The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held on Thursday 1 May 2014 at 9.30 am
Lecture Theatre, Education Centre,
Princess Royal Hospital

PUBLIC SESSION MINUTES

Present:

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<tr>
<th>Name</th>
<th>Title</th>
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<tr>
<td>Mr P Latchford</td>
<td>Chair</td>
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<tr>
<td>Mr H Darbhanga</td>
<td>Non Executive Director (NED)</td>
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<td>Dr R Hooper</td>
<td>Non Executive Director (NED)</td>
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<td>Mr D Jones</td>
<td>Non Executive Director (NED)</td>
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<td>Mrs D Leeding</td>
<td>Non Executive Director (NED)</td>
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<td>Mr B Newman</td>
<td>Non Executive Director (NED)</td>
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<td>Dr S Walford</td>
<td>Non Executive Director (NED)</td>
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<td>Mr P Herring</td>
<td>Chief Executive (CEO)</td>
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<td>Mrs S Bloomfield</td>
<td>Director of Nursing and Quality (DNQ)</td>
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<td>Dr E Borman</td>
<td>Medical Director (MD)</td>
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<td>Mrs D Kadum</td>
<td>Chief Operating Officer (COO)</td>
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<td>Mr N Nisbet</td>
<td>Finance Director (FD)</td>
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<td>Mrs J Clarke</td>
<td>Director of Corporate Governance/Company Secretary (DCG)</td>
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In attendance

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<th>Name</th>
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<tr>
<td>Miss V Maher</td>
<td>Workforce Director (WD)</td>
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<td>Mrs D Vogler</td>
<td>Director of Business &amp; Enterprise (DBE)</td>
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Meeting Secretary

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<th>Name</th>
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<tr>
<td>Mrs B Graham</td>
<td>Committee Secretary</td>
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Apologies:

None

2014.1/057 WELCOME: The Chair welcomed everyone to the meeting. The Chair also welcomed Mr Brian Newman to his first Board meeting and congratulated him on his appointment on 1 April as a Non Executive Director. The Chair also congratulated Sarah Bloomfield on her substantive appointment to the role of Director of Nursing & Quality.

2014.1/058.1 CHAIR’S AWARD

This month’s Chair’s Award went to Sister Nicky Brierley who had been nominated by her colleagues in the Coronary Care Unit at the Princess Royal Hospital for several reasons. Her fundraising efforts included her most recent run at the London Marathon, raising over £1,000 for “Sense” which supports the blind and deaf people. This run is one of eight long distance runs she is taking part in this year; others include “A Good Day to Tri Hard” on 14 June for the Lingen Davies Cancer Fund, as well as completing the Ironbridge Half Marathon for a friend and colleague who was diagnosed with an aggressive form of breast cancer.

2014.1/058.2 RETIREMENT

The Director of Corporate Governance (DCG) wished to put on record her thanks to Barbara Graham, Committee Secretary, for her contribution to the Trust Board as it was her last meeting before retiring after nearly 34 years in the NHS. The Board presented Barbara with a retirement gift and card and made tribute to the many years of support and diligence to the Board and the organisation.

 .................. Chair
29 May 2014
PATIENT STORY

The Director of Nursing & Quality (DNQ) introduced Mrs Julie Locke who briefed the Board on the importance of communication, particularly in relation to end of life care. Mrs Locke took the opportunity to thank the many doctors and nurses who had previously cared for her husband David when he had a renal transplant 23 years ago and also had major surgery for bowel cancer. She said unfortunately the last few weeks of his life did not reflect that care. Mrs Locke said there was a lack of information in the last week of David’s life and no one mentioned end stage renal failure to them. She found out later that low blood pressure which he had had prior to admission was a clear indicator of this condition. She felt patients’ families need to know the facts because if she had known the true position she would never have gone home on the Saturday and her son would have been by his father’s bedside when David died.

Mrs Locke said the response to her initial letter was very positive and she had met with the Consultant Oncologist and agreed on key points around communication. Also the Renal Unit had secured funding for a Renal Psychologist to support end stage failure; also comments from the Renal Consultants were taken back to the Renal Unit after David’s death to make sure this experience did not happen to others.

Mrs Locke thanked the Board for listening to her story and said that David’s death had left a huge void in their lives, he loved his cricket and they would always be grateful to the doctors that gave him a chance of life following his transplant 23 years ago. She reminded the Board that “knowledge is powerful so not talking is not an option”.

The Director of Nursing & Quality (DNQ) said she had met with Mrs Locke, followed up issues from the nursing perspective and acknowledged that there were huge learning points to come out of this story, and from the medical point of view. The DNQ said that when objective setting for the year ahead, end of life care should be included, particularly around having timely and informed conversations with patients and their families. The Medical Director (MD) added that end of life is a subject our society in the 20th century finds difficult to discuss and this includes senior clinicians who view death as failure because they are trained to look for success and ensure people survive.

Mrs Leeding (NED) said after listening to a number of patient stories over the last few months she saw a trend around communication and she felt there needed to be a plan drawn up on how to more effectively communicate with patients as the Trust appears to have a basic problem to address on every level. Dr Walford (NED) said from his experience the more people that are involved in a patient’s care the less likely it is that anyone takes responsibility for communications, however, he said that the DNQ is working on a strategy that will include more emphasis on this for the future.

The Chair said there were three main themes taken from this patient story to ensure SaTH becomes an excellent organisation, these included:

- Integrated support and lead clinicians;
- Improving communications
- End of life care and choices

The Board thanked Mrs Locke for sharing her experience and agreed that it would regularly review main themes arising from patient stories to ensure actions were being progressed. Action: DNQ.

DECLARATION OF INTEREST

An up-to-date list of interests was presented of members’ declarations and this included Mr Newman’s (NED) declarations. There were no interests declared in relation to any matters on the agenda.
MINUTES OF THE MEETING HELD IN PUBLIC on 27 March 2014 were APPROVED subject to the following amendments:

Page 5, Financial Strategy 2014/15, last bullet point to be deleted and replaced with the following:
- The TDA are expecting a five year plan from the Trust by July 2014.

Page 12, Trust Committee Meetings Update, Finance Committee meeting 25 Mar 2014, last bullet point should have read “Losses/Special Payment – the Committee received and reviewed these items.

Page 13, Stakeholder Communications, last paragraph, 2nd line, 3rd sentence should have commenced “In relation to performance…”

MATTERS ARISING FROM THE FORMAL BOARD MEETING HELD ON 27 MARCH 2014

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<tr>
<th>Item Number</th>
<th>Agenda Item</th>
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<tr>
<td>2014.1/024</td>
<td>Winter Planning for Emergency Services – This item is on the agenda but the formal assessment will be presented to Board on 26 June 2014.</td>
<td>Action: COO.</td>
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<tr>
<td>2014.1/028</td>
<td>IPR – Workforce – The WD said this is included in the Workforce Committee summary later.</td>
<td>Item complete.</td>
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<td>2014.1/031</td>
<td>HR Policies – Guidance on NEDs expenses to be brought back to the Board.</td>
<td>Action: WD - 29 May 2014.</td>
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<tr>
<td>2014.1/040</td>
<td>CEOs Briefing – Impact of key staffing shortages – to be discussed under CEO’s Update.</td>
<td>Item complete.</td>
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<td>2014.1/041</td>
<td>Future Fit Programme – Mr Walford (NED) said the Board did not want the plan to contradict guidance e.g. day case surgery. Discussion concluded that it is not a point in time but confirmed that the Q&amp;S Committee will follow this up.</td>
<td>Item complete.</td>
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<tr>
<td>2014.1/042</td>
<td>Financial Strategy 2014/15 – The Finance Committee received the CIPs by Centre.</td>
<td>Item complete.</td>
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<tr>
<td>2014.1/044</td>
<td>Outcome of arbitration and budget to be discussed later.</td>
<td>Item complete.</td>
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<td>2014.1/045</td>
<td>IPR Self Certification – a qualifying note was sent.</td>
<td>Item complete.</td>
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<td>2014.1/049</td>
<td>Healthcare Economy-wide flow improvements – progress is included in the report.</td>
<td>Item complete.</td>
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<tr>
<td>2014.1/051</td>
<td>Trust Committee Meetings Update Finance Committee - Booking &amp; Scheduling full report due to Fin. Committee in Jun.</td>
<td>Action: COO</td>
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FORWARD PLAN for the period May to June 2014 was RECEIVED. It was noted that the Strategic Planning item had been included on the Forward Plan for the Board Development agenda in September 2014.

It was suggested that a pre meeting for the Non Executive Directors (NEDs) would be arranged prior to the next Board meeting. It was therefore agreed that the next Board meeting should commence at 10 am instead of 9.30 am. Action: Secretary.

CHIEF EXECUTIVE’S OVERVIEW:

Future Fit Programme
The CEO said discussion with the Project Team suggested that the modelling required will be extensive and will push the public consultation back until at least June 2015, after the general election. However it is expected that in January 2015 clarity about the options and the preferred service model with some indication of the estate options may be agreed and available to the public.

Outcome of formal arbitration with Telford & Wrekin CCG
At the last Board meeting the prospect of arbitration regarding the 2014/15 contract with Telford & Wrekin CCG was identified. Further discussions with the CCG failed to reach agreement and a formal arbitration panel considered the CCG’s case and the Trust’s counter-arguments on 1 April 2014. There were four items disputed by the CCG:

- Changes to the coding and counting of patient activity initiated by the Trust in 2013/14 equivalent to £0.8 million. The Panel found in favour of the Trust.
- The CCG disputed a number of issues relating to Rehabilitation Services at PRH. The Panel found in favour of the Trust but suggested that the nature of the rehabilitation service required by the Commissioners should be resolved as soon as possible. Discussions are on-going.
- The CCG disputed the coding of Stroke services but as the financial value was £140,000, the Panel did not consider this item, due to the low materiality of the issue.
- The CCG wished to reduce the contract value by £2.6 million to reflect the impact of their QIPP (Quality, Innovation, Productivity & Prevention) savings schemes. The Panel reinforced the national guidance that QIPP schemes must be underpinned by robust plans that are properly formed and evidenced. Therefore the Trust has not yet finalised the contract with Telford & Wrekin CCG.

**Assessment of workforce risks associated with dual site services**

The CEO said the review of the level of risk associated with the limited medical workforce availability in the Emergency Departments and in Acute and General Medicine, and to a lesser extent ITU, is in progress with a view to this being submitted to the May Board meeting. **Action: CEO - 29 May 2014.**

**National Sustainability Award**

The Trust participated in the National Sustainability Award in London and the CEO was delighted to announce that SaTH was a runner up for its work with volunteers and community engagement. We now have over 400 Trust volunteers and the Trust was commended in the way we engage with staff, working with young people, and over 600 partner volunteers from Leagues of Friends and Royal Voluntary Service. The CEO congratulated the DCG and her team on this achievement.

Members **NOTED** the CEO’s report.

**2014.1/064 CLINICAL SERVICE STRATEGY UPDATES :**

**64.1 Unscheduled Care – Presentation from Dr Kevin Eardley, Care Group Medical Director for Unscheduled Care.** A copy of the PowerPoint slide is attached to the minutes.

Dr Eardley described the challenges and opportunities for unscheduled care in our hospitals. He outlined several drivers for change including the importance of meeting and maintaining national standards and guidance, the Keogh review, making sure that services are clinically and financially sustainable, having the workforce to deliver safe care, meeting changing patient needs and expectations. In particular delivering excellence that the Trust needs to attract, support and retain excellent staff. It also needs to deliver quality first, in a way that best delivers access for patients, with a trained and supported workforce, within the resources available.

Dr Eardley described a focus on three particular areas of length of stay - 0 day, 3 day and 7 day. Focusing on each of these stages helps to ensure that people stay in hospital no longer than they need to in order to receive the care and treatment that only hospitals can provide.

At the shorter end this includes early consultant assessment, ambulatory care and short stay (e.g. 23 hour); middle range includes early specialist opinion and pull/push to the appropriate ward; at the longer end this includes focusing on issues such as frailty and early planning for safe and timely discharge. Underpinning all of this is the need and desire for more integrated working with health and care partners, and moving towards seven-day working etc. Priorities for the coming years include:

- Embedding a patient safety focused culture
- Developing the transition plan to keep services safe during the NHS Future Fit review
- Developing and implementing the workforce strategy that supports the above
- In partnership with commissioners, focus on service redesign for cardiology, urgent care centres and care of the older patient.
- Engaging staff in service redesign, reform and reconfiguration

Potential actions in the coming years include:
- Opening Ward 17 short stay ward – this opened earlier in April
- Further development of ambulatory care
- Implementing an Urgent Care Centre model alongside ED

A particular challenge is the wider unscheduled care team and in particular the dwindling availability of specialist geriatricians (in common with other hospitals across the country) there is a need to think very differently about the workforce model for providing care for the elderly. Alongside these challenges there are some workforce opportunities as we could bring more cardiology care back into the county so that fewer patients need to transfer out of county to specialist heart centres but achieving this would mean consolidating some of our specialist expertise onto one of our two sites so that services can be kept safe in the county with senior clinicians available or accessible 24hrs 7 days a week.

Dr Eardley said that these steps are likely to only mitigate the risks we face in the short and medium term, and on behalf of our patients we need the NHS Future Fit Programme to develop a compelling and safe vision for the future.

Dr Walford (NED) speaking from a clinical background complimented Dr Eardley on his presentation. He said there was outstanding clarity and understanding in this group and he would be confident to endorse what had been said.

Mr Newman (NED) referred to the difficulties in recruiting to key posts and asked if it was a reflection of national or local issues. Dr Eardley said it was both: there are national shortages in key skills, and in this market we are not a competitive employer given the duplication of services across two small sites, the challenges of split-site working and the onerous on-call responsibilities. Doctors are much more attracted to bigger, specialist centres elsewhere. Dr Eardley said if the Trust was able to develop a compelling clinical vision for the future then it will be better able to retain our current staff and attract new ones, and this will keep services safe and keep them in the county.

Scheduled Care – Presentation from Mr Mark Cheetham, Care Group Medical Director for Scheduled Care and Consultant Colorectal Surgeon. A copy of the PowerPoint slide is attached to the minutes.

Mr Cheetham highlighted some of the key successes over the last few years e.g. establishing RSH as the county’s main centre for acute surgery giving patients early and regular access to consultant opinion; establishing the Trust as a Centre for Abdominal Aortic Aneurysm screening which is helping to keep vascular surgery in our hospitals, and opening the new Lingen Davies Cancer Centre. The surgical developments have also helped to establish RSH as a Trauma Unit as part of region-wide Major Trauma Networks.

Some of the big drivers for change in scheduled care includes seeking to separate Emergency and Elective surgery wherever possible (e.g. so that demands for emergency care do not put pressure on beds and resources leading to frustration and inconvenience of cancellations; there is better senior supervision of major/complex cases, and quality of care is improved) and finding ways to bring more planned care closer to home. Key design principles include making sure that the way we provide care is wrapped around the patient, and designing pathways of care that provide as much as possible as close to home and/or at the convenience of the patient.

The Trust has not consistently met 18-week referral to treatment time (RTT) standards and improvements needs to be relentless in looking at every step in the journey for the patient. In cancer standards we need to launch a review; and there are also reviews required in Ophthalmology and Musculoskeletal (MSK). There is a health community-wide review underway in MSK to make sure that we have the right pathways in place for the future. There is an important link to NHS Future Fit as with a single Major Emergency Centre we would be able to benefit from bringing specialist expertise together into a single Major Orthopaedic Trauma service. There is a need to develop robust plans to achieve the Critical Care quality standards, a need to continue to improve Patient Access and Outpatient Services and review performance of all financially challenged specialties.
Another driver relates to the Trust facing growing demands i.e. the population is growing and this includes an ageing population with multiple co-morbidities. The Board was updated on the current stage of development of the model for Planned Care that is emerging from the NHS Future Fit work. The vision has been developed with staff and patients focusing on (a) what specialties and services need to be available alongside Major Emergency Centres and (b) what specialties and services can be at a Planned Care Treatment Centre with separate resources and capacity from the main Emergency Centres. Some surgical specialties must be located alongside the emergency front door so that critically ill patients have early access to specialist clinical opinion; others can be located away from this site as the majority of activity is planned and/or routine.

It was also acknowledged that the experience of Booking & Scheduling for our patients is not always up to the high standards they deserve. Improvements are underway including the recent establishment of a dedicated Booking Office which helps to extend opening hours and improve response times for calls and queries. This Office does not yet cover all types of bookings, and we are looking at ways to bring more of our booking processes into a one-stop-shop for patients.

The focus of the Scheduled Care Group strategy over the next few years will be to improve the efficiency of pathways and service lines, by reviewing systems and processes whilst aiming to improve clinical standards, clinical outcomes and the patient experience to ensure that services are clinical and financial sustainable as the FutureFit solution becomes a reality.

The Chairman said he found both presentations helpful in considering the Trust’s 5-year plan and they made absolutely clear the need for review and reconfiguration of hospital services, in order to keep these services safe and in the county. He said we need clear plans for managing the transition until there is a clear vision for the future. However it is clear that:

1. There is a need for clinical reconfiguration in short/medium term.
2. We need to ensure any future design attracts medical staff needed to deliver the services.
3. The current duplication of services is placing increasing pressure and risk on services
4. Clinical Leads will need to shape decisions and take responsibility for the governance journey.

The Board thanked Dr Eardley and Mr Cheetham for their presentations and looked forward to receiving the presentation on Women’s & Children at the next meeting. Action: DBE – 29 May 2014.

2014.1/065.1

STRATEGIC PRIORITIES YEAR END REPORT 2013/14

The Board RECEIVED and NOTED progress against delivery of our 2013/14 Strategic Priorities. The report was submitted for information and had been discussed last month.

2014.1/065.2

FINAL TWO YEAR OPERATING PLAN 2014/15 AND 2015/16

The Director of Business & Enterprise (DBE) introduced the Two Year Operating Plan which set out how the Trust intends to deliver appropriate, high quality and cost effective services for patients over the next two years in light of the challenges facing the NHS.

The Trust submitted its initial Draft Two Year Operating Plan to the Trust Development Authority (TDA) on 5 March 2014. Following the submission, the Trust received feedback from the TDA including challenges with regard to its Long Term Financial Plan (LTFP). The plan was subsequently reviewed to reflect feedback from both the TDA and comments from the March Trust Board. During March, contract discussions progressed and the financial implications have been reflected in changes to the final financial plan which was submitted to the TDA on 4 April 2014.

The Board’s attention was drawn to the following material changes to the Operating Plan in sections:

- s8.3 Operating surplus/deficits: The forecast operating deficit for 2014/15 has moved from a deficit of £6.2 million to a deficit of £8.2 million based on the final level of transitional support agreed by the CCGs.
s8.4 Transition support: The Trust assumes that transitional support will be provided over the years 2014/15 to 2017/18 in recognition that costs of duplication will remain unavoidable until service reconfiguration has been completed. The level of transitional support assumed is as follows: 2014/15 £1.0 million and from 2015/16 £3.0 million each year thereafter.

s8.6 QIPP assumptions: Local QIPP schemes for the 2014/15 require a greater level of development by both Clinical Commissioning Groups, and hence do not feature within the 2014/15 contract. This position was accepted by Shropshire CCG as part of contract negotiations. The arbitration held on the 1 April 2014 adopted this position in respect of Telford and Wrekin CCG. The Trust, in setting its financial plan for the period 2014/15 – 2018/19, has recognised that QIPP savings will be required to support financial sustainability within the health economy; as such progressive levels of QIPP savings (£3 million per year) have been introduced from 2015/16.

The DBE said that the Trust has further meetings with the Trust Development Authority (TDA) in May 2014 to discuss further our financial position therefore this may be brought back to the Board at a future date.

The Board APPROVED the Two Year Operating Plan 2014-16 subject to any further proposed changes to the plan being reported back to the Board.

CARE QUALITY COMMISSION (CQC) INPATIENT SURVEY

The Director of Nursing & Quality (DNQ) introduced the results of the annual national inpatient survey conducted by the Picker Institute on behalf of the Care Quality Commission (CQC) across all acute and specialist NHS hospitals. Data was collected in September 2013 from patients admitted during the month of August 2013, with the results released in April 2014. The results are used by the CQC to inform their quarterly Intelligent Monitoring Report (IMR) and by other organisations such as NHS England and NTDA.

The DNQ said the most recent survey was generally positive and demonstrated that the Trust had made significant improvements in a number of areas. There were no areas which showed a statistically significant decrease in performance. Compared to the 2012 survey, 10 areas had moved from the "worse" to the "about the same" bracket. More focused work is required in order to build on and deliver further improvements.

An action plan to focus on all areas including those seen to be “worse” than other Trusts will be reviewed quarterly by the Clinical Quality & Safety Committee and much of this work will be incorporated into the Patient Experience Strategy which is currently being developed. The DNQ expressed thanks to the people of Shropshire for responding to the survey and the positive messages would be used to encourage staff to make the necessary improvements.

The Board RECEIVED and NOTED the Inpatient Survey.

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 March 2014 which summarised the Trust’s performance against all the key quality, finance, compliance and workforce targets and indicators for 2013/14. The report confirmed that SaTH is currently at Escalation Level 4 (of 5) in the NHS Trust Development Authority's Accountability Framework. This is classified as a “material issue” requiring interaction led by the Director of Delivery & Development. Regular meetings are being held with the TDA to update them on SaTH’s improvement trajectories. Key areas have been highlighted in the report.

QUALITY (Patient Safety, Effectiveness and Patient Experience)

The Director of Nursing & Quality (DNQ) provided an overview of the activity in March 2014 when a number of improvements within quality and safety were noted including eliminating Grade 4 pressure ulcers and further work is being conducted to make improvements with Grade 2 and 3 pressure ulcers. The following points were noted:

- WHO checklist (safer surgery) – some external scrutiny is being undertaken on this issue at present relating to performance and methodology of measurement.
- Infection Prevention & Control – showed 3 cases of *C difficile* in March, a year-end performance of 31 cases against a target of 27; and an improved performance of 31% reduction compared to last year.
The target set for 2014-15 is generously set at 38 whereas the previous year was 27 cases. An internal target will also be set. The Chair said the Board needs to know how targets are set for 2014-15 and asked for more information at the next meeting. **Action: DNQ – 29 May 2014.**

- Risk Adjusted Mortality Index (RAMI) – The Medical Director (MD) said that the Trust is tracking the national peer average and this showed sustained improvement over the last 3 years. Systems are being put in place that “leap frog” to achieve much better performance. From the beginning of April 2014 completed consultant-related outcome performance will be available – relating to individuals and teams. The Chair said that national benchmarking data was often complex and it was important for the Board to be aware of where the Trust sits in relative terms in relation to clinical outcomes. Reference was made to the action in June 2014 when the Board would receive performance, quality, finance and workforce issues in a more integrated approach and the Board supported the move for consultant performance to be included in this. **Action: MD – 26 Jun 2014.**

- There were 12 Serious Incidents reported in March, 11 related to clinical effectiveness.

**OPERATIONAL PERFORMANCE**

The Chief Operating Officer (COO) gave an overview of the operational performance for March 2014. **RED RAG : Overview of Performance Standards by Exception** was included in the report. Board members were briefed on the following:

**A&E 4 Hour Access Standard** : The year-end position was 93.4%, and 10,000 more patients were treated within the four hour target. March’s performance saw the highest Emergency Department attendance over the year by 10%.

**Referral to Treatment (RTT) : Admitted** - All specialties are on track to achieve 18 weeks in accordance with the Remedial Action Plan (RAP) but, the Trust failed the national RTT target in March. The COO advised that she had received a call from NTDA for SaTH to develop a plan to bring our target forward and to do this the Trust will look at providing an extra Day Surgery Theatre at PRH.

**Referral to Treatment (RTT) : Non admitted** - The Trust failed to deliver the overall performance of the non-admitted standard, which was predicted, as it is now reducing the Ophthalmology backlog (those waiting over 18 weeks). This work will continue for a few months. The CCGs have commissioned additional activity from ‘The Practice’ (an independent provider) to cope with the level of demand within this service. SaTH needs to have a sustainable 18-week trajectory to be able to tender, therefore the glaucoma service will close to all routine referrals (to enable the backlog of patients to be cleared as quickly as possible) and they will go through triage as part of a new service model.

NHS England had re-commissioned the Oral surgery service at Stichley Dental Practice (a primary care service) with effect from 1 May 2014 and this will support the delivery of the Oral Surgery non-admitted performance within SaTH. This service was closed in December and subsequently SaTH has been receiving in excess of 50 additional referrals per week. These referrals are being clinically reviewed and where appropriate will be seen in the primary care service.

**Cancer Performance** : The unvalidated position for March indicates that the Trust had only failed the 62-day target, which is a significant improvement on previous performance. Further details of the reasons for non-achievement of the 62-day standard were detailed in the exception report. A Remedial Action Plan [RAP] is in place for cancer and details the actions to be taken in the four challenged tumour sites: Colorectal, Lung, Upper GI and Urology. The Intensive Support Team (IST) will be working with the clinical centres to review patient pathways so that SaTH delivers all of the cancer standards from Quarter 2 in 2014/15. They are also working with Radiology to assess the gaps in capacity in relation to demand through the Cancer pathways.

**Winter** – the Trust has delivered higher activity levels than ever before. Cancelled operations have reduced as well as ambulance delays. The COO paid tribute to the staff for their hard work as whilst we are not where we want to be the improvement is significant.

In answer to questions, the COO confirmed the following:

- In terms of harm to patients, it was pointed out that a process is in place to identify long waiters. Over the last year there had been 15 patients.
- The Trust has not damaged its customer-based market in Ophthalmology as the current alternative provider is a temporary situation. Our strategy is to get our own house in order to enable pathway change.

Mr Newman (NED) said that in terms of market research we have been consistently losing market share and asked whether a reduction in waiting times could help the position. The FD said that this would not be possible because our contract is based on delivering a specified amount of activity and Commissioners would not be able to fund any increase. The CEO added that once the backlog is cleared it will provide the opportunity to regain our market share.

The Board AGREED that the direction of travel is very positive.

FINANCIAL PERFORMANCE

The Finance Director (FD) introduced the item and advised that at year-end (31 March 2014) the Trust recorded a surplus amounting to £65k, but he said it is worth reflecting that at half-year we had a £6.2 million deficit and a programme was put in to accelerate cost savings. In the month of March there was a surplus of £1.2 million; pay costs increased in the month to £17.7 million due in part to staff delaying annual leave to deliver operational goals. It was noted that overall, pay costs have been around £17.4 million which is consistent with our budget.

A cash balance of £2.2 million was held on the Balance Sheet at the end of March 2014. The Trust repaid all temporary borrowing as required on 24 March 2014 following receipt for support of £4 million from NHS England.

The Trust overall achieved the three statutory targets i.e. the breakeven target by delivering a surplus of £65k; achieved the External Financing Limit of £21.3 million and achieved the Capital Resource Limit of £29.7 million.

Mr Jones (NED) said that whilst this is a positive picture there is a need to monitor “Pay” and “Non Pay” budgets for the year and to operate within them. The CEO said the whole issue of annual leave is being discussed at the Hospital Executive Committee on 27 May 2014.

WORKFORCE

The Workforce Director (WD) introduced this section of the paper, the following points were NOTED:

- **Sickness Absence** - the year end position was 4.12% against an annual target of below 4%. Whilst the target had not been met it showed an improvement which equated to 3,326 calendar days being saved compared to last year.
- **Appraisal rate** had improved during March when 80% of staff had received an appraisal also a significant increase was seen in the number of doctor appraisals.
- **Apprenticeship Framework** – over the last 12 months the Trust had supported 166 individuals through an apprenticeship framework, this is the highest in the West Midlands region.
- **People Strategy** – Implementation of the strategy commenced in April. Key activities were to begin to embed the values, roll out the Leadership Development Programme, draft a 5 year Workforce Plan and introduce a values-based recruitment for consultant appointments.

On concern from Dr Hooper (NED) in relation to the appraisal rate, Mrs Leeding (NED) said that she had met with the Workforce Director and the biggest issue is quality of the appraisals. This will be the next stage and then to start implementing improvement plans to take this forward. The Medical Director added that the appraisal rate for medical staff had improved to 83% from 70%.

MONITOR LICENCE CONDITIONS SELF-CERTIFICATIONS

Appendix 1 & 2 - Monthly Self Certifications – NHS Trust Development Authority (NTDA) Requirement
The Trust followed the formal process and will submit the monthly self-certification templates for March 2014:

- **Monitor Licensing Requirements** – summary of each relevant licence condition. A summary of the submission was included at Appendix 1 of the report. All conditions were marked compliant.
- **Trust Board Self Certification Board Statements covering clinical quality, finance and governance** was included in the report at Appendix 2. The Trust is reporting a Financial Risk Rating of 3 for the month of March 2014 and 2 for the year. Non-compliance around performance issues. Action plans are in place to recover all the targets.

The Board **NOTED** the Integrated Performance Report for March 2014 and **APPROVED** the self-certification submissions to the NTDA. It was noted that this is for March 2014 and whilst there are risks going on next year SaTH is still a going concern. The Board **AGREED** that a qualifying note should continue to accompany the Self Certification to the NTDA approving finance but on the understanding that NTDA is underwriting a known deficit. **Action: FD.**

### SATH 2013/14 WINTER PLAN REVIEW

The Chief Operating Officer (COO) presented a brief summary of the review of the Trust’s Winter Plan for 2013/14 and some of the recommendations for the 2014/15 Winter Plan.

The COO said whilst this report looks at SaTH’s actions and its continued ongoing programmes all year round, emergency pressures do not switch off at the end of April. Feedback from staff across the Trust indicated that this winter felt much better. No patients waited over 12 hours and the number of cancelled operations had also reduced from 100 the previous year to 14 in 2013/14.

Discussions are already underway internally and with our local health economy in preparation for Winter 2014/15. Feedback had been given to the TDA and NHS England regarding the need to release Winter funding earlier to enable the recruitment of staff on short-term contracts rather than having to rely on expensive agency staff. As a health and social economy the initial discussions have been centred around ensuring that planning for winter is a whole year event.

The Trust is also in discussion with smaller local providers who are now in the process of closing down their additional winter facilities. Also for 2014/15 planning we are in discussions with Healthcare at Home – a private company - about a proposed “recovery at home” initiative to manage patients with special acute medical needs. They are currently contracted with many Trusts (e.g. Heart of England, Coventry & Warwick and others) and are carrying out a scoping exercise to look at releasing hospital capacity for the coming winter. There is also a need to look at ways to improve discharge rates for the weekends.

The Board **NOTED** that the report concluded with some recommendations to be taken into consideration in the development of the 2014/15 Winter Plan as follows:

- A focus on continuous improvement across urgent care pathways all year round must continue;
- Lessons learnt from Winter 2013/14 will be used to inform both our own internal plan and the whole health and social care economy plan for Winter 2014/15;
- Baseline reports to be in place prior to the winter to better monitor the impact of winter funding and return on investment;
- Recruitment to winter funded posts to commence in June 2014 with staff in post by October 2014;
- Integrated working to be developed with Shropshire Community Trust to maximise the benefit to patients both as business as usual;
- The need to make improvements in performance against the A&E 4 hour standard, across the whole year, but in particular over the Winter period.

The Formal Review of the Health Economy report will be reported to the Urgent Care Working Board this month and then to the Board. **Action: COO – 26 Jun 2014.**

.................................Chair

29 May 2014
Dr Hooper (NED) expressed significant thanks for this report. He said that Executive Directors had put forward plans for the winter, the plans had been delivered and this delivery has had the intended outcome. He said it was a credit to the frontline staff and clinical/operational teams who have made this happen.

2014.1/069 SYSTEM STRATEGY UPDATE

The Chief Executive gave a verbal report. He said last month this item was introduced with the aim of trying to improve our systems as an organisation. Four important areas were laid out to try to “leap frog” ahead i.e.

- Develop an appropriate strategy for investment because we have a reactive approach;
- Develop a coherent strategy around Information Technology because we have out of date equipment (e.g. Radiology)
- Develop a comprehensive strategy for re-design
- Use market analysis and business intelligence to improve and develop the business.

The CEO said this is work in progress and gave the following update:

- The CEO and DBE met with BT Healthcare to see how they can help SaTH improve technology;
- Wider system strategy - a team from University Hospital of North Staff (UHNS) met EDs and discussed what could be done in partnership. It was agreed in principle to engage in discussions about mutually advantageous network arrangements with UHNS going forward.

The Board NOTED the update.

2014.1/070 INFORMATION GOVERNANCE REPORT 2013/14

The Finance Director provided the report which demonstrated SaTH's 2014 Annual Assessment scores and included relevant updates in the IG Framework. Information Governance is now included in the Trust Development Authority (TDA) Accountability Framework. The Board RECEIVED and REVIEWED the Information Governance Toolkit update.

2014.1/071 TRUST COMMITTEE MEETINGS UPDATE

The Chair advised that he had proposed to establish a new Committee of the Board called Business Development and Engagement Committee as it was felt there was a gap in that area. If approved this Committee would be Chaired by the Director of Business & Engagement

The Board also NOTED that:

- the Financial Recovery Board is to be dis-established as it was agreed that the current structure was not adding value to the process. To gain greater ownership throughout the organisation there will now be a regular update on progress every two weeks to the Executive Directors and a monthly update to the Finance Committee through the Finance Director.
- Following the appointment of Mr Newman (NED) from 1 April 2014, the Chair had refreshed NED Committee membership and responsibilities along with the current Committee structure at Attachment 2.
- The COO’s name was omitted from the Workforce Committee membership. Action: DCG to amend.
- Mr Jones (NED) / Chair of Finance Committee pointed out that the current quoracy required and Executive Director in addition to the FD’s deputy, when the FD was unable to attend and it was proposed to change this. The Board AGREED to this change. Action: Finance Committee to amend ToR.
- Dr Walford (NED) / Chair of Q&S Committee also referred to a quoracy and the deputy issue and said this would need to come back to the Board in June. Action: Q&S Committee to consider ToR.
- NED Leads now included Mr B Newman overseeing “Procurement”.

.................................Chair
29 May 2014
Finance Committee meeting 29 April 2014: The summary was TABLED and NOTED.
Mr Jones (NED) Chair of the Committee confirmed that two monthly reviews of the Future Configuration of Hospital Services (FCHS) indicated that the project is on track for completion in September 2014 and is on budget.

Clinical Quality & Safety (Q&S) Committee meeting 23 April 2014: The summary was NOTED.
Dr Walford (NED) Chair of the Committee briefed the Board on the Adult Safeguarding section of the summary. It was noted that this is a relatively new procedure where other organisations can raise concerns and he was assured that SaTH’s data is completely transparent. The Q&S Committee supported the view of the DNQ that the Adult Safeguarding Board would benefit from the appointment of a suitable independent Chair. The Board also SUPPORTED and ENDORSED this view.

Hospital Executive Committee meeting 29 April 2014: The summary was TABLED and NOTED.

Workforce Committee meeting 11 April 2014: The summary was NOTED. The Workforce Director (WD) referred to the second summary point relating to “Improving People Management” in the organisation, where the Committee received a proposal relating to two key issues (i) for all managers to attend a briefing session led by the CEO; the session will ensure a shared understanding of the role of a manager and will cover regular communications. It will also be an opportunity to talk about our values and the importance of managers living the values. (ii) a Management Development Programme is being proposed which should improve managers’ skills.

The Board RECEIVED and REVIEWED Committee Updates.

The Board NOTED the NED membership, role responsibilities and the Committee structure and the new reporting arrangements for financial recovery schemes.

The Board APPROVED the establishment of the Business Development and Engagement Committee as a formal Sub-Committee of the Board

2014.1/072 REPORT ON THE USE OF THE CORPORATE SEAL

The Director of Corporate Governance (DCG) introduced the report which updated on the use of the Trust’s Common Seal since the last update in April 2013, pursuant to Section 9 Standing Orders “Custody of Seal and Sealing of Documents”. The Board NOTED the Sealings as detailed in the Register for the period 9 March 2013 to 31 March 2014.

2014.1/073 ANNUAL LOSSES AND COMPENSATIONS AND WRITE OFFS

The Finance Director (FD) introduced the report and advised that the report summarised the losses and special payments during 2013/14 that required Trust Board approval. The Board NOTED and APPROVED the annual losses, compensation and write-offs of bad debts.

2014.1/074 STAKEHOLDER ENGAGEMENT

The Communications Director provided an update when the Board NOTED the following:
- The Trust Charity Development Lead had been successful in recent grant applications for the Women & Children’s Unit; and held a Charity Team Party earlier in the month.
- Over Easter a young child called Luke, from Sir Alexander Fleming School in Telford, organised a competition at his school and all the proceeds raised paid for Easter eggs for the Children’s Ward.
- The two Leagues of Friends and Lingen Davies Fundraisers are working together on shared goals.
- Funding had been received from the Arts Council to improve photography throughout RSH.
- The Communications Team is sadly losing two of its members - Chris Hudson has already left and Andy Rogers will be leaving shortly. Recruitment has commenced.

Dr Walford (NED) asked whether there was more that can be done to engage our shadow members who had been recruited in anticipation of our FT Board of Governors. The DCG said there are almost 10,000 members and there were a number of mechanisms in place to engage with them, but that previous advice had not supported forming a shadow Council of Governors.

..............................Chair
29 May 2014
QUESTIONS/COMMENTS FROM THE FLOOR

1) A member of the public was very impressed with the level of enthusiasm in the Trust to make real changes quickly to improve services. He urged more engagement in this work to design services that patients need. The Chair thanked him and said this would feature in Board meetings.

2) The following questions related to the Two Year Operating Plan and the NHS Future Fit Review:

(a) Would one of the existing two sites be substantially downgraded if there is a new Major Emergency Centre on a new site? The CEO said it needs to be clear that there is a service vision i.e. specialist emergency hospital and another diagnostic centre for planned work. The options to have this configuration have been modelled and during the course of the next 12 months that modelling around different site options should proceed so there is no pre-conceived view on what the solutions would be.

(b) Reference to Value for Money (VFM), the Emergency Care Centre could cost £200 million but there is no indication in the plan where this money is coming from. The CEO said in relation to VFM, it is important in this evaluation to particularly note that RSH site is much older, the backlog is significant and development is more complex. That will be a factor to be taken into account however there are no conclusions drawn from this.

(c) Has the Trust considered the potential impact if Commissioners take a more competitive approach by putting more services out to tender? The Medical Director said he was aware of the potential impact and there is a risk. He said the need for co-operation is absolutely paramount.

(d) The change of direction by the new Chief Executive of NHS England had been noted and will this mean that there is a different direction going forward for local hospitals? The Medical Director said he has regular discussions with the CEO of NHS England and there is potential for a different model. There is a need to demonstrate to NHS England how to make substantive improvements in care.

3) Mr Sandbach handed over a letter to the Chair which suggested that SaTH make immediate temporary changes to clinical services in the interest of improving patient safety. He said he was very worried that the Trust is at major risk in recruiting key staff and having reliance on locums. He believed this could lead to catastrophic failure leading to avoidable injury and death. Dr Walford (NED) said the Board had heard a range of views today and it demonstrated the difficulties the Board is trying to deal with. The Chair said there was a lot of detail covered in this item and he would be willing to meet with Mr Sandbach outside the meeting.

4) Mr Jones, PALS Volunteer, personally thanked Barbara Graham for providing him with Board information over the years and said she will be missed. The PALS service has been very busy. Mr Jones also referred to his treatment of glaucoma five years ago and said he had recently received "brilliant" treatment again from Mr Ewan Craig and he would like his comments passed on to Mr Craig. Action: MD.

REVIEW OF MEETING

Observational Review

1. A member of the public referred to the CQC inpatient survey and spoke personally about his experience at the beginning of January 2014 when he was an inpatient for 10 days. He said he received high quality care on the Respiratory Ward. His experience of the care from staff and information shared was very positive.

2. Mr Sandbach also said a member of his family received services and although staff are dedicated one of the flaws in the system was discharge processes and he suggested that members of the Board sit in the discharge area and listen to what patients are saying. Delay in receiving medication is an issue.

Members Review: The CEO said that the meeting had lasted four hours which was considered too long. The CEO noted the comment from the floor that if items are removed from the meeting then the information must remain available to the public by other means.

.........................Chair
29 May 2014
DATE OF NEXT MEETING

Formal Board Meeting – Thursday 29 May 2014 at 10.00 am in Seminar Rooms 1 & 2, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.

Special Board Meeting – Thursday 5 June 2014 at 5 pm in Seminar Room 1, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital (to Adopt the Annual Accounts).

The meeting then closed.
## MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETING ON 1 MAY 2014

<table>
<thead>
<tr>
<th>Item</th>
<th>Issue</th>
<th>ACTION OWNER</th>
<th>DUE DATE</th>
</tr>
</thead>
</table>
| 2014/010 | Integrated Performance Report  
To develop Board reporting so all papers include performance, quality, finance and workforce issues in a more integrated approach and to routinely include Centre-specific performance against all these measures in IPR. | CEO | 26 Jun 2014 |
| 2014.1/024 | Winter Planning for Emergency Services  
Formal Review of Health Economy report not due until April. | COO | 26 Jun 2014 |
| 2014.1/031 | HR13 Reimbursement of Travel, Accommodation & Subsistence Expenses - Guidance for NEDs expenses from TDA around change of the scope. | WD | 29 May 2014 |
| 2014.1/040 | CEO’s Briefing – Impact of key staffing shortages  
NEDs attendance at CCG Boards/vice versa. Chair to discuss representation at respective Boards. | Chair |  |
| 2014.1/048 | Board Assurance Framework  
Clinical Service Vision to be presented to the Board. | CEO | 29 May 2014 |
| 2014.1/051 | Trust Committee Meetings Update  
- Finance Committee : Booking & Scheduling – source of leadership be agreed to ensure SOP compliance. Full report due in June 2014.  
- Learning from RCA - Summary of changes to operational systems and clinical care derived from learning to be summarized at public Boards. | COO | 26 Jun 2014 |
| ADNQ | 26 Jun 2014 |
| 2014.1/053 | People Strategy  
WD and Head of OD to present on workforce transformation. | WD | 26 Jun 2014 |
| 2014.1/059 | Patient Stories – DNQ to regularly review main themes arising from patient stories to ensure actions are progressed. | DNQ | On-going |
| 2014.1/063 | CEO’s Overview – Assessment of Workforce Risks  
Review of the level of risk to be submitted in May. | CEO | 29 May 2014 |
| 2014.1/067 | IPR – Quality :  
Target setting for 2014/15 - The Board requested more information on how targets are set;  
Risk Adjusted Mortality Index (RAMI) Consultant related outcome performance to be included in new integrated approach IPR report. | DNQ | 29 May 2014 |
| MD | 26 Jun 2014 |
| 2014.1/067 | IPR – Finance : Issue of annual leave will be discussed at next HEC meeting on 27 May and outcome will be reported to the Board. | CEO | 29 May 2014 |
| 2014.1/071 | Trust Committee Meetings Update  
Q&S Committee – Quoracy and the deputy issue to be brought back to the Board in June. | Q&S Chr | 26 Jun 2014 |
| 2014.1/075 | Questions/Comments from the floor  
- Appreciation to be passed to Mr E Craig.  
- If Board meeting is made shorter, it was requested that some items should remain available to the public by other means. | MD | May 2014 |
| CEO | Monthly |
The Shrewsbury and Telford Hospital NHS Trust

Scheduled Care

Clinical Service Strategy
Drivers for Change

- Design Principles
- Separation of Emergency and Elective Surgery
- Delivering Core Standards
- Growing Demand
- Financial Sustainability
- Future Fit
### Drivers for Change – Design Principles

<table>
<thead>
<tr>
<th>Role</th>
<th>Organisation</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Focus</strong></td>
<td>What is my responsibility as a patient in managing my own condition as I move between primary and secondary care (duty of care, backup, IT)</td>
<td>Systems/processes wrapped around the patient</td>
</tr>
<tr>
<td><strong>Care Focus</strong></td>
<td>Evidence base delivery of care</td>
<td>Model built around pathway – based on care closer to home</td>
</tr>
<tr>
<td></td>
<td>Reduce geographic variation</td>
<td></td>
</tr>
<tr>
<td><strong>System Focus</strong></td>
<td>Right care based on pathway – seeing right person first</td>
<td>Clearly defined capability of institutions</td>
</tr>
<tr>
<td></td>
<td>Care delivered at lowest level of resource use for agreed level of quality</td>
<td>Access to advice or clinician appointment/to diagnostics/to specialist opinion or therapy/to ongoing care</td>
</tr>
</tbody>
</table>

![Logo](logo.png)
Drivers for Change – Separation of Emergency and Elective Surgery

“Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can if well planned, resourced and managed reduce cancellations, achieve a more predictable workflow, provide excellent training opportunities, increase senior supervision of complex/emergency cases, and therefore improve the quality of care delivered to patients”.

*Recommendations for practice, published by the Royal College of Surgeons of England (2007)*
Drivers for Change – Delivering Core Standards

1. Referral
   - Referral guidelines
   - Perioperative coordinator
   - Review and plan for patient care developed

2. Outpatients
   - One-stop approach to scheduling
   - Collocates bed assignment, waiting list, perioperative coordinators and schedulers

3. Patient service centre
   - Protocol driven
   - Booked 4-6 weeks before surgery date

4. Pre-admission clinic
   - Surgery booked 2-4 weeks before planned date, no cancellations

5. Operating theatre, procedural suites
   - Electronically scheduled at the time of surgical booking

6. Beds

7. Discharge and continuing care
   - Event-driven discharge
   - Links back to GPs for ongoing care, minimising outpatient attendances

Protocol-led process throughout the entire patient journey
Drivers for Change – FutureFit

PATIENTS
• Education
• Information
• Prevention

Facilitated self management:
• IT/Map of Medicine
• Expert Patients
• Voluntary groups

System Navigators

Patient
• Peer worker
• Specialist Nurse
• Therapist
• GP
• IT

Self Help
• Guided self care

Low Professional Input
• Multiple centres for day case/minors
• Basic diagnostics (X-ray/USS)
• Access to therapies

Medium Professional Input
• One or two local centres for intermediates/day case (may or may not be co-located with high input centre)
• Diagnostics (USS/CT/MRI/Nuclear etc.)

High Professional Input
• One centre for majors (co-located with but separate from emergency centre)
  • HDU
  • Diagnostics (USS/CT/MRI/Nuclear etc.)
  • Referrals out of area for cardiac, neuro, etc.

PRIMARY CARE

INFORMED DIRECT ACCESS

Diagnosis known
(simple)

Diagnosis unknown
(complex)

Communication

Information/Education

Make It Happen
We Value Respect
Together We Achieve
Our Vision for Surgery

Services in Major Emergency Centre

• Critical Care Services
• Orthopaedic Trauma
• Major Vascular surgery
• Major colorectal surgery
• Bariatric surgery
• Major urology
• Head & Neck Cancer surgery
• Maxillofacial trauma
• Ophthalmology emergencies
• Diagnostic including cross sectional imaging

Services in Planned Care Treatment Centre

• Facility to initiate organ support and safe transfer
• Elective orthopaedics
• Breast surgery
• Venous surgery
• Hernia and laparoscopic cholecystectomy
• ENT, Max Facs & oral
• Cataract surgery & occuloplastics
• Medical retina treatment
• Outpatients and Diagnostics
The Scheduled Care Group has mapped its priorities against the Trust wide objectives:

• Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards:
  - Deliver RTT consistently and sustainably
  - Complete a root and branch review of our cancer services
  - Detailed service reviews for ophthalmology and musculoskeletal services

• Develop robust plans to achieve Critical Care quality standards
• Continue improvements in Patient Access and Outpatients Services
• Review performance of all financially challenged specialties through SLR
Our Priorities – Improving Productivity – Enhanced Recovery Programme

**Quality**
- Improved clinical outcome
- Early detection of complications
- Additional care interventions e.g. chemotherapy, radiotherapy may be given earlier if required
- Quality standards met e.g. Care Quality Commission, cancer standards, NICE guidance
- Operational standards met e.g. 18 Weeks; cancer pathways
- Harmonisation of care across the NHS

**Local health community**
- Closer working partnerships (primary care and acute)
- Improved reputations (primary care and acute)

**PATIENT**
- Improved experience
- Empowered as a partner in his/her care
- Planned, earlier rehabilitation – earlier return to normal activities (work/social)
- Reduced exposure to hospital infection
- Fewer complications and readmissions

**Staff**
- Improved multi-disciplinary experience
- Team building opportunities
- Education/training
- Improved focus on the use of technology
- Recognition for achieving improvements in quality and patient experience

**Productivity**
- Reduced length of stay
  - Bed days saved (including ITU and HDU, where applicable)
  - Potential to treat more patients with same resources
  - Increased capacity for trusts
  - Longer term tariff benefits

Proud To Care
Make It Happen
We Value Respect
Together We Achieve
## Our Priorities - Sustainable RTT Performance

<table>
<thead>
<tr>
<th>Specialty</th>
<th>RTT Admitted performance delivery date</th>
<th>RTT Non Admitted performance delivery date</th>
<th>Admitted Sustainable</th>
<th>Non Admitted Sustainable</th>
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<tr>
<td>Colorectal surgery</td>
<td>01/03/2014</td>
<td>√</td>
<td>01/05/2014</td>
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</tr>
<tr>
<td>Upper GI</td>
<td>01/04/2014</td>
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<td>01/04/2014</td>
<td>√</td>
</tr>
<tr>
<td>Vascular</td>
<td>01/02/2014</td>
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<td>01/02/2014</td>
<td>√</td>
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<tr>
<td>Breast</td>
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<td>√</td>
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<tr>
<td>Urology</td>
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<tr>
<td>ENT</td>
<td>01/07/2014</td>
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<td>01/07/2014</td>
<td>√</td>
</tr>
<tr>
<td>Max fax and oral surgery</td>
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<td>√</td>
<td></td>
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<tr>
<td>Ophthalmology</td>
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<td>TBC</td>
<td>01/07/2014</td>
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<td>Gynaecology</td>
<td>√</td>
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<td></td>
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<tr>
<td>T&amp;O upper limb</td>
<td>01/10/2014</td>
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<tr>
<td>T&amp;O lower limb</td>
<td>01/10/2014</td>
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<td>01/10/2014</td>
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<td>Spinal</td>
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<td>Dermatology</td>
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<td>Neurology</td>
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<td>Respiratory</td>
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<td>01/03/2014</td>
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<td>General Medicine</td>
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<tr>
<td>Cardiothoracic surgery</td>
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<td>Neuro surgery</td>
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<tr>
<td>Other (inc Pain)</td>
<td>01/05/2014</td>
<td>√</td>
<td>01/05/2014</td>
<td>√</td>
</tr>
</tbody>
</table>
Our Priorities - Patient Access and Outpatients Centre

• Roll out Netcall remind + outpatient reminder service to all OPD clinics

• Trial and finalise the “Friends and family test” to OPD clinics

• Work with centres to improve planning processes and embed the notion of the “reasonable offer of appointment” timing of no less than 3 weeks notice

• Improving communication within teams and centres

• Work in partnership with clinical centres and CCG colleagues to maximise Choose and Book usage

• Develop Standard Operating Procedures for nursing teams

• Develop options appraisal for evening and weekend working session

• Develop board metrics and dashboards on performance and quality metrics

• Work toward centralising admissions teams, booking teams and reception function throughout the Trust
## Cancer Services

### SWOT ANALYSIS

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Robust Peer Review schedule delivered within National deadlines</td>
<td>• Insufficient operational capacity within some specialties and departments</td>
</tr>
<tr>
<td>• MDT metrics for each MDT team established</td>
<td>• No dedicated Teenage &amp; Young Adults (TYA) lead for the Trust</td>
</tr>
<tr>
<td>• Auditable mechanism for 2WW referrals</td>
<td>• Poor compliance with Peer Review measures in some areas</td>
</tr>
<tr>
<td>• Macmillan Cancer Information &amp; Support Centre Manager in post for patient support</td>
<td>• Skin cancer patients outsourced to third party private provider without a robust SLA and penalty system in place</td>
</tr>
<tr>
<td>• Cancer Service Improvement Facilitator in post</td>
<td>Reliance on tertiary referral providers for some specialities (e.g. Upper GI, Gynae)</td>
</tr>
<tr>
<td>• Cancer Survivorship Service Improvement Facilitator recruited to commence April 2014</td>
<td></td>
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<tr>
<td>• Secured funding for Macmillan therapy team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• First appointments within 7 days (not 14 days)</td>
<td>• Lack of Clinical Nurse Specialist for some areas including TYA services</td>
</tr>
<tr>
<td>• Diagnostic investigations within 7 days</td>
<td>• Patients choosing to have treatment elsewhere</td>
</tr>
<tr>
<td>• Histopathology reporting within 7 days</td>
<td></td>
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<tr>
<td>• Appointments with Oncologists within 7 days</td>
<td></td>
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<tr>
<td>• Service improvements based on cancer patient feedback (National and local MDT Cancer Patient Experience survey results)</td>
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</tr>
</tbody>
</table>
Our Priorities - Cancer Services – Service Improvement

• Establish a Cancer Programme Board and develop a Cancer Strategy

• Ensure delivery of the Cancer waiting time standards consistently across all MDTs

• Enhance patient experience through engaging with patient representatives for pathway mapping within MDT teams

• Collaborate with all MDTs to develop a Cancer Strategy and ensure robust service model for all areas especially where current gaps exist

• Standardise operating procedures, data reporting and escalation processes to improve MDT working & patient tracking.

• Develop Health & Well Being services for cancer survivors
Our Priorities - Cancer Services – Service Developments

• Improve pathways in Lung, Upper GI, Colorectal and Urology

• Investment in Radiotherapy Service – 3rd Linear Accelerator

• Cancer Screening Programmes for Bowel Scoping and Breast age extension

• Macmillan Integrated Therapy Service
Our Priorities - Critical Care Strategy – Clinical Standards

• Current Service on 2 sites
• Dedicated on call rota
• Performance against national standards
• Recruitment Plan (next 12 months)
• Critical Care Nursing Standards
• Development of a workforce plan
• Growth in Demand
• Bed Occupancy
• Additional Capacity Business Case
• FutureFit Solution
Other Priorities - Musculoskeletal

- Challenged Speciality – Health Economy Review
- Provider of Choice
- Service Model Issues (RSH, PRH, RJ&AH)
- RTT Challenge
- Largest Income Generator but negative contribution
- Health Economy Review
- Best Practice Tariff opportunities for fractured neck of femur
- Single Orthopaedic Trauma Site – FutureFit
The focus of the scheduled care group strategy over the next few years will be to improve the efficiency of pathways and service lines, by reviewing systems and processes, while aiming to improving clinical standards, clinical outcomes and the patient experience to ensure that services are clinically and financial sustainable as the FutureFit solution becomes the reality.
The Shrewsbury and Telford Hospital NHS Trust

Unscheduled Care

Clinical Service Strategy
Drivers for Change

• Provision of a high quality safe emergency services

• Clinically and financially sustainable

• Workforce

• 7 days a week

• Changing Demographic and Patient Needs

• New model required in the delivery of Emergency and Urgent Care services
Drivers for Change

Hospitals 'on brink of collapse'

By Nick Triggle
Health correspondent, BBC News

Hospitals in England could be on the brink of collapse, leading doctors say.

The Royal College of Physicians said the triple effect of rising demand, increasingly complex cases and falling bed numbers was causing problems.

The college’s report claimed urgent care was already being compromised and warned the situation would get worse unless something was done.

But the government rejected the suggestion, saying the NHS was ready for the challenges it was facing.

Patients' lives at risk in NHS hospital wards 'on brink of collapse'

Patients’ lives are at risk in NHS hospital wards that are “on the brink of collapse” due to a critical shortage of out-of-hours doctors and growing numbers of the elderly.
Unscheduled Care – Aims & Objectives

Right place, Right person

Valued & skilled teams

Quality, safety, flow in ways that are clinically and financially sustainable
Operational concepts:

Four themes of operational working that underpin the methods by which we will achieve our aims. These are:

1. Supporting service improvements led by the specialist multidisciplinary team

2. Building resilience into processes that deliver high quality care

3. Optimally use bed base in support of patients going to the correct specialist ward

4. Engaging staff to share our values, standards and aims.
Service Improvement

ANATOMY + PHYSIOLOGY
Excellence ⇔ Excellent People

Motivated and well managed workforce

with sufficient capacity to deliver quality, safety and flow seven days a week

in a way that is clinically and financially sustainable

Appropriate environment that supports continual improvement
Quality

Cost & Workforce

Access

CLINICALLY & FINANCIALLY SUSTAINABLE
Unscheduled Care – making it happen

- Early Consultant Assessment
- Ambulatory Care
- Short Stay Ward/Unit

- Early specialist opinion
- Pull/push onto appropriate specialist ward

- Planning management and discharge
- Board Round
- Frailty Project

Integrated working with health and social care service partners
Cross site working; RSH bed reconfiguration; Site management
Stroke service; 7 Day Working; workforce review
Emergency admissions where the length of stay is zero

2.3 Count of Zero LOS Emergency Admissions : Medicine Centre

Data Updated: 2014-02-10 14:47:23
Average length of stay of an episode (excludes zero LOS) (medical only)
Unscheduled Care – Priorities

1. Embed a patient focussed safety culture to ensure that services are safe and key quality standards are achieved

2. Develop a transition plan that maintains the safety and short term sustainability of our services pending the outcome of the FutureFit

3. Develop and implement a Workforce Strategy in support of Point 2.

4. In partnership with commissioners progress service reconfiguration and service transformation priorities being Cardiology, Urgent Care Centres & Care of the Older patient.

5. Staff Engagement Plan to motivate and involve staff in service redesign, reform and reconfiguration to reduce existing recruitment issues and increase capacity

6. Identify efficiencies through service redesign and effective data capture to ensure the long term financial sustainability of services
Unscheduled Care – making it happen

Year 1 – 2 PRH

- Continuing Improvements in delivery of care to the elderly
- Further Development of Ambulatory Care
- Mitigating the risks associated with Emergency Department
- Implementation of a number of workforce initiatives
- Implement UCC Model alongside ED
- Examining Options for establishing a CDU facility within A&E
- Developing the Cardiac Centre model, in support of a Cardiac Centre for the Trust
- Open the new short stay ward (Ward 17)
- Maintain and improving the single site hyper acute, acute Stroke unit
Unscheduled Care – making it happen

Year 1 – 2 RSH

- Continuing Improvements in delivery of care to the elderly
- Further Development of Ambulatory Care
- Mitigating the risks associated with Emergency Department (ED)
- Implementation of a number of workforce initiatives
- Implement Urgent Care Centre Model alongside ED
- Establish the RSH Children’s Assessment Unit alongside ED
- Medical bed reconfiguration
Unscheduled Care – making it happen

Whole system approach

Innovative workforce
Unscheduled Care – making it happen

Improving care for those attending our Emergency Departments with Minor Illness and Minor Injury

Whole system approach

Innovative workforce
Primary Care clinicians delivering a new stream for patients who attend our Emergency departments with minor illness and minor injuries:

‘Walk Ins’
- Minors
- Majors

UCC
- Minors
- Majors
Unscheduled Care – making it happen

Improving care of the elderly in our hospitals

Whole system approach

Innovative workforce

- A&E: 4.2%
- Emergency Adms: 11.0%
- Ordinary Elective: 8.0%
- Elective Day Case: 8.4%
- Maternity: -1.4%
- 1st OP: 6.8%
- OP Procedure: 6.5%
- Follow-Up OP: 8.9%
Unplanned Acute Utilisation Rates by Single Year of Age

Males

- A&E
- Emergency Adms

Females

- A&E
- Emergency Adms

Experience Counts
Number of A&E attendances where disposal is admitted to hospital by site

3.5 % A&E Attendances under 4 Hours : (all data)

Data Updated: 2014-02-10 14:47:23

Winter 10/11  Winter 11/12  Winter 12/13
UCGE Activity – January 2014

3.1 Count of A&E Attendances: (all data)
Data Updated: 2014-02-10 14:47:23

- Winter 10/11
- Winter 11/12
- Winter 12/13
PRH Total daily number of Patients on selected wards with a length of stay greater than 14 days (Ave = 53)

RSH Total daily number of Patients on selected wards with a length of stay greater than 14 days (Ave = 49)
Model of Excellent Care for the Elderly

• “Excellence” is more a model of care than a physical location

• The absolute key to this model is the need to recognize the speed that decompensation can take hold in elderly patients.

• The benefit therefore starts with a model that focuses on optimizing individual patient potential and mobilisation from the start.

• The full benefit of this model can only be realised through whole health economy change.

• What we have learnt from other health economies which are more evolved is the benefit of being able to offer a range of options so that care can be stepped up or down according to the needs of an individual patient.

• This is more easily achieved in a vertically integrated model that has overcome the handicaps of organizational boundaries, competitive behaviours and separate funding streams
## Care of the Elderly Centre of Excellence

*This Care of the Elderly Service could be provide using a Hub and Spoke Methodology*

<table>
<thead>
<tr>
<th>Service which could be delivered in the Acute (Hub) –</th>
<th>Service which could be delivered in the Community (Spoke)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Urgent care centre, ED, CCC or direct referral from GP</td>
<td>• Community hospital beds</td>
</tr>
<tr>
<td>• Frailty team (<em>Geriatrician</em>, nurse, therapists placed in AMU and available at each stage)</td>
<td>• Community rehab service (integrated)</td>
</tr>
<tr>
<td>• Integrated social worker</td>
<td>• Virtual Ward (manage patients with comprehensive advice and care package in own home)</td>
</tr>
<tr>
<td>• Elderly Care Assessment</td>
<td>• Future potential for GP Virtual Ward hub (admission avoidance)</td>
</tr>
<tr>
<td>• Acute beds (aim for +/- 72 hour LOS and AVLOS 6 days)</td>
<td></td>
</tr>
<tr>
<td>• Acute rehab beds (stage 1 step down)</td>
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</tr>
</tbody>
</table>
Unscheduled Care – making it happen

Improving care for those Cardiac Disease requiring interventional Treatment/diagnostics

Our anatomy and physiology
Development on Cardiology

The Model below summarises how services could further develop across community, acute and tertiary care over the next 2 years subject to the necessary business case approvals.
The Model below summarises how services could further develop across community, acute and tertiary care over the next 2 years subject to the necessary business case approvals.

Anatomy
PRH – create an Ambulatory Care and Cardiac Transfer Unit

Physiology
Daily Coronary angio/intervention list
Daily AMU in reach
Unscheduled Care – making it happen

Yes, but .................................
Unscheduled Care – making it happen

Futurefit

Shaping healthcare together
One Major Emergency Centre

Our clinicians are unanimous in their view that the only clinically sustainable solution to the configuration of our EDs is a single site.

Future Fit: Acute and Episodic Care Model
Unscheduled Care Development

2 Year Plan – This plan will only mitigate the problems within the service in the short / medium term

- UCC
- Elderly care
- Specialist Service Improvements
- Cardiology
- Stroke
- Haem/Oncology
- Renal
- Workforce

Futurefit
Shaping healthcare together
The Unscheduled Care Group have an exciting and challenging strategy for the next few years, this is seen as a period of evolution, during which services will be developed to provide the best possible outcomes and quality within the physical constraints of the Trust. This period of evolution is also seen as critical in ensuring SaTH is able to recruit high quality staff into all posts, to deliver a sustainable service while moving forwards the single major emergency centre becoming a reality