustained improvement.

Coroner Inquests and Rule 43 (3.13) – There were two Coroner Inquests undertaken during August. Both concluded as accidental deaths. There have been no Rule 43 reports in August 2013.

The ADQN said that a number of Workshops had been held to discuss patient care metrics and it had been agreed to make some changes with the aim of giving greater assurance to the Board.

On the issue of deterioration of discharge rates, the COO said she is personally leading the project focusing on “simple” discharge. There is an action plan and SaTH has joined up with others across the community to improve the process.

On the issue of Junior Doctors – the CEO said that changeover takes place in August and February and this provides a greater risk whilst they get used to new procedures including antibiotic prescribing. They may be risk adverse around admitting people and slower in the discharge process. It is necessary to make sure during the period of handover that we supplement senior doctor cover.

OPERATIONAL PERFORMANCE - The Chief Operating Officer (COO) introduced Section 4 of the report:

Cancer targets – In August performance over a wide range of cancer targets was disappointing (unvalidated position showed the Trust failed to deliver 5 of the 9 standard cancer targets). A joint investigation with CCGs, at their request, is being undertaken and a revised action plan will be formulated to deliver sustainable cancer performance within three months. The plan will be brought back to the Board in October. **Action: COO – Oct 2013.**

Stroke – continues to be performed on a single site and performance against the standard of patients stay on a stroke ward was at the highest it has been this year at 90.32% against a target of 80%.

A&E 4 hour wait target – following 3 months of delivery in May, June and July, the Trust failed to achieve the target in August. Whilst partly due to junior doctor handover, the main reason was due to the increase in the number of patients on the ‘safe to transfer’ list and number of beds available in the community. On 9 September 2013 the Trust had 89 patients on the ‘safe to transfer’ list compared to a patient safety level of 30 patients. The COO said the pressure is being managed proactively and cancellation of elective patients is being kept to a minimum. It was noted that the Shropshire CCG this week will agree to purchase additional beds.

Referral to Treatment (RTT) position – although the Trust failed the target, performance had improved. The CEO, COO and Assn COO Scheduled Care attended the TDA Summit on RTT delivery with 21 other organisations. The COO will be developing an action plan and will approach the Elective Care Intensive Support Team to request increased support, although it was noted that it normally takes at least five months to clear a backlog.

52 week RTT breaches – in relation to the technical issue discovered in July, the COO advised that following validation there were five breaches in Quarter 1, five breaches in July, six in August plus a further 28 identified, making a total of 44 breaches. All remaining 28 patients now have TCI dates. The COO advised that she will be reviewing reports to the Board to ensure assurances are in place.
INTEGRATED PERFORMANCE REPORT (IPR), BOARD GOVERNANCE AND MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS (Continued)

Dr Hooper (NED) advised that the Audit Committee through their Terms of Reference had debated whether to call the Trust’s partners i.e. two CCGs, two Councils and the Community Trust to the Audit Committee to discuss patient flow, specifically the reason why patients remain in hospital when safe to transfer. It has had serious implications for SaTH in failing our 4 hour A&E target, the RTT targets and is resulting in losing income and potential reputation of the Trust. The CEO said there is acceptance within the health economy that we need to do things differently and although Dr Hooper’s analysis was correct, SaTH has no authority to hold partners to account but should exercise the issue through the correct bodies e.g. NTDA who then talks to NHS England which holds CCGs to account. The Acting Chair said he was satisfied at the moment that there is adequate pressure being exercised by the CEO and the Executive Team. The MD said that even in the short time he has been in the Trust he had seen considerable advances in working co-operatively with health care partners. He supported the CEO and felt we are all more likely to succeed with health care partners working collaboratively.

The CEO advised that another impact facing SaTH relates to Telford & Wrekin Council’s decision to reduce its spend on Social Care because of their overspend. Having discussed with the COO it is clear that health services will need to respond to this decision as this is likely to further exacerbate the discharge situations.

The Acting Chair said that through the Tripartite meeting there is a need for collaborative arrangements and common understanding how to develop a better health system.

**FINANCE** - The Finance Director (FD) introduced this section of the report and said that the headline position at Month 5 was that the Trust had a significant and unplanned overspend of circa £5 million. Without remedial action it was likely that the Trust would be facing a £9 million deficit at year end. There were a number of factors contributing to the position which he outlined:

**Income**: At the end of August the Trust had underachieved against the Income target by £1.422m. This unexpected reduction was due to underperformance consistent in all areas of activity but predominantly elective inpatients and day case activity. Page 19 income activity showed 4% down in A&E, 1.5% down in Outpatients attendances, 7.7% down in elective day cases, 11% down in elective inpatients and 2% down in emergency inpatients. This is significantly impacting on the Trust’s financial position.

**Pay spending**: Up to the end of November, the 3 month moving average monthly pay spend operated within a £16.7m to £16.8m range. From December to March it increased from £16.6m to £17.4m and since May had marginally reduced to £17.3m but this still exceeded the levels contained in the Financial Recovery Plan by £775k. This figure needs to reduce to an average of £16.5m for the rest of the year to achieve a balanced financial position by year end. Whilst income had fallen, the level of activity in first four months is consistent with contract delivery i.e. Income is not expected to grow from now to end of the year. If Pay spend continues to grow it will produce very significant problem. Without corrective action the Trust will face a deficit of £9.8 million. Corrective actions have been identified, and if undertaken, it is believed it will bring the deficit down to £3 million by year end but it is not believed that corrective actions will bring the Trust back to a breakeven position by year end. It was noted that the NTDA expected a break even position but were currently working on a forecast deficit of £2.4 million. The corrective actions include:

- **Income** – looking at ways to draw back performance over the remaining 6 months of the year;
- **Bank and Agency staff** – 400 wte presently employed, need to make a substantial reduction to save £3.7 million over the next 6 months of the year. However there are significant operational issues that need to be considered first. A major element is within nursing and nursing over-establishments. The ADQN said that discussions are planned from tomorrow with Heads of Nursing, Matrons and Ward Managers to look at each ward for headcount on a case by case basis bearing in mind clinical risk, sickness levels etc. Excessive sickness levels in some areas made reductions more difficult but sickness is being robustly managed moving forward to make sure it is sustainable. The ADQN said she expected to be in a position by close of play on 27 September, from a clinical risk perspective, to take on recovery plans by each ward. Also there have been a number of improvements to staffing and supervisory levels which are cost neutral.
FINANCE (Continued)

- Enhanced Patient Support (EPS) - revise the amount of 40 wte employed to support EPS. Last year 22 wte were employed and it is planned to revert back to this figure. The ADQN said that EPS is used mainly in Medical Wards for dementia patients, disabled, aggressive or patients who could be subject to harm. Following discussion with senior nurses and ward managers they are extremely supportive in changing our current guidelines to trigger EPS cover by changing the approach to request and authorisation so that it is based on clinical risk to the patient. This will be audited to ensure patient safety is maintained. There is confidence around this reduction provided the recruitment plan is also implemented to appoint into substantive posts.

- Sickness – there is an opportunity to substantially reduce the over-establishment. The COO and ADQN have been reviewing the information to determine the availability of making the EPS change and reducing over establishment and it was planned to implement these changes from 9 October 2013.

The FD said that it is going to be very challenging to bring down this level of spend but it is important to come to a conclusion around the recovery plan and to do it very quickly. Mr Jones (NED) expressed concern that the growth in pay costs did not relate to activity and that a year ago agency staff were converted into permanent posts and based on the current explanations it seemed little had changed. Without immediate remedial actions the position would become increasingly difficult to address by year end and a deficit outturn impacts on our longer-term plans in relation to Foundation Trust, so felt there was very fragile assurance. The CEO advised that the Financial Recovery Plan (FRP) was being reconstructed and would also be looking at recovery of income. There was historically a lack of budget management and confusion about nurse staffing levels which were now being addressed. The Acting Chair said it would be helpful if the Financial Recovery Plan can be brought back to the Board. **Action: CEO/FD – Oct 2013.**

**Non Pay** – using the 3-month average spending to establish the underlying rate of non pay spending indicates that the Trust is spending at an average rate of £7.1 to £7.3 million (currently £7.28 million) For the period September 2013 to March 2014 this needs to be contained within £7.613 million.

Mrs Leeding (NED) asked how Pay had got out of hand over the last few months and why there had been no control by managers who should manage their budgets. The CEO said there had been great confusion around nursing levels and increased levels of EPS which have gone beyond anticipated levels. The COO and ADQN will remove this confusion. They had put controls in to Heads of Nursing to only sign off agency staff but it has not been enough.

Following concerns from Mr Jones (NED) that there is no long-term strategic plan for formal FT purposes, the CEO said it is his intention to put in additional controls at the earliest opportunity.

In relation to cash position the FD said work is underway to maximise the level of creditor suppression i.e. the ability to make payment at a level to be consistent with 90-95% target is not currently an option for us and would only be possible if we receive a £10 million cash injection. In the absence of that we always aim to pay people in order but not necessarily within the 30 days limit. Dr Hooper (NED) asked what the Board could do to encourage the TDA not to penalise the Trust. The FD said the TDA have made available £3 million of temporary borrowing which will continue to the end of March 2014, but will then have to be repaid. In order to avoid a significant cash problem we need to get our spending down and have discussion with the NTDA to get a permanent injection of cash.

Dr Walford (NED) said he was concerned about the Board’s fiduciary duties; the health service was strategically recalibrating itself after the Francis Report, Keogh Review etc., and in doing so had raised the patient experience and safety to higher levels, so SaTH needs to balance these priorities as well as informing the community that we cannot continue providing services in the current configuration.
INTEGRATED PERFORMANCE REPORT (IPR), BOARD GOVERNANCE AND MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS (Continued)

WORKFORCE report was received and NOTED.

MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS

Page 27 Appendix 1 and 2 - Monthly Self Certifications – NTDA Requirement
The Trust followed the formal process and was submitting the monthly self certifications templates for August:

1. **Monitor Licensing Requirements** – covering Monitor licence requirements. A summary of the submission was included at Appendix 1 of the report. All conditions were marked compliant.

2. **Trust Board Statements covering clinical quality, finance and governance** was included in the report at Appendix 2. The Trust is currently rated as having material issues “red” in Governance and Finance risk Rating.

The Board confirmed it will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times. The Board NOTED the Integrated Performance Report for August 2013 and APPROVED the self certification submissions to the NTDA.

2013.1/246.1

WINTER PLAN – TDA WINTER PLAN SUBMISSION

The COO presented the Winter Plan submission which is required by the Trust Development Authority and has to be signed off by the Board before 30 September 2013. She advised that the TDA will use the submitted winter operational plan and completed template to gain assurance that the Trust has planned to deliver sufficient capacity based on predicted activity. The COO said internal arrangements aim to ensure there is sufficient capacity to meet demand, particularly in the Emergency Department (ED) with plans in place for medical and nurse recruitment to address staffing numbers and skillmix; additional capacity in terms of beds with plans in place to create 60 additional community beds and plans to increase support services and staff during the winter period. This will include senior review on attendance/admission to ED/Acute Medical Unit (AMU) as early as possible following patient presentation, with daily senior review of all patients and same day access to diagnostics for inpatients, and clear, robust arrangements around discharge planning.

The COO referred to Page 16 and confirmed that the Board will receive monthly reports on the effectiveness of the Winter Plan as part of the IPR. Page 21 detailed key risks which include insufficient inpatient bedded capacity within the Trust, inability to recruit relevant staff, and insufficient pull from the community to reduce the fit to transfer list to create capacity. An additional risk around norovirus and flu pandemic was also described. The COO said that whilst last year was difficult there was no massive outbreak of flu but if this happened this year it would put increased pressure on beds. The Trust is also required to immunise 75% of its staff and SaTH has been very proactive in this and had managed to acquire adequate supplies.

Emergency Department Consultant recruitment is ongoing. It remains a risk and it is a national problem. As part of the plan there are schemes in place to provide an additional 60 beds outside the hospital and 9 virtual beds. The COO said that the difference for SaTH this winter as opposed to last winter will be a more robust internal Winter Plan, new protocols, permanent staffing in escalation areas, new operational team structure, improved patient flow processes in Emergency Departments and discharge planning; and the whole health economy working together.
WINTER PLAN – TDA WINTER PLAN SUBMISSION (Continued)

In answer to questions from the NEDs, the COO confirmed that:
- 7 day working is affordable - Radiology has already gone through management of change and provides 7 day working and also some Physiotherapists;
- Bed modelling had taken place and lessons had been learnt over the last couple of years to prepare our internal plan;
- It was confirmed that other health organisations have a role to play in delivering the Winter Plan and therefore will be held to account for non delivery of their part through Areas Teams and through the TDA.
- The COO will monitor the position on a weekly basis.

The Board APPROVED the Winter Planning Assurance submission for sign off to the TDA but with the expectation that to do so will require health community partners to deliver their elements.

2013.1/246.2
WINTER PLAN – LOCAL HEALTH ECONOMY WINTER PLAN

The COO presented a summary of the plans to utilise the additional winter funding that has been made available across the local health and social care economy. The detailed plan is subject to sign off from the Secretary of State. An amendment was made at Paragraph 8 which should have read “SaTH’s proportion of the £4 million is £1.2 million...”. The Board NOTED the Local Health and Social Care Economy Plan.

2013.1/247
A CALL TO ACTION / CLINICAL SERVICE STRATEGY UPDATE

The CEO introduced this item and gave the presentation “Call to Action/Clinical Services Strategy update” which has also been received by Clinical Commissioning Groups (CCGs), Councils and Joint Health Overview & Scrutiny Committee. Each organisation is being asked to understand how this debate is being taken forward particularly in relation to many challenges facing delivery of sustainable hospital services (copy of slides attached to the minutes).

The aims of “Call to Action” are as follows:
- To have an honest and realistic debate about health and care;
- To agree our shared priorities;
- To help local people understand why the NHS needs to change;
- To work in partnership on the bold actions needed to build an excellent NHS now and for the future;
- To set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered;
- To provide an opportunity to share your views and ideas on the future of the NHS.

Nationally this means the NHS will need to:
- Shift the focus from buildings to services
- Meet the needs of an ageing population, many of whom are living with multiple long term conditions, through strengthened care closer to home
- Changing, not charging
- Openness and transparency about where we get it right and where we get it wrong
- An honest and realistic debate across the country about how the NHS will be shaped

Locally there are a number of challenges that the health community face. These include in acute services:
- Increasingly moving to consultant-led service with appropriate levels of sub-specialisation to provide the best care, e.g. Intensive Therapy Unit, Accident & Emergency, Stroke Services
- National workforce challenges in key areas that reduce our ability to recruit and retain, e.g. A&E and Paediatrics
- Local workforce challenges, with split-site services and onerous on-call arrangements making roles unattractive
- Poor supporting infrastructure in key areas, e.g. A&E, Critical Care
A CALL TO ACTION / CLINICAL SERVICE STRATEGY UPDATE (Continued)

In community services there are challenges around:
- Supporting people in the community to maintain their independence
- Providing care closer to home in a very rural county
- Rising demand

The CCGs will use the feedback from Call to Action (and other involvement/engagement) to inform development of 3-5 year commissioning plans. This will inform a Clinical Services Strategy review which will develop options for the future of local hospital services.

The Board NOTED the contents of the presentation.

TO RECEIVE AND REVIEW GOVERNANCE AND COMPLIANCE UPDATES:

TO APPROVE STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

The Finance Director (FD) introduced this item and advised that a review of the Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board had taken place with key changes outlined in the paper. The Board NOTED the key changes and APPROVED the documents.

BOARD ASSURANCE FRAMEWORK AND RISK REGISTER

The Chief Executive presented this item and advised that the Risk Committee met on 14 August 2013 and reviewed the Board Assurance Framework and Risk Register. The Committee determined that:

- The Falls Prevention Risk (RR96) should be separated under the overall part of delivering safe care risk, and classed as a high risk.
- People & Innovation (RR423) - recent staff engagement and work done around values has been very positive but it was decided to keep this as Amber as it is only the first part of the programme.
- Patient Flow and matching demand with capacity (RR561) had been covered under the IPR section of the meeting and will continue to be High Risk.
- Clinical Service Vision (RR668) – was dealt with under “Call to Action” presentation, however, whilst progress is being made this should remain on Amber.
- Governance (RR669) – Until a new Chair has been appointed (interviews due 3 October) and subsequent NED appointed the risk remains on Amber.
- Financial position (RR670) – Is High Risk.

The Acting Chair said that Board assurance on its principle risks is absolutely vital. Dr Hooper (NED) confirmed that members of the Risk Committee were satisfied with assurances in place. The Board REVIEWED and APPROVED the Board Assurance Framework and CONSIDERED that presently no additional assurances were necessary to assure the Board that the risks to the strategic objectives are being properly managed.

ANNUAL AUDIT LETTER 2012/13

The Finance Director (FD) presented the Annual Audit Letter for 2012/13 which summarised key issues arising from the work that the Trust’s external auditors KPMG carried out during 2012/13. The letter will be published on the Audit Commission’s website. The letter highlights areas of good performance and also provides recommendations to help the Trust improve performance. Key recommendations were highlighted in Appendix A. The Audit Committee received the Annual Audit Letter at its meeting on 19 September by KPMG.

The Board NOTED the content of the Annual Audit Letter 2012/13 and APPROVED its publication on the Trust’s website.
249.1 RESEARCH AND DEVELOPMENT (R&D) ANNUAL REPORT 2012/13

The Medical Director (MD) presented the R&D Annual Report for 2012/13 which provided an overview of the work of the R&D Department in 2012/13. It demonstrated very good work being undertaken throughout the Trust. The report includes patient recruitment into clinical trials for the year, research and financial governance and a summary of the aims, objectives and challenges for 2013/14. In terms of recruitment of patients participating in clinical trials, although this has fallen, income linked with the private sector remains very healthy. The R&D Department is fully self-funded.

The MD said he was pleased to champion this area and particularly as it won its first Trust Award for Research and Development. The Board NOTED the R&D Annual Report for 2012/13.

249.2 INTEGRATED EDUCATION ANNUAL REPORT 2012/13

The Workforce Director (WD) introduced this item and said that education and learning is a valued and key activity in the organisation in supporting staff to improve the quality of the service they deliver and the outcomes for patients. During 2012/13 the Trust provided over 80 Foundation Doctor training positions in conjunction with the West Midlands Deanery and supported 161 staff to complete vocational qualifications. There is still a need to improve statutory and mandatory training requirements, this was highlighted in the report and will be managed through the Workforce Committee.

The Board NOTED the Integrated Education Annual Report 2012/13. The Acting Chair said the Annual Report was a very comprehensive document and on behalf of the Board he wished to thank the authors for their hard work in compiling this. The Board would reflect on the fact that 80% of staff are taking a learning opportunity. It was noted that a full Training Report will be presented to the Board in November.


250 FALLS ACTION PLAN UPDATE

The Acting Director of Quality & Nursing (ADQN) introduced the paper which provided an overview of the actions to reduce, as far as possible, patient falls within SaTH and includes assurance to the Board that the Trust is reviewing falls across the Trust on a monthly basis via the Falls Prevention Task Group; and measures are being implemented to prevent falls via a planned approach. The report also provided data and comparative data on falls performance within the Trust, which showed that the Trust was currently slightly below the National patient Safety Agency (NPSA) mean of 5.6 per 1000 bed days. There was no comparative data available in relation to the more serious, RIDDOR-reportable falls. It was noted that the prevention of falls is a major issue for the NHS and that nationally 30% of people over 65 fall each year and this risk increases with age. Nationally more than half of all inpatient falls in acute hospitals occur at the bedside, during transfer or when patients mobilise to use the bathroom. The review and audit of nursing documentation will be an ongoing priority in order to embed the need and thoroughness of robust risk assessment and record keeping in relation to reducing the risk of falls. The training and education of staff regarding falls will continue to form part of mitigating actions against falls. In order to support thorough record keeping in relation to falls, there have been a number of changes to the nursing documentation to assist the nursing staff and these changes have been reviewed and overseen by Corporate Nursing, Health & Safety services and Legal services/Health & Safety team. The review and falls management within the Trust will continue to be overseen by the Task Group and reported to the Clinical Governance Executive and Quality & Safety Committee.
2013.1/250 FALLS ACTION PLAN UPDATE (Continued)

In answer to questions from the NEDs, the following points were noted:

- An independent audit is being undertaken by Deloitte, the Trust’s internal auditors, which has been commissioned by the Audit Committee. There is an experienced clinical lead involved in the assessment to ensure all aspects of local practice are thoroughly audited.
- Mr Jones (NED) expressed disappointment at the comment that it was difficult to benchmark other organisations. It was noted that some Trusts report slightly differently. **Action: ADQN will ask comparative Trusts.** It was noted that SaTH had asked Deloitte to provide feedback and this will be reported to Audit Committee when the report is finalised and the action plan will be monitored through Quality & Safety Committee.

The Board **NOTED** the report.

2013.1/251 CQC ACTION PLAN UPDATE - following an unannounced CQC Inspection at PRH in April 2013.

The ADQN introduced an update of actions undertaken to provide assurance against the standards for Outcomes 1 and 4. It was noted that the CQC visited 3 Wards and gave very balanced feedback however there was a level of concern with some practices i.e.

(1) Respecting and involving people who use services and  
(4) Care and welfare of people who use services.

The action plan had been submitted to the CQC who were very happy with the format. There was also a review and audit of nursing documentation to embed actions and ensure that improvements are sustained. Also the ongoing training and education of staff regarding the importance of respecting and involving people who use our services and their care and welfare will continue to form part of the actions to prevent poor patient experiences and outcomes. It is likely that they will visit again before the end of the calendar year to demonstrate that we have embedded the necessary actions.

The Board **NOTED** and **REVIEWED** the report.
2013.1/252 QUESTIONS FROM THE FLOOR RELATING TO ITEMS ON THE AGENDA

Mr Ron Jones TABLED a paper which detailed 3 questions:

Q1 When committing itself to the work associated with FCHS in August 2010, the Board set down three Principles:
1. Two vibrant and well balanced Hospitals;
2. Commitment to A&E Services on both sites;
3. Access to General Surgery on both sites

Mr Jones asked: if these principles were based on poor judgement by the Board in 2010 and on a false premise; were the public misled during 2010 and 2012 on the Board’s commitment to these principles; were local, national clinical teams and various local representative bodies misled by the Board during and after consultation about the validity and seriousness of adherence to these three principles or had the CEO overstepped his responsibility in making statements (identifying that A&E may not exist in the future) which have not been discussed or agreed by the Board, and appear to be set against agreed Board principles and stated Trust Board promises to the public?

Q2 The Board has not received an update on FCHS since 28 March 2013 and the Board has not discussed or agreed publicly over the past 6 months any new public discussion or new public consultation about the configuration of hospital services in Shropshire. This new initiative does not appear in any Board document between April 2012 and not in 2012 Annual Report under Looking Ahead or in Strategic Context. Has the recently announced Public Review/Debate/Consultation on Configuration of Hospital Services in Shropshire, as signalled by the CEO and CCG Accountable Officer, been discussed by and/or sanctioned by the Board in any form, if not, when can the public expect to be advised by the Board as to its intentions?

Q3 In April Board “Forward Plan” a document titled “Clinical Services Strategy – a detailed paper on way forward” was signalled for discussion in May, then June, then September. September has arrived but no paper and it no longer appears in the Forward Plan as a Strategy. When can the public expect to see this paper and what relevance has it to the current concerns about Hospital Service Re-configuration as defined by the CEO?

The CEO said in the context of what was said to the Joint HOSC, he had not said that an A&E may not exist in the future, what he had said was that Royal College standards state that ideally A&E should have senior medical cover for 16 hours a day, 7 days a week and that there should be a minimum of 10 consultants on a single site with a population of 500,000. Currently SaTH has 6 consultants across two sites which meant that there was not senior cover on-site.

The CEO said he had informed the meeting that it was unrealistic to deliver these standards in the context of our current A&E configuration however he did not say an A&E department will close. He said there is a need to look at innovative ways to deliver services to provide the highest quality care to patients.

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A2

- The CEO said that the Call to Action is a national call to discuss services which has been incorporated into our planned clinical service review because it is impossible to sustain health services as they are. It will be an open discussion to seek options. The Board’s position has not shifted and there should be a set of options for consultation early in 2014.
- The MD said that health care is constantly changing and public expectations have changed profoundly. So there is a need to rethink how to reconfigure services. One of the messages we have learnt from temporarily relocating our own Stroke Services onto a single site is to involve senior clinical decision makers.
- The Communications Director (CD) referred to the first issue and said that the Debate is a commissioner led process and they have asked all of the organisations to contribute to the debate. Also the clinical service strategy is discussed as a key objective within the Annual Plan.
- The DCG referred to the Board Assurance Framework papers discussed previously in Paper 6ii and said that one of the Trust’s key strategic risks was that if we do not have clear clinical service vision then we may not deliver the best services to patients and the controls and assurances listed included the shadow Programme Board meeting in September and the Clinical Service Strategy being developed for the purpose of public consultation which demonstrates that there has been transparency about the need for public consultation in the public session of the Board.
- The CEO said that our prime responsibility is to provide quality and safe services to patients. We do want two very vibrant hospitals going forward and need to work with the commissioners as ultimately they decide where they purchase services.

Mr Ron Jones said that the Board needs to communicate very carefully with the public to help them understand what is actually going on in the Trust.

A3 The DBE said that she had discussion with CCG colleagues concerning the “Clinical Service Strategy” and it will go into the formal process next month. The CEO added that the Call to Action has put a national context to our local issues. The Commissioners are leading the process looking at hospital services and SaTH is only one participant.
Mr Sandbach said he had witnessed a very depressing meeting with more “reds” on the finance paper than “greens”. He wished to ask the Board to develop a very clear policy of shrinking the amount of buildings as the Trust cannot afford them. He asked if the organisation would consider developing bringing forward a hospital without walls solution to be developed to go alongside the Call for Action.

The Acting Chair said that the CCGs will look at ways for organisations to operate so we have to work to a more effective health system for the county of Shropshire. It is up to the clinicians to tell us what is safest and affordable to provide the best care for patients.

Mr Sandbach warned that the Trust is losing patients to the east of the county and he suggested the Trust engage with local GPs to find out why this is happening e.g. T&W are buying beds in the private sector and if they continue to do this it will reduce SaTH’s income. He advised that “Hospitals without Walls” is where CCGs see themselves going.

Mr Sandbach said in order to get people to Trust Board meetings why not send out invites to those people who have sent in Appreciation letters.

Mr Sandbach asked why he had not received a letter to open up 40 beds instead of 24 beds in the Management Centre at PRH, to future proof the Trust.

Mr Jones (NED) apologised for the delay and confirmed that a response had been sent to Mr Sandbach this week.

DATE OF NEXT MEETING:

Formal Board Meeting – 31 October 2013 at 9.30 am in Seminar Rooms 1 & 2, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.

The meeting then closed.
### UNRESOLVED ITEMS FROM THE PUBLIC TRUST BOARD MEETING ON 26 SEP 2013

<table>
<thead>
<tr>
<th>Item</th>
<th>Issue</th>
<th>ACTION</th>
<th>PRIORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>226</td>
<td><strong>Booking and Scheduling</strong> – The COO advised that the paperwork went to the Finance Committee. Sara Biffen, Asst COO, will be asked to present this at the next Finance Committee. <strong>Item on-going.</strong></td>
<td>COO</td>
<td>ASAP</td>
</tr>
</tbody>
</table>
| 243  | **Chief Executive’s Report – Stroke Service**  
- Mr Jones (NED) raised the issue that the Hyper/Stroke Service transfer had not been fully explained to the public i.e. it did not include centralising the Rehabilitation pathway which remains on both sites. This message would be reinforced.  
- The Board would receive a progress report in Oct 2013. | CEO/CD | ASAP |
| 245  | **IPR – Operational Performance**  
**Cancer targets** – In August performance over a wide range of cancer targets was disappointing (unvalidated position showed failure to deliver in 5 of the 9 standard cancer targets). An investigation with CCGs at their request is being undertaken and a revised action plan will be formulated to deliver sustainable cancer performance within 3 months. The plan will be brought back to the Board in October. | COO | Oct 2013 |
| 245  | **IPR – Finance Position**  
The FD said that it is going to be very challenging to bring down this level of spend but it is important to come to a conclusion around the recovery plan and to do it very quickly. The Acting Chair said it would be helpful if the Financial Recovery Plan can be brought back to the Board. | CEO/FD | Oct 2013 |
| 249.2| **Integrated Education Annual Report 2012/13**  
It was noted that a full Training Report will be presented to the Board in November 2013. | WD | Nov 2013 |
| 250  | **Falls Action Plan Update**  
Mr Jones (NED) expressed disappointment at the comment that it was difficult to benchmark other organisations. It was noted that some Trusts report slightly differently. The ADQN will ask comparative Trusts. | ADQN | ASAP |
A Call to Action

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now & for future generations?
Aims of Call to Action

• To have an honest and realistic debate about health and care
• To agree our shared priorities
• To help local people understand why the NHS needs to change
• To work in partnership on the bold actions needed to build an excellent NHS now and for the future
• To set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered
• Provide an opportunity for you to share your views and ideas on the future of the NHS
WHAT ARE THE NATIONAL CHALLENGES?
Every day the NHS saves lives and helps people stay well, but 65 years ago, many people faced choosing between poverty if they fell seriously ill or forgoing care altogether.

Today:
• The NHS treats 1,000,000 people every 36 hours
• Between 1990 and 2010, life expectancy in England increased by 4.2 years
• 88% of patients in the UK described the quality of care they received as excellent or very good
Throughout these changes the NHS continues to be highly valued by the public.

Source: Ipsos Mori 2013
What challenges will the health and care service face in future?

**Demand for NHS Services**
- Ageing Society
- Rise of long-term conditions
- Increasing expectations

**Supply of NHS Services**
- Increasing costs of providing care
- Limited productivity gains
- Constrained public resources
What's next?

Rise in Long Term Conditions

Diabetics up 29% by 2025 to reach 4 million

An ageing population

The number of over 80s will double by 2030

Increasing expectations

Seven day access requested

How do we prioritise our resources to address these challenges?

- Limited financial resources
- If we do nothing by 2020, the NHS could face a gap in funding of £30bn
What does this mean nationally?

- Shift the focus from buildings to services
- Meet the needs of an ageing population, many of whom are living with multiple long term conditions, through strengthened care closer to home
- Changing, not charging
- Openness and transparency about where we get it right and where we get it wrong
- An honest and realistic debate across the country about how the NHS will be shaped
So what is happening in practice?

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England.

The engagement will be patient and public-centred through hundreds of local, regional and national events as well as through online and digital resources.

It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients.
Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health care services.

This is NOT about:

- Privatising the NHS
- Charging for services
- Restricting access
DEMOGRAPHICS AND OPPORTUNITIES IN SHROPSHIRE AND TELFORD & WREKIN
### Demographics

<table>
<thead>
<tr>
<th>Shropshire</th>
<th>Telford &amp; Wrekin</th>
</tr>
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<tbody>
<tr>
<td><strong>290,000 people</strong></td>
<td><strong>170,000 people</strong></td>
</tr>
<tr>
<td>Predominantly rural population with county town and market towns, generally older than national averages.</td>
<td>Predominantly urban population, generally younger than national average.</td>
</tr>
<tr>
<td>Overall population growth of 8% between 2001 and 2011, with 24% rise in number of people aged 65+</td>
<td>Overall population growth of 8% between 2001 and 2011, with higher proportion of people from BME communities than Shropshire.</td>
</tr>
<tr>
<td>Life expectancy is higher than England averages and all-age all-cause mortality is lower. The overall health of the population is good.</td>
<td>Whilst health status is improving, challenges remain in areas such as cancer, heart disease and stroke mortality (particularly for men).</td>
</tr>
<tr>
<td>Inequalities persist with no significant increase in life expectancy in the most deprived areas, with the gap between affluent and deprived areas increasing.</td>
<td>A quarter of children live in poverty and some wards in the 10% most deprived nationally.</td>
</tr>
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</table>
# Urban and Rural Opportunities

<table>
<thead>
<tr>
<th>Urban</th>
<th>Rural</th>
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<tbody>
<tr>
<td>Urban deprivation</td>
<td>Rural deprivation and isolation</td>
</tr>
<tr>
<td>Urban access and congestion</td>
<td>Accessibility and public transport</td>
</tr>
<tr>
<td>Dense population</td>
<td>Disperse population</td>
</tr>
<tr>
<td>Major population centres</td>
<td>Market towns, villages and hamlets</td>
</tr>
<tr>
<td>Main acute hospitals</td>
<td>Community hospitals</td>
</tr>
<tr>
<td>Opportunities for providing health centre / hub services</td>
<td>Challenges to providing accessible services efficiently</td>
</tr>
<tr>
<td>Generally associated with poorer health status</td>
<td>Generally associated with better health status</td>
</tr>
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</table>
Commissioning for quality and outcomes

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
WHAT ARE THE CHALLENGES IN SHROPSHIRE AND TELFORD & WREKIN?
Shropshire health challenges

- Ageing populating – people aged 85 and over has increased by 35% from 6,211 in 2001 to 8,400 in 2011. Compared to a rise of 24% in England and Wales.
- Health inequalities – e.g. people living in the most deprived areas of Shropshire are significantly more likely to die prematurely from cardiovascular disease and cancer than those living in the least deprived areas.
- Lifestyle risk factors to health – e.g. almost a quarter of people aged 16 years are classed as obese.
- Dramatic increase in the number of people suffering from a long term illness or disability.
- Access to health care particularly in rural areas; availability of public transport.
- Providing sustainable and high quality services that best meet the needs of our urban and rural communities.
• In top 30% of most deprived local authorities in the West Midlands
• Ageing population with both the 65 – 84 and 85+ age groups increasing by over a fifth between 2010 and 2011
• Early death rates (under 75 years) from cancers and heart diseases remain
• Number of people with dementia set to increase by 17% by 2015 (1,850 people)
• Estimated 4,418 people (16+ years) will have diseases related to breathing but only 3,077 were recorded as diagnosed at the end of March 2012
• Providing sustainable and high quality hospital services that best meet the needs of our urban and rural communities
Challenges for our acute hospitals

Increasingly moving to consultant-led service with appropriate levels of sub-specialisation to provide the best care, e.g.
- Intensive Therapy Unit
- Accident & Emergency
- Stroke Services

National workforce challenges in key areas that reduce our ability to recruit and retain, e.g. A&E and paediatrics

Local workforce challenges, with split-site services and onerous on-call arrangements making roles unattractive

Poor supporting infrastructure in key areas, e.g. A&E, critical care
Challenges for our community services

- Supporting people in the community to maintain their independence
- Providing care closer to home in a very rural county
- Rising demand
Opportunities

- Improved clinical outcomes, e.g. single site stroke service.
- Reduced mortality and disability due to consultant decision-making closer to arrival at hospital.
- Bringing teams together provides greater opportunities for seven-day working and more innovative ways of working.
- Attracting the best workforce to sustain services.
- Closer working and integration for community services with social care, voluntary sector and other partners.
- Mobile technology provides further opportunities.
- The challenge needs radical solutions – not more of the same.
## The context

<table>
<thead>
<tr>
<th>National standards and guidance</th>
<th>How do we make sure that our health services are meeting national standards for the future?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>Can we recruit or develop the workforce we will need to deliver services in new ways?</td>
</tr>
<tr>
<td>Partnerships</td>
<td>How do all parts of the health and care system work together with the person at the centre?</td>
</tr>
<tr>
<td>Capital</td>
<td>What will it cost in capital terms to transform services? Can we borrow this, and can we afford the revenue consequences?</td>
</tr>
<tr>
<td>Revenue</td>
<td>How do we deliver this within the resources available to us from the public purse?</td>
</tr>
<tr>
<td>Needs and expectations</td>
<td>How do we best meet the expectations and needs of both urban and rural communities?</td>
</tr>
</tbody>
</table>
1. What do you think are the main challenges and opportunities for the NHS over the next 5 years?

2. What is most important to you and why?

3. What might be some options for change?
Next steps

• CCGs use feedback from Call to Action (and other involvement/engagement) to inform development of 3-5 year commissioning plans

• Joint “Clinical Services Strategy” Programme will develop options for the future of local hospital services?