

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held on Thursday 25 August 2011
Lecture Theatre, Education Centre, Princess Royal Hospital

PUBLIC SESSION MINUTES

Present:	Dr J Davies	Chairman
	Mr M Beardwell	Non Executive Director (NED)
	Mr B Simms	Non Executive Director (NED)
	Mr D Jones	Non Executive Director (NED)
	Dr P Vernon	Non Executive Director (NED)
	Dr S Walford	Non Executive Director (NED)
	Mrs S Assar	Non Executive Director (NED)
	Mr A Cairns	Chief Executive (CEO)
	Mrs V Morris	Director of Quality & Safety/Chief Nurse (DQS)
	Dr A Fraser	Medical Director (MD)
	Mr N Nisbet	Finance Director (FD)
	Mrs J Clarke	Director of Compliance & Risk Management (DCRM)
	Mrs D Vogler	Director of Strategy (DoS)
In attendance	Mrs B Graham	Committee Secretary
	Mr Adrian Osborne	Director of Communications
Apologies:	Mrs T Cookson	Chief Operating Officer (COO)

2011.1/105 WELCOME - The Chairman welcomed everyone to the meeting and confirmed that this was a meeting held in public and not a public meeting. However, due to the interest in the Future Configuration of Hospital Services - Outline Business Case item the Chairman proposed to allow questions from the public before the Board voted on the proposal.

2011.1/106 DECLARATION OF INTEREST by members in relation to any matters on the agenda : None.

2011.1/107 MINUTES OF THE MEETING HELD IN PUBLIC on 28 July 2011 were **APPROVED**.

MATTERS ARISING FROM THE MEETING HELD ON 28 JULY 2011	
(20.1)	Foundation Trust Update – Trust Executives met with the DoH and SHA in August to review the development plan to become an NHS Foundation Trust. At the conclusion of this meeting, there was a general agreement to support SaTH's application for FT status by December 2013. The Trust will now finalise the milestones within the Tripartite Agreement and submit this to the DoH and SHA for formal approval by end of August. Action: DCRM.
(61.1)	Quality Report "Protected meal times" : The Hospital Executive Committee (HEC) is committed to resolving the issue and updated protocols will be available in September. Action: DQS.
(61.3)	National Inquiries and External Reports – Report to be brought back in September. Action: DQS
(74)	Annual Report & Summary Finance Statements – Item on the agenda. Item complete.
(83.1)	Productive Operating Theatre Project – Report due in 6 months. Action: COO – Jan 2012
(83.2)	Urgent Care Network Update – Winter Plan scheduled to be signed off with PCTs in September. Action: COO.
(83.3)	Quality Account 2010/11 – An Executive Summary will be produced for the AGM. Action: DQS/DoC.
(85.3)	Board Development Plan – Work is progressing and feedback would be received at the Board Development sessions planned for 14 th September and 18 th October, 2011. Action : Chairman
(89.1)	AOB : Security Issue – The CEO advised that a review of Security matters was underway and the outcome will be reported to the September meeting. Action: CEO

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Chairman
29 September 2011

(97.4)	Quality Report – Q&S Review Visit – Item on the agenda. Item complete .
(98.1)	Finance Report M3 – Items relating to SHA support and Bed Watch practices are covered under the Finance Report. Item complete .
(99.1)	Future Configuration of Hospital Services – Item on the agenda. Item complete .

2011.1/108.1 CHAIRMAN'S REPORT

New Appointments

The Chairman said he was delighted to announce the following two appointments to complete the Executive Management Team :

- Victoria Maher has been appointed as Workforce Director and she will take up her position on a full-time basis on 17 October 2011. Victoria's NHS experience has included senior roles in both Stoke on Trent Community Health Services and The Dudley Group of Hospitals NHS Foundation Trust.
- Adrian Osborne has been appointed Director of Communications. Formerly, he was the Trust's Head of Communications & Business Development.

SHA/PCT Update

As a result of the delays in taking the Health and Social Care Bill through Parliament, the following interim arrangements will now take effect from September 2010:

- West Midlands SHA will cease to exist and will become a part of the Midlands and East Cluster. Sarah Boulton has been appointed Chair and Executive appointments are due to be made by end of September.
- Although The Trust's operational relationship with Commissioners will be through the West Mercia Cluster, the Shropshire County PCT and Telford and Wrekin PCT will continue to exist as separate legal entities and their Boards will continue to meet in order to discharge their governance responsibilities.

Update on Meetings during the month :

- The Chairman said he had met with the Chairman of the South Staffordshire & Shropshire Healthcare NHS Foundation Trust (Mental Health Trust) and that they were keen to work with SaTH in three areas : Tele Medicine, Liaison Psychiatry and Self Harm issues.
- A meeting had taken place with NHS T&W Board to discuss quality and safety issues. This was a very useful meeting and a positive response was received from the Board.
- The Chairman attended the SHA Chairs meeting at which the main theme had been Stroke Services. SaTH was identified as one of the best performing Trusts in the West Midlands.

Mr Beardwell (NED) said access to appropriate psychiatric advice and support in A&E had been an issue for the Trust for a number of years. He asked if there was any indication that our patients might have access to consultant psychiatric advice in A&E. The CEO said there is a great deal of goodwill with the Mental Health Trust and they accepted that it is their responsibility and that they would respond with some degree of urgency to draw up a plan. In addition, there was agreement to do some joint work around patients in the hospital, designing a different way of working to enhance the quality of care and provide additional support to patients and carers; and also to speed up the efficiency of care for these patients. The CEO said he would report back to the Board in a couple of months **Action: CEO - Nov 2011**.

Mr Simms (NED) noted that SaTH was one of the best performing Trusts in the West Midlands in terms of Stroke Care and he asked how the population could be made aware of this achievement. The CEO said that whilst he accepted that some progress can be confirmed - and he paid tribute to Dr Campbell and his Team - he would not be entirely satisfied until SaTH was best performing Trust in the country. He recognised that this would be hard to achieve as there were some challenges to overcome, particularly in access to neurosurgery. Mr Simms (NED) accepted this view but felt there was a lot of good work going on within the hospital and he was concerned that the 500,000 population that we serve are not aware of this. The CEO spoke of an example where the Trust had been nationally recognised for its Colorectal Cancer service as best in the country with the best survival rates over the last 12 months. The Royal College of Surgeons had acknowledged this achievement and it had attracted a lot of Press coverage and he said in this particular instance it was right to be proud of this service.

2011.1/108.2 CHIEF EXECUTIVE'S REPORT

The CEO reported that the Trust has been through a difficult period during which some of the promises given to our patients had not been met, however, improvements are now being seen, in particular:

- A&E 4 hour maximum wait target of 95% was now being achieved on a regular basis despite huge pressures.
- HSMR is falling and, more importantly, crude death rates are falling. He noted that this is likely to mean that the quality of care is improving - and there were encouraging signs in clinical quality that needed to be acknowledged.
- Cancer Services (31 and 62 day referral to treatment) waiting time standards have been difficult to achieve over the last few months but the CEO was confident that from September the Trust will start to achieve these standards on a consistent basis.
- Patient fall numbers are statistically declining and this is about getting ward managers and staff to understand what they can do to make the environment safer and this is coming through via the LIPS Programme.
- Pressure Sore numbers have significantly reduced as a result of the DQS and her team doing a great deal of work to make sure the standards are being worked through.
- Venous Thromboembolism (VTE) performance has improved in terms of the requirement to assess and treat proactively the risk of developing a blood clot in the vein. Performance has risen to 80% which is a significant improvement since April and this is due largely to the work of the MD.

The Chairman noted that this all round improvement was very encouraging and was a great tribute to the work of the CEO and the Executive Team. He thanked everyone for their contribution but also recognised that there was more work to be done.

2011.1/109 QUALITY AND SAFETY

109.1 WEST MIDLANDS SPECIALISED COMMISSIONING – RSH TRAUMA UNIT DESIGNATION SUBMISSION

The Chief Executive, on behalf of the COO, introduced the paper and explained that there is evidence that there is a clear benefit to patients if they can get to a Trauma Centre as fast as possible when seriously injured. Trauma Centres have all the relevant surgical and medical facilities on site such as neurosurgery and cardiothoracic support but as part of the pathway of care to ensure patients are stabilised and safely transferred to Trauma Centres a number of Trauma Units need to be established. West Midlands Strategic Commissioning Group aim to establish a small number of Trauma Centres and a network of Trauma Units across the region and based on our rural geography SaTH has been invited to apply to be a Trauma Unit. Consistent with the existing model, an informal Expression of Interest was submitted as requested on 27th July to request that Royal Shrewsbury Hospital A & E Department be part of the Trauma Unit network, and a self assessment was submitted on 9th August.

The CEO confirmed that if successful there would be no change in terms of reconfiguration nor in the way trauma services are currently provided in either of the Trust's hospitals, in particular, complex traumas will continue to be directed to the RSH site. The Board was assured that this would not adversely affect PRH A & E Department. The CEO said he was very confident that RSH would be successful in securing designation as a Trauma Unit.

The Board **APPROVED** the submission to designate RSH A & E Department as a Trauma Unit.

The Chief Nurse/Director of Quality & Safety (DQS) introduced the item and referred to the Q&S Review Visit undertaken jointly by the SHA, West Midlands PCT Cluster and the 2 local PCTs on 11 July 2011. Following the visit there were key issues that needed urgent attention and an action plan was **TABLED** for the Board's information. There are some particular issues that need to be worked through further, including medical staffing and our response to patients with deteriorating conditions. Mr Simms (NED) said it was refreshing to see a proper action plan with clearly defined deliverables and timescales. Dr Vernon (NED) added that the quality of data was also important (e.g. in terms of VTE and pressure sores) and consequently the Board now knows where the problems are and this gives the Board confidence that the MD and DQS will get the right results. Dr Vernon added that the Q&S Committee will continue to monitor the action plan.

The Board **NOTED** the Action Plan.

2011.1/110

PERFORMANCE

110.1

FINANCE UPDATE

The Finance Director (FD) introduced the Finance Report which summarised performance over the period April to July and also provided a forecast outturn for the year. The FD specifically briefed the Board on the following :

- **Month 4 Financial Position** showed a year to date deficit of £1.125 million versus a planned deficit at the end of July amounting to £746k.
- **Income** in the month of July showed a surplus of £491k which was £153k better than planned and partially compensates for adverse performance versus plan in the previous three months.
- **Pay Budgets** – spending on Pay was £124k below budget but year to date there was an overspend of £387k. However, concerns remain over the level of cost incurred in respect of Agency medical staffing which in the month of July exceeded budget by £334,000, and as a result, at the end of July the Trust had overspent by £1.126 million on medical staff.
- **Forecast Outturn** - without management action the Trust is predicting an overspend at the year end amounting to £2.944 million, as a consequence of a Pay overspend amounting to £1.2 million, Non-Pay overspend of £1.4 million and a delay in the closure of ward beds (estimated at two months) costing the Trust £344,000. Management actions have been identified over the use of temporary nursing and medical staff, which, when combined with tighter budgetary controls over Pay and Non-Pay budgets, generate cost savings amounting to £2.6 million. It is planned to reduce agency staff close to zero by October 2010. The second phase of ward closures will be brought forward from January 2012 to November 2011 to enable the Trust to recover £344,000.
- **Liquidity** - Short term liquidity concerns have led to a slight deterioration in the speed of payments to suppliers (from 81% paid within 30 days in June to 78% in July). The Trust is however to receive in full cash in respect of the support provided from the SHA which will enable these liquidity issues to be addressed.

The FD expanded on the changes being put in place which included the MD leading a group to look to improve the whole process of appointing medical agency and locum staff. The team is set up and it is expected to see a more rigorous approach within six weeks and a reduction in the amount of spending for the remainder of the financial year.

Dr Vernon (NED) said that it was a tremendous improvement to finally see that agency staff costs are being effectively controlled and to see that the FD is following these costs on a weekly basis is a real step forward.

FINANCE REPORT (Continued)

The MD said that our agency medical and locum costs were running at £9.6 million a year, which is too high. He reported that it had been decided to make certain changes in terms of not filling consultant posts immediately with agency staff; using standard agency contracts and improving control of middle and lower grade medical staff. Also, the Medical Staffing activity will be consolidated into one department and discussion is ongoing with regard to their willingness to cover weekend on-call duties. The fill rate for FY1 medics is important and the Trust has become part of the Black Country Deanery which is expected to improve future fill rates.

The FD said that one area of concern within the financial recovery plan was the slippage in the closure of wards. The plan was that the 1st Phase would take place in August 2011 and the 2nd Phase in January 2012. However following discussion at the Hospital Executive Committee (HEC) on 23 August it was clear that medical staff recognised the need for urgent action. It was agreed that a proposal would be drawn up for September to bring the two phases together to close 100 beds by November 2011 which will allow the financial recovery and other savings.

The FD advised that the July Board meeting of the SHA had approved £6.5 million support and that the Cluster would be making the payment to SaTH as a single lump sum payment in August. The Board agreed this was really positive news which demonstrated the good working relationship which now existed with the Cluster.

Mr Jones (NED) referred to the month by month spend figure for non pay costs which showed an increase of £1 million in August. The FD said this is being looked into but that early indications were that it related to purchase of disposables following the commissioning of the CSSD.

Dr Vernon (NED) said he had recently visited one of the Wards when a Ward Manager suggested that they do not receive a non pay budget as it sits above them. He asked if this could be investigated to ensure that the right people are holding the budget. **Action: FD.**

The Chairman referred to the high cost of Bed Watches which was highlighted at the July Board and asked for assurance that the new procedures had been introduced to control the cost of this activity. The DQS advised that there were now clear controls on the use of staff for Bed Watches and authorisation for agency staff is now much more robust. The DQS said that in the future there will be a central recruitment process for nursing and agency staff.

The Board **NOTED** and **APPROVED** the actions being taken to address the forecast deficit; and **NOTED** the Month 4 financial position.

The Finance Director (FD) introduced the Performance Report for Month 4. He noted that the CEO had covered certain areas within his Report and therefore focussed on the following :

B9 Reflect Commissioner's Plans in our capacity plans and delivery our contractual commitments. In terms of delivery this is an ambitious programme to be delivered by March 2012. The delivery of Referral to Treatment (RTT) targets remains a significant challenge for the Trust and is subject to ongoing discussions with the PCTs. The FD said there were multiple reasons why RTT targets are not being achieved. A proportion relies on PCTs taking certain action to reduce activity and an element of this had slipped. Patient Choice was another factor for example in Ophthalmology extra capacity had been provided in Telford but despite this patients were choosing to wait over the 18 weeks to be treated at RSH. The Trust is also working to better manage the scheduling of patients which could improve the position. The FD said progress is being made but not at the required pace. The CEO added that 100 additional operating lists had been performed per month over and above our normal capacity and 100 additional clinics held which reflected the huge effort being made to resolve the situation. The Intensive Support Team (IST) had been asked to return to the Trust because the Trust wanted to ensure that the Patient Administration System is fit for purpose. IST suggested that the trajectory should be adjusted to ensure it is realistic. In relation to the 62 Day Cancer 85% target – our performance was 81.4% in July which showed an 8-10% improvement over the last two months. It was noted that this involves a small number of patients. Work is being undertaken to identify the most problematic areas (Urology and Lower GI) and it is envisaged that this will move us back towards the target. The FD warned that although the 85% target may be achieved in month he was concerned that the accumulative delivery of the target may not be achieved in the full year.

A5 Eliminate Waste and Non Value Adding processes. The Reference Cost Index is produced annually as a national submission to the DoH. The calculations are based on FCE data rather than spell data and SaTH has an FCE to spell ratio significantly higher than the national average and the unit price calculated is diluted which improves the Trust's RCI. As a result the RCI, although a measure, does not truly reflect the Trust's cost per spell of care. The FD said this is not a very useful measure but it does confirm that the Trust is expensive.

Dr Vernon (NED) referred to the Balanced Scorecard chart and pointed out that there were too many blank columns. The DoS said that by Quarter 3 she expected to bring further measures to the report. The report will continue to be reviewed as part of Board Development to determine whether there was too much or too little information. The CEO referred to the Board Development sessions scheduled for September and October as an opportunity to review the report in more detail. It was **AGREED** to return to this item in 2-3 months time. **Action: CEO/DoS – November 2011.**

C6 Ensure patients suffer no avoidable harm. The DQS pointed out that there were actually 10 Serious Incidents in July (not 9 as stated in the report).

The Board **NOTED** the performance in Month 4.

2011.1/111 GOVERNANCE

111.1 SCHEDULE OF ITEMS PURCHASED BY THE LEAGUE OF FRIENDS

The FD introduced the paper which informed the Board of the generous purchases of hospital equipment by the Friends of the PRH totalling £188,012.00; and the Friends of RSH totalling £196,253.99 during the period April to August 2011.

111.1 SCHEDULE OF ITEMS PURCHASED BY THE LEAGUE OF FRIENDS (Continued)

Mrs Assar (NED) informed the Board that she had taken over as Chair of the Charitable Funds Committee and at a handover meeting in June both Leagues of Friends reinforced their wish to work together rather than as two separate organisations. She felt that this was very encouraging. It was pointed out that the list of equipment should normally have been funded by the Trust but it reflected the financial difficulties of the Trust. It was suggested that it would be appropriate to write to the Chairs of the LoF's confirming that the Board had received the report and formally recording the Board's appreciation. **Action: Chairman.**

The Board **NOTED** the generous purchases by both Leagues of Friends and expressed their appreciation for all the hard work involved in raising these large sums of money.

The Chairman also took the opportunity to refer to the recent Ceremony to mark the start of construction at the new Cancer Centre at RSH in which the major contributor was the Lingen Davies Charity. The Shrewsbury League of Friends had also made a contribution to the project.

111.2 CAPITAL EXPENDITURE APPROVALS PROCESS - The Board **AGREED** to **DEFER** this item to allow the opportunity to incorporate a revised Delegation of authority. **Action: Finance Director.**

111.3 DRAFT ANNUAL REPORT & SUMMARY FINANCIAL STATEMENTS 2010/11

The FD introduced the item and advised that the Trust is required to produce an Annual Report, reflecting the Annual Reporting requirements for NHS Trusts as set out in the NHS Finance Manual and to present it to the Annual General Meeting (AGM) before the end of September following the reporting year. The FD presented the Annual Report and Summary Financial Statements 2010/11 for approval subject to any final amendments. Subject to approval and final amendments, the Director' signatures and independent Auditors statement will be included in the printed Annual Report for presentation to the AGM on 15 September 2011.

Following discussion it was agreed that the Director of Communications would provide an Addendum to the Annual Report setting out the strategy as part of Looking Forward to 2011/12.

The Board :

- **APPROVED** the Annual Report and Summary Financial Statements 2010/11 subject to final amendments including the Director' signatures and the independent Auditors statement.
- **CONFIRMED** to the best of its knowledge and belief that there is no relevant audit information of which the Trust's Auditors are unaware and that members of the Trust Board have taken the steps they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust's Auditors are aware of that information.
- **AGREED** that the Director of Communications would provide an Addendum to the Annual Report setting out the strategy as part of Looking Forward to 2011/12.

The Chairman appreciated the efforts of all who contributed towards the report and thanked them on behalf of the Board.

112 STRATEGY

112.1 FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (OBC)

The Director of Strategy (DoS) confirmed that the Board had received an update every month since the public consultation was approved. The OBC has been built on the outcome of the public consultation and supports the implementation of reconfiguration of some hospital services between the Princess Royal Hospital in Telford (PRH) and the Royal Shrewsbury Hospital (RSH). The programme of work had taken 6-9 months and focused not only on the new build but also changes in redesigning models of care that will continue over the coming months and years.

FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (Cont'd)

The CEO introduced the Outline Business Case (OBC) and gave a PowerPoint presentation (*copy of slides attached*). He said the proposal will secure high quality, safe and sustainable local hospital services; making sure we continue to provide 24 hour acute surgery and making sure the range of inpatient Women & Children's services are maintained by planning to move out of the deteriorating Maternity building.

The CEO said it is important to note that this reconfiguration only affects some of the services in the Trust. Most services for most patients will remain the same such as: A&E services at both hospital sites, most outpatients and diagnostics unchanged and most day case procedures unchanged; children's Assessment Unit at both hospitals (24 hours at PRH; 13 hours at RSH); Midwife Led Unit at both hospitals and emergency medical patients and emergency surgery at both hospitals (e.g. heart attacks, serious chest infections, road traffic accidents). Areas that would change will include improved new facilities for cancer patients at RSH, Surgery will be concentrated at RSH, Head and Neck inpatients will move to PRH and new modern facilities at PRH will provide safe and sustainable Maternity and Children's Services.

The OBC was prepared in accordance with the agreed standards and format for business cases in line with Department of Health and Treasury's Five Case Model of the OBC exploring the scheme from the following five perspectives:

- The Strategic case – describes the case for change, why the proposal is necessary and how it fits with local and national strategies;
- The Economic case – asks whether the preferred solution meets future service requirements and offers best value for money;
- The Commercial case – tests the likely attractiveness of the proposal to developers and outlines the approach of using P21+ best practice framework;
- The financial case – asks whether the financial implications of the proposed investment is affordable and confirms the funding arrangements;
- The management case – highlights implementation issues and demonstrates the Trust's capability of delivery.

All five cases had been addressed in the OBC as detailed on the slides. Future population changes have also been taken into account to manage the consequences of future growth e.g. the numbers of people aged 65-79 will increase significantly over the next 5-10 years. Benchmarking has indicated that other hospitals are achieving more and therefore part of the plan is to become more efficient. The CEO said that the organisation is fully committed to offering patients more productive and high quality services than currently offered and from a taxpayer's point of view it is very important not to "over build".

Bringing the two Inpatient Paediatric Units on to a single site will cost more to ensure the right staffing levels for a much bigger PRH Unit. It has been agreed through clinically led discussions that it would be right to have a Paediatric Assessment Unit (PAU) at PRH and RSH both adjacent to Emergency Care, this way staff will work across both and share their expertise. There will be increased consultant availability at peak times; introduction of Advanced Paediatric Nurse Practitioner roles and three consultant rotas - one each for PRH and RSH (in support of A&E and PAU) and the Neonatal Intensive Care Unit. There will be a separate Paediatric Oncology Service. In terms of the model offered in Paediatrics at RSH – a vast majority of children attend A&E and these children are not seen by a Paediatrician, however, within the proposal in the event that support from a Paediatrician is required in A & E, there will be access to a consultant paediatrician.

As part of the case it has been recognised by clinical teams that over the course of next few years space can be reduced, for example in Obstetric the numbers indicate fewer beds so recognising that the Trust needs to continue to work on efficiency.

FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (Cont'd)

Economic Case: an appraisal of the options was conducted both non financial and financial assessments:

PRH - Option 4 is recommended to provide a 2-storey new build to include:

- Antenatal obstetric inpatient beds,
- Delivery suite,
- Neonatal Unit (NICU, SCBU),
- 2 Obstetric theatres and support accommodation,
- Parents accommodation,
- Transitional care obstetric beds,
- Paediatric oncology
- Some paediatric inpatient beds (including adolescents bays)
- Paediatric outpatients.

One of the principal benefits of PRH is to reuse and refurbish the site covering :

- Postnatal obstetric inpatient beds,
- Paediatric inpatient beds,
- Paediatric Assessment Unit (PAU),
- Inpatient Head and Neck beds (Ward 8),
- Inpatient gynaecology beds,
- Gynaecology assessment and Colposcopy and
- All non clinical support (i.e. relatives overnight, administrative centre, teaching space).

There is also an additional car parking area. A more detailed transport plan is being developed including the provision of a shuttle bus between sites.

RSH - Option 6 is recommended for relocation and refurbishment to include :

- Acute surgery consolidation on Level 4 Ward Block
- SAU & MAU reconfigured to provide an integrated assessment zone utilising adult Head & Neck Ward;
- Midwifery-led Unit and antenatal clinic, EPAS and PANDA relocated on ground floor Ward block
- PAU located adjacent to A&E in vacated Paediatric Head & Neck Unit
- Administrative staff relocated from Admin Corridor Outpatients block; HR Houses at PRH and off site at Douglas Court to Maternity Block;
- Paediatric Outpatients relocated to current Admin Corridor Outpatient Block.

Commercial Case: the use ProCure 21+ a DoH team is being recommended as it offers best value in terms of capital and revenue costs through improved efficiency and elimination of waste, reduces many risks to the project costs and timetable and removes much of the adversarial nature of the design and construction management process.

Financial Case: A preferred capital option for both RSH and PRH has been identified, requiring a necessary capital loan of £34.96 million repayable over 27 years. PRH solution will cost £28 million and RSH solution will cost £6 million. The impact on the Trust of additional revenue costs is £1.5 million in 2014 rising to £1.6 million in 2021. The CEO said that it is believed that through a Cost Improvement Programme (CIP) developed for the next 3 years it can support this additional cost. For this there are eight prioritised CIP schemes for 2012/13 including capacity management, medical workforce – locums, nursing workforce – agency, admin and clerical review and a robust programme management.

Management Case: There is a sound programme structure in place with the Office of Governance Commerce assurance. If the OBC is approved there is a set of objectives including the appointment of a Project Delivery Director. The Assurance Framework processes included Local Assurance Panel, Office of Government Commerce, National Clinical Advisory Team, Joint Health Overview and Scrutiny Committee, Clinical Assurance Group and Equality Impact Assessment.

FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (Cont'd)

The CEO said an important part of the consultation was the whole question of travel. A significant amount of work had taken place with the West Midlands Ambulance Service and the Welsh Ambulance Service and he wished to pay tribute to both services in regard to this. There is now a Memorandum of Understanding about to be put in place. They will communicate with each other so that an English Ambulance can respond to a Welsh call and vice versa. Capabilities have been strengthened with a network of first responders in rural locations providing increased ability to attend to urgent calls. This has never been developed before. Additionally both services will employ community paramedics over the next few years. They are also working with BT in relation to locations and postcodes.

The CEO confirmed that SaTH has been working with parents, listening to concerns around children's service and addressing those issues e.g. providing individual plans on how to access the service around the clock and managing transport for families with children undergoing chemotherapy; also simplifying access to transport for routine appointments in and out of the county; and improving door to needle times.

There is an aim to improve transport between the two sites and more work is required and engagement with the communities. If the OBC is approved there will be additional car parking at PRH, the development of a shuttle bus and a series of options to reduce congestion on both sites and car usage of staff.

The CEO said there is a lot more work to be undertaken to make sure that the Full Business Case is completed by March 2012 including continuing to work with clinicians, staff, local communities and engage with local partners and stakeholders. The CEO formally sought the approval of the draft OBC and put in place arrangements for capital of £34.96 million and to ask the SHA to approve the OBC on 27 September 2011 to enable the building can commence on site in 2012.

Attachment 2 updates the Board on recent activities within the wider Programme of work that is ongoing relating to Public and Stakeholder engagement and the progress with ongoing assurance activities that will continue into the next phase should the OBC be approved.

Mr Beardwell (NED) said it was a good moment to see this project moving forward and he congratulated officers who had contributed to this so far. He asked the following questions :

- (i) *During consultation some NEDs met with Paediatricians and Neonatologists who advised of their concerns about the proposals but said they said they would be content to make the proposals for Paediatrics work safely for patients. What discussions have taken place with the consultants in recent months and do they have any remaining concerns and if so would these be met.* The CEO said that the RSH Paediatricians and Neonatologists had initially raised some concerns at the start of the process but with goodwill they worked with the Medical Director and are now prepared to sign up to agreed care pathways. It was pointed out that this change is what is being recommended in new guidelines from the Royal College of Paediatricians. As an illustration of support, one of the Neonatologists is leading work to look at the experiences in Scotland. She is developing assessment skills that will secure a safe and workable solution. The MD added that the last surgeon appointed to PRH in Breast Surgery is also trained in Paediatric surgery so her expertise will be invaluable.
- (ii) *Why has the figure 13 been chosen for hours of PAU at RSH, and what happens 5 minutes after "closing"?* Paediatric Assessment Unit is not an inpatient children's unit but a unit which provides very defined and clear services for children. Royal College data has been followed which advises that this facility can only be offered where it makes sense to so do. After 10 pm the proposal is to taper off the service from approx. 8 pm to cease taking in new patients. At night time mum rings the GP, and if the GP decides the child needs to be admitted the GP calls for an Ambulance and the child goes straight to Telford. The CEO pointed out that we will never turn anyone away. If mum brings a child straight to hospital at 11.30 pm the child will be treated through A&E (backed up by a Paediatrician) to stabilise that child and make a decision whether to transfer to Birmingham Children's Hospital or safely transfer to Telford. Staff between A&E and PAU will be working across units and A&E staff will be trained in Paediatrics. The CEO added that through the consultation it has proved very helpful to hear people's concerns and it is proposed to continue to seek their views in future.

FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (Cont'd)

- (iii) *Asked for details of current discussions with all ambulance services on response and travel times. When can we expect a resolution?* The CEO said he believed through the consultation process that the Ambulance response times have already started to improve. The move to a community based model provides a much more mobile paramedic service.
- (iv) *What is the specific capital spend at RSH and how is this broken down? Will this spend compromise our future needs for major capital spend or deplete areas of RSH?* The CEO said this is an attempt to deal with very specific patient safety and sustainability issues. The only route to be taken to deliver the financial plan is to become more efficient in the use of resources and in generating surpluses.
- (v) *When will the surgical inpatient service start to be transferred from PRH to RSH?* The CEO advised that acute surgery covers three specialties - vascular, colorectal and upper GI surgery. On vascular surgery there is an opportunity to develop part of the national programme for Aortic Aneurysm (AA) Screening in Shropshire and the contingency is to offer 24/7 AA surgical service. We are looking at whether we can shift 7 cases from PRH to RSH therefore concentrating vascular surgery hoping to be achieved by April 2012. Colorectal is much larger and more complex and entails a significant amount of intensive care to our organisation. A series of options are being developed to speed up the process. Upper GI – plans are being developed which involve deciding where to site the bariatric surgery dimension.

Mr Jones (NED) asked for more detail in relation to the overall bed model for the future. The CEO said that the demography of our population is changing and the forecast over the next 10 year period would present additional demand equating to 180 beds. That level of growth would be unaffordable and therefore other solutions have to be sought (e.g. people will be treated at home, technology and different kinds of medication). In terms of planning physical space some progress has been made in the way our medical patients are cared for to create some space as part of the solution. Within the new build we have agreed specific elements of the service and there is confidence around this. Conversations have taken place at HEC and there is an absolute understanding that we can do better. Dr Walford (NED) endorsed the CEO's comments and confirmed that these are realistic assumptions.

Mrs Assar (NED) asked for further information regarding the Programme Management arrangements. The CEO said that depending on approval of the OBC from this Board and the PCTs, a Programme Director would be in post by October/November and the support team to progress the work to Full Business Case (FBC) stage. A Programme Board would also be set up with representation from the Trust Board and PCTs in order to make sure that all the strands are covered and changes made will be in the right order and deliverable. It will also hold developers to account and ensure all the assurances are kept.

This item was opened up to the general public for further questions :

Mrs Caroline Bond asked if the Trust planned to demolish the Maternity Unit building at RSH.

The CEO said the building was wholly unfit for clinical accommodation however it was being considered for office accommodation, subject to light refurbishment, particularly as the Trust is currently paying heavy duty rent for offices at Emstrey Business Park and could also accommodate some movement of back offices to release prime space.

FUTURE CONFIGURATION OF HOSPITAL SERVICES (FCHS) OUTLINE BUSINESS CASE (Cont'd)

Following questions from the Chairman the CEO confirmed the following :

- Urology is mostly day surgery and will stay as it is but a small amount of urology inpatient work will be maintained on RSH site.
- Stroke : The challenge of offering a modern stroke services including 24 hour thrombolysis on two sites has been overcome by operating a Stroke team “out of hours” in conjunction with Stoke and Mid Staffs through the use of tele health.
- Radiology : The two Radiology Departments now operate as a single Radiology Department on two sites and this has transformed the service in terms of radiology reporting.
- £34 million capital funding – Approval of the OBC is expected from the SHA Board on 27 September 2011 to move to a Full Business Case (FBC). Approval of the FBC is contingent on SaTH demonstrating its financial viability and therefore it is absolute that we deliver our financial targets this year to put forward our request for the funding. We also need to demonstrate that our plans for 2012-14 are very robust, the CEO said he was confident of this. When the FBC is approved in March 2012 we will submit a request to the SHA for approval and the DoH will then release the money. It was clarified that the cash is not secured until the end of the financial year so we proceed on that basis. The FD said that the contractor is content with this arrangement and he explained the advantages of appointing ProCure 21+ as they belong to an Executive Group of Contractors to allow change in the risk profile.

The Trust Board :

- **APPROVED** the Outline Business Case for the Future Configuration of Hospital Services for commending to the SHA Board; specifically the preferred capital options for both RSH (R6) and PRH (P4), the requirement for a Department of Health capital loan of £34.96m repayable over a period of 27years and ProCure 21+ as the preferred procurement strategy.
- **AGREED** to progress the FCHS work programme to Full Business Case stage subject to receiving the necessary support from the Boards of NHS Telford and Wrekin and Shropshire County PCT and the approval from NHS West Midlands (NHSWM) and **NOTED** the timescale for submission of the Outline Business Case to the Boards of the Primary Care Trusts and NHSWM Strategic Health Authority.
- **NOTED** the high level milestones for the next phase of the FCHS Programme notably the workforce implementation and change management plan, (Section 11.2.8) the procurement strategy and implementation timescales (Section 15.5) and the programme management arrangements (Section 17.0) within the OBC.
- **NOTED** that a more detailed programme and resource plan for the next 6 months for all work streams within the FCHS Programme will be presented to the Trust Board at the September meeting for approval.
- **NOTED** the continued progress on the wider Future Configuration of Hospital Services Programme and in particular the Public and Stakeholder Involvement events and the ongoing assurance activities.

The Chairman, on behalf of the Board, thanked all those involved in the preparation of the Outline Business Case in particular Debbie Vogler, Kate Shaw, Chris Benham and Chris Needham for their hard work. He looked forward to receiving the Full Business Case in the future.

2011.1/113 **OUTCOME SUMMARIES FROM COMMITTEES**

- **Finance & Performance Committee – 26 July 2011 received and noted.**
- **Hospital Executive Committee – 26 July 2011 received and noted.**
- **Risk Management Executive Committee – 2 August 2011 received and noted.** The CEO confirmed that a more established reporting process to the Audit Committee will commence. The DCRM said that the Risk Register was going through validation for presentation at the September meeting. The CEO added that the list of attendees including senior doctors and clinicians gave a good indication that risks were being acted on.
- **Clinical Quality & Safety Committee – 21 July 2011 received and noted.** Dr Vernon (NED) said the outcome summary showed the depth of issues being dealt with e.g. delayed transfers of care, SHA review and external reports. He said the quality report is the prime focus of the meeting where the concentration is on pressure sores, VTE, mortality and falls. He added that work is ongoing to improve transfer of care between SaTH and the community.

The Chairman added that the Board relies on the work of Committees to keep the full Board informed of areas of concern and he took the opportunity to thank everyone involved for their hard work.

2011.1/114 **ANY OTHER BUSINESS – None.**

2011.1/115 **QUESTIONS FROM THE FLOOR**

Comment Mr Tom Jones, PALS Volunteer, paid tribute to Mr Craig for the excellent care he received whilst a patient of his.

Mr Jones said he was concerned about the condition of the building at PRH in particular the guttering around the buildings which needs urgent cleaning. Patients and visitors have noticed that water has started to run down the walls of the building.

A The Chairman said he had also noticed this problem and he would be following it up personally. **Action: Chairman.**

2011.1/116 **DATE OF NEXT MEETINGS :**

- **Thursday 15 SEPTEMBER 2011 at 3 pm in Dinwoodie Theatre, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.**
- **Thursday 29 SEPTEMBER 2011 at 9.30 am in Seminar Rooms 1 & 2, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital.**

The meeting then closed.

UNRESOLVED ITEMS FROM TRUST BOARD MEETING HELD IN PUBLIC ON 25 AUGUST 2011

Item	Issue	ACTION LIST
20.1	Foundation Trust Update The Trust will finalise the milestones within the Tripartite Agreement and submit this to the DoH and SHA for formal approval end of August.	DCRM
61.1	Quality Report Protected Meal Times – HEC is committed to resolving this issue and updated protocols will be presented to HEC in September.	DQS – Sep 2011
61.3	National Inquiries and External Reports - Report to be brought back in September 2011.	DQS – Sep 2011
83.1	Productive Operating Theatre Project - A further report was required in 6 months time.	COO - Jan 2012
83.2	Urgent Care Network Update Winter Plan scheduled to be signed off with the PCTs in September.	COO – Sep 11
83.3	Quality Account 2010/11 This will be produced for the AGM.	DQS 15 Sep 2011
85.3	Board Development Plan – Work is progressing and feedback would be received at the Board Development sessions planned for 14 Sept and 18 Oct 2011.	Chairman Sep&Oct 2012
89.1	AOB : Security Incidents affecting staff The CEO advised that a review of security matters was underway and the outcome will be brought back to the next meeting.	CEO Sep 11
108.1	Chairman's Report - Psychiatric Advice and Support in A&E : The CEO would report back to the Board in a couple of months.	CEO-Nov 2011
110.1	Finance Report <ul style="list-style-type: none"> ▪ Ward Managers suggested that they do not receive a non pay budget as it sits above them. FD agreed to investigate this to ensure the right people are holding the budgets. 	FD - asap
110.2	Performance Report Balanced Score Card : The CEO referred to the Board Development sessions scheduled for Sep & Oct as an opportunity to review the report in more detail. It was agreed to return to this in 2-3 months time.	CEO/DoS Nov 2011
111.1	Schedule of Items purchased by the LoFs The Chairman agreed to write to the Chairmen of the LoFs formally recording the Board's appreciation.	Chairman
111.2	Capital Expenditure Approvals Process – Item deferred to allow the opportunity to incorporate a revised Delegation of Authority.	FD
112.1	Future Configuration of Hospital Services The Board approved the OBC. A more detailed programme and resource plan for the next 6 months for all work streams within the FCHS Programme will be presented to the Board at the September meeting for approval.	DoS Sep 2012
115	Questions from the floor Guttering around the PRH building needs to be cleaned. The Chairman noticed this problem and he would be following it up personally.	Chairman