

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD MEETING
Held on Thursday 27 January 2011
Seminar Room 5, Shropshire Education & Conference Centre, Royal Shrewsbury Hospital

PUBLIC SESSION MINUTES

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

2011.1/01 WELCOME

The Chairman welcomed everyone to the meeting and introduced Tina Cookson and Vicky Morris as full members of the Board following their appointment as Chief Operating Officer and Director of Quality & Safety/Chief Nurse, respectively. He also advised that Neil Nisbet had been appointed Finance Director, with effect from 1 April 2011 and, that in the meantime, David Gilbert will continue as Interim Finance Director and a Member of the Board.

In addition, the Chairman noted that Julia Clarke had been formally appointed as Company Secretary. In this important new role, she will be a non voting member of the Board and will take the lead on the Trust's FT application.

2011.1/02 DECLARATION OF INTEREST by members in relation to any matters on the agenda - None.

2011.1/03 MINUTES OF THE PREVIOUS MEETINGS HELD IN PUBLIC

03.1 Minutes of the Extraordinary meeting held on 2 December 2010 to address the future configuration of hospital services were **APPROVED**.

03.2 Minutes of the Formal Board meeting held on 3 December 2010 were **APPROVED**.

.....
Chairman
24 February 2011

MATTERS ARISING FROM THE MEETINGS HELD ON 2 AND 3 DECEMBER 2010

Annual Report on Complaints - Waiting Times in Outpatients (35.3)

This item would be discussed later in private session. Item **complete**.

Budget and Capital Plan 2010/11 – Presentation on QIPP plans for 2011/12 (36.2.1)

The FD confirmed that a summary of QIPP performance to date had been circulated to members. Emerging QIPP proposals for 2011/12 to be discussed in private session. Item **complete**.

Clinical Governance Annual Report 2009/10 - Selected cases to be presented to the Board (49.3).

The Quality & Safety Committee is looking into this. Work in progress. **Action: Q&S Committee**.

Patient Falls (62.1) National definitions to be introduced. Item **complete**.

Service Line Reporting (63.4) A demonstration of system has been scheduled for next Finance & Performance Committee. Item **complete**.

Use of IPADS for Board papers (64.1) To be addressed during first quarter of the year. **Action CEO**

HSMR Update (76.1) The Board will receive a 3 monthly update of the Global Trigger Tool outcomes. **Action: MD/DQS; and Q&S Committee – Feb/Mar 2011.**

Clinical Governance Executive Report (76.3) Establishment of new Board Committees

Item will be covered under Committee Terms of Reference later in the meeting. Item **complete**.

ME Outcome Summary – Cytology Cervical Screening (78.1) **Action: CEO in Feb 2011.**

CEO's Report – Francis Inquiry (93.2) - Item on the agenda. Item **complete**.

CEO's Report – Whistleblowing Policy (93.3) The policy is out to consultation. **Action: DCRM – Mar 2011.**

CEO's Report – Urgent Care Network (93.7) Item on the agenda. Item **complete**.

IPR Quality Issues (94.2) All items covered later in the agenda. Item **complete**.

IPR Performance Issues (95.2) All items covered later in the agenda. Item **complete**.

Charitable Funds Annual Report & Accounts 2009/10 (95.3)

The FD confirmed that clarification on the expenditure of resources had been circulated to members. The investment policy will be reviewed as part of the Charitable Funds Committee regular activities. Item **complete**.

Dates of Board meetings in 2011 (95.6) Board dates from April to December 2011 will be confirmed in early February. **Action: Chairman.**

Committee Structure/Membership Update (96.1) Terms of References were on the agenda. It was noted that the Risk Management Executive Terms of Reference are still being formulated. **Action: CEO.**

Questions Session (99) The DQS had followed up Mr Jones' concerns relating to the apparent shortage of nursing staff on Wards 15/16 at PRH. The DQS would arrange a further meeting with Mr Jones to feedback the findings. **Action: DQS.**

2011.1/04 CHAIRMAN'S REPORT

04.01 The Chairman reported that last month had been an exceptionally busy time for the Trust, not only with the launch of the consultation process (Keeping it in the County) which had involved many meetings and discussions; but also with the recruitment of the new Executive Team and Centre Chiefs.

The Chair wished to thank all staff for their hard work and commitment in coping with the bad weather and exceptional level of activity over the past few months.

The Chairman reported that the two PCTs are substantially downsizing their operations and for operational purposes will effectively merge over the next two months. They will, however, still maintain separate identities with separate Boards. The Chairman has arranged regular meetings with the two PCT Chairs in order to maintain continuity at Board level.

The RSH League of Friends will be holding a Charity Race Day on Thursday 21 April 2011. They hope to raise £60k and are looking for sponsors. Members were encouraged to support this event.

2014.1/04 CHIEF EXECUTIVE'S REPORT

04.2.1 **Pressure on services and its consequences:** The Chief Executive acknowledged the pressure that the hospital has been under and the increasing trend in non elective urgent care provision to patients. He pointed out to the Board that whilst it is SaTH's responsibility to manage this additional work and ensure the safety of patients, the PCTs only pay 30% of the tariff. The CEO said that although it is absolutely right for the Trust to treat additional patients requiring urgent care, there is a significant increased cost for extra doctors and nurses. Also, scheduled operations are having to be cancelled so that SaTH loses that income as well. The CEO was optimistic that a constructive dialogue with the PCTs would ultimately lead to a resolution of this problem. The CEO also took the opportunity to convey a "big thank you" to all staff who had worked admirably during this busy period to ensure quality of care to patients.

04.2.2 **Investment in Services :** Over the last 6 months decisions had been made to make some urgent investment in a number of services which were struggling due to enormous pressures, these included :

- Oncology – agreement to appoint three additional Consultant Oncologists on the RSH site to strengthen this service and in addition to increase the number of radiographers to support the service.
- Obstetrics – agreement to appoint three Consultant Obstetricians, 15 Midwives and a number of middle grades in Obstetrics and Anaesthetics.

04.2.3 **Designated Bariatric Centre :** The CEO was pleased to announce that SaTH had recently been formally designated a Bariatric Centre. This work will be carried out by the Upper GI Consultants.

04.2.4 **Application for FT Status :** The Health and Social Care Bill currently before Parliament makes it clear that all Trusts who are currently not Foundation Trusts will need to achieve this before April 2014, so unless SaTH becomes a Foundation Trust by this date it will cease to exist as an independent organisation and will be merged in some form with a successful FT. Also, the Bill makes it clear that SaTH will need to be licensed for the provision of the services it provides. This licensing process is very formal and the CEO noted that it will be a criminal offence to offer services without the appropriate authorisation in place.

05.1 UPDATE ON FUTURE CONFIGURATION OF HOSPITAL SERVICES PROGRAMME

The CEO advised that the public consultation document “Keeping it in the County”, was issued by the two PCTs on 9 December 2010 and that the consultation will run until 14 March 2011.

It was confirmed that following their visit on 8th December, the National Clinical Advisory Team (NCAT) had provided verbal assurance on the proposal to be shared with the public as part of the formal public consultation. Their report concluded that “the single proposed option seems logical and we believe could deliver safer and more sustainable service across the county and beyond. The model for maternity care is an excellent example of this. An opportunity to achieve much needed capital investment for the people served seems to be available. The option appears to be widely supported by stakeholders in primary and secondary care. However, it is critical that the clinical leaders and senior managers continue to work together to:

- Define all the pathways
- Identify risks that currently exist and those that are potentially increased by this option
- Develop solutions with fellow clinicians, other stakeholders and patients and the public that meet and exceed current levels of quality and safety
- Ensure that transport and travel plans and systems are robust
- Develop a comprehensive governance system”

In addition, NCAT stated achievement of the four Secretary of State criteria for reconfiguration but note that it is imperative that in considering adaptations to pathways of care that further evidence is sought to ensure that the risks highlighted are considered and mitigations put in place”.

It was noted that there is an ongoing and active discussion taking place about some aspects of the proposals and the CEO wanted to make it absolutely clear that there is a real risk of losing services if this proposal fails to go ahead. He was particularly concerned about the future of vascular surgery which is in many ways the “life blood” of the service we provide and underpins the security of the performance of major surgery in the hospital. If it is not possible to bring all vascular services together it will not be possible to offer an Abdominal Aortic Aneurysm screening service to patients.

The CEO reported that the neonatal intensive care doctors are very worried about moving services to Telford and are fearful that the services they provide would be taken over by Wolverhampton. The CEO said he had received confirmation from the specialist Commissioners that the provision and allocation of neonatal intensive care services is not under any risk of being transferred as a consequence of the consultation proposals.

Head and Neck cancer services is another service that is currently potentially at risk but the CEO was very optimistic that this service will be secured in the county.

- The Director of Strategy (DoS) reported that a programme had been established to take forward the recommendations of the Office of Government Commerce (OGC) and NCAT as follows: Three Clinical Working Groups have been established led by Andrew Tapp (Maternity & Neonatology), Frank Hinde (Children’s Services) and Tony Fox (Surgery). These groups also include GPs and are progressing well.
- Finance and Estates Working Group (led by the FD) will cover operating costs, capital requirements, funding and transport issues. West Midlands Ambulance and the Welsh Ambulance Service have been involved.
- A Change Management Working Group had been set up to deal with the implications for staff who will need to move sites.
- An overarching Clinical Assurance Group led by the Medical Director will include a group of GPs.

UPDATE ON FUTURE CONFIGURATION OF HOSPITAL SERVICES PROGRAMME (Continued)

An update on the above activities will be reported to the Board, STEG and HME on a monthly basis.

The CEO confirmed that the assurances from NCAT on the proposal also recognised the risks of not making the changes. Dr Walford (NED) added that the NCAT report to the Secretary of State directly and comprise of nationally recognised experts – the tone of their report was very supportive.

Formal recommendations will be presented to the Trust and PCT Boards in March following the end of the consultation process.

The Board **NOTED** :

- the process and plan for public consultation;
- the content of the consultation documents;
- the progress to date of the consultation;
- the Phase1B Action Plan and key milestones.

05.2 PAEDIATRIC SAFEGUARDING QUARTER 3 REPORT

The Director of Quality & Safety (DQS) reported on issues and developments in relation to Safeguarding Children over the last quarter. She noted that new policies - "Children who Fail to Attend Appointments" and "Parents who Take Self Discharge" - have been approved by the Clinical Governance Executive.

It was also noted that staff training is ongoing with 61% of staff having received safeguarding training at Levels 1, 2 and 3. Every Board member will receive annual training, preferably through a staff group session.

The DQS confirmed that she is the nominated lead and the Executive portfolio holder for both Paediatric and Adult Safeguarding.

Following discussion, the Board **NOTED** the contents of the report and **AGREED** the following:

- Safeguarding Policy should be cross referenced with the Whistleblowing Policy. **Action: DQS/DCRM.**
- All Safeguarding issues will be reported through the Q&S Committee with variances reported to the Board. **Action DQS.**

05.3 NATIONAL INQUIRIES AND EXTERNAL REPORTS – BOARD AWARENESS OF KEY ISSUES FOR IMPROVEMENT

The Director of Quality & Safety (DQS) introduced the paper and said that the Board would recall receiving a paper in 2010 which outlined the key recommendations arising from the Francis Report. At the time, it was agreed that these recommendations would be tracked through the Audit Committee.

The DQS noted that, in addition to the Francis Report, there have been a number of other national Inquiries and Reports into quality and safety issues that the Board need to note. The Board also need to be able to demonstrate that the issues in these reports have been considered and actions put in place to ensure that patient safety, clinical effectiveness and patient experience are not affected through similar issues. Following a review of Board papers over the last few years, it appears that, apart from the Francis Report, none of these other Inquiries and Reports have been formally received for consideration by the Board. She proposed therefore to use a framework developed by the Strategic Health Authority; together with the electronic tracking tool, for the Quality & Safety Committee (QSC) to track the recommendations and implementation from the various Reports and Inquiries and review any trends/themes emerging from the review.

05.3

NATIONAL INQUIRIES AND EXTERNAL REPORTS – BOARD AWARENESS OF KEY ISSUES FOR IMPROVEMENT (Continued)

A list will be compiled and a detailed action plan prepared for consideration by the QSC in February.
Action: DQS.

Dr Vernon (NED) referred to the discussion at the last Q&S Committee meeting which noted there were 300+ recommendations. He said the key is to make sure we audit, produce an action plan and learn from the exercise. It is the intention to bring them all together and have a comprehensive overview.

Mr Beardwell (NED) felt that it was not possible to track all 300+ recommendations. However, Dr Vernon pointed out that there was a lot of repetition within the number of recommendations and a large number had already been addressed. He said that the Board had to follow national guidance, it was not in its power to pick and choose, but there is a key need to establish a priority list.

The Chair said he looked forward to receiving a progress report at the next Board meeting. **Action: DQS.**

The Board **APPROVED** that the proposal that Quality & Safety Committee review and track the recommendations from the Francis Report and other national Inquiries and Reports

05.04

URGENT CARE NETWORK BOARD

The Chief Operating Officer (COO) reported on the continued over performance in emergency admissions and A&E attendances and the planning being undertaken through the Urgent Care Network to ensure the maintenance of quality patient care across the health and social care economy.

It had been agreed by the Urgent Care Network (Chaired by the CEO) to create a new body to be known as the Urgent Care Network Board which recognised the need for stronger Primary Care leadership. This new Board will be responsible for developing an Urgent Care Strategy which is clinically led and agreed by all partner organisations.

The COO reported that in terms of the 2010/11 contract the actual number of Urgent and Emergency attendances had been expected to reduce over the winter period as PCT schemes to reduce attendances were implemented but this did not happen. She further highlighted the correlation between discharge numbers and A&E breaches and the significant increase in delayed discharges over the last month.

Following discussion, the Board recognised SaTH's obligation to critically examine its own processes and improve internal patient flows and pathways. The following actions were noted :

- Appointment of Unscheduled Care Value Stream Lead
- Review of urgent care patient pathways within SATH using a multi disciplinary team approach with a tightly managed programme of work at each site.
- Review of Clinical Site management team to ensure sufficient autonomy, decision making and accountability of this service
- Refocus the Discharge Transformation Team on effective planning and the Delayed Discharges.
- Move to Clinical Centres and service line reporting to improve the focus on pathways and quality outcomes
- Engagement with other NHS and Social Care stakeholders, Commissioners and patients to use our collective activity information to review the effectiveness of the current pathways, services and system of care.

Mr Beardwell (NED) referred to the graph entitled "Actual A&E attendances against contracted A&E attendances" and queried the large spikes in activity on 5 December and 5 January without any corresponding ambulance activity. He also questioned the activity of the Walk-In Centre at PRH. The COO said that the spikes were most likely due to self referrals as a result of the winter weather but the overriding problem is that the plan appears not to be recognising the overall level of demand.

URGENT CARE NETWORK BOARD (Continued)

Dr Walford (NED) added that A&E activity doesn't always recognise ambulance activity; and the first peak probably related to slips and falls due to the adverse weather. In relation to contract planning he suggested that SaTH should be looking not at the number of admissions but how long people stay in hospital. In his opinion he considered there were too many groups of people involved in the process. He also pointed out that when reviewing the number of admissions and discharges there were far fewer on the weekends. He considered the report to be a good start and that it describes how hard people are working.

The CEO said the reason we are not discharging as fast as we should at weekends is a serious point but there are various issues to consider.

Mr Simms (NED) said it was an interesting piece of work – patient care should always remain our priority but we need to be aware of the cost implications.

The Board **NOTED** the contents of the report and requested clarity on the full cost implications of the increased demand from A&E and emergency admissions and also the effectiveness of walk-in centres.
Action: COO.

05.05

INTEGRATED PERFORMANCE REPORT – QUALITY

The DQS presented the Quality Report for the period ending 31 December 2010 and advised that a new and improved format was being developed and would be taken through the Q&S Committee prior to submission to the Board. The report confirmed that Stroke national and local targets, MRSA, C difficile, Cancer 14 and 31 day and Rapid Access Chest Pain targets were all achieved. However, the targets for Thrombolysis, A&E, 18 weeks and Cancer 62 days were not delivered in the month. The following observations were noted:

- Patient falls –there is a need for further work to identify patients who are frequent fallers and the policy needs to be more robust.
- HSMR rates - the Q&S Committee are overseeing the work being undertaken around mortality rates. Detailed work sent to the CQC on an outlier alert on Cardiac Dysrhythmias has been accepted and the alert has been closed.
- Tissue viability – an internal review was undertaken and it was confirmed that patients are being assessed. A care plan to ensure prevention/reduction is being developed with senior nurses and ward managers.
- Thrombolysis cardiac - Dr Walford (NED) said he was still worried about the continued low number of patients (3 year to date) arriving at hospital.
- Cancelled Operations – 1-2 operations were cancelled every day but it was pleasing to note that no one waited more than 28 days to be treated.
- Venous Thromboembolism (VTE) risk assessments on admission – The DQS said the graph was blank due to difficulties experienced in the use of the Vitalpac system. This is a NICE requirement and the information should have been collected from April 2010. In the absence of an effective electronic solution a manual risk assessment system has been in use since December. It was noted that the Trust's CQUINN payment may be at risk.

The Board **NOTED** performance against a range of Key Performance Indicators covering Quality, Delivery and Foundations.

06.1 FINANCE REPORT – MONTH 9

The FD advised that the Month 9 financial report had been reviewed in detail at the Finance & Performance Committee meeting on 25 January 2011. Significant actions to improve the situation were as follows:

- Approval to appoint to replacement posts has been devolved to Divisions in order to speed up recruitment and lessen reliance on premium agency costs to cover vacancies.
- Executive review of recruitment to all new posts will be undertaken on a weekly basis.
- Divisions to implement plans to reasonably reduce costs and increase CIP gains from January 2011.
- Engagement in discussions with Shropshire County PCT in respect of forecast outturn position.

It was noted that the impact of the 30% tariff on non elective admissions equated to £600k in the month of December and is expected to be some £3 million for the full year.

Mr Simms (NED) said he had difficulty in respect of the recommendation that the Board should note and approve the finance report as in the regular report the Trust is showing a “green” rag rating because of the surplus but we missed the target of £400k so it should show a “red” rag rating. The Chair agreed and said there is a need to look critically at the budget plans for next year which have to be robust and deliverable. The F&P Committee needs to undertake an early review of the budget plans which have to have an emphasis on improvement projects. The FD said that we are in the process of agreeing a System-wide QIPP Plan with the PCTs based on a certain level of activity and insisted that the Trust should be fully reimbursed if it delivers the plan. If there is uncertainty about the activity level then there should be risk sharing with the Commissioners.

The Board **NOTED**:

- The December trading deficit;
- The surplus reported to NHS West Midlands after application of non-recurrent Strategic Change Reserve funding;
- Ongoing review of forecast position and discussions with Shropshire County PCT in respect of forecast outturn;
- Actions being taken to control expenditure in the latter part of the year and manage the cash position.

06.2 INTEGRATED PERFORMANCE REPORT – PERFORMANCE

The COO advised that a revised report for the period ending 31 December 2010 would be **TABLED** for review and comment following the meeting. The key facts included :

- A decrease in daycase rate;
- An increase in elective length of stay at RSH but a decrease at PRH;
- A decrease in non elective length of stay at both sites;
- The number of staff employed was 4,242 wte;
- Validated sickness absence rate for September was 4.7%.

The COO advised that this report was discussed in detail at the Finance & Performance Committee meeting on 25 January 2011 when it was agreed that a fresh reporting approach will be in use from 1 April 2011 to include, benchmarks and specific action plans.

The Board **NOTED** performance against a range of Key Performance Indicators covering Quality, Delivery and Foundations.

06.3

MEMBERS' DECLARATIONS OF INTEREST

The Director of Compliance & Risk Management (DCRM) advised that the Code of Accountability requires all Board members to declare interests which are relevant and material to the NHS Board of which they are a member. The DCRM confirmed that the following declarations include those received from new Executive Directors as follows :

Dr John Davies	<ul style="list-style-type: none"> ▪ Trustee of Market Drayton Action for Health ▪ Chairman of Moreton Say Parish Council
Mr Martin Beardwell	<ul style="list-style-type: none"> ▪ Director, Impact Alcohol Advisory Services
Dr Peter Vernon	<ul style="list-style-type: none"> ▪ Managing Director of Alberi Limited ▪ Director of H10 Limited ▪ Related to the Directorate Manager of Facilities
Mr Dennis Jones	<ul style="list-style-type: none"> ▪ None
Mr Barry Simms	<ul style="list-style-type: none"> ▪ None
Mrs Sue Assar	<ul style="list-style-type: none"> ▪ Director of Assar Consulting Limited which seeks to do business with the NHS.
Dr Simon Walford	<ul style="list-style-type: none"> ▪ Chairman of Governing Body, Wolverhampton Grammar School ▪ Governor, University of Wolverhampton ▪ Director, Wolverhampton Academies Trust ▪ In receipt of an NHS Pension
Mr Adam Cairns	<ul style="list-style-type: none"> ▪ Occasional paid consultancy work for Guidepoint Global Advisers
Mrs Julia Clarke	<ul style="list-style-type: none"> ▪ Chairman of Shropshire Council's Standards Committee (wef 1 April 2009) ▪ Deputy Chairman of the National Security Management Professional Accreditation Board
Dr Stephen Evans	<ul style="list-style-type: none"> ▪ Member of the Medical Managers' Committee of the British Medical Association
Mrs Debbie Vogler	<ul style="list-style-type: none"> ▪ None
Mrs Tina Cookson	<ul style="list-style-type: none"> ▪ None
Mrs Vicky Morris	<ul style="list-style-type: none"> ▪ None
Mr David Gilbert	<ul style="list-style-type: none"> ▪ Partner in Bonduca Ventures LLP which sell consultancy and financial management services to NHS and other organisations.
Dr Ashley Fraser	<ul style="list-style-type: none"> ▪ Chairman of Shropshire Education and Conference Centre Company Limited; ▪ Hon. Colonel 202 (Midlands) field Hospital; ▪ Medical Director of NHS Employers.

The Board **CONFIRMED** that the declarations listed above were correct and agreed to advise the Committee Secretary or DCRM immediately or within **six** weeks of any future changes.

06.4

COMMITTEES – TERMS OF REFERENCE

Following discussion of the Terms of Reference: for Board Committees as proposed, the following amendments were agreed:

- Quality & Safety Committee – COO and Head of Communications will become members. Dr Vernon (NED) also proposed to invite a member of the public to join the Committee
- Finance & Performance Committee – Head of HR will become a member.

It was noted that any NED who is not a designated member of a Board Committee will routinely receive the agenda/ and papers and may attend at the invitation of the Chairman. An attendance record will be maintained for all Committees.

The Board **APPROVED** all the Committee Terms of Reference subject to the above amendments.

07.1 FOUNDATION TRUST MEMBERSHIP AND ENGAGEMENT

It was noted that :

- the Chairman had written to the Department of Health confirming the Board's intention to achieve Foundation Trust status by December 2013.
- The SHA is assessing the Trust's proposed FT trajectory and has requested a declaration relating to the Trust's Quality and Safety, a self assessment of the Board's capability and submission of the latest draft LTFP. These have to be submitted to the SHA by 31 January 2011.
- A contract is scheduled to be signed off by the Trust, SHA and DoH by 31 March 2013.

There are 18 aspirant Trusts within the West Midlands region and SaTH is listed in Category 2 which indicates that there are outstanding quality and performance issues to be resolved and which will require external support.

The DCRM reported that FT Membership continues to grow and that future membership recruitment and engagement activities are planned, including a programme of Health Lectures ([DCRM to circulate details](#)).

A copy of the submission to the SHA will be circulated to Board members.

The Board **NOTED** :

- The next steps to achieving NHS FT status as set out in the paper;
- The new policy and guidance for existing and applicant NHS FTs and deadline for responses to the SHA;
- FT membership recruitment;
- Current engagement activities and future engagement plans.

08.1 HR POLICIES

The DCRM introduced the following HR policies for consideration :

- HR32 Ill health retirement
- HR37 Employment Break Scheme
- HR47 Managing Staff exposed to Blood Borne viruses in the Workplace
- HR53 Dress Code and Appearance

All policies had been agreed at TNCC and Management Executive.

It was noted that all policies presented to the Board are published in full on the website.

The Board **APPROVED** the policies listed above.

2011.1/09 OUTCOME SUMMARIES FROM COMMITTEES – RECEIVED FOR INFORMATION

- Management Executive – 21 Dec 2010
- Finance & Performance Committee – 2 & 30 Nov 2010 & 6 Jan 2011
- Clinical Quality & Safety Committee – 29 Nov & Dec 2010

The Chairman took the opportunity to thank all these Committees for their work..

2011.1/10 ANY OTHER BUSINESS – None.

2011.1/11 QUESTIONS FROM THE FLOOR

Q1 Mr Ron Jones: Referring to Enclosure 2 Impact Assessment (Item 6.1) – asked what cost savings would be needed to fund the loan required to implement the proposals?

A1 FD: We are working on a planning assumption that the capital work will require between £25-30 million over 25 years; therefore £1 million per year plus interest of £1.6-1.7 million will be needed to service the loan. The savings required by the Trust to fund the loan are significant and will be achieved by bringing services together and eliminating duplication, including reduction in numbers of agency/temporary staff. The Chair added that, whilst the reconfiguration would not in itself produce major cost savings, he expected it to create an opportunity for significant efficiencies across the board to be introduced.

Q2 Mr Ron Jones: How many staff will have to move from RSH to PRH and vice versa?

A2 CEO: There are no immediate workforce implications but staffing issues are being addressed by the working groups. He said that if Mr Jones wanted further information concerning this issue or any further issues they could be added to the list of questions he had already sent into the Trust. A reply is being prepared to answer Mr Jones' questions.

Q3 Mrs Davies: What proposals have already been agreed for the removal of cancer treatment from Shrewsbury to Telford because the Lingen Davies Cancer Unit at Shrewsbury was set up specifically for patients and relatives to be close to the patients? Many people have been in contact with me and asking about the future of cancer services at Shrewsbury because donations to fund the cancer unit have been collected chiefly from the people of Shropshire and Mid-Wales. Also the Rainbow Unit was specifically created for cancer children and if it is moved what facilities will there be for them and their parents?

A3 CEO: The Rainbow Unit is not closing but moving and under the proposals it is intended to recreate the Rainbow Unit in Telford with an improved standard of accommodation for children and their families.

The Trust is currently recruiting to fill 3 Oncologist posts and there is potential to enhance the adolescent service. At the end of the consultation period Shrewsbury would be the site for the most significant and complex surgery i.e. abdominal, upper GI and vascular and all of these services complement the delivery of cancer services for patients. The only exception will be specialist Head and Neck services that needs to be located where the Children's Unit is sited, so this would move to Telford. In terms of overall Cancer Services they are definitely staying in Shrewsbury.

Q4 Mrs Davies: What is the future of the Head & Neck Services given that many people in rural areas of Shropshire and Mid-Wales have donated so much money.

A4 CEO: He noted that Telford is in Shropshire and PRH also serves Market Drayton, Bridgnorth and Whitchurch. The battle we are facing is to retain Head & Neck surgery services in Shropshire. If Paediatrics centralise in Telford, the Head & Neck service would have to be in Telford because they need to be located near to a child friendly environment. What we are proposing is to establish a first class children's environment of the right standard and right team.

A4 DCRM : Mrs Davies should be reassured that every set of plans for the proposed new Cancer Centre in Shrewsbury had involved Andrew Prichard, Consultant Head & Neck Surgeon. Project meetings have been held regularly and another is planned in March. An invitation was extended to Mrs Davies to attend. The Lingen Davies Chair sits on the Project Board and is sighted on all the proposals. The new Cancer Centre is a £5 million development and the planning application should be submitted on 31 January 2011.

2011.1/12 **DATE OF NEXT MEETING : 24 FEBRUARY 2011 at 9.30 am in Room D, Education Centre, PRH.**

The meeting then closed.

UNRESOLVED ITEMS FROM TRUST BOARD MEETING HELD IN PUBLIC ON 27 JANUARY 2011

Item	Issue	ACTION LIST
(2010)		
49.3	Jan 11 – Clinical Governance Annual Report 2009/10 Selected cases to be presented to the Board in a private session in Q1 2011. Work in progress.	Q&S Committee
64.1	Jan 11 - Use of iPads for Board papers. To be addressed during first quarter of the year.	CEO
76.1	Jan 11 – HSMR Update - Clarify specific changes to HSMR reporting The Board will receive a 3-month summary of the Global Trigger Tool outcomes. Q&S Committee to also follow up on this.	MD/DQS & Q&S Committee – Feb/Mar 11
78.1	Jan 11 – ME Outcome Summary – 19 October 2010: Cytology Cervical Screening A paper would be brought back to the Board to confirm arrangements.	CEO – Feb 2011
93.3	Jan 11 – CEO’s Report - Whistleblowing Policy – Policy is out to consultation.	DCRM - Mar 2011
95.6	Dec 2010 – Dates of Board meetings in 2011 Board dates from Apr-Dec 2011 will be confirmed early February.	Chair – Feb 2011
96.1	Jan 11 – Committee Structure/Membership Update Risk Management Executive Committee Terms of Reference are still being formulated	CEO
99.	Jan 11 – Questions Session - DQS to feedback findings to Mr Jones relating to his concerns.	DQS
(2011)		
05.2	Jan 11 – Paediatric Safeguarding Q3 Report <ul style="list-style-type: none"> ▪ Safeguarding Policy should be cross referenced with the Whistleblowing Policy. ▪ All Safeguarding issues will be reported through the Q&S Committee with variances reported to the Board. 	DQS/DCRM DQS
05.3	Jan 11 – National Inquiries and External Reports <ul style="list-style-type: none"> ▪ A prioritised list of recommendations and actions will be compiled for consideration by the Q&S Committee in Feb. ▪ Report to Board 	DQS – Feb 2011 DQS – Feb 2011
05.4	Jan 11 – Urgent Care Network Board The Board requested clarity on the full cost implications of the increased demand from A&E and emergency admissions and also the effectiveness of walk-in centres.	COO
07.1	Jan 11 – FT Membership and Engagement Details of the Health Lectures will be circulated to Board members. A copy of the submission to the SHA will be circulated to Board members.	DCRM DCRM